# Mental health and health needs of asylum seekers and refugees

# INTRODUCTION

## 1. 1 Background

Asylum seekers and refuges is a growing problem affecting many European countries as well as the UK. In the recent years the number of asylum seekers and refugees entering UK has increased, attracting the attention of the media, politicians as well as ordinary people. It is a controversial subject leading to intense debate and discussions and unsurprisingly to different views and perspectives. The increase in the numbers seeking asylum has led to governments and the international agencies grappling with the problems of providing adequate humanitarian assistance in the third world and avoiding floods of asylum seekers arriving at their doorstep (Timothy et al 2009). This has also led to changes in asylum policies with the governments responding to the rising problem with a range of measures aimed at deterring asylum applications.

Mental illness is one of the leading causes of illness around the world and estimated to affect up to a third of the British population. It is especially common amongst asylum seekers and refugees, which may be due to them having experienced loss, bereavement, torture, rape etc. Their mental health can then be exacerbated due to displacement and their situation in the UK. There is a lot of stigma attached to mental illness, and the mentally ill still face discrimination in many ways, which results in many not seeking treatment. The exact cause of mental illness is a subject doctors still argue about. Society has been known to play a key role, but recently there has been a growing concentration on the role of genes.

## 1. 2 Who are Asylum-seekers?

An asylum seeker is someone who has fled their country to find a safe place elsewhere. Under the 1951 Convention on Refugees, an asylum applicant must be able to demonstrate a well-founded fear of persecution in their country of origin for reasons of political opinion, religion, ethnicity, race/nationality, or membership of a particular social group (Burnett 2002). They must also be able to show that they are unable to obtain any protection or help from their own national authorities (Burnett 2002). ‘ The Refugee or Person in Need of International Protection (Qualification) Regulations’ 2006 updates parts of the convention. Asylum applications in the UK are sent to the Home Office.

Over the last ten years there have been several pieces of legislation introduced which has created an ever changing climate of policy on refugees and asylum seekers. This is a result of the significant numbers of rejected asylum seekers who have had all means of support withdrawn from them and are now destitute in the UK.

Asylum seekers represent a vulnerable population due to a host of pre- and post-migration risk factors. Pre-migration factors include torture and refugee trauma, which may result in mental and physical illness. Moreover, asylum seekers often come from conflict areas, without access to adequate health services. Post-migration factors also play a role for health. They include detention, length of asylum procedure, language barriers, and lack of knowledge about the new health care system.

Destitute asylum seekers are those people who are unable to access support for their basic needs from the government or from their own resources. The position of rejected asylum seekers is appalling, with many unable to return to their country of origin for reasons beyond their control and yet they are not allowed to work and support themselves (Dumper et al 2009).

Below is a table showing the various definitions of refugee status:

| | |
|---|---|
| Asylum seeker | Someone who has submitted an application for protection under the Geneva Convention and is waiting for their claim to be decided by the Home Office. |
| Refugee | Someone |

| | |
|---|---|
| | who’s claim has been accepted and has been granted |
| status | Indefinite Leave to Remain, and is also eligible for family reunion. |
| Exceptional Leave to or Remain (ELE/ELR) | The Home Office accepts that there are strong reasons that the person should not return to their |

| | |
|---|---|
| | country of origin. ELR is discretionary and for varying periods depending on the age of the applicant and other circumstances |
| Refusal | Someone who's application for refugee status has been rejected. |

### 1. 3 Reasons for seeking Asylum

The causes of refugees and asylum flows are many from the effects of conflict and wars, political upheaval, to economic problems and search for a

better life. These displaced people face many problems such as oppression, poverty and disease. Some of them have been held captive and tortured in their own countries; some have been prosecuted because of their political or religious beliefs and some because they belong to a minority ethnic group.

### 1. 4 UK Asylum Policy

Services offered to refugees and asylum-seekers in the United Kingdom are largely determined by national legislation that in turn informs policy and practice. The introduction of the National Asylum Support Service (NASS) at the end of the 1990s was accompanied by several Acts of Parliament that have been added to by further legislation, the most recent being the Asylum and Immigration Act 2004.

While historically UK has a long tradition of providing refuge to people fleeing from prosecution, the Government has recently sought to affect the behaviour of asylum-seekers through legislation intended to discourage asylum-seekers from coming to the UK. For example the support withdrawn from asylum-seekers who have exhausted their claim is designed ultimately to either persuade people to return to their country or make it easier for the Home Office to remove them. In the same way, provision of support to asylum-seekers is often conditional on their agreeing to be dispersed to different parts of the country (Johnson 2003).

### 1. 5 Statistics of asylum seekers in the UK

The main source of data on the UK asylum process and flows of individuals through it is the Home Office RDS units. Throughout the asylum process, administrative data is entered into a number of computerised databases,

which are supported by a small number of manual systems. The Case Information Database (CID) records information on applications, decisions, appeals, removals (including voluntary assisted returns), persons held in detention and persons leaving detention. The Asylum Seekers Support System Database (ASYS) records details of asylum seekers applying and receiving support (ICAR 2009).

The UK received 25, 930 applications for asylum in 2008, compared to 23, 430 in 2007 making it an increase of 11%. The highest level of asylum applications, in the last decade, was in 2002, with levels falling significantly after that. It was not until 2008 when the number of applicants started increasing once again. The chart below shows the number of applicants received in the UK between 2000 -2008. The chart was taken from the Information Centre about Asylum Seekers and Refugees (ICAR) Statistics paper.

**Figure 1: Applications for asylum in the UK excluding dependents 2000-08** (ICAR 2009).

The main countries of origin of asylum applicants in 2008 were Afghanistan (14%),

Zimbabwe (12%), Iran (9%), Eritrea (9%), Iraq (7%) Sri Lanka (6%), China, (5%), Somalia (5%), Pakistan (5%) and Nigeria (3%) (ICAR 2009).

The majority of people seeking asylum in UK are single men under the age of 40 who come from countries in conflict (Burnett et al 2001).

**Figure 2: Showing age and gender breakdown of UK asylum seekers**
(Refugee Council 2009)

The above diagram shows the break down of the gender of principle applicants to the UK. Males under 35 are the majority, whilst females seeking asylum are only a ration of twenty percent.

### 1. 6 Rational for the study

Asylum seekers and refugees have been the subject of media as well as political attention for many years. However, they receive bad publicity and majority of the time are stigmatised. They are perceived to come to the UK to take advantage of the welfare system and to receive host of benefits and entitlements. However, this could not be more wrong as asylum seekers and refugees flee their country not because of choice but due to circumstances and a search for sanctuary and help. They are not allowed to claim benefits and are forced to live 30% below the poverty line (Kirklees Council 2007). Furthermore, most of the asylum seekers come from well off backgrounds; and it is only the rich and well off that are able to make the long journey, and hold skilled jobs in their native countries (FPH 2008).

Asylum seekers and refugees are most vulnerable groups of people at risk of developing mental problems (FPH 2008). Although there is awareness that asylum seekers and refugees are more likely to experience psychological problems factors such as asylum and immigration policies as well as social and economic exclusion and racism all exacerbate their mental condition. Having experienced all kinds of atrocities from torture, rape, imprisonment,

witnessing killings, loss etc., they are faced with further problems once arriving in the UK and their mental state further deteriorates.

Although refugees and asylum seekers' physical health needs are usually no greater than the host populations this is not the case in relation to mental illness. There are many gaps in our knowledge about the extent of mental health issues affecting asylum seekers and what should be done in addressing these concerns. There is hardly any scholarly literature available on this topic and the general population need to be more aware of the issues and challenges faced by asylum seekers, and what effect it has on their mental health.

## 1. 7 Aims

Chapter two

## 2. 1 Method

A review was carried out of studies investigating the mental health of asylum seekers. The results and findings of carefully selected and reliable studies, searched systematically from databases and published sources were summarised. Other sources included NHS, Home Office, charity organisations, books, newspapers and magazines, and finally a general internet search was conducted. The following electronic databases were used CINHAL, Medline, BMJ, Cochrane, Pubmed, Academic search complete, and psycho info. The task of reviewing was done very methodically, with step to step plan being implemented, which involved:

* the way existing studies are found

* how the relevant studies are judged in terms of their usefulness in answering the question.

The following search was performed, searching the title, abstract and any subject heading fields in each database, for example ‘ asylum seekers’, ‘ mental health’, ‘ health effects of detention’. Studies published in journals were selected that involved asylum seekers and mental health, irrespective of whether the research question was addressed directly. Abstracts were screened against set criteria, and if they met the criteria full copies were obtained and looked at and relevant information extracted. Cited references were also looked at.

Chapter three

Results and Analysis

### 3. 1 Health needs of Asylum-seekers

The basic health needs of refugees and asylum seekers are generally similar to those of the host population, although due to poor and lack of healthcare they may have many conditions untreated.

**Figure 3: Most common health issues affecting asylum seekers.**
(Wilson 2002).

The above graph, taken from a report done by Northern and Yorkshire public health observatory (Wilson 2002) shows the most frequent health issues encountered by asylum seekers. The ‘ general/minor health issues’ includes coughs, colds, flu, viral infections etc. Mental health issues are the most common and include anything from depression, anxiety, stress, loneliness, to

torture related psychological problems, post traumatic stress etc. (Wilson 2002).

People seeking asylum come from different countries and cultures, and have had range of different experiences affecting their health and nutritional state. Once in the UK they face further problems affecting their health such as the effects of poverty, dependence and lack of cohesive social support. On top of this they face racial discrimination which can result in inequalities in health and also have an impact on opportunities in and quality of life. Their experiences also shape their acceptance and expectations of health care in the UK (Burnett et al 2001). Those from countries with not so well developed health care system may expect hospital referral for conditions that in the UK are treated in primary care. This can result in refugees and asylum seekers feeling disappointed and health workers feeling irritated and overwhelmed by the many and varying needs of asylum seekers (Burnett at al 2001).

Most refugees experience difficulties in expressing health needs and in accessing health care. Poverty and social exclusion have a negative impact on health. Initially refugees and asylum seekers will need help to make contact with health and social support agencies. Professional interpreters are also essential, as they help to overcome both bi-lingual and inter-cultural communication and as a result able to understand the specific health needs of asylum seekers (Bhatia et al 2007).

Although the health needs of asylum seekers and refugees should be a priority, the availability and capacity of healthcare services should also be

considered. There is a general feeling amongst healthcare providers that the decision about where to disperse asylum seekers are based purely on the availability of accommodation and factors such as the capacity of healthcare services are not taken into account (Johnson 2003). However, healthcare providers agree that the presence of asylum seekers highlights existing weaknesses in healthcare provision and does not necessarily create new problems (Johnson 2003). Due to the complex and confusing legal status of asylum seekers, the majority of healthcare providers are unsure how asylum status relates to healthcare entitlements. NHS staff are usually ignorant about the rights and entitlements of immigrants, and are also not adequately trained (Johnson 2003).

### 3. 2 Mental Health and its causes

Mental Health is defined as ‘ a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community’ (WHO 2010).

Mental Illness is defined as ‘ any disease of the mind; the psychological state of someone who has emotional or behavioural problems serious enough to require psychiatric intervention’ (Save the Children 2010).

The very nature of seeking asylum or human rights protection in the UK means that a person has suffered in some way in their country of origin and is looking for protection and safety in the UK. Nearly all those seeking asylum have experienced some form of atrocities that mental health issues are almost always intrinsically bound with their personal circumstances and

nature of their claim (Burnett et al 2001). However, due to the stigmas and taboos associated with anyone suffering from any problems of the mind most people do not mention their mental suffering (Save the Children 2010). Most see mental illness as an enduring problem from which there is no recovery. It is therefore evident that those dealing with asylum seekers must address mental health issues with each applicant, making it clear to them that there is support and treatment available to them. It is crucial that asylum seekers feel safe and supported in order for them to reveal details not only crucial to their claim but also crucial to letting the person assisting them identify and provide assistance for the person’s particular need (Save the Children 2010).

Majority of the asylum seekers will show signs and symptoms of psychological distress, but this does not necessarily mean that they are suffering from mental illness. Asylum seekers may show symptoms of depression and anxiety, panic attacks, poor sleeping patterns, nervousness and anxiousness (Burnett 2002). They may also develop behaviours to avoid stimuli that reminds them of past experiences, with some also experiencing memory and concentration problems (Burnett 2002). Such symptoms are often reactions to their past experiences and current situations. Many of them will have been forced to leave their family behind or may even not know the whereabouts of their family. Their state of mental health may worsen due to social isolation, poverty, hostility and racism, which all have a negative impact on their health (Burnett et al 2002).

Arrival, detention and uncertainty, practical issues, e. g. housing, lack of employment, living in a climate of prejudice, family dislocation and reunion, domestic violence and living in the shadow of deportation are all reasons

identified that contribute to the poor mental state of asylum seekers and refuges (Burnett 2002).

Majority of the asylum seekers have suffered some sort of prosecution and harassment in their country of origin, enduring torture, rape or bereavement. They have also experienced the stress of flight and exile. Psychological morbidity has been extensively documented among refugee populations (Burnett et al 2002). The experience of detention compounds the misery of refugees. Captivity is stressful in any context, but is particularly debilitating when it occurs over an indeterminate period and to people who have had previously traumatic experiences of detention (Burnett 2002).

Some asylum seekers show signs of anxiety, depression, guilt and shame as a result of the atrocities they may have suffered. Such symptoms are common responses to grief and distress and should not be viewed as psychiatric illness. Common experiences in asylum seekers and refugees after trauma include poor sleeping patterns, distressing dreams, headaches, palpitations, sweating, loss of concentration, jumpiness, low mood and frequent crying, irritability etc. Symptoms such as consistent failure to carry out daily tasks, frequent expressed suicidal thoughts and ideas, social withdrawal and self-neglect, and behaviour that is abnormal or strange are symptoms that may require specialist help (Burnett 2002).

### 3. 3 Mental health of dispersed asylum seekers

One of the major initiatives introduced by the Asylum and Immigration Act 1999 is the dispersal of asylum seekers requiring provision of long-term accommodation form London and the South-East to other parts of the UK

(Cornelius 2007). This is due to the fact that long term accommodation is more readily available and cheaper and also to lessen pressure on services and resentment by local communities. However, it is believed that dispersal of asylum seekers is associated with higher rates of psychiatric disorder (Heptinstall et al 2004). Other issues such as loss of newly established support networks, racially motivated crime against dispersed asylum seekers are also common (Heptinstall et al 2004). Although most asylum seekers cope quite well with dispersal, there are those however that become distressed and show signs of dispersal-related mental disorder (Cornelius 2007). Supporting such individuals can be challenging for most mental health clinicians.

Asylum seekers referred because of dispersal-related mental disorder can be divided into two broad categories: mild to moderate psychiatric disorder and severe psychiatric disorder (Cornelius 2007). The majority of affected individuals are likely to experience mild to moderately severe psychiatric disorder with no major risk concerns, whereas a small proportion of individuals may have severe psychiatric disorder such as psychosis or a severe depressive episode associated with risk of harm to self or others (Cornelius 2007). The differing severity, complexity and risk profile of these two groups suggest that mental health strategies for support are likely to be different (Cornelius 2007).

Clinicians should undertake a detailed assessment of the needs and risk profiles of asylum seekers, with the aide of interpreters with knowledge of mental health issues. If the outcome of the assessment shows the individual to have forms of mild to moderate severe psychiatric disorder with no major

risks then the mental health support should be focused on helping the individual accept and adjust to dispersal (Cornelius 2007). However, individuals may show signs of being acutely psychotic and severely disturbed with risk of harming themselves and others and such individuals should not be dispersed. There is evidence to suggest that abrupt cessation of psychiatric treatment can result in serious deterioration of the individual's mental health and compromise long-term recovery (Cornelius 2007).

### 3. 4 Children and Adolescents

Although the majority of asylum seekers and refugees are adults, there are however many children who arrive in the UK seeking refuge. While some arrive with family, there are those that arrive alone as unaccompanied asylum-seeking children. These children are likely, at an emotional level to have experienced some sort of terror, grief, shame, guilt etc. (Burnett 2002). They may have experienced imprisonment, beatings, rape, they may have witnessed others subjected to violence, or been subjected to torture due to their political or religious belief of their parents, their colour of skin, and may have lost or been separated from their family. All these experiences and events have different impacts on children.

Refugee Children and asylum-seekers are more likely to develop psychological problems due to their experiences (Mind 2009). These children may experience both physical and psychological symptoms that trouble them such as sleep disturbances, feeling of loneliness, isolation, difficulty in learning and a general feeling of unhappiness and anger. They may experience anxiety, aggression, nightmares, poor concentration, withdrawal, and behaviour such as bed-wetting (Burnett 2002).

Although unaccompanied children are most likely to suffer from mental health problems, children with families present may also suffer from mental health problems as a result of finding themselves feeling unsupported and having to fend for themselves due to absent parents as a result of work or other problems. Furthermore, parents dealing with their own emotional problems are unlikely to care for their children properly, which can result in psychological and physical problems (McCormack et al 2005).

### 3. 5 Health implications of detained asylum seekers

Health professionals world wide are concerned about the potential detrimental effects detention has on the mental health of the detainees (Procter 2005). An experiment carried out by Sultan and O'Sullivan in which they observed participants inside an immigration centre found that 32 of 33 detainees displayed symptoms of major depressive illness (Procter 2005). The majority also showed deterioration in their mental state as the length of detention increased. Detained children also showed signs and symptoms of mental distress, which included anxiety, disruptive conduct, nocturnal enuresis, sleep disturbances, nightmares, sleepwalking as well as cognitive development (Procter 2005).

Once released the detainees mental illness is likely to deteriorate and it is known that adult asylum seekers who have been in immigration detention display a threefold increase in mental illness subsequent to their release (Procter 2005). Trauma, upsetting memories about detention, feeling of hopelessness and sadness are the common symptoms experienced by those detained. These symptoms were also present among detainees in an investigation carried out by Dudley (2003), who also found rioting, violence,

and hunger strikes common inside immigration detention facilities with 264 incidents of self-harm reported over an 8-month period among detainees (Procter 2005). Once the detainees are released from immigration detention, they face new challenges and stresses in the context of existing mental health problems (Procter 2005).

In another study carried out by Thompson and colleagues found that Tamil asylum seekers detained during 1997 and 1998 found the detainees experiencing high levels of depression, post-traumatic stress, anxiety, panic and physical symptoms compared to those asylum seekers living in the community (Steel et al 2004). This study found detention to be injurious to the mental health of asylum seekers with mental health deteriorating with increased length of detention. The study also indicated that adults and children are regularly distressed by memories of detention and feeling of immense sadness and hopelessness about being in detention. Parents of children also felt they were unable to care for or support and control their children's behaviour (Steel et al 2004).

Hundreds of children are detained in immigration centres every year in the UK because their families face deportation. Medical experts say this can have harmful health implications on the children. The Royal Colleges of Paediatrics, GPs and Psychiatrists say other countries have found alternatives to detention and want the British government to take a different approach to stop the physical and psychological damage suffered by children (Wilson 2009). These children are among the most vulnerable and detention causes unnecessary harm to their mental and physical health.

The average stay of children at Yarl's Wood, the UK's largest immigration removal centre, is fifteen days but a third are detained for more than a month. Detaining children for any length of time is a frightening experience that can have lifelong consequences (Wilson 2009). As well as the potential psychological impact, these children invariably experience poor physical health as they cannot access immunisation and preventative services (Wilson 2009).

### 3. 6 Previous research/studies on health of asylum seekers

Knowledge about asylum seekers' health and access to health care services is still limited. Literature on asylum seekers health mainly concerns mental health problems and infectious diseases. Burnett & Peel reviewed the literature and found that one in six asylum seekers had severe physical problems and two-thirds had experienced mental problems. Prevalent physical problems included tuberculosis, HIV/AIDS, hepatitis A and B, parasitic diseases, and non-specific body pains (Burnett et al 2001). Mental health problems include depression and Post Traumatic Stress Disorder, which are due to traumatic experiences, including torture. Asylum seekers are at the risk of having many and severe health problems of a varied nature.

Literature on asylum seekers use of health care services and the barriers they face when seeking care is hard to find. Asylum seekers, however, find themselves in a difficult situation as they are residing in a country, sometimes for years while waiting for a decision in their case, without necessarily having the same legal rights as citizens. They may face limitations on access to health care compared with the citizens. This

combined with the asylum seekers already vulnerable health and with possible restrictions on access to care may result in their health deteriorating (Burnett et al 2001).

Studies carried out in the UK have found that one in six refugees has a physical health problem severe enough to affect their life with two thirds having experienced anxiety or depression.

Medical screening of newly arrived asylum seekers exist in the majority of the EU countries as well as the UK. However differences exist in the way medical screening is carried out. In the UK medical screening is only carried out in the so-called induction or reception centres. Newly arrived asylum seekers who do not enter these centres access medical screening randomly. Medical screening may be available for asylum seekers living outside the centres, but using it depends on individual initiative and there might be a number of barriers. Medical screening programmes also differ in their content from one EU country to another. For example, TB screening was included in the screening programmes of all countries but one, whereas screening for mental health problems was carried out in less than half the countries (Norredam et al 2005).

Overall, medical screening programmes appear to have two aims. One is to secure the well being of asylum seekers, and the other to guarantee the safety of the population in the host country. The content of the screening programmes is likely to depend on how the country priorities these aims. For example, screening for infectious diseases seems more related to the safety

of the host population and mental health screening more to the well being of asylum seekers (Norredam et al 2005).

Regarding access to health care, the study shows that access was restricted to only emergency care at the time of arrival in 10 countries (Norredam et al 2005). The results, however, do not show, if some countries offered alternative measures in case of chronic illness. The study also found that asylum seekers faced a number of practical barriers when seeking health care. Most of the barriers were concerned with immigrant populations in general, and are related to language, culture, and lack of information about the health care system in the host country. However, practical barriers specific for asylum seekers were also identified. The most severe of which include waiting for months or years on paperwork that will ensure access to health care, while only having access to emergency care in the meantime. The literature also shows that asylum seekers access to health care may be compounded by other barriers, such as confinement in detention centres, and dispersal policies leading to disruptive and compromised care (Norredam et al 2005).

The study also shows how legal access to health care services have changed over time for asylum seekers in three countries. Asylum seekers rights to health care are immediately restricted to emergency care if their application is refused (Norredam et al 2005). Failed asylum seekers may also be stripped of the other rights in an attempt to force them out of the host country. Failed asylum seekers include persons who cannot return because their countries are deemed unsafe by UNHCR. UK is one of the countries using increasingly restrictive measures towards failed asylum seekers. Failed

asylum seekers used to have free access to NHS, but since 2004 they cannot obtain free secondary health care (Norredam et al 2005).

In another study in which the impact of detention on asylum seekers was examined, found that detainees are rendered hopeless and powerless in detention (Pourgourides 1997). The unknown duration and reasons for detention mean they are unable to make sense of their predicament and deal with it in a meaningful way. The unpredictable outcome of detention, in particular the fear of deportation is a constant cause of stress. Detention denies asylum seekers the resources to cope with adversity, blocks adaptation to the host society and impairs psychological healing (Pourgourides 1997).

Depression, anxiety, demotivation and despondency are all responses to detention as well as misery and suffering (Pourgourides 1997). The study highlighted high levels of stress and distress amongst detainees. The detainees appear to be able to cope for the first month or two in detention but then after that they become increasingly frustrated, demotivated and apathetic. They start showing signs of psychological symptoms such as sleep and appetite disturbances, symptoms of post-traumatic stress, psychosomatic symptoms etc