Mental health of refugees and asylum seekers in Australia

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Refugees and asylum seekers may have experienced traumatising events, such as civil conflict or torture, that have had an impact on their mental health. Open honest communication with health professionals is essential to help them overcome these traumas.

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Australia is broadly perceived as a haven of safe refuge by those fleeing persecution, war or civil conflict in countries around the world. In 2008 to 2009, under the 1951 United Nations Convention relating to the status of refugees, just over 13,500 people were granted protection to live in Australia through its refugee and humanitarian program, the majority having been granted refugee status offshore.[1] This figure is expected to increase to about 13,750 in 2009 to 2010.

Fleeing from war or conflict alone is not sufficient criteria for refugee status; there must be at least a reasonable fear of persecution. However, about 2400 of the 13,500 people granted protection to live in Australia in 2008 to 2009 arrived in the country before applying for asylum as a refugee.[1] These asylum seekers for the most part enter by air on tourist or other temporary visas and are deemed as authorised entrants, whereas the much smaller number who arrive by boat or air without visas are deemed unauthorised.

Since 1992, unauthorised entrants have been mandatorily detained in various facilities, currently principally on Christmas Island and the Curtin and Darwin immigration detention centres in WA and the NT, respectively. Detention may be implemented at other times at the discretion of the Department of Immigration and Citizenship on health, safety or security grounds; however, most asylum seekers live in the community.

An application for protection, whether refugees and asylum seekers are in detention or living within the community, may take years to be processed due to the decision-making and legal processes. A significant proportion of onshore applications for

Improvements for asylum seekers and refugees

A number of positive changes beneficial for the mental health of asylum seekers and refugees were announced in the 2009/10 Federal Budget. These were:

- a small increase in the refugee and humanitarian program to 13,750 places
- the introduction of complementary protection for the nonrefoulement of people who meet criteria under other human rights treaties to which Australia is obligated
- the cancelling of the '45-day' rule so that asylum seekers are permitted to access Medicare and receive work rights irrespective of the timing of the lodgement of their asylum application
- a broadening of the community care programs into national programs.

More details are available online at: www.refugeecouncil.org.au/docs/releases/2009/090518_Federal_Budget_RCOA_brief.pdf

asylum are made more than 45 days after arrival in Australia. This resulted in these individuals and their associated families not being able to access Medicare and most not being able to work or study, although this was changed in the 2008/09 Federal Budget (see box on this page). Asylum seekers cannot access Centrelink benefits but a small proportion meeting eligibility criteria may receive financial assistance through the Asylum Seeker Assistance Scheme administered by the Australian Red Cross. Most asylum seekers are, however, reliant on charity to cover their living expenses and healthcare costs.

Traumatising experiences

The traumatising experiences of refugees and asylum seekers can be categorised as occurring:

- in the country of origin
- in transiting countries and/or refugee camps
- during transit to Australia and/or in Australia.

For refugees granted protection visas offshore, the latter experience generally does not apply. Traumatising experiences in the country of origin are frequently thought to be torture; however, this is generally the exception rather than the rule. Instead for many the traumatising experiences are due to political, ethnic or religious persecution and harassment by authorities of themselves or their families. This may involve being caught up in or witnessing war or civil conflict. Experiences in transiting countries and/or refugee camps are commonly also traumatising because authorities may abuse, exploit or torment fleeing people and refugee camps may be places of great deprivation, ongoing abuse and/or exploitation.

Transiting to Australia by boat is extremely risky, as evidenced by the sinking of SIEV X in October 2001 and the death of more than 350 people. Once in Australia those who arrive with permanent protection visas will have a different experience to those who arrive seeking asylum. Asylum seekers may be detained from days to years and will experience uncertainty while their protection claim is being processed. Those whose claim is rejected will then face the prospect of repatriation.

Impact on mental health

The cumulative effects of these traumatising experiences will impact on the mental health of most refugees and asylum seekers. However, the symptoms and effects will vary according to:

- the severity, duration and extent of the traumas
- the social and family support available
- the pre-existing mental health of the individual
- the person's age and personal coping resources
- the person's cultural and religious constructs
- availability of early access to appropriate care
- the societal response including acceptance and validation
- the provision of the opportunity to normalise life.

Symptoms may include major depressive symptoms of lowered mood, anhedonia, poor concentration, short-term memory loss, poor sleep, reduced appetite, suicidality, and feelings of helplessness, guilt and shame. Guilt and shame may be about family and colleagues left behind in the country of origin or may be related to traumatic experiences. In addition, somatic symptoms of depression are prevalent in many cultures and may manifest as headache, neck pain, chest tightness, abdominal discomfort, nausea, weakness, fatigue or dizziness. The physical health status of many refugees and asylum seekers is compromised and exclusion of physical disease needs to be undertaken before ascribing somatic symptoms to psychological or psychiatric states.

Post-traumatic symptoms may include experiencing vivid and terrifying nightmares, fearing authorities including doctors, feeling constantly threatened, feeling powerless and having a sense of a contracted or barren future. However, not all symptoms that are a requisite for a diagnosis of post-traumatic stress disorder (PTSD) as defined by the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*)-IV are present. These symptoms include persistent re-experiencing of the traumatic event or hypervigilance.

Although major depression and PTSD are common psychiatric disorders in refugees and asylum seekers, symptoms and presentations are frequently heterogeneous and confusing. Hence, grief, anxiety, and psychotic and dissociative symptoms may manifest. Similarly, expressions of this distress, such as substance abuse or dependence, domestic

violence, self-harm or social withdrawal in adults, and nightmares, separation anxiety, school refusal or elimination disorders in children, occur.

Management

The highly specialised management of the psychological and psychiatric sequelae of torture is principally through statewide referral services such as the Victorian Foundation for the Survivors of Torture or the NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors. However, many refugees or asylum seekers may not access, meet criteria for or choose to attend such services.

The fundamental principle of interactions with refugees or asylum seekers is the establishment of trust, which has often been violated in the past including by health professionals. The experience of the patient should be validated and open honest communication is essential. It should be remembered that many countries from which refugees and asylum seekers are from are without basic medical services and the process of a standard medical appointment may be both mysterious and frightening.

Asylum seekers require detailed, clear and comprehensive documentation of physical and psychological stigmata of torture, abuse or deprivation for migration-related and legal-related medical reports. The use of interpreters is generally necessary and advisable, and care should be taken that the patient is not threatened by the ethnic, religious or cultural identity of the interpreter.

The principles of treatment of psychiatric and psychological disorders in refugees and asylum seekers are no different to those for the general population. Antidepressants, such as the selective serotonin reuptake inhibitors (SSRIs), are appropriate when a diagnosis of major depression or PTSD is made, cognisant that higher doses are generally required and that the SSRIs have demonstrated efficacy for patients with PTSD. Somatic symptoms that do not ameliorate with the depressive disorder require further investigation and should be assumed to be of physical origin until this has been excluded. Benzodiazepines may be used for the treatment of patients with anxiety symptoms (for example, diazepam 2 to 5 mg three times a day as needed) or insomnia (for example, temazepam 10 to 20 mg at night as needed). Occasionally, low-dose antipsychotics (for example, quetiapine 25 to 150 mg daily as needed in divided doses or olanzapine 2.5 to 5 mg at night as needed; off-label use) are helpful in patients with intractable anxiety, especially if it is associated with dissociation.

Brief psychotic symptoms in the context of external stressors are not uncommon in refugees or asylum seekers and should be treated with a brief course of antipsychotic medications (for example, quetiapine, olanzapine, chlorpromazine, trifluoperazine) until the acute stressor has abated. These psychotic symptoms commonly include delusions of persecution and second person auditory hallucinations.

Psychotherapy is essential but should not be interpreted as a specialist only undertaking. Clearly for many refugees and asylum seekers referral to a psychologist, psychiatrist or specialist mental health service is essential; however, this should not be forced upon people. The exception here may be children with such problems where at least a specialist assessment is mandated. Nevertheless, supportive, active listening, and a noninquisitorial approach by health professionals including GPs may provide a therapeutic environment sufficient for the person's need to process the trauma and grief of his or her experience.

Conclusion

Doctors are generally perceived by most refugees and asylum seekers as a trustworthy and significant authority figure. Hence the doctor's ability to engender a trusting, respectful and validating relationship with the patient cannot be overemphasised in healing these traumatised populations. MT

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COMPETING INTERESTS: None