Refugees and asylum seekers in Europe

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Keywords
Ethnic minority groups, refugee and asylum seeker, mental disorders, mental health services, legislation

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According to Rechel et al. (41), migrants make up a growing share of European populations, but immigration is politically controversial and the need for continued immigration to Europe is still poorly recognised. Bhugra et al. (4) emphasise that refugees and asylum seekers constitute one of the groups at the highest risk of developing mental disorders and are among the most vulnerable groups in society. Due to war, social or political instability, or socio-economic, familial or administrative conflicts, they have frequently been subjected to physical, sexual and/or psychological violence and traumatic bereavement. The proportion of traumatised people with a serious mental disorder – including disorders that are not trauma-related – is very high, and the healthcare systems which are currently in place are not prepared for this specific group of traumatised migrants. Frequently, they have experienced not just one single trauma, but multiple trauma, as well as hardship related to both pre-migration and migration experiences (4). Additionally, they often have difficulties in the new host society. Immigrants and refugees, especially those who are newly settled, often have poor knowledge about how the healthcare system works, what help they can obtain, or how to communicate their suffering and need for help in an understandable
way (1, 24). It is therefore necessary for all mental health professionals to be sensitive to cultural and contextual aspects of communication (2, 43). Cultural sensitivity and culturally competent services are some of the key concepts in mental healthcare services for these minority groups (39, 43). For refugees and asylum seekers, specific targeted services may be needed, at least in the initial stages (43). This article will give an overview of the current mental health situation for refugees and asylum seekers in Europe.

Statistical data

According to the UNCHR (47), “refugees include individuals recognised under the 1951 Convention relating to the Status of Refugees; its 1967 Protocol; the 1969 OAU Convention Governing the Specific Aspects of Refugee Problems in Africa; those recognised in accordance with the UNHCR Statutes; individuals granted complementary forms of protection; or those enjoying temporary protection. The refugee population also includes people in a refugee – like situation” (47, p. 56). Also according to the UNCHR, “asylum seekers are individuals who have sought international protection and whose claims for refugee status have not yet been determined, irrespective of when they may have been lodged” (47, p. 56). By the end of 2013, 51.2 million people had to leave their living places for reasons of persecution, conflict, generalised violence or human rights violations. By the end of 2014, this number had increased to 59.5 million individuals, 8.3 million more people than the year before (47). The 28 Member States of the European Union (EU) registered 301,000 individual asylum seekers in 2012, and in 2013, this number increased to 396,800. The highest statistic was registered in 2014, however, with 570,800 new asylum seekers. This is a 44 per cent increase compared to 2013. The record number of newly registered asylum seekers was registered in Southern Europe and Turkey, where in comparison to 2013, the number increased exponentially in 2014 to 170,700. This is an increase of 95 per cent in comparison to 2013. The main recipient countries in 2014 were Italy and Turkey (48). The Syrian Arab Republic, Iraq, Afghanistan, Serbia / Kosovo and Eritrea were the five top regions from which asylum seekers came and registered for asylum in the 44 industrialised countries in 2014. Over the last five years, Syria has remained the main country of origin of these asylum seekers. In the years between 2010 and 2014, Sweden was the country which received the largest number of asylum seekers with 24.4 asylum seekers per 1,000 inhabitants, while Belgium received 8.3, Malta 17.5 and Germany 5.3 (all per 1,000 inhabitants) (48).

Epidemiology of post-traumatic stress disorders

Breslau (5) reported that between 15 and 20 per cent of people exposed to traumatic events experience symptoms and impairment lasting for several days or weeks (5). The overall prevalence of post-traumatic stress disorder (PTSD) among women was twice as high as for men, but for some age-groups the female: male ratio approached 3:1. The conclusion of the researchers was that for a better understanding of the development of PTSD, reproductive factors and social responsibilities ought to be taken into consideration (9). According to Kirmayer et al. (21), a major component of the PTSD syndrome is subserved by a conditioned emotional response of ‘fear.’ Reminders of the context where threat originally occurred evoke anxiety, and this is managed by cognitive and behavioural efforts to avoid such contextual cues, resulting in emotional numbing and withdrawal (21). Epidemiological studies in the general population show that the psychological consequences do not occur in all those who experience traumatic events, but appear only in a fraction of those exposed to such events; the traumatic event itself therefore does not sufficiently explain why post-traumatic stress disorder develops or persists (or diminishes) with the passage of time (50). According to Kessler et al. (20), the estimated lifetime prevalence of PTSD in the general population is 7.8%. The authors underlined that the traumas most commonly associated with PTSD are combat exposure and witnessing violations among men and rape and sexual molestation among women. Furthermore, its occurrence depends on various risk factors. In a meta-analysis of risk factors for post-traumatic stress disorder in trauma-exposed adults, Brewin et al. (7) described factors such as gender, age at trauma, and race as predicting PTSD in some populations but not in others. Additionally, they listed factors such as education, previous trauma, general childhood adversity and psychiatric history, reported childhood abuse, and family psychiatric history as having more uniform predictive effects. Brewin et al (7) worked out that individually, each of the risk factors had only a modest effect, but that factors operating during or after the trauma, such as trauma severity, lack of social support, and additional life stress, had somewhat stronger effects than pre-trauma factors. Breslau (6) documented the protective effects of higher levels of intelligence, independent of social and educational status (6). Mazur et al. (31) reported that 60% of asylum seekers suffer from psychological disorders with an important comorbidity of PTSD and depression (64.2%). Furthermore, the authors pointed out that the seriousness of the symptoms was correlated with less adaptive defence mechanisms (a higher incidence of defence mechanisms such as acting-out and
distorted self-image). It is very important to take all of this information into consideration when dealing with traumatised refugees and asylum seekers, who are at a high risk for mental disorders such as PTSD.

**Mental health of refugees and asylum seekers**

**Adults**

Refugees and asylum seekers often have traumatic experiences in their host countries prior to, during and after migration, on arriving in the receiving countries (4). The reported rates of post-traumatic disorders are often high, lying between at anything from 3 to 86 % among refugees and asylum seekers who have experienced physical and sexual violence, torture, loss of family members and persecution (4). The very large range is partly due to differences in methodology and study populations. In a meta-analysis, Lindert et al. (29) pointed out that the rates of common mental disorders (CMD) is twice as high in refugee populations in comparison to economic migrants (40% vs. 21%). Fazel et al. (12) found in a systematic review that refugees who resettle in certain Western countries are around ten times more likely to have post-traumatic stress disorder than age-matched general populations in the same countries (USA, Australia, Canada, Italy, New Zealand, Norway and UK). The authors underlined that worldwide, tens of thousands of refugees and former refugees who have resettled in Western countries are likely to have post-traumatic stress disorder (12). In a study which aimed to describe, compare, and predict mental health outcomes among different migrant groups and native residents in Switzerland, Heeren et al. (15) reported that asylum seekers, refugees and illegal migrants showed high psychiatric morbidity. Significant percentages of asylum seekers (54.0%) and refugees (41.4%) fulfilled criteria of PTSD. Clinically relevant symptoms of anxiety and depression were reported by asylum seekers (84.6%) and illegal migrants (both 63.1%, resp.) and illegal migrants (both 47.6%) (15). Slewaw-Younan et al. (46) reported that PTSD was found to vary from 8 to 37.2 %, with depression fluctuating more widely, ranging from 28.3% to 75% amongst Iraqi refugees located in Western countries. Refugees who have been exposed to severe violence often have chronic pain or other somatic syndromes (22). Laban et al. (26) could prove that the risk of PTSD and CMD in asylum groups increases with the length of time the person is in a waiting position after their application for asylum. Porter and Haslam’s (38) meta-analysis documented that refugees had worse outcomes if they were older, better educated, female and had higher a socioeconomic status and rural residence prior to displacement. Other risk factors were unemployment, absence of family support and complicated asylum processes (27). Schweitzer et al. (44) found evidence among refugees from Sudan for a history of traumatic events. Less than 5% met the criteria for post-traumatic stress disorder, but 25% reported clinically high levels of psychological distress. The authors believe that these results indicate that social support – particularly perceived social support from the migrant’s ethnic community – plays a significant role in predicting mental health outcomes. They brought to light that pre-migration trauma, family status and gender were also associated with mental health outcomes (44). Gupta (16) pointed out that PTSD is associated with ill-defined or medically unexplained somatic syndromes such as, e.g. dizziness, somatoform syndromes, several medical conditions such as cardiovascular, gastrointestinal, pain and sleep problems.

**Children and adolescents**

Regarding the psychological impact of disasters, many studies report that women and girls report more emotional problems, stress, depression and PTSD than males, often aggravated by the difficulties of caregiving (13). Child and adolescent refugees suffer most often from significant conflict-related exposures (30). Montgomery (35) reported that the reactions of the children do not necessarily constitute post-traumatic stress disorder. 77 % suffered from anxiety, sleep disturbance and/or depressed mood upon arrival in the host country. The author found that sleep disturbance (with a prevalence of 34%) was primarily predicted by a family history of violence. At follow-up, 25.9% suffered from clinically relevant psychological symptoms such as defiance, hyperactivity, aggression or antisocial features. Montgomery (35) underlined that traumatic experiences before arrival and stressful events in exile predicted more internalising behaviour, while witnessing violence and frequent school changes in exile predicted more externalising behaviour. In this review of four empirical studies in Denmark, Montgomery (35) described that school participation, having Danish friends, language proficiency and the mother’s education also predicted more internalising behaviour (35). Fazel et al. (11) undertook a systematic search and review of individual, family, community, and societal risk and protective factors for mental health in children and adolescents who were forcibly displaced to high-income countries. The authors found that exposure to violence has been shown to be a key risk factor, whereas stable settlement and social support in the host country have a positive effect on the child’s psychological functioning.
Mental healthcare in Europe

Information about the health of migrants, particularly refugees and asylum seekers, is scarce in Europe, which makes it difficult to monitor and improve migrant health (40). One of the most fundamental barriers for migrants, refugees and asylum seekers in accessing health services in Europe are inadequate legal entitlement and, where entitlement exists, mechanisms for ensuring that they are well known and respected in practice (36). The problems are greatest for asylum seekers and undocumented migrants (18). Mladovsky et al. (33) collected data from health policy experts in 25 European countries. By 2009, only eleven countries had established national policies to improve migrant health that go beyond migrants’ statutory or legal entitlement to care. The authors asserted that the analysis of migrant health policies in Europe is still underdeveloped and that there is an urgent need to monitor the implementation and evaluate the effectiveness of these diverse policies. In another study of 16 EU countries in 2008 two countries (Romania and Slovenia) still requested that asylum seekers cover the full cost of secondary and hospital care and of most drugs (41). Within the EU and across the rest of Europe, huge differences exist in national asylum policy regimes and how easily countries grant long-term residency status and citizenship, which have consequences for access to health and other social services (41). With regard to undocumented migrants, many countries in Europe restrict entitlements to health services in the belief that this will discourage the entry of new migrants (34). Undocumented migrants are in this sense a particularly vulnerable group, many being likely to be exposed to further trauma in the host country; certain groups such as trafficked women may be kept under highly degrading and traumatizing circumstances.

One of the greatest problems is that of language barriers, undermining both the accessibility of health services for migrants and their quality. Kluge et al. (24) conducted structured interviews with health services located in areas with high immigrant populations in 16 European countries (n = 240). The authors collected responses on the availability of data on service use by immigrant patients, the provision of interpreting services and immigrant staff members. They found that data on service use by immigrants were recorded by only 15% of services. More than 40% of services did not provide any form of interpreting service and 54% of the services reported having no immigrant staff. Kluge et al. (24) documented that mental health services were more likely to use face-to-face services, and both mental health and emergency services were more likely to have immigrant staff members (24). Other barriers include a lack of familiarity with rights, entitlements, and the overall health system, gaps in health literacy, social exclusion, and direct and indirect discrimination (34). Lederbogen et al. (28) report that stigma and social exclusion also affect the recovery process and social participation itself, including participation in the healthcare system. According to Rose et al. (42), stigma is considered to be an amalgam of ignorance and stereotypes, prejudices, and discrimination (42). Subsequently, alienation and stereotypes are mobilised related to that group, in turn leading to ignorance and prejudice, and thus causing discrimination and stigmatisation not only against that specific group of ethnic minorities, e.g. asylum seekers, but also against all immigrants (25). Additionally, perceived discrimination contributes substantially to the prevalence of depression in ethnic minority groups (17). In order to assess and improve the quality of care provided for ethnic minorities, including asylum seekers and refugees, there is a great need to improve the availability of data on their service utilisation throughout Europe and to provide more consistent access to interpreting services (24). The aim should be to reduce the barriers so that these groups reach the same level of utilisation as patients of the background population.

Cultural competence in mental health care

In dealing with ethnic minorities, including asylum seekers and refugees, mental healthcare professionals should be culturally competent, which is defined as the ability to understand and be aware of cultural factors in the therapeutic interaction between the therapist and the patient (3, 19, 39, 43). Several publications underline that cultural competence represents a comprehensive response to the mental health care needs of immigrant patients and requires knowledge, skills, and attitudes which can improve the effectiveness of psychiatric treatment (23, 39). Based on an awareness of the fact that therapists see each patient in the context of the patient’s culture as well as their own cultural values and prejudices, cultural competency comprises cultural sensitivity, cultural empathy and cultural insight (3, 32, 43). Therefore, it is necessary that cultural competence should be considered both at an individual/clinical level as well as at an institutional level (14, 37, 39, 45). On the institutional level, legal imperatives can lead to proper and prompt change especially when related to languages, monitoring for adherence and availability of culturally appropriate structures such as food and rooms for prayer (43). On the individual level, the key principles are related to clinical features such as listening carefully to the patient, eliciting information on the psychopathology in a culturally appropriate manner and assessing needs and suggesting changes in management
Using the Cultural Formulation Interview (CFI) can help to obtain information during a mental health assessment about the impact of culture on key aspects of a patient’s clinical presentation and care. According to DSM-5 (10), CFI may be especially helpful when there is difficulty in diagnostic assessment owing to significant differences in the cultural, religious, or socioeconomic backgrounds of patients, uncertainty about the fit between culturally distinctive symptoms and diagnostic criteria, difficulty in judging the severity of an illness or impairment (10). Communication between psychiatrists and patients of different cultural origins with differing language capacities is sometimes impossible without the help of interpreters. Therefore, psychiatrists and other mental health professionals should develop conceptual models, skills, and experience for conducting cross-language interviews using interpreters (43, 49). Language ability plays an essential role in the ability of ethnic minorities to utilise the healthcare system (43). The provision of enhanced culturally and linguistically sensitive services may support these groups to utilise the healthcare system more (8). Non-professional translators (family members, members of hospital staff etc.) can have a negative impact on medical treatment due to erroneous translation in the form of omissions, additions, or indeed changes to the initial message: furthermore, using children as interpreters should be avoided, as this may confront them with matters that could be traumatic (43). In order to eliminate language barriers and improve patient satisfaction and understanding, professional translation can therefore be helpful; indeed, in some cases it is indispensable.

Future prospects

Industrialised countries such as those in Europe are likely to receive increasing numbers of people from ethnic minorities such as refugees and asylum seekers. The proportion of traumatised people with a serious mental disorder such as PTSD among this population is high. Therefore, the available healthcare services should prepare themselves for this specific group of traumatised people from ethnic minorities including asylum seekers and refugees. On an individual level, using the Cultural Formulation Interview (CFI) can help to obtain information during a mental health assessment about the impact of culture on key aspects of a patient’s clinical presentation and care. Additionally, cultural competence training for all professional staff could be very helpful. Furthermore, the legislation should be changed towards including more humanistic aspects in mental healthcare. Lastly, data on the mental health of immigrants is scarce, leaving a gap that we recommend be filled.

Conflict of interest

The authors declare that there is no conflict of interest.

Compliance with ethical guidelines

This article contains no studies on humans or animals.

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