Mental health and the asylum process
Key Findings and Recommendations

My PhD tried to understand what affects people's mental health during the asylum process. I had the privilege of working with many incredible Afghans and Iranians, including mental health practitioners, who spoke to me about the asylum process. I am extremely grateful for the personal stories, insight, and opinions they provided. As a small step to repay these efforts, I have produced this summary. For my PhD I:

1. Summarised 49 studies on mental health risk factors during the asylum process (e.g. unhygienic accommodation, unemployment).
2. Worked with three Iranian and Afghan organisations on mental health projects to understand how to work with migrants in a mutually beneficial way.
3. Interviewed people on their experiences and opinions of the asylum process. I spoke to people who had sought asylum, those who worked with them, and Iranian and Afghan community members.

I go through each recommendation below and summarise the supporting evidence. Recommendations are targeted at GPs and mental health practitioners. This is a very broad grouping and some recommendations may be more or less feasible for people in different parts of the mental health system. If any part of these recommendations and findings is relevant to your work I can:

- Present findings in more detail to your clinic, hospital or organisation.
- Work with you to implement some of the recommendations.
- Advise on using my thesis as evidence to support your work.

Recommendation 1: Discuss mental health through social relationships, metaphor and the body

Mental health discussions with Afghan and Iranian sanctuary seekers could begin by talking about social relationships, using culturally appropriate metaphors and identifying psychosomatic complaints. Rather than speak directly about their experiences of mental health problems, participants preferred to speak about mental health more generally, through metaphor, or indirectly through discussion of family concerns and acculturation stresses. The weather was used as a key metaphor by participants to describe the perceived mental attack from the asylum process. In addition, people described the mental health impacts of the asylum system as embodied. They suggested that, as their bodies became more distant and unfamiliar, their mental health deteriorated. Social relationships, metaphor and the body could be used to adapt the Mental Status Examination. For example, when assessing mood, it might be useful to start by asking patients for a personal weather report. This is where a practitioner asks the patient "if you were a weather system, what would be your personal weather report?" (see Tschannen-Moran 2012).

Both the mental health metaphor of the weather and focus on the body as a site of mental health problems, produce visceral descriptions of an outside attack. People reported feeling attacked by the adversarial asylum process, and especially during the substantive asylum interview. Thus, findings demonstrated how the asylum interview acts, via gaslighting and provoked desperation, to erode people's sense of self. Ultimately, it contributes to dependency and depression.

Recommendation 2: Cultural humility can improve access to mainstream mental health services

Western mental health concepts often dominated the interaction between mental health practitioners and, Iranian and Afghan sanctuary seekers. Practitioners could usefully be open to, understand and acknowledge non-Western mental health concepts. For example, Baasher (2001), writing from the University of Khartoum, argue that the Quran comments on mental health when giving directives for 'a firm belief… endurance of hardship and resolution of stress'. Some health and well-being papers from Iran focus on spiritual mental health and use the spiritual wellbeing scale developed by Paloutzian and Ellison (1982). It might also be useful to use positive psychology terms. Positive psychology constructs used around employment, referring to 'existential fulfilment', 'vigour', 'dedication', 'absorption' and fulfilment (see Tomic and Tomic 2010) could be particularly useful with Iranian and Afghan sanctuary seekers as they chime with cultural values of reciprocity, responsibility, and hard work.

Formal mental health services were rarely accessed by participants, particularly Afghans. This was partly linked to a lack of English language ability. However, it was also linked to a limited practitioner and GP understanding of different cultural conceptions of mental health. GP surgeries should allow additional time to see sanctuary seekers, recognising the time needed to understand their cultural conceptualisations of and language used to talk about mental health, as well as the additional time required for interpretation. This is already the case in some GP surgeries. This recommendation could provide a post-registration focus to the Doctors of the World Safe Surgeries initiative addressing sanctuary seeker access to healthcare. This initiative encourages GP practices to improve sanctuary seeker accessibility by suggesting seven steps including never 'insisting on proof of address documents… identification… or proof of immigration status (p3).

The British Psychological Society has published guidelines for working with refugees and asylum seekers, with key recommendations including 'showing respect', using 'professional interpreters', opening up space for a discussion of 'experiences of racism, hostility and hate crimes' (for more information see Cardemil and Battle 2003 for more information), and 'recognising the diversity and the resilience of asylum seekers and refugees'. While thesis findings support these recommendations, they also highlight the need for targeted and co-created guidance for professionals working with Afghans and Iranians, two significant groups of sanctuary seekers in the UK. The guide could include a list of culturally specific

mental health terms such as Zar, an Iranian condition understood as where a spirit takes control of a person, invading their heads and to deleterious outcomes such as self-harm (Moghaddam, 2012).

Recommendation 3: Provide patients space to express and resist asylum process difficulties

Sanctuary seekers that participated in this research wanted to speak out against their marginalisation in the asylum process, as well as their parasitic media image. There was a related demand for mental health practitioners to bear witness to people's suffering. Mental health practitioners should create space for sanctuary seekers to talk about, and resist, negative asylum process experiences and framings. Where sanctuary seekers propose political violence – such as the hunger strikes at Yarl's Wood detention centre (Bulman 2018) or the Napier Barracks fire (Trilling 2021) - mental health practitioners should be supportive of the person, acknowledging the potential therapeutic benefits of such action and refraining from judgement.

A crucial component to bearing witness may be acknowledging the potential mental health impact of race and discrimination. Mental health practitioners could usefully refer to French et al.'s (2019) 'radical healing for People of Color'. This framework is grounded in 'collectivism', 'critical consciousness', 'radical hope', 'strength and resistance', and 'cultural authenticity and self-knowledge,' and links to many of the pillars used by many of the sanctuary seeking participants of the studies presented in this thesis (e.g., community support, cultural dignity). For French et al., 'social action is a critical component of radical healing'.

Recommendation 4: Acknowledge people's internal, cultural strengths during treatment

Sanctuary seekers arrived with resilience deriving from their cultural identity and migration experiences. This kept them going through the gruelling asylum process. Cultural dignity, spiritual beliefs, and education were important sources of this strength for Afghan and Iranian sanctuary seekers. Helping people retain their cultural roots could, therefore, help them cope with the asylum process. Poetry could be an important to this. It has helped preserve the Persian identity for almost a thousand years (Bekhrad 2018). Olszewska (2007) documents how Afghan refugees in Iran have used it to sustain their Afghan identity taking 'pride both in their non-Iranian origins and in their common heritage with Iranians' (p203). The validation of cultural activities could counter the infantilising, patronising, and agency-sapping narratives often present in Home Office discourse.

Practitioners conducting group therapy could recreate a version of the 'healing ceremonies' mental health programme developed by the International Organisation for Migration, for Rohingya refugees. This was a series of group gatherings that 'used and developed cultural

assets, such as music and other artistic expressions, through strengthening positive, culturally grounded, coping mechanisms' (Rebolledo 2019). In her work with Afghan refugees, Olszewska (2015) studied a poetry circle that helped participants process mental health problems. She argued that poetry served as 'therapy, and as testimony'. Practitioners could usefully facilitate the creation of these poetry circles in their group therapy work.

Recommendation 5: Use different treatments at different stages of the asylum process

Herman's (1992) triphasic model of trauma recovery suggests initially beginning therapy with safety and stabilisation. However, the asylum process creates instability and insecurity in people's lives. This occurs through: the adversarial, lengthy and deeply personal asylum substantive interview; the many months and even years people must wait for a decision after the interview; and the policy of forced dispersal, often to unhygienic accommodation far people's support networks. However, evidence suggests that therapy can still be beneficial during the asylum process (e.g. ter Heide & Smid, 2015; Drozdek et al., 2013, Stenmark et al.).

Mental health treatment might be usefully tailored to the different stages of the asylum process and directed by sanctuary seeker needs. For instance, a patient might need treatment for acute trauma and retraumatisation after the asylum interview. This is likely if the interview lasted many hours, the interviewer was hostile and suspicious, and the patient was compelled to recount difficult experiences. In contrast, the mental health support needed during the wait for a decision will be different. Here, patients are in stasis, watching their future plans deteriorate, lacking control and in a state of fearful uncertainty.

Overall, mental health treatment and support provided by mental health practitioners is most useful when it is a long-term endeavour, with time needed to build trust and to help people regain the identities, memories and purpose lost both prior to arrival in the UK and during the asylum process.

Recommendation 6: Design services and values in opposition to asylum process practices

Participants reported feeling attacked, threatened, disbelieved, and re-traumatised by the asylum interview and, resultantly, betrayed by the Home Office. After the interview, people entered a bureaucratic cycle characterised by a life-freezing and future-destroying waiting. Mental health services may be at risk of replicating the most difficult aspects of the asylum process and my PhD recommends examining the structure of service provision to ensure that it is in opposition to the asylum process.

Accordingly, the few participants who had accessed mainstream mental health services preferred an authoritative, succinct and practically focussed service. And a service where their stories are believed. In their review of sanctuary seeker access to mental health services, van der Boor and White (2020) report that participants felt discriminated and rejected by healthcare professionals. Participant 'concerns were not taken seriously' by practitioners and people faced open hostility. In such interactions, sanctuary seekers relive the asylum process.

Occupational therapy (therapy based on encouraging meaningful and fulfilling activities), therefore, could be useful when working with Iranian and Afghan sanctuary seekers. This is supported by the growing number of occupational therapists and increased academic focus on the discipline in Iran (Fallahpour 2004). Blankvoort et al. (2018) explore the potential style of occupational therapy sanctuary seekers might benefit from as refugees, reporting that they desired therapists to be 'connectors… bringing refugees together', 'matchmakers… matching refugees to new opportunities in their new settings', and 'translators… of culture and society'.