



# Commissioning mental health services for vulnerable adult migrants

## Guidance for commissioners

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People who migrate to our shores due to severe, sometime unimaginable hardships in their country of origin are vulnerable to a host of potential mental health problems. Such challenges arise from oppressions that drive their decision to migrate, also separation from family, friends and cultural networks. They're often exacerbated by experience of the asylum process, in particular the use of detention centres, and the lack of appropriate health and other support services. Equally, vulnerable migrants may have existing, untreated mental health problems.

At Mind we believe that everyone experiencing a mental health problem should get both support and respect. This guidance goes some way to achieving this through enabling mental health services that truly address the needs of vulnerable migrants. It places the voices of people with direct experience of such journeys at the heart of mental health commissioning.

Our hope is that mental health commissioners and others responsible for developing policy in this area will make use of this guidance in setting priorities and taking decisions.

**Paul Farmer**, Chief Executive, Mind

## Feedback

We welcome feedback on the guidance and are keen to engage and learn from models of good practice which can be shared nationally through the NHS England Equality and Health Inequalities Knowledge hub – [england.nhs.uk/ourwork/gov/equality-hub/](http://england.nhs.uk/ourwork/gov/equality-hub/)

I am delighted to endorse this new guidance to improve mental health service provision for vulnerable migrants. The traumatic nature of many experiences of migration is on our television screens nearly every day at present. At the same time evidence continues to mount that there are often long term health consequences, especially mental health consequences associated with becoming a migrant, even in relatively benign circumstances. The recommendations in this report should help commissioners better understand the needs of service users, and with the strong focus on involving service users and people from migrant communities in shaping services, should help services themselves become more relevant, appropriate and successful in their work with some of the most vulnerable and marginalized people in British society.

**Alex Bax**, Chief Executive, Pathway

Throughout the development of the policies and processes cited in this document, we have:

- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and
- Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

This comprehensive guidance is essential reading for NHS Commissioning Managers, to help deliver Parity of Esteem and, as outlined in the NHS *Five Year Forward View* to reduce health inequalities by 'improving mental health outcomes through; better prevention, increased early access to treatments and crisis care, integrating care to reduce premature mortality and new ways of delivering services.'

The guidance informs the effective commissioning of mental health services for vulnerable migrants, including refugees, asylum seekers and people who have been trafficked into the UK. Using the guidance to commission services will help empower one of society's most vulnerable groups to get the most appropriate and accessible healthcare required; at the right time, at the right place and in the right way.

**Dr Angela Burnett**, GP and co-author of this guidance

The first version of this commissioning guidance formed part of a wider project undertaken by us at the request of the Department of Health in 2005/6 and was further developed by Sile Reynolds. The guidance has subsequently been updated and adapted to include recent changes in policy and in the commissioning landscape by the current authors. We are delighted to see its publication.

**Dr Pauline Lane**, Reader in Mental Health, Department of Primary and Public Health, Anglia Ruskin University

**Professor Rachel Tribe**, School of Psychology, University of East London

# Foreword

I am delighted to provide the foreword to this guidance which I hope will help improve commissioning in this important area and, as a consequence, achieve excellent quality of care for vulnerable migrants.

All health professionals have a duty of care to everyone seeking health care, including vulnerable migrants. Indeed, the NHS *Five Year Forward View*<sup>1</sup> places great emphasis on addressing health inequalities, and improving physical and mental health. This emphasis is reflected in this guide and should prove useful in helping commissioners make better informed decisions. Lack of access to appropriate high quality care has deleterious effects on the health of those who are amongst the most excluded and vulnerable in our society, thereby undermining policies aiming to reduce health inequalities, and infringing the basic Human Rights obligations of the UK.

The UK has an honourable record of ratifying international human rights treaties. Among them are several that include the right to the highest attainable standard of physical and mental health<sup>2</sup>. This human right encompasses equitable access to health care. Moreover, it places binding international obligations on public authorities. It is time for the United Kingdom to take this fundamental international human right more seriously and this guidance is one important step in that direction.

Charging vulnerable migrants for health care could reduce access to health care provision for a group already marginalised and poorly served.

Health and social care services currently provide a wide range of mental health care and support to migrant people. However, Mind's work in this area<sup>3</sup> has shown that many commissioners find it difficult to identify and address the specific mental health needs of migrants, largely due to gaps in appropriate information and experience. Commissioners must consider how to effectively engage migrant users and communities in planning, evaluating and improving services.

This would ensure that migrants' circumstances and needs, which are often highly complex, requiring ongoing consultation, review and evaluation of care, can be accommodated.

Mind, with the support of the Faculty for Homeless and Inclusion Health/Pathway, commissioned the research and publication of this guide to assist Health and Social Care commissioners to achieve culturally and linguistically sensitive mental health services for vulnerable adult migrants. The authors have adopted a style which means it can be used as a reference point which is not prescriptive and which builds on commissioners' skills and experience. It offers clear guidance on the different stages of the commissioning process including needs assessment, service design and review, deciding priorities, community development and user engagement, compliance with Equality legislation and responsibilities to reduce health Inequalities under the Health and Social Care Act 2012, clinical standards, measuring health outcomes, monitoring and evaluation. Each section contains examples of good practice and case studies with details of contacts and resources.

The guidance aims to achieve:

- meaningful engagement with migrant communities and practitioners who work with vulnerable migrants
- culturally appropriate needs assessments
- co-designed services
- excellent outcomes

A number of Mind user groups have already been using the guidance to engage effectively with their local commissioners, in order to improve the quality of mental health services for vulnerable migrants I hope you find the guidance very helpful.

**Professor Steve Field CBE FRCP FFPH FRCGP,**  
Chairman, National Inclusion Health Board

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# 1. Introduction

**I was really in crisis with multiple problems with my health and social situation. The community advocacy project supported me, helped me to go to the hospital and explained my medication. They helped me to understand my illness and supported me at home - if they had not been there I could have ended up in a mental health institution, my children taken into care and no community support.**

Population movement is an integral part of an increasingly globalised society. The estimated total long-term immigration to the UK in the year to September 2012 was 500,000, significantly lower than previous years<sup>4</sup>. These figures include an estimated 273,000 non-EU citizens, 105,000 people from New Commonwealth countries and 58,000 people from EU8 (central and eastern European) countries. Asylum seekers make up only a small proportion of inward migration, although they may be among the most vulnerable. In 2012, asylum applicants excluding dependants numbered 21,785 (falling from a peak of 84,000 in 2002)<sup>5</sup>.

The growing size, diversity, mobility and vulnerability of the UK migrant population have important implications in planning and delivering mental health services. Understanding people's migratory experiences is essential if commissioners and providers of mental health services are to establish the link between these highly risk-laden experiences and migrants' subsequent mental health needs. People migrate to the UK from abroad for diverse reasons, which makes migrants a very heterogeneous group.

Vulnerable migrants include people who are seeking asylum, refugees and those with humanitarian protection and their families, separated children, Roma, Gypsies and Travellers, people who are undocumented,

refused asylum seekers and those who are trafficked for various forms of forced labour, sexual exploitation and modern slavery.

Immigration status for asylum seekers is often fluid: as an illustration, if an asylum claim is refused, the person can appeal or make a fresh claim but will be homeless and may have no access to free secondary health care until that claim is processed. At present 30 per cent of those refused receive a positive decision once reviewed by an independent tribunal. Therefore commissioners need to develop pathways which ensure that healthcare is stable and robust throughout the pattern of changes in status.

The term vulnerable is used to describe those who have been adversely affected by circumstances leading to or resulting from migration and refers to their circumstances rather than an attribute of people themselves<sup>6</sup>.

New migrants from these different groups frequently face adversity before, during and after arrival in the UK, resulting in complex service needs<sup>7</sup>. If people's psychological problems are not addressed early on, individuals may develop severe and enduring mental health problems<sup>8</sup>. Some may have experienced multiple bereavement and will lack contact with their usual support structures. However, at the same time, it is also important to recognise that migrants are expressing normal psychological reactions to highly abnormal experiences and practitioners need to be cautious not to over-medicalise what may be appropriate responses<sup>9</sup>.

Addressing psychological problems can require a different approach and a longer time-frame, as the person may not be sufficiently stable or ready for psychological interventions such as CBT and may need a period of monitoring and symptom control. Many women, and some men, are survivors of sexual violence which will impact on their physical and mental health.

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**There is the expectation that asylum seekers coming from war-torn areas, who have been tortured, raped, imprisoned, trafficked, separated from families and friends, should arrive in the UK and cope with everything without any help or treatment. Many of us do cope but some can't and the most vulnerable go from crisis to crisis and end up in the street, prison or sectioned under the Mental Health Act.**

A meta-analysis of published literature on the health of refugees shows that refugees have an overall increase in psychological ill-health, which is not an inevitable consequence of conflict and trauma but which also reflects the socio-political conditions faced in host countries. It concludes that improving such conditions could improve mental health outcomes<sup>10</sup>. Survivors of torture and trafficking have often experienced extreme circumstances where they are exposed to uncontrollable and unpredictable events, which can result in severe and longer-term post trauma disorders<sup>11</sup>. Racial discrimination and the immigration process itself may impact on mental well-being<sup>12</sup> and migrants' high risk of homelessness and destitution<sup>13</sup> creates circumstances that further exacerbate their already fragile mental health<sup>14</sup>, so close working with the housing sector is important.

High levels of mental health problems have been identified in immigration detainees, with anxiety, depression, post-traumatic stress, self-harm and suicidal ideation, being commonly reported<sup>15</sup>. Detained asylum seekers have higher levels of self-harm and suicide as compared with the United Kingdom prison population<sup>16</sup>.

The suicide rate amongst Gypsies and Travellers is also higher than the general population. Studies have shown greatly raised levels of depression and anxiety, the two factors most highly associated with suicide, with relative risks

20 and 8.5 times higher than the general population<sup>17</sup>. Communities who suffer oppression, racism and rejection of their way of life are likely to experience heightened levels of substance misuse, suicide and self-harm all of which inflict a negative impact on the health and wellbeing of the rest of the family. It is recommended that Gypsies and Travellers and other vulnerable migrants should be included as a category in all health records to assist in mapping of self-harm, depression and associated risk factors.

As part of the government's commitment to reducing health inequalities in access and in health outcomes, policy has focused largely on tackling health inequalities of black and ethnic minorities. Less emphasis has been placed on the specific needs of migrants, reflecting the impact of their migration experiences. As a result there is relatively less evidence on health outcomes, needs and barriers to care for migrants as part of national data sets, which limits the strategic planning, service design and equalities monitoring which are essential to good commissioning practice.

The Department of Health 'Commissioning for Patients' fact sheet<sup>18</sup> makes it clear that NHS commissioning should be characterised by a better understanding of the health needs of the local population, including those unregistered, partnership working with patients to decide what services will best meet their needs, purchasing services that offer choice, and monitoring of the quality and outcomes achieved. This guide aims to support commissioners to achieve these and to successfully address the complex needs of vulnerable and diverse migrant populations. Commissioners should be aware that those unregistered will include undocumented and invisible populations, who rarely make use of traditional services and may actively avoid contact with the state. Community organisations may be best placed to provide services for people in these situations, and should be actively supported.

While this guidance focuses on adults, many of the issues covered are also relevant for commissioners and providers of CAMHS (child and adolescent mental health services). CAMHS need to work closely with education services and involve parents and the wider family in assessments and interventions. Special care needs to be taken to enable a smooth transition from CAMHS to adult services and to ensure no gap in service provision for young people whose age is uncertain or disputed.

## 1.1 Migrants' mental health

### Reducing health inequalities

Migration is known to be associated with poor health outcomes for marginalised and socially disadvantaged populations. Research continues to show a persistent pattern of ethnic differences in service experience and service user testimonies<sup>19</sup> and that the ethnic origin of a patient may unfairly affect access to medical care.

The Right to Health, protected in international covenants to which the UK is a signatory<sup>20</sup>, is binding and fundamental. It means that everyone has the right to the highest attainable standard of physical and mental health, which includes access to health care.

Commissioners are subject to the Equality Duty, which requires them to be responsible for everyone living in their area. Included are those unregistered with GPs<sup>21</sup>, who may be asylum-seekers, refugees, trafficked persons, victims of modern slavery, undocumented and invisible populations who rarely make use of traditional services and may actively avoid any contact with statutory services.

Additionally, commissioners need to take account of gender discrimination and the particular vulnerabilities of migrant women and girls to various forms of violence, including rape, Female

Genital Mutilation and early forced marriage, and their special service needs.

Migrant communities are often described as “hard to reach”, but commissioners should ensure that they are not “easy to ignore”.

Commissioners also have a responsibility to identify and redress health inequalities. An inclusive approach recognises that social justice must be a key element of the design and delivery of health services, prompting commissioners to focus on the most vulnerable, thereby facilitating their full participation in a cohesive and diverse local community.

The Marmot Review<sup>22</sup> has identified potential cost savings and better quality and improvements through:

- innovative, people-centred design and commissioning of services which could produce significantly better health outcomes for the most vulnerable by recognising challenges and tailoring services to meet their needs
- better co-ordinated services that provide a holistic approach based on the full extent of need
- early identification and intervention which are key to preventing longer-term, more costly health problems. Investment at an early stage can produce savings over the long term.

### Promoting equality and diversity

The Equality Act 2010<sup>23</sup> (the Act) replaced the previous anti-discrimination laws with a single Act, a key measure of which is the public sector Equality Duty<sup>24</sup> (the Duty). The Duty requires public bodies and others carrying out public functions to consider the needs of all individuals in their day-to-day work – in shaping policy, delivering services and in relation to their own employees. Commissioners are subject to the Duty in relation to the commissioning of mental health services.



The Equality and Diversity Forum's report *Who's still missing?* considers how public authorities might use the Equality Duty more effectively to incorporate refugee and migrant communities into their work<sup>25</sup>

Commissioners also have a duty to promote equalities and demonstrate progress in reducing health inequalities as outlined in the NHS Constitution<sup>26</sup>, the NHS Outcomes Framework<sup>27</sup>, and the Care Quality Commission's (CQC) Essential Standards<sup>28</sup>. The NHS Equality Delivery System<sup>29</sup> offers an optional tool for providers and clinical commissioning groups that provides a framework and equality objectives closely linked to CQC criteria.

### Compliance with public health targets and national standards

Consideration of the needs and experiences of vulnerable migrants is important to ensure compliance with national standards and statutory requirements, including the NHS reform white paper *Equity and Excellence: Liberating the NHS*<sup>30</sup> and *Legislative framework and next steps*<sup>31</sup>, as well as the public health strategy and outcomes framework *Healthy Lives, Healthy People*<sup>32</sup>, and the national mental health strategy *No health without mental health*<sup>33</sup>. All stress commitment to better community engagement, more patient choice and services that are responsive, timely and appropriate.

Under the NHS Act 2006 (as amended by the Health and Social Care Act 2012), clinical commissioning groups and NHS England must make arrangements that secure the involvement of people who use, or may use, services in:

- planning the provision of services
- the development and consideration of proposals for change in the way those services are provided – where the implementation of the proposals would have an impact on the manner in which the services are delivered or the range of services that are delivered

- decisions to be made by the NHS organisation affecting the operation of services. NHS Foundation Trusts and other Trusts providing NHS-funded services have a separate but similar legal duty regarding the involvement of service users under Section 242 of the NHS Act 2006<sup>34</sup>.

### Cost efficiency

An inclusive approach to commissioning can result in both economic and public health benefits. Vulnerable groups such as migrants often incur disproportionate costs per person, owing to the complexity of their needs and high use of emergency care. While data on the cost-effectiveness of healthcare spend on vulnerable groups is limited, evidence suggests that intervention has cost-benefits and that improving health inequalities could save the NHS £5bn per year<sup>35</sup>.

## 1.2 Migrants' Entitlement to NHS treatment

Migrants often face barriers when they try to access health services, as NHS entitlement rules relating to immigration status are complex and have given rise to much confusion.

Everyone, irrespective of immigration status, is eligible for full GP registration, meaning that:

GPs may register anyone as an NHS patient, as long as they do not discriminate. This includes refused asylum seekers and undocumented migrants. In addition GP practices have a contractual duty to provide emergency treatment and immediate necessary treatment free of charge for up to 14 days to any person within their practice area.

Accident and Emergency, sexually transmitted infections including HIV, TB and compulsory psychiatric treatment is currently free for everyone.\*

All asylum seekers with an active claim and their dependents, refugees, those with humanitarian protection or discretionary leave, those with Indefinite Leave to Remain and residents of EEA states and Switzerland are all entitled to full access to primary, secondary and tertiary NHS care without charge.

The regulations governing secondary care are more complex, with some migrants being liable to be charged. Everyone must be given immediately necessary and urgent hospital treatment regardless of their immigration status and ability to pay, although a charge may be levied if they do not qualify for free care. If a clinician deems that a migrant liable for charges needs immediately necessary or urgent mental health care but the person is unable to afford treatment, then that treatment should not be withheld. New exemptions from charges have been recently introduced in respect of services provided to migrants as a consequence of torture, Female Genital Mutilation, domestic violence and sexual violence. Children looked after by a local authority, including those unaccompanied, are also exempt.

**Immediately necessary** treatment is any treatment which is needed to save a person's life or to prevent a condition from becoming immediately life-threatening or which is required promptly to prevent serious damage from occurring. **Urgent** treatment is treatment which cannot wait until the person returns to his/her home country.

Those with low or no income and not in receipt of benefits, may qualify for an HC2 certificate which gives access to free prescriptions and help with other NHS costs<sup>36</sup>.

For further guidance on NHS entitlements see:

- Guidance on implementing the overseas visitors' hospital charging regulations, Department of Health (2015)
- BMA Overseas visitors accessing NHS primary medical services: Guidance for GPs
- RCGP Position Paper on Asylum Seekers/ Vulnerable Migrants and Access to Primary Care

### 1.3 Addressing barriers to health care

Some migrants find it difficult to raise concerns about mental health due to differing cultural perspectives of mental illness. Rates of somatisation (presentation of mental health problems in the form of physical symptoms that have no identifiable physical origin) are high among refugees and asylum seekers, suggesting that the true prevalence of mental health problems may be masked. Costly over-investigation and referral of physical complaints is common, resulting in heightened anxiety and polypharmacy. A relationship of trust is crucial in the identification of mental health problems and the delivery of care and support services, which can be improved by continuity of care and access to trained interpreters and advocates<sup>37</sup>. Community based health awareness programmes can reduce the stigma of mental health in migrant communities and can assist with navigation of health services.

**Mental health services are seen by our community as a place for mad people who have no hope of being cured. They are the cursed and you should not care too much about them – this stigma causes a lot of problems, including isolation, which makes their illness worse.**

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\* These services are only free as long as the patient has not traveled to the UK for purposes of receiving such treatment.

Accessible appointments of appropriate length should be offered. The complex problems and language needs of vulnerable migrants may require longer appointments than usual.

Interpreters are not always available and people are sometimes obliged to rely on friends or family to interpret, or to attempt to communicate complex ideas while lacking fluency in English. It is imperative that healthcare workers offer a qualified interpreter, trained to work in a mental health context, to all those who need language support. Without an independent interpreter, a survivor of domestic violence or trafficking will be unable to disclose their situation without compromising their safety.

Face to face, rather than telephone, interpreters are preferable in mental health settings, particularly for distressed patients. However there may be a tension between the familiarity of being supported by someone from a person's own community and concerns of confidentiality and in some circumstances the relative anonymity of a telephone interpreter or advocate may be preferred. The governance implications of not using independent interpreters need to be understood.

Mental health problems in BME communities have increased in recent years<sup>38</sup> The 2009 annual census of the number and ethnicity of all psychiatric and learning disability inpatients in England and Wales found 22 per cent of all patients to be from BME groups, compared with 20 per cent in 2005. The overall BME population identified in the Census for this period was 12.9 per cent, which demonstrates over-representation of BME communities in mental health services. However there are still large gaps in mental health services, particularly in the provision of education, awareness, information materials and health promotion that specifically tackle stigma in migrant communities and access to primary care<sup>39</sup>.

Some migrants do not register with a GP - particularly short-term and younger economic migrants and undocumented migrants. This maybe because when faced with so many practical issues they do not prioritise their own health or may disregard health as a form of self-harm or neglect. Trafficked persons are likely to be denied access to health care by those controlling them, unless they develop a serious health problem. Those undocumented may be anxious about GPs as figures of authority linked to the state, or GPs may have refused to register them based on incorrect guidance concerning entitlement to care. Some may have experienced multiple refusals of registration.

Prior to PCTs being abolished a study in 2010 highlighted that over two-thirds of PCTs in London<sup>40</sup> issued incorrect guidance to GPs that they should only register people living legally in the UK for more than six months, despite the fact that the 'ordinarily resident' test applies only to secondary care. CCGs should avoid demanding proof of immigration status and residence before they register patients.

The barriers migrants face in accessing mental health services, including language difficulties, lack of interpreters, cultural beliefs and practices, restrictions in entitlement to healthcare, social isolation, racism, stigma, unemployment and poverty, may affect the perception and utilisation of available mental health services and may act as a significant disincentive to accessing services at an appropriate time. Vulnerable migrants may lack a secure address to receive appointment letters and home-based interventions are out of reach for those who are homeless.

For further details please consult Guidance for NHS commissioners on Equality and Health Inequalities Legal Duties\*.

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\* [england.nhs.uk/ourwork/gov/equality-hub/legal-duties/](http://england.nhs.uk/ourwork/gov/equality-hub/legal-duties/)

## 2. Strategic Planning

### 2.1 Underlying values and principles

In addition to their usual approach, commissioners should aim to:

- adopt a multi-agency partnership approach to commissioning, collaborating with social services, voluntary and migrant community organisations to identify the migrant population profile, needs, expectations and experiences, and cross-referencing a range of data and information sources
- ensure that JSNAs include regularly updated information on the mental health needs of local migrants, including their particular challenges in accessing and utilizing services
- undertake an equality impact assessment of all new services and as part of reviewing services to ensure that policies and services are inclusive for migrants
- promote social inclusion and independence
- build capacity in migrant communities to engage in community consultation and networks as equal partners to identify need, define service specifications, monitor and provide services
- embed an equalities approach in every stage of the commissioning process, from strategy to service specification and monitoring
- engage community-based service provision, Community Development Workers, health advocates and migrants as partners in the wider determination of mental health outcomes
- develop culturally sensitive preventive and talking therapies such as multicultural counselling and advocacy services
- develop low cost and high impact culturally appropriate health promotion interventions working with established community organisations and responding to the needs of the most vulnerable migrant groups.
- develop low cost and high impact culturally appropriate health promotion interventions working with established community
- Promote approaches that encourage the lawful sharing of information between health and social-care professionals in support of multi-agency care delivery

### 2.2 Standards for Commissioners<sup>41</sup>

- The accountable officer for vulnerable migrants (whether in a CCG or NHS Board regional office) should be at Director level or above.
- Evidence of partnership working with statutory and voluntary sectors and service user engagement should be published.
- Standard data sets concerning the numbers of vulnerable migrants, their health and associated expenditure should be collated, reported and acted on by commissioners at least annually. Data should be collected in such a way that targets do not distort outcomes.
- Means of enhanced/easy access to health care for vulnerable migrants should be described and publicised for each area – including specialist services, enhanced access and outreach services from mainstream providers. GP Practices should be regularly tested for whether they are operating within the terms of their contract when registering vulnerable migrants.
- Commissioners should require proactive care planning, moving away from gate-keeping (spending time assessing and rationing entitlement) towards proactively planning to meet people's needs.
- Commissioners should require horizontal patient-centred integration (care planning and continuity across community settings and service provider boundaries), so that people can receive continuity of care even if they change immigration status and/or move from the address that originally gave them access to that care.



- Commissioners should require vertical integration (care planning and continuity of care into secondary care and back into the community) and a clear expectation of compassion, communication and continuity of care between primary, community and secondary care.
- Outcomes and measures of success should be shared across multiple agencies, such as reductions in hospital admissions, A & E attendances and multiple GP appointments.

## 2.3 Joint Strategic Needs Assessment (JSNA)

Commissioners are responsible for everyone living in their area, including those unregistered with GPs<sup>42</sup>. Joint Strategic Needs Assessments are potential sources of information on the health needs of the local population but their usefulness is dependent on whether information on ethnicity and the health needs of migrants has been included. Those unregistered may include undocumented and invisible populations who rarely make use of traditional services and may actively avoid any contact with the state.

By their nature, migrant populations are extremely diverse, less visible, mobile and poorly captured by current national data sets, data sources and surveys. In addition, migrant communities and their needs are not static and may change quickly, so they present considerable challenges to commissioners seeking to stay ahead of local population changes. One of the greatest challenges for commissioners is identifying and quantifying the invisible migrant population - including undocumented migrants, spouses, and refused asylum seekers - as they may have no contact with statutory services and therefore are not captured in any monitoring data, yet these are often the most vulnerable migrants. Commissioners should therefore utilise

relevant data sources (listed in appendix 3) in order to achieve as accurate a picture as possible of the needs of vulnerable migrants and to understand the expectations of mental health services of different communities within the local population. People may have distinct needs related to their experience of migration, varying expectations according to their perception of mental health, and different awareness levels of available services and routes to access.

A Joint Strategic Assets Assessment (JSAA) identifies local assets which can protect health and wellbeing and improve outcomes, including the quality and accessibility of local services and community resources and protective factors such as social and cultural resources within communities. An assets based approach can contribute to reducing health inequalities<sup>43</sup>.

## 2.4 Community engagement/development

Community development is about building active and sustainable communities based on social justice, mutual respect, participation, equality, learning and cooperation. It involves changing power structures to remove the barriers that prevent people from participating in the issues that affect their lives.

A 'co-production' approach to needs assessment (involving migrant service users and community members at the earliest point in the commissioning process), acknowledges the expertise, experience and networks within migrant communities, and will allow commissioners to identify population profiles and needs, highlight gaps in service provision and design culturally appropriate and effective services.

Involvement in service planning and delivery means more than just completing a consultation questionnaire or attending an event. For migrant



communities, it means being recognised, having a safe space to meet, providing mutual support, gaining knowledge, skills and confidence to engage more widely, being listened to with respect and receiving honest feedback about decisions.

There should be a named person with whom community groups can link as a bridge to contact commissioners.

Commissioners should bear in mind the immense diversity within and across migrant communities. Some members within communities such as women, young people and lesbian, gay, bisexual and transgender (LGBT) people may be poorly represented by traditional community or religious 'leaders'. Research with migrant gay men highlighted their enhanced needs and the impact of compound minority status<sup>44</sup>.

The dynamics of population change and turnover of new communities arriving with different needs and experiences provides a range of opportunities for NHS commissioners to collaborate with local community and voluntary sector groups in working with vulnerable migrant communities. Engaging with specific communities and networks that have previously had limited contact requires an investment of time, effort and resources, but is likely to have a positive impact on reducing health inequalities. The shifting landscape of service provision and governance may confuse those who have recently arrived and are learning to navigate statutory structures. Consistency, transparency and sustainable resourcing to support community networks are crucial to build trust and credibility in the consultation process.

Migrant Community Organisations (MCOs) and service users groups are often able to inform commissioners about good practice and gaps in the system, and to improve mental health services. However MCOs reliant on volunteers are often poorly resourced to facilitate consultation with members of migrant communities. Furthermore, competition between MCOs for

statutory funding can hinder partnership work. Community engagement and consultation require infrastructure development and sustainable funding.

A number of national strategies and targets aiming to improve health and wellbeing and reduce health inequalities highlight the importance of involving local communities in health-related activities, particularly those experiencing disadvantage<sup>45,46</sup>.

Approaches include citizens' panels and juries, neighbourhood committees and fora, community champions and the collaborative methodology (used in initiatives such as the Healthy Communities Collaborative)<sup>47</sup>.

## 2.5 Review current service provision

The extent to which existing service provision meets the current and anticipated future needs of the local migrant population should be reviewed with a clear understanding of how service investment could be better targeted. Better recording of ethnicity and identification of migrants will make it easier to measure the current impact of services. Commissioners should take into consideration migrant experiences when mapping current services, analysing capacity and demand and auditing referrals and pathways in order to ensure that vulnerable migrants' experience of mainstream mental health services is equivalent to that of the local indigenous population. The involvement of migrants in mental health action groups or user groups can allow commissioners to examine care pathways taken by migrants, and identify any inappropriate or ineffective practice.

Like other vulnerable and marginalised communities, migrants may use accident and emergency services because they offer a simpler, more direct and highly visible point of contact for people who may not be aware of

more appropriate pathways. Clear care pathways are a key element of demand management, and include delivering community-based prevention and awareness-raising programmes, in order to draw activity away from secondary care. Migrant organisations are often well placed to deliver community-based early intervention and prevention services, as they may be better equipped to deal with access issues such as language support, lack of awareness, stigma, exploration of expectations of treatment and cultural influences. The lives of many vulnerable migrants are unpredictable and drop-in services may be easier to access.

Migrants' experiences of therapeutic interventions may differ: counselling may be an unfamiliar concept for many migrants, who are not accustomed to discussing their intimate feelings with a stranger. Some may benefit from services and support that are not explicitly about mental health, such as creative groups, sports, social events and language classes, but through which messages about mental health can be communicated.

Service review should include the full range of statutory-funded mental health services, including specialist provision and Local Enhanced Services, as well as non-funded services provided by the voluntary and community sector that perform a formal or informal therapeutic function. Commissioners should have an understanding of the role played by general wellbeing and social interaction services provided by the voluntary sector, particularly with regard to the cost benefit achieved through early intervention and diversion away from costly NHS services. This will allow commissioners to identify valuable resources within migrant communities in line with the co-production approach (see section 2.4)

Routine and consistent collection and analysis of ethnicity, language needs, including dialects, religion, country of birth and outcomes data is fundamental to robust commissioning, enabling

commissioners to develop a good understanding of the accessibility and effectiveness of existing services in addressing the needs of vulnerable migrants (see section 2.3 on needs assessment and 4.1 on monitoring outcomes).

## 2.6 Decide priorities and define the strategy

By working with partners, stakeholders, communities, users and carers, commissioners should develop a coherent and well-evidenced commissioning strategy, laying out clear recommendations for future services with plans for delivery and a timescale for change.

Commissioners should ensure that services are in place to provide gender and culturally sensitive support for women. For a comprehensive set of guidelines see *Guidance for commissioning health services for vulnerable migrant women*<sup>48</sup>.

Key national and local strategic drivers include wellbeing and self-care, early intervention and community-based care, integration of care across organisations, a whole pathway approach, personalisation and choice, quality, safety and effectiveness, patient experience and outcomes and plurality of providers, all of which offer opportunities to improve accessibility and effectiveness of mental health service for vulnerable migrants.

Mainstreaming service provision is a key strategic driver and, as a consequence, tackling barriers to accessibility must be a strategic priority. In designing the strategy, commissioners must challenge barriers to access and include appropriate information provision, language support and advocacy services, health promotion and mental health awareness.

Some people's needs may not be met by mainstream interventions and will require

specialist or culturally specific services. Survivors of torture with complex mental health needs may require specialist help. Freedom from Torture, a voluntary organisation provides therapeutic mental health services for survivors of torture and their families, and also supports and trains other organisations in both the statutory and voluntary sectors, increasing their capacity to provide care for torture survivors<sup>49</sup>. However limited funding and capacity within the voluntary sector may leave those with complex needs but who do not meet specific criteria without provision.

Evidence on which resource allocation decisions are based needs to be presented clearly and publicly. Suspicions about unfair access to resources can fuel resentment between migrant communities and service providers, highlighting the importance of visible fairness through good communications and accountable forms of governance. Migrant stakeholders, alongside others, should have an opportunity to comment on the strategy through public consultation and engagement with the Health and Wellbeing Board.

## 2.7 Equality Impact Assessment (EqIA)

Equality Impact Assessments aim to improve the quality of local health services by ensuring that individuals and teams consider the likely impact of their work on different communities or groups. It involves anticipating the consequences of the organisation's policies and services on different communities to ensure that any negative consequences are eliminated or minimised and opportunities for promoting equality are maximised.

An EqIA considering the impact on migrants consists of two sequential parts:

a) An initial screening of services and policies on their relevance to migrants

b) A full assessment, if the initial screening has identified a possible adverse/negative impact on migrants.

A negative or adverse impact is an impact that could disadvantage migrants as a group. This disadvantage may be differential, where the negative impact on one particular group of migrants is likely to be greater than on another.

A positive impact is an impact that could have a positive effect on one or more groups, or improve equal opportunities and /or relationships between groups, which may also be differential.

An EqIA should be applied to policies, practices and services to ensure:

- all new policies or changes in services do not discriminate against any sector of the migrant community
- improved access, cultural sensitivity and uptake of mental health services including mental health promotion and well being
- evidence for tackling health inequalities and making progress towards meeting the health needs of vulnerable migrants
- partnership with other stakeholders including community groups to become more accountable to local people including migrants
- effective Public and Patient Involvement strategies which reach out to and include traditionally excluded migrant groups
- improved equalities monitoring of the workforce to increase the diversity of staff to reflect the migrant and BME population that they serve.
- periodic reviews of progress using achievable and measurable patient outcome indicators, the results of which should be openly disseminated through websites and other public media

For a step by step guide to conducting EqIAs see Appendix 1.

## 2.8 Recommendations for improving strategic planning

- Recognise migrants as a specific and diverse population in strategic planning and assessment and take reasonable steps to measure or estimate undocumented and clandestine populations and assess their needs.
- Recognise the evidence base on migrants' specialised mental and physical health needs and gender-specific needs of women and girls.
- Cross-reference national and local data including the Mental Health Minimum Data Set, Regional Public Health Observatory health profiles<sup>50</sup>, Annual Population Survey, Census data, ONS migration data, GP registrations by local authority (Flag 4), National Insurance Numbers, Workers Registration Scheme, data from schools and higher education institutions and Home Office asylum statistics. A full critique of available data sources can be found in the Health Protection Agency report 'Understanding the health needs of migrants in the South East region'<sup>51</sup>.
- Ethnicity data collected by service providers can provide proxy information on the local migrant population. However, ethnicity categories rarely reflect the heterogeneity of the migrant population. Providers should be contracted to collect data on country of origin, nationality or preferred language, which may give a better indication of migration status, with consistent ethnicity data collection across the full range of primary care, mental health and acute services. Rio collects information on ethnicity, nationality and first language spoken, which can be usefully combined to identify the needs of the local population. GPs routinely collect ethnicity data and can add "country of birth" on EMIS and VISION computer systems<sup>52</sup>.
- Consider undertaking more focused research into specific migrant groups such as Eastern European agricultural workers, refused asylum seekers, torture survivors, or thematic areas, such as interpreting and advocacy support services, mental health promotion and community development workers depending on local need.
- Map migrant community organisations and local community-based service provision, and build networks with particularly marginalised communities.
- Consult migrants about the best way to involve them in community consultations and consider creative methods of engagement. Faith groups, shops, schools, festivals, sports events and the internet are all ways of engaging with 'easy to ignore' or traditionally excluded groups.
- In partnership with the local authority, encourage initiatives to address gaps in community and service user engagement through capacity-building and community cohesion activities. This may include assisting migrant organisations to access appropriate and sustainable funding for infrastructure development.
- Support partnerships with the police to encourage hate crime reporting.
- Examine the purpose, membership and remit of existing community engagement networks, including BME health networks and fora, to ensure they are effective and inclusive. Work with the local Council for Voluntary Services, HealthWatch and service user groups to ensure that they involve migrant communities. Invite migrant community leaders and service users to participate in management committees, steering groups, and client feedback groups, ensuring that a range of engagement opportunities are made available that include representatives who may have different levels of expertise, availability and prioritisation.
- Migrant communities may become disenchanted and disengaged if they are repeatedly consulted



without experiencing any apparent change or benefit. Active dissemination of the needs assessment findings, as well as plans for using the information, and the criteria for allocating resources fairly and transparently should be built into the commissioning and monitoring process.

- Identify and carry out Equality Impact Assessments and, in collaboration with migrants, determine which mechanisms will improve access to 'hard to reach' services, for example outreach or advocacy workers.
- Work with local health organisations to provide guidance and training to GP practices to ensure vulnerable migrants are registered (see Section 1.2) and training for qualified and student healthworkers.
- Consider alternative pathways for referral including midwives and health visitors, befriending schemes, health advocate programmes, RCOs, other community groups and service user support groups.
- Strategic planning should reference relevant key issues including those relating to education, housing, employment, child poverty, health inequalities and community cohesion, as identified in the JSNA or equality impact assessment, and cross-referenced with those outlined in complementary national and local strategies.
- Compliance with the Equality Duty requires collecting and analysing data (patient and staff profiling, engagement of public and excluded communities) and using this data to analyse the impact of decision making and processes on protected characteristic groups. Using the tools provided by the Equality Delivery System will help commissioners to meet equality objectives through the design of a commissioning strategy that is inclusive and equalities focused<sup>53</sup>.
- Encourage small community-based organisations to engage in the commissioning process as potential service providers through partnership bids and sub-contracting, raising awareness of mental health issues, services and care pathways within migrant communities.

- Promote approaches that encourage the lawful sharing of information between health and social care professionals in support of multi-agency care delivery. These approaches should draw on community-wide information sharing and integrated care initiatives wherever possible.

## 2.9 Examples of good practice in strategic planning

### Nottingham City JSNA 2010

The Nottingham City JSNA includes a chapter dedicated to migrant issues in the city, with information on service provision and levels of need, using data from a detailed needs assessment funded by the Migrant Impact Fund. National and local data and interviews with health professionals, migrants, community representatives and voluntary sector service providers were submitted to the Refugee and Asylum Seekers (RAS) Health Forum for comment.

A Locally Enhanced Service (LES) was established, requiring participating GPs to identify a lead clinician for asylum seekers, keep a register of asylum seekers, use a specific template for new patient checks, offer screening checks, health promotion and education on using the NHS. Face to face interpreters must be booked for the initial health check, with telephone interpreters for follow-up consultations.

Services are regularly audited and anonymised data from the New Patient Health Check is shared with NHS Nottingham City, which informs the future commissioning of services. This is an example of how the JSNA and the GP LES, set up in conjunction with the advocacy process, have mutually reinforced each other<sup>54</sup>.

### From Outside to Involvement – improving access to health and social care for new migrants (Walsall)

A needs assessment revealed that over 1200 new migrants enter Walsall from abroad every year,



mainly from South Asia and Eastern Europe<sup>55</sup>. Four key areas of health need were identified: maternal and child health, health protection, mental health, and access to primary care. A partnership venture of health, local authorities and voluntary sector to improve access to health and social care for new migrants was funded by the Migration Impacts Fund<sup>56</sup>.

### The BME Health Forum (Kensington, Chelsea and Westminster)

The Black and Minority Ethnic (BME) Health Forum, funded by NHS Kensington & Chelsea and NHS Westminster through a Service Level Agreement, is a collaborative partnership between statutory, voluntary and community organisations that aims to improve health and reduce health inequalities for BME communities in KCW. While not exclusively a migrant forum, the majority of its members are from migrant and refugee backgrounds. The Forum aims to both empower communities to engage effectively in debate with health services and to enable statutory services and health professionals to respond adequately to the health needs of BME communities.

Areas of work include:

- removing barriers to accessing healthcare for BME communities by engaging with clinicians, health trusts, community organisations and patients, improving links and communication and raising awareness.
- researching, scrutinising and influencing strategic policy issues and initiatives within the health services to ensure that policy makers are aware of their impact on BME communities.
- supporting BME communities and organisations to voice their health concerns, bringing these to the attention of commissioners and providers and ensuring that they are taken into account in the planning, commissioning and delivery of services.

- supporting the voluntary and community sector in their delivery of health and wellbeing projects by a variety of strategies including commissioning, providing skills and information, demonstrating value and raising concerns to the relevant statutory sector bodies.<sup>57</sup>

### NHS Birmingham East and North Community Development Workers

Community Development Workers (CDWs) are aiming to raise awareness of mental health issues within local black and minority ethnic (BME) communities. They helped to produce a drama programme, which captures the views of BME children and young people on mental health and rolled out a mental health training programme aimed at BME carers. This is now being extended to carers from within the Somali and Irish communities.

The Communications and Involvement team has supported Barbershop<sup>58</sup>. Aimed at BME communities, this quarterly community-led magazine, available in local barbershops, invites people to write about their mental health experiences.

The CDW team, in partnership with other agencies, helped to organise a Mosque Mental Health road show to raise awareness of mental health in faith based communities. Over 450 people in four mosques have accessed the information stand and following the success of this, it is due to be rolled out to other faith groups over the coming year.

### Norwich Mind Community Development (Work) Programme (CDW)

Norwich Mind CDW programme runs Cultural Competence training for service providers and delivers culturally competent<sup>59</sup> and appropriate services across cultures, working with volunteers, associates and community leaders who reflect the community's cultural diversity<sup>60</sup>. It hosts social

events at which music, food, and entertainment reflect cultures represented and also helps build cohesive communities. The programme provides mental health awareness courses to BME communities/groups to increase awareness, reduce stigma and build capacity within the communities. The training is also delivered in Portuguese and Somali. The programme works in partnership with and seeks advice from cultural organisations while maintaining client confidentiality and with non-mental health agencies to better support clients with their needs which directly or indirectly affect their well-being and mental health.

### Norwich Mind – Inclusion Project

The project began with well established links to migrants as well as established referral routes via GPs, Mental Health Link Workers, Wellbeing Service Practitioners, the Red Cross, Stonham, the Matthew Project, the New Routes Project and self-referral opportunities. Advertising material in 17 languages, covering the majority of the communities living in Norwich, has been placed in strategic places throughout the city.

After consulting project participants the inclusion project has developed a holistic intervention model which includes:

- empowering participants to choose from a comprehensive and varied package of interventions and therapies, administered in a respectful and culturally sensitive manner
- facilitating opportunities to engage with the community and to celebrate multiculturalism
- adopting a learn-by-doing approach backed up by a constant gathering and analysis of participants' input and feed-back

### Bath and North-East Somerset- Gypsy and Traveller communities

In 2012-2013 Bath and North East Somerset (BANES) and North Somerset NHS working with their local authorities in a specially convened public health consortia jointly commissioned an in-depth local health needs assessment focused specifically on Gypsy/Traveller/ Showmen/Boater/ Roma communities, with an explicit focus on understanding service needs and improving local quality standards pertaining to health improvements for these marginalised communities.

Whilst Gypsies and Travellers are recognised by Inclusion Health and the DH as groups at particular risk of increased morbidity/mortality, to date this is the first and only UK study which has explored the health needs of 'boaters' (residential live-aboard boat-dwellers), finding health discrepancies, inequities in access and levels of untreated needs of (often older, single male) 'continuous cruisers/boaters' mirroring existing data pertaining to the health status of Gypsies/ Travellers/migrant Roma.

The research (undertaken by Bucks New University) incorporated a survey of a wide range of health professionals who have contact with these marginalised groups, as well as in depth studies of service users' experience, enabling the exploration of barriers and solutions to commissioning, good-practice in service delivery/joint commissioning and staff training needs/knowledge of specialised care requirements. At the time of writing, based upon recommendations in the report, BANES is undertaking a pilot study into the format and feasibility of delivering tailored services and specialist training for health professionals working with these groups<sup>61</sup>.

## Refugee and Asylum Seeking Women who have experienced sexual violence. Training Programme/pod-casts and publication

Independent Academic Research Studies (IARS) a London based charity which specialises in working with young, vulnerable people has, in partnership with Buckinghamshire New University/IDRICS developed a three year Comic Relief funded programme which explores the service provision needs and experiences of refugee and asylum seeking women (RASW). The project which focuses on women's gendered experience of seeking and receiving medical and legal services, with a particular focus on developing good practice, trust building and overcoming administrative barriers which can reduce access to health care consists of a number of phases, including an in-depth survey of RASW's experiences, production of a free-to-download 'good practice in undertaking research with RASW' publication and pod-casts in which RASW role-play good and bad practice scenarios in relation to health-care professionals engagement with them.

In the on-going (final) phase of the project refugee and asylum-seeking women involved in the project, in partnership with IARS, are now delivering tailored half-day face to face training sessions for health care practitioners who work with this particularly vulnerable group. What is unique about the evidence-based programme is that refugee and asylum-seeking women are directly involved in design and delivery of the training/materials. IARS/IDRICS are also available to support commissioners in designing/developing specific services designed to support this particular group of vulnerable service users<sup>62</sup>.

## 3. Commissioning Services

NHS England and CCGs both have a legal duty to promote patient choice and patient involvement. Both must have regard to these duties when contracting and therefore expect providers to promote these aspects too\*.

### 3.1 Supporting patient choice

Migrants will require information, data and support if they are to share in decisions about their care. In reality, many have no access to, or are unable to use existing information and data, due to language difficulties, poverty, illiteracy, lack of confidence, unfamiliarity with the system or mental health problems. Mental health services can be effectively invisible for many potential users, and vulnerable migrants may need additional support to understand how and where to access the right services to suit their needs.

Migrants come from countries with very different health and social care services to the UK and they may have no or poor experience of mental health services. Commissioners should ensure that services aim to raise awareness about mental health issues, services and care pathways among marginalised migrant groups. A clear communication strategy that ensures commissioned services are advertised and accessible to vulnerable groups, including migrants, should be included in tender documents, with information on the process of needs assessment, the range of therapeutic interventions available, and their entitlements and rights including advocacy services and complaints procedures. This is particularly important for anyone subject to detention under the Mental Health Act.

Migrants, particularly older migrants and women, may be illiterate in their own language. DVD and audio resources are useful tools in such

circumstances for conveying health promotion messages. However, attention must be paid to the quality of the presentation, the appropriateness of the images and situations, the sensitivity of the language used and the culture of the intended audience. Social media and texting are useful ways of maintaining contact with mobile clients.

Gatekeepers, such as community or religious leaders, can assist in disseminating health promotion messages or information about services, as they can act as ‘cultural brokers’ and translate unfamiliar concepts to both service users and providers. However, commissioners should not assume that everyone is happy to disclose mental health problems within their community, or that community leaders are skilled in communicating messages about mental health. This approach should be supported by community development and capacity-building as described in Section 2.4.

Bi-lingual health advocates can help service users to make informed choices and communicate their wishes, especially important for those whose first language is not English.

### 3.2 Designing service specifications and contracts

Integrated commissioning will enable a unified system to make better use of resources and promote better outcomes.

Whole population services which recognise migrants’ needs are more likely to reach them.

Improving Access to Psychological Therapies (IAPT) services may not address the more complex long-term needs of vulnerable migrants and other options need to be available.

Migrants may benefit from a range of creative therapies as an alternative to traditional talking therapies, as these can be seen as less stigmatising and more appropriate and

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\* [easterncheshireccg.nhs.uk/Downloads/Your-Views/Legal%20Duties%20for%20CCGs%20for%20Consultation%20and%20Engagement.pdf](http://easterncheshireccg.nhs.uk/Downloads/Your-Views/Legal%20Duties%20for%20CCGs%20for%20Consultation%20and%20Engagement.pdf)

accessible. In addition, they often have the advantage of building community and individual strength and resilience. Non-medical interventions such as art therapy<sup>63</sup>, sport, poetry, singing, music, dance, sewing, gardening, multimedia, and other forms of occupational therapy or activity<sup>64</sup> may provide opportunities for health promotion and early intervention with migrants.

Religious and spiritual support can play a significant role in the lives of migrants, some of whom may have experienced faith-based persecution. Religious or spiritual leaders are widely consulted by those experiencing mental distress, although not all migrants ascribe to a faith. Working in partnership with local religious and spiritual groups can be an effective approach to mental health promotion, wellbeing and recovery. Faith visitors working in North West London Mental Health Trust offer faith based support and a prayer service<sup>65</sup>. Hospital chaplaincy services offer spiritual support to people of all faiths and none.

Diversity and equality should be considered at the specification stage and monitored throughout the process. An equality impact assessment, linked with a pre-qualification questionnaire for service providers, could be used for the initial stages of contract design. This will reveal potential providers' approach to equality and diversity at an early stage and will help to clarify commissioners' requirements.

### 3.3 Principles for clinical standards in the health care of vulnerable migrants<sup>66</sup>

- Continuity – a trusting relationship formed with a familiar clinician.
- Multi-disciplinary collaborative care is central to effective care as many vulnerable migrants present with multiple healthcare needs.

- Person centred care with service user involvement in planning and delivery e.g. the Care Programme Approach<sup>67</sup> used in mental health services.
- Promote recruitment of clinicians who reflect the ethnic diversity of service users.
- The Recovery Approach<sup>68</sup> should be incorporated in the design of all services, making shared decision making the norm *“No decision about me without me”*<sup>69</sup>.
- Specialist services should act as a catalyst to improve care through the local health service.
- Services should actively seek to offer treatment to all vulnerable migrants, including those with no recourse to public funds.
- Assertive outreach for non-engaged clients.
- Recording of housing status with regular review.
- Participation in documenting, researching and publishing on the mental health of vulnerable migrants, evaluation of service delivery models and continuous monitoring of longer term outcomes.
- Develop links with relevant bodies for the provision of education and involvement in undergraduate and postgraduate training of medical, nursing psychological therapies and social work students.
- Promotion of care of vulnerable migrants as a viable and attractive career choice.

### Standards for community health services <sup>70</sup>

- Services for vulnerable migrants should accept self or non-agency referral for initial assessment.
- In areas with high numbers of vulnerable migrants, specialist services should be provided to ensure expertise and flexible service provision.



- All services should be prepared to work with people with drug or alcohol problems as well as mental health issues. Mental health services should develop good partnerships with drug and alcohol services to ensure effective joint working.
- Access to care can be enhanced by outreach.
- A flexible approach based on patient choice to overcome geographical barriers to accessing care. Vulnerable migrants are often very mobile and this would ensure maintenance of therapeutic relationships with homeless or mobile migrants who temporarily move out of the catchment area of the Community Mental Health Team.
- Enhanced and easy access to psychological therapies for individuals and group work tailored to the needs of vulnerable migrants.
- Support and training should be available for other health workers and for non-healthworkers in understanding and working with vulnerable migrants with mental health problems.

### Standards for psychological services<sup>71</sup>

- Flexible services with open access by self-referral.
- Provision for specialist psychologists and psychotherapists to directly deliver psychological therapies and support all staff involved through consultation and the provision of facilitated reflective practice.
- Psychological services should be carefully evaluated in terms of outcome and should adopt an “evidence generating practice” approach to interventions. All staff should be trained in monitoring outcomes meaningful for service users and to enable them to see meaningful change as a result of their input.
- Other services which are involved in care (e.g. social services and voluntary sector staff)

should continue to support the person so that therapy is supported and reinforced by a wider team of enabling staff.

### Standards for counselling services<sup>72</sup>

- Flexible services with open access by self-referral.
- Flexibility of location for service provision.
- Recognition of the need to create a culture of trust and for opportunistic outreach and pre-engagement in the form of non-clinical but transitional activities (e.g. creative activities such as art groups).
- The counselling approach should be capable of assessing immediate, medium and longer term needs with a mix of crisis management, supportive counselling skills, problem clarification and solving skills.
- The dynamics of the therapeutic relationship should be taken into account, in order to support beyond the referral process to more structured treatment

### Standards for immigration detention and prison medical services<sup>73</sup>

Detention increases the risk of mental health problems including anxiety, depression, post traumatic stress, self-harm and suicide<sup>74, 75</sup>.

- Health care in immigration removal centres should meet the same standards as UK prisons as a minimum.
- Health care staff should use a standard primary care record system which should be passed on to the NHS primary care record system on release.
- All detainees should have a careful risk-assessment, which considers self-harm and risks of continued detention.

- Rule 35 of the 2001 Detention Centre Rules<sup>76</sup> requires doctors and healthcare teams in immigration removal centres to report the case of anyone whom they are concerned may have been tortured, may be suicidal or whose health may be injuriously affected by continued detention. In cases where there is independent medical evidence that people have been tortured, they should be released in all but exceptional circumstances. Allegation of torture by immigration detainees should trigger a case management review and the process should be open to audit.
- Interpreters should be used for all mental state examinations unless the detainee is fluent in English.
- Regular reviews of notekeeping and prescribing practice should be carried out.
- Permanent specialist staff should be recruited rather than relying on locums.
- Sedation and restraint during deportation are areas of potential concern.
- Standards for substance misuse services<sup>77</sup>

Alcohol and drug misuse are often hidden problems among migrant communities due to cultural expectations and stigma<sup>78, 79</sup>.

- Services need to be easily accessible and confidentiality emphasised.
- Consider offering a confidential self-referral phone line for non-English speakers, with a dedicated number and an answering machine, so that calls can be returned with an interpreter available.
- Those with drug and alcohol problems must be able to access help with both issues from one key worker.
- Primary care delivered services may improve co-ordinated delivery of health care and preventative services.

- Offer close links (ideally on the same site) with services offering welfare and housing advice and support into education, training and work.

### 3.4 Developing providers

Creating greater diversity within the pool of service providers (an objective of the NHS reforms) requires sensitivity to the capacity of smaller organisations to engage in the commissioning process as potential service providers. The commissioning process presents a number of logistical challenges for migrant community organisations, which may lack the infrastructure, financial resources or capacity to present a robust case for funding or to compete with larger providers. Commissioners should support them through capacity building funds to become service providers.

Mental health services should be staffed by professionals with skills and understanding to work flexibly and creatively with vulnerable migrants. Staff need to be aware of the impact of immigration, and particularly torture, detention and the asylum determination process, on mental health, and on help-seeking behaviour. Assessments should recognise natural psychological reactions to highly abnormal experiences and not over-medicalise what may be appropriate responses.

### 3.5 Interpreting, language and communication

Lack of English can be a major barrier to accessing mental health services and language fluency may be lost or reduced through distress or mental illness. Mental health assessments and interventions depend on language and effective communication. Commissioners should ensure that providers have a clear policy and arrangements for interpreters trained in working

with mental health issues for patients with language difficulties. The use of informal interpreters, family members and children should be avoided.

Staff must also be appropriately trained, and be confident and competent in working with interpreters in a mental health context. Face to face, rather than telephone, interpreters are preferable in mental health settings, particularly for distressed patients. Continuity of interpreter, as well as clinician, will enable trust to develop and it is good practice to offer a choice of gender for both interpreter and clinician, if possible. Longer appointments will be needed in order to address complex issues and to allow time for interpreting.

Interpreters may be hearing first hand harrowing stories concerning torture and other traumatic events and will need support and supervision, particularly if they have had similar experiences themselves.

Providers of mental health services should ensure that interpreting services adhere to quality assurance standards specified within the contract, including provision of specific training on mental health and appropriate clinical supervision for all interpreters. . Bidders should be asked at the PQQ stage of tendering for a detailed explanation of how interpreting services will be provided in their service and the anticipated costs.

NHS England is currently developing a quality standard for interpretation and translation services which will support commissioners to commission effective Interpreting and Translation services in primary care setting. The Crown Commercial Services is currently tendering for providers to go onto a national Interpreting and Translation Framework. Both of these pieces of work aim to ensure an improvement in the quality of interpreting and translation services for all vulnerable groups in the future.

### 3.6 Recommendations for commissioning of services

- Provide translated welcome packs, leaflets, flyers using images to overcome issues of illiteracy, or commission DVDs explaining GP registration and available services. Important correspondence, such as appointment letters and information on diagnosis, should always be written in the client's own language to prevent confusion or non-attendance and a secure mailing address identified. Initial correspondence should be written in simple clear language, which facilitates translation. Podcasts, DVDs and cartoons have been used successfully with Gypsy, Roma and Traveller communities where literacy levels may be low<sup>80</sup>.
- Design and deliver mental health promotion programmes in partnership with migrants, community organisations and service providers, and make use of accessible community venues including youth centres, schools, leisure facilities, faith organisations and local businesses, as well as existing advice drop-ins as ways of disseminating information.
- Champion and develop the role of health advocates to act as a cultural bridge between service providers and users and to ensure access to appropriate services. This could be linked into a peer advocacy programme to develop capacity with members of migrant communities.
- Work closely with migrant service users, community organisations and service providers to develop outcome measures for mental health services that reflect the experience of patients and the benefits they derive from the service, and to develop culturally sensitive care pathways.
- All service specifications should cover quality and equalities requirements including non-discrimination, support for access and culturally specific interventions.

- Specifications should include clear statements about the general duty on providers to eliminate unlawful discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations.
- Protection and security measures need to be prioritised when planning care for especially vulnerable migrant groups, such as survivors of trafficking and modern slavery, women and girls fleeing forced marriages and genital cutting.
- Commissioners should stipulate that providers conduct equality impact assessment of care pathways to ensure ease of access and cultural sensitivity of contracted services.
- Consider a range of evidence-based interventions in the community sector, specialist centres and support teams offering a multidisciplinary and holistic approach to delivering services to vulnerable migrants in a safe, welcoming environment. Grants may be a more suitable way of funding small grassroots organisations. By giving organisations more autonomy and reducing the administrative workload grants can provide value for money and an effective way to support communities as well as encouraging innovation, and targeting communities that have less access to services.
- Encourage small voluntary and community organisations to submit partnership bids for service contracts, and large service providers to sub-contract to smaller community-based providers where appropriate, e.g. mental health services awareness, advocacy, interpreting services.
- Local NHS organisations and Councils should support capacity building programmes for small community based migrant organisations to bid for health awareness, interpreting, advocacy and other support services in partnership with bigger voluntary organisations/ providers.
- Recognise that engagement and capacity building require investment and can take some time to establish.
- Ensure that universal and comprehensive equality, diversity and cultural competency training, covering the overlap of culture and mental health, and issues related to literacy or poor comprehension is included in service specifications and contracts.
- Use resources and expertise within migrant communities to raise awareness of mental health professionals of the needs of migrant communities.
- Specialist training, with regular updates, on the asylum legal process, working with interpreters and the impact of torture can be provided by organisations with expertise on migrants' mental health and support services, such as the Refugee Council, Freedom from Torture, the Helen Bamber Foundation and Remedy.
- Commissioners need to consider an independent patient audit process and ensure that providers have arrangements in place to monitor and improve quality.

### 3.7 Examples of good practice in service commissioning and design of contract specifications

#### Migrant and Refugee Communities Forum (MRCF) – Bi lingual mentoring support scheme

People who come to MRCF seeking support have complex needs, with multiple disadvantages. These include post-conflict trauma among refugees, lack of training opportunities for medical professionals with non-transferable professional qualifications, and lack of access to legal advice, housing, jobs and education, including English classes. They are also isolated and stigmatised. As a result, many migrants cannot find employment, lack affordable housing and may be exploited and forced into poverty.



These factors have combined to create the conditions where vulnerable migrants neither have a voice nor can exert influence over debates or policies which affect their lives.

In 2007, in order to utilize the skills of unemployed refugee doctor users who wanted to give something back, MRCF developed a bilingual mentoring support scheme for them to deliver for non English speaking migrants and refugees experiencing mental ill health, using a US cultural brokerage model. Mentees not only reported feeling better, but started attending college, volunteering and some secured paid work.

MRCF has since opened the mentoring role to all individuals who want to support migrants and refugees. Training and structured support is provided for mentoring vulnerable migrants and refugees weekly for at least six months to help them break out of isolation and build confidence for a new start. Fifty people annually access mentoring support and some have progressed to mentoring other vulnerable people.

One mentee, a 42 year old Burundian woman, accessed the mentoring programme following six weeks detention in the UK. Her sudden arrest and experience in detention had made her very anxious and depressed. Her weekly meetings with her mentor gave her emotional support which helped her to get through this difficult period; subsequently she joined the MRCF women's group and attended English classes. Her self-confidence has grown and she has spoken about her experiences at a conference and published her story on the mentoring blog.

### Music Share Project, Wakefield

This project is a partnership between NHS Wakefield District and Wakefield Cathedral aimed at improving the mental health and well-being of asylum seekers through the medium of music. The project provides a series of music workshops for asylum seekers and refugees, enabling them

to share culture through songs, music and stories and involves musical artists and volunteers in each session. Specific sessions are held for women, men and families. In order to reach as many members of the asylum seeking and refugee community as possible some sessions take place at the Initial Accommodation Centre, and some are linked to coincide with drop-in sessions at the Education Centre. Teaching each other songs and stories encourages cultural exchange and respect, and builds confidence in a new environment. Participants with more English skills assist others with interpretation, translation and form filling. Sharing food at the end of sessions allows friendship networks to form in a safe and welcoming environment. Additional benefits to clients include improved English language, decreased social isolation and improved well-being through enjoyment of music and integration into the group. Feedback has been positive.

**This was the best day I experienced since coming to England. I feel less stressed and wish I could come and drum every day.**

### Traumatic Stress Clinic

Psychologists offer assessment and specialist trauma therapy using interpreters for migrants with mental health problems arising from trauma. The team's cognitive behavioural approach to trauma includes addressing the guilt, shame and fear associated with their experiences. The therapy helps people to develop coping strategies. Where appropriate, clients are linked in with outreach services for help with psycho-social issues including immigration, housing, welfare benefits and community care. The Traumatic Stress Clinic also run training workshops for other NHS mental health professionals, as well as some voluntary organizations on managing the mental health needs of refugees and asylum seekers.<sup>81</sup>



## Doctors of the World, London clinic (formerly Project London)

This project organises a free clinic in East London for vulnerable people, a large proportion of who are migrants, who face barriers to accessing health care. In 2011 nearly 1750 people were seen at the clinic, many of whom had been refused GP registration and primary care (including some who were clearly entitled to care), because of lack of knowledge and understanding of regulations among administrative staff. The project provides a valuable service in ensuring that users are registered with a GP and receive healthcare<sup>82</sup>.

## Rethink Mental Illness – Kent and Medway Community Development Worker Service

This service employs Community Development workers to work at a strategic level. They aim to raise awareness for difference and diversity to be valued, embraced and seen as an asset by mental health services. The team influences service development through advising on BME issues and catering to the needs of diverse communities and all the equality strands across Kent and Medway. They work with seldom heard communities to tackle stigma in relation to mental health issues and encourage communities to seek help at the early stages of experiencing mental health distress.

They work alongside communities to improve confidence in using mental health services as well as signposting to relevant services including therapies, peer support services, Improving Access to Psychological Therapies (IAPT) and pharmacological interventions that are culturally appropriate and effective. The service achieves this through the provision of Mental Health Awareness workshops to communities, spiritual and faith leaders, service providers and other voluntary groups. Through raising awareness and understanding of cultural, religious and spiritual beliefs they aim to bridge gaps between

mental health providers and the local communities. In turn it is hoped that the prejudice, injustice and inequalities faced due to the stigma and ignorance associated with mental health/ illness will be reduced within these marginalised communities.

## Rethink Mental Illness – Sahayak Kent

Rethink Mental Illness - Sahayak found that South Asian women experiencing domestic violence were unable to access responsive services. Domestic violence within South Asian culture contributes to especially vulnerable situations for people with uncertain immigration status, through extended family involvement and concepts of honour and shame. Rethink's Oppressed Voices project spoke to women and conducted multi-agency research, revealing that stigma prevented participants from reporting domestic violence, and 95 per cent felt there was a language barrier to getting help for the resulting depression and emotional pain. Oppressed Voices has raised awareness about the issue within South Asian communities and has led local police to look at the way they address domestic violence with young people, through early intervention work to raise the issue in schools. Work to improve access to GPs for non-English speaking women is ongoing.

## Asian Mental Health Helpline

A culturally sensitive listening and information service for the Asian community in Kent and East Sussex, for anyone affected by mental health issues - whether they are service users, carers or friends. Languages offered are Gujarati, Punjabi, Hindi, Urdu or English.<sup>83</sup>

## 'Mother Tongue', Reading

### Overcoming the language barriers to accessing talking-based therapies

This non-statutory organisation provides counselling and practical support in over twenty

languages and can offer support in other languages through trained and culturally sensitive interpreters. Approximately 40 per cent of the client group are unaccompanied asylum-seeking young people\*.

### **Mental Health First Aid (MHFA) courses, Oxford**

This series of four three-hour courses educate and empower people to recognise those with common mental health problems, and offer guidance and listening in a crisis. The MHFA courses were developed in Australia and are now used in many countries. The Royal Society for Public Health is developing a nationally-recognised qualification in MHFA for those who have completed the training. In Oxford, the courses are funded through the Migration Impact Project (within Oxfordshire Community and Voluntary Action) and delivered by Restore. They are offered to those who have contact with migrant groups, including leaders in migrant communities and volunteers at Saturday schools and are not designed to replace professional help. Participants are actively recruited, targeting ethnic minorities who may otherwise not be aware of training. The course is taught in English, Arabic, Urdu, Polish and Portuguese<sup>84</sup>.

### **Derman, Hackney**

Derman's aim is to help and support the Kurdish and Turkish speaking community to overcome emotional and practical difficulties. The mental health service comprises counselling, mental health support and mental health outreach work. The project also provides an advocacy service which includes interpreting, improving the appropriateness of health services and improving health outcomes, providing information and expertise to health professionals to facilitate the bridging of the cultural and language gap<sup>85</sup>.

### **Diverse Cymru BME Mental Health Support Team**

Diverse Cymru provides services to BME people in Wales who are affected by mental health problems. A holistic approach is taken which focuses on empowerment in order to increase independence, improve wellbeing and promote recovery. It also works to raise awareness of issues surrounding BME mental health and to achieve race equality in mental health services, policy and practice.

Services offered include befriending, advocacy, support for individuals, family and carers, home and hospital visits for in-patients, children's service, a service user support group and recreational activities.

Diverse Cymru produces information resources and develop and deliver training courses for professionals in the health, public and voluntary sectors, covering a wide range of race and mental health related topics<sup>86</sup>.

### **Groundswell Homeless Health Peer Advocacy (HHPA)**

This award-winning service supports homeless people (including vulnerable migrants) to access healthcare, delivered by volunteers with personal experience of homelessness. In addition to providing practical support such as accompaniment to appointments; Peer Advocates build the skills and confidence of clients to access health services independently.

HHPA reduces use of A&E, missed appointments and unplanned admissions; resulting in improved health and a 42 per cent reduction in NHS costs (*Young Foundation HHPA Evaluation 2014*). Peer Advocates help staff to communicate with chaotic, vulnerable patients; supporting health services to work more effectively with homeless people<sup>87</sup>.

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\* mothertongue.org.uk

**Homeless people feel judged, that causes a lot of anxiety. A Peer Advocate can help, having someone by your side who won't judge you, someone who has been there as well. As a Peer you can share your experience and show there is a solution, then clients can find their own confidence and begin advocating for themselves.**

### **Mental Health Services for Gypsies and Travellers – DVD resource**

In common with many BME communities there is an intense reluctance to discuss issues of depression/mental health/emotional wellbeing amongst Gypsy and Traveller populations. It is recognised by practitioners that there is a grossly inflated suicide rate amongst these communities in the UK (Cemlyn et. al., 2009) although in the absence of clear ethnic monitoring of these populations, the extent of suicide/para-suicide is hard to quantify. However in Ireland, suicide amongst Irish Travellers is six times the national average and accounts for 11 per cent of all Traveller deaths (The All-Ireland Traveller Health Study, 2010), with 65 per cent of such suicides being carried out by people under the age of thirty. Anecdotally, similar patterns pertain in the UK. The Traveller Movement (a national policy and lobbying organisation) has created a groundbreaking culturally accessible DVD resource *Tell Someone* in which Gypsies and Travellers who have experienced mental illness themselves, talk about accessing services, available support, culturally appropriate service delivery, internal community attitudes and the need to challenge of the taboo/stigma associated with acknowledging the need for assistance.

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\* [mothertongue.org.uk](http://mothertongue.org.uk)

# 4. Monitoring and Evaluation

## 4.1 Monitoring and managing performance

Monitoring plays a significant role in ensuring that equality and inclusion objectives are met. However vulnerable migrants are rarely distinctly identifiable in routine administrative data sets and statistics.<sup>88</sup> Comprehensive evaluation will identify any unintentional inequities resulting from commissioning decisions, and will provide vital information to assist in the prediction of future need, costs and appropriate preventive measures. Effective monitoring of outcomes for migrants relies on systematic data collection by providers, broken down by ethnicity and, if appropriate, by religion and migration indicators such as language, nationality or country of birth. Commissioners should establish whether all sectors of the population are able to access services, whether the experience of services varies between groups, and whether those services are equally effective in improving health outcomes for all users. However, quantitative data of service users alone would be insufficient to give the full picture of the quality of services and access to them. Qualitative information on the level of satisfaction of users and their carers should be used alongside quantitative data.

Migrant communities should be involved in the evaluation and assessment of mental health services and service providers should support the development of such groups as part of their contract. While generic patient surveys can provide good information on the effectiveness of services, they may not be fully representative of the service user base or seek the sort of information that will identify unmet need in the migrant population. Clinical audits can, equally, give useful information on patient outcomes but rarely take ethnicity into account. Commissioners and providers should encourage a greater focus on ethnicity in both mechanisms, in order to obtain a rich source of data and information on migrant experiences and outcomes.

The commissioning process itself, from the initial needs assessment through to the award of a contract, can take well over a year, during which time the profile and needs of the migrant population may have changed significantly. In order to be more flexible, some general quality and performance issues may be better addressed through variations to existing contracts. The commissioning of specialist dedicated new migrant services should be considered where the number involved or access issues are significant.

Equality impact assessment is key to the monitoring and evaluation of new or existing mental health services to ensure they are culturally sensitive and that they do not discriminate against migrants. Commissioners should support providers to undertake both preliminary and full impact assessments as part of their review or evaluation process.

## 4.2 Recommendations to improve monitoring and evaluation

- Determine who will be responsible for evaluating and monitoring equality elements at different stages of the commissioning cycle.
- Provide equalities and cultural competency training for those responsible for monitoring and contract management.
- Refer to the outcome measures identified in relation to migrants or BME communities, as well as good practice from across different sectors.
- In line with the goal to make mainstream services more accessible and culturally sensitive, outcomes and key performance indicators (KPIs) relating to BME and/or migrant uptake of services and experience of recovery should be included in all service specifications, using a co-production approach.

- Ensure community involvement in the monitoring and evaluation process.
- Encourage providers to put in place additional measures to promote equality e.g. equality impact assessments
- Take prompt action if the provider fails to comply with equality aspects of a contract, particularly regarding accessibility and the collection of equalities' monitoring data.
- Targeted focus groups with migrant service users, communities and staff may offer the best mechanism for gathering information on the accessibility, cultural sensitivity, patient outcome, value for money and effectiveness of services.
- Collect monitoring data on migrant admissions to acute mental health services and accident and emergency departments.

### 4.3 Examples of good practice in monitoring and evaluation

#### East Sussex County Council Race Equality in Mental Health Service (REMHS)

The REMHS team is funded jointly by NHS East Sussex Downs and Weald and Hastings & Rother and ESCC. Their work plan aims to address the cultural competence of the workforce across all mental health services and the team has already undertaken placements within key mental health services, inpatient services, primary care IAPT services, and CAMHS, which include conducting interviews with practitioners and service users, helping with Equality Impact Assessments, providing a BME resource file and coordinating partnership events. The placement with the Assertive Outreach Team worked particularly well, as the presence of the REMHS worker created a space for developing dialogue around equality and ethnicity issues in relation to mental health. The team attends staff meetings across

the county to update on their work and to raise awareness of BME mental health issues, including attendance at the County-Wide Approved Mental Health Professionals meeting to feed back on Needs Analysis data.

The REMHS team works within GP surgeries to improve access to primary care mental health services for BME communities with two GP practices piloting a review of BME access to primary mental health services to establish how surgeries meet BME patient needs and how services adapt for users for whom English is not their first language.

#### Liverpool PCT and patient profiling

Liverpool PCT has conducted a patient profiling exercise enabling commissioners and GPs to identify vulnerable groups and gaps in service provision. Practices collect patient data, including ethnicity, religion, spoken and read language, and interpretation needs. The data enables identification of certain trends, such as marked increases of European migrants in areas where employers are contracting in workers. The Equality Data Manager has trained practice staff to use a toolkit containing a data collection form, a clinical template, protocols for data entry, information around BME health, including mental health and health advice leaflets in different languages<sup>89</sup>.



# 5. Supporting the delivery of the Mental Health Strategy<sup>90, 91</sup>

Commissioning mental health services for vulnerable migrants, as described in this guidance, will support the delivery of the mental health strategy in the following ways:

## **More people will have good mental health**

Prevention and early intervention will result in fewer migrants developing mental illness.

## **More people with mental health problems will recover**

If migrants with mental health problems are able to access mental health care and treatment at the most appropriate time they can manage their condition and are more likely to maintain social relationships, housing, education and employment.

## **More people with mental health problems will have good physical health**

Ensuring that people's physical health problems are addressed, through accessing GP services and ensuring that mental health providers highlight this, will promote health and well-being.

## **More people will have a positive experience of care and support**

Ensuring services address the needs of vulnerable migrants through language support, cultural appropriateness and awareness of their particular circumstances and experiences will promote an environment which engages people and which enhances recovery.

## **Fewer people will suffer avoidable harm**

Removing barriers to access, improved mental health services, prevention and health promotion play a significant role in reducing avoidable harm. Culturally sensitive and accessible services may encourage vulnerable migrants to access support before a problem becomes a crisis. Immigration detainees have a high incidence of self-harm and careful risk assessment is needed to identify those at risk from continued detention.

## **Fewer people will experience stigma and discrimination**

The stigma of mental illness is particularly marked in some migrant communities. This can be addressed by commissioning services which are culturally sensitive, raise staff understanding and include community based health awareness programmes.

## 6. Using the guidance – the experiences of Harrow CCG and Mind

Using this guidance, Harrow Mind user groups developed a project in 2014, which brokered a dialogue and increased cooperation between local commissioners and vulnerable migrant communities in order to build capacity and advocate for the needs of vulnerable migrants locally and to ensure accessible and responsive services for these communities.

Two capacity-building workshops were initially facilitated with community representatives from the Afghan, Tamil, Somali and South Asian communities, followed by a half day workshop with community members and representatives from Harrow's CCG and Public Health.

The first capacity building workshop informed community representatives about the commissioning process and introduced them to the role of Healthwatch. Attendees identified specific community health and wellbeing needs as well as current gaps in mental health services provision.

The second capacity building session focused on planning the half day workshop with commissioners. Community representatives were given background information about those attending, as well as a summary of recommendations for commissioners outlined in key national guidance and research in this field.

It was agreed that each community group would be given a 10 – 15 minute slot at the meeting to outline the following issues relevant to each community:

- Migration experiences
- Health and Wellbeing status (including cultural perceptions of mental health)
- Service utilisation, including specific challenges and successful initiatives
- Recommendations and priorities

Subsequently seven community representatives met with members from Harrow CCG and Public

Health, who comprised the GP lead for mental health, a lay member, the mental health services commissioning manager and a public health representative. The workshop programme included an explanation of the background and context to the work, presentations from migrant community representatives, a description of Mind in Harrow's approach to working with vulnerable migrant communities with some examples of good practice, Mind's recommendations for improving local commissioning and concluded with an open discussion between commissioners and community representatives.

Following on from the half day workshop a debriefing/feedback session was held with community representatives. Participants were given the opportunity to feed back what they felt had gone well and what could have been improved. They were also asked about their interest in continuing involvement in influencing commissioners on design and delivery of mental health services for vulnerable migrant communities. Commissioners were also asked for their feedback on the half day workshop.

### 6.1 Analysis of Achievements against Outcomes

#### **Outcome 1: Raising awareness amongst commissioners and service providers of the mental health needs of vulnerable migrants as well as the gaps in service delivery and the obstacles to accessing services**

The half day workshop with commissioners raised awareness of the specific mental health needs of four vulnerable migrant communities (Tamil, Afghan, Somali and South Asian). Personal testimonies of individual community representatives effectively illustrated areas of unmet need. Feedback from a commissioner stated "Mind in Harrow's workshop was very

effective at using individual stories to illustrate broader unmet needs”.

While preparing the presentations took longer than anticipated, this proved an extremely effective way of illustrating unmet need and giving community representatives a voice. Personal testimonies addressed a variety of obstacles to accessing services. Common obstacles were summarised and addressed in local recommendations for improving commissioning.

## **Outcome 2: Ensuring mental health service providers are able to design and deliver accessible and responsive services to migrants and are monitoring uptake and outcomes among their migrant service users**

An assessment by Mind of the CCG’s Public Sector Equality Duty in their Equality, Diversity and Human Rights Strategy and Action Plan and the JNSA Refresh 2013/2014 mental health and wellbeing identified a lack of up-to-date local demographic data and analysis of how this corresponds to mental health needs in Harrow’s JSNA. This therefore represented a lack of an evidence base to inform commissioning. Responding to the draft commissioning intentions for 2015/2016 and to the Chair of Harrow Healthwatch, Mind recommended that the JSNA should be reviewed and updated, utilising the community intelligence of voluntary sector organisations, community groups and service users. Mind shared good practice guidance with relevant parties on developing a JSNA that effectively addresses the needs of vulnerable migrant groups based on National Mind’s guidance.

Following on from recommendations at the half day workshop, a statement was added to Harrow’s draft commissioning intentions for 2015/2016 requiring providers to “...make

reasonable adjustments to service delivery to ensure that the needs of currently under served groups [including those with mental health problems]... are met”. Mind’s formal response to the draft commissioning intentions requested an action point to be added stating what commissioning/contracting changes will be introduced to ensure that mental health service providers make ‘reasonable adjustments’ and that these are implemented and monitored so that the needs of under-served groups are better met.

The presentations from Mind and the community representatives gave good practice examples and summarised the key factors that result in services being accessible and responsive to migrant needs. Feedback from the half day workshop suggested that this was communicated effectively. One of the commissioners stated “the Mind in Harrow workshop demonstrated the need for tailored approaches to meet the needs not only of different communities but of different individuals within those communities based on their own experiences.”

## **Outcome 3: Enabling migrant service users and communities to have a better knowledge of available services, entitlements and pathways to care and a good understanding of their role in influencing the design and delivery of mental health services**

At the capacity building workshops, 15 community and organisational representatives were provided with information about the commissioning process and the role that they could play in influencing the design and delivery of mental health services. They were introduced to key partners (local and national) in the commissioning process, and informed about how the NHS functions, key stages in the commissioning process and key policies and guidance.

Feedback from the capacity building sessions indicated that all community and organisational

representatives felt the purpose of the sessions was clear, they felt able to participate and that their opinions were valued. Whilst all participants felt that they had learnt more information about the commissioning process, a common concern was that it was difficult to get a "...full understanding of the restraints for commissioners and the framework within which they were operating." Mind found that there was a lack of information available about the commissioning process at a local level and the platforms for community engagement in the decision-making process. Despite this, community and organisational representatives were keen to engage: after the first capacity building session, 91 per cent of participants planned to get involved in future campaigning and influencing decisions affecting mental health services. At the debrief session, all participants wanted to be informed about future ways of getting involved in this work.

A key challenge in achieving this outcome was the short amount of time available to engage with community representatives. Whilst Mind in Harrow was in the fortunate position of having community representatives who had already been involved in its culturally specific projects and therefore had a basic understanding of mental health service provision, it was ambitious to expect all this information to be conveyed over the course of two workshops, along with preparation for a half day workshop with commissioners. By virtue of the fact that the community representatives are from migrant communities, with a significant proportion of them having faced the same barriers in accessing services as the communities they represented (language, poor understanding of the system), it took time for them to develop the sufficient knowledge, understanding and skills base in order to effectively engage and participate in the half day workshop with commissioners.

#### **Outcome 4: Improving co-operation between commissioners, voluntary and statutory service providers and the local community, to ensure that services are accessible for and responsive to the needs of vulnerable migrants**

By successfully engaging commissioners, public health, vulnerable migrant community and organisational representatives in a half day workshop, this project achieved a unique round-table discussion and put the highly complex mental health needs of vulnerable migrant communities on the commissioning agenda.

Mind recommended that the CCG should set up and chair a local, multi-agency migrant health forum which would bring together the local community, culturally specific agencies and commissioners, would influence commissioning, inform strategic planning; and build trust between groups and commissioners.

## **6.2 Response from the Commissioners**

Following Mind in Harrow's feedback to NHS Harrow CCG's Draft Commissioning Intentions 2015/16, the CCG responded, addressing each of the specific points raised. In summary, the response stated:

- 1) Achieving 'parity of esteem' and establishing the principles of the Mental Health Crisis Care Concordat (Feb 2014) is a key priority of Harrow CCG.
- 2) Having acknowledged the recurrent inequality which faces various groups in accessing local NHS services, the CCG aims to engage these groups and understand the barriers they face by launching a new pilot scheme which will work with community volunteers. Mind in Harrow was invited to contribute to a review

of the lessons learnt from previous initiatives, particularly with respect to migrant groups.

- 3) To ensure that Harrow JSNA review reflects the mental health needs of all Harrow residents, CCG commissioners will meet with Harrow Public Health to share priorities.
- 4) As part of CCGs Public Equality Duty, the CCG expects all providers to make 'reasonable adjustments' to their services for people with disabilities, which includes mental health needs, and will be developing core elements to define what is expected in respect of mental health services.

## 6.3 Lessons learnt/Conclusions

Engagement and capacity building with vulnerable migrant communities takes time and requires investment.

Following funding cuts, many culturally specific organisations are struggling with the day-day survival of their respective organisations. This meant that it was difficult to get consistent engagement with organisational representatives about 'bigger picture' issues.

Time is needed to create a common language and approach that both commissioners and the local community can understand and realistically implement.

Communication between the CCG and public health is crucially important. A comprehensive JSNA, informed by data and analysis, needs to reflect the mental health needs of vulnerable migrant communities.

Transparency is needed about how decisions and priorities are agreed by commissioners, in order to know who is accountable for what and whether recommendations are realistic.

In order to influence commissioners locally, drawing on national policies and guidance was essential e.g. DOH Mental Health Crisis Concordat. It is important to be explicit about how the national guidance links with commissioners' priorities.

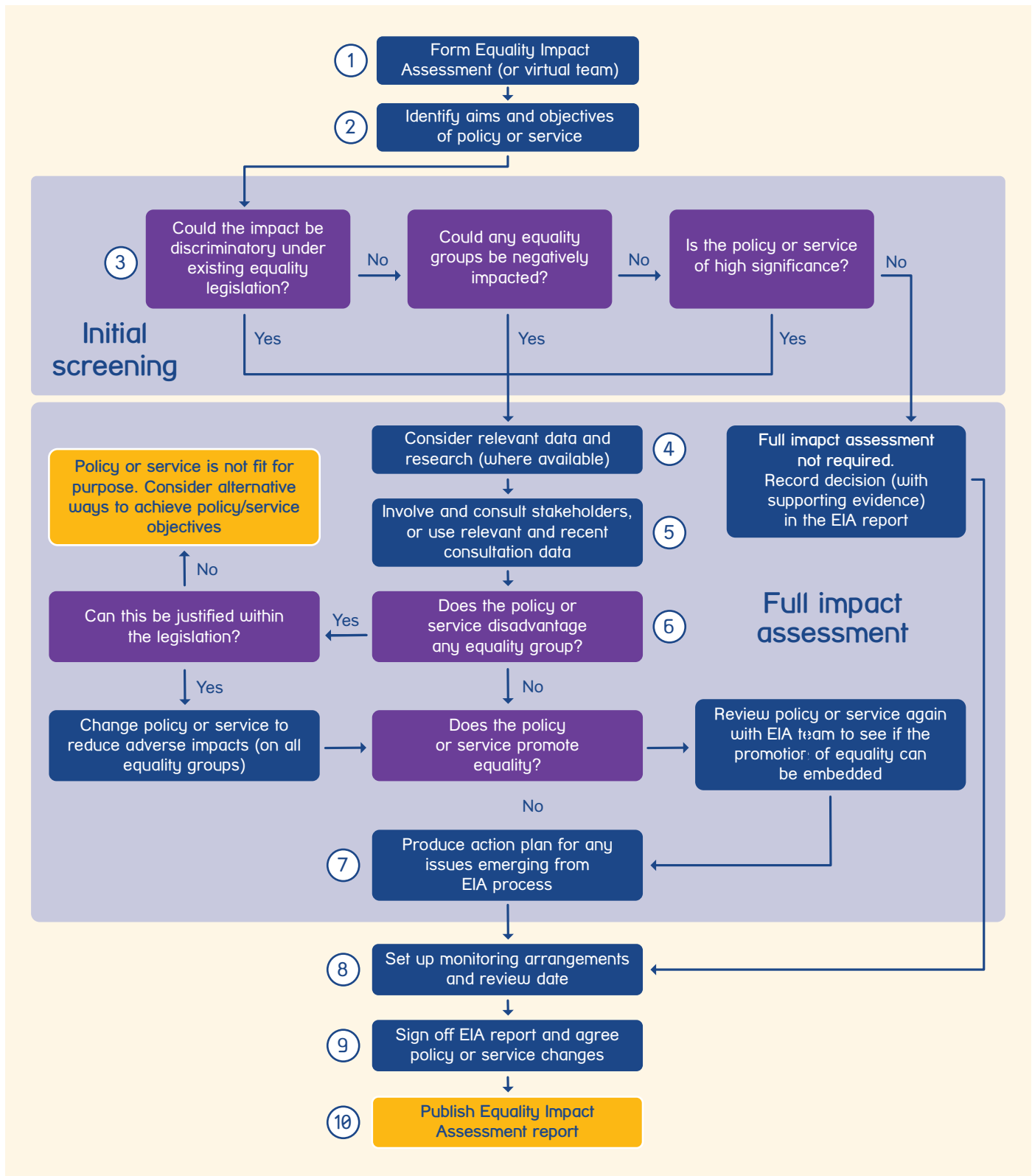
The importance of using 'expert patients' and the patient experience to bring issues alive was acknowledged.

Voluntary sector organisations are encouraged to focus on monitoring, outcomes and identifying impact in order to secure funding.

For further information please contact [j.hinton@mindinharrow.org.uk](mailto:j.hinton@mindinharrow.org.uk)



# Appendix 1: A step by step process of Equality Impact Assessment



Source: Lewisham Primary Care Trust<sup>92</sup>

# Appendix 2: References and resources

## Equality and diversity

The EHRC has produced a range of useful guidance<sup>93</sup> for public bodies on the general equality duty, the specific duties and to whom they apply. This guidance was issued prior to the revision of the draft specific duties, so is no longer fully up-to-date. However, it will still be of use in setting out the requirements of the general equality duty and the steps that can be taken to meet that. EHRC will be publishing revised guidance to reflect the new draft specific duties as soon as possible.

Equality Act 2010: *Public Sector Equality Duty – what do I need to know? A quick start guide for public sector organisations*, Government Equalities Office<sup>94</sup>.

Towards Race Equality in Health: a guide to policy and good practice for commissioning services<sup>95</sup>.

Race for Health (2011) *Tackling health inequalities in the new NHS: recommendations for action*<sup>96</sup>.

Marmot Review (2010) *Fair Society Healthy Lives: Strategic Review of Health Inequalities in England post 2010*<sup>97</sup>.

DoH (2010) *Inclusion Health: improving primary care for socially excluded people*<sup>98</sup>.

Joint Commissioning Panel for Mental Health (2010) *Practical Mental Health Commissioning: a framework for local authority and NHS commissioners of mental health and wellbeing services*, JCPMH<sup>99</sup>.

## Strategic Planning

Engagement in the commissioning cycle: A guide for service users, carers, the public, GPs, commissioners and other stakeholders in mental health care services, Best Practice Guidelines (2011)<sup>100</sup>.

Voluntary Organisations Disability Group Guide to involving the voluntary sector in JSNA<sup>101</sup>

South East Migrant Health Study Group (2010) *Understanding the health needs of migrants in the South East region: a Report by the South East Migrant Health Study Group on behalf of the Department of Health, Health Protection Agency*<sup>102</sup>.

WMPHO *How many migrants are there in the West Midlands and who are they?*<sup>103</sup>.

Department of Health (2011) *Joint Strategic Needs Assessment and joint health and wellbeing strategies explained. Commissioning for populations*<sup>104</sup>.

Department of Health (2007) *Guidance on Joint Strategic Needs Assessment*<sup>105</sup>.

Rose N, Stirling S, Ricketts A, Chappel D. (2011) *Including migrant populations in Joint Strategic Needs Assessment: a guide*<sup>106</sup>.

Perry J. and El-Hassan A. (2009) *More responsive public services - a guide to commissioning migrant and refugee community organisations* Joseph Rowntree Foundation<sup>107</sup>.

Rodger, E. and Chappel, D. (2008) *New Arrivals in North East England: Mapping migrant health and NHS delivery*, Durham University/Stockton on Tees: North East Public Health Observatory<sup>108</sup>.

Ricketts, A. (2008) *Health & Migration in the North West of England: An overview*, Manchester: North West Regional Strategic Migration Partnership<sup>109</sup>.

West Midlands Strategic Migration Partnership<sup>110</sup>. Regional Strategic Migration Partnerships were initially set up as the main regional policy fora in the UK on issues of dispersal, accommodation and support of asylum seekers and the integration of refugees. In 2007, their remit was expanded to include all other recently arrived migrant groups. They work closely with central and local government, statutory service providers

and voluntary, community and migrant organisations in local areas to co-ordinate and provide advice, support and services for migrants and to ensure that migration issues are a key part of local plans. In most regions they include specific task groups, for instance in health, housing and employment.

## Commissioning Services

NEF (2010) Public Services Inside Out: putting co-production into practice<sup>111</sup>.

The Royal College of Psychiatry has identified good spiritual care as a component of effective therapeutic intervention for many people<sup>112</sup>.

Commissioning Framework for language support (2011), East of England<sup>113</sup>.

Transcultural Health Care Practice: An educational resource for nurses and health care practitioners, Royal College of Nursing<sup>114</sup>.

The NIMHE Race Equality and Cultural Capacity Training Programme<sup>115</sup>.

The Department of Health's Ten Essential Shared Capabilities, form part of the basic building blocks for the training of all mental health staff. There are two particularly relevant ESC capabilities entitled 'respecting diversity' and 'challenging inequality'<sup>116</sup>.

Choose Well is a national communications campaign to explain the differences between primary, urgent and secondary care, to support self-care and to help reduce the misuse of accident and emergency services, 999 and GP services<sup>117</sup>.

Choose Well Manchester has clear and clinically assured access and pathway information in over 40 languages and a range of video content in the top 10 migrant community languages (particularly those where mother-tongue illiteracy is prevalent)<sup>118</sup>.

The NHS England Equality and Health Inequalities Knowledge hub is designed to provide support and assistance to the NHS, and beyond, in promoting equality and tackling health inequalities for all patients, communities and the NHS workforce. It brings together equality and health inequalities resources and provides useful links and information for the sharing of good practice<sup>119</sup>.

# Appendix 3: Migration data sources

## International data

**Global migration.** The United Nations Statistics Division provides a range of information on global migration<sup>120</sup>

**European Union migration.** Information about migration in the EU, including asylum data, enabling comparisons of different member countries<sup>121</sup>

## National data [UK]

**UK Statistics Authority.** The UK Statistics Authority's 'migration hub' covers most UK migration statistics<sup>122</sup>.

**The Office for National Statistics [ONS]** also has a wide range of relevant statistics. Migration is covered under the 'Population' theme<sup>123</sup>.

**The Home Office** publishes regular migration statistics<sup>124</sup> covering basic national data on people who have migrated to the UK for protection, family, education or work reasons. Regional data on dispersed asylum seekers is included in the quarterly 'Immigration Statistics' publication.

## Local data

**Migrant workers** information on new national insurance numbers allocated to foreign nationals is available from the Department for Work and Pensions, using their 'tabulation tool'<sup>125</sup> This gives information on age, nationality and area of residence.

**Migrant workers from EU A8 countries.** More detailed information about A8 nationals registering under the Worker Registration Scheme between 2004 and May 2011 is available to local authorities<sup>126</sup>. This covers a variety of demographic and work-related information, such as dependants, industry and intended length of stay. Transitional controls

[requiring A8 nationals to register to be able to work in the UK] ceased in May 2011.

**Overseas students in higher education.** Annual data on international students is provided by the Higher Education Statistics Agency. The 'institution level' downloads gives numbers of students from outside the UK studying at a particular educational institution<sup>127</sup>.

**Employers and education providers.** Information on organisations that are licensed to sponsor students or migrant workers from outside the EU under the points-based system<sup>128</sup>. However these lists cover the whole UK and are arranged alphabetically, so it is not easy to work out how many sponsors are in a particular local area – total numbers of these sponsors in each local authority area can be obtained from local migration profiles.

## Understanding migration data

Migration Yorkshire provides an overview of migration data available for each area of Yorkshire and Humber in local migration profiles<sup>129</sup> Summaries of profiles can be downloaded from the statistics section.

**MIST network** (The new migration statistics network for Yorkshire and Humber). Primarily an email network, it enables people to ask questions and share answers about migration statistics at a local level. Find out more on the MIST network page<sup>130</sup>

**Local area migration indicators** provided by the Office for National Statistics for each local authority<sup>131</sup> (scroll to the 'data' section). The indicators include: international arrivals and departures, those without British citizenship, foreign nationals registering with a GP, national insurance numbers issued to foreign nationals, and Worker Registration Scheme data for A8 nationals. The spreadsheet enables the creation of graphs using the data.

**Local information systems.** Some areas have coordinated their population data sources in a 'local information system', although each one is organised differently. Eleven 'local information systems' in Yorkshire and Humber are available online<sup>132</sup>.

**Local authority briefings on age and ethnic group population projections.** In July 2010, the University of Leeds produced a new methodology for population projections at a local authority level by ethnic group and age for the years 2001–2051. The Yorkshire and Humber Public Health Observatory has produced local authority based briefings based on these projections<sup>133</sup>

Green AE, Owen D and Adam D (2008) *A resource guide on local migration statistics*, prepared for the Local Government Association by the Institute for Employment Research, University of Warwick<sup>134</sup>.

IPPR [Institute for Public Policy Research] produces regular analyses of national migration statistics<sup>135</sup>.

The ICAR website [Information Centre about Asylum and Refugees] has a statistics section with downloadable reports<sup>136</sup>.

The Migration Observatory website enables the creation of a range of charts using migration data<sup>137</sup>. Briefing papers drawing on available migration data are also available.

Migration Yorkshire is a local authority-led regional migration partnership, hosted by Leeds City Council, working with agencies across the statutory, voluntary, community and private sectors to help support the delivery of high quality services to migrants in a way that benefits everyone living in local communities. Details of their work, information about policy and research, and local services for migrants, including asylum seekers and refugees is available on<sup>138</sup>.

There is a substantial research base on migration in Yorkshire and Humber on the online migration

research database<sup>139</sup>. **Local migration services** have expertise in dealing with new migrant groups in their area, and often collect their own monitoring data, listed in the online A-Z of organisations<sup>140</sup>.

Other regional migration fora may maintain a list of local voluntary sector infrastructure organisations which can help put commissioners in touch with local migrant community groups: [wmsmp.org.uk](http://wmsmp.org.uk)

The Children's Legal Centre publishes a directory of services for young refugees and migrants, many of whom also work with adults<sup>141</sup>.

Education departments – primary schools are often the first to see the impact of changing language profiles and can give valuable insight into the communities in their area.

Local authority and hospital interpretation service requests, which are self-selected on the basis of need, can also give a clear and up-to-date picture of the changing language profile of an area.



# Appendix 4: Other published guidance relevant to mental health commissioners

Feldman R (2012) *Guidance for commissioning health services for vulnerable migrant women* Women's health and equality consortium and Maternity Action<sup>142</sup>.

A series of guides for commissioners of mental health services, published by the Joint Commissioning Panel for Mental Health (2012)<sup>143</sup> including *Guidance for commissioners of mental health services for people from black and minority ethnic communities*<sup>144</sup>.

Faculty of Homeless Health (2011) *Standards for commissioners and service providers*<sup>145</sup>.

RCGP Clinical Innovation and Research Centre (CIRC) (2013) *Improving access to health care for Gypsies and Travellers, homeless people and sex workers*<sup>145</sup>.

# Appendix 5: Acknowledgments

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For further information about references in these endnotes, please contact: [equality@mind.org.uk](mailto:equality@mind.org.uk)

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