

Mental healthcare of asylum-seekers and refugees

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Abstract Many health professionals feel ill-equipped to deal with the complex needs of asylum-seekers and refugees. This article offers an overview of the literature, and reviews the demography, epidemiology and causes of mental illness in refugee and asylum-seeker groups. It discusses the types of service configurations and service response that would be appropriate. It highlights the findings of the Royal College of Psychiatrists' consensus team and their position statement on the treatment of refugees and asylum-seekers. It finishes with some thoughts about what clinicians can do to improve their treatment. Clearly, there is a need for more training, education and service development.

The terms asylum-seeker and refugee are often used in the same breath although they mean different things (Box 1). Essentially, asylum-seekers are people who have applied for asylum and refugees are people who have been successful in such an application.

Box 1 Terminology

'Asylum-seeker' and 'refugee' are legal classifications that vary from country to country. The definitions below apply to the UK.

Asylum-seeker

A person who has made a formal application to the Home Office for asylum status and is waiting for a decision.

Refugee

A person whose asylum application has been successful. A refugee is granted permission to stay in the UK under the terms of the 1951 United Nations Convention on the Status of Refugees. This states that: a refugee must be outside their country; have a well-founded fear of persecution because of their race, religion, nationality, membership of a social group or political opinion; and be unable or unwilling to return to the country for fear of persecution. Individuals who do not meet refugee criteria may still qualify for 'humanitarian protection' or 'discretionary leave'.

Previously the process of seeking asylum in the UK was long and drawn out. The New Asylum Model, introduced by the Home Office for all asylum-seekers in March 2007, is intended to speed up decisions to enable rapid integration or removal from the country (Box 2). If an initial application is turned down the individual may appeal. An application can be considered failed only when the legal process, including all appeals, has been exhausted. Even then there may be clear reasons why the Home Office cannot remove an individual from the UK, such as ill health or if their country is deemed too dangerous.

Demography

Worldwide there are about 10 million asylum-seekers and refugees. The vast majority of these reside in low-income countries, sometimes in refugee camps. Only 23% of asylum-seekers and refugees are in Europe and only 3% in the UK. They make up less than 0.5% of the UK population (Office of the United Nations High Commissioner for Refugees, 2006a).

In recent years there has been a downward trend worldwide in the total number of refugees, but the problems have not decreased as there is an upward trend in the numbers of people displaced within their own countries.

There has been a fall in applications for asylum in the UK in recent years, with numbers dropping from 91 600 in 2001 to 30 840 in 2005. If the size of

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Box 2 The asylum process in the UK

Applying for asylum under the New Asylum Model

- All applicants attend a screening interview
- Applications are divided, on the basis of their characteristics, into segments or tracks that determine their processing and the support offered
- An application registration card (ARC) is issued, which acts as a photo identity card
- Each application is allocated to a 'case owner', who manages all aspects of the case
- The individual may apply to the National Asylum Support Service for support
- Supporting evidence such as a medical report may be submitted at interview

The three possible outcomes of interview

- Refugee status is granted. In 2005, a change in law made refugee status in the UK no longer permanent: limited leave is granted for 5 years, after which the case is reviewed. People receiving refugee status before this date are allowed to remain indefinitely
- Humanitarian protection or discretionary leave is granted
- The application is refused. The applicant has the right to appeal to the Asylum and Immigration Tribunal. If their appeal fails they face deportation and may be held in a detention centre

Asylum-seekers awaiting a decision on their claim, or awaiting deportation after a failed application, may be held in detention centres. At any time during the asylum appeal, the applicant can return home voluntarily.

domestic populations is taken into account, then the UK ranks 14th in the European Union for the number of applications. The number of applicants who receive refugee status in any particular country reflects that nation's policies and practices and ease of entry rather than the numbers of people legitimately seeking asylum in them.

In 2005 the nationalities applying to the UK in greatest numbers were Iranian, Eritrean, Chinese, Somali and Afghan. The majority of the principal (head of family) applicants in 2005 were under 35 years old and male, although there was a significant number (about 3000) of unaccompanied asylum-seeking children (Heath *et al*, 2006).

Although the number of asylum-seekers and refugees in the UK is low they are concentrated in certain parts of certain cities. In London they make up 5% of the population and form 11% of the

case-loads of some community mental health teams (McCull & Johnson, 2006).

Epidemiology

Mental health professionals must take care in labelling normal reactions to pre- and post-migration stressors as mental illness. The majority of asylum-seekers and refugees have no mental illness (Watters, 2001; Summerfield, 2003). They use their own resources and coping strategies to deal with the considerable difficulties encountered in their country of origin, during migration, in their new country and in the asylum process.

However, studies in high-income countries show that levels of psychopathology and mental illness, in particular anxiety and depression, are higher in refugee and asylum-seeker groups than in the general population (Burnett & Peel, 2001). Another review found that refugees resettled in Western countries were about 10 times more likely to have post-traumatic stress disorder (PTSD) than age-matched general populations in those countries (Fazel *et al*, 2005). Other studies suggest that there may be more somatic presentation of psychological problems among asylum-seekers and refugees (Tribe, 2002; Van Ommeren *et al*, 2002).

Asylum-seekers and refugees are often considered as a single population, but the two groups have different social risk factors, not least because asylum-seekers are still dealing with uncertainty because of their unresolved status and because UK laws and social policy change. There is also much diversity within groups.

Asylum-seekers and refugees can present with complex medical needs, including infectious diseases, psychiatric disorders and complications from injuries due to trauma, including torture and violence. Reasons for the complexity of medical needs include the burden of disease in the country of origin, lack of access to healthcare and other pre- and post-migration stressors.

Issues of validity occur within transcultural epidemiology, and describing the extent of psychopathology in asylum-seekers and refugees can be problematic (Van Ommeren, 2003). Many assume that PTSD will be prevalent in these groups because of the factors in their countries of origin that caused them to migrate and seek asylum elsewhere. However, PTSD and PTSD treatments have been criticised as Western concepts that are inappropriate for asylum-seeker and refugee groups (Bracken *et al*, 1995; Summerfield, 1999). The diagnosis of PTSD may also cause professionals to focus on pre-migration problems, potentially neglecting the effect of continuing adversities caused by asylum policies and social context.

There is some evidence that post-migration problems have a significant impact on psychological well-being. A Norwegian study compared the admission diagnoses of refugees with those of asylum-seekers (Iverson & Morken, 2004). It found that the asylum-seekers had much higher rates of PTSD than the refugees (45% *v.* 11%). This was interpreted as reflecting the high level of stress arising from the asylum process. Further support for the importance of current social factors comes from a study of 84 male Iraqi refugees in the UK (Gorst-Unsworth & Goldenberg 1998). Although 65% of the group had suffered systematic torture in Iraq, only 11% met the criteria for a diagnosis of PTSD. Depression was much more common (in 44%), and current poor social support was found to be a stronger predictor than past trauma. Psychological morbidity was associated with separation from children, lack of contact with political organisations in exile, and few confidants and social activities.

A meta-analysis of studies comparing the mental health of refugees with that of control groups from the host countries found that refugees (including asylum-seekers and internally displaced people) had an overall increase in psychopathology (Porter & Haslam, 2005). However, this increase was not an inevitable consequence of acute wartime stress. Refugees who were older, better educated, female, and of rural residence and higher socio-economic status pre-displacement had worse mental health outcomes. Morbidity was significantly associated with post-migration factors such as a lack of permanent accommodation and restricted opportunity to work.

Data on substance misuse rates for UK refugee and asylum-seeker groups are sparse. There are a number of risk factors, not least their concentration in poor areas of the UK, which would be considered to put them at high risk. There are concerns about the use of khat in Somali, Ethiopian and Yemeni men. This is a legal social activity but it seems to be more problematic in the UK than in countries of origin. It is possible that excessive khat use will exacerbate the psychological problems caused by pre-existing stressors (Warfa *et al*, 2007), including the asylum process.

Understanding pre-migration and post-migration adversity

Three-quarters of current UK asylum applicants are from countries in conflict. Not surprisingly, many asylum-seekers and refugees have experienced pre-migration adversities that may affect their health (Box 3).

Box 3 Common pre-migration adversities

- War
- Imprisonment
- Genocide
- Physical and sexual violence
- Witnessing violence to others
- Traumatic bereavement
- Starvation
- Homelessness
- Lack of healthcare

The process of migration can in itself be a risk factor. Journeys to the UK can be long and hazardous, and they frequently lead to separation from families and communities.

In the past few years there has been increasing research into post-migration adversities, including aspects of the asylum system, which can compound the impact that social isolation, poverty and cultural alienation have on health. The psychological health of asylum-seekers in the UK is affected by the 'seven Ds' (Box 4), and it is important to note that many of them can be modified in the host country. Sensitive social policy can minimise risk factors for illnesses in asylum-seeker and refugee groups and is vital for a preventive health strategy.

Discrimination

Asylum-seekers and refugees are often stigmatised in host countries. A recent report from Office of the United Nations High Commissioner for Refugees (2006*b*) condemned the attitudes of the politicians and press who have turned asylum-seekers and refugees into 'victims of intolerance' and 'faceless bogeymen'. There is growing evidence that perceived discrimination carries a psychological toll (McKenzie, 2003; Karlsen *et al*, 2005).

Detention

Amnesty International UK (2005) reports that about 25 000 people were being held in 10 removal centres in the UK in 2004–2005. Increasing numbers of children were also detained (Save the Children, 2005). Little is known about why people are detained or for how long, but there is growing evidence that detention substantially worsens the health of asylum-seekers (Silove *et al*, 2001; Fazel & Silove, 2006). In addition to the impact of detention itself, there are concerns that detainees do not have access to satisfactory health service provision (Cutler, 2005).

Box 4 Common post-migration adversities: the 'seven Ds'

- 1 Discrimination
- 2 Detention
- 3 Dispersal
- 4 Destitution
- 5 Denial of the right to work
- 6 Denial of healthcare
- 7 Delayed decisions on asylum applications

Dispersal

The support package offered by the National Asylum Support Service (NASS), a department established by the Home Office, involves enforced dispersal to relieve the burden on London and the south-east of England. Asylum-seekers usually get no choice in where they are sent, they may be moved many times, and arrangement of transfer can be chaotic. This can destabilise development of social networks as well as disrupting the continuity of any care.

Destitution

Asylum-seekers in the UK receive benefits that amount to 70% of the lowest level of income support. There are no central statistics on destitution in asylum-seekers in this country, but there have been recent changes in policy that previously contributed to higher numbers of destitute asylum-seekers, including Section 55 of the National Immigration and Asylum Act 2002. Such changes were in larger measure due to pressure put on government by a number of local reports (Patel & Kerrigan, 2004; Save the Children, 2005; Lewis, 2007).

Denial of healthcare

All asylum-seekers and refugees in the UK are entitled to free access to primary healthcare services. However, in April 2004 the law changed so that failed asylum-seekers in the UK are now no longer eligible for free secondary healthcare, except in cases that are deemed immediately necessary or life-threatening.

Delayed decisions

It is recognised that the length of the asylum process adversely affects health (Steel *et al*, 2006). A Dutch study reported that an asylum process that

lasted for more than 2 years more than doubled the risk of psychiatric disorder (Laban *et al*, 2004). In the past, asylum-seekers in the UK often had to wait months or years for an initial decision on their asylum status. The introduction of the New Asylum Model aims to speed up decisions and improve their quality. There are clearly some improvements, for example each asylum-seeker is now assigned a named case worker who is responsible for all aspects of their case. Unfortunately, the balance may not yet be right. There is concern that the time between applying, submitting evidence and receiving a decision is now too short (in some cases only 11 days). This may be insufficient for a new arrival to access the help required to make a proper application. The discontinuation of the 'statement of evidence forms' (SEFs) has also raised concern, as it removes the requirement for asylum-seekers to write down their reasons for claiming asylum. In response to the latest asylum statistics Donna Covey, Chief Executive of the Refugee Council, said: 'initial decision-making is still shockingly poor. This is shown by the continuing success rate of appeals – almost one in four are successful, rising to 50% for Somali nationals and 51% for Eritrean nationals' (Covey, 2007).

Denial of the right to work

Asylum-seekers in the UK are initially prevented from undertaking paid work. If they have not received an initial decision on their asylum status after 12 months they can apply for permission to work (this applies only to the principal applicant). Lack of work can inhibit social integration and increase poverty.

The Royal College of Psychiatrists' consensus report

Existing services in the UK do not meet the needs of refugees and asylum-seekers with physical or psychological difficulties. The Royal College of Psychiatrists has responded by producing a position statement. It was built on a literature review and a consensus of specialists in the field from all sectors. It states that:

To promote health and to prevent the development of mental and physical illness the refugee and asylum seeker population of United Kingdom require three main areas of action:

- 1) Public policy that minimizes the impact of social risk factors for physical and mental illness;
- 2) Equitable access to a full range of health, social care and legal services that are capable of delivering appropriate and high quality care; and,

- 3) That public bodies organise to fulfil their duties under national and international law [Royal College of Psychiatrists, 2007: p. 3].

The statement proposes a number of initiatives to form the basis of service development. They include health and race impact assessments of policies that affect refugees and asylum-seekers. Early targets for such assessments will include policies on dispersal, detention and the exclusion of some groups from rights under the Children Act 2004. Training is recommended for all health and social care staff in culturally sensitive and appropriate care for refugees and asylum-seekers.

The statement advises that improved services should be designed in conjunction with refugee communities. It envisages single points of access, in existing sites such as 'one-stop shops' and National Health Service walk-in clinics, which could facilitate access to, and signpost and coordinate the use of, existing health, legal, social and voluntary services. It highlights that the full range of health and related services should be available at all times throughout the asylum process in the UK, including for those whose claims have failed.

It also states that:

The current discourse in the media and from Government concerning refugees and asylum seekers focuses on economic migrants and does not reflect the global ethical importance of the asylum system or the situations from which refugees and asylum seekers have fled. The discourse does not focus on the strengths and positive contribution of asylum seekers and refugees to society. This leads to a stigmatisation of refugees and asylum seekers which has a negative impact on their health.

Public bodies covered by the Race Relations Amendment Act should develop external relations strategies capable of delivering their duty to promote good relations between the wider public and refugees and asylum seekers [Royal College of Psychiatrists, 2007: p. 10. Bold as in original].

What can clinicians do?

Clearly, there is much that can be done in service development, but it is not clear what can be done at a clinical level. Surprisingly little research has been conducted on how to manage the mental health needs of asylum-seekers and refugees. Much of our knowledge comes from the experience of specialists working in the field and from inference from work with minority ethnic groups. It is based on the assumption that there are a number of intertwined problems: pre-migration difficulties, problems due to migration itself, social problems due to minority ethnic status and service difficulties in

cross-cultural assessment and treatment. Below we offer some tentative thoughts on what clinicians can do to improve the treatment they offer.

Prevention

It is clear from the literature that government policy can contribute to the creation of physical and psychological problems, as well as exacerbate problems in those who are already suffering. Although psychiatrists may not be directly involved in policy formation and primary prevention they can advocate for it. The presentation of research by clinicians of the deleterious impact of detention is important in changing the approach of governments to this issue. In the UK, organisations such as the Medical Foundation for the Care of Victims of Torture (www.torturecare.org.uk) and Medical Justice (www.medicaljustice.org.uk) are lobbying for change using clinical examples of cases in which asylum policies have had a negative impact on health.

The Independent Asylum Commission, launched in October 2006, has conducted an 18-month long independent nationwide review of the UK asylum process (www.independentasylumcommission.org.uk). The Commission examined key issues including: access to the asylum process, the process itself, appeals, treatment of vulnerable groups, detention, material support and removals from the country. The review process involved three methods of information-gathering: public hearings across the country where personal testimonies were heard, submission of written evidence and reports from expert witnesses. Recommendations from the Commission have been published in three reports (Independent Asylum Commission, 2008*a,b,c*). The Commission aims to work with the UK Border Agency and other relevant bodies to implement these recommendations.

Service structure

Developing equitable services is difficult given the changing patterns of asylum. Asylum-seekers may have been unreasonably denied access to other services, including primary healthcare, so that their pathways to care may seem obscure. It is therefore key for clinicians to be non-judgemental about the fact that illness behaviour may be used to facilitate access to arguably more relevant primary healthcare services, social and legal care. Developing knowledge of and good connections with relevant local services helps the delivery of better care and avoids the pitfalls of disjointed services.

Box 5 Useful websites

Asylum Aid (www.asylumaid.org.uk)

A charity that provides legal advice and representation to asylum-seekers (www.asylumaid.org.uk)

Health for Asylum seekers and Refugees Portal (HARP) (www.harpweb.org.uk)

A public-sector research organisation providing social inclusion research and online health information for health professionals and voluntary agencies working with minority communities

Information Centre about Asylum and Refugees (ICAR) (www.icar.org.uk)

An independent information and research organisation based in the School of Social Sciences at City University, London

The Refugee Council Online (www.refugeecouncil.org.uk)

An independent organisation offering direct help and support to asylum seekers and refugees, and acting to ensure that their needs and concerns are addressed

Working with asylum-seekers and refugees

Understanding the challenges of treating asylum-seekers and refugees and ways of improving practice is fundamental. Reading articles such as this is a start as they contain information about the asylum process. But a more comprehensive training package on the rights of this group, on common problems faced, medico-legal issues, competent assessment and the values and ethical principles that should form the basis of care should be available to all. A number of websites contain useful and regularly updated information on asylum-seekers and refugees and can be valuable tools (Box 5).

Individual clinicians may achieve a higher degree of cultural competency, which can be defined as a set of academic and interpersonal skills allowing the management of diverse populations and the understanding of cultural differences and similarities. However, this must be supported by organisational structures, for example, care pathways that offer equal access for asylum-seekers, funding for interpreting services and flexibility to ensure that longer out-patient appointments are possible.

As with any diverse group, it is difficult to offer specific guidelines that will cover all eventualities. There are, however, some basic principles.¹

Assessment

Sufficient time is needed in an assessment to reduce the patient's anxiety and slowly to take a history. It might take several sessions to build a trusting relationship and rapport. Clinicians should gain collateral information on the region, culture and conflict before the interview and they need to be aware of any socio-cultural taboos that might be important during it.

Before the interview the team should discover what language the patient prefers to be interviewed in, check that the interpreter booked speaks the same language and that there are no impediments to disclosure. For example, a woman who has been the victim of rape may find it easier to talk to a female psychiatrist through a female interpreter. The interpreter's booking should allow sufficient time for clear communication of their role before the interview and for debriefing after. It should not be assumed that interpreters will not be traumatised by what they hear. Family members should not be used as interpreters except as a last resort. Interpreters can be a source of useful information, but they are often not experts and their information should be treated cautiously.

Clinicians should be very wary of ascribing any difficulties in the interview or presentation to culture unless they are certain that these are culturally mediated. For example, a belief in witchcraft, commonly held in certain areas, does not mean that a patient's specific beliefs are not delusional.

It is essential to make a full assessment, ensuring that physical problems are not missed, particularly as this may be the first clinical contact. Physical needs resulting from poverty, conflict and torture include incomplete immunisation, rape/sexual assault, landmine injuries, beatings, malnutrition and a higher risk of diseases that have increased prevalence in the country of origin (e.g. parasitic diseases, tuberculosis, hepatitis and HIV/AIDS).

Diagnosis

A balanced formulation will take into account pre- and post-migration factors. The assessment can often be dominated by the disclosure of trauma, attempts to make a diagnosis of PTSD and the perceived need to treat anxiety and depression. However, using a dimensional rather than a categorical approach to assessment may help clinicians consider functional impairment, personality factors

1. Related articles in *Advances in Psychiatric Treatment* include Bhugra & Ayonrinde (2004), Dogra & Karim (2005) and McKenzie (2008). Ed.

and social circumstances as well as the intensity and type of psychological symptoms.

The use of psychiatric models of trauma and diagnostic labels alone may overshadow positive strengths and undermine efforts to establish in the patient a sense of personal and community agency following social upheaval and dislocation.

Treatment

It is important to consider where the individual is in the asylum process when considering how to prioritise interventions. Psychological and pharmacological interventions are appropriate at times. However, when the patient is destitute, awaiting asylum decisions or facing forced dispersal of themselves, family or friends, practical help and advocacy may be more important. Indeed, it may be inappropriate to try to work through earlier trauma when there are such pressing current issues. Help in finding avenues into work or education and in developing social networks and social support will be key parts of any care plan and will improve the outcome. Information on local English classes and identification of local non-statutory groups such as refugee community groups that will support the patient and their family is vital.

Liaising with social services, legal teams and directly with the asylum-seeker's caseworker for asylum applications and advice on housing and financial entitlement is often required. Some asylum-seekers may wish for and benefit from a medical report to support their application.

Biological and psychological treatment depends on the diagnosis and should follow standard guidelines, such as those of the National Institute for Health and Clinical Excellence (NICE). Note that the NICE guidelines recommend that psychoactive medication should not be the first-line treatment for PTSD (National Collaborating Centre for Mental Health, 2005). Instead, they suggest cognitive-behavioural therapy or eye-movement desensitisation reprocessing (EMDR) as part of a package of care. For patients with other common mental disorders, counselling, supportive psychotherapy and practical befriending are the mainstay of treatment. There is evidence that some patients prefer problem-focused rather than emotion-focused psychological work, perhaps because in some cultures talking therapies are not commonly used (Summerfield, 2001).

Detention and admission under the Mental Health Act should be considered carefully and practised with delicacy following a risk assessment. Formal admission might exacerbate any presentation because incarceration and compulsory treatment could resemble earlier traumatic experiences.

Research and development

Although there is sufficient evidence to start the process of improving the mental healthcare that refugees and asylum-seekers receive, more detailed information is required. Fundamental to this will be the commissioning of good-quality research on patients' needs and service utilisation and on the effectiveness of different approaches to treatment. The validity of diagnostic instruments and the concepts on which these are based need urgent assessment. New service configurations will need monitoring and evaluation.

Conclusions

Healthcare professionals, including psychiatrists, would benefit from more education and training on issues facing asylum-seekers and refugees. Research on service models for and service response to asylum-seekers and refugees is necessary to improve our practice. The medical profession is in a strong position to advocate for more humane asylum policies and this opportunity should not be wasted.

Declaration of interest

None.

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MCQs

- The New Asylum Model does not include:**
 - screening interviews
 - segmentation
 - statement of evidence forms
 - application registration cards
 - dedicated case owners.
- The legal document that provides the definition of a refugee is:**
 - the 1951 UN Convention on the Status of Refugees
 - the National Asylum Support Service
 - the New Asylum Model
 - published by the Independent Asylum Commission
 - the Home Office Asylum Statistics Annual Report.
- The meta-analysis on the mental health of refugees by Porter & Haslam found that:**
 - there was no overall increase in psychopathology among refugees
 - the increase in psychopathology was an inevitable consequence of war trauma
 - more educated refugees had better mental health outcomes
 - male refugees had worse mental health outcomes
 - restricted work opportunities were associated with morbidity.
- As regards asylum-seekers and refugees in the UK:**
 - pre-migration factors are aetiologically more important than post-migration factors in producing mental health problems in asylum-seekers
 - the majority of refugees are economic migrants
 - once an asylum-seeker's initial claim fails they must go to a detention centre
 - more than half of asylum-seekers and refugees worldwide are living in Europe
 - failed asylum-seekers are entitled to free primary healthcare services.
- Recognised post-migration adversities exclude:**
 - denial of right to work
 - desegregation
 - discrimination
 - destitution
 - dispersal.

MCQ answers

1	2	3	4	5
a F	a T	a F	a F	a F
b F	b F	b F	b F	b T
c T	c F	c F	c F	c F
d F	d F	d F	d F	d F
e F	e F	e T	e T	e F