A submission to the Senate Legal and Constitutional Committee's "Inquiry into the administration and operation of the Migration Act 1958"

Submitted by Guy Coffey of Northcote, Victoria

The following submission pertains to two matters falling within the ambit of the inquiry:

1) **mental health services for persons held in immigration detention.**

2) **the refugee determination process in relation to the role of credibility assessments made by the Refugee Review Tribunal.**

I make this submission in a private capacity, but it is based on my experience working with a number of organizations. From 1998 to the end of 2003, I regularly performed psychological assessments of detainees at the Maribyrnong Immigration Detention Centre (MIDC) in Melbourne. I did this in my capacity as a clinical psychologist employed at the public mental health service from which MIDC requested mental health services from time to time (this service was the Saltwater Clinic, Werribee Mercy Mental Health Program). At the end of 2003, Global Solutions Ltd, assumed management responsibilities at the centre, replacing Australasian Correctional Management, and they contracted private psychological services. Consequently the public mental health facility was called on much less frequently, although the inpatient service has admitted acutely unwell detainees occasionally (several admissions per year). From the beginning of 2004 to the present, I have continued to assess detained people at MIDC but in a private pro bono capacity on the request of legal representatives of detainees.

My relevant vocational experience is as follows. I have worked in public mental health services for 18 years as a clinical psychologist. I am currently the direct services program coordinator of the Victorian Foundation for Survivors of Torture. I am a sessional clinical psychologist at the Post Traumatic Stress Disorder program, Veterans Psychiatry, the Austin and Repatriation Medical Centre, Heidelberg, Victoria.

I will set out my submission briefly and in point form. I would be happy to expand on any of the matters identified if that would assist the inquiry.

1) mental health services for persons held in immigration detention.

The relationship between public mental health services and the MIDC

- there has not been any formal agreement between State MH services and the Commonwealth in regard the services that local MH services are to make available (the IDC services contract simply states that the IDC service provider should avail themselves of external specialist health services where appropriate). I understand that this is the case nationally. This is despite the fact that from the end of the 1980s significant numbers of persons have been detained. It is noted in the Palmer report that a MOU between the SA Mental Health Service and Baxter was finally signed in April, 2005, after the inquiry had begun, and after Cornelia Rau had been admitted to Glenside hospital.
- There has been no resources provided to the public mental health facility to provide for additional work associated with assessment and treatment of detainees. I understand that no or minimal resources have been provided nationally to public MH facilities engaged in providing a service to IDCs.
- The relationship between MIDC and the MH service has been ad hoc, with no policy framework or guidelines other than those worked out between the two organizations. The consequences have been the following:

- There has been ambiguity with regard to the distribution of duty of care responsibilities.
    - Following an assessment by the MH service, the assessing professional does not have any further right of access to the detainee – patient.
    - The MH service cannot ensure its clinical opinions are followed.
    - Its therefore often unclear whether the MH service is merely offering an opinion or has some level of ongoing responsibility.
- There has been ambiguity in the nature of the relationship between the MH service, the detained person, and the IDC.
    - It has been asserted by DIMIA that they and the IDC managers are the clients of the MH service. The MH service would normally regard the person they assess as their client/patient, and that their first duty lies with the patient. This tension became apparent in a number of ways: for example when reports were written and given to detainees' legal representatives.
- Tensions arise between the therapeutic priorities of the MH service and the security concerns of the IDC.
    - It was routine practice under ACM for detainees to arrive at the clinic escorted by two or three detention officers and wearing handcuffs.
    - Admissions required that officers be present on the ward, and sometimes that detainees be kept in secure wards (these practices appear to be now modified or abandoned).

- The policy and legislation governing MH services and the IDC (ie the mental health acts and related state policies, and the Migration Act and regulations and related policies) have an uneasy and often antithetical relationship.
    - State mental health acts require treatment to be delivered in the least restrictive way possible consist with the patient's needs. Security requirements to which the detainee is subject have caused the basic principles of the MH Acts to be qualified, or contradicted.

<u>The adequacy of mental health services at the centres</u>

- Public MH facilities possess multidisciplinary teams with a range of skills. These skills are not replicated in the health staff within IDCs. In the context of MH services having unreliable access to the IDCs, mental health services at the centres are inadequate.
- In contrast to staff at public MH facilities, IDCs staff are isolated professionally, and do not have the benefit of clear policy framework. They do not have the benefit of peer review, or the immediate availability of psychiatric opinion. Their level of training and experience is often such that if working in a public facility, they would be receiving close supervision and would not be required to make complex independent decisions.
- Public MH facilities have evolved over the past one hundred years to be relatively open and accountable organizations governed by patients rights based legislation and policy (they are however often grossly under-resourced). The mechanisms of accountability and oversight do not exist for the IDC health services.
- Again in contrast, the MH services within the IDCs have been created outside the accumulated knowledge of public psychiatry, apparently without reference to what has been learnt about service delivery, and disconnected from the range of expertise in the treatment of specific psychological and psychiatric conditions that exists in the public sector (eg in the treatment of psychological trauma, mood disorders, early psychotic conditions etc).
- A major obstacle to the efficacy of MH professionals contracted by the IDC managers is the detainees' frequently held perception that these staff act in the interests of management. Some believe that their health assessments are not treated confidentially.

<u>The implementation of recommended treatment</u>

- There is documented evidence that recommendations by external MH professionals and services are sometimes not implemented (see for eg. HREOC A Last Resort. National Inquiry into Children in Immigration Detention (2004); Mares, S. and Jureidini,, J. (2004) Psychiatric assessment of children and families in immigration detention – clinical, administrative and ethical issues. 28(6) *Australian and New Zealand Journal of Public Health.* 520; Human Rights Committee: CCPR/C/81/D/1011/2001; 19 August 2004; Submitted by Francesco Madafferi et al.)
- My experience has been that there are a number of reasons why recommendations may not be implemented:
    - The facility may not have the expertise to implement the recommendation or the detention environment may make certain treatments unimplementable.
    - Psychological and psychosocial treatments are difficult to implement in detention because, even if the expertise is available (and often it is not), the environment is often an insuperable barrier to the provision of such treatment.
    - Recommendations with regard to pharmacological treatments are more readily implemented.
    - Recommendations least often followed in my experience related to opinions that the detained person can not be treated in the detention environment, and that therefore considerations should be given to releasing the individual on a bridging visa (under s 2.20(9) of the migration regulations). The grounds whereby this refusal to act on such an opinion are opaque. The practical operation of this provision requires urgent examination. Seriously mentally ill individuals have in my experience been left to deteriorate over months and years in disregard of expert opinion regarding the damaging effect that ongoing detention is having.

<u>The Deportation of Mentally Ill Persons</u>

- 'Failed' asylum seekers and other detained persons who have not been successful in their visa applications are removed if 'fit to travel'. There is no requirement within the Migration regulations to consider detainees' mental health prior to removal, in regard to their capacity to subsist and survivor upon their repatriation. This has led in practice to the deportation of seriously mentally unwell persons, including detainees who myself and others have assessed as posing a significant risk to themselves due to suicidality or an incapacity to perform basic daily tasks.

<u>The Ethics of working in immigration detention</u>

- Health professionals working within detention are required to participate in coercive or security related practices that are clearly inimical to detainees' psychological well-being or have their objective non-therapeutic goals. For example, they monitor persons isolated in observation rooms. They are asked to attempt to modify disruptive behaviour. They are tacitly required to accept an environment that often prevents any effective psychological treatment being provided. Health professionals working in detention centres have been confronted by serious ethical challenges to their professional integrity. Some organizations have argued that the detention environment, as it has been, inevitably compromises the professional's adherence to ethical practice. For example, on 25.4.2005 the Mental Health Council of Australia stated: "The council maintains that mental health professionals employed by DIMIA contractors or in state services to provide care to detainees are compromised in their professional duty of care to their patients – by working in a system which ignores their professional advice and which is inherently bad for mental health"

2) **the refugee determination process in relation to the role of credibility assessments made by the Refugee Review Tribunal.**

There has been a long standing concern among both lawyers and mental health professionals involved in protection visa applications, that DIMIA and the RRT are too ready to dismiss asylum seekers' claims on the grounds of the applicant's purported lack of credibility. According to this view, the evidence adduced to impugn the applicant's credibility is often not sound, and psychological evidence submitted by the applicant which tends to affirm the applicant's claims or explain why adverse inferences about credibility should not be hastily drawn, is given insufficient weight. I have written a paper on this issue which sets out this argument by examining the sources of credibility evidence adduced by the RRT. I conclude that RRT decisions should be informed by explicit guidelines with respect to formulating opinions about an applicant's credibility. The paper's citation is "The Credibility of Credibility Evidence at the Refugee Review Tribunal" 15 (2003) *International Journal of Refugee Law* 377. It is available electronically at http://ijrl.oxfordjournals.org/.

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