Psychiatria Danubina, 2019; Vol. 31, Suppl. 3, pp 395-399 *Conference paper*

PROVIDING PSYCHIATRIC HEALTHCARE TO ASYLUM SEEKERS: REFLECTIONS AND CHALLENGES

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SUMMARY

Background: *According to the United Nations High Commissioner for Refugees the number of people forced to leave their home as a result of conflict, persecution, violence or human rights violations remains high with 68.5 million forcibly displaced people worldwide. Asylum seekers are vulnerable in terms of mental health but they receive very little specific psychiatric care. The purpose of this literature review is to examine current situation regarding asylum seekers' psychiatric healthcare.*

Subjects and methods: *This research was conducted using a keyword search on Medline, PubMed and Google Scholar.*

Results: *The literature on the management of the mental health of asylum seekers focuses on the issue of post-traumatic stress disorder. There is little data on other forms of mental illness in this population. The prevalence of post-traumatic stress disorder among asylum seekers is higher than in the general population and its clinical expression is varied and often complex because it involves various vulnerability factors. Guidelines for post-traumatic stress disorder recommend cognitive behavioral therapy with, in some cases, the use of pharmacotherapy. Given the specificities of the asylum seekers' population, in many cases it is not possible to set up such therapy immediately. Asylum seekers face a number of challenges in accessing mental healthcare.*

Conclusion: *Management of the mental health of asylum seekers requires special attention and guidelines for the general population are not directly applicable to this specific population. The literature focuses on the issue of post-traumatic stress disorder. This review was not able to analyse the state of existing care offer in Belgium for managing the mental health of asylum seekers and the care pathways they take.*

Key words: *asylum seekers – mental health – treatment*

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INTRODUCTION

According to the United Nations High Commissioner for Refugees, in its report for the first half of 2018, the number of people who have been forced to leave their home as a result of conflict, persecution, violence or human rights violations remains high with 68.5 million forcibly displaced people worldwide, including 40 million internally displaced people, 25.4 million refugees and 3.1 million asylum seekers. European countries are seeing an increase in the number of asylum applications (UNHCR 2018). In Belgium, the Federal Migration Centre reports that 15.373 people filed an initial application for international protection in 2017 (MYRIA 2018).

Migrants' access to health care is not equal to that of the host population (Silove et al. 2017). They receive very little specific psychiatric care (Laban et al. 2007). Asylum seekers are vulnerable in terms of their mental health (Tomasini 2016).

Several studies have addressed the issue of the prevalence of mental illness among migrants and asylum seekers. There is great variability in this prevalence among the various studies in relation to methodological and clinical factors (Turrini et al. 2017). However, it is possible to show a trend in the prevalence of certain mental disorders (Fazel et al. 2005). The prevalence of mood disorders and substance use disorders is similar to that of the host population. There are no prevalence data available about psychotic disorders for asylum seekers group. The prevalence of post-traumatic stress disorder is higher for asylum seekers (Priebe et al. 2016).

Post-traumatic stress disorder experienced by asylum seekers has a different expression, severity and evolution from that observed in the general population, with the presence of more frequent psychiatric comorbidities (Nose et al. 2017). This difference is related to the specific circumstances that asylum seekers face (Beltran et al. 2008), including the traumatic events experienced in their country before migration but also the traumatic events experienced during the migratory journey. Asylum seekers also face post migratory factors and daily stressors after arriving in the host country (Crumlish & O'Rourke 2010, Silove et al. 2017, Turrini et al. 2017). The migration itself can also be experienced as traumatic or destabilizing (Tomasini 2016).

Studies have shown that there is a correlation between the number of traumatic events in the country of origin and during the migratory journey and the development of post-traumatic stress disorder (Tomasini 2016). It has also been shown that post-migration factors play a role in the development and maintenance of post-traumatic stress disorder (Kinzie 2006, Palic & Ask 2011). Post-migration factors also influence mental health with an increase in psychiatric morbidity (Momartin et al. 2006).

Given the increasing number of asylum seekers and their potential vulnerability with regards to mental health, the purpose of this review is to look at current data from the literature on taking care of the mental health of asylum seekers.

SUBJECTS AND METHODS

This research has been conducted by using a keyword search on Medline, PubMed and Google Scholar. The keywords used were essentially: asylum seekers, mental health, depression, post-traumatic stress disorder, prevalence, treatment, psychotherapy, social intervention. A second step was to compare the results collected.

RESULTS

The literature on the management of the mental health of asylum seekers focuses on the issue of the management of post-traumatic stress disorder. There is little data about other types of mental illness in this population. Given the specificities of the asylum seeker population, the management of post-traumatic stress disorder in the general population is not completely transferable to asylum seekers and needs some adaptation (Nose et al. 2017).

The guidelines for the management of post-traumatic stress disorder among asylum seekers suggest the use of trauma-focused cognitive behavioral therapy (Turrini et al. 2017). Cognitive behavioral therapy focused on specific symptoms can be used for people who are not suitable or who are reluctant to engage in trauma-focused cognitive behavioral therapy (NICE 2018). Antidepressant treatments as Sertraline or Venlafaxine may also be considered, but not as a first-line treatment (NICE 2018, Sandahl et al. 2017, Sonne et al. 2016). Antipsychotic treatments (Risperidone in first-line) may be considered if there are disabling symptoms and behaviors and if the symptoms have not responded to other drugs or psychological treatments. Guidelines emphasize the need to include the person itself and its family members or carers in the care process. It is also important to maintain safe environments to avoid continued exposure to trauma-inducing environments (NICE 2018).

Asylum seekers face a number of challenges in accessing mental health care. It is important to be able to develop solutions to prevent these difficulties leading to inequality in the management of the mental health of asylum seekers (Priebe et al. 2016).

One of the first difficulties encountered is the language barrier, which makes it difficult to seek care and to be understood by caregivers. Communication difficulties represent a major obstacle, including in the process of psychotherapy. The use of interpreters must be proposed (Priebe et al. 2011).

Another problem is the lack of records concerning medical and psychiatric history. A careful anamnesis must be constructed (Priebe et al. 2011).

Asylum seekers are also faced with a lack of knowledge regarding the health care network of the host country (Leduc & Proulx 2004). In particular, they do not know where to ask for medical support, resulting in more frequent use of emergency departments. Caregivers themselves have a lack of knowledge of the healthcare network and the specificities of caring for asylum seekers. Health professionals who are working with asylum seekers must be able to inform asylum seekers of the availability of care and the procedures for using it. This implies that professionals must themselves be trained in this subject (Priebe et al. 2016).

Cultural differences in understanding and beliefs about mental health and its treatment are also a challenge that needs to be addressed. Professionals should be aware of these differences and must be attentive to this reality. They must be trained specifically in caring for asylum seekers' health (Priebe et al. 2011).

It is also important to take into consideration that asylum seekers do not have stable administrative status (Momartin et al. 2006). In addition, they often face precarious living conditions that force them to prioritize their basic needs rather than mental health care (Silove et al. 2017). The instability of housing and frequent moves do not allow continuity of care in mental health. Finally, it must be remembered that asylum seekers face an asylum procedure. Mental healthcare services that treat asylum seekers need to have some flexibility in terms of organization (Tomasini 2016). Good coordination between and within services is encouraged, in order to ensure continuity of care and facilitate the transition from one service to another. It is important to work with family members and any carers that the patient identifies (NICE 2018). The literature also highlights the importance of supporting the social integration of asylum seekers given the complex interactions between mental health and social insecurity (Heeren et al. 2012). The vulnerability of some asylum seekers should be taken into account in the asylum procedure (Vanoeteren & Gehrels 2009).

Another difficulty in managing the mental health of asylum seekers is the identification of psychiatric pathologies. Indeed, it is difficult to distinguish between post-traumatic stress disorder and distress reactions in people who are continually exposed to post-migration stressors (Nose et al. 2017, Silove et al. 2017). In addition, the clinical presentation of post-traumatic stress disorder is variable, with sometimes atypical presentations or presentations that highlight somatizations pointing to a physical origin which may not be referred to psychiatric care. It is essential that professionals be informed of such possibilities in order to detect and treat mental pathologies. Similarly, it is important to ensure good coordination between physical and mental care because physical care can be a gateway to mental health care (Tomasini 2016).

Finally, it should be noted that asylum seekers can sometimes feel a certain mistrust of healthcare professionals or have certain expectations that healthcare professionals cannot take into account (Priebe et al. 2016). Caregivers can also experience psychological repercussions when taking care of people in traumatic situation (Roisin 2010). The literature recommends favouring stable therapeutic relationships and organizing care in a humane and respectful environment. Multidisciplinary teamwork with time for sharing and time for group supervision is also highlighted.

DISCUSSION

The management of the mental health of asylum seekers is complex and requires some adjustments to the methods of management of the mental health of the general population.

One of the first difficulties is the identification of mental disorders, as Silove et al. point out. It is necessary to be able to distinguish temporary distress linked to environmental factors from psychiatric disease. Psychiatric illnesses have varied and sometimes atypical clinical pictures: distinguishing the different conditions would allow better orientation towards the appropriate services (Silove et al. 2017). Identifying people with a psychiatric vulnerability would also allow them to be directed to the appropriate form of care before a psychiatric disorder becomes chronic, psychiatric comorbidities appear, or auto- or hetero-aggressive behavior causes a risk to life (Heeren et al. 2012). In some cases, the first request for care is during a moment of crisis (behavioral disorder, self-harm, suicidal ideation): professionals are asked to find solutions in an emergency. So it appears to be essential to promote prevention in mental health care for asylum seekers. It is therefore necessary that front-line actors who are working with asylum seekers (social and legal workers, volunteers) and care professionals be sufficiently trained on particular aspects of the mental health of asylum seekers as well as the existing arrangements for their care. They must be able to inform asylum seekers of the availability of care and the procedures for using it. It would seem to be important to pay more attention to the points of access to asylum seekers' mental healthcare and their care pathways in order to use the current offer of care correctly and to think about the creation of new services that take into account the specific needs of this population.

Management of mental healthcare requires some creativity and flexibility on the part of the therapist. Patients rarely have immediately sufficient capacity to start trauma-focused cognitive behavioral therapy and, in addition, it is difficult to address the issue of trauma in precarious and unsafe conditions. According to Tomasini and Silove et al, psychotherapy with asylum seekers must be conceived as a combination of work that aims to recreate a supportive social environment that reduces daily stressors and individual trauma-focused psychotherapy (Silove et al. 2017, Tomasini 2016). In addition, the psychotherapeutic work should make a space for events in the news and be done with caution when the question of the trauma is approached. This psychotherapeutic work around the traumatic history needs a bond of trust to be created with the therapist in advance. There are few studies of alternatives to cognitive behavioral therapy and the studies are less methodologically rigorous (Palic & Ask 2011). More studies about psychotherapeutic work with asylum seekers are required. For the patient to be psychologically available for psychotherapy, his or her basic needs (including sleeping in safe conditions, having access to food, water, clothing and physical care) must be met.

Engaging in psychiatric follow-up with an asylum seeker often means that professionals are involved in the asylum procedure: including requests for reports to corroborate a health problem that the procedure should consider, reports to prove the requirement for continuation of health care in Belgium, reports for the granting of specific aid. Apart from these documents, there is all the support of the person in this path of asylum application. During the asylum application, asylum seekers must provide a precise chronological account of the reasons for which they are seeking asylum. This account is sometimes called into question by the authorities, which leads some people to feeling that the trauma they have experienced is not recognized. The phases of the asylum procedure and its stressful context as well as the resulting waiting period can adversely affect some asylum seekers. The temporality of the procedure that imposes a detailed life story where the psychotherapy will accompany the person to a process of reconstruction of this story is also an element that must be taken into consideration during psychotherapeutic work (Vanoeteren & Gehrels 2009).

Taking care of the mental health of asylum seekers requires particular attention to networking. Networking with providers of physical care is important to avoid unnecessary additional medical examinations but also not to label as "psychiatric" a physical pathology. Good coordination between the different services ensures continuity of care. This coordination should extend to the various health services that asylum seekers use, but some information can also be extended to the social services, legal services or migrant aid associations they are involved with. Obviously, they must have respect for medical confidentiality. Networking must be done with attention to specificities such as language barriers, cultural differences or belief systems. This kind of working coordination must allow a mesh to be knit around the patient, and this in a climate of welcome and kindness.

It is important to emphasize the importance of multidisciplinary teamwork for this type of care. Indeed, as caregivers we are confronted with the unbearable nature of some life stories, precarious social circumstances and the difficulty of being able to create a link in the therapeutic relationship, as the therapist may be considered to be a source of insecurity by the patient. All of this sometimes leads to feelings of discouragement and helplessness and time for supervision and sharing within the team is essential.

CONCLUSION

The literature on the management of the mental health of asylum seekers has mainly focused on the issue of the management of post-traumatic stress disorder. There is little data about other mental conditions. The prevalence of post-traumatic stress disorder among asylum seekers is higher than in the general population and clinical expression is varied and often complex because it involves multiple vulnerability factors. The management of the mental health of asylum seekers requires special attention and guidelines for the general population are not directly applicable to this specific population.

Post-traumatic stress disorder guidelines recommend cognitive behavioral therapy with, in some cases, the use of pharmacotherapy. Nevertheless, in many cases it is not possible to set up trauma-focused cognitive behavioral therapy immediately and mental healthcare follow-up is often a combination of social support to reduce daily stressors and provide basic needs associated with therapeutic work, taking into account current events while putting in place progressive and careful work on the trauma.

This literature review has highlighted the importance of training those professionals working with asylum seekers on the mental health of this population and the specificities of its care. It is particularly important to distinguish people with a psychiatric pathology from those with psychosocial distress, in order to provide them with adequate care and to prevent possible complications related to mental disorders. If psychiatric care is required, it must be realized through networking and within a multidisciplinary team. The literature also stresses the importance of supporting the social integration of asylum seekers given the complex interactions between mental health and social insecurity.

The purpose of this literature review was not to analyse existing care offer in Belgium for managing the mental health of asylum seekers and the care pathways they take. However, such work would permit to have a better picture of the existing healthcare offer in Belgium, ensure better coordination between the available services, avoid saturating certain existing care services thanks to better targeting and consider the creation of new care options.

Acknowledgements: *None.*

Conflict of interest: *None to declare.*

Contribution of individual authors:

Derlet Ophélie & Deschietere Gérald both made substantial contributions to conception and design, and/or acquisition of data, and/or analysis and interpretation of data.

References

1. *Beltran RO, Llewellyn GM & Silove D: Clinicians' understanding of International Statistical Classification of Diseases and Related Health Problems, 10th Revision diagnostic criteria: F62.0 enduring personality change after catastrophic experience. Comprehensive psychiatry 2008; 49:593-602*
2. *Crumlish N & O'Rourke K: A systematic review of treatments for post-traumatic stress disorder among refugees and asylum-seekers. The Journal of nervous and mental disease 2010; 198:237-251*
3. *Fazel M, Wheeler J & Danesh J: Prevalence of serious mental disorder in 7000 refugees resettled in western countries: a systematic review. The Lancet 2005; 365:1309-1314*
4. *Heeren M, Mueller J, Ehlert U, Schnyder U, Copiery N & Maier T: Mental health of asylum seekers: a cross-sectional study of psychiatric disorders. BMC psychiatry 2012; 12:114*
5. *Kinzie JD: Immigrants and refugees: the psychiatric perspective. Transcultural psychiatry 2006; 43:577-591*
6. *Laban CJ, Gernaat HB, Komproe IH & De Jong JT: Prevalence and predictors of health service use among Iraqi asylum seekers in the Netherlands. Social psychiatry and psychiatric epidemiology 2007; 42:837-844*
7. *Leduc N & Proulx M: Patterns of health services utilization by recent immigrants. Journal of Immigrant Health 2004; 6:15-27*
8. *Momartin S, Steel Z, Coello M, Aroche J, Silove DM & Brooks R: A comparison of the mental health of refugees with temporary versus permanent protection visas. Medical Journal of Australia 2006; 185:357-361*
9. *MYRIA: La Migration en chiffres et en droits 2018. Droit de vivre en famille sous pression. Résumé du rapport, 2018*
10. *National Institute for Health and Care Excellence: Post-traumatic stress disorder. NICE guideline 2018; NG116: 54*
11. *Nosè M, Ballette F, Bighelli I, Turrini G, Purgato M, Tol W et al.: Psychosocial interventions for post-traumatic stress disorder in refugees and asylum seekers resettled in high-income countries: Systematic review and meta-analysis. PloS one 2017; 12:e0171030*
12. *Palic S & Ask E: Psychosocial treatment of posttraumatic stress disorder in adult refugees: A systematic review of prospective treatment outcome studies and a critique. Journal of affective disorders 2011; 131:8-23*
13. *Priebe S, Sandhu S, Dias S, Gaddini A, Greacen T, Ioannidis E et al.: Good practice in health care for migrants: views and experiences of care professionals in 16 European countries. BMC public health 2011; 11:187*

14. *Priebe S, Giacco D & El-Nagib R: Health evidence network synthesis report 47. Public health aspects of mental health among migrants and refugees: A review of the evidence on mental health care for refugees, asylum seekers and irregular migrants in the WHO European Region. Geneva: World Health Organization, 2016*
15. *Roisin J: De la survivance à la vie: essai sur le traumatisme psychique et sa guérison. PUF, 2010*
16. *Sandahl H, Jennum P, Baandrup L, Poschmann IS & Carlsson, J: Treatment of sleep disturbances in trauma-affected refugees: Study protocol for a randomised controlled trial. Trials 2017; 18:520*
17. *Silove D, Ventevogel P & Rees S: The contemporary refugee crisis: an overview of mental health challenges. World Psychiatry 2017; 16:30-139*
18. *Sonne C, Carlsson J, Bech P, Elklit A & Mortensen EL: Treatment of trauma-affected refugees with Venlafaxine versus Sertraline combined with psychotherapy-a randomised study. BMC psychiatry 2016; 16:383*
19. *Tomasini V: Prise en charge de l'état de stress post-traumatique chez les" migrants avec un parcours de demande d'asile": regards croisés sur les dispositifs existants en Rhône-Alpes. Médecine humaine et pathologie, 2016*
20. *Turrini G, Purgato M, Ballette F, Nosè M, Ostuzzi G & Barbui C: Common mental disorders in asylum seekers and refugees: umbrella review of prevalence and intervention studies. International journal of mental health systems 2017; 11:51*
21. *UNHCR: Mid-Year Trends 2018. United Nations High Commissioner for Refugees; accessed 26 April 2018*
22. *Vanoeteren A & Gehrels L: La prise en considération de la santé mentale dans la procédure d'asile. Revue du droit des étrangers 2009; 155:492-543*

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