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Addressing mental health needs of asylum seekers and refugees in a London Borough: epidemiological and user perspectives

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

The objectives of this study were to undertake a needs assessment of mental health services for asylum seekers and refugees in the London Borough of Haringey, to estimate accurate numbers of asylum seekers and refugees who need mental health services, and to understand their perspective on mental health needs and services. The mental health needs of asylum seekers and refugees in Haringey were determined through a needs assessment exercise, using epidemiological and corporate approaches. The representatives of the main asylum seeker communities in Haringey were interviewed to find out what the mental health needs of this group and their community are, and how best to provide services to them. Estimates of number of asylum seekers and refugees in Haringey ranged from 5000 to 35 000, with a current best-guess figure of 31 000. The community representatives' views suggested that the factors affecting mental health of asylum seekers and refugees were not directly under the remit of the National Health Service (NHS). They felt that practical issues like education, employment, and social inclusion should be addressed alongside provision of effective professional help like psychotherapy or pharmacotherapy. They also felt that language and cultural barriers were significant impediments to constructive engagement with mental health services for this group. Mental health needs of asylum seekers/refugees are broad based, with implications for public health, social services, primary care, and mental health services. Approaches to developing services for asylum seekers and refugees should be multidisciplinary, and community driven, addressing language and cultural barriers.

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

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Introduction

About 350 000 asylum seekers (out of approximately 4.2 million in Western Europe) have come to the UK in the past decade, from about 35 countries (Summerfield, 2001). Of these, most are living in London and the Southeast of England (Aldous *et al.*, 1999; Fassil, 2000). Box 1 shows the definition of a refugee, and Table 1 shows various types of immigrant status related to being an asylum seeker or a refugee.

Asylum seekers/refugees present a special challenge to mental health services: they are migrants, far away from their significant others, culture and environment (Lavik, 1998). Furthermore, they are forced migrants, with a possible heavy burden of persecution and extreme traumatization from fleeing conflict, major upheaval, situations of torture, and travelling across national borders (Westermayer and Wahmanholm, 1989; Gorst-Unsworth and Goldenberg, 1998; Sandford, 2002). Finally, they have to adapt to a new and foreign society with their

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, UK. Email: taniamisra@hotmail.com

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Box 1 Definition of a refugee

A refugee is a person who 'owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of his nationality, and is unable or, owing to such fear is unwilling to avail himself of the protection of that country.'
(Home Office website – http://www.ind.homeoffice.gov.uk/default.asp?pageid=15)

There are also 'economic' and 'environmental' refugees – fleeing poverty, environmental degradation or catastrophe, though they don't always fit the UN's definition. Refugees are distinguished from other migrants by their lack of choice.
(World Refugee Survey 2002. US Committee for refugees, Washington D.C.)

Table 1 Definitions related to asylum seekers and refugees

Asylum seeker	Asylum claim submitted, awaiting Home Office decision.
Refugee status	Accepted as a refugee under the Geneva Convention, given leave to remain in the UK for four years, and can then apply for settled status (indefinite leave to remain, see below).
	Eligible for family reunion for one spouse and all children under 18 years.
Indefinite leave to remain (ILR)	Given permanent residence in Britain indefinitely. Can apply for British nationality after 12 months of ILR.
	Eligible for family reunion only if able to support family without recourse to public funding.
Exceptional leave to remain/enter (ELR/E)	The Home Office accepts there are strong reasons why the person should not return to the country of origin and grants the right to stay in Britain for three years. Also called 'Humanitarian protection'.
	Expected to return if the home country situation improves.
	Ineligible for family reunion.
Refusal	The person has been refused asylum, but has a right of appeal within strict time limits.

own cultural baggage facing new values, norms, laws, climate, dress, food, housing, work, and recreation (Marsella, 1994; Lavik, 1998; Tribe, 2002a). Several studies suggest that exile-related stressors such as social isolation, poverty, language difficulties and uncertainty may be as powerful as events before flight (Lavik *et al*., 1996; Pernice and Brook, 1996; Silove *et al*., 1997; Gorst-Unsworth and Goldenberg, 1998; Blair, 2000; Sandford, 2002). They often present with characteristic disorders and symptoms, requiring health care access to systems that are already overburdened (Keyes, 2000). Somatization is common, as physical pain may be much more acceptable than psychological pain (Lipson, 1993; Summerfield, 2001; Tribe, 2005). However, epidemiological studies of refugees indicate higher than expected rates of psychopathology. Delayed and missed bereavement is common among this group, the obvious losses being the deaths and separations of family and friends during flight (Tribe, 2002b). The prevalence of depression in this group ranges from 18–50% (Silove *et al*., 1997; Gorst-Unsworth and Goldenberg, 1998; Hermansson *et al*., 2002; Turner *et al*., 2003). Post-traumatic stress disorder (PTSD) is common, ranging from 11–50% in several studies, and as high as 68–100% in specialist clinic populations (Lavik *et al*., 1996; Gorst-Unsworth and Goldenberg, 1998; Weine et al., 2000; Hermansson *et al*., 2002; Turner *et al*., 2003). Mood, anxiety, and substance disorders are also common (Gorst-Unsworth and Goldenberg, 1998; Hermansson *et al*., 2002). Organic brain lesions are notably more frequent than in other populations, from injuries, nutritional deficiency, inadequate medical care, toxins, and epidemics (Westermayer, 2000).

However, the levels of mental health problems documented in various studies have to be viewed in light of the fact that they are based on western psychiatric constructs, which are culture bound but not universal. There is also an issue of inequity in access to primary care and mental health services for many asylum seekers/refugees, further worsened by the dispersal policy operational since April 2000 (Connelly and Schweiger, 2000; Immigration and Nationality Directorate Communication Team, 2000; Hodes and Goldberg, 2002; Silove *et al*., 2005). In London, where more than 85% of refugees have been living, pressures are felt by the statutory sector in providing services for this group (Audit Commission, 1999).

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In the UK NHS, some primary care trusts are contracting with mental health trusts to provide services for refugees. However, these services often have small budgets and limited skill mix, and may not be linked adequately to mainstream mental health services (Hodes and Goldberg, 2002). Some voluntary sector services involve refugees as trained counsellors. Many of these are specific to refugee communities (Immigration and Nationality Directorate Communication Team, 2000). Yet there are few, if any, structures for consulting refugee communities and little consideration of their needs in community care plans and service specifications (Summerfield, 2001). To treat them appropriately and ensure equity in access to health care, a comprehensive knowledge base is necessary.

We report here the findings from a needs assessment project that was undertaken to develop a service model for the mental health care needs of asylum seekers and refugees in a highly deprived part of London. We used epidemiological and corporate approaches (1994) to assess mental health needs. This project therefore provides important lessons for other service providers, who often have to respond to the needs of these new and vulnerable clients very quickly when they are dispersed into areas where there is no capacity for, or history of, dealing with these groups.

The project was carried out in the London Borough of Haringey, which is located in the north of the capital. There are large concentrated areas of deprivation in Haringey and an unemployment rate of 8.9%. This is more than the London average of 6.5%, and over double the national average (Haringey Council, 2003a). Over half of its 222 000 people come from ethnic minority backgrounds, and Haringey Council (2003b; Haringey Primary Care Trust, 2003c) provides services to one of the largest number of asylum seekers amongst boroughs in London. Asylum seekers from a number of countries including Turkey, Kurdistan, Kosovo, as well as those from African and Asian countries live in Haringey (Haringey Council, 2003b).

Methods

The project was undertaken from November 2002 to December 2003. The epidemiological and corporate approaches used were based on the needs assessment framework suggested by Stevens and Raftery (Stevens and Raftery, 1994).

The epidemiological approach was used to estimate the number and proportion of mental health service users amongst asylum seekers/refugees in Haringey. The corporate approach was used to determine the need for mental health services from the service users' perspective.

Needs assessment framework

Epidemiological

Estimates of the number of asylum seekers and refugees in Haringey were made, based on national figures, data from the Greater London Authority (GLA), the Health of Londoner's Project, and previous work done on assessing the health needs of asylum seekers and refugees in Haringey (Klynman and Connolly, 2000). Data from Haringey Council's Asylum Seekers' Service was used to estimate the number of asylum seekers and refugees living in the borough requiring support. The number of mental health consultations requiring interpreters was used as a proxy indicator of service use by this group.

Corporate

Semi-structured interviews were chosen because they provide detailed feedback but ensure that specified subject areas are covered (Bowling, 2002). All the interviews were carried out face to face. We used a validated open ended interview schedule, based on the tool developed by the Three Boroughs Asylum Seekers' Team in Lambeth, Southwark, and Lewisham (Webster and Rojas, 2000).

Using a purposive sampling approach, leaders or key members of the refugee community organizations (RCOs) representing the main refugee groups in Haringey were identified – based on information provided by Haringey Council: namely – Albanians, Kosovans, Turkish, Kurdish, Turkish and Greek Cypriot, Somali, Iraqi, and Afghan. The RCO representatives (or leaders) were chosen because their wide experience and their position in the community gives them a good understanding of the issues. Ten community representatives were interviewed, using face to face as well as telephone interviews. Tania Misra carried out and transcribed

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all the interviews. Grounded theory was used to analyse the interviews.

Results

Number of asylum seekers and refugees

Most refugees in the UK live in London. A report by the GLA provides the most comprehensive estimate of between 3 50 000 and 4 20 000 refugee and asylum seekers in London (Fassil, 2000). Haringey Council used the midpoint of this figure (3 85 000) as its best estimate of this population in London.

Figure 1 compares the number of principal asylum applicants in Haringey with other boroughs in north-east London (2003b). Figure 2 shows that there are 4654 asylum services' clients in Haringey (2003b). These figures pertain to clients of Haringey Council's asylum seeker's service, which only provides support to destitute asylum seekers and those entitled to other forms of support. Their number has been dropping as the National Asylum Support Service (NASS) takes over cases, and they are dispersed outside London.

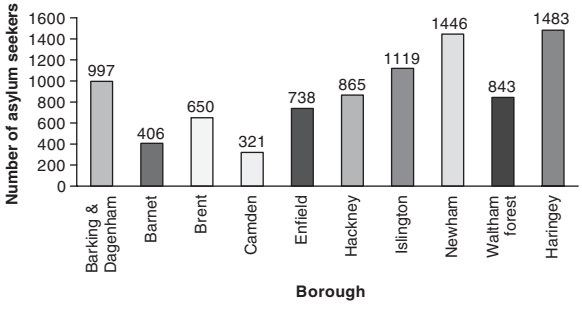

Figure 1 Number of asylum seekers (individual applicants) receiving support in Haringey and other boroughs in north-east London (September 2003)

Those who are self supporting, living with families or friends, or working are not included in these counts. Refugees, those granted indefinite leave to remain (ILR), those refused asylum but not removed, and those placed in Haringey from other boroughs are also not included in these figures. Hence, the routinely available statistics underestimate substantially the actual number of asylum seekers and refugees in the borough, many of whom are likely to have significant mental health problems (Figure 2).

The Health of Londoner's Project estimated the number of asylum seekers and refugees in Haringey in 1999 was 15 000–17 500 (Bardsley and Storkey, 2000). With the further influx into the borough since 1999, the current number of refugees and asylum seekers is probably between 20 000 and 35 000, with a best estimate of 31 000 (Haringey Council, 2003b). Anecdotal evidence from Haringey's asylum seekers' service and specialist teams dealing with this group indicates that one-third (10 000) to one-half (15 000) of asylum seekers and refugees need substantial support for coping with their circumstances.

Data from a local day care facility for mental health for the year 2002, recorded 776 link worker appointments, out of a total of 4072 total appointments, 19% of all sessions. In the absence of proper

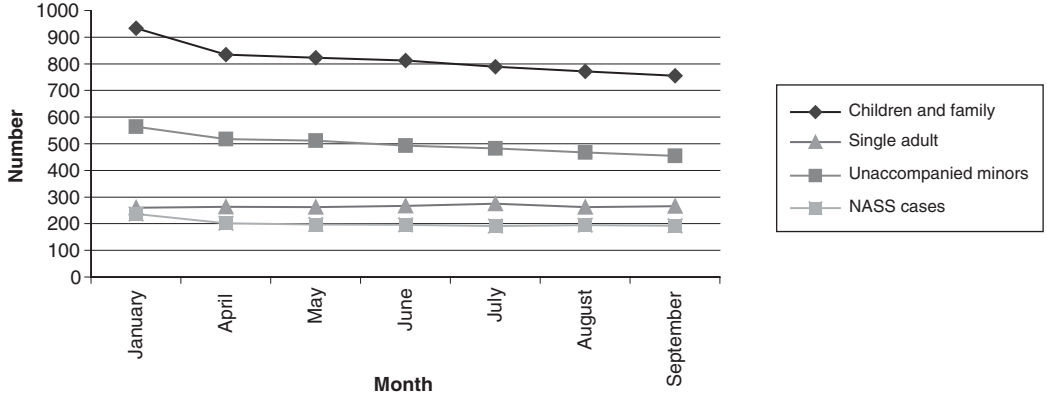

Figure 2 Number of asylum seekers supported in Haringey (September 2003)

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recording of asylum seeker status in the health service, these figures provided a proxy indicator of the workload from recent immigrants, who are most likely to be asylum seekers. However, this provides a very rough, indicative figure only.

Users' views

The corporate health needs assessment involved interviewing service providers and users, focusing on adults of working age (as asylum seekers and refugees belong mainly to this group). The views of users of mental health services are presented in this paper; those of service providers are presented in a second paper. The quotations represent those quotes from the user interviews that highlight the theme of the discussion under one topic area.

Problems of access

i) A third of registrations with general practitioners for this group have to be secured by the primary care trust through allocation, typically taking five to eight weeks to obtain. This causes delays in receiving treatment in primary care and getting referrals to specialist services.

ii) Lack of knowledge about the health and social care system often results in people not presenting to the appropriate clinician or service. Not understanding the language of referral appointment letters causes missed appointments, and further delays in accessing services.

iii) Language difficulties are a significant barrier to effective consultations. There are inadequate interpreting facilities in primary care, specialist clinics, and hospitals. Even when interpreting services are available, it is more difficult to obtain effective treatment for mental health problems when the clinician has to communicate with the patient through an interpreter. This is particularly the case with psychological and cognitive therapies.

> People with mental health problems need counsellors who speak their own language. If you go through an interpreter, it's very hard to tell your true feelings.
>
> (Community representative 1)

iv) Cultural barriers are present. Many people are unwilling to use mental health services because they feel stigmatized by doing so. Generally, women are more open to counselling than men.

> There is often a culture of denial within some cultures toward mental illness. The Kurdish community has a term for mental illness – 'sakat', which has derogatory connotations, and invites prejudice.
>
> (Community representative 2)

> The men are the most difficult to engage with – because of their pride. They are not allowed to work, which makes them feel they've lost their power, their everything. This is very stressful. They feel lonely and depressed, and feel bullied and persecuted … but they are not willing to admit that they have a problem for which they need help.
>
> (Community representative 4)

Therapies provided in the western model of care may be inappropriate for non-western groups. Constructs of illness vary among different groups, and need to be understood to treat them effectively. Many mental health issues are dealt with by talking and sharing with friends and family, instead of seeking outside help. However, some people do seek psychological therapies if they become very vulnerable.

> In English, Depression has a meaning. But there are problems when there are no words for a condition in a culture, and people cannot identify that they have a mental health problem.
>
> (Community representatives 2 and 3)

> Psychological therapy takes out religion – but you need something to believe to keep your spirit alive. The treatments available have no provision for building strength in a spiritual manner.
>
> (Community representative 3)

> Talking may bring out old wounds, which may not be good.
>
> (Community representative 6)

Predominant mental health problems

i) The main sources of mental stress were problems encountered before and after migration.

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Seeking refuge in a new country is highly stressful. Depression and PTSD are commonly seen, but are not the only problems encountered in this group.

ii) Much of the mental ill health is related to the asylum process, particularly insecurity about the asylum claim and an unfamiliar legal process. It can take four to five years to get proper accommodation, refugee status and employment.

iii) Living in an alien environment and culture leads to a risk of isolation. Loss of their normal social environment and lack of integration also contribute to high levels of stress in these groups. In the Somali community, social isolation leads to people chewing a highly addictive substance called 'khat' in large quantities and over longer periods, which is harmful.

> We didn't have any depression in … when there was no war. The weather was lovely, and there were a lot of people to talk to.
>
> (Community representative 5)

For people who have been in the UK for some time and have refugee status, such as the Turkish and Albanian communities, the main mental health issues arise from adapting to a new culture and way of life. These are related to issues such as the breakdown of marriages, domestic violence, dealing with crime and drugs, and coping with children rebelling against the community's norms.

iv) Somatization of mental health problems is common. Mental ill health often manifests as somatic problems such as tiredness, headaches, and digestive disorders.

Main service issues

i) Inadequacies in the provision of language support and delays in getting appointments and assessments by a mental health care provider were key issues for this group.

ii) There is often a lack of confidence in health services. Asylum seekers and refugees visit their general practitioners frequently, but often feel that the treatment they receive is ineffective. They tend to have more faith in those local doctors who speak their language.

> Most people have a very cynical view of health services, with many feeling that services are not culturally appropriate and people in the health service are disinclined towards them.
>
> The doctor should be like a prophet, not a warlord!
>
> (Community representative 5)

iii) Many groups, particularly women, see themselves as being especially vulnerable. Women were often the victims of rape or domestic violence, and wish to be seen by female doctors and counsellors.

Discussion

The needs assessment identified issues of service access and equity, and the need for trained counsellors from within the refugee communities, and a greater involvement of the representatives in service development to make the services more acceptable and effective for this group. Nearly all groups emphasized the need for more practicable solutions such as constructive engagement of the unemployed, addressing boredom and isolation, and support for language and vocational training courses that can lead them to contribute to society, rather than health service based programmes.

The findings of our study are opposed to the conventional view of this group as one requiring intensive psychological support and prolonged care under the health services. Much of the refugee literature suggests high levels of mental health problems for this group, as various psychiatric morbidities. These studies have used existing (western) tools for evaluating this group, which many not be valid or appropriate. Box 2 summarizes the comments made by community representatives for improving the mental health service provision for asylum seekers and refugees.

One of the biggest constraints of this needs assessment project was the lack of local data on the number of asylum seekers living in the area and the number using mental health or primary care services. Estimates were made based on national data, figures from the council, and some local data from previous studies (Jones, 1999; Klynman and Connolly, 2000). This highlights the need for better information on this group of users, because without

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Box 2 Users' suggestions for improvement

1) Services should focus on both physical and mental health.
2) Some specialist psychologists and counsellors should work exclusively for this group.
3) RCOs should be consulted about changes to services.
4) Having a health worker from the community, who understands the culture and speaks the language, would help improve people's perception and access to mental health care.
5) Community based activities to address boredom and isolation, and to engage the unemployed constructively.
6) Support for people to help themselves – such as English for Speakers of Other Languages (ESOL) classes, vocational courses.
7) Development of pathways to employment for highly qualified people (eg, doctors, teachers, and nurses) who want to contribute constructively to society.

this information, planning services for this group is very difficult.

Data on the use of interpreters was used to generate a proxy measure of service use by this group. However, interpreting services may also have been used by people from minority ethnic communities who were not asylum seekers. Moreover, they only represent those who present to mental health services, and do not estimate unmet need.

Interviews with representatives of the main RCOs provided the user perspective for this study. Direct interviews with asylum seekers and refugees were not conducted for this study as it was a rapid appraisal. It was felt that a broader perspective would be gained from community representatives, who would be aware of a wider range of issues. Moreover, they would provide a more objective view of matters, which was considered important due to the sensitivity of the subject.

Conclusions

Many refugees who present to services may not view themselves as suffering from sickness, but rather from a range of social, political, and economic problems. Thus, practical advice, language tuition, advocacy, and particularly employment are important in improving their mental health. In addition, there is a need to raise awareness regarding the specific problems of asylum seekers and refugees among health service providers, particularly addressing cultural barriers and stereotypes. Finally, because of their complex needs, services for this group have to be broad based, involving social services and advocacy groups, as well as primary care and specialist mental health services.

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