

A civilised society

Mental health provision for refugees and asylum-seekers in England and Wales



For better
mental health

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Key findings and recommendations

Restrictive policies on healthcare, education, accommodation, welfare support and employment are functioning to socially exclude and marginalise refugees and asylum-seekers, both exacerbating existing mental health problems and causing mental distress. Current government policy is inherently contradictory. On the one hand mental health policy recognises the increased vulnerability of asylum-seekers and refugees and the need to support them. On the other hand asylum and immigration policy creates an environment which is having a devastating impact on the mental health, wellbeing and long-term integration prospects of refugees and asylum-seekers. Mind's latest research has found that despite experiencing high levels of mental distress, refugees and asylum-seekers face many challenges accessing mental health services in England and Wales.

Findings

The language barrier

- The quality and availability of face-to-face interpreting services vary considerably across England and Wales. It can be particularly difficult to source interpreters in less ethnically diverse dispersal areas.
- There is a variable and often limited use of interpreting services within mainstream mental healthcare services. The use of friends and family as interpreters is still common.
- There is a lack of knowledge among mainstream healthcare professionals of how to work with interpreters.
- There is limited provision of therapeutic services in other languages.
- The cost of interpreting services remains a major problem for voluntary organisations.

Cultural differences

- There is a lack of cultural awareness and understanding of refugee issues among mainstream healthcare professionals and third-sector staff.
- There is limited provision of culturally appropriate services in mental healthcare.

Healthcare entitlements

- Vulnerable individuals are unable to access the mental healthcare they need as a result of the restrictions on healthcare for refused asylum-seekers in England.

Gaps in service provision

- There is a lack of therapeutic and psychosocial services available to refugees and asylum-seekers to address intermediate mental health needs.
- There is limited availability of specialist services to treat those who have experienced torture.
- There are extremely limited mental health services for, and expertise in, working with refugee children and young people.

Statutory healthcare sector

- There is a lack of a co-ordinated approach by some primary care trusts and local health boards to meet the needs of asylum-seekers and refugees. This results in the voluntary sector having to fill gaps in service provision, despite being overstretched and underfunded. There is also not enough collaboration with voluntary sector and refugee community organisations.

GP practices

- There has been a general improvement in practice but there is still considerable variation in access to GP services. Problems include:
 - Refugees and asylum-seekers can still find it difficult to get registered with many GP practices, this is particularly a problem for refused asylum-seekers.
 - Many GP practices do not provide interpreting services.
 - Refugees and asylum-seekers are too often not referred for psychological therapies.

Secondary mental healthcare

- Pathways into secondary mental healthcare services are often too rigid and do not take into account the needs of refugees and the role of refugee support agencies.
- Access to child and adolescent mental health services (CAMHS) for refugees and asylum-seekers is particularly problematic

Detention centres

- Many individuals with severe and enduring mental health problems are being detained.
- Mental healthcare within detention centres is inadequate to deal with the high levels of mental distress experienced by detainees, especially those with severe and long-term problems.

Voluntary sector mental health services

- Refugee and asylum-seeker mental health service providers are struggling to meet the demand for their services and are finding it increasingly difficult to obtain funding.
- Mainstream voluntary sector mental health services are often not accessed by refugees and asylum-seekers.
- There is not enough co-operation between refugee community organisations and voluntary mental health services.

Recommendations

Primary care trusts and local health boards in areas with refugee populations to:

- ensure that the Department of Health guidance on healthcare entitlements is extensively disseminated and properly implemented
- provide compulsory training to all relevant frontline staff, including GPs, on understanding the refugee experience, culture and mental health and how to use interpreting services
- stress the importance of using interpreting services to all staff and to ensure all staff working with refugees and asylum-seekers are able to access interpreting services
- give staff clear guidelines of when to use services and ensure that friends and family are not asked to act as interpreters unless it is the express wish of the patient
- work in partnership with local authorities to improve and develop interpreting services where there is a need
- recruit more bilingual staff and increase provision of therapies in other languages
- ensure the provision of culturally appropriate mental health services which take account of the specific needs of refugees and asylum-seekers
- ensure that Increasing Access to Psychological Therapies (IAPT) services take account of the specific needs of refugees and asylum-seekers
- increase partnership-working and involvement of refugees in the development and provision of mental health services
- develop and invest in services to meet the mental health needs of refugee and asylum-seeker children, young people and families and services to address trauma and torture
- ensure a system is in place to enhance pathways into primary care for refugees and asylum-seekers, such as specialist asylum-seeker GP practices or health access workers
- ensure pathways into secondary mental health services are made more flexible to recognise the needs of refugees and asylum-seekers and the role of refugee support organisations in those pathways

- provide GP surgeries with focused support and incentives to encourage the registering of refugees and asylum-seekers, in particular refused asylum-seekers, while taking into account the complex needs of these patients and the extra time and resources required to work with them
- recognise the need for mental health services to be able to meet the needs of detainees and ensure that referrals to secondary services from detention centres are prioritised to minimise trauma to vulnerable detainees.

Government to:

- provide full access to healthcare to all asylum-seekers regardless of status – the provision of secondary healthcare to refused asylum-seekers should be dependant on need and not immigration status
- ensure, as a minimum, that the proposed changes to healthcare entitlements are implemented to ensure free access for the most vulnerable refused asylum-seekers
- review current practices of detaining individuals with pre-existing mental health conditions and children
- fund the development of specific mental health services for refugee children, families and young people who are experiencing mental distress
- support and fund capacity building for refugee community organisations (RCOs) to enable them to work in mental health and encourage partnerships between the statutory and voluntary mental health sector and RCOs.

United Kingdom Borders Agency to:

- develop and implement guidelines for mental healthcare provision within detention centres in order to guarantee adequate provision across the detention estate
- provide a comprehensive mental health service tailored to the specific needs of refugee and asylum-seeker children
- require that regular, compulsory mental health training which includes how to identify signs of torture and trauma is provided to all detention centre staff
- ensure that there are systems in place at all detention centres which provide speedy pathways into statutory services if a detainee experiences severe mental distress.

Voluntary sector mental health service providers in areas with refugee populations to:

- make their services more accessible and appropriate for refugees and asylum-seekers
- ensure that, where there is a need, the costs for interpreting services are included in funding applications
- increase partnership-working with, and involvement of, refugees and refugee community organisations in, mental health service provision.

Introduction

Every year thousands of people¹ arrive in the United Kingdom seeking sanctuary. Fleeing conflict, political upheaval and persecution, they have often experienced extreme levels of trauma and loss. Many have been imprisoned and tortured, subjected to rape or sexual violence and have watched their friends and family die. The journey they make to safety is often long and dangerous. All that was familiar to them – their homes and communities – has been lost and upon arrival in the UK they face the challenge of building new lives for themselves, in an unfamiliar and often hostile environment.

The combined impact of these experiences on the mental health and wellbeing of refugees and asylum-seekers can be devastating. Many will need support to enable them to move on with their lives and integrate into UK society. The challenge for mental health services in England and Wales is to meet the needs of this diverse group.

Mind is committed to inspiring the development of quality mental health services, which respond to the diverse needs of refugees and asylum-seekers. However, we know that refugees and asylum-seekers experience many difficulties in finding and accessing appropriate services. This aim of this report is to explore these difficulties in more detail and provide practical examples of how they are being overcome.

This report outlines the major factors contributing to mental distress among refugees and asylum-seekers after their arrival in the UK. It draws on interviews with a diverse range of mental health service providers from the statutory and voluntary sector to build up a picture of current service provision in England and Wales, highlighting some of the challenges faced by mental health services alongside the response needed.

As most asylum-seekers are now sent to live in dispersal areas the majority of the research was carried out with service providers outside of London.

Definition of refugee and asylum-seeker

In the UK two terms are used to describe those who come here seeking refuge – asylum-seeker and refugee. These two labels denote a difference in legal status.

An asylum-seeker is someone who has lodged an application for asylum with the UK authorities under the 1951 Convention Relating to the Status of Refugees.

A refugee is someone who has been found by the authorities to be at risk of persecution and whose asylum claim has been accepted.

The category asylum-seeker will therefore include those who may eventually be recognised as refugees, some whose claim will be refused, and others who will be given some other form of residence permit, such as humanitarian leave to remain.

1. In 2007 there were 23,430 applicants for asylum (Home Office, 2008).

Factors influencing the mental health of refugees and asylum-seekers in England and Wales

Refugees and asylum-seekers experience a higher incidence of mental distress than the wider population (Future Vision Coalition, 2009). The most common diagnoses are trauma-related psychological distress, depression and anxiety (Crowley, 2003). However, these individuals come from a variety of backgrounds and cultures, and they will deal with their experiences in very different ways. By no means all will develop mental health problems. Neither should they be viewed as helpless victims. That they have arrived in the UK is usually an indicator of their strength and resilience. It is also important not to medicalise what many would regard as normal reactions to abnormal events.

Much of the distress experienced by refugees and asylum-seekers can be linked to the events that led to the departure from their home country. However, there is strong evidence that mental distress is also a result of difficult living circumstances experienced in the UK (Crowley, 2003; Ward & Palmer, 2005; Phillimore, 2007). Mental health policy (Department of Health, 1999; 2005) recognises that refugees and asylum-seekers are a particularly vulnerable and at-risk group, however, progressively more restrictive UK asylum policies have had an increasingly negative impact on mental health and wellbeing (Murphy et al., 2002; Royal College of Psychiatry, 2007).

This section will examine the mental health of refugees and asylum-seekers in the UK, with a specific focus on the detrimental impacts of the UK asylum system on the mental health of refugees and asylum-seekers.

In the UK, immigration can be a controversial, highly politicised topic. The media coverage of refugees and asylum-seekers is frequently negative (ICAR, 2004). Immigration often takes centre stage in political campaigning, particularly by the far right. This has fostered an unwelcoming environment for those who arrive here seeking asylum, leading to significant impacts on mental wellbeing.

Claiming asylum

The UK asylum process has received a great deal of criticism over its poor performance and although there is recognition that the system is improving there are still many problems. The Independent Asylum Commission (IAC) commends the improvements but states that nonetheless, “the treatment of asylum-seekers falls seriously below the standards to be expected of a humane and civilised society.” A culture of disbelief still exists among decision-makers and additional vulnerabilities of individuals, such as mental health needs, are not being addressed (IAC, 2008).

In the past, the length of time it has taken for the Home Office to make decisions on claims has been problematic with people waiting for over 10 years in some cases. The introduction of the New Asylum Model in 2007 expedited the decision-making process but there are concerns about the new timescales. There is too little time for lawyers to gather evidence such as medical legal reports to support torture claims. In addition, individuals who have experienced torture or other kinds of trauma may not yet be ready to talk about their experiences and this information can be crucial for their asylum claim (Centre for Social Justice, 2008). The process of claiming asylum is often further complicated by restrictive access to legal aid and the difficulty of obtaining a solicitor. The Independent Asylum Commission states that these factors culminate in “perverse and unjust decisions” being made (IAC, 2008).

Recent research by Mind, carried out with refugee community groups, identified that the length and often seemingly arbitrary nature of the asylum process are major causes of stress and insecurity for asylum-seekers, with people living in fear that they could be detained and deported at any time (Mind, 2009). This makes it difficult for people to settle, or plan for the future significantly affecting their mental wellbeing.

Dispersal

Since 1999, asylum-seekers who are unable to provide housing for themselves have been sent to live in different parts of the UK on a 'no-choice' basis. This process does not take into account community support networks, family or friends. Prior to dispersal most refugees and asylum-seekers were located in the South East resulting in networks of well established refugee community groups. In dispersal areas, refugee community groups tend to be less developed. Research has shown how important and beneficial access to these kinds of support networks is to integration and wellbeing (Boswell, 2001 & 2003; Wren, 2004).

The areas in which dispersed asylum-seekers are housed are in many cases deprived areas with multiple social problems and little experience of diverse communities. This has often resulted in social tension and racism towards refugees and asylum-seekers (Boswell, 2003; Reeve & Robinson, 2006).

Accommodation

Accommodation provision for asylum-seekers has improved over the last few years but there are still concerns that it can be poor quality and unsuitable in some cases (Shelter, 2001; Refugee Media Action Group, 2006) and those who are supported by friends or family often face overcrowding. Poor housing has been shown to have a negative impact on mental health (Foresight Mental Capital and Wellbeing project, 2008). Several of the service providers consulted for this report mentioned the impact housing has on the mental health and wellbeing of asylum-seekers they are working with and that it affects the mental health interventions that can be made.

"It is very difficult with asylum-seekers – if they are depressed and can't sleep and they live in rubbish accommodation, then you can't give the usual advice you would give, like de-clutter bedroom and have a hot drink..."

Counsellor, Awetu, Cardiff

One mental health service provider described several cases of individuals who had been imprisoned in their country of origin and whose mental health needs had not been taken into

account when they had been allocated housing. These asylum-seekers had then been retraumatised when they had been given a small box room, which reminded them of a prison cell.

The national charity Refugee Action told Mind that they feel the UK Borders Agency are good at taking into account the needs of those with physical disabilities when making decisions about where to source accommodation, but mental health needs are often overlooked as staff are not trained to identify them.

Lack of English language skills

Language is one of the most important factors for integration and to enable participation in society (Wren, 2004; Duke, 1996; Temple & Moran, 2005). Those who arrive here unable to speak English face significant challenges in engaging with the host community and accessing support. This can lead to profound isolation. A shortage of English classes and new rules introduced in 2007 excluding asylum-seekers from free classes until they receive a positive decision to their asylum claim or they have been waiting for a decision for six months or more, make learning English particularly challenging.

Work and benefits

Asylum-seekers currently receive just over 50 per cent of income support² and since 2002 they have been prohibited from working.³ As a result, many are living in poverty and they are deprived of the important integration opportunities which employment can provide (Bloch, 2002). The inability to provide for yourself and your family or to contribute to society impacts negatively on self-esteem, confidence and mental health, especially for men (Mind, 2009). The impact of poverty and long-term unemployment on health and mental

2. This is £35.15 a week compared with £64.30 a week for those on income support. These reduced benefits were introduced in October 2008.

3. If an asylum-seeker does not receive a decision within 12 months they can apply for permission to work but there is no guarantee that they will be granted permission.

wellbeing has been well documented (Mind, 2009; Murphy & Athanasou, 1999).

Refused asylum-seekers

A government policy introduced earlier this decade withdrew all support, both housing and financial, from those who have had their asylum claim refused. The only option open now to refused asylum-seekers is to apply for Section Four or 'hard case' support, which provides basic accommodation on a no-choice basis (which could be far from support networks) and £35 in vouchers a week.

To qualify for this support people must meet certain criteria, which include committing to return to their country of origin as soon as it is safe and practical to do so and showing that they are making travel arrangements, or proving that they are unable to return. For those who do not meet the criteria⁴ or who do not want to apply because they fear being persecuted if they are returned, find themselves without recourse to any benefits or the right to work and many face destitution (Refugee Action, 2006). Several service providers highlighted that individuals with mental health problems are even less likely to feel able to sign up to Section Four support.

"Some people do sign up to Section Four to survive but often those who have the more severe mental health issues don't."

MAAN Somali Mental Health Project, Sheffield

Although there are no official figures on the extent of destitution among refugees and asylum-seekers in England and Wales, some estimates range from 300,000 to 500,000 (Taylor, 2009). Studies have also shown that considerable numbers of refugees and asylum-seekers who are entitled to support, including many children, are also destitute (Children's Society, 2008; Brown, 2008). As the numbers continue to grow, this issue is a significant cause for concern among refugee agencies (Brown, 2008; Refugee Action, 2006; Dumper et al., 2007; Smart & Fullegar, 2008) and was raised by many service providers in Mind's research.

Refugee Action describes the despair and hopelessness of individuals who find themselves

destitute (Refugee Action, 2006) and studies show incidence of mental health problems among this group is high (Refugee Action, 2006; Dumper et al., 2007; Mind, 2009). Although many may have been experiencing mental distress before they became destitute, it is clear that destitution is exacerbating these conditions (Refugee Action, 2006) and this has been supported by the findings of Mind's research. In recognition of this, Mind has joined the Still Human Still Here campaign which calls for an end to the destitution of refused asylum-seekers.

"Destitution and its effects on people's health, mental and physical, is one of the most important issues in the asylum field. We come across many people who are verging on mentally ill in our destitution projects and the longer they are in this situation the more their mental health deteriorates and the more socially excluded they become."

Nick Scott Flynn, Head of Refugee Services, British Red Cross

Healthcare restrictions

All asylum-seekers and refugees are entitled to access primary healthcare free of charge, although refused asylum-seekers are registered at the discretion of the GP. However, in 2004 restrictions on free secondary healthcare were introduced. The impact of this policy for refused asylum-seekers, who are often destitute and unable to return home through no fault of their own, is that almost all secondary care is now chargeable unless it is emergency treatment, family planning, compulsory mental health treatment or treatment for certain infectious diseases. As a result, many vulnerable people now have very limited access to healthcare, including noncompulsory secondary mental healthcare services.

In 2008, a judicial review ruled that refused asylum-seekers could, in some cases, be regarded as ordinarily resident in the UK and therefore entitled to secondary care without charge, though each case should be decided individually. This ruling was overturned in March 2009. The Court of Appeal also found that trusts have the discretion to withhold treatment pending payment and also the discretion to provide treatment where there is no prospect of paying for it. It also found the Department of Health guidance unlawful because

4. Many countries may refuse to issue travel documents and there may be no safe route of return to certain countries.

it was unclear about the circumstances where overseas visitors should be treated. As a result new interim guidance has been produced and an ongoing review of healthcare entitlements has proposed that certain categories of refused asylum-seekers should be able to access free secondary healthcare. However, many refused asylum-seekers will still not benefit from these changes.

Wales, however, has made a specific commitment to provide healthcare for asylum-seekers regardless of status. The change to the rules was signalled by the Assembly Government's Health Minister, Edwina Hart, in 2008: "I believe the mark of a civilised society is the way in which it treats its people, particularly the sick and dying."

Need for 'looking after'

Where destitute individuals have a clear need for mental healthcare they can try to access support from their local authority under the National Assistance Act. However, there are no national guidelines for provision and Mind has found that eligibility is inconsistent across local authorities (see Dumper et al., 2007).

The rising number of destitute asylum-seekers is putting increasing pressure on local authorities who have to fund support from local budgets. Furthermore, since a legal ruling in 2008 (*M. v Slough*), the threshold for eligibility has been raised making it harder for those experiencing mental health problems, such as depression and trauma-related psychological distress to gain support.

Service providers have told Mind that they are concerned that local authorities who are currently more sympathetic will start to reassess cases under the new threshold, especially as for many of them expenditure on supporting these individuals is high. Without access to this support many more vulnerable people will be at risk. Although National Assistance is an invaluable safety net, service providers also highlighted some of the problems this type of support can entail.

"Once a client says they are better there is no longer a duty of care so they will lose accommodation. There is no easy solution. We have had three Eritrean women in bed and breakfast for two to three years. The support maintains mental health but if you take it away the problems will return. Also this kind of accommodation has big

problems. We have a guy who has been in a bed and breakfast for four years with no cooking facilities, he can't have friends round so it impossible to have a social life or to build a support network."

Asylum-Seeker Team

Detention

Another aspect of the UK immigration system is the increasing use of detention. Asylum-seekers can be detained at any point in the asylum process. At any one time around 3,000 people, including children, are held in the 11 removal centres across the UK (London Detainee Support Group, 2009). Currently, there is no time limit on detention in the UK and some people have been held for years at a time without knowing when they might be released.

Immigration guidelines state that vulnerable people including those with serious health conditions, mental ill health, children, those with physical disabilities, and those who have been tortured should only be detained in exceptional circumstances. However, the Refugee Council, Medical Justice, Bail for Immigration Detainees (BID), Children's Society and several detainee visitors groups told Mind that in practice many vulnerable people are being detained, sometimes for long periods. Mind's research has also identified strong evidence of the detention of individuals who have complex mental health needs. This included a recent example of a man who was in local authority care and being treated for schizophrenia when he was detained and who attempted to hang himself in detention.

"People simply deteriorate – suicide attempts and sectioning are common. The stress of being in a chaotic environment with the constant threat of deportation for many months is devastating for people with pre-existing vulnerabilities."

Jerome Phelps, London Detainee Support Group

In the UK there have been many reports which detail the high levels of mental distress and self-harm among detainees (Cohen, 2008; *Independent*, 2008). More detailed research in the USA and Australia has shown that detention, and particularly the indeterminate length of detention,

has severe consequences for the psychological health of those detained (see Keller et al., 2003).

“Many of the children and young people we have worked with [in detention] have been experiencing mental health and emotional and wellbeing problems, often as a result of their detention or post-traumatic experiences or a combination of both these factors. We have worked with children, young people and parents who have been torture survivors, have suffered from depression, anxiety and post traumatic stress disorder and who have threatened or attempted self-harm or suicide. Many of these individuals were detained for several weeks, some for up to a year or more.”

Children’s Society, 2008

Children and young people

Although the majority of asylum-seekers are adults, there are many children arriving in the UK seeking refuge. In 2007 around 7,700 children sought asylum here (Refugee and Migrant Justice, 2009). Some of these children arrive with family, or may join family members through the family reunion programme. Many also arrive alone as unaccompanied asylum-seeking children.

Refugee children and young people have been shown to be at significant risk of developing psychological problems if they are not provided with the right kind of support (Fazel & Stein, 2002; Young Minds, 2005). The Government has recognised the importance of meeting the needs of these vulnerable children and in *Every Child Matters* unaccompanied asylum-seeking children are described as “some of the children with the greatest need” in the UK (DFES, 2003). Despite these observations, the asylum system in the UK has significant adverse effects on the mental health and wellbeing of children and young people (Refugee and Migrant Justice, 2009).

“We have young people who have been doing really well in therapy and then they go to an immigration hearing and feel they have been interrogated and disbelieved. It reverses all the good work that has been done and you have to start again.”

Children’s Society, 2008

Children and young people who arrive unaccompanied often face very stressful examinations to prove their age and they are granted leave to remain only until 17, at which point their case is reviewed causing great insecurity and compounding the difficulties faced in the transition between child and adult services.

Summary

The consequences of the hostility towards refugees and asylum-seekers and the restrictive policies on healthcare, education, accommodation, welfare support and employment are to socially exclude and marginalise an already vulnerable group of people, both exacerbating existing mental health problems and causing mental distress. The increase in destitution and the impact it is having on the lives of refugees and asylum-seekers is a harsh example of this. Current government policy is inherently contradictory. On the one hand mental health policy recognises the increased vulnerability of asylum-seekers and refugees and the need to support them, while on the other, asylum and immigration policy creates an environment which is having a devastating impact on the mental health, wellbeing and long-term integration prospects of refugees and asylum-seekers. The impact on children and young people is no different and has worrying consequences for their futures.

Refugees, asylum-seekers and mental health services

Despite evidence showing the extent of the distress caused by the process of claiming asylum and living as a refugee, Mind's research found there are significant obstacles to accessing appropriate mental health services in England and Wales. The Department of Health has recognised the need to overcome these barriers in past and current mental health policy including, the National Service Framework for Mental Health (1999), Delivering Race Equality (2005), Improving Access to Psychological Therapies and New Horizons, the new Department of Health mental health strategy, currently being developed. However, as Mind's research indicates there is still much work to be done. New Department of Health guidelines on commissioning mental health services for asylum-seekers will be published early next year and should tackle some of the issues raised by this report.

This section presents the views and experiences of services providers who are working with refugees and asylum-seekers and outlines the key challenges to accessing support including language, cultural differences and the need for a holistic approach, and provides some practical examples of how service providers are responding to these challenges. It then takes a look at some of the challenges refugees and asylum-seekers have in accessing different areas of services provision including GP practices, secondary care, detention centres and the voluntary sector. We also outline work Mind has undertaken with some service providers to develop their capacity to work with refugees and asylum-seekers.

The challenges and the responses

"In secondary care there is generally very little expertise of working with interpreters."

Healthcare worker, Sheffield

The language barrier

Mind found that one of the major barriers preventing refugees and asylum-seekers accessing mental health services is language. Not enough is being done to overcome this obstacle (Harp, 2006; Ward & Palmer, 2005; Fay, 2007; Kings Fund, 2000). The quality and availability of face-to-face interpreting services across England and Wales vary enormously and interpreting services are sometimes underused within mainstream services (KCW BME Forum, 2008; Refugee Council, 2007; Fay, 2007; Murphy et al., 2002). Many mainstream staff lack skills in working with face-to-face interpreters and using telephone-interpreting services. The result is unsatisfactory experiences for service users, which can impact on their willingness to engage with services. There are many specialist services that are responding to these challenges. The following highlights some specific obstacles facing service providers and examples of how they are being addressed.

The challenges

- Dispersal areas (eg, Norfolk and Wales) which are not traditionally diverse and where there are small refugee populations, find it particularly difficult to source interpreters and often have to cater for a huge range of languages.
- Interpreters are often not experienced in the field of mental health and effective interpreting in therapeutic settings can require specific skills and knowledge.
- There are few therapeutic services in other languages.

A response – Wrexham Mind

Wrexham Mind offers specific counselling for refugees and asylum-seekers and most of their referrals come through the Medical Foundation for the Victims of Torture or the Welsh Refugee Council. There is no face-to-face interpreting service locally and they feel that drawing their own interpreters from the local refugee community, which is very small, could be problematic in terms of confidentiality. It would also be difficult to meet the need for the many languages spoken by their service users. As an alternative they use a telephone interpreting service to overcome the language barrier in their counselling services. Despite some criticism that telephone services are not suitable for dealing with complex mental health problems (Murphy, 2003), Wrexham Mind and several other specialist service providers we spoke to use them to work therapeutically with clients with great success in areas where they would normally not be able to access services.

“There is not much access to interpreters, they are not properly trained and they tend to come from a small local community. We have had problems with confidentiality in the past and we only have 20 [interpreters] covering 53 languages so prefer to use LanguageLine [commercial service]. It is pretty much the same situation across Wales.”

Asylum Seeker Nurse, Newport

A response – Tower Hamlets and Newham Mind, London

Mind in Tower Hamlets and Newham is based in a diverse area of London, with high numbers of refugees and asylum-seekers. In response to the needs of this diverse community the service employs bilingual counsellors, delivers counselling in 11 languages and employs black and minority ethnic advocates and support staff. They are currently running a new project which has trained 12 people with personal experience of mental distress and carers to become community interpreters and to be able to support people in mental health services, reducing the language barrier. An important element of the training is to ensure that the interpreters have an understanding of the cultural background of the people they will be interpreting for. They also have mental health awareness training as an integral part of their course.

A response – Solace, Leeds

Solace is a charity which provides free counselling, psychotherapy and advocacy in the Yorkshire and Humber region. In addition to a senior therapist they have a number of experienced volunteer counsellors and advocates who have been trained to work with the very particular needs of refugee and asylum-seeker clients. They use interpreters for counselling to overcome the language barriers. Interpreters are offered training and support to ensure they have the skills to work effectively in a therapeutic setting.

Further concerns

- Despite good practice guidelines to the contrary, the use of friends and family as interpreters is still common (Thom, 2008). Where friends and family are used, there may be a reluctance to disclose mental health conditions owing to the stigma surrounding mental health in many refugee communities.
- People reported difficulties with LanguageLine, such as not always being able to access the appropriate language and its interpreters having insufficient knowledge of mental health issues.
- Statutory staff who work regularly with refugees and asylum-seekers not being given access to interpreting services. For example, health visitors who make home visits are not provided with work mobile phones and other statutory staff working with refugees and asylum-seekers not being given access to interpreting services.
- One respondent noted that although statutory staff in their area are able to use telephone interpreting services for free, they have not been made aware of this and have not been trained in their use (Thom, 2008).
- The cost of interpreting services was a major issue for many of the voluntary organisations consulted and a particular barrier for many mainstream voluntary sector services which have often not included interpreting costs in funding bids.

“Language is one of our greatest concerns, without money for interpreters what do we do with individuals after the initial contact?”

Local Mind association

“Gaps in services are often filled by the voluntary sector but they often can’t afford interpreters.”

Specialist GP

Recommendations are for...

Primary care trusts and local health boards in areas with refugee populations to:

- provide compulsory training to all relevant frontline staff on how to use interpreting services
- stress the importance of using interpreting services to all staff and ensure all staff working with refugees and asylum-seekers are able to access interpreting services
- provide staff with clear guidelines of when to use services and to never use friends and family as interpreters, unless it is the express wish of the patient
- recruit more bilingual staff and increase provision of therapies in other languages
- work in partnership with local authorities to improve and develop interpreting services where there is a need.

Voluntary sector mental health service providers in areas with refugee populations to:

- ensure that where there is a need for interpreting services these costs are included in funding applications.

Cultural differences

“There are lots of barriers to overcome to get to secondary services but it doesn’t mean that when they get there that services are suitable.”

Black and Minority Ethnic Mental Health Liaison Officer

Mental health is understood differently across cultures. The discourse used in western countries to refer to mental health may not always be easily translated and western approaches to treatment may be unfamiliar or felt to be inappropriate. Service providers identified the following factors that make accessing mental health services difficult for refugees and asylum-seekers.

Challenges

- In many cultures, spirituality and religion are regarded as intrinsic to mental health and wellbeing and the family often plays an important role in treatment approaches. This is not always recognised by mental health professionals in the UK.
- Mental health problems can also carry a great deal of shame and stigma and may be regarded as an incurable condition in some cultures. As a result people may be very suspicious of mental health services, which makes seeking and accessing support particularly challenging (also see Department of Health, 2004).
- Refugees and asylum-seekers often lack knowledge of the UK healthcare system, which can lead to confusion and misunderstandings for staff and patients.

A response

Manchester PCT and Salford PCT have produced a DVD to help people who are new to the UK learn about the NHS. It is in English but has voiceovers in Arabic, Farsi, Kurdish, Polish, Sylheti, Somali and Urdu. It can be downloaded at www.blackhealthagency.org.uk

- Service providers generally felt there is a lack of cultural awareness and understanding of refugee issues among healthcare professionals (Harp, 2006; Crowley, 2003; Phillimore, 2007). Although most PCTs and LHBs provide equality and diversity or cultural competency training, it can be very basic and does not always cover the particular needs and experience of refugees and asylum-seekers. Delivering Race Equality has developed an indepth training course (Race Equality Cultural Awareness Programme – RECAP) to improve cultural awareness among NHS staff and are rolling out a train the trainer package in 2009/2010.

A response – The Somali Advocacy Project, Mind in Harrow

The project was set up in partnership with a refugee community organisation, 'The Horn Response Project' founded by the Somali community to provide advice, information, advocacy and interpreting to people with mental health problems. In order to expand the project they approached Mind in Harrow with a view to bid jointly for funding. Together they set up an advocacy service to help people access mental health services; combat the stigma of mental health and fear and mistrust of NHS services; and improve the cultural awareness of mental health professionals; eg, the need to take account of the role of religion and family in treatment approaches. The advocate is Somali and he acts as a bridge or cultural broker between mental health services and the individual and their family. He also provides support with practical issues and helps people experiencing mental distress get in touch with family members. Relatives have often lost contact because of the stigma around mental health and their perception that it is an incurable condition. A large part of his role is explaining the mental health system to people with mental health problems and their families and encouraging trust and understanding between patients and mental health professionals.

A response – Plymouth Asylum-Seeker and Refugee Mental Health Team

In response to dispersal Plymouth Teaching PCT set up the team in 2002. It began as a screening organisation, which referred refugees and asylum-seekers with mental health needs on to secondary care. However, because the refugees and asylum-seekers they referred did not always have good experiences of secondary care services, it was decided that the team should expand their role and also provide treatment. The staff team are experienced in different therapeutic approaches so are able to respond flexibly to the needs of clients. They also provide cultural competence and awareness training within the PCT.

The team identified areas that needed to be addressed in order to improve services for its client group. These included a lack of service user involvement and health promotion in other languages; a staff team that was entirely female; a lack of cultural diversity; and a need to develop the training they offered by involving individuals from different cultural backgrounds.

In order to improve the services a user involvement project was developed and three male asylum-seeker and refugee service users from different communities were recruited as volunteers. The project has been very successful in reaching out to refugee communities and increasing the cultural awareness of the team. The volunteers are now involved in interpreting, providing cognitive behavioural therapy and they are also involved in the training and teaching that the team offers.

"I had a client come in for an appointment and I felt he was acting quite strangely, he wouldn't look at me and would barely talk. I was worried he might have become ill again. Luckily because I had one of our volunteers acting as an interpreter he was able to explain to me that the man hadn't wanted to come to the appointment because it was Ramadan but he came out of respect, and because I am a woman he couldn't really look at me. The volunteer also gave me advice of how I could have dealt with the situation differently."

Mental Health Professional, Plymouth ASR team

The challenge

- Service providers told Mind that some mental health professionals can be reluctant to work with refugees and asylum-seekers because they feel anxious that they are not equipped with the necessary skills (see Dumper et al., 2007; McColl et al., 2008).

“We do find that some people [statutory mental health professionals] are terrified of picking up cases.”

Sheffield Transcultural Team

“I worry about how efficient the services we could offer would be without proper understanding.”

Local Mind association

“Community mental health teams see themselves as a generalist service and don’t feel that they have the expertise, especially to deal with post traumatic stress disorder, but if they have experience of dealing with anxiety etc, they can also deal with this.”

Specialist GP practice, Coventry

A response – Medical Foundation for the Victims of Torture

The Medical Foundation for Victims of Torture provides counselling for individuals who have experienced torture. They have bases in London, Manchester, Birmingham and Glasgow. As they have a limited capacity to provide counselling they often offer support to statutory mental health professionals or voluntary organisations to enable them to work with clients.

“We spend time helping them see how refugees and asylum-seekers can fit in with their criteria and are not something altogether different if they already deal with anxiety and depression.”

Medical Foundation North West

Recommendations are for...

Primary care trusts and local health boards in areas with refugee populations to:

- provide compulsory training to all relevant frontline staff on understanding the refugee experience, culture and mental health
- provide indepth training on the mental health needs of refugees and asylum-seekers to mental health professionals working with refugees

- ensure the provision of culturally appropriate mental health services
- ensure that mental health services take account of the specific needs of refugees and asylum-seekers
- increase partnership working with, and involvement of, refugees and refugee community organisations in mental health service provision to increase cultural awareness and appropriateness of services.

Voluntary sector mental health service providers in areas with refugee populations to:

- make their services more accessible and appropriate for refugees and asylum-seekers.

The need for holistic services

Through necessity, refugees and asylum-seekers tend to be preoccupied with the practical issues they face on arrival. Service providers told Mind that for refugees and asylum-seekers dealing with their asylum claim, accommodation issues and negotiating a new culture and systems usually take priority over their mental health, even though they may know they need help. Unless basic needs for safety and security are met it is difficult for refugees and asylum-seekers to engage successfully with mental health services.

“There is a mixture of [statutory sector] workers feeling overwhelmed and deskilled and those who don’t look behind the practical problems, often because they are overstretched.”

Sheffield Transcultural Team

The challenges

- Refugees and asylum-seekers often lack support networks and may have little contact with the host community and as a result mental health professionals can be regarded as people who can help with practical matters. However, mental health professionals may not have much understanding of the situation of refugees and asylum-seekers and are not used to being confronted with the practical needs of clients. This can mean they do not look beyond the practical problems the service users present them with. They also may not have the time, knowledge or resources to enable them to

provide any practical help which can be frustrating for both staff and refugees and asylum-seekers (Crowley, 2003).

- For some refugees and asylum-seekers, a focus on practical needs may be a coping mechanism to avoid confronting their trauma.
- In some cases where mainstream mental healthcare staff recognise the interaction between the practical issues and mental health of patients, but do not feel able to address the practical concerns it can lead to staff feeling deskilled and in some cases unwilling to deal with the mental health concerns.

“There is the attitude that if people are depressed it is to do with their asylum case and it is not their role [CMHT] to deal with it.”

Specialist GP practice, Coventry

A response – Refugee Centre Specialist Team

The specialist team is based in the main London office of the Refugee Council. It was established to help meet the health and mental health needs of vulnerable refugees and asylum-seekers. The location means that individuals are able to access all of the practical help they may need. The Specialist Team is made up of a health access worker, whose role is to enable clients to access care; bilingual support workers, who provide counselling and advocacy for refugees and asylum-seekers with mental health support needs; and a women’s worker, whose role is to provide gender-sensitive support to vulnerable women. They have their own therapeutic casework model, which was developed for clients with mental wellbeing and psychosocial needs. The model combines counselling and advocacy to address internal emotional distress as well as the external, practical problems that cause it.

Further concerns

As a result of treatment in their country of origin and by government agencies, such as the Home Office in the UK, it is common for refugees and asylum-seekers to have a mistrust of authority figures. There is also evidence that in some political regimes healthcare professionals have been involved in torture which further deters refugees and asylum-seekers from engaging with services (Department of Health, 2003). Linked to this is a fear of disclosure of information to officials, for example about mental health conditions, and concerns about how this information may be used or may impact on their asylum claim (Palmer and Ward, 2005; CVS, 1999). Consequently, as the specialist providers told Mind, it can take a long time to build enough trust to develop an effective therapeutic relationship. Health professionals need to be made aware of these issues and the length of mental health interventions for refugees and asylum-seekers needs to be flexible to reflect this.

Recommendations are for...

Primary care trusts and local health boards in areas with refugee populations to:

- ensure that mental health services take account of the specific needs of refugees and asylum-seekers. This requires a holistic approach where dealing with practical needs through casework or good signposting occurs in tandem with any therapeutic interventions.
- increase partnership building with voluntary sector services to facilitate good signposting.

Service provision across the sectors

The following section highlights concerns raised by Mind's research about service provision across the statutory sector, detention centres and the voluntary sector.

"As far as I can see not much work [with refugees and asylum-seekers] is being led by the PCT and there is not much partnership working by them either."

Community Engagement Manager, PCT

Statutory healthcare

The approaches of PCTs and LHBs across England and Wales vary considerably in the provision of appropriate mental health services for refugees and asylum-seekers. Some respondents reported that their local statutory health services are proactive and supportive but others did not feel that sufficient attention is being given to the needs of refugees and asylum-seekers. There was also felt to be a lack of partnership working with refugee community organisations and other voluntary mental health service providers.

Several service providers told Mind they felt the improved statutory mental health service provision for refugees and asylum-seekers in their local area was down to the commitment of specific individuals and not the result of a strategic approach by the PCT or LHB. This piecemeal approach of statutory services to the mental health needs of refugees and asylum-seekers often results in the voluntary sector filling gaps in service provision, despite being overstretched and underfunded.

"Initially they [the local health board] weren't doing anything but they are being more proactive now, but mental health for refugees and asylum seekers is pretty much left up to Mind and there is no money available from the LHB."

Local Mind association

Healthcare entitlements

Mind's research which took place before the March 2009 ruling has indicated that as a result of the restrictions on healthcare entitlements in England, many vulnerable asylum-seekers and refugees are struggling to access the mental healthcare that they need from the statutory sector. The situation of refused asylum-seekers, who are not entitled to free secondary care, was of particular concern for service providers (see Refugee Council, 2007; Dumper et al., 2007). Service providers told Mind of many examples of refused asylum-seekers with severe mental health problems only being able to access secondary mental healthcare when they are sectioned, a process often involving police. Some of these individuals were released with no follow-up care. As a result their mental health often deteriorated again, requiring further sectioning.

"If you have a negative decision it is much harder to access health services, we come across quite a lot of people who have been sectioned, released and not linked in with other services."

Refugee Action, Leicester

"We are most worried about 'failed' asylum-seekers... most we see have mental health problems and until recently they have had no right of access [to secondary health care]. Even now there are some difficulties and there is a need to educate asylum-seekers that they can access services and also PCT staff, as there is still a lack of knowledge about entitlements."

Refugee Action, Portsmouth

Healthcare restrictions are also causing considerable confusion among statutory staff in England and in some cases resulting in refugees and asylum-seekers who are entitled to all healthcare being refused both primary and secondary care. The confusion appeared to be more pronounced in some parts of the country, which suggests variation across PCTs in the guidance provided to staff. Asylum-seekers and refugees are also unsure of

what they are entitled to and as a result are less likely to engage with services.

However, respondents said that despite attempts by government to restrict access, there are many statutory services that are committed to treating asylum-seekers regardless of their status.

Mainstream GP practices

“With GPs it is a lottery to have a good one, especially one with mental health insight.”

Local Mind association

The consensus from respondents was that although many GP practices have become more accessible and culturally aware, there is still far too much variation. Many practices are sympathetic and provide a good service but in too many, it was felt, the treatment of refugees and asylum-seekers could be poor and at times discriminatory. Without access to primary care it becomes almost impossible to access statutory mental health services. Below are some of the concerns service providers raised.

There is reluctance among some GPs to register refugees and asylum-seekers. Refused asylum-seekers find it particularly difficult to find a practice that will register them (see Phillimore et al., 2007; Refugee Council, 2007; Kensington, Chelsea and Westminster BME Forum, 2008). There is confusion over the healthcare entitlements of refugees and asylum-seekers, particularly among reception staff. Also, GPs can view refugees and asylum-seekers as very time- and resource-intensive patients because of the cultural differences, language issues and often complex needs of this group.

“There is patchy use of interpreters in GP surgeries and they are still often asked to use friends or family.”

Voluntary organisation, Portsmouth

Although there has been a general improvement in provision of interpreters in GP practices many GP practices still do not provide interpreting services for patients. GP practices are often the first contact that asylum-seekers will have with health services. It is therefore essential that patients are able to communicate their needs properly. Even where accessing face-to-face interpreters is a challenge, most GPs will have access to a telephone interpreting service.

Some providers told Mind that a common reason GPs gave for not using interpreting services was the cost. However, several respondents said they felt that the greater challenge is the extra time and effort involved in using interpreters. In some cases the GP was funded by the PCT or LHB for telephone interpreting, but was still not willing to use it.

“We got an interpreting service 13 years ago and they are trained to work in different areas – GPs can access it with discount rate and they do it more now, also because the PCT has stressed the need to have equal access but you always have one or two who won’t use interpreters.”

Health visitor, Newcastle

A number of refugees and asylum-seekers were unsatisfied with the treatment received from their GPs. However, it was suggested that in many cases this was due to refugees’ and asylum-seekers’ lack of understanding of the NHS system, GPs’ working under time constraints and a lack of cultural awareness and understanding of refugee issues among GPs.

“We will accompany clients to GPs where there have been problems and in most cases we find that it is often just a time pressure issue.”

Plymouth Asylum-Seeker and Refugee Mental Health Team

“GPs generally found that patients wouldn’t be offered therapies [by secondary mental health services] so would come back to us and ask us to do more counselling.”

Specialist GP practice

Some GPs were criticised for prescribing antidepressants rather than referring patients for therapy (see KCW BME Forum, 2008; Refugee Council, 2007; Kenami et al., 2001). However, this may in part be because GPs find it difficult to identify services they can refer patients on to.

Assist, Leicester

The Assist practice in Leicester is a specialist GP practice that offers a range of services to asylum-seekers including mental health services such as counselling, art therapy and CBT. They also have a consultant psychiatrist who visits once a fortnight. With help from the Medical Foundation for the Victims of Torture, they have set up their own service for those who have experienced torture. When they opened, they knew that mental health would be a major issue. As a result, they employed more nurses to enable GPs to have more time to spend with patients. They are also a lifeline for the increasing number of destitute asylum-seekers who find it difficult to access primary care within mainstream services.

Coventry Refugee Centre

The centre provides essential information and practical help to refugees and asylum-seekers in Coventry. They also provide a therapeutic service with multicultural counselling, art therapy, massage and run a women's group that meets once a week. The service has paid counsellors and interpreters who see about 30 clients a week. The service is based in the same building as the specialist Meridian asylum-seeker GP practice, with which they have good links. This means that individuals registered with the practice have easy access to mental healthcare services and practical support.

Specialist GP practices for asylum-seekers have been one way that some of these problems have been overcome.⁵ They have been extremely successful in ensuring asylum-seekers can register with a GP, improving accessibility, care provision and building specialist knowledge and expertise. Some also provide mental healthcare services, or have formed good links with mental healthcare providers in the voluntary sector. These practices are usually able to take on casework or have good signposting in place, and can therefore meet the practical needs of refugees and asylum-seekers, which improves mental wellbeing.

5. Once patients gain refugee status they are usually asked or encouraged to register with a mainstream practice.

“The situation used to be bad, GPs didn’t want asylum-seekers. But this has improved with education and because I act as a liaison between asylum-seekers and GPs. The feedback is that they have found this very helpful.”

Asylum Seeker Nurse, Newport

Other responses by statutory services to improve pathways into primary care for asylum-seekers and refugees include; health access workers who aim to ensure everyone arriving in dispersal areas is registered with a GP, and healthcare professionals who act as a liaison between practices and patients. Education and training of mainstream GPs and practice staff have also been shown to improve access and care.

“In Sheffield awareness has improved. We do a lot of education work especially with discriminatory GP practices. Also the Mulberry Practice is a consortium of a few GP practices that have a lot of refugees and asylum-seekers so there is a lot of shared learning.”

Sheffield Transcultural Team

Secondary care services

One of the main problems identified by those interviewed is that the majority of refugees and asylum-seekers who are experiencing mental distress do not meet the criteria required to access secondary services. However, their needs are too complex to be met by short-term primary care interventions (Kings Fund, 2000). Mind's research identified further complications in accessing secondary care services:

- There is a lack of pathways into secondary mental healthcare which take account of the role of refugee support agencies in the lives of refugees and asylum-seekers. Several support agencies told Mind that they come into contact with many individuals who are experiencing extreme mental distress but who may not be registered with, or do not want to go to, their GP. It is often difficult to link these individuals into secondary services as there is a reluctance to take referrals from the voluntary sector unless they are health professionals. Due to the barriers refugees and asylum-seekers face in accessing health services and the fact that a refugee agency may be the only organisation they have contact with or trust, this may be the only pathway into secondary services available to them.

- Long waiting lists and the strict referral criteria for Child and Adolescent Mental Health Services are particularly problematic for refugee and asylum-seeker children.

“It is much worse that adult mental health services. There is very little provision or understanding of refugee children. It is very frustrating and is less accessible than adult services.”

GP

- Two service providers raised several concerns about the secondary care interview. These included: refugees finding it too reminiscent of a Home Office interview; taking a detailed history straight away does not provide enough time to build trust; and that the questions are not sensitive to different cultural understandings of mental health and wellbeing and so can result in misdiagnosis.

“There is much misdiagnosis; medical professionals are often reluctant to listen.”

Refugee advocate, local Mind association

- Accessing interpreters for refugees and asylum-seekers who are having an acute episode can be difficult. This can significantly affect diagnosis.

MAAN (Somali Mental Health Project), Sheffield

The Somali Mental Health Project is based in Sheffield and helps the Somali community and refugees and asylum-seekers access mental health services, including those provided by the voluntary and statutory sectors. They see themselves as a bridge for the community into statutory services, which is part of a holistic approach. They also provide advocacy support for those who have experienced crisis. They have a good relationship with the local PCT, and work closely with community psychiatric nurses (CPNs) and psychiatrists to ensure that mental health professionals are aware of cultural issues and their clients experiencing mental distress have trust in statutory services.

“Our service is a bridge for the community into statutory services, it is a two-way bridge as the service providers don’t have access to the community. There is a lot of fear of the system and we work to ensure there is trust and to encourage culturally sensitive services.”

Recommendations are for...

The Government to:

- provide full access to healthcare to all asylum-seekers regardless of status. The provision of secondary healthcare to refused asylum-seekers should be dependant on need and not immigration status
- implement as a minimum the proposed changes to healthcare entitlements to ensure free access for the most vulnerable refused asylum-seekers.

Primary care trusts and local health boards in areas with refugee populations to:

- ensure that the Department of Health guidance on healthcare entitlements is extensively disseminated and properly implemented
- work more closely with refugees and refugee community organisations in the development and provision of mental health services
- ensure a system is in place to enhance pathways into primary care for refugees and asylum-seekers, such as specialist asylum-seeker GP practices or specialist health access workers
- provide GPs with focused training, support and incentives to encourage registration of refugees and asylum-seekers, in particular refused asylum-seekers
- take into account the complex needs of these patients and the extra time and resources required to work with them
- ensure pathways into secondary mental health services are made more flexible to recognise the needs of refugees and asylum-seekers and to recognise the role of refugee support organisations in those pathways.

“It took a long time to get her help. She was put on suicide watch which made her worse, someone following her everywhere, being woken up regularly...”

Local Mind association counsellor talking about a detained service user

Detention centres

Over the last two years, Her Majesty's Inspectorate of Prisons (HMIP) has expressed a number of concerns about mental healthcare provision within immigration detention centres. These include a lack of access to counselling, registered mental health nurses being required to undertake generic nursing duties, no mental healthcare provision for children or young people, unsuitable facilities for vulnerable detainees, poor use of interpreting services, and lack of training for healthcare staff in identifying signs of torture or trauma (HMIP, 2008–2009).

Mind's research identified similar failings. Service providers told Mind that they feel overall provision within centres is not adequate to deal with the high levels of mental distress experienced by detainees. Although respondents noted many staff were doing what they could to support detainees, they were restricted in what they could offer due to the limited mental healthcare provision within centres. Currently, there are no specific guidelines on the level of mental health services that should be in place. Service providers highlighted the following concerns:

"In Yarl's Wood the mental health services provided seem very inadequate... it would be a start if the staff appeared to be sympathetic, currently there seems to be a huge conflict of interest, staff seem to put immigration needs before those of the patients. If healthcare was part of the NHS, maybe that would be an improvement."

Detainee Visitors Group

- The impact of inadequate mental health service provision on detainees with severe and enduring mental health problems, and the lack of facilities to deal with vulnerable individuals who are experiencing a crisis.

"Many detainees are too seriously disturbed to be properly supported in detention. If detention must be used as an improvised alternative to a secure unit (eg, where no beds are available for a detainee to be sectioned), a radically different environment should be provided with equivalent support. Colnbrook have a Vulnerable Persons Unit, which seemed a positive step in principle but was severely criticised in the last HMIP report."

Jerome Phelps, London Detainee Support Group

- Some respondents mentioned that detention centres sometimes find it difficult to make referrals to the local secondary mental healthcare services and that this is often dependant on the capacity of the local NHS services. The result is that vulnerable individuals remain in unsuitable conditions in a detention centre precisely when they require specialist care.

"Our current understanding is that CAMHS does not receive the funding needed to provide a full service tailored to meet the specific needs of children and young people detained in Yarl's Wood."

Children's Society

"What is provided often depends on the links with the local mental health trust and what the local mental health trust can do."

United Kingdom Border Agency representative

"We know from medical staff at Brook House that they have tried to refer individuals to services. This is a response we got from a member of medical staff. He is referring to a man who sought psychiatric care six weeks ago, having attempted suicide twice: 'We are aware of the need for this man to be seen by psychiatrists and have referred him to our local services in line with the instructions we have for such referrals from the PCT. We are still waiting for him to be reviewed and I have both today and yesterday contacted the commissioners in an effort to clarify when this man will be seen'."

Gatwick Detainee Visitors Group

- There are few services for those experiencing intermediate mental health problems such as depression, anxiety and trauma-related psychological distress, with no provision in some centres. The lack of services for children and young people was of particular concern.

"We are aware that there is a counselling service but the counsellors only have limited training in counselling children. Our current understanding is there is not dedicated specialised counselling or therapy provision for children and young people within the detention centre."

Children's Society

“Detention Centre healthcare staff said a lot that they ‘didn’t want to open up a can of worms’ by asking people about their distress because they were scared they wouldn’t be able to deal with it.”

Anonymous

- Many staff feel ill-equipped with the appropriate skills to deal with the complex mental health needs of refugees and asylum-seekers, or to identify those who have undergone torture or trauma. Staff therefore often lack the skills to identify individuals for whom detention is inappropriate. When UKBA were consulted, they explained that it has taken them some time to identify an organisation to provide staff with training on identifying torture and trauma, but that they aim to have training in place soon.

“Because of the uncertainty of the time people will be here for we won’t try and treat PTSD.”

Detention centre mental health nurse

- The high turnover in many removal centres and the nature of indefinite detention means that staff may have no indication of when an individual may be released or deported. This affects the work that mental health professionals carry out with patients and the kind of care that will be offered by staff.

Recommendations are for...

The Government to:

- review current practices of detaining individuals with pre-existing mental health conditions and children.

United Kingdom Borders Agency to:

- develop and implement guidelines for mental healthcare provision within detention centres in order to guarantee adequate provision across the detention estate
- provide a comprehensive mental health service tailored to the specific needs of refugee and asylum-seeker children
- require that regular, compulsory mental health training which includes how to identify signs of torture and trauma is provided to all detention centre staff

- ensure that there are systems in place ensuring speedy pathways into statutory services if detainees experience severe mental distress, in all detention centres.

PCTs in areas with detention centres to:

- recognise the need for mental healthcare services that meet the needs of detainees. Ensure that trauma to vulnerable detainees is minimised by prioritising referrals to secondary services from detention centres.

Voluntary sector services

Specialist refugee and asylum-seeker services

In England and Wales the voluntary sector offers a wide range of therapeutic and psychosocial services tailored to meet the needs of refugees and asylum-seekers and BME communities. As a result, they often find themselves addressing gaps in statutory sector service provision. Most of those consulted are struggling to meet the demand for their services and in addition are finding it increasingly difficult to obtain funding.

“Although we know that there are certain nationalities that are not accessing our services, we don’t currently have the capacity to reach out to these communities because we have such a long waiting list, so there are large numbers of refugees and asylum-seekers without services.”

Solace, Leeds

Voluntary sector projects that provide mental health services for refugees and asylum-seekers and which also involve refugees in service provision or are set up by RCOs (see p.16) often find it easier to reach refugee communities. However, dispersal has meant that RCOs in many parts of England and Wales are not as well developed as in the south-east of England. Many of the specialist services consulted either did not have much contact with local RCOs, or had found it hard to engage with them.

“Anyone can access our services so we would have expected people [refugees and asylum-seekers] to come through the doors but they haven’t really.”

Local Mind association

Mainstream voluntary sector

Although specialist voluntary sector organisations reported a huge demand for their services, Mind’s research revealed mainstream voluntary sector mental health services were often not accessed by refugees and asylum-seekers. Many of the mainstream services we consulted were concerned about the reasons for this, and how they may be perceived by refugees and asylum-seekers.

“We are not necessarily seen as a multi-cultural organisation. We offer services that are open to all, but are constantly checking that it isn’t exclusionary. But I am aware of how it might seem like a ‘white’ service.”

Local Mind association

“We really want to offer services but we need guidance.”

Local Mind association

However, it was clear that specialist mental health providers and refugee support agencies feel that more mainstream services should be providing services to refugees and asylum-seekers. Mind’s research demonstrates that although there is willingness to increase engagement with refugees and asylum-seekers, such engagement is complicated by the following factors:

- Many providers fear they lack the expertise and knowledge, and are often unsure of how to engage with refugee communities.
- Racism and prejudice among existing service users can make services unwelcoming for refugees and asylum-seekers.
- Some refugees support agencies reported that they would not refer people to mainstream services because of a belief that such services are not equipped to meet the needs of refugees and asylum-seekers.

“One of the barriers to engagement is prejudice among service users”

Local Mind association

Recommendations are for...

Voluntary sector mental health service providers to:

- make their services more accessible to increase the availability of mental health services for refugees and asylum-seekers
- ensure that where there is a need, costs for interpreting services are included in funding applications
- work more closely with refugees in the development and provision of mental health services.

The Government to:

- support and fund capacity-building for RCOs to work in mental health and encourage partnerships between the statutory and voluntary mental health sector and RCOs.

Gaps in service provision

“Most clients don’t qualify for statutory services so it becomes very difficult. They are not really meeting the criteria for intervention – that is, no severe and enduring mental illness – but they may have other issues like post traumatic stress disorder, so need support. But there are no services to meet these problems and many of our clients need the kinds of services that the Medical Foundation for the Victims of Torture offers.”

Refugee Council SE England

“There is less and less money to work with refugee children and young people.”

Lisa Nandy, Children’s Society

Mind’s findings highlight particular gaps in mental health service provision for refugees and asylum-seekers.

- A lack of appropriate therapeutic services and psychosocial support services (eg, befriending or mentoring), to address intermediate mental health needs like depression, anxiety and trauma-related psychological distress.
- There are few statutory services that specialise in treating those who have experienced torture.⁶

6. It is estimated that up to 30% of asylum seekers or refugees have been tortured depending on the definition of torture used and the country of origin (Burnett & Peel, 2001).

The voluntary sector, principally the Medical Foundation for the Victims of Torture, is often relied upon to meet this need. However, many struggle to meet the demand for their services. Also, there are many areas of the country that have no access to this type of specialist service.

- There is a shortage of services for children, young people and families, both in the voluntary and statutory sector. Securing funding for this type of service is particularly challenging (see Save the Children, 2005; Young Minds, 2005). Statutory services such as Child and Adolescent Mental Health Service (CAMHS) are under-resourced and underfunded and in many areas struggle to meet the needs of refugee children (see Young Minds, 2005; Joy et al., 2008).

The Children's Society – Harbour Project, Oxford

The Harbour project is a school-based mental health service for young refugees and asylum-seekers in Oxford. They offer consultation with the schools and work therapeutically with those children and young people who are struggling with emotional or psychological distress, disturbance or trauma as a result of their refugee experience. To support their various needs, they will work with them on an individual, family or group basis.

Two therapists are involved in the project – an occupational therapist and an arts psychotherapist. They use a number of approaches including talking, art, practical and solution-focused work. Where necessary, interpreters are used. The needs of the young refugees they work with are often complex, therefore, with the consent of the young person, the project works closely with other services to try to meet these needs.

“We have a three-year-old from Zimbabwe who is in a mess and there is not much we can do with him, there are no services.”

Asylum seeker nurse, Swansea

Recommendations are for...

Primary care trusts and local health boards in areas with refugee populations to:

- ensure that IAPT services take account of the needs of asylum-seekers and refugees
- develop services to address trauma and torture where there is a need
- develop and invest in services to meet the mental health needs of refugee and asylum-seeker children, young people and families.

The Government to:

- make funding available for the development of specific mental health services for refugee children, families and young people who are experiencing mental distress.

Our response: Mind's refugee and asylum-seekers project

“The main issue for us is to find out who is out there and how we can help.”

Local Mind association

In summer 2009, Mind undertook pilot work with several local Mind associations (LMAs) across England and Wales. The aim of the project was to provide capacity-building support for local Mind associations who were keen to engage more with refugees and asylum-seekers and to make their services more accessible.

The LMAs who took part were based in areas with sizable refugee populations but a shortage of suitable mental health services for refugees and asylum-seekers. At the start of the project, there was no clear understanding of why this should be.

There were several common factors for the LMA staff. The majority felt they lacked knowledge of refugee issues, which meant they did not feel confident about working with refugees and asylum-seekers. The language barrier was also a concern, especially as there was little or no money available from current budgets to pay for interpreters. Commonly asked questions were:

- Who are the refugees and asylum-seekers in our area, where are they from, what are their needs and how do we find out?
- How do we go about engaging with them?

The aim of the pilot was to tackle these concerns and provide LMAs with the knowledge, local information and links to enable them to develop work with refugee communities.

Generally, Mind found that the LMAs were not linked into local refugee support services. Conversely, local refugee support agencies did not refer refugees to LMAs because they did not know much about the services on offer, or whether the services could meet the needs of refugees and asylum-seekers. Consequently, part of the support provided was to research the local services for refugees and encourage relationship-building with the refugee sector.

Refugee support organisations are well placed to provide training about the asylum process, the experiences of refugees and share knowledge about local refugee communities. In several areas, the local refugee support services identified a need for mental health awareness training. As a result reciprocal training was planned.

LMAs are currently developing links with local refugee organisations, swapping training, identifying how they can access language support and planning to develop their work with refugees and asylum-seekers. The plans include making an existing drop-in suitable for destitute asylum-seekers and providing services at refugee drop-in sessions. As a result of the project the LMAs reported being more confident about their ability to offer services to refugees and asylum-seekers. They also aim to engage more with refugees and asylum-seekers in the future.

“I feel we have been able to network and identify possible partnership-working opportunities with other organisations who work within this field. We have identified different ways of engaging with such groups and have the support of the local refugee centre in doing so.”

“We are aware of the different areas to focus upon in order to make our services more accessible including anti-stigma work, working with interpreters and engaging refugees and asylum-seekers in activities such as gardening projects.”

“The support given was very useful in terms of creating the organisational commitment of working with refugees and asylum-seekers. There is now a more tangible commitment within the organisation to work with refugees and we have developed some concrete steps towards making one of our drop-ins more accessible.”

Conclusion

Refugees and asylum-seekers are often in need of mental health support in order to be able to move on with their lives and the detrimental impact of the asylum system in the UK on mental health and wellbeing makes the provision of mental health support even more crucial. Mind's research reveals that the mental healthcare system is regularly failing refugees and asylum-seekers; in particular children and young people. There are many barriers which make it difficult for this group to access mental health services such as language, cultural differences and factors specific to their experience as refugees. It is clear that not enough is being done by mainstream mental health services to overcome these obstacles and to ensure equality of access to mental healthcare. Mainstream services need to learn from the many innovative ways that specialist services in the voluntary and statutory sector have met these challenges. This should include increased provision of culturally appropriate, holistic services, which recognise the specific needs of asylum-seekers and refugees.

In order to move forward, health professionals must recognise the importance of language and mental health services must ensure they make available effective interpreting services. It is essential that the statutory sector raises staff awareness of refugee issues and increases the flexibility of existing services and pathways into mental healthcare. We need to improve access to, and care within, GP practices. That said, there remains a need for specialist refugee and asylum-seeker services. The standard of mental healthcare within detention centres should reflect the impact detention has on the mental health of detainees and should minimise the mental health impact of detention. The practice of detaining children and those with pre-existing mental health problems should be reviewed.

The vital role that the voluntary sector plays and the support it provides to the statutory sector should be recognised and supported by PCTs. This should include increased partnership working with the voluntary sector and particularly with refugee community organisations to ensure that services are appropriate. The mainstream voluntary sector can also play a part by developing the capacity of their services to meet the needs of refugee and asylum-seekers and Mind aims to work towards this goal in partnership with local Mind associations across England and Wales.

“Staff now feel more knowledgeable about the issues, the information about the lack of financial support and inability to work has allowed us to ‘right’ the misconceptions about asylum-seekers held by service users.”

“We hope that as a result of working with a local refugee support organisation we will establish better pathways, although language remains a barrier to services. We hope that we will be able to take referrals with a clearer knowledge of what our own limitations are and who can help.”

“We really enjoyed the realistic and optimistic approach to working with refugees and asylum-seekers and feel that despite language barriers we still have something to offer.”

References

- BBC Online (2009), 'Failed asylum-seekers health help', <http://news.bbc.co.uk/1/hi/wales/8151255.stm>
- Bischoff A., Bovier P., Isah R. et al. (2003), 'Language barriers between nurses and asylum-seekers: their impact on symptom reporting and referral', *Social Science & Medicine* 57(3): 5–12
- Boswell C. (2001), 'Spreading the costs of asylum-seekers: A critical assessment of dispersal policies in Germany and the UK', Anglo-German Foundation, London
- Boswell C. (2003), 'Burden-Sharing in the European Union: Lessons from the German and UK Experience', *Journal of Refugee Studies* 16(3): 316–35
- Brown D. (2008), *More destitution in Leeds – repeat survey of refugees and asylum-seekers approaching local agencies for support*, Joseph Rowntree Foundation
- Burnett A. and Fassil Y. (2002), *Meeting the health needs of refugees and asylum-seekers in the UK: an information and resource pack for health workers*, Department of Health
- Burnett A. and Peel M. (2001), *Health needs of asylum-seekers and refugees*, *BMJ* 322:544-7
- Centre for Social Justice (2008) *Asylum Matters – Restoring Trust in the UK Asylum System*
- Children's Society (2008), *Living on the Edge of Despair: child destitution report*
- Cohen J. (2008), 'Safe in Our Hands? A study of suicide and self harm in asylum-seekers', *Journal of Forensic and Legal Medicine* 15: 235-44
- Crowley P. (2003), *An Exploration of Mental Health Needs of Asylum-seekers in Newcastle*, The Tyne, Wear and Northumberland Asylum-seeker Health Group
- CVS Consultants (1999), *A Shattered World – The mental health needs of refugees and newly arrived communities*
- Department of Health (1999), *National service framework for mental health: modern standards and service models*
- Department of Health (2005), *Delivering race equality in mental health care: An action plan for reform inside and outside services and the Government's response to the Independent inquiry into the death of David Bennett*
- Department of Health (2004), *Celebrating our Cultures: Mental health promotion for refugees and asylum-seekers*
- DFES (2003), *Every Child Matters*
- Dugan E. (2008), 'Alarming' rise in self-harming at detention centres', *Independent* 31 August
- Dumper H., Malfait R. and Scott-Flynn N. (2007) *Mental Health Services in Birmingham- a report to help inform the strategy of the Refugee Council in this area*. Refugee Council.
- Dumper H., Malfait R. and Scott-Flynn N. (2006), *Mental Health Destitution and Asylum-seekers – a study of destitute asylum-seekers in the South East of England*
- Fay M. (2007), *Refugees and asylum-seekers in Newcastle upon Tyne – an overview of Mental Health Service Needs, Provision and Pathways*
- Fazel M. and Stein A. (2002), 'The mental health of refugee children', *Arch Dis Child* 87: 366–70
- Gosling R. (2004), *The needs of young refugees in Lambeth, Southwark and Lewisham: summary of research findings*, HAZ
- Foresight Mental Capital and Wellbeing Project (2008), *Final Project report – Executive Summary*, The Government Office for Science, London
- HMIP (2007), *Report on an announced inspection of Dover Immigration Removal Centre*, 19–23 March
- HMIP (2008), *Report on an unannounced full follow-up inspection of Harmondsworth Immigration Removal Centre*, 14–18 January 2008
- HMIP (2008), *Report on an announced inspection of Yarl's Wood Immigration Removal Centre*, 4–8 February 2008
- HMIP (2008), *Report on a full announced inspection of Tinsley House Immigration Removal Centre*, 10–14 March 2008
- HMIP (2008), *Report on an unannounced full follow-up inspection of Campsfield House Immigration Removal Centre*, 12–16 May 2008
- HMIP (2008), *Report on an announced inspection of Oakington Immigration Reception Centre*, 16–20 June
- HMIP (2008), *Report on a full announced inspection of Colnbrook Immigration Removal Centre*, 17–21 November 2008
- HMIP (2009), *Report on an announced inspection of Lindholme Immigration Removal Centre*, 16–20 February 2009

- HMIP (2009), *Report on an announced inspection of Haslar Immigration Removal Centre, 20–24 April 2009*
- Home Office (2008), *Asylum Statistics United Kingdom 2007*
- Independent Asylum Commission (2008), *Fit for purpose yet? The Independent Asylum Commission's Interim Findings*
- Information Centre about Asylum-seekers and Refugees (2004), *Media Image, Community Impact*
- Joy I., van Poortvliet M. and Yeowart C. (2008), *Heads up: Mental health of children and young people*, New Philanthropy Capital
- KCW BME Health Forum (2008), *Access to GP Practices for Black and Minority Ethnic Communities in Kensington, Chelsea and Westminster*
- Keller A., Rosenfeld B., Trinh-Shevrin C. et al. (2003) 'Mental health of detained asylum-seekers', *The Lancet* 362
- King's Fund (2000), *The Health and Well-being of Refugees and asylum-seekers*, King's Fund, London,
- Mansoor A. et al. (2006), *Report of the community-led research project focusing on the mental health needs of refugees and asylum-seekers in Manchester*, Harp
- McColl H. and Johnson S. (2006), 'Characteristics and needs of refugees and asylum-seekers in contact with London community mental health teams: a descriptive investigation', *Soc Psychiatry Psychiatr Epidemiol* 41(10): 789–95
- Mind (2009), *Improving mental health support for refugee communities – an advocacy approach*
- Mind (2009), *Men and mental health: Get it off your chest*
- McKenzie K., McColl H. and Bhui K. (2007), *Improving services for refugees and asylum-seekers: Position Statement*, Royal College of Psychiatrists
- Murphy G. and Athanasou J. (1999), 'The effect of unemployment on mental health', *Journal of Occupational and Organizational Psychology* 72: 83–99
- National Institute of Mental Health (2003), *Inside Outside: improving mental health services for black and minority ethnic communities in England*
- Phillimore J., Ergun E., Goodson L. et al. (2007), *They do not understand the problem I have: refugee well being and mental health*, Joseph Rowntree Foundation
- Refugee Action (2006), *The Destitution Trap*
- Refugee and Migrant Justice (2009), *Does every child matter? Children seeking asylum in Britain*
- Refugee Media Action Group (2006), *Seeking asylum: a report on the living conditions of asylum-seekers in London*, Migrants Resource Centre
- Reeve K. and Robinson D. (2006), *Neighbourhood experiences of new immigration: reflections from the evidence base*
- Smart K. and Fullegar S. (2008), *The Destitution Tally: an indication of the extent of destitution among refugees and asylum-seekers*, IAP partnership
- Taylor D. (2009), *Underground Lives: an investigation into the living conditions and survival strategies of destitute asylum-seekers in the UK*, PAFRAS
- Thom N. (2008), 'Using telephone interpreters to communicate with patients', *Nursing Times* 104(46): 28–9
- Ward K. and Palmer D. (2005), *Mapping the provision of mental health services for refugees and asylum-seekers in London*, ICAR
- Wren K. (2004), *Building Bridges: Local responses to the resettlement of asylum-seekers in Glasgow*, Scottish Centre for Research and Social Justice
- Young Minds (2005), *Minority Voices – Research into the access and accessibility of services for the mental health of young people from Minority Ethnic Groups*

Appendix – Methodology

Review of literature

A review of relevant research and literature was undertaken to inform the research.

eight individuals working within voluntary sector organisations were also interviewed. These ranged from mainstream and specialist mental health organisations to local and national refugee support agencies.

Data collection

The data were collected from a combination of face-to-face and telephone interviews over a three-month period in winter 2008/2009. Voluntary and statutory mental health service providers and refugee agencies from dispersal areas were identified and further individuals and organisations to interview were identified by snowball sampling.

It proved difficult to access staff working within detention centres. However, two detention health-care staff were interviewed and this was supplemented by interviews with the Children's Society, Medical Justice, Bail for Immigration Detainees, three detainee support groups and United Kingdom Borders Agency detention policy staff.

A wide range of professionals were interviewed, including staff within local Mind associations, staff in other voluntary organisations working with refugees and asylum-seekers, Asylum-seeker Health Teams, Equality and Diversity Leads, Community Development Workers, GPs working in specialist GP practices and staff working within detention centres.

Case studies

Good practice organisations and service providers were identified from the consultations and case studies from these are included in the report to illustrate how barriers are being overcome in different areas of England and Wales.

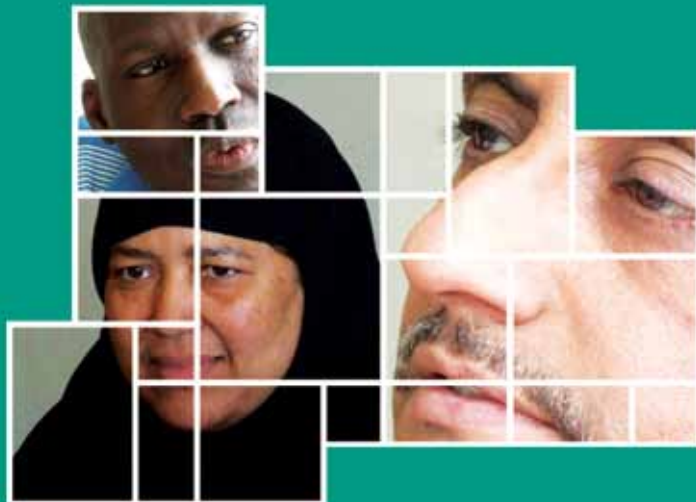
In total 96 interviews were carried out. These included 33 interviews with individuals working within 20 different primary care trusts and local health boards across England and Wales. Fifty-

Research Limitations

It is not possible to generalise from the data collected as they are qualitative and based on a non-random sample.



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mental health**



For details of your nearest local Mind association and of local services, contact Mind's helpline, *MindinfoLine* on 0845 7660 163, Monday to Friday 9.00am to 5.00pm. Speech impaired or deaf enquirers can contact us on the same number (if you are using BT Text direct, add the prefix 18001). For interpretation, *MindinfoLine* has access to 100 languages via Language Line.

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