

Managing and Understanding Psychological Issues Among Refugee Applicants

Guidelines for Best Practice

Resources Manual

Legal

Jill Hunter Professor,
Faculty of Law, UNSW

Linda Pearson Visiting Fellow,
Faculty of Law, UNSW

Mehera San Roque Senior Lecturer,
Faculty of Law, UNSW

Ronnit Redman Lecturer,
Faculty of Law, UNSW (2002 – 2007)

Mental Health

Zachary Steel Associate Professor,
PRTU, School of Psychiatry, UNSW

Naomi Frommer Research Officer,
PRTU, School of Psychiatry, UNSW

Derrick Silove Professor & Director,
PRTU, School of Psychiatry, UNSW

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Jill Hunter, BA LLB *UNSW* PhD *Lond*
Professor, Faculty of Law, UNSW

Linda Pearson, BA *Syd* LLB *UNSW*
LLM, MPP *Syd*
Senior Visiting Fellow, Faculty of Law,
UNSW, (Senior Lecturer 2005 -2009)

Mehera San Roque, BA LLB (Hons)
Syd, LLM *UBC*
Senior Lecturer, Faculty of Law, UNSW

Ronit Redman, BA LLB (Hons), *Syd*,
LLM, *McGill*
Lecturer, Faculty of Law, UNSW (2002 –
2007)

Mental Health

Zachary Steel, BA (Hons) *Macq*, M
Clin Psych, PhD *UNSW*
Associate Professor, Psychiatry
Research & Teaching Unit, School of
Psychiatry, UNSW

Derrick Silove, MB ChB, MD *UNSW*,
FRANZCP
Professor & Director, Psychiatry
Research & Teaching Unit, School of
Psychiatry, UNSW

Naomi Frommer BA (Psych) (Hons)
LLB *UNSW*
Research Officer, Psychiatry Research &
Teaching Unit, School of Psychiatry,
UNSW

ACKNOWLEDGEMENTS

The researchers are grateful for the feedback received from and discussions with decision-makers, psychologists and advisors

We thank the 73 applicants who gave consent for the researchers to have access to reports and decision records

To Ronnit Redman whose intellectual passion, love of life and untimely death on 7th January 2007 is remembered by her colleagues in this, her project.

Suggested citation:

Hunter, J., Steel, Z., Pearson, L., San Roque, M., Silove, D., Frommer, N., Redman, R. (2013). Managing and Understanding Psychological Issues Among Refugee Applicants: Resources Manual and Guidelines for Best Practice. Sydney: Faculty of Law and Psychiatry Research and Teaching Unit, University of New South Wales.

Produced with the financial assistance of the Faculties of Law and Medicine, UNSW, and the Law and Justice Foundation of NSW.

The Law & Justice Foundation seeks to advance the fairness and equity of the justice system and to improve access to justice, especially for socially and economically disadvantaged people.

<http://www.lawfoundation.net.au>

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The resources in the research report and this Resources Manual are directed to assist refugee applicants and all those who participate in the refugee status determination process, including migration agents, lawyers, health and allied health professionals and decision-makers.

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Author Contacts: J.Hunter@unsw.edu.au (Law) & Z.Steel@unsw.edu.au (PRTU)

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*Resources Manual & Guidelines for Best Practice for Managing & Understanding
Psychological Issues Among Refugee Applicants*

A RESOURCES MANUAL

Managing & Understanding Psychological Issues Among Refugee Applicants Guidelines for Best Practice

An Overview of the Research¹

Those who seek to establish refugee status in countries such as Australia must undergo a comprehensive evaluation process to establish whether they have a well-founded fear of persecution that comes within the United Nations Refugee Convention definition. This definition has been incorporated in to the Australian Migration Act.²

"A person who owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it.."

In Australia this decision-making framework includes a primary decision by an Australian Department of Immigration and Citizenship (DIAC) officer. If this determination is adverse, the applicant can seek a complete review on the merits by the Refugee Review Tribunal (RRT).

The evaluation process is intrinsically challenging and the Office of the United Nations High Commissioner for Refugees (UNHCR) and human rights organisations have raised concerns that procedural challenges in determining refugee claims may create a set of demands that could lead to the *refoulement* or return of bona fide refugees to risk further persecution. It is a well-recognised fact that asylum seekers frequently flee persecution in circumstances that prevent them retaining documentation or other objective proof of their claim of persecution. Some will have had to travel on forged documentation and even break the law in order escape persecution. With little or no corroborating evidence supporting an applicant's claim for refugee protection, an applicant's credibility becomes critical to their application. While the UNHCR guidelines outline some broad principles to be applied when assessing an applicant's credibility, decision-makers face particular challenges in both the management and the evaluation of applicants who have trauma-related psychological damage.

In Australia both the Department and Tribunal provide guidelines on significant issues relating to decision-making in refugee status determinations. These guidelines caution decision-makers against placing too much reliance on the significance of missing documents, they note that allowance should be given to refugee applicants who have mental health problems and that care should be taken in judging an applicant harshly over delayed disclosure of violent, shameful or stressful aspects of the applicant's experiences that support their application for refugee protection.

¹ This manual was originally published as Part 3 of the original research report. See Hunter, J., Steel, Z., Pearson, L., San Roque, M., Silove, D., Frommer, N., Redman, R. (2010). *Tales of the Unexpected & Refugee Status Decision-Making: Managing and Understanding Psychological Issues Among Refugee Applicants*. Sydney: Faculty of Law and Psychiatry Research and Teaching Unit, University of New South Wales. Contact details on front cover regarding further information from the researchers.

² The UN General Assembly *Convention Relation to the Status of Refugees* (1951) as amended by the UN General Assembly *Protocol Relation to the Status of Refugees* (1967).

In the study that formed the basis of this report, referred to hereafter as the Tales study¹, we analyzed various aspects of the application and determination of a representative sample of 46 cases involving 52 refugee applicants. Our focus was upon the context in which applicants' presentation as credible witnesses can be impaired by virtue of their mental ill health, in a context where credibility is central to decision-making. All of the applicants in the study sample were assessed by mental health professionals and all provided psychological reports in support of their claim for refugee protection. The sample reveals a high proportion of applicants suffering PTSD and other psychological condition. The psychological evidence evinced a pattern of cognitive disturbances and dissociative symptoms associated with traumatic experiences that might exert adverse effects on the presentation of applicants' claims and demeanor during an interview or hearing. In particular, inconsistencies, inaccuracies, and confused chronology in applicants' accounts appeared to manifest most prominently in a subset of applicants exhibiting substantial memory and concentration impairments. These results support the empirical literature (Bogner, Herlihy & Brewin, 2007; Herlihy, Frestman, Turner, 2004; Rousseau et al, 2002; Van-Velsen, Forst-Unsworth & Turner, 1996) that individuals who have suffered trauma of a humiliating nature (eg, sexual abuse or violations) are likely to be impeded psychologically by the shame and stigma involved from fully disclosing the experience.

The study was the first in Australia and internationally to examine the role of expert psychological evidence in the determination of refugee claims. It explored the challenges facing mental health professionals, decision-makers, applicants and their representatives when mental health professionals seek to communicate the significance of trauma-related psychological sequelae to refugee status decision-makers.

First, in the Study's sample decision-makers rarely expressed reliance on psychologists' diagnoses and conclusions. Only a small percentage of decision-makers even referred to the expert reports. Those who did refer to a report regularly disagreed or ignored important elements in the reports, particularly those relating to credibility assessment. Through a number of illustrative case studies we explored the contexts in which decision-makers preferred their own lay judgment on the applicant's presentation of his or her claim to that of an expert. In addition we explored the reason why so many decision-makers appear to ignore psychological reports; or dismiss, minimise or misuse the conclusions of an expert and we identified the qualities in reports and in decision-making that enhance mental health experts' input in the decision-makers' task.

Second, the study also presented an evaluation of the psychological reports submitted by the applicants in the 46 cases. This evaluation raises issues relevant to the role and presentation of expert psychological evidence in applications for refugee protection. In terms of these broader issues, consultation with psychologists revealed that those who specialise in refugee mental health often feel frustrated at decision-makers' apparent neglect of the contents and conclusions in their reports and that decision-makers draw conclusions that appear to be at odds with a sound understanding of the impact of trauma on applicants' presentation of their claim. Some psychologists indicated that this frustration may fuel a desire to press applicants' cases through their reports. Consultations with groups of decision-makers indicated that for many decision-makers lack of objectivity and neutrality in psychologists' reports is viewed as a matter of significant concern.

The study highlighted a persisting conundrum in refugee adjudication, namely, legal representatives

and decision-makers often eschew exploring details of traumatic events yet failing to inquire contributes to non-disclosure and unexplained inconsistencies. This complex situation is exacerbated by the fact that decision-makers in some instances do not accept psychological explanation for non-disclosure of trauma-related information adopting instead an interpretation of non-disclosure that discredits the applicant.

With respect to the psychological reports in the study sample it is clear that while those in this study represent a cohort of specialist refugee health professionals, some reports were drafted in a manner that failed to match decision-makers' expectations of professionalism. A significant number of the reports appeared to advocate the applicants' cases, some quite stridently. From a decision-maker's perspective advocacy reflected a lack of professional objectivity, and thus diminished the potential utility of a report.

One explanation for the flawed communication between mental health professionals and decision-makers relates to respective discipline goals. Psychologists are trained and also practice in a therapeutic-model environment. Their code of professionalism means that their relationship with an applicant prioritises support and acceptance of the applicant and the professional goal is to develop a good therapeutic management plan. For decision-makers, the process requires that applicants' claims be tested for authenticity. As already mentioned, fact-finding is further challenged in refugee status determinations because there may be good reasons behind applicants inability to offer little objective supporting evidence in the form of documents. Nevertheless the process of determining refugee status involves close scrutiny of claims and evaluating accounts that in other environments would be considered deeply suspicious. Whilst the difficulties of genuine refugees are acknowledged, dishonest and exaggerated claims of persecution mingle in a pool of honest but, due to mental ill health, poorly presented claims. Distinguishing the honest and accurate claims from the dishonest and inaccurate ones presents a conundrum.

The Refugee Claim Context

Overview of the Legal Framework

Australian migration law and practice provide a number of avenues for the making and determination of claims for protection, or asylum, in Australia. The primary avenue for those in, and seeking to remain in, Australia is that provided by s 36 of the *Migration Act 1958* (Cth). This creates a class of visa known as “protection visas”, and sets out the criteria for the grant of such a visa. Until the passage of the *Migration Amendment (Complementary Protection) Act 2011*, s 36 required that the claimant be a non-citizen in Australia to whom the Minister is satisfied Australia has protection obligations under the *Refugee Convention and Protocol*.¹ In March 2012 Australia introduced an alternative way of meeting the criteria for a protection visa, which is that the claimant is a person to whom the Minister is satisfied Australia has protection obligations because the Minister has substantial grounds for believing that, as a necessary and foreseeable consequence of the non-citizen being removed from Australia to a receiving country, there is a real risk that the non-citizen will suffer significant harm (s36(2)(aa)).² This legislated system of complementary protection incorporates Australia’s international obligations under the *Convention against Torture*, the *International Covenant on Civil and Political Rights*, and the *Convention on the Rights of the Child*, and has broadened the parameters of protection decision-making, within the existing framework of the focus on the status of an applicant as a legal issue, informed by an understanding of the political, social and economic contexts relevant to applicants’ claims.³ We note at the outset that the decisions that were the subject of the Tales Study related to claims for protection based on the Refugee Convention grounds, and not on the expanded criteria for protection under the complementary protection amendments.⁴

In Australia the decision-making framework commences with a primary decision by an officer of the Australian Department of Immigration and Citizenship (DIAC) acting as delegate of the Minister, which may include an interview with the applicant.⁵ If the departmental determination is adverse, the applicant can seek a review on the merits by the RRT, an independent merits review body. The procedure before the RRT is non-adversarial. Hearings are conducted by a Tribunal Member who sits

¹ The UN General Assembly *Convention Relation to the Status of Refugees* (1951) as amended by the UN General Assembly *Protocol Relation to the Status of Refugees* (1967). A refugee is defined as someone who, owing to a well-founded fear of being persecuted for reasons of race religion, nationality, membership of a particular social group or political opinion, is outside the country of nationality and is unable or unwilling to avail themselves of the protection of that country.

² Section 36(2A) provides that a person will suffer “significant harm” if they will be arbitrarily deprived of life; the death penalty will be carried out on that person; or the person will be subjected to torture, to cruel or inhuman treatment or punishment, or to degrading treatment or punishment. Section 36(2B) qualifies what is taken to be a “real risk”, and s36(2B) provides that a person is taken not to satisfy the criterion in s36(2)(aa) in certain circumstances, including having committed a serious non-political crime, or security reasons.

³ J McAdam “Australian Complementary Protection: A Step-by-Step Approach” (2011) 33 *Sydney Law Review* 687.

⁴ For that reason in this article we have generally used the term “refugee” in relation to the decision-making process, while acknowledging that the circumstances that may give rise to a finding of a real risk of significant harm may well generate the types of mental health issues reflected in the applications that formed part of our study.

⁵ The primary reference point for Departmental delegates is the Procedures Advice Manual (known as PAM). In addition, since 2007 Departmental decision-makers are guided by the Administrative Review Council’s Best-Practice guides. There are five Guides, the most relevant being Guide 3: *Decision making: Evidence, Facts and Findings*.

alone. The RRT is not bound by the rules of evidence, and the Member can take into account any material that he or she considers relevant,⁶ as long as the Member acts according to “substantial justice and the merits of the case”.⁷ In addition to considering documentary material and any oral evidence provided by the applicant, the RRT Member will consider “country information”, that is, documentary material on conditions in various countries derived from the Department of Foreign Affairs and Trade, the UNHCR, human rights organisations, newspapers, and material from international bodies such as the US State Department and the UK Home Office.

Unless the RRT is able to make a decision in the applicant's favour on the documentary material, it must put the applicant on notice of information adverse to their case, provide the applicant with an opportunity to appear to give evidence and provide arguments in person, and arrange for an interpreter to be present if required.⁸ The RRT can affirm or vary the decision under review, or set it aside and substitute a new decision.⁹ The RRT will generally only be examining whether the claim made for protection under s 36 is satisfied: there are other criteria to be met before a protection visa is granted, including health and public interest criteria. In most cases if the RRT finds that the criterion in sub-sections 36(2)(a) or (aa) that Australia has protection obligations is met, it will remit the application to the Department to consider the remaining criteria.

There is no right of appeal from a decision of the RRT, and the only challenge possible is by way of an application for judicial review to the High Court, Federal Court or Federal Magistrates Court.¹⁰ Judicial review of migration decisions is limited to review on the basis of jurisdictional error. The concept of jurisdictional error is the subject of intense academic and judicial scrutiny.¹¹ Grounds on which an application for judicial review may succeed include a failure to comply with an essential procedural requirement of the *Migration Act*, or reaching a conclusion not supported on the material before the decision-maker, or establishing a reasonable apprehension of bias by the decision-maker. Nonetheless, the scope for overturning a departmental or RRT decision through judicial review is slight.¹² If the reviewing court finds a reviewable error, the usual outcome is that the RRT decision is set aside and the matter is remitted to the Tribunal for reconsideration (usually by a different Member).

⁶ *Migration Act 1958* (Cth), s 424.

⁷ *Migration Act 1958* (Cth), s 420(2)(b).

⁸ *Migration Act 1958* (Cth), ss 425, 427(7).

⁹ *Migration Act 1958* (Cth), s 415.

¹⁰ Section 474 of the *Migration Act* attempts to limit judicial review but it does not prevent judicial review of decisions made under the *Migration Act* affected by jurisdictional error. The history of legislative attempts to limit or preclude judicial review of migration decisions is traced in S Gageler “Impact of Migration Law on the Development of Australian Administrative Law” (2010) 17 *Australian Journal of Administrative Law* 92. In addition to judicial review remedies, an applicant who is unsuccessful at the RRT can apply to the Minister who can substitute a decision more favourable to the applicant (*Migration Act 1958* (Cth), s 417: see *Plaintiff S10-2011 v Minister for Immigration and Citizenship* [2012] HCA 31).

¹¹ See M Alderton, M Granziera & M Smith “Judicial review and jurisdictional errors: The recent migration jurisprudence of the High Court of Australia” (2011) 18 *Australian Journal of Administrative Law* 138; M Aronson, B Dyer & M Groves *Judicial Review of Administrative Action* (4th ed, 2009 Thomson Reuters) [1.80]-[1.90]; M Leeming *Authority to Decide: The Law of Jurisdiction in Australia* 2012, Federation Press, Ch 3.

¹² See *Minister for Immigration and Citizenship v SZJSS* (2010) 273 ALR 122.

These Guidelines

These guidelines were developed in 2010 and are based on the researchers' expertise across the fields of procedural, refugee and administrative law and in the specialised domain of research and clinical practice in refugee mental health uniquely span the health/law disciplinary divides. Our aim has been to fill an important gap in the support of decision makers, mental health professionals and applicants' representatives with a view to creating an informed and practical understanding for managing the challenges for applicants with trauma-related psychological damage where little or no documentation or other objective evidence exists, and credibility is pivotal to decision-making. In these circumstances psychological and emotional conditions may combine with a mismatch of cultural norms and expectations to make refugee status evaluation a particularly complex task.

Putting aside some short, but excellent references to the role of expert medical evidence in the *International Association of Refugee Law Judges' Guidelines on the Judicial Approach to Expert Medical Evidence*,¹³ domestically in Australia there are no guidelines to assist applicants and their representatives in determining when psychological evidence should be sought, how such evidence can assist in documenting applicants' trauma histories and provide guidance to understand the complex psychological issues associated with an applicant's claim and their presentation under questioning. This gap is significant because applicants' representatives are in a position to play an important role in ensuring optimal expert information is before a decision maker.

Even with the development of the Migration Review Tribunal/Refugee Review Tribunal, *Guidelines on Expert Opinion Evidence* in 2009 and the Federal Court Practice Note equivalent in 2011¹⁴ there is only barebones generic guidance for mental health professionals providing psychological reports as expert evidence for consideration by decision-makers. The *Tales of the Unexpected* study shows that synchronising mental health expert guidance to the needs of decision makers requires more detailed and further directed support.

Further, although the Migration Review Tribunal and Refugee Review Tribunal have developed in recent times publications for decision makers guiding credibility assessment,¹⁵ the management and support of vulnerable people¹⁶ and explaining the significance of social and cultural issues raised by a person's gender¹⁷ there are no structured or detailed publicly accessible guidelines to assist decision-

¹³ http://www.iarjl.org/general/images/stories/working_parties/guidelines/Final_guidelines_March_2011.pdf, (June 2010), [referred to as the IARLJ Guidelines]. The IARLJ Guidelines are predominantly directed to decision makers and to medical experts. They are drafted also to include expert reports from psychiatrists and psychologist. Some of the guidelines are extracted below.

¹⁴ [http://www.mrt-rrt.gov.au/Files/HTML/P-C-GU-GuidanceExpert OpinionEvidence.html](http://www.mrt-rrt.gov.au/Files/HTML/P-C-GU-GuidanceExpert%20OpinionEvidence.html) (MRT/RRT, May 2009), see also Practice Note, Chief Justice, Federal Court of Australia, CM 7 - *Expert Witnesses in Proceedings in the Federal Court of Australia* at <http://www.fedcourt.gov.au/law-and-practice/practice-documents/practice-notes/cm7>. (August 2011).

¹⁵ See *Guidance on the Assessment of Credibility* (Migration Review Tribunal and Refugee Review Tribunal, 24 March 2012) at <http://www.mrt-rrt.gov.au/CMSPages/GetFile.aspx?guid=df229896-7a1e-49c9-aa88-f42feed0cde>.

¹⁶ *Guidance on Vulnerable Persons*, see <http://www.mrt-rrt.gov.au/CMSPages/GetFile.aspx?guid=14e44c96-1485-484c-9eaa-f987029cec40>, (Migration Review Tribunal and Refugee Review Tribunal, June 2012)..

¹⁷ *Gender Guidelines*, see <http://www.mrt-rrt.gov.au/CMSPages/GetFile.aspx?guid=11c672f8-2b33-43f5-93df-684ce9b77782> (Migration Review Tribunal and Refugee Review Tribunal, March 2012).

makers' assessment of the impact of psychological factors on applicants' presentation of their claims, or to assist in the interpretation of psychological evidence placed before them.

It is with these complex challenges in mind that the researchers in the study created a Resources Manual of guidelines. This Manual provides a unique and accessible step-by-step guide to best practice strategies that focus particularly upon the circumstances and perspectives of

- **psychologists and psychiatrists** working in the field of refugee health assessment,
- **decision-makers in the refugee status determination process**, and
- **refugee applicants' supporters and representatives**, whether they be migration agents, lawyers or from support organisations.

Many aspects of existing Australian guidelines are incorporated or built on in these guidelines. In addition, the IARLJ Guidelines, including the references and quotations from United Kingdom, European and Canadian case law, are of additional assistance, particularly the following extracts:¹⁸

"Introduction

1.2.5. Any medical report or psychiatric report deserves careful and specific consideration, bearing in mind, particularly, that there may be psychological consequences from ill treatment which may affect the evidence which is given by the applicant. Attention should be given to each and every aspect of medical reports.... If the judge decides to reject any medical report there is a positive obligation to do more than merely state that it had been 'considered'. The decision maker must provide some meaningful discussion as to how he or she had taken account of the applicant's serious medical condition before making a negative credibility finding. The failure to do so in this case would be likely to be considered to be a 'reviewable error.' .

* * * * *

The Role of Expert Medical Evidence

3.1. Expert medical evidence is obtained for one or more of the following purposes:

- to substantiate claims of ill-treatment;
- to establish a correlation between physical or psychological injuries and the alleged torture or ill-treatment
- to explain a claimant's difficulties in giving evidence or recounting events by
 - (a) providing possible explanation(s) for inconsistencies and/or contradictions within a claimant's narrative of events;
 - (b) providing possible explanation(s) for reticence or reluctance in divulging a full account of events, for example delay in divulging allegations of sexual assault and/or other forms of violence directed against an individual,
- to address the possible effect of removal and return to the country of origin upon a person's physical or mental well-being or that of a family member;
- to assess treatment needs.
- to reduce the need for the claimant to give testimony about traumatic events.

¹⁸ http://www.iarjl.org/general/images/stories/working_parties/guidelines/Final_guidelines_March_2011.pdf, (June 2010), Please note that these extracts omit citations included in the IAJRLJ guidelines.

3.2. Expert medical evidence may not prove conclusively whether or not someone was tortured or had suffered serious physical or psychological injury. Rather, the medical report provides expert opinion on the degree to which the injuries or behaviour presented correlate with the allegations of torture/ill-treatment.

3.3. Expert medical evidence should form an integral part of any findings of credibility and should not be separated from other evidence.

3.4. The judge may, in the context of the evidence as a whole, have to consider the possibility that the claimant is feigning the symptoms he or she puts forward.

...

* * * * *

4. Standards to Ensure Uniformity and Consistency of Expert Medical Evidence

...

4.8. A holistic approach should be adopted to the evaluation of expert medical evidence. A report which does not contain all of the above should not be disregarded as deficient.

...”

Managing & Understanding Psychological Issues Among Refugee Applicants: Guidelines for Best Practice

The Guidelines for Best Practice included in this Resource Manual provide step-by-step focused guidance to enhance the role, support and guidance of mental health evaluations of refugee applicants with vulnerabilities arising from trauma-related mental and emotional impairment.

This manual will assist:

- Refugee applicants
- Psychologists, psychiatrists, social workers, counselors, or other suitably qualified mental health professionals who are assisting refugee applicants
- Migration agents, lawyers in private practice and specialist refugee services, including pro bono providers of assistance to asylum seekers.
- Decision-makers on refugee-status applications, and personnel within decision-making bodies:
 - Administrative decision-makers (DIAC officers and RRT members)
 - Judicial decision-makers in the Federal Magistracy and Federal Court.

Part one

**Guidelines for Mental Health Professionals: Expert Reports,
Diagnoses & Management Plans for Refugee Claimants**

1. Guidelines for Mental Health Professionals: Expert Reports, Diagnoses & Management Plans for Refugee Claimants

1.1 The Expert Report in the Refugee Determination Context

- ❑ Within the refugee decision making process, a report can have a number of roles. It is important that you are clear as to the role that your report can play in assisting the decision-maker and that your report addresses that role. For example,

- ❑ Is it to assist the decision-maker in their interactions with the applicant?

For example,

- By providing clinical recommendations about the management of the psychological symptoms that may be experienced by the applicant at interview.
- By providing information about aspects of the applicants mental state that may affect his/her behavior or responses to questions at interview.

- ❑ Is it to provide clinical information to the decision-maker that supports aspects of the applicant's claim?

For example,

- A diagnosis that the applicant suffers from a mental disorder that is consistent with having a history of exposure to trauma.
- Evidence about the consistency of reported symptoms with the presentation of the applicant observed by the clinician.
- Provision of a detailed trauma history elicited within the contexts of a clinical interview that may provide information of relevance in the assessment of persecution by the decision-maker.

- ❑ Is it to provide expert evidence to the decision-maker that may be relevant in understanding reasons behind particular inconsistencies within the applicant's account?

For example,

- The extent to which symptoms of mental disorder are present that could affect the testimony of the applicant.
- Evidence of impairments in the autobiographic memory of an applicant that may be associated with prior exposure to potentially traumatic events
- Factors that may be associated with a full or partial delay in disclosure of an important part of the biographical history of the applicant such as in the reporting of sexual assault.

- ❑ Australian and overseas studies support the development of guidelines, addressing issues that have arisen regarding refugee applicants who have or are experiencing difficulties relating to their mental or emotional well-being and/or who have provided a report from a mental health professional to support their application for refugee status.
- ❑ These guidelines seek to address concerns expressed by decision-makers, legal advisers, psychologists, psychiatrists, social workers, counsellors, and other suitably qualified mental health professionals.

- ❑ Complex issues of fact are central to the determination of refugee status. Some facts, arising as they often do, from unusual situations, require probing and analysis by the person responsible for determining the claim. Your report can assist in determining those facts and in understanding aspects of the applicant's past and current behavior.
- ❑ If you have been asked to provide a report in support of an asylum seeker (hereafter referred to as an applicant) whose case is being reviewed by the Refugee Review Tribunal, please ensure that you have read and complied with the MRT/RRT *Guidelines on Expert Opinion Evidence*. The MRT/RRT *Guidelines on Expert Opinion Evidence* are available at: <http://www.mrt-rrt.gov.au/Files/HTML/P-C-GU-GuidanceExpertOpinionEvidence.html>.
- ❑ The MRT/RRT *Guidelines on Expert Opinion Evidence* will also be a helpful reference if the report is in support of an application that is being considered by the Department of Immigration and Citizenship.
- ❑ There are equivalent guidelines at the Federal Court level. See Practice Note, Chief Justice, Federal Court of Australia, CM 7 - *Expert Witnesses in Proceedings in the Federal Court of Australia* at <http://www.fedcourt.gov.au/law-and-practice/practice-documents/practice-notes/cm7>.
- ❑ You might also find additional assistance from the IARLJ Guidelines. http://www.iarlj.org/general/images/stories/working_parties/guidelines/Final_guidelines_March_2011.pdf.¹⁹
- ❑ It is the task of the Department or the Refugee Review Tribunal to ascertain whether the claim for refugee status according to the Refugee Convention grounds has been satisfied.

"A person who owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it.."

This is a complex process that requires, at a minimum, knowledge of the relevant sections of the *Migration Act 1958* (Cth) and related legislation, awareness of judicial judgments that define the interpretation that should be applied to the Act, information about the conditions within the source country from which the applicant has left, review and evaluation of the testimony or other evidence provided by the applicant and consideration of the credibility of the information provided by the applicant.

¹⁹ http://www.iarlj.org/general/images/stories/working_parties/guidelines/Final_guidelines_March_2011.pdf, (June 2010) (and see extracts at the commencement of these guidelines).

- ❑ Fundamental to the writing of a report on behalf of an applicant for refugee status is an understanding of the role of the expert report within the decision making context. As the MRT/RRT *Guidelines on Expert Opinion Evidence* state: “An expert providing an opinion does so to assist the Tribunal in matters relevant to the expert’s area of expertise and is not an advocate for an applicant or any other party.”

1.2 The Fundamentals of Professionalism

- ❑ Your report will be read and assessed by a departmental officer and/or by a Refugee Review Tribunal member and/or by a Federal Magistrate and/or by a Federal Court judge. It is extremely likely that these people have no background in clinical psychology or psychiatry. For that reason, your report needs to be clear, focused, professional and its main messages should be relevant and intelligible. You should assist the decision-maker by stating what findings within your report you believe are relevant to the task before the decision-maker.
- ❑ Provide your report on letterhead, dated, typed and signed. The process for determining refugee status may not be as formal as a traditional courtroom determination, but it is treated as determining matters of high significance both to the applicant, and the Australian community. A report that fails to display the basic elements of professionalism creates the impression that it is ill-considered and not worthy of great weight.
- ❑ In compliance with the MRT/RRT *Guidelines on Expert Opinion Evidence*, your report should include a declaration that all relevant matters known to the expert have been disclosed, and that no such matters have been withheld from the report:

I declare that all relevant matters known to myself with regard to this report have been disclosed, and that no such matters have been withheld from the report.

- ❑ Your report needs to be clear and well-structured for its purpose. The structure and elements discussed in more detail below are offered because of criticisms and concerns that have been raised by people, without training in psychiatry and psychology, who need to use the reports to assist applicants or as an aid to decision making. The structure and elements discussed below respond to concerns that it can be difficult to understand reports, to follow the structure that is adopted, and to know what to make of gaps in the report. You could consider structuring your report with the headings recommended below, but whatever structure and headings you choose you must ensure that your report is clearly structured with a view to making explicit the basis for your well-reasoned conclusions.

1.3 Your Professional Credentials

- Describe your professional qualifications.
- Describe your professional experience. This may variously include:
 - How long you have been in practice relevant to your clinical observations and diagnosis in your report.
 - Outline any clinical experience of particular relevance to the current clinical context, including the number and/or range of relevant cases seen.
 - List any professional or other background that is relevant (*eg* you have worked in the Sudanese community for X years; you speak or are of Sudanese background; you are familiar with the circumstances, customs or health issues of Sudanese women etc).
- Describe any relevant peer related activities or research such as presentations at peer conferences or publications in a field relevant to your report, diagnosis or clinical observations.
- Describe any continuing training that is relevant to your report, for example, by attending conferences, by subscribing to or regularly reading literature in the discipline or relevant to the diagnosis and management of people with the clinical condition described in your report.
- List your membership or association with any relevant professional bodies.
- Explain the extent to which you treat or have a professional association with people who are refugees or who have sought refugee status.
- Explain the extent to which you treat or have a professional association with people who have the clinical conditions described in your report.
- In addition to listing the above information within the body of the report it may be valuable to append a copy of your curriculum vitae to the report.

1.4 What were the Situations in which a Report was Sought?

- Studies show that decision-makers appreciate knowing whether you saw the patient because they were seeking therapy for certain symptoms or whether you were asked to provide a report for the purpose of the refugee status determination.
- Ensure your report does not appear to exist in a vacuum. The MRT/RRT *Guidelines on Expert Opinion Evidence*, mentioned above, indicate that your report include a statement of the instructions given to you, “and of the questions or issues that the expert was asked to address”
- The MRT/RRT *Guidelines on Expert Opinion Evidence* also state: “If a medical expert or psychologist has a pre-existing relationship with the person who is the subject of the report, for example, if he or she is the person’s treating physician, this should be identified in the report”.
- If you are providing a report only for the purpose of the refugee status determination you should indicate:
 - Does the applicant have a diagnosable medical condition relevant to his or her claim or his or her current behavior and/or emotional or mental state?
 - If yes, do you recommend a course of treatment?
 - If no, why not?

1.5 Describing the Circumstances Relevant to your Report

- The number of interviews.
- The length of interviews.
- The name and qualifications of any other parties in attendance such as a health care interpreter.
- The presence of language or other communication challenges (and any relevant action taken).
- Elements in your communication with the applicant that make it likely you achieved/or did not achieve a particularly good rapport with the applicant.

1.6 Taking a History and Presenting the Narrative Account of the Applicant's Past and Current Circumstances

1.6.1 Presenting the Narrative

- It is appreciated by those who determine claims for refugee status that clinicians need to obtain a history of the events or circumstances that may have caused, or may explain, aspects of the applicant's current and past mental and emotional well-being. It is also recognised that mental health professionals may have specialized skills in obtaining a narrative account of material that is associated with psychological distress as might occur with exposure to potentially traumatic events or is of a sensitive nature such as sexual abuse or rape.
- However, because it is the acceptance by *the decision-maker* of the applicant's account of past events and circumstances that is central to determining the refugee status claim, a number of problems can arise from the presentation of the narrative in the expert report. These include:
 - that information may be discounted or ignored where it is only included in an expert report, and no explanation is given for why this information has not appeared elsewhere;
 - that information may be discounted or ignored where it is only included in an expert report and therefore appears as a late disclosure of information by the applicant, and no explanation is given for the late disclosure;
 - problems that arise where the expert report disguises or avoids addressing flaws in an applicant's account.
- It is preferable that your report does not begin with a repetition of the narrative that is available elsewhere in the application. This may make it difficult for the decision-maker to perceive what your report adds to the applicant's case. The following examples are provided to indicate ways in which the report can refer to the narrative history taken, without needing to repeat information already available in the application:
 - **Situation Example 1:** If the narrative that has been presented to you is essentially or entirely consistent with the information already provided in the applicant's statement, then your report can simply note the aspects of the narrative that are relevant to your diagnosis and opinion, as well as noting that the narrative provided for the purposes of the report was consistent with that provided elsewhere in the application. If you wish you can append a copy of the narrative account submitted to the department to your report.

- **Situation Example 2:** if the narrative provided to you appears to be inconsistent with the narrative provided elsewhere in the application, your report should note these inconsistencies. If it is appropriate, your report should address possible reasons behind these inconsistencies. This is an opportunity to explain to the decision-maker why the inconsistencies may or may not be relevant to assessing the truthfulness of the applicant's case.
- **Situation Example 3:** If the narrative obtained in the course of your treatment/assessment includes additional information about the applicant's experiences that have not been previously disclosed this needs to be carefully documented (see below: Particular Issues Relating to Late Disclosure). If this new information is relevant to your diagnosis, then it should be noted in the report. If appropriate, your report should offer an explanation of the factors that can lead to late disclosure.

1.6.2 Addressing the Strengths and Weaknesses in the Applicant's Narrative

- ❑ It is very likely that the applicant's account of past events and circumstances will be closely scrutinised and possibly challenged. If your report is for a review by the Refugee Review Tribunal, the applicant's account has probably already been found wanting by the Department in various respects.
- ❑ In addition, most decision-makers will not accept your summary of the applicant's suffering uncritically, particularly as such claims often relate to their claim for seeking refugee protection in Australia. This is because of the nature of the process is to test the evidence in the context of a reality that there are people who make false claims for refugee status.
- ❑ For this reason, if for the purpose of reaching a diagnosis or set of conclusions, you accept the applicant's accounts uncritically and/or without expressing consideration of possible falsehoods or flaws, your diagnosis and conclusions may be viewed by the decision-maker as lacking weight. To meet this concern, explain how you have reached your conclusions as to the elements of the applicant's account you accept or do not accept, and your reasons for doing so. For example:
 - You might indicate strategies that you employ to evaluate the accuracy and exaggeration of symptoms.
 - You might indicate that certain symptoms are consistent (or inconsistent) with particular traumatic occurrences.
 - For example, *"psychological symptoms of depression and PTSD presented by the applicant were consistent with the traumatic events s/he claimed to have experienced."*

- You might explain that certain past or present behaviour is consistent (or inconsistent) with exposure to particular exposure to potentially traumatic occurrences.
- You might indicate that you are unsure on any of the above matters, but in your professional opinion for therapeutic purposes you will accept that the applicant's account of events and circumstances is honest and is their best attempt to relate an accurate picture of what has occurred.
- You might indicate that in your view elements of the applicant's account are likely to be exaggerated, but other elements or features do not appear to be exaggerated. Where this is relevant, explain the basis for your conclusions.

1.6.3 Particular Issues Relating to Late Disclosure

- ❑ Psychologists have reported in an Australian study that they obtain greater detail and insight of the events, circumstances and challenges facing the applicant than appears to be known to the applicant's migration agent/legal representative. This additional material may be important to the applicant's case. Some mental health professionals in the study have reported that there is pressure to include this additional material in their report because it may not otherwise appear in the applicant's case.
- ❑ However, only including this information in the report is undesirable if it is not directly linked to your clinical assessment and conclusions. It may create the impression that you are assisting to build a case for the applicant – in other words, that you lack objectivity.
- ❑ If the additional information you obtain is not directly relevant to your clinical findings it is important to discuss with the applicant whether he or she would be willing for this additional information to be included in a separate report for the applicant to give their representative, who can then advise the applicant if this information is relevant and should be included in an addendum to the application statement.
- ❑ If the additional information you obtain is appropriate and relevant to your clinical findings, then this information can be included in your report and the report should offer an explanation of the factors that can lead to late disclosure of the alleged abuse or trauma. This is an opportunity to explain to the decision-maker why late disclosure may or may not be relevant to assessing the truthfulness of the applicant's case. It is preferable to also raise with the applicant the importance of discussing this additional information with their representative, so as to enable them to decide whether it should also be included in an addendum to the application statement.

1.7 Providing a Clear Assessment of the Applicant's Mental Health

- ❑ The readers of your report may or may not have previous experience in interpreting the meaning and significance of mental health evidence. For this reason it is important that any technical words should be explained in lay language.
- ❑ You should provide an explanation of the consequences of your diagnosis for the treatment and management of the applicant, and particularly whether (and why) further treatment is recommended, or not recommended
 - For example, *“At this stage, without the applicant being willing (or able) to take medication for depression and anxiety or the possibility of obtaining counseling by a female counselor [from the applicant’s particular ethnic group], no further treatment beyond monitoring the applicant’s situation is recommended at this time.”*
- ❑ Refugee decision-making (at the department or Tribunal stage) is enhanced if your professional expertise can assist in advising on matters that may help with advice regarding the support or management of the applicant, particularly when he or she is being questioned. You should provide assistance, where relevant, as to whether (and why) the applicant would benefit by particular consideration when they appear for interview, or in the Tribunal. For example:
 - *“A’s psychological state is likely to affect his ability to answer questions”*
 - *“...the blunted affect displayed by X is consistent with a pattern of diminished responsiveness and withdrawal in persons who have survived violent or life-threatening traumas”*
 - *“A showed signs of dissociation as evidenced by his total lack of emotional reaction when describing the events leading up to and including his alleged arrest and beating at the hands of ...”*
 - *“It seemed that when talking about his traumatic experiences, his anxiety interfered with his cognitive ability to concentrate and he became increasingly confused.”*
- ❑ You should express your view as to whether you would consider it possible to attribute – or not – the applicant’s current state of mental or emotional well-being to, for example:
 - aspects of the alleged persecution (or exposure to traumatic events which form part of the claim for protection); and/or
 - the events that took place subsequent to fleeing the alleged persecution and prior to arrival in Australia; and/or
 - the current (or post-arrival) circumstances of the applicant.

1.8 Providing a Foundation to support your Assessment & Conclusions

- ❑ As in all disciplines, decision-makers in the refugee status determination process must evaluate all the information offered to them. They will evaluate your report on the basis of your professional expertise and qualifications, on the amount of time you been able to take in assessing the applicant, and also on the basis of the intellectual support you provide for your assessment and conclusions.
- ❑ As a consequence, you should provide the basis or foundation upon which you reach each of your diagnoses and subsequent clinical findings. For example:
 - Did you rely on structured or standardized assessment procedures? What are the salient research findings about the validity of the assessment procedures generally and also within the context in which it has been used for the current assessment
 - Did you rely on the identification of particular symptoms to reach a diagnosis? How do the symptoms you identify relate to your diagnostic formulations? Has your diagnostic formulation been made according to the criteria listed within DSM-IV, ICD-10, research into emerging conditions, or on the basis of your clinical experience? Did you discount any particular matters? Why?
 - Are there elements of uncertainty which you could draw to the decision-maker's attention? Why do you have these uncertainties?

1.9 Explaining Gaps in your Report

- ❑ Decision-makers have reported that they are troubled by certain gaps in reports. For example perceived gaps include those relating to matters that are typically expected in a psychological assessment, such as the absence of a therapeutic management plan. Other perceived gaps might be matters that would be relevant in determining refugee status, such as why an applicant's a delayed disclosure with respect to certain traumatic and/or shameful incidents may be explicable on mental health grounds, but other analogously traumatic and/or shameful incidents were disclosed promptly by the applicant.
- ❑ The MRT/RRT *Guidelines on Expert Opinion Evidence* indicate, "If there are any matters upon which the expert is unable to comment, or for which insufficient information is available, this should be noted in the report".
- ❑ If there are elements, such as those mentioned above, that you cannot address you should state that fact.
- ❑ You should state all relevant diagnoses, or where relevant, if in your professional judgment the applicant suffers from no diagnosable medical condition.

1.10 Be Objective – do not engage in advocacy

- ❑ Experts providing information to assist any legal process, including the determination of refugee status, are not advocates for a party. An expert witness's paramount duty is to assist the decision-maker and not to the person retaining them. Experts have an overriding duty to assist a Tribunal or a Court on matters relevant to the expert's area of expertise: see MRT/RRT *Guidelines on Expert Opinion*, mentioned above. These are legal principles relevant to providing an expert report or opinion. Expression of them in a court context is found in Practice Note, Chief Justice, Federal Court of Australia, CM 7 - *Expert Witnesses in Proceedings in the Federal Cour of Australia*, guidelines 1.1-1.3 (see <http://www.fedcourt.gov.au/law-and-practice/practice-documents/practice-notes/cm7>).
- ❑ In the UNSW study, *Tales of the Unexpected & Refugee Status Decision-Making* (Hunter et al., 2010) it was reported that some Tribunal members interviewed expressed concern regarding the professional objectivity of some mental health professionals in view of items expressed in their reports. Phrases that may seem innocuous to mental health professionals may, from the perspective of a decision-maker, suggest that the expert witness is inappropriately pressing for acceptance of the applicant's claim. For example, do not include statements that may imply that the expert report is making submissions on behalf of the applicant, such as:
 - *"The [Department] delegate has failed to comprehend..."*
 - *"In order to address some of the issues raised in the [Department] delegate's decision..."*

1.11 Summary of Key Points

1.11.1 Things to Do

- ❑ Be clear about the role of your report. Is it to assist the decision-maker in their interactions with the applicant? Is it to explain to the decision-maker reasons behind particular inconsistencies within the applicant's account? Is it to support the applicant's claim by providing a clinical diagnosis that they have suffered trauma?
- ❑ Provide concluding remarks, that are supported by the body of your report, regarding the applicant's mental health that reflect relevantly upon the applicant's current and ongoing situation with respect to treatment and also with respect to the hearing or interview process: the decision-maker wants to know about the here and now.
- ❑ Indicate whether and in what manner the applicant's experiences may have affected their capacity to provide a clear, consistent narrative.

- ❑ Indicate the consistency or inconsistency of the applicant's behavior with someone who has experienced what the applicant claims to have experienced.
- ❑ Indicate whether there are ethnic and linguistic matter that in your professional experience might introduce trans-cultural biases and misunderstandings in an Australian context.
- ❑ Indicate whether there are mental or emotional health issues that will affect the capacity of the applicant to give evidence or be interviewed in the refugee-evaluation context. Explain with whatever specificity is possible regarding possible impacts upon the applicant's capacity.
 - For example, *'[The applicant] was unwilling to provide information about experiences while in detention as he found these to be "very shameful"; capable of disclosing them "in this [the psychologist's interview] confidential context."*
- ❑ Explain, with recourse to your professional judgment, how these matters might be most appropriately managed within the decision-making process.
- ❑ Present in your report Illustrations that substantiate your conclusions. For example:
 - *"A did not respond in a uniform way to every symptom that was presented to him and denied the existence of a number of symptoms; demonstrating that he was not merely exaggerating his symptoms to assist his application to gain refugee status."*
 - *"A showed signs of dissociation when describing the torture he suffered while imprisoned. This was evidenced by his lack of affective responsiveness when describing the events that he stated happened. This behavior is consistent with a post-traumatic stress response where an individual becomes dissociated from emotional content of torture and trauma. This is also known as emotional detachment"*.
- ❑ Organise your conclusions in a manner that is accessible to a decision-maker. Review the headings used to ensure that the report clearly differentiates between the narrative provided, clinical observations, clinical findings, conclusions and treatment options.
- ❑ Limit your conclusion(s) to areas associated with your training and expertise. For example, a statement that you believe the applicant's conversion from Islam to Christianity is genuine may create an impression that the clinician is blurring the role of the report and acting as an advocate for the applicant.

1.11.2 Things Not to Do

- ❑ Uncritically accept the applicant's assertions regarding their claim of persecution or base your clinical findings entirely on the assumption that these facts are true. It is possible that all or some of these claims will be contested.
- ❑ Adopt the role of the applicant's advocate at the expense of professional objectivity.
- ❑ Merge contested factual conclusions into clinical findings in such a manner that it is impossible for the decision-maker to accept clinical findings if the decision-maker is unwilling to accept certain factual conclusions.
- ❑ Include, or develop points based on matters irrelevant to your diagnosis or to the decision-maker's needs.
 - For example, by focusing extensively on the narrative of trauma of the journey to Australia, which may be relevant to understanding the applicant's presentation at the hearing, but is not relevant to the refugee claim itself.
- ❑ Make findings or draw conclusions without providing guidance to the decision-maker of the significance of those findings to the refugee decision making process.
 - For example, indicating that A's is suffering PTSD and MDD, "*causing clinically significant impairment in functioning*", but no statement is provided of how this may impact on A's present case.
- ❑ Include statements of belief (or disbelief) of an applicant's account without an explanation linked to your professional expertise.

1.12 Beyond a Report – Additional Assistance for Vulnerable Applicants

- ❑ It is clear from the principles contained in the MRT/RRT *Guidance on Vulnerable Persons* (GVP, MRT/RRT, 2009) issued in June 2009, that the Refugee Review Tribunal seeks to ensure that "the inherent dignity of vulnerable persons is recognised and respected". See <http://www.mrt-rrt.gov.au/CMSPages/GetFile.aspx?guid=14e44c96-1485-484c-9eaa-f987029cec40>³
- ❑ The MRT/RRT Guidance define a vulnerable person as anyone "whose ability to understand and effectively present their case or fully participate in the review process may be impaired, due to their age or physical, mental, psychological or intellectual condition, disability or frailty".

³ This guideline, dated June 2012, post-dates the guideline of June 2009 that formed the basis of our analysis in the research report.

- ❑ The MRT/RRT Guidance seeks to ensure that proper account is taken of the needs of vulnerable people. This includes providing additional support and understanding in proceedings because vulnerable parties or witnesses may face particular difficulties in the review process arising from impaired ability to understand and effectively present their case, and fully participate in proceedings.
- ❑ The MRT/RRT Guidance permits consideration by the Tribunal Member of “particular procedural arrangements or additional representation or support” for a vulnerable applicant where this is desirable in an individual case: guideline 4.5 (GVP, MRT/RRT, 2009). While there is no obligation on an applicant to have a support person or a representative, guideline 5.4 (GVP, MRT/RRT, 2009) provides:

“A support person can assist a vulnerable person with his or her case by providing support at a Tribunal hearing ... by contacting the Tribunal on the vulnerable person’s behalf ... Support persons include friends, relatives or church leaders or medical practitioners, social workers, counselors or psychologists”.

Checklist for Writing the Expert Report

- Does your report recognise and engage with the refugee determination context?
- In drafting your report, have you taken into account the relevant guidelines, such as the *MRT/RRT Guidelines on Expert Opinion Evidence*?
- Is it clearly and professionally presented?
- Have you included your professional credentials? (see section 1.3)
- Have you outlined the situation in which the report was sought? (see section 1.4)
- Does the report describe the circumstance relevant to the report? (see section 1.5)
- Is the narrative account of the Applicant's past and current circumstances included as the basis for your opinions in a format that accommodates the decision-makers expectations of the report? (see section 1.6)
- If relevant, does the report provide an explanation for additional biographical or other information that has not been previously disclosed? (see section 1.6.3)
- Does the report provide a clear assessment of the applicant's mental health including treatment plans where applicable? (see section 1.7)
- Does the applicant's account and symptoms provide a foundation to support your assessment & conclusions and is this clearly articulated for the decision-maker? (see section 1.8)
- If applicable, does the report acknowledge gaps in either the account or the report itself and provide an explanation where appropriate? (see section 1.9)
- Does the report fulfill its function as an objective assessment designed to assist the decision-maker? (see section 1.10)
- Have you reviewed the summary of key points in section 1.11?
- Does the report include clear, concluding remarks or conclusions?
- Could the applicant be classed as "Vulnerable" in line with the *MRT/RRT Guidance on Vulnerable Persons*? (see section 1.12)

Part two

Guidelines for the Applicant's Representative: Expert Mental Health Reports for Refugee Claimants

2. Guidelines for the Applicant's Representative: Expert Mental Health

Reports for Refugee Claimants:

2.1 General Principles

- ❑ The Guidelines in this Resource Manual respond to the findings in the UNSW Study, *Tales of the Unexpected and Refugee Status Decision-Making* (Hunter et al., 2010), evaluating the quality of and weight to be accorded to psychological reports tendered by refugee applicants.
- ❑ Ensure that any expert from whom you seek a mental health report has a copy of this Resource Manual for their reference.
- ❑ Ensure that any expert from whom you receive or seek a report has received, read and complied with the relevant Guidelines issued by the Tribunal or Court.
 - For the RRT this is the *MRT/RRT Guidelines on Expert Opinion Evidence*, available at <http://www.mrt-rrt.gov.au/CMSPages/GetFile.aspx?guid=763c87f0-757f-459a-9912-f0d187920f33>
 - For the Federal Court the equivalent guidance can be found in Practice Note CM 7 (Chief Justice, Federal Court of Australia) - Expert Witnesses in Proceedings in the Federal Court of Australia, available at: <http://www.fedcourt.gov.au/law-and-practice/practice-documents/practice-notes/cm7>
- ❑ The *MRT/RRT Guidelines on Expert Opinion Evidence* and the Federal Court Practice Note CM 7 also provide guidance for reports being presented to the Department of Immigration and Citizenship.
- ❑ The UNSW Study (Hunter et al., 2010) identified concerns held by decision-makers regarding the professional objectivity of some of the reports written by mental health professionals. Specifically the following issues have been raised:
 - The appearance of an uncritical acceptance of the applicant's assertions regarding the claim of persecution, related facts, and current symptoms bearing on the mental assessment of the applicant.
 - The adoption by the mental health professional of the role of the applicant's advocate at the expense of professional objectivity.
 - The merging of factual conclusions into clinical findings in such a manner that it is impossible to accept clinical findings if the decision-maker is unwilling to accept certain factual conclusions.
 - The focus on irrelevancies (for the purpose of the decision-maker) for example, focusing on the trauma of the journey to Australia.

- The inclusion of factual material in the report that does not appear elsewhere in the application.
 - The inclusion of statements of generality that lack an explanation of relevance to the decision-maker, for example, indicating that the applicant is suffering PTSD and Major Depressive Disorder, “causing clinically significant impairment in functioning”, but no statement of how this may impact on ability to present their case.
- ❑ Where relevant, it is helpful to include referral documentation explaining why the applicant sought assistance from a mental health professional.
- ❑ It is important to be clear about the purpose of the report in supporting your client’s case. For example, a report may be able to assist the decision-maker in their interactions with your client, explain to the decision-maker the reasons behind inconsistencies in your client’s account, or support your client’s account by providing an independent evaluation that they have suffered significant exposure to previous trauma. This is discussed in more detail below, and in Part 1 of this publication.

2.2 Relying on a Mental Health Professional’s Report

- ❑ Expert reports from a mental health professional can be helpful to your client’s case in a number of ways. A report may be able to:
- assist the decision-maker in their interactions with your client, for example by drawing to the decision-makers attention difficulties your client may have in communicating their story; and/or
 - explain to the decision-maker the reasons behind particular features or inconsistencies in your client’s account; and/or
 - support your client’s account by providing an independent evaluation that they have suffered significant trauma.
- ❑ It is usual practice for information of the history obtained by a mental health professional to be fully documented in their report. However, when seeking an expert report from a counselor, psychologist, psychiatrist, social worker or other suitably qualified health professional, ask them to provide only a short history of the salient events and circumstances relevant to their diagnosis and management of the applicant in their report. Request that the psychologist provide separately from their report, where they believe it is appropriate, a full statement of the history revealed by the applicant, signed and dated.
- ❑ The ability of psychologists to obtain an extensive trauma history is considered to be a skill associated specifically with psychological/psychiatric training. Many mental health professionals have reported that, compared to an applicant’s representative or a decision-

maker, they obtain greater detail from applicants regarding their report of events, circumstances and challenges because of their expertise in discussing sensitive and distressing material. While you may find it easier to obtain details about your client's experiences through the assistance of a qualified professional, it is important that biographical or narrative information relevant to your client's claim does not only appear in the expert's report, but is also presented in your client's application directly.

- ❑ If additional biographical or narrative information disclosed to the health professional is of relevance to the protection claim, it is important that you instruct the mental health professional to consider whether it is appropriate to include a conclusion, based on their professional judgment, regarding possible or probable reasons why the applicant had not previously disclosed this material.
- ❑ If the additional biographic information is not of direct relevance to the protection claim, but is relevant to the diagnosis and management of the applicant's health it is important that you instruct the mental health professional to explain the reason for its inclusion in the report.
- ❑ If additional biographical information or narrative about your client's experiences is revealed or disclosed during consultations with a psychologist, counselor or other professional, and this is relevant to the protection claim, this should also be included in an addendum to the application that is separate from the body of the report. Where applicable expert report can address the reasons behind this late disclosure. (See 2.4 below)
- ❑ Part 1.6 above provides more detailed examples of how to address the presentation of the narrative account in an expert report.

2.3 Exploring & Explaining any Mental Health Issues

- ❑ When seeking to document an applicant's mental health, consider also that the report should present as completely as possible any relevant mental health diagnosis and management plan.
- ❑ For this reason, it will be important to document the following:
 - Has the applicant attended a medical clinic, a doctor, social worker, counselor, psychologist, social worker, a leader at their place of worship, or someone or a similar place regarding a mental health issue?
 - Has someone suggested to the applicant that s/he visit such a person or a clinic because they have noticed that the applicant appears to be mentally, emotionally or physically unwell?

- Is there a reason why the applicant, although feeling mentally, emotionally and physically unwell has not visited a mental health professional?
- Is there any previous documentation regarding the applicant's mental health?
- How has the applicant's mental health affected their ability to provide information about their experiences and/or interact with authorities? Does it affect their ability to present their case and/or interact with the decision-maker?
- Does the applicant's current mental health give rise to a vulnerability that can be addressed within the context of the MRT/RRT *Guidance on Vulnerable Persons*? (see 2.5 below)

2.4 Seek and record reasons for gaps or inconsistencies in the applicant's account.

- ❑ Where there are indications of inconsistency or delayed disclosure in the applicant's account, seek to determine if there is an explanation for this. Consider if it is possible that despite the inconsistency or delay the applicant's account remains honest, but inaccurate or flawed due to personal, psychological or other reasons. It is important to ensure the applicant gives an honest account, but consideration should be given to the following possible reasons:
 - The possible psychological sequelae of the applicant's traumatic experiences;
 - Poor memory or confusion;
 - Shame and embarrassment;
 - Fear, including fear that applicant would not be believed, or might be punished;
 - Failure to appreciate relevance.
- ❑ Where appropriate these issues might be best explored and explained with assistance from a mental health professional.
- ❑ If the explanation is related to factors outside of the expertise of the mental health professional, but are revealed through consultations, then it may be preferable for this to be included elsewhere in the application in addition to being referred to in the report.

- For example, the following information was provided by a psychologist in a report the UNSW Study, “A’s reluctance to disclose information when he feared that the interpreter was of a fascist political base ...”. This is an example of an important explanation to put before the Department/Tribunal.

2.5 Providing the Decision-Maker with Early Identification of Vulnerability

- ❑ It is clear from the MRT/RRT *Guidance on Vulnerable Persons* (June 2009), available at see <http://www.mrt-rrt.gov.au/CMSPages/GetFile.aspx?guid=14e44c96-1485-484c-9eaa-f987029cec40>, (Migration Review Tribunal and Refugee Review Tribunal, June 2012), that the Refugee Review Tribunal seeks to ensure that ‘the inherent dignity of vulnerable persons is recognised and respected’. The Guidance defines a vulnerable person as anyone “whose ability to understand and effectively present their case or fully participate in the review process may be impaired, due to their age or physical, mental, psychological or intellectual condition, disability or frailty”.
- ❑ The Guidance seeks to ensure that proper account is taken of the needs of vulnerable people. This includes providing additional support and understanding in proceedings because vulnerable parties or witnesses may face particular difficulties in the review process arising from impaired ability to understand and effectively present their case, and fully participate in proceedings.
- ❑ Guideline 3.2 (*GVP*, MRT/RRT, 2009) provides that a person’s representative may inform the Tribunal of issues relating to vulnerability of a party or witness.
- ❑ Guideline 3.1 (*GVP*, MRT/RRT, 2009) indicates that it is:

“preferable that vulnerable persons are identified as early as possible [including prior to the consideration or testing of evidence] and that appropriate accommodations are made as soon as practicable, including ensuring a flexible approach to the processing of cases involving them”.

2.6 Obtaining Additional Support from a Psychologist, Psychiatrist, Social Worker, Counselor or Friend for a Vulnerable Applicant

- ❑ The identification by the Tribunal of vulnerability of an applicant will enable the applicant’s claim to be given special consideration in the allocation of the Tribunal member (see guideline 4: *GVP*, MRT/RRT, 2009), special case management consideration (guideline 4.4: *GVP*, MRT/RRT, 2009) and the highest priority status for expedited determination, subject to any delays arising from the need to address matters related to the applicant’s vulnerability (guideline 4.2: *GVP*, MRT/RRT, 2009).
- ❑ The Guidance permits consideration by the Tribunal Member of “particular procedural arrangements or additional representation or support” for a vulnerable applicant where this is desirable in an individual case (guideline 4.5). While there is no obligation on an

applicant to have a support person or a representative, guideline 5.4 (GVP, MRT/RRT, 2009) provides:

“A support person can assist a vulnerable person with his or her case by providing support at a Tribunal hearing ... by contacting the Tribunal on the vulnerable person’s behalf ... Support persons include friends, relatives or church leaders or medical practitioners, social workers, counselors or psychologists”.

Checklist for the Applicant's Representative

- Has the expert considered the issues raised in Part 1 of this Resource Manual?
- Does the report comply with the MRT/RRT *Guidelines on Expert Opinion Evidence*?
- Is the purpose of the report clear, and do the conclusions of the report clearly address that purpose? (see section 2.2)
- Does the report clearly differentiate between the factual narrative provided to the psychologist and the clinical findings and opinion of the expert? (see section 2.2)
- Have you ensured that any additional information about your client's experiences relevant to your client's claim has been included in the application? (see section 2.2)
- Does the report clearly identify the diagnosis and, where relevant, outline the clinical background and/or treatment plan? (see section 2.3)
- If relevant, does the report provide guidance on the effects of the applicant's mental health on their ability to present their case? (See sections 2.2 & 2.3)
- If relevant, does the report engage with and explain inconsistencies in the applicant's account? (see section 2.4)
- Is your client a Vulnerable Person within the definition of the MRT/RRT *Guidance on Vulnerable Persons*? Can the expert report assist the decision-maker to address those vulnerabilities? (see section 2.5)

Part three

**Guidance for Decision Makers: Understanding Mental Health
Issues & Evaluating Expert Psychologist's Reports in a
Refugee Status Application**

3. Guidance for Decision Makers: Understanding Mental Health Issues & Evaluating Expert Psychologist's Reports in a Refugee Status Application

3.1 Traumatic Experiences and Psychological Sequelae²⁰

- ❑ Research examining the influence of traumatic experiences on the consolidation and retrieval of memories indicates that the ways in which traumatic experiences are encoded (or laid down) and processed are structurally different from non-traumatic experiences (Ehlers & Clark, 2000; Foa & Riggs, 1993; Koutstaal & Schacter, 1997).
- ❑ The normal process by which memories are encoded and integrated appears to be disrupted among traumatized individuals because of the extreme anxiety and stress individuals are experiencing during the process of encoding traumatic memories. Therefore, instead of being encoded into memory in a coherent, organized and integrated manner, traumatic experiences are often encoded in a disorganized and fragmentary manner (Brewin, Dalgleish, & Joseph, 1996; Foa, Molnar, & Cashman, 1995; Foa & Riggs, 1993).
- ❑ Individuals with chronic Post Traumatic Stress Disorder (PTSD) symptoms will typically display impaired information processing and emotional and physiological functioning, and have greater difficulty in integrating traumatic experiences into a meaningful narrative (Silove, 1999). An extreme avoidance response can also interfere with the processing and recounting of traumatic experience, particularly impeding the integration of traumatic experiences into memory, which can subsequently limit an applicant's ability to speak about traumatic experiences (Dunmore et al., 2001; Ehlers & Clark, 2000; Foa & Riggs, 1993).
- ❑ Traumatic experiences can exert profound effects in other cognitive and behavioral domains, such as:
 - distorting and altering the individual's perception of time and space (Terr, 1984; Pynoos & Nader, 1989),
 - causing memory blocks and, in extreme circumstances, complete or partial amnesia for the traumatic incident (Kirmayer, 1996; Koutstaal & Schacter, 1997; McNally, Clancy, Schacter, & Pitman, 2000),
 - producing temporary dissociative phenomena such as emotional detachment, flashbacks, derealisation and depersonalization in the individual (Ehlers & Clark, 2000; Kirmayer, 1996; Koutstaal & Schacter, 1997), and
 - causing ongoing concentration impairments; and hyper-reactivity to environmental cues or triggers reminiscent of the traumatic event.

²⁰ See also *Guidance on the Assessment of Credibility* (Migration Review Tribunal and Refugee Review Tribunal, 24 March 2012) at <http://www.mrt-rrt.gov.au/CMSPages/GetFile.aspx?guid=df229896-7a1e-49c9-aa88-f42feeed0cde>, guidelines 4.3 and 5.3.

- ❑ Research indicates that even central elements of traumatic events may be described with a discrepancy rate of up to 20% (Herlihy, 2002). For this reason seeking complete consistency in an account may be a flawed basis upon which to discredit an applicant diagnosed with PTSD or displaying symptoms of other significant mental health problems.
- ❑ Refugees, with and without PTSD, have been shown to exhibit discrepancies in narrative accounts over repeated interviews. The discrepancies may increase with the length of time between interviews and the presence of PTSD. There may be more discrepancies in details peripheral to the account than in details that are central to the account (Herlihy et al, 2002). It is important that decision-making should focus on overall credibility and that peripheral details should not be a focal point for this purpose.

3.2 Beyond Procedures: Key Considerations Relevant to Addressing Psychological Sequelae of Trauma

- ❑ The UNSW Study (Hunter et al, 2010) revealed tensions between what mental health professionals consider the purpose of their health evaluation of an applicant, and how the decision-making process views this evaluation. For example, psychologists believe the decision-making process repeatedly fails to achieve a functional understanding of psychological evidence in the context of traumatised applicants.
- ❑ In the UNSW Study sample (Hunter et al., 2010), a substantial proportion of decision-makers at the primary (77%) and reviews (59%) stages made no explicit reference to applicants' mental health, or to supporting psychological reports, in the process of decision-making.
- ❑ Studies indicate that refugee applicants are at heightened risk of psychiatric disorders due to their trauma histories. Complex traumatic presentations can be easily misunderstood by lay people, including decision-makers.
- ❑ The absence of overt manifestations of mental disorder in an applicant at interview or in a hearing cannot be taken as evidence that the applicant or the testimony they provide is unaffected by mental disorder.
- ❑ Studies reveal that refugee decision-makers are prone to misinterpreting post-traumatic symptoms as evidence of lack of credibility in claimants' testimonies (Rousseau et al., 2002; Steel et al., 2004; Hunter et al., 2010).
- ❑ International refugee literature (Herlihy, Frestman, Turner, 2004; Millbank, 2009; Rousseau et al., 2002; Steel et al., 2004) has highlighted the endemic problem in refugee determinations of relying on consistency as a determinant of the credibility and veracity of applicants' testimonial accounts, particularly those that have suffered extensive trauma. Undoubtedly in many contexts consistency, coherence, and early revelation of the details of a claim reflects strong credibility. As the research described above indicates, however, there are situations where these features may be absent yet the account given

is genuine. Indeed, inaccuracies and confused chronology in an applicant's account appears to manifest most prominently in a subset of applicants exhibiting substantial memory and concentration impairments.

- ❑ A number of decision-makers from the 2001-2004 sample evaluated by the UNSW Study (Hunter et al., 2010) relied on consistency as a key criterion to judge an applicant's credibility adversely, even though the applicant's symptoms were consistent with traumatic stress responses. Despite the psychological reports indicating that the presence of memory disturbances was commensurate with the clinical presentation of traumatized individuals, decision-makers appeared to disregard this information in their interpretation of applicants' fractured and discrepant accounts. Qualitative data indicate that decision makers across the primary and review stages regard inexplicable inconsistencies in applicants' accounts as evidence of unreliability and a basis for dismissing their claims.
- ❑ The UNSW Study (Hunter et al., 2010) highlights a persisting conundrum in refugee adjudication, namely, that legal representatives and decision-makers often eschew exploring details of traumatic events. This may be because of time constraints or because it is distressing and difficult to manage conversations. Yet the failure to make such inquiries may contribute to non-disclosure by applicants, often of details pivotal to their claim. This complex situation is exacerbated by the fact that decision-makers may not accept a psychological explanation for non-disclosure of trauma-related information.
 - In the UNSW study, applicants with disclosure difficulties also showed significant exposure to a range of potentially traumatic events, often of a sexually humiliating nature, and a high concentration of mental distress. They displayed high symptoms scores and prevalence of PTSD and depression.
 - Delay in raising a claim or providing information may be relevant to evaluating the credibility of an applicant. There may, however, be medical, social or cultural reasons that explain a delay. In the UNSW Study 2009 applicants showing delay in raising claims or submitting additional information in claims of trauma following a partial disclosure were judged as unconvincing witnesses and their accounts were generally disbelieved. There was an overall trend across the primary and review levels in which decision-makers were highly critical of delayed or partial disclosure of trauma materials, citing contradictions and variances in applicants' statements as evidence of falsehood and bases for refusal.
 - Further, a number of decision-makers, despite having health reports providing detailed information with respect to the applicant before them, made no reference to the psychological impediments to disclosing traumatic experiences, treating newly or partially disclosed information as fabrications.
 - These results are consistent with the trauma literature on disclosure of sexual abuses and violations (Bogner, Herlihy & Brewin, 2007; Herlihy,

Frestman, Turner, 2004; Rousseau et al., 2002; Van-Velsen, Forst-Unsworth & Turner, 1996) that show that individuals who have suffered trauma of a humiliating nature (eg, sexual abuse or violations) are likely to be impeded psychologically by the shame and stigma attached to from fully disclosing the experience.

- ❑ There is a need for decision-makers to be cautious regarding the possibility of misinterpreting mental health professionals' therapeutic goals. On occasion, reports may fail to accord with procedural imperatives of refugee determination but often discipline differences, rather than professional failures, account for the mental health professionals' focus on matters outside those of central importance to decision-makers' interests. For example:
 - Neglecting to incorporate the absence of mental illness in a report is not a sign of partiality, but rather a (professional) convention that reflects the lack of medical need to manage or address an applicant's good health.
 - It is common practice for mental health professionals to obtain an extensive clinical history from the applicant in formulating their clinical findings. In some cases this may involve the inclusion of a detailed description of an applicant's pre-migration experiences of alleged abuse and persecution and how these experiences relate to the applicant's clinical history and current mental state.
 - Within a therapeutic context, it is unlikely that the mental health professional will test the truthfulness of an applicant's history. For their purposes, they may accept the history, or some version of it, in order to provide a context for understanding the mental state of the applicant. A finding by the decision-maker that part of this history is unlikely to have occurred should not necessarily be seen as invalidating the clinical findings presented.

3.3 Mental Impairment & Vulnerability: Addressing Disadvantage

- ❑ A large proportion of applicants before the decision-maker will have experienced exposure to a range of potentially traumatic events prior to their arrival in Australia, irrespective of the Convention status of the events they have experienced. It is easy for the untrained professional to misinterpret these signs and symptoms of posttraumatic stress as normal behavior. For this reason, mental health reports that provide reasoned explanations for behavior that might otherwise be viewed as discrediting can be crucial.
- ❑ High rates of Post Traumatic Stress Disorder (PTSD) have repeatedly been identified across multiple studies with asylum seeking populations. Some individuals with PTSD may become markedly distressed when recounting aspects of their exposure to trauma. It is

also common for individuals with PTSD to experience emotional numbing when relaying their narrative account.

- ❑ In some cases an individual may develop an extreme form of emotional disengagement referred to as dissociation. An individual in a dissociative state will often appear normal, but in fact they may be only partially responsive to their environment and unable to comprehend the context or gravity of the situation.

- ❑ The nature of the decision making environment is not conducive to the identification or management of mental disorder. The gravity of the situation and the inquisitorial nature of the interaction minimise the likelihood of an applicant disclosing their mental distress or suffering.

- ❑ The presence of mental disorder is not easily identified by behavioral signs and symptoms unless the applicant is interviewed by a competent mental health professional within the context of an appropriate clinical setting.

- ❑ As a consequence it is quite possible for an applicant with serious mental disorder to present in a manner which disguises/hides their symptoms when in fact there may be very substantial mental health impairment.

- ❑ It is clear from the MRT/RRT *Guidance on Vulnerable Persons* (June 2009) (*GVP*, MRT/RRT, 2009) (available at <http://www.mrt-rrt.gov.au/Conduct-of-reviews/default.aspx>) that the Refugee Review Tribunal seeks to ensure that ‘the inherent dignity of vulnerable persons is recognised and respected’. The guidelines define a vulnerable person as anyone “whose ability to understand and effectively present their case or fully participate in the review process may be impaired, due to their age or physical, mental, psychological or intellectual condition, disability or frailty”.

- ❑ The Guidance seeks to ensure that proper account is taken of the needs of vulnerable people. This includes providing additional support and understanding in proceedings because vulnerable parties or witnesses may face particular difficulties in the review process arising from impaired ability to understand and effectively present their case, and fully participate in proceedings.

- ❑ The considerations raised in the MRT/RRT Guidance are equally applicable at the Departmental decision-making level.

3.4 Early Identification of Vulnerability

- ❑ Guideline 3.1(*GVP*, MRT/RRT, 2009) indicates that it is “preferable that vulnerable persons are identified as early as possible [including prior to the consideration or testing of evidence] and that appropriate accommodations are made as soon as practicable, including ensuring a flexible approach to the processing of cases involving them”.

- ❑ Guideline 4.4 (GVP, MRT/RRT, 2009) indicates that an experienced case officer will be assigned to the case involving a vulnerable applicant.

3.5 Special Procedural Adjustments for Vulnerable Applicants

- ❑ In applying the guidelines relating to expediting and varying the processes regarding a refugee status claim by a vulnerable applicant, it should be noted that under guideline 4.5 (GVP, MRT/RRT, 2009), “[i]f appropriate, the case officer should direct the vulnerable person to a community or government organisation that can offer access to health care, counseling or other assistance that may be required to meet the vulnerable person’s needs”.
- ❑ The Guidance permits consideration by the Tribunal Member of “particular procedural arrangements or additional representation or support” for a vulnerable applicant where this is desirable in an individual case: guideline 4.5 (GVP, MRT/RRT, 2009). Whilst there is no obligation on an applicant to have a support person or a representative, guideline 5.4 (GVP, MRT/RRT, 2009) provides:

“A support person can assist a vulnerable person with his or her case by providing support at a Tribunal hearing ... by contacting the Tribunal on the vulnerable person’s behalf ... Support persons include friends, relatives or church leaders or medical practitioners, social workers, counselors or psychologists”.

- ❑ In conducting a review the Tribunal should consider the possible difficulties faced by a vulnerable person (see, guideline 7.2 (GVP, MRT/RRT, 2009), including:
 - inability to communicate effectively;
 - impaired memory or behavior or impaired ability to recount relevant events;
 - symptoms that have an impact on the consistency and coherence of testimony;
 - a fear of persons in a position of authority and associating the Tribunal’s review process with that fear (especially in the case of persons who are survivors of torture or trauma);
 - mobility or health issues which may make attending a Tribunal hearing at its premises very difficult;
- ❑ An overriding consideration for the decision maker is trying to facilitate the applicant feeling as confident and calm as possibly during what is an inherently stressful and anxiety-provoking experience. The Tribunal should permit an adjournment for assistance

or the preparation of a medical report where it considers it appropriate, (see guideline 7.4: *GVP*, MRT/RRT, 2009). The Guidance also suggests some strategies to address the difficulties facing a vulnerable person (see guideline 7.3: *GVP*, MRT/RRT, 2009):

- encouraging the person and his or her representative to seek access to the Tribunal and Department case files prior to the scheduled hearing;
- requesting an interpreter of a particular gender;
- ensuring that an interpreter is appropriately briefed about the vulnerability issues;
- encouraging the person to be supported during a hearing;
- creating an informal setting for the hearing;
- allowing any other procedural accommodation that may be reasonable in the circumstances;
- conducting a hearing for a Refugee or Migration Review Tribunal application in private, if appropriate;
- informing the person about whether the hearing will be conducted in public or in private;
- creating an open, reassuring and supportive environment in order to establish a relationship of confidence and trust between the Member and the person and to facilitate the full disclosure of sensitive and personal information;
- questioning should be done in a sensitive and respectful manner. Questions should be formulated in a way that the vulnerable person understands;
- the tribunal should consider taking evidence from family members or close friends if a vulnerable person is highly agitated or unable to provide coherent evidence;
- if the vulnerable person has difficulty providing oral evidence in person, allowing the vulnerable person to provide evidence via videoconference or other means;
- monitoring the vulnerable person and providing short breaks or adjournments as appropriate, as well as accommodating requests for short breaks or adjournments;
- during the hearing of claims concerning sexual violence or other traumatic incidents, an adjournment or second hearing may be appropriate if a person is becoming or has become emotionally

distressed. It is important that a person is not further traumatised by the process of giving evidence;

- encouraging a person to seek appropriate counseling or other support services after a hearing or recommending to the person's representative that such services be sought.
- Finally, the Guidance acknowledges the need to avoid disclosure in Tribunal decisions of identifying information or unnecessary disclosure of information of a sensitive, private or personal nature (see guidelines 8.1, 8.2: *GVP, MRT/RRT, 2009*). To the extent that it is possible the Tribunal should endeavor to ensure that the person receives appropriate support at the time they receive the decision (see guideline 9.2: *GVP, MRT/RRT, 2009*).

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Those who seek to establish refugee status in countries such as Australia must undergo a comprehensive evaluation process to establish whether they have a well-founded fear of persecution that comes within the United Nations Refugee Convention definition

This Resources Manual has been developed in response to the findings of the Tales Study examining the role of expert psychological evidence in the determination of refugee claims in Australia. There are complex challenges that face mental health professionals, decision-makers, applicants and their representatives when mental health professionals seek to communicate the significance of trauma-related psychological sequelae to refugee status decision-makers.

This Manual provides an accessible step-by-step guide to best practice strategies in the preparation and interpretation of mental health evidence that focus particularly upon the circumstances and perspectives of

- Psychologists and psychiatrists working in the field of refugee health assessment,**
- Decision-makers in the refugee status determination process and**
- Refugee applicants' supporters and representatives, whether they be migration agents, lawyers or from support organizations**

ISBN 978-0-9807906-1-0