Social Work with Refugee Survivors of Torture and Trauma

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Introduction
Although the refugee torture and trauma field of practice has been established relatively recently, both internationally and within Australia, the problem of human rights abuses and suffering caused by oppressive regimes has existed for much longer. This chapter focuses on social work with traumatised refugees – people who have suffered from state sanctioned violence, or war, and who have been forced to flee from their homelands. In fear of persecution if they were to return to their own country, they have sought asylum in many countries, including Australia.

Related areas of practice include working with tortured or traumatised Australian born people, such as the indigenous population, and Australian war veterans. These significant topics merit attention on their own, as they involve large populations of people within Australian society, whose situations arise from specific, historical events which have shaped our nation, Social work with people of non-English speaking backgrounds is also a broad area of practice which intersects with refugee work.

Thinking about torture and refugee trauma rises painful thoughts about human suffering, cruelty, and the problem of evil in the world. The idea of people abusing and killing others through organised violence is so horrible that it is a natural response to deny the existence of these aspects of life; yet there is a human compulsion to face them as well. Central to the social work code of ethics is a commitment to social justice and valuing the rights of all people. Working with survivors of human rights abuses is therefore an important field for social workers, which relates to the core values of our work.

This field of practice has clear political dimensions. Torture and trauma are the result of abuses of power. Social workers in this field are exposed to stories of gross human rights violations, and cannot maintain neutral opinions concerning the actions of various groups and regimes. Conversely, one is also exposed to the complexities of civil and international conflicts; one’s own political ideologies, stereotypes and beliefs are all challenged in this work.

The political legislative and social issues which form a background to this field of practice have both world wide and national contexts. International developments such as wars, civil conflicts, abuse of citizens by governments, and the ensuing refugee crisis around the world all interact with torture and trauma work in Australia. A disturbing reality is that the majority of the refugees and humanitarian entrants to Australia every year (currently about 12,000 people) are torture and trauma survivors who have come from these situations. It is necessary for social workers in this field to develop an understanding of organised violence and its effects on individuals, families and societies, and also of the refugee experience of escape and surviving in refugee camps.

At an Australian national level, the topic of immigration and the treatment of asylum seekers has risen as a crucial area of debate between the political parties in recent years. The last two decades have been a time of significant growth and change in migration law and practice, with refugee appeals becoming a major focus of the judicial review work of the Federal Court of Australia. Crock makes the point that the ambivalent social attitudes towards accepting
refugees into Australia are reflected in the harsh law and policies regarding on-shore applicants for refugee status. It is also useful to compare Australia’s refugee policies and law with those of other refugee receiving countries; most western countries now fear a massive influx of refugees, and are tightening their border control laws. (Crock, 1998: 163, v,3). These recent developments in refugee law, federal politics and refugee social policy impact directly on social work practice with survivors of torture and trauma.

Examining Australia’s refugee law and policies raises fundamental issues about Australian society and its values. These include topics such as international human rights and civil liberties, foreign relations, national sovereignty, population policy, industrial relations, environmental protection and wealth distribution. Australia’s law and policies regarding refugees need to be understood in the broader context of the history of Australia’s immigration program – which has been a dominating influence in the formation of the Australian nation. (Crock, 1998:v). This important discussion is beyond the scope of this chapter, but relevant to study of social work.

The broader scope of social work practice, examining people in societies is ideally suited to this field of practice. An understanding of the client group requires a detailed knowledge of the psychological affects of trauma on individuals, families and groups, and of the social, political and legal dimensions of refugee community work and refugee social policy. Social workers need to become familiar with the histories and politics of various international conflicts and to develop skills and theory in working cross-culturally and in a multicultural team. Social workers can build on their initial professional training to specialize in a particular area, such as management, community development work, psychotherapy, family therapy, group work, case management, social research, or in a combination of these.

As the refugee torture and trauma field is relatively new in Australia, the history and roles of social work practice in this area are in the process of early development. As it is a new field of work, the first half of the chapter will introduce the major issues in understanding the client group o torture and trauma survivors. This will include:
(i) an introduction to the refugee situation in the world and Australia’s humanitarian program
(ii) the individual and societal dimensions of torture, and phases of refugee trauma including escape and living in refugee camps
(iii) issues facing refugees in Australia, such as torture and trauma related problems, grieving and losses associated with the refugee experience, and resettlement issues in the new society.

The second half of the chapter will provide a background to social work practices in Australia with this client group, and will introduce:
(i) a summary of current legal, political and social policies influencing work with refugee survivors of torture and trauma in Australia
(ii) a brief history of the recent development of refugee torture and trauma services in Australia. Lastly a description of the development of the social work roles in this new field of practice will be provided, focusing on the New South Wales experience. The current environment for social work within the broader health system will also be referred to in this discussion. Some ethical issues facing social workers in this field, and the future of social work with this client group will also be examined.

World Refugee Situation and Australia’s Humanitarian Program
The United Nations High Commission for Refugees (UNHCR) described the current total number of people who have been forced to flee their homes, whether as refugees or internally
displaced persons, as being around 50 million (see [http://www.unhcr.ch](http://www.unhcr.ch)). Of these, there are approximately 22 million refugees and other “people of concern” (returnees, asylum seekers, internally displaced persons) within the UNHCR mandate, and the remainder are additional internally displaced persons.

The UNHCR defines refugees as people who are outside of their own country and who cannot or do not want to return because of a well founded fear of being persecuted for reasons of their race, religion, nationality, political opinion or membership of a particular social group. There are many displaced people with “refugee – like” experiences who do not fit this narrow definition, and who have not been able to gain the status of being a refugee, either from the United Nations or from a government which has signed the UN or regional instruments on the status of refugee (see [http://www.unhcr.ch](http://www.unhcr.ch)). Up to 80% of the world’s refugees are women and children. Resettlement is offered to less than 3% of the world’s refugees. (Refugee Health Policy Advisory Committee, (RHPAC) 1997.5)

These statistics point to a world – wide situation of millions of people fleeing persecution, war human rights abuses and serious discrimination. There are refugees and internally displaced people from in and around the Middle East, (Palestine, Afghanistan, Iraq, Iran, Lebanon for example), Africa, the former Yugoslavia, the former USSR, East Asia, the Indian subcontinent, Central and Latin America. Currently, the largest number of refugees are listed as coming from Afghanistan (2.6 million) and approximately half a million respectively from Iraq, Bosnia and Herzegovina, Somalia, Burundi and Liberia. There are more than three million refugees from each of the following countries: Sudan, Croatia, Sierra Leone and Vietnam. (see [http://www.unhcr.cr](http://www.unhcr.cr))

Since the Second World War, of the 5.5 million people who have migrated to Australia, more than 560,000 people have arrived under the humanitarian programs, initially as displaced persons and more recently as refugees. (Crock, 1998: 124). World events have influenced Australia’s pattern of refugee intake. For example, following World War II, large numbers of displaced people from Europe settled in Australia. People have fled to Australia from totalitarian governments, for example, from Hungary (1956), from Czechoslovakia (1968), and more recently, from South and Central America, from Iran, Iraq, Vietnam, Cambodia, Laos and China. Some refugees have escaped ethnic or religious persecution, for example, for example, many groups from the Middle East, Russians from China, Tamils from Sri Lanka and Fijian Indians. Others have fled civil and international wars, for example, people from Afghanistan, Somalia, Ethiopia, Sudan, Palestine, the former Yugoslavia. (Jupp, J (1994) quoted in RHPAC, 1997:8). Since 1996, Australia has received about 12,000 humanitarian entrants per year. ([http://www.immi.giv.au](http://www.immi.giv.au)). Over 40% of the humanitarian entrants to Australia settled in NSW between 1991-1997. Victoria received about 34% of the entrants over the same period. Of the NSW arrivals the majority have settled in the South Western Sydney (38%) during this period, followed by 21.5% in Western Sydney. Smaller proportions have settled in other parts of Sydney, and in rural areas. (RHPAC,1997-9-10).

Mc Gorry (1995:464) sites several studies which show that the majority of refugees have suffered significant levels of trauma and have also undergone many losses. (Westermeyer et al, 1991; Krupinski et al, 1973; Krupinski and Burrows, 1986). There is also a significant number of refugees who have suffered torture. Pittway (1991: 68 –9) described the most significant finding of her research about refugee women as being the extent and degree of torture and trauma experienced by refugee women prior to arriving in Australia; Pittway fount that this had been grossly underestimated – almost three quarters of her sample of 204 women
had suffered medium levels of trauma. Torture and trauma services from across Australia indicated to the NSW Refugee Health Policy Advisory Committee in 1997 that 80% of refugees from certain countries had suffered significant levels of torture and trauma.

The following section which introduces the experiences of these refugees will first examine the nature of torture, and then more broadly describe phases of refugee trauma.

**Torture and Refugee Trauma**

**Torture**

Torture and ill treatment of prisoners had been reported in over 100 countries. (Evatt, 1996; citing Amnesty International reports). Torture must be one of the most terrifying and horrible aspects of human existence. The pre-medicated aspect of such cruel acts is disturbing.

Cunningham, Silove and Storm summarised many forms of physical and psychological maltreatment. Physical torture commonly reported including beatings; forced standing (often, while naked); bondage; suffocation; burnings; electric shocks; sexual abuse; mutilation; submersion in or irrigation with cold water. Psychological torture can include disorientation by sleep disruption and sensory deprivation; hallucinations and paralysis caused by drugs; solitary confinement; denigration and insults; sham executions; false accusations; prolonged interrogations; being forced to watch loved ones raped; tortured or killed. (1990-502). Just reading comprehensive accounts of torture leaves one felling sickened, terrorised and/or perverted. It is overwhelming and unbearable to even imagine these events.

Hosking (1990:11) points out that torture is not limited to any one geographical region political ideology. There appears to be a higher rate of torture in countries with military dictatorships or regimes which do not allow individuals or groups to participate in the political decision making process.

**The Social and Political Effects of Torture and State-Sanctioned Violence**

As described above, the purpose of torture is not only to punish individuals or to extract information. Modern torture is often directed at destroying the integrity of the individual’s personality. (Reid and Strong, 1988:340-346). Political opponents are then seen to be destroyed, spreading terror and compliance with those in power, in the broader society. For example, Becker, Lira et al, (1990:1) discuss the effect that systematic political repression has had on both individuals and the society in Chile, describing how there has been a general “social damage” in the society which could be understood as a “psychosocial trauma” (1990:2).

The paper written in 1989 by the Jesuit priest Martin-Baro, just prior to his murder in El Salvador, describes the psychological effects of state violence on the general population as including people’s thinking and behaviour becoming stereotyped, polarised and rigid; people becoming isolated and losing their confidence in themselves and each other, a general devaluing of human life (1989:3-5). The conclusion of the paper outlines the societal dimensions of state terrorism clearly:

> “I would like to emphasize the social dimensions of torture, disappearances, abductions, and terrorism. It is important because for every tortured Salvadorian killed, there are at least 10,000 who are violently forced to abdicate from their personal options and values. For every disappeared person, there are at least lives and to determine their life projects. And that is why we think that even when we are speaking of very deep psychological problems, we are talking about political problems”. (1989:5).
Phases of Refugee Trauma
Raphael (1986:124-148) introduced the idea of phases of refugee trauma. These phases including living in a country in the midst of widespread violence and upheaval; being arrested, tortured or attacked, or having family members and/or friends being tortured or killed; becoming internal fugitives and then fleeing the country itself; suffering deprivation, overcrowding and violence in refugee camps; attempting resettlement in a country of asylum. (quoted in Silove, Tarn, Bowles and Reid, 1991:484-485). These phases will be broadly referred to in the following discussion.

Living in Situation of War or State Terrorism
Most refugees come from countries where there have been years of political, social and economic instability. Many flee international or civil wars, and situations of military dictatorships, oppression and violence. People suffer from ill health as a result of famine, disease and poor medical facilities. Their economic circumstances are effected by political corruption and deprived living conditions. They fear persecution from the authorities or certain groups, within the society. Many lose their livelihood. Some see their close family members “disappear” or arrested, tortured, imprisoned or killed. (Hosking, 1990:8).

The situation in Afghanistan is one example of massive destruction and ten years’ war (1979 – 89), leading to the deaths of approximately two million people, hundreds of thousands of disabled people and more than six million refugees. Attacks on people included air and artillery bombardments, the placing of millions of landmines, mass, killings, torture and imprisonment, burnings in canals, dying from poisoned water, being thrown from planes. There was a particularly large number of civilian casualties, mainly women and children. The aftermath of the Soviet occupation was a group of warring factions. – a people who have been divided from each other by the occupying force as a way of controlling resistance. Of the 17 million Afghan people, at least one third now live in exile, and more than two million are displaced as refugees inside the country. Life expectancy is 42 years. (Amnesty International Report, 1992; Arnold, 1981, Bonner, 1981; Dupree, 1973; - quoted in Bowles and Haidary, 1994: 5).

Escape
Refugees escaping from their country can be exposed to danger and violence. For example, Krupinski and Burrows estimate that thirty per cent of Vietnamese boat people were robbed by pirates and over ten per cent were raped or abducted. Nearly one hundred thousand boat people died in the seas, by starvation when engines failed or by pirate attack. (quoted in Hosking, 1990:12). There are countless stories of the shocking cruelty of these pirate attacks, yet there have been no apparent attempts by the authorities to punish those who committed these acts. (1990:13).

Refugees who escaped from their countries by sea often have the experience of not being allowed to land when they reach a new destination. Those who escape by land, for example from Cambodia or Laos, have been often hiding from soldiers, crossing minefields, swimming across wide rivers under artillery fire, trying to avoid capture by boarder police. Refugees escaping the massacres of the civil war in Somalia, for example, speak of walking for several months to the refugee camps in Kenya, experiencing attacks by militias, starvation and exhaustion.

Life in Refugee Camps
People who have managed to reach camps generally live in appalling conditions there. There is a lack of effective law enforcement and internal security. Mollica and Jalbert refer to the “deterrence” principle of refugee camps: how camps are deliberately made inhospitable places so as to deter people from fleeing to them. (1989, quoted in Cunningham and Silove, 1993:753). For example, refugees are often robbed, assaulted or raped in the camps by the people who are meant to be protecting them. They live in overcrowded, unsanitary conditions, often without sufficient food or water.

Mehraby (1999:14-15) describes the current situation in one camp for Afghan refugees. “The houses were very small with two to three rooms and small windows with plastic coverings rather than glass. A house this size would be shared by three families... there was one school for the 15,000 children, and it went to primary school level only. Girls were not allowed to attend... there was one public health clinic...The main health problems were infectious diseases... Most deaths among children at the camp could have been prevented by immunization”

Hoskings describes how camp life is crushing and uncertain. Refugees are afraid to return home, yet know that resettlement countries are unwilling to accept them. People may survive in refugee camps for years with little hope of resettlement. (1990:15). A Khmer colleague described how waves of panic and terror can sweep through a refugee camp suddenly; people are living in constant fear and fear helpless. Violence is common. People are angry and traumatised. Gangs may rape, blackmail or rob other refugees within the camp. Hoskins discusses how domestic violence is frequent, and most of the victims of beatings, stabbings, shootings, harassment and sexual assault are women. Most suicide attempts are by young women following an argument with a close relative, usually their husband. Hosking point out that women and children are the most vulnerable to violations of their fundamental rights (1990:15).

**Issues Facing Refugees in Australia**

Aroche and Coello (1994:1) describe a model of three kinds of challenges faced by refugees in their country of resettlement: (i) torture and trauma issues (ii) migration and resettlement issues, including grieving and losses of living in exile, (iii) normal life cycle stages and personality/family issues.

Aroche and Coello point out that these issues not only affect individuals, but also families, social networks, communities, and these people and groups interact with the social and political systems of the country of resettlement. In addition, these issues interact with each other, within the context of the cultural, psychological, educational and religious dimensions of the individual, family or community. (1994:5)

The interconnected issues facing refugees in Australia will be briefly described using this model of three kinds of challenges.

**Problems Due to Refugee Torture and Trauma**

Many survivors of torture and trauma experience chronic symptoms which continue for many years. These include symptoms of (i) hyperarousal (for example, sleep problems, irritability, poor memory and concentration) (ii) re-experiencing the traumatic events (for example, traumatic nightmares, traumatic intrusive memories, flashbacks) (iii) numbing and dissociation (for example, avoiding thinking about the past, avoiding people or places that remind one of the past, being unable to remember aspects of the traumas, general social withdrawl, inability to feel certain emotions, restricted sense of the future). Judith Herman describes this condition as
the “dialectic of trauma” (1992:47), where the symptoms vacillate between a constant re-
re-experiencing symptoms predominate, whereas later the numbering symptoms seem stronger.

Judith Herman writes that traumatic events (such as torture) confront human beings with the 
severe experiences of helplessness and terror, and people come face to face with violence or 
death. (Herman, 1992:33). During torture, a person’s sense of identity, trust in others and 
personal, life sustaining, beliefs are deeply attacked. The psychological structures of the self, 
and also on the systems of attachment and meaning that link individual and community. 
(Herman, 1992:51)

In addition, the developmental stage of life in which the trauma started is important in 
understanding the effects upon the person and family concerned. For example, the kinds of 
issues faced by survivors who have been traumatised from an early age are far more deeply 
embedded in themselves and in their relationships. Another issue relevant for understanding 
different reactions and recoveries is the severity and length of the trauma. For example, some 
people may have survived years of imprisonment and torture, and others, one night of detention 
and assault. While not meaning to minimise the latter experience, severity of experience is an 
important dimension for understanding the effect of trauma on people.

There is an important emphasis in this field not to pathologise people who are considered to 
have “normal responses to abnormal experiences,” and therefore to avoid psychiatric labels, 
such as chronic or complicated post traumatic stress disorder. At the same time, these 
categories of symptoms can be a helpful framework for people to understand their confusing 
and debilitating condition.

Trauma can be carried by an entire family, and by groups and refugee communities. The loss, 
disappearance, or torture of a parent or sibling traumatises all other family members also, and 
living with a person with severe post traumatic condition is continually distressing. Domestic 
violence can follow in a family where the male has been arrested and tortured, and then acts 
out aggressively or in response to internal triggers from his imprisonment. (Footnote 1) The 
psychological and social effects on the general population of living under state terrorism, as 
described by Martin-Baro above, can be seen mirrored in the distrust and splitting rife in many 
refugee communities. (Footnote2) One colleague who worked as a counsellor in Sarajevo during 
the recent war said that living in such a situation seemed to bring out the best in some people 
and the worst in others, as if polarisation also occurred along this continuum as well. People 
have to live with their past choices and their histories, many refugee families and social 
relations have roots which extend prior to coming to Australia. [1]

Viewing refugees as being traumatised people with multiple problems is only one side of their 
story. It is important to affirm the survival and the hope which these people have maintained 
through their lives. While avoiding stereotyping refugees as “victims or heroes,” it must be 
recognised that these are determined people who have come through a gauntlet of 
overwhelming life experiences to finally reach a country of resettlement. Many are, in fact 
outstanding individuals who have suffered for their convictions. When trying to describe effects 
of refugee trauma, there is a challenge in recognizing the depth of suffering, together with 
affirming the courage need to endure such horrible experiences, and their aftermath.

Problems Due to Migration and Resettlement
In addition to suffering from the reactions associated with traumatic experiences, refugees have 
to endure the normal grieving and adjustments of moving to a new country. Migration in itself is
a considerable upheaval in life. It involves multiple and enduring losses of career, status, family and social connections, material possessions and homes, familiar surroundings and social systems, emotional and sustaining connections with one’s past and childhood, of a sense of belonging.

There are some additional issues, which refugees face in the migration process. These include being forced to flee their homes (rather than choosing to leave), not being able to return home and not having chosen to come to Australia but rather escaping here as a last resort. Many refugees in Australia feel guilty and agonise over relatives “lost” in the war zone back home, or starving and sick in hopeless situations in refugee camps. Many refugees cannot properly begin their new lives in Australia as emotionally and financially they are focused on the situation of close relatives overseas. Coming from cultures where the extended family can often live together under one roof, the definition of “close” relative can include a large number of people. The grieving following the separation from these relatives in deep. Many refugees spend a considerable proportion of their lives trying to care for family members overseas, for example saving money to send to relatives in camps, and enduring protracted application processes to sponsor relatives in Australia.

Hence, in addition to suffering from severe trauma symptoms, refugee survivors of torture and trauma also are coping with painful losses and separations. Most refugees present with a combination of trauma and grief symptoms. These can be expressed at an individual, family or community level. (Savage, 1999 and Bowles, 1995)

The refugee Health Policy Advisory Committee (1997: 14-16) summarised some significant practical factors that impact on the process of resettlement for refugees. These include (i) unemployment (ii) income support (iii) accommodation (iv) English language ability and (v) living in rural or isolated areas. Although refugees may be suffering from a combination of trauma-related and grieving psychological issues, pressing survival practicalities are generally what concern them upon arrival in Australia. These practical problems tend to exacerbate each other.

**Individual and Life Cycle Issues**

Reactions to trauma and torture, and issues relating to the losses of migration and resettlement challenges, intersect with the refugee’s own family and personality issues. Individual reactions to trauma and migration are unique. Herman’s discussion of vulnerability and resilience (1992:57-61) makes the point that no two people have identical reactions, even to the same event. People’s reactions relate to their childhood history, their emotional conflicts, their adaptive style, to their family resources, to their current life issues and situations. There is a wish to avoid value judgements in these discussions, but rather to understand reasons for individual reactions to trauma.

There are specific issues for groups of refugees, such as refugee children, adolescents, women, men, aged refugees and asylum seekers. There are summarised in the Refugee Health Policy Advisory Committee document (1997: 17-26). For refugee children, problems include high vulnerability to disease in refugee camps; arrested psychological development due to early trauma, deprivations and broken families; the vulnerability of unaccompanied minors without parents to look after them. Refugee adolescents also suffer from these problems, which complicate the development of their adult identity and may lead to acting out in relation to drugs or sexual behaviour.
For refugee women, a major problem is the high rate of sexual abuse suffered as part of the refugee trauma. STARTTS estimates that at least one third of refugee women have experienced sexual assault, and for some nationalities this proportion is much higher. (1997:22). Refugee women suffer from many health problems due to lack of facilities and screening in refugee camps over long periods (for example cervical cancer, sexually transmitted diseases) and due to some cultural practices such as female genital circumcision. The birth of children can be especially traumatic for refugee women as it may trigger memories of sexual abuse. Domestic violence is another common problem for refugee women whose partners may have been tortured and who are acting out the abuse on their wives. The isolation of refugee women also makes them more vulnerable.

Men are more likely to have experienced longer terms of imprisonment and more lengthy, extreme forms of torture. They are more likely to have bullets or shrapnel embedded in their bodies, to have poorly set broken bones, and other injuries. Often they spend long periods of isolation in Australia, waiting for their applications to sponsor their families to Australia to be processed. Other problems include unemployment and poor self confidence due to loss of status in the family as the breadwinner and traditional head of the family. Men are less likely to seek support from groups or from counsellors, or to attend any health services. (1997:25)

Older refugees include those who arrived in Australia soon after World War II, and those who have recently arrived as elderly migrants to join their refugee adult children. Their special problems include lack of English, isolation, and psychological stresses associated with unresolved past traumas, losses and crises, unfulfilled expectations, the stresses of assimilation and cultural difference. (1997:26)

**Australia's Response: Legal, Political and Social Policy Dimensions of Refugee Resettlement**

*Legal and Political Issues Relevant to Social Work with Traumatised Refugees*

Many Australians have ambivalent attitudes towards accepting asylum seekers into our society. On the one hand, Australia is seen to be a generous country, which has accepted refugees from overseas since the end of the Second World War. We are proud of our harmonious, multicultural society, which stands in contrast to the hatred and violence between different ethnic groups living side by side in many other countries. Yet racism and discrimination has always been a strong influence in our own nation’s development. Many people find it difficult to cope with refugees making Australia their home. There is fear of invasion by asylum seekers from countries in our region. This is accompanied by an ignorance of the torture and trauma experience of these people and a low level of recognition of Australia’s international legal responsibilities towards refugees (Crock, 1998:v, 163)

In recent years, the humanitarian program intake has been set at approximately 12,000 per annum since 1996, and planned to remain at this level until the year 2000: see http://www.immi.gov.au. Of these 12,000 places, 10,000 are for people selected overseas, and 2,000 are reserved for on shore applicants.

Within the Australian community, there has been little controversy regarding the overseas program. However, public concern about the on shore applicants has been out of proportion with their numbers. (Footnote 3) Crock (1998:8) describes the near hysteria in some sections of the broader Australian community about the arrival of the boat people, and refers to other 1993 opinion polls which show that popular acceptance of “Asian” migration is tenuous. She also
discusses recent political debates regarding immigration and the rise of the One Nation Party which advocated an end to the migration program (1998:2) Crock claims that the current government's harsh policies towards on shore asylum seekers reflects the feelings in the electorate. (1998:8). She also points out that although the number of appeals to the RRT and the Federal Court continues to rise, the judges appear to be becoming increasingly cautious in their approval of refugee applications. (1998:134 (Footnote 4)

[2] The Detention faculty at Port Hedland was established in 1991. A complaint was lodged to the UN Human Rights Committee regarding the isolation and imprisonment of asylum seekers in this outpost in 1992. This Committee ruled that, contrary to Australian policies, asylum seekers should only be detained where they represented a risk to national security, or in cases where their identity needed to be determined. Crock points out that Australia has not, yet responded in real terms to these rulings, nor to international criticism regarding our detention policies. (1998:30-32)

The Australian Law Commission Report, August 1994, examined the admission of women refugees from overseas, and also issues, facing female applicants within Australia, in one of its chapters. (Crock, 1998:160). It pointed out that female refugees were greatly disadvantaged in a number of respects. Firstly, the report found that in 1994, there were three men admitted into the country for every one woman. As a response to this finding, the gender balance to the overseas program has been corrected and by 1977, the ratio was almost even.

Secondly, female applicants were less likely to be able to demonstrate good settlement prospects, than men, having received fewer educational and career opportunities in their homeland. Women found it harder to prove that they would be in danger of persecution at home – they often filled support roles without the public political profiles which were more common for men and which provided an objective basis for their fear of attack.

A major issue was whether rape and sexual harassment can be accepted as persecution; in many countries a major form of oppression is systematic or random acts of rape by military groups, yet this has often been seen as a by product of war rather than persecution. In general, it can be argued that the definition of a refugee fits more comfortably with male experience than female experience, even though over two thirds of the world's refugees are women. (Crock, 1998:160-162) (Footnote 5)

[3]

5.2 Social Policy and Service Provision for Refugees in Australia
It was difficult to locate many current formal analysis of social policy and service provision for refugees in Australia. One of two studies using policy analysis models are available for the refugee service systems in the USA (Potoky, 1996) and United Kingdom (Barclay, 1998). There would appear to be an important gap in this area of study currently.

The Bureau of Immigration and Population Research (BIPR), within DIMA (Department of Immigration and Multicultural Affairs), was closed down in 1996 by the federal government, and many of its functions are no longer carried out. The design and analysis of comprehensive policies for assisting refugees is given scant attention in Australia, especially when compared to the amount of resources provided to establish legislation and guidelines for processing/rejecting applications for permanent residence. This section will briefly refer to kinds of service provision for refugees in Australia, as a context for then examining the specific services for refugee survivors of torture and trauma.
The 1990 paper written by the Refugee Resettlement Working Group (RRWG) outlined the extensive role played by the non-government sector in refugee resettlement, complemented by some limited government funding programs, largely form the DIMA. The general policy is that community non-government organisations are the best service providers for refugees as they understand their needs, are accessible and can provide the most appropriate support. The problem with this idea is that it places a great responsibility, including a financial one, on small newly arrived refugee groups who are fragile themselves. (1990:197)

Recently the NSW Health Department published a policy paper (the first of its kind in Australia) concerning the current knowledge about the health needs of refugees and the strategies required to address them. This paper was written by the Refugee Health Policy Advisory Committee (RHPAC) in 1997, and provides an overall perspective on refugee health issues in NSW. [4]

6.0 Development of Torture and Trauma Services
The establishment of specialised services for refugee survivors of torture and trauma is a relatively new development. Following the second world war, Jewish welfare societies around the world were the pioneer services providing assistance for Jewish survivors of the holocaust. (Cunningham, 1996:74). The first service specifically for refugee survivors of torture began in Western Europe in the mid 1970’s (the RCT in Denmark) and others began to be set up in Europe and North America in the late 1970’s and early 1980’s. Corresponding services were set up in countries in which the human rights violations were being carried out, especially in Latin America. (McGorry, 1995: 463). By 1997, it was estimated that there would be at least 265 centres around the world, (Cunningham, 1996:74). They included services within repressive countries, where health professionals and volunteers may be working at considerable risk to the safety to themselves and their families; services in countries of first asylum, for example, health workers in refugee camps, usually working long hours with few resources; services in countries of resettlement. (Cunningham and Silove,1993:751). Large international networks have been established linking these services together. (Footnote 7)

Within Australia, the first clinic for assisting tortured refugees was the one established in Brisbane form 1985 within the Mater Misericordiae Hospital Child and Family Psychiatric Service. In 1987, the report to the NSW Government Department of Health by Reid and Strong led to the establishment of the first torture and trauma service. STARTTS, in Sydney in August 1988, and assisted the development of other services in other states, such as the Victorian Foundation of Survivors of Torture which commenced work in June 1989. Centres have now emerged in most other states and in some multiple services now exist. A central issue for most services is the combining of community development and individual, clinical approaches in order to meet the broad needs of the client group. (McGorry, 1995:463-4) (footnote 8) [5]

7.0 The Development of Roles for Social Workers in Torture and Trauma Services
Torture and trauma services in Australia operate in a diverse range of models, some following a more traditional medical model, and others combining a range of interventions within a broad community development framework, including clinical work, groupwork, bodywork, community consultations, education, refugee policy work. In the more traditional services this would appear to be the case all over the world in these services) the roles of social workers tend to be more family and welfare oriented. In services combining community development approaches with
psychological and other interventions, the roles of the social worker tend to be more flexible and diverse.

This section will examine more closely the development of various roles for social workers within the NSW service, STARTTS over the past eleven years since its inception.

7.1 Description of STARTTS
STARTTS has gradually developed a broad framework of community development, within which there are many levels of intervention for refugee survivors of torture and trauma. These include individual and family work; groupwork; community work, including networking and working with refugee communities; influencing the mainstream health system, social policy work and working with other issues at a socio/political level. (Aroche and Coello, 1994:7) STARTTS provides a psychiatric service, bodywork service, a youth program, an employment program, and more recently has received funding to co-ordinate the Early Intervention Program for refugees. This year STARTTS was responsible for the mental health needs of the refugees from Kosovo in NSW, (Operation Safe Haven).

The STARTTS management committee is appointed by the NSW Minister of Health, and the organisation is a unique “in between” position of being a community organisation, (able to receive funding from various bodies and also having a sister fundraising and lobbying group. “Friends of STARTTS), and at the same time receives much administration support from the NSW Health Department. The staff work under public service awards and conditions. A feature of STARTTS is the high proportion of workers who have a refugee and/non –English speaking background. The development of the service and referral of clients has relied much upon the understanding and commitment of these workers who have formed a bridge between STARTTS and the refugee communities. Over the past eleven years, it has developed from a handful of workers to a group of about seventy – five staff.

7.2 History of Social workers in STARTTS
STARTTS had a policy from the beginning of staff not following professionally defined roles (ie the social worker looks after the family, the doctor manages the team and performs medical assessments, the psychologist does testing and psychotherapy), but rather using all skills, both professional and personal, of each worker. (Cunningham and Silove, 1993:759) Staff were gradually employed to fill generalist counsellor/project officer and bicultural counsellor positions from a variety of professional backgrounds, including social work, psychology, art therapy, community nursing, welfare training.

Initially there were two social workers at STARTTS in the team. One became the first permanent manager of the service, and the other (the author) was the first counsellor/project officer. Initially the team was small, and the emphasis was on trying to respond to the needs of the client group rather than fitting rigid role definitions. In early days, both social workers were involved in clinical work, including consultations with refugee communities, attending interagencies, setting up support groups for refugee. Gradually, as more staff were employed, for example a psychologist with special skills and knowledge was employed as the community development worker staff were able to specialise more in a particular area. STARTTS was set up to develop into a specialist service providing expertise and research concerning working with refugee survivors of torture and trauma to the mainstream health sector; it was important for some staff to gain in depth knowledge and skills in different areas, while others remained as generalists.
There are many refugee families in Australia who live in chaos and fear—where life events seem to ongoingly retraumatise them. For example, many families have survived years of hiding from place to place, fleeing the violence and massacres of civil wars, and living in desperation and danger in refugee camps. Upon coming to Australia, these experiences remain inside the family, and they can continue to live as if this is still their reality.

Refugee networks and organisations are vulnerable to internal conflicts— for example, traumatised members can easily feel attacked, become outraged, accuse others of being “the enemy” be too vulnerable to tolerate criticism or difference of opinion.

In the last twenty five years, there have been several large scale influxes of asylum seekers: 2087 Vietnamese “boat people” arriving between 1976-1981; thousands of Chinese applicants following the 4 June 1989 pro democracy demonstrations in People’s Republic of China; another 652 “boat people” from Cambodia and PRC arriving between 1989-1992 (Crock, 1998:127-128). Structured decision making regarding these applications, and the recent major involvement of the Federal Court in these matters has accompanied these waves of on shore asylum seekers.

The current Australian mechanisms for determining refugee status for on shore people are that the applicants must complete a detailed form, and many seek legal advice in these applications. The DORS section of the Department of Immigration (DIMA) processes these applications, including interviewing most applicants. The Refugee Review Tribunal (RRT), set up in 1993, has jurisdiction to review these decisions. Refugee claimants who fail before the RRT have a right to appeal to the Federal Court under part 8 of the Act. (Crock, 1998:129)

A related issue is that of female applicants fleeing domestic violence. These cases are more likely to be approved if there can be a link made between the domestic violence and political or religious issues—for example, a woman from a violent marriage who had fled her husband, committed adultery, and who would be stoned to death should she return home. In cases where there is no obvious political connection, the question is more whether the state would provide protection for these women in violent family situations. This is a controversial area, as most governments are lacking in this regard, and Australia is unable/unwilling to offer protection to all victims of domestic violence who have inadequate protection elsewhere. (Crock, 1998:148-151). The number of these applications for refugee status on the basis of domestic violence continues to rise.

The kinds of government grants available from DIMA for community organisations include the Grant in Aid (GIA) Scheme, Migrant Resource Centre (MRC) Scheme, Community Refugee Resettlement Scheme (CRSS), Migrant Access Projects Scheme (MAPS). This funding is for all people of non English speaking background, both migrants and refugees. NGOs which assist refugees and which may be eligible for these grants include (1) ethnic specific organisations, for example the Khmer Community of NSW and the Timorese Australia Council; (II) mainstream charities providing emergency and material relief, such as The Smith Family and St Vincent de Paul (III) migrant resource centres (IV) peak organisations such as the Refugee Council of Australia (RCOA) and its subcommittee, the Council of Churches (NCCA) through its Refugee and Migrant Services Division. In addition, there are loose structures of volunteers associated with churches, mosques and temples, and
individuals from communities who are known to be helpful and resourceful, who provide a tremendous amount of assistance to refugee arrivals. (RRWG, 1990:199-200)

**Footnote 7:** There are now two international bodies concerned with the development of services to torture survivors: the IRCT (International Council for Rehabilitation of Torture Victims) and the International Society for Health and Human Rights. Australia has representatives on both of these organisations. Some of the issues being addressed by these bodies at present include moving towards regionalisation, caring for the workers of torture and trauma survivors, and activities aimed at trying to prevent torture, for example the recent denouncing by the IRCT of members of the Turkish government involved in torture. (Cunningham, 1996:76)

**Footnote 8:** Mc Gorry describes how he has visited many torture and trauma services around the world, and places them on a continuum according to which approach is given emphasis; “At one extreme a more or less traditional health service, and at the other, a purely socio-political paradigm – a fiercely determined self help approach based on political solidarity with the survivor” (1995:465). The influence of and respect for professional work tends to be in inverse proportion to that accorded to political and community work. Cunningham and Silove (1993:754) discuss this issue in terms of there being two broad categories of services for traumatised refugees in countries of resettlement: those which address the broad range of welfare needs of refugees and those which focus specifically on the psychological needs of people who have been tortured. Specialised services can only concentrate on psychological needs if the general welfare and health needs of refugees are being met by other services.