Mental healthcare needs of refugees

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Abstract

The individual experiences of refugees and asylum seekers can contribute to elevated rates of psychiatric disorders. The causation of these conditions varies according to stresses experienced and journeys individuals take in their migration to new countries and cultural settings. The mental health practitioner must be informed of the cultural idioms by which suffering is expressed in the refugee's community, the social stigma associated with particular traumatic experiences and with mental illness. Because of their experiences of victimization, refugees may be reluctant to disclose experiences of trauma and, as is typical of common mental disorder worldwide, the presentation of mental distress in the first instance is often in the guise of somatic complaints. The specific needs of this group will include dealing with traumatic experiences without pathologizing normal human responses.

Keywords asylum seekers; mental health needs; post-traumatic stress disorder; refugees

The 1951 Geneva Convention defines a refugee as someone who has '*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] A further distinction of 'asylum seeker' is made for people who have left their country of origin, have applied to be recognized as a refugee and are awaiting a decision from the host government. In the UK, asylum seekers must apply for recognition as refugees at the earliest point of arrival and those whose refugee status is accepted are accorded the same legal, social, education and other welfare rights as those of a British citizen. A more temporary provision, of Exceptional Leave to Enter/Remain, can be granted to people who do not meet the criteria for refugee status but who, nevertheless, cannot be returned to their countries of origin on humanitarian grounds.

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Statistics

Currently, there are over 20.8 million 'people of concern' to the United Nations, including 2.9 million Afghans, 2.5 million Colombians, 1.8 million Iraqis, 1.6 million Sudanese and 839,000 Somalis. Refugees constitute about 40% of this population, or 8.7 million people worldwide. Pakistan and the Islamic Republic of Iran continue to be the main asylum countries, between them hosting one in five of the world's refugees.[2] Although a startling figure, this is, in fact the lowest on record since 1980 and the fifth consecutive year in which a decrease has been recorded. Voluntary repatriation, mainly of Afghans from Pakistan is the single most important reason for this decrease.

During 2005, there were some 668,000 applications for asylum or refugee status in the industrialized world, the majority to Europe (374,000). As might be expected from the previous paragraph, new asylum applications have also declined in many countries over the past 5 years. Table 1 shows illustrative data reported by the United Nations High Commissioner for Refugees for 2001 and 2005.[2] Over this 5-year period, the largest total number of asylum seekers was reported by the USA (379,520), followed by the UK (325,810) and France (281,630), although all three countries have seen a substantial reduction in 2005 compared with earlier years. Presenting these figures in relation to the size of the national population provides a crude way of reflecting capacity. Thus, Cyprus received 30 asylum seekers per 1000 population in 2005, compared with just 5.5 in the UK and 2.4 in Europe as a whole.

Refugees and psychiatric disorders

The spectrum of mental ill-health among refugees differs in degree and presentation rather than in any absolute way from that of the host population. The most common disorders are those characterized by anxiety and depression, such as post-traumatic stress disorder (PTSD) and major depression, reflecting the experience of trauma and loss that these populations experience.

Prevalence

Perhaps not surprisingly, given the fact that most studies have been of selected help-seeking populations, there is considerable discrepancy in rates of disorder between different studies; for example, the reported rate of PTSD in adults varies between 3–86%. A recent systematic review of psychiatric surveys based

Asylum applications, 2001–2005

Country	Year		Total	Per 1000 inhabitants	
	2001	2005	2001–2005	2005	2001–2005
Cyprus	1770	7770	24,760	9.3	29.6
France	54,290	50,050	281,630	0.8	4.7
UK	91,600	30,460	325,810	0.5	5.5
USA	104,340	48,770	379,520	0.2	1.3

Source: United Nations High Commissioner for Refugees, 2006.[2]

Table 1

on unselected refugee populations identified 20 studies providing results for 6743 adults from 7 countries and 5 surveys of just 260 refugee children from three countries. Of the adults, 9% were diagnosed with PTSD, 4% with generalized anxiety disorder (GAD) and 5% with major depression. Only two studies included psychotic disorders, with a prevalence of 2%. The studies of children recorded a prevalence of 11% for PTSD. These rates are considerably lower than those reported in some studies, reflecting the more rigorous criteria, including interview-based assessments rather than reliance on self-report questionnaires. Nevertheless, these numbers are clinically important. The authors conclude, for example, that refugees are about 10 times more likely to have PTSD than age-matched native populations in the countries surveyed.[3]

While the attention of most studies has been on PTSD and major depression, increased rates of mental disorder relative to the domiciled population of GAD, panic disorder, substance abuse and self-harm are also commonly reported.[4] Co-occurrence of various combinations of these disorders is also common.

There is little accurate information about the prevalence of illicit drug and alcohol abuse and dependency amongst refugee communities, even though refugees are at greater risk of exposure to the main risk factors for drug use, being concentrated in poorer areas of cities in which drug use is endemic and rates of unemployment are high. Some drug use, such as the chewing of Khat, is a common social activity among men of Somali, Ethopian and Yemeni heritage, but appears to have become more problematic among young men post-migration, as use in this population has greatly increased. There is some concern among elders in this community that this excessive use might be a gateway to the use of alcohol and other drugs.

Risk factors

It is accepted that these increased rates of disorder are brought about by exposure to trauma and other stressors. By definition, all refugees are fleeing their home countries for fear of violence or persecution.

Pre-migration: many refugees and asylum seekers have experienced severe pre-migration trauma, including protracted mental and physical torture, mass violence and genocide, witnessing the killings of family members and friends, sexual abuse, kidnap of children, destruction and looting of personal property, starvation and lack of water and shelter.[5] To these terrors of violence and persecution can be added multiple losses – of family and friends, money, employment and status. These traumatic events pre-migration are established risk factors for long-term mental health problems, the risk being greater the worse the degree of the traumatic exposure.

Post-migration: arrival in a safe haven may provide initial relief but it is not uncommon for frustration and disillusionment to develop as new problems emerge. These include language and cultural barriers, concerns about legal status and entitlements, unemployment, homelessness, isolation, lack of access to education and healthcare services, and family separation. It is these post-migration problems that are most open to being addressed by the host country, yet there is surprisingly little public acceptance of the importance of tackling these problems. For example, everyone accepts the need to give immediate humanitarian aid in the crisis and to preventing further violence, but are less forthcoming on their support for the refugee's needs for employment, education, family reunification and religious and cultural support, despite good reasons for thinking that addressing these needs quickly might lessen or avert future ill-health. There is evidence from at least one study that a protracted asylum procedure is a risk factor for psychiatric problems.[6]

Clinical services

Although all refugees in the UK are entitled to NHS care, including specialist secondary care if indicated, access is not always straightforward, requiring at the very least some familiarity with how healthcare is organized. Apparent difficulties with access have prompted the development of specialist refugee health teams connected to primary care, especially in cities where there are large migrant populations. These teams provide information and advice to refugees, facilitate access to healthcare and provide support to frontline services. They often work in loose partnership with a variety of refugee community organizations that deliver immigration advice and assistance with housing and welfare benefits.

Diagnosis

The avoidance of precipitate diagnostic judgements is essential for a balanced assessment. Once trauma has been disclosed, the acknowledgement of symptoms of anxiety and PTSD are certain to follow, though the significance of these symptoms needs careful interpretation: not every symptom warrants treatment.

