Asylum seekers and Refugees in Newcastle upon Tyne – an overview of Mental Health Service Needs, Provision, and Pathways

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as part of the Delivering Race Equality in Mental Health Action Plan (2005-2008), Northumberland, Tyne and Wear Focused Implementation Site

Commissioned by the Gateshead Voluntary Organisations Council (GVOC) through the Value Added Grant

May 2007
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Executive Summary

Aims and Methods

This report
- identifies priority areas in mental health service provision to asylum seekers and refugees on which attention should be focused across Northumberland, Tyne and Wear over the next two years, until December 2008.
- Based on qualitative research (semi-structured, face-to-face interviews), it assesses what key staff from the voluntary sector as well as frontline clinicians and practitioners see as the main issues in mental health service availability and provision to asylum seekers and refugees in Newcastle.
- Identifies priorities for further research and engagement.

Barriers in mental health service access and provision for asylum seekers and refugees

There are a number of barriers asylum seekers and refugees, but also health professionals themselves, are confronted with in accessing and referring to appropriate health services. These were mentioned by all interviewed professionals, regardless of whether they work in primary or secondary care or in the voluntary sector.

In sum, these barriers are:
- Lack of signposting and knowledge about what services are available and where to point patients.
- Language barriers.
- Cultural barriers and lack of cultural awareness. Health practitioners lack the confidence and awareness to deal with someone from this particular patient group but also, on the other hand, asylum seekers lack the knowledge and experience of a western medical system, including western understandings of mental health and approaches to treatment and care but also systems of confidentiality.
- Lack of trust and 'culture of disbelief'. Asylum seekers and refugees are often not believed to be ‘authentic’. Herein clearly lies a danger of resulting inappropriate or substandard care. Asylum seekers and refugees are reluctant to trust the western medical profession and/or the asylum system itself.
- Disjointed services and fragmented service provision.

Factors influencing mental health service provision to asylum seekers and refugees

A number of factors influence and shape the mental health service provision to asylum seekers and refugees in Newcastle. These are as follows:
Local context: Ethnic diversity in Newcastle

There are several social and cultural and political factors specific to Newcastle that make it perhaps a more difficult place to be an asylum seeker than in other, larger and more cosmopolitan/multicultural places.

- Newcastle’s ‘whiteness’ contributes significantly to negative cultural typifications of BME communities in general, and asylum seekers and refugees in particular.
- Asylum seekers and refugees tend to be clustered in the East and West Ends of Newcastle respectively, with an imbalance both in the amount of Asylum seekers and refugees resident and the services available towards the West End.
- There is a widespread lack of cultural awareness throughout health provision in Northumberland, Tyne and Wear and a need for more and better training and awareness raising.

Service Provision

There is a need for a combination of specialised Mental Health services and an improvement of mainstream services to better serve the particular needs of asylum seekers and refugees.

- Making a certain amount of well placed specialised services (e.g. transition GP practice) available would address some of the existing barriers in access to mental (as well as physical) health care services asylum seekers and refugees.

Services in need of improvement:

General Practice

- Evidence suggests that there would be benefits in having a transition GP practice.
- There is a need for better medical reports by GPs.

The Crisis Assessment Team (CAT) Service or Crisis Assessment

- Need for more culturally appropriate assessment, including consistent adequate interpreting service.
- Need for a debate about psychiatric crisis versus social crisis in risk assessment and suicide prevention.

The changing NHS and NTW Mental Health Trust

- The effects of the NHS’ ‘Constant Revolution’ (Talbot-Smith 2006) such as quick turnover in NHS staff and management, leads to instability and unsatisfactory links between sectors and within the NHS.

Voluntary and Community Sector

- Evidence suggests that there is a need to better link the voluntary sector and the statutory sector.
• There is evidence that the NHS increasingly relies on voluntary organisations and community services. Adequate financial recognition of these increased responsibilities and workloads is required.

**Homelessness**

• Addressing the effects of homelessness and destitution remains a significant concern in particular in the voluntary sector. Individuals whose asylum claim has failed but who remain (often for prolonged periods of time and/or underground) in Newcastle remain a contentious point. In effect, they require increased care, but their right to access care beyond the most basic level, relinquishes.
• There remains a humanitarian responsibility to care for these people and voluntary organisations in particular carry most of this responsibility.

**Interpreters**

• Evidence suggests that despite a satisfactory number of interpreters being available, there remains a need to raise health and other professionals’ willingness and ability to work with them (including the need to take seriously the effects this has on consultation times).

**Diagnoses**

• Evidence suggests that there is a need for a more holistic approach (Watters 2001) to mental health diagnoses which consider mental health needs, physical health needs, and practical needs as interlinked and mutually constitutive.

**Recommendations**

Based on the evidence gathered for this report, it is recommended to:

• Consider the need to re-establish a transitional GP Practice.
• Improve incentives for GPs to work with asylum Seekers and refugees.
• Work towards a combination of specialised and mainstreamed services for asylum seekers and refugees.
• Improve GP services with regards to assessment and adequate referral practice.
• Increase awareness and implementation of the available policies, research and guidance on cultural awareness and ethnic diversity and medical practice.
• Improve Crisis Assessment Service including assessment procedure and consideration of social needs of individuals.
• Financially acknowledge the increased responsibilities and workloads of voluntary organisations.
• Equip and encourage front-line staff to work with asylum seekers and refugees and adequately adjust their workloads.
• Address difficulties involved in interpreting, particularly within crisis situations.

Michaela Fay
• Acknowledge that the mental health needs of Refugees differ significantly from those of asylum seekers and specify services accordingly. Further research into differing needs of asylum seekers and refugees is advisable.
• Involve asylum seekers and refugees in meeting the needs of recommendations.
• Conduct further substantial research with asylum seekers and refugees.
• Extend the findings of this research across Northumberland, Tyne and Wear and to draw upon good practice across the North East.
• Extend the findings of this research to determine gender specific mental health needs, revolving in particular around issues such as domestic violence and mental health problems raised by pregnancy and child birth.
• With view to the wider Black and Minority Ethnic communities, engage in an ongoing debate about social needs versus medical and mental health needs.

1. Introduction: Context and Background

This study forms part of the Northumberland, Tyne and Wear DRE action plan. The scoping study was required to assess the current context of service provision for asylum seekers and refugees and to identify key areas for improvements in service delivery.

The study is limited to Newcastle upon Tyne. The West End of Newcastle has been a particular focal point of research and development in the past. This study aims to counter balance such studies by paying attention to other key areas in and around Newcastle (in their own right and in relation to the West End), in particular the East End.

It was agreed necessary to focus the study upon one locality. However it has always been the intention that the study will be of high relevance to all areas of Northumberland, Tyne and Wear.

This research was commissioned by members of the Asylum Seeker, Refugee and Migrant Delivery group of the Northumberland, Tyne and Wear Focused Implementation Site through the Department of Health’s Value Added Grant.

This research is conducted with particular view of the 2005 Department of Health 5 year ‘Delivering Race Equality’ Action plan for tackling discrimination in NHS and local authority mental health services. The national action plan identifies the need for services to address the needs of particular client groups including asylum seekers and refugees.

The study is a reflective one but its main aim is to recommend the priority areas on which attention should be focused across Northumberland, Tyne and Wear over the next 2 years – until December 2008.

Michaela Fay conducted the research on which this report is based. She holds a PhD in the Social Sciences from Lancaster University and worked, at the time of conducting this research, as an independent researcher.
1.1 Asylum seekers and Refugees in Newcastle

It is difficult to determine exact figures of asylum seekers and refugees either nationally or regionally. There are however, statistics that confirm there is now a substantial population of Asylum seekers and refugees in Newcastle upon Tyne. At the end of September 2006 there were 3647 asylum seekers in the North East in NASS accommodation, an increase of (23.08%) from June 2006. 1353 (37.1%), were living in Newcastle.¹

Being an asylum seeker or refugee is often a lonely experience, at best an experience of eventual successful and permanent integration into the host society, at worst it is a life threatening/ending situation. In any case, it means living precariously. It means being vulnerable, at the mercy of an often unforgiving system. Most likely, it means having survived torture, rape and other war traumata. Often, it means being separated from one’s family and community, living in isolation. It means not being able to work. It means living in fear of deportation. It means waiting. If granted Refugee status, it means starting all over, re-entering a ‘normal’ life from within the precarious, sometimes desperate situation of having waited for months, sometimes years, for one’s claim to be granted. In sum, it is not a desirable situation to be in and one that raises a number of needs.

Asylum seekers and refugees have a number of health needs – some specific, some equivalent to other groups. Given the circumstances, past and present, under which asylum seekers and refugees find themselves, it is perhaps obvious that mental distress plays an important role within the spectrum of health problems asylum seekers and refugees might have and require treatment for. However, it is important to distinguish between social needs and mental health needs.

There are, as Burnett and Peel suggest “many and varying needs of asylum seekers, some of which are non-medical but nevertheless affect health. Addressing even a few of these needs may be of considerable benefit. Previous studies in the United Kingdom have found that one in six refugees has a physical health problem severe enough to affect their life and two thirds have experienced anxiety or depression” (Burnett and Peel: 2001).

1.2 Delivering Race Equality in Mental Health Action Plan 2005-2008

‘Black and Ethnic Minority communities in England do not get the mental health care services that they are entitled to’. In order to address this fact, the Department of Health Action Plan ‘Delivering Race Equality in Mental Health (2005-2010) was designed in order to create better, more responsive services; to better engage services with their local communities; and to increase the information available on services and how to access them. As part of this Action Plan, 500 community development workers working on race and mental health are being introduced across the country. There will be 17 in Northumberland, Tyne and Wear and 3 in Newcastle by the end of 2007.

¹ http://www.refugee.org.uk/statistics.htm
Northumberland, Tyne and Wear is one of 17 Focused Implementation Site (FIS), which means the area has signed up to implementing the Delivering Race Equality in Mental Health Care Action Plan (DRE) faster than other areas of the country, by 2008. Leadership at a high level across the NHS and the voluntary sector is committed to this aim and a Project Manager was put into place January 2006. A specific Northumberland, Tyne and Wear DRE action plan is in place with a specific group focusing on improving services for asylum seekers and refugees. This group is the Asylum Seeker, Refugee and Migrant Delivery Group, chaired by the North of England Refugee Service. This study focuses upon Newcastle, however the delivery group works across Northumberland, Tyne and Wear.

This report highlights the mental health needs of asylum seekers and refugees and explores services and pathways available in Newcastle. In particular, the report pays attention to the interaction between social, medical, and cultural circumstances. It questions and discusses the often unavoidable medicalisation of asylum seekers and refugees within the health and social care systems.

### Summary

This scoping study forms part of the Northumberland, Tyne and Wear Delivering Race Equality (NTW DRE) Action plan 2005 – 2008.

Due to a limited budget the study is limited to Newcastle.

### 2. Methods and Scope

This research was designed as a scoping study to identify the mental health care needs of asylum seekers and refugees in Newcastle, to inquire into what services are available, what barriers in accessing services prevail, and which improvements in the network of service and care provision might be needed. No such research has as yet been carried out in Newcastle with the exception of Philip Crowley’s (2003) report. The findings of Crowley’s report indicate a clear need for further research into this area but have as yet not been followed up.

For this scoping research Michaela Fay conducted 10 semi-structured interviews with health care managers, practitioners, and members of the voluntary sector who work with asylum seekers and refugees. The aim of the selection of interviewees was to cover as wide a range of relevant professionals as possible for the scope of the study.

- Beyond researching other relevant professionals there is a serious need to expand research of this kind to include asylum seekers and refugees themselves.

This was not possible for this study due to the timeframes, which did not allow ethical approval. All interviews were conducted face-to-face. Interviews lasted an average of one to one and a half hours and were transcribed by the researcher.

Aim of the interviews was

- To understand what the barriers are for the workers in accessing, delivering or improving services for asylum seekers and refugees.
- To explore the referral processes through primary and secondary care.
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- To explore the relationship between services provided by the voluntary and statutory sectors.
- To understand how diagnoses of poor mental health are made.
- To ask if any changes have been made to improve services and access for asylum seekers and refugees.

Due to financial and time constraints, this study was designed as a scoping study. As such, the results are limited to Newcastle. In order to better understand the health and social needs and available services to asylum seekers and refugees, it is pivotal to extend this research in order to compare different locations in the Tyne and Wear region. Different regions in the North East demonstrate examples of good practice (p29-31) and in order to improve the overall standard of care and service provision for these groups, it would be necessary to identify these regional examples and ‘translate’ them to other regions.

2.1 Data Analysis

Data analysis followed basic principles of grounded, qualitative social research. This report reflects the outcomes of this process of analysis (e.g. Wetherell & Potter 1988 and Potter 1996). It represents the voices of those individuals who participated in the research in order to illustrate the wider context. Selection of quotes was done by Michaela Fay on the basis of themes that emerged from multiple readings of the interviews and systematic comparison of interviews for patterns and anomalies. Quotations are taken from across all interviews.

Summary
The study employs grounded qualitative social research methods. Semi-structured interviews with professionals in the field were conducted and analysed.

3. Local context: Cultural awareness and ethnic diversity

When considering the access to and provision of services – be that mental health related or otherwise – to asylum seekers and refugees in Newcastle, it is important to consider the region itself in its specific local context.

There is a range of services available to Asylum seekers and refugees in Newcastle. There are voluntary organisations such as North of England Refugee Service (NERS) and the West End Refugee Service (WERS). Also, in the voluntary sector, the Medical Foundation is a service designated at addressing health needs arising from torture experience. There are furthermore a number of community based projects such as Common Ground and the Comfrey project.

There are services available and some of these have been described as examples of good practice (see section 7). However, the evidence suggests that these services are notoriously under resourced and often not very well integrated with each other or the Health and Social Care sector.
3.1 Ethnic diversity and cultural awareness

With respect to cultural diversity, Newcastle is, as one of the interviewees for this report put it, “20 years behind in some ways” (Voluntary Organisation). Cultural diversity is still not the norm in Newcastle. Furthermore, Newcastle is a relatively ‘static’ city. The indigenous population tends to stay put, influx from other parts of the country and other (European) countries is slower than in other parts of the country. This lack of mobility, as one General Practitioner interviewed for this research indicated, is also reflected in the makeup of medical staff in the local NHS. Arguably more than elsewhere in the country, nurses and other practitioners tend to be ‘locals’ with little ‘natural’ awareness of people from other cultures in general and members of BME communities in particular.

“There’s still an awful lot of doctors and nurses who have no idea of the issues.” (Voluntary Organisation)

The general lack of cultural differences and racial awareness has been raised repeatedly:

“It’s very, very subtle. You know, it’s not overt. Nobody is doing anything against anybody deliberately. Or anything like that. But it’s that willingness to change things [that is lacking].” (Statutory Sector Manager)

“I think it’s more basic than [money]. It’s about people’s willingness to change the way they do things.” (Statutory Sector manager)

This general lack of cultural differences and racial awareness is further exaggerated when comparing the East and West Ends of Newcastle with regards to cultural diversity and services available to asylum seekers and refugees.

Perhaps unsurprisingly, the West End is described as a more appropriate and welcoming area. As the only area of Newcastle with already established ethnic communities, asylum seekers and refugees can easily ‘blend in’. This is not the case in the East End:

“In Walker, you almost carry a label that says ‘Asylum seeker’, if you’ve got dark skin.” (GP)

The social and cultural environment (e.g. the offers of ethnic foods on the local shops in West Road) – regardless of the high level of deprivation in the West End – can lead to an improvement of social integration and possibly general better mental health.

“Geographically, the East End is much more isolated, geographically much more deserted. In the West End there’s a big hospital there and Westgate Road is a big busy road, it’s a short walk into town, relatively. To me it has more sense of being … not far from the heart of Newcastle. The East End seems to me much more remote and deserted and isolated and with quite a large expanse of housing. Not much else. […] And I think there’s a much more socio-economic mix in the West. You’ve got Fenham running into Benwell and Elswick and you have some relatively affluent people short distances away from extreme deprivation. And the East End is much more generally working class. I mean the huge thing- the absolutely huge thing that I noticed is the complete absence of ethnic minority populations in the East, apart from asylum seekers and refugees.” (GP)
Because of the higher concentration of asylum seekers and refugees in the West End there are consequently more services available. This results in somewhat of a catch-22 situation.

“There’s more in the West End for people [...] obviously, because there are more clients there.” (GP)

The West End Refugee Service (WERS) is commonly described as an example of very good practice within the voluntary sector (see below). It has in fact become somewhat of a place of refuge, so to speak, for asylum seekers not only from the West End. WERS’ services however remain limited to clients from the West End and it has had to guard its own boundaries in order to remain efficient in serving its designated client group, despite having experienced an increasing demand both from clients and the NHS.

“I think it’s positive but when you look at the scale of what we do, in the bigger picture it’s tiny. And obviously our clients here are only a proportion of people even in the West End. [W]e try to sort of keep those boundaries because I think otherwise you would become much less focused and much less efficient if you were trying to sort of do all things for everyone right across the city.” (WERS)

Similarly, GPs in the West End have been experienced and described as more willing and better trained and equipped to deal with asylum seekers and refugees patients. Whereas it is reassuring to know that there are a number of trusted GP practices, this invariably leads to a further specialisation of the West End to deal with these groups of people, consequently carrying the danger of ghettoisation.

3.2 Ensuring race equality

Each NHS organisation must have a Race Equality Scheme and Action Plan in place by law. This scheme commits professionals to promote race equality and to tackle race discrimination and there have been positive changes in raising cultural awareness. The current Race Equality Scheme and Action Plan (2006 – 2008) in place in the NTW NHS Trust is aligned to the aims of the Delivering Race Equality Action Plan².

Despite this legislation, there remains concern about the double standards of care for asylum seekers and refugees (and potentially BME communities in general) and lack of awareness of cultural differences:

“There are double standards. And I think if a person is accompanied by a white, reasonably articulate person they’ve got more chance of getting things sorted.” (Voluntary Organisation)

“I hesitate to call it racism but I sometimes think- I think it probably is. I mean, I don’t think it’s malicious racism. [...] I wouldn’t quite go as far as to say there’s malice there but I think [...] it is prejudice that is perhaps understandable in terms of people’s life experiences but that is really not acceptable.” (GP)
3.3 Community Development Workers

The newly established posts of Community Development Workers (CDW) have been specifically created by the Department of Health to further ensure that race equality and cultural awareness are applied in practice throughout mental health services. One of the aims of CDWs is to support and guide health professionals in applying Race Equality Legislation in their practice:

“I'm raising the level of awareness. It's not about accountability because the Delivering Race Equality and the Race Relations Amendment Act are the strategy documents that influence everybody's practice. I shouldn't have to come down heavy on anybody and say 'You're failing your duty to provide that'. I shouldn't have to do that and that's why I'm saying I don't ever want to have to be in that position where I have to come down heavy and say 'You have failed'. And I'm there to make sure that people who are at that strategic level of service delivery, service managers, know what their responsibilities are under the Delivering Race Equality and the Race Relations Amendment Act. It's up to them to read that and take that into account for their practice.” (CDW)

CDWs provide a useful link between the strategic and managerial level and the frontline and so far creating these posts seems to be a positive step in the right direction.

Nonetheless, evidence suggests that there is still a danger that awareness of cultural differences, interest and expertise in working with asylum seekers and refugees remains in small pockets, rather than being spread out equally across the system. Furthermore, there is a danger that CDW become the ‘token’ workers relied on to do the work of raising cultural awareness when what is needed is a systematic, embedded improvement.

General Practice (GP) and the Crisis Assessment Service (CAT) have been identified as having gatekeeper function with regards to access to mental health services and mental health care provided to asylum seekers and refugees.

Both areas have been described as in need of improvement in some respects.

Summary
The relative lack of ethnic diversity in Newcastle leads to problems in the support and mental health care of asylum seekers and refugees.

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2 Community Development Worker for Black and Minority Ethnic Communities Final Handbook – Mental Health Policy Implementation Guide DH 2006

Community Development Worker for Black and Minority Ethnic Communities Education and Training – Mental Health Policy Implementation Guide DH 2005

Community Development Worker for Black and Minority Ethnic Communities Education and Training Interim Guidance – Mental Health Policy Implementation Guide DH 2004
There is a lack of cultural awareness both in the native population and in the health care system.
The newly established Community Development Workers (CDW) have been having positive effects on the system.

4. Services in need of improvement

4.1 General Practice

With the recent changes towards a more market-oriented system that the NHS has been undergoing over the past decade, the role and remit of GPs has been, and still is, changing significantly. This impinges in a number of ways on the care and services available to asylum seekers and refugees.

Since 2004 GP practices can choose whether they offer additional ‘personal medical services’ (PMS) beyond the basic services included in the ‘general medical services’ (GMS). Practices can opt out of providing additional services or opt in to providing enhanced services (such as minor surgery). PMS arrangements in particular were introduced to give practices more flexibility of service provision and a degree of freedom to specialise and develop expertise and special interests. The latter is particularly important with respect to working with vulnerable groups such as asylum seekers and refugees (see Talbot-Smith and Pollock 2006: 52).

General Practitioners (GPs) are usually the first point of contact anyone has with the NHS. As gatekeepers to secondary care, they are, as one voluntary organisation’s manager interviewed for this project put it, “the lynch pin in all this” (Voluntary Organisation).

The evidence suggests a number of key issues arising with regards to GPs:

4.2 Time and Trust

Time constraints are mentioned as one of the single most significant barriers in adequate service provision to asylum seekers and refugees. If it is necessary to work through an interpreter, for example, the standard seven minutes GP consultation time effectively shrinks to half. There is a need to increase consultation time with these patient groups in order to account for any additional language or cultural needs and barriers.

It is furthermore mentioned that trust is a major barrier in receiving adequate mental health care. Asylum seekers and refugees tend not to trust doctors and other professionals and often are not aware of systems of patient confidentiality, therefore withhold important information. It can also not be assumed that asylum seeker and refugee patients are familiar with the NHS and the British medical system.

In addition, there is a very significant, different kind of time line to take account of for asylum seekers and refugees – that of the asylum process itself. Representatives of the voluntary sector in particular lamented *their* lack of time when it comes to referrals and NHS waiting lists, which often are not compatible with the ever increasing speed
with which asylum claims are processed. This can lead to measures of expediency on behalf of the voluntary sector.

“when you’re dealing with appeals and the need for reports, you’re running against the clock and you’re running against somebody else’s ticking clock, which is the Home Office’s. And it doesn’t leave very much time for a normal referral mechanism to take place. So to me, I have sometimes to give it a kick start. For example, I needed to get that case out of primary care into secondary because I knew if I could get it into secondary, I could get those reports done fairly quickly but if I left it for a couple of consultations with the GP, then wondering what to do and then eventually a few months later referring to the mental health team, it would have been too late for this man.”

(CDW)

The lack of trust of asylum seekers and refugees in health professionals is perpetuated by what has been called a “culture of disbelief” amongst health professionals:

“During the consultation [the GP] said to this young lad, ‘You allege to be from Kuwait? Are you sure you are not from Iran or Iraq’? […] He says ‘So you allege you were tortured’? And he’s going ‘Yes, I was’. So there was an immediate [disbelief]. It was the use of the word ‘alleged’, repeatedly, over and over again.” (CDW)

4.3 Lack of information and knowledge

There is evidence that GPs who do not specifically deal with asylum seekers and refugees lack the necessary information and knowledge about some of the special needs of these patient groups and are therefore unable to correctly refer clients to appropriate services:

“A while ago I went to a doctor’s appointment with a client who I thought would qualify for a section 21 and I went in to the GP’s appointment with him and the GP didn’t know what a section 21 was! I had to explain what it was and then get him to do it. Well, if I hadn’t been there, [that] wouldn’t have happened.” (Voluntary Organisation manager)

4.4 Working with interpreters

Often issues surrounding interpreters are reported to result in a failure to provide adequate service to asylum seekers and refugees. Evidence suggests that a number of problems derive from this area:

- The general shortage of interpreters, covering the required range of languages.
- A reluctance of medical staff to have interpreters ‘ordered’ when necessary, often even after prior discussion with voluntary organisations staff, for example.
- Medical staff’s lack of skill to work through interpreters effectively.
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- The need to increase face-to-face time that arises when working through an interpreter.
- Difficulties around doing psychological work through an interpreter.

4.5 Medical reports

At varying points throughout the asylum process, in particular from a legal point of view, detailed, competent medical reports become of great importance. The GP, alongside some voluntary organisations such as the Medical Foundation, are key in producing such reports. There is however, evidence that GPs do not have sufficient knowledge of writing medical reports for their asylum seeker patients in support of their asylum claim:

“I need a report to prove to this government and prove to the court that this person is ill. So then our big issue is how can we get well written reports from medical practitioners who are dealing with people? And that’s where we have come into conflict with mental health practitioners, particularly some of the consultants, who do not see that as part of their role. They are just there to […] taking more resources.” (Solicitor)

Summary

Single most significant barrier is time. There is a lack of knowledge around the situation of asylum seekers and refugees, their rights, needs and appropriate services, and also around the ability of GPs to write good quality medical reports.

4.2 CAT Service – Crisis Assessment

Alongside Accident & Emergency (A&E), the Crisis Assessment Team (CAT) is one of the services dealing with acute mental health crises, such as apparent psychotic behaviour and/or suicide risk. It is also a gatekeeper in the system of pathways. Patients can be referred to the CAT Service from any other care provider or community and other social services and institutions.

The assessment undertaken by the CAT Service aims to determine whether someone presents with an acute mental health problem. Part of the assessment is an examination of a person’s psychiatric and social history. This is recorded on care coordination assessment documentation for reasons of standardisation. The aim of the assessment is to distinguish between a mental health/psychiatric crisis and a social crisis, leading to psychiatric symptoms.

On the basis of their assessment, the CAT Service offers then a number of possible services and referrals:

- It is possible to refer on to a psychiatric ward, although the service was set up as a direct alternative to hospitalisation.
- The aim is to refer back to community health services and/or primary care.
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- They might offer a short term out-patient care package including crisis management and risk management as well as some short term therapy, addressing the acute aspect of the patient’s mental health situation.

The assessment routine is the same for every patient, regardless of their national or ethnic background. Often, there are difficulties to have an interpreter present during an assessment. There is no special training or resources available to deal with issues of language and/or cultural differences:

“I am not aware of any training. There may be something that the Trust runs that people have to put themselves forward for but I haven’t seen anything, I’m not aware of anything. And I’m sure there are Trust protocols with regards to interpretation but I’m not aware that our team’s been involved in anything specific. […] Unfortunately I think we just bumble through, to tell you the honest truth. We get interpreters when we can, as often as we can.” (CAT Service staff member)

And with regards to work practice and service delivery:

“Even in times when it’s been very, very difficult to get accurate interpretation, we’ve generally managed to kind of scrape through […] I can’t think of a situation where we’ve actually been unable to deliver a service at all, there’s none that spring to mind but I’m sure it’s been a close call sometimes.” (CAT Service member)

Health professionals and voluntary organisations workers equally have had difficult experiences with this service. This description of one voluntary organisation manager sums this up:

“The Crisis Assessment Team, the way they assess people, I think it’s just totally not right for our client group. It’s useless! […] I know all their questions. What really bothers me is that for the people who find it very difficult to talk about their problems and indeed don’t answer, it doesn’t work. Because what you have to do, when they ask you ‘Have you thought about killing yourself?’ is say ‘Yes’ and they say ‘Have you thought about exactly how you’re going to do it?’ and this is their way of assessing how serious somebody is. But, for a lot of cultures, actually speaking about the problem, they can’t do it. […] And so this sort of series of questions of assessing somebody’s risk is totally inappropriate. […] I mean I don’t know what else they can do in the system. […] But they say things like ‘Oh this person’s situation is caused by the fact that they got nowhere to live or they’re frightened to go back to their home country’. So you say to them ‘Well, if they’re threatening to kill themselves, does it matter what’s causing it?’ But they have to make this clear distinction with something that’s been caused by their situation and their environment rather than a clinical depression. And I say ‘If they hang themselves tomorrow, what’s the difference?’ […] And nine times out of ten- nothing really happens as a result.” (Voluntary Organisation manager)

As the above description of the assessment process suggests, the CAT Service’s aim to distinguish between psychiatric crises and social crises can be described as problematic and inappropriate to asylum seekers and refugees.

Michaela Fay
“If the person hasn’t got an acute mental health problem and isn’t in crisis as a result of this [...]. If those things don’t apply, then we need to think ‘Why is this person being referred to us? Is it a social crisis, is it do to with refugee status or asylum status? [...] We cannot as a service make a rule that we will be involved with people because they will kill themselves if they are forced to go home. [...] The only thing that we can really help people with is a mental health problem. Because that’s what we do as a service.” (CAT Service staff member)

The evidence strongly suggests that distinguishing psychiatric from social crises requires further investment. In particular, because it can be said that some of the issues and needs around language and cultural awareness especially will extend beyond the group of asylum seekers and refugees to members of other BME backgrounds. It is necessary that a service as crucial as this one is adequately prepared to take these into consideration in their service delivery.

Summary
Support for Crisis Services in terms of working with this client group and securing interpreters is required. Current assessments are not picking up the needs of asylum seekers and refugees. Further debate is needed about distinguishing between a psychiatric and social crisis as this determines care provided.

5. Mental Health Needs and Diagnoses

There is a considerable amount of research into the health needs, mental and otherwise, of asylum seekers and refugees. Watters, for example suggests that Western professionals in the fields of mental health and social care tend to see psychosocial problems as distinct from physical ones. This, however, might not be useful for adequate service provision to asylum seekers and refugees where the very situation of being part of the asylum process can easily lead to symptoms such as anxiety and depression. The Western medical model, however, makes it difficult to consider ‘normal reactions to abnormal situations’ as distinct from psychiatric disorders. Furthermore, taking into account the cultural backgrounds of asylum seekers and refugees users, many may not share Western categories or even be aware of their existence. They may, for example not be in the habit of separating ‘internal’ problems from ‘external’ ones. Instead, as Ingleby and Watters suggest, they may view psychological, material, social, political and somatic problems as inseparable. As a result, they may not regard individual treatment as an appropriate response to them (Ingleby and Watters 2005: 196/7).

What then, given this background, are the health needs (physical and/or mental) of asylum seekers and refugees? There are without a doubt particular health needs – physical and mental – specific to asylum seekers and refugees and these differ from other indigenous populations.
However, it is often difficult to distinguish mental health problems from physical health conditions. Often they overlap and what is potentially a mental health problem may present as a physical issue.

“I would say their initial registration tends not [to] pick up [mental health problems]. I mean we look for it when people first register … it’s one of the things that we look for but I’m not sure [first registration is] terribly good at picking up mental health problems. … I think screening for mental health problems is difficult, I think people […] except with the most serious mental health problems want to know you before they start to discuss mental health problems with you. I think there are a range of quite complicated cultural reasons and a lot of mental health problems in asylum seekers who come through our door initially as physical health problems because people don’t know how to talk about it or because of a whole range of medical reasons of how mental health manifests itself.” (GP)

In effect, there is evidence that asylum seeker and refugee populations tend to be registered with a limited number of GP practices. This seems to be due to a number of reasons:

- A small number of practices have special agreements with the PCT to treat these patient groups in particular (including the relevant implications on budgets and practice income).
- Local concentration of asylum seeker and refugee populations.
- Lastly, certain GP practices, especially where doctors have taken a special interest in dealing with these patient groups, have become known to voluntary organisation for example, as ‘good and trusted’ in dealing with the particular needs of asylum seekers and refugees and clients are sent specifically to these practices. Such trusted practices tend to be in the West End of Newcastle (see above).

There is evidence for a trend of these specialised practices to cover the overwhelming majority of necessary mental health care, ranging from medication to assistance with practical matters such as dealing with housing or benefit organisations.

“Sometimes you are doing very practical things for people. […] you know if the root of someone’s problem is anxiety about their asylum claim and you can help by providing evidence in connection with their claim, then often that’s actually the most useful thing you can do.[…] I quite often find myself just writing notes in English for people to take to some agency or company or government body that they’re trying to deal with […]”

There are of course questions arising as to the responsibilities and remit of professionals dealing with asylum seekers and refugees. It is often not clear cut what qualifies as and requires health care, and what lies in the remit of voluntary organisations or simply humanitarian responsibilities (see section 6.3).

There is evidence that in particular the overlap between mental health needs and physical health needs and/or indeed practical needs poses difficulties to diagnoses as well as referrals to appropriate services.

It has also been suggested that treatment might not always be easy to identify and can remain inadequate and inappropriate to the individual’s needs:
“There’s a lot of over-prescribing, a lot of diagnosis of psychological difficulties that are highly inappropriate.” (GP)

“There’s also an issue about the way we provide service. You know it’s medication, admission to hospital, a certain amount of counselling, therapeutic work. That’s not always appropriate. Some of the staff - I can’t prove this - some of the staff I think, believe that this person is presenting in this way so they don’t have to be sent home. Now, I’m not sure that [this] does go on but I think people who actually appear on wards, in mental health services are genuinely very unwell. Now again, whether that’s a diagnosed mental health condition or acute distress, [but] if clinicians have training and understanding they would come to that diagnosis.” (Secondary care psychologist)

There is thus a tendency within the medical sector to over-medicalise and pathologise. It is advisable that a debate about this tendency is had in order to improve the adequacy and efficiency of services.

“I mean there is a problem about pathologising, I agree. But I think part of the problem as well is that the asylum process is so awful. And so traumatising for people that it’s very hard to separate, you know, what is the earlier trauma that they’re responding to and what is going on now? And sometimes in order to actually get somewhere with the asylum case, you do have to focus on the mental health issues, because it’s the one thing that might be listened to. So the whole question of suicide risk and risk assessment becomes very, very relevant. And so, you know, while not wanting to pathologise, it becomes the focus of your work.”(Secondary care psychologist)

5.1 Torture and Trauma

Unlike other groups in society, it is safe to assume that asylum seekers and refugees have previously experienced some kind of torture or trauma. This distinguishes these groups, including their health needs, significantly from other groups.

“that’s something that’s got to be considered other than in the general population. Because you wouldn’t assume that somebody who’s lived in Newcastle all of their life, when they go to register with a doctor, you know [you wouldn’t ask them] ‘Have you been raped or tortured?’ it just wouldn’t be appropriate.” (GP)

However, it is important to consider torture and trauma within adequate boundaries. It should not be taken as invariably leading to specific mental health problems. It has been stressed that resilience among these groups is high and if torture and trauma are elevated to prime causes of mental health problems, this can lead to a skewed perception of the person’s overall needs as well as to inappropriate treatments.

In fact, it is often the asylum process itself that can be more traumatic than previous traumas and that can lead to deterioration in mental health.
Evidence also suggests that trauma is being used as an excuse to reduce one’s remit of responsibilities and to pass asylum seekers and refugees through the service maze. This, according to this secondary care psychologist can lead to inappropriate caseloads of primary care workers in particular:

“Often it [trauma] is being used as an excuse, I think, not to engage with this work. To say ‘Well, our criteria is for people who’ve got psychoses’. Because, ok sometimes you might have an asylum seeker who also had a history of schizophrenia, but that’s pretty rare. What you have is people who are traumatised. […] But if it’s to do with a war trauma or a political trauma, somehow it’s being seen as ‘Well, that’s not within our service’. So I think there is reluctance to get involved. And my experience is that a lot of the work is left within primary care. So you have counsellors in primary care and mental health workers who are left carrying very complex cases which they really shouldn’t carry.” (Secondary care psychologist)

5.2 Refugee status

In addition, it has been suggested that there should be a distinction between mental health needs of asylum seekers and refugees. Evidence suggests that once refugee status is gained, despite individuals gaining increased access to services, their status in society remains unsure. It seems to be at this point that people have an increased need for services.

“often what happens is that once things settle down you get into more of a normal life that that’s when the impact of the trauma starts to hit you.” (CDW)

“People who have been successful in getting refugee status but then have to deal with the separation from home. Those things impact as well and you get people who have an adjustment reaction.” (CAT staff member)

Once refugee status has been gained, these individuals are treated as anyone else. However, it seems necessary to remember that certain aspects of their situation and requirements (language etc.) do not change over night and specialist services should still be available and applicable to this group of people.

5.3 Homelessness and Destitution – Section 21, a catch 22?

Despite having been addressed (e.g. Prior 2006), homelessness and destitution remains a big problem.

“the other point we’re hitting is end-of-line cases. Cases who have run out, they are destitute, they’re on the streets and the only way for them to access-possibly access some help is if they have eh a mental health assessment which agrees that they have needs over and above destitution. And then Social Services will take some responsibility for them. And we have had an increasing number of those people.” (Solicitor)
“It's the single biggest issue that we are faced with every day.” (Voluntary Organisation)

“So actually it’s just letting people go down, down, down, down, down until they do become an emergency.” (Solicitor)

Summary
Diagnosis is based on British system. Need to consider the service and treatment needs of asylum seekers and refugees following a holistic approach.

6. Service Delivery

6.1 Problems and Challenges

6.1.1 Lack of Coordination

Inadequate commissioning choices have been mentioned as contributing to poor coordination and joint working between services, leading especially to a gap between voluntary organisations and the statutory sector.

“I think we have a problem in Newcastle where the people responsible for commissioning and the people responsible for providing health care are really very separated from each other and there’s a real ‘them’ and ‘us’, you know, they are not working well together is my view.” (GP)

It was repeatedly reported that the lack of joint working across, but also within, service leads to problems in adequate service provision.

“We have very strangely fragmented specialist mental health services in Newcastle. The last time I counted the number I could think of in my head it was something like 11 different services all of them operating independently. I think everyone recognised that that causes practical problems." (GP)

6.1.2 Under-resourced/Over-stretched

Because services have not only been described as fragmented but also as often under resourced, one consequence has been that individual services become ‘territorial’ and protective of their individual remit. This further perpetuates fragmentation.

“There are far too many [services] that work in isolation… services are under resourced anyway, so everyone is very protective of their own patch and .. because of lack of resources people are often seen by a service and [told] ‘Well, we can't help you, we'll pass you on to somebody else or we'll pass you back to your GP’. And of course the people for who that works the least well
are the people that are unfamiliar with the system and not very well equipped
to assert their rights. And asylum seekers as frightened, vulnerable, non-
English speaking newcomers to the country unfamiliar with the service and
often very damaged are about as poorly equipped to assert their needs, as
anyone is. So, I think they are particularly poorly served by inadequacies of
the integration of services." (GP)

6.1.3 Flexibility

Evidence suggests that rather than creating an increasing list of new services, what is
needed is a more flexible and open approach.

"[Providing an appropriate and responsive service is] about recognising that
not everybody fits into this box ... you know. And that's what we should be
doing in designing services. WE need to recognise that things are not clear,
you know." (PCT staff member)

Such an approach has been likened to a flow chart, where remits are permeable and
fluid:

“If the person fits in here, then they go here, if they don’t then they go here
and then what are the consequences of that? So you get an idea, so that
anybody can look at it and think, ‘Right, this person’s arrived, and this is
what's happened, this is what I have to do’. Rather than saying ‘All right, the
person's arrived, this is what’s happened, oh I think I'll send them over here
and another person saying ‘Here’ and then this isn’t the right place for them to
go.” (PCT Staff member)

“And it’s not about people getting it wrong at the front desk or trying to muddle
through. It’s about the mechanisms in place to support them. Can make it
easier, you know. And yeah, in some cases that will have a financial
implication but it’s about managers then making a case to say that without
this, this is the consequences. You know, that you're wasting staff time, it’s
gonna cost this amount of money if you do- if you don’t do it but if you do do it,
it’s gonna cost this and we’re actually gonna save money in the long run!”
(PCT management staff member)

6.1.4 Capacity to ‘skill up’ staff

Those working on the front line, especially in the voluntary and community sector are
often hit hardest by the interpersonal and institutional complexities of working with
Asylum seekers and refugees. Yet, providing support and training to them is difficult:

“you decide that you want people in adult services who actually work at the
front line, you gotta release them from their case load to attend the training
and you gotta evaluate the benefit from it. So where is that [the capacity] coming from when we've got all that other training we've got to deliver? We're
short on the front line anyway. So are we actually gonna withdraw staff to do
training for a relatively small population? So these are always compet- it basically boils down to competing priorities.” (PCT management staff member)

“So, for example, it’s not in my job description that I’m doing this work. At all. I have the understanding of my manager, you know, that it is important and that it’s important to me and I say that it’s a special interest and I feel that it’s important that we do it and they say ‘Right’- I think it’s very hard for people to say ‘No, you can’t do this work’ because then it would be seen as- [of course] you know. But nobody has actually said ‘Yes, you can take a day a week and it’s part of your job and you can do it.”(Secondary care psychologist/voluntary organisation)

6.1.5 Difficulty in changing and influencing service provision

“I know that my manager who’s the psychology manager tried to take the work that we’ve done and write a number of letters to different commissioners and sometimes we didn’t even get a response, let alone a negative response, not even an acknowledgement. So it was very frustrating. Within the trust it was also very difficult because, management kept changing and you talk to one manager and they say ‘Yes, we think it’s very good’ and then - their job would be gone. Someone else would come and- it was never seen as a priority, although there was a lot of people saying ‘Oh yes, yes, yes, it’s very important.” (Secondary care psychologist)

“So one of the things I have to say is - how amazed I was that over all these years this work has never been- there’s never been links made [with each other]. It’s been so difficult. People were going off, doing something, getting funding from somewhere, networking with other people has been impossible. And I don’t know if it’s the nature of the issue or if it’s the nature of the way things work in mental health or what it is but it’s very frustrating.” (Secondary care psychologist)

“You can keep asking people, but we all know, it’s translation, access to services, isues about gender, issues about lack of understanding of frontline staff. We know all that! So why keep asking people, cause communities are saying, ‘you surveyed us to death. We don’t want anymore, we want to see change’. So what [the Race and Mental Health Action Group] tried to do is look at things, how we can change things within the services, rather than asking for more money.” (NHS/PCT manager)

6.2 Specialised services versus mainstreamed services

Because of the increase in the asylum seeker and refugee population the pressure on front line staff has increased. There is increased pressure on organisations and on individuals now and it is important to be aware of who has been named and equipped
to offer a specialised service and who has become a specialised service ‘by default’, i.e. by becoming known as good.

“Again, should you set up services specifically for [asylum seekers and refugees] then it becomes ghettoised, it allows mainstream services to say ‘There you go’.”

There has been no consensus across interviews whether it is more adequate to provide specialised services to asylum seekers and refugees or incorporate these groups into mainstreamed services. There is evidence for both approaches and also for a combination of both.

“You need to do both. On the one hand you need to be aware of what makes [these clients] different, so you can [cater] to those different needs. On the other hand, you need at the same time to hold yourself up to the same standards that you hold yourself to all of your patients.” (GP)

“Because I think that what you need is a bit of both. I think it’s very useful to have a transitional GP practice, dedicated to asylum seekers. Because, in the earlier stages, you know, just arriving - you have multiple needs and unless it’s a very, very well aware GP practice their needs may not be addressed as well as they would be if you’ve got a practice which is dedicated to that and they can then help with the transition into the NHS. And just facilitate the pathways. And ideally you should be in that practice to start with and then be moved on to another practice once the initial needs are being addressed.” (Secondary sector psychologist)

It was mentioned that the provision of specialised primary care (GPs) has actually worsened in the recent past in Newcastle:

“I think there is a problem since the, you know the dedicated primary care.. GP practice that was set up in Newcastle was cut. […] there was a dedicated service, eh traditional service- North Tyneside still has it but Newcastle had one and they- In the West End, yes. It was Philip Matthews who was the GP… and they just terminated the contract […] he was very, very good because he has got a lot of experience and is very committed and has done very good work and so, at least if you have to contain somebody in primary care you had, you know, you had a practice that.. was able to offer something. And then the link between the primary care and the secondary care can be made stronger. But what happens now is I think people are within different practices and then if they’ve got mental health needs they usually get referred to a counsellor or the primary care mental health worker. And then I think one of the difficulties as well is that it’s very very hard to- to refer on.” (Secondary care psychologist)

“I don’t like unique services wholly for asylum seekers. I don’t like that. And the reason why I don’t like that because I’ve worked in mainstream and I’ve worked with specialist practices over the years. I think specialist practices
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work. They provide a very good service... for a few. But those who are not in that GP practice and are not able to attend there, to be registered there because they live outside its catchment area or whatever, ehm, they don't get the same service. That's not equal. But also the knowledge remains in that specialist service around the whole issue around claiming asylum and, health screenings, new arrivals need to have and booking an interpreter how to use an interpreter effectively. That knowledge becomes insular within that specialist service and what happens then is, when people who have been in that specialist service for a long time, when they move house because they've got their refugee status and then they go into mainstream services, it's like a kick in the teeth. Because they're in and out, you know, there isn't that happy smiley face, first name term with the receptionist, you've got the same interpreter all the time whether you need it or not. I personally, and this is just on my experience, feel that we should be moving away from, in North Tyneside we are, we should be moving away from the specialists and putting it out, which is where my training [as a CDW] is coming in, is that all GP practices, all community mental health specialists, everybody should have a basic awareness and if they have a new case then they know who to ring. And then everybody gets a skill that is shared and we get a new quality of service.”

(CDW)

6.2.1 Specialist work around Gender

Evidence indicates that further research into gender specific (mental) health needs would further aid developing adequate and useful services.

“I do think there’s an issue about women’s services, services for women. There are some groups in the voluntary sector but I think we should be doing more [to address specifically gendered needs]. I think there’s alcohol and there’s domestic violence within those communities. I think there is quite a high rate of suicide within those groups as well that goes unrecognised until things do happen. And I think women in some communities feel isolated and feel very depressed.” (PCT manager)

“And I think there’s a need for men’s groups as well, you know. It isn’t just about women. [...] I don’t know what the level of alcoholism is within certain groups but it is said there is quite a lot.” (PCT manager)

6.3 Voluntary organisations and statutory services

“Here [in the voluntary sector] if we want to do something we just get on and do it because we don’t have to go through channels and as long as my committee are happy with what we’re doing, we do it! And I need action like that, I can’t bear just hanging around while people jack [...]” (Voluntary Organisation manager)
There is currently a trend within the NHS to keep an increased amount of health care in primary care (Talbot-Smith 2006). This leads to increased importance of and burden on voluntary organisations as, in effect, one side effect of this NHS change is the ‘outsourcing’ of services to voluntary and community organisations (see section 7.1). At the same time, there seems to be no adequate financial recognition of the additional burdens shouldered by the voluntary organisations. Commissioning practices need to be adequately revised.

“If there are services being provided by the voluntary sector I think- really do think there has to be some recognition […]. The NHS, just as I see it, are increasingly relying on the voluntary sector to provide services, you know whether it’s in disability or anything. [And] it’s not enough I think to say ‘Oh you are doing a great job’. They have to support that. And our funding situation is so fragile now that I do think there is a need to look at and recognise in a financial way what we’re doing, you know? […] I think the NHS have got to say ‘OK’- you know they’re always talking about partnership, how much we’re valued and that’s fine but- eh, putting the money where their mouth is. And I do find it very difficult. It’s not enough to be highly regarded. Because if we go under … the NHS will really get clobbered […] so you know, a cheque would be good.” (Voluntary sector manager)

Evidence points towards a number of clashes between these two different institutional systems, resulting in tensions, which can be counter productive to effective and efficient service provision:

“I think sometimes the voluntary sector are very anti the statutory body. You know, they feel that the statutory body haven’t got time, don’t understand, don’t come up with service.” (PCT manager)

Some of the communication problems between the voluntary and the statutory sector can be said to be linked to the ‘constant revolution’ in the NHS – especially the problems arising from the constant and quick turnover of staff and management are huge.

“Some of the voluntary sectors [are] fed up with our organisations [statutory sector]. We [are] too big, we [are] constantly changing, all the managers are changing all the time. They’re struggling for money; they see the Trust put a lot of money in a lot of areas. And they would hear about people who haven’t had a good experience. So I think they were a bit anti us.” (PCT manager)

The Race and Mental Health Action group aimed precisely at bridging some of such gaps and smoothing communication between sectors, which is partly why it has been experienced as positive and useful in the improvement of services ‘from within’. Rather than creating yet more posts and new schemes, the Race and Mental Health Action group aimed at working with the resources and links already in existence, thus strengthening the relationship between the sectors.
6.4 The impact of individuals

Closely related to the relationship between the voluntary and statutory sectors, is the role individuals play in ensuring the quality of mental health services to asylum seekers and refugees. Evidence suggests that much of the work with and around Asylum seekers and refugees in the Trust, not to mention the Voluntary sector, is built on the personal interest and involvement of a small number of committed individuals. This raises a number of management and budgeting issues.

“I think it’s very much left to the individual person and it’s happening not just to that person, it’s happening to people. The time that’s being wasted across the organisation because there isn’t anything else there or they’re trying to sidestep a system that’s there but is not working.”

“I still think it is a worry that there is a trend to kind of identify ‘Oh So and So has got a special interest or they’ve got some experience’, so ‘Let’s refer all the cases to them’ and then not recognise that actually if they do do this work […] then management has to [take that into account].” (Secondary care psychologist)

It is necessary to acknowledge the additional work that is carried out by these individuals. Evidence suggests that such recognition – financial, emotional or managerial – is often lacking:

“There are a number of staff in the organisations who have an interest in this area of work. Sometimes one or two people have chosen to do [this work] because they happen to be interested. […]But their managers don’t wholly understand the issues. And [the managers are] quite happy for them to do it because otherwise these people would then be on the caseload of people who don’t understand the issues.” (Secondary sector psychologist)

“I find that when I’m talking to [my managers] and I’m talking about very, very senior people—about responsibilities into race relations, disability discrimination, age, gender and all of this, they just glaze over. Because to them it all seems complicated. […] ‘Oh that’s what [Name] does’. So they’re quite happy for [Name] do to it. But it shouldn’t rest with me, you see. It’s not about me.” (PCT manager)

Summary

There is an over-reliance on individuals and an increased burden on the voluntary organisations.

A debate needs to be had about the advantages and disadvantages of specialised and mainstreamed services respectively.
7. Examples of Good Practice

There are a number of services, institutions and also individuals who have been mentioned as examples of good practice and/or schemes leading to positive changes. The examples used in this section represent only a fraction of services and organisations available and have been chosen on the basis of the interview material. There are other successful and important organisations such as the North of England Refugee Service (NERS) and the Comfrey Project for example, although they cannot all be detailed here.

7.1 The West End Refugee Service (WERS)

The West End Refugee Service has been mentioned repeatedly as a competent and effective service. It was established in 1999 and in fact, it has built up such a good reputation that it is now not only having to safeguard its own geographical boundaries (and remain exclusive to asylum seekers and refugees in the West End which is where it is funded to operate) but also from the NHS who are increasingly relying on WERS as a backup, even replacement service:

“It’s difficult here. Because we’ve been successful here and we’re highly regarded and in a way that makes you your own worst enemy because […] And it’s impossible and you’re trying to do everything properly and by the book and everyone’s going ‘Oh this is great’ and then- you get all the stuff. So getting the balance is very hard and it’s not right at the moment because- we- we sometimes get referrals from GPs for counselling! And we’re like, well really- that’s not really how it’s supposed to work!” (WERS manager)

WERS offers a wide range of well integrated services:

- They see approximately 120 people through the door every week. A large number of these are homeless.
- They have been able to offer small allowances to homeless and destitute people.
- There is a daily drop in advice service as well as a clothing store.
- Furthermore, they offer a befriending scheme and home visits, both of which have been evaluated as highly useful and successful. These schemes in particular have been set up as preventative measures in order to keep levels of isolation and loneliness and the resulting detrimental effects on mental health as low as possible.
- They provide education programmes and awareness raising:
  “Still a large part of what we do is trying to combat negative stereotyping.” (manager)
- They provide signposting of services:
  “In all services we provide the big thing is just telling people where they can go … that’s why the networking is so crucial.” (manager)
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- Recently, they have set up their own counselling service. This enables them to an extent to bypass the NHS system’s pathways and waiting lists.
- They consider themselves lucky to have one volunteer worker who speaks eight different languages, which improves the level of service they can offer.
- Turnover of staff is extremely low, which is seen to add to the high level of service they can provide.

7.2 The Race and Mental Health Action Group

The Race and Mental Health Action Group, when it still existed, was experienced as a successful scheme that began to address some of the issues around raising cultural awareness, integrating services, and crucially, strengthening the links between the statutory and voluntary sectors.

In fact, the Action Group formed precisely in response to poorly integrated services and a lack of networking especially between the voluntary and the statutory sector:

“For a number of years before [the group came into existence], there’d been all these little groups, doing really good work, very focused, very motivated in improving services for different groups. And they did well and they all had action plans but they came to a full stop because there was never any money. And the commissioners weren’t really prepared, with all the other priorities that they had, to put money into it. So all these groups got very frustrated, […] and then set up another group.” (NHS/PCT manager)

As its title indicates, the Action group aimed to:

“Change what we got rather than constantly trying to get new money in because it’s not there. I mean it should be there but it isn’t. So you gotta be realistic about what you can and cannot do.” (NHS/PCT manager)

The action group focused on collating the action plans of the varying existing groups across sectors and aimed to produce one plan that was perceived as realistic and doable within the existing system. It was experienced as successful due to this action-oriented approach but also evidence suggests that it can be seen as an example of successful leadership.

“We need preventative services and we need posts that actually concentrate on working with different groups. But that’s not gonna come. So we gotta work with what we’ve got. And I think the key really is having something like the Race and Mental Health group, which for some reason gathered momentum and people wanted to join in, people were interested. So I think it’s about leadership as well.” (NHS/PCT manager)

The seizing of the Action Group was described throughout the interviews as a great loss and is seen as a step backwards.
7.3 The Medical Foundation

Evidence suggests that strong links have been forming between primary as well as secondary care and the Medical Foundation.

“the good thing really is that the Medical Foundation is here, so you got that bit of specialist service both in terms of referring cases but also in terms of supporting professionals.” (Secondary care psychologist)

The Medical Foundation’s work focuses on the effects of torture. It offers training and supervision to statutory sector staff and also works directly with asylum seekers and refugees by providing specialised counselling. By providing such a specialised service, the Medical Foundation can be said to take some of the stress out of the NHS secondary care system.

Summary
It is useful to learn from these services and develop in other areas. It is important to recognise the value of these services without overusing them.

8. Conclusion

The consensus among the professionals interviewed for this report can be summarised as: “A lot has changed, but...”. There have been a number of positive changes in the provision of mental health services to asylum seekers and refugees in the recent past. Certainly, the establishment of Community Development Workers (CDWs) appears to be a step in the right direction. Equally, the Medical Foundation has been identified as a beneficial institution. There are a number of highly regarded GP practices providing specialised care to these groups. Newcastle itself as a host region has been found to slowly be changing into a more multicultural city.

However, these changes could not outweigh the sense of a make-shift nature of services that transpires from the research. There persists a lack of cultural awareness both in the indigenous population of Newcastle as well as through most services. There persists also what has been described as a ‘culture of disbelief’ towards asylum seekers and refugees, which is perpetuated by negative representations of Asylum seekers and refugees in the media. Alongside the notorious lack of resources to focus on developing and providing adequate mental health services, the lack of coordinated and joined up working between services and the fast turnover of NHS staff has been lamented as major barriers in the improvement of services to asylum seekers and refugees.

It remains important, of course, to research how the service users in question view these issues.

There are a number of reasons for adequate provision of mental health services to asylum seekers and refugees. The provision of effective health and social care to asylum seekers and refugees is partly motivated by human rights principles, as they are laid down in the 1951 Geneva Convention on Refugees. Further to this, however, it might be in the government’s interest to adequately care for this group in order to avoid serious problems and thus increased costs later on. Despite the high rate of
unsuccessful asylum claims, every asylum seeker deserves to be viewed as a potential refugee and thus as a potential new member of this society. A refugee hindered by serious psychosocial problems and unable to find work and integrate into the host society is however likely to become dependent on the state for a range of support. Future-oriented, effective and appropriate services should take into account that what happens today will always have an effect tomorrow.

Some References


Fox, A. (2001). *An Interpreters Perspective*, the Medical Foundation for the Care of Victims of Torture.


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