Asylum seeker access to crisis mental healthcare in Hounslow

Abstract:

Background: Hounslow Crisis Assessment and Treatment Team (HCATT) offers short-term, intensive, community-based support to individuals experiencing mental health crisis. A number of referrals are on behalf of asylum seekers and other forcibly displaced individuals (FDIs).
Aims: The study aimed to establish the proportion of FDIs in the HCATT caseload and the additional needs of this group, to explore ways in which they can be better supported.
Methods: All referrals were examined over a 5-month period. Address data and electronic notes were reviewed to identify FDIs. For these individuals, additional data regarding language barriers, trauma exposure and diagnosis were collected.
Results: Of the 441 referrals accepted, 13 were regarding FDIs with 7 of these being asylum-seekers awaiting an outcome of their claim. 61.5% of FDIs had a language barrier recorded. 87% of individuals reported exposure to trauma, whether pre- or post-migration or related to their journey.
Conclusions: FDIs are underrepresented in the HCATT caseload, possibly due to cultural barriers to accessing mental healthcare as well as issues surrounding acceptability of HCATT. Methods to encourage early intervention for FDI mental health include training for staff in culturally-sensitive care as well as production of literature that raises awareness of available support.

Introduction

The growing diaspora of asylum seekers in the United Kingdom represents a diverse range of displaced families and individuals. In 2022, the UK received applications for asylum for 89,398 people, which was more than double the number of people applying for refugee status in 2019 (1). This mirrors a growing population of forcibly displaced people worldwide, which in 2022 grew by 19.1 million - the greatest increase ever recorded (2).

The terms "asylum seeker" and "refugee" are often used interchangeably, however it is generally accepted that the difference between these two terms lies in whether an individual's claim to asylum has been accepted, granting them 'settled status'. The term "migrant" is much broader, encompassing all people who migrate from their home country whether to seek asylum or for other purposes such as social or economic. Amnesty International defines an asylum seeker as follows:

> "*An asylum seeker is a person who has left their country and is seeking protection from persecution and serious human rights violations in another country, but who hasn't yet been legally recognized as a refugee and is waiting to receive a decision on their asylum claim.*" (3)

In the UK, asylum seekers are afforded certain rights including free NHS care and legal representation (4). If an application for asylum has been accepted an individual can be granted either Refugee or Humanitarian Protection status – this allows them to remain in the UK for at least five years, at which point they can apply for indefinite leave to remain. During this time, they also gain the right to work and to access social welfare (5).

For many of these individuals the journey to the UK is fraught (2,6). It is well-documented that exposure to trauma such as this increases an individual's vulnerability to developing psychiatric disorders. Indeed, the prevalence of serious mental illness (SMI) in the UK asylum seeker population was estimated to be around 61% (7), with the World Health Organisation predicting that even this is likely to be an underestimate due to multifactorial underreporting (8).

A number of factors that increase risk of deterioration in an individual's mental health during the process of being forcibly displaced and claiming asylum elsewhere have been identified. These are briefly summarised below.

Pre-migration factors:

One pre-migration factor that is common to many asylum seekers is separation from family, whether they are forcibly displaced from one another by conflict or turbulent journeys or separated due to host-country migration policies (9). As these family members often serve as a protective factor against psychological distress, separation can amplify the effect of pre-migration trauma (9). In addition, where individuals have fled nations where the culture holds strong collectivist values, separation from key family connections can precipitate the breakdown of an individual's self-identity, further magnifying their psychological distress (10). In a study done by Liddel et al, participants who had a missing family member found their future focus was diminished by unremitting anxiety regarding the safety of their family, forcing them to focus only on the short-term (10). They also reported reduced participation in traditional cultural practices, further isolating them from their cultural identity (10).

In addition, fear or experience of violence is a major pre-migration factor in predisposing to Post-Traumatic Stress Disorder (PTSD) in particular. However, notably it has been shown that an even greater predictor of development of PTSD following exposure to violent conflict is the presence of post-migration stressors, as absence of these stressors has been shown to significantly moderate the psychological distress caused by pre-migration trauma (11).

Silove et al identified numerous other pre-migration factors that predispose to psychological distress which were present in over 25% of asylum seekers involved in their study (12). These included but were not restricted to: witnessing a murder/unnatural death of a family member/ friend, being close to death, forced separation from family members and torture.

Post-migration factors:

Post-migration, unsuitable accommodation has been identified as a significant psychologically stressing factor. A Freedom Of Information request done by the Refugee Council showed that since the covid-19 pandemic the number of asylum seekers being housed in temporary hotel accommodation for greater than 35 days has increased despite recommendations having been made to reduce this number (13). Additionally, the rate at which individuals are moved from this initial hotel accommodation to community-based "dispersal" accommodation is slowing, exacerbating the backlog of individuals awaiting more suitable accommodation (13).

Poverty has also been identified as a significant post-migration factor in predisposing to psychological distress. Individuals who are housed in full-board hotels receive £8 per week from the Home Office for expenses such as travel, clothes and non-prescription medicines (13). As a consequence of this restrictive budget, the Refugee Council found that social integration of individuals housed in these hotels was impaired due to difficulties accessing public transport and clothing (13). This social isolation produces yet another psychological stressor on these individuals.

In addition, it has been shown that individuals who have their claims approved show significant improvements in symptoms of PTSD, depression and anxiety compared to those awaiting a decision on their asylum claim. This improvement remains even after pre-migration exposure to trauma is controlled for (12). By contrast, whilst awaiting a decision on an asylum claim in the UK individuals are commonly housed in temporary hotel accommodation, possibly creating a mental impression of impermanence and of an ongoing journey. Given that The Refugee Council have reported that living in hotels is "centred around waiting" (13), it is likely that there are many asylum seekers for whom uncertainty of immigration status increases their vulnerability to mental illness.

Indeed, in March 2023, 42% of UK asylum seekers were housed in hotels whilst awaiting the outcome of their asylum claim (14). A number of these hotels are in the Hounslow area, likely due to its proximity to Heathrow airport. These hotels fall under the catchment area of Hounslow Crisis Assessment and Treatment Team (HCATT), a community-based team which provides support to individuals in mental health crisis with intensive home treatment (15).

Given the prevalence of SMI in asylum seekers and refugees as well as their rapidly increasing number in the UK, it might be expected that this would produce untenable strain on NHS mental health services local to these hotels. In order to test this hypothesis and seek to inform how we best serve this population, a retrospective study of HCATT referrals was performed to examine the number of referrals that came from forcibly displaced persons. Average duration of HCATT input was compared between forcibly displaced individuals and the general population. Notes were also made of additional language needs that this population had as well as the prevalence of trauma exposure in this population.

Method:

All referrals to HCATT from 1st April 2023 to 31st August 2023 were examined – this amounted to 593 referrals in total. Each referral was assigned a unique identification number which was stored together with the service user's Medical Record Number (MRN) in a separate spreadsheet for confidentiality purposes. Of note, multiple referrals of the same individual within this period were counted separately.

The length of time each referral was open was calculated, from date of referral to date of discharge. All referrals that had the same referral and discharge date were immediately excluded, as this suggested there was no role for HCATT.

Following this, additional exclusion criteria were applied to referrals that lasted one day or more:

- Referral rejected prior to / immediately after initial assessment
- Admission to ward immediately following initial assessment
- Case still open at start of data collection – 18th September 2023
- Referral taken on behalf of another service

Of the 593 referrals during the April to August 2023 period, the following were excluded (*fig 1*):

Of the remaining 441 referrals, each individual's electronic progress notes were reviewed.

Firstly, each individual's address was classified as follows:

Location	Code
General community	A
The Atrium Hotel	B
St Giles' Hotel	C
Ramada Hotel	D
Heston Hyde Hotel	E
Mental health ward	F
Incarcerated	G

Table 1 - Coding of address data

Subsequently, all progress notes were searched for the terms "asylum" and "refugee", to ascertain whether an individual may be an asylum seeker who is housed outside of one of these hotels, or an asylum seeker with settled status.

Two groups of data were formed. Group 1, the Forcibly Displaced group, contained all individuals whose notes made reference to them being an asylum seeker or refugee. Of note, a handful of patients had the words "asylum" or "refugee" in their notes but this was not in relation to the service user themselves and therefore these individuals were counted in Group 2, the General Population group. The mean and standard deviation for the length of time a referral was open was calculated for these two groups (*Table 3*).

In order to gain more insight into the ways in which the Forcibly Displaced group interacted with the service, further data was collected from all progress notes (including those notes not made by HCATT) for individuals in this group. Firstly, the patient's Immigration Status and, if applicable, how long they had been settled was recorded. The aim of this was to investigate the proportion of forcibly displaced individuals who had made an asylum claim. Secondly, the native language of the patient was recorded, such that the impact of any language barriers on the referral could be assessed. If present in the notes, this data was enriched by any clinician comments on whether language was identified as a barrier to care. Additionally, any mention of trauma was noted, along with whether this occurred pre-migration, in relation to their journey to the UK, and/or post-migration. This was recorded considering the evidence that asylum seekers experience higher levels of trauma (12, 11). Finally, the diagnosis was recorded, such that any deviation from general trends could be examined.

Results:

Of the included referrals, the following address data were identified:

Location	Number
General community	431
The Atrium Hotel	1
St Giles' Hotel	4
Ramada Hotel	1
Heston Hyde Hotel	1
Mental health ward	1
Incarcerated	2

Table 2 - Address data

All 7 individuals whose address was in one of the hotels dedicated to housing asylum seekers were found to have made asylum claims. A further 6 individuals were identified whose notes referenced that they may have been forcibly displaced (*fig 2*).

The average length of time the referral was open was compared for these two groups, to examine whether there is a significant difference in how long HCATT provided input for forcibly displaced individuals as compared to the general population. These data are shown below:

	Mean duration referral open (Number of days, 2 DP)	Standard deviation in days (2DP)
Forcibly displaced individuals	7.23	7.50
General population	11.39	12.69

Table 3 - Average duration of HCATT input in days (2dp)

In order to compare the length of time referrals were open between the groups and investigate whether the duration of input for asylum seekers was statistically significant with respect to those of the other general population, a hypothesis test was carried out on the above results. Since the amount of time a referral can last, and the sample size for the general population is reasonably large, a normal distribution is most appropriate to model these times. Group 1 was calculated to have a mean of μ=11.39 days and σ=12.69 with N=428, whereas group 2 was calculated to have a mean of μ=7.23 days and σ=7.50 days with N=13. Using the standard Normal distribution calculations, the significance of the difference in populations was found to be P=0.2407, and therefore not significant to the standard 5% significance level.

The proportion of referrals being made for asylum seekers was also compared to the proportion of individuals resident in Hounslow who are classed as asylum seekers legally. Since the likelihood of a member of the population being referred to HCATT is discrete and well modelled by a binomial distribution, a hypothesis test was carried out on the percentage of such referrals with respect to the two groups. 3000 of the total Hounslow population of 293,000 are classified as Asylum seekers, meaning that an approximation of the probability of a person referred to HCATT being an asylum seeker is p = 3000/293000 = 0.0103. This study found that 6 of the 414 referrals to HCATT were of those legally classed as asylum seekers, such that the hypothesis under test was that asylum seekers were over-represented in the referrals: $P(X \geq 6)$ is significant for this distribution with n = 414 and p = 0.0103. Using standard binomial distribution calculation, we can see $P(X \geq 6) = 0.257$, and therefore this result is not statistically significant and asylum seekers have not been found to make up more referrals than the other general population.

For the forcibly displaced population, additional data was identified regarding diagnosis, language and trauma exposure as shown in figures 3,4 and 5 respectively (language has been changed to gender neutral in order to protect identity).

Discussion:

Length of time referral open:

No significant difference was found between the length of time a referral was open for the general population vs the forcibly displaced group. Given the high degree of variability in the data, with standard deviations greater than the mean in both groups, it is likely that a much larger data set would be needed to establish whether a trend exists. In addition, further analysis to subcategorise data would allow more meaningful comparisons to be made by controlling for factors that are known to influence length of time a referral is open. For instance, categorising by diagnosis, risk assessment on referral and whether or not a patient was referred for psychological input, as psychology sessions typically occur over a period of weeks.

Diagnosis:

No single diagnosis stood out as most prevalent in the forcibly displaced group. In studies performed elsewhere, PTSD has been shown to be especially prevalent in this group (16), however a data set of 13 forcibly displaced individuals is likely too small to be reflective of trends that have been observed on a wider scale. Additionally, as no data were collected for diagnoses in the general population, no comparison can be made between the two groups.

Number of referrals:

Asylum seekers make up around 1% of Hounslow's population as a conservative estimate: the population of Hounslow in 2023 is estimated to be around 293,000 (17), with Hounslow housing just over 3,000 known asylum seekers in May 2023 – 1.02% of the Hounslow population Only 6 of the individuals in this study would be classed as asylum seekers in Hounslow's statistics as individuals who have made an asylum claim and have not yet had their claim accepted – accounting for 1.36% of the HCATT referrals.

According to these results, there was no significant difference between asylum seekers and the general population in likelihood to be supported by HCATT. Given the significant histories of trauma in this population, with only 13% of forcibly displaced individuals in this study not having a reference to trauma in their notes, it is reasonable to assume that some proportion of mental

health crises in this population are therefore not recognised or reported.

In addition, it is quite possible that those individuals whose notes do not make reference to trauma have either not had this explored or have been unwilling to discuss this with mental healthcare staff. Indeed, it has been shown that discussion of trauma exposure can itself be traumatising for the individual seeking help (18).

Despite this low number of referrals, anecdotally, many HCATT staff were surprised by how few individuals in the caseload were forcibly displaced, as there exists a general impression that asylum seekers formed a much larger proportion of the caseload than this.

Why are asylum seekers overrepresented in the staff's memory of the HCATT caseload?

The study found that just thirteen possible asylum seekers were treated by HCATT over the April to August period – just 2.95% of the caseload, with the proportion of those having made an application for asylum that is either pending or has been accepted being even lower at 2.27%. It is difficult to ascertain why staff disproportionately notice these referrals but it is nonetheless an important question to ask.

It may be that the barriers to providing effective care to this population create great dissatisfaction amongst staff and therefore loom large in their memories. For example, when treating patients in hotels that provide temporary accommodation there is always a risk that that patient will be moved by the Home Office to alternative accommodation outside the Hounslow Area. When this happens the new address is not shared with HCATT - this brings an abrupt end to the interventions being provided by HCATT. Subsequent inability for the team to handover effectively to an alternative Crisis/ Home Treatment Team or General Practitioner (GP) due to uncertainty about a patient's new address only adds to that dissatisfaction for staff. Even more critically, it adds to the instability that asylum seekers experience and may force them to have to articulate once more their often traumatic history to a new team who are unable to view the history that has already been shared and documented.

It is also possible that this group's comparatively increased care needs cause them to be overrepresented in the minds of HCATT staff. This group is more likely, for instance, to have complex trauma which predisposes them not only to PTSD but also to significant complexity of symptoms, in which multiple clusters of symptoms are present to a clinically significant level (19). Such complexity is likely to require a higher intensity of intervention.

Furthermore, additional care needs arise from the language barriers that are so prevalent when treating this. Language barriers are not exclusive to those who have been forcibly displaced, but as shown by the HCATT data are common in this group with only four out of the thirteen forcibly displaced individuals not having some degree of language barrier group (*fig 4*). In 2023, asylum seekers arriving in the UK mostly hailed from Iran, Albania and Afghanistan (1), however relatively few of the UK population are able to speak Farsi, Albanian, Dari or Pashto (the main spoken languages of these three countries, respectively). Staff rely on telephone interpretation services or, when these are unavailable, family members as interpreters. It is common in healthcare to use family members as interpreters, and both the advantages and limitations to this are well-documented (20). For instance, family members are well-placed to provide additional emotional support and can also aid in recalling advice and management plans after a consultation has ended (20). However, in the context of a mental health crisis, individuals may experience feelings of shame surrounding their traumatic experiences that prevent them from sharing via an interpreter who is known to them. The use of a professional interpreter does not appear to provide the ideal solution however. For example, the language spoken by the service-user may not be supported by the interpretation service, or may not be available at the time of the appointment.

Irrespective of method of interpretation, any consultation where either party is not speaking in their native tongue is vulnerable to cultural misunderstandings – this can create further frustrations to effective communication that may cause healthcare staff to over-represent asylum seekers in their memory of the team caseload. Whilst the breadth of factors involved in culturally-sensitive care is outside the scope of this paper, it is relevant to note briefly the importance of awareness of 'cultural idioms of distress'. Each culture has its own idioms of distress that carry significance for members of that culture that cannot be directly translated. For instance, in the West one of the most common cultural idioms of distress centres on the concept of back pain. Phrases such as "a weight on my shoulders", "a pain in the neck", "more than I can bear" and "to get on someone's back about something" all refer to causes of psychological distress (21). Translated word for word into another language, these metaphors lose some of their significance. In addition, these idioms can transcend metaphor, with psychological distress manifesting itself as physical back pain (22). Indeed, the intersection between psychological and physical pain has been shown to be of great significance, with physical pain in those who have comorbid depression having been shown to be more intense and protracted than in those who do not have depression (22,23). If these cultural

idioms are not recognised, the depth of complexity and meaning that is so critical to a phenomenological understanding of an individual's lived experience and subsequently establishing psychiatric diagnosis is lost.

Unfortunately, it is also possible that there are pre-existing expectations among staff that asylum seekers would create a disproportionately large burden on psychiatric services due to polemic media discourse surrounding immigration (24, 25). Asylum seekers in particular have been portrayed with suspicion, construed as possible exploiters of the asylum system. It is important to acknowledge this narrative so as to not only avoid becoming complicit in it but to also better comprehend the discrimination this group may face and to be active in fostering an environment in which these individuals are not treated with inappropriate suspicion.

Why are we seeing so few referrals from asylum seekers in Hounslow?

Due to the nature of HCATT's service, able to offer intensive home support within 24 hours at no financial cost, commonly-cited barriers to accessing care such as long waiting lists, costly travel and affordability were not applicable to HCATT (23). However, despite this, a number of barriers remain. Some of these barriers are related to cultural attitudes towards mental health and therefore may be difficult to affect. However other barriers are connected to the HCATT service itself and may be possible to overcome.

One such cultural difference that may prevent asylum seekers reaching out to HCATT for support in crisis is a difference in help-seeking behaviours. Given the heterogeneity of cultures that comprise the UK asylum seeker population it is outside the scope of this study to comment on the full variety and nuance of these differing help-seeking behaviours. However, it is worth noting that it has been shown that individuals may prefer to seek help from a community figure or traditional/faith healer prior to seeking help from NHS services in both Kurdish and Somali asylum seekers (26, 27).

Indeed, lack of awareness of other cultural explanations of why distress occurs may also impair rapport between an asylum seeker and mental healthcare staff (28). Unfortunately, there is a paucity of data describing the efficacy of traditional practices and so it is impossible to comment on the degree to which they may be beneficial.

Stigma may also be at play, with a systematic review by Satinsky et al identifying a number of studies where asylum seekers expressed a concern they may be stigmatised by their communities for seeking support for mental health (23).

With regards to service-based barriers, acceptability of services has been identified as a key barrier (18). It has been shown that where mental healthcare staff do not share a cultural background with an asylum seeker, there can be impaired trust and therefore reduced acceptability of the service (29). One method to make a service more acceptable is to include peer support workers in mental healthcare services for asylum seekers. Research to develop and evaluate such a service is currently underway at the University of Plymouth (30).

Similarly, language barriers and limitations to interpretation services as described above may also deter individuals from seeking help (18). Issues surrounding language barriers may not be completely overcome within a service with limited resource. However, staff having training to broaden understanding of both idioms and explanations of distress that differ from those commonly used in the UK may help to make services more acceptable to asylum seekers.

Limitations:

One key limitation of this study is that, as a retrospective study, patient and staff perspectives were not collected. Further studies to collect data on how asylum seekers perceive the service in various domains such as accessibility, acceptability and, in particular, their awareness of the support on offer would be very beneficial to guiding improvements to the HCATT service.

Another limitation was sample size. If the mean and standard deviation in each group remained constant, a sample size of 38 asylum seekers would be required in order for differences in referral duration to be significant – requiring approximately a further 15 months' data to be collected.

In addition, as mentioned above, more granular data is needed to compare more suitably the duration of HCATT input data for these two groups. For instance, recording of diagnosis and which members of the multidisciplinary team were involved in care as these factors may influence duration of input.

Conclusions and future direction:

This study identified that forcibly displaced individuals only comprise a very small proportion of the HCATT caseload (2.95%). Forcibly displaced individuals who did come into contact with the service had a high prevalence of trauma exposure (at least 87%) which, if reflective of the asylum seeker population as a whole, would suggest that the prevalence of mental illness secondary to this would be higher in this group than in the general population. It is therefore reasonable to assume that mental health crisis in forcibly displaced individuals is underreported and that they are underrepresented in the HCATT caseload. A variety of barriers to access have been demonstrated by previous studies, both related to cultural differences and to challenges in accessing mental healthcare services. The following methods of promoting asylum seeker access to mental healthcare are suggested:

Training to promote awareness of cultural idioms and explanations of distress

Currently, there is a paucity of training that seeks to equip healthcare providers to provide a culturally sensitive approach to treating forcibly displaced individuals. Assuredly, given the heterogeneity of the asylum seeker population, no such training could easily encompass these various cultural idioms and explanations of distress exhaustively. However, even if training only seeks to provide an awareness of various cultural explanations of distress, this may promote more compassionate care as staff would be better equipped to recognise and adapt to differences in worldview. Furthermore, it has been shown that training in refugee and migrant-specific healthcare maps to 5 of the GMC's recommended outcomes for undergraduate medical students (31).

Literature to promote awareness of the support available

In addition, raising awareness of what mental health support is available in the UK may increase the numbers of asylum seekers reaching out for support. Actively seeking to intervene earlier in this way may improve outcomes for refugee mental health in the longer term, subsequently promoting social inclusion for refugees who are granted settled status in the UK. This could be done by designing literature to be provided in hotels in multiple languages.

Figures

Exclusion criteria	Number excluded
Referred and discharged on same day	121
Referral rejected prior to / immediately after initial assessment	22
Admission to ward immediately following initial assessment	1
Case still open at start of data collection – 18th September 2023	8
Referral taken on behalf of another service	1
Total:	**152**

Figure 1: The Exclusion criteria used for this study with numbers of referrals excluded per category

Identification number	Residence at time of referral	Immigration status
243	Heston Hyde Hotel	Asylum seeker awaiting decision on claim
310	St Giles' Hotel	Asylum seeker awaiting decision on claim
363	St Giles' Hotel	Asylum seeker awaiting decision on claim
549	The Atrium Hotel	Asylum seeker awaiting decision on claim
550	St Giles' Hotel	Asylum seeker awaiting decision on claim
562	Ramada Hotel	Asylum seeker awaiting decision on claim
44	Community	Asylum seeker granted asylum – in the UK for 12 months
245	Community	Asylum seeker granted asylum since 2009
504	St Giles' Hotel	Asylum seeker granted asylum immediately prior to referral
432	Community	Asylum seeker granted asylum 2019
336	Community	Forcibly displaced but has not started asylum claim
448	Community	Asylum seeker whose claim has been rejected awaiting deportation
514	Community	"Overstayer" considering applying for asylum

Figure 2: Individuals identified as possibly forcibly displaced and their immigration status at time of referral

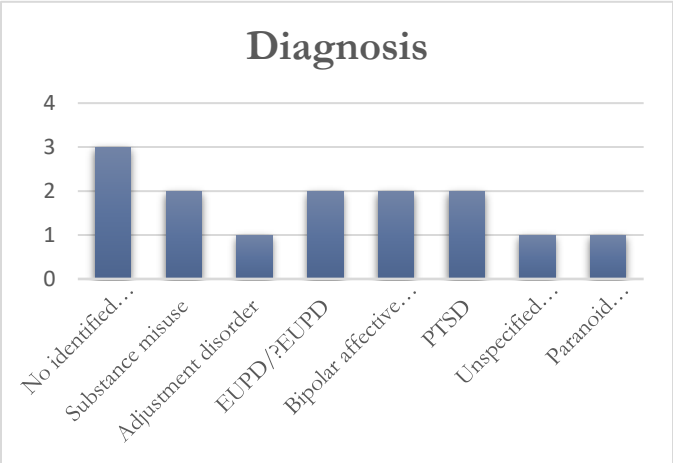

Figure 3: Diagnosis data for forcibly displaced individuals

Identification number	Language barrier
243	"...fairly able to communicate in English but prefers … interpreter"
310	"...spoke fluent... English"
363	"...happy to converse in English and does not want an interpreter"
549	"...limited English.... Assessment conducted via Silent Sounds"
550	"Assessment performed via Language Line since no in-person translator present." "... needs specialist help with Arabic language capability."
562	"...interpreting over the phone.... facilitated by an interpreter"
44	"conversational English was good and did not appear to be a barrier in our assessment"
245	"Their English is basic… struggling to express themselves"
504	"Their use of English is very limited which further restricts their ability to mix with people", "they derive anxiety from attending college to learn English… They experience hopeless thoughts such as "I will never learn the language"."
432	"Farsi is first language" – but no communication difficulties documented
336	Not mentioned in notes
448	"Patient only speaks Urdu and Hindi. Understands some English but speaks very little."
514	"Struggled to find some words in English"… "Verbal comprehension tests could not be carried out due to the language barrier"

Figure 4: Quotations from the notes regarding language barriers for the Forcibly Displaced group

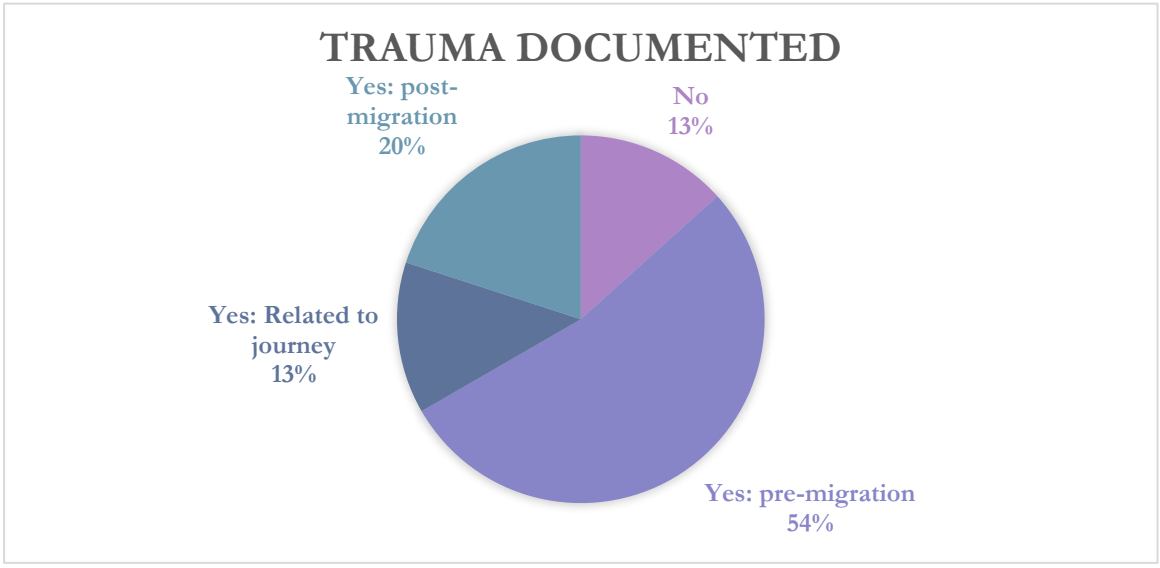

Figure 5: Prevalence of trauma exposure in the Forcibly Displaced group

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