STTARS

(SURVIVORS OF TORTURE AND TRAUMA ASSISTANCE AND REHABILITATION SERVICE).

SUBMISSION TO THE SENATE INQUIRY

INTO

THE ADMINISTRATION AND OPERATION OF THE MIGRATION ACT 1958

INTRODUCTION

STTARS welcomes the opportunity to make this submission to the Senate Inquiry into the administration and operation of the Migration Act 1958

We have examined the Committee's Terms of Reference and this submission selectively addresses items directly relating to the work of STTARS with survivors of torture and trauma who have been held in detention centres in Australia. Recommendations are made in relation to these items.

SERVICE PROFILE

STTARS is a not for profit community managed organisation with no religious or political affiliations. It has been funded by both State and Commonwealth governments since 1991 to provide services to survivors of torture and other trauma related to the refugee experience through health assessment and referral, information provision, counselling and advocacy, training of other service providers, research and service innovation. STTARS is an active member of the Forum of Australian Services for Survivors of Torture and Trauma and an accredited member of the International Rehabilitation Council for Torture Victims.

CLIENT PROFILE

For the past 3 years STTARS has undertaken routine assessment of all refugees who arrived in South Australia including 264 people released from detention centres on Bridging or Temporary Protection Visas. Of the people released from detention centres, 162 have been assessed by STTARS as suffering psychological problems which <u>severely</u> interfere with their every day functioning. Ability to carry out daily tasks and attend to basic needs is seriously impaired. Learning ability is disrupted by poor concentration, memory impairment and sleep disturbance. Many experience debilitating psychosomatic complaints such as headaches and gastrointestinal disturbances. Other effects are less apparent but their impact on someones health and well being is no less destructive, - the loss of a sense of meaning and purpose to life, the loss of a sense of self worth and the damage to the ability to trust are enduring reactions, affecting the capacity to form new relationships and adjust to life in a new country. The most commonly reported diagnosable disorders are:

- post traumatic stress disorder (PTSD)
- major depressive disorders
- anxiety disorders.

High rates of suicidal ideation and actual self harm are common amongst this group.

RESPONSE TO COMMITTEE TERMS OF REFERENCE

This submission responds specifically to items a) and c) from the Committee's Terms of Reference.

A) THE ADMINISTRATION AND OPERATION OF THE *MIGRATION ACT 1958*, ITS REGULATIONS AND GUIDELINES BY THE MINISTER FOR IMMIGRATION AND MULTICULTURAL AND INDIGENOUS AFFAIRS AND THE DEPARTMENT OF IMMIGRATION AND MULTICULTURAL AND INDIGENOUS AFFAIRS, WITH PARTICULAR REFERENCE TO THE PROCESSING AND ASSESSMENT OF VISA APPLICATIONS, MIGRATION DETENTION AND THE DEPORTATION OF PEOPLE FROM AUSTRALIA;

For the asylum seeker who is already traumatized, disorientated and unable to speak English the assessment process for visa applications is very confusing. There are long delays during which the applicant is given no information and no feedback is sought. This leads to frustration, anger and finally resignation and depression. The first interview with a DIMIA case officer is often difficult for a number of reasons. The importance of this initial interview is often poorly understood by the applicant. The applicant is extremely anxious and fearful and may omit details or feel pressured to give responses to questions they are unable to recall the answers to eg. specific dates, places and names of individuals. Later these omissions or inaccuracies are interpreted as deliberate attempts to conceal or distort accounts. Interpreters contracted by DIMIA may be competent in the required language but belong to an ethnic group which is not sympathetic or even hostile towards their claims. (eg. a Pashtun interpreting for a Hazara applicant).

With respect to the content of applications case officers sometimes fail to recognise that the after effects of trauma commonly include discontinuity of experience, a sense of detachment and loss of control. This may mean that during structured assessment interviews a traumatized individual may suffer significant short and long term memory loss or impairment. The phenomenology of Post Traumatic Stress Disorder often involves memories which are vivid and emotionally laden but fragmented and disorganized. This often results in retrieval deficits and a failure to integrate experiences. PTSD is considered a memory disorder by many clinicians and researchers. Cue utilization theory suggests that traumatic experiences may narrow the focus of attention and exclude peripheral information. Exposure to war trauma may disrupt concentration, memory and some cognitive functioning. This will adversely affect an applicants ability to recall the strict chronology of events or the detail of events which are embedded in experiences of high emotional valence. In some interviews where the officer is predisposed to doubt the veracity of claims, the questioning style may begin to resemble an interrogation. This may trigger intrusive thoughts and feelings from the past and precipitate mild dissociative episodes or other defensive strategies where the applicant may appear disinterested or remain silent. This may be interpreted as the applicant being uncooperative or evasive. Over a period of time and with fairly intensive counselling and therapeutic interventions, the applicant may begin to integrate some past experiences and recall further details. When this additional information is submitted it may be viewed with suspicion or even considered a fabrication to strengthen his or her claim.

RECOMMENDATIONS:

- That DIMIA case officers providing initial assessments receive training to understand and recognise symptoms of post traumatic stress and work sensitively with asylum seekers.

c) THE ADEQUACY OF HEALTHCARE, INCLUDING MENTAL HEALTHCARE, AND OTHER SERVICES AND

ASSISTANCE PROVIDED TO PEOPLE IN IMMIGRATION DETENTION;

The mental health of people living in detention centres or released into the community on Bridging or Temporary Protection Visas is affected by several unique and significant factors including:

- the experience of lengthy periods of detention with no certainty of release and fear of being forcibly returned to their countries of origin.

- separation from family for an indefinite period with the attendant anxiety and guilt about the fate of family members left behind and the shame that they are failing to protect or provide for their families.

- ncertainty about their future in Australia and stress associated with the refugee determination process, which for some applicants lasts a number of years.
- egative community attitudes toward unauthorised entrants and the stigma of having been detained and viewed as a criminal.

Individuals held in immigration detention indefinitely and facing the possibility of forced deportation are at considerable risk of developing significant mental health issues, of engaging in self harm or developing a psychiatric disorder which requires hospitalization. Their situation in many ways may resemble their former persecution and imprisonment: dependent on others for survival, fearful of seeking psychological help because they believe it may jeopardize their chances of securing a permanent visa, constantly confronted by their own helplessness, having limited rights, confronting bureaucratic indifference and hostility, living in conditions which are incomprehensible to them, enduring long periods of waiting and disappointment, being subjected to unreasonable pressure to obtain papers (eg. travel documents, passports) which are impossible to procure, and living in a prison-like environment out of public view. In particular the geographic and social isolation and the indefinite nature of detention under the constant threat of forced deportation is highly corrosive of mental health. Detainees are also frequently confronted with the behaviours of other traumatized individuals and often experience a deterioration of their physical health due to chronic insomnia and diminished appetite. They lack opportunities to ventilate their feelings and assimilate the meanings of their experiences because the environment is not one of emotional safety and support. This extremely stressful environment is experienced as a re-traumatization and serves to aggravate existing mental disorders arising from pre-existing trauma. The fear and anxiety combine to negate and overwhelm normal coping capacities creating a spiral into mental disorder.

All of the above has a particular effect on families with children held in detention. Children have usually experienced multiple traumatic events including the loss of close family members. In addition to exposure to the the highly stressful detention environment, changes in family relationships resulting from dislocation, family discord, parents who have serious health problems, and lack of peer support further adversely affect children. Women may also have particular mental health and social support needs deriving from previous experiences of physical and sexual assault and rape but may feel reluctant to voice their needs, especially in cultures where men are traditionally the spokespeople. An enormous burden of responsibility and guilt is placed on children and their parents where families are required to separate in order for the children to be released from detention. It is highly distressing for both the children and their parents to be separated from each other and this in turn has a destructive effect on family relationships.

Detention facilities have a custodial rather than a therapeutic focus which often results in security being emphasized at the cost of care. Detention centre staff have little experience of, or training in, recognizing or working with mental disorders and can be unsympathetic and unskilled in their management strategies. When disorders manifest the custodial response is to manage the behavior by placing the individual in isolation under surveillance which in turn often exacerbates the

problem. Individuals who are suffering from a mental disorder and held in detention centres are not able to secure the benefit of early interventions because their presenting behaviours tend to be viewed as adjustment disorders arising from their detention rather than trauma related. The longer symptoms persist without appropriate intervention, the less potential there is for remission. Requests to provide an independent psychiatric examination are frequently met with the assertion that internal services are adequate and there is no need for independent assessment or intervention. Visiting professionals are treated with suspicion instead of as a valuable resource integral to the overall care and support of detainees. In addition to the importance of using professionals who are experienced in working with survivors of torture and trauma, independent psychological assessment of those in detention is critical to avoid the potential of confusion between the custodial and therapeutic roles. Furthermore, policies and procedures that are security focused mitigate against the development of the trusting relationship in a safe environment that is essential to the therapeutic relationship. While acknowledging the difficulties of creating a therapeutic environment within a custodial setting it is nonetheless important to minimise harm. The therapeutic environment must be appropriate, for example it should have minimal surveillance to allow privacy.

RECOMMENDATIONS:

- The the period spent in detention be kept to an absolute minimum – no more than 3 months.
- That community based mechanisms of surveillance are used in preference to detention.
- That independent psychological assessment of those in detention be provided.
- That normal custodial procedures be adapted for refugee survivors to avoid inadvertently replicating likely past experiences of torture/trauma.
- That counselling services be independent of the custodial organisation.
- That counselling should be readily available while in detention.
- That access to external professional and social supports be encouraged and that release from detention involve a properly managed handover into community services.
- That once someone has been accepted as a refugee with legitimate claims to asylum in Australia they be granted a permanent visa and not have to re-apply for a temporary visa.