

Lethal Hopelessness: Understanding and Responding to Asylum Seeker Mental Deterioration

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Background and Context

This special edition of the *Shared Learning in Clinical Practice Newsletter* discusses mental health, suicide and self-harm related considerations for asylum seekers living in the Australian community who arrived by boat between August 2012–December 2013. This group of asylum seekers - numbering approximately 30,000 - have become known in public policy as the 'legacy caseload'. Many have been under significant psychological strain waiting up to four years to have their claims for refugee protection assessed. There is an inevitable deterioration in individual mental health, with several suicides in the past 24 months¹ and reports of many more 'near misses'.



Photo courtesy of Barat Ali Batoor

Most asylum seekers in the legacy caseload have been living in the community and are on bridging visas while awaiting the assessment of their protection visa applications. Processing of applications has been protracted and subject to several government policy changes. Social support services for the majority of the legacy caseload in the community has been limited. A reduction in government funding for legal assistance has also led to lengthy delays in accessing no-cost assistance in preparing visa applications.

An asylum seeker whose application is successful will only be granted either a three year Temporary Protection visa (TPV) or a five year Safe Haven Enterprise visa (SHEV). At the expiration of those terms current policy is that a refugee will likely only receive another temporary visa² and will not have access to Permanent Protection. Projections on future government policy for this group are difficult but it is clear that this group will be facing a minimum of ten years on a temporary visa and are thus facing long periods of separation from family, thus creating a particular subclass of 'outlander' (i.e. an alien/foreigner who likely will never 'belong') that service providers have not previously experienced or have the means to effectively assist.

¹ October 2015 an Afghan, Khodayar Amini, set himself on fire while on a video call with two refugee advocates. He said he feared being detained again. June 2015, Raza, Afghan Hazara, jumped in front of a Perth train. He was living on a bridging visa and had been interviewed by police a day earlier. In October 2014, a 29-year-old Tamil, Leo Seemanpillai, set himself on fire outside his house, suffering burns to 90% of his body. Source: Australian Border Deaths Database <http://artsonline.monash.edu.au/thebordercrossingobservatory/publications/australian-border-deaths-database/>

² This will be upon demonstrating that they still have claims to be a refugee or if they satisfy very limited criteria for particular employment or partner visas.

While health care workers, legal representatives, settlement support workers (and others) have a role to play in helping to reduce distress associated with disclosure and ultimately find a way forward to provide comfort, culturally competent and appropriate engagement will continue to be needed to facilitate support as early as possible.

Mental Deterioration and Perceived Burdensomeness

The core interpersonal components of suicidal ideation for asylum seekers is a feeling that they cannot continue with extensive and prolonged uncertainty, that they are not living a meaningful life, and an overwhelming sense of burdensomeness to oneself and to others. Prolonged uncertainty, particularly for people with a past history of trauma, existing mental health problems and mental illness impacts upon interpersonal confidence and autobiographical memory. Inconsistencies in autobiographical memory can lead to questions regarding the credibility of asylum seeker claims for refugee protection. If this phenomenon occurs and asylum seekers claims for protection are rejected, it opens up a worsening decline in mental health³ whereby the person feels trapped by their circumstances⁴, hopeless and helpless. Even if claims for protection are successful a refugee will only receive a TPV or a SHEV, and another extended period of uncertainty or limbo. News of another period of waiting is for many a 'tipping point'. Worsening mental deterioration for asylum seekers can lead to the phenomena of 'cognitive constriction', whereby the person is restricted in their *perception* of themselves and others, *emotional* responses to their situation, and the *logic* of what constitutes a solution to their situation (an ideal outcome of a visa or death). The person feels boxed in and 'shuts down' from well-meaning others.⁵

Available options for supporting people in such states are limited by the scale of perceived burdensomeness, self-blame and aloneness. While asylum seekers with previous suicide or self-harm distress may be more likely to value support from individuals within their own social or cultural network (for example, family and friends) than the support of health and social professionals, the nature of worsening distress and trauma is such that the immediate family and social group is becoming a diminishing protective factor against deteriorating mental health. Without changes to current policy, asylum seekers living in the Australian community with worsening hopelessness and deteriorating mental health are likely to deteriorate even further.

An additional complexity in this situation is thwarted belongingness, purpose and identity. This has significant inter-subjective consequences; such as adversely impacting upon relationships between, for example, husband and wife, neighbours, among siblings and other immediate family members who are also under significant strain. Individuals who are experiencing disconnectedness from others who they have had previous close relationships with are more rather than less likely to become increasingly socially isolated, internalise mental distress and ruminate over how life could or should be. This is of particular concern; it makes for a complex set of circumstances contributing to risk of family and intimate partner violence, alcohol and substance use, self-harm and suicidal behaviour. It becomes increasingly difficult for such individuals to trust others and seek help during a period of crisis. If this situation worsens so too will the corollaries of hopelessness, futurelessness and being a perpetual outlander. This situation sits in stark contrast to a person in mental distress or suicidal states who hears a loved one, a close friend explicitly state that they are loved and valued, and that their life has meaning and purpose. In such circumstances the distressed person might be more able to reduce the distress brought about by ever present thoughts that they are a burden to themselves and to others.

³ See also Sundram and Loi, "Long waits for refugee status lead to new mental health syndrome" *The Conversation*, <https://theconversation.com/long-waits-for-refugee-status-lead-to-new-mental-health-syndrome-7165>

⁴ Procter, N. 2005, "They first killed his heart (then) he took his own life". Part 1: A review of the context and literature on mental health issues for refugees and asylum seekers" *International Journal of Nursing Practice*, vol. 11, pp. 286–291.

⁵ Procter, N. 2013. Engaging refugees and asylum seekers in suicidal crisis, *Australian Nursing and Midwifery Journal*, vol. 20, no. 9, 44.

Public Shame: A Critical Service Delivery Challenge

The current plight of asylum seekers outlined above presents a significant and complex service delivery challenge. At the very least, how the services provided might improve identification of specific individuals with deteriorating mental health. Second, how to optimally differentiate those who readily come forward with worsening mental health from those who are reluctant to engage due to a range of other factors, not limited to, but inclusive of, stigma, shame or guilt associated with their situation. For the latter group, an additional challenge will be how to identify and support individuals deeply stigmatised, embarrassed and troubled by statements by people in public office and others that their expressions of distress and associated experiences are disingenuously motivated by the single want to remain in Australia.

In this context it is not surprising that the health or human service worker who may directly ask about mental health, mental distress, suicidal ideation or perceptual abnormalities may not get a straight answer. There are significant reasons why an answer may be difficult to obtain. Stigma and fear of being re-detained, being seen as a *perpetual outcast*, or simply frightened by what such a disclosure might lead to are possible reasons for holding back an accurate answer. Shame (particularly among males) is also a key consideration. Shame has the potential to hinder an individual's willingness to report mental distress and despair. Mental distress and mental ill health in this context must also take into account the increased uncertainty for asylum seekers as discrete phenomena that brings greater risk of deterioration. While these health effects may not be immediately apparent, manifest as episodic, an accumulation of what can be best described as *lethal risk deterioration* will contribute to poorer mental health prospects in the short to medium term. The complexity of interacting mental health and community related factors such as community acceptance, hope, family and social connectedness is likely to have a compounding effect. Additional factors influencing asylum seeker mental distress include political events in Australia and the way public individuals perceive their issues and concerns as something to be actively undermined, invalidated and dismissed. These factors are apparent to many asylum seekers. They also overlap, with each contributing to worsening individual mental health outcomes. Mental health care providers, in their underlying principals, design and delivery, need to accommodate this complexity and address a range of aspects simultaneously.

A reluctance to seek help, a shortage of available services and barriers to legal support for processes attendant upon Refugee Status Determination, increase the risk that the needs of asylum seekers with a mental health condition will go untreated and potentially develop into more serious conditions. Mental distress and mental ill health among asylum seekers will likely take many forms and degrees of severity. An integrated response to mental distress and mental illness, therefore, depends on a range of skills and services provided by a variety of health and social care professionals. The type service provided and role played will depend on how it is resourced and the nature of distress and risk. To address the complex and intersecting mental health needs of asylum seekers will likely require a broadening of the roles some workers can perform. Health workers need to be willing and able to identify the various aspects of ill-health and mental health protective factors that they may be presented with and provide initial comfort and support. This extension reflects the interconnection between mental health issues in migration histories of individuals concerned. The integration of services and care and the requisite training required will be most beneficial when delivered within a compassionate service culture. To deliver integrated care may necessitate the education of the workforce to enable them to cross traditional demarcations and provide initial care for health symptoms beyond their specialty.

Lethal Hopelessness

There are increasing reports of many people within the asylum seeker community being at advanced stages of feeling mentally trapped, figuratively boxed in, especially hopeless and helpless. Whether the person's perspective is influenced by events in the recent or distant past, contemporary events in Australia or elsewhere, or any possible combination of these, the picture is one of *lethal hopelessness*. Medical, nursing and allied health professionals working in hospital emergency departments will likely encounter stories of deep emotional distress and despair from asylum seekers that are unlike mainstream mental health presentations. A possible starting point for dialogue with those in suicidal states experiencing deep mistrust, ambivalence and avoidance - a state of malignant alienation - could be about trying to make the person's unbearable problems, anger and defeat 'better enough' to allow time to stop and think about alternatives to

death. If meaningful dialogue can be found it may help to reframe for the asylum seeker the difficulty they are in as something that is painful and difficult - *but tolerable* with the right help, support and comfort, then this may provide a window of opportunity helping to prevent worsening alienation and anguish. The intervention should draw from relevant concepts of validation and trauma informed practice, taking genuine steps to understand and accept the person's subjective trauma experience.

In clinical practice this means taking steps to avoid a response to individuals feeling they are trapped or 'boxed in' along the lines of, *"You will just have to make things work, get over it, won't you?"* A trauma informed response would be something like, *"When you say I can't live like this, I can't take this anymore, what is the **this**?"* Deeper dialogue and engagement between individuals leading to a redefining of the problem in alternate terms, for example, of a need to do something to stop excruciating psychological pain and anguish is a strategy worthy of consideration. The aim of this work will be to begin trying to diffuse the source of the person's constricted focus on one single outcome or solution (death), thus creating a space for the person to shift albeit temporarily from their experience of unbearable injustice enough to help them think about alternatives to killing themselves. Outside observers can always interpret the behaviour of others with excruciating distress from their own viewpoint, but they will not be able to understand the crucial individual context behind such distress, anger or suicidality without the active assistance of the person concerned. The focus of the response back to asylum seekers who feel that are trapped or boxed in by their circumstances should be guided by the very real need to find a way to decrease the lethality associated with their feeling hopeless, disenfranchised and trapped.

Many asylum seekers have experienced extremes of threat, violence, distress and despair. Acknowledging that violence and threat teaches withdrawal, anxiety, distrust, overreaction, hypervigilance and aggression coping behaviours is important in trauma informed practice. Through active empathy, culturally appropriate engagement and consistency in a coherent and coordinated fashion reactions to trauma may be helped. Human connectedness and genuine comfort for others in such circumstances can be more powerful than what is said by the worker.

Practical support and assistance should be guided by practical application of trauma informed communication and awareness. Below are suggested guidelines for practitioners working in health and human services, law and other professions encountering distressed asylum seekers;

- Always use an accredited interpreter, not a friend, or family member – unless in case of emergencies.
- Using statements such as 'What has happened to you?' rather than 'What's wrong with you?', or 'Everything's ok with you – right?', 'Are you feeling ok? All good – right?' which assumes something is wrong about the person.
- Ask: 'What do you find most comforting?', 'What is important to you?', 'What do I or should I know about you?'
- Acknowledge the importance of the location and time of therapeutic conversation. Where possible offer the option of meeting in an area the person prefers, to provide a sense of control and choice. Although timeframes for meeting may also be limited, where possible, offer the options of meeting in a community rather than clinical setting and allocate sufficient time for the conversation so that it does not feel 'hurried'.
- Consider the importance of facilitating a clear and unhurried introduction of self and building familiarity with the asylum seeker. Initially focusing on who you are not what you are, take the time to find common ground, such as sharing knowledge of the persons country, previous work with asylum seekers and refugees (particularly if the person has had contact with a mental health worker in the past) and interest in working in this area.



- Show respect and a genuine interest in the person's wellbeing, through consistency of interactions, honesty, openness and dependability. Let the asylum seeker know what to expect – what is the purpose of the conversation and how will it support them with moving forward.
- Consider previous experiences of held detention, government authorities, service providers, either through direct personal experience or secondary exposure, and how this might impact on your relationship.
- Consider the environment, your posture, gestures and eye contact, take the lead on what is most comfortable for the person.
- Where possible, try to facilitate the initial mental health assessment as a more informal conversation rather than a list of questions.
- Reflect on your own cultural values and benchmarks for practice and be open to exploring and understanding behaviours and functioning through a different cultural lens.
- Acknowledge sensitive topics and the potential discomfort when asking about daily living (e.g. travel to and from hospital, employment, school, self-care); however, also highlight the benefits of gathering this information to assist the person with moving forward.
- Listen to the language used and how the person is telling their story; wherever possible and appropriate use similar language and communication styles in your own interactions. Create an environment that allows the person to tell their story, from their perspective, using their language.
- Allowing time to listen and respond. Do not assume, selectively hear or pre-empt. The dismissal or conditioning of a response from a person with a trauma history ahead of time can lead to lack of social and cultural connection and rapport affecting future service use trajectory and engagement.
- In an assessment situation, it may be more calming to begin with general questions, gradually become more specific. This approach acknowledges the sensitivity and personal nature of someone's situation rather than reinforcing a person's avoidance of engagement and connection.
- Being mindful of an increased suicide and self-harm risk as trauma memories and re-traumatisation can trigger cycles to be repeated.



Photo courtesy of Barat Ali Batoor

Collaborative Safety Planning For Risk of Suicide and Self Harm

Trauma informed collaborative safety planning with asylum seekers at risk of suicide and self-harm should consist of tangible reminders of the person's reasons for living. For example, a culturally appropriate safety plan may include names of family members not in Australia, photos of people close to the person in distress, experiences the person wants to have that bring about a calmer sense of self. The key is to help asylum seekers to think about the reasons for living and to find cognitive or behavioural cues to promote hopefulness within the expression of the real-self – knowing that this self has changed to an emotional state that makes them feel fragile and vulnerable. This may take the form of asking the person about their inner suicide struggle; to remember how they feel when they are not suicidal. Ideally health and human service employees should be working with transcultural experts and advisors whenever possible. Mental health practitioners should never impose a safety plan on an asylum seeker. The safety plan should, as far as possible be developed and defined as a co-construction *with* the asylum seeker, involve tangible reminders, prompts and cues linked to their explanatory model of reasons for living and strategies they identify in the current context how best to comfort their distress. By taking tangible steps in safety planning, it will take mental health professionals to a closer point of understanding depth of distress and immediacy of suicide risk.