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Mental health of refugees in inner-London

What follows is an attempt to describe the provision of mental health care for refugees (including asylum seekers). Our views are based on our work with refugees in inner-London and on consultation with service providers.

There are some 50 million refugees and displaced persons in the world (Bruntland, 2000), of which about 250 000 are in London. In the UK, refugees are entitled to the same level of health care as the local population but there are difficulties in ensuring its provision. The *National Service Framework for Mental Health* (Department of Health, 1999) emphasises that special help is needed for excluded groups such as refugees.

Political considerations

Government policies have a considerable impact on the health of refugees. Within the Home Office is the National Asylum Support Service (NASS), which provides accommodation and living expenses for asylum seekers. Its policy of 'dispersal' of asylum seekers has been controversial. It seems that most asylum seekers wish to stay in or near London. Presumably this is to be near fellow countrymen or to avail of greater economic opportunities. Asylum seekers are housed in temporary 'holding facilities' in London and are dispersed to other parts of the country after a few weeks or months. This adds uncertainty to already disrupted lives. Health care may be affected. One example from our work is of a woman from Kosovo who was being treated for psychosis. She was then suddenly 'dispersed' to Liverpool, jeopardising the continuity of her treatment. The Home Office maintain that they try to take such issues into consideration but a body of opinion, including The Refugee Council (2000), is increasingly concerned about the adverse effects of the policy. The more controversial voucher scheme for essential expenses is problematic: it can cause shame to people who have had enough of that experience. One of our patients with cognitive impairment was unable to understand how to use them.

About 900 refugees per year are detained either in prison or in special centres (The Refugee Council, 2000). Some of them are detained primarily because of mental illness. Concern has been expressed about the quality of the assessment and the treatment of these detainees (Bunce, 1997) and about the adverse effects of detention on this vulnerable group.

Psychiatric disorder in refugees

Many studies have found high rates of psychiatric disorder among refugees. Post-traumatic stress disorder (PTSD) and depression are the most common (de Jong *et al*, 2000). Wide variation in the rates of disorder can be attributed to differing cultures and experiences in the groups sampled. Rates of PTSD may have been exaggerated owing to a wish to attract resources to help refugees by 'talking up the numbers' (Watters, 2001). The prevalence of PTSD is at its lowest in epidemiological samples (3–16%) and may rise to 90% in psychiatric clinic populations (Silove, 1999). The validity and usefulness of the concept of PTSD have been questioned, particularly in non-Western cultures (Summerfield, 2001), on the grounds that it 'medicalises' and oversimplifies complex problems of suffering.

In providing help it is likely that practical advice, language tuition, advocacy and particularly employment are most important (Eastmond, 1998). Nevertheless, there is a group of refugees who have been so traumatised that treatment is called for. There is substantial evidence that both psychological and pharmacological approaches are helpful. Of the former, cognitive–behavioural approaches have been most studied (Foa, 2000). Large double-blind placebo-controlled trials have shown that selective serotonin reuptake inhibitors are effective, particularly sertraline (Brady *et al*, 2000) and paroxetine (the only drug licensed for PTSD in the UK). Other antidepressant drugs show promise (Cyr & Farrar, 2000).

The health service

Most initial health care contacts take place in general practice. Some refugees find it difficult or even impossible to obtain primary health care or are offered only temporary registration (Jones & Gill, 1998), leaving them vulnerable to receiving a less comprehensive service.

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There is generally no record kept of the numbers of refugees on the list of a general practice. This is an obstacle to service planning and resource allocation.

By far the greatest problem is that of language. We elicited the views of inner-city general practitioners (GPs) by postal questionnaire. From 435 GPs in our sample, 257 (59%) replied. Three-quarters were not satisfied with the arrangements for interpreters. The same professional interpreting service is used both by general practice and by the psychiatric services. There were long delays in obtaining assistance. Sudden influxes of refugees from particular locations were cited as reasons for delay but it was our impression that the service was underresourced.

A telephone-interpreter system was used in urgent situations but this was criticised as being expensive and unsuitable for the exploration of complicated psychological problems. There were also problems with volunteer interpreters and fears about confidentiality. Children might be expected to interpret for adults, often about inappropriate topics, leading to embarrassment.

Among those consulted there was a widespread feeling that refugees should be helped by someone from their own culture. Many of the problems reported concerned cultural issues such as different health beliefs. For example, we were told that depression did not exist as a concept in Kurdish culture. A tendency to express distress by somatic symptoms was noted.

Rates of admission of refugees to psychiatric facilities in the UK are unknown but clinical experience suggests that these may be higher than the general population. Uncertainty about whether refugee status will be granted may complicate treatment.

In our area there is a team of non-clinical workers who help refugees to access clinical care by providing information in many languages and by liaising with the health service. These often have familiarity with more than one culture and are known as bi-cultural or link workers. They have been found to be very useful and their deployment is being expanded.

Refugee community groups

There is little evidence of consultation with refugees themselves about their mental health needs. Watters (2001) described a survey of the provision of mental health services for refugees throughout Europe. Consultation with refugees was found to be 'extremely rare'. In the UK the *National Service Framework for Mental Health* (Department of Health, 1999) argues that services should be planned and implemented in partnership with local communities. The voice of refugees is best heard through refugee community groups (RCGs).

These RCGs are voluntary groups that serve as a social network for refugees from specific communities. They provide a wide range of support services, including English and mother-tongue classes, counselling, advocacy, day centres and basic supplies in urgent cases such as food, clothes and blankets. (Although they mostly rely on volunteers, some have paid workers and most receive some financial support from local or central government.)

We interviewed representatives of 13 such organizations in inner-London. Most pointed out that mental illness had a different meaning in their culture than in England. Shame and stigma were often more pronounced. In many less developed countries psychiatric hospitalisation is reserved for those with very severe and intractable problems.

Depression was the most common problem described, often connected with isolation, racism, lack of occupational opportunities and losses sustained in the home country. Loneliness was an issue. We were not able to quantify the extent of mental illness but we were given descriptions of breakdowns and suicide.

In general, RCGs had a poor opinion of the mental health services in this country. They complained of finding it difficult to find out about services and to gain access to them. Bad experiences with interpreters were described. Many felt that services were not appropriate to their culture and some felt that health workers were not well-disposed towards them.

In alleviating mental problems, family, friends, elders and traditional healers were mentioned. Churches were helpful. The RCGs made a plea for partnership with the health service, feeling that there were areas of potential mutual benefit such as interpreting, cultural awareness, education and advocacy.

Non-governmental organisations (NGOs)

These play a vital role, both in helping refugees directly and in raising public awareness of the issues. The Refugee Council finds accommodation for asylum seekers, a task delegated by the Home Office. It also provides day care in its own premises, where vulnerable refugees receive support and trained nurses assist with the early detection of mental illness and liaise with local psychiatric services to provide rapid treatment. It has the advantage of close connections with RCGs, who provide interpreters and other support.

The Medical Foundation for the Victims of Torture is a highly respected charity that employs a variety of approaches to assessment and treatment. Individual and group psychotherapy are important components of its activity and its resources tend to be overwhelmed.

Conclusions

It is important to recognise that there are two phases in the career of the refugee in the new country. In the first phase the refugee is newly arrived and his or her needs are basic: food, accommodation, legal advice, medical attention and orientation to the new country and its language. It is only when these basic needs have been met, which may take some time, that the refugee can enter the second phase during which treatment for conditions such as traumatic stress can be considered.

The psychiatric team has an important clinical role to play in the assessment and treatment of mental illness. Clinicians should attend to the patients' construction of mental health problems and the cultural context of these

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while exercising caution in the use of Western classifications. The numbers of refugees using the service should be recorded to help argue for extra resource allocation. Arrangements for interpreters should be monitored closely because we have found that they are often unsatisfactory. Professional interpreters are best (Phelan & Parkman, 1995) but they could be supplemented with volunteers if properly organised. Written information should be available in various languages. The psychiatric services should forge links with NGOs and RCGs, who want to play a greater role. This could be of mutual benefit with interpreting, befriending and cross-cultural understanding.

On a larger scale there could be more cooperation between health authorities in different parts of London. This has been recommended in various reports but there is little sign of it happening. This illustrates the difficulty in, and perhaps the resistance to, helping this vulnerable group.

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European Union of Medical Specialists – activities of the Section and Board of Psychiatry

The European Union of Medical Specialists (UEMS) was set up on 20 July 1958, 16 months after the Treaty of Rome was signed. In 1962, the UEMS Section of Psychiatry was established. It was, however, relatively inactive until it was revitalised following a meeting of the European Societies in 1990 called by the Royal College of Psychiatrists and chaired by Dr (now Dame) Fiona Caldicott. The UEMS Board of Psychiatry was established in 1992 as a working group of the Section with a particular focus on training matters. The Section is currently chaired by Dr Anne Lindhardt (Denmark) and the Board is chaired by Professor Manuel Gomez-Beneyto (Spain). Both Section and Board meet twice a year.

Over the years, the Section and Board have focused on standards for training in accordance with contemporary knowledge and current developments in Europe. It has always been and remains crucial to balance the desire for harmonisation with the recognition of cultural and structural differences. The Section and Board see their role as a quality assurance organisation, setting standards by stimulating the process of development in member countries. It is for the national professional bodies to use these standards and recommendations internally to achieve the goals in their own countries. The Board has not seen it as either helpful or necessary to act as a European examining board for the speciality.

Apart from the full European Union members, there are also a large number of associate member countries. The Association of European Psychiatrists (AEP), the European Federation for all Psychiatric Trainees (EFPT), the Permanent Working Group (PWG) and the Mental Health Regional Office of the World Health Organization also attend, with observer status.

The Section and Board have set up a number of working groups to focus on important UEMS Charters (Box 1) and on fields of activity more exclusively relevant to psychiatry (Box 2). The last three activities in Box 2 are still at an early stage.

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