

LIFE IN LIMBO



MSF's psychosocial support
for asylum seekers in Sweden





Information in Arabic about MSF's psychosocial support activities in Skaraborg. Photo: Karin Ekholm. Front page: Asylum seekers move from one centre to another. Photo: Farshad Shamgoli.

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EXECUTIVE SUMMARY

Between August 2016 and August 2017, Médecins sans Frontières/Doctors Without Borders (MSF) ran a project in Skaraborg county, Sweden, as part of its humanitarian support for refugees and migrants. The aim of the project was to contribute knowledge and resources to improve the mental well-being of asylum seekers in Skaraborg. The project enabled asylum seekers to take well-informed steps towards getting the support they need and helped strengthen their coping mechanisms. The core assumption was that early psychosocial interventions could improve the mental wellbeing of asylum seekers suffering from mental health distress, and that such interventions could prevent symptoms from worsening.

The target group was people who were in

the asylum process and who were suffering from mild to moderate symptoms of depression or post-traumatic stress disorder (PTSD), such as worry, anxiety and feeling depressed. People with symptoms of more severe psychological disorders were referred to primary or specialist care.

The project involved screenings, individual counselling sessions, psycho-education, health information, help with referrals to primary and secondary health care and psychosocial activities. This support was offered at the centres where the asylum seekers lived.

The majority of the asylum seekers that were offered support by MSF came from war-torn countries such as Syria, Afghanistan and Iraq. They had endured traumatic experiences,

including violence and torture; some had seen family members and friends disappear or been killed. Many had risked their lives to reach Europe and Sweden. As well as the traumas they carry with them from the time before and during their journeys, several stress factors in Sweden were shown have had a negative impact on their well-being. A prolonged asylum process had led to a feeling of having lost control over their lives. The uncertainty over whether they will be able to get a residency permit created worry and fear. Asylum seekers had to move abruptly and with short notice from one centre to another. This interrupted the types of activities that would otherwise create stability, such as school, health care and social contacts.

Many asylum seekers struggle to access limited mental health care. In several cases, MSF found that asylum seekers were initially denied care because they were in the asylum process. They were only given access to the health centre after MSF staff exerted pressure. There was a lack of early identification of mental health problems among asylum seekers. This was partly because only some actually received a health screening, but also because of a lack of targeted initiatives to detect mental health disorders among this group. Furthermore, a lack of information about where and how to seek help, communication difficulties and social stigma around mental health were further barriers in accessing care.

It is of great importance that people in the asylum process are offered psychosocial support at an early stage, to prevent and alleviate symptoms of PTSD and depression. This should be addressed through targeted initiatives and measures that enable asylum seekers to seek care more easily. This requires a concerted effort from decision makers, the health care sector, social services, government agencies and civil society. It is also important to continue with initiatives that improve the understanding of asylum seekers' rights among staff within

the health care sector, social services, at asylum centres and in other professions that work closely with them. The negative consequences of restricting access to care are significant not only for people in need of care, but also for society at large in the form of a greater burden on emergency services.

Furthermore, shortening the time taken to process asylum claims (without compromising on the thoroughness of the investigation) would reduce the time that asylum seekers are stuck in a legal limbo. One of the most significant causes of stress and worry that MSF observed among asylum seekers was the fear of having their claim rejected and being forced to return to their country of origin. It is obvious that this worry cannot be "cured" through either psychological or medical interventions. But MSF's work in Skaraborg, as well as in other countries, has shown that relatively simple initiatives can achieve an improvement in the mental well-being of asylum seekers, who often find themselves in vulnerable and troubling situations.

MSF hopes that the model of intervention that was implemented in Skaraborg will serve as guidance and inspiration for the health sector, social services, civil society and government agencies, and that this will ultimately lead to improvements in the psychosocial support given to asylum seekers in Sweden and beyond. A detailed description of MSF's model of intervention can be found in the handbook *Operational Manual for Psychosocial Support to Asylum Seekers: MSF's Model of Intervention*.

STOCKHOLM FEBRUARY 2018.

INTRODUCTION

The asylum process is, for many asylum seekers, a period in limbo. They find themselves in a situation characterised by prolonged waiting, uncertainty and powerlessness, living with the fear of having their claim rejected and being returned to their country of origin. On top of this, many have experienced trauma and suffering in their home countries or during their journey, which they still carry with them. Asylum seekers often experience a lack of factors that usually create a sense of calm and stability, such as social networks and a sense of belonging.¹ Mental health is defined by the World Health Organization (WHO) as, “*a state of well-being in which every individual realizes his or her own potential, can cope with normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community*”.² Good mental health can play a crucial role in whether a person will manage to secure and establish themselves in the new country.

In several studies, the prevalence of mild or moderate symptoms of depression and post-traumatic stress disorder (PTSD) has shown to be higher among asylum seekers than among the general population. In particular, the Swedish National Board of Health and Welfare estimates that 20% to 30% of asylum seekers in Sweden are suffering from psychological problems.³ A study by the Swedish Red Cross showed that psychological distress are widespread among asylum seekers. The study also

shows that psychological issues are considerably more prevalent among asylum seekers than newly arrived people who have been granted asylum, with higher prevalence of disorders such as depression, anxiety, PTSD and low self-esteem.⁴ Research among unaccompanied minors also paints a sombre picture. For example, a screening of PTSD symptoms among 208 unaccompanied minors aged 9-18 in Uppsala, Sweden showed that 76% were at risk of PTSD.⁵

In Sweden, just as in other European countries, MSF has noted a general lack of support initiatives for mental health and observed how reception conditions and conditions related to the asylum process contribute to mental health symptoms. Several commendable initiatives from civil society organisations, health care services and government agencies have greatly increased the coverage and capacity to deliver effective psychosocial support. However, there is a clear need for measures that can alleviate the burden of mental distress and to prevent a deterioration of the mental well-being of an already vulnerable group.⁶ Moreover, many asylum seekers experience significant barriers in the access to mental health care, including a lack of clarity concerning health care law and regulations, a lack of knowledge about the Swedish health care system, communication barriers and a lack of knowledge among care providers about asylum seekers' legal entitlements.

¹ Röda Korset. Nyanlända och asylsökande i Sverige: En studie av psykisk ohälsa, trauma och levnadsvillkor. 2016.

² http://www.who.int/features/factfiles/mental_health/en/

³ Socialstyrelsen. Psykisk ohälsa hos asylsökande och nyanlända migranter. 2015. Sid 7.

⁴ Röda Korset. Nyanlända och asylsökande i Sverige: En studie av psykisk ohälsa, trauma och levnadsvillkor. 2016. Sid 27.

⁵ Salari, Malekian, Linck, Kristiansson & Sarkadi: Screening for PTSD symptoms in unaccompanied refugee minors. *Scandinavian Journal of Public Health*, 45, 605-611

⁶ Röda Korset. Nyanlända och asylsökande i Sverige: En studie av psykisk ohälsa, trauma och levnadsvillkor. 2016. Sid 7.

PSYCHOSOCIAL SUPPORT FOR ASYLUM SEEKERS: MSF'S MODEL OF INTERVENTION

MSF has, for 15 years, been delivering medical care and other humanitarian assistance to people fleeing to Europe. Between January 2004 and October 2005, MSF ran its first ever operational project in Sweden, which guided undocumented migrants to health care services in Stockholm. These activities were later handed over to the Swedish Red Cross. Since 2015, MSF has considerably increased its support to refugees, asylum seekers and undocumented migrants on their way to Europe. In particular this has been through search and rescue operations in the Mediterranean Sea; operations along migrant routes and in centres in Greece, Italy and the Balkans; and with asylum seekers in Germany, Belgium, France and Sweden. Mental health support is an integral part of MSF's response in these countries.

Between August 2016 and August 2017, MSF ran a project in Skaraborg county in Sweden. The project offered asylum seekers psychosocial support through mental health



Asylum seekers from Afghanistan during a journey organised by MSF. Photo: Niklas Bergstrand.

screenings, individual counselling sessions, group sessions and psychosocial activities. The aim of the project was to use our knowledge and resources to improve the psychological well-being of asylum seekers in Skaraborg through implementing a model of psychosocial support. It involved enabling individuals to take active and informed steps to seek care and improve their coping mechanisms. During the project, MSF offered psychosocial support to 550 asylum seekers at four asylum centres and nine homes for unaccompanied minors.

Concept

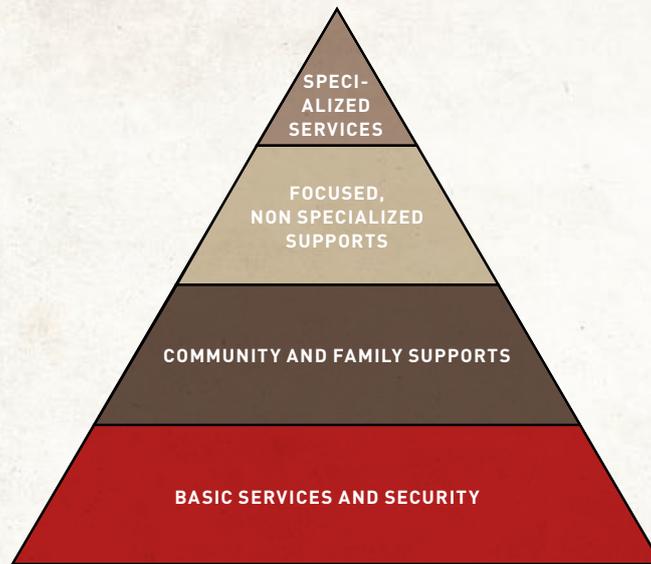
The core concept of the project was that early psychosocial interventions could increase the mental well-being of asylum seekers and prevent it from worsening. The assumption was that such interventions could, in the long run, alleviate the pressure on emergency and specialist services. This assumption was supported by a report issued by the Västra Götaland regional administration, which recommends the deployment of improved health care initiatives at an early stage to prevent increased morbidity.⁷ In a report from 2015, the National Board of Health and Welfare also recommended an investment in measures to prevent psychological distress among asylum seekers in the long term.⁸ Furthermore, international studies have shown that providing regular preventive care, as opposed to providing only emergency care, is cost-saving for health care systems. Treating a condition only when it becomes an emergency not only endangers the health of the patient, but also results in a greater economic burden to health care systems.⁹

⁷ Västra Götalandsregionen, Asylsökandes vårdkonsumtion i Västra Götaland 2011-2016, sid 39.

⁸ Socialstyrelsen. Hälsa- och sjukvård och tandvård till asylsökande och nyanlända. 2016. Sid 52.

⁹ European Union Agency for Fundamental Rights. Cost of exclusion from healthcare. 2015. sid. 33.

FIGURE 1 | LEVELS OF INITIATIVES FOR PSYCHOSOCIAL SUPPORT IN EMERGENCY SETTINGS



The United Nations Inter-Agency Standing Committee (IASC) has developed guidelines for psychosocial support in emergency settings.¹⁰ The guidelines build on a model of multi-layered support to respond to levels of mental health needs. The most general ones are found at the bottom, and the most specialized at the top. (See Figure 1)

1. Basic services and security: The most fundamental needs among asylum seekers should be guaranteed through ensuring personal safety and security, and the provision of food, shelter, clean water and basic health care.

2. Community and family support: This includes activation of social networks and support, such as parental skills programmes health information, stress-reducing activities and information about the host country.

3. Focused, non-specialised support: This level represents the support to indi-

viduals or groups in need of more focused care, such as psychological first aid. This support can be provided by people who do not necessarily hold a qualification or degree in psychology.

4. Specialised services: This comprises specialist care for the smaller group of asylum seekers in need of qualified medical or psychological/psychiatric care.

The target group for MSF's model of intervention was people within the asylum process suffering from mild to moderate symptoms of depression or PTSD, such as stress, anxiety and feeling depressed. People with more severe symptoms, as well as those with physical problems, were guided to primary and specialist care. The focus for MSF's intervention was within the second and third level of the pyramid, and also included support in collaboration with local civil society organisations.

¹⁰ <https://interagencystandingcommittee.org/mental-health-and-psychosocial-support-emergency-settings-0/content/iasc-guidelines-mental-health>

Set-up

The project has consisted of three counsellors, four cultural mediators, one psychologist, one civil society focal point and administrative staff.

The psychosocial support was offered by counsellors with a professional background, for example in social work, anthropology or nursing. In order to develop a model that was as simple and resource-saving as possible, MSF did not demand that counsellors hold a degree in psychology or psychiatry. However, experience within a similar field, for example work with asylum seekers or experience of group support, was a requirement. A psychologist was part of the team to ensure the quality of the support and to identify cases where referral to more specialised care was needed.

The counsellors worked in collaboration with cultural mediators who spoke Dari, Farsi or Arabic, and had experience and knowledge of the social conditions of the asylum seekers' home countries. Apart from acting as an interpreter, the role of the cultural mediator was to

bridge linguistic and cultural divides between the counsellor and the asylum seeker. The cultural mediators received training in communication skills, active listening, psychological first aid and basic understanding of psychological issues, including how to identify people potentially in need of mental health care.

A civil society focal point was responsible for initiating and coordinating activities in collaboration with voluntary and civil society organisations.

Activities:

SCREENING: MSF offered to screen participants for symptoms of mental health distress using a standardised screening tool called the Refugee Health Screener (RHS-13), which was developed to identify individuals suffering from, or at the risk of, developing mental health problems. The form, consisting of 13 questions, is not designed to make a diagnosis, but is focused on identifying symptoms of depression and PTSD and self-identified stress reactions. It only takes a few minutes to complete and can be self-



Cultural mediator Sanna informs three women from Syria and Iraq about MSF's psychosocial activities. Photo: Karin Ekholm.

administered. For those reporting a score above a certain threshold, or if the counsellor assesses that there is a need, a more in-depth assessment is offered. Depending on the outcome of these assessments, interventions such as counselling sessions, psycho-education, psychosocial activities or referral to specialised care may be offered. During the course of the project, MSF screened 219 people and offered a subsequent in-depth assessment to 56% of these (122 people).

COUNSELLING SESSIONS: This type of support was offered to asylum seekers showing mild to moderate symptoms of mental health problems. It was offered to a number of people who had received disturbing news, such as an asylum claim rejection or notification to unaccompanied minors that their age had been assessed to be 18 or above. The asylum seeker was offered up to five sessions with the aim of stabilising and normalising his or her condition and to teach them about positive coping strategies that they could apply in everyday life. The sessions were also aimed at monitoring their well-being and to prevent a deterioration of their mental health. The role of MSF's counsellors was as

an active listener, providing a safe place where individuals could talk and express themselves freely to someone who is there to support them. The counselling is not meant to replace the care and treatment offered by a qualified mental health professional or that of existing care, but rather functioned as complementary support for those with milder symptoms or those waiting to have access to primary or specialist care. In total, MSF offered individual counselling sessions to 131 people.

PSYCHOLOGICAL FIRST AID: This comprises a set of simple techniques that can be used to support people who have recently experienced a difficult situation. The method includes support to help the patient feel calm and protected from further harm. Psychological first aid does not require the person providing the aid to have any clinical expertise, and should be distinguished from clinical mental health care. It is an empathic and pragmatic approach to assist people in distress, and can be administered by anyone with the relevant training. MSF offered psychological first aid in instances when asylum centres were closed and when residents have had to move at short notice to new centres



MSF holds a group session for unaccompanied minors. Photo: Niklas Bergstrand.



Cultural mediators Bassel and Sanna talk to Khalidoun who fled from Syria with his daughter Nawar. Photo: Karin Ekholm.

in municipalities far away. MSF also provided advice about possibilities of receiving care and support in the new location.

PSYCHO-EDUCATION: MSF ran group sessions on stress management, psychosomatic problems, sleep problems and mental health awareness. It also offered information sessions on parental skills and effective communication with children. In total, 49 sessions were held with 414 participants. The purpose of the sessions was to help the participants develop an understanding of the sometimes-overwhelming feelings that can occur as a result of the stress factors they encounter. For example, asylum seekers may experience changes in their sleep patterns, a lack of appetite or irritability. In these instances, it can be reassuring to discover that these reactions are normal in such a situation, and to be provided with simple tools that can help alleviate them.

HEALTH INFORMATION: MSF ran a series of health information sessions to strengthen asylum seekers' understanding and knowledge of the Swedish health system, to inform them about the types of care and support available, and what they were entitled to. MSF held nine group sessions in Dari, Farsi and Arabic with 89

participants, and also individually as part of the counselling sessions.

REFERRALS TO PRIMARY AND SPECIALIST CARE: In more serious and complicated cases, it was necessary to refer asylum seekers to more specialised care. This included cases when the person showed symptoms of psychosis, were unable to take care of themselves, ran the risk of self-harm or harming others, or had experienced severe trauma, such as torture or sexual violence. In such instances MSF's counsellors guided the person to the necessary care provider. In some cases, this involved writing referral letters describing the person's symptoms, with the aim of providing a clearer picture to health care staff about their condition. In those cases where the asylum seeker faced barriers to accessing care, the counsellor took an active role in guiding them through the health care system, and often maintained a dialogue with the health care staff. Over the course of the project, 87 people (40% of all those screened) required further help and assessment from the health care system, 60 (27%) were directed to mental health care services, and 58 (26%) were directed to psychosocial support activities organised by MSF. In a few cases, MSF had to contact emergency services in order to prevent suicide or self-harm.

PSYCHOSOCIAL ACTIVITIES: MSF arranged psychosocial activities such as knitting, cooking, painting, excursions and sport events throughout the project. These activities were sometimes organised with local voluntary organisations. Such activities can have a stress-reducing effect and can create a sense of social belonging with the host community and others who are facing the same situation. The assumption was that interventions to improve well-being do not necessarily need to be restricted to counselling or specialised care. Participants played an active role



MSF has organised many social activities during the course of the project. One of these was a volleyball tournament. Photo: Anna Rehnberg.

themselves in suggesting which activities to organise.

CULTURAL BRIEFING: MSF held 15 cultural briefing sessions to 139 asylum seekers to provide them with information about different aspects of Swedish culture. MSF also held six sessions about culture in Afghanistan and Syria to 75 staff working with asylum seekers.

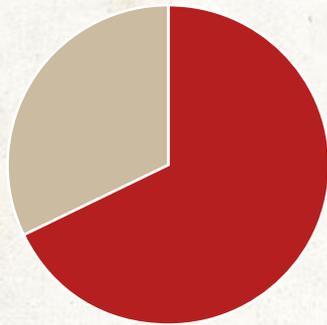
TRAINING AND CAPACITY BUILDING: MSF offered limited training sessions and guidance to staff at asylum centres and in social services who were in daily contact with the asylum seekers. MSF offered training in suicide prevention to staff at homes for unaccompanied minors, as well as facilitated training in trauma-conscious care through Save the Children.

MSF has emphasised the need for offering support as close to the asylum seekers' homes

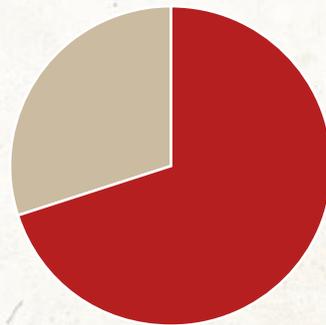
as possible, and has therefore regularly visited the asylum centres and homes for unaccompanied minors with mobile teams who have offered support and psychosocial activities. This has contributed to building greater trust and understanding for the organization and its operations. At certain asylum centres, MSF has not been granted permission by the Migration Agency to organise activities at the centre itself, and has therefore had to use facilities nearby, with significantly lower attendance rates as a result. Due to logistical constraints, MSF's model of intervention has not actively focused on providing assistance to asylum seekers living in private accommodation, although they have been welcomed to the MSF office for support and guidance.

FIGURE 2 | DEMOGRAPHIC PROFILE

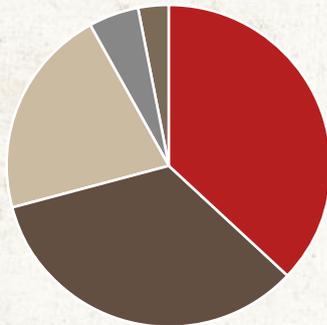
of the 219 people who have received a screening by MSF.



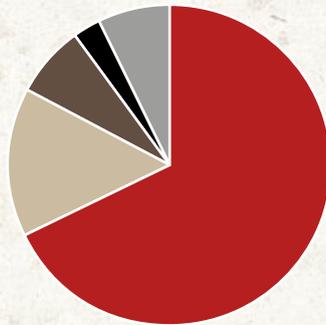
■ 68% HAVE BEEN IN SWEDEN MORE THAN A YEAR
■ 32% HAVE BEEN IN SWEDEN LESS THAN A YEAR



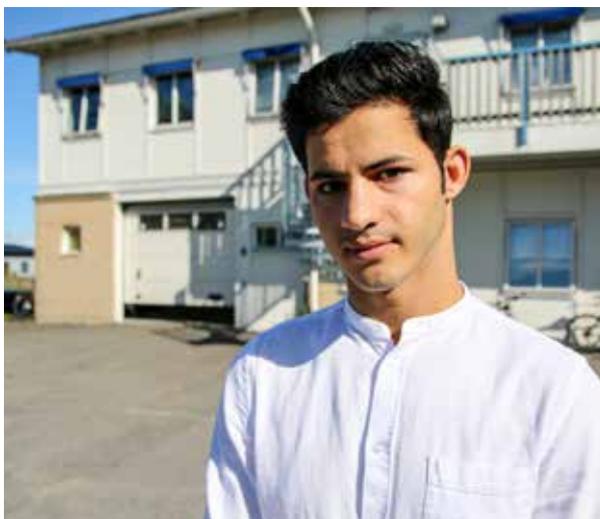
■ 70% MEN
■ 30% WOMEN



■ 37% ARE BETWEEN 18-29 YEARS
■ 34% ARE 18 YEARS OR YOUNGER
■ 21% ARE BETWEEN 30-39 YEARS
■ 5% ARE BETWEEN 50-64 YEARS
■ 3% ARE BETWEEN 40-49 YEARS



■ 68% ARE FROM AFGHANISTAN
■ 15% ARE FROM SYRIA
■ 7% ARE FROM IRAQ
■ 3% ARE FROM IRAN
■ 7% ARE FROM OTHER COUNTRIES



Nyaz came to Sweden as an unaccompanied minor from Afghanistan over two years ago. He still does not know whether he will be allowed to stay. Photo: Niklas Bergstrand.

SYMPTOMS

SYMPTOMS OF ANXIETY: tension (headaches, pounding heart, insomnia, difficulty breathing), stress, sudden unexplained physical symptoms (chest pain, shortness of breath), dizziness, light-headed or faint, intense or sudden fear for no apparent reason (for example, fear of dying or of losing control), trembling or shaking, sweating, constant worry

SYMPTOMS OF DEPRESSION: sadness, loss of interest or pleasure, loss of energy and tiredness, disturbed sleep, lack of appetite, poor concentration, loss of self-confidence or self-esteem, feelings of hopelessness, feelings of guilt, crying, suicidal thoughts

SYMPTOMS OF PTSD: intrusive memories, flashbacks and nightmares, sense of numbness, detachment from other people, over-vigilance, easily startled, poor-quality sleep, irritability, excessive anger, poor concentration or memory, overwhelming fear when reminded of the event

PSYCHOSOMATIC PROBLEMS: chest pain, tiredness, back pain, nausea, poor appetite, headaches, dizziness, palpitations, breathing difficulties, sleeping problems, lack of energy

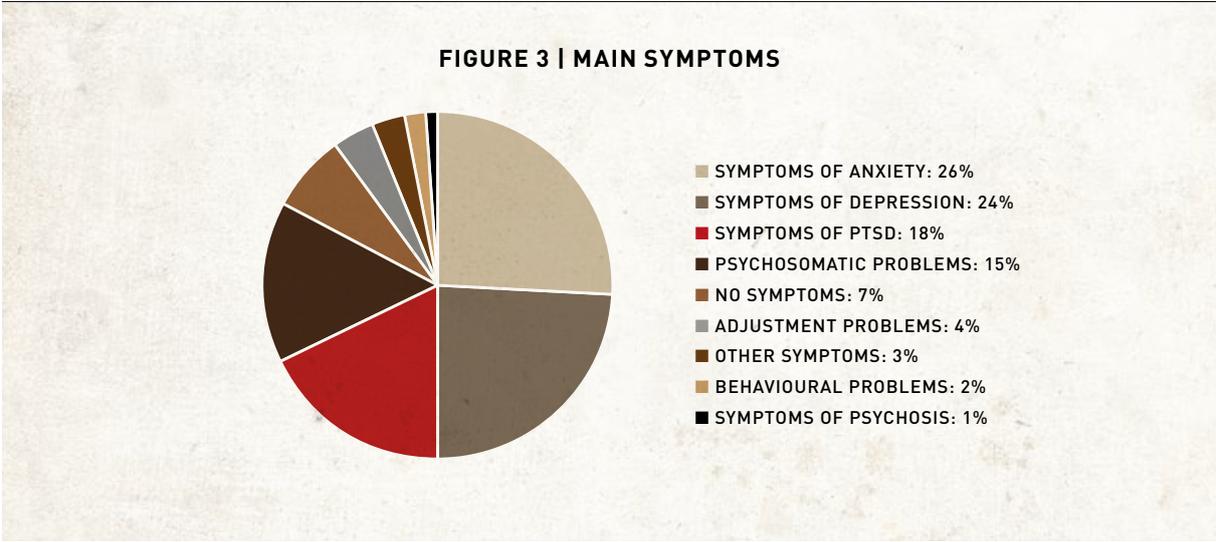
ADJUSTMENT PROBLEMS: inability to manage everyday chores, anxiety, feelings of despair

OTHER SYMPTOMS: symptoms not related to any particular diagnosis

BEHAVIOURAL PROBLEMS: substance abuse, aggressive behaviour, hyperactivity, withdrawal

SYMPTOMS OF PSYCHOSIS: delusions, hallucinations, detachment from reality, strange beliefs, disorganised thoughts, disorganised or strange speech

Asylum seekers with symptoms of PTSD or depression may experience so-called psychological dissociation under moments of pressure, for example during an interview with the Swedish Migration Agency. In such an altered state of awareness, the asylum seekers distance themselves from their experiences, and may fail to give appropriate answers to questions relating to their history, leading to inconsistent testimony. They might suppress sensitive information, such as a history of rape or torture. Discrepancies in history are often used as a key reason to reject an asylum claim. MSF has not carried out any specific analysis of this. However, when writing their referral letters, the counsellors underscored the symptoms shown by the asylum seeker (for example memory problems) because of the impact this may have in the asylum interview.



Among the 122 people that underwent in-depth assessment, the following were recorded as the main categories of symptoms:



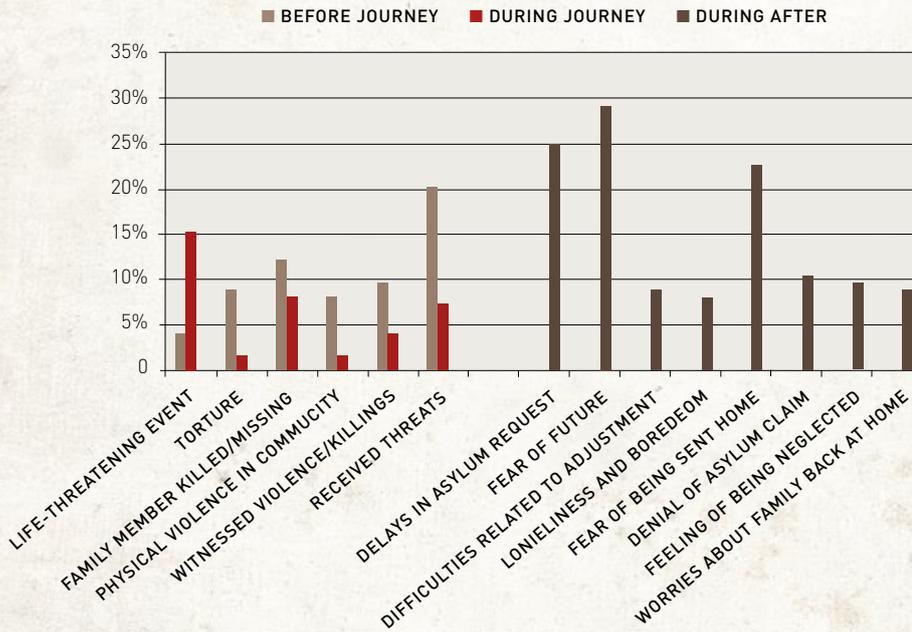
CAUSES FOR MENTAL HEALTH DISTRESS AND DISORDERS

The problems that the asylum seekers face can be reactions to traumatic events that happened in their countries of origin and their journeys, and can also be linked to their situation in Sweden. It is important to note that such issues are often normal reactions to an abnormal situation.

An individual's reaction to emotional trauma is complex and difficult to predict. While some individuals may experience relief when talking about traumatic memories, others may

respond with worsening symptoms, and they may become overwhelmed or re-traumatised. Therefore, the counsellor needs to be careful to avoid provoking further harm. MSF's counsellors are not clinical treatment providers, and will not have proactively asked any questions about traumatic events during the screening. This means that such experiences will only have been recorded in instances where the asylum seeker chooses to recount them, and thus are probably more common than has been reported.

FIGURE 4 | SELF-REPORTED LIFE EVENTS AMONG INDIVIDUALS PRESENTING FOR IN-DEPTH MENTAL HEALTH ASSESSMENT BY MSF, GÖTENE, SWEDEN (2016-2017)



Among the 122 individuals undergoing an in-depth assessment, the main "life events" before and during their migration were recorded, as well as the post-migration difficulties faced by asylum seekers in Sweden. Events/difficulties were brought up without prompting; no direct questioning was done. The main two conditions at each stage (before, during, and after migration) were recorded.

Experiences in country of origin

The majority of the asylum seekers that MSF offered support to came from war-torn countries, such as Syria, Afghanistan and Iraq. They had experienced potentially traumatic events, such as violence and torture, or seen family members or friends killed. Some had faced extreme economic hardship, including a lack of food, water, shelter and other basic needs and resources. A study by MSF in Lesbos, Greece showed that two-thirds of the patients who received care from MSF for psychological problems between January and June 2017 had been victims of violence before arriving in Greece, and a fifth had been tortured. Half of the women who came for a gynaecological consultation during the same period had been victims of sexual violence before arriving in Greece.¹¹

Of those people who underwent an in-

depth assessment by MSF in Skaraborg, 29% had experienced some form of violence, 9% had experienced torture, and 16% had had a friend or family member killed or go missing.

Experiences during the journey

The journey to finding refuge can be perilous. It can involve physical harm, such as sexual violence and/or extortion, as well as exposure to medical diseases. MSF regularly encounters people who have endured extreme situations during their journeys to Europe. Since the summer of 2016, MSF has offered care and support to people held in deplorable and inhuman conditions in detention centres in Libya. As well as experiencing brutal violence and exploitation, many suffer from diseases that are exacerbated by or are a direct result of the conditions in the overcrowded centres.

¹¹ MSF. A Dramatic Deterioration for Asylum Seekers on Lesbos. Juli 2017. Sid 3.

Over the last few years, hundreds of thousands of people have risked their lives attempting to cross the Central Mediterranean and Aegean Sea in small, unseaworthy boats. In 2016, 5,143 people died in the attempt.¹² Those who reach the shores of Europe found cramped and unsanitary living conditions in overcrowded camps on the Greek Island of Lesbos. Many experienced prolonged detention and violence.¹³ Data and testimonies collected by MSF in its projects in Serbia also show recurring examples of how police on the borders of Hungary, Croatia and Bulgaria have used violence against people attempting to cross.¹⁴

Situation in Sweden

On top of the past traumas that refugees carry with them before they arrived in Sweden, several types of stress factors in the host country have shown to have a negative effect on asylum seekers' mental well-being.¹⁵ A well-functioning reception system that aims to minimise such stress factors is therefore of importance. The following factors have been identified by academia and other actors as contributing to a deterioration of mental well-being, and is also in line with MSF's experience in Skaraborg.

A PROLONGED AND DELAYED ASYLUM PROCESS: A prolonged asylum process can lead to passivity among asylum seekers, due to the

lack of control over their lives, a lack of meaningful daily activities, and an imposed passive role created by the reception system. Data from the Swedish Migration Agency shows that the average processing time (i.e. the time between when a claim is lodged and a decision is made) for asylum applications concluded in November 2017 was 602 days.¹⁶ According to EU directives, the handling process should not exceed six months, except in exceptional circumstances such as mass arrivals. In reality, few EU member states fulfil these obligations.¹⁷ International studies have shown that a drawn-out asylum process, together with living at an asylum centre, has negative consequences for a person's mental health,^{18,19} and that mental health among asylum seekers tends to be worse than among refugees that have been granted a residence permit.²⁰ Although it is important that the asylum process is thorough and fair, the mental health implications of a prolonged time in limbo also need to be recognised and addressed by the Migration Agency. MSF's data, based on screenings done on people at various stages in the asylum process, does not show a marked deterioration of asylum seeker's mental health during the first two years of the process. However, the lack of improvement among people more than a year after their arrival is a cause for concern.

¹² <https://missingmigrants.iom.int/>

¹³ MSF. Confronting the mental health emergency on Samos and Lesbos. Oktober 2017.

¹⁴ MSF. Games of Violence – Unaccompanied children and young people repeatedly abused by EU member state border authorities. September 2017.

¹⁵ Porter M, Haslam N. Predisplacement and postdisplacement factors associated with mental health of refugees and internally displaced persons: a meta-analysis. *JAMA* 2005;294(5):602-12.

¹⁶ www.migrationsverket.se (4 december 2017)

¹⁷ <https://www.ecre.org/wp-content/uploads/2016/10/AIDA-Brief-DurationProcedures.pdf>

¹⁸ Laban CJ, Gernaat H, Komproe IH, Schreuders BA, De Jong J. Impact of a long asylum procedure on the prevalence of psychiatric disorders in Iraqi asylum seekers in the Netherlands. *Journal of Nervous and Mental Disease*. 2004;192(12):843-51.

¹⁹ Porter M, Haslam N. Predisplacement and postdisplacement factors associated with mental health of refugees and internally displaced persons: A meta-analysis. *JAMA*. 2005;294(5):602-12.

²⁰ Gerritsen AAM, Bramsen I, Devillé W, Van Willigen LHM, Hovens JEJM, Van der Ploeg HM. Physical and mental health of Afghan, Iranian and Somali asylum seekers and refugees living in the Netherlands. *Social Psychiatry and Psychiatric Epidemiology*. 2006;41(1):18-26.

“There are not that many things to do around the asylum centre. You feel sad, passive, you can’t do anything.”

FEMALE ASYLUM SEEKER FROM AFGHANISTAN

“Here at the asylum centre I get food, then I always go back to my room and isolate myself. I have many different thoughts, but nothing that can keep me occupied or can make me change them. That’s the situation for a lot of people at the asylum centre. If there was something to keep busy with, then you could forget about your thoughts or think about something else at least.”

MALE ASYLUM SEEKER FROM AFGHANISTAN

“I try and think positive, but all the Afghans I know have had their claims rejected.”

MALE ASYLUM SEEKER FROM AFGHANISTAN

“The worst thing for me has been waiting for this negative thing, that there will be a rejection. The only thing that can make me feel better is to be given a residence permit.”

MALE ASYLUM SEEKER FROM AFGHANISTAN

“The people I have met tell me that the biggest problem for them is whether they will be able to stay in Sweden or not. We cannot affect that, but just listening helps more than you would think. I remember a man from Iraq who had been kidnapped and tortured by IS. In the end, he managed to escape and made it to Sweden. We had many talks and he told us repeatedly how much it meant to him that we were there and listened.”

MSF CULTURAL MEDIATOR

UNCERTAINTY / FEAR OF REJECTION:

Uncertainty about the future often leads to worry and anxiety. “Fear of the future” was the most commonly mentioned life event during the in-depth assessment (29%), followed by “delays in asylum request” (25%) and “fear of being sent home” (23%). Although it was not explicitly stated by the asylum seekers MSF has talked with, it can be assumed that systemic factors such as the new temporary legislation granting temporary residence permits and limiting the possibility of family reunification might add to the uncertainty, frustration and fear among asylum seekers. This is also suggested by the National Board of Health and Welfare who state that the new asylum law risks increasing mental distress.²¹

RELOCATIONS: Many asylum seekers have been forced to relocate as a result of many asylum centres gradually closing across the country.

Three out of the four centres where MSF was present closed down during the project. Residents were forced to move abruptly and at short notice, causing distress and disrupting previous stabilising factors, such as social networks, school attendance and ongoing health care provision. It has also resulted in a discontinuation of the support to the individuals that MSF had been supporting.

Even though funds were allocated to the municipalities to allow unaccompanied minors to stay even after they turned 18,²² this did

²¹ Socialstyrelsen, Hälsa- och sjukvård och tandvård till asylsökande och nyanlända. 2016. Sid. 30.

²² <http://www.regeringen.se/artiklar/2017/07/fragor-och-svar--ensamkommande-som-fyller-18-ar/>

not always happen.²³ It should be noted that a number of municipalities in Skaraborg allowed unaccompanied minors who were assessed to be 18 or over to remain at the home for unaccompanied minors during their appeals process. Several individuals and civil society organisations have also taken commendable steps in hosting minors when the system failed them. Despite this, MSF encountered more than 20 cases of unaccompanied minors who had turned 18 or where the Migration Agency had assessed them to be over 18, that had been relocated to an asylum centre for adults.

They were often forced to abruptly leave a life of relative security and belonging for a regular asylum centre where they often experienced greater insecurity and a lower standard of living. They lost the social support of a legal guardian and a social secretary, and had to change school and caregiver. In the new centre they usually have to share a room with several other people, often from different backgrounds to their own. Several young asylum seekers mentioned to MSF staff that they found it difficult to sleep or to concentrate on their homework at the new centres. Such factors can contribute to a worsening of the mental well-being of a young person who is already in a very difficult situation.

“The staff simply told me one day ‘you have to move to an asylum centre for adults’. I didn’t even have a suitcase, so they got some trash bags and put my things in them. At the new asylum centre, I had to share a room with older people who drank alcohol, smoked hash and made a lot of noise at night.”

MALE ASYLUM SEEKER FROM AFGHANISTAN

“Many of the boys who turn 18 need to move from their home. It is like death for them. They have established themselves here. And now when there is no asylum centre here anymore they need to move to a completely new area. We had a boy who had to be hospitalised because he felt so bad as a result of that.”

STAFF AT AN UNACCOMPANIED MINORS’ HOME, SKARABORG

REJECTION OF ASYLUM CLAIM AND AGE ASSESSMENTS

In cases where the real age of an unaccompanied minor is disputed, the Migration Agency may request an age assessment. MSF has observed that the decision by the Migration Agency that a person is determined to be 18 or older often is communicated at the same time as the decision that the person’s asylum claim is rejected.

In at least three cases, MSF observed how the mental health of young asylum seekers rapidly deteriorated after they had received such a notification. Among other things, they described strong feelings of hopelessness and disempowerment that led to suicidal thoughts and actions, which required emergency psychiatric care.

“Many feel like they have no control over their own lives. One of the youngsters said that the only decision he had control over was when he would die.”

MSF COUNSELLOR

²³ <http://sverigesradio.se/sida/artikel.aspx?programid=83&artikel=6750214>

Rashid came to Sweden two years ago. He shows the scars from when he was attacked by the Taliban with a bayonet in Afghanistan. Photo: Niklas Bergstrand.



RASHID'S STORY

” *I have nightmares about the night the Taliban attacked our house. I was nine years old. We had a large house with many rooms. My family was in another part of the building from me. It was around 11 at night when they crashed into the front door with a car. When I woke up I saw two strangers in the doorway with Kalashnikovs that had bayonets attached. I was going to run away, but they stabbed me with the bayonet in the chest and the head. After that I don't remember anything.*

My two uncles died that night. The Taliban shot one of them in the chest and the other in the neck. And they shot my father in the foot with a pistol. They were going to kill everybody in the family. When I woke up again, I was in a car heading towards Kabul where I was in hospital for four days. Then we fled over the border to Iran.

We lived in Iran for nearly four and a half years. That was the worst time in my life. When you are a refugee in Iran they don't treat you like a human. You are just like an animal. I worked for a company that made clothes for women. We didn't go out much because we were scared of the police.

My mother had decided that I would travel to Europe. It wasn't my choice, I wouldn't have done it, but she forced me. We didn't have any money, but she borrowed some from the person she worked for.

The journey took nearly two months. When we were going by boat from Turkey to Greece we got lost at sea. It takes normally 40 minutes between Turkey and Greece, but it took us one night and one day. There were many small children, women and old people onboard. We had a hole in the boat and we had run out of gasoline. No one died, but it was very close to sinking. We were very lucky that didn't happen.

When I came to Sweden it was like the gates to heaven had been opened. But after some time, a few months, a year, two years, they told me, 'You can't stay. You have to go back to hell.' I have had many problems, but now I feel a bit better because I take two types of medication. I am a bit calmer, otherwise I get angry very often. I have problems with my heart and have trouble sleeping. I've had trouble breathing and have been stressed a lot. When my asylum claim was rejected it got worse. I had problems with suicide. I tried to do it twice, and also when I was in Iran.

It's really hard to follow classes in school when you feel bad. I went maybe once a week, or for a few days. I couldn't sleep and was awake all night. Now I fall asleep around three or four and get up at six.

I don't know how they can consider Afghanistan to be safe to go back to. When we moved to Iran they said, 'You're not allowed to stay here.' Then here in Sweden they say, 'You're not allowed to stay here.' But I don't know where my home is. I just want to live in a free country.

*Rashid is not his real name.



Asylum seekers move from one centre to another. Photo: Farshad Shamgoli.

ACCESS TO CARE AND MENTAL HEALTH SUPPORT

Despite their vulnerability, asylum seekers' access to care and support is often restricted. This was confirmed in a 2016 report by the National Board of Health and Welfare, which states that there are obstacles for such groups to reach health care, especially specialist care, and that asylum seekers do not always receive the care they are entitled to.²⁴ The report describes challenges in accessing health care and in identifying mental health needs, such as a lack of information to both asylum seekers and health care staff and a lack of translators to overcome linguistic and cultural barriers. The report also mentions a lack of coordination between health care staff and non-health care actors, and a lack of standardised screening tools, clarity concerning referrals and know-

ledge among health care staff in how to handle various forms of mental health problems. The report emphasises the importance of strengthening the provision of care for mental health problems, better dissemination of information, capacity building for health care staff and other staff working with asylum seekers, and developing specially targeted health promotion programmes for affected groups.

A report from Rosengrenska Stiftelsen, a voluntary network of health care staff in Gothenburg, presents an overview of cases where undocumented migrants in Gothenburg faced numerous obstacles to receiving care, such as lack of knowledge by care providers of asylum seekers' entitlements and references to legislation concerning "care that cannot wait".²⁵

²⁴ Socialstyrelsen, Hälso- och sjukvård och tandvård till asylsökande och nyanlända. 2016. Sid. 7.

²⁵ Rosengrenska stiftelsen. Redovisning vårdhinder. 2016.



'CARE THAT CANNOT WAIT'

According to Swedish law, all people have the right to receive emergency care. Adult asylum seekers also have, on top of emergency care, the right to receive “care that cannot wait”, as well as maternity care, abortion services, family planning and care regulated by the Swedish Communicable Diseases Act. Asylum seekers under 18 are offered health care on the same basis as children with Swedish citizenship.²⁶

The term “care that cannot wait” is open to different interpretations, and it is, in practice, up to each health care provider to assess what kind of care should be provided. The implication is that patients may be granted care on the basis of their legal status, rather than a decision based on medical needs alone. The National Board of Health and Welfare wrote in a 2014 report that the term is incompatible *with medical work ethics, that it is inapplicable in health care, and that it risks jeopardising patient safety.*²⁷ This is also mentioned in a statement by the Right to Care initiative, which has been signed by at least 20 different bodies representing various health care professions.²⁸

Six county councils have chosen to offer asylum seekers and undocumented migrants care on the same conditions as regular citizens. The motivations for these decisions were ethical and moral, in combination with political will. One county stated that the notion of “care that cannot wait” meant that the ethical principles of medical care and human dignity could not always be followed.²⁹ The access to care for asylum seekers may therefore vary depending on which region the person is living, as well as the assessment that each health care provider makes.

A report by the Västra Götaland regional administration indicates that the region would be able to reduce the need for inpatient care among asylum seekers if they were given access to health care on the same terms as Swedish citizens. This, among other measures, could lead to reduced costs for the region through reduced costs for institutional care. It would also alleviate the pressure on health care staff who often need to make difficult decisions about what care should be offered to asylum seekers.³⁰

²⁶ <http://rkrattsbaser.gov.se/sfst?bet=2008:344>

²⁷ Socialstyrelsen. Vård för Papperslösa. Sid 7.

²⁸ www.vardforpapperslosa.se

²⁹ Socialstyrelsen, Hälso- och sjukvård och tandvård till asylsökande och nyanlända. 2016. Sid. 27.

³⁰ Västra Götalandsregionen, Asylsökandes vårdkonsumtion i Västra Götaland 2011-2016. Sid 40.

Barriers to health care

In Skaraborg, MSF also observed a number of barriers to asylum seekers accessing adequate mental health care.

RESTRICTIONS BY CARE PROVIDER:

In cases where a person required referral to a health care provider, this was, most often, to a primary health care centre. While some primary health care centres make no distinction on the basis of legal status, it was necessary for MSF's counsellors to exert more pressure on certain centres in order for them to accept asylum seekers as patients.

When referring asylum seekers to primary health care centres in Skaraborg, MSF found that staff at certain health centres made the assessment that mental health problems among asylum seekers should be considered "care that can wait". The result was that people were initially denied care on the grounds that they are still in the asylum process. In certain cases, this interpretation included cases of suicidal thoughts and fainting from extreme emotion.

DELAYS IN INITIATING TREATMENT:

The nearest centre for referral of trauma cases was the Red Cross trauma centre in the town of Skövde. If a person is accepted to the Red Cross trauma centre, the average time before they can begin mental health treatment is 11 months (although waiting times may vary for other centres in country).

GAPS IN HEALTH SCREENING AND IDENTIFICATION OF MENTAL HEALTH PROBLEMS:

All asylum seekers should be offered a health screening,³¹ but not everybody actually receives

one, and there are differences in how much emphasis is put on identifying mental health problems during the screening process. There is a lack of standardised screening tools, and, as a result, large differences in how different counties carry out health screenings. 164 (75%) of the 219 asylum seekers that MSF screened had undergone a health screening in the Swedish system, but only 44 of those screened (26%) stated that they had been asked any questions about their mental health. This suggests an overall lack of identification of mental health problems.

LACK OF HEALTH INFORMATION AMONG ASYLUM SEEKERS:

Asylum seekers often lack knowledge and information about where to go for help. They also lack information about their rights.³² This can lead to overuse of emergency care services for issues that could be handled by regular care providers. In a study carried out by MSF in two asylum centres in Skaraborg, less than 20% of those questioned answered that it was easy for them to find information about where to go for mental health support and care, and less than 40% answered that it was easy to find information on illnesses in general.³³

COMMUNICATION DIFFICULTIES:

Linguistic and cultural differences can be significant barriers for asylum seekers to access care. Effective communication is a crucial to making an accurate diagnosis and providing correct treatment.³⁴ The use of cultural mediators can bridge the gap between counsellor and asylum seeker, as has been shown in MSF's project in Skaraborg. Several similar initiatives in the Västra Götaland region, where cultural medi-

³¹ <http://www.socialstyrelsen.se/sosfs/2011-11>

³² WHO. Public health aspects of mental health among migrants and refugees: a review of the evidence on mental health care for refugees, asylum seekers and irregular migrants in the WHO European Region. Sid 10.

³³ Mental Health for Asylum Seekers in Sweden – Asylum seeker and asylum centre staff wellbeing. 2016. Sid 4.

³⁴ WHO. Public health aspects of mental health among migrants and refugees: a review of the evidence on mental health care for refugees, asylum seekers and irregular migrants in the WHO European Region. Sid 11.

ators have been integrated in the health care system, have also shown promising results.³⁵

LACK OF FAITH IN THE HEALTH CARE SYSTEM:

Asylum seekers may harbour a mistrust toward public institutions based on previous experiences of persecution and fear of being reported to authorities. This may discourage patients from sharing personal information, such as that related to their mental well-being.³⁶

“When the children first come to us they don’t know any Swedish at all. It takes time to come to the point where you can explain to them how the Swedish system works. They get really scared when [people from] social services come because they think it’s an authority who have come to punish them. They see public institutions as something dangerous.”

STAFF MEMBER AT A HOME FOR UNACCOMPANIED MINORS, SKARABORG

STIGMA:

Many people experience difficulties freely expressing themselves about their mental health. MSF has taken steps to de-stigmatise

and normalise the idea of seeking help from a counsellor, and to break the notion that a person seeking mental health support is ‘crazy’.

“According to my experience, mental health is a very stigmatised issue within all cultures. It’s often been hard to initiate a conversation about mental health with a new person. And when the person needs to be directed to specialist care then he or she says, ‘I’m not crazy, I don’t need a psychologist’.”

MSF COUNSELLOR

“We Afghans, we don’t show that we feel bad. I can’t tell on the outside if a person is feeling bad. But some of my friends are really suffering. One of them is thinking really a lot about the interview with the Migration Agency. He says to me, ‘do you think they will send me back to Afghanistan?’ I tell him that he needs to try and think positive.”

ASYLUM SEEKER FROM AFGHANISTAN

³⁵ Västra Götalandsregionen. Kulturtolkare - en studie kring behov och form. 2017

³⁶ WHO. Public health aspects of mental health among migrants and refugees: a review of the evidence on mental health care for refugees, asylum seekers and irregular migrants in the WHO European Region. Sid 13.

CONCLUSIONS AND RECOMMENDATIONS

The EU's refugee and migration policies have become more and more restrictive over the last few years. Borders have been enforced through physical and administrative barriers which prevent people from passing through them. This results in an already vulnerable group being forced to risk their lives to reach safety in Europe, which can badly scar their mental health. MSF has long urged the EU to work towards safe and legal alternative pathways to reach Europe. One example of this is through family reunification; however, Sweden's temporary asylum law in 2016 severely restricted this option. MSF has also called on EU governments to ensure a humane refugee reception for asylum seekers, in line with agreed EU-directives. MSF has seen how substandard reception conditions in countries like Greece and Italy can negatively affect mental health. It is very important that such factors are recognised and addressed.

MSF's project in Skaraborg was limited in terms of time, geographical scope and the number of people who have received support. It has therefore not always been possible to draw general conclusions about the situation for asylum seekers across the whole country. MSF are, however, not alone in pointing to the need for extended interventions to address mental health issues among asylum seekers. There are numerous reports by civil society organisations and agencies, like the National Board of Health and Welfare, that also point to this. These issues should be addressed through targeted interventions and measures to increase access to care for asylum seekers. It is also important to continue with initiatives to increase the knowledge and capacity among health care providers, social services, staff at asylum centres and other professionals who work directly with asylum seekers.

The outcomes of our project point to a number of factors linked to the asylum system which have a negative impact on the mental well-being of asylum seekers.

- There is a lack of early identification and follow-up of asylum seekers suffering from mental health disorders. Improved health screening coverage, including early identification of mental health distress, would increase the chances of detecting these problems at an early stage. Clear guidelines and support need to be provided to health care staff in order to enable more effective follow-up.
- People in the asylum process often experience a number of obstacles to accessing care. This may involve health care staff that deny, delay or question the asylum seeker's request for help, with reference to his or her legal status. One of MSF's core principles is to deliver impartial aid, based solely on needs and not legal status. There are obvious and significant humanitarian imperatives for doing so. The negative consequences of restricting access to care are significant for the individuals concerned and society at large. MSF urges decision makers and care providers to ensure that asylum seekers are given equal access to care as Swedish citizens, regardless of origin or legal status.
- For unaccompanied minors who turn 18, moving from an unaccompanied minors' home to a regular asylum centre can cause great psychological strain, especially if it involves moving to another part of Sweden. Municipalities must, with the help of resources they have been allocated, ensure that unaccompanied minors can remain in the municipality even

after they turn 18. A softer and less abrupt transition, where the social safety net is not ripped apart from one day to another, would alleviate the psychological strain on many vulnerable young asylum seekers. Similarly, any forced movement of asylum seekers (be they adult or minor) from one home or centre to another should be minimised.

■ The uncertainty and powerlessness that characterise the asylum process has a negative influence on the mental well-being of asylum seekers. A shortening of the time taken to process applications (without jeopardising the thoroughness and fairness of the investigation) would lessen the time stuck in limbo. The Migration Agency must therefore take into consideration the negative impact on mental well-being that an extended process has. Authorities must also ensure that asylum seekers are regularly updated with information about their asylum claim.

MSF's model of intervention

One of the main causes of stress and worry that asylum seekers told us about was the fear of having their asylum claim rejected. It is clear that this is not something that can be 'cured', either through psychosocial initiatives or through psychological or medical interventions. On the other hand, MSF's work in Skaraborg has shown that through relatively simple initiatives, it is possible to help improve the mental well-being of asylum seekers that are facing an uncertain and worrisome future. Studies have shown that early interventions can prevent symptoms from developing into more serious conditions that require specialist care.

A decentralised model of intervention, with mobile teams offering support at the asylum seekers' homes, was an effective way of reaching out to asylum seekers and building trust. The possibility to carry out psychosocial

activities in connection to the place of residence is therefore of importance. Cultural mediators can also help bridge the cultural and linguistic gap between counsellors and asylum seekers.

MSF hopes that the model of intervention that has been applied in Skaraborg can serve as guidance and inspiration for other actors within health care, social services, civil society organisations and government agencies, and that innovative structural solutions can be developed in accordance with local needs. A detailed description of MSF's model of intervention can be found in the handbook *Operational Manual for Psychosocial Support to Asylum Seekers: MSF's Model of Intervention*.

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