Post-migration geographical mobility, mental health and health service utilisation among Somali refugees in the UK: A qualitative study[†]

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Abstract

Migration is known to be associated with poor health outcomes for certain marginalised and socially disadvantaged populations. This paper reviews a number of reasons why residential mobility in the 'host' country may be associated with poor mental health for refugee populations and reports on a qualitative study of Somalis living in London, UK, and their beliefs about the relationship between residential mobility, poor health and health service use. Two discussion groups were undertaken with 13 Somali professionals and four groups with 21 lay Somalis in East and South London, UK. Lay Somalis did not wish to move accommodation but felt they were forced to move. Some Somali professionals believed that the nomadic history of Somalis made them

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more likely to elect to move in order to escape problems of living, but this was not supported by the lay group. Frequent geographical movements were seen as stressful and undesirable, disrupted family life and child development and were detrimental to well being. Residential mobility was also perceived to interfere with health care receipt and therefore should be more comprehensively assessed in larger quantitative studies.

Introduction

There has been a growing interest in understanding the health needs of refugee communities in Europe and North America (Silove et al., 1997; Steel et al., 2002; Mollica et al., 1998; Hondius et al., 2000; Danso, 2001; Lie, 2002; Vergara et al., 2003; McCrone et al., 2005). Somalis are amongst the largest groups of asylum seekers coming to the UK; nevertheless, little is known about their health and settlement needs. The post-migration literature of geography on the health of refugees and their integration processes is scant. This paper focuses especially on migrant residential mobility after arrival in the UK and considers the implications for health and healthcare.

A growing body of research is focusing on the significance of residential mobility for health of populations (Brimblecombe et al., 2000; Boyle, 2004). The 'healthy migrant' thesis argues that socially advantaged populations with high levels of residential mobility are most likely to move towards more privileged settings which are beneficial for health. However, there are also a significant number of studies suggesting the effect of 'malign migration' whereby marginalised and socially disadvantaged groups experience higher than average levels of residential mobility which is detrimental to health (e.g., reviewed by Curtis et al., 2004). This latter 'malign' form of residential mobility is common in inner city areas and has often been invoked in relation to poor and socially excluded populations with relatively poor mental health. People in these groups are thought to be more mobile because of a shortage of suitable housing and because of exclusion and discrimination experienced in some residential areas. Moreover, it is sometimes argued that these inner city populations, irrespective of cultural origins, present particular challenges to health and social services

because of the problems of maintaining stable contacts with key health professionals such as general practitioners and social workers, and this may compromise their effective access to, and use of, social and health-care services.

A proliferation of the literature has examined and explored the role of residential instability in the mental health status of homeless groups (Hamid et al., 1993; Craig and Timms, 2000; Lamont et al., 2000). The findings of these studies suggested that transient populations have a wide range of social problems, higher levels of unmet need and significant levels of severe mental illnesses. Hamid et al. (1993) proposed that homelessness exists because of the lack of adequate housing provision to the poorest and underprivileged members of society and that the psychological problems of people without stable residential places might be the result of material deprivation and homelessness. These problems are long standing; Johnsen et al. (2005) noted a historical observation that 'able-bodied' people who were in receipt of welfare assistance were viewed as the 'undeserving poor', with farreaching social and policy implications, in terms of how the State and society conceptualised and responded to the social care needs of the undeserving poor people. Like the British born socially excluded citizens with histories of poverty and homelessness, geographical mobility is common among asylum seekers and refugees in the UK. With limited financial resources, language and communication barriers and with cultures and customs which differ from those of the majority in the host country, asylum seekers and refugees are more vulnerable to social exclusion and marginalisation following migration to a new country (Ager, 1993; Sinnerbrink et al., 1996; Silove et al., 2000; Beiser and Hou, 2002; Watters, 2001; Watters and Ingleby, 2004).

Dislocation from the country of origin because of wars and experiences of human rights abuses followed by recurrent displacements within the country of refuge may all add to psychological distress. They are subjected to discrimination and stigma, which misrepresent these groups as being particularly associated with crime, loss of employment and as a drain on public resources available to established local communities. Danso (2001) therefore suggested that Ethiopian and Somali refugees face social exclusion and a number of social problems including experiences of unemployment, overcrowding, discrimination and everyday racism that might have created obstacles to their integration into the host nations.

Nomadism as a 'way of life' is another attributed characteristic that is used to represent patterns of geographical mobility among Somali refugees across a number of countries. Descriptions of the Somali society include migration as an essentially culturally accepted part of everyday life (Rousseau et al., 1998). Rousseau states that the nomadic way of life 'predisposes' Somalis to value travelling as a way of maturing (Rousseau et al., 1998). Through a series of case studies, Rousseau and her colleagues explored the pre-migration dreams of young Somalis in Canada, Ethiopia and Somalia. They suggested that it is easy for Somalis to migrate en masse for three main reasons. Firstly, their nomadic background predisposes them to mass migration. Secondly, peer pressure creates 'special migratory dynamics' and, thirdly, many young Somalis see migration as an adventure. Consequently, they concluded that many young Somalis dream about migrating to other countries. Another assertion is that youngsters make plans to travel, and in so doing substitute 'dream travel' for 'real travel', but if the real travel fails to materialise, the dream travel locks them in a timeless transitional period. According to the authors, it is during this transitional period in which many young Somalis slide into 'madness' (Rousseau et al., 1998). Other researchers have explained the post-migration geographical mobility of Somalis moving from Denmark, Sweden and Holland to the UK in terms of this nomadic analysis. However, this representation of the 'nomadic culture' of Somali people has the potential to be detrimental to the understanding of their experience since, if it implies that mobility is a voluntary choice, it may heighten the risk of exclusion. Curtis et al. (2004) review from a geographical perspective how travellers, homeless people and other very mobile groups are at particular risk of social exclusion because they are not associated with fixed 'defensible' territorial areas, and they are viewed with suspicion as somehow 'subversive' and threatening to 'respectable' social 'norms' of residential stability and land ownership.

Aside from the stressors of war and the rigours of migration in response to political oppression, poverty and inadequate housing in the destination country, a further theoretical explanation for migration being a stressor is that of attachment to place. Fullilove (1996) proposed that displacement due to residential mobility causes disruption of attachment to 'places' that is inherently distressing and disruptive to psychological well-being. She argues that this can result from residential displacement within an urban area as well as international migration. She proposed that individuals require a 'good enough'

environment in which to live, determined by a degree of attachment, familiarity and their identification with place. Attachment involves a mutual bond between a person and a beloved place. Familiarity involves processes through which a detailed knowledge of a place is gradually built up. Place identity involves derivation of a sense of self from places in which one passes one's life. If this identification or attachment is threatened by displacement, problems associated with nostalgia, disorientation and alienation may ensue, with associated risk to mental health. If newly arrived refugees often experience a good deal of insecurity and change in their circumstances in Britain, this theory would suggest that post-migration geographical mobility could be detrimental to the mental health of mobile refugees, even after they have arrived in safe countries and are given refugee status.

Aims

The purpose of the study was to explore from Somali perspectives the meaning of geographical mobility, how much of an issue geographical mobility is in the lives of Somalis, and to listen to how this may relate to mental health status and health service use. We particularly aimed to explore Somali narratives and realities of geographical mobility and mental health.

Methods

We found few studies had specifically explored post-migration residential mobility and mental health of refugees in the UK and abroad, and, in the absence of an existing body of research on their experiences, we have chosen a predominantly qualitative method. Qualitative methods offer the possibility of allowing informants to explain their experiences from their own point of view and they provide rich descriptions of the meanings that are attached to these experiences. These methods are therefore preferred when investigating social processes and narrating the significance of social problems for poor mental health that have not previously been researched (Green and Thorogood, 2004). As is the case for quantitative research, methodological issues in qualitative research need careful attention. Meticulous research designs can significantly improve the trustworthiness of qualitative findings (Mays and Pope, 1995; Green and Thorogood, 2004; Curtis et al., 2000).

A 'purposive sample' of participants were recruited for this study from local Somali professional networks (see Appendix A for details) and from amongst local communities of lay Somalis using non-health-related venues such as cafes, community centres, mosques and telephone call centres where many Somalis make cheap international telephone calls. It would have been impossible to select a statistically representative sample, since neither the exact numbers of refugees, including Somali refugees in Britain is known, nor do we know the number of Somalis living in the two locations (East London and South London) where we recruited participants, and there are no relevant sampling frames. With this in mind, we identified the aforementioned venues iteratively through local participant observations by the researchers who spent time in local cafe´ s and talked to local Somalis in their usual social networks. Our selection criteria for the purposive sample were that people should be recruited from both sexes and from specific areas where noticeable numbers of Somali people lived, and Somalis from varied socio-economic backgrounds were invited to participate in the study. Although we cannot claim that this is a 'representative' sample from which we can make generalisations to the whole Somali community in London, we believe that our selection methods provided a group of informants whose views could be close to those of other Somalis living in the two locations of London.

Interviews were undertaken in the year 2001; of the 42 invited to participate, seven failed to attend the discussion group meetings for reasons not mentioned to the researchers; one person objected to tape recording and left the room before the interview began. We cannot speculate how the views of the non-respondents would have been different from those of the participants and how this might have influenced research outcomes; ethical approval for this research was granted on the condition that non-responders were not asked any questions about reasons for non-response.

The discussion groups drawn from professional networks were held at the Institute of Community Health Sciences, Queen Mary University of London and at the British Refugees Council in South London. In total, we completed in-depth group discussions with 13 Somali professionals in two groups and 21 Somali lay people in four groups. The four lay group discussions were held at community venues in South and East London. In each recruitment location, we held one mixedgender Somali professional discussion group, one with lay Somali men and one with lay Somali women (see Tables 1a and b for details of

Table 1

Sex	Type of profession	Area of work
(a) Demographic characteristics of the professional participants (two professional discussion groups)		
Age range: 25–55 years		
Female	Counsellor	East London
Male	Social worker	East London
Male	Housing officer	East London
Female	Housing officer	East London
Female	Advocacy worker	East London
Male	Somali project worker	East London
Male	Counsellor/caseworker	South London
Female	Project worker	South London
Male	Psychiatrist	South London
Male	Community worker	South London
Female	Case worker	South London
Male	Physician	South London
Male	Housing officer	South London

Sex	Occupational status	Area of residence
(b) Demographic characteristics of the lay group participants (four lay discussion groups)		
Age range: 19–65 years		
Female	Housewife	East London
Female	Unemployed	East London
Female	Unemployed	East London
Female	Unemployed	East London
Female	Housewife	East London
Female	Pensioner	East London
Female	Unemployed	East London
Male	College student	East London
Male	Unemployed	East London
Male	Asylum seeker	East London
Male	University student	East London
Female	College student	South London
Female	Housewife	South London
Female	Housewife	South London
Female	Unemployed	South London
Female	Unemployed	South London
Male	Unemployed	South London
Male	Student	South London
Male	Community volunteer	South London
Male	Unemployed	South London
Male	Asylum seeker	South London

some of the key characteristics of the informants). Ethical approval was obtained from local research ethics committees.

The participants explored the meaning of health and risks to health, with a special focus on residential instability. A topic guide evolved from participant observation, from the research group's interests in residential mobility and health, and by modification of the topic guide as interviews proceeded. The topic guide made clear to the researchers that residential mobility was to be mentioned if the participants did not spontaneously mention it, after 1 h of a 2 h group session. Nevertheless, participants were allowed to discuss health and social problems of living in their own terms. Potential participants were reassured that any information they provided would be held in the strictest confidence and that participation or refusal to participate would in no way affect their rights to healthcare and social services. The researchers organising the discussion groups were bilingual in Somali and English.

All six group discussions were tape-recorded. The two groups involving professionals were conducted in English as all participants could speak English well; the four lay group discussions were held in Somali language due to limited English speaking skills. The four group discussions that were conducted in Somali language were translated into English. To provide some more systematic information on their status and experience, participants were also asked to respond to the same semistructured questionnaire on demographic background, residential mobility and health status (see Appendix A).

Analysis

Systematic manual text analyses of the six discussion groups was performed using the Framework analysis method (Green and Thorogood, 2004). This content analysis method is used to summarise and classify data from group discussions and in-depth interviews within a structured thematic framework that is derived and extended during the analysis. The framework method consists of a number of stages including familiarisation with the transcribed interviews, identifying a thematic framework, indexing key themes and sub-themes, charting, mapping and interpretation. This process of thematic identification was repeated on a second occasion, using Nvivo (Bazeley and Richards, 2000), a qualitative software package, in order to further test the reliability of coding decisions. The two methods were largely in agreement, and where there was disagreement, this was resolved by a reex-

amination of the text. The main categories were geographical mobility, health effects of mobility, health service utilisation and health problems. New categories were created for a host of other issues including changing gender roles associated with migration and the effects on mental health identified by the participants. The views, experiences and themes of each group were examined separately before they were compared, and where sufficiently similar, they were aggregated in reporting the findings. Consequently, we report the findings from the two professional groups together and then the lay female and male discussion group participants.

As a way of visualising some of the questionnaire information given by some of the respondents about their residential histories, we plotted the pattern of movement on a map. This was constructed using postcode information provided by the respondents for each of the addresses where they had stayed, which was linked to digitised information on position and plotted cartographically using 'Arcview' geographical information system software. The point locations of the informant's different residential addresses were plotted as an overlay on administrative maps of the boundaries of different local health agencies (Primary Care Trusts) to illustrate how informants had moved between areas of responsibility of different local health organisations. We also used incorporated data on varying levels of multiple deprivation in small areas (based on a composite deprivation score for electoral wards; DLTR Deprivation Index 2000).

Results

A number of core themes emerged: the frequency of residential mobility and factors contributing to these movements, the health and social effects of constant change of addresses, and common mental and physical health problems among Somali refugees.

An image of geographical mobility

Participants suggested that young single people change residential places more frequently than families. They estimated that it took more than 5 years before most Somalis found permanent accommodation in London. Frequency of movement varied from one individual to another but, on average, was about four times in a 5-year period. The geographical pattern of movement for one individual is depicted in
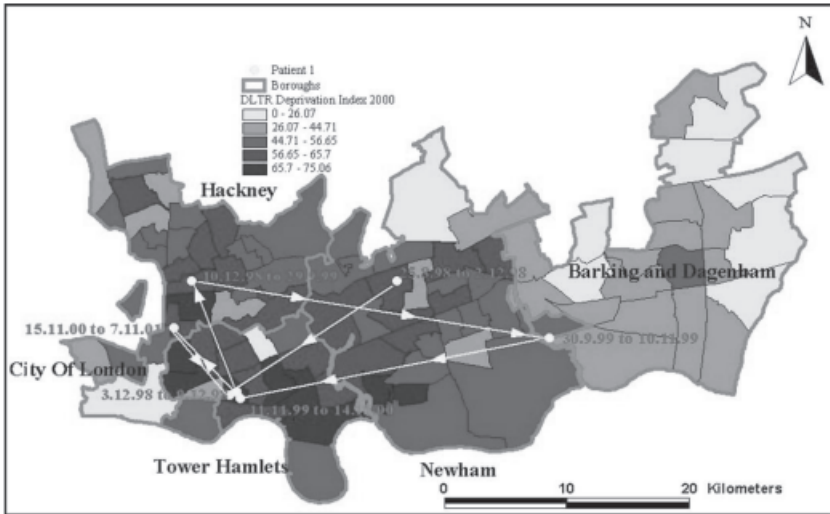
Figure 1. Subject movement and deprivation.

Fig. 1 to illustrate the type of residential trajectory that was being reported.

The map shows a Somali respondent's residential movement since arrival. This individual moved repeatedly from one relatively deprived area to another equally deprived, or more deprived location, and thus the moves did not seem to be related to upward mobility, at least in terms of the quality of the general socio-economic environment. In this case, the subject made a series of movements across Primary Care Trust (PCT) boundaries, so that the administrative health service agency responsible for his care will have changed repeatedly. This may make it more difficult to maintain continuous and effective healthcare access. The dates for periods spent at each address are shown and the map illustrates an erratic pattern of movement over quite a large area in East London, sometimes involving return to places where the person has lived before. While it would be inappropriate to read too much into the map alone, this pattern seems more likely to be the result of 'chaotic' and 'unsettled' residential experience, rather than an organised strategy to move from a temporary 'reception' area to a more permanent home in another part of the city.

Residential movements: Narratives of why and how

Several informants gave first-hand accounts of the residential mobility that they had experienced since arriving in the UK:

> When I came to this country I was taken to a hostel in London. After a while I moved to a friend's house but could not live there and started looking for another hostel in Hammersmith. I then moved to Bristol looking for a job and stayed there for a while and came back to London and lived in Southall. I moved to Manchester and eventually settled in Leicester. After three years I returned back to London and I am living now in East London. There are several reasons why I lived in all these different places but the main ones were lack of proper accommodation and looking for a job, (male, lay).

> Let me give you an example. My family and I myself moved a number of times. It is different when the housing officers say 'this family moved voluntarily'. I do not move voluntarily and I know a lot of people and a lot of families in different boroughs who change addresses because they have to. I myself did four times within three years until eventually I got a place of my own. And I didn't mean to move, I hate to move, but I had to, (male professional).

> Some of the houses are also damp so some people like to move to better houses or you may have problems with your neighbours. So moving to places is something that is compulsory, (female, lay).

The quotes show that the reasons and frequencies of these moves can vary considerably, and they support the impression given visually by the map discussed above, of 'unplanned' and 'chaotic' residential experiences. The reasons given for the frequent residential instability amongst the discussion group participants were shortlets in temporary housing, poor housing conditions, overcrowding, location, racism and discrimination and employment opportunities. Both the professional and lay groups experienced greater numbers of residential movements in the first few years after arrival in the UK. A common issue that emerged in all groups was the experience of a 'forced move'. The professional and lay participants suggested that they were put in temporary accommodation in the first place but that this 'temporary' situation could become prolonged to anything from 6 months to over 5 years with a number of moves taking place between temporary accommodation during the period:

Sometimes people are put into bed and breakfasts because of housing shortage and because of the waiting lists etc. Then they are moved from B&B to temporary accommodation for one, two or three years. After that, when the lease expires, then they need to move to another accommodation, (female, professional).

I think mobility in the Somali community is caused by lack of housing facilities in the area they are living. Most of the people I know do not have stable accommodation like council houses, which forces them to be very mobile, (male, lay).

Some participants reported that Somalis who suffered racial abuse and violence in their permanent residents were forced to flee the area of residence:

There are other things that actually cause people to move too, of course, such as racism. There are places in Tower Hamlets where people are actually threatened to be firebombed unless they moved out by a set date, (male, professional).

Those who do have a permanent accommodation in some areas also experience extreme racism, they (Somalis) fear for their kids and they actually move, (female, professional).

Safety is another factor that causes them to move, (male, lay).

A common theme of problems of community fragmentation and perceived discrimination in housing policy also emerged from the interviews:

Every other community has somebody in the Council except the Somali community. So you will see a lot of new houses are given to other people, (female, lay).

It is the council who decides to move them from one place to another, (female, professional).

Even if they move you to another place, it will be another temporary accommodation, this is something that happens to all Somalis because no one speaks on their behalf, (female, lay).

For most participants, several moves of accommodation were necessary not only due to a shortage of suitable housing but also due to the process by which stable housing is allocated by local authorities. This process involves the allocation of temporary residential places to

Somali refugees, which they feel obliged to accept for fear that refusal may jeopardise their chances of better housing offers. Meanwhile, it is their perception that permanent places were reserved for 'other communities'.

Moreover, finding suitable accommodation and locations with good amenities and schools were not the only factors Somalis consider when moving to other residential places. Instead of moving from a deprived district to better-resourced locations, most participants moved to similar or even more deprived districts. This was partly because of the nature of the temporary housing provision we described above, but also some participants perceived that cultural factors, wishing to be nearer other Somalis, account for some of these movements:

> There are other causes why people move around including being near other Somalis or where they can get culturally appropriate support, (male, lay).

> Somalis, they are very suspicious by nature. They can't trust you unless the person is very close to your clan. For example, whenever you meet a Somali, he will ask you "which tribe do you belong to? So, they are very suspicious. You always like to go where people you know live, (female, professional).

Another concept that was repeated a number of times by the professional participants was the nomadic nature of the Somali society and how this nomadic background facilitates geographical mobility:

> Some of the movements in the Somali community can be explained by social factors in terms of our nomadic background which is very mobile, in search of a better life, work etc. Perhaps these could be some of the reasons as to why they prefer to move around all the time, (male, Professional).

> There are other aspects which is that we have a nomadic culture, we used to move with the rains so you'd have a lot of people who never settled in one place and were always on the move, (male, professional).

This was not expressed within the lay groups suggesting that such suppositions are part of a stereotypical picture that is invoked to explain a tendency to be mobile. On the contrary, some of the lay participants emphasised that residential instability would have been

worse for many Somalis if the Somali culture was less accommodating in helping to find places to live for their compatriots:

> If it were not for the culture and religion of our community, thousands of people would have been homeless living on the street, (male, Lay).

This also suggests that professionals from Somali background themselves may hold stereotypical views of their culture of origin, either due to professional training or their own acculturation experiences in Britain moving them away from identification with Somali people. Such myths may discourage professionals from pursuing housing solutions or healthcare interventions if the Somali community itself is assumed to willingly participate in residential moves that compromise the delivery of care.

Perceived effects of mobility on mental health and health service utilisation

Core themes of 'stress', 'distress', 'worry' and 'anxiety' precipitated by pre-migration and postmigration geographical instability emerged from the interviews. Both professional and lay groups perceived that mobility had a detrimental effect on mental health. Residential mobility was discussed as a global risk factor for poor mental health, where residential instability was often explored within a context of other risk factors including homelessness, past traumatic experiences, attachment and adjustment problems, community fragmentation, language barriers, and racism and discrimination:

> In South London you have someone who never wanted to come here but had to come here, live in a small flat and maybe never registered with a G.P., having sort of poor health. And he is moved again, to another place, where he was kicked out maybe from his flat. So that affects their mental health, there's no stability. I think that is a factor. It might not create a physical health problem, but that is a major mental problem, (male, professional).

> When I was doing this housing allocation work and when you send people to a particular place, if they think there is nobody that they know in that area, they become very anxious, (male, professional).

> This is a post-traumatic area. They cannot predict what they are going to expect. So, I feel they may not get enough information of what may

happen to them if they stay there and what's going to be next steps, they may have such a kind of fear and doubt, (male, professional).

But also you have got to look at the young women and men and the group that is actually suffering mental illness, they are homeless, they are common and they are mobile. If you look at hospitals, at those who have committed suicide, for example, are from the group that are unstable…various instability. If you go to the mental health institutions, you would think this is a particular group anyway, (male, professional).

Most participants, particularly the male professional group, suggested that residential instability, past traumatic experiences, homelessness were all interrelated. They perceived that these interacting difficult life events are associated with poor mental health outcomes. Another common theme that emerged was the perceived association between residential mobility, social network and mental health. Some participants suggested that the combination of residential mobility and the loss of community support is a major concern:

Everything turns upside down when you change your current accommodation. It is not an easy thing. When you know one area very well, when you know a lot of people in that area, who could help you with your problems and all of a sudden you go to another area that puts on you a lot of pressure and then this pressure brings stress with it. Going to a new area is not an easy thing, (female, Lay).

When you move to a new place, you lose the person with whom you used to talk or if you lose your relatives and friends it will make you worry a lot and you get a lot of anxiety, (female, lay).

When a family moves from one place to another they face adjustment problems because once they were in a place they used to adjust and, due to language barriers, which are quite common among the Somali refugees, once they move from one place to another the first thing they experience is the adjustment to the new place. They get nervous, establishing some kind of social, cultural understanding of the environment in which they have moved is one of the main problems that is coming up. This is one of the first things. This will cause a lot of irritations, a lot of distress. Due to the language barriers, normally this is the main starting point of having some kind of mental distress, whether that will lead to clinically manifesting symptoms, is unknown. But this is a basic factor of creating a worry, (male, professional).

For all professional and lay groups, the most popular medical services accessible to the vast majority of Somali refugees were services available from a GP. However, some participants, both from the professional and lay groups, focused on how difficult it was for some Somalis to register with their local family doctors, get good reception or find appropriate translation services:

> My family arrived in this country recently and I took them to register with my GP. It took me for four months to get them registered. I do not know why it has taken such a long time, (lay, male).

> And the other thing is, when a particular person is sick, he will move from this area to a certain other part of London. The link between that person and the GP will be cut because by the time he registers with another G.P, he will lose maybe the pills, he will lose maybe the check ups and things so, (professional, male).

> The other thing is that we do not get good reception at GP surgeries, (lay, female).

Most lay participants were in agreement that mobility was particularly bad for people with poor health status:

> So she wasn't feeling well in the first place and when she goes through these things she even worries more and her health deteriorates as a result. And there a lot of people like her. For some people, moving places makes them ill but for others they were already ill and it will make things much worse for them, (lay, female).

> One day I had a real pain and went to Accident & Emergency at our local hospital. I saw a doctor and without proper diagnosis he told me to see my GP. I said to him that if I could I wouldn't have come here and waited for such long hours. He insisted there is no urgency and I should see my GP. I did not see this as…personal but realised that there something wrong with the system. In Africa doctors examine the patient even if they see the person has no problem but here doctors look at their computer and decide to give you paracetamol without even touching your body, (lay, female).

According to the above lay and professional views, some Somali patients bypass their family practitioners and seek treatment at Accident and Emergency Departments because they were not satisfied with the way they were treated by their primary healthcare providers

or because they were not registered with local family doctors. Current research (e.g., reviewed by Curtis et al., 2004; Gatrell, 2002) on use of A&E confirms this pattern, which is common to populations in more deprived areas where primary care services are more 'stretched' or of poor quality. McCrone et al. (2005) showed that Somali refugees with unmet healthcare needs had high rates of contact with refugee services, and, to a lesser extent, with doctors other than GPs and psychiatrists.

Healthcare professionals' unfamiliarity with the cultural and medical practices of Somali refugees could be another reason why some Somalis were dissatisfied with the quality of health services. For example, the lay views described earlier also seem to be alluding to healthcare practices in Somalia where the norm was that the trained physician would only be consulted when pains or injuries became unbearable. In return, the physician was expected to carry out a thorough physical examination that would take a considerable time and might result in various physical tests. Both lay and professional participants also expressed concerns that frequent mobility was stressful and often disrupted family life, child development and the relationship with health services:

> Generally, what I observed is when it comes to health problems is that normally, once they are settled in one borough or one area, if they are registered with a GP in that area, and when they move to another place, the first thing which I have observed is interruption of continuity of care which they may have had in their own district, their own GP. This is the first problem, if I can call it that. I don't know whether it's a health problem as such or it's a problem related to the utilisation of services, (professional, female).

> This happened to me. Moving around is really a headache. The children go to School in one area you move to another area then the children will miss their friends and teachers and the whole moving business make you stressed and it even affects the health of the children. Likewise if you have outpatient appointments and then change your address you will have to travel from a long distance to see your specialist so it will affect your health. You can't be bothered to ask for a transfer because you lose your current treatment and they will put you on a new waiting list. That is the problem and it will make you stressed, (lay, female).

Discussion

The results of this qualitative study describe the meanings given to residential mobility by Somali professionals and lay Somalis living in two parts of London. The perceived determinants of post-migration mobility and its effect on health were discussed in some detail, showing that the link between residential instability, mental health and health service uses is not only of importance to professionals, but also for lay respondents.

Residential mobility was seen as stressful, compromising health and social care delivery, and was often resented. Participants reported detrimental impacts on physical health care, and on the well being of their children, including their schooling and development. There was less emphasis in the lay group compared to the professional group on diagnoses of mental health problems such as depression and PTSD. These findings are in keeping with the knowledge that refugees have many traumatic experiences both before and after fleeing their country of origin (Bhui et al., 2003a, b; Jaranson et al., 2004). The different emphasis on mental and physical consequences of mobility between lay and professional groups reflect differences in the professional and lay models of illness, with the Somali lay models of ill health more typically expressed in terms of bodily complaint than emotional or mental distress. Culturally determined ways of talking about health may also explain some reluctance to speak freely about mental health problems, not necessarily because respondents consciously avoided discussing mental illness, but because there was an absence of language or concepts in Somali culture that formulate mental distress as a health problem worthy of seeking treatment from healthcare agencies. Health professionals trying to help Somali refugees and assess their health status may need to be sensitive to these ways of expressing illness and distress, which may differ from those of the majority of the population.

Although the experience of frequent residential instability can be stressful for all people, regardless of their background or group or class affiliations, the plight of mobile refugees is complicated by additional social problems that other vulnerable groups do not share with refugees. Many refugees have language and communication barriers. Others will have difficulty coming to terms with premigration life events and the separation from homeland. Other refugees experience stressors including racism and discrimination, adjustment problems and the

loss of community and social networks. Advice and help offered by health and social services may need to take into account these multiple difficulties which may make it particularly hard for refugees to find settled accommodation.

Forced mobility or voluntary movements?

The sense that migration to Britain was forced and there is little chance of returning to the country of origin, compounded by the high degree of involuntary movement once arrived in the UK, was seen as a health risk by the informants. This theme of 'forced mobility' being especially unwelcome was common among all discussion group participants. Some of this forced mobility can be directly related to government policy. For instance, the Immigration and Asylum Act 1999 (Home Office, 2002) includes a provision for the dispersal of newly arrived asylum seekers away from London and the south-east to other regions of the UK in order to ease public pressure on housing provision, particularly in areas where there is a shortage of affordable housing. But most migrants, given the choice, will select a location that is close to others from their 'home' country, where they can take advantage of the experience of those who have come before and retain something of their unique culture. Dispersal may be to parts of the country where there are few existing ties, with a fearful and hostile local population and where public services have limited capacity to deal with the cultural and linguistic needs of the migrant. In such circumstances, it is hardly surprising that it takes a considerable time and several moves before any sense of personal stability is achieved. That this might also be detrimental to mental health is hardly surprising.

Preoccupation and worry about residential instability, and decisions about the future, with little control over those decisions, all contribute to psychological distress. Residential instability was not only seen as bad for mental health but also as detrimental to social cohesion and general wellbeing. Discrimination is clearly a disturbing experience for refugees, and has been shown to be related to common mental disorders (Chakraborty and McKenzie, 2002). Some of the discussion group participants reported that those who experienced racial abuse and violence were forced to leave their residences, so discrimination may also add to the reasons for residential moves.

Caution needs to be exercised when applying theories of 'nomadism' out of their original context as they may have little relevance to

post-migration geographical mobility. The idea that changes of residence have more to do with a nomadic lifestyle than with the reality of reasonable efforts to improve personal circumstances runs the risk of pandering to racist stereotypes of the 'undeserving' or 'bogus' asylum seekers. In our study, some professional participants did indeed put forward nomadism, and its influence on Somali refugees living abroad, as a possible explanation for mobility. However, this was quite inconsistent with the account from the lay participants, whose views were simply that they had been forced to move to secure employment, get appropriate and adequate housing, be near relatives or escape from overcrowding, racism and discrimination. In this respect, we believe the experience of Somali refugees and the reasons for geographical mobility are not dissimilar from other refugee groups.

It is widely acknowledged that the complex needs of mobile populations are difficult to address in conventional services. The New NHS encourages patient partnership strategies to include patient, carer, and public involvement in decision-making. But for highly mobile refugees, such a dialogue is difficult to establish especially if there are cultural differences in language, expectations and exposure to multiple social problems. These difficulties call for both greater overall awareness among healthcare professionals of the needs of geographically mobile migrants and for adjustments to the way access to public services is arranged to meet the special needs of refugees. We recommend the introduction of a national strategy to ensure that public services appropriately meet the needs of mobile refugees and asylum seekers. Staff training and working with health and social care professionals from refugee communities may reduce the variations in access to appropriate health and social services among transient refugees. This said, it may be challenging for public service providers to be able to recognise and attract professional refugees in the regions given that asylum seekers are often geographically dispersed. Although many of these adjustments (relaxing catchment area rules, having ready access to interpreter services, etc.) are agreed in principle, difficulty accessing adequate healthcare remained one of the most common problems mentioned by almost all participants, particularly when they moved from one location to another. The lack of flexibility of healthcare organisations, and the inability to provide care beyond a geographically limited area made little sense to our research participants, especially when they had little choice about their residential moves. In conclusion, while the current European Union strategy sets out minimum

standards on reception conditions, housing and access to healthcare for people with special needs and resources (The European Council, 1999), the reality, as described by many of our participants, still falls a good way short of the ideal.

Acknowledgements

Appendix A. : Discussion group questionnaire

Opening questions

Tell us your name, where you live and one thing you enjoy most?

How did you feel when you first arrived in the UK?

Transition and key questions on mobility and health effects

In your experience, how frequent do Somali people move?

From and to where do you or your fellow Somalis move?

What type of places do Somalis stay/sleep?

What do you think causes people to be mobile?

How does mobility affect people's health?

Can you think of the impact these movements have on your health?

Where can we contact Somali people to make sure we do not miss some group in our survey?

Key questions on health

What health problems do you have?

How do you sort them out?

When do you think of mental health problem, what comes to your mind?

What do you think could be the cause?

Can you think of the impact of mobility on health?

Key questions on service utilisation and discrimination

What is your experience of the local services such as GPs, Psychiatrists or other health services?

Have you ever been discriminated? What happened then? How does that affect your health? Or your mental health?

Of all the needs we discussed, which one do you think is the most important to the Somali community in general?

Final questions

Is there anything else that we should have talked about but did not?

This is the first in a series of groups like this that we are doing, do you have any advice on how we can improve?

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