Mental health of asylum seekers and refugees

In 2020, 82 million people worldwide were forcibly displaced. In the same year, the UK received applications for asylum for over 37,500 people. Over 40% of those were women and children, and 8% were children who had arrived in the UK alone without a parent or guardian.

This information is aimed at health and social care professionals in the UK coming into contact with displaced people. It provides information, guidance and support to ensure timely, high-quality care. View a more comprehensive version of this advice on the **Royal College of Psychiatrists' website.**

Experiences of mental health disorders in asylum seekers and refugees

- Asylum seekers and refugees can experience poor physical and mental health, pre-existing illnesses, physical injuries, exposure to communicable diseases, and undiagnosed or poorly-treated medical conditions.
- Contributing factors to poor mental health include experiencing psychological trauma, continuous uncertainty, barriers to support and discrimination before, during and after migration.
- Distress among displaced people is very common; this is not a mental illness but can persist without timely and appropriate support networks.
- Common mental illnesses in displaced adults include PTSD, depression, anxiety disorders and psychosis. There are high rates of distress, grief and PTSD in displaced people under 18.
- Children, women, elderly, disabled and LGBT+ displaced people are at particular risk of developing mental illness.
- Alcohol and substance use disorders, and intellectual disabilities further increase care needs.
- Some displaced people will already have received care for a mental illness before they arrive, while others can become unwell after arriving.
- Most displaced people will not be able to provide medical documents or a treatment history.

Approaches and principles

- **Psychological first aid** - Incorporating the principles of psychological first aid and paying attention to your clinical interviewing skills to sensitively engage with patients.
- **Trauma-informed practice** - Recognising the impact of trauma on psychological and social wellbeing, avoiding over-medicalising understandable distress, understanding the risks of re-traumatisation and second-hand trauma, and approaching treatment with a focus on safety, sensitivity and collaboration.
- **Cultural competence** - Working to understand the cultural context of the way patients express distress, seek help and explain illnesses, explaining local healthcare systems and entitlement to care and becoming familiar with treatment norms in the country of origin of those who are already being treated.
- **Working with interpreters** – Communicating clearly with the interpreter, avoiding using family members, focussing on confidentiality and transparency, using the same interpreter where possible and ensuring translators understand care and treatment norms in the country of origin of the individual.
- **Working with children** – Understanding the impact of trauma on physical, mental and social health, the unique struggles of unaccompanied minors, the impact of separation and importance of family connections, and referring to children specific services if needed.

Need for triage

- Where displaced people have multiple, disabling, persistent or severe symptoms, perform triage to understand the possible need for referral into specialist mental health services.
- Health screenings should incorporate physical, mental and social health concerns and be performed as soon as possible.
- Health screenings should provide a safe space for disclosures of trafficking, modern slavery, sexual exploitation, female genital mutilation (FGM) and previous torture, identifying individuals still at risk.
- Familiarity and engagement with local **safeguarding** pathways and practice is crucial.
- Identify support and therapeutic services, both through NHS health and social care and third-sector organisations.
- Self-harm and suicide risk should be approached non-judgementally, assessing intent to die where there has been an attempt, and drivers to the event, and ensuring safeguarding.

Psychosocial interventions and mental health treatment

- Professionals may come into contact with displaced people with mental health needs through a number of avenues.
- Early psychosocial support for distressed people can help prevent mental illness and should include information and support to help understand distress and manage difficult emotions.
- Prepare to listen to traumatic experiences with compassion.
- Ensure approaches to treatment are evidence-based and reflect NICE guidelines.
- Services should consider how treatments can be made culturally appropriate.
- Seek feedback from service users about their experience and how best to support them.
- Encourage links with local communities and with people with shared experiences.

Specialist care

- Individuals who have experienced multiple or repeated trauma, particularly those who experience loss of trust, 'agency' and the ability to imagine a personal future, those who engage in inappropriate risk-taking and those with unexplained physical symptoms, may be at risk of developing **complex PTSD**.
- These individuals may need referral to specific therapy focusing on stabilisation, processing trauma and eventually psychosocial integration.
- Where professionals are documenting torture and ill-treatment they should use the **Istanbul Protocol Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.**

Barriers to accessing healthcare

- **Systemic barriers** – These include a lack of awareness from healthcare professionals of entitlement to care and the needs of displaced people, a lack of specialist services, a lack of availability or willingness to use interpreting services, lack of documentation, frequent changes to accommodation, digital poverty and experiencing conscious or unconscious discrimination.
- **Individual barriers** – Individuals can be unfamiliar with the UK's rights and services, have language, literacy and cultural barriers, fear retribution and re-traumatisation from disclosing their experiences, have a lack of trust of authority figures, a loss of agency as a result of displacement, and additional health and learning needs.

Further resources, references and information on the content presented here is available on the Royal College of Psychiatrists' website, alongside information about support available to NHS staff.

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