would be a good start. But there is no scope to ask people to do significantly more—consultants are already working at least 50 hours a week for the NHS, beyond the legal limit. This is one reason why the government's ill conceived seven year prohibition on private practice has been so widely condemned—it would not affect the amount of NHS work done. Nor do I agree that bonus payments for meeting targets are the way forward. We have all experienced the distortions in good clinical decision making caused by undue emphasis on reducing waiting lists. What motivates professionals is quality of care; the remuneration system should underpin that motivation, not introduce incentives to pervert it.

The Central Consultants and Specialists Committee believes that a new contract can deliver better quality of care for patients, ensure a reasonable life for future consultants, and enable managers to plan and deliver services more effectively. The committee has recently published some proposals for such a contract and is calling on the government to enter into discussions about it.

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Asylum seekers and refugees in Britain

Health needs of asylum seekers and refugees

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This is the second in a series of three articles

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People who are seeking asylum are not a homogeneous population. Coming from different countries and cultures, they have had, in their own and other countries, a wide range of experiences that may affect their health and nutritional state. In the United Kingdom they face the effects of poverty, dependence, and lack of cohesive social support.[1] All these factors undermine both physical and mental health. Additionally, racial discrimination can result in inequalities in health and have an impact on opportunities in and quality of life.[2]

Refugees' experiences also shape their acceptance and expectations of health care in the United Kingdom.[3] Those from countries with no well developed primary healthcare system may expect hospital referral for conditions that in Britain are treated in primary care. This can lead to disappointment for refugees and irritation for health workers, who may also feel overwhelmed by the many and varying needs of asylum seekers, some of which are non-medical but nevertheless affect health. Addressing even a few of these needs may be of considerable benefit.

Previous studies in the United Kingdom have found that one in six refugees has a physical health problem severe enough to affect their life and two thirds have experienced anxiety or depression.[4 5] Disentangling the web of history, symptoms—which may be minimised or exaggerated for a range of reasons—and current coping mechanisms requires patience and often several sessions. Medication should be as simple as possible.

Summary points

- Asylum seekers and refugees are not a homogeneous group of people, and have differing experiences and expectations of health and of health care
- Symptoms of psychological distress are common, but do not necessarily signify mental illness
- Trained interpreters or advocates, rather than family members or friends, should be used wherever possible if language is not shared
- Community organisations provide invaluable support and can reduce the isolation experienced by so many refugees
- Particular difficulties which face women are often not acknowledged
- Support for children, especially unaccompanied minors, needs to be multifaceted, aiming to provide as normal a life as possible

Physical needs

In a study carried out in the United States, 5% of Koreans and 15% of Cambodians were found to be positive for hepatitis B surface antigen.[6] In Spain, 21% of migrants from sub-Saharan Africa were chronic carriers of hepatitis B[7]; hepatitis A and meningitis may be more prevalent, depending on country of origin.[8] HIV prevalence is likely to mirror that in the country of origin, although some refugees may have been placed at particular risk. (HIV/AIDS will be covered in the last paper in this series.) Benign tertian malaria may not be seen until several years after arrival.[6]

In 1988, 3.4% of refugees arriving in the United States had tuberculosis.[6] In Britain, new arrivals should be screened for tuberculosis at the port of entry, but in practice only a small proportion is screened, and tuberculosis in those who apply for asylum after arrival will not be identified until later. Currently no screening is carried out at the channel ports (P Le Feuvre, S Montgomery, personal communication, 2000), or at cargo ports, where some asylum seekers may arrive (P Matthews, personal communication, 2000). Some areas with large numbers of refugees have set up screening programmes, but their coverage varies. A study in Blackburn of a sample of 1085 immigrants found 11 cases of tuberculosis at the

port, and a further 40 cases subsequently, of which seven (17%) were lost to follow up.[9] The process is stigmatising, however, and seems to focus more on protecting the native population than benefiting the health of the new arrivals.[10] Refugee health in many areas in Britain has become the responsibility of communicable diseases departments, giving the impression that refugees are vectors of infection, but refugees with infectious diseases needing care and treatment are the minority.

Parasitic diseases may also be found.[11] Gastrointestinal symptoms were reported by 25% of a group of asylum seekers in Australia[12] and are common in asylum seekers in Britain, particularly young men. *Helicobacter pylori* is commoner in people from poorer countries[6]; high rates of diabetes, hypertension, and coronary heart disease are found in people from Eastern Europe.[8] There is also a risk of substance misuse as a coping strategy.[13] Some may have experienced episodes of malnutrition and poor hygiene and sanitation. Headaches, backache, and non-specific body pains are common; they may be of musculoskeletal origin, as a consequence of trauma, muscular tension, or emotional distress.

Children and adults may be incompletely immunised, from lack of opportunity, and which immunisations they have received may be unclear (P Le Feuvre, S Montgomery, personal communication, 2000).[8] Access to dentists is important, as dental problems are common.[8]

Psychological needs

People may show symptoms of depression and anxiety, panic attacks, or agoraphobia.[14] Poor sleep patterns are almost universal but may not be described spontaneously. Some may be anxious and nervous or may develop behaviours to avoid stimuli that remind them of past experiences. Problems with memory and concentration may hinder learning. Many will have been forced to leave other members of their family behind and may not know their whereabouts, or even if they are alive or dead. The Red Cross or Red Crescent can help with the tracing of relatives (see box on "useful information").

Such symptoms are often reactions to refugees' past experiences and current situations. Social isolation and poverty have a compounding negative impact on mental health,[15] as can hostility and racism.[2] If medication is indicated, it should be kept to a minimum. Reducing isolation and dependence, having suitable accommodation, and spending time more creatively through education or work can often do much to relieve depression and anxiety. Positive changes can be seen as immigrants adjust, are reunited with families, and take up educational and employment opportunities.[16] But there are many barriers preventing people from rebuilding their lives.

Many refugees wish to tell their story, which in itself may be therapeutic,[17] but it should not be assumed that people must go through this in order to recover,[18] as some find it extremely distressing. Every culture has its own frameworks for mental health and for seeking help in a crisis.[19] Mozambican refugees describe forgetting as their usual cultural means of coping with difficulties. Ethiopians call this "active forgetting."[20]

Counselling

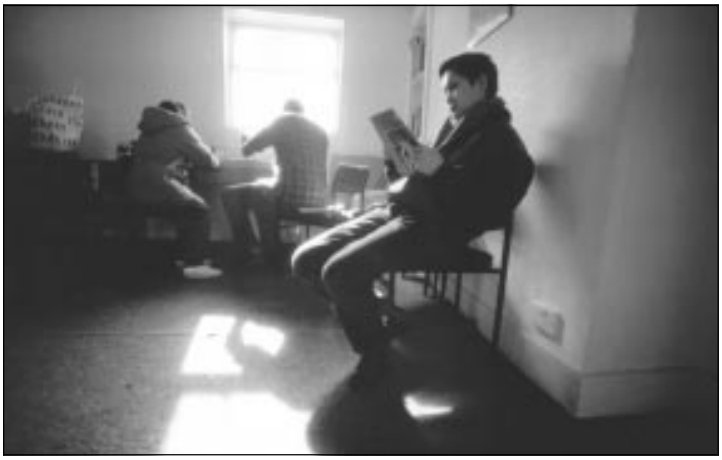
Counselling may be an unfamiliar concept for many refugees who are not accustomed to discussing their intimate feelings with a stranger outside the close family circle.[21] Counselling is currently a Western-orientated concept; its usefulness depends on an individual's socioeconomic background and cultural orientation (V Nguyen-Gillham, personal communication, 2000), and for it to work, a trust building and befriending relationship must develop first. Informed consent is the first step to building trust, and clinicians need to explain their way of working and the rationale for using talking as a medium for potential healing (N Patel, personal communication, 2000). Assistance with practical matters may also help to develop trust. Counselling can be helpful if it is culturally sensitive to the needs of ethnic minorities; in this respect it can be useful if members of refugee communities develop counselling skills.[22]

Isolation

Refugee community organisations are invaluable in supporting refugees and acting as advocates. They can provide information and orientation and reduce the isolation experienced by so many refugees.[23] In a study of Iraqi asylum seekers in London, depression was more closely linked with poor social support than with a history of torture.[24] Informal groups, structured in a culturally familiar way, can be a useful way of sharing experiences and ways of coping and making sense of past experiences.[25] It is important for refugees to develop ongoing links and friendships with people in the host community as well as making contact with people from their own countries,[26] and the best mental health outcomes may be achieved in this way.[27] Many community and religious organisations have welcomed refugees. Recent hostile media headlines and comments from politicians, however, have not nurtured good relationships, and there has been an increase in negative feelings towards refugees and consequent racist attacks on them.[28]

Communication

It is important to for the services of a trained advocate or interpreter to be available unless patient and



KAREN ROBINSON/FORMAT

Mental health projects for refugees, such as this one in east London, help reduce social isolation and stress

MELANIE FRIEND/FORMAT

Disentangling the web of history, symptoms, and coping mechanisms often requires several sessions

health worker speak the same language. Refugees may bring a family member or friend to interpret. Though this may help in obtaining background information, it may result in inaccurate interpreting and also make it difficult to discuss sensitive issues such as sexual health, gynaecological problems, sexual violation, domestic violence, or torture. Using children to interpret may place inappropriate responsibilities on them.

Using the same interpreter for all consultations can help the development of trust, but exiled communities may polarise into groups reflecting conflicts in the home countries and not every interpreter will be universally trusted. Interpreters and advocates can provide valuable information for health workers on cultural and other relevant issues. Telephone interpreting can be useful when there are no local interpreters. Also, health workers may need training in working with interpreters.

Information on health

Information about health services needs to be in relevant languages, and some culturally appropriate examples are available covering general access to services (see "useful information"). Some areas have produced leaflets describing local services, but not all refugees are literate, particularly women.[29] Somali culture, for instance, focuses more on oral communication—written Somali dates only from 1972 (N Dirie, personal communication, 2000) and story telling is an important way of disseminating information which has been used in health promotion.[13] Health advocates and refugee community organisations are important in increasing awareness about health. Smoking, for example, is a problem it may be useful to address, as it tends to be high in some groups of refugee men (P Le Feuvre, S Montgomery, personal communication, 2000).

Women

Displacement is difficult for all refugees, but women are often the most seriously affected.[30] They are vulnerable to physical assault, sexual harassment, and rape, and their experiences and fears have tended not to be taken seriously.[31] As refugees, they may have to take on new roles and responsibilities, including being heads of disrupted households; they may also have to assume responsibility within the community for education and cultural cohesion, two of the most critical factors for coping, particularly early on, yet this is often not acknowledged.[30] Training and employment programmes are almost always targeted at men, leaving women in a weak position to care for themselves and for their families. Where a man is present, stress may make him unable to fulfil his family responsibilities. Divorce and serial marriage are common in communities living under pressure, which may leave women with sole responsibility for the children and with overwhelming domestic responsibilities.[31]

The needs of women may not be identified, especially in cultures where the man is traditionally the spokesperson. Women are less likely to speak English or to be literate,[29] but it is important to speak to them directly, using an independent interpreter rather than a family member. They are more likely than men to report poor health and depression.[29] They may be lonely and isolated but often welcome the opportunity to belong to a group, where they may benefit from the contact and support.

Screening and health promotion programmes tend to have a low uptake among refugee women. In one study only 5% of women aged over 50 had gone for breast screening and only 53% reported having had a cervical smear test,[29] and in another less than 25% of women refugees from the Horn of Africa reported having had a smear test.[32] Trained advocates can enable women to discuss their health and choices more easily and can remedy misconceptions about health screening.[13]

Women need to be offered sexual health care, family planning, and maternity care that is sensitive to their cultures. They should be offered choice as to the sex of the health worker they see and of interpreter.[33] Health workers need to be aware that some women will have undergone genital mutilation and that this can affect sexual health and childbirth.

Domestic violence

The effects of external violence may be played out within the family. A refugee woman is particularly vulnerable to domestic violence as she may lack family and community support[34] and may fear being alone more than a violent relationship. If a woman is working and her husband is unemployed, the reversal of traditional family roles may create tensions. She may tolerate her partner's violent behaviour because of the violence he has experienced and be reluctant to inform against him because of experiences of the police or legal system and fear that confidentiality may be breached. In addition, a woman whose asylum claim is linked to that of her husband may lose her refugee status if they separate.[34]

Useful information

Relative tracing services—for Greater London only, contact the International Welfare Service, British Red Cross, 54 Ebury Street, London SW1W 0LU (tel 020 7730 6179): elsewhere in UK contact the local branch of British Red Cross

Access to Health Services leaflets are available from the Refugee Council Information Service, 3 Bondway, London SW8 1SJ (tel 020 7820 3085)—open 10 am to 1 pm Mon-Fri

Children

Children may be living in a fragmented family, be with unfamiliar carers, or have arrived alone. They may have experienced violence or torture themselves or have witnessed atrocities; some may have been abducted to become child soldiers and forced to commit violent acts themselves. They may have developmental difficulties, seeming to be mature beyond their years and in a caring role with their parents yet be immature in other situations such as school. They may show anxiety, nightmares, withdrawal, or hyperactivity but few need psychiatric treatment. Support for children needs to be multifaceted, aiming to provide as normal a life as possible, imparting a sense of security, promoting education and self-esteem. It is also important to support parents, as they may be facing difficulties themselves.[35] In some areas, health visitors are taking a leading role in working with refugee families, extending their caseloads to include families with children over 5 years of age.

The most therapeutic event for a refugee child can be to become part of the local school community, to learn, and to make friends,[35] though there is always a possibility of bullying. For a health worker, contact with the school can be very helpful. Some areas have employed refugee support teachers who provide help to refugee children in school and may be alert to any problems. Unaccompanied minors are especially isolated and vulnerable. Ongoing contact with social services is important to ensure that they have a needs assessment and care plan, and this should be regularly monitored.

Conclusions

The basic health needs of asylum seekers and refugees are broadly similar to those of the host population, although previous poor access to health care may mean that many conditions have been untreated. Symptoms of psychological distress are common but do not necessarily signify mental illness. Many refugees experience difficulties in expressing health needs and in accessing health care. Poverty and social exclusion have a negative impact on health. Initially refugees will need help to make contact with health and social support agencies. Professional interpreters are essential.

Time, patience, and a welcoming approach will break down many barriers, but some refugees have problems that need specialist help and support for which there are few resources, especially outside London. It is crucial that these resources are developed before large numbers of asylum seekers are dispersed.

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