



UNHCR

United Nations High Commissioner for Refugees
Haut Commissariat des Nations Unies pour les réfugiés

SUBMISSION

BY THE

OFFICE OF THE UNITED NATIONS HIGH COMMISSIONER FOR REFUGEES

ON THE

INQUIRY INTO THE SERIOUS ALLEGATIONS OF ABUSE, SELF-HARM AND NEGLECT OF ASYLUM-SEEKERS IN RELATION TO THE NAURU REGIONAL PROCESSING CENTRE, AND ANY LIKE ALLEGATIONS IN RELATION TO THE MANUS REGIONAL PROCESSING CENTRE

REFERRED TO

THE SENATE LEGAL AND CONSTITUTIONAL AFFAIRS COMMITTEE

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EXECUTIVE SUMMARY

- UNHCR's position on transfer arrangements in relation to asylum-seekers and for the purposes of asylum processing is well established. Asylum-seekers should ordinarily have their claims processed and benefit from protection in the territory of the State where they arrive or which otherwise has jurisdiction over them. UNHCR's view is that the global refugee system is undermined when States deny access to territory for certain categories of asylum-seekers and refugees.
- Australia's transfer of asylum-seekers to Nauru and Papua New Guinea for processing, and the denial of settlement in Australia for those found to be in need of international protection, does not extinguish the legal responsibility of Australia for the protection of the transferred asylum-seekers and refugees. This includes ensuring proper protection for asylum-seekers and refugees regardless of their mode of arrival.
- UNHCR has found in both Papua New Guinea and Nauru that the punitive conditions of open-ended mandatory detention in a highly securitized environment and the lack of any viable long-term solution for transferred individuals has exposed asylum-seekers to circumstances causing harm, notably related to mental health, as well as different forms of alleged abuse. It is evident that the guarantees, protections and rights owed to transferred asylum-seekers and refugees, have not been fully met by either the Government of Australia, nor the Governments of Papua New Guinea and Nauru (as relevant), and the transfer arrangements do not adequately comply with international laws and standards.
- UNHCR finds that long-term, viable solutions are not available in Nauru or Papua New Guinea, even on a temporary basis. Overall, the lack of any viable long-term solutions necessitates urgent action to remove all transferred asylum-seekers and refugees from Papua New Guinea and Nauru to a safe country that provides humane conditions in line with international standards. Australia, together with Papua New Guinea and Nauru (as relevant), share responsibility to ensure that the rights of the concerned individuals are fully upheld, and that solutions are found for them in line with international law and State practices, as well as accepted standards of treatment.

I. INTRODUCTION

1. The Office of the United Nations High Commissioner for Refugees (UNHCR) welcomes the opportunity to provide a submission to the Senate Legal and Constitutional Affairs Committee (the ‘Committee’) on its *Inquiry into the serious allegations of abuse, self-harm and neglect of asylum-seekers in relation to the Nauru Regional Processing Centre, and any like allegations in relation to the Manus Regional Processing Centre* (the ‘Inquiry’).

II. UNHCR’S STANDING TO COMMENT

2. Australia is a party to the *1951 Convention relating to the Status of Refugees* and its *1967 Protocol relating to the Status of Refugees* (together, the ‘1951 Refugee Convention’).¹
3. UNHCR makes this submission pursuant to its supervisory role with respect to the 1951 Refugee Convention and in particular Article 35 thereof, and its mandate under the *1950 Statute of the Office of the United Nations High Commissioner for Refugees*.²
4. UNHCR’s submission addresses the following terms of reference of the Inquiry:
 - a) The obligations of the Commonwealth Government and contractors relating to the treatment of asylum-seekers and refugees, including the provision of support, capability and capacity building to local Nauruan authorities (section III below).
 - b) The factors that have contributed to the abuse and self-harm alleged to have occurred (section IV below).
 - c) The provision of support services for asylum-seekers and refugees who have been alleged or have been found to have been subject to abuse, neglect or self-harm in the Lombrum ‘Regional Processing Centre’, East Lorengau Refugee Transit Centre and ‘Regional Processing Centres’ on Nauru or within the Nauruan community (section IV below).

¹ The term ‘1951 Refugee Convention’ is used to refer to the *Convention relating to the Status of Refugees*, opened for signature 28 July 1951, ATS 5 (entered into force for Australia 22 April 1954) as applied in accordance with the *Protocol Relating to the Status of Refugees*, opened for signature on 31 January 1967, ATS 37 (entered into force for Australia on 13 December 1973).

² UN General Assembly, Resolution 428 (V), *Statute of the Office of the United Nations High Commissioner for Refugees* (1950), Annex.

5. In making this submission, UNHCR draws on the findings of its seven monitoring visits to the Republic of Nauru (Nauru) and eight visits to Manus Island, Papua New Guinea, since 2012, and the recommendations that have been shared with the Governments of Australia, Nauru and Papua New Guinea following those missions.

III. THE OBLIGATIONS OF THE COMMONWEALTH GOVERNMENT AND CONTRACTORS RELATING TO THE TREATMENT OF ASYLUM-SEEKERS AND REFUGEES

6. UNHCR's general position, as stated in previous submissions, is that asylum-seekers and refugees should be processed in the territory of the State where they arrive, or which otherwise has jurisdiction over them (in this case, Australia).³
7. UNHCR acknowledges the complex challenges of mixed migration maritime movements faced by States in the region. In particular, UNHCR has long advocated for stronger regional and international cooperation to address mixed migration maritime movements in a way that respects the legitimate concerns of States, but also the individual protection and humanitarian needs of those who resort to dangerous travel, including by sea.
8. Any cooperation arrangements between States should be based on responsibility sharing for refugee protection in accordance with international law, not responsibility shifting, in order to enhance protection in all concerned States and in the region as a whole.
9. The legality and appropriateness of any transfer arrangement needs to be assessed on a case-by-case basis, subject to its particular modalities and legal provisions. Any transfer arrangement needs to guarantee that each asylum-seeker is:
 - a) individually assessed as to the appropriateness of the transfer, subject to procedural safeguards, prior to transfer. Such safeguards include an opportunity to rebut the presumption of safety in the individual's particular circumstances. Pre-transfer assessments are particularly important for vulnerable people, including unaccompanied and separated children whose best interest must be a primary consideration;
 - b) admitted to the proposed receiving State;
 - c) protected against *refoulement*;

³ UN High Commissioner for Refugees (UNHCR), *Guidance Note on bilateral and/or multilateral transfer arrangements of asylum-seekers*, May 2013, para.1 <<http://www.refworld.org/docid/51af82794.html>> ('*UNHCR Guidance Note*').

- d) given access to fair and efficient procedures for the determination of refugee status and/or other forms of international protection;
- e) treated in accordance with accepted international standards (for example, appropriate reception arrangements; access to health, education and other basic services; safeguards against arbitrary detention; non-detention of children; use of detention for adults only as a last resort, where legal grounds are shown, and subject to judicial control; use of alternatives to detention wherever possible; and identification and provision of assistance to persons with specific needs); and
- f) if recognized as a refugee, able to enjoy asylum and timely access to a durable solution that includes the following guarantees:
 - i) protection from *refoulement*, in any manner whatsoever; and otherwise enjoy the rights under the 1951 Refugee Convention and other international laws and standards in full and without discrimination, in law and in practice. In particular, the arrangement would provide for lawful stay, access to employment and/or self-employment opportunities, education for children, freedom of movement including the right to choose one's place of residence, and the right to travel outside the territory;
 - ii) an adequately resourced local integration programme is in place which provides the services and support needed by refugees to adjust to a new society;
 - iii) the possibility for family reunification in order to ensure the unity of the refugee's family is maintained; and
 - iv) the capacity of the receiving State and the commitment of the local community are able to sustain such an arrangement.⁴

10. The obligation to ensure that conditions in the receiving State meet these requirements in practice rests with the transferring State, in this case Australia, prior to entering into such arrangements.⁵

11. Since the Government of Australia's announcement in 2012 that it would recommence 'offshore processing', UNHCR has raised its concerns about the offshore arrangements and the detrimental impact for those individuals who would be affected by these arrangements, among other elements. UNHCR recommended to the Government of Australia to allow asylum-

⁴ See UNHCR, *Position paper Bilateral and/or Multilateral Arrangements for Processing Claims for International Protection and Finding Durable Solutions for Refugees*, 20 April 2016 <<http://www.unhcr.org/en-au/publications/legal/5811773d4/bilateral-andor-multilateral-arrangements-for-processing-claims-for-international.html>>. See also, *ibid* para.3.

⁵ See UNHCR Guidance Note, above n 3.

seekers arriving by sea into Australian territory to be processed in Australia.⁶ Over numerous visits to monitor the transfer arrangements in Nauru⁷ and Papua New Guinea,⁸ UNHCR has found that the policies, operational approach and harsh conditions do not comply with the above-mentioned international standards. Australia, together with Papua New Guinea and Nauru, share responsibility for ensuring that the rights of the concerned individuals are fully upheld, and that *solutions are found for them* in line with international law and State practices, as well as accepted standards of treatment. Following the April 2016 visits to Nauru and Papua New Guinea, UNHCR has publicly called for the immediate movement of asylum-seekers and refugees to humane conditions with adequate support and services.⁹

IV. THE FACTORS THAT HAVE CONTRIBUTED TO THE ABUSE AND SELF-HARM ALLEGED TO HAVE OCCURRED, AS WELL AS THE PROVISION OF SUPPORT SERVICES FOR ASYLUM-SEEKERS WHO HAVE BEEN ALLEGED OR HAVE BEEN FOUND TO HAVE BEEN SUBJECT TO ABUSE, NEGLECT OR SELF-HARM

12. UNHCR would like to draw attention to four key factors relevant to the Inquiry, in light of the findings from regular visits to Nauru and Papua New Guinea to monitor the transfer arrangements since 2012: consequences of open-ended mandatory detention and inadequate legal and physical conditions of detention and treatment; predictable mental health deterioration of transferred asylum-seekers and refugees; lack of viable long-term solutions; and lack of adequate protection for asylum-seekers and refugees with specific needs.

A. Consequences of open-ended mandatory detention and inadequate legal and physical conditions of detention and treatment

13. On the basis of UNHCR's frequent monitoring visits to Papua New Guinea and Nauru, including the April 2016 visits with medical experts, UNHCR has found that the open-ended mandatory detention and the inadequate conditions and treatment that asylum-seekers and

⁶ See UNHCR, *UNHCR reviewing Australian changes on offshore processing*, 17 August 2012 <<http://www.unhcr.org/en-au/news/briefing/2012/8/502e226e9/unhcr-reviewing-australian-changes-offshore-processing.html>>.

⁷ See UNHCR, *UNHCR monitoring visit to the Republic of Nauru*, 26 November 2013 <<http://www.refworld.org/docid/5294a6534.html>> ('*UNHCR Monitoring Report Nauru 2013*').

⁸ UNHCR, *UNHCR monitoring visit to Manus Island, Papua New Guinea*, 26 November 2013 <<http://www.refworld.org/docid/5294aa8b0.html>> ('*UNHCR Monitoring Report Manus Island 2013*').

⁹ See UNHCR, *UNHCR Calls for the Immediate Movement of Refugees and Asylum Seekers to Humane Conditions*, 2 May 2016 <<http://www.unhcr.org/en-au/news/press/2016/5/5810087d4/unhcr-calls-for-immediate-movement-of-refugees-and-asylum-seekers-to-humane.html>>.

refugees have been subjected to over the years have contributed to their mental health deterioration as well as self-harm, abuse and neglect.

i. Long-standing concerns relating to open-ended mandatory detention and inadequate conditions and treatment

14. UNHCR has consistently and over a number of years raised its concerns about the open-ended mandatory detention of asylum-seekers and the legal framework and physical conditions for the detention and treatment of asylum-seekers transferred by Australia to Nauru and Papua New Guinea. In November 2013, UNHCR found in Nauru¹⁰ and Papua New Guinea¹¹ that the “policy and practice of detaining all asylum-seekers at the detention centre referred to as the ‘Regional Processing Centre’, on a mandatory and open-ended basis, without an individualized assessment as to the necessity, reasonableness and proportionality of the purpose of such detention amounts to arbitrary detention that is inconsistent with international law”.
15. Moreover, UNHCR found that “the legal framework and physical conditions for the detention and treatment of asylum-seekers remain below international standards and, overall, do not provide for a safe, fair and humane standard of treatment for asylum-seekers transferred under the bilateral arrangements to the Regional Processing Centre”.¹²
16. UNHCR expressed that it was “deeply troubled that as long as the focus remains primarily on deterrence, the humanitarian, ethical and legal basis of asylum, and the protection of refugees, will be seriously undermined”.¹³ UNHCR has continued to raise concerns about the conditions and treatment of individuals transferred to Nauru and Papua New Guinea and in particular the serious harm as a result of open-ended mandatory detention. The findings of the reports in November 2013 remain valid.

¹⁰ UNHCR Monitoring Report Nauru 2013, above n 7, p.2.

¹¹ UNHCR Monitoring Report Manus Island 2013, above n 8, p.2.

¹² UNHCR Monitoring Report Nauru 2013, above n 7, p.2 and *ibid* p.2.

¹³ UNHCR, *UNHCR calls for compassion and legal principles to be at centre of policy responses*, 23 November 2012 <<http://www.unhcr.org/en-au/news/press/2012/11/58101d507/unhcr-calls-for-compassion-and-legal-principles-to-be-at-centre-of-policy.html>>.

ii. Changes to detention policy at Lombrum ‘Regional Processing Centre’ on Manus Island, Papua New Guinea, and ongoing concerns

17. Since early 2015, recognized refugees have been permitted to relocate to the East Lorengau ‘Refugee Transit Centre’, which was anticipated as a measure prior to locally ‘integrating’ in Papua New Guinea. At the time of UNHCR’s April 2016 visit, 411 refugees had refused to apply for visas that would subsequently lead to their movement from the Lombrum ‘Regional Processing Centre’ to the East Lorengau ‘Refugee Transit Centre’. The vast majority of refugees UNHCR spoke with on its April 2016 visit cited fears for their safety among the many reasons that prevented them from moving out of the Lombrum ‘Regional Processing Centre’.
18. On 26 April 2016, the Supreme Court of Papua New Guinea determined the detention of asylum-seekers at the Lombrum ‘Regional Processing Centre’ unconstitutional and illegal¹⁴ as it violates the right to personal liberty guaranteed by section 42 of the *Constitution of the Independent State of Papua New Guinea*.¹⁵ The Government of Papua New Guinea then implemented changes to the detention policy, including allowing asylum-seekers to take bus trips out of the ‘Regional Processing Centre’ daily. In August 2016, the Minister for Immigration and Border Protection stated an intention to close the Lombrum ‘Regional Processing Centre’, announcing: “It has been the longstanding position of this Government to work with PNG to close Manus...”.¹⁶
19. Despite the changes to the detention policy, asylum-seekers and refugees living at the Lombrum ‘Regional Processing Centre’ have restricted freedom of movement at the time of this submission to the Inquiry. This is owing not only to security regulations related to the Lombrum Naval Base, where the Centre is located, but other factors including fear arising from security threats against asylum-seekers and refugees outside the Lombrum ‘Regional Processing Centre’.
20. UNHCR has observed over successive visits, including its visit in April 2016, excessive levels of security at the Lombrum ‘Regional Processing Centre’, creating an institutionalized and punitive environment, wholly inappropriate for asylum-seekers and refugees.

¹⁴ In the *Namah v Pato*, 2016, PGSC 13, decision handed down on 26 April 2016.

¹⁵ *Constitution of the Independent State of Papua New Guinea 1975*.

¹⁶ See Minister for Immigration and Border Protection, ‘Manus Regional Processing Centre’, *Media Release*, 17 August 2016 <<http://www.minister.border.gov.au/peterdutton/Pages/MANUS-REGIONAL-PROCESSING-CENTRE.aspx>>.

21. Furthermore, UNHCR observed overcrowding in Oscar and Delta compounds for recognized refugees during the April 2016 visit, with highly reduced personal space for privacy or solitary reflection. The dwellings in Delta and Oscar compounds at the time of UNHCR's visit in April 2016 provided approximately 1.68m² per person, which is half the minimum international standard for prisons.¹⁷ The risks to public health and mental health of such overcrowding are considerable, and the possibility of abuse is increased due to the limited spaces to move persons in need of protection away from potential threats.

iii. Changes to detention policy at the 'Regional Processing Centres' on Nauru and ongoing concerns

22. The Government of Nauru introduced in October 2015 legislative and policy amendments to allow the 'Regional Processing Centres' to change from held detention facilities to remain open on a permanent basis, and had moved more than 800 refugees from the 'Regional Processing Centres' to 'settlement' sites at the time of UNHCR's visit this year.

23. Although UNHCR welcomed this development,¹⁸ key aspects of conditions are indistinguishable from previous detention arrangements. This includes the number of security guards, the configuration of the fences at the perimeters and the sub-compounds and the overcrowding in accommodation, including the continued use of communal tents ('marquees') for protracted periods of time. Individuals remain living in a detention-like setting, which not only has a very detrimental impact on mental health, but also increases the risk of abuse and self-harm.

¹⁷ This figure cites a number of international standards. The standard (4m² per person in a multioccupancy cell) of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) – from the Council of Europe. This standard has existed since the 1990s. In their latest document, they have recommended that the desirable standard be expanded as 4m² was considered too crowded: see European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), *Living space per prisoner in prison establishments: CPT standards*, 15 December 2015 <<http://www.cpt.coe.int/en/working-documents/cpt-inf-2015-44-eng.pdf>>. The UNODC in their criteria for assessing prisons in post-conflict settings (most of which are in developing countries), set a minimum of 3.4 m²/person. The dwellings in Delta and Oscar have persons in multioccupancy cells at twice this density. See United Nations Office on Drugs and Crime (UNODC), *A Prison Evaluation Checklist for Post-Conflict Settings* <https://www.unodc.org/documents/justice-and-prison-reform/FINAL_GFP_Prison_Evaluation_Checklist_-_July_2014.pdf>. ICRC recommend 3.4 m²/person: see International Committee of the Red Cross (ICRC), *Water Sanitation and Hygiene and Habitat in Prisons: Supplementary Guidance*, March 2013 <<https://www.icrc.org/eng/assets/files/publications/icrc-002-4083.pdf>>. Thus there is consensus across multiple bodies about what constitutes reasonable personal space.

¹⁸ See UNHCR, *UNHCR Welcomes Change in Nauru's Detention Policy*, 5 October 2015 <<http://www.unhcr.org/news/press/2015/10/56128b5b6/unhcr-welcomes-change-naurus-detention-policy.html>>.

24. The conditions and treatment in the ‘Regional Processing Centres’ remain wholly unacceptable, more so for families with children. UNHCR has regularly raised the need for all infants and children, together with their families, to be released immediately from the ‘Centres’ into appropriate, hard-walled accommodation, until viable and long-term solutions can be found for them as a matter of urgency.

B. Predictable mental health deterioration of transferred asylum-seekers and refugees

25. The adverse impact of immigration detention on mental health including increased rates of post-traumatic stress disorder, depression and anxiety has been documented by medical professionals and evidence indicates that there is a deterioration of mental health resulting from open-ended mandatory detention.¹⁹

26. UNHCR has observed that the mental health of transferred asylum-seekers and refugees in Nauru and Papua New Guinea has declined significantly over time. Therefore, on the most recent visits to Papua New Guinea from 10 to 15 April 2016 and to Nauru from 25 April to 1 May 2016, UNHCR focused on health and, in particular, mental health.

27. The UNHCR delegation included three expert medical consultants, who *inter alia* undertook surveys of the mental health of asylum-seekers and refugees to highlight the extent of the harm, and to encourage immediate action by the Governments of Australia,²⁰ Papua New Guinea and Nauru who have a responsibility for the protection and care of these individuals.

28. The medical experts observed that the overwhelming majority of asylum-seekers and refugees in Papua New Guinea and Nauru had no pre-existing psychiatric disorder prior to their detention at the ‘Regional Processing Centres’ even though a considerable proportion had been exposed to trauma.

¹⁹ Filges T et al., ‘The impact of detention on the health of asylum-seekers: a systematic review’ (2015) 13 *Campbell Systematic Reviews*; Bull M et al., ‘Sickness in the system of long-term immigration detention’ (2012) 26(1) *Journal of Refugee Studies* 47; Coffey GJ et al., ‘The meaning and mental health consequences of long-term immigration detention for people seeking asylum’ (2010) 70 *Social Science & Medicine* 2070.

²⁰ UNHCR encourages further studies in the diagnostic prevalence of the mental illness by the Governments who have a duty of care. As expressed previously by UNHCR, Australia has a duty of care to all transferred asylum-seekers and refugees, which requires that appropriate legal and procedural safeguards are in place to ensure that each individual is protected from harm. See UNHCR, *Submission by the Office of the United Nations High Commissioner for Refugees to the Senate Select Committee on the Recent Allegations Relating to Conditions and Circumstances at the Regional Processing Centre in Nauru*, 27 April 2015 <<http://www.unhcr.org/en-au/publications/legal/5811912b7/submission-to-the-senate-select-committee-on-the-recent-allegations-relating.html>> (‘*UNHCR Senate Committee Submission into Nauru 2015*’).

29. The prolonged, arbitrary and indefinite nature of immigration detention in conjunction with a profound hopelessness in the context of no durable settlement options has corroded these individual's resilience and rendered them vulnerable to alarming levels of mental illness.
30. In both locations, the medical experts noted that specific individual medical interventions are relatively ineffective due to the nature of the complex interplay of psychiatric and psychosocial factors, and poor adherence to standard treatment strategies.
31. Further, the medical experts found that that there are inadequate services in place in both Nauru and Papua New Guinea to address the present health concerns of refugees, and that it will not be possible to establish appropriate systems in a reasonable timeframe.
32. From the interviews and assessments it was evident that family separation resulted in a marked deterioration in mental health. It is critical for the mental health of refugees that separated families are reunited.

i. Mental health concerns in Papua New Guinea

33. During UNHCR's April 2016 visit, the medical experts surveyed 181 asylum-seekers and refugees on Manus Island,²¹ and found that 88 per cent were suffering from a depressive or anxiety disorder and/or post-traumatic stress disorder. The average length of detention in the Lombrum 'Regional Processing Centre' of those surveyed was 29.6 months. Furthermore, a number of very severe psychiatric disorders were identified, including gross psychopathology consistent with psychosis as well as psychotic dissociation. Full details of the study are in the Appendix to this submission.
34. The comparable populations for which reliable data are available are: refugees resettled in Australia; asylum-seekers in the Australian community; and prisoners. The rates of moderate or high psychological distress in newly resettled refugees in Australia are 35 per cent for men and 46 per cent for women.²² The prevalence of depression or anxiety is estimated to be 10 per

²¹ This represented 20.6 per cent of the population residing in the Lombrum 'Regional Processing Centre' and 33 per cent of those in the East Lorengau Refugee Transit Centre.

²² David Marshall, National Centre for Longitudinal Data, *Building a New Life in Australia: The Longitudinal Study of Humanitarian Migrants*, Data Highlight No.2/2015
<https://www.dss.gov.au/sites/default/files/documents/09_2015/data-highlight-no-2-2015-bnla_pdf.pdf>.

cent in male prisoner populations,²³ and 61 per cent for asylum-seekers living in the Australian community.²⁴

35. The prevalence of post-traumatic stress disorder is estimated to be nine per cent in resettled refugee populations,²⁵ 21-30 per cent in male prisoner populations,²⁶ and 52 per cent for asylum-seekers in the Australian community.²⁷
36. Many of those surveyed by medical experts had either witnessed or been directly impacted by the violent assaults on asylum-seekers and refugees at the Lombrum 'Regional Processing Centre' in February 2014. They described these experiences as "terrifying" and "horrific", resulting directly in post-traumatic stress disorder or catalysing pre-existing traumatic memories into post-traumatic stress disorder according to the medical experts.
37. Furthermore, the medical experts observed that a significant number of asylum-seekers and refugees reported experiences of bullying, intimidation and harassment by security staff, which has resulted in them being frightened, withdrawn and submissive in their interactions with Lombrum 'Regional Processing Centre' staff. These conditions have precipitated and/or exacerbated major depressive disorders in vulnerable individuals.

²³ Fazel S and Danesh J, 'Serious mental disorder in 23,000 prisoners: systematic review of 62 surveys' (2002) 359 *Lancet* 545.

²⁴ Hocking DC, Kennedy GA, and Sundram S, 'Mental disorders in asylum seekers: the role of the refugee determination process and employment' (2015) 203(1) *J Nerv Ment Dis* 28, p.28.

²⁵ Fazel M, Wheeler J, and Danesh J, 'Prevalence of serious mental disorder in 7,000 refugees resettled in Western countries: A systematic review' (2005) 365 *Lancet* 1309.

²⁶ Gibson LE, Holt JC, and Fondacaro KM et al., 'An examination of antecedent traumas and psychiatric comorbidity among male inmates with PTSD' (1999) 12 *J Trauma Stress* 473; Wolff N, Huening J, and Shi J et al., 'Trauma exposure and post-traumatic stress among incarcerated men' (2014) 91(4) *J Urban Health* 707.

²⁷ Hocking DC, Kennedy GA, and Sundram S, above n 24, p.28.

38. Several factors suggest that the rate of self-harm (reported to be 0.3 per cent for actual self-harm, and 0.1 per cent for threatened self-harm for 2015)²⁸ is an under-estimate:
- a) First, the rate of *actual* self-harm reported by International Health and Medical Services (IHMS) is greater than the rate of *threatened* self-harm, an inversion of the usual pattern. This inversion is only seen when suicide is unexpected and there is no identification approaches for self-harm. In the Lombrum ‘Regional Processing Centre’ system, there are institutional processes for handling suicidal action and threat which were in evidence on the team’s monitoring mission. Therefore, one would expect threats of self-harm to outnumber actual self-harm.
 - b) Secondly, the reported rate of actual self-harm is significantly less than the rates reported in comparable populations or in other immigration detainee populations.²⁹
 - c) Thirdly, the medical experts gathered oral evidence during the surveys of numerous first-hand accounts of self-inflicted lacerations, voluntary refusal of food and fluid, and deliberate overdosing of stockpiled medications. Although unverified, this would have grossly exceeded the reported rate.
39. The medical experts observed that the data supplied to them relating to self-harm on Manus Island is inconsistent with international data on comparator populations, as explained above, and that both the collection and analysis of the data may not accurately reflect the true rate of self-harm.

²⁸ In addition to concerns about reporting of incidents, the data provided to UNHCR by International Health and Medical Services is poorly defined and the summative rates are incorrectly calculated. International Health and Medical Services reported that there were forty incidents of actual self-harm and eight incidents of threatened self-harm over 2015. Whether these refer to repeat incidents in a smaller number of people, or to isolated instances of actual and threatened self-harm by, respectively, forty and eight people is not stated. The population rates provided by month to UNHCR are only reliable if each of the incidents refers to separate people; that is, each incident of self-harm indicates one person who had threatened or conducted one incident of self-harm over the year, an assumption which is not borne out by detainees’ or International Health and Medical Services clinicians’ accounts of the behaviours of refugees and asylum-seekers at Lombrum Regional Processing Centre. The summary statistic provided to UNHCR was incorrectly calculated as an average of the monthly rate, rather than the overall rate per year, resulting in an underestimate of rates even on the data presented.

²⁹ Self-harm rates (as defined by action rather than threat) are of 2 per cent in the prisoner population (Australian Institute of Health and Welfare, *The Health of Australia’s Prisoners 2012*. Cat. no. PHE 170, 2013), and is reported to be higher among immigration detainees (Robjant K, Hassan R, and Katona C, ‘Mental health implications of detaining asylum seekers: systematic review’ (2009) 194 *British Journal of Psychiatry* 306). See also Indig D, Topp L, Ross B, Mamoon H, Border B, and Kumar S et al., *2009 NSW Inmate Health Survey: Key findings report* (Justice Health, 2010).

40. The medical experts concluded that the dire mental health issues observed could not be appropriately addressed in Papua New Guinea, as explained further below. UNHCR has recommended that all asylum-seekers and refugees be removed to safe and appropriate conditions where they can access skilled medical care as a matter of urgency and that those presently transferred back to Australia should be placed in a safer environment that will have ongoing health benefits.

ii. Mental health concerns in Nauru

41. During UNHCR's April 2016 visit to Nauru, of the 53 asylum-seekers and refugees surveyed at the 'Regional Processing Centres' and 'settlement' areas in Nauru,³⁰ medical experts found that overall 83 per cent³¹ suffered from post-traumatic stress disorder and/or depression. In addition to the surveys, the medical experts collected qualitative information from asylum-seekers and refugees interviewed on Nauru.³²

42. The interviews by the medical experts, revealed prevalent despair, desperation and a sense of injustice among asylum-seekers and refugees. Many felt that they had no future or sense of hope. Parents interviewed reported acute experiences of hopelessness, stemming from a loss of self-agency, inability to care for their families and safety concerns.

³⁰ The medical experts initially intended to administer mental health surveys to 20 per cent of the population in Nauru to assess the presence, rates and severity of post-traumatic stress disorder and depression. Unfortunately, a series of incidents occurred associated with the grave mental illness in the asylum-seeker and refugee population, including ongoing self-harm and suicide attempts that were present prior to UNHCR's visit. This meant it was not possible for the medical experts in such extreme and tense circumstances to interview the numbers of asylum-seekers and refugees originally intended.

³¹ Surveys were conducted in relation to asylum-seekers and refugees from Regional Processing Centres 2 and 3 and settlement sites Fly Camp and Nibok. 57 per cent of those interviewed were asylum-seekers and 43 per cent were refugees. Approximately one quarter of the participants were female. The sample contained asylum-seekers and refugees from 11 countries of origin.

³² In order to gain an understanding of the extent of mental disorder in the asylum-seeker and refugee community, a series of mini-clinical interviews were planned, in which two tools would be used. Firstly, general mental health was to be assessed using the Kessler Psychological Distress Scale (K-10). The K-10 is a screening self-report tool used to determine levels of general distress based on questions relating to depression and anxiety. See Kessler RC et al., 'Short screening scales to monitor population prevalences and trends in non-specific psychological distress' (2002) 32 *Psychological Medicine* 959. Secondly the presence of Post-Traumatic Stress Disorder (PTSD) was to be quantified using the Post Traumatic Stress Disorder-8 (PTSD-8). The PTSD-8 is an 8 item screening instrument for PTSD. It is a theoretical derivative of the gold standard Harvard Trauma Questionnaire that is validated for use in cross-cultural settings and in refugee/asylum-seeker populations. The PTSD-8 taps into each of the 3 domains of PTSD (intrusion, hypervigilance and avoidance) that are mentioned in the Diagnostic and Statistical Manual of Mental Disorders – V (DSM-V). See Mai Hansen et al., 'PTSD-8: a short PTSD inventory' (2010) 6 *Clinical Practice & Epidemiology in Mental Health* 101. Children were interviewed only in the presence of a carer and age-appropriate tools were used. The CES-DC was used to screen for depressive symptoms and a separate survey was administered to the carer regarding the child's health.

43. In the ‘Regional Processing Centre’, parents are under severe conditions where they no longer are able to effectively parent, resulting in security personnel and other Centre service providers in some cases assuming functions as *de facto* parental figures. Children are nocturnally bed-wetting until early to mid adolescence. Separation anxiety and oppositional behaviours in addition to depressive syndromes were also observed – all indicating severe psychiatric symptoms arising.
44. From the interviews with asylum-seekers and refugees as well as information received from service providers, it was clear that there had been increasing rates of self-harm and attempted suicides on Nauru at the beginning of 2016 attributed to the deterioration in mental health. Methods varied from sewing lips, ingesting harmful substances and objects, attempted hangings and self-immolations. Thoughts and plans to suicide were frequently reported by interviewees due to their feeling of helplessness, hopelessness and despair.
45. During UNHCR’s visit in April 2016, it was reported to UNHCR by service-providers as well as asylum-seekers and refugees interviewed that two to three months prior to UNHCR’s mission there has been a sharp increase in the levels of mental illness and distress among asylum-seekers and refugees, with escalating despair and agitation. However, this was not reflected in the data provided to UNHCR by IHMS staff.
46. UNHCR received statistics on actual and threatened self-harm on Nauru for 2015 that raise several concerns in terms of the efficacy of the data. Over the year, one per cent of the population is reported to have self-harmed, and 0.5 per cent of the population is reported to have made a perceived threat of self-harm.
47. The medical experts opined that *prima facie* a figure of one per cent is at odds with the high level of suicidal thinking and behaviour that was reported by refugees and asylum-seekers, and by the clinicians caring for them in Nauru. Several factors suggest the rate of self-harm is significantly under-estimated:
- a) First, the rate of *actual* self-harm is greater than the rate of *threatened* self-harm, an inversion of the usual pattern which is only seen when suicide is unexpected and there are few management approaches. As a result, one would expect the threats of self-harm to outweigh actual self-harm.

b) Secondly, the reported rate of actual self-harm is significantly less than rates reported in comparable populations or in other immigration detainee populations in Australia. The reported statistics are therefore inconsistent with the much higher prevalence of mental illness observed on Nauru than in these populations.³³

48. UNHCR notes that in Nauru, the criminalization of suicidal behaviours may have acted as a barrier to service providers recording the extent of suicidal threat or behaviour.³⁴ Since UNHCR's visit, there have been positive legislative changes which now means that suicide is no longer criminalized. This presents an opportunity to review the processes used to record self-harm ideation and behaviour and the accuracy of the data.

49. Notwithstanding these developments, UNHCR has observed over time an escalating situation with respect to mental illness and distress that is not likely to reduce under the present circumstances and that the establishment of mental illness, distress and suicidal ideation are pervasive and hyper-endemic within the asylum-seeker and refugee population. UNHCR therefore recommends that all asylum-seekers and refugees transferred to Nauru be removed to humane conditions where they can access appropriate services as a matter of urgency.³⁵

50. Moreover, it is critical to reunite families, separated between Australia and Nauru. As previously mentioned, UNHCR has found that the separation of immediate family members is linked to the serious deterioration in mental health and has recommended that this be addressed as a matter of urgency.

C. Lack of viable long-term solutions

51. The lack of viable long-term solutions for the asylum-seekers and refugees transferred to Papua New Guinea and Nauru is a major contributing factor to self-harm in the context of overall mental health deterioration. This has been raised consistently by UNHCR since 2012,³⁶ and is elaborated below in light of the present situation.

³³ Self-harm rates (as defined by action rather than threat) are of 2 per cent in the prisoner population (Australian Institute of Health and Welfare, above n 29), and is reported to be higher among immigration detainees (Robjant K, Hassan R, and Katona C, above n 29). See also Indig D, Topp L, Ross B, Mamoon H, Border B, and Kumar S et al., above n 29.

³⁴ See repealed *Criminal Code 1899* and the in force *Criminal Act 2016*.

³⁵ UNHCR has recommended that asylum-seekers and refugees presently transferred back to Australia not be returned to Nauru, and that individualised assessments are undertaken to assess the appropriateness of their ongoing detention in onshore facilities.

³⁶ See, for example, UNHCR, *Submission by the Office of the United Nations High Commissioner for Refugees: Inquiry into the incident at the Manus Island Detention Centre from 16 February to 18 February 2014*, 7 May 2014, paras.29-

52. UNHCR has regularly raised concerns about a ‘return oriented environment’. In 2013, for example, UNHCR noted in relation to individuals transferred to both Papua New Guinea³⁷ and Nauru³⁸ that it was clear that some asylum-seekers at the ‘Regional Processing Centres’, who may have been *bona fide* refugees or in need of complementary protection, may have contemplated a return to their country of origin as a result of the uncertainty around refugee status determination processing, the prospect of lengthy delays in accessing a durable solution and the harsh conditions at the ‘Regional Processing Centres’.
53. The return-oriented environment for transferred asylum-seekers and refugees in Nauru and Papua New Guinea remains particularly concerning in light of their serious deterioration in mental health. Critically ill individuals may not be able to make an informed decision about return. Moreover, the country of origin may not be in a position to provide the mental health services required. For some individuals, *sur place* refugee claims may have arisen as a result of the mental health issues that have arisen at the ‘Regional Processing Centres’ in Nauru and Papua New Guinea.
54. Notwithstanding its ongoing responsibility to find solutions for transferred refugees, as noted above, Australia has consistently maintained that it will not permit durable solutions in Australia for any refugees transferred to Nauru or Papua New Guinea in Australia.
55. UNHCR is concerned that there are no integration opportunities in Papua New Guinea and no viable long-term solutions for individuals transferred to Nauru at the present time, for the reasons that follow.

i. Lack of integration opportunities or viable long-term solutions in Papua New Guinea

56. UNHCR recognises the efforts by the Government of Papua New Guinea to implement ‘settlement’ services and supporting policy, including efforts to seek employment and training opportunities for refugees. Despite these efforts, UNHCR finds that integration of transferred refugees in Papua New Guinea is not possible, and has communicated this to the Governments of Papua New Guinea and Australia.

41 <<http://www.unhcr.org/en-au/publications/legal/581192bb7/inquiry-into-the-incident-at-the-manus-island-detention-centre-from-16.html>> (*UNHCR Inquiry Submission into the Incident at Manus Island 2014*); UNHCR Senate Committee Submission into Nauru 2015, above n 20, para.16.

³⁷ UNHCR Monitoring Report Manus Island 2013, above n 8, p.2.

³⁸ UNHCR Monitoring Report Nauru 2013, above n 7, p.3.

57. UNHCR has in the past raised concerns about the formidable challenges to achieve integration of refugees transferred to Papua New Guinea. In particular:

“From UNHCR's first-hand experience in supporting Melanesian and non-Melanesian refugees in Papua New Guinea over approximately 30 years, it is clear that sustainable integration of non-Melanesian refugees in the socio-economic and cultural life of Papua New Guinea will raise formidable challenges and protection questions. UNHCR has consistently referred ‘non-Melanesian’ refugees who have arrived spontaneously in Papua New Guinea for resettlement to third countries, including to Australia, over a number of years and as recently as 2013, precisely because of severe limitations and significant challenges of finding safe and effective durable solutions in Papua New Guinea itself.”³⁹

58. These concerns have been compounded by the deterioration in mental health of the transferred asylum-seekers and refugees, as outlined above.

59. As an over-riding concern, refugees have informed UNHCR that they cannot settle in Papua New Guinea owing to a pervasive fear for their safety. UNHCR has raised concerns with the Governments of Australia and Papua New Guinea in relation to several attacks in the community on refugees who attempted to settle, for whom there has not been adequate protection.

60. Moreover, a range of measures intended to facilitate integration of refugees in the Papua New Guinean community have not worked. The reasons for this failure include *inter alia* the difficulties caused by the ‘comparable measures’ policy (see below); the lack of possibility for family reunification; and, in particular, the lack of access to appropriate health care.

61. First, the Government of Papua New Guinea National Refugee Policy⁴⁰ establishes the principle that support offered to refugees settling in Papua New Guinea must remain comparable to that available to local people. The policy does not take account of the inherent disadvantages faced by refugees, who are not able to call upon family, clan or cultural support from the community and require the resources to establish themselves entirely independently. Refugees do not benefit from social connections or protections available to locals through the

³⁹ UNHCR Inquiry Submission into the Incident at Manus Island 2014, above n 36, para.36.

⁴⁰ Government of Papua New Guinea, *National Refugee Policy*, June 2015

<http://www.immigration.gov.pg/images/PNG_National_Refugee_Policy_FINAL_ENDORSED_BY_CABINET.pdf>.

‘wontok’ system. Refugees do not have access to land ownership, for residential or subsistence purposes, and therefore must cover the substantial costs of housing and food on an ongoing basis, making basic survival difficult. The use of ‘comparable measures’ impedes local integration and compounds the already difficult circumstances facing transferred refugees.

62. Secondly, refugees are separated from immediate family members. Family reunification applications in Papua New Guinea, while permitted under the National Refugee Policy, require that the refugee first establish effective settlement and financial independence and this is impossible in practice. It is an established fact that the unity of the family is a key facilitator of effective settlement which is absent in this context.
63. Thirdly, asylum-seekers and refugees cannot access appropriate mental health services in Papua New Guinea. The type, extent and severity of mental disorders presented by the asylum-seeker and refugee population sharply contrasts with the range of disorders typically seen within the Papua New Guinea context. The lack of psychiatrists, psychologists and mental health nurses in Papua New Guinea would result in refugees living in the community being untreated or inadequately treated, resulting in considerable morbidity and functional impairment.
64. Any ‘settlement’ in Papua New Guinea is not a viable option for refugees, even on a temporary basis. Refugees transferred to Papua New Guinea do not have access to integration possibilities and cannot return to their countries of origin, they have been left in a state of limbo about their future. UNHCR has found that this uncertainty has been a major contributing factor to mental deterioration and hence a great barrier to settlement in Papua New Guinea.

ii. Lack of viable long-term solutions in Nauru

65. UNHCR has repeatedly raised concerns about the lack of long-term, sustainable solutions available to refugees in Nauru. In particular, in November 2013, UNHCR clearly raised its concern that recognized refugees, including unaccompanied and separated children, will have little or no prospect of settlement in Australia, notwithstanding the shared responsibility of both Australia and Nauru to provide durable solutions. This is a particularly acute issue given that Nauru will be unlikely to provide long term and sustainable solutions for refugees in accordance with the 1951 Refugee Convention.⁴¹

⁴¹ UNHCR Monitoring Report Nauru 2013, above n 7, p.2.

66. In relation to ‘settlement’ in Nauru, it is noted that it was intended that refugees transferred to Nauru by Australia would remain temporarily.⁴² Even for those who have moved out of the ‘Regional Processing Centres’ into the community, UNHCR is concerned that the criteria for settlement are not being met. For example, the community-based ‘settlement’ areas to which refugees have been moved are established in a way that does not allow for meaningful engagement with or local integration into the community, creating ‘ghetto-like’ situations. While the accommodation meets basic needs for shelter, it hinders integration by projecting a continuation of the detention environment and separation from the local community.⁴³
67. UNHCR finds that settlement on Nauru is not an option, even on a temporary basis. The health, educational, child protection and welfare, social and vocational needs of the refugee population on Nauru grossly exceed the capacity of Nauruan services. Attempting to resettle refugees in Nauru for any longer than a short duration carries considerable risk of harm to the refugees with regard to unmet health, educational and other needs.
68. With regard to potential solutions in countries other than Australia and Nauru, UNHCR notes the ongoing efforts of Australia to find solutions. However, to date, such opportunities have been limited to relocation to the Kingdom of Cambodia (Cambodia) from Nauru of five refugees under a bilateral agreement reached between the Governments of Australia and Cambodia. Notwithstanding the announcement on 29 October 2016 that three refugees wish to move to Cambodia,⁴⁴ indications strongly suggest that local integration in the longer term is not possible for refugees relocated to Cambodia with only one transferred refugee of the five remaining there in addition to one newly arrived.
69. Cambodia does not present a viable solution in the long-term for refugees. As individuals transferred to Nauru do not have access to ‘settlement’ possibilities locally, cannot find a durable solution in Nauru and cannot return to their countries of origin, they have been left in a state of limbo about their future. UNHCR has found that this uncertainty has been a key contributing factor to mental deterioration.

⁴² *Memorandum of Understanding between the Republic of Nauru and the Commonwealth of Australia, relating to the transfer to and assessment of persons in Nauru, and related issues*, 3 August 2013.

⁴³ UNHCR observed that several settlement locations are constructed from similar demountable units to those used in the ‘Regional Processing Centres’ and are established in fenced compounds with a layout closely resembling that of the ‘Regional Processing Centres’, albeit on a smaller scale.

⁴⁴ Aun Pheap, ‘Government Approves Latest Refugee Transfer from Nauru’, *The Cambodia Daily (online)*, 28 October 2016 <<https://www.cambodiadaily.com/brief/government-approves-latest-refugee-transfer-nauru-119869/>>.

D. Lack of adequate protection for asylum-seekers and refugees with specific needs

70. The issue of self-harm and abuse, actual and alleged, in Nauru and Papua New Guinea must be viewed in light of particular concerns arising for asylum-seekers and refugees with specific needs. In this context, UNHCR has regularly raised protection concerns relating to instances of actual or perceived sexual orientation and gender identity, torture and trauma survivors, as well as individuals with a physical disability in both Nauru and Papua New Guinea. In addition to this, UNHCR has grave concerns about inadequate protection measures for women and children in Nauru.

i. Lack of protection for persons with specific needs in Papua New Guinea

Sexual orientation and gender identity and sexual violence survivors

71. UNHCR has raised on a number of occasions with the Governments of Australia and Papua New Guinea the serious protection concerns with regard to instances of actual or perceived sexual orientation and gender identity.⁴⁵ During UNHCR's April 2016 visit, allegations were made that some asylum-seekers and refugees have been the target of bullying, harassment and sexual assault, including rape, at the Lombrum 'Regional Processing Centre'. UNHCR observed during the visit that measures to address this situation were inadequate. Although UNHCR was advised that survivors can be moved to separate compounds away from alleged perpetrators, such measures are insufficient to address the protection needs and concerns of victims.⁴⁶

72. UNHCR has raised concerns during the April 2016 visit with senior staff of both Broadspectrum and Wilson, companies contracted by Australia to provide services in the 'Regional Processing Centres', that there were a number of allegations of sexual assault made by asylum-seekers and refugees interviewed. Senior staff members responded on at least one occasion that allegations of sexual assault, including rape, are unsubstantiated and asylum-seekers and refugees may simply be exaggerating such claims. Staff did not appear to appreciate or take into account the serious welfare concerns for survivors of sexual assault, despite acknowledgement of the lack of forensic capacity by local police to investigate. The

⁴⁵ Male same-sex sexual activity is prohibited under the criminal code. Government of Papua New Guinea, *Criminal Code Act 1974*, Part IV, Division 2 'Offences Against Sexual Morality'.

⁴⁶ UNHCR found that this was further exacerbated by the recent measures to only combine refugees in the Delta and Oscar compounds and asylum-seekers in the Foxtrot and Mike compounds.

result is that the approach to allegations of sexual assault, including both prevention and response, is inadequate. This gives rise to duty of care concerns, not only in terms of the service providers, but also in relation to the Governments of Papua New Guinea and Australia.

73. Measures need to be put in place pro-actively to try to prevent sexual assault, abuse and self-harm from occurring, including taking appropriate measures to protect persons with specific needs. The likelihood of a continuation is increased considerably in such highly institutionalized environments like the Lombrum ‘Regional Processing Centre’.

Torture and trauma survivors

74. UNHCR has raised concerns with the Governments of Australia and Papua New Guinea that there are inadequate measures to protect and treat survivors of torture and trauma. Many have been (re-)traumatized during the violent incidents of 2014 and the death of Mr. Reza Berati as well as incidents during protests in 2015, as stated above. This has precipitated or exacerbated post-traumatic stress disorder in these individuals, much of which has not been recognized or adequately treated. Those who witnessed the death of Mr. Reza Berati require special services for the trauma they have suffered and many of these individuals remain deeply fearful of reprisal attacks on them by local staff.
75. UNHCR observed that the arrangements at the ‘Supported Accommodation’ – the purpose of which is to provide temporary respite for around six asylum-seekers or refugees at a time, including those with mental health issues – is inappropriate. Given the grave mental health concerns identified by the medical experts in the majority of the population, the number of spaces available are minimal, and the conditions do not provide a safe space for ‘time-out’ or ‘rehabilitation’.

ii. Lack of protection for persons with specific needs on Nauru

Children and women

76. In relation to child asylum-seekers and refugees, the Report of *UNHCR's monitoring visit to the Republic of Nauru* of November 2013 observed that:

“Overall, the harsh and unsuitable environment at the closed RPC is particularly inappropriate for the care and support of child asylum-seekers. UNHCR is also concerned that children do not have access to adequate educational and recreational facilities.

In light of the overall shortcomings in the arrangements, highlighted in this and earlier reports, UNHCR is of the view that no child, whether an unaccompanied child or within a family group, should be transferred from Australia to Nauru.”⁴⁷

77. Despite some developments, including the establishment of a *Division of Child Protection Services* in 2015⁴⁸ and several amendments to provisions in the *Crimes Act 2016* relating to children,⁴⁹ UNHCR's concerns identified more than two and a half years ago remain. Of particular concern is that due to the serious mental illness of parents, there is an increased possibility of harm to children and/or family homicide-suicides.

78. The medical experts interviewed children in April 2016 and observed evidence of high levels of emotional and psychological distress.⁵⁰ Of concern is that most children interviewed spontaneously disclosed that they had been part of recent events in detention or in the community, including self-harm or violence by others. Among those old enough to reflect upon their learning at school, many described increased difficulty with attention and retention of learning, something which had become worse over their years of schooling in open-ended mandatory detention. These children are likely to be describing learning difficulties because of

⁴⁷ UNHCR Monitoring Report Nauru 2013, above n 7, p.2.

⁴⁸ Government of Nauru, *National report submitted in accordance with paragraph 5 of the annex to the Human Rights Council resolution 16/1: Nauru*, 14 October 2015, A/HRC/WG.6/23/NRU/1, p.10 <<http://www.ohchr.org/EN/HRBodies/UPR/Pages/NRSession23.aspx>>. The division is aimed to provide “stronger, consistent and efficient technical, policy and support service on children’s issues in Nauru”, has a mandate of “establishing national systems and processes to respond effectively and efficiently to cases of child abuse and neglect”, and is supported by the Domestic Violence Unit of the Nauru Police Force.

⁴⁹ These include increases to the penalties for offences relating to children and the creation of a specific offence of ‘child neglect’: see *Crimes Act 2016* Div. 7.3 and s. 94.

⁵⁰ All children interviewed reported feelings of sadness, anger, and loss of interest in activities that had once been pleasurable. While some of the older children expressed anger about their situation, younger children appeared numbed and withdrawn.

the cumulative effects of trauma. UNHCR understands from visits to schools and discussions with the Department of Education that neither additional resources nor training has been dedicated to recognize and respond to children with learning difficulties associated with chronic trauma.

79. Welfare and development matters relating to infants and toddlers are of particular concern. The impact of impaired parenting due to parental despair and mental illness, the absence of family or community support and the challenging physical environment place young children (zero to five years) at significant risk of compromised development from emotional, cognitive and physical perspectives. In this context, the intolerable situation for asylum-seekers and refugees, as well as the breakdown of normal family structures and intra-familial relationships may place women and children at heightened risk. Living in these conditions, as well as a physically hostile environment in poorly ventilated tents, is especially traumatizing to children, in the context of mandatory and open-ended detention that will exacerbate or precipitate mental and physical illness into the future for them.
80. In relation to both child and women refugees, there have been multiple allegations of sexual assault being perpetrated both inside and outside the ‘Regional Processing Centres’.⁵¹ Notably, this was documented in the 2015 Moss Review which found, among other matters, that:
- a) the existing arrangements for identifying, reporting, responding to, mitigating and preventing incidents of sexual and other physical assault at the centre need to be improved. In particular, there are limited resources for sexual assault to be investigated by Nauruan authorities;
 - b) there is a level of under-reporting by asylum-seekers of sexual and other physical assault, generally due to family and cultural reasons; and
 - c) in relation to children, there were both reported and unreported allegations of sexual and other physical assault.⁵²

⁵¹ Select Committee on the Recent allegations relating to conditions and circumstances at the Regional Processing Centre in Nauru, *Taking responsibility: conditions and circumstances at Australia’s Regional Processing Centre in Nauru*, August 2015, p.99
<http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Regional_processing_Nauru/Regional_processing_Nauru/Final_Report>.

81. Although the Governments of Nauru and Australia have taken steps to address the concerns and recommendations raised in the Moss Review, UNHCR remains concerned that such measures are not appropriately comprehensive. In particular, UNHCR understands that the forensic capacity of the Nauru Police Force to investigate allegations of sexual-based violence against women and children remains extremely limited, despite efforts to enhance capacity through the assistance of the Australian Federal Police. Further, during UNHCR's April 2016 visit claims were made by women asylum-seekers and refugees that they had been sexually assaulted (including rape).

Actual or perceived sexual orientation or gender identity

82. UNHCR has raised on multiple occasions with the Governments of Australia and Nauru the serious protection concerns with regard to instances of actual or perceived sexual orientation and gender identity, which may or have given rise to abuse. The passage of the *Crimes Act 2016* (Republic of Nauru) decriminalized same-sex sexual conduct, which was welcomed by UNHCR. However, this does not necessarily mean that societal attitudes have changed.

V. CONCLUSION

83. In general, UNHCR notes that any concerted and cooperative action by States with the aim to 'save lives at sea' should ensure respect for international law. A State should guarantee that appropriate access is provided to fair and efficient asylum procedures for those seeking international protection, and timely durable solutions are in place for those found to be in need of international protection. UNHCR's longstanding position is that if an asylum-seeker seeks the protection of a Contracting State, that State should process the asylum-seeker on its territory and if found to be a refugee the Contracting State should support local integration within its territory. Any transfer arrangement in relation to asylum-seekers must not occur if relevant international laws and standards are not complied with.

84. With these observations in mind, UNHCR's monitoring missions to Papua New Guinea and Nauru have assessed how the transfer arrangements have evolved over time, with an exceptional emphasis in the April 2016 missions on health concerns. UNHCR has found that

⁵² Philip Moss, *Review into recent allegations relating to conditions and circumstances at the Regional Processing Centre in Nauru*, Recommendation 4, p.47 <<https://www.border.gov.au/ReportsandPublications/Documents/reviews-and-inquiries/review-conditions-circumstances-nauru.pdf>>.

the punitive conditions of open-ended mandatory detention in a highly securitized environment and the lack of any viable long-term solution for transferred individuals has exposed them to circumstances causing harm, notably related to mental health.

85. Overall, it is evident that the guarantees, protections and rights owed to transferred asylum-seekers and refugees have not been adequately fulfilled by either the Government of Australia, the Government of Papua New Guinea or the Government of Nauru, and the transfer arrangements do not appropriately comply with international laws and standards. Australia, together with Papua New Guinea and Nauru (as relevant) share responsibility for ensuring that the rights of the concerned individuals' are fully upheld, and that appropriate solutions are found for them in line with international law and State practice, as well as accepted standards of treatment.
86. UNHCR has found that there are no viable long-term solutions available for asylum-seekers or refugees transferred to Nauru or Papua New Guinea, including no possibility for temporary settlement in either location. This necessitates urgent action to remove all transferred asylum-seekers and refugees from Nauru and Papua New Guinea to Australia, whose obligation to provide protection and appropriate settlement opportunities remains extant.

UNHCR Regional Representation in Canberra

12 November 2016

APPENDIX

A survey of depression, anxiety and post-traumatic stress symptoms and disorder in asylum-seekers and refugees in the Manus Island Regional Processing Centre and Transit Centre

Study design and setting

The present research was conducted at the Regional Processing Centre (RPC) and East Lorengau Transit Centre (ELTC) on Manus Island in Papua New Guinea. The purpose of this research was to establish taxonomies and rates of depressive, anxiety and post-traumatic stress symptoms and disorder of those residing in the Manus RPC and ELTC and to elucidate the factors contributing to such conditions, including the refugee status determination stage and pre-detention experience. Interviews were conducted with willing participants during a visit to the RPC by a visiting Australian psychiatrist, a general practitioner and Papua New Guinea's Chief Psychiatrist. All interviews were conducted between 11 and 14 April 2016.

Recruitment and participants

All participants on Manus Island are men and reside in one of four compounds or, alternatively, the Transit Centre. Participants were recruited by word of mouth and flyers during the visit. All participants were fully informed in their language of choice (on site interpreters were used as needed) that their individual responses would be kept confidential and that participating in the research would neither help nor hinder their case for refugee status determination or associated legal processes.

Aims

The purpose of this paper is to outline the findings in relation to psychiatric morbidity (depressive, anxiety and post-traumatic stress disorders) of the Papua New Guinea RPC and ELTC detainees. In particular, we sought to investigate the prevalence of posttraumatic stress (PTS) and depressive/anxiety symptoms, and to establish the prevalence of PTSD and the presence of a depressive or other anxiety disorder. We explored predictive clinical and environmental factors of the aforementioned psychiatric morbidity.

Instruments

K10

The Kessler Psychological Distress scale (K10) (Kessler et al., 2002) is a simple measure for psychological distress which taps depression and anxiety symptoms. The K10 is used widely, both in clinical practice and epidemiological research and is believed to provide a link between practice and research by allowing a comparison of the severity distribution of nonspecific distress among community versus clinical cases (Kessler et al., 2003).

The interviewer-administered version of the K10 was employed to determine symptom severity of anxiety and depression, and to ascertain likely incidence of depressive and/or anxiety disorders. This version is reverse scored, from 1 (all of the time) to 5 (none of the time), with the aggregate score ranging from 10 to 50 and must be re-scored to allow comparison with other K10 data for which higher scores reflect more severe symptomatology. The time frame is the last 30 days and the interviewer-administered version has an additional 8 questions pertaining to functional impairment and treatment seeking behaviours which are not investigated here.

PTSD-8

The PTSD-8 is screening tool for PTSD based on the Harvard Trauma Questionnaire (Mollica, McDonald, Massagli, & Silove, 2004) which has been validated in a range of culturally and linguistically diverse populations, particularly those from refugee-like backgrounds. The PTSD-8 comprises eight items from the Harvard Trauma Questionnaire, each of which are scored on a Likert scale of 1 (Not at all) to 4 (Most of the time). It has been found to be a psychometrically robust measure, both for assessing posttraumatic stress (PTS) symptom severity, and as a diagnostic proxy for PTSD (Hansen et al., 2010). Participants are asked to consider each item and respond by reporting how much the symptom has bothered them since the trauma and in the last month.

Caseness

Caseness for a depression and/or anxiety disorder (D/AD) was determined by an aggregate K10 score of ≥ 30 . This is a conservative cut-point and was based on the reported statistics of specialist mental health services populations for which individuals with a score in the range of 30–50 were categorised as experiencing “severe levels of distress consistent with a diagnosis of a severe depression and/or anxiety disorder” (Australian Bureau of Statistics, 2012).

PTSD Caseness was derived from the algorithm established by the developers of the PTSD-8. A case is deemed PTSD positive with a score of ≥ 3 for at least one of: items 1-4, *and* item 5 or 6, *and* item 7 or 8.

Demographic Information

Demographic information collected included date of birth, ethnicity, language spoken, date of arrival on Papua New Guinea, site/compound, previous detention sites and duration, pre-, peri-and post-migration trauma and the site of these (to a maximum of three), current medical and psychiatric conditions, current medications prescribed, pre-migration psychiatric history, and refugee status and the refugee status determination decisions (for each of the three stages).

Statistical Analysis

Univariate planned comparisons to investigate differences across groups, symptom scores, diagnostic categories and demographic variables employed non-parametric analyses (i.e., Mann–Whitney *U*, Kruskal-Wallis and Chi squared tests, and Spearman’s Rho correlations).

Multiple linear regression was conducted to identify clinical and demographic predictors of PTS and depression/anxiety symptom severity. Depression/anxiety and PTS symptom scores were reflected and log-transformed to attain normal distributions required for parametric analyses. Logistic regression equations were performed to determine predictors of PTSD and D/AD caseness. All correlations and Fisher’s Exact tests were 2-tailed, and the alpha throughout was set at the 0.05 level unless otherwise specified.

Results

Descriptive Statistics

A total of 181 male participants took part in the study. Twenty-two were based at the Transit centre, and the remaining 159 resided in one of the four compounds, representing 20.6% of the total Papua New Guinea Regional Processing Centre (RPC) population (i.e., 880 men) and approximately one third of those residing in the transit centre. Descriptive statistics are presented in Table 1.

The men’s ages ranged from 19–63, with the mean being 30.9 ± 7.2 years. Whilst the sample comprised 16 ethnic groups (including ‘stateless’ individuals), the majority (60.8%) was Iranian,

Afghani or Pakistani. The mean time at the RPC was 29.6 ± 1.7 months and 76.8% of participants had received a positive decision for refugee status determination. The remainder were asylum-seekers – i.e., those who had yet to apply, whose application was pending, or had been rejected.

All individuals in the Transit Centre ($n=22$) had been granted refugee status, in addition to the majority of those in the Delta (98.4%) and Oscar (100%) compounds. The majority of asylum-seekers were in the Foxtrot (96.8%) or Mike (100%) compounds.

There were no differences between the asylum-seekers and refugees in age ($U=2627$, $p=0.36$) or time in Papua New Guinea ($U=2359$, $p=0.31$). Similarly, the two groups did not differ on medical conditions, psychiatric conditions, previous psychiatric history or prescribed medication.

Individuals with an experience of pre-migration torture or trauma were more likely to be a refugee (83.8%) than asylum-seeker (16.2%), with an odds ratio 3.46 (95% CI 1.51 –7.92). However, refugees also comprised the majority (60%) of individuals who did not report pre-migration torture or trauma.

Ethnicity was the other distinguishing factor between the refugee and asylum-seeker groups. Every Iraqi, Pakistani, Sudanese, and Rohingya had been given refugee status, as had 92% of Afghans. In contrast, only 56% of Tamils and 53% of Iranians were determined to be refugees.

Detention experience

The majority of men (92.2%, $n=165$) had experienced detention prior to being transferred to Papua New Guinea, overwhelmingly within the Australian detention network (91.4%), although detention prior to arriving in Australia was also reported (See Table 2).

The median time spent in pre- Papua New Guinea detention was 1 month (IQR = 0.26–1.50). Total time in detention including Papua New Guinea was 31 months (IQR = 28.6–33.0). Time spent in detention before arriving in Papua New Guinea was comparable for asylum-seekers and refugees, as was total time spent in detention.

A Spearman's Rho correlation matrix found no relationship between duration of detention and PTSD or depression/anxiety severity. This was the case for the total sample, and for refugees and asylum-seekers separately.

A weak to moderate association ($\rho = -.287, p = .01, n = 82$) was found between pre-migration trauma and total time in detention for refugees but not asylum-seekers, indicating that those who had experienced pre-migration trauma were more likely to have spent longer in detention. Previous psychiatric history was moderately associated ($\rho = -.569, p < .001, n = 41$) with pre- Papua New Guinea detention duration for asylum-seekers but not for refugees ($\rho = -.125, p = .15, n = 135$).

A weak ($\rho = .257, p = .003, n = 135$) correlation was also found, between time in Papua New Guinea and being in the transit centre for the refugees.

Psychiatric morbidity

No differences emerged in rates of PTSD ($\chi^2(4) = 4.45, p = 0.35$) or D/AD ($\chi^2(4) = 3.29, p = 0.51$) between the interviewers.

Overall, symptoms of PTS and depression/anxiety were moderately correlated ($\rho = 0.551, p < .001, n = 176$). As presented in Table 3, there was no difference between the asylum-seeker and refugee groups in PTSD or D/AD prevalence, however asylum-seekers scored significantly higher on post-traumatic stress symptoms than the refugees, with a small effect size ($r = .17$). Asylum-seekers also scored higher on symptom severity for depression/anxiety, with a small effect size ($r = .16$).

No significant differences emerged for psychiatric morbidity across the five RPC sites.

No relationship emerged between age and either PTSD ($U = 2060, p = 0.06, n = 177$) or D/AD ($U = 1289, p = 0.16, n = 180$), nor symptom severity for PTS or depression/anxiety.

Two separate multiple linear regressions were performed with depression/anxiety and PTS symptom severity as the respective outcome measures. To reduce the number of predictor variables being entered into the regression equation at the outset, a Spearman's Rho correlation matrix was performed with all the predictor variables and the two outcome variables. Predictor variables that showed a significant relationship with either of PTS or depression/anxiety symptom scores were then entered simultaneously into the respective multiple regression equation with missing values deleted pairwise. The results of both analyses are presented in Table 4.

The principal predictor for each of the two symptom scores was the other measure. Depression/anxiety symptom score, current psychiatric condition and refugee status accounted for 34% of the

variance in PTS symptom severity, with depression/anxiety symptom score making the only unique contribution, constituting 25% of the variance.

PTSD diagnosis was removed from the regression equation predicting depression/anxiety symptom severity due to a better model fit with PTS symptom score alone. The final model accounted for 31.6% of the variability in depression/anxiety symptom severity, with PTS symptom score making the only significant unique contribution (23.4%), in addition to current psychiatric condition, ethnicity and refugee status.

A Spearman's Rho was performed to examine the relationship between PTSD and all clinical and demographic factors. Variables that resulted in an alpha level of ≤ 0.10 were input as predictors into a logistic regression with PTSD as the binary outcome variable. The independent variables entered into the equation were: age, medical condition, (current) psychiatric condition and depression/anxiety (K10) score.

The logistic regression model was statistically significant, indicating an ability to distinguish between those with and without PTSD, $\chi^2(4, N=174)=37.68, p<0.001$. As shown in Table 5a, only medical condition and depression/anxiety score made a unique statistical contribution to the model, which overall explained between 19.5 % (Cox & Snell R squares) and 30% (Nagelkerke R squared) of variance in PTSD status, and correctly classified 82.2% of cases.

The same procedure was conducted for the logistic regression for D/AD as for PTSD, with the exception that only variables in the Spearman's Rho correlation with a p value of 0.05 were considered, in order to limit the number of factors entered into the equation. RPC site, whilst having a weak significant relationship with D/AD diagnosis was omitted due to the outcome of a more robust analysis which found the relationship to be non-significant (see Table 3). The independent variables entered into the equation were: pre-migration torture/trauma, (current) psychiatric condition and PTS score.

The logistic regression model was statistically significant, indicating an ability to distinguish between those with and without D/AD, $\chi^2(3, N=181)=36.21, p<0.001$. As shown in Table 5b, only PTS score made a unique statistical contribution to the model, which overall explained between 23.5 % (Cox & Snell R squares) and 42.3% (Nagelkerke R squared) of variance in D/AD status, and correctly classified 88.9% of cases.

Discussion

The rates of caseness for depressive or anxiety disorders and/or PTSD in the asylum-seeker and refugee population in the Manus Island RPC or ELTC are amongst the highest recorded rates of any surveyed population. They are many-fold higher than in mainstream Australian populations and higher than that recorded in asylum-seeker populations living in the Australian community. It is likely that the circumstances, conditions and duration of detention have contributed significantly to the development of these disorders. In particular most participants reported the February 2014 disturbance as being particularly traumatic both in itself and in reactivating memories of past trauma. This is consistent with sensitisation of traumatic memories given that 71% of the sample had previous torture or trauma experiences but only 11% had been diagnosed with a psychiatric disorder.

Much of this prevalence has not been identified and remains untreated and thus poses a considerable morbidity risk to the affected individuals. In addition, individuals who had sought treatment in the past were disengaging from the health service provider, believing that the services were unhelpful. The exception was the OSTT service which most patients identified as being helpful. It should be noted that only a very small number of people were receiving treatment through this service due to capacity constraints.

These affected individuals in particular with respect to the absence of treatment will experience significant morbidity and potentially mortality from suicide and it is likely will require considerable treatment to regain premorbid levels of functioning. It is important to note that such treatment services do not exist within the mainstream Papua New Guinea health system.

The relative absence of any mediating risk or mitigating factors is likely due to a ceiling effect of many of the predictor variables. The comparative lack of variance in many expected relevant factors such as duration of detention is the most plausible explanation, although, their actual relevance is still possible. As with previous studies⁵³ the strongest predictor of mental disorder was the presence of another disorder indicating the severity of the morbidity and the importance of early recognition and effective treatment.

⁵³ Hocking DC, Kennedy GA, Sundram S. Social factors ameliorate psychiatric disorders in community-based asylum seekers independent of visa status. *Psychiatry Res.* 2015 230(2):628-36.

There were a number of potential limitations that may have influenced the findings. The sample were self-selected and may not have represented the true prevalence of psychiatric morbidity in the RPC or EFTC. We believe that only those well enough to present for the interviews attended and that many who were too unwell did not attend suggesting a potential under-estimate of the prevalence. Individuals may have over-reported symptomatology believing that this may have some indirect benefit for their situation. This seems unlikely given that most were already found to be refugees and there were no major differences between the asylum-seeker and refugee samples. Variation in translation by interpreters may have skewed results, although this seems unlikely given the lack of any major differences between the language groups.

Conclusion

The prevalence and severity of mental disorders presented by the asylum-seeker and refugee population on Manus Island is extreme. Furthermore, it is not apparent that current treatment services recognise or are adequately treating these patients placing them at further risk of deterioration. Moreover, the type, extent and severity of these mental disorders is unprecedented within the Papua New Guinea health system. It sharply contrasts with the range of disorders typically seen within the Papua New Guinea context. That is Papua New Guinea mental health services are structured to assess and treat low prevalence illnesses such as schizophrenia, bipolar disorder and substance related disorders. There is no current skills capacity within Papua New Guinea public mental health services to address severe post-traumatic stress disorder and current resourcing will not be able to cope with the surge of cases with major depression.

TABLES

Table 1 – Socio-demographic characteristics of sample

		<i>Total n=181*</i>	<i>Refugee</i>	<i>Asylum-seeker</i>	<i>Statistic</i>
		<i>%**</i>			
Refugee Status	Determination				
	Refugee	76.8 (139)			
	Asylum-seeker	23.2 (42)			
Ethnicity					$\chi^2(1)=5.74, p<0.02, n=181$
	Iranian	30.4 (55)	20.9 (29)	61.9 (26)	
	Pakistani	16.6 (30)	22.6 (30)	-	
	Afghan	13.8 (25)	16.5 (23)	4.8 (2)	
	Rohingya	7.7 (14)	10.1 (14)	-	
	Sudanese	6.6 (12)	8.6 (12)	-	
	Iraqi	5.5 (10)	7.2 (10)	-	
	Tamil	5.0 (9)	3.6 (5)	9.5 (4)	
	Somali	5.0 (9)	5.0 (7)	4.8 (2)	
	Bangladeshi	3.3 (6)	2.9 (4)	4.8 (2)	
	Stateless	2.2 (4)	2.2 (3)	2.4 (1)	
	Lebanese	1.1 (2)	-	4.8 (2)	
	Vietnamese	1.1 (2)	-	4.8 (2)	
	Ahwaz	0.6 (1)	-	2.4 (1)	
	Karen	0.6 (1)	0.7 (1)	-	
	Burmese	0.6 (1)	0.7 (1)	-	
Spoke English					$\chi^2(1)=1.04, p=0.31, n=180$
	Yes	21.1 (38)	23.2 (32)	14.3 (6)	
PNG RPC Site					$\chi^2(1)=2.00, p=0.16, n=181$
	Delta	33.7 (61)	43.2 (60)	2.4 (1)	
	Oscar	30.9 (56)	40.3 (56)	-	
	Foxtrot	17.1 (31)	0.7 (1)	71.4 (30)	
	Transit Centre	12.2 (22)	15.8 (22)	-	
	Mike	6.1 (11)	-	26.2 (11)	
Pre-Arrival detention					<i>Fisher's Exact p=0.32, n=179</i>
	Yes	92.2 (165)	93.5 (129)	87.8 (36)	
Pre-Migration					$\chi^2(1)=7.84, p=0.01, n=139$
Torture/Trauma					
	Yes	71.2 (99)	77.6 (83)	50.0 (16)	
Peri & Post-Migration					<i>Fisher's Exact p=0.58, n=181</i>
Torture/Trauma					
	Yes	97.8 (177)	97.1 (135)	100 (42)	
Previous Psychiatric					<i>Fisher's Exact p=0.10, n=178</i>
History					
	Yes	11.2 (20)	8.6 (12)	19.0 (8)	
Medical Condition					$\chi^2(1)=0.11, p=0.75, n=180$
	Yes	57.5 (104)	58.3 (81)	54.8 (23)	
Current Psychiatric					$\chi^2(1)=1.26, p=0.26, n=178$
Condition					
	Yes	64.6 (115)	62.0 (85)	73.2 (30)	
Prescribed Medication					$\chi^2(1)=0.05, p=0.82, n=181$
	Yes	49.4 (88)	51.5 (70)	42.9 (18)	

* Total ns less than 181 are due to missing data

** Refers to valid percentage, excluding missing data

Table 2 – Frequencies of pre- Papua New Guinea detention episodes (N=176 *a*)

Pre-detention site	% (<i>n</i>)
Australian territory	90.9 (160)
<i>Christmas Island</i>	85.8 (151)
<i>Darwin</i>	4.5 (8)
<i>Melbourne</i>	0.6 (1)
Indonesia	3.4 (6)
Iran	1.7 (3)
Malaysia	1.1 (2)
Other country <i>b</i>	2.8 (5)

a *N* refers to total detention episodes reported (to a maximum of two sites), not number of participants.

b *n*=1 – PNG, Saudi Arabia, Somalia, Sri Lanka, Sudan

Table 3– Psychiatric morbidity by Refugee determination status and Papua New Guinea RPC site

	Total	Refugee Determination Status		PNG RPC Site				
		Refugee	Asylum-seeker	Delta	Foxtrot	Mike	Oscar	Transit Centre
PTSD	79.1 (140)	76.5 (104)	87.8 (36)	80.0 (48)	90.0 (27)	81.8 (9)	70.9 (39)	81.0 (17)
<i>Statistic</i>		$\chi^2(1)=1.81, p=0.18, n=177$		$\chi^2(4)=4.48, p=0.34, n=177$				
Depressive/Anxiety Disorder	88.4 (160)	87.1 (121)	92.9 (39)	93.4 (57)	90.3 (28)	90.9 (10)	87.5 (49)	72.7 (16)
<i>Statistic</i>		<i>Fisher's Exact</i> $p=0.41, n=181$		$\chi^2(4)=6.97, p=0.14, n=181$				
Symptom severity	<i>Md (IQR)</i>							
Posttraumatic stress	26 (22-29)	26 (22-28)	28 (24-31.5)	25 (23-28)	28.5 (23.8-31.3)	26 (24-32)	26.5 (20-29)	24 (20-27)
<i>Statistic</i>		$U=2140, p=0.03, n=176$		$\chi^2(4)=7.54, p=0.11, n=176$				
Depression/Anxiety	41 (35.0-45.5)	40 (33-45)	44 (39.8-46)	41 (37.5-45)	44 (39-46)	45 (39-47)	37.5 (32.3-44.8)	39 (27.8-47)
<i>Statistic</i>		$U=2267, p=0.03, n=181$		$\chi^2(4)=5.06, p=0.28, n=181$				

Table 4 – Predictors of depression/anxiety and PTS symptom scores

Predictor variable for PTS	Adj R Square	Statistic	Part correlation	Predictor variable for Depression/Anxiety	Adj R Square	Statistic	Part correlation
	.340	$F(3,169)=30.56, p <.0001$.313	$F(4,168)=20.62, p <.0001$	
Depression/Anxiety score		$t=-8.00, p <.0001$	-.50	PTS score		$t=-7.69, p <.0001$	-.49
Psychiatric condition		$t=2.24, p=.03$.14	Psychiatric condition		$t=1.65, p=.10$.10
Refugee status		$t=-1.40, p=.16$	-.09	Ethnicity		$t=-0.97, p=.33$.06
				Refugee status		$t=-0.54, p=.59$	-.03

Table 5a – Clinical and demographic predictors of PTSD caseness

Predictor variable	<i>B</i>	S.E.	Wald	df	<i>p</i>	Odds Ratio	95% CI
Age	.02	.03	.39	1	.54	1.02	0.96 – 1.07
Medical condition	-1.10	.45	6.14	1	.01**	.33	0.14 – 0.79
Psychiatric condition	-.60	.46	1.74	1	.19	.55	0.22 – 1.34
Depression/anxiety score	-.11	.03	19.05	1	.00*	.90	0.85 – 0.94

* Significant at the 0.001 level

** Significant at the 0.05 level

Table 5b – Clinical and demographic predictors of depression or anxiety disorder caseness

Predictor variable	<i>B</i>	S.E.	Wald	df	<i>p</i>	Odds Ratio	95% CI
Psychiatric condition	-.77	.63	1.50	1	.22	.46	0.14 – 1.59
Pre-Migration Torture/trauma	-.92	.62	2.17	1	.14	.40	0.12 – 1.35
PTS score	-.23	.05	19.41	1	.00*	.79	0.72 – 0.88

* Significant at the 0.001 level

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