“Understanding how asylum seekers and refugees access and experience mental health support in Leeds”

A report on PAFRAS/Touchstone Action Research project 2011-2012

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NHS Airedale, Bradford and Leeds
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Section 1

1.1 Introduction

In July 2011, NHS Leeds commissioned Positive Action for Refugees and Asylum Seekers (PAFRAS) and Touchstone to undertake some participative research into

- the way in which Refugees and Asylum Seekers (RAS) navigate their way into and through Mental Health Services of Leeds,
- how existing support systems can be made leaner and more responsive,
- how the system might better respond to the needs of people in mental distress, but who do not meet the criteria for mental health interventions.

The research element of the work was hosted and performance managed by Touchstone within the BME Community Development team. This research is a collaborative piece of work drawing on the strengths of both Touchstone and PAFRAS.

1.2 Background

Leeds is the third largest dispersal centre for the UK with more than 1390 RAS.\textsuperscript{1} Research indicates that this group is five times more likely to have mental health needs than the general population and more than 61% will experience serious mental distress.\textsuperscript{2} People in this group are less likely to receive mental health support than the general population\textsuperscript{3}, and 37% of those RAS asked said they had been to Accident and Emergency departments in the preceding 6 months.\textsuperscript{4}

Although not all African people in Leeds have come to live here as a result of seeking asylum, the data on African people living in Leeds is indicative of the difficulties RAS face in using mental health services.\textsuperscript{5} In 2010 people of African origin made up more than 1.6 % of total inpatient admissions to Leeds and York Partnership Foundation Trust (LYPFT),\textsuperscript{6} even though they make up 0.34% of the total population of Leeds.\textsuperscript{7} Similarly, the proportion of African people on Care Programme Approach (CPA) is double what could be extrapolated from the Census figures, with those not on CPA but under the care of LYPFT almost three times the expected levels.\textsuperscript{8} After White British people, Africans present the second highest number of people presenting mood (affective) disorders to secondary services in the city.\textsuperscript{9}

Recent cuts to support and advice services for RAS (including destitute asylum seekers)\textsuperscript{10} have already put significant stress on those remaining services (e.g. Immigration Advisory Service has closed; PAFRAS experienced a 10% increase in demand for their bi-weekly drop-ins against a backdrop of 75% reduction in their funding,\textsuperscript{11} with 73% of those visiting identifying as destitute RAS.) Leeds retains a large number of asylum seekers who have chosen to fall “outside the system” because they fear an enforced return.

\begin{itemize}
  \item \textsuperscript{1} Equality Team Leeds City Council (2011). Equality and Diversity Annual Report 2010 to 2011, Leeds City Council
  \item \textsuperscript{3} Aspinall, P. & Watters, C. (2010). Refugees and asylum seekers: A review from an equality and human rights perspective, Equality and Human Rights Commission Research report 52, University of Kent
  \item \textsuperscript{5} Statistics on specifically RAS usage of services are not widely available.
  \item \textsuperscript{6} Ethnicity Distinct Service Use by CPA, LPFT internal monitoring, 2010
  \item \textsuperscript{7} Leeds Census (2001) LCC – nb ONS Experimental population estimates from Mid 2009 suggest a figure closer to 1.32%
  \item \textsuperscript{8} Ethnicity Distinct Service Use by CPA, LPFT internal monitoring, 2010
  \item \textsuperscript{9} Ethnicity Inpatient Diagnosis, Finished Consultant Episodes, LPFT internal monitoring, 2010
  \item \textsuperscript{10} E.g. the closure of Immigration Advisory Service http://www.guardian.co.uk/law/2011/jul/11/immigration-advisory-service-closes-blames-government
  \item \textsuperscript{11} PAFRAS: 6743 visits during the period 4/9 – 3/10 ; 7409 visits during the period 4/10 – 3/11
\end{itemize}
Many RAS are survivors of physical assault, sexual harassment, rape or torture and other traumatic experiences. The social isolation, uncertain housing and racism which many RAS describe as features of life in the UK can compound these difficulties make it even harder for people to seek or to receive the assistance they need.

To be effective at supporting people in these circumstances, existing systems need to better understand the nature of their interventions: what works, what doesn’t; and to deliver these interventions in ways which are more effective, represent better value for money, and with clear unambiguous outcomes.

By combining the strengths of PAFRAS and Touchstone, in collaboration with statutory and voluntary partners, the research team aimed to produce evidence and actions that will shape a leaner, more effective and better value response to the mental health needs of RAS in Leeds.

1.3 Research objectives and project purpose

The aims of the research were to deliver

- a more robust evidence base for RAS mental health interventions in Leeds;
- a clear indication of the cost of particular successful (and unsuccessful) interventions;
- a greater understanding of the way in which the RAS mental health system works, by all participants;
- experience of joint working and co-produced solutions to complex problems;
- a reduction in inappropriate referrals and attempted interventions;
- less misunderstanding and greater engagement from RAS communities in treatment;
- clearer and more effective care pathways leading to
  - a more responsive system and
  - substantial cost savings

There was already widespread acknowledgement and awareness of the main issues in Leeds: 13 14

- limited involvement of RAS in helping to design and direct mental health services targeting RAS communities
- the inaccessibility of mental health services to RAS
- lack of understanding by RAS of what mental health services can offer
- language and cultural barriers
- the stress generated in the system by inappropriate referrals to mental health services of people in mental distress, but who do not meet the eligibility criteria for treatment by mental health services, and the costs that these incur,
- The substantial costs generated outside mental health services (A&E departments, Ambulance Service, GPs, Police, Voluntary Sector) by inappropriate referrals (including self-referral) of RAS in mental distress,
- The damage and distress which occurs when people become caught up in a mental health system which is ill equipped to meet their needs, and the vicious cycle of fear and stigma this produces.

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12 www.solace-uk.org.uk
13 Single Equality Scheme, NHS Leeds, 2009;
What has been lacking so far is a systematic method by which this awareness can be used to transform services, by those with experience of these difficulties.

Our hypothesis was that by employing an Action Research approach to understanding the experiences of RAS with poor mental health, those with experience of being excluded from services, and those providing services, we can better understand what works, why it is successful, as well as providing a driver for change inside and outside of services.\textsuperscript{16 17 18}

\subsection{1.4 Methods and Approach}

\textbf{Oversight}

A small multi-agency steering group was convened to oversee the research, with membership drawn from NHS Leeds Mental Health Commissioning, Touchstone IAPT, and Voluntary Action Leeds BME Network.

\textbf{The Research team}

Although co-ordinated by a single person, the research itself was conducted by a mixture of staff from mental service providers, volunteers, service users, and those excluded from mental health services.

\textbf{Methodology}

A mixed methodology was used, drawing upon ideas taken from the values of action research, action learning, and participatory appraisal. The research team were very keen

\begin{itemize}
  \item to find a way in which all participants could better understand the systems and processes of which they are a part (research), and
  \item to use this understanding to make dynamic changes to this same system (action) rather than feeling like passive recipients of someone else's analysis.
\end{itemize}

A longer description of the rationale behind this approach can be found at Appendix 1.

\textbf{The Action Learning Sets for RAS and MH workers}

After gathering the details of services involved in RAS support and mental health across the city\textsuperscript{19}, a targeted invitation to participate in action learning set was sent to staff from these organisations, as well as to a wider health and social care organisations. The aim of this set would be to reflect on current features of the MH/RAS system and how this could be improved upon.

Six action learning sets took place between November 2011 and June 2012, with membership drawn from

\begin{itemize}
  \item Addiction Dependency Solutions (ADS)
  \item Burmantoft Health Centre
  \item Leeds IAPT Consortium (IAPT)
  \item Leeds Survivor Led Crisis Service (LSLCS)
  \item North East Leeds Community Mental Health Team
  \item Positive Action for Refugees (PAFRAS)
  \item Solace
  \item Street Outreach Team
  \item York Street Health Practice (YSHP)
\end{itemize}

\begin{footnotes}
16 \url{http://www.uclan.ac.uk/schools/school_of_health/assessment_approaches_health_improvement/}
17 Delivering Race Equality, DH 2006
18 6.22 p59 No Health Without Mental Health, DH, 2011
19 \url{http://wisdomap.com/w/FMjRZk/} Mike Chitty, 2012
\end{footnotes}
Although managers and staff of secondary mental health services expressed interest and support and were actively encouraged to attend throughout the life of the Action learning Sets, no-one was able to participate.

**The Interpreter Group**

The research team recruited and trained volunteer interpreters to support in running focus groups and individual interviews. A three day interpreter training programme was devised and delivered by PAFRAS and Touchstone BME CDWs – combining interpreting skills with mental health awareness, to assist in the development of a volunteer interpreter team to support the recruitment delivery of focus groups with individuals from RAS backgrounds.

**Focus Groups**

A series of nine focus groups took place during November 2011 – January 2012, to provide a rapid assessment of themes and perspectives which could be discussed and analysed by members of the action learning sets. The intention was to draw upon the knowledge and understanding of

- RAS who met the criteria for mental health services and with experience of using them and
- RAS who did not meet the criteria for mental health services, but who have experience of mental distress, and experience of attempting to access mental health support in Leeds.

**Deciding on themes/ who to interview in depth**

Data collected from the nine focus groups (thirty-six participants) was independently analysed by three researchers. Their individual analysis were synthesised in a set of 7 key experiences which we decided to investigate further. These were

1. Survivors of torture and other trauma
2. People with mental health problems with families
3. People experiencing severe psychological stress and behavioural problems (i.e. not mental illness)
4. People with both mental health difficulties and difficulties managing their use of either drugs or Alcohol (i.e. dual diagnosis)
5. People experiencing serious mental health symptoms (e.g. psychosis) who might be expected to use secondary mental health services
6. People expressing suicidal ideation
7. People whose mental health problems combined with physical health problems

**One to One interviews**

Fifteen one to one interviews took place, resulting in fifteen case studies. Five of these (the studies appearing in the table as black) can be read in full in the appendix.

Although we set out to interview two people whose experience was dominated by one particular key experience (i.e. two people who were dually diagnosed) we found that experiences frequently overlapped and that many people identified with several of the key areas.

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<td>5. Psychiatric symptoms</td>
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<td>6. Suicidal Ideation</td>
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<td>7. Physical &amp; Mental Health</td>
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Additional Action Learning Sets
We had planned two additional action learning sets made up of RAS with experience of mental distress who were engaged with mental health services, who were not engaged with mental health service as a means of assisting them to gain greater knowledge and understanding of the system they described.

However, during the focus group and 1:1 interviews, it rapidly became apparent that there was insufficient enthusiasm for such a project by people experiencing mental distress.

*Fig 1 – The original action learning proposal*
## Section 2  Findings

### 2.1 The Action Learning Sets

The purpose of the action learning sets was for participants to identify areas of concern within the mental health and RAS support system and to take action to address these concerns. Many of these issues have already been addressed, or well on the way to completion. The themes, issues and actions were chosen by participants themselves, based on their own experiences, and the feedback and testimony from the Focus Groups and one to one interviews.

<table>
<thead>
<tr>
<th>Issues identified by participants</th>
<th>Actions taken</th>
<th>Outcomes</th>
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<tr>
<td><strong>Problematic referral routes between Voluntary &amp; Statutory Sectors</strong></td>
<td>• Joint meetings with Solace, YSHP and PAFRAS to troubleshoot referrals</td>
<td>• Referral protocols agreed - increased joined up working</td>
</tr>
<tr>
<td>• Struggling reciprocal referrals and avoidance to offer multi-agency interventions (PAFRAS/IAPT/SOLACE/YSHP).</td>
<td>• Joint meeting with PAFRAS and YHSP</td>
<td>• IAPT partners have established RAS champions within their teams</td>
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<td>• Referral routes into IAPT needs to be better understood by PAFRAS/Solace</td>
<td>• ‘Induction’ visits for YSHP staff to Solace, and reciprocal visit to YSHP for Solace.</td>
<td>• Reduced waiting time to access (e.g. Solace waiting times halved from 6-7 months to 1-2 months)</td>
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<tr>
<th>Language Barriers</th>
<th>• Created a list of interpreting services</th>
<th>• Better staff awareness of issues relating to language support</th>
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<tr>
<td>• Language barriers created by not having multilingual staff</td>
<td>• Produced list of most frequently used languages spoken by RAS in Leeds</td>
<td>• Services better able to maximise impact of interpreted materials</td>
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<tr>
<td>• Difficulties in identifying/using interpreters effectively</td>
<td>• List of interpreting services/costs produced</td>
<td>• Greater consistency of expectations around use of interpreters</td>
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<tr>
<td>• Difficulties in knowing which written material to translate</td>
<td>• Devised joint protocols on use of interpreters across the action learning set</td>
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<tr>
<th>The meaning of Advocacy</th>
<th>• Agreed working definitions</th>
<th>• Improved effectiveness and joint working</th>
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<tr>
<td>• A lack of shared understanding of the term is leading to problems across the system</td>
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<tr>
<th>Awareness of Advocacy Support Services</th>
<th>• Advocacy mapping has started</th>
<th>• Reduced duplication of work and some staff already have a greater understanding of how advocacy supports therapeutic outcomes</th>
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<tr>
<td>• Advocacy services for RAS need to be identified that can support clients during therapy</td>
<td>• Advocacy joint meetings between Solace and PAFRAS to avoid duplication</td>
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<tr>
<td>Health Services need to access advocacy as part of effective healthcare for RAS</td>
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2.2 The different meanings of “Advocacy”

Through the process of action learning and action research the word “advocacy” was used by participants in a variety of ways. Although the general purpose of advocacy is commonly understood to be

“Taking action to help people to:
• Express their views, wishes and concerns
• Access information and services
• Have their interests represented
• Secure their rights
• Explore options and choices”\textsuperscript{20}

We found a marked difference in the way the word “advocacy” is used and understood within statutory mental health provision and organisations working with refugees and asylum seekers.

Within Refugee and Asylum Seeker services, advocacy usually means “Independent advocacy” and

\textsuperscript{20} http://www.leedssafeguardingadults.org.uk/documents/policies_procedures/imca_safeguarding_and_advocacy_policy.pdf
is most often concerned with the securing of immigration status, and meeting basic health and welfare needs. It is usually provided by the same person (or at least the same agency) and can take the form of medium/long-term\textsuperscript{21} casework. It is usually reactive in nature, and responds to the changing circumstances of the person seeking advocacy.

Within statutory mental health, advocacy most often relates to “Statutory Advocacy”- Independent Mental Health Advocates and Independent Mental Capacity Advocate, which have particular legal/technical definitions, clearly defined role, and operate in a reasonably predictable framework. These are most usually short-term relationships, in response to the use of mental health law by professionals.

\textit{The findings and recommendations of this report recommend the wider use of advocacy in the non-statutory, independent advocacy sense.}

\section*{2.3 Refugees and Asylum Seeker Perspectives}

These findings are drawn from the focus groups and one to one interviews. We have attempted to group them thematically

\subsection*{2.3.1 Inadequate/Insufficient Professional Assistance}

\begin{itemize}
  \item \textit{Many RAS feel that workers who focus on a single aspect of their case (e.g. housing, or mental health) to the detriment of their wider wellbeing.} This left many RAS feeling that they were not listened to, or that workers do not fully appreciate the interconnectedness of the difficulties they face. People also reported feeling that the physical symptoms they presented were connected to their poor mental health, but that medical staff failed to recognise this connection.
  
  \item \textit{Inconsistent care and lack of understanding by GP's has led to physical health issues not being adequately investigated} - resulting in one third of the 1:1 interviewees reporting unnecessary emergency NHS admissions.
\end{itemize}

\subsection*{2.3.2 Problems with appropriate Referrals and long waiting time}

\begin{itemize}
  \item \textit{RAS often lack a clear route into and out of mental health support. Even staff with experience of supporting RAS found it hard to find and secure appropriate mental health support for their clients.} Many people reported confusing referral processes where they did not understand what was happening, or where or why they had been referred. As a consequence many people reported repeating their stories over again, moving from one service to another, and a lack of clarity in referral process led to them to doubt the knowledge, understanding or commitment of the workers concerned.
  
  \item \textit{Some service users found it very difficult to book initial appointments with their GP.} Although this is a common experience with General Practice, this particularly impacts on RAS seeking support with their mental health, as they often do not know their rights or how to complain effectively.
  
  \item \textit{Lengthy waiting times for mental health services to process referrals, and reliance upon postal communication leads to many people losing contact with services.} The average waiting time for mental health support was reported as 4-6 months. During this period, people reported changing address several times. A reliance on postal communication often leads to letters going missing and appointments being missed. There was a marked preference for communication by (usually mobile) telephone and text message.
\end{itemize}

\textsuperscript{21} \url{http://www.advonet.org.uk/index.php?option=com_content&task=view&id=59&Itemid=135}
• **Sign-posting is unpopular** and perceived as an ineffective method of self-management, especially when people did not understand the service being offered. Even where signposting information was provided to RAS, by the time people came to use it, this information had been lost or forgotten. The solution was felt to be greater joined up working between agencies – with eligibility and suitability being confirmed before the referral is actually made. Many RAS thought referrals should also be followed up by text or phone – to ensure that people understand and remember when, where, and why they should be in particular places.

2.3.3 **Inadequate or confusing information for RAS clients**

• **There remains deep frustration at the lack of consistent up to date information regarding existing services in Leeds. Most RAS expressed the need for a central point of information and help,** physically locating all the services together and making all the possible information available for RAS in various languages. Confusion over the physical location of services often makes them very difficult to access, especially for people who are already distressed. A service user said, ‘why don’t they have services in the same place? I get lost.’

2.3.4 **Clients’ Values and Beliefs**

• **Many RAS with symptoms of mild to moderate mental health problems do not recognise these as indicating difficulties with their mental health.** This can lead to people not seeking assistance with difficulties until problems have become more severe.

• **Many clients are unclear about what information [about their mental health] is shared with authorities outside the mental health system.** Differences in socio-cultural background result in concerns around confidentiality and stigma associated with mental health and a fear that accessing services might negatively affect their application for asylum.

• **Mental ill health remains deeply stigmatised in many RAS communities** and many people fear being labelled as having mental health problems. Cultural inhibitions, suspicion of being misdiagnosed or fear of being “sectioned” inappropriately, and concerns around confidentiality being breached are potential barriers to seeking mental health support. Myths and stereotypes abound, unchecked and unchallenged, and there is little knowledge or awareness of programmes like Time to Change outside mental health services.

2.3.5 **Clients’ Needs and expectations**

• **There can be a mismatch between the expectations of RAS and the ability of workers to meet these expectations.** Where this potential mismatch is not recognised or challenged, or where staff do not actively manage expectations, clients can be left with a sense of being let down or even feeling betrayed or abandoned by the service, and even the wider System.

2.3.6 **Engagement**

• **Many potential service users expressed a lack of trust in [mental health] specialists and services.** Poor first impressions/contacts with services make a lasting impression, as do negative word of mouth reports. RAS specific organisations have better understanding and therefore help more; it feels as though other services do not see RAS clients as a priority.

• **For most service users, physical and mental health needs were less important than housing and food needs.** For clients to prioritise mental health interventions over other pressing concerns, they need to know how mental health interventions will influence or make a difference to their needs/struggles, and what a positive outcome will look like. There appears to be little psycho educational work at present – although where it does exist (e.g. group work at Solace), there has been a reduction in DNAs, and outcomes have improved.
• **The cost or inconvenience of travelling long distances for mental health appointments reduces client engagement.** Those organisations who assist clients with travel tickets or lifts often find client engagement improves. Some RAS described high levels of anxiety prior to appointments in places they had not visited before, and said that having to travel to another part of town on a strange bus route reduced the likelihood of them attending successfully. The cost of public transport is also a significant barrier to engagement.

2.3.7 Socio-cultural isolation

• **Many RAS clients learn English as a way of better equipping themselves to ask for help and make complaints.** Poor quality interpreters can be big hindrance, and many people prefer to work without them, once their English is strong enough.

• **Volunteering is often a way for RAS to reduce their social isolation as well as an opportunity to share their knowledge and understanding with others.**

• **Most volunteering opportunities within RAS organisations focus on RAS offering practical support to other RAS.** There appear to be few opportunities for RAS to influence the way in which services are planned or governed, outside periodic “consultation exercises.”

• **Providing training to community members, organising workshops, seminars etc. can help spread awareness about mental health issues** and also sensitise other community members, volunteers, professionals about the socio-cultural, psychological issues etc. faced by RAS and adapt accordingly.22

2.3.8 Perceived effect of immigration status on the quality of care provided

• **Refugees report the attitude of service providers improving when their immigration status changes.** The confusion around eligibility for services left some people feeling “we are not allowed to have any support” and “we are less important than other clients” and that they do not have equal rights as other clients.

• **Some people felt patronised by staff** and treated as though they were stupid, even though systems and procedures were confusing and opaque.

2.4 Mental Health and RAS Workers’ perspectives

These findings are drawn from the action learning sets and interviews with staff and managers from secondary mental health services

2.4.1 **Services often struggle to communicate effectively with clients.** Professional interpreting services are not available at every service, especially those in the voluntary sector due to limited funding. There is heavy reliance on bilingual staff or volunteer interpreters who are often inexperienced in mental health, and some clients find it hard to trust volunteers who are not adept at managing confidentiality effectively.

2.4.2 **The complexity of problems presented by RAS means that all organizations struggle to resolve these in isolation.** However, pressing immigration or housing concerns may present a barrier to effective treatment of mental health needs.

2.4.3 **Agencies that don’t collaborate with others often feel isolated, duplicate work and confuse clients.** Ironically, this was particularly true of organisations who said they provide

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22 The recent Migrant Community Network programme includes a Mental Health Awareness component, and Talking Our Language mental health awareness programme delivered by Touchstone CDWs provides a template for culturally sensitive work in this area.
a wraparound or holistic service (e.g. Solace, PAFRAS), when they found their services unable to meet the needs of individuals with particularly acute mental health needs.

2.4.4 **Workers in both sectors highlighted the importance of understanding what other services did.** Throughout our conversations there was confusion regarding what help and services each organisation provided, and misconceptions were only overcome through deliberate and sustained joint working.

2.4.5 **Ambiguous policies and roles result in “no one being clear who is doing what and where responsibility lies.”** Some of this was felt to be a reflection of different organizational culture/size development. However, the most successful partnerships all identified clearly communicated roles and responsibilities.

2.4.6 **Care is poorly coordinated across different service sectors, and would benefit from a common approach.** Staff from secondary mental health services expressed frustration at the difficulties they faced while referring to some voluntary sector projects due to a lack of clarity on when and how they would work with referrals from secondary mental health. Conversely, staff in the voluntary sector expressed frustration at the rigidity of statutory sector referral procedures.

2.4.7 **The ever-changing policy landscape on immigration, NHS organisations, and drastic cuts to all sectors make adapting to new changes and collaboration even more difficult.**

2.4.8 **The best outcomes are delivered by well-trained, self-confident teams.** Mental health workers sometimes admitted to a lack of confidence in their ability to work effectively with survivors of torture and other traumatic events. Similarly, the people we spoke to said that specialist mental health training for interpreters was needed to build their confidence at working with people in distress, to ensure they understood the context in which they were interpreting, as well as the negative impact of inaccurate or summary translations.

2.4.9 **Mental health services working with RAS need to integrate advocacy services into care pathways,** to ensure the barriers to engagement in treatment are removed.

2.4.10 **The development of dual diagnosis services may present an interesting model of shared care pathways for the sector** – where services work in parallel with each other, complementing one another, rather than competing or being delivered one after the other. Mental health staff realised the importance of developing collaborative models based on up-to-date mapping of provision and shared working arrangements.

2.4.11 **Creating a strategic network for RAS mental health services will provide a mechanism for achieving greater collaboration.** This network will mostly involve senior staff holding managerial roles and provide a continuation of the work started by the action learning set. There was concern from all participants that such a network would need a nominated facilitator to coordinate these multi-agency reflections.

2.4.12 **A forum for reflective practice alongside other agencies will improve the quality of client outcomes.** Such a forum would provide an opportunity for personal and professional development of staff as well as more cost effective interventions. Although there is currently no agreed mechanism (outside CPA) to discuss complex RAS clients used across the system, PAFRAS, Solace and York Street Health Practice are currently piloting a complex case review process, which has shown early signs of success.
Section 3 – Pathways around the system

3.1 The impact of immigration status on RAS mental health service users, and the care pathways they use

It is widely acknowledged that the UK asylum system is complex, and has undergone frequent changes and amendments by successive governments.

The services for which RAS may be eligible often depends upon their immigration status. Put simply, a person seeking asylum who also has mental health services may find themselves eligible for a mental health service one day, ineligible the next, and then eligible once again - depending on the status of an appeal\(^\text{23}^{24}\). This leaves many service users and providers confused as to what can be provided and what they can expect.

In addition, immigration status impacts upon where an asylum seeker’s housing is provided. A person may find that they move many times, or be told they must live in a completely different town/city depending on the which properties are available to the Home Office housing provider. Alternatively, they may be told that their asylum claim has been unsuccessful and made destitute.

As a consequence, many asylum seekers gravitate towards voluntary sector provision - which is independent of statutory services – who do not usually withdraw support based on immigration status.

In such circumstances, creating a robust care pathway is very challenging, given that people find themselves in or outside the system with very little notice.

3.2 The care pathways of Refugee Asylum Seekers

The picture derived from the interviews and action learning sets is too confusing to adequately present in a single diagram.

The general picture is one of voluntary sector engagement (via PAFRAS or Solace) who then provide either mental health triage, crisis management, independent advocacy support, and either group work (stress management), individual therapy (Solace) or referral onwards into both primary and secondary health care systems.

Although this sounds simple, what we have found it that apparently simple referral pathways can be confused by changes to a client’s immigration status, a client being removed to a different part of the country, or confusion on the part of the referrer as to what the destination service actually provides.

It is not unusual for clients to have had dealings with both statutory and secondary care at some point. As with many black and minority ethnic groups, RAS feel more able to connect with services when they are provided with

- Advocacy, and practical support
- Care co-ordination
- Engagement and relationship building

\(^\text{23}\) [http://www.ind.homeoffice.gov.uk/asylum/]
\(^\text{24}\) [http://www.asylumaid.org.uk/pages/the_asylum_process_made_simple.html]
- A flexible, person centred approach
- Cultural competence and capability
- Additional support in the form of either complementary therapies or volunteering opportunities

Instead of a single diagram, we have presented six journeys through services at Appendix 3.

3.2.1 Torture/Trauma
The majority of the services users we spoke with (and two thirds of the case studies) reported experience of trauma and/or torture. For most, what interventions they had came from Solace – who also proved instrumental in referring people into secondary services.

For most of these clients, the complimentary therapies provided by Solace and In Touch were also felt to be effective in the management of on-going pain and physical symptoms, with staff describing how effective these therapies were at building engagement with clients, and preventing drop-out.

None of the statutory services (adult psychological services) offer similar complementary therapies, although they have approached Solace to supplement their care with these interventions.

3.2.2 Families
Although we were keen to get a picture of what life was like for people with RAS families, they spoke very little of specialist family support available to them.

None of those interviewed mentioned the support of social services or Children’s teams. For the most part, support was offered in the same way as it is offered to single people or couples. Given the circumstances of the people we spoke with (having no recourse to public funds) it is not surprising that they were not receiving much support from Children’s Services.

More surprising was the relatively low profile and uptake of Solace Family Services. It appears that most referrals to this service come from NHS partners (Child and Adolescent Mental Health Services) although there is too little evidence to draw conclusions as to why so few people know about this offer, or how effective this service is.

3.2.3 Psychological Stress
Seeking refuge in the UK necessarily entails significant amounts of psychological stress. Working one to one with people who are isolated and experiencing existential peril for prolonged periods of time can also put significant strain on workers.

Both PAFRAS and Solace provide mental health triage to ensure people in significant distress are escalated within the mental health system appropriately.

In addition, they provide group activities for people to share coping strategies and provide mutual support, whilst they await specialist mental health services.

It is hard to underestimate the importance of these groups to both services and the people they serve. They provide a useful opportunity for isolated distressed people to socialise, to show solidarity, as well as building on a solid base of psycho-social education and guided self-help.

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25 [http://www.rcpsych.ac.uk/PDF/Mental%20health%20triage%20scale%2058.pdf](http://www.rcpsych.ac.uk/PDF/Mental%20health%20triage%20scale%2058.pdf)
3.2.4 Dual Diagnosis

Referrals in/out of drugs services seem reasonably straightforward, once a person is registered with primary care. This reflects the significant work done in both substance use and mental health services to ensure joined up care and the principle of “no wrong door” - which the first door you come to gets you to the right place. Co-ordination of care remains a key issue in this area, although where a person’s mental health is not managed under CPA arrangements - this often appears to fall to advocacy to provide continuity and communication.

3.2.5 Psychiatric Symptoms

As with dual diagnosis, once clients are “in the system” – i.e. registered with GP services, the routes into receiving support from secondary services are relatively straightforward.

However, it appears that these routes into care are significantly jeopardised by poor communication (lack of interpreters), or a poor understanding of how to treat a mental illness which is compounded by the effects of trauma.

It is significant that both case studies quoted suggest the importance of Solace as a backstop for Secondary services – providing people with on-going support, and fostering a level of trust that appears to have saved lives.

3.2.6 Suicidal ideation

Our interviews and focus groups confirmed a widely held belief that many RAS openly discuss their intention to self-injure, or to kill themselves when articulating their fear of the future, or their dissatisfaction with the present. We also know from the recent suicide audit that statistically, this client group are highly unlikely to appear in the suicide statistics.

Staff within the voluntary sector (especially PAFRAS and Solace) have developed a variety methods of mental health risk management which frequently do not involve secondary services (e.g. crisis counselling, group counselling) or which seek to remove the immediate stressors (e.g. housing crisis, threat of deportation) through independent advocacy.

However, these methods cannot always contain someone who is intent on harming themselves. This leads to emergency contact with secondary services.

Where there has been little or no prior involvement with secondary services, secondary services often struggle to respond in an effective or timely manner, leading to frustration on all sides. This failure to respond can lead to the costly and traumatising involvement of the Police, Out of Hours GPs and the Accident and Emergency Department.

That there appear to be few recorded fatalities amongst this client group is a matter of good fortune.

3.2.7 Physical health problems

Where good relationships with primary care exist, physical health problems appear to be dealt with quite well. Where communication is poor, it is not unusual for a RAS to shop around for support (with various GPs, A&E, voluntary sector) until good communication is established, and the physical health problems discussed and addressed.

It appears that signposting is both unpopular and not very effective with this group. Similarly, where specialist services are situated some distance from where clients live, the anxiety and expense of travel to a new place often make appointments difficult to attend.
Independent advocacy often provides continuity and engagement to a highly transient client group in the wait between referral and initial appointment.

### 3.3 Types of treatment

The 1:1 interviews mapped the different types of treatment, number of times they were accessed, and whether or not participants found them helpful. There may be a difference between how helpful a treatment is felt to be and its actual efficacy – however, the research team lacked a more objective method of assessing the relative merits of particular interventions.

The graph below shows the total number of interventions experienced by the 15 people we interviewed – 136 interventions in total – averaging over 9 per person.

![Graph showing number of interventions](image)

A further breakdown of which interventions were felt to be most helpful can be found at Appendix 4 – types of treatment and preference.

### 3.4 Analysis of trends

At present, independent advocacy services are offered to RAS by a range of providers in Leeds (including RETAS, Refugee Council, and Advocacy Support) although the people we interviewed mainly accessed advocacy via PAFRAS and Solace. These services (provided by PAFRAS and Solace) are by far the most frequently accessed by the clients questioned, regardless of the nature of their difficulties.

The role of advocacy seems particularly vital when dealing with clients whose circumstances can change rapidly. It is often the advocate that remains the central point of contact as a client journeys through services, and who advocate for greater flexibility and understanding from services.

The complementary therapies provided by Solace and In Touch are remarkably popular with clients, and there is a large amount of anecdotal evidence to suggest that they alleviate some of the pain and medically unexplained symptoms reported by RAS clients. As the complementary
/services offered by Solace are largely provided by volunteers, their complementary offer depends on the volunteers available. This is certainly an area which would benefit from some detailed and systematic research – to discover which interventions are the most effective – in order that a core offer can be decided upon and resourced.

It is unsurprising that the more systematic therapeutic interventions (Pharmacological, individual therapies) generated the most ambivalence – with the notable exception of in-patient stays.

3.5 Features of an effective mental health pathway for Refugees and Asylum Seekers

Although it is beyond the scope of this paper and project to say exactly how mental health and RAS organisations will eventually achieve this, we offer some thoughts and reflections on what this might look like, based on our previous findings.

<table>
<thead>
<tr>
<th>Features of an effective care pathway</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A common approach to mental health triage (and risk management)</strong> will help services to prioritise what response is needed, by whom, and in what time scale.</td>
</tr>
<tr>
<td><strong>A common approach to assessment and support planning</strong> that is directed by the client and which is shared across all services (at the point of referral) will ensure continuity of service, and reduce the need for assessment and reassessment.</td>
</tr>
<tr>
<td><strong>Independent Advocacy needs should be an essential feature of support planning for all RAS with mental health problems.</strong> We have previously noted the confusion over what is meant by advocacy. Ideally this need for independent advocacy - to address “social” problems of housing, money, transport and more general support needs would be met by mental health providers “in house.” Where providers cannot provide this support themselves, they should refer on to independent advocacy support.</td>
</tr>
<tr>
<td><strong>A common approach to information sharing and confidentiality</strong> - where needs cannot be met effectively by a service, consent should be sought to refer elsewhere and a common format for information sharing agreed (beyond the standard referral form) – to ensure clients do not have to repeat themselves over again.</td>
</tr>
<tr>
<td><strong>A common approach to case management/co-ordination and review</strong> to prevent multiple or contradictory referrals or interventions being made.</td>
</tr>
<tr>
<td><strong>Responsibility for facilitating and co-ordinating these changes across to the sector needs to rest with a named individual, perhaps using the successful model used to transform Dual Diagnosis services in Leeds.</strong></td>
</tr>
</tbody>
</table>

Figure 2 outlines a suggested route into services, for those RAS who are not in contact with services
Figure 2. A possible model care pathway for RAS with mental health problems

*NB* red arrows denote a two way referral relationship
**3.6 The role of secondary services**

Secondary services have been a notable absence in our discussions of effective mental health interventions for RAS so far. As we have seen, the reorganisation of community mental health services and the implementation of the single point of access meant that they were unable to participate in the action learning programme.

However, when discussing the role of community mental health services, both VCF and primary care providers point to a secondary care service which struggles to engage and effectively support this client group – for all the reasons outlined at section 3.1.

Not only do Solace and PAFRAS provide the stability to vulnerable RAS to access other services in the first place; the ongoing support of Solace and PAFRAS often enables secondary services to engage with this group. It is not unusual for CPNs to use PAFRAS Drop-Ins as a way of maintaining contact with their clients. When CPNs find themselves unable to engage with survivors of trauma, they refer on to Solace.

It is telling that both VCF and secondary services tend only to think of one another as a last resort - when they have exhausted their internal range of options. For shared care to be properly effective, the point of collaboration needs to come sooner and a proactive approach taken to collaborative models of formulation and care.

There is a danger that by ignoring the role and [financial] resources needed to make PAFRAS and Solace work, these services could cease to provide the skilled and effective support which enables secondary services to deliver to this client group.

Similarly, there is a real danger that unless VCF partners like Solace and PAFRAS can start to quantify the impact they have on secondary care (in terms of crisis management, effective referral assessment and conversion, and ongoing support to recovery through complementary therapies and independent advocacy), that they will go unrecognised and un-resourced. To prevent this, they will need to start articulating their roles in the same terms as secondary services, and meshing with the models of care planning, risk management, and outcome measurements used within secondary care.

The movement made by the action learning sets in overcoming barriers to collaboration in primary care has been significant. It is imperative that secondary care is able to find ways to participate in the continued action learning sets, and to support collaborative ways of care management in this area.
## Section 4 – Recommendations & Conclusions

### 4.1 Recommendations made by RAS Clients

<table>
<thead>
<tr>
<th>Assessment &amp; Support Planning</th>
<th>Recommendations made by RAS Clients</th>
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</thead>
</table>
| • Clients experience the “segmented” delivery of services as a lack of empathy by staff, or lack of understanding of their holistic needs  
• Support provision is sometimes patchy, ill-coordinated and poorly understood by staff and service users  
• Inconsistent care and lack of understanding by GP’s has led to physical health issues not being adequately investigated | Immediate Priorities  
1.1 All support services should produce clear method statements of who they work with, what is offered and the criteria of how people enter/leave the service.  
1.2 Organisations should map where they “fit” in the system and how their services can work most effectively with key partners (on the model of Dual Diagnosis service services in Leeds)  
1.3 Agencies should develop a common framework of collaborative assessment and care planning shared with clients and across organisations  
1.4 Independent advocacy support and access to transport should feature in all care plans for RAS clients |

<table>
<thead>
<tr>
<th>Referrals, Signposting &amp; Waiting times</th>
<th>Recommendations made by RAS Clients</th>
</tr>
</thead>
</table>
| • Referrals to other services take a long time.  
• “Signposting” for clients in distress fails as often as it succeeds  
• Services often “hold on” to service users rather than leave them without support in the intervening period  
• The rapid assessment and triaging of clients mental health needs (like that provided by PAFRAS) helps sustain engagement, improves self-management of distress, and reduces likelihood of crises developing | Immediate Priorities  
2.1 Increase access to peer-support groups such as Solace/PAFRAS’ stress management group which help contain psychological distress – and which should be distinct from the wider offer of support offered by the host organisations  
2.2 Waiting lists and estimated waiting times should be clearly communicated at the point of referral  
2.3 Where a service cannot be provided immediately, clients should be offered peer or group support, where appropriate  
Longer term Goals  
2.4 All services working with RAS in mental distress should host staff trained in the principles and use of mental health triaging techniques  
2.5 Group activities - such as self-help groups can be a useful adjunct to one to one therapy, and should be resourced as a viable and cheaper alternative to 1:1 advocacy interventions |
### Inadequate and confusing information

<table>
<thead>
<tr>
<th>Recommendations made by RAS Clients</th>
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<tbody>
<tr>
<td><strong>Immediate Priorities</strong></td>
</tr>
<tr>
<td>3.1 All services to offer access to an online information and a shared list of useful resources developed on common topics, especially diagnosis and treatment options (e.g. Mind, Rethink, NHS Choices)</td>
</tr>
<tr>
<td>3.2 Where information cannot be translated, services internet browsers to be configured with online translation services e.g. Google Translate</td>
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<tr>
<td>3.3 BME Community Development Workers to collaborate with service providers to produce psychoeducational interventions to RAS service users to reduce stigma, and to increase engagement</td>
</tr>
</tbody>
</table>

**Longer term Goals**

| 3.4 Ways of sharing information (and translations) electronically should be explored e.g. establishing a Welcome To Leeds Wiki, and a single website produced |
| 3.5 Each service to produce a short FAQ about their services, and short “How To” audio/video resources (YouTube/MP3s) developed to explain how particular services work, or to deal with common queries |
| 3.6 Time to Change activities should see RAS communities as a key community for engagement |
| 3.7 The Migrant Community Networkers should ensure their work continues to address issues of stigma in their training course |

### Engagement

<table>
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<tr>
<th>Recommendations made by RAS Clients</th>
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<tbody>
<tr>
<td><strong>Immediate Priorities</strong></td>
</tr>
<tr>
<td>4.1 Where engagement with services is proving difficult, reminders of appointments should be sent by text to mobile phones, and transport arrangements explored</td>
</tr>
<tr>
<td>4.2 Mental health services should explore ways of delivering services to clients in places where clients may already seek assistance with food or housing (e.g. PAFRAS)</td>
</tr>
<tr>
<td>4.3 RAS and Mental health services should urgently explore the shared use of buildings and facilities to deliver services – and where these facilities are owned/managed by VCF partners, space should be rented on the basis of full cost recovery</td>
</tr>
</tbody>
</table>

**Longer term Goals**

| 4.4 Wider use of psycho-educational interventions to assist RAS clients better understand and manage their situations |
### Socio-cultural isolation

**Recommendations made by RAS Clients**

<table>
<thead>
<tr>
<th>Immediate Priorities</th>
<th>Longer term Goals</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>RAS frequently report feeling isolated by lack of spoken English and meaningful occupation</strong></td>
<td>5.1 Service providers to ensure clients have formal mechanisms to feed back into service design/delivery/evaluations – and where these mechanisms exist – to prioritise membership from RAS community members</td>
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<td></td>
<td>5.2 Support RAS to engage in meaningful activities: volunteering work, physical exercises and relaxing activities to help them integrate and to improve their self-worth</td>
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<td></td>
<td>5.3 NHS and Social Care commissioners should recognise the importance of advocacy support in the effective delivery of mental health care to RAS, and explore models of peer and self-advocacy and guided self-help in this area</td>
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<td></td>
<td>5.4 Organisations working with RAS to ensure clients and former clients feature on boards of governance/trustees as well as other volunteering opportunities</td>
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<td></td>
<td>5.5 Promote wider uptake of bursaried places for Mental Health First Aid for groups offering volunteer placements to RAS community organisations</td>
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</table>

### Perceived effects of immigration status on treatment

**Recommendations made by RAS Clients**

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<tr>
<th>Immediate Priorities</th>
<th>Longer term Goals</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Asylum seekers in particular feel they have fewer rights than clients with status</strong></td>
<td>6.1 Services providing to RAS should undertake Equality Impact Assessments to ensure perceived discrimination is overcome</td>
</tr>
<tr>
<td><strong>Once “leave to remain” has been granted, many clients experience mainstream services as unequal</strong></td>
<td>6.2 Asylum seeking clients should be encouraged to use the complaints procedures by services if they believe they are receiving unfair treatment</td>
</tr>
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<td></td>
<td>6.3 All staff working with RAS to receive regular Asylum awareness training as well as specialised trainings about complex MH issues specifically addressing the 7 identified areas of concern to understand the process, and to sensitize them to the effects this can have on clients</td>
</tr>
</tbody>
</table>
### 4.2 Recommendations made by mental health and RAS workers

<table>
<thead>
<tr>
<th>Issues raised by professionals</th>
<th>Recommendations made by mental health and RAS workers</th>
</tr>
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<tbody>
<tr>
<td><strong>The complexity of problems presented by RAS means that all organisations struggle to resolve these in isolation</strong></td>
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<td><strong>Mental health services working with RAS need to integrate advocacy services into care pathways</strong></td>
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<td>•</td>
<td>• 7.1 Agencies should develop a common framework of collaborative assessment and care planning shared with clients and across organisations</td>
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<td>•</td>
<td>• 7.2 Agencies should develop a shared competency framework for workers in this area to ensure they are equipped to support the socio-cultural, psychological issues etc. faced by RAS</td>
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<tr>
<td></td>
<td><strong>Longer term Goals</strong></td>
</tr>
<tr>
<td></td>
<td>• 7.3 Commissioners of mental health services should ensure advocacy for RAS is a specific strand of the wider commissioning strategy for advocacy in Leeds</td>
</tr>
<tr>
<td><strong>Services often struggle to communicate effectively with clients</strong></td>
<td>Immediate Priorities</td>
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<tr>
<td>•</td>
<td>• 8.1 Ensure all clinical staff have undergone training in effective use of interpreters, drawing on experience and expertise of LTHT/Solace/Touchstone, - including the use of Language Line telephone service</td>
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<tr>
<td>•</td>
<td>• 8.2 Continue to develop and deliver entry-level volunteer interpreter training based on PAFRAS/Touchstone model</td>
</tr>
<tr>
<td>•</td>
<td>• 8.3 Provide regular training for volunteer and paid interpreters (Solace/Touchstone)</td>
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<tr>
<td></td>
<td><strong>Longer term Goals</strong></td>
</tr>
<tr>
<td></td>
<td>• 8.4 Create a shared (list) of experienced and mental health trained interpreters in Leeds, in conjunction with LYPFT, LTHT and LCH</td>
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<tr>
<td></td>
<td>• 8.5 Ensure all interpreters listed have undergone mental health first aid training in order to challenge mental health stigma, and to better understand the context in which they are working</td>
</tr>
<tr>
<td></td>
<td>• 8.6 Ensure all interpreters are trained to provide accurate interpretation of what clients say, not an interpretation of the mental health issue being discussed</td>
</tr>
<tr>
<td><strong>Care is poorly coordinated across different service sectors, and would benefit from a common approach</strong></td>
<td>Immediate Priorities</td>
</tr>
<tr>
<td>•</td>
<td>• 9.1 Organise regular complex case meetings on the base existing PAFRAS/YSHP/SOLACE monthly meetings that can support delivering multi-agency interventions Professionals assessing RAS to act as a single point of access - RAS ‘champion’ who will be regularly in contact with other agencies</td>
</tr>
<tr>
<td>•</td>
<td>• 9.2 Create a quarterly strategic network for RAS workers and mental health services to co-ordinate their activities</td>
</tr>
<tr>
<td></td>
<td><strong>Longer term Goals</strong></td>
</tr>
<tr>
<td></td>
<td>• 9.3 LYPFT to nominate a clinical representative from secondary mental health services to attend this strategic network</td>
</tr>
<tr>
<td></td>
<td>• 9.4 Organise ‘multi-agency cloud of information’ that can help avoid duplication</td>
</tr>
<tr>
<td>Issues raised by professionals</td>
<td>Recommendations made by mental health and RAS workers</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-----------------------------------------------------</td>
</tr>
<tr>
<td>• Ambiguous policies and roles result in “no one being clear who is doing what or where responsibility lies”</td>
<td>Immediate Priorities</td>
</tr>
<tr>
<td>• The ever-changing policy landscape on immigration, NHS organization, and drastic cuts to all sectors make adapting to new changes and collaboration even more difficult</td>
<td>10.1 To avoid further confusion - a clear definition of “Advocacy” in RAS contexts needs to be agreed upon by advocacy providers, with explicit reference to mainstream mental health and wider advocacy services</td>
</tr>
<tr>
<td>• The best outcomes are delivered by well-trained, self-confident teams</td>
<td>Immediate Priorities</td>
</tr>
<tr>
<td>• Agencies working who don’t collaborate with others often feel isolated, duplicate work and confuse clients</td>
<td>10.2 Review of policies and roles with support from other RAS organisations to maintain consistency across agencies</td>
</tr>
<tr>
<td>• The development of dual diagnosis services may present an interesting model of shared care pathways for the sector</td>
<td>10.3 All services to publish and circulate clear guidelines about the roles, policies and criteria for professionals working with RAS</td>
</tr>
<tr>
<td>• Creating a strategic network for RAS mental health services will provide a mechanism for achieving greater collaboration</td>
<td>Longer term Goals</td>
</tr>
<tr>
<td>• A forum for reflective practice alongside other agencies will improve the quality of client outcomes</td>
<td>10.4 Regularly map of existing MH, Well-Being and Advocacy services in Leeds</td>
</tr>
</tbody>
</table>

| Immediate Priorities | 11.1 Conduct a sector-wide audit of training needs for MH workers working with refugees to identify the most pressing concerns – including guidance on supporting survivors of torture  |
| Immediate Priorities | 11.2 Identify the agencies best placed to provide training and development on these issues  |
| Immediate Priorities | 11.3 Provide specialized training for interpreters  |

| Long term Goals | 12.1 Create a quarterly strategic network for RAS workers and mental health services to co-ordinate their activities  |
| Long term Goal | 12.2 The first task should be to map what they do and how people enter/exit their services  |
| Long term Goal | 12.3 The second task should be to address organisational issues of confidentiality and consent for information to be shared  |
| Long term Goal | 12.4 The third task of this group should be to develop a multi-agency assessment and support planning tool  |
| Long term Goal | 12.5 Organise regular complex case meetings on the base existing PAFRAS/YSHP/SOLACE monthly meetings that can support delivering multi-agency interventions  |

| Immediate Priorities | 13.1 Organise regular complex case meetings, with membership based on existing action learning set that can support delivering multi-agency interventions  |
| Immediate Priorities | 13.2 Widen participation to include secondary mental health and other agencies  |
| Immediate Priorities | 13.3 LYPFT to nominate a clinical representative from secondary mental health services to attend this network  |

| Longer term Goals | 12.6 Create a cloud of information on services that is regularly updated  |
4.3 Conclusion

The state of mental health care and support in Leeds for RAS is complex and difficult to understand. We have seen that even those providing services and those experiencing them find it difficult to navigate, and recommendations are easy to make, and hard to implement.

There is an urgent need for better coordination across the sector and a move away from the piecemeal development which has taken place over the last 15 years. There is valuable, effective work being undertaken in pockets across the city but interventions and outcomes are often variable. Although it is hard, models of shared care and meaningful outcome measurements need to be agreed across the sector. This is the only way in which the various agencies can prove the effectiveness of their interventions, and ensure their continued role in an era of fewer resources, greater demands and in the face of hostility towards asylum seekers and refugees in the popular press.

Central to the success of this project is a change in organisational culture. Services and teams have arisen – especially within the voluntary sector – as a response to unmet needs, often devised and delivered according to the values and priorities of those providing them, as much as in direct response to the demands of the client group.

Praise and affection from the vulnerable client group they serve are important indicators of success for specialist RAS organisations. But if this success means clients are not encouraged to access mainstream services - or those specialist organisations are not helping those same mainstream services to change and improve - specialist organisations become unwitting collaborators with a system which remains stacked against people who seek refuge in Leeds.

NHS commissioners play a large role in facilitating this success through canny budgetary decisions, and leveraging the financial support of wider public services (Criminal Justice, Social Care, and Public Health) to support the mental health needs of RAS. But the sector can and must initiate change itself – if it is to direct these changes. Our worry is that issues of organisational ethos and identity will trump the need for specialist services to become better at working in partnership. Ultimately, a refusal by the successful elements of the VCF (e.g. PAFRAS, Solace) to help other non-specialist providers to be more effective through collaboration, or to adopt shared measurements of outcomes may lead to their services ceasing to exist.

A great start has been made in the form of the action learning sets, which we hope will grow into a more systematic response to the complex challenges created by people with complex lives. Great changes have already taken place across the system: services are talking and collaborating more and misconceptions and prejudices are being questioned. But a collective effort need to be made to sustain this momentum, and to keep asking one another the hard questions about the value we bring to the system as a whole, as well as the individuals we assist. Our future lies in greater collaboration, and sharing what we have with one another. Our future lies in greater collaboration, and sharing
Appendix 1: Action Research Methodology

Why we chose this method

Action research was felt to be more in tune by the agencies that had built close relations in these communities, and wanted to involve individual clients in describing their experience; action research offers a qualitatively closer view of the lives of the participants, mitigating to some extent the perceived advantage of statistical reliability. This approach was validated by the NHS leads commissioning the programme for these very reasons.

Action research takes the initial forum of participants, assembled through invitation, and recognising no rank other than that offered through their own experience – implicit is the notion that ‘those that lives it knows it’, so professionals are participants in a learning situation as much as clients, all looking to achieve improvement in the patient experience. It is an attempt to maximise the impact of minority community experience in influencing mainstream delivery, with the essential role of the community organisation acknowledged and even preserved.

The group is led by a facilitator, who will keep the discussion focussed on the objective throughout the planned sessions while allowing related themes to be developed as they arise, to illustrate or amplify a point. Material that is discussed is encouraged to be honestly shared within the group, with personal details being erased from notes taken of the discussion – different resources may be deployed to assist in recording, e.g. audio or photographic records. Recurring themes are reviewed regularly, indeed reviewing is a key part of the learning, as it shapes further discussion, and allows important issues to gain the levity they demand. The process is iterative and progressive.

This cyclical method recognises and responds to an awareness of the impact society and our environment have on our lives, and when investigating trans-cultural phenomena it is essential to be able to report this as it is felt, for the transfer of knowledge and social mores determine progress in social situations for newcomers. Action learning is also known as participative action research, and is essentially participative; it must be driven by reflection on practice, imposing the discipline that changes incorporated in the process will be monitored for effectiveness: it is a dialectical process between a group of participants who have assembled to improve their practice by incorporating a change element that is subsequently monitored within the process, it is thus empirical and has the potential to initiate transformation.

In addition to the participatory nature of the research, meetings were structured as action learning sets, again to equalise the power relation amongst participants and to encourage the concept of the space as a continuing learning environment for the respectively assembled groups: clients and professionals alike. The programme was of six action learning sets (or meetings) for each sub-group: clients, professionals, ex-clients and interpreters scheduled over a nine-month period.

A triangulation method was established at the end of the project – anonymised case studies covering seven areas of concern were reviewed again by a group of clients, ex-clients and researchers identifying consistent themes, and areas requiring further study. While this is the first study of its kind it is to be hoped it is not the last, as we believe it and the results and recommendations it offers, are ground-breaking and offer a significant opportunity to embark on positive change.

See also the material for participants at [http://leedsras.posterous.com](http://leedsras.posterous.com)
Appendix 2: Case Studies

Case Studies

Case 5 is a Lebanese refugee with experience of trauma, psychological stress, and physical and mental health problems

Services involved
Chapeltown Health Centre
PAFRAS
Medical Foundation
Solace
Adult Psychological Services
St George’s Crypt

Background
Case 5 is from Lebanon and has refugee status and has been in the UK since 2005. Case 5 was in prison in Lebanon for around four years and was a victim of torture. He witnessed the death of many friends when he was in the army, which he says haunts him still. He also experiences headaches as a result of a violent attack in Leeds by ‘racist people’ and is on a lot of medication. He describes that he is like two different people and can have blank periods where he may have done things like got into a fight but has no memory of this; ‘I see black because of too much stress’.

Case 5 has Post Traumatic Stress Disorder (PTSD) and anger management problems and has found it difficult to manage his thoughts and feelings. He had been arrested on a number of occasions when he first arrived in Leeds, but as he has worked with services he has gradually developed effective coping mechanisms. The interview was difficult to piece together as Case 5 struggled to remember dates when things occurred. He feels that he is often discouraged from expressing himself, as he can be very passionate and loud and he says that some workers have not liked this.

2005 – 2008
Case 5 is prescribed medication for pain relief that he says is not working. He said he discussed this with his GP at Chapeltown Health Centre but that his GP did not listen. Although he reiterated these problems to GP two more times, he still felt ignored. He says he eventually collapsed and awoke in hospital with an Arabic doctor explaining he nearly died as a result of being prescribed incorrect medication.

During this period he had many problems with inadequate housing that exacerbated his asthma and his GP and Leeds city Council were unable to arrange alternative accommodation.

When NASS support was stopped, Case 5 was made homeless and he went to Ireland. During this period he was in hospitalised again with physical health problems. After 3 asylum refusals in Ireland he returned to Leeds. He says he cannot understand why the Home Office (HO) is so unhelpful.

Case 5 describes both PAFRAS and St Georges Crypt as being a huge support to him on his return, and that they enabled him to build up his social and emotional support network. Case 5 was volunteering at PAFRAS which he says helped him to give something back after all the support they have provided him. In 2007 Case 5 was referred to Solace by PAFRAS, he was assessed and attended individual counselling sessions, complementary therapy and advocacy support there until 2009.
Case 5 reports that after 2 attacks that happened in 2008 he could not speak for a long time; he reported them to the police but he says they did nothing. Case 5 says that PAFRAS tried to help him to press charges but there was still no action; he feels very angry and frustrated about this situation.

2009
Solace referred Case 5 to Adult Psychological Services (APS) and he began therapy there. Case 5 recalls that the Mental Health (MH) worker at PAFRAS and doctor at APS referred him to the Medical Foundation in London, and a report was completed that influenced his asylum case. It was PAFRAS who co-ordinated this. He says it is difficult: he gets tired of talking about his past, he feels scared by people as he is too stressed, and has flashbacks which makes it hard to talk about things. Case 5 doesn’t know where he has been referred to and reports being asked a lot of details about his history over and over again which he found very difficult and frustrating.

2010
Case 5 got refugee status. He said that there was good communication between Solace, Touchstone IAPT and APS, but then went on to describe a negative experience he had at APS. He said that he felt that a doctor there was being racist towards him and he reported this to a worker at PAFRAS who agreed that the doctor was not treating Case 5 well. He felt that the doctor was talking to him like he was back in prison and under interrogation; ‘a two hour questioning session’. He reported a comment by the same doctor that if he was already receiving help from PAFRAS, why was he accessing their services?

He reports that Solace are “great” and he feels that there is a lot of wrapping support offered and he feels relaxed when he goes there; ‘Solace for me now I look on as family’. Case 5 was attending group therapy instead of individual therapy as a transition before discharging and he is discharged from Solace at the end of 2010.

2011
Case 5 attended APS weekly and valued this service, but still found it difficult to talk about his past. APS re-referred Case 5 to Solace as they said did not know what to do, or to engage with him due to his complex issues. Solace agreed to work in partnership with APS to support Case 5. It was agreed that APS would provide individual therapy and Solace would provide group therapy and advocacy support. This way of working appears to have worked well. He had access to interpreters at Solace and PAFRAS if he needed them, but once he had established a good relationship with them, he felt empowered to talking to workers in English. At APS he said that he always needed an interpreter. Case 5 continued to receive anti-depressant medication from Chapeltown Health Centre.

Case 5 experienced problems with his neighbours whose behaviour had a huge impact on his mental health. He feels that his home should be a sanctuary but likens it to being a prisoner again tortured both physical and mentally.

2012
The problem neighbour issues continue and he is trying to get re-housed with the help of Solace and APS; he reports that he cannot sleep due to noise and is always frightened at home, which is difficult especially when he comes home after therapeutic sessions and needs to relax.

Case 5 continues to access both Solace and APS and he enjoys the Exercise Movement Group at Solace. It is hoped that there will be a planned discharged from both services in autumn 2012.
Case 6 is an Iranian refugee with experience of trauma, psychiatric symptoms, suicidal ideation and physical health issues.

Services involved
Bradford psychiatric hospital
St James’s hospital
Adult Psychological Services
Newsam Centre
Leeds Asylum Seeker Support Network (LASSN)
Solace

Background
Case 6 came to the UK from Iran in 2009. Case 6 had a senior position in a key government ministry, and when he tried to resign from this position his request was refused and he was imprisoned and placed in solitary confinement for 2 years. He was subjected to torture leaving him with scarring and severe damage to his back for which he has undergone surgery in the UK and his home country.

Case 6 cannot recall the details of his arrival into the UK, which he states is due to the high levels of painkillers he was taking at the time. The physical and psychological torture experiences have had a significant impact on PY in terms of suicidal ideation and physical and psychological stress.

2009
Case 6 was put on the Solace waiting list in September 2009 but he is unclear of who referred him to this service. Case 6 is very confused about this time; he stated that ‘when I came to this country I was a totally broken person’. He attempted suicide on a number of occasions and was admitted to a Psychiatric Hospital in Bradford in November 2009. Case 6 acknowledged that the hospital intervention stopped him from taking his life but went onto describe that being in hospital made his mental health (MH) issues worse than before. The medication he was prescribed helped but he felt ‘controlled and under investigation’ by the doctors and stated that the conditions in the hospital were terrible and reminded him of being in prison again; ‘I was not allowed from the corridor and that was horrible for me’

2010
Case 6 was discharged from Bradford Psychiatric Hospital in 2010 but he is uncertain of exact dates. He describes 2010 as a time when he had a lot of involvement with Adult Psychological Services (APS), St James Hospital and Bradford Psychiatric Hospital. Case 6 describes this as not a good experience; ‘I’ve seen many doctors not satisfactory... the doctors are right about me they believe the things that happened to me cannot be removed or treated by the medication’.

Case 6 described a better experience with a psychiatrist he saw regularly at Newsam Centre; ‘he was good and explained about the medication and the limits of the medication’. When asked about his experience of talking treatments, case 6 described feeling so fearful that he could not express himself, how he wanted to, but felt that the person in front of him would not be able to understand. ‘I was fighting 2 battles: the 1st I needed to prove to them that I was not a crazy person; don’t treat me like a crazy person and don’t force me to go to hospital. And the 2nd was my illness which was very difficult.’
Case 6 accessed his GP to initiate further treatment options for his back problems as the pain relief was not working; however the GP failed to remember about his condition. Although he had been seeing case 6 for a long time, Case 6 felt that he didn’t have ‘a proper understanding or care for his problems’ so continued his medication.

2011
By February 2011 Case 6 was working with a befriender from Leeds Asylum Seeker Support Network (LASSN) although he is unclear how he accessed this service. LASSN referred him once again to Solace.

It seems that Case 6 was prioritised by Solace because of his previous referral in 2009 and in April Solace assessed him, and one to one therapy commenced. He explained that from most places he just received medication, but Solace treated all of his issues. ‘I didn’t tell the truth, because by telling the doctors the truth it will satisfy them but will destroy me... No one knows the whole truth about me, but my relationship with Solace led to me sharing the majority of my story, and I felt more comfortable there than speaking to the doctors’

Solace referred Case 6 to Adult Psychological Services (APS) and in August the one to one therapy at Solace ceased. In September Case 6 had psychiatry assessment at APS. He is still accessing other support from Solace; ‘If it wasn’t for Solace I would be laid in a cemetery’

2012
Case 6 continues to receive on-going support from Solace and stated that ‘they gave me the confidence to not feel like I was a crazy person’. He has begun to engage with weekly acupuncture sessions there and so far he says the sessions are going ok and he has felt a very immediate pain relief. Case 6 does still struggle immensely with back pain and is taking 400 – 430 tablets a week for both pain relief and his MH: he says that they do not seem to really help to relieve his pain, and this on-going pain significantly affects his MH. Case 6 sees a Psychiatrist every 2 months but more upon request at APS.
Case 7 is a failed asylum seeker from Zimbabwe with experience of psychological stress, family difficulties, and physical and mental health problems

Services involved
General Practice  Solace
PAFRAS  Adult Psychological Services
Refugee Council  St George’s Crypt

Background
Case 7 is a failed asylum seeker from Zimbabwe awaiting an appeal decision from the Home Office (HO). Case 7 lives in shared accommodation and attends a GP in her local area. She has 2 children and 2 grandchildren all of whom have status to live in UK; she tells me that she has no family who could support or care for her back in her country of origin. Case 7 talks about the death of her parents and brother who died whilst she has been in the UK and is upset that she could not return home for their funerals. Case 7 states that she cannot return to her country due to political situation which will put her at risk of significant harm. Case 7 receives and provides an enormous amount of support from and to her family here in the UK. She states that any severing of these ties will significantly affect her mental health. The symptoms she presents are anxiety, high levels of stress, panic and depression.

2005 – 2009
Case 7 arrived in Leeds and describes that some of her mental health issues were already present due to the harassment she had received in her own country, but she says that it has deteriorated since being in the UK. In 2007 she accessed St George’s Crypt for support and in turn they helped her to find PAFRAS. Until 2008, Case 7 stated that PAFRAS provided her only emotional and practical support, and referred her to the Refugee Council to help her claim Section 4 support. As a result of being accepted for this support, Case 7 was moved to another city by the HO for the whole of 2009. Case 7 stated that this was a difficult time as she felt isolated and did not receive any mental health support.

2010
Case 7 came back to Leeds and wanted to attend the PAFRAS drop-in but she was living too far from the drop in which made it difficult for her to get there. This was partly due to the severe arthritic symptoms Case 7 experiences; although she receives medication for this, she says it only helps a little. Later in 2010, she moved closer to PAFRAS so she was able to attend more frequently which she was happy about; ‘they did a lot for me they helped me; without them (PAFRAS) I might be dead’.

2011
PAFRAS referred Case 7 to In Touch for stress and pain management; Case 7 stated that she gets a lot from the sessions (that she still attends) and they help her to relax. PAFRAS also referred her to Solace and has been attending the PAFRAS & Solace joint stress management group. Solace made a referral to Adult Psychological Services (APS) at Blenheim Terrace. When asked of her experience of this service Case 7 said that it was positive one: she had felt listened to, relaxed and they wrote a letter of support for her case to the Home Office. However, she found it difficult to get to these appointments, as she had to get 2 buses and received no help with travel costs.

2012
Case 7 is living in shared accommodation with another lady she describes as disrespectful of house rules; shouting, drinking and inviting lots of strangers around to the property. Case 7
stated that she cannot sleep and is terrified that someone is going to break into her room and kill or injure her. Case 7 is becoming more stressed and pre-occupied with her pending case decision: she says that the immigration case significantly contributes to her poor mental health and that she is constantly worried about the possibility of being taken away from her family and returned to a country where she is sure she will face danger.

Case 7 discussed a time when she felt confused about appointments at APS when her worker went on leave. Case 7 was unclear about when her next session would take place and she felt that she ‘didn’t want to push it by calling and chasing it’. She is still attending PAFRAS but less frequently than she used to; she sees a caseworker and mental health worker at PAFRAS and she still attends the Stress Management Group at Solace. Solace called her GP to request they assess her mental health, following her expression of suicidal ideation. When I asked case 7 about these thoughts she said ‘well maybe that will be a better option’
Case 12 is an Iranian refugee with experience of trauma, psychiatric symptoms, suicidal ideation and physical and mental health problems

Services involved
Leeds College of Building
A & E service
GP
Solace
Leeds Asylum Seeker Support Network
St James Hospital
Immigration Advice Service

Background
Case 12 survived torture, persecution, imprisonment and threats to his life in Iran followed by a traumatic escape to UK. His family had to go through similar hardships. He went to the police as soon as he reached the UK and was “imprisoned for a day”. The Home Office (HO) put him in a hostel in Wakefield and later, he was relocated to various locations including Bradford, and eventually Leeds. After a failed asylum claim, Case 12 has now got refugee status. He has a history of suicide attempts and self-harm including cutting himself, banging his head against the wall and attempting to jump off bridges in a state of fugue. He is on antidepressant medication and remains a vulnerable person in need of continuous psychological support.

2007 - 2010
Case 12 received support from NASS and Immigration Advice Service (IAS). He had to relocate 14 times since he came to UK. Case 12 told that he felt frightened, unwanted and lost. It was difficult to track his journey because he could not accurately remember the dates when he moved into his accommodations. In Leeds, a befriender from Leeds Asylum Seeker Support Network (LASSN) saw him weekly. Apart from this he remained isolated.

Case 12 felt depressed and hopeless. He attempted suicide on several occasions and was rushed to A & E and revived each time. Case 12 said, ‘I had no hope and felt scared. I did not know where to go. Some voice in my head tells me to kill everybody and my own self too’.

2010
In January his asylum claim appeal was refused and he was left shattered. He said, ‘I was alone in the court in front of the judge. I had no solicitor. I was asked no questions related to my case. The HO also informed him that he would no longer receive any NASS. His interpreter informed him about Solace. Case 12 told that Solace helped him a lot and that he had received various complimentary therapies there.

Later that year, he was detained under the Mental Health Act following an incidence of self-harm. Case 12 was relocated to Leeds after he was discharged from the hospital. He was refused mental health support by Leeds Community Mental Health Team (CMHT). He told that there was no interpreter when he was being assessed and that he could not explain his situation clearly and never agreed to being discharged from the CMHT.

2011
Case 12 visited St James Hospital for a second back operation, because of an acquired infection. He had barely recovered from the surgery when he was harassed and attacked by some local youths. This incident not only hurt him physically but also exacerbated his mental health difficulties. He was angered by the way police handled his case and believed that the officers discriminated against him.

Solace supported him through this period, helping him to report the incident to Stop Hate, Leeds. He was extremely frightened and frustrated. With the help of Leeds City Council (LCC) and Solace he moved into a shared accommodation, only to find the place infested with cockroaches.
On the positive note, Solace helped him to enrol onto a course at Leeds College of Building. Case 12 was very excited about this and worked harder to get his ESOL certificates with the help of a tutor from LASSN. Solace helped him to access the CMHT and also directed him to make a fresh asylum appeal.

2012
In January, Case 12’s asylum appeal was successful. The initial joy of obtaining a status in UK soon dissipated when faced with the difficulties this status brought: a notice from the Council to vacate his accommodation put him in a state of crisis. His ‘voices’ returned and he threatened to harm himself. He said, ‘I don’t even remember how many times I had to shift from one place to another. If they try and move me out of this place, I will set the house on fire. I have planned out everything.’

Case 12’s therapist at Solace reported that his MH difficulties worsened at this point and they made an urgent referral to the CMHT. A worker from CMHT visited Case 12 at his home. The therapist from Solace called Case 12 to follow up with him and he disclosed that he had taken an overdose as he was so distressed. The therapist immediately called the emergency services and he was taken to the A & E and was saved.

Apart from complex MH difficulties, Case 12 suffered from recurrent back infection, and pain in the leg and chest. He had to undergo surgery twice for his back, but his problems persist. Case 12 attended a few physiotherapy sessions but was not relieved of the pain.

He is very unhappy with the CMHT, as he feels that they abandoned him when he needed their support the most. He complained that the waiting time for physiotherapy and dental appointments is too long. Case 12 said that the only place that gives him strength to move on is Solace. He said, ‘Solace is my home. I rush there whenever I feel lonely and want to talk. I go there when I am hopeless. They have helped me with food, home, solicitor; they always call to check if I am OK, they never postpone.’ He also said, ‘My GP is very good. The A & E service is very good. I do not know why and when I harm myself but they always save my life. I am also thankful to Leeds College of Building for giving me a chance to study and make friends.’

Case 12’s mental health remains very fragile. He is extremely anxious and cannot rationalize things. Any uncertain and stressful situation can act as a trigger for him to break down and harm himself.
Case 13 is a refused asylum seeker from Russia with experience of torture, psychological stress, dual diagnosis and suicidal ideation

Services involved
Positive Action for Refugees (PAFRAS) Leeds General Infirmary (LGI)
York Street Health Practice (YSHP) Chapel Allerton Hospital
Refugee Education Training and Advice (RETAS) Physiotherapy
Service (RETAS) In Touch
St George’s Crypt Solace
Brain Injury Rehabilitation Team (BIRT) Increasing Access to Psychological Therapies

Background
Case 13 is a refused asylum seeker who came to the UK in 2005 after fleeing from Russia, where he claimed that he was assaulted by the authorities for knowing ‘compromising information’. After the attack, he regained consciousness in hospital and ran away immediately. The assault resulted in physical and psychological injury, some of which is irreversible. Case 13 arrived in Dover and then he travelled around for a few weeks; sleeping on the streets, and eventually settling in a city in the North of the UK. He was staying in a house with several other unregistered immigrants when a man was stabbed there. Case 13 went to the police to report the murder and instead he stated that he was questioned by the police about the murders and sent to prison.

2006 - 2010
Case 13 was released from prison and moved to a Northern town and was then sent to a detention centre and detained for seven and a half months. This is when he was first told about the asylum claim system; in March 2006, his first claim for asylum was refused. After his refusal, he ran away from the address where he was staying. Case 13 has been living in various addresses ever since, using cannabis and alcohol as a coping mechanism as he says that it takes him ‘away from my problems’.

2011
By early 2011, Case 13’s psychological state was rapidly deteriorating. He was arrested on one occasion for attempting to jump from a bridge in Leeds.

In January 2011, he was told about PAFRAS by a friend, and started attending for support with his asylum claim. He describes PAFRAS as playing an important role in developing his support network, saying ‘...from PAFRAS I started finding out about the things that I do now.’ From PAFRAS, Case 13 was registered at York Street Health Practice (YSHP) He started engaging with the Mental Health (MH) service there and began counselling, which he was not very impressed by; ‘I don’t feel like it’s helping me but sometimes I need to talk to somebody’, ‘You can just talk to chair, things like that’. The GP at YSHP also prescribed antidepressants. When

Case 13 registered with YSHP, he was given a pack of leaflets with information on support for asylum seekers. This had information about Refugee Education Training Advice Service (RETAS), and he began English classes with them.

Case 13 was referred to St Georges Crypt by workers at PAFRAS. This was to consult with a specialist at the Brain Injury Rehabilitation Team (BIRT), about the brain injuries he had suffered during his assault in his own country. He said of this ‘He took my mental problem. Brain injury. I felt like he was helping me more than anyone else’. Case 13 said that the specialist listened to him, and gave him tips on how to cope with his brain injury. Case 13 also explained that the antidepressants that he was taking were not working, so the specialist told him exactly which antidepressants to ask for. His antidepressants were subsequently changed by the GP at YSHP.
The specialist sent a letter to YSHP to request a referral for a CT scan, which was made by YSHP. Case 13 says that he was given information by the BIRT about herbal treatments which may help his condition, but he says that these are too expensive and that there is no support available to purchase them.

An appointment was made at Leeds General Infirmary regarding Case 13’s CT scan, and he was invited for a consultation to discuss the results. He was not happy with the treatment he received there. He says that the consultant just looked at his wound with no proper examination and then he was discharged. ‘And that was it. I received a report. It was so many irrelevant information about how I survived but no word about my brain injury and what caused. It was just like I was very disappointed with this.’

Case 13 was given a free pass to the gym by YSHP MH service. He said that ‘It helps me to relax. After gym I felt like nothing else bothers me, I just want to sleep’. Case 13 had to stop going to the gym, however, as he fell off his bike and injured his back.

He consulted with his GP at YSHP about the pain in his back and he was prescribed painkillers and heat rub. He was also referred to Chapel Allerton Hospital for monthly acupuncture. He says that this improved the pain for a couple of days, but the pain then returned. Case 13 consulted with his worker at PAFRAS about this, who contacted YSHP, who made him an appointment with the physiotherapist who visits YSHP fortnightly. Case 13 attended two sessions, but found travelling to appointments difficult without his bicycle.

Case 13 also said that he suffers from memory problems, attributed to his brain injury. He has difficulty remembering appointments, and has missed some because of this.

The PAFRAS mental health service referred him to In Touch for weekly appointments. He said that the massages he received there were effective, but again he had trouble accessing the service without his bicycle.

2012
Case 13 was referred to Solace by PAFRAS, and he began attending in February 2012. He is still on the waiting list to receive one to one therapy, and he is expecting to wait several months longer for an appointment.

He began attending a stress management group, a joint project with PAFRAS and Solace, that he says helps him to cope sometimes. He also began participating in an exercise group, and is now a volunteer helping to lead this group. Case 13 says that it is a great help that Solace pays for his bus tickets from the town he stays in most of his time to Leeds, as he cannot get to Leeds otherwise.

He says that he has had difficulty attending appointments with YSHP as he has no means of getting there. He says that he would like to attend appointments on a Thursday and Friday when Solace pays for his bus tickets to Leeds. However, he claims that YSHP do not book appointments in advance, and this is difficult because ‘you have to ring same day, phone busy then they say no more appointments; It’s not easy to get appointment’.

The PAFRAS MH service referred Case 13 to IAPT at YSHP as he was complaining that he wanted some practical solutions to some of his mental health problems. He is currently attending appointments there. PAFRAS have also consulted with the BIRT on Case 13’s behalf, regarding his brain injury, who said that they are currently waiting on a functional scanner and that he can access this service when it arrives. However, they don’t think that they will be able to support him further due to his refused asylum seeker status.
Case 15 is a Libyan refugee with experience of torture, psychological stress, and physical and mental health problems

Services involved
Bellbrooke GP Surgery
Chapel Allerton Hospital
Solace
Primary Care Mental Health Services

Background
Case 15 fled Libya after persecution and repeated torture in prison. Case 15 said that he was and still is struggling to cope on a daily basis due to chronic physical pain, flashbacks, nightmares and insomnia. He was granted Indefinite Leave to Remain in 2010. He has lived in Leeds for the past 2 years.

2010
Case 15 registered with a GP at Bellbrooke Surgery, where he booked an appointment regarding the chronic physical pain he was enduring as a result of being tortured. He said that he had severe pain in his back and knee, was suffering from dizziness and was unable to sleep. The GP prescribed co-codamol. Case 15 returned to the Bellbrooke Surgery, as the tablets were making him feel bad, and he was still not sleeping. The GP changed his pain medication to Paracetamol, and prescribed sleeping tablets.

2011
The GP at Bellbrooke Surgery referred Case 15 to Primary Care Mental Health Services at Burmantoft and Seacroft clinic. He says that he was discharged from this service as he was unable to attend his appointment on one occasion.

Case 15’s GP then made a referral to Solace. He did not attend until early 2012, however, due to the seven month waiting list.

Case 15 says that the health services in Leeds are not the same as in the last city he stayed in. He said that he had a ‘good doctor’, and he did not like a lot of the doctors at his Bellbrooke Surgery, ‘some were good, some were bad’. When asked if he knew that he could request a specific doctor to treat him, he said that he did not.

2012
Bellbrooke Surgery referred Case 15 to Chapel Allerton Hospital for an x-ray on his knee and lower back. He was also put on the waiting list for physiotherapy at the hospital.

Case 15 was assessed by Solace after his GP at Bellbrooke Surgery had referred him there in 2011. He did not understand what his GP was saying to him, however, so he was unaware that he had been referred. After being on the waiting list for seven months Case 15 is currently accessing advocacy services and one to one therapy sessions there.

Case 15’s therapist at Solace got in touch with Bellbrooke Surgery to find out why there had been no contact since Case 15’s x-ray. They said that Case 15 had attended an appointment with the consultant at H3 to discuss his results. However, the hospital did not contact an interpreter so he did not understand what was being discussed.

Case 15 has been accessing advocacy at Solace for support with many issues. Case 15 told the advocates at Solace that he is extremely stressed due to the fact that he is unable to pay his household bills. They are currently supporting him to make a claim for increased disability benefits as he is unable to work. Solace invited Case 15 to a complimentary therapist who
specialised in pain management. He became very suspicious of this therapy, as he thought that it would involve spiritual healing, which he said that he did not agree with. He said that he did not want to see a ‘witch doctor’, and that it was ‘no good’. He stated that it was not explained to him the exact type of therapy he would be receiving and this caused confusion. Case 15 is currently enrolled at an exercise group at Solace, which he is enjoying.

Case 15 has a wife and son, and his MH problems have had a serious effect on his family life. He said that the noise at home makes it difficult to maintain close relationships with his family, and they often stay away from home to give him space. Therapists at Solace asked Case 15 if he wanted to invite his wife for a joint therapy session, but he refused, saying that his problems were only about him.

The GP at Bellbrooke Surgery forwarded a letter to therapist at Solace. This was from the Consultant Rheumatologist outlining his findings. Case 15 was diagnosed with mechanical joint pain with subsequent muscle weakness and deconditioning. He was referred for physiotherapy sessions, but he missed his first appointment. The Consultant Rheumatologist requested that he be put back on the waiting list to have the appointment re-booked. The consultant referred to all of Case 15’s issues in this letter, including his sleeping problems and financial issues.

Case 15 expressed his confusion regarding the health service that he received in Leeds: ‘I don’t know who I am talking to most of the time. People don’t communicate with each other’.
Appendix 3 – 15 Care pathways

Client 1 is a destitute asylum seeker with experience of trauma, psychological stress, and physical health problems.

Client 2 is an asylum seeker (s4) with experience of trauma, family, psychological stress, and suicidal ideation.
Client 3 is a destitute asylum seeker with a family, psychological stress, and suicidal ideation

Client 4 is a destitute asylum seeker with experience of trauma and physical health problems
Client 5 is a refugee with experience of trauma, psychological stress and physical health problems.

Client 6 is a refugee with experience of trauma, psychological stress, psychiatric symptoms, suicidal ideation and physical health problems.
Client 7 is an asylum seeker (s4) with a family, psychological stress, and physical health problems

Client 9 is an asylum seeker (s4) with experience of psychological stress, and physical health problems
Client 8 is a destitute asylum seeker, with experience of psychological stress, dual diagnosis, suicidal ideation, and physical health problem.
Client 10 is an asylum seeker (s4) with experience of trauma and psychiatric symptoms

Client 11 is an asylum seeker (s4) with experience of psychological stress and physical health problems
Client 12 is a refugee with experience of trauma, psychiatric symptoms, suicidal ideation and physical health problems

Client 13 is a destitute asylum seeker with experience of torture, psychological stress, dual diagnosis and suicidal ideation
Client 14 is an asylum seeker (s4) with experience of trauma and suicidal ideation

Client 15 is a refugee with experience of torture, psychological stress, and physical health problem
Appendix 4 - Types of treatment and preference

Survivors of Trauma

Families

People undergoing significant psychological stress & behavioural difficulties
Dual Diagnosis

Psychiatric Symptoms

Suicidal Ideation
Physical and mental health issues

![Bar chart showing different methods of dealing with physical and mental health issues.]

- Crisis
- Pharmacological
- Individual talking
- Family therapy
- Self-help/Group
- Psycho-education
- Alternative/complementary
- Advocacy
- Triaging
- In-patient

Legend:
- Red: Physical and Mental Health Issues Unhelpful
- Blue: Physical and Mental Health Issues Helpful