



Social factors ameliorate psychiatric disorders in community-based asylum seekers independent of visa status

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ABSTRACT

The impact of industrialised host nations' deterrent immigration policies on the mental health of forced migrants has not been well characterised. The present study investigated the impact of Australia's refugee determination process (RDP) on psychiatric morbidity in community-based asylum-seekers (AS) and refugees. Psychiatric morbidity was predicted to be greater in AS than refugees, and to persist or increase as a function of time in the RDP. The effect on mental health of demographic and socio-political factors such as health cover and work rights were also investigated. Psychiatric morbidity was measured prospectively on five mental health indices at baseline (T1, $n=131$) and an average of 15.7 months later (T2, $n=56$). Psychiatric morbidity in AS significantly decreased between time points such that it was no longer greater than that of refugees at T2. Caseness of PTSD and demoralisation reduced in AS who gained protection; however, those who maintained asylum-seeker status at T2 also had a significant reduction in PTS and depression symptom severity. Reduced PTS and demoralisation symptoms were associated with securing work rights and health cover. Living in the community with work rights and access to health cover significantly improves psychiatric symptoms in forced migrants irrespective of their protection status.

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1. Introduction

1.1. Background

The global burden of displaced persons has consistently exceeded 38 million over the last decade (United Nations High Commissioner for Refugees, 2014). At the end of 2013, 59.9 million were forcibly displaced, with over 86% of refugees being hosted by developing nations (United Nations High Commissioner for Refugees, 2015). However, in 2014, an estimated 1.47 million people sought asylum in the world's industrialised nations, recording a 45 percent increase in new claims from the previous year (United Nations High Commissioner for Refugees, 2015). This trend has

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resulted in the implementation of policies of deterrence for some of these governments. Such policies include detention, lower acceptance rates and restricted access to work rights and health care (Silove et al., 2000). One country to instigate such policies has been Australia which, despite allowing many asylum-seekers to reside in the community, has individuals engaged in protracted refugee case determinations with limited means of support. This is in spite of the majority of asylum-seekers eventually receiving protection (Department of Immigration and Citizenship, 2011, 2012).

In potential conflict with the aforementioned policies of deterrence is the International Covenant on Economic, Social and Cultural Rights (ICESCR), of which many host nations – including Australia (Human Rights Law Resource Centre Ltd., 2009) – are signatories. In recognition of the basic economic, social, and cultural factors necessary for individuals to live with dignity, the ICESCR includes the rights to work, to a wage sufficient to support a minimum standard of living, and to enjoy the highest attainable standard of physical and mental health (Office of the United Nations High Commissioner for Human Rights, 1976).

The majority of studies have documented the deleterious impact of immigration detention on the mental health of asylum-seekers (Thompson et al., 1998; Steel and Silove, 2001; Sultan and O'Sullivan, 2001; Ichikawa et al., 2006; Robjant et al., 2009) with only a few studies prospectively investigating the prevalence of mental disorder in asylum-seekers undertaking the refugee determination process (RDP) whilst living in the community (Davis, 2006; Silove et al., 2007; Ryan et al., 2008; Steel et al., 2011). Of these, three (Davis, 2006; Ryan et al., 2008; Steel et al., 2011) had a follow-up period equivalent to the current study, but recruited a substantially smaller cohort ($N=19$) (Davis, 2006), or did not incorporate structured psychiatric interviews to moderate self-report data (Ryan et al., 2008; Steel et al., 2011). Studies have uniformly been of short duration documenting that psychiatric morbidity in asylum-seekers persists or worsens in those not granted protection. This mandates a need to track psychiatric morbidity over a realistic timeframe and to differentiate the characteristics of community-based asylum-seekers from the health impact of detention (Green and Eagar, 2010).

1.2. Aims of the study

We sought to plot the trajectory of psychiatric morbidity and its psychosocial determinants in community-based asylum-seekers engaged in the RDP. Based on previous literature, it was expected that (1) psychiatric morbidity would be greater for asylum-seekers than refugees, and that (2) asylum-seekers' symptoms would persist or worsen as a function of time in Australia's RDP. Additionally, the influence of various socio-political factors on symptomatology was examined and to our knowledge, it is the first study to explore psychiatric morbidity and the influence of basic human rights such as health care and work rights on mental health in AS beyond the primary stage of the RDP.

2. Method

2.1. Participants

A convenience sample of 131 adult community-based asylum-seekers ($n=98$) and refugees ($n=33$) were recruited through the casework programme of the Asylum Seeker Resource Centre (ASRC) in Melbourne, Australia. The ASRC is a non-governmental charitable organisation that provides welfare, legal and health assistance to community based asylum-seekers (www.asrc.org.au).

Fifty-six participants were able to be re-interviewed 10–24 months ($M=15.7$, $SD=3.63$) after the initial interview.

2.2. Ethics

Research approval was granted by the Victoria University Human Research Ethics Committee (VUHREC) and conforms to the provisions of the Declaration of Helsinki in 1995 (5th revision). All participants were assured of anonymity and confidentiality of the data and written consent was provided by all participants.

2.3. Instruments

Posttraumatic stress (PTS) symptoms were assessed with the Harvard Trauma Questionnaire-Revised (HTQ) (Mollica et al., 2004) whilst depression and anxiety symptoms were measured by the 25-item Hopkins Symptom Checklist (HSCL) (Mollica et al., 1987). Both instruments have been extensively validated in the assessment of psychiatric morbidity in traumatised, culturally-diverse populations (Mollica et al., 1987).

The 27-item Psychiatric Epidemiology Research Interview-

Demoralisation Scale (PERI-D) (Dohrenwend et al., 1980) was employed as a self-report measure of non-specific distress, and the 23-item Post-migration Living Difficulties Checklist (PMLDC) (Silove et al., 1998) measured current life stressors.

Socio-demographic data was collected, including information relevant to participants' experience in the refugee process. Demographic information gathered included whether participants had consulted a counsellor or psychiatrist between time points.

Translated versions of some measures (HTQ and HSCL) were used for participants who were not conversant in English, while the remaining measures and socio-demographic questions were interpreted in situ, employing professional interpreters.

2.4. Data analysis

Participants who met the MINI criteria for a psychotic disorder ($n=3$) were removed from analyses due to the instruments not having been validated in this population.

Cut-off scores for the HTQ and HSCL were validated at T2 using a modified version of the Mini-International Neuropsychiatric Interview 6.0 (MINI, Lecrubier et al., 1997), for which the major depression (MDD) and posttraumatic stress disorder (PTSD) modules had been adapted for asylum-seekers (Durieux-Paillard et al., 2006). Cut-off scores for the HSCL and the HTQ were then determined based upon optimal rates of specificity and sensitivity. A cut-off score of ≥ 2.29 for depression as measured by the HSCL yielded 100% specificity and 87% sensitivity. A cut-off score of ≥ 2.50 for PTSD as measured by the HTQ resulted in 96% specificity and 88% sensitivity. These cut-off scores were then applied to the Phase I data to establish caseness for MDD and PTSD at T1.

Caseness for demoralisation was determined using previously reported cut-off scores of 1.27 (males) and 1.55 (females) (Fenig and Levav, 1991; Levav et al., 2008), and was applied at both time points.

Parametric and nonparametric bivariate analyses were employed for descriptive statistics and group comparisons.

Generalised linear mixed effects modelling (GLMM) was employed for multivariate analyses.

For all GLMM analyses, participant ID was taken as the subject variable and a random effect, with time as the repeated measure. The repeat measure and random effects covariance types were set at diagonal and variance components, respectively. Variables input as fixed effects were determined for each analysis.

Analyses with non-normally distributed symptom scores as target (outcome) variables (i.e. PTS, depression, anxiety and demoralisation) were set to a gamma distribution with a log link. Post-migration stress was normally distributed; hence all analyses with this as the target variable were set to a normal distribution with an identity link. Analyses examining diagnostic categories (i.e. PTSD, MDD and demoralisation) as target variables used binomial distribution with logit linking.

Statistical analyses were conducted using the Statistical Package for the Social Sciences (SPSS) for Windows v.22 (IBM Corp., 2013) and an alpha of 95% was applied throughout.

3. Results

3.1. Socio-demographic characteristics of participants

The majority of the total sample ($n=131$) was male (84%) and conversant in English (90.1%), with a mean age of 34.9 years ($SD=10.7$). Table 1 presents the socio-demographic characteristics of the sample. At baseline, three-quarters of the sample were asylum-seekers and 28% retained this status at follow-up. There were no differences in country of origin (excluding 'other' $n=3$)

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