editorials

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Asylum-seekers, refugees and mental health services in the UK

In May 1999 the Home Office strategy group handling the reception of 4000 Kosovan refugees being airlifted to the UK made confidential recommendations. Writing at a time when most had not even landed, they none the less stated that the Kosovans were "in a serious state of trauma and chronic illness with a need for long-term counselling and support" (*Guardian*, 18 May, 1999). But a subsequent, still unpublished, study of approximately 2000 of these painted a very different picture. Very few saw themselves as having a mental health problem at all, let alone a long-term one, bearing out observations by refugee workers that there had been no demand for counselling (N. Savage, personal communication). So who knew best?

More than one-third of 1 million asylum-seekers (out of approximately 4.2 million in western Europe) have come to the UK in the past decade from about 35 countries, the vast majority of whom are in London and the South-East. Waiting times for a Home Office decision on an asylum claim have averaged several years, a period of insecurity that may impede the task of coming to terms with a new environment. Many are now excluded from the cash-based welfare system. Given the strongly negative images promoted in the mass media and in government statements, asylum-seekers can feel stigmatised even at supermarket check-out counters when they must produce food vouchers and thus identify themselves. Official policy is now for dispersal across the country, often to locations with far less ethnic diversity and with under-prepared social welfare and health services. None the less, only a minority of asylum-seekers are likely to go home.

To date, there is a paucity of data on patterns of utilisation of health services by asylum-seekers and refugees, including mental health. General practitioner (GP) surgeries represent a point of reference at a time when they have few others, and some GPs see them as frequent attenders. Presentations are typically in somatic idiom, often non-specific bodily pains, headaches, dizziness and weakness, which reflect both culturally ordained modes of help-seeking and their view of what is appropriate to bring to a medical setting (Lin *et al*, 1985). It is simplistic to merely label these complaints 'psychosomatic' (Kirmayer & Young, 1998). Requests for psychoactive preparations point to the prevalence of poor sleep, distress and anxiety in this population, as well as reflecting the relative ease with which these have been obtained from doctors or pharmacies in home countries. Some asylum-seekers present in psychological mode because they have picked up that a medical report may influence the gatekeepers to scarce social resources like housing or refugee status. The general lack of provision of interpreters for GP surgeries is a significant impediment to empathic primary health care.

Asylum-seeker admission rates, whether voluntary or involuntary, to in-patient psychiatric facilities by comparison to the general population are not known. It is possible that they will come to be over-represented in secure settings, as are Afro-Caribbean Britons. So too with suicide rates, although there are anecdotal accounts of a cluster of suicides by young Somali men in East London (some of whom had previously been in-patients) and there was one in the Kosovan cohort airlifted here. Those with a preflight history of psychological vulnerability or extended use of psychiatric medication seem over-represented among psychiatric referrals. It is not uncommon to encounter patients in admission units or in follow-up who speak very little English, yet with scant recourse to interpreters or repeated reliance on a family member or friend. A properly resourced, supervised and utilised interpreter service is the most quickly achievable means of raising the standard of mental health services for this population, and arguably one marker of whether this is an objective being taken seriously.

Ignorance of cross-cultural factors means that some patients receive inappropriate diagnoses. Indeed, we still know little about the degree of 'fit' between mainstream mental health services and presentations by asylum-seekers from cultures where Western psychiatry has little purchase. Moreover, mental health services offering morally and politically neutral technologies may not necessarily be well-equipped to address human pain linked to moral knowledge of the kind thrown up by war and human rights violations. Watters (1998) points to the poor knowledge of the mental health needs of asylum-seekers and refugees in a particular locality and notes that existing mechanisms for 'ethnic monitoring' may say little about refugee populations because the categories

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editorials

used are too broad. There are few, if any, structures for consulting refugee communities, and no consideration of their needs in community care plans and in district health authority specifications.

On a cautionary note, the frequent references to refugee 'mental health problems' (a term that is often used loosely, or figuratively), and concern about access to services, may sometimes belie the complex realities at stake. Even those who have overcome the initial hurdles, including the right to remain in the UK, may continue to grapple with dilemmas rooted in a broken social world – disrupted trajectories, loss of status and cultural alienation – for which psychiatry and talk therapy do not have solutions (Summerfield, 1998).

A referral to mental health services may relate as much to assumptions being carried by the GP or other referrer as to how the asylum-seeker presents or what he or she is seeking. A referrer may assume that, in particular, those with a history of exposure to torture or atrocity are self-evidently candidates for a diagnosis of post-traumatic stress disorder (PTSD) and a psychological intervention. The problems associated with the application of PTSD to non-Western survivors on a supposedly universalistic basis have been critiqued elsewhere (Summerfield, 1999). PTSD has become a catch-all diagnosis and signifier, yet its criterial features are frequently epiphenomenal and not what refugees consider important. PTSD checklists distinguish poorly between the physiology of normal distress and the physiology of pathological distress, so over-recruitment of cases is common.

Trauma counselling aimed at a 'working through' has become a familiar provision in Britain, but recent studies have cast doubt on its efficacy and suggested that harm can be done (Wessely *et al*, 1998; Mayou *et al*, 2000). Anyway, most asylum-seekers come from cultures in which the detached introspection of talk therapy is an alien activity: in a recent survey with 759 respondents in London, 76% of those offered counselling or psychotherapy rated it as poor or very poor (Baluchi, 1999). A more accepted model for counselling might be characterised as one that assumes some background knowledge of the political landscape from which a particular client has fled, is eclectic and streetwise, acknowledging that practical advice and advocacy is of itself psychologically supportive and that a recounting of traumatic experience is an option but not a necessity. This may mean attending more to function-focused and problem-focused coping styles ('How are you doing?' and 'What do you need to do?') than the emotion-focus ('How are you feeling?') more typically associated with counselling and with a Western, but not generally a non-Western, cultural idiom.

Arguably, psychiatric models have never sufficiently acknowledged the role of social agency and empowerment in promoting mental health. Moreover, the PTSD model assumes a single causative link between an index event and subsequent mental state. The refugee literature refutes this, highlighting the pivotal role of family and social networks in providing support and nurturing problem-solving strategies. Refugee communities, at present mostly concentrated in London, can be influential. There are trends towards the conflation of very diverse populations of war victims and refugees into a unitary category of the 'traumatised', associated with psychopathology – as the Home Office strategy group appear to have done in their pronouncement on the Kosovans. Undue pathologisation may promote abnormal illness behaviour and increase people's sense of themselves as passive victims rather than active survivors. There may be risks that the host society offers refugees a sick role rather than what is really sought: opportunities for meaningful citizenship as part of rebuilding a way of life. In the survey of Kosovan refugees mentioned in the first paragraph, almost everyone nominated work, schooling and family reunion as their major priorities.

A recent telling study in Sweden compared two cohorts of families of survivors of a particular Bosnian concentration camp. The families were originally from the same town in Bosnia and had similar socioeconomic backgrounds. By chance, half the families had been sent to a place where there was temporary employment but no psychological services, the other half to a place where no employment was available but there was a full range of psychological services. At follow-up at 1 year a clear difference had already emerged. The group given work seemed to be doing better, and the majority of adults in the second group were on indefinite sick leave (Eastmond, 1998).

In the UK unemployment is associated with early death, divorce, family violence, accidents, suicide, higher mortality rates in spouse and children, anxiety and depression, disturbed sleep patterns and low self-esteem (Smith, 1992). Work has always been central to the way that refugees resumed the everyday rhythms of life and re-established a viable social and family identity. It is undoubtedly harder now that jobs in the UK are less plentiful than they were in the past, and the new policy of dispersal will mean locations with higher unemployment rates than in London. While efforts must be made to improve the capacity and sophistication of mental health services for those with poor functioning, the longer-term fortunes of the majority of today's asylum-seekers will depend primarily on what happens in their social, rather than their mental, worlds.

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editorials

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Learning centres: a new approach for service improvement

The Northern Centre for Mental Health is developing new ways of learning in adult mental health services

There is little doubting the intention of this government to change the NHS and place quality at the top of the agenda. Confirmation of this can be found from two main sources: the plethora of policy papers issued since May 1997, all of which signal change to the way the health service works (eg. through the introduction of primary care trusts), and, perhaps more importantly, much clearer expectations of how things will be done (Department of Health, 1997; 1998*a*; 1998*b*). The times when clinicians could shape services on their own seems to be gone and the balance of power has shifted away from the time that a minister of health could say: "We may be sure that the progress of medical thought and method will still be well ahead of our departmental practice." (Powell, 1961) It is interesting to note that this was the minister who launched the mental hospital closure programme all those years ago. Now there seems little else from ministers but impatience at the lack of progress and blame for errors that, to many, seem unavoidable and unpredictable. Doctors find themselves in a changed and changing world, with greater central prescription challenging clinical freedom.

The causes for this are varied. Some are acts of commission (too much policy, too much politics) and some are acts of omission (not enough resources, not enough understanding). Public expectations have increased too, and nowhere more so than in mental health, where the National Service Framework (NSF) spells out vastly increased expectations of user involvement in the planning, delivery and evaluation of care (Department of Health, 1999).

Although our colleagues in physical medicine are beginning to feel the heat of public accountability in a way that is all too familiar to us in psychiatric practice, feelings of *schadenfreude* would be unworthy. One of the more recurrent themes in the modernisation project is government frustration at the failure of good practice to spread more rapidly. It is difficult to explain this state of affairs. On the one hand, there has to be a case for the slow spread of good practice being merely the proper consideration of evidence. Why change if there is no proof that the change will be for the better? On the other hand though, many of the changes that would make the greatest improvement to the quality of life for users are the things that are hard to quantify, such as swift access, choice in treatment regimes and locations and support and encouragement to get a job or find a better place to live.

If we accept for a moment that we are all reluctant to learn from each other and change familiar ways of working without good reason, we have to ask what factors might account for this state of affairs? Although the reasons are complex, some of them may be:

(a) The new service models set out in the NSF require a different set of skills. Assertive outreach, for example, operates where the client is, at times to suit him or her and in ways that meet his or her needs. How many of today's trainees are equipped to undertake present state examinations in bus shelters or cafés? How many are adept at the interpersonal skills necessary for leading a team? Leadership at local level becomes multi-faceted; developing services and managing teams and resources can make it easy to lose sight of the need to change and adapt, as the sheer pressure of competing demands overshadows the best of intentions.

(b) Organisations can be frustratingly indifferent to the new skills acquired by their staff. Most people can recount examples of how people attend training courses and return to work eager to apply new skills, only to find apathy. If organisations are not prepared to enable newly skilled staff to practise their newly acquired competence, disillusionment can soon set in. Scarce training resources will have been wasted. All

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