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Development and policy

Mental health training for bilingual co-workers in the context of working with people seeking asylum and refuge

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ABSTRACT

This paper covers four main areas in relation to providing mental health care for people seeking asylum and refuge. It firstly describes the variability in service provision for people needing the additional resource of language interpreting. Secondly, it highlights the significant level of psychological distress in adults and young people. It then describes a model of training that develops a partnership approach between the mental health practitioner and the bilingual co-worker. Finally, collaborative ways of working are suggested in order to enhance the effectiveness of their work.

Note: the terms *people*, *adult*, *family*, *young person* or *children* will be used throughout this paper to refer to those seeking refuge or asylum unless specific distinctions are required with regard to their asylum-seeking or refugee status. This has been done in order to keep in mind that they are people first and foremost, who have been displaced under particular socio-political circumstances, rather than to label them as refugees or asylum seekers.

The term *bilingual co-worker* will be used to acknowledge the broader skill and expertise that many language interpreters bring to their work, and the breadth of work they are able to do in addition to interpreting during a therapeutic encounter.[1,2]

Introduction

Bilingual co-workers play an important role in bridging the language and cultural barrier between service users and practitioners, and in facilitating better access to care. However, it is important to consider the context in which they do their work. They are often asked to interpret in services that have not been established specifically to respond to the immediate and long-term mental health needs of people seeking refuge and asylum.[3,4] Although some services have become better at providing in-house training and support, most bilingual co-workers continue to work in isolation with no supervisory or managerial support.[5]

The task of interpreting is a complex one that goes beyond the literal translation. Practitioners often do not appreciate the breadth of skills and roles that are involved in this task. Effective interpreting draws on the human presence of the bilingual co-worker in the work. It also involves establishing trust, rendering translation that makes sense to both the practitioner and service user, and cultural brokerage in order to facilitate a good working alliance. Therefore, the term bilingual co-worker is preferred over that of interpreter, as this captures the complexity associated with the task of interpreting. The rationale and model of the bilingual co-worker has been reported in detail elsewhere.[1,2]

There continues to be a debate on what constitutes the most appropriate role for community interpreters.[6,7] Leanza has identified the key roles for an interpreter as being a system agent (facilitating access to the service for the user), an integration agent (bringing together the service user's and practitioner's views), a community agent (supporting the service user within their community and helping the practitioner gain an understanding of the service user's community context), and a linguistic agent (rendering a meaningful translation).[8]

Bilingual co-workers are directly exposed to the complex needs and emotional responses of people requiring their help. This implies that training for bilingual co-workers has to extend beyond developing their proficiency in interpreting and translation skills. There are also training implications for practitioners in developing their competency to work with people from different cultural backgrounds from their own; including their ability to work collaboratively with bilingual co-workers. Finally, effective models of co-working and practice need to be developed. This paper attempts to address each of these issues.

Emotional needs of adults and young people

The ongoing burden of receiving people who are escaping war and persecution continues to fall on the poorer countries, as developed countries actively pursue policies to restrict entry.[9–11] In the UK, specialist mental health provision has been developed in the larger cities. However, this is counteracted by dispersal policies that have relocated people in towns, where they have few community networks and less specialist help.[12]

For many people the emotional aftermath of having experienced trauma is not far from the surface.[13,14] A significant number remain vulnerable to psychological distress on reaching a host country.[15,16] Studies have shown adults to have higher levels of psychological distress.[17–21] Many adults report symptoms consistent with post-traumatic stress disorder (PTSD).[22–24] A lack of community and intimate relational support structures render people at greater risk of getting depressed.[25] This risk is also increased by unemployment, continuing to live in poverty, experiencing racial discrimination, and not having adaptive coping strategies when trying to adjust to life in a new country.[26,27]

High numbers of children and young people have been reported to show symptoms associated with PTSD, depression, or higher levels of psychological distress.[28–35] Children are at greater risk of psychological difficulties when they have reduced support networks, when their parents are experiencing mental health problems, and when there is parental or familial conflict.[28,31,36,37]

Despite the context of human violation and trauma, many people are able to draw on their inner resources, show resilience in the face of adversity, and find ways of getting on with their lives. Having a coherent contextual, familial and individual narrative to locate traumatic experiences can go some way to counter the risk of developing psychological problems.[38–41] The emotional support derived from containing intimate or professional helping relationships can add stability to a person's life.[42–46] However, it is difficult to anticipate to what extent psychological reactions to trauma are an appropriate transient response to what has occurred.[47] It is also difficult to screen for people who are at risk of developing long-term mental health problems.[48,49]

Unfortunately, people's attempt to adjust to a new life is further compounded by having to deal with the ambivalence or open hostility emanating from the receiving country.[50–54] This ambivalence is manifest in legislation, reactive policy making, fragmented strategies for supporting new entrants, service provision, discriminatory practice, media portrayal, and on occasion a lack of human regard.[9,55–59] Negative attributions by others can have a detrimental impact on maintaining a positive sense of one's identity.[60] The issue of trust is a very significant one for people who have had this taken away through human violations such as torture.[61] The hurt, the pain, the lack of trust, the emotional turmoil, and psychological distress of service users, is experienced first hand by bilingual co-workers in their work.

Service provision

Primary and secondary healthcare settings can play an important role in providing innovative services that draw on preventative and community based interventions.[62–64] In both Britain and North America, recent literature is beginning to describe individual, group, familial, school-based and community interventions in meeting the emotional needs of children and young people.[65–67] These interventions have applied established psychological approaches such as cognitive–behaviour therapy (CBT) in helping people manage their psychological responses to trauma, or using a narrative approach. Innovative community based programmes for helping families establish local networks as a source of emotional and

social support have also been described. However, there remains a need for a stronger link to be made between research, policy and the delivery of evidence-based preventative and secondary interventions, at the local community, national and international level.[68–71]

Inevitably many bilingual co-workers become receptors of the receiving country's ambivalence in their working encounters with practitioners, and experience vicarious trauma in their contact with service users, an experience which also resonates with sign language interpreters.[5,72,73] It is not surprising that many bilingual co-workers become distressed by their work, given that most of them have not undergone specific training in mental health. Their job is made difficult where they have no background knowledge of mental health or understanding of the service context. Having no formal management structures, supervision or support compounds the problem, and some bilingual co-workers become reluctant to take new assignments in mental health following distressing experiences. Some interpreters find it difficult to juggle the emotional demands of the work, while others are left with unresolved dilemmas they encounter in their work. Informally many interpreters report their sense of not being wanted in the therapeutic encounter or being seen by practitioners as an added burden to the work. They also recount experiences of outright hostility, disregard, or disrespect emanating from practitioners or service users.

The importance of bilingual co-workers

Bilingual co-workers aid the provision of effective services for adults, young people and families. However, the availability of adequate language interpreting support for practitioners and families varies across services and different parts of Britain. Many people prefer a family member to interpret for them due to issues of trust, and often rely on their children for this task.[74] However, there are certain advantages in having trained bilingual co-workers carry out this task.[75]

Even when interpreting services are available, practitioners tend to be reluctant to make use of them.[76–78] Very few practitioners undergo specific training in how to work effectively with bilingual co-workers. However, it has been shown that practitioners who have had prior training in working with interpreters are more likely to make use of them in their work.[79]

Practitioners have reported difficulties in finding effective ways of working with bilingual co-workers.[78,80–82] They are often unsure about their role when working with bilingual co-workers, and worry about the accuracy of translation. They find it hard to develop trust, especially when they feel that the bilingual co-worker is taking over in the work. Practitioners also report not having sufficient time for briefing and debriefing, or being able to build up a working relationship with the same bilingual co-worker over a period of time.

Bilingual co-workers have little dedicated training in mental health. When asked they have requested training in topics including: (a) understanding treatment strategies for trauma and traumatic grief; (b) mental health aetiology; (c) understanding emotional reactions to their work and dealing with these; (d) psychological theories; and (e) strategies for self-care.[72] There is also a need for joint training between practitioners and bilingual co-workers if effective collaborative practice is to be developed.[83,84]

Formalised interpreter training has helped to professionalise and increase recognition of this work (e.g. accredited training for community interpreters provided by the National Community Interpreting Project Workers' Educational Association in London). This training is beginning to pay greater attention to the work that interpreters carry out in mental health.

Training for bilingual co-workers and practitioners

In response to the training needs of bilingual co-workers, a project was set up to provide them with an introductory course in mental health. One of the principal aims of this training project was to introduce bilingual co-workers to the psychological frameworks that mental health practitioners employ in their work, particularly in relation to trauma. Another aim was to increase the participants' understanding of the approaches used by different mental health professions. It was hoped that increasing their knowledge would place participants in a stronger position from which to carry out their work. The value base underpinning this training was that of developing the existing knowledge, skill, expertise, and experience that the participants brought to this training.[1,2,85] The mode of delivery was primarily experiential, in order to help the participants develop their existing interpreting skills in ways that would enhance their skills and be complementary to the work carried out by mental health practitioners.

An important component of this training was to build in time for a regular reflective group. The group lasted for the duration of the whole training with the same facilitator. Reflective practice is seen as integral to training and continuing professional development in many mental health professions.[86] The reflective group enabled course participants to have a designated space to integrate their learning with their personal experience, and to have an opportunity to explore the emotional impact of their work in a safe environment.

The structure of the training project (funded by the Home Office Refugee Integration Challenge Fund) set up by the author is now briefly described. This project provided a 10-day training in mental health for interpreters supporting people seeking refuge and asylum in mental health settings. It was aimed at interpreters who had themselves sought asylum or refuge in the UK, or those interpreters coming into contact with service users in need of refuge or asylum. The course was repeated on three separate occasions. There was a maximum limit of 16 participants for each time the training was run. The main structure of this training is given in Table 1.

It was also hoped that mental health colleagues would develop their practice by becoming involved

Table 1 Programme for developing a psychological framework when working with trauma in the context of people seeking asylum and refuge

Day	10 am–12 noon (including short break)	12–1 pm lunch	1–2.15 pm	2.15–2.30 pm break	2.30–4 pm
Day 1	Interviewing skills and psychological assessments		Interviewing skills and psychological assessments		Interviewing skills and psychological assessments
Day 2	Interviewing skills and psychological models		Interviewing skills and psychological models		Reflective group
Day 3	Working with children and families		Working with children and families		Working with children and families
Day 4	Adult mental health		Mental Health Act		Reflective group
Day 5	Cross-cultural understanding of children and child protection		Protection issues in relation to children and child protection		Protection issues in relation to children and child protection
Day 6	Understanding trauma		Understanding trauma		Reflective group
Day 7	Models of co-working between practitioners and bilingual co-workers		Models of co-working between practitioners and bilingual co-workers		Models of co-working between practitioners and bilingual co-workers
Day 8	Working in psychiatric settings		Managing risk in adult mental health		Reflective group
Day 9	Working in social care settings with older people		Working in social care settings with older people		Working in social care settings with older people
Day 10	Developing effective practice		Developing effective practice		Reflective group

in providing the training, and learning from the issues brought up by the course participants. One way in which this was facilitated was by getting more practitioners involved with each new run of the training, and allowing for a two-way process of learning.

Towards a co-working model of practice

Given some of the issues highlighted above it is important that training such as this leads to a more effective model of co-working between practitioners and bilingual co-workers. The key elements and benefits of the collaborative co-working approach are briefly described below.

- *Securing the help of the most appropriate bilingual co-worker*: where possible it is important for practitioners to identify beforehand the most suitable bilingual co-worker. This is best done in liaison with the interpreting agency. Doing so avoids placing service users and bilingual co-workers in uncomfortable, and at times, unworkable situations (e.g. discomfort due to potential differences in religious or political background between service user and bilingual co-worker, male bilingual co-worker being booked to carry out an assessment with a young women who has been raped). Hence, planning for the work is crucial for its success.
- *Building up working relationships with local interpreting agencies*: co-working improves when practitioners and bilingual co-workers gain better knowledge of each other's work. The working relationship is enhanced when practitioners and bilingual co-workers are able to maintain regular contact over time. It is, therefore, important to build up and maintain these links, and induct new workers to the services that already exist. Ongoing joint training ensures that models of good practice and good working relationships are maintained and not lost with changes in personnel.
- *Negotiating and clarifying the role*: it is important to clarify and agree the respective roles that the practitioner and bilingual co-worker will take on, so that ill-feeling and confusion do not arise. Two workers who are clear about their role and who are working well together, increase the confidence and trust that the service user will have in them. Also, a bilingual co-worker should not be asked to undertake work that is inappropriate, or beyond his/her level of training or experience (e.g. not asking a bilingual co-worker to explain a diagnosis or treatment in the absence of a practitioner). At other times it may be appropriate for a bilingual co-worker to take on a broader role where they have the skills, training, or experience to do this (e.g. cultural consultant, health advocacy). Given the earlier discussion about the debate and breadth of the interpreting task, it has to be acknowledged that this process of negotiation is a complex one. However, an honest dialogue between practitioners and bilingual co-workers prior to starting the work can go a long way to preventing the types of difficulties that can arise in the co-working relationship.
- *Briefing for the language bilingual co-worker*: briefing is vital for ensuring that the practitioner gives sufficient information about the referral, and their style of work, to the bilingual co-worker. A bilingual co-worker has to be respected as a professional in his or her own right, and be given the relevant information they require in order to carry out their work more effectively. Briefing is particularly important where a bilingual co-worker may be new to mental health work. It should be an ongoing part of the work.
- *Maintaining continuity of co-workers*: to enable service users to feel safe and able to explore intimate details of their life, it is important that they can build up trust in the practitioner and bilingual co-worker. Having the same workers helps with this process of building up trust, and facilitates a good working alliance all round. This also avoids unnecessary replication of information-giving and anxiety for the service user.
- *Debriefing*: having some time built in after the appointment allows the practitioner and bilingual co-worker to attend to issues that may not be possible to discuss in the presence of the service user. It also gives the two workers time to discuss and understand personal feelings arising from the work. Debriefing can also be used to clarify any misunderstandings that have arisen in the work and readjust treatment plans or objectives, and for developing a better understanding of the service user's needs. Debriefing reduces the risk of misdiagnosis or implementing culturally inappropriate interventions.
- *Reflective practice*: this can be built into the time allocated for debriefing, or made available separately to practitioners and bilingual co-workers. Practitioners are usually more familiar with models of clinical supervision or reflective practice. However, bilingual co-workers should also have access to debriefing or supervision, given the emotional impact of working in the context of refuge and trauma.

Summary

Many people are exposed to traumatic experiences and uncertainty in their country of origin. Their attempt to escape persecution or threat to their personal safety, sometimes involves them in perilous journeys, along which they are placed at further risk of harm. On seeking refuge or asylum in a receiving country they encounter further barriers, and new challenges, that impact on their ability to maintain their psychological wellbeing.

Connecting with another person's overwhelming despair without losing hope or trust presents practitioners and bilingual co-workers with challenging emotional demands. It is for these reasons that mental health training should be provided for bilingual co-workers. Such training enables them to have a context for understanding the practitioner's work. It also gives them a psychological framework from which to carry out their interpreting task and process the emotional impact of their work.

Equally there is a need for practitioners to have training that increases their competency to work with people who have different cultures and life experiences from their own. There is also the need for joint training between bilingual co-workers and practitioners in order to promote collaborative practice. Both practitioners and bilingual co-workers need to be respected as professionals in their own right, and feel equally able to contribute to each other's work. Carrying out the work in a structure that allows for better communication and mutual support increases the efficacy and quality of service for people having complex needs.

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CONFLICTS OF INTEREST

None.

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