Primary Care Mental Health 2005;3:00–00

Guest editorial

Expanding the primary mental health team for refugees and asylum seekers

Angela Burnett
The Sanctuary Practice, John Scott Health Centre, Green Lanes, London, UK

Liben Gebremikael BA MA BD Dip Int Couns
London, UK

Worldwide over 19 million people are in exile.[1] Numbers fluctuate, principally according to the human rights situation in each country. The vast majority remain in neighbouring countries, most of which have scarce resources with which to provide for their needs. Only those with significant resources travel to industrialised countries, such as the UK, where numbers of asylum applications, in common with other receiving countries, have been falling for the past few years.

Experience of persecution may include war and violence, detention and torture, rape and seeing others ill-treated or killed. Many people report experiences associated with traumatic events, including nightmares, intrusive thoughts, hypervigilance and anxiety. Current experiences of the asylum system, including detention, may remind them of past events. People have little control over their circumstances or their future – it is as if their life is in limbo, which may be hard to tolerate.

Many people feel more able to withstand severe hardships, including torture, in their original country because they could explain the reasons in political, religious or other meaningful ways. In contrast the difficulties facing them in their country of exile may be overwhelming because they contradict expectations of a sympathetic response to an asylum application.[2]

Meaningful understanding and social support have been identified as protective factors buffering the effects of helplessness and dependence.[3] However the asylum system tends to undermine these. Denied the right to work, asylum seekers without means of support become dependent on welfare, although many have valuable skills and experience which could benefit the UK.[4] Dispersal from the south east to other parts of the UK may offer the possibility of better accommodation and of being more settled, although this has not been the experience of everyone, particularly those with a disability. However, unable to choose where they settle, people seeking asylum may be separated from the support of relatives, friends and refugee community organisations (RCOs; organisations set up by refugees themselves with the aim of providing support to their own communities) and may become isolated and withdrawn. The important role played by RCOs will be examined in more depth in this article.

Psychological issues

Expressions of distress and coping strategies differ both between and within cultures, which can complicate assessment and treatment of psychological health problems of people in exile. Cultural differences and difficulties with language and communication may increase the possibility of a misdiagnosis of mental illness.[4]

Common expressions of psychological and emotional distress may have different meanings in different cultural and social settings. Natural expressions of grief and distress concerning highly abnormal experiences should not be pathologised. Diagnoses such as post-traumatic stress disorder should be used cautiously as they may not address the complex way in which historical, social and political factors interact and impact on the experience of communities.[5] 'Symptoms' should be understood in context, through the meaning they represent to the person experiencing them.[6]

Several people have stressed the need for healthworkers to acknowledge the political nature of their work.[7,8] Jones (p. 239) points out that 'a tendency to focus on individual psychology while ignoring political and social context may appear to

confer neutrality but will have adverse psychological and political consequences'.[7] She believes that clinicians have 'a duty not just to be psychologically sensitive, but also politically literate and well-informed; otherwise one cannot fully understand the problems nor the most effective remedies for our patients. ... Attempts to remain neutral in the face of genocide are likely to be construed as tacit collaboration with the aggressor and make any effective therapeutic work impossible' (p. 233).[7]

The most valuable inputs for many people are supportive listening and practical assistance to rebuild their lives – restoration of normal activities as far as possible can be the most effective promoter of mental health and can do much to relieve sadness and anxiety. Community, religious, spiritual and creative links may be important sources of support. People have survived against huge odds, and their resilience may be a strength to utilise.

However, those whose ability to function remains impaired may need additional intervention. Mental health services, for those who need them, should be accessible, flexible and appropriate, reflecting National Service Framework standards. Antidepressants may be considered for concurrent depressive illness. Interpreters trained in mental health are crucial for people who do not share a common language with healthworkers (see section on interpreters). In many societies, mental health carries significant stigma, which may deter people from accessing services. Offering services within the community may be more acceptable and close links should be established between primary care teams, community mental health teams (CMHTs) and the voluntary sector, including RCOs.

Using Western models can be limiting, and culture needs to be at the heart of appropriate psychological interventions. Eisenbruch has suggested that the experience of people in exile can be considered as a form of 'cultural bereavement'.[9] His work with Cambodian refugees in Australia showed traditional healing to be more effective for them than Western models of psychological support.

Issues for specific groups

Displacement is difficult for all exiled people, but for women especially, by dint of their less powerful position in society.[10] They may assume an unfamiliar position as head of a household and breadwinner, while lacking the support of family and community networks. Many women and some men are survivors of violence, which may have been sexual in nature. Men may find it harder to adjust to the lower status and powerlessness experienced in exile. Use of alcohol and drugs may ensue.

Children may be living in a fragmented family, or may be unaccompanied. They may have experienced violence or torture themselves, or may have witnessed such acts. Some have been forced to become child soldiers, themselves committing violent acts. Their experiences may lead them to believe that adults are untrustworthy and that their parents are unable to protect them.[11] They need multifaceted support that aims to create as normal a life as possible, promoting education and self-esteem, and supporting parents.[12]

Older people, while represented in small numbers among newly arrived asylum seekers, face particular difficulties. More likely to be in poor health, they may find it difficult to adapt to new surroundings, which may result in confusion and disorientation.

Entitlement to care

Since April 2004 people not 'lawfully resident' in the UK, including failed asylum seekers and undocumented migrants, are liable for NHS hospital charges, unless they have an emergency problem, or are already receiving care for a specific illness. Currently they are still eligible for free primary care, although the government is due to publish a decision, which may result in the withdrawal of all free healthcare (except emergencies or treatment for certain infectious diseases) from people who have been refused asylum in the UK.

Many people who have failed in their claim and are facing deportation are living under extremely stressful circumstances, which threaten their mental wellbeing. There have been several reports of suicide and attempted suicide at this time, and many healthworkers are greatly concerned that people will be unable to access services that they need.

Working with interpreters

One of the main barriers for refugees and asylum seekers accessing primary healthcare services is their lack of English, particularly when it comes to describing health problems to professionals. Using friends, relatives or children as interpreters is problematic not only in terms of issues of confidentiality and stigma, but also in exposing children to sensitive and inappropriate health information about their parents or relatives.

Well-trained interpreters can make assessment easier and more comprehensive, the planning and delivery of care more accurate, and can increase compliance with treatment.[13] The presence of an interpreter has been found to enhance the patient–doctor relationship, by improving communication.[14]

Interpreters translate not only language but also cultural context. This is crucial in mental healthcare, where the language of psychological distress differs between cultures. For example, an experience of hearing voices of deceased relatives may not necessarily be an auditory hallucination, but rather an accepted way of processing loss and bereavement.

Box 1 A model of good practice

The Newton Medical Centre and Harrow Health Centre in Westminster (London) provides a specific interpreter/community health worker for different languages on different days of the week. This has eased appointment making by receptionists, and has improved the provision of assessment and care. Continuity of interpreter helps in building a trusting relationship with the client and a better working relationship with health professionals.

The role of refugee community organisations and other voluntary agencies

The psychosocial nature of mental health difficulties experienced by exiled people shifts the framework of providing healthcare from a purely medical context. In addition, the barriers faced by refugees and asylum seekers in accessing primary healthcare services render the role played by the voluntary sector invaluable. Research has shown that the pathway to healthcare is not as simple as moving from identifying a mental health problem to seeking help from health services. It is more complex and 'includes a wide range of voluntary and user organisations'.[15]

Isolation has been identified as being a primary cause for mental health problems for refugees and asylum seekers. 'At an extreme level, isolation can result in a state of marginalisation in which refugees and asylum seekers are detached from the host society and from people from their own backgrounds. This form of isolation is associated with the highest level of mental health problems.'[16]

Primary health professionals often express frustration about the pressure on their workload and time when refugees and asylum seekers request letters of support. Frustration may also be felt by service users if they feel that health professionals are not giving enough attention to their non-medical problems.[14]

Although access to healthcare in the UK is free in most circumstances, several refugees and asylum seekers have experienced difficulties in registering with general practitioners (GPs) due to lack of language and knowledge about the healthcare system.[15] Some practices have been reluctant or have refused to register refugees and asylum seekers due to the extra support that the client group may demand, but also due to the feeling of not knowing how to deal with the anticipated 'trauma effects' with this client group.[15,17]

It is within this wider context that the role of voluntary agencies in the provision of primary healthcare and particularly mental healthcare becomes invaluable. A recent study showed RCOs are often the first point of call for refugees facing crises and emergencies because of their accessibility and empathy.[14] Since the primary cause of psychological stress for refugees and asylum seekers, particularly in the post-migratory environment, incorporates practical problems such as housing, benefit, isolation and immigration issues, voluntary organisations provide indirect healthcare by resolving practical issues. RCOs also offer support in facilitating access to mental health services. Faith organisations also provide spiritual, social and community support. Both may additionally provide:

- day care activities
- early identification of mental health problems and referral for formal assessment
- befriending schemes.

Refugees themselves should be involved in planning, implementing and evaluating services, both as users and through consultation and joint working with RCOs and other voluntary agencies. However, given the different culture between statutory and voluntary sectors, and differences in levels of power, funding and resources, careful attention needs to be given to developing joint working, as it is unlikely to happen spontaneously.

Voluntary organisations 'have an important preventative function through helping refugees establish social support networks and also a sense of context and purpose'.[15] As well as helping clients, there are potential mutual benefits for both statutory and voluntary organisations from joint working practices, with improved learning opportunities for staff and the knowledge that others are available to assist with complex and time-consuming issues.

Box 2 Models of good practice

The Bayswater Families Centre
The Centre is a National Children's Home project providing comprehensive family support service to homeless and refugee families in the Borough of Westminster in London. Jointly funded by Westminster Primary Care trust (PCT) and Westminster Council, community nurses and a community health worker provide health support to refugee families through helping families to register with GPs in the area and acting as a link between GPs and clients (e.g. facilitating the provision of interpreters, negotiating support letters when necessary and acting as a cultural advisor).

Primary healthcare worker in Oxford
Oxford City PCT employs a worker to help refugees and asylum seekers to access primary care and voluntary agencies, facilitating cross-referrals for mental health and social support. In conjunction with Refugee Resource, a local voluntary agency, training is provided for primary healthcare professionals, aiming to raise awareness of refugee mental health and improve working practices.

ACKNOWLEDGEMENT

With thanks to Aruna Mahtani for her comments.

REFERENCES

1 United Nations High Commissioner for Refugees. www.unhcr
2 Burnett A and Thompson K. Enhancing the psychosocial well-being of asylum seekers and refugees. In: Barrett KH and George WH (eds) *Race, Culture, Psychology and Law*. Thousand Oaks: Sage Publications, 2005, pp. 205–24.
3 Silver RL and Wortman CB. Coping with undesirable life events. In: Garber J and Seligman MEP (eds). *Human Helplessness: theory and applications*. New York: Academic Press, 1980, pp. 279–340.
4 Burnett A and Fassil Y. *Meeting the Health Needs of Refugees and Asylum Seekers in the UK, an Information and Resource Pack for Health Workers,* London: London Directorate of Health and Social Care, Department of Health, 2002. www.london.nhs.uk/newsmedia/publications/Asylum_Refugee.pdf (accessed 17 August 2005).
5 Bracken P. Hidden agendas: deconstructing post traumatic stress disorder. In: Bracken PJ and Petty C (eds). *Rethinking the Trauma of War*. London: Free Association Books, 1998, pp. 38–59.
6 Summerfield D. Addressing human response to war and atrocity. In: R. Kleber *et al* (eds). *Beyond Trauma*. New York: Plenum, 1995, pp. xx–xx.
7 Jones L. The question of political neutrality when doing psychosocial work with survivors of political violence. *International Review of Psychiatry* 1998;10: 239–47.
8 Swartz L and Levitt A. Political repression and the children in South Africa: the social construction of damaging effects. *Social Science and Medicine* 1989; 28:741–50.
9 Eisenbruch M. From post traumatic stress disorder to cultural bereavement: diagnosis of Southeast Asian refugees. *Social Science and Medicine* 1990;33:673–80.
10 Ferron S, Morgan J and O'Reilly M. *Hygiene Promotion: a practical manual for relief and development.* London: Care International and Intermediate Technology Publications, 2000.
11 Dawes A. *Psychological Discourse abut Political Violence and its Effects on Children*. Paper prepared for a meeting on the Mental Health of Refugee Children Exposed to Violent Environments, Refugee Studies Programme, University of Oxford, 1992.
12 Melzak S and Kasabova S. *Working with Children and Adolescents from Kosovo*. London: Medical Foundation for the Care of Victims of Torture, 1999.
13 Edwards R. Working with interpreters: access to services and to user views. *Community Care* 1995;
14 Gebremikael L. *The Role of Refugee Community Organisations – The Experience of the Ethiopian Health Support Association*. Dissertation submitted in partial fulfilment of the requirements of the Tizard Centre, University of Kent for the degree of the European MA in Migration, Mental Health and Social Care, 2004.
15 Watters C *et al*. *Good Practice in Mental Health and Social Care for Refugees and Asylum Seekers*. University of Kent and Utrecht University, 2002.
16 Berry (1997)
17 Audit Commission. *Another Country, Implementing Dispersal under the Immigration and Asylum Act 1999*. London: Audit Commission Briefing Paper, 2000.

ADDRESS FOR CORRESPONDENCE

Angela Burnett, The Sanctuary Practice, John Scott Health Centre, Green Lanes, London N4 2NU, UK. Tel: +44 (0)207 683 4767; email: a.c.burnett@qmul.ac.uk.

Uncited references

Ager A *et al*. Community Contact and Mental Health Amongst Socially Isolated Refugees in Edinburgh. *Journal of Refugee Studies* 2002;15(1).
Burnett A and Peel M. Asylum Seekers and Refugees in Britain; Health Needs of Asylum Seekers and Refugees. *British Medical Journal* 2001;322.
CVS Consultants & Migrants and Refugee Community Forum. A Shattered World: The Mental Health Needs of Refugees and Newly Arrived Communities, CVS Consultants, 1999.
Goldberg D and Huxley P. Mental Illness in the Community; the Pathway to Psychiatric Care, London, Tavistock Publications, 1980.