Working Clinically with Asylum Seekers Forced to Return to their Country

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• A failed asylum seeker is one who has had merits review rejection (ie minister’s delegate and tribunal refusal or under fast track process) and judicial review and ministerial intervention options are exhausted or not pursued.
A proportion of failed asylum claims is a necessary consequence of a discriminating refugee status determination process.

There is a lack of any necessary correlation between the extent an asylum seeker may have been subject to traumatic events in their country, and the strength of their claims.

There is no formal legal relationship and only a tenuous practical relationship between the legal entitlement to protection and the psychological need for security owing to past trauma.
Mental health of failed asylum seekers as compared with pending and temporarily accepted asylum seekers


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Table 3 Traumatic events and psychiatric outcome measures for FAS and pending/temporarily accepted AS

<table>
<thead>
<tr>
<th>Variables</th>
<th>Samples</th>
<th>Group differences(^a)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>FAS (N=40)</td>
<td>AS (N=40)</td>
</tr>
<tr>
<td>Number of traumatic events experienced(^b)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(M (SD))</td>
<td>6.68 (4.49)</td>
<td>6.68 (3.45)</td>
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<tr>
<td>PTSD (PDS)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Severity (sum score), (M (SD))</td>
<td>16.68 (12.88)</td>
<td>19.99 (12.68)</td>
</tr>
<tr>
<td>Diagnosis, (N (%))</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full-blown PTSD</td>
<td>18 (45.0)</td>
<td>20 (50.0)</td>
</tr>
<tr>
<td>Sub-clinical PTSD(^c)</td>
<td>9 (22.5)</td>
<td>11 (27.5)</td>
</tr>
<tr>
<td>No PTSD</td>
<td>13 (32.5)</td>
<td>9 (22.5)</td>
</tr>
<tr>
<td>Anxiety (HSCL-25)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Severity, (M (SD))</td>
<td>2.30 (0.73)</td>
<td>2.25 (0.80)</td>
</tr>
<tr>
<td>Clinically significant, (N (%))</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>31 (77.5)</td>
<td>27 (67.5)</td>
</tr>
<tr>
<td>No</td>
<td>9 (22.5)</td>
<td>13 (32.5)</td>
</tr>
<tr>
<td>Depression (HSCL-25)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Severity, (M (SD))</td>
<td>2.41 (0.60)</td>
<td>2.37 (0.71)</td>
</tr>
<tr>
<td>Clinically significant, (N (%))</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>35 (87.5)</td>
<td>32 (82.1)</td>
</tr>
<tr>
<td>No</td>
<td>5 (12.5)</td>
<td>7 (17.9)</td>
</tr>
<tr>
<td>Pain Intensity (VRS), (M (SD))</td>
<td>2.35 (1.83)</td>
<td>2.40 (1.88)</td>
</tr>
</tbody>
</table>

\(a\): The following tests were used: paired \(t\)-tests (normally distributed continuous data); Wilcoxon matched-pairs signed rank test (ordinal data); McNemar’s test (binomial data).
\(b\): As this variable was matched, variable group differences were calculated solely for control reasons.
\(c\): Defined as meeting criteria for only two out of three PTSD symptom clusters according to DSM-IV.
Four propositions about working with failed asylum seekers:

1. That an asylum seeker we are treating faces removal does not alter our duty to do what we can to help the person psychologically within what is feasible.

2. At least some asylum seekers can still benefit from continued treatment despite instability in their circumstances and the prospect of removal.

3. The reason the asylum seeker’s claims have been rejected may be relevant to our approach to treatment and the production of psychological evidence.

4. It is important to avoid appearing to collude with removal or becoming primarily an advocate opposing it.
At least some failed asylum seekers can still benefit from continued treatment despite instability in their circumstances and the prospect of removal

- The evidence that asylum seekers can benefit from psychological treatment;
  eg: Treating PTSD in refugees and asylum seekers within the general health care system. A randomized controlled multicenter study H. Stenmark et al. Behaviour Research and Therapy 51 (2013) 641-647 (Refugee N=50; AS=31: at 6months NET gp= 54% with PTSD; TAU= 81%)

- Reinforcing what has been learnt in ongoing treatment:
  -cognitive techniques in managing re-experiencing phenomena; affect regulation; ensuring avoidance doesn’t undermine maintenance of relationships and meaningful activity; activity scheduling; treating depression psychologically and pharmacologically.
Applying knowledge gained about the client:

-Sources of distress: it may be trauma related phenomena; but it may be many other things;

-What disrupts daily functioning – it may or may not be trauma related;

-the quality of daily life in terms of ability to maintain purposeful activity and relationships;

-What precipitates declines in functioning; what is protective;
- Ongoing relationships with family and friends in home country;

- The capacity to distinguish between past and future events and to take in new information about possibilities in the future.
Applying knowledge gained about the client cont.

- The capacity to distinguish between anxious rumination and problem solving

- The extent the RSD process is perceived as unjust and whether this is likely to be expressed in self-defeating ways (e.g., conduct leading to re-detention)
Non persecution related fears regarding repatriation:

- Anger about the years wasted in Australia;

- Humiliation and feeling of failure in returning to their family or community;

- Facing the family’s anger and disappointment that an attempt to help them escape their predicament has failed;

- Having to deal with debts and potential destitution as a consequence of paying for the failed bid to find asylum;

- Finding a source of income;

- Having to re-imagine a future for themselves now the bid for asylum has failed.
"Persons found not to be in need of protection must be returned to their country of origin expeditiously. This is crucial to a fair and credible asylum system because it removes expectations that mere arrival in a place secures permanent residence, thereby breaking the people smugglers model."

- Minister Peter Dutton, March 2016

There are occasions however where treatment needs should be considered in the timing of return.
The reason the asylum seeker’s claims have been rejected may be relevant to our approach to treatment and the production of a psychological report.

1. Claims which were unmeritorious from the start. No significant past harm and none likely to occur.

2. Claims involve experience of discrimination which do not amount to ‘serious harm’ or ‘substantial harm’

3. Claims involve non convention forms of trauma

4. Credible claims of serious harm experienced but unlikely to be repeated due to changes in country situation.

5. Despite the RSD decision, there is an objective possibility of serious harm.
Circumstances where a further psychological report might be considered:

1. Relatively low levels of harassment or discrimination may lead to a significant and intractable mental health deterioration;

2. Within country relocation is unreasonable on mental health grounds;

3. Credible disclosure post-rejection of claim relevant experiences.
The ethical dimension to working with failed asylum seekers:

• Affirming the client’s response without entering into commentary about the merits of the decision.

• Maintain our position of providing treatment and support.

• We should not move into a position of advocacy; there will be occasions however where provision of psychological and mental state information to DIBP will be relevant to the just and compassionate dealing with the case.