Editorial

Mental health and the asylum process

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Ir J Psych Med 2011; 28(2): 57-60

A refugee, according to the United Nations and Irish law, is: *"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"*.[1,2]

An asylum-seeker is a person who has left his or her country of origin, has applied for refugee status in another jurisdiction and is awaiting a decision on that application.[3] The majority of asylum-seekers are from countries that are in conflict.[4] Because asylum-seekers lack refugee status under the UN Convention Relating to the Status of Refugees, they do not have the rights to which a refugee is entitled under international law.

The prevalence of mental disorder among all forcibly displaced people is high, because of pre-migration traumas, difficulties encountered during migration, and post-migration stressors.[5,6] From a mental health perspective, the situation that asylum-seekers find themselves in after arriving in their destination country differs in key respects to the situation of a refugee.

Asylum-seekers experience post-migration stressors that refugees do not.[7] They have insecure residency status and live in constant fear of repatriation.[8] Asylum applications may take years to process and during this time people seeking asylum in Ireland do not have the right to work or to private accommodation.[9] The asylum process is adversarial, with the burden of proof placed on the asylum-seeker.[10] Detention, a stressor that refugees do not endure once they achieve refugee status, has repeatedly been shown adversely to affect mental health.[7,11]

Asylum in Ireland

There were 2,689 applications for asylum in Ireland in 2009.[12] Fifty-six applicants were unaccompanied minors. The number of applications by year has been steadily decreasing since 2002, and is now at its lowest rate since 1996. There was a 30% drop in applications between 2008 and 2009[12] and the number appears to be decreasing still further based on figures for the first six months of 2010.[13]

The obligations of the Irish State towards asylum-seekers are laid out in two Acts. The Refugee Act, 1996,[2] provides the legal framework for the process of determining whether persons seeking asylum are granted refugee status. Section 8 of this Act details the process of assessing an application for refugee status.[2] Although it does not specifically mention refugees or asylum-seekers, the Child Care Act, 1991,[14] provides for the care by the State of unaccompanied minors. Section 5 of this Act states that a health board (now the HSE) shall provide suitable accommodation to any child who is homeless.[14] There is no legislation that specifically details the obligations of the State with respect to provision of health services for asylum-seekers, although asylum-seekers are entitled to a medical card and to access public health services,[15] including catchment mental health services.[16]

In Ireland, people who have made an application for asylum are cared for under a system of direct provision. While waiting for their cases to be processed, asylum-seekers in Ireland must live in full-board accommodation centres rather than in independent accommodation. There are 47 direct provision centres dispersed around the country, in 19 counties.[9]

The system of direct provision means that asylum-seekers cannot exercise autonomy in the most basic of everyday activities such as preparing food. Visitors must sign in and out of the reception centre. There is no right to work and asylum-seekers receive a weekly stipend of €19.10 for an adult and €9.60 per child, sums that have not risen since 2000 although the cost of living has risen by over 30% in that time.[17] Asylum-seekers in state-provided accommodation in Ireland are insecure in their residence within the State: they may be moved from reception centre to centre without consultation, resulting in inevitable disruption to their lives. The system has been severely criticised, including the charge that direct provision violates the basic human rights of adequate housing for asylum seekers.[18,19]

Risk factors for mental disorder in asylum-seekers

Refugees and asylum-seekers are at high risk of mental disorder.[5,6] Events that lead to mental disorder are disproportionately experienced by refugees and asylum-seekers before they migrate.[4,6] The traumatic experiences that lead to later psychological distress are often the events that lead the person to flee in the first place, such as serious injury, being close to death, rape, torture, or witnessing the murder of a family member.[6] Other risk factors for post-migration mental disorder among refugees and asylum-seekers include forced separation from family, an arduous migration, and post-migration factors such as resettlement stress and racism.[6]

For asylum-seekers, factors come into play that do not apply to refugees, such as the trauma of the asylum process itself. A recent meta-analysis found a consistent association between the experience of immigration detention practices and poor mental health, reporting that feelings of hopelessness and a sense of injustice were particularly salient.[7]

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SUBMITTED: NOVEMBER 13, 2010. ACCEPTED: MAY 4, 2011.

https://doi.org/10.1017/S0790966700011447 Published online by Cambridge University Press

Institutional detention can, according to the British Medical Association (BMA), remind torture victims of their experiences and can compound the psychological damage already suffered. The BMA argues that asylum-seekers should not ordinarily be detained; if detention is used, then the reception centre should be comfortable and healthcare needs should be met.[20] There is evidence that Irish reception centres are often in poor condition.[18,21] Healthcare needs can remain unmet in reception centres partly due to difficulties in continuity of care.[20]

In Ireland, health needs may be unmet because appropriate statutory services are difficult to access. Local catchment services may not meet the particular needs of this population; the College of Psychiatry of Ireland noted that the mental health care of asylum-seekers requires skills "not normally found in a conventional mental health setting", such as the capacity to manage the psychological sequelae of torture; the College also noted the problem of lack of continued of care contributed to by the system of direct provision and dispersal.[16] A survey by the College found that the majority of consultant psychiatrists felt their services were ill-equipped to deal with the complex mental health needs of asylum-seekers, and following this the College recommended that psychiatrists be trained in transcultural psychiatry and in the preparation of reports on asylum-seekers.[16] Along with others,[22] the College has recommended that multidisciplinary teams with an interest in the mental health of asylum-seekers should be established in urban centres in Ireland.[16] No such team yet exists and it has been noted that services to help refugees and asylum-seekers recover from the psychological sequelae of torture are "almost absent".[23] SPIRASI, a voluntary organisation that provides care to the survivors of torture,[23] was noted by the College of Psychiatry to be attempting to provide a mental health service for asylum-seekers where the State was not.[16] Funding to allow SPIRASI to function as a national centre has not always been available,[16] but as of 2011 the organisation accepts referrals from around the country.[24]

Reported rates of torture among asylum-seekers vary according to the definition used and other cultural factors.[4] A meta-analysis of the relationship between torture and other traumatic events among refugees, asylum-seekers and other displaced people included 84 studies that reported a prevalence of torture. The reported prevalence was 21%.[25] No similarly robust figure exists for asylum-seekers alone. A Danish study reported that 45% of 142 newly arrived asylum seekers had been exposed to torture,[26] and a comparable figure (39%) was found in a study of asylum-seekers in the UK.[27] While higher prevalences have been reported, selection bias is an issue in such research: a prevalence of torture of 84% was reported in a study of 134 asylum-seekers in a United States study, but this group had been recruited from a mental health program specifically for survivors of torture and trauma.[28] There are no national data on the prevalence of torture among asylum-seekers in Ireland, but one study reported that 32% of asylum-seekers presenting for mental health care in St. James's Hospital in Dublin over a two-year period had been tortured.[29]

Post traumatic stress disorder

There is considerable debate about the adequacy of the concept of post-traumatic stress disorder (PTSD) to grasp the complexities of how different traumatic experiences produce their sequelae, particularly in non-Western populations.[30] Nevertheless, it is widely used in research studies as a key marker of mental health status.[5]

Refugees are 10 times more likely to be diagnosed with PTSD than the general population in the countries in which they resettle, according to a Lancet review that reported a prevalence of PTSD of 9% among adult refugees and 11% among children.[5] This estimate may be conservative, as a meta-analysis of data from over 80,000 refugees and persons exposed to conflict reported a prevalence of PTSD of 30.6%.[25]

Asylum-seekers are reportedly even more vulnerable to PTSD than refugees. Silove and colleagues reported that 37% of a sample of asylum-seekers in Australia met full criteria for PTSD.[31] A study comparing rates of anxiety, depression and PTSD among refugees and asylum-seekers from Iran and Iraq in Sydney found that those without refugee status were five times as likely to have PTSD as those with refugee status, though some of this discrepancy was explained by a difference in the groups' reported experience of traumatic events.[32] A recent Irish study found that 63% of asylum-seekers had PTSD symptoms, compared to 21% of refugees.[15] In this study, three-quarters of asylum-seekers endorsed symptoms of depression and anxiety, compared to one-third of refugees. The authors reported that asylum-seeker status was a proxy for more severe post-migration stress, including uncertainty about residency status, loneliness, and discrimination.[15]

Traumatic memory and the asylum process: a role for mental health expertise?

People seeking asylum the world over are expected to explain clearly why they will be at risk if they return to their homeland. This involves providing a coherent account of the events that led them to flee, which is expected to be consistent over a number of retellings. Discrepant accounts can be considered evidence that the events being described are fabricated for the purposes of gaining entry into the receiving country.[33,34] In many receiving countries, there is an atmosphere of suspicion regarding the bona fides of asylum-seekers.[35] While there is no accounting for individuals, there is abundant evidence to suggest that people seeking asylum are more likely to under-report than over-report their symptoms.[33,36-39]

Firstly, people who have had difficult dealings with authorities in their homeland may find it difficult to engage with authorities in their destination country, and cultural and language barriers may impede diagnosis of mental health difficulties.[36] Secondly, discussion of traumatic experiences can itself be traumatic[37] and people may be reluctant to discuss their experiences if to do so exacerbates psychological distress; or they may feel shame about their experiences, such as rape or sexual torture, and not wish to disclose them.33 Thirdly, those people who are least able to describe their traumatic experiences are sometimes those who have been most damaged by them. The traumas that lead to forcible displacement are often physical traumas, like torture and organised violence, that may result in cognitive impairment.[38,39]

PTSD itself may be seen as a disorder of memory: traumatic stress overwhelms the brain's ability to store autobiographical memories in the normal way, and fragmented memories

https://doi.org/10.1017/S0790966700011447 Published online by Cambridge University Press

of traumatic experiences are typical.[40] In fact, re-integration of traumatic memories into normal autobiographical memory, so that they become less overwhelming and disabling, is a key goal of PTSD treatment among refugees.[40,41] It has even been shown that inconsistent accounts of trauma are associated with more severe PTSD symptoms.[34] That the perceived credibility of an asylum-seeker's story still depends on the perceived consistency of reports of traumatic experiences is not in keeping with the neuroscience of memory, and mental health experts familiar with the literature should be advising those who design and administer the asylum system.

Rather than viewing high rates of PTSD among asylum-seekers as evidence of large-scale deception, a more reasonable way to view this level of psychiatric morbidity is as evidence of psychological damage done by a re-traumatising asylum process.[42] Risk factors for PTSD that are particular to asylum-seekers include insecure accommodation, denial of the right to work, excessively stringent asylum processes, and difficulties dealing with immigration officials.[6,42] Mental distress is exacerbated by a mix of distress, demoralisation, and loss of autonomy.[43] Some authors have gone as far as to describe the asylum policies of western governments as "excessively harsh policies of deterrence", which aim to discourage forcibly displaced people from seeking refuge in their jurisdictions, rather than to live up to the standards of the UN Convention Relating to the Status of Refugees.[42]

Suicide and suicidality

The Reception and Integration Agency in Ireland does not publish the causes of death of those people who die in its care.[44] Consequently, it is not possible to know the number of suicides among asylum-seekers in Ireland. Data from the United Kingdom are also sparse, but such evidence as exists suggests that the rates of self-harm and suicide in this population in the UK are remarkably high.[45] A Danish study found a rate of suicide attempts by asylum-seekers that was 3.4 times the rate for native Danes, and found that a longer application process predicted a higher likelihood of an attempt.[46] A study of EU asylum policies found that children in detention centres were highly vulnerable. They experienced high levels of deliberate self-harm, along with mood disorders, anxiety disorders and PTSD.[47]

A social model

The British Medical Association[20] identified lack of access to health care as a key difficulty of asylum-seekers. This includes primary and secondary mental health care, according to the College of Psychiatry of Ireland.[16] There is little doubt that health services for forcibly displaced people are inadequate, but consideration of the management of mental health problems among asylum-seekers experiencing depression, anxiety, PTSD and suicidality should not stop there. We should view mental disorders among asylum-seekers as disorders that can be prevented by social means as much as disorders that can be treated medically.

A frequently cited Australian study investigated the associations between post-migration stressors and anxiety, depression and PTSD among asylum-seekers. The researchers listed 10 post-migration stressors that caused "serious or very serious problems" among more than 30% of the group of asylum-seekers that they studied. The most frequently cited problem was fear of being sent home (a serious or very serious problem among 81% of the sample), while over 40% reported that delays in processing their application was a serious or very serious problem, a similar number endorsing "no permission to work".[31]

A landmark meta-analysis of the mental health of refugees and asylum-seekers found that the most important post-displacement predictors of good mental health were the right to work and the right to adequate accommodation. People settled in stable independent accommodation had better mental health than those settled in institutional accommodation or temporary independent accommodation. The authors concluded that more humane treatment of people seeking asylum, rather than provision of mental health services, was a key solution. They argued that psychological distress among asylum-seekers could be "significantly remediated by generous material support on the part of governments and agencies".[6]

The evidence is clear that any of several changes to the asylum system would at a stroke ameliorate the psychological harm that the system can inflict. These include enforcing a strict upper limit on the amount of time asylum-seekers must wait for a decision; dismantling the inhumane system of direct provision and dispersal, allowing asylum-seekers to stay in reception centres or to look for independent accommodation; and giving asylum-seekers the right to work. Moves such as these would not only have a direct positive effect on the health of a hugely vulnerable population, but would go some way to dispelling the culture of doubt and hostility that pervades our public discourse around asylum seekers. It is also important that health professionals realise the pressures faced by asylum seekers and work positively to provide continuity of care to this marginalised and stigmatised group.

Acknowledgment: The authors would like to thank the Office of the Refugee Applications Commissioner and the Irish Refugee Council.

Declaration of Interest: None.

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