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DOI: https://doi.org/10.1093/eurpub/ckq016

European Journal of Public Health, Vol. 21, No. 2, 184–189

doi:10.1093/eurpub/ckq016 Advance Access published on 14 July 2010

Mental health of failed asylum seekers as compared with pending and temporarily accepted asylum seekers

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Received 22 July 2009, accepted 29 January 2010

Background: Asylum seekers (AS) and refugees often suffer from severe psychopathology in the form of post-traumatic stress disorder (PTSD). As PTSD impacts memory functions, and as asylum applications rely on personal accounts, AS with PTSD are at more risk of being rejected than refugees. **Methods:** We studied the mental health of failed asylum seekers (FAS, $N = 40$) and a matched sample of AS ($N = 40$). Participants were administered structured interviews on sociodemographics, flight, exile and standardized questionnaires on PTSD, anxiety, depression and pain. **Results:** Both samples were severely affected; >80% exhibited at least one clinically significant condition. **Conclusion:** Given the great vulnerability of these individuals, long and unsettling asylum processes as practised in Western host countries seem problematic, as does the withdrawal of health and social welfare benefits. Finally, high rates of psychopathology amongst FAS indicate that refugee and humanitarian decision-making procedures may be failing to identify those most in need of protection.

Keywords: asylum seekers, credibility, mental health, rejection of asylum.

Introduction

In response to the increasing numbers of immigrants, typical host areas such as Europe, North America and Australia have in recent years tightened their immigration laws and asylum procedures. Only a small proportion of those seeking asylum in such countries are recognized as refugees.[1] Those rejected face repatriation to their countries of origin, where they believe themselves to be at risk of harm or persecution.[2] Consequently, growing numbers of failed asylum seekers (FAS) are deciding to remain illegally in the 'host' countries.[3] Only rough estimations on the numbers of these 'undocumented migrants' exist. As many as 22 500–58 000 *sans papiers* (French: without papers) whose application for asylum was declined are estimated to live in Switzerland.[3]

Asylum seekers and refugees are at high risk of ongoing mental health problems.[4,5] As many of them are traumatized by war, political/ethnic oppression and torture, it is not surprising that post-traumatic stress disorder (PTSD) rates of up to 70% have been found in community samples of AS and refugees.[5,6] Amongst those, especially individuals without secure residency status—be it pending cases[7–9] or rejected AS[10]—appear to be at high risk to suffer from ongoing mental health problems. In this context, it is especially alarming that the presences of traumatic experiences and PTSD directly influence refugee-status decision-making[11,12] as both variables severely impact various memory functions known to give personal accounts credibility.[13,14] Consequently, AS with PTSD might be more likely to be refused refugee status.[11]

In addition to their pre-migration trauma, individuals without secure residency visa suffer substantial post-migration stress,[7–9,15] insecurity regarding their legal status[10,16,17] and ongoing fear of repatriation and persecution.[10,18] These stressors may be particularly harsh in FAS for several reasons. In many host countries, FAS are supposed to leave the country within a defined period, and welfare benefits are discontinued immediately. Those who stay in the country lose their accommodation, are not permitted to work and receive no economic support. Finally, their health insurance coverage is discontinued, they are no longer entitled to free non-urgent primary or secondary care.[19,20]

A dearth of data exists on the general and especially mental health conditions of rejected AS who decide to stay on in Western countries. Despite discussion of these issues by general practitioners,[21,22] only one study so far has investigated the short-term impact of asylum-claim decisions on the trajectory of traumatic stress and other psychiatric symptoms.[10] Individuals living in illegality are by nature hard to locate and to study. From a moral perspective, however, we cannot ignore their fate. Therefore, our study aimed to investigate actual living conditions, trauma load and mental health of rejected AS with long histories of living in illegality and to compare their outcomes with those of non-failed AS.

Methods

Design of the study

The study compares FAS with AS whose claim was still pending or temporarily accepted, respectively, at the time of the study. All data were collected through direct interviews and standardized questionnaires. The FAS-sample was recruited from December 2008 to February 2009—a time when ~150 *sans papiers* had occupied a church in Zurich fighting for better asylum policies and provisions for hardship cases. Contacts were made with the help of *Bleiberechts–Kollektiv Zurich* (an organization defending the rights of undocumented migrants), and *Meditrina Zurich* (an outpatient health service for migrants without medical insurance or income). Interviews took place either in the squatted church, in the café of the *Bleiberechts–Kollektiv Zurich* or in shelters for *sans papiers*.

Inclusion criteria were illegal residency status following a rejected asylum claim. The AS-sample was recruited with the help of the Swiss Federal Office for Migration, which provided us with names and addresses of unselected individuals who were applying for asylum during a defined period and who were assigned to the canton of Zurich. Recruitment and assessment took place between July 2008 and April 2009. AS (total sample size: $N = 142$) were interviewed in their domiciles or at our department at their convenience. Inclusion criteria were having applied for asylum in Switzerland, and having a valid visa. Each FAS was matched with an AS from the full AS-sample. Matching variables were sex, age, years of education and the number of traumatic events experienced. The latter variable was considered a matching variable, firstly, because it likely mediates mental health as well as the asylum status. Secondly, compared to the FAS the randomly recruited total AS sample was similarly severe traumatized indicating to have experienced $M = 5.20$ ($SD = 4.27$) traumatic event types.[23] Cohen's effect size $d = 0.34$ indicates the absence of essential group differences between the total AS sample and the FAS. Consequently, to conclude that, due to the matching, no differences in trauma-load occurred it was necessary to consider trauma (variable) as a matching variable. In cases of more than one possible match, matching partners were chosen by randomization.

Before assessments, potential participants were informed in detail about the aims of the study and assured that participation was voluntary and that all data would be treated confidentially. All participants gave their consent to the study. The ~45-min assessment consisted of an interview conducted by trained psychologists from our department. If necessary, trained interpreters assisted the interviewers. All mental health questionnaires were translated and back-translated into the 11 main languages spoken by AS and refugees in Switzerland, using established translation/back-translation procedures.[24] Most participants were thus able to answer the questionnaires by themselves. Individuals who did not understand any of these languages or who did not have the necessary level of literacy completed the questionnaires in interpreter-assisted face-to-face interviews. The Ethics Committee of the canton of Zurich approved the study.

Sample

The first sample consisted of FAS ($N = 40$) whose claim for asylum in Switzerland had been rejected, but who had decided to stay on illegally. Most of these mainly male participants were single. They originated from 18 countries with an average duration of stay in Switzerland of 5.8 years and a mean duration of living in illegality of $M = 34$ months (range = 1–108 months). Over one-third (36.4%) had lived in Switzerland illegally for >2 years.

In the second sample, 78% of participants' asylum claims were still pending, whereas 23% had been rejected asylum status but obtained temporary visas. As a result of the matching procedure, most of the participants ($N = 40$) in this sample were also male. More than one-third of them were married. They originated from 17 countries and their average duration of stay in Switzerland was nearly 4 years. For sociodemographic characteristics, see table 1.

Measures

By means of a structured interview we assessed the demographic characteristics (such as sex, age, ethnicity, religion, education, etc.), the reason for the participants' migration as well as characteristics of the situation in Switzerland (such as duration of stay in Switzerland, but also variables targeting integration such as working, contacts to Swiss or satisfaction with life in Switzerland). Variables for this part of the assessment were adapted from previous research.[25,26] Mental health variables were assessed by standardized questionnaires. Traumatic events were assessed using part one of the Harvard Trauma Questionnaire,[27] a common instrument assessing 17 types of traumatic life events known to affect refugee populations (range = 0–17). In this article, we refer solely to the number of traumatic event types that participants indicated having experienced themselves.

The Posttraumatic Diagnostic Scale[28] is a Diagnostic and Statistical Manual of Mental Disorders, Version IV (DSM-IV)-based 17-item self-report assessing the PTSD symptom severity experienced by the respondent in the month prior to assessment. Each item is rated on a 4-point scale (range = 0–51). The PDS has demonstrated validity and reliability and is recommended as a particularly useful tool for screening and assessing PTSD.[28]

The Hopkins Symptom Checklist-25 (HSCL-25)[29] assesses symptoms of anxiety (10 items) and depression (15 items) on a 1–4 scale. Individuals with a mean score >1.74 are considered to be symptomatic. The scale has very good validity and reliability and has been adopted for use in refugee populations.[29]

The intensity of pain experience during the past month was measured by the 1-item Verbal Rating Scale (VRS, from Short Form 36 (SF-36)),[30] that is rated on a 6-point scale from '0 = no pain' to '5 = worst pain possible'. The VRS is established as a valid, reliable and change-sensitive measure of subjective pain.[31]

The 8-item EUROHIS assesses quality of life.[32] Responses to the eight items (5-point scale, range = 8–40) form a sum-score, with higher scores denoting higher quality of life.

Data analysis

The data were coded and analysed using the Statistical Package for Social Sciences version 17.0 (SPSS 17.0). Descriptive statistics were used to examine the demographic variables, characteristics of the living situation in Switzerland and the mental health variables. Kolmogorov–Smirnov tests were used to analyse whether the interval data were normally distributed. Paired sample *t*-tests (normally distributed continuous data), Wilcoxon tests for paired samples (ordinal data), McNemar–Bowker tests (nominal data) and McNemar's test (binominal data) were applied to identify differences between the two samples.

Results

The situation in exile

Although the samples were matched on sociodemographic characteristics, they differed significantly on most variables concerning life in exile (table 2). While the FAS had no valid visa by definition, the claims of more than three-quarters of the AS-group were still undecided after ~4 years in Switzerland. The groups also differed significantly in their duration of stay in Switzerland, with the FAS having been in the country longer than the AS—by necessity: asylum applications take years to process. While AS were more likely to have family members in Switzerland, the FAS indicated more social contacts with Swiss people. Regarding variables that are often seen as indicators of 'integration', such as working, command of German and following the news of the host country as well as the home country, no group differences emerged. Relative to FAS, pending/temporarily accepted AS were significantly more satisfied with their living

Table 1 Demographic characteristics of FAS and pending/temporarily accepted AS

Demographic characteristics	Samples		Group differences[a]	
	FAS ($N=40$)	AS ($N=40$)	t(df)/χ^2(df)	p
Sex[b], *N* (%)				
Male	38 (95.0)	38 (95.0)		1.000
Age[b] (in years)				
Mean	32.10 (7.11)	32.40 (7.86)	$t=0.49$ (39)	0.627
Range	22–51	18–51		
Region of origin, *N* (%)			$\chi^2=9.33$ (7)	0.230
Africa	18 (46.2)	11 (27.5)		
West Asia (incl. Turkey)	16 (41.0)	16 (40.0)		
East Asia (incl. Russia)	5 (12.8)	5 (12.5)		
South America	0 (-)	2 (5.0)		
Europe (incl. Balkan states)	0 (-)	6 (15.0)		
Marital status, *N* (%)				0.003
Single	36 (90.0)	25 (62.5)		
Married	4 (10.0)	15 (37.5)		
Education[b] (in years)				
M (SD)	9.78 (4.69)	9.70 (4.18)	$t=0.11$ (39)	0.914
Religion (main categories), *N* (%)			$\chi^2=3.22$ (3)	0.360
Muslim	14 (35.0)	20 (57.1)		
Christian	19 (47.5)	9 (25.7)		
Other	7 (17.5)	6 (17.1)		
Reasons for migration (main categories), *N* (%)			$\chi^2=4.93$ (3)	0.177
War	4 (12.1)	7 (17.5)		
Political persecution	9 (27.3)	16 (40.0)		
Ethnic/religious persecution	20 (60.6)	9 (22.5)		

a: The following tests were used: paired *t*-tests (normally distributed continuous data); McNemar–Bowker test (nominal data); McNemar's test (binominal data).
b: As these variables were matched, group differences were calculated solely for control reasons.

conditions in Switzerland and indicated better quality of life. Nevertheless, the groups did not differ regarding homesickness, with about two-thirds of each sample indicating that they felt homesick very often.

Number of traumatic experiences

Both samples—the FAS sample as well as the total AS sample—were severely traumatized. Therefore, we controlled the trauma load by using it as a matching variable. As a result of this procedure, both groups had experienced comparable numbers of traumatic event types. These included high-impact traumatic events such as imprisonment (FAS: 60.0%; AS: 40.0%), torture (FAS: 30.0%, AS: 47.5%) and the killing of family members (FAS: 32.5%, AS: 40.0%).

Mental health

The proportion of this non-clinical population with mental problems was high. Both groups indicated comparably high PTSD symptomatology. Based on the symptom severity-rating categories suggested by the authors of the PDS,[33] the whole sample showed moderate symptom severity; separate analysis of the PTSD cases only revealed 'moderate to severe' symptom severity (FAS: $M=25.60$, SD = 10.81; AS: $M=26.51$, SD = 9.13). Accordingly, less than one-third of each sample did not meet criteria for full-blown or sub-clinical PTSD, respectively. Similarly, both samples reported high anxiety and depression severity scores with more than two-thirds being clinically significant in both conditions as well as 'moderate' pain intensity during the last month. The samples did not differ regarding PTSD, depression, anxiety or pain intensity. Descriptive statistics and group differences for traumatic events and mental health variables are reported in Table 3.

Based on the PDS and HSCL-25 scores, only 12.5% ($N=5$) of the FAS and 17.5% ($N=7$) of the AS did not meet the criteria for any of the diagnoses assessed (full-blown PTSD, anxiety and depression). In contrast, 37.5% ($N=15$) of the FAS and 53% ($N=21$) of the AS suffered from all three conditions, and 47.5% ($N=19$) of the FAS and 22.5% ($N=9$) of the AS from two conditions. The groups did not differ regarding their overall prevalence of mental illness ($Z=-0.15$, $P=0.882$).

Discussion

Asylum has become a major issue of political debate in the Western world. It is known that many AS suffer severe mental health problems,[4] and that substantial numbers of FAS decide to stay illegally in the 'host' country.[3] To our knowledge, this is the first study to compare the mental health of FAS with that of pending/temporarily accepted AS. Only one study to date has examined the immediate effects of rejection on AS.[10] Reasons for the dearth of data may be that AS are *per se* an understudied population and that FAS, particularly, are very difficult to recruit.

One main finding of our study is that both samples showed severe mental health problems. Particularly, PTSD rates ~50% in both samples are alarming. These figures are consistent with previous findings in AS[5] and FAS samples.[10] They are significantly higher than in Western populations, where epidemiological studies have found PTSD rates ranging from 0% in Switzerland[34] to 1–2.2% in Germany[35] and 8% in the United States.[36] From a psychopathological perspective with a particular focus on traumatic events and PTSD symptomatology, it appears that people applying for asylum in Switzerland are severely traumatized by pre-migratory factors, such as surviving war and torture, and suffer from severe mental health problems. Consequently, they would desperately need mental health care. However, in contrast to pending/temporarily accepted AS, who theoretically do have access to mental health care—although specialist centres are rare and overcrowded—FAS do have limited or no access to

Table 2 Characteristics of the situation in Switzerland (CH) for FAS and pending/temporarily accepted AS

Situation in Switzerland	Samples		Group differences[a]	
	FAS ($N = 40$)	AS ($N = 40$)	t(df)/Z	P
Years since entry, *M* (SD)	5.78 (4.59)	3.93 (3.50)	$t = 2.87$	0.007
Type of visa[b], *N* (%)			$\chi^2 = 40.00$ (3)	0.000
Pending cases	0 (–)	31 (77.5)		
Temporary visa	0 (–)	9 (22.5)		
Failed/no visa	40 (100)			
Family members present, *N* (%)				0.002
No	37 (92.5)	24 (60.0)		
Yes	3 (7.5)	16 (40.0)		
Social contact beyond family, *N* (%)			$Z = -2.27$	0.023
Never	4 (10.0)	11 (27.5)		
Sometimes	17 (42.5)	19 (47.5)		
Often	19 (47.5)	10 (25.0)		
Social contact to Swiss, *N* (%)			$Z = -0.58$	0.564
Never	14 (35.9)	12 (31.6)		
Sometimes	19 (48.7)	18 (47.4)		
Often	6 (15.4)	8 (21.1)		
Working, *N* (%)				0.687
No	38 (57.6)	33 (89.2)		
Yes	2 (14.3)	4 (10.8)		
Command of German, *N* (%)			$Z = -1.36$	0.174
None	8 (20.5)	16 (40.0)		
Little	15 (38.5)	11 (27.5)		
Sufficient	14 (35.9)	9 (22.5)		
Fluent	2 (5.1)	4 (10.0)		
Follow the news, *N* (%)			$\chi^2 = 4.27$ (3)	0.233
No	16 (40.0)	11 (28.2)		
Home country	9 (22.5)	5 (12.5)		
Home country and CH	15 (37.5)	23 (59.0)		
Satisfaction with life in CH, *N* (%)			$Z = -0.36$	0.000
Very good	4 (10.3)	13 (32.5)		
OK	9 (23.1)	16 (40.0)		
Very bad	26 (66.7)	11 (27.5)		
Homesickness, *N* (%)			$Z = -0.08$	0.938
Never	6 (15.0)	4 (10.3)		
Seldom	0 (0.0)	2 (5.0)		
Sometimes	16 (40.0)	16 (41.0)		
Often	18 (45.0)	17 (42.5)		
Quality of Life (EUROHIS), *M* (SD)	19.23 (4.79)	24.17 (6.17)	$t = -4.69$ (39)	0.000

EUROHIS: short form of the WHOQOL-Bref quality of life assessment.

a: The following tests were used: paired *t*-tests (normally distributed continuous data); Wilcoxon matched-pairs signed rank test (ordinal data); McNemar–Bowker test (nominal data); McNemar's test (binominal data).

b: As this variable was matched, group differences were calculated solely for control reasons.

non-emergency health care, including mental health consultations.

Besides the adversities that many AS have faced in their home countries, high levels of post-migration stress caused by factors such as living in illegality or uncertainty about asylum decisions are hypothesized to negatively impact the mental health of AS and FAS.[10] Our results show that, even though no group differences emerged regarding variables indicating integration, FAS were less satisfied with their actual living conditions and also reported lower quality of life as compared to AS. The fact that these major—albeit not surprising—findings are not reflected in differing rates of psychopathology might be explained in ceiling effects regarding psychopathology in both samples or in the fact that both samples do experience high levels of actual stress, be it pending asylum decisions or the fact of living in illegality.

As in other host countries, in Switzerland applicants whose claims for asylum are rejected, but who have a severe illness such as PTSD that cannot be treated in the home country, qualify for temporary 'humanitarian' visas. The alarmingly high rate of PTSD cases in the FAS sample shows that the authorities are failing to make use of this possibility—although it is evident that many of those rejected will not have access to PTSD treatment in their home countries. Alarmingly, a recent study found that, even after psychological training, official judicial interviewers were unable to identify PTSD cases during asylum interviews.[6] From a psychological perspective, it is obvious that many of the FAS would qualify for a temporary humanitarian visa.

The relatively small sample size as well as the use of self-reports (as opposed to clinician ratings) are a limitation of the study as both factors have been found to overestimate mental disorder-prevalence estimates.[37,38] The use of larger samples as well as inclusion of structured diagnostic interviews, in addition to standardized questionnaires, would be helpful for future studies. As the study design was cross-sectional, we cannot draw conclusions on longitudinal patterns or make causal inferences. Future studies should employ longitudinal data and include a comprehensive psychological assessment. While we were able to recruit a random sample from all AS living in the canton of Zurich, the FAS sample were recruited from protesters fighting for better asylum policies and provisions for hardship cases. It is conceivable that they may have felt a wave of hope, solidarity and social support from the Swiss population during this protest. As the participants in our study may be the more active and courageous of

Table 3 Traumatic events and psychiatric outcome measures for FAS and pending/temporarily accepted AS

Variables	Samples		Group differences[a]	
	FAS ($N = 40$)	AS ($N = 40$)	t(df)/χ^2(df)/Z	P
Number of traumatic events experienced[b]				
M (SD)	6.68 (4.49)	6.68 (3.45)	$t = 0.00$ (39)	1.000
PTSD (PDS)				
Severity (sum score), *M* (SD)	16.68 (12.88)	19.99 (12.68)	$t = 1.09$ (37)	0.284
Diagnosis, *N* (%)			$Z = -0.70$	0.487
Full-blown PTSD	18 (45.0)	20 (50.0)		
Sub-clinical PTSD[c]	9 (22.5)	11 (27.5)		
No PTSD	13 (32.5)	9 (22.5)		
Anxiety (HSCL-25)				
Severity, *M* (SD)	2.30 (0.73)	2.25 (0.80)	$t = 0.34$ (39)	0.738
Clinically significant, *N* (%)				0.424
Yes	31 (77.5)	27 (67.5)		
No	9 (22.5)	13 (67.5)		
Depression (HSCL-25)				
Severity, *M* (SD)	2.41 (0.60)	2.37 (0.71)	$t = 0.23$ (38)	0.819
Clinically significant, *N* (%)				0.754
Yes	35 (87.5)	32 (82.1)		
No	5 (12.5)	7 (17.9)		
Pain intensity (VRS), *M* (SD)	2.35 (1.83)	2.40 (1.88)	$t = 0.11$ (39)	0.911

PDS: Posttraumatic Diagnostic Scale. HSCL: Hopkins Symptom Checklist-25. VRS: Verbal Rating Scale.
a: The following tests were used: paired *t*-tests (normally distributed continuous data); Wilcoxon matched-pairs signed rank test (ordinal data); McNemar's test (binominal data).
b: As this variable was matched, variable group differences were calculated solely for control reasons.
c: Defined as meeting criteria for only two out of three PTSD symptom clusters according to DSM-IV.

those FAS living in illegality, it is also possible that our data underestimate the PTSD rate in FAS. Comparing FAS with successful asylum claimants may help to specify the relation between insecure or secure visas and mental health. In this study, we used an *ad hoc* list of post-migration living problems—although this list was derived with regard to previous research,[25,26] further studies indispensably should include a more detailed measure of post-migration stress.

Our results have implications for both policy-makers and clinicians. The rates of severe mental problems in the groups of FAS and AS are alarming. Specifically, the high rates of PTSD and high symptom severity suggest that these individuals have survived severe trauma; moreover, the data show that PTSD is a common condition in AS, whether recognized by the state as refugees or not. Given these findings it seems crucial to establish effective means of identifying and providing adequate medical treatment for traumatized AS early in the asylum process. As argued before, the denial of medical support to FAS is unethical and affects the most vulnerable people in Western host countries.[15,21,22]

Furthermore, given the vulnerability of AS, Western host societies must continue to work to improve asylum decisions. Firstly, it seems doubtful that decision-makers to date have a sufficient understanding of the effects of PTSD to inform their decisions about these vulnerable individuals. Psychological knowledge could help them to better understand the often complex presentation of claimants with mental health needs, and thus ensure that these claimants are offered the necessary protection in the form of asylum or at least temporary visas.[11,14,39] Secondly, to reduce post-migration stressors and to foster the healing of this vulnerable group, the usually long and unsettling asylum processes should be accelerated substantially and should be followed by immediate and intensive means of integration into the host country.

Acknowledgements

The study was funded in part by the Swiss Federal Office for Migration. First and foremost, we thank our participants for taking part in this study. We additionally wish to acknowledge the help of the following institutions in the recruitment of participants: *Bleiberechts–Kollektiv Zurich*; *Kasama Zurich*, a café for refugees; Anselm Burr, vicar of St. Jakob's Church; *Meditrina Zurich*, a health meeting point for individuals with no medical insurance or income and the Swiss Federal Office for Migration. We additionally thank Nadia Copiery for her help in data collection, Lutz Wittmann and Hanspeter Mörgeli for their statistical advice and Lukas Nick and Jane Herlihy of the Centre for the Study of Emotion and Law for their helpful comments on the manuscript and Susannah Goss for English-language editing.

Funding

This study was supported in part by the Swiss Federal Office for Migration.

Conflicts of interest: None declared.

Key points

- Failed asylum seekers showed as much severely affected mental health as pending and temporarily accepted asylum seekers.
- Long and unsettling asylum processes seem problematic, as does the withdrawal of health and social welfare benefits after rejection of asylum claims.
- The high rates of psychopathology amongst the rejected asylum seekers indicate that refugee and humanitarian decision-making procedures may be failing to identify those most in need of protection.

References

1 United Nations High Commissioner for Refugees. *2007 Global trends: refugees, asylum seekers, returnees, internally displaced and stateless persons*. Geneva: UNHCR, 2008.

2 Glendenning P, Leavey C, Hetherton M, et al. *Deported to danger: a study of australia's treatment of 40 rejected asylum seekers*. Sydney: Edmund Rice Centre for Justice and Community Education, 2004.

3 Longchamp C, Aebersold M, Rousselot B, Ratelband-Pally S. In: Bern GFS, editor. *Sans-papiers en Suisse: c'est le marché de l'emploi qui est déterminant, non pas la politique d'asile. Rapport final sur mandat de l'office fédéral des migrations*. 2005.

4 Fazel M, Wheeler J, Danesh J. Prevalence of serious mental disorder in 7000 refugees resettled in western countries: a systematic review. *Lancet* 2005;365:1309–14.

5 Johnson H, Thompson A. The development and maintenance of post-traumatic stress disorder (PTSD) in civilian adult survivors of war trauma and torture: a review. *Clin Psychol Rev* 2008;28:36–47.

6 Gäbel U, Ruf M, Schauer M, et al. Prävalenz der Posttraumatischen Belastungsstörung (PTSD) und Möglichkeiten der Ermittlung in der Asylverfahrenspraxis. *Zeitschrift für klinische Psychologie und Psychotherapie* 2006;35:12–20.

7 Laban CJ, Gernaat HB, Komproe IH, et al. Postmigration living problems and common psychiatric disorders in Iraqi asylum seekers in the Netherlands. *J Nerv Ment Dis* 2005;193:825–32.

8 Silove D, Steel Z, Watters C. Policies of deterrence and the mental health of asylum seekers in western countries. *JAMA* 2000;284:604–11.

9 Silove D, Sinnerbrink I, Field A, et al. Anxiety, depression and PTSD in asylum-seekers: assocations with pre-migration trauma and post-migration stressors. *Br J Psychiatry* 1997;170:351–7.

10 Silove D, Steel Z, Susljik I, et al. The impact of the refugee decision on the trajectory of PTSD, anxiety, and depressive symptoms among asylum seekers: a longitudinal study. *Am J Disaster Med* 2007;2:321–9.

11 Herlihy J, Scragg P, Turner S. Discrepancies in autobiographical memories-implications for the assessment of asylum seekers: repeated interviews study. *BMJ* 2002;324:324–7.

12 Herlihy J, Turner S. Should discrepant accounts given by asylum seekers be taken as proof of deceit? *Torture* 2006;16:81–92.

13 Herlihy J. Evidentiary assessment and psychological difficulties. In: Noll G, editor. *Proof, evidentiary assessment and credibility in asylum procedures*. Leiden/Boston: Martinus Nijhoff Publishers, 2005;123–40.

14 Herlihy J, Turner SW. The psychology of seeking protection. *Intl J Refugee Law* 2009;21:171–92.

15 Steel Z, Mares S, Newman L, et al. The politics of asylum and immigration detention: Advocacy, ethics, and the professional role of the therapist. In: Wilson JP, Drozdek B, editors. *Broken spirits: the treatment of traumatized asylum seekers, refugees, war and torture survivors*. New York: Brunner-Routledge, 2004, 659–87.

16 Ryan DA, Benson CA, Dooley BA. Psychological distress and the asylum process: a longitudinal study of forced migrants in Ireland. *J Nerv Mental Dis* 2008;196:37.

17 Momartin S, Steel Z, Coello M, et al. A comparison of the mental health of refugees with temporary versus permanent protection visas. *Med J Aust* 2006;185:357–61.

18 Steel Z, Frommer N, Silove D. Part I – The mental health impacts of migration: the law and its effects. Failing to understand: refugee determination and the traumatized applicants. *Int J Law Psychiatry* 2004;27:511–28.

19 Norredam M, Garcia-Lopez A, Keiding N, Krasnik A. Risk of mental disorders in refugees and native Danes: a register-based retrospective cohort study. *Soc Psychiatry Psychiatr Epidemiol* 2009;44:1023–29.

20 Norredam M, Mygind A, Krasnik A. Access to health care for asylum seekers in the European Union – a comparative study of country policies. *Eur J Public Health* 2006;16:286–90.

21 Romero-Ortuno R. Eligibility of non-residents for NHS treatment: failed asylum seekers should not be denied access to free NHS care. *BMJ* 2004;329:683.

22 Williams PD. Why failed asylum seekers must not be denied access to the NHS. *BMJ* 2004;329:298.

23 Schmidt M, Maier T, Müller J. *Mental health of asylum seekers after 1 month compared to 12 months of living in Switzerland*, University of Zurich, Zurich, 2010 (submitted for publication).

24 Bontempo R. Translation fidelity of psychological scales: an item response theory analysis of an individualism-collectivism scale. *J Cross Cultural Psychol* 1993;24:149–66.

25 Heckmann F. From ethnic nation to universalistic immigrant integration: Germany. In: Heckmann F, Schnapper D, editors. *The integration of immigrants in European Societies*. Stuttgart: Lucius and Lucius, 2003, 45–78.

26 von Lersner U, Wiens U, Elbert T, Neuner F. Mental health of returnees: refugees in Germany prior to their state-sponsored repatriation. *BMC Int Health Hum Rights* 2008;12:8.

27 Mollica RF, Caspi-Yavin Y, Bollini P, et al. The Harvard Trauma Questionnaire. Validating a cross-cultural instrument for measuring torture, trauma, and posttraumatic stress disorder in Indochinese refugees. *J Nerv Ment Dis* 1992;180:111–16.

28 Foa EB, Cashman L, Jaycox L, Perry KJ. The validation of a self-report measure of posttraumatic stress disorder: the Posttraumatic Diagnostic Scale. *Psychol Assessment* 1997;9:445–51.

29 Mollica RF, Wyshak G, Khoun F, Lavelle J. Indochinese versions of the Hopkins Symptom Checklist-25. *Am J Psychiatry* 1987;144: 497–500.

30 Ware JE, Sherbourne CD. The MOS 36-item short-form health survey (SF-36). I. Conceptual framework and item selection. *Med Care* 1992;30:473–83.

31 Williamson A, Hoggart B. Pain: A review of three commonly used pain rating scales. *J Clin Nurs* 2005;14:798.

32 Nossikov A, Gudex C, editors. *EUROHIS: developing common instruments for health surveys*. Amsterdam: IOS Press, 2003.

33 Foa EB. *PDS (Posttraumatic Stress Diagnostic Scale) Manual*. Minneapolis: National Computer Systems, 1995.

34 Hepp U, Gamma A, Milos G, et al. Prevalence of exposure to potentially traumatic events and PTSD. The Zurich Cohort Study. *Eur Arch Psychiatry Clin Neurosci* 2006;256:151–8.

35 Perkonigg A, Kessler RC, Storz S, Wittchen HU. Traumatic events and post-traumatic stress disorder in the community: prevalence, risk factors and comorbidity. *Acta Psychiatr Scand* 2000;101:46–59.

36 Kessler RC, Sonnega A, Bromet E, et al. Posttraumatic stress disorder in the National Comorbidity Survey. *Arch Gen Psychiatry* 1995;52:1048–60.

37 Keller A, Lhewa D, Rosenfeld B, et al. Traumatic experiences and psychological distress in an urban refugee population seeking treatment services. *J Nerv Mental Dis* 2006;194:188–94.

38 Steel Z, Chey T, Silove D, et al. Association of torture and other potentially traumatic events with mental health outcomes among populations exposed to mass conflict and displacement: a systematic review and meta-analysis. *JAMA* 2009;302:537–49.

39 Rousseau C, Crepeau F, Foxen P, Houle F. The complexity of determining refugeehood: A multidisciplinary analysis of the decision-making process of the Canadian immigration and refugee board. *J Refugee Studies* 2002; 15:43–70.