THE NEW ZEALAND MEDICAL JOURNAL
Journal of the New Zealand Medical Association

NZMA New Zealand Medical Association

Prevalence of victims of torture in the health screening of quota refugees in New Zealand during 2007–2008 and implications for follow-up care

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Abstract New Zealand annually accepts approximately 750 quota refugees from around the world for resettlement in New Zealand. The humanitarian nature of the quota composition consists of those who are determined by the United Nations refugee agency to be in high need of immediate protection, a large proportion of medical and disability cases, and women and children at risk. Quota refugees arrive in group intakes and participate in assessment and orientation for the first 6 weeks at the national Mangere Refugee Resettlement Centre in South Auckland. This paper describes the findings of screening for refugees with a history of torture during 2007–2008. There were 144 refugees or 19.2% of the new arrivals found to have histories of torture during this period. The implications for future research, and follow-up care of people who have survived torture are discussed.

Torture, according to United Nations Convention (2010), is defined as:

> …any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him, or a third person, information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in, or incidental to, lawful sanctions.[1]

Throughout human history, torture has been used as a means of exerting political control through terror, persecution and coercion. In the 21st Century, torture is universally acknowledged as an abhorrent practice and a war crime, prohibited under international law. Torture is almost universally considered unjustified, unethical and illegal under any circumstances, yet Amnesty International reported that it continues to occur in 65 out of 144 countries studied.[2]

The United Nation's *Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* was ratified by New Zealand in 1989. As part of fulfilling international humanitarian obligations, New Zealand annually accepts a quota of approximately 750 forced migrants referred by the United Nations High Commissioner for Refugees (UNHCR).[3] All are provided with medical and mental health assessment and orientation during a stay of 6 weeks at the national Mangere Refugee Resettlement Centre (MRRC).

Quota refugees, in groups of approximately 125, arrive six times each year and spend the first 6 weeks in assessment and orientation at the national Mangere Refugee Resettlement Centre. Among the agencies is RASNZ (Refugees as Survivors New

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Zealand) which provides psychological, psychiatric and clinical screening and management of refugees with mental health problems.

At the MRRC, government and non-government agencies provide a comprehensive range of services from agencies including Immigration New Zealand, the Refugee Medical Centre operated by Auckland Regional Public Health, RASNZ, the specialist refugee mental health centre, AUT University Refugee Centre, and Refugee Services Aotearoa (RSA) working in practical settlement support.

The principal study on the health status of quota refugees in New Zealand has been reported by McLeod and Reeve (2005) and involved 2992 new arrivals who were screened and treated over a 10-year period.[4] Infectious diseases included tuberculosis, parasitic or bacterial illness, and a relatively small proportion of HIV positive cases. Non-infectious conditions included iron and vitamin D nutritional deficiencies. There were 349 cases of female genital mutilation reported. An earlier study (Reeve 2002) reported that 20% of the refugee intake had been subjected to some form of significant physical mistreatment in detention.[4]

Identified medical and mental health conditions are initially treated at the MRRC, with follow-up referral to clinics and community health services in multiple settlement centres. It is internationally recognised that victims of torture may constitute a significant proportion of general refugee populations and that survivors typically require substantial specialist treatment for rehabilitation and successful integration in the resettlement.[5–7]

Given that survivors of torture, as a sub-group of refugees, can be expected to have more complex, and enduring community follow-up care requirements, their identification at an early stage of selection or arrival is an important part of the needs assessment phase.

Until 2007, there had been no systematic procedure at the MRRC for screening or identifying victims of torture. Although torture survivors had presented during treatment and were statistically recorded, there had been no systemic means of identifying them from the culturally and linguistically diverse groups of refugees arriving in each intake. Although it was previously recognised that a substantial proportion of the refugees arriving in the New Zealand quota had experiences of being subjected to torture, the actual numbers or the particular nature of the case histories had not been compiled or analysed prior to 2006. This paper reports on the findings from screening of refugees for 2007/8.

Methods

During the 2007–2008 intake period, arriving refugees were screened by the RASNZ clinical and research teams at the MRRC for not only trauma, but an indicated or verified history of torture. Pre-arrival screening included UNHCR case note records. During the pre-selection and selection mission phases of the quota intake process, refugees inside camps or accommodation centres are interviewed by UNHCR case officers and personal histories are taken. Further case notes are collected by Immigration New Zealand (INZ) case officers who interview refugees for possible inclusion in the quota intake.

All case records indicating a history of torture were identified and confirmed upon arrival in New Zealand. Confirmation was through direct interviews with new arrivals, corroborated with UNHCR case note records, medical records, witness reports, and clinical observations.

Many newly arriving quota refugees also self-disclose a history of torture upon initial screening through mental health assessment and education groups operating at the MRRC during the first weeks

of orientation. These service users often self-refer to psychiatric assessment and treatment if they have a history of torture or trauma, or symptoms of Post-Traumatic Stress Disorder (PTSD), or other related mental health problems. A further group of refugees who may have been victims of torture are identified during medical screening by Auckland Regional Public Health and referred to RASNZ services.

Those who are identified via any of these means as having experienced torture, were further provided with psychometric assessment applying translated versions of the Harvard Trauma Questionnaire and the Hopkins Symptoms Checklist.

Results

Descriptive characteristics of all quota refugees screened at the MRRC during this period are shown below in Table 1 by origin of nationality. The corresponding characteristics of refugees identified as survivors of torture are shown in Table 2.

Table 1. Statistical characteristics of quota refugees during 2007–2008 by national origin identified as victims of torture

Identified Torture Victims	**2007–2008**	
Nationality	**Number**	**Proportion of refugee nationality**
Afghanistan	11	17%
Algerian	0	0
Armenia	0	0
Burundi	0	0
Bhutan	23	31%
China	0	0
Colombia	6	21%
Congo, Democratic Republic of	9	43%
Djibouti	0	0
Eritrea	4	5%
Ethiopia	3	25%
Indian	0	0
Indonesian	0	0
Iran	4	36%
Iraq	23	26%
Mauritania	0	0
Myanmar	31	12%
Nepal	5	100%
Palestinian	1	20%
Pakistan	1	100%
Rwanda	7	28%
Somalia	3	17%
Sri Lanka	4	100%
Sudan	9	30%
Turkey	0	0
Vietnam	0	0
Total	**144**	

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Table 2 shows the general refugee intake statistics by category, ages and gender.

Table 2. Statistical characteristics of all quota refugees during 2007–2008 by entry categories, age, and gender (N=750)

Age	n
13 – 17	**127**
18 – 60	**419**
60+	**4**
Gender	**n**
Female	**391**
Male	**359**

Table 3 shows the proportions of those demographics and categories identified as victims of torture (N=144)

Table 3. Statistical characteristics of all quota refugees during 2007-2008 intakes identified as victims of torture by entry categories, age, and gender

Entry categories	n	%
Medical / Disabled	73	50%
Protection	63	44%
Women at Risk	5	4%
Family Reunion	3	3%
Ages	**n**	**%**
0 – 4	0	0
5 – 12	1	1%
13 – 17	3	2%
18 – 35	63	44%
31-60	75	52%
60+	2	1%
Gender	**n**	**%**
Female	9	6%
Male	135	94%

Origin of survivors—Of the 750 refugees arriving over the course of this annual period, 144 or 19.2% were identified as victims of torture under the UN definition. Table 1 shows that the largest numbers of those found to have suffered torture were from Bhutan, Afghanistan and Iraq. The highest proportions of victims relative to smaller intake numbers, however, were from origins in Nepal, Republic of Congo, and Sri Lanka.

Gender—The overwhelming majority (94%) were male with only 9 women reporting a history of torture. The women reporting torture had principally been subjected to systemic rape by militia or forced to witness the killing or torture of other family members.

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Age—The overwhelming proportion of victims were men aged between 18 and 60. The small number of children and adolescents were not directly tortured but forced to witness torture, massacre, rape or related severe harm to family members.

Nature and types of torture inflicted—Psychological torture reported involved use of extreme stressors and situations such as sensory deprivation, mock execution, forced nudity, solitary confinement or violation of social norms and humiliation. Reported cases principally involved forced witnessing of torture or rape committed to other family members, friends or associates. Psychological torture can inflict severe suffering with no externally visible physical effects.

Of the 144 identified victims, 31% had been subjected exclusively to psychological torture, 63% exclusively physical torture and 21% reported experiencing both. Physical methods of torture reported included exposure to extreme cold, burning, beatings, physical suspension, forced painful posture, dehydration, starvation, simulated drowning, removal of teeth, damage of fingers, hands, feet or toes, rape, whipping, or simulated asphyxiation. No cases of use of electrical current in torture were reported in this group. During this particular initial intake of Nepalese refugees from Bhutan, the practice of *chepuwa* was first reported. Chepuwa is a Bhutanese technique of torture applying tight clamping of the thighs or legs with bamboo for extended periods of time.

Identity of the perpetrators—State-sponsored torture, inflicted by, or at the instigation of, or with the consent or acquiescence of officials or others in a similar capacity constituted the largest proportion of alleged perpetrators. Victims most frequently reported that perpetrators included military or police officers, agents, paramilitary guerilla forces, or, in a few cases, ethnic gangs during widespread genocide as occurred in Rwanda.

Discussion

The findings indicate that nearly one fifth of the total quota refugee intake during the annual period studied had been survivors of torture. In a majority (73%) of cases there were multiple corroborating confirmations such as UNHCR notes, self-reporting, and test results or witnesses.

Validity of the sample is considered likely to be high on the basis that quota refugees are already accepted for entry and, unlike asylum seekers, have no possible secondary gain motives from falsely claiming a history of torture. For this reason, asylum seekers were not included in the study. Indeed, it is in our opinion more likely that quota refugees would underreport a history of torture. Survivors of torture may not initially reveal the history to their doctor because of fear, or due to overwhelming traumatic memories which have been repressed.

Torture experiences may have led victims to no longer view the world as a "safe, and benevolent place upon which they could have an impact" (p243).[6] This outlook is likely to permeate all aspects of their lives, and impact on how patients view health providers.

Western health providers are likely to note physical complaints such as pain of often undetermined apparent psycho-somatic origin, headache, cardiopulmonary symptoms,

sleep disturbances, nightmares, and impaired cognition and memory. Refugees and migrants frequently do not manifest symptoms in the same way as people from Western backgrounds and may tend to express psychological distress in somatic complaints. However, a history of head injury and underlying neurological damage may require further investigation. There may also be a concurrent underlying cause of orthopedic, neurological, or lingering medical effects of past injury.

The most common long term mental health sequelae for torture survivors include post traumatic stress disorder (PTSD), with frequent comorbidity of anxiety disorder and depression.[8] Torture often has profound and enduring effects on victims that may extend for long periods of time and manifest in different ways 7.

Recovery from torture will logically involve the re-establishment of basic trust and positive relationships. Taking a history from a survivor may be marked by his or her experience of having their beliefs and opinion, as extracted by an authority figure, leading to their persecution. Extra time and attention will need to be devoted to establishing rapport and developing trust with survivors.

Assessment and treatment processes are likely to be complex, requiring time to gain an understanding of the person and their family, culture and context. For former refugees and survivors, building trust with health practitioners, or others viewed as authority figures, may be challenging. In addition, many frequently require interpreters and may not understand or have not been exposed to Western health care practices or models of care.

The Istanbul Protocol was a landmark step in recognising the importance of effective process in securing the rights of torture victims to rehabilitation, reparation and protection.[9] In 2003, the United Nations Commission on Human Rights drew the attention of governments to the principles of the Protocol as a useful and practical tool in addressing and preventing torture. This international standard contains detailed procedures, and practical steps for medical, mental health and legal specialists to recognise and document evidence that may assist in recovery and rehabilitation for survivors, as well as in bringing perpetrators to justice and for advancing future prevention of torture.

In New Zealand, Te Pou, the National Mental Health Workforce Centre, has recently published a practice guide for health practitioners working with refugees and migrants in a resource book, including an overview of psychopharmacological issues in treatment.[10]

In 2003 the Ministry of Health produced a handbook for health professionals providing information about effectively communicating with refugee patients and about how and when trained interpreters should be involved in service delivery.[11]

Conclusion

It is suggested that future research should further examine the proportion and characteristics of survivors of torture in UNHCR intakes in other years, and consider comparisons of health and settlement outcomes between survivors of torture and refugees who did not have those experiences. Given the relatively high proportions of survivors of torture in the New Zealand refugee quota composition, it is important for

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medical practitioners to be aware of some of the issues and special needs among this group of patients.

Traumatised refugees and survivors of torture have come to New Zealand to begin new lives. Medical practitioners have important roles in the successful resettlement process through assessment and case management leading to rehabilitation and recovery.

Competing interests: None.

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