Barriers to effective practice for health visitors working with asylum seekers and refugees

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Abstract
The objective of this study was to determine the barriers to effective practice that health visitors experience when working with refugees and asylum seekers. This was a qualitative study based on the analysis of in-depth interviews with a purposive sample of 14 health visitors describing their experiences working with refugees and asylum seekers. These were analysed using the Framework process, a thematic matrix-based analytical method. The findings identified that the barriers to effectiveness for health visitors when working with refugees and asylum seekers were underpinned by ineffective use of services and stretched resources. The results imply that commissioners of services need to have an understanding of these barriers to commission effectively.

Keywords
Health visitors, refugees, asylum seekers


No potential competing interests declared

Introduction
It has been recognised that health professionals encounter barriers to providing effective care for refugees and asylum seekers for many different reasons (Aldous et al, 1999; Cowen, 2001; Dar, 2000; Fassil, 2000). As well as barriers related to language, culture, lack of information or UK legislation, as many as 20% of refugees will have physical problems that affect their day-to-day life (Burnett and Peel, 2001).

They may have experienced the psychological trauma and physical health problems as a result of rape or sexual assault as a form of persecution, with the consequences of sexually transmitted diseases including HIV (Peel, 2004).

Many will have had experience of a traumatic event such as being assaulted, tortured and/or captured or witnessing killings (Silove et al, 1997). There are also high incidences of mental health problems often related to traumatic experiences (De Jong et al, 2000). However, some studies have found that the threat of deportation during the asylum process and the fear of returning to the situation from which they had made great efforts to escape had a significant contribution to mental health problems suffered by this client group (Philimore et al, 2007; Laban et al, 2005). Furthermore, refugees and asylum seekers from countries with diverse health care systems may have difficulty adjusting to the primary care gate-keeping system of the UK and expect direct access to hospital-based specialists (O’Donnell et al, 2008).

To address these issues a qualitative study of in-depth interviews with health visitors was conducted, commencing in 2006. One of the aims of the study was to identify the barriers to effective practice that health visitors experience in their work with refugees and asylum seekers. The methods and one specific finding of this study have previously been reported as a peer-reviewed article in this journal (Burchill, 2011). This published finding was that despite changes in legislation to prevent harm to children, the health visitors were working with the complexities of needs among refugees and asylum seekers related to safeguarding both children and vulnerable women. As well as working with families who would disappear from the systems in place to safeguard children, they also worked with women and children who were caught in a cycle of domestic abuse due to their immigration status, with no support from other professionals.

Previous research has identified the challenges of developing a health promoting relationship between health visitors and refugee women (Drennan and Joseph, 2004) and this paper will present a further range of barriers to working effectively with this client group.

Methods
Setting
The study site was a London borough, which has traditionally been an area with a high concentration of refugees and asylum seekers, although this has decreased in recent years. In addition, there is a particular local issue of a transient population who stay short-term, having considerable impact on local healthcare services.

Recruitment and sampling
Recruitment was conducted by approaching potential participants through a presentation at their main professional meeting. The presentation provided details of the proposed study and asked the health visitors whether they could be contacted individually to request that they participate in the study. Sampling was purposive, in which participants were selected for their ability to contribute to the data (Morse, 1991).

The inclusion criteria was for participants to have attended the initial presentation, to be a registered general nurse with a post-registration public health qualification in health visiting and to have worked in the borough for a minimum of two years, as it would be highly likely that they would...
have worked with refugees or asylum seekers. The PCT and the Local Research and Ethics Committee granted approval for the study.

**In-depth interviews**

A topic guide was developed for the in-depth interviews based upon the concepts that had arisen from an initial literature review. This consisted of a number of broad statements that would help guide the interview. The interviews were conducted at various health centres across the borough in which the participants worked.

**Analyses**

The interviews were taped and transcribed verbatim and the analysis was facilitated using the Framework method (Ritchie and Spencer, 1994). Framework is a matrix-based analytical method involving a constant comparative approach in which the codes are continually reassessed and interpreted. The themes that were identified were compared across the data and discussed between the author and external researchers. There are two key stages that characterise this approach: the first requires managing the data and the second involves making sense of the evidence through descriptive or explanatory accounts. Quotations were then chosen to illustrate the particular issues described.

**Results**

One of the key findings to emerge from the research was that there were barriers to effective practice for health workers when working with refugees and asylum seekers and this theme was underpinned by sub-themes of ineffective engagement and stretched resources.

**Ineffective engagement**

The health visitors in this study were found to have problems accessing appropriate services for refugees and asylum seekers. The client group had little understanding of the NHS and the gate-keeping system of GPs often caused confusion.

Participants talked about the difficulties accessing a GP for their clients in the first instance because sometimes the GP surgery would refuse to register them for various reasons. On many occasions participants talked about families and individuals inappropriately using more expensive services such as A&E for treatment of minor illnesses such as colds or flu.

“They often get rejected from GP surgeries, you know when they attend routine appointments and they can’t assert themselves or they are not particularly well heard so they seem to use A&E a lot” (Interview 8)

On other occasions they advised their client to go to Accident and Emergency for treatment because they were unable to get them registered with a GP and were concerned about their need for medical attention.

“If I felt obviously they were really quite ill and needed to be seen immediately I would just have to send them to A&E … [they] have tried to get local GPs and they just haven’t been able to” (Interview 6)

Inflexibility in the primary healthcare team tended to frustrate the health visitors who at times would feel that they were the only service trying to help some of these people. The clients’ lack of understanding of the systems frequently exacerbated the problem as well as inefficient communication. A typical example was when a letter written in English was sent to a family for an appointment with a paediatric consultant without informing the health visitor, resulting in a missed appointment because the family could not read English.

It was also acknowledged that people who have been moved around frequently may be reluctant to engage with services because they have been let down in the past. Then there were instances of families not engaging with services because the parents were engaging in some form of criminal activity, such as prostitution or drug dealing and the children playing truant from school.

Another reason cited for clients not engaging with services was the clients’ lack of awareness of what the services were for. If the health visitors had managed to engage their clients with child health clinics they found that they were more willing to attend and quite amenable to the service.

For health visitors to perform child surveillance, engaging families with services was seen to be necessary but not always easy with this client group. Innovative examples of engagement included learning the language of their clients or setting up clinics in more accessible community centres for people who were not attending appointments.

Some of the health visitors talked about being flexible in their approach by filling out driving licence applications at child health clinics or making telephone calls regarding unpaid bills, which helped gain the trust of their clients and encouraged engagement, enabling the health visitor to perform the child health surveillance required. Over time, the following participant noticed an increase in attendance from refugees and asylum seeking families at her child health clinic:

‘After a year or so I was getting about 14 or 15 people every Monday morning and often it would be for a variety of things like driving licence applications and different things but they got to know me and got to trust me and I thought that was good because they were accessing the service for whatever reasons’ (Interview 1)

Once they had accessed health services, the participants talked about the difficulties of engaging with people who present with many vague symptoms that were not easily treatable. Sometimes this was recognised as being psychosomatic illness that was probably a result of physical or psychological trauma. At other times participants recognised that there was a big difference in the cultural understanding of health and illness. For example, one health visitor talked about postnatal depression being a western term and that people from some countries do not have the same language for mental illness as those in the western world.

For example, someone presenting with a heart pain might actually be trying to describe his or her depression. Another participant talked about how some of her clients had no concept of recovery, one example she gave was when a client told her she had diarrhoea but when asked questions she discovered it was two years previously. Most of the participants were aware that although their clients could not articulate what was wrong with them, they were often presenting to health services for a reason and an objective of their assessment would be to discover what that reason was.

“They may have psychosomatic symptoms, that can be common, you may find as well that they may have frequent visits to their GP or A&E departments and indirectly, although they may not even know this themselves, it could be actually something underlying.’ (Interview 14)

The participants were concerned that the façade of somatic symptoms could potentially lead to the wrong diagnosis or no diagnosis at all when depression may be present. They
reported frequent vague symptoms amongst their refugee and asylum-seeking clients and their assessment of the needs of their clients was perceived to be of particular importance in these instances.

**Stretched resources**

Resources were repeatedly referred to during the interviews. Having clients with multiple problems requiring input from many health and social organisations was often seen as a drain on resources. Having to repeatedly visit families and individuals meant that the health visitor would have limited time to deal with their mainstream clientele and at times they viewed this negatively.

The added cost of the use of interpreters was also mentioned on occasion. For some participants, refugees and asylum seekers were seen as placing a burden on resources as a result of inefficient systems that moved refugees from one borough to another. If the refugee had high health needs they would be constantly linked into services then moved on, only to require linking in again with other services.

Repeatedly the participants mentioned the needs of refugees and asylum seekers that required a large amount of input compared to their mainstream clients. The following participant discussed how the majority of a new birth visit was taken up by the father discussing the impact of the war in Iraq and the effect previous torture had on his physical health:

‘Because it [his leg] was fractured in so many places so, you know most of the visit was discussing that, so again you know you just think you are going in, you plan your day and you’ve got three new births and two movements in and you plan your day thinking right I’ve got an hour or an hour and a half for this but really it doesn’t always work like that.’ (Interview 4)

Often having to work with the extended family and referring individuals to many other services was time consuming and required more visits on a regular basis. One health visitor talked about the extensive work she did with the grandparents following a new birth visit. They had witnessed a great deal during the war in their country of origin, and this was still affecting their health.

‘I did a new birth (visit) and the grandparents were there … I spent more time with them on this new birth, you know, the mother was absolutely fine you know a young 20 year old girl, but the grandparents hadn’t slept a full nights sleep for like four years, they were just having like severe nightmares, night sweats … because of what they had gone through in the war, so you have to be more flexible rather than going and saying, right I am going to discuss cot death and erm, and immunisation, because that’s not what it’s about.’ (Interview 4)

The grandparents had witnessed the killing of their neighbours during conflict in their home country. In this case the health visitor listened to their stories then got them linked in with a GP, then referred on to a specialist support service that provided counselling in their mother tongue.

Again, working with the extended families in this way required an investment of time that had a knock-on effect for the work of the health visitor. A further issue following referrals to external organisations was that at times the participants would see little improvement in the outcomes for the family or individual, despite a number of organisations being involved with them.

‘She has a lot of flashbacks and about a month ago one of her friends was raped and murdered in Iraq so that’s brought it all back for her and so we had to get lots of other mental health services involved again, so it’s quite complex and I can’t really see a way out of it for her because she has had counselling, she’s got a lot of people going in, she gets me going in, she gets an outreach worker going in, she’s had a social worker going in, she’s now got somebody from [anon] Family Centre going in, she’s had counselling from refugee support services, but really for her nothing really changes.’ (Interview 1)

Having a number of services working with a family or individual, but demonstrating no improvement in outcomes had implications in terms of appropriate use of resources. The participants also talked about how they thought some of the services were being abused by individuals and families, with some of their clients expecting more resources, such as welfare and benefits, than were necessary. On occasion, some participants talked about working with people who they suspected were economic migrants who had travelled to the UK because they had heard there were good benefits, and this was generally frowned upon.

‘The way I understand divorce is that you and your partner don’t see one another again, but then I went in to visit her with a third child from the same man … they want to get social benefits as much as possible, because they still are really and truly having a relationship with their partner, such are the kinds of abuse that I think needs to be looked into.’ (Interview 13)

The participants’ expertise in core health visiting was overshadowed by the difficulties they had in learning the systems around immigration, housing, welfare and benefits, again feeling that they lacked the knowledge to deal with these issues. This was particularly evident when there were issues such as lack of immigration status. The time they needed to spend on some of these issues meant that they had less time to concentrate on their work, which they believed reduced the quality of their health visiting function.

**Discussion**

The difficulties in effectively engaging refugees and asylum seekers with services were evident with many of the participants describing their frustrations with this issue. Lack of effective engagement meant that refugees and asylum seekers were not receiving adequate services to meet their needs. Their underlying health problems were not being adequately dealt with, leading to further health problems that could have been prevented.

Many refugees and asylum seekers from countries with diverse health care systems have difficulty adjusting to the primary care gate-keeping system and expect direct access to hospital-based specialists (Ritchie and Spencer, 1994). This can lead to their disappointment as well as irritation of the health workers (Phillimore et al, 2007). GPs have reported increased pressure from work resulting from patients who cannot speak English and who have a multitude of problems, not all of them health related (Coker, 2004).

GPs and health workers are often unsure about the entitlements to health services for refugees and asylum seekers (McColl et al, 2006). At the time of the research, in their efforts to reduce illegal migration the government had set out guidelines to deny failed asylum seekers access to healthcare (DH, 2004). This seemed to be having an impact on the ability of health visitors to register their clients with some GPs or to assist them in accessing health and social services. Another factor was the vague symptoms that
asylum seekers and refugees often presented with to health services. Somatization has been described in non-western cultural groups as taking the form of vague, generalized symptoms that include tiredness, weakness, fever or pains all over (Helman, 2007). It has also been described as a cultural patterning of psychological or social disorders explained by physical symptoms and signs and has been particularly associated with depression (Patel, 2001).

In these cases, people suffering with low mood and depression complain of frequently changeable physical symptoms such as headaches, palpitations, weight loss, dizziness, lots of pains everywhere, and so on. Patel notes that the word ‘depression’ often has no clear equivalent in non-European languages and in many of these languages there is no clear differentiation between depression and anxiety. Therefore, understanding and diagnosing illness with people from cultures who use somatic terms can be difficult and has the potential to lead to the wrong diagnosis, or no diagnosis at all when depression is present.

The findings of this study indicated that health visitors felt that they had difficulty dealing with asylum seekers and refugees effectively because of the lack of resources and time, leaving less time to work with their mainstream clients. This impacted on the amount of time they could spend delivering the Child Health Promotion Programme, now succeeded by the Healthy Child Programme (DCSF, 2009), which is what the health visitors were commissioned to provide.

The health visitors reported that more expensive services such as accident and emergency were being used when less expensive services such as general practice could have been used. They were aware that there were a finite number of resources in the NHS, but they were witnessing these being used inappropriately. Further frustration was evident when their own time at work became a resource that was stretched, resulting in a decrease in the quality of the work that they could provide. These issues were seen as barriers to being able to practice effectively.

Conclusion
This study has highlighted the barriers to effective practice that health visitors experience when working with refugees and asylum seekers with complex needs. These barriers had an impact on the quality of their work and contributed to the difficulties in effectively engaging this client group with appropriate services.

The complex needs also had an impact on resources, which were often already stretched. However, by being flexible in their approach the participants were able to find ways to engage with this client group. It is recommended that health professionals share innovative ways of working in order to reduce the barriers experienced by refugees and asylum seekers.

Furthermore, there needs to be an increase in awareness among primary care staff of entitlement to health services for this particular client group. It is also important that commissioners have an awareness of these barriers to effective practice when deciding how to invest in the most appropriate services for vulnerable populations.

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References


