1 Introduction

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Asylum seekers look for protection from another country as they flee from actual or perceived persecution in their own. It is estimated that there are around 13 million asylum seekers worldwide (Fazal, Wheeler and Danesh, 2005). However, only 17% of the world's refugees live in the developed West (Tribe, 2002). In 2009, 25,935 people claimed asylum in the United Kingdom (U.K.) (Home Office, 2009). Asylum in the U.K. is granted under the 1951 United Nations Convention relating to the Status of Refugees (United Nations High Commissioner for Refugees; UNHCR, 1951) which states that those seeking asylum must have a "well-founded fear of persecution" in order for them to be considered for refugee status. This fear may be related to a person's race, religion, nationality or maybe a product of their political or social opinions. Many seek asylum when their home country is suffering from war, conflict or dictatorship. In 2007, only 19 out of 100 asylum seekers who applied for status in the U.K. were actually successful. A further 9 out of 100 were given permission to remain for humanitarian and other reasons (U.K. Border Agency, 2009). It is not an easy process and many face destitution or deportation in the end. According to the Home Office Asylum Statistics (August 2008), the nationalities accounting for the highest numbers of applicants were; Afghan, Iranian, Iraqi, Chinese and Eritrean.

The decision to seek asylum is never an easy one but it is often a necessity. The devastating effects which war and persecution can have on a person's wellbeing can be long-lasting and often the trauma of witnessing atrocities will remain with a person for long periods of time and will undoubtedly impact on a person's emotional and psychological wellbeing.

Refugee Action (2006b) released one of the first in-depth national surveys of destitution among asylum seekers. This stated that once applications were refused asylum and all appeal rights have been exhausted, along with all financial and accommodation support terminated, asylum seekers are then expected to return home to the country where they are highly likely to face persecution. Refused asylum seekers have the option of applying for state support under what is known as Section Four. However, to receive this support they must sign up to return home voluntarily or have a fresh asylum claim. With no financial support, food and accommodation are difficult to procure, and many people live in a state of limbo sleeping where they can find temporary shelter and relying on food parcels donated by charities. In effect, they face forced destitution. Refugee Action, an independent national charity working with asylum seekers and refugees, reported that in 2005/6 40% of all requests for help came from destitute asylum seekers.

In some cases asylum seekers are placed in detention whilst they await their application decision. Detention has been part of the U.K.'s government response to immigration for several decades (Cutler and Ceneda, 2004). However the rationale for detention seems to be ever changing (Owers, 2008b) and is, in practice, seemingly arbitrary. The government's aim is the removal of 'failed' asylum seekers. This objective is reflected in the change of the name of these centres from detention centres to removal centres. Yet the length of time people spend in these centres, waiting for removal, can range from weeks to years. Detention centres are deemed 'healthy prisons' where immigration detainees are supposedly provided with safety, respect, activities and preparation for their release. However, the reports of an unannounced inspection of one of the largest immigration removal centres in the U.K. was carried out in 2006 by the HM Chief Inspector of Prisons (Owers, 2006), found

that this 'healthy prison' was not performing sufficiently. The report followed the suicide of one of its detainees in 2004 and it was revealed that there were large reports of bullying of the detainees by the custodial officers and over 60% of the detainee's reported that they felt unsafe. Evidence suggested a complete lack of care and understanding of the detainees' situations and anxieties. The report also found that there was a distinct lack of mental health support available and that staff had very little knowledge of how to work with victims of torture. Understandably, such conditions can be seriously detrimental to the mental wellbeing of those placed in detention. Furthermore, a study carried out on behalf of Asylum Aid (Cutler and Ceneda, 2004), a charity providing advice and legal representation to asylum-seekers and refugees, found that detention exacerbated existing health problems due to the poor quality of care available in the centres. The lack of interpreters and specialist services to deal with victims of trauma, torture and rape only served to worsen the asylum seekers physical and mental health.

Unfortunately, the process of seeking asylum within the U.K. is not supportive of reducing the traumatising impact of pre-migration events. Retelling of events, uncertainty of outcome, and limits to benefits such as housing, employment and health services, impact significantly, and negatively, on the lives of those seeking asylum (Djuretic et al, 2007; Misra et al, 2006; Ryan et al, 2008).

Entitlement to healthcare in the U.K.'s National Health Service (NHS) for those seeking asylum is ever changing. The Department of Health (DH) has altered its stance on the entitlement to free care a number of times in the last five years. Currently those still in the asylum process or those granted leave to remain are eligible for primary and secondary care. However, this is no longer the case for those whose asylum claim has

been refused.

A judicial review which took place in April 2008 concluded with the High Court ruling that failed asylum seekers may be considered 'ordinarily resident' in the U.K. which would therefore entitle them to free NHS hospital treatment. However this decision remained in place for just one year. In April 2009 the DH appealed against this High Court decision and the law now states that "failed asylum seekers are not entitled to free hospital treatment within secondary care (DH, 2009b)." The DH is also in the process of reviewing access to primary healthcare for failed applicants. At present, access to primary healthcare is at the general practitioners' (GP) discretion. What appears to be customary practice, however, is that the constant changes have limited the dissemination of information and many health care professionals are unsure of the correct entitlements.

1.1 Background and rationale

Ryan, Benson and Dooley (2008) believe that while asylum seeking has become a major political issue in the Western world the research on its psychological impact is still in its infancy.

There is a reported high prevalence of mental health problems amongst the asylum seeking and refugee population ranging from post traumatic stress disorder (PTSD) to depression. Bruntland (2000) claims that on average over 50% of refugees present in host countries with mental health problems. Some studies have even found as high prevalence as 50-100% of PTSD amongst this population (Misra et al., 2006). Furthermore, Refugee Action (2006b) found over half of those surveyed for their

national survey of destitution experienced mental health problems. These problems could stem from numerous origins such as an individual's genetics, the decision and reasoning provoking a person to flee their home country or the uncertainty of their status in another country. It is through this proposed research that the factors which affect the emotional and psychological wellbeing of asylum seekers will be investigated.

A report carried out by the Home Office (Black et al., 2005) on the illegally resident population in detention in the U.K. interviewed 83 detained migrants about their motivations for coming to the U.K., how they came here, their experiences whilst here and their involvement in the job market. 88% of the participants were male and over half of them had attended secondary education of some sort. 60% of interviewees had entered the U.K. illegally. The rationale for coming to the U.K. was the perceived danger to themselves and their family in their country of origin. Many stated that they chose to come to the U.K. rather than other countries due to the apparent safety of the country, the availability of jobs, linguistic connections or the presence of family and friends.

Tribe (2002) discusses in her paper on the mental health of refugees and asylum seekers that for the majority, becoming an asylum seeker is not a choice in the way that most immigrants make the choice to change their country of residences. Many people seeking asylum are forced to flee without the luxury of foresight and planning (Maffia, 2008). It is through war or persecution that these people have to make the often devastating decision to leave behind their home, families and friends, and their lives. Seeking asylum often occurs at extremely short notice and often to unknown destinations (Tribe, 2002).

The World Health Organisation (WHO) states that the mental health of refugees in emergencies is a high priority of their work (Brundtland, 2000). In 2001, the WHO alongside the Red Cross and Red Crescent societies developed a Rapid Assessment of mental health needs of refugees, displaced and other populations affected by conflict and post conflict situations (Petervi et al., 2001). WHO believe it is the current lack of international consensus over the legal definitions of what constitutes a refugee which deprives people of the support they need. The figures they give include not only refugees but also asylum seekers, internally displaced and repatriated persons and other non displaced populations affected by war and organised violence which increases the number from 13 million (Fazal et al., 2005) to 50 million worldwide (Bruntland, 2000). Five million of which the WHO believe to present in their host countries with a 'chronic mental disorder' such as PTSD and another five million more suffering from psycho-social problems which affect their lives. Throughout this research, refugees, asylum seekers, internally displaced and repatriated persons and other non displaced populations will henceforth be referred to as people seeking asylum unless otherwise stated.

The asylum process brings about cognitive, emotional and socio-economic burdens which will have a profound affect on the majority of people. Coupled with the traumatic experiences they have faced whilst living in their home country, the asylum seeking population may experience devastating effects to their wellbeing. Many people have experienced personal torture, sexual violence and have witnessed killings of family and community members (Refugee Action, 2006b). Unfortunately, the emotional and psychological effects of experiencing such trauma do not simply disappear when one enters the U.K. to seek asylum (Turner et al., 2003). Furthermore, the heavy burdens

of insecurity of status, social exclusion and, in some cases, destitution can exacerbate these issues (Maffia, 2008; Misra et al., 2006) if not create more.

Traditional emergency response would simply include food, water and shelter with issues such as health and other needs being delayed and at times neglected (WHO, 2003). However, the importance of mental health needs in these situations is becoming increasingly recognised WHO released a publication in 2003 addressing Mental Health in Emergencies which deals with the mental and social aspects of populations exposed to extreme stressors (WHO, 2003). This states that within the acute emergency phase it is advisable to put into place only those social interventions that do not interfere with acute needs such as food, water and shelter. This would suggest that mental health needs may be set aside in the initial interaction but ought to be approached as soon as those prioritised needs have been met. Whilst understandable that mental health needs are not prioritised during the acute phase of emergencies, in this instance when a person first arrives in the U.K., there is a danger, however, of these needs becoming neglected. Brundtland (2000) believes that the growing global awareness of the impact of war on the mental health of people seeking asylum has increased the international commitment to address this issue. Presumably, the issue of mental health within this population should therefore have been included within U.K. health policy and government documents yet, a decade later, this has yet to be given the priority in the U.K. that it has been accorded by the WHO. It could be argued that the emotional and psychological needs of those seeking asylum have been neglected if not ignored all together by those involved in the development of the asylum system in the U.K.

The King's Fund is a charity working towards better health in the U.K., they released a

paper in 2000 addressing the health and well-being of asylum seekers and refugees. They found that many asylum seekers enter the U.K. with mental health needs as a result of torture, conflict and war (Woodhead, 2000). Given the huge impact war has on large populations Brundtland (2000) foresees that care on an individual basis is not realistic and that community-based psychosocial rehabilitation should be part of primary health care in order to create sustainable resources. Misra et al. (2006) carried out an epidemiological and user's perspective study into addressing the mental health needs of asylum seekers. This stated, as have many other reports, that language difficulties were a major issue with regards to involving people with mental health services as well as the lack of cultural awareness of service providers. They conclude that many refugees may not view themselves as having mental health problems but rather a range of other issues which are affecting their lives such as social, political and economic problems and would therefore benefit from much more practical help such as language lessons, advocacy and employment advice. Nevertheless, this is not to rule the importance of mental health service intervention for this population. There is a need for all aspects to be considered when caring for people seeking asylum. Watters (2005) agrees that a multi-disciplinary approach is needed to incorporate the political and social aspects of people seeking asylum and refugees. The focus of this literature review will be the determination of the importance of exile-related stressors along with those stressors produced by life in the UK such as social isolation, language difficulties, uncertainty and poverty, in the declining mental health of people seeking asylum.

It is well established in the literature that there are significant factors impacting on the emotional and psychological wellbeing of people seeking asylum. Pre-migration events along with large failings within the U.K's asylum system and inadequate health services

all have contributing factors to the ill mental health experienced by this population. Each of these factors will be the focus of this study and will be discussed in depth within this critical review.

Aim:

The aim of this study is to examine and critically review the literature addressing the emotional and psychological needs of people seeking asylum in the U.K.

Objectives:

- To introduce the subject area and the rationale for this study
- To explore the research process conducted within the study
- To critically review, analyse and evaluate the research addressing the emotional and psychological needs of people seeking asylum and other related literature and policy.
- To consider the service provisions available for this population.
- To discuss the implications of the study with regards to mental health nursing and develop recommendations for further research or service development.
- To conclude with key findings and explore the limitations of the conducted study
- To reflect upon the research and study process

2 Methodology

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A critical review method was decided upon to identify the importance and relevance of the literature available and to enable in-depth analysis of this research in order to provide the author a deeper understanding of the emotional and psychological needs of people seeking asylum (Aveyard, 2007, Hart, 1998). Critical review methods differ from other forms of research in terms of structure. Critically reviewing the research literature allows for the work itself to guide the direction of the review. In this way the whole process becomes organic in nature, allowing much more freedom for the author to explore in any way the research takes them in terms of concept development (Hart, 1998). It is then the prerogative of the author as to how they begin to narrow down concepts and formulate the research question (Crème and Lea, 2008). With no inclusion and exclusion criteria from the onset the author has a much broader base through which to investigate their question (Polit and Tatano Beck, 2006). With other research methods there is a clear structure set out from the beginning (Hek et al., 2000; Noordzij et al., 2009) which limits the extent of self exploration of the research. However, without clear structure the author may deter away from the original focus of the dissertation.

A critical review method enables identification of the weakness of certain theories, opinions or claims, and allows the author to give judgement about the merit of the material (Geetham, 2001). These judgements should then be supported with a discussion of the evidence and reasoning involved. It is considered essential to analyse the quality of the information in order to determine its contribution to the overall argument (Aveyard, 2007). It is through this process that the author aimed to produce a valid and relevant dissertation.

Initial searches of the databases with the keywords “asylum seekers” and “mental health” produced a significant enough quantity of literature to justify a critical review of the subject area. Due to the international nature of the research question it was not unexpected to find that a significant proportion of the literature was a product of non-UK research, published in the English language. Whilst this is relevant in terms of recounting the detrimental effects experienced by those seeking asylum, it would not be relevant in relation to the law surrounding asylum status within the U.K. nor if the author chose to focus heavily on the U.K’s stance on the research question. It was decided upon to include international research where there is no mention of legislation or law outside of the U.K. as to include this would contribute to a more thorough critical discussion.

The main literature search used academic databases including CINAHL, MEDLINE, PSYCHINFO and ASSIA with the key words “Asylum seekers”, “Refugees”, “Mental Health”, “Psychological impact”, “Psychological trauma”, “Destitution”, “Displaced” and these were combined to find the most relevant research and in many cases produced duplicate findings. A research diary was kept to allow the author to document progress and highlight any issues identified through searching in order to make effective development in their search for relevant literature. A brief reading of the abstracts of the literature allowed the author to assess the articles for eligibility, based upon their relevance to the aims of the study. Those which were not deemed adequate were noted within the research diary so as not to be looked at again. An up to date literature review was desired, therefore reports from before 2000 were discounted unless they were significant within the development of asylum status or care.

It has been asserted that reviewing only the easily located studies will lead to a biased view of the research (Conn et al., 2003). Therefore searching only computerised databases would not be sufficient enough to lead to an intensive debate of the literature. Further searches were carried out into library collections and internet searches. Nevertheless, computerised databases provided the most relevant texts. To increase the bulk of available research, ancestry searching was also conducted using secondary citations. This enabled the author to find other possible appropriate studies via the use of citations in the original texts. However, it is to be noted that if too heavily relied upon, this can lead to a further biased opinion of the research as it is more likely for the text to cite only those further studies which are in agreement with their own (Conn et al., 2003). Whilst ancestry search would 'expand the number of eligible studies' there needs to be a focus on other research methods in order to provide the author with a balanced view of the literature and to allow for their own opinions to formulate throughout the research process.

As part of the focus of this review was to comment on the services available for people seeking asylum which help with emotional and psychological needs, the author also searched through Department of Health (DH) policies and also, through websites searches, found charity organisations which provide help for people seeking asylum such as Refugee Action, Refugee Council and MIND.

The literature located was read and its relevance to the aim of the study was evaluated and recorded. Each article was read and a further analytical evaluation of the research was conducted (Hart, 1998) which helped to form the following critical literature review.

3 Findings

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The literature review produced vast amounts of studies relating to the key words, these were combined and searched again in order to obtain more manageable numbers of articles for the researcher to utilise within this critical review. The articles were selected on a relevance basis using the abstracts available from the databases. The majority of the findings reported largely on post-migration events as stressors to emotional and psychological well-being of those seeking asylum although there was the acknowledgement within most studies that pre-migration events were a major concern of trauma exposure and on set of mental health difficulties.

The cognitive, emotional and socio-economic burden imposed on individuals, families and communities whilst seeking asylum are vast (Bruntland, 2000). The overall findings suggest that the emotional and psychological needs of people seeking asylum are far greater than the U.K. health services provide for. Distress is caused by a combination of the experiences of extreme events pre-migration, the dangers and anxiety of flight, and the ongoing stresses of life in the U.K. (Maffia, 2008). However, the prevalence of mental health diagnosis within people seeking asylum is accounted for differently within most studies (Djuretic et al., 2007, Eytan et al., 2007, Fazel et al., 2005, Hollifield et al., 2002, Misra et al., 2006, Ryan et al., 2008, Woodhead, 2000).

Fazel et al (2005) recognise that the relevant epidemiological evidence to support pre-migration trauma and its links to mental health problems is generally sparse and apparently conflicting. Furthermore, its interpretation has been complicated by the use

of different sampling and assessment methods. There are concerns that selective citation of estimates of mental health prevalence at the lower end of the range have contributed to a neglect of refugee mental health (Fazel et al., 2005). Conversely, Bruntland (2000) argues that entire refugee populations become 'mentally disturbed' and are in need of intensive psychiatric care need to be avoided. Suggestions for a universal screening tool which accounts for the cultural differences and language difficulties would alleviate such issues and reduced the stigma surrounding this population (Barnes, 2001, Eytan et al., 2007, Savin et al., 2005).

Currently there are limits on the provision of free health care within the U.K's NHS for those seeking asylum. Furthermore there is a question of the quality of care people receive when they are entitled to it (Siva, 2009).

The following chapters explore the impact of pre-migration and post-migration experiences of people seeking asylum, developing arguments based on critically reviewing the literature in order to gain a greater understanding of the emotional and psychological needs of this vulnerable population.

4 Pre-migration events

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People are granted asylum owing to a well founded fear of being persecuted and are unable to, or due to such fear are unwilling to, return to their country of origin (UNHCR, 1951).

Those who flee their country and seek asylum in the U.K. have often experienced devastating trauma linked to war, human rights violations, torture, sexual violence, harsh detention in addition to an uprooting from their lives (Barnes, 2001; Bruntland, 2000). All of these will indisputably have an effect on a person's emotional and psychological wellbeing yet the long term effects of this are mediated by risk and protective factors present during the time of such trauma (Montgomery, 2008). People seeking asylum can suffer a range of health problems relating to their experiences and can arrive at their host country with pre-existing mental health problems or the onset of related difficulties. These can be linked to war, political persecution, torture and imprisonment and the conditions of flight from their country of origin (Refugee Council, 2005).

There is a major concern for the mental health of this population with incidences of PTSD, depression and anxiety being the most prevalent diagnoses (Eytan et al., 2007; Fazel et al., 2005; Hollifield et al., 2002). However, the occurrence of these diagnoses has never been agreed upon. Fazel et al. (2005) found in their systematic review of psychiatric surveys amongst the refugee population in western countries that estimates for PTSD in adult refugees ranged from 3-86% and for depression 3-80%. There are clear inconsistencies with these numbers which could be attributed to the

type of screening assessments being used within the studies, the difficulties of which will be discussed in detail in a later chapter. Misra et al. (2006) stresses the importance of viewing the results of psychiatric surveys in light of the fact they are based on western psychiatric constructs, which are culturally bound but not universal as they do not take into account alternative cultural perceptions of mental health.

Fazel et al (2005) conducted a meta-analysis of 20 psychiatric surveys based on interviews of unselected refugees and current diagnosis of PTSD, major depression, psychotic illness or generalised anxiety disorder (GAD). They found that one in ten refugees resettled in western countries has PTSD, one in twenty has major depression and one in twenty-five has GAD, along with a large probability that these will overlap in most people. PTSD is a potentially disabling condition that is characterised by traumatic flashbacks, hyper vigilance and emotional numbing (Brady et al., 2000). Pre-existing emotional and psychological difficulties can impact on a persons' ability to cope with resettlement within a new country (Turner et al., 2003) and can lead to the development of long lasting mental health problems.

Watters (2006) believes that refugees may be particularly vulnerable during the process of fight to violence and sexual and economic exploitation yet argues that the process of flight itself on the mental health of those seeking asylum has been given relatively little attention in the literature. It was found within the research for this review, there is more of an emphasis on the post-migration aspects of the lives of those seeking asylum.

Khawaja et al. (2008) researched into the narratives of Sudanese refugees. They found that when talking about pre-migration events people predominately focused on four major themes: meeting basic needs, loss, impact on life activities and experiences of trauma. It may be that by re-building lives within host countries these people are able to adapt, finding new life activities and meeting their basic needs, yet the impact of trauma and loss will be ongoing. Part of Khawaja's research looked in to the coping strategies used throughout experiences of trauma. Many turned to religion and social support networks. It is important that these coping strategies are encouraged within the U.K. to cope with post-migration life.

Much of the research assumes that people seeking asylum will arrive in the U.K. already experiencing emotion and or psychological distress (Bruntland, 2000, Eytan et al., 2007). However, it has been suggested by Steel et al. (2002) that the intensity of these 'illnesses' can, for many, subside over time with resettlement and integration into a new country of residence. They explored the long term effects of psychological trauma on the mental health of Vietnamese refugees resettled in Australia finding that the risk of mental illness fell consistently over time once they had been granted refugee status and had started to rebuild their lives. Yet Djuretic et al. (2007) carried out research into the mental health of migrant workers from the former Yugoslavia now settled in the U.K. which found that whilst traumatic experiences previous to resettlement may 'subside' there were large pressures within their new lives in the host country which continued to affect their mental wellbeing. Whilst both of these provide valid arguments, neither can be generalised to be applied to such a large diverse population. There are vast individual differences in the experiences of pre-

migration, flight and post-migration as illustrated through the vast differences in prevalence rates (Fazel et al, 2005).

4.1 Conclusion

There is a great sense of loss for this population, the loss of loved ones, community, language and culture all of which ultimately leads to a loss of identity (Djuretic et al., 2007). Arriving in the U.K. many people seeking asylum hope they will be able to begin to rebuild their lives yet due to the post-migration events within the U.K., resettlement and integration become increasingly difficult to obtain.

There is a significant amount of evidence which links PTSD with the degree of trauma exposure in refugees (Turner et al., 2003). However there also appears to be a cumulative effect, with both pre-migration trauma exposure and post-migration factors being implicated in overall psychiatric morbidity within the population (Eytan et al., 2007, Fazel et al., 2005). It is questionable as to whether or not it is the post-migration events which have the larger detrimental effect on the mental health and wellbeing of people seeking asylum.

5 Post-migration events

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A report by the British Medical Association (Board of Science and Education, 2002) found that although most asylum seekers are healthy on arrival to the U.K. their health subsequently deteriorates as a result of environmental factors (Refugee Council, 2005).

There are many contributing factors to post-migration events within the U.K. which impact on the emotional and psychological wellbeing of people seeking asylum (Bhatia et al., 2007; Djuretic et al., 2007; Keller et al., 2003; Maffia, 2008; MIND, 2009a;2009b; O'Donnell et al., 2008). Their state of health can also be affected by destitution, prolonged separation from family members, difficulties with cultural adaptation and lack of perspective of one's future during lengthy asylum determination procedures (Refugee Council, 2005) which are experienced by the majority, if not all, of those seeking asylum in the U.K. This lengthy period of uncertainty surrounding one's status and legal right to be in the country will surely only serve to further traumatise this population. Misra et al. (2006) believe these factors may even be as powerful as events that occur before migration in contributing to mental health problems.

The impact which immigration and asylum has on the U.K. is forever debated within the media, most often in a negative light (Pearce et al., 2009). Yet there is a deficit in the evidence, or indeed public interest, in the positive impact that the asylum seeking population and other migrants have on society in the U.K. (Ryan et al., 2008). Refugees and asylum seekers bring many economic, cultural and social benefits but still some of the media is overwhelmingly negative (Refugee Action, 2006a). These are people who have escaped wars and persecution and normally after an extremely

difficult journey have managed to reach the U.K. They are resourceful, resilient, intelligent and courageous and should be regarded as a potential resource rather than a drain on resources (Maffia, 2008). Furthermore Ryan et al. (2008) believe that as a host society it is our responsibility to create social environments in which such resources can flourish. Many people who seek asylum express the desire to work for themselves in order to provide for their families rather than relying on government benefits or charity donations (CSIP, 2006). However due to the restrictions place upon them by the Home Office they are prevented from contributing to society and building a life for themselves. It is the ignorant and overwhelmingly biased media portrayal which promotes the widespread misconception that people seek asylum within the U.K. purely as a means to gain benefits and free health care (Pearce et al., 2009). On the contrary if people were to look deeper into the dire situation faced by these people they would frequently find this not to be the case.

Maffia (2008) believes that the stresses of life in the U.K. for this group are constant and ongoing and argues that it is the conditions in the U.K. rather than extreme events in the country of origin which are more likely to lead to anxiety and depression.

5.1 The Asylum Process

Whilst there needs to be limits to the asylum process due to political and governmental reasons (UK Border Agency, 2009), there still needs to be vast improvements in order to make the process more benevolent (Refugee Action, 2006b).

The lives of those seeking asylum are very different from those of the host population and are to a large extent out of the individuals' control (Maffia, 2008; Ryan et al., 2008). They are subject to severe constraints imposed on them (See table one) by the Home Office as they await decisions and they are restricted in the way they are able to live their lives (Centre of Social Justice Report, 2008).

Table one: Entitlements for Asylum seekers[1]

	Asylum seeker- Claim in process	**Asylum seekers- Claim refused**	**Refugee**
Financial support	Supported (70% of income support for adults; 100% for under 16s)	Supported (vouchers only, limited to certain goods and outlets)	Not supported
Housing	Housed	Housed	Not housed, but some rights
Primary care access	Can use the NHS free. Entitled to free prescriptions	Can use the NHS free, down to GP discretion	Can use NHS free
Secondary care access	Can use NHS free	Previously classed as 'ordinary resident' now unable to access free secondary care	Can use NHS free
Right to work	Not permitted to work	Not permitted to work	Eligible to work/obtain benefits

People seeking asylum have to apply for the right to remain within the U.K. upon their arrival (UK Boarder Agency, 2009). The wait for a decision to be made by the Home Office can range from hours to months (Djuretic et al, 2007). This uncertainty promotes distress (Ryan et al., 2008) and can impede the process of coming to terms

[1] Adapted and updated from Faculty of Public Health (2008)

with their new life in an unfamiliar culture and environment (Summerfield, 2001). The U.K. government published a five year strategy for immigration and asylum which took into consideration these lengthy waiting times and developed the New Asylum Model (NAM) (Home Office, 2006). Anyone who has claimed asylum since March 2007 will be processed within this new model. This was introduced as a "faster, more tightly managed asylum process with an emphasis on the rapid integration or removal." (Refugee Council, 2007) The main aim of NAM is for the process of application to be completed within six months of applying (Refugee Council, 2007) which should in theory decrease the level of distress created by uncertainty.

In order to make a claim, those seeking asylum usually have to relate a coherent account of events experienced which they claim has led to their fear of returning home (UK Boarder Agency, 2010). The legal process for identifying valid claims involves written statements, interviews and court hearings. The decision maker then has to determine whether or not the story is credible. It is often the case that there is no independent corroborating evidence about the applicants' personal experience and therefore the decision is solely down to the Home Office official's opinion. Unfortunately, the lack of evidence is not the only hurdle when retelling events of trauma. One of the symptoms of PTSD (ICD-10, 2007) is the inability to recall, either partially or completely some important aspects of the period of exposure to the stressors. Yet this is not considered by Home Office officials and discrepancies in a person's story throughout the asylum process can lead to their claim being refused on this basis (Herlihy et al., 2007). Due to this, Herlihy et al (2007) concluded that there is a need to find ways of developing a broader evidence base regarding this population and their needs which is then disseminated to Home Office decision makers in order to

improve such inequalities. They believe that if this was achieved then there would be a more 'robust' system in place which would achieve fairer decisions for all and prevent destitution.

As discussed within the introduction once an asylum claim is refused and all appeal rights have been exhausted there are only a few options which a person can take. To apply for section four support and commit to returning to their country of origin (Refugee Action, 2006b), to submit a new claim with fresh evidence, or become an illegal resident and therefore destitute (Amnesty International U.K., 2006).

5.2 Destitution

As a result of legislation over the last decade significant numbers of those rejected for their asylum claims have had all means of support withdrawn from them and have become destitute (CSIP, 2006).

Refugee Action (2006b) and Amnesty International U.K. (2006) argue that the government is deliberately using destitution as a instrument to force failed asylum seekers to leave the country despite the fact that in both charities experience, destitution is believed to make return to countries of origin less likely. Destitute asylum seekers have no recourse to public funds and are denied the rights to support themselves (CSIP, 2006) leading to negative views of themselves and a feeling of purposelessness (Maffia, 2008). The Care Services Improvement Partnership (CSIP;

2006) conducted interviews in the South East region of the U.K. with 49 destitute asylum seekers and a range of service providers who have a role in developing or providing services to people seeking asylum in this area. They found that most of the fears of destitute asylum seekers were related to returning home, not being able to provide for themselves and being forced to sleeping rough. Many report suffering with depression due to the fear produced by destitution (Amnesty International U.K., 2006, Refugee Action, 2006b) along with feelings of worthlessness as a result of not being able to provide for themselves and having to heavily rely on the charity of others for even the most basic of needs such as shelter, food and water.

Positive Action for Refugees and Asylum Seekers (PAFRAS) is a charity which works with destitute asylum seekers in North West England. They conducted interviews with 56 destitute asylum seekers from 20 different countries, all of whom reported to suffer with mental health problems (PAFRAS, 2009). They believed that their mental health had deteriorated immensely as a result of destitution. Refugee Action (2006b) found in their study of the destitute population in the U.K. that many feel that their struggle to cope with mental ill health could be lessened if they had somewhere to stay, basic food and a means of supporting themselves.

5.3 Detention

Individuals can be held in detention centres if they are deemed by the Home Office to have exhausted all of their legal rights to appeal. Many remain in such 'healthy prisons' indefinitely whilst they await removal to their country of origin or to a third country

(Owers, 2006). It has been reported that the mental health of those who are detained is extremely poor (Keller et al., 2003, Steel et al., 2006) with high symptom levels of anxiety, depression and PTSD with suicidal and self harm thoughts (McLoughlin, 2006, Robjant et al., 2009a) which are exacerbated the longer a person is kept in detention although causality cannot be inferred (Robjant et al., 2009b). Yet access to mental health services is extremely limited within detention centres (Keller et al., 2003). Furthermore, following Owers 2006 unannounced inspection for Harmondsworth detention centre she conducted a follow up inspection which found even with significant improvements the centre had a long way to go (Owers, 2008a). There had been no attempt to improve access to mental health care and there was still a lack of input by staff concerning welfare issues of the detainees.

What is more, detention can have a considerable impact on re-traumatising this population. Keller et al. (2003) found that experiences within detention centres triggered feelings of isolation, powerlessness and resurrected disturbing memories of suffering from pre-migration events which continued even after release.

McLoughlin (2006) questioned whether it was possible and beneficial to promote mental health in such unhealthy settings. She found that externally operated programs such as law reform campaigns, culturally appropriate health promotion work and advocacy groups' were more effective than health promotion ran by detention centre staff. Charities such as Liberty help to promote the health, legal and human rights as well as fighting for the improvement of quality of life for detained asylum seekers (Gask, 2007).

5.4 Isolation

Human beings are not designed to live in isolation (Maffia, 2008) and having access to social support is recognised as providing considerable protection against stress. Dispersal of newly arrived people seeking asylum from London and the South East to other parts of the U.K. was introduced by the Immigration and Asylum Act (1999, c.33). Those seeking asylum have no choice of where they are dispersed to even if they have family or community connections already in place in the U.K. (Ryan et al., 2008). Moreover, they are often placed within less ethnically diverse regions which do not have the adequate social welfare support and health services for this population (Audit Commission, 2000, Sales, 2002, Summerfield, 2001) leading to further isolation. Supporting dispersed asylum seekers with regards to their emotional and psychological needs proves more difficult due to the inadequate support systems. Ani (2007) believes it to be such a challenge as mental health clinicians within dispersal regions are unlikely to be familiar with the policies and agencies involved in caring for people seeking asylum. Those who wish to be placed with other family members can appeal to their caseworker, who should consider each case individually (Home Office, 2009) although it is made clear that most personal circumstances will not be sufficient to prevent dispersal. Whilst the policy of dispersal is controversial, due to the economic and political appeal, it is likely to remain in place indefinitely (Ani, 2007). Therefore it is necessary that appropriate services within these areas be developed (Audit Commission, 2000).

Isolation for this population leads to a further depletion in support resources. Ryan et al. (2008) believe the capacity of a person to manage stressful demands depends largely on access to resources which include personal, material, social and cultural

resources. Voluntary services within large cities such as London are able to provide many social and cultural resources. However, due to the lack of culturally diversity within some dispersal areas, voluntary services are few and far between and the risk of social exclusion and isolation is far greater than in urban centres (New Horizons, 2009).

5.5 Cultural differences

Mental health is not widely accepted as a construct by all international communities (Franks et al., 2007; Maffia, 2008). There is therefore an argument for the acknowledgement of the cultural differences in the expression of syndromes related to mental health (Fenton et al., 1996).

Summerfield (2001) believes that PTSD has become a 'catch all' diagnosis and that the critical features of PTSD are considered to be important to people seeking asylum in comparison to their other struggles. The differences in understanding symptoms of mental health illness is likely to contribute to the gaps in the assessment of the mental health of people seeking asylum and furthermore may lead to the over-representation of such communities within mental health care (Francis, 2005; Gharial, 2007). Eisenbruch 1991 (cited in Watters 2006) has argued that the profound sense of loss should be more clearly recognised in the mental health field and has proposed the establishment of specific psychiatric category of 'cultural bereavement'. The issues regarding culturally appropriate screening are discussed in detail with chapter six.

5.6 Re traumatisation

Post-migration events can contribute to the re-traumatisation of this population through re-telling of event during the asylum process (Mendeloff, 2009) or being imprisoned in detention centres (Keller et al., 2003). Furthermore, trauma counselling which is aimed at working through events as a form of treatment for PTSD has been doubted by some, suggesting that more harm can be done by reliving these experiences (Summerfield, 2001).

Ryan et al. (2008), when consulting with refugee charities regarding sensitive screening tools, found that the charities requested that questions on pre-migration trauma should be avoided in order to minimize the intrusiveness of the interviews. However, Eytan et al. (2007) established throughout their study, people seeking asylum rarely refused to answer questions regarding pre-migration events and frequently expressed a sense of relief that someone had finally put what they had been feeling into words. Although it must be considered that this was only based on a small sub section of the population and cannot be generalised.

5.7 Conclusion

Turner et al. (2003) believes it is probable that mental health problems will constitute the greatest health burden in refugee communities. Yet it is important to remember that refugees' reactions are normal reactions to abnormal situations (Bruntland, 2000) and may not necessarily require mental health input but rather a period of adjustment.

In summary, the U.K asylum process and other aspects of post-migration life place enormous demands on the asylum seeking population (Ryan et al., 2008). It is not a question of whether these people will experience emotional and or psychological difficulties, but more of how we can help minimise or resolve these. This population experiences massive social loss of all that is familiar; family, loved ones, language, culture, land, social status, contact with peer group (Maffia, 2008) and the services provided to them should account for such loses not exacerbate these through practices such dispersal, detention or destitution (Ani, 2007, McLoughlin, 2006).

Although there is a heavy suggestion that post-migration events have more of an impact on the emotional and psychological needs of people seeking asylum (Khawaja, 2008) it is important that the effects of pre-migration events are not overshadowed or dismissed. Steel's findings (2002) state that trauma exposure was the most potent and only consistent predictor of the current mental illness and that post-migration events appear to cause more of a social-based problem which results in distress rather than 'psychoses'. Steel (2002) concludes with the argument that post-migration 'stressors' might diminish after prolonged resettlement. This advocates the need for a holistic approach to care for people seeking asylum, combining the social and psychological needs of individuals (Maffia, 2008).

6 Screening

6 Screening

It has been discussed that both pre-migration and post-migration events contribute to the emotional and psychological effects of seeking asylum. However, the symptoms produced from experiencing such trauma and the significance of these symptoms is not clear as many are not easily characterised by western defined disorders such as PTSD and depression. Summerfield (2001) believes that a referral to mental health services may relate as much to assumptions made by the referrer as to the presentation of the person seeking asylum as to their actual need. There is an assumption that those with a history of torture are self evidently PTSD suffers (Summerfield, 2001) when this may not be the universal case. This creates a difficulty when screening for a defined diagnosis and has meant that there is no standardised assessment or screening tool which can be universally applied. Hollifield et al. (2002) found the data regarding refugee trauma and health status to often be conflicting and difficult to interpret because of the various methods and instruments used for data collection, analysis and reporting. This led to the development of their study which analysed 125 psychiatric instruments used in empirical studies for measuring trauma and health status in refugees. They found few of them to be reliable; out of these 125 only twelve of them had been specifically developed for the target populations.

Eytan et al. (2007) believe that people seeking asylum have a high risk of developing mental health problems yet that appropriate screening for trauma for those deriving from diverse origins remains a challenge. There are a number of different ways in which the literature reviewed for this dissertation has advocated for screening people seeking asylum for mental health symptoms. With so many different interpretations of

assessment methods it is no wonder the prevalence rates are as variable as Fazel et al. (2005) found.

There is a need for one model through which emotional and psychological needs are assessed (Fazel et al., 2005). This will allow for uniform assessment and therefore treatment throughout the U.K. Moreover, there is a need to move away from the desire to classify symptoms with a diagnosis. Summerfield (2001) argues that psychiatric models have never sufficiently acknowledged the role of social agencies or of the role of empowerment in promoting mental health. Involving these aspects would, in an ideal world, make services more appropriate and accessible. Developing such an assessment which incorporates the most relevant aspects of other diagnostic models and accounts for the reported diagnoses and stresses found in the research literature has been attempted within many of the studies reviewed.

Eytan et al. (2007) conducted a study into the transcultural validity of a structured diagnostic interview with the aim of producing a diagnostic instrument which could be used within primary care settings for people seeking asylum from diverse origins. Their interview comprised selected sections from the Mini International Neuropsychiatric Interviews (MINI) relating to PTSD and major depressive episodes (MDE). The MINI is a structured diagnostic interview based on DSM-IV criteria. With the use of interpreters the sections of this interview that were selected for this study were adapted in the context of the life of the study population. Eytan et al. further catered for the target population of their study as, although the interview had already been translated into 39 different languages, additional improvements were made by rewording questions if

they were ill adapted, culturally too direct or too complex for the level of language ability. The product of this was a French reworded version of the MDE and PTSD sections of the MINI. While the adaptations accounted for language differences, the DSM-IV is still a western model of diagnosis which assesses for western constructs of psychiatric symptoms and is therefore limited by this (Misra et al., 2006) and thus not wholly culturally valid.

The aforementioned interviews were carried out by general nurses whilst screening for health problems upon arrival in Geneva. The results were then judged against the results of a systematic clinical assessment carried out by a mental health specialist, either a psychiatrist or a psychologist, who were blinded to the results of the previous interviews. The results produced were similar, 30-34% for MDE and 24-29% for PTSD for the interviews and the specialist's diagnosis respectively. By using the specialist opinion, Eytan et al. were able to validate their diagnostic tool. Due to the significant number of diagnoses they concluded that screening for PTSD and MDE upon arrival to the host country should be at least an ethical concern if not a public responsibility.

Djuretic et al. (2007) carried out a series of focus groups and in depth interviews firstly to examine pre and post-migration factors that may explain the differences in levels of mental distress among these groups. Second to this Djuretic et al. hoped to use the qualitative findings to inform the development of a culturally sensitive questionnaire. This study used a sample of refugees from the former Yugoslavia who are now resettled in the U.K. However, this study focused more on the experiences of immigration and accessing support services as opposed to Eytan et al.'s focus on

mental health diagnosis. Djuretic et al. found that during interviews and focus group participants would express more concern regarding impaired social functioning rather than psychological effects when describing the impact on their experiences on their health. The focus group and interviews were carried out in the native language of the study population. Whilst this allows for improved validity and facilitated easier data collection, there is a question surrounding culturally biased answers. It could be the case that participants do not discuss issues related to mental health in detail if they believe that this issue is not culturally acceptable. Djuretic et al.'s findings support suggestions that the wider social issues have greater impact on their lives than pre-migration events. Therefore consideration of social issues should be included within the initial assessment of emotional and psychological needs. As this study was conducted in the U.K. it may be more valid than Eytan et al.'s although the culturally validity of these screening tools should be thought of in terms of being culturally appropriate for the population of the study as opposed to being applicable in a U.K. setting. When thought of in this way, both Eytan et al and Djuretic et al. used the native language of participants and adapted their studies to be more culturally appropriate. However, interpreters or native speaking assessors are not always available (MIND, 2009a). Hollifield et al. (2002) believes that inadequate resources, along with other methodological difficulties further complicate accurate measurement of mental health symptoms.

Robjant et al. (2009) carried out a cross-sectional questionnaire study into the psychological distress amongst immigration detainees. They used both the hospital anxiety and depression scale (HADS) and the impact of event scale-revised (IES-R) to measure the psychological distress experienced by these people. The HADS (Zigmond

and Snaith, 1983) is a 14 item questionnaire which has two subscales, anxiety and depression. The IES-R (Weiss, 1996) is a 22 item questionnaire measuring post traumatic disturbance which measures intrusion, avoidance and hyper arousal symptoms relating to the experience of any specific stressful events. Their study also included part one of the post traumatic diagnostic scale (PDS; Foa, 1995) which is a checklist of types of traumatic events which are associated with the development of PTSD. Finally, there was a purpose-designed biographical section which was included to gather demographic information which entailed briefly asking about social support. The large focus of this study was to assess the psychological distress experienced whilst in detention. Robjant et al. had clearly developed a thorough assessment questionnaire and accounted for the reported effects within the literature. Their results showed high levels of distress amongst both detained asylum seekers and those living in the community. However, there were higher levels of depression, anxiety and PTSD symptoms in those who were detained. However this study was limited by the fact that participants were asked to complete the questionnaire in English. This excluded many from answering altogether or at least in enough detail due to the lack language proficiency. This makes the reliability of the diagnosis of mental health problems questionable (Barnes, 2001).

6.1 Conclusion

Eytan et al. (2007) believe that the outcome for PTSD and MDE can be significantly improved with early intervention. Furthermore, Savin et al. (2005) believe that early detection and support could ease the stress of resettlement. If screening is not conducted and these needs are left unidentified and little or no help is provided there is further risk of poor health and social outcomes (Barnes, 2001). It is therefore

important that screening should be conducted upon arrival to the host country to allow time for adequate support and treatment. Savin et al. (2005) recommend that systematic mental health screening, psych-education and mental health referral should be incorporated into the initial public health examinations for all newly arrived asylum seekers. In addition it would be optimal to conduct screening in asylum seekers first language (Barnes, 2001).

7 Services

7 Services

Restriction to health care services have been reported to be detrimental to both the physical and mental health of refused asylum seekers (Kelley and Stevenson, 2006). Furthermore, the confusion regarding the eligibility to NHS care hinders those seeking asylum from receiving the care to which they are entitled. (CSIP, 2006, Joels, 2008, MIND, 2009a).

7.1 Access to the NHS

As discussed previously, the DH's stance on providing health care for people seeking asylum is forever changing (DH, 2006a; DH, 2008; DH, 2009b). Local health authorities are only officially able to do as the law allows them. However, the law can be interpreted in many different ways. As the CSIP (2006) found, some health authorities pick and choose which guidance and policies to follow. Delivering Race Equality (DRE) was developed in 2005 by the Department of Health (DH, 2005a). This was a five year action plan for all organisations responsible for mental health care to improve services for Black and Minority Ethnic (BME) groups in which those who seek asylum are included. The DRE sets out three main priorities; more appropriate and responsive services, community engagement and better dissemination of information. Yet by denying access to services for some of the asylum seeking population, these aims are not being universally endorsed. Furthermore the ideals of the DRE are not being met.

The DH's current position is that access to healthcare for failed asylum seekers is to be limited (Siva, 2009). Primary care is available at General Practitioners' (GP) discretion yet secondary care is unavailable unless it is paid for. CSIP argues that refusing treatment on the basis of payment is a contradiction of the first core principle of the U.K's NHS;

'The NHS will provide a universal service for all, based on clinical need, not the ability to pay.' (DH, 2006b)

Failed asylum seekers have no right to free treatment, no right to work and no means to pay (Joels, 2008). For some returning home is not a practicality due to continuing conflict in their home countries which leaves them faced with destitution in the U.K. (Faculty of Public Health, 2008; Refugee Action, 2006b) and therefore stranded with no access to health care (Refugee Council, 2003). Whilst it can be argued from a political point of view, that limiting access to healthcare will impede "health tourists" (Williams, 2005) and protect finite resources (DH, 2003b), it is wrong for the government to target the most vulnerable when there is no evidence that these people are seeking asylum for health gains (Williams, 2005) . Furthermore, although the DH's decision to limit entitlement to care only affects failed asylum seekers, MIND's report into improving mental health support for refugee communities found that even for those with entitlement to receive healthcare in England, it does not necessarily ensure effective engagement or outcomes (MIND, 2009a).

The regulations governing eligibility to healthcare have been accused of being confusing and open to interpretation (CSIP, 2006; Joels, 2008, MIND 2009a). Due to the frequent changes and apparent contradictions surrounding entitlements there is

confusion amongst many health care professionals as to what is the 'right' thing to do for those seeking asylum who need to access health services (MIND, 2009a).

A review of the progress of the DRE was conducted in 2009 (DH, 2009a) which found that often primary care staff are unsure about the rights of asylum seekers to treatment. This creates a further hurdle for people seeking asylum when trying to accessing care. This uncertainty has led to front line staff appearing ignorant of the needs of this population or at times wilfully obstructive in allowing people access to primary care (CSIP, 2006).

MIND (2009a) released recommendations for the mental health provisions for refugees and asylum seekers which they named 'A Civilised Society'. They believe that better dissemination of information should be found throughout all sectors involved within asylum seeker care. Whilst this would surely alleviate such confusion as to who has entitlements, it will not be able improve the situation for failed asylum seekers as they will still have no legal rights to receive free care. For some, the generosity of nurses and other healthcare professionals who are willing to help, despite the restrictions, is the best they can hope for (Refugee Action, 2006b) although these are few and far between and illegal.

7.2 Access to Mental Health Services

Mental health services are for the large part within secondary care services and therefore not available to all those seeking asylum. The Sainsbury Centre for Mental Health (2002) noted that mainstream mental health services were difficult for BME groups to access. It often falls on the voluntary sector or primary health care services to cope with the complexities of the needs of this population (Bahtia and Wallace, 2007) who are often without the resources and or the full understanding of how to help effectively (Maffia, 2008).

The Wellbeing Project, ran by Refugee Action was examined by Maffia in 2008. She concluded that involvement with mental health services can be stigmatising and damaging to individuals who come from cultures and background whose understandings of mental health differs from that of the west.

New DH guidelines on commissioning mental health services for asylum seekers are due to be published later this year (MIND, 2009a). MIND are hopeful that their recommendations set out in 'A Civilised Society' will be largely influential on the DH's decisions for these guidelines. Nevertheless, MIND (2009a) does recognise that the majority of those seeking asylum who are experiencing mental health distress do not meet the criteria to warrant referral to secondary care services. However, Woodhead reporting for the King's Fund (2000) emphasises that the needs of these people are far too complex to be met solely by short term primary care interventions. In light of this, the DH's focus for mental health care for asylum seekers should be to improve primary

care services along with improving non-mental health professionals' knowledge of the needs of this population in order to bridge this gap.

7.3 Access to Primary Care Services

GP's become a point of access to services for people seeking asylum when there are few other ways in which they can access help (Summerfield, 2001).

Bhatia and Wallace (2007) conducted a series of interviews in a walk-in centre in North London which catered for people seeking asylum who were having difficulties accessing health, housing, employment, interpreting and legal services. These interviews produced three main themes; difficulties in accessing the healthcare system, the impact of these difficulties and improvements they would like to see in the future.

On first arriving to the U.K. it would be helpful for people seeking asylum to be given accurate information regarding entitlements to care along with information of local GP practices with whom they will be able register (Bhatia and Wallace, 2007). While the DH does provide an introduction to the NHS in a number of different languages this has not been updated for the past five years (DH, 2005b). Bhatia and Wallace (2007) believe that this could be improved by Primary Care Trusts (PCT) working together with local refugee agencies and the Home Office to keep up to date information regularly available.

The general lack of interpreters within PCT's is significant (Summerfield, 2001) and due to language difficulties GP's understanding of patients needs is limited, some symptoms may be misinterpreted and go untreated because of this and may lead to few appropriate referrals to secondary care (Bhatia and Wallace, 2007). Interpreters are sometimes used throughout the NHS. However, these are expensive and often unreliable (MIND, 2009a). Some use relatives or friends although this practice is thought by GP's to be inappropriate and there are many ethical concerns over the use of lay interpreters especially when children are used (Bhatia and Wallace, 2007). As a rule professional interpreters are to be used when available (Barnes, 2001).

Franks et al. (2007) found that many people seeking asylum found GP surgery environments to be intimidating. Bhatia and Wallace (2007) believe that perceived stigma could interfere with the willingness of people seeking asylum to access care when they need it. A review of the DRE (2009a) reported that in some cases those seeking asylum found there was a lack of sensitivity to their situation. For example, one asylum seeker reported that;

'My GP gave me a diagnosis of 'Asylum Seeker' on a sick certificate. Being an asylum seeker is not an illness. I felt very depressed and angry.'

However, it could be argued that this hostile environment is more a result of lack of understanding. Franks et al. (2007) believe that in order to work effectively with diverse populations, different culturally understandings of mental health need to be taken into account. Maffia (2008) argues some professionals may feel out of their

depth and that they do not have the expertise to cope with experiences so far removed from anything they have encountered before. Furthermore, Maffia (2008) believes that if healthcare professionals were to have the insight into the way in which culture shapes world views and are willing to bear this in mind when treating individuals and to question respectfully and listen and learn constructively, then the relationship process can be very therapeutic. Public consultation for the DRE (2005) also recommended that mental health professionals should receive better training to deliver care in a 'culturally competent way'. In a national study of race related training by Bennett et al. (2007) it was found that 91% of organisations provided such training for their employees. However, they also found that most of training had a 'generic focus' and thus suggested the need for inclusion of more service user based information which could be applied to practice as otherwise the training turns more into 'a meaningless collection of exotic trivia' as argued by Ferns (2003).

With regards to other forms of support, many people turn to family or friends during times of difficulty (Khawaja, 2008) and they usually become a good source of information regarding support services available (Bhatia and Wallace, 2007). However, as discussed previously, due to the policy of dispersal people are being separated from communities in order to relieve the burden of over populated London.

7.4 Voluntary services and Refugee Community Organisations

The limitations to current service provisions have led to over reliance on already heavily burdened voluntary services (CSIP, 2006). The voluntary sector is usually run by those who have had similar experiences and wish to provide help to others. They are able to ensure appropriateness of care from an 'insider' perspective which is, as

Clarke (2003) suggests, the best way to address sensitive issues within ethnic cultures. For people seeking asylum practical help can be sought through Refugee Community Organisations (RCO). While no single definition of a RCO exists, Griffiths et al. (2005) believe 'they are refugees serving their own people'. MIND (2009b) produced a report for RCOs that aims to develop mental health advocacy and more effective engagement with services. The report was also aimed at primary health commissioners and staff who wish to work more successfully with those seeking asylum. In a sense this report has recommended guidelines for working with this population. At the outset of MIND's project, very few RCOs had the confidence or knowledge to advocate on mental health issues. It was felt that with education into mental health and the services available, RCO's would have a better understanding and therefore be able to advocate for those seeking asylum who required mental health service efforts.

Misra et al. (2006) interviewed community representatives from the asylum seeking population and they highlighted a need for more practical solutions such as constructive engagement of the unemployed, addressing boredom and isolation, and support such as language lessons and vocational training courses. Involvement with RCO's has been said to have considerable impact on the self esteem and wellbeing of people seeking asylum (MIND, 2009b). Maffia (2008) believes empowering an individual can enable them to support others within their community and by offering language and vocational courses it can lead to those who seek asylum to feel as though they are contributing to society (Misra et al., 2006).

7.5 Conclusion

Lack of knowledge and understanding of both services and those seeking asylum appears to be a major concern with regards to people seeking asylum accessing services (MIND, 2009a). There needs to be a multi agency approach to service requirements and needs (Watters, 2006). This involves improving pathways into care and allowing voluntary agencies to refer to statutory services (MIND, 2009a). This may lead to over referral by voluntary sector staff in the beginning due to lack of understanding of mental health needs. However, as many people seeking asylum only have contact with voluntary agencies there is a need for services to work together rather than alone. It would be valuable for PCT's to provide education and training along with regular updates to GPs and others who work with this population regarding their needs and entitlements to care (Bhatia and Wallace 2007; MIND 2009a; WHO, 2003).

Although this chapter has focus heavily on the barriers to accessing care it is not to say that people seeking asylum receive no input from NHS services. There are services, mainly within London (Joels, 2008), which work closely with people seeking asylum. The Three Boroughs Primary Health Care Team (Refugee Health Team, 2008) are a multidisciplinary team which provides a holistic approach to care with access to both general and mental health services. They work effectively with the community, signposting people to other services which can help with practical needs. However, there is still a great need for specialised services of this population which are available not just within the capital but all over the U.K. The National Asylum Support Service

(NASS) is the government body that is usually responsible for looking after people who are seeking asylum in the U.K. (Islington Council, 2009). However Refugee Council (2005) believe that NASS support has insufficient information available regarding the provision of health service support within all the dispersal areas in the U.K. which needs to be improved.

8 Implications for mental health nursing

8 Implications for mental health nursing

As discussed throughout this review, there is yet to be a uniform coherent stance of the mental health care needs and therefore services available for those seeking asylum. There is a clear need for services which address the emotional and psychological needs of these people in context of the individual cultural and linguistic needs.

8.1 Service improvements

Currently there is a much needed emphasis on improving the quality of mental health care for BME communities (DH, 2005a) in which those who seek asylum are included. However, as discussed throughout this dissertation there is a clear need for individual refugee and asylum seekers services and policy directives. Hopefully with the publication of MIND's civilised society (2009a) policy documents and government help will be developed and implemented in the next few years which will take into consideration their recommendations. This will allow not just mental health services but indeed all care services to understand their role in improving the quality of life for those seeking asylum in the U.K. The researcher understands that MIND's vision of a 'civilised society' is very much idealistic yet feels that by setting the benchmark high then services should be able to understand just how large the gap in service provision is for this population. There is a need for public understanding of the complex issues which are faced by people seeking asylum (Pearce et al., 2009). This is not to say that all of the experiences discussed within this review will be experienced by each person

who hopes to seek refugee within the U.K. but the researcher feels that there is a need for these to be explicit. A better understanding of the experiences of people seeking asylum will surely decrease the stigma surrounding this group.

There needs to be an overall improvement in the dissemination of information to both health services and those seeking asylum (DH, 2005, MIND 2009a; 2009b). Many people seeking asylum have no prior experience of accessing a primary care services as a gateway to care (Siva, 2009) and with the lack of up to date information (DH, 2005b) it is to be expected that people will be confused as where they may be able to access care.

The use and availability of interpreters ought to be improved greatly in conjunction with education for interpreters with regards to mental health. Language difficulties have been problematic during asylum process interviews (Herlihy et al., 2007) screening for mental health illness (Djuretic et al., 2007) and accessing care services (Bhatia and Wallace, 2007).

What is important, something which the Refugee Action acknowledged with the Wellbeing project, is to remember that there is nothing which healthcare professionals can do to change what has happened before arrival to the U.K., nor the way in which the Home Office and the asylum process operates (Refugee Action, 2009). However we can work to help people rebuild their lives, promote a feeling of safety and begin to learn about their cultural needs in order to approach care in a holistic way (Maffia, 2008).

8.2 Collaboration between statutory and voluntary services

Currently there are many charities and RCO's working tirelessly to improve the quality of life for this population and at times without the financial or outside support from statutory agencies to fully meet the mental health needs of people seeking asylum (MIND 2009b). Despite this, the work they carry out is extremely beneficial and can be used as a building block for statutory services to work alongside especially within dispersal areas. The Three Boroughs Refugee Health Team in London (Refugee Health Team, 2008) work in partnership with the local voluntary sector providing care within day centres, community organisations as well as GP practices to improve access to Primary Health Care. There is a need for more PCT's to develop such services in order to breach the gaps identified.

Many charities work hard to develop research which they hope will be used by service providers and policy makers to provide more appropriate care (MIND, 2010; Researching Asylum London, 2010). Refugee Action runs projects across the U.K. which work towards improving access to mainstream services and enhancing opportunities for people seeking asylum to become more independent (Refugee Action, 2010).

Through the work Refugee Action and the Refugee Council have conducted with RCO's (MIND, 2009b) it has been recognised that there is a need to provide support for RCO's to help develop their services in order to help the wider populations of asylum seekers in the U.K. The Basis Project (2010) is a new service working across England

which has been funded for the next five years to provide support to the hundred's for RCO's in helping them manage, develop and sustain their work.

Unless the DH alter their stance and allow access to services for all asylum seekers then the care provided to promote their emotion and psychological wellbeing will have to continue to be met through voluntary and community organisations.

8.3 Improvements to the asylum process in the U.K.

Although not a nursing implication essentially, it would be imprudent not to mention this factor. The current U.K. asylum process has been noted throughout the research to be detrimental to the emotional and psychological well-being of those seeking asylum. As this is a uniform service which has contact with all those who choose to seek asylum within the U.K. it would be advantageous to the well-being of this population if the services were to be improved. Whilst this may not be easily attained, there should be a moral responsibility for those who work within the Home Office and deal with the asylum process to be aware of the negative impact the process has on a person's emotional and psychological health. MIND (2009a) believe that due to the detrimental impact the asylum system in the U.K. has on the mental health and wellbeing of those seeking asylum it makes the provision of mental health support even more crucial.

9 Limitations

9 Limitations

9.1 Limitations of this review

Whilst people seeking asylum are one of the most vulnerable groups within the U.K.'s society, within this group there are some individuals who are more vulnerable still (Bruntland, 2000). About 9 million of the world's 13 million refugees live in developing countries and about half of these are children. However, most mental health screening research regarding the mental health wellbeing is conducted in adult refugees in the West (Fazel et al., 2005).

This review only researched into people seeking asylum within the western world where services, although evidently restricted, are essentially available. This was due to the literature reviewed being mainly conducted in the U.K., America or Australia. Unfortunately, the breadth of this subject area was far beyond the capacity for this literature review and owing to the importance of the mental health needs of asylum seeking children and of the support and services provided in developing countries the researcher did not want to merely mention it briefly within this review as this may mask the complexity of need. Further critical reviews of the literature would be necessary to make recommendations for the services needed to improve the wellbeing of asylum children and those seeking asylum within developing countries.

The researcher used the term people seeking asylum throughout this review. Whilst recognising this grouped a large population of refugees, asylum seekers and other

displaced people as one, it was simply for ease. However, for the large part, the literature focused on those with refugee status. There is little research been carried out with the sole focus on the asylum seeking population (Ryan et al., 2008) and although Silove et al. (1998) compared levels of distress between refugees and asylum seekers and found no differences in distress levels experienced by both, there are understandably differences in their experiences in post-migration life.

9.2 Limitations of the research process

Searching the online journals produced vast amounts of research when the terms were searched on their own. This, however, was not the case when combining the terms to find the relevant research for this review and the results were limited. The researcher, however, found it useful once accessing the combined searches to look within the reference lists of the journal articles to point out further reading. As this topic is becoming more of a front line issue (DH, 2005, MIND, 2009a) the research found is relatively new and up to date providing the researcher with the desired current literature review.

The choice of conducting a critical literature review allowed the researcher the freedom to expand their knowledge of the subject area and for the ongoing development of a critical thinking writing style. The formation of the review itself changed dramatically throughout the process as the researcher acquired a greater depth of knowledge into the issues and experiences of those seeking asylum in the U.K. On completion of the review the researcher believes that, due to the vast complexities and difficulties

experienced by this population, this review only serves as an introduction to these and would like to emphasise the need for further in-depth reviews to be conducted within each chapter in order to develop more thorough recommendations.

The researcher did at times find it difficult to separate the literature into individual chapters due to the interlinked nature of the arguments posed by the literature. The process required organisation, commitment and enthusiasm on the researcher's part and has vastly improved the researcher's critical writing and thinking skills. This research has also inspired the researcher to keep up to date with upcoming developments in this area of mental health care with the hope that the new DH guidelines due to be developed this year will greatly improve the quality of services for this population.

10 Conclusion

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It has been discussed that the emotional and psychological needs of those seeking asylum are complex in nature. Many experience horrific events during pre- migration which most people will never comprehend. The impact of these experiences can be life altering and the emotional and psychological effects great. On entering the U.K., for many these effects are heightened, if not overshadowed, by the asylum process and the experiences of attempting to resettle in the U.K. There are huge inequalities faced by this population including limited access to funds, health care, employment and accommodation (MIND, 2009a). Considering reduction of inequalities is a government priority there should therefore be strategies which include action to address the needs of people seeking asylum (Faculty of Public Health, 2008). There needs to be further improvements across all areas with which those seeking asylum come into contact in order to lessen the emotional and psychological burdens placed upon this already vulnerable population.

The emotional and psychological wellbeing of people seeking asylum should be a multi agency concern. It is not plausible that these issues will be resolved in the short term and by solely improving access to mental health care. Watters (2006) believes that in order to do justice to the complexity of this issue there needs to be a multidisciplinary approach which embraces political, social and healthcare services and the impact these may have on the contexts in which refugees receive mental health care. The British Medical Association (BMA) calls on the government to allocate sufficient funds and implement effective policies to ensure that the health of this minority group does not deteriorate in the U.K. (BMA, 2009).

However, it is not only the healthcare needs which need to be met. Franks et al. (2007) argues that mental health problems have been found to be a lesser priority amid the many social and material challenges of making a life in the U.K. due to the heavy restrictions placed upon them. For this reason providing counselling or psychotherapy alone may not be the most appropriate way of improving mental wellbeing. There is an argument that host societies offer people seeking asylum a 'sick role' rather than what they really seek: opportunities for meaningful lives and a chance to rebuild a new home (Summerfield, 2001). Refugee Council have been campaigning to allow asylum seekers to work. They believe that by being able to work it will combat destitution, benefit the economy and community along with aiding integration and re-skilling asylum seekers in order to offer them a better future (Refugee Council, 2010a).

Preventing the development of mental health problems is of crucial importance within this group of people and should be given high priority (Maffia, 2008). Furthermore Savin et al. (2005) believe that with early detection the process of healing wounds inflicted by traumatic past experiences can begin much earlier. With this healing, people seeking asylum will be more able to contribute to their families and to society and start to rebuild their lives. Furthermore, they will also be more proficient in coping with the added pressures inflicted on them by the currently restrictive policies of the Home Office.

Whilst early intervention has been a priority within mental health care for a number of years now with the development of the early intervention in psychosis teams (Positive,

2010), there appears to be no such services available for those seeking asylum. Health screening upon arrival to the U.K. does not appear to be standard practice unlike in Geneva as Eytan et al. (2007) found. They concluded that in order to be efficient and to have a public health impact, screening should be made possible without recourse to mental health specialists. Allowing for mental health problems to be detected by the Home Office officials during the initial screening would improve the chances of early detection and therefore treatment. The BMA also recognises the need for physical and mental health screening as soon as possible in order for the appropriate treatment and support to be provided (BMA, 2009). As Eytan et al.'s (2007) interviews were conducted by general nurses as opposed to mental health trained staff it may be that the structured diagnostic interview used within this study is one of the more appropriate to be used within initial screening at least in the sense that the needs are being addressed at the first encounter.

There was a consensus within the literature that frequent changes in the policy and entitlements to care caused confusion and became a barrier to accessing services itself. Joels (2008) believes that nurses, in particular, as patients' advocates, need to have better policy awareness to help those seeking asylum to obtain the services they need, while also adhering to their professional and ethical codes.

Cultural awareness is especially important when caring for refugee populations (Bhatia and Wallace, 2007). Morris et al. (2009) believe that whilst maintaining the culture of a person's place of origin can often provide comfort to newly arrived asylum seekers it can at times create its own barrier to accessing healthcare systems of the host society.

They believe that the cultural stigma and lack of understanding of mental health needs can prevent those seeking asylum from looking for access to care. Whilst Djuretic et al. (2007) found that preserving one's culture was a protective factor as it created a sense of belonging, they also found that some people felt a sense of 'liberation' coming to the U.K. as they believed they could freely communicate their mental health needs and access the applicable services.

Refugee Action (2006b) believes there is a new and growing excluded class of people within the U.K.

"those whose asylum claims have been refused, who are unable to return to their countries of origin, who have no contact with the authorities, no access to work or mainstream support services and little prospect of their situation being resolved."

Destitution has an undeniable impact on a person's emotional and psychological wellbeing. Many live in abject poverty and have been driven to give up hope of ever regaining a sense of a 'normal' life. Still Human Still Here is a national campaign run with the combined help of many organisations with the hope bringing an end to destitution in the U.K. They aim to extend asylum support, to be granted permission to work and access to health and education until the time of departure from the U.K. or they are granted leave to remain (Refugee Council, 2010b , Still Human Still Here, 2009).

Those seeking asylum are a resilient population (Turner, 2003) yet life within the U.K. for this vulnerable minority is testing and in many ways not conducive to recovering from traumatic events. The situation needs to improve greatly for this population in order to promote emotional and psychological wellbeing. As Refugee Action (2006b)

have previously argued, irrespective of their current status those who seek asylum should have their needs identified and be offered appropriate care and support which is consistent throughout their stay in the U.K.

11 Reflections on the dissertation process

11 Reflections on the dissertation process

From the outset of this dissertation I have gained extensive knowledge and understanding not only in the area of asylum seekers and mental health care but also in the importance of cultural understanding and culturally appropriate care.

I originally chose to conduct my own research into the narrative formation of stories of the asylum process. However, due to deliberation from the Medical School ethics board I had to abandon my original proposal due to the lack of time. The subject area was still a great interest of mine and after consulting with my supervisor the decision was made for a critical review of the literature to be conducted.

Deciding to conduct a critical review of the literature whilst allowing me the room for deeper exploration into the subject area, did at times overwhelm me. As discussed in the conclusion, this led me to believe that the subject area was too vast to be condensed into such a small amount of words and thus I may not have been doing justice to the topic area. However, the aim was to develop a broad literature review, encapsulating the emotional and psychological needs of people seeking asylum and I hope I have expressed throughout this review the significance of these needs.

During the final weeks of the assignment I discovered the need for organisational skills especially with regards to time keeping. Whilst I struggled at times to balance placement and completion of my dissertation I was reminded through my work at the

Department of Psychological Medicine the reason for which I was inspired to research this area. I worked alongside experienced nurses who welcomed my opinion on caring for this marginalised population and who were appreciative of the information I could pass on to them. This motivated me to complete my dissertation. I am extremely happy with my completed work and hope that it has been informative, captivating and has raised issues that some readers may not have considered before.

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