

# Policies of Deterrence and the Mental Health of Asylum Seekers

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**S**INCE THE CONVENTION ON REFUGEES was adopted by the United Nations in 1951,<sup>1</sup> challenges to meeting the humanitarian needs of displaced persons have become greater and more complex. The ratio of those with legitimate refugee claims being resettled has decreased from 1:20 in the 1970s to 1:400 in the late 1990s,<sup>2</sup> with a concomitant growth in numbers of on-shore refugee applicants or asylum seekers. *Asylum seekers* are defined as persons who seek protection under the Convention on Refugees after entering another country on a temporary visa or without any documents.

The vast majority of persons displaced by war and persecution seek refuge in neighboring countries, particularly in the developing world. Of these displaced persons, only a minority will lodge asylum applications to be resettled in another country. Others travel directly to reach countries in which they apply for refugee status, with the majority lodging claims in countries of Europe, North America, and Australasia (hereafter referred to as developed countries). This article focuses specifically on the group recognized by international law as asylum seekers—persons who have formally filed an application for refugee status in the country in which they currently reside. Much of the controversy surrounding refugee policies in developed countries focuses on asylum seekers, with viewpoints expressed by politicians, by the news media, and by lobby groups becoming increasingly polarized.

In the past, most refugees who permanently resettled in the traditional recipient countries of North America, Europe, and Australasia were screened prior to arrival in a host country. In the last decade, increasing numbers of unauthorized refugees or asylum seekers, those who formally lodge application for refugee status in the country in which they are residing, have applied for protection after crossing the borders of these countries. Concerns about uncontrolled migration have encouraged host countries to adopt policies of deterrence in which increasingly restrictive measures are being imposed on persons seeking asylum. These measures include, variously, confinement in detention centers, enforced dispersal within the community, the implementation of more stringent refugee determination procedures, and temporary forms of asylum. In several countries, asylum seekers living in the community face restricted access to work, education, housing, welfare, and, in some situations, to basic health care services. Allegations of abuse, untreated medical and psychiatric illnesses, suicidal behavior, hunger strikes, and outbreaks of violence among asylum seekers in detention centers have been reported. Although systematic research into the mental health of asylum seekers is in its infancy, and methods are limited by sampling difficulties, there is growing evidence that salient postmigration stress facing asylum seekers adds to the effect of previous trauma in creating risk of ongoing posttraumatic stress disorder and other psychiatric symptoms. The medical profession has a role in educating governments and the public about the potential risks of imposing excessively harsh policies of deterrence on the mental health of asylum seekers.

JAMA. 2000;284:604-611

www.jama.com

Although policies relating to asylum vary from country to country and these policies have been in a state of flux in recent times, several key concerns have been raised across a number of countries about the status of asylum seekers.<sup>3-6</sup> Since research among asylum seekers is in its infancy, we will draw not only on empirical investigations, but also on reports by human rights groups to examine the effect of evolving policies of deterrence on the health and psychosocial well-being of asylum seekers.

## HISTORICAL BACKGROUND AND CONTROVERSY

To justify a refugee claim according to the Convention on Refugees, an applicant must prove that "owing to a well-

founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular group or political opinion, (he/she) is outside the country of his nationality and is unable to or unwilling to avail himself of the protection of that country. . . ."<sup>1</sup> The number of persons eligible for refugee status has increased substantially. During the last 2 decades of the 20th century, more

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than 35 civil wars and a larger number of lower-intensity conflicts have occurred. A striking feature of many of these conflicts is the widespread brutalization and “ethnic cleansing” of civilians, producing large population movements.<sup>2,7,8</sup> The United Nations High Commissioner for Refugees (UNHCR) has estimated that 50 million people have been forcibly displaced, with 22 million people within the mandate of the UNHCR, including some 13 million persons meeting the criteria of the Refugee Convention.<sup>2</sup> The numbers of displaced persons or spontaneous asylum seekers arriving unheralded have increased markedly, with approximately 7 million such persons entering developed countries from 1985 to 1998.<sup>2,9</sup> In the United States alone, numbers of persons seeking asylum have increased from fewer than 3000 per annum prior to 1980 to a peak of 154 000 in 1995.<sup>10</sup>

Adding complexity to the problem is the general increase in pressure for migration from developing countries, particularly those in which poverty and lack of opportunity are endemic. The confluence of the 2 pressures—population movements to flee persecution and migration to escape poverty and to seek better opportunities—creates a complex geopolitical dilemma, especially since there is a close interrelationship between civil war, internecine conflict, economic underdevelopment, and impoverishment. Distinctions between political and economic refugees have become increasingly difficult to make, yet the Refugee Convention<sup>1</sup> only specifies obligatory protection for the former category.

Developed countries have responded to fears of uncontrolled immigration by introducing policies of deterrence that include more stringent visa restrictions; sanctions and fines applied to those transporting persons without valid documentation; rigorous border checks and document inspections; interdiction of suspected people smuggling vessels at sea; and expedited removal of asylum seekers whose claims are judged to be manifestly unfounded.

In claiming refugee status, the burden of proof rests with the asylum seeker,

which is a daunting task given language and cultural barriers, lack of knowledge about international law and legal procedures, and the reality that oppressive states do not document their intentions to persecute dissidents. Asylum seekers may be hesitant to approach authorities to lodge claims because of previous experiences of state-directed persecution, hence delaying the process of obtaining legal protection. Many do not receive appropriate legal advice or they may unwittingly engage incompetent or unscrupulous immigration agencies to represent them. The interrogative approach used to test claims during lengthy interviews with immigration officials is attended by many risks and pitfalls.<sup>4,5</sup> Asylum seekers with symptoms of posttraumatic stress disorder (PTSD) or depression may experience psychological dissociation under pressure and in such an altered state of awareness may fail to give appropriate answers. Posttraumatic stress disorder may impede memory, leading to inconsistent testimony.<sup>3</sup> Lack of trust of officials may lead to evasiveness. Sensitive material such as a history of rape or sexual trauma may be suppressed. Yet discrepancies in histories often are used as the key reason for rejecting refugee claims.<sup>3,11</sup> In recent times, recipient countries have implemented more stringent assessments as to whether asylum applicants may be safely returned to other regions within their country of origin. A number of countries, particularly in western Europe, have begun rejecting applications for persons seeking asylum in which claimants have passed through a safe country without lodging an asylum claim.<sup>2,12</sup> A stricter interpretation of the Refugee Convention<sup>2</sup> has led some countries to limit claims of persecution only to state-directed actions. However, in a growing number of conflicts around the world, militia groups, warlords, and other nongovernmental paramilitary forces are the source of human rights violations and oppression. The general consequence of the more stringent application process for refugee policy is that the applications of most asylum seekers are rejected. The average

refugee endorsement rates for countries within the European Union from 1989 to 1998 was slightly more than 9%. In the United States, application success rates were somewhat higher for this period at 14.3%.<sup>13</sup>

A range of other measures arising from a broad policy of deterrence have been applied variously across several countries, including restricted access to legal services; limits on independent judicial review of asylum decisions; imposition of financial penalties on asylum seekers who appeal against negative decisions; and restricted access to housing support, medical treatment, welfare, and work permits.<sup>2,14-17</sup> A number of governments in Europe, the United Kingdom, and North America have instituted policies of systematic dispersal of asylum seekers across the country.<sup>18</sup> In the United Kingdom, asylum seekers who refuse to take up the offer of relocation to a specified area will, in the future, lose entitlements to an accompanying package of social support.<sup>19</sup> Even more serious is the growing practice of detaining asylum seekers in prisonlike immigration facilities or in actual state prisons, an issue considered in greater detail below.<sup>20-23</sup> The application of stringent refugee determination procedures has drawn widespread criticism from the UNHCR,<sup>2</sup> human rights organizations such as Amnesty International,<sup>20,24</sup> and members of the medical profession and their organizations.<sup>3-6,14,15</sup> The important question for mental health professionals is whether the rigors associated with the asylum process adds to or compounds the stress caused by past traumas in those with bona fide refugee claims.

## ASYLUM SEEKERS Trauma Exposure and Psychiatric Status

In the last decade, epidemiological studies across diverse cultures and contexts have documented high levels of trauma exposure in displaced populations,<sup>25-28</sup> with the evidence now being strong that trauma exposure is a predictor of long-term poor mental health among these groups.<sup>29-35</sup> A number of studies have spe-

cifically documented extensive trauma exposure in the subgroup of asylum seekers. Thonneau et al<sup>36</sup> found that among 2099 asylum applicants in Quebec, 18% reported previous exposure to torture. Similarly, the Association pour les Victimes de la Repression en Exil found that 20% of people applying for asylum in France reported past torture.<sup>37</sup> In several studies<sup>5,16,17</sup> undertaken in Australia, more than 20% of asylum seekers reported experiencing previous torture, more than a third reported imprisonment for political reasons, and a similar number reported the murder of family or friends. Similar findings were reported in a sample of Burmese asylum seekers in Japan,<sup>38</sup> with even higher rates of torture and rape reported in a UK-based clinic study of asylum seekers from Sierra Leone.<sup>39,40</sup>

Asylum seekers take extreme risks in attempting to reach safety. Those who embark on long sea voyages endure overcrowding, deprivation of food and water, and, on occasions, robbery and exploitation. Deaths or near drownings have occurred when unseaworthy vessels have sunk or were abandoned. "People smugglers" commonly extort money from asylum seekers, provide them with false information, or leave them stranded without further means of transport.<sup>41</sup> The desperate measures that may be taken by asylum seekers were highlighted by a recent report of 58 Chinese people dying due to suffocation in an enclosed truck while attempting to enter the United Kingdom without being detected.<sup>42</sup>

It is only recently that the mental health of asylum seekers has attracted specific scientific attention, and research has been limited to only a few of the relevant recipient countries of the developed world. We previously<sup>16</sup> reported that 14 of 40 consecutive asylum seekers attending a community assistance center in Australia displayed symptoms of PTSD with 13 exhibiting symptoms of major depression. Steel et al<sup>43</sup> reported that premigration trauma was associated with emotional disability among 62 Tamil asylum seekers in Australia, with trauma exposure ac-

counting for 33% of PTSD symptoms, 31% of anxiety symptoms, and 23% of depressive symptoms. Ichikawa<sup>38</sup> found that 5 of 61 Burmese asylum seekers in Japan met criteria for PTSD, with 19 displaying symptoms of major depression and anxiety, respectively. Begley et al<sup>44</sup> found that 20 of 43 asylum seekers in Ireland had symptoms consistent with major depression and 23 suffered significant levels of anxiety. In a sample of 60 asylum seekers studied in Australia, Hosking et al<sup>45</sup> reported that more than 60% displayed high levels of psychological distress.

Jensen et al<sup>46</sup> found that 34 of 49 displaced persons referred for psychiatric care in Sweden, experienced PTSD; the majority were asylum seekers (33/49). High rates of PTSD were found by Drozdek et al.<sup>47</sup> A total of 56 of 74 asylum seekers, who had received psychiatric service in the Netherlands, experienced PTSD. Fifty East Timorese asylum seekers assessed by a torture and trauma service in Melbourne, Australia,<sup>48</sup> were found to be experiencing PTSD and most were experiencing major depression. Forty-five percent reported significant suicidal ideation. Thus, even though selection and other biases may have influenced prevalence rates of disorder in these populations, there is at least *prima facie* evidence of substantial psychological morbidity among asylum groups residing in several recipient countries.

### Importance of the Postmigration Environment

A number of authorities<sup>3-6,23,49</sup> have noted that the stress asylum seekers face in developed countries may exacerbate risk of ongoing PTSD and other psychiatric disorders, a pattern that would be consistent with that found in the wider refugee population.<sup>34,50-52</sup> In a study of 84 Iraqi asylum seekers living in the United Kingdom, Gorst-Unsworth and Goldenberg<sup>53</sup> reported that low levels of social support and financial difficulties after migration were associated with heightened levels of depression. In a sample of asylum seekers attending a community welfare center in Australia, hardships associated with the refugee ap-

plication process and harsh living conditions in the postmigration environment were associated with ongoing symptoms of PTSD, anxiety, and depression.<sup>16</sup> Postmigration stress was also reported to be associated with PTSD symptoms many years after exposure to the original traumas of war among Tamil asylum seekers in Australia.<sup>17</sup> Salient ongoing stressors identified across several studies included delays in the processing of refugee applications, conflict with immigration officials, being denied a work permit, unemployment, separation from family, and loneliness and boredom. For the Tamil asylum seekers, we<sup>34</sup> further showed that risk of PTSD symptoms was disproportionately increased in traumatized asylum seekers when they were faced with poverty and discrimination, fears of repatriation, separation from family members, or exposure to interviews by immigration officials. Hosking et al<sup>45</sup> reported an association between length of time since lodging applications for refugee status and severity of psychological distress among asylum seekers in Australia, findings that have been supported by other studies.<sup>16,47,54</sup> The persistence of symptoms of PTSD and other psychiatric disorders in asylum seekers after migration contrasts with the general finding that psychological symptoms tend to decrease for authorized refugees as time passes after resettlement.<sup>55-60</sup> Nevertheless, inferences drawn from the small body of recent studies on asylum seekers need to be tentative, given the limited number of studies undertaken, the correlational nature of the analyses, sampling biases, and the absence of long-term follow-up investigations. Also, not all samples of asylum seekers have shown increased levels of distress compared with refugee comparison groups.<sup>61</sup>

### Access to Health and Welfare Services

Access to health and welfare services for asylum seekers varies across countries. In the United Kingdom and the Netherlands, asylum seekers are entitled to the full range of medical services provided

by the respective national health programs. Despite this, inequities in access to health services for asylum seekers have been widely reported in those and other countries,<sup>6,15,62-64</sup> with particular concerns being raised about the availability of psychological services.<sup>47,65</sup>

For example, asylum seekers who fail to lodge an application for refugee status in Australia within the first 45 days are disqualified from the state-sponsored universal health insurance scheme, a service that is available to all other permanent residents in Australia. Even those asylum seekers who have been granted access to health care lose this entitlement once their primary application has been rejected. Most rejected asylum seekers appeal that decision and the appeal process can take several years to conclude, so that there is a substantial number of refugee applicants living in Australia without access to health care.<sup>66,67</sup> For these asylum seekers, the only possibility for obtaining health care is through the aid of charities or by receiving care from a small number of volunteer physicians. Similar exclusionary policies in relationship to health services have been documented in France.<sup>68</sup> Limitations in access to state-supported health care is particularly onerous for those asylum seekers who are not granted work permits and therefore cannot afford to pay for private health care, or who cannot work because of ill health or language barriers. Thus, there tends to be a compounding of disability and disadvantage in some asylum seekers in whom economic, health, and trauma-related difficulties interact with each other to undermine any efforts to achieve sustainable living conditions while awaiting the outcome of refugee claims.

### Mandatory Detention

Detention is one of the most controversial aspects of recently introduced procedures applied to asylum seekers in developed countries. In the United States, the number of unauthorized immigrants detained has increased from 6000 in 1995 to more than 16000 in 1999.<sup>69</sup> Five thousand of these are estimated to

be asylum seekers.<sup>69,70</sup> Increasing reliance on detention of asylum seekers is evident across several of the major European countries, the United Kingdom, and Australia.<sup>18,21</sup> For example, in the United Kingdom, a 3-fold increase in the number of detained asylum seekers was observed between 1993 and 1996 with 850 detained at any time after that date.<sup>71</sup> Recently, 2 new detention facilities have been established in remote locations in Australia with the capacity to hold 2000 "illegal" migrants, the majority of whom are expected to be asylum seekers.

Some asylum seekers are held in detention facilities for considerable periods of time.<sup>72</sup> A 1998 report in Australia identified more than 80 detainees who had been held in detention between 2 and 5 years.<sup>21</sup> In the United States, a 1998 Human Rights Watch report found that some detainees, including asylum seekers, were held for periods of up to 4 years.<sup>73</sup> In some detention facilities, access to legal, social, and health services is limited,<sup>20,21,71,73</sup> as is contact with compatriot communities and relatives settled in the larger metropolitan areas. In Australia, the Human Rights and Equal Opportunity Commission has suggested that the boredom and frustration of prolonged detention together with social isolation may be responsible for outbreaks of violence, including domestic violence, among detainees and between detainees and officials.<sup>21</sup> Single women and unaccompanied minors may be at increased risk of abuse and exploitation when confined in mixed-sex detention facilities.<sup>2,74-76</sup> Cases have been documented of women and their infants being held in high-security sections of detention centers against explicit medical advice.<sup>21</sup> Access of children to educational facilities in some centers has been inadequate, a problem that may have long-term consequences for children detained for prolonged periods.<sup>21,77</sup>

In some countries, transfer of detainees between centers occurs with little or no notification and without opportunity for contacting family or legal counsel.<sup>20,21,73</sup> In Australia, the United Kingdom, and the United States, some asylum

seekers are held in correctional facilities with convicted criminals.<sup>14,49</sup> In the United States, Human Rights Watch reported several incidents in which detainees had been assaulted by criminal inmates.<sup>73</sup> Allegations also have been made that, in some instances, asylum seekers have been physically mistreated by correctional officers.<sup>73</sup> Similar accusations have been made against immigration officers in detention centers.<sup>20</sup> Claims have been made of the use of solitary confinement, and of forcible sedation by injection of detainees, raising ethical concerns about the role of health professionals involved in such environments.<sup>20,21,73</sup>

A controversial aspect of detention relates to the adequacy of the judicial review process in determining the need for ongoing incarceration.<sup>21,49</sup> Amnesty International has cited 3 cases in the United States in which officials have continued to detain individuals whose refugee claims had been endorsed.<sup>20</sup> Referring to the situation in the United States, Amnesty International concluded that the detention system "concentrates extraordinary power in the hands of single individuals acting as decision-makers, and (the process) lacks effective oversight or review."<sup>20</sup> Summarizing the experience in the United Kingdom, Salinsky<sup>49</sup> concluded that "Lawyers and those who work with refugees are often at a loss to understand apparently arbitrary decisions to detain particular individuals, and equally unexplained decisions to release (some of them)."

Several international covenants and legal instruments require that appropriate and timely health care and other essential services are provided to detainees including asylum seekers.<sup>21</sup> Recommendations made by international human rights bodies include the universal implementation of initial screening for infectious diseases and other chronic or severe medical conditions among asylum seekers held in detention.<sup>20,21</sup> Yet, concerns have been raised about the health care provided in these settings. In July 1999, the *New York Times* reported that 90 asylum seekers held at a detention center in Queens, NY, con-

tracted tuberculosis from a fellow inmate.<sup>78</sup> In a survey of 14 detention centers in the United States, Human Rights Watch identified several examples in which there was neglect of health care needs.<sup>73</sup> This included inappropriate use of analgesics in which physical investigations should have been undertaken for symptoms of pain and excessive prescription of tranquilizers. In all centers visited, dental care was limited to tooth extractions only.<sup>73</sup> Similar concerns about the standard of medical services provided in detention facilities have been raised in Australia.<sup>21</sup>

The potentially deleterious effect of detention on the mental health of asylum seekers has been raised repeatedly.<sup>14,21-23,79</sup> Broad indicators of psychological distress among asylum seekers in detention include high rates of attempted suicide<sup>23,80,81</sup> and hunger strikes.<sup>21,49,82-84</sup> In a study of 25 detained Tamil asylum seekers in Australia, Thompson et al<sup>85</sup> found twice the level of exposure to war-related trauma compared with compatriot asylum seekers and refugees living in the community. Eighteen of these detainees reported exposure to torture, almost all reported that a family member or friend had been murdered, and 22 had been exposed to a life-threatening situation in their homeland. Detained Tamil asylum seekers exhibited significantly higher levels of depression, suicidal ideation, posttraumatic stress, anxiety, panic, and physical symptoms, compared with compatriot asylum seekers, refugees, and immigrants living in the community.<sup>85</sup>

Constraints in access to and sampling of detained asylum seekers, as well as potential reporting biases, caution against definitive inferences being drawn from these studies. Nevertheless, there does appear to be convergence between research data and the impressions gained by human rights groups and involved health professionals that detention may be a powerful contributor to psychological distress in asylum seekers.

## COMMENT

The plight of asylum seekers often evokes contradictory public responses. At times,

there is an outpouring of public sympathy and compassion for those displaced by war and oppression and at other times, asylum seekers are depicted as queue jumpers or unscrupulous intruders intent on undermining the fabric of host societies. To some extent, contemporary refugee policy mirrors this paradoxical image. Authorized refugees are provided with specialist services such as torture and trauma treatment programs,<sup>86-88</sup> while some of their asylum-seeking counterparts are held in prisonlike detention centers in which conditions are antithetical to the principles of rehabilitation.

Such contradictions in the treatment of displaced persons need to be understood in their full historical, geopolitical, economic, and psychological complexity. The frames of reference adopted by protagonists of the policy of deterrence (in most instances, those who hold power) differ substantially from those of human rights advocates and health professionals who are committed to ameliorating the plight of asylum seekers. The arguments mounted by adherents of deterrence are buttressed by powerful historical trends. The integrity of the nation-state is one of the cornerstones of the current world order that allows nations to claim an inalienable right to protect their borders from uninvited outsiders.<sup>2</sup> As a consequence, public outrage can easily be provoked by the perception that a specific group of immigrants, such as asylum seekers, are posing a fundamental threat to national sovereignty.

The dilemma of asylum also needs to be considered in the context of the increasing economic divide between the minority of technologically developed, wealthy nations, and those third-world countries that remain indebted, impoverished, and underdeveloped. Factors that encourage migration from many underdeveloped countries are complex and involve economic duress and exposure to mass oppression, human rights violations, civil war, and forced displacement. Other factors encouraging migration include the desire to join compatriots in resettlement countries and the

drive to seek treatment for health problems. In several regions of the world, such as the Horn of Africa, Central Asia, parts of Latin America, and the Middle East, a convergence of some or all of these factors creates a complex set of forces resulting in the movement of large numbers of persons. However difficult the task is, it remains important to distinguish between bona fide refugee applicants and illegal immigrants. At one extreme, there is a risk that criminals may attempt to exploit asylum procedures to escape prosecution in their home country, at the other, legitimate refugee claims may be denied and asylum seekers sent back to situations of persecution because the determination process has been excessively severe.

## The Role of Health Professionals

Health professionals thus have a central role in the task of supporting genuine asylum seekers in several ways: by contributing to the broad areas of education and awareness raising, undertaking further research, building constituencies for advocacy, and ensuring that the health needs of asylum seekers are given higher priority.<sup>3-6,63,67</sup> Together with human rights workers, health professionals have a responsibility to promote the humanistic principles embodied in the Refugee Convention,<sup>1</sup> which was drafted in a spirit of global commitment to ensuring protection for those fleeing oppression worldwide.

At the same time, advocates for asylum seekers need to be pragmatic in relationship to the capacity and willingness of countries in the developed world to absorb an ever-increasing number of asylum seekers. Serious consideration needs to be given, therefore, to solutions that are less than perfect. Recent initiatives, such as the establishment of temporary safe havens for displaced persons from Kosovo and East Timor, need to be evaluated closely since they may offer a model for the temporary care of those displaced by war.<sup>89-91</sup> Several countries have introduced provisions that allow temporary residency for legitimate asylum seekers with the expectation that many will be able to re-

turn to their homelands once sufficient time has passed for those countries to achieve peaceful solutions to their political problems. Programs of temporary asylum have drawn criticism on the grounds that they circumvent the time-honored principle of permanent resettlement and that they create conditions of prolonged insecurity for asylum seekers. Major challenges remain to ensure that decision making is accurate and just when determining that it is safe for an asylum seeker to be returned to the country of origin. Nevertheless, temporary asylum in the community may be preferable to prolonged detention in prisonlike conditions, and societies may be more willing to admit larger numbers of asylum seekers if there is an assurance that they will ultimately return to their homelands.

The brief review of the scientific literature provided herein illustrates the need for a greater focus of research effort on the special health issues faced by asylum seekers. Formidable challenges are encountered in undertaking research among asylum seekers, obstacles that go beyond the usual transcultural constraints in translating psychometric measures.<sup>92-94</sup> Representative sampling of asylum seekers is made almost impossible by the dispersal of subjects, by the absence of population registers, and by the inherent fears asylum seekers hold about divulging information to strangers.<sup>16,17</sup> In addition, access by researchers to populations in detention centers is made difficult by the reluctance of governments to allow scrutiny of these institutions. Some asylum groups may wish to use research as a vehicle for publicizing their plight, thereby introducing an exaggeration bias in the data collected. To date, all published research has been cross-sectional, limiting the inferences that can be drawn. Research initiatives need to progress to longitudinal designs, even though the task of following-up a highly mobile population presents formidable challenges. Nevertheless, it is imperative, as new provisions such as temporary residency regulations are introduced, that researchers attempt to evaluate the affect of these policy changes

on the mental health and well-being of asylum seekers.

An important dilemma is the extent to which mental health professionals should work collaboratively with immigration officials in providing care for asylum seekers. Superficially, cooperation appears to be an attractive option, but the ethical risks for health professionals are complex and extensive. One of us (D.S.) experienced numerous ethical dilemmas in attempting to provide emergency mental health care for asylum seekers on a hunger strike.<sup>82</sup> We are aware of several other health professionals who have abandoned their posts in detention centers for conscientious reasons. Even when independent torture and trauma rehabilitation services have agreed to assess and treat detained asylum seekers, confrontations have occurred, for example, over whether the patient is transported to the treatment center in handcuffs. At the same time, volunteer groups of health care professionals have formed in several countries to provide cost-free treatment to those asylum seekers who cannot afford medical attention. Closer coordination and exchange among these groups at an international level could assist in sustaining these valuable contributions.

While training of immigration officers to understand the affect of psychological trauma on asylum seekers may be valuable, particularly in relationship to risks associated with intensive interviewing, there is no guarantee that trainees will implement the lessons learned. Similarly, anecdotal evidence suggests that the extent to which psychiatric or psychological reports are taken seriously in the asylum determination process appears to vary greatly, with some immigration officials paying little attention to documentation of trauma-related mental health issues.<sup>3,5,81</sup> Despite this, Pourgourides et al<sup>81</sup> reported that medical reports prepared for detained asylum seekers in the United Kingdom were instrumental in securing a positive asylum outcome in many instances. Aron<sup>3</sup> and Baker<sup>4</sup> also have argued strongly for a key role of mental health reports in providing col-

laborative evidence to support the claims of asylum seekers. Physicians for Human Rights has published guidelines for the provision of medical testimony to assist in the process of asylum applications.<sup>95</sup> There may be a particular value in combining medical and psychological reports with physical investigations, such as bone scintigraphy, offering promise in supporting the testimony of physical abuse in asylum seekers.<sup>96-98</sup>

Nevertheless, the medical profession remains relatively weak in relationship to powerful government departments that control the fate of asylum seekers. Interagency coalitions with membership drawn from human rights groups, other nongovernment organizations, the legal profession, and health professionals may be more effective than individual health professionals in advocating for asylum seekers. Such groupings need to engage more effectively with large professional bodies such as national and world medical associations and federations. The potential power of consumer or user advocacy groups, which have transformed mental health policy throughout the developed world, is an important lesson from the broader mental health field that needs to be developed. Cultural diversity, political divisions, and transient membership of an asylum group make it difficult to identify and promote leadership structures within that population. However difficult the task may be, it is incumbent on professional advocates to engage in the task of developing leadership among asylum seekers to forge a more effective constituency that is able to lobby government and international agencies such as the United Nations.

Strategies to ensure minimum standards in health care for asylum seekers have been promoted,<sup>2,21,99</sup> and wider adoption and implementation of these principles are desirable. Nevertheless, when there is no uniformity across countries in the level of medical care considered to be mandatory for all indigenous citizens, it is difficult to establish universal standards of care for any subpopulation such as asylum seekers. A more

effective strategy may be to strengthen the network of voluntary health care professionals working with asylum seekers while using available research findings to highlight the public health risks of contemporary asylum policies and procedures. For example, there is ample evidence that the detention policy incurs high financial costs,<sup>21,79</sup> expenses that might be more productively directed toward providing minimum levels of health and welfare support when locating asylum seekers in the community. At the same time, restrictions in access to health care and social services appear to be associated with deteriorating physical and mental health among asylum seekers,<sup>16,17,54</sup> an outcome that ultimately may add to the burden of care for families and, in some instances, for the community at large. A demonstration of the link between policy and health costs may influence governments to reconsider some of the more draconian aspects of recent policy changes. In this way, health professionals might be able to harness the strengths of their disciplines to advocate for the human rights of asylum seekers without risking the oft-made accusation that physicians are straying beyond their disciplinary boundaries in their calls for justice for this group.

## CONCLUSIONS

A battleground is beginning to emerge with lines drawn between asylum seekers and governments. Governments are becoming even more intent on excluding all uninvited immigrants, irrespective of their reasons for uprooting. The more strident is the claim that the developed countries will be overwhelmed by asylum seekers, the more willing governments and the public appear to be to stray from the humanitarian mission of offering safe haven to persons fleeing persecution. The medical profession has a legitimate role in commenting on the general and mental health risks of imposing restrictive and discriminatory measures on asylum seekers, especially when some of these administrative procedures threaten one of the fundamental principles underpinning the practice of medicine: *primum non nocere*.

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