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Refugee and Asylum Seeker Communities and Access to Mental Health Support: A Local Case Study

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Abstract

The complex mental health needs of refugee and asylum seeker (RAS) communities, often resulting from past trauma, are not met by overburdened and inadequate service provision. Pre-displacement, in-transit, and post-settlement traumas create a specific set of mental health needs which underfunded mental health services often cannot meet, despite the illusion of access to a range of services. This paper aims to explore how a range of stakeholders responded to inadequate provision at the local level. Interviews and focus groups with regional stakeholders, charities and RAS community groups, which were conducted as part of wider mixed-methods project on international migration in Northern England, revealed several gaps in provision. Findings indicate that charities and community groups are often left to fill the gap and provide signposting and liaison with local authorities. However, these groups are often ill-equipped to provide sufficient support but the absence of commissioned services leaves limited options. We conclude by suggesting that further research is necessary on trauma, RAS communities, and the pathways to mental health support.

Keywords Refugee · Asylum seekers · Trauma · Mental ill health · Support

This paper uses data from a mixed-methods research project that mapped the impact of migration on the settled community of a town in Northern England [1], which included identifying impacts on local service provision [2]. Significant questions emerged about the scale of mental health issues within the local refugee and asylum seeker (RAS) community, alongside gaps in service provision. The original contribution shows that gaps in service provision for complex trauma and mental health needs are filled by local Voluntary and Community Sector (VCS) groups. This article outlines literature on RAS mental health to present a framework that situates the existence of trauma at three stages: in the events that preceded exit from country of origin; in transit; and in settlement in the UK [3, 4]. Following a short methodological discussion of our case study, we present qualitative findings to illustrate our argument; that RAS mental health is distinct from a wider mental health crisis in respect to specific traumatic experiences and that service provision is often unsuitable, despite the best intentions of a range of stakeholders. As global and regional events continue to propel migrants from their countries of origin [5], understanding the nature and impact of trauma along various points of the migration journey will be essential in ensuring adequate support in host countries and local authority (LA) areas.

Background

Mental health has increasingly moved to the forefront of public consciousness: research demonstrates rising levels of mental ill health, anxiety, and depression [6], particularly in the context of the Covid-19 pandemic, as well as the limits to service provision [7]. RAS communities are far from homogenous and do not exhibit the same mental ill health issues but do represent a population exposed to specific

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mental health affects [8]. Lindencrona et al. [9] argue that refugees are more likely to face post-traumatic stress disorder (PTSD), depression and anxiety compared to settled populations. DeAntsiss et al. [10] identified a range of reported mental health problems in refugee children including learning difficulties and impaired school function, defiance and hyperactivity, eating disorders, sleep disturbance, aggression, bedwetting, nail biting, suicidal ideation and attempted suicide, self-harm, introversion and tiredness. DeAntsiss et al. [10] also found children were often more resilient and many refugee children showed no adverse effects of traumatic experiences, indicating the complex nature of mental health. Here, we recognise the impact of pre-displacement trauma, transit and flight, and post-displacement or settlement trauma as distinctive [11–13] requiring specific responses from a range of services [14].

Pre-displacement triggers, those events that force refugees and asylum seekers from their home countries, appear to be influenced by traumatic war experiences, levels of education [4], socio-demographic factors, age, loss of parents, and high levels of exposure to trauma and violence [10]. In Briggs' study of refugees across Europe [5], many had faced war, bombings, terrorism, political murder, torture, beheadings, rape and sexual assault. In older refugees with lower levels of education and extreme traumatic experiences, Bogic et al. [4] found a higher incidence of PTSD. Jewkes' [15] work on female prisoners follows Burstow's contention that trauma is a fluid phenomenon that exists on a complex continuum. Dura-Vila et al. [3] found that more recent arrivals and younger refugees had considerable mental health needs and were often more likely to have exposure to war and violence.

Post-settlement factors also appear to impact upon RAS mental health [11]. McColl and Johnson [14] neatly summarise this,

> In the UK, post-migration adversities include social isolation, discrimination, poverty, lack of stable housing, and uncertainty about asylum applications. Government policies and legislation can also contribute to post-migration adversities for asylum seekers and include dispersal, detention, and denial of the right to work. These adversities and the cultural diversity of refugee populations are likely to make meeting their needs a considerable challenge for UK mental health services. (790).

The administrative process of seeking asylum has been linked to heightened anxiety, particularly if the culture or atmosphere of that country is hostile or unwelcoming [10, 16]. Jannesari et al's systematic review [11] found seven themes associated with mental health problems amongst asylum seekers: working conditions; social networks; economic class; living conditions; healthcare; community and identity;

and the immigration system. All link to post-migration. Additionally, Kim's [12] study of Latino and Asian refugees in the US found unemployment, everyday discrimination and limited English were significantly associated with poor mental health. Likewise, McColl and Johnson [14] identified high and unmet need, which included finance and housing, social contact and daytime activity, were all post-settlement factors. Kim [12] further suggests that post rather than presettlement traumas were less likely to affect mental health outcomes, but the combination of pre- and post-settlement traumatic experience creates a specific set of issues that require trauma-informed intervention.

This increases pressure on local support services, including health care. In their case study of a North London community intervention, Harris and Maxwell [17] found that therapy and counselling alone were not sufficient to support refugee communities. DeAntsiss et al. [10] highlighted problems with limited access to same culture child mental health services, high cost, waiting times, service complexity, bureaucracy and a reliance on primary health care. Relatedly, McColl and Johnson [14] point out the cultural and linguistic barriers that services must overcome to manage complex clinical need. Pre- and post-migration effects play a significant role in RAS mental health and impacts upon support services. We now turn to our project to situate our research in this context.

Methodology

This research comes from a Controlling Migration Fund (CMF) study commissioned by a local authority in Northern England [2]. We mapped the impact of international migration on the settled community of an anonymised local authority area. Research objectives included: mapping demographic change; considering the impact of recent demographic change on community cohesion; issues related to crime; and the impact of international migration on local services. We analysed public and private data to provide baseline insight and attended almost 100 meetings with a wide variety of stakeholders. The project team undertook 41 semi-structured interviews with stakeholders, partners, local VCS, BAME and refugee support groups, and community residents. We also conducted focus groups with VCS, BAME and refugee support groups, speaking to 21 additional participants. We employed participant observation and ethnographic methods spending extensive time in two town centre wards, in excess of 50 hours, which included informal discussions with residents and business owners, and attending community meetings. Project stakeholders included the local authority, the regional police force, the Police and Crime Commissioner's office, local representation from Public Health England and the Regional Migration

Partnership. This phase of the project ran from 2017 to 2019. The project received ethical approval from the host institution's Research Ethics Committee.

The local authority area covers a population of around 140,000, increasingly sustained by inward international migration [2, 18]. This locale has undergone a sustained and challenging process of deindustrialisation and entrenched socio-economic deprivation [1]. According to the English Indices of Deprivation [19], over 50% of wards in this local authority area are situated within the 20% most deprived wards in the UK. Around 10% of the local population were born outside the UK, from around 50 different countries, whilst long-term Asian and Middle Eastern communities settled from the 1950s onwards. Recent Eastern European arrivals have further concentrated migration in three central wards, where the 2011 census reported 25–30% of residents as non-UK born. Additionally, the local authority is an asylum seeker dispersal area. We have anonymised the local authority area and all participants have been given pseudonyms.

Findings

The findings on mental health and the RAS community reflect consistent themes across the literature relating to the severity of trauma (post and pre-settlement), mental ill health, and gaps in service provision. This was confirmed both by RAS community groups and by stakeholders including public health officials, police officers and mental health professionals. Year-on-year funding cuts to NHS mental health provision have led to a system stretched to crisis point, which cannot respond to mental health need [7], let alone for those with complex and multiple vulnerabilities. In addition, our research location has historically experienced some of the highest rates of asylum seeker dispersal in the UK. Given that decisions on dispersal areas are based solely on the availability of low-cost housing stock with no regard for the impact on local services, this may have increased pressure on mental health service provision in the town. The absence of a multi-agency approach to RAS mental health care or adequate service provision through normal channels left VCS organisations to fill the gap.

Our data highlights the scale and extreme nature of mental ill health amongst the RAS community. Respondents from the focus groups with BAME and refugee support groups both agreed that mental health represented the biggest issue facing this community. One participant referred to 'extreme trauma' while another spoke of people in a state of 'mental chaos'. This manifested in suicides, fatal interpersonal violence, as well as people sleeping rough despite their right to remain. Another focus group participant from a refugee support group, Sam, referred to people carrying knives with others afraid to leave their homes. Indeed, although they represent extreme cases, our findings refer to several deaths due to trauma and mental illness in recent years, exemplified here:

> There's quite a lot of issues with mental health within our communities. I know…a number of people who have mental issues, some of them are not aware of it but you can see from them. I have one friend who is now in [secure mental health hospital], yeah, he's there because he killed somebody in the house he used to share. He came in as an asylum seeker…I used to see him…I used to advise him as well. And this happened, I met him, I give him advice. I was talking to Talking Therapies for an appointment for him so they would see him and over the weekend he stabbed somebody in the house.
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> We have cases that are sad to see; you see someone deteriorating…because they're not getting enough support here…I know a lady who was here who used to bring their child for play area here [local VCS] for children, she started deteriorating slowly and eventually it escalated after a few months. The next thing she was walking almost naked in the streets here, but still nothing will be done.

These quotations show both the nature of trauma and mental ill health and also the feeling that timely support was missing or inadequate. In the first case, the RAS community functions as the support mechanism, talking to a troubled individual, providing guidance and even contacting Talking Therapies. In the second, the community member bears witness to this woman's decline in the absence of appropriate support.

This is not to say that there is an *absence* of provision. A range of services are available, from self-referral to the local mental health trust, asylum seeker-commissioned GP services, Talking Therapies, and charitable support. The local authority also employs liaison officers which is a positive step. However, it is widely recognised that mental health provision in general is underfunded and the common view amongst the RAS community, and those working with them, was that services for their community were inadequate. Findings did identify issues with poor signposting, absence of joined up provision and a lack of bespoke trauma-informed provision capable of dealing with language barriers as well as a lack of intermediate-level support [17]. A health care professional, Jane, working with the local Public Health team emphasised this point,

"one of the big issues for vulnerable migrants, asylum seekers, refugees and some BME EU is around accessing mental health, appropriate mental health. Because, there are services that are available, but it's not necessarily suitable for people who might have experienced like you know,

adverse things like torture or like, rape and persecution. And, what you find is that people then start to present in A&E first of all, and then in the Mental Health Trust when they reach a crisis point."

Trauma and mental ill health in the RAS community must be viewed within the wider context where public services, including mental health provision, have seen funding cuts and capacity reductions that impact upon *all* community members [7]. If mental health provision is already difficult to access, groups with specific vulnerabilities and a higher degree of need will encounter barriers to access. On the face of it, there may be a list of options which give the impression that mental health support is available, but the difficulty in securing access coupled with the complexity of need renders this availability illusory. Moreover, refugee and asylum seeker communities have specificities that require understandings of trauma and would benefit from a trauma-informed approach [20]. Often, the misrecognition of trauma as cultural difference, 'difficult' behaviour or simple misunderstanding can inadvertently exacerbate an issue. In interviews with local authority and NHS staff and police officers, RAS mental health was not regarded as an overwhelming issue or drain on service provision but its distinct features, usually characterised as differences in experience and background, were acknowledged. Ultimately community members were quick to point out that charities, third sector and the refugee communities themselves filled the gap and provided support for complex cases which clearly involve trauma.

Discussion

We offer a new contribution to the literature via data from a funded project in Northern England that shows the specific nature and severity of mental ill health amongst RAS communities. The community itself suggested that traumatic experience manifests as mental ill health and creates service provision challenges for stretched public services. Refugee and asylum seekers inevitably face multiple traumas before and during their settlement in destination locales and support is required at all levels to help manage and cope with this trauma. As with the wider community, mental health and other public services face straitened conditions that prevent adequate and immediate levels of support and this is only anticipated to grow in the wake of the Covid-19 pandemic. We saw how the community itself, and charitable organisations, were expected to assume a high degree of responsibility to support those with complex trauma and specific need due to a lack of awareness or provision within local public services. This is unsustainable in the long-term and further research into trauma-informed service across all public sector providers alongside support for community members

learning to cope with the day-to-day realities of trauma is required otherwise cases such as those identified here will continue to occur.

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