FEATURE

‘This is silent murder’ – are we medicalising human distress caused by the reality of life as an asylum seeker in the UK?

The number of displaced people, including asylum seekers and refugees, in the UK continues to rise. This article highlights findings from two participatory community listening exercises on the topic of health of displaced people.

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The number of displaced people in the UK due to war, persecution and political instability continues to increase. In 2022, there were 74,751 asylum applications made to the UK Home Office, the highest number since 2002.[1] By displaced people we here refer to asylum seekers, refugees and undocumented migrants.[2] The average waiting time for an initial decision on an asylum case is likely to be between one and three years and is increasing.[2]

Displaced people face significant trauma and adversity in their country of origin, or during their journey such as war, persecution or imprisonment. Generally, they are less likely to access health and social care and have poorer health than the general population. They are more likely to be diagnosed with mental health conditions than the general population, including higher levels of stress, depression, anxiety and post-traumatic stress disorder.[3]

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Funded by the NIHR Clinical Research Network small grants programme, we ran two community engagement in health research events in conjunction with a community organisation supporting asylum seekers and refugees in the East of England. The events aimed to introduce the concept of health research, increase inclusion and remove barriers between academic research and this under-researched community. Over 70 men and women were brought together to discuss healthcare and health research in the UK, assisted by professional interpreters. Participants came from 14 different countries, at different stages of the asylum process, from newly arrived asylum seekers in initial hotel accommodation through to refugees who have established their lives in the UK.

Social, environmental and political factors which were impacting on their wellbeing and how this made them feel were widely discussed (Figure 1).

Postmigration stressors included uncertainty, frustration and hopelessness around the protracted nature of the immigration processes and fear stemming from the perception of a hostile political environment. The lack of meaningful activities due to a ban on working and limited volunteering opportunities created abundant time for rumination about the past, worry about family back home and a feeling of being in limbo. They also spoke of environmental factors such as living conditions in Home Office accommodation, poverty (an asylum seeker in initial accommodation receives £8 per week towards clothes, non-prescription medicines, sanitary products and travel), feeling isolated due to language barriers and lack of community cohesion and connection. There was a lack of control over their fundamental daily needs such as choice of food, where they live, where they can go and a feeling of monotony. There were deep-seated grief and feelings of loss over relationships, homes, identity and belonging, causing significant sadness and suffering. Overwhelmingly there was a feeling of being voiceless, with their struggles not being heard or validated, rejected from society and indeed feeling ‘silently murdered’ (this phrase was poignantly described by one participant). The distress they felt was universally felt to be an entirely natural response to their situation. Many spoke of visiting health professionals with symptoms of distress such as poor sleep, pain, headaches and feeling worried and being given anti-

Figure 1

Participant's views on how it feels to seek asylum in the UK.

Source: Illustrator credit: Chris Spalton.

depressants or strong pain medication which were neither beneficial nor wanted.

These events demonstrated some practical aspects which could offer support, hope and lower distress in this group. This included fostering a sense of agency and autonomy, a desire to recreate a sense of community, a new home and be busy with meaningful activities, such as work. There was a desire to contribute to society and support each other by sharing knowledge, a need to feel secure and safe, and to have some hope of a future to enable them to recover from their past trauma.

Postmigration stressors are well documented and compound the impact of past trauma on the mental health of displaced people.[4] Distress among displaced people is very common and is not in itself necessarily a mental illness, although it can result in mental illness without timely and appropriate intervention. Distressed displaced people need help and support but there is a gap in the literature on the most acceptable and effective treatments, and we need to move away from purely Westernised diagnoses and treatments towards culturally informed care.[5] These listening events suggested that interventions for distressed displaced people lie outside the purely medical sphere. Fear and stigma around mental health within communities of origin and diaspora communities may prevent displaced people from expressing distress and accessing care.[6] Some languages do not have the words for mental health, let alone anxiety or depression and they may be translated into words which are stigmatising, unhelpful or shameful. Culture can influence all aspects of illness and expression of distress and somatisation can be common in displaced people. Displaced people may wish to tell their story, but counselling may be unfamiliar and uncomfortable for people who may not wish to discuss feelings with a stranger.[7] In Mozambique and Ethiopia, people may use 'active forgetting' to cope with trauma[7] so the cultural framing of therapeutic interventions must be nuanced and tailored to the individual.[8]

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Interventions for distressed individuals could be taken out of the healthcare sphere and placed within communities, so as not to unnecessarily stigmatise and label individuals who may feel shame at experiencing disruption in their mental

health due to their culture of origin or gender norms. Social capital and connectedness to others are key resources to improve mental health of displaced people.[9] Indeed, Wenning[10] concluded that the three most common resources related to displaced people making meaning of life are work, education and religion.

The voices of the individuals involved in these community listening events clearly demonstrate that the asylum process in the UK is damaging to the health and wellbeing of displaced people. It also suggests a need to develop interventions which are evidence based and moving beyond a purely Westernised medical model to include tackling the wider social determinants of health. There is a clear willingness from these two events for under-researched groups to engage in research and provide this evidence base and to co-produce interventions.

CONFLICT OF INTEREST

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