

Addressing mental health needs of asylum seekers and refugees in a London Borough: developing a service model

Tania Misra Specialist Registrar in Public Health, Department of Primary Care and Social Medicine, Imperial College, London, UK, **Ann Marie Connolly** Director of Health Improvement, Department of Primary Care and Social Medicine, Imperial College, London, UK, **Nicole Klynman** London School of Hygiene and Tropical Medicine, Keppel Street, London, UK and **Azeem Majeed** Professor of Primary Care and Social Medicine, Haringey Teaching PCT, Trust Headquarters, St Ann's Hospital, London, UK

The aim of the study was to investigate the experiences of professionals who treat asylum seekers and refugees, as well as those responsible for the planning, management and delivery of mental health services to this group in Haringey; and to identify and address key areas of difficulty to assist development of appropriate mental health services for this group in Haringey. Individual face to face interviews were conducted with the service providers using a semi-structured interview schedule. The results were triangulated with another study done in general practices in Haringey. Fourteen service providers – health professionals, service managers and commissioners who were involved in responding to the mental health needs of asylum seekers and refugees in Haringey. Findings from a previous study were used for primary care professionals' views. The main issues faced by providers in dealing with mental health needs of asylum seekers and refugees were: increased demands placed on the time and resources of already stretched mental health services, language and cultural barriers, the difficulties in working through interpreters in delivering therapy, and the need for longer consultation time. Asylum seekers and refugees were felt to seek health professionals' help with matters that were outside the professionals' remit. Some providers were unsure of the appropriateness of the western model of treating mental illness for this group. Development of better information on these particular groups locally, and the use of appropriately trained health professionals from the asylum seeker and refugee community to both inform and provide mental health services, would be appropriate responses. A model of service provision addressing the wider influences on the mental health of this group is proposed, that would address the concerns raised by providers and users.

Key words: asylum seekers; mental health; needs assessment; refugees

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Introduction

All refugees coming to the UK, including asylum seekers, are entitled to National Health Service

(NHS) treatment by general practitioners (GPs), although under the 2004 regulations, asylum seekers whose applications have been rejected and have exhausted all rights of appeal are not allowed access to in-patient services (Table 1) (Refugee Council, 2004; Home Office, 2004). Despite a high level of need, refugees are often unable to get appropriate services from mainstream health and social agencies. There is little data on patterns of utilization of health services by asylum seekers and refugees,

Address for correspondence: Dr Tania Misra, Specialist Registrar in Public Health, Department of Primary Care and Social Medicine, 3rd floor, The Reynolds Building, Charing Cross Hospital, Imperial College, London W6 8RP. Email: taniamisra@hotmail.com

Table 1 Asylum seekers entitlements to health services

Status	Primary care	Secondary care
Asylum seeker	Yes	Yes
Asylum seeker affected by section 55 of the National Immigration and Asylum Act, 2003	Yes	Yes
Asylum seeker at any stage of appeal	Yes	Yes
Asylum seeker awaiting a judicial review	Yes	Yes
Unsuccessful asylum applicants receiving 'hard cases' grant	Yes	Yes
Unsuccessful asylum applicants awaiting deportation	Yes	Hospital decides entitlement based on the individual's complete circumstances
Unaccompanied children and young people under 18	Yes	Yes
People granted Exception Leave to Remain or Enter (ELR/ELE), or Humanitarian Protection (HP)	Yes	Yes
People with refugee status	Yes	Yes

Source: Refugee Council <http://www.refugeecouncil.org.uk/infocentre/entit/sentit004.htm>

including mental health, but they are perceived to generate high workload for primary health care teams (Summerfield, 2001).

The Government supports destitute asylum seekers awaiting a decision regarding their asylum claim. It provides financial support, equivalent to 70% of income support, and accommodation on a no-choice basis away from London and the Southeast (Connelly and Schweiger, 2000). The dispersal policy, which has been operational since April 2000, has relocated asylum seekers and refugees to areas where services have less experience of dealing with them and their complex needs. Hence, it has probably reduced the accessibility of primary care and mental health services for many in this group (Hodes and Goldberg, 2002).

Mental health services in Haringey face a variety of challenges, reflected in high admission rates.

Social deprivation, population density and mobility, unemployment, and large numbers of single parent families are common in Haringey and influence the prevalence of mental health problems. A high proportion of people from black and ethnic minority groups and the large number of asylum seekers and refugees add to the difficulties faced by mental health services in Haringey (Commissioning Team, 2002; Misra *et al.*, 2005).

Primary care services in Haringey face high levels of demand from the local population (Commissioning Team, 2002). Specialist mental health services are dominated by the costs of in-patient beds and forensic in-patient costs, which divert resources from community based services, thus limiting the capacity for prevention (Commissioning Team, 2002).

Amongst asylum seekers and refugees, very few people need specialist psychiatric assessment (Burnett and Peel, 2001). However, psychological problems, and in some cases frank mental illness, may develop as a result of the stresses of conflict and exile (Burnett and Peel, 2001). When this project was started, there was little provision of mental (or other) health services specifically for asylum seekers and refugees. There were problems with registration with GPs, and it typically took 3 to 6 months for an asylum seeker or refugee to reach a mental health service after initial presentation to a GP. There was substantial concern about access to mental health services for this group.

In our first article, we examined the epidemiological aspects and user perspectives of the need for mental health services among refugees and asylum seekers. In this second article, we describe the views of clinicians and service providers (Stevens and Raftery, 1994), and outline a model for mental health services in Haringey.

Methods

Members of the local authority asylum seekers' team and the Racial Equality Council were interviewed. Important service providers who played a key role in delivering and managing mental health services to this group were identified – psychiatrists, psychologists, service managers, and commissioners – and were interviewed (Box 1). Pre-validated and tested open-ended interview schedules were used. Tania Misra carried out and transcribed all

Box 1 List of service providers interviewed

Haringey Asylum Seekers' Service	3
Haringey Racial Equality Council	1
Psychiatrists	2
Psychologists	2
Service Managers	2
PCT Commissioners	4

interviews. Grounded theory was used to analyse the data (Bowling, 2002). The interview findings were summarized in four thematic categories: problems of access, predominant mental health problems, main issues in providing services to asylum seekers and refugees, and providers' suggestions on how to provide a better service.

Most of the mental health care is provided by GPs; hence it was essential to include their views in the needs assessment. A study done in Haringey in 2000 by Klynman and Connolly had elicited the views of primary care professionals on health care provision for asylum seekers/refugees (Klynman and Connolly, 2000). This study included a survey of all practices and in-depth interviews of key primary care staff such as GPs, practice managers, receptionists, and nurses in six local practices (Klynman and Connolly, 2000). Interactions between primary care staff, GPs, and asylum seekers and refugees had been observed and patient case notes were also reviewed. Results of the Klynman study provided the GP perspective on mental health needs of this group (Klynman and Connolly, 2000). These were triangulated with the results from this study, to formulate a model of care and delivery that would be appropriate to the needs of asylum seekers.

Results

Problems of access

i) *Referrals*: Mental health referrals are made to the Community Mental Health Teams, but there are long waiting times. Most referrals to mental health services come from GPs and their referral letters often do not mention the patient's immigration status. Haringey Teaching Primary Care Trust (HTPCT) commissions

counselling sessions for 15 patients per year from an inter-cultural therapy centre, but the demand for services is much greater than this. Highly traumatized people or torture victims are referred to the Medical Foundation for the Care of Victims of Torture, but its waiting list at that time was over 18 months and hence it was not suitable for dealing with acute problems.

- ii) *Interpreters*: All tiers of service have access to Teaching Primary Care Trust (TPCT) funded link workers for interpretation. Telephone interpreting is not often used. The link workers are considered to generally provide satisfactory interpretation. Often, appropriate interpreters cannot be arranged for first appointments, as the language spoken by the patient is not recorded in the referral letter. The Local Authority's Asylum Services have a pool of trained interpreters, but they have limited experience of interpreting in health service settings.
- iii) *Length of consultation*: Extra time is required for working with interpreters in mental health, depending on the patient's condition. Doing psychoanalytic work with link workers and interpreters is difficult because the patient's body language and the interpreter's words have to be combined to make sense of the interaction. Moreover, not all therapists feel confident about dealing with the problems of refugees and asylum seekers.

There are two perspectives in dealing with asylum seekers and refugees: 'Oh God! This is impossible – too much trauma! Or – No problem at all!'
(Health care provider 1)

- iv) *Missed appointments*: The uncertainty of this group's life – such as lawyer's appointment or Home Office interviews clashing with a therapy session – leads to missed appointments, or re-scheduling, which increases the administrative load and leads to further delays in accessing treatment.
- v) *Constraints*: The significant demands made by this group on the already stretched staff's time and skills, affects the capacity to deliver services. They often request certificates and letters for the Home Office, or for housing departments, which is seen as an inappropriate use of practitioners' time.

Main mental health needs

i) *Primary Care practitioners* provide most of the mental health care for this group. In the study done in 2000, providers felt that mental health needs were the commonest reasons for a visit to the GP among this group (Klynman and Connolly, 2000). The main conclusions from that study, which focused on primary care services for asylum seekers and refugees, are summarized in Box 2.

Many GPs found it hard to explore problems such as depression or somatisation as they felt that the interpreter may not be accurately translating the words, or there may not be a word for depression in the language being used. They also felt that their westernized ideas of depression may not be appropriate, but some practices did treat depressed patients successfully.

ii) *Psychological therapy services* deal with most of the mental health referrals for this group. Commonly seen problems are post traumatic stress disorder (PTSD), depression, and generalized anxiety.

A patient with depression and social phobia might respond to the Cognitive Behavioural Therapy (CBT) approach in

normal circumstances, but if they do not have a secure base, internal and external reality merge and problems become more complex. If the practical issues are resolved, it is easier to focus on psychological and emotional issues. For a psychological treatment to be effective, a person needs to be focused on improving them.

(Health care provider 2)

iii) *Psychiatry and other services*: Psychotic cases constitute a small proportion of cases from asylum seeker and refugee groups. These usually present in accident and emergency (A&E), and are referred to Psychiatry. Only the most severe mental health problems are handled by psychiatrists, many of which present via Section 136 of the Mental Health Act (removal to a place of safety by the police) rather than via GP referrals. Some groups of asylum seekers have high rates of drug use, which can lead to early onset of psychosis. Young women sometimes self-harm.

Main service issues

Many asylum seekers are referred to specialist mental health services because primary health care providers do not always have the time or

Box 2 Conclusions from study done in General Practices in Haringey by Klynman and Connolly in 2000

Main conclusions

- Many practices are struggling to provide good services for asylum seekers and refugees.
- There are variable numbers registered with different practices and differing policies of registration of these groups between practices.
- Language is the biggest problem in dealing with this group.
- Some asylum seekers and refugees have inappropriate expectations of services.
- GP practices are often expected to deal with non-medical issues when there seems nowhere else for the asylum seeker or refugee to go.

Specific problems in relation to mental health issues.

- Somatisation of depressive symptoms.
- Difficulties in finding a common ground to talk.
- Problems of working through interpreters.
- Cultural barriers – the GPs interviewed were unsure about the relevance of western models of treatment of depression.
- Difficulties in referring to counselling services due to long waiting lists, and no clear referral pathways to the services.

specialist knowledge to deal with them, and because of somatisation of mental illness among many refugee groups.

Providers suggestions for improvement

Providers of mental health services had a number of suggestions about how to improve services and improve joint working between primary care teams and specialist services.

- The collection of more accurate information on the numbers of asylum seekers and refugees using mental health services.
- Use appropriately trained asylum seekers and refugees to address language and cultural barriers. For example, the Haringey Drug Advisory Service Team recruited a Turkish counsellor to a post that provides one day a week for training and support to obtain formal qualifications to practice counselling in the UK.
- More resources for language and interpretation services.
- Training for all levels of mental health and primary care workers to raise awareness of the mental health needs of refugees and asylum seekers.

Proposed service model

For many refugees, restoration as far as possible of their normal life can be an effective promoter of mental health. Most people would rather be active independent citizens than recipients of benefits (Burnett and Peel, 2001). The main priorities for developing mental health services for asylum seekers and refugees identified in the needs assessment are outlined in Box 3.

- i) *An Asylum Seekers and Refugee Health Support Team* as a first line support service is a key proposal. This team would actively support mental health services in providing care to this group by addressing those issues that are outside the remit of health services, yet are crucial to their mental health. The role of this team would be to:
- Conduct initial health checks to identify physical and mental health needs.
 - Help in registering with a GP.
 - Provide information about how to use the NHS appropriately.
 - Refer to the appropriate tier within the local mental health services.

Box 3 Priorities for the development of mental health services for asylum seekers and refugees at PCT level

1. The development of a first line health support team to address the practical issues of daily living for this group, and their basic health needs.
2. Information about how the NHS operates and how to access mental health services.
3. Help with registration with a GP and hence access to the full range of primary care services.
4. Primary care teams need to be aware of the common mental health problems experienced by different refugee groups. The first health check should include consideration of past and present circumstances, ethnic origin, and the physical and mental health effects of trauma, in addition to the usual 'New Patient Screening'.
5. Adequate language support through interpreters or link workers.
6. Language support should be accompanied by training for primary care and mental health teams to enable them to work more effectively with interpreters.
7. The development of proper data recording systems for asylum seekers and refugees seen within the health service at all levels.
8. Clear referral and care pathways within the mental health service for this group.
9. Appropriate counselling services for emotional and psychological consequences of trauma, flight and resettlement.
10. Programmes to support the re-qualification process, and subsequent employment by the NHS of refugees with health care qualifications.
11. Links between the PCT, mental health services and refugee community organizations and groups that wish to influence the development of services and programmes for their communities.

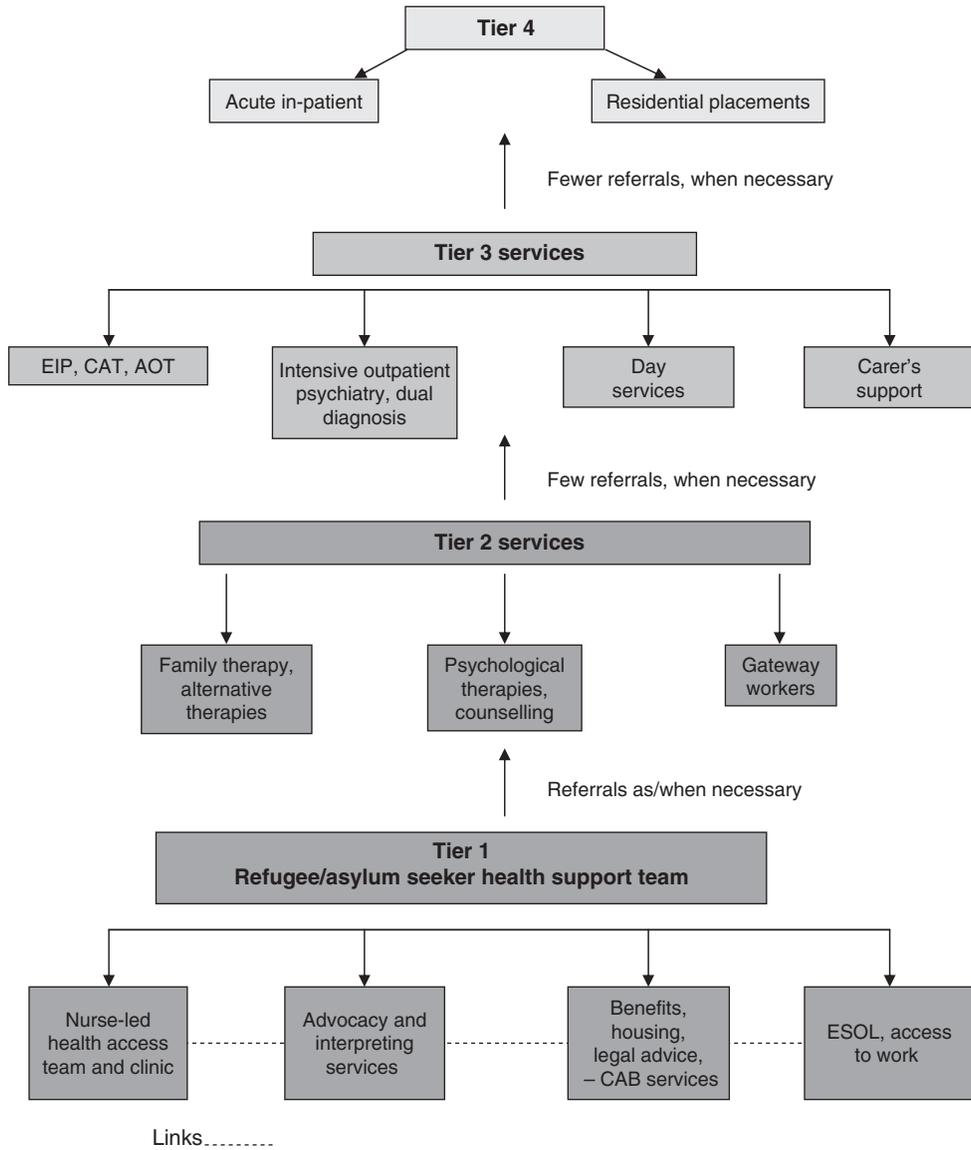


Figure 1 Model of mental health services for asylum seekers and refugees

- Assist with housing, education, ESOL (English for Speakers of Other Languages) classes, employment, legal advice, benefits, and social support through effective links with the Citizens' Advice Bureau, and the borough's Asylum Seekers' Team, the Housing team and Education Services.
- ii) *Composition of the Asylum Seekers and Refugee Health Support Team.* The team would comprise a Team Leader (nurse) and a Health Advocate (health visitor) employed full time. Health care professionals who are in the process of re-qualifying in this country could be used as lay health advisors whose role would be

to provide information on the NHS, such as how to register with a GP, to new arrivals from their community in their own language. They might also develop UK recognized qualifications in mental health care concurrently.

- iii) *Links with Mental Health Services* The Health Support Team would have direct links with primary care and with different tiers of mental health services (see Figure 1). They would be trained to manage patients, and would be able to refer directly to specialist mental health services where necessary.

Discussion

In this article, we presented mainly the views of service providers, elicited by semi-structured interviews. It is recognized that there are limitations in this approach due to rapid appraisal methodology, and the purposive nature of the sampling of interviewees. The views of GPs were based on a large study done 2 years before this study (Klynman and Connolly, 2000). However, there was a large level of agreement of views between and within user and provider groups, which would indicate consistency between the studies and increase the validity of the findings.

GPs found it difficult to deal with mental health problems of this group, and many felt that the westernized models of care may not be appropriate approaches. Many GPs refer patients to psychological therapies as they feel unable to deal with them. In the health service, GPs are often aware of the problems faced by this group, but do not have the training or the referral options to deal with them (Laurence, 2002).

Within psychological therapies, PTSD, depression and generalized anxiety were the most commonly seen disorders, but therapists felt that if patients' issues of daily living are solved, they can focus on getting better. Undue pathologization of this group has been criticized, and the refugee literature emphasizes addressing issues in their social rather than their mental world (Lipsedge, 2001; Summerfield, 2001). Burnett also stresses the importance of not turning the normal expression of grief and distress concerning highly abnormal experiences into a medical problem (Burnett and Peel, 2001).

Attempts to professionalize and pathologize the refugee experiences are perceived as intrusive by

refugees (Timimi, 1998). On the other hand, this study strengthens the evidence that asylum seekers and refugees experience difficulty in accessing mental health services. The development of care pathways for this group, based on evidence based algorithms (Figure 1), could alleviate some of the difficulties encountered by both users and providers of mental health services.

The providers needed more resources for language and interpretation services. Difficulties arise in communicating therapeutically with patients who do not share the same language as the clinician (Bolton, 2002). They also felt that more accurate information on this group would help better planning of services. Similarly, in discussing the provision of services for asylum seekers based on experience with Kosovan refugees, Ghebrehewet stresses the need for resources to follow asylum seekers and the development of a secure national database of asylum seekers, which could be made accessible to all agencies (Ghebrehewet *et al.*, 2002).

Other important issues raised were the need for training of mental health and primary care workers at all levels, and the recruitment of workers from the refugee communities within mental health services. Watters suggests provision of interpreting services, along with provision of training to mental health workers, advocacy services to navigate through health and social care systems and specialized services run by refugees for particular needs of refugee communities (Watters, 2001).

Conclusions

In the process of settlement in a new country, asylum seekers and refugees first need to feel safe. Their immediate needs are related to survival, provision of food, accommodation, information on various systems and services in the new country, basic familiarity with the local language, legal advice, and primary health care. It is only when these needs have been met, that they can benefit from treatment for conditions such as PTSD or depression.

The provision of health services for asylum seekers and refugees must be considered within this framework. These are important lessons for other primary care trusts (PCTs) struggling similarly to provide a coherent mental health service for asylum seekers and refugees in a rapidly changing policy

environment. Other key lessons include the need for better information on asylum seekers and refugees and making use of appropriately trained health professionals from this group to help in the planning and provision of mental health services.

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References

- Refugee Council.** 2004a: 3-3-2004a. Retrieved 19 May 2006 from: <http://www.refugeecouncil.org.uk/infocentre/ertit/sertib004.htm>.
- Home Office.** 2004b: 3-3-2005b. Retrieved 19 May 2006 from: http://www.homeoffice.gov.uk/ind/en/home/lawspolicy/refugee_integration.html.
- Bolton, J.** 2002: The third presence: a psychiatrist's experience of working with non-English speaking patients and interpreters. *Transcultural Psychiatry* 39, 97–114.
- Bowling, A.** 2002: *Research methods in health*, second edition, Buckingham: Open University Press, 351–401.
- Burnett, A. and Peel, M.** 2001: Asylum seekers and refugees in Britain – the health of survivors of torture and organised violence. *British Medical Journal* 322, 606–609.
- Commissioning Team, H.T.P.C.T.** 2002: *Draft model of care – mental health services for adults of working age in Haringey*. London: Haringey TPCT.
- Connelly, J. and Schweiger, M.** 2000: The health risks of the UK's new asylum act. *British Medical Journal* 321, 5–6.
- Ghebrehewet, S., Regan, M., Benons, L. and Knowles, J.** 2002: Provision of services to asylum seekers. Are there lessons from the experience with Kosovan refugees? *Journal of Epidemiology and Community Health* 56, 223–26.
- Hodes, M. and Goldberg, D.** 2002: The treatment of refugees: service provision reflects Britain's ambivalence. *Psychiatric Bulletin* 26, 1–2.
- Klynman, N. and Connolly, A.M.** 2000: *Primary care services for asylum-seekers/refugees in Haringey: a pilot study*. London: Tottenham Primary Care Group.
- Laurence, B.** 2002: Asylum seekers and refugees: an uncertain exile – public health perspective. *Healthcare Counselling and Psychotherapy Journal*, April, 29–30.
- Lipsedge, M.** 2001: Commentary. *Advances in Psychiatric Treatment* 7, 222–23.
- Misra, T., Connolly, A. and Majeed, A.** 2005: Addressing mental health needs of asylum-seekers and refugees in a London borough: the user perspective. *Primary Health Care Research and Development* 7, 242–249.
- Summerfield, D.** 2001: Asylum-seekers, refugees and mental health services in the UK. *Psychiatric Bulletin* 25, 161–63.
- Timimi, S.** 1998: Refugee families have psychological strengths. *British Medical Journal* 317, 475.
- Watters, C.** 2001: Emerging paradigms in the mental health care of refugees. *Social Science and Medicine* 52, 1709–18.