

A SHATTERED WORLD

THE MENTAL HEALTH NEEDS OF REFUGEES AND NEWLY ARRIVED COMMUNITIES

‘there is no greater sorrow on earth than loss of one’s native land’ – Euripides 431 BC

**MIGRANT & REFUGEE COMMUNITIES FORUM
& CVS CONSULTANTS**

CONTENTS

SECTION A INTRODUCTION

1. Introduction
2. Acknowledgements
3. Working Definitions

SECTION B ISSUES

1. Key Themes In Recent Patterns Of Migration of Refugees And Asylum Seekers To The UK
2. Why Mental Health And Refugees Is An Issue
3. Presenting Need
4. Key Themes
5. Two Refugee Communities
6. Refugees And Pathology
7. Pathways To Care
8. The Specific Syndromes

SECTION C FACTORS AND CONDITIONS

1. Specific Factors
2. Specific Syndromes

SECTION D APPROACHES

1. Introduction
2. The Role Of Refugee Communities And Individuals
3. Cultural Considerations
4. Outreach, Health Awareness And Prevention Strategies
5. Practical Support
6. Assessment Arrangements
7. Children And Young People
8. Counselling
9. Specific Counselling Approaches
10. Bicultural And Transcultural Counselling
11. Interpreting
12. Get Busy
13. Complementary Therapies
14. Spirituality And Religion
15. The Link Between Community And Clinical Services
16. Recommendations

SECTION E CASE STUDIES

1. Introduction
2. NHS Services
 - A. Crisis Intervention Scheme - Healthy Islington
 - B. Intercultural Refugee Counselling Project – Camden & Islington NHS Trust
 - C. Refugee Outreach Team - Lambeth, Southwark and Lewisham Health Authority
 - D. Refugee Public Health Nurse - Barking, Havering and Brentwood Health Authority
 - E. Refugee Support Psychologist - Forest Health Care NHS Trust
 - F. Refugee Support Project - Willesden Centre for Psychological Treatment
 - G. Somali Counselling Service - Tower Hamlets Health Care Trust
 - H. Tavistock Clinic Refugee Services – Tavistock & Portman NHS Trust
 - I. Traumatic Stress Clinic
 - J. Traumatic Stress Clinic Bosnian Project
 - K. Traumatic Stress Service
- 3 Specialist Independent Sector Organisations
 - L The Bayswater Family Centre
 - M Evelyn Oldfield Unit
 - N The Medical Foundation for Victims of Torture
 - O Nafsiyat
 - P Refugee Support Centre
 - Q Saheliya
- 4 Refugee Organisations Providing Mental Health Services
 - R The Bosnian Project (Welcare)
 - S Chinese Resource Centre
 - T Islington Somali Community Association
 - U Islington Zairean Refugee Group
 - V Latin American Womens Rights Service
 - W Somali Welfare Association
 - X Refugee Action

SECTION F APPENDICES

- 1 Access To NHS Services
- 2 Bibliography
- 3 CVS Consultants
- 4 The Migrant and Refugee Communities Forum

An Executive Summary has been published as a separate document.

1. REFUGEES AND MENTAL HEALTH

The aim of this publication is to:

- Describe why the mental health needs of refugees are a cause for major concern in the UK today;
- Provide information on the types of mental health problems that are being presented;
- Give background information on the typical causal factors arising both here and in the country of origin;
- Focus on issues of access to health care;
- Describe some of the experiences from the perspective of two of the larger recent refugee communities;
- Explore some of the particular factors that affect service development in this context;
- Detail a range of positive strategies that can be developed to improve the mental health of refugees;
- Provide case studies for those wanting more detailed information on some of the services that have been developed.

As a sub-theme we have also covered linked issues of substance misuse where these were reported to us.

2. TARGET AUDIENCE

The target audience for this publication is wide. It has been produced at a time when

- refugee issues are the subject of much (often unhelpful) media coverage;
- Government has published a white paper on the treatment of asylum seekers which has had a mixed reception but where generally there is a perception that, at the very least, we will be moving towards a structured and more efficient method of receiving refugees, processing their applications and providing resettlement facilities for those allowed to stay;
- There is considerable concern from health care professionals, the voluntary sector and refugee community organisations themselves about mental health issues.

At one level then we hope that the report will simply be informative for those who wish to better understand the issues of mental health, trauma, etc. amongst refugees in this country.

Secondly we hope that it provides valuable information on key considerations and effective approaches for those wishing to develop services for refugees with mental health problems. The case studies and the contact list are included precisely for this purpose and to enable contact to be made amongst those working in or considering working in this field.

Thirdly, as we hope we will be able to demonstrate, a key factor in better mental health for refugees is a vastly improved system of reception, resettlement and integration into UK society. We, therefore, hope the report will be informative for and influential on those policy makers and others charged with overhauling current asylum seeking arrangements.

3. LITERATURE REVIEW

The initial stage of the project was to undertake a literature review. Whilst there is a wide range of international material on refugee health issues generally; the information on mental health is fairly limited and is mostly targeted on aid workers operating with displaced people abroad.

There is, however, some very useful material that has been produced in the UK. Writers such as Derek Summerfield of the Medical Foundation for Victims of Torture; Stuart Turner at the Traumatic Stress Clinic and Renos Papadopoulos at the Tavistock and Portman NHS Trust have produced a large number of very helpful papers and reports. Many of these, we suspect, have only been read by a specialist audience to date. We certainly refer to and have been influenced by their arguments and those of others. Other useful sources of information are the Refugee Council and the Mental Health Foundation.

In addition we came across some very valuable local information some of which was produced by refugee community organisations themselves.

Finally, as part of considering, appropriate models and methods of working with refugees with a mental health problem we looked more broadly at the literature on black and minority ethnic communities and mental health and counselling in the UK.

All these publications and reports are detailed in the bibliography.

4. THE CASE STUDIES

A key part of the review was to undertake a large series of case studies. In all we undertook some 38 interviews with different projects providing services to refugees with mental health problems.

24 of these interviews have been written up as case studies in Section D of this report¹.

The format for the interviews and for the case studies as they are written up here was to:

- a) explore the history, what prompted the service to be set up in the first place;
- b) understand who the users were, which community did they come from; what were the presenting problems;
- c) describe the range of services that were being provided and the ways in which they differed from and linked in to main stream mental health services;
- d) encourage those interviewed to describe for us what they saw the particular key issues as being; what factors needed taking into account; what unmet needs were there, what strategies worked best etc.

The case studies are attached because:

- a) many of the projects describe innovative and imaginative models;
- b) they illustrate better than any other source the type and volume of mental health problems there are amongst refugees;
- c) we hope that those interested may make direct contact and that those considering setting up new services may learn from the experiences described here.

The position of some of these agencies is insecure, largely for funding reasons, and we understand that two services have closed down as a consequence of funding being withdrawn. This is very much to be

¹ The reason that there are 24 rather than 38 case studies is that in some instances we interviewed different staff from the same agency and in some instances the interviews covered information that we had already derived from other interviews

regretted and emphasises the need to present a strong case for a new and enhanced commitment of service commissioners in this area.

We have also drawn on the experience of the case studies on a very regular basis during the course of this report. Their experience is the base material on which this publication has been put together. The reader will need to use the list of abbreviations given at the beginning if they wish to link the main text to the case studies.

Case studies are organised on three levels:

- a) those services provided from within the NHS;
- b) specialist providers of mental health services to refugees;
- c) those services provided by refugee community organisations themselves.

5 A REFUGEE COMMUNITY GROUP FOCUS

A key theme in all the publications in this series has been to attempt to address issues from a user perspective. There are two main reasons for this. Firstly we want to describe the particular needs as they are experienced by users; gain a sense of how they define mental health and well being; and understand from their perspective the types of intervention that are likely to be most acceptable and most effective. But also, and perhaps more importantly the second reason is that we wanted to draw out and describe user-led initiatives and/or describe processes that actively engage users in positive strategies to achieve good health.

A key dilemma that this report will explore is the concept of the refugee as 'passive victim'. We hope to combat that negative appraisal through drawing on many examples of the active engagement of refugees and refugee communities in helping themselves.

The route to achieve a user focus for this review was to identify four specific refugee community groups and to attempt to work with community based organisations from those communities to understand mental health from their perspective.

The aim was to chose four populations where:

- a) there has been a recent influx of refugees from that community into the UK in the recent past;
- b) there is evidence that mental health is a major cause of concern;
- c) the communities were likely to have different needs and different attitudes to mental health;
- d) we covered a wide geographical range.

In conjunction with the steering group for this project the following four communities were chosen:

- Bosnian
- Latin American
- Somali
- Zairean

14 of the interviews were with community groups from these populations and in addition a number of the other agencies were chosen because they specifically focussed on one of these populations.

In practice one or two of these interviews were effectively abortive as key volunteers (few of the groups had paid staff) were unable to see us and some of the interviews only reinforced what we had already learnt elsewhere. This is not a criticism of the groups as some are newly formed or informal and rarely have the resources of other community agencies. However, it is worth noting that even where

considerable preparation has taken place (identifying potential groups; explaining what the review was all about; setting up meetings etc) the fall out rate is still considerable.

The net result is that whilst case studies of community organisations from all four populations are included we ended up with substantially more comprehensive information on mental health issues for Bosnian and Somali refugees than for the other two communities. It is for this reason that section B5 focuses on these two communities.

A2 ACKNOWLEDGEMENTS

This project was commissioned by the Department of Health as one of a series of exercises intended to investigate and offer general guidance on different aspects of ethnicity and health. Related projects have covered mental health and counselling services for ethnic minorities and two previous reports in this series: *Ethnicity and Disability: Moving towards equity in service provision* and *Ethnicity and Learning Difficulties: Moving towards equity in service provision*

The project was managed by a steering committee consisting of:

Tahera Aanchawan	Formerly of the King's Fund and now an independent consultant
Belinda Calaguas	Formerly Director of the Migrant & Refugee Communities Forum and now Deputy Director of Wateraid
David Jobbins	Team Leader, Lambeth, Southwark and Lewisham Health Authority Refugee Outreach Team
Peter Smith	Director of the Migrant & Refugee Communities Forum
Meena Raj	CVS Consultants
John Reading	CVS Consultants

The research and field work studies were undertaken by Meena Raj and John Reading who also wrote the handbook.

Dr Kate Harris (Psychologist) undertook the peer review of the final report.

The Refugee Council provided much of the factual data on asylum statistics etc referred to through the text.

The project was funded by a grant from the Department of Health. The views expressed in this report do not necessarily reflect the views of the Department of Health. The authors are grateful for the Department's support and in particular that of Veena Bahl, the Department's Adviser on Ethnic Minority Health. They would also like to thank all those individuals and agencies who contributed to the review.

A3 WORKING DEFINITIONS

REFUGEE

The legal definition of a refugee as adopted in the 1951 United Nations Convention is:

"a person who owing to well founded fear of being persecuted for reasons of race, religion nationality, membership of a particular social group or political opinion, is outside the country of nationality and is unable, or, owing to such a fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, unwilling to return to it"

The term “refugee” includes people with three different types of immigration status as recognised by the Home Office.

Full refugee status

Exceptional leave to remain

Asylum seekers awaiting a Home Office decision on their asylum applications

ASYLUM SEEKER

An asylum seeker as defined in the 1971 Immigration Act, is

"a person who may apply for asylum in the United Kingdom on the ground that if he were required to leave, he would have to go to a country to which he is unwilling to go owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion. Any such claim is to be carefully considered in light of all relevant circumstances".

TORTURE

Torture victims are a particularly vulnerable group within the refugee community whose needs frequently remain unrecognised or overlooked. Amnesty International (1987) reported the use of "brutal torture and ill treatment" in over 90 countries in the 1980's.

Torture as a definition is problematic. The United Nations (1984) Convention against Torture, defines it as:

An act by which severe pain or suffering (physical or psychological) is intentionally inflicted on a person for such purposes as (a) obtaining information; (b) obtaining a confession; (c) punishment; (d) intimidation or coercion; (e) any reason based on discrimination.

Torture can also be perceived as

"the forceful persuasion of an individual group out of their natural bodily, physical and psychological state, through the infliction of severe (either or both) physical and mental suffering ... for the purpose of strategically silencing/ repressing people who hold opinions contrary to those in power."

Further consideration is, however, needed for the term 'torture victim'. To talk of refugees who have experienced torture or trauma associated with torture as 'victims' ignores the fact that these people are actually 'survivors' who live and cope with the long-term and daily effects of torture.

A4 EXECUTIVE SUMMARY

Given the length of this report it was decided to produce an Executive Summary as a separate document. Please contact either of the agencies who produced the report for copies (contact details are inside the cover).

SECTION B ISSUES

B1 Key Themes In Recent Patterns Of Migration of Refugees And Asylum Seekers To The UK

1 INTRODUCTION

One person with a severe and untreated mental health condition is cause for concern. The interviews we undertook and the other literature on the subject suggests that:

- there are large numbers of refugees with mental health problems in the UK;
- prevalence may be higher than amongst other communities;
- access to appropriate treatment may be less frequent.

Such views are impressionistic because, as far as we are aware, no one has undertaken a quantitative study in this area. At this stage evidence that mental health issues amongst refugees are a major cause for concern is derived from refugee community organisations themselves who consistently place mental health at or near the top of their list of unmet priorities; and health professionals in both the independent and the statutory sectors, working in areas with significant refugee populations, who report on wide spread distress and ill health. Much of the substance of this report will be to feed back those views and consider what can be done.

In this introductory section we thought it might be helpful to summarise the existing factual and statistical information on patterns of migration to this country produced by the Home Office and the Refugee Council. What that gives us is very detailed information on those seeking asylum status and the way in which patterns of migration change in relation to crises in different parts of the world. This information is valuable in three ways:

1. It indicates that there are very distinct patterns of migration to this country with different populations seeking admission. So in basic terms at the beginning of the 90's the largest group was Bosnian people; in the mid 90's it was Nigerian people and at the end of the decade Kosovo Albanians are seeking admission.
2. Furthermore it becomes transparent from this that most of those seeking admission are fleeing a crisis such as civil war, rather than having the status of 'economic migrant'.
3. There are factors in the political circumstances in the country of origin and in the process of flight that may be expected to impact on mental health in some instances.

Given that we will argue that an effective response to the mental health needs of refugees needs to take cultural factors into account (and in some respects requires a culturally specific service) then it is also clearly very useful to know which countries generate the most applications for asylum status in the UK.

2 ASYLUM STATISTICS IN THE UK

Information on refugees and asylum seekers in the UK for the last ten years was kindly provided by the Refugee Council.

Asylum applications

The numbers of applications for asylum in the UK for the last ten years have risen from just over 4,000, in 1987 to over 30,000 in 1997. Asylum applications fell from 43,965 in 1995 to 29,640 in 1996. In 1997, there was a slight increase in applications again, which reached 32,500.

One major factor behind the increase after 1993 was the annulment of the presidential elections and derailment of democratisation in Nigeria. Over 15,000 Nigerian nationals have applied for asylum in the UK over the last ten years. Other large numbers of applications have been submitted by nationals from countries with internal civil conflicts - former Yugoslavia, Sri Lanka, Somalia and Turkey - and those with documented human rights abuses, including Ethiopia, India, Pakistan, Ghana and Zaire.

There was much debate during the passage of the 1993 and 1996 Asylum Acts about the genuine nature of asylum seekers. General statistical patterns by no means give us an absolute answer to this question. As the countries quoted above show, however, statistics do tend to support the view that asylum seekers are fleeing from situations where they face the risk of persecution. There is a correlation between the countries from which asylum seekers come, and political, ethnic and religious crises.

The majority of refugees flee to neighbouring countries, many of which have economic and political crises of their own. In July 1997, the United Nations High Commission for Refugees (UNHCR) noted the following as the top ten countries of asylum: Iran, Pakistan, Germany, the United States of America, Federal Republic of Yugoslavia, Zaire, Sudan, Guinea, Ethiopia and the Ivory Coast.

Asylum seekers' major countries of origin

For three of the past four years, Nigeria has been the country producing the highest number of asylum applicants in the UK, with over 14,000 applications between 1993 and 1996.

India, Somalia, Pakistan, Sri Lanka, Turkey and the former Yugoslavia have all been among the top ten refugee producing countries in the UK from 1993 – 97, reflecting the continued civil conflict in these countries.

In 1996, the former Soviet Union and Columbia entered the list for the first time, reflecting the deterioration in human rights in those countries which continued to cause the flight of refugees in 1997. In 1997, China also joined those countries which produced almost 2,000 asylum seekers coming to the UK.

It may be noted that the most common nationalities of asylum seekers in the UK differ from the most common nationalities of refugees across the world recorded by UNHCR, reflecting the fact that most asylum seekers go to neighbouring countries. The top ten countries of origin as noted by UNHCR in July 1997 were: Afghanistan, Bosnia and Herzegovina, Iraq, Liberia, Somalia, Eritrea, Rwanda, Angola and Sierra Leone.

The number of applications coming from within Europe increased notably in 1996-97, as countries in Eastern Europe suffered more upheavals following the fall of Communism, for instance in Albania, and unrest continued in former Yugoslavia. An increase in the persecution of ethnic minorities in the region, such as Roma people living in central and Eastern Europe, has been evident.

B2 WHY MENTAL HEALTH AND REFUGEES IS AN ISSUE

Given all the other pressing social and health care concerns in UK society today from drug misuse among the young to long term care for the elderly, why should we concern ourselves with the mental health of refugees or single this area out for particular focus? What is it about the particular circumstances of refugees that makes mental health such a common problem, often in very acute and distressing ways?

We hope that the cumulative evidence of the case studies and other material reported on here will provide a substantial and convincing answer to the first question. In headline terms, however, it is worth while drawing attention to some of the more extreme manifestations of mental health problems amongst refugees in the UK today such as:

- The numbers of young Somali boys and men committing suicide in a most dramatic and gruesome fashion (and who come from a community in which suicide is virtually unknown in the country of origin);
- The three mental health units we visited in psychiatric hospitals which contained a very high proportion of refugees who had been compulsorily admitted;
- The evidence provided by the Medical Foundation For Victims Of Torture (MFVT) of the large number of torture survivors seeking their help and their inability to deal with any more than the extreme cases of need;
- A similar situation at the two Trauma clinics.

The services we will describe are inundated with requests for help.

The second question, about the particular circumstances of refugees that makes mental health such a common problem, is more complex and so we wanted to summarise some of the key themes underpinning that question as a prelude to considering them in detail and exploring possible responses.

The kind of factors that seem to be relevant include:

- The likelihood that some refugees will have had mental health problems in their country of origin regardless of any major political upheaval or other recent factors in the country as a whole.
- The certainty that factors associated with political upheaval in some of the countries of origin such as imprisonment; torture and other ill-treatment; loss of home and job; ill treatment, separation from or death of family or friends; can lead to mental health problems for some but certainly not all of those who have undergone such experiences.
- Loss on a temporary or permanent basis of 'one's native land'.
- The process of trying to rebuild a life in another country and the reception one receives.

Any of these factors can lead to severe mental health problems though not necessarily immediately or even shortly after admission into the UK. We will describe many examples where mental health problems only begin to emerge when the person has been resident in the UK for a number of years.

One of the case studies, Refugee Action², provides a clear account of what is a common process. The agency is most involved with clients during their resettlement period. In their experience, during these early stages, people are mainly concerned with obtaining material possessions, getting a job and establishing themselves in society. Mental health is very much neglected during this time unless it is an extreme problem. Immediately newly arrived refugees are highly motivated to get housed, obtain employment, ensure that their children are schooled, etc. It is only after a period of anything up to two to three years that mental health problems may begin to emerge partly because other aspects of their lives are stable.

For some the problem will be immediate and for some it will be deferred. For some there will be no mental health problem before they arrive in the UK and one will only emerge as a consequence of factors entirely to do with their experience here such as insecurity, poverty, racism, isolation and lack of contact with family, poor housing etc.

The refugee experience is, of course, the epitome of the loss of security and stability, the 'shattered world', and for many, sooner or later, that shattered world will impact on psychological as well as material and physical well being.

B3 PRESENTING NEED

² Case Study X - Refugee Action p---

1 INTRODUCTION

In this section we want to describe the different kinds of mental health experiences and problems that refugees are presenting with and from this start to identify some of the key underlying factors.

2 CHILDREN AND ADOLESCENTS

The largest group presenting to Nafsiyat³, for instance, is children and adolescents. These are often children who have experienced at first hand the most appalling experiences. Examples described to us included children seeing a parent abused, beaten or taken away never to be seen again. Others had endured a day to day existence in a civil war with their village or town under siege. In many instances parents had remained using their limited resources to enable their children to flee to a place of safety.

Many of the recent waves of refugees have included unaccompanied children or children where only one parent (usually the mother) has been able to flee. Particularly for communities like the Somali where the role of the father is dominant this can lead to parenting and family problems in the UK. Nafsiyat describe those adolescents they see with behavioural problems, particularly pent up anger, who may have lost parents and be living with other relatives. Younger children are also facing difficulties at school because of the trauma experienced in their early lives which may leave them withdrawn or prone to bouts of rage and frustration.

Some children will simply get on with their lives in a new community, learning English and making friends. Others may be deeply distressed and require specialist help. Many simply need a protective, loving and stimulating environment

3 WOMEN

There are also a series of specific problems affecting women refugees. Some may have been raped or otherwise sexually abused (the case of the systematic rape of Bosnian Muslim women is an obvious harrowing example); others may have been tortured or imprisoned; others are separated from husbands, families and children.

And, as we will describe, for many the problems arise while trying to rebuild a life in a new country. The status of women in different communities is a key factor. Some may have come from a male dominant culture and now find themselves in an environment where they have to become more assertive and independent as they may be the wage earner or a single parent.

Latin American Women's Rights Service (LAWRS)⁴, the only service exclusively for women that we saw, summarise the range of problems they see in their women users. Most women who approach their service are in crisis with problems such as depression, a low sense of self-esteem, or loss of cultural identity. Post Traumatic Stress Disorder is reasonably common mostly affecting women from Columbia, Equador and Peru. Symptoms include recurring nightmares, anxiety, etc.

Some women have been admitted to Mental Health Units in connection with experiences of sexual violence, torture, etc. Second generation women face issues such as intergenerational conflict or cultural conflict where they feel torn by the differing demands of their new environment and their family traditions.

Whilst LAWRS was the only women-specific service that we interviewed, many of the case studies described the separate and particular needs of women refugees and the measures they were taking to address these.

³ Case Study 0 - Nafsiyat p----

⁴ Case Study V - Latin American Women's Rights Service p-----

4 MARITAL PROBLEMS

Many of the groups describe how severe marital problems can impact on mental health. Perfectly stable marriages in the country of origin come under huge pressure in the country of exile. In some instances roles will have changed fundamentally and the man may no longer be the provider. His self-esteem may be badly affected as a consequence. Men may have difficulty coping with the lack of status, having nothing to do as employment is not an option or difficult to find and may then, hardly surprisingly, dwell on the past. Women may then have difficulty coping with the inaction and depression of their partners. Many of the case studies refer to examples of domestic violence and broken marriage.

5 TRAUMA RESPONSES

The whole area of response to trauma and the Post Traumatic Stress Disorder (PTSD) syndrome is huge and complicated and subject to major debate and dispute amongst experts in the field. We will explore it further in Section C2 below. Whatever position one takes on the PTSD issue there is no doubt of the high level of signs of distress that are a consequence of traumatic experience. It is worth repeating one of the definitions of torture given above.

"the forceful persuasion of an individual group out of their natural bodily, physical and psychological state, through the infliction of severe (either or both) physical and mental suffering ... for the purpose of strategically silencing/ repressing people who hold opinions contrary to those in power."

Torture and repression are intended to psychologically destabilise. Derek Summerfield⁵ describes as a new tool of war or new strategy in war, 'the deliberate process of annihilating the security and mental well being of a particular community through continuous threat, intimidation and violence'.

In addition to this systematic process there are literally thousands of examples of individuals enduring extreme physical and psychological assault on a random or one off basis. The hapless bystanders who are the victims of war, the families of those who are persecuted, those caught up in processes not of their making and beyond their control, can all become traumatised and in need of help.

We need to stress here and elsewhere that mental health problems are not an inevitable consequence of trauma. Many people, who have gone through exactly the same harrowing experiences, nonetheless cope well and unsupported. One area of fruitful research has been to explore whether one can identify the factors that help such people survive traumatic experiences more effectively and without the need for external intervention. Others, of course, do not and need the help described below.

The Traumatic Stress Service⁶, for instance, work with people including refugees with a range of different mental health conditions but all of whom exhibit severe trauma responses. In their view this probably only applies to a minority of the refugees in the country. Staff work with people who are experiencing severe depression and Post Traumatic Stress Disorder. This accounts for approximately half of all clients they see. The main reactions are alienation, stress, acculturation, nightmares and flashbacks, etc.

The reactions to trauma are varied but may also include forgetfulness, the inability to concentrate, losing all trust in those around you including family members, and lack of sleep. None of the reactions are that surprising given the experiences undergone.

6 DEPRESSION

Refugees are presenting to services with every degree of depression from the low level depression where there is a need to provide social and supportive environments for people who are feeling isolated and depressed to extreme cases that may lead to suicide.

⁵ Summerfield D The Impact of War and Atrocity on Civilian Populations 1996

⁶ Case Study K - Traumatic Stress Service p----

Depression is sometimes described as a side effect of trauma whereby an individual becomes withdrawn, non-communicative and unwilling to engage in any form of social activity. Equally it may express itself in sudden and uncontrollable emotional outbursts.

Depression for many can also be viewed in terms of 'cultural bereavement'. Much like the loss of a loved one this kind of bereavement entails the loss of country, cultural values and close friends and relatives. This loss of an old known and familiar world with all the patterns of accustomed behaviour that entails; can lead people to withdraw into themselves rather than engage with a new and unwelcoming environment.

7 BEREAVEMENT

*Fleeing survivors are haunted by the spirits of their dead relatives, for whom the traditionally prescribed burial rituals have not been enacted.*⁷

Bereavement is a common problem. Refugees may have lost members of their immediate or extended family and this may have been the prelude to their fleeing the country. Other families might be more literally 'lost' – they simply do not know whether they are alive or dead or where they are. Refugees in this country may also receive reports that may be difficult to substantiate of deaths or losses in the family who remained.

Bereavement can be particularly problematic when the body is not found as, for a number of communities, it is impossible to grieve properly without having the body to grieve over. Funeral rites and related religious ceremonies normally play a huge part in the grieving process. For many communities the religious process after death for the soul of the deceased cannot take place. In basic terms the soul cannot enter heaven. For many communities, like the Muslim, grave side ceremonies at fixed stages after a death are a fundamental part of the faith and an obligation few Muslims would wish to ignore.

8 SUICIDE

Suicide amongst refugees seems to be frighteningly common. One group spoke of six Somali boys who had killed themselves in the previous year; another spoke of 20 Somali people who had committed suicide. Many of these suicides have been very dramatic including young men throwing themselves under trains and off buildings.

Many people that we spoke to felt that suicide amongst refugees particularly affected the young. It is important that this should be further explored and, if true, that the reasons why it should be so and what should be done about it, be clearly established.

9 OTHER MENTAL HEALTH REACTIONS

Needless to say, refugees will also experience the whole range of mental health problems that can affect any community. These vary from those relatively mild states of mental ill ease and anxiety that are sometimes described as affecting the 'worried well' to very severe psychotic behaviour.

The kind of behavioural problems that we have described as affecting adolescents and children may also affect older men too. At the Willesden Centre⁸, many male clients will present with somatic problems (where a psychological problem is described in or manifests itself in physical terms). Memory problems are common and some clients are distracted to a point where their behaviour puts them at risk. Anger is also very common (particularly from men who have been in prison).

⁷ Summerfield D The Impact of War and Atrocity on Civilian Populations 1996

⁸ Case Study F - Refugee Support Project – Willesden Centre for Psychological Treatment p----

10 SUBSTANCE MISUSE

As described in the introduction a sub theme on which we will touch, from time to time, is substance misuse. This is both as a problem in its own right and because of those cases of complex need ('dual diagnosis' as it is commonly known) whereby an individual has simultaneously both a mental health and a substance misuse problem and the two factors need treating together. There are three themes here:

- Boredom and depression leading to the use of both drugs and alcohol at levels which can cause problems.
- Young men, in particular, for whom the family structure has broken down (father may be dead or missing) drifting into a drug culture.
- The particular problem of khat.

Khat (which is described in more detail in the section on the Somali community below) is a narcotic leaf widely harvested in Somalia and other countries in the region and chewed by men. The khat leaf is imported in large quantities into this country and is not, at present, subject to control as a restricted drug.

The problems of chewing khat are described by two agencies. The Medical Foundation for the Victims of Torture (MFVT)⁹ refer to a higher incidence of khat usage in the young Somali population that can exacerbate an individual's mental health situation and lead in some cases to suicide. The Somali Welfare Association (SWA)¹⁰ have noted high levels of suicide amongst male Somali refugees which has been linked to the use of khat and the long term psychological effects it has on users.

Khat is not the only problem and both Nafsiyat and SWA referred to major problems with young people and alcohol and drugs, with a tendency for young men in particular to turn to drugs as a way of coping with their situation. Other interviews suggested that drugs were a particular problem partly because of their easy availability and partly because some young Muslim men were applying the specious logic that whereas alcohol was banned by the Quoran, drugs were not. Drugs and alcohol are being used, according to some of the agencies, as a way of dealing with worries, sleeping difficulties or simply out of boredom.

B4 KEY THEMES

1 INTRODUCTION

Underpinning these presenting needs is often a number of key themes that flow from the refugee experience. In this section we aim to explore those themes as understanding them helps shape and inform the delivery of services

Firstly, however, we need we need to emphasise a critical point (dealt with in more detail in B6) below:

The refugee experience is not, in itself, pathological; there should be no automatic assumption that the refugee experience leads to mental health problems.

This is axiomatic as otherwise we are in danger of turning all refugees into patients, into helpless victims in need of a panoply of mental health services. Rather we will argue that we need to identify the strengths, the resilience, the skills and coping mechanisms that so many individuals, families and communities have and identify how best we can assist and enhance these positive characteristics at the same time as supporting those in crisis appropriately.

2 ACCULTURATION

⁹ Case Study N - The Medical Foundation for the Victims of Torture p----

¹⁰ Case Study W - The Somali Welfare Association p--

Acculturation describes the problems of adapting one's lifestyle to a new environment and particularly a new culture. Refugees are often not prepared for the reality of being a refugee in a foreign country. According to the Refugee Support Centre¹¹, a counselling centre in Stockwell, poor housing and bad conditions generally can often come as a shock to people who may be from quite privileged backgrounds. Other refugees may have been skilled professionals at home but have difficulty securing recognition of those skills and qualifications in another country. The net result may be that the only option is manual labour.

Many of the case studies also describe resistance to cultural acclimatisation. Many refugees come with the expectation that they will return home once the political crisis or war has come to an end. Adapting to the English way of life may initially seem a betrayal, a turning of one's back on the community, traditions, family and colleagues to whom one is committed. This is particularly the case for older refugees whereas the children will more naturally learn a new language and make new friends.

Acculturation can clearly lead to isolation and despair particularly if the person is not linked into refugee organisations for their community. MFVT noted that there have been some problems with different communities adapting to British culture. An example was given of Kurdish women living in Hackney where they were obviously not able, or wanting to adapt to this new way of life in Britain which was so different to their village life back home and were beginning to express this unhappiness in terms of "mental ill health".

Language difficulties, another frequently mentioned problem, serve only to compound this sense of unhappiness and isolation according to Dr Kate Harris, the Refugee Support Psychologist.¹² When asked how it felt to be in the UK, one of her users said "lost, very lost". Others said that they felt they were still emotionally in their country of origin, despite being physically in the UK. The loss of a familiar country or culture was perhaps the hardest of all the problems they had to face.

Closely associated with acculturation is the concept of 'culture shock'.

3 CULTURE SHOCK

'**Culture shock**' describes the process of coming to terms with the otherness of a different society. It affects even those refugees with a positive attitude to being in a new country and who want to build a new life for themselves.

At one level culture shock is simply a question of recognising that things are done differently in a new country and that it is necessary to adjust (or at least understand) that similar processes are actually undertaken in ways that perhaps appear similar but actually are very different. So in most countries the styles of driving a car, eating a meal and mourning the dead are actually quite different.

The process of culture shock for refugee communities goes much further than this. Firstly you are not in England for a holiday but as a consequence of having to flee from your home country. Secondly hospitality does not seem to be the order of the day but rather detention centres. Thirdly you may be brown-skinned or not able to speak English and this, for reasons that seem completely bewildering, causes people to abuse and revile you and call you names. Fourthly, you may have been a person of education, qualifications, high profile job, good standing in your community, but this counts for absolutely nothing and now you are a taxi driver working all hours to make ends meet. Fifthly you may have had a broad network of family and friends to support you and you to support them back home and here you are unsure who to talk to. All of this is what is meant by culture shock.

SWA talk of the extreme sense of disillusionment of many of their members resulting from having escaped the horrific conditions of civil war only to find that even their minimal expectations of their host

¹¹ Case Study P - The Refugee Support Centre p--

¹² Case Study E - Refugee Support Psychologist at Forest NHS Healthcare Trust p---

country are not being met. Other case studies refer to refugees who come from a tradition where hospitality to a guest, even an unexpected guest, is a matter of duty and honour. Their inhospitable reception in the UK may leave some disgusted and dismayed. But largely it is simply the case that very few refugees are likely to be prepared for what life is really like in England, particularly life in relative poverty.

4 UNMET EXPECTATIONS

Nafsiyat found that it was often the case that the families of male refugees had enabled them to flee the country with the hope that the families will be helped financially when the person has settled and found a job. When this cannot be achieved there is an added burden on that individual which can result in psychological problems.

Many of the communities affected may have a tradition of young men seeking work abroad and sending part of their wage home to support family members. Turkish people have historically sought work in countries like Germany. The original Somali communities in this country are of merchant sea men who settled here a century ago. Whilst it seems unlikely that many of the recent waves of refugees come here with these economic factors at the top of their priority list; it is nonetheless likely to be a part of their sense of duty to their family at home.

Many of the users seen by Kate Harris talked of the difficulty in adjusting to not having a job at all. They might have arrived with expectations that they could make a good life for themselves in the UK, but later had the disappointing realisation that this was not going to be possible. She also describes how women with young children, who might have led full lives in their country of origin, find themselves trapped in the home with children they were afraid or unable to allow out. Tellingly, she describes one man who was helping as a volunteer in a refugee organisation in his time off from his job as a hospital porter. In his country of origin he had run the hospital.

There have been a number of suicides known to Nafsiyat, which can directly be associated with the individual's refugee status, their resulting loss of personal standing and not being able to cope with that loss.

5 FAMILY VALUES / INTERGENERATIONAL CONFLICT

All communities experience a degree of inter-generational conflict where the expectations and perhaps values of parents and children differ. The problems can, however, become more acute when it is not just a question of two generations but also of two cultures. Refugee parents assiduously attempting to sustain their traditional values and expectations in their children, may have to contend not just with the process of growing up but with a process of growing up that they may feel has been profoundly affected, even debased, by Western values and standards. Parents may feel (rightly or wrongly) that they are losing control and that their children are exposed to corrupting behavioural patterns through their white peers (usually this means drugs and sex but may also include that their child wants more independence or answers them back).

The child on the other hand may feel torn between two sets of expectations (those of family and those of peers) or may feel the expectations are simply too great. This latter factor may be one explanation of why young women from a number of newly arrived communities appear to suffer such high levels of depression including attempted suicide.

For young people, particularly teenagers, the problem may be one of feeling torn between two cultures: that of their parents and that of the country they are now growing up in. At Nafsiyat they see a number of teenagers presenting with problems associated with dealing with conflicting cultures and issues around identity.

The Refugee Support Centre¹³ also describe the problems arising from the change in power dynamics between children and parents. It is often the children who find it easier to learn the language and assimilate into the culture that sometimes results in a role reversal whereby parents are reliant on their children to access services. This can cause problems whereby parents feel out of control themselves and also feel that they are “losing” their children to an alien culture.

6 INSECURITY / INSTABILITY

Refugees may suffer from identity problems associated with losing their home, family and country – “the broken world”. Added to which according to staff at the Bayswater Family Centre¹⁴ there is also the further complication of instability and uncertainty regarding their future: they live under the constant fear that they may be deported.

The research literature describes the basic steps a refugee suffering from trauma or other psychological distress needs to go through as part of rebuilding their lives as being:

- Securing safety and security for themselves and their family
- Access to any treatment that may be required
- Rehabilitation and integration into the new community.

According to the psychiatrist at the Traumatic Stress Clinic¹⁵ many refugees are not able to go through these stages because they never complete stage one. They may only be given exceptional leave to remain in the country which could change and which leaves them in a permanent state of insecurity. Remember that applications for asylum status have been taking up to six years to process. There is, therefore, a great feeling of instability and insecurity amongst those whose status is undecided.

In interviews carried out by the Traumatic Stress Clinic, most of those interviewed said that the uncertainty and insecurity resulting from long delays in hearing from the Home Office was a major stress factor. Most users were still waiting to hear the result of their asylum application from the Home Office. Many people wait two years, sometimes more, to receive an answer. All said that Exceptional Leave to Remain (ELR) was very much more likely to be granted than full refugee status. ELR carries no permanent security nor does it grant rights of family reunion.¹⁶

7 POVERTY / PRACTICAL NEEDS

The causal problems of mental ill health can often be very simple - poor or temporary housing in a run down neighbourhood; denial of benefits or other financial means to support one’s family; lack of a job. According to Bayswater Family Centre the most common initial problem for their users is decent housing. Lack of appropriate housing often leads to other problems such as child abuse and marital difficulties.

Problems of a new country and a new language would create difficulties for most people in seeking employment. For refugees there is the additional factor that they are not actually allowed to work during the first six months they are in the country. Islington Somali Community Association¹⁷ very simply note that most of their clients with mental health problems are not working and that if they can get work many of the problems are diminished or disappear.

Issues of poverty should not be understated either. One consequence of the 1996 Asylum and Immigration Act is that unless an asylum seeker registers at the port of entry they are not entitled to

¹³ Case Study P - Refugee Support Centre p---

¹⁴ Case Study L - The Bayswater Family Centre p---

¹⁵ Case Study I - The Traumatic Stress Clinic p---

¹⁶ Access to NHS Services for Refugees and Asylum Seekers – see Appendix 1

¹⁷ Case Study T – Islington Somali Community Association p---

income support. This means that they have to survive on food parcels or meals provided in hostels and bed & breakfast accommodation and will have no disposable income whatsoever.

A particularly disturbing comment was made by the consultant psychiatrist at MFVT describing his work with victims of torture. For his clients, the pressures of their current living arrangements are as likely to lead to mental health problems as the torture they previously experienced. One of the key dangers in terms of the response from professionals to the mental health needs of refugees is that any problem experienced by a refugee is automatically attributed to their past trauma and not to their current situation which may be traumatic in itself.

8 RACISM

A number of the case studies referred to the fact that their users had no experience of racism prior to coming to this country. Whether that was the case or not the experience is likely to be profoundly disturbing. Racism impinges on mental health in a whole host of brutal and insidious ways. At its most overt the threat and the fact of verbal and physical abuse is intended to demean, to intimidate and to traumatise and it does. In more subtle ways racism may result in self-doubt, denials or dilemmas over cultural identity, the so-called 'internalised racism' where you begin to dislike or even hate aspects of who you are.

9 OTHER ISSUES

There are many other telling factors: physical ill health particularly when untreated; a sense of guilt in having survived and escaped when other loved ones may still be at risk; a burning desire to right the wrongs in one's country.

The pressures are enormous.

B5 TWO COMMUNITIES

1 INTRODUCTION

As described in the introduction one of the key approaches in the review was to attempt to establish a perspective on mental health from the point of view of a number of different refugee community groups. The four groups chosen for the study were:

- Bosnian
- Latin American
- Somali and
- Zairean.

We, therefore interviewed a wide range of projects that had either been developed by refugee community organisations themselves (Cambridge Bosnian Refugee Support Group; Islington Somali Community Association; Islington Zairean Refugee Group; Latin American Advisory Committee; Latin American Women's Rights Service; Somali Welfare Association; Refugee Action Bosnian Project) or were specifically focused on a particular community (The Bosnian Project; Somali Counselling Service; Traumatic Stress Clinic Bosnian Project). Most of these interviews are included in the case studies section.

In practice we found there was considerably more material and activity arising from or focused on Bosnian and Somali people and so this section looks at mental health issues specifically for these two communities. In both cases the intention is to describe in brief some of the experiences refugees may have had and more particularly to summarise information derived from the literature and case studies on attitudes to mental health in those countries and the types of mental health services available.

2 THE SOMALI COMMUNITY

About fifty per cent of the Somali Community in the UK are single women and children, with the husbands either having been killed or detained in Somalia.

According to the Somali counsellor at the Somali Counselling Service¹⁸ a person is either 'sane' or 'mad' in Somalia, there are no degrees of gradation in between and there are no words for anxiety, psychosis, counselling etc. The concept of mental illness amongst Somalis, she argues, is limited to severe mental disorders, and does not extend to depression or stress. Basically lower level mental health problems are dealt with within the family (and anyway are not nearly so prevalent) and may not be regarded as requiring help. Until recently the only facilities were asylums without treatment where the very seriously disturbed were incarcerated.

Physical symptoms of stress, such as headaches and difficulty sleeping, will be recognised, but will not be identified as stress related. Many Somalis rely on the methods of traditional healers. People are very frightened of mental health professionals over here and particularly of psychiatric hospitals.

According to the Somali Counselling Service there are many health problems which are traditionally seen in Somali culture as being caused by the will of God, and there is a strong taboo around such problems. Mental illness is one such problem and thus any treatment associated with any aspect of mental health would be seen by many Somalis as particularly offensive, making it very difficult for most Somalis to come forward and seek stress therapy, for example. Other projects, however, felt that the grip of religion was less strong for Somali people and that the real issue was a lack of awareness of mental health issues and symptoms and a lack of awareness of the services that are available.

The few localised studies that have taken place suggest wide spread mental health problems within the Somali community. A survey¹⁹ carried out by Drs. Rowland and Blackmore found that over 86% of the Somali Community in Sheffield were experiencing psychological problems that would cause a significant degree of distress. In another study²⁰ of 32 cases, 61.5% of the sample had stress-related illness such as post-traumatic stress disorder, anxiety and cultural shock related difficulties. Moreover, 38.5% had serious mental illness such as psychosis, depression and manic-depression.

Khat, the narcotic derived from leaves grown naturally in the region, was banned from use in Somalia in the late seventies and early eighties as it was becoming a major problem and causing family breakdowns and economical difficulties. That prohibition was basically perceived to fail and widespread use continued. Its use in the UK is commonplace and whereas previously its use was very much amongst groups of men as a recreational activity, its use has now spread throughout the community. Attitudes to its use are very mixed from those who see it as a harmless relaxant like a pint of beer after work to those who are concerned that over use may induce a whole series of negative factors from lethargy and lack of motivation to a purported link with serious mental ill health.

3 THE BOSNIAN COMMUNITY

A report produced by the Traumatic Stress Clinic²¹ suggests that there are about 2,500 Bosnians in the UK who arrived through the government programme. In addition to these, there are a large number of people from former Yugoslavia who sought asylum in the UK independently. Some of those arrived with

¹⁸ Case Study G – Somali Counselling Service p---

¹⁹ A Rowland and C Blackmore 1996

²⁰ ditto

²¹ The Traumatic Stress Clinic - Bosnians in the UK

'convoy groups'. A total of 14,000 individuals have applied for asylum. One third of these have yet to be given a decision by the Home Office. (Source Home Office, June 1996).

The initial phase of refugees from Bosnia were the so-called 'programme Bosnians'. These were men who had been held, beaten and starved in the Serbian concentration camps and who were relocated under a United Nations programme to a number of countries including Western Europe. Approximately 800 were taken by the UK with a view to providing medical rehabilitation prior to returning to their country. Subsequently a number were joined by their families. Much of the initial work of psychologists and counsellors etc was with this group.²²

One of the most striking findings in the report concerns the specific situation of Bosnian women. Thousands of women were raped, physically abused, threaten with death, bullied.

'As a rule, the women survivors of sexual violence and rape were rejected by their own husbands and families. Such cruelty is deeply embedded in a cultural attitude that blames the woman for being raped, and also blames the male members of the family because they have not been able to protect them'.

'Bosnian society is a patriarchal society, more so in rural areas and villages where the worst atrocities and war crimes have been committed. In such society sexual violence is seen as an event that women bring upon themselves. They are valued for their sexual purity and this value is destroyed by sexual violence. Women's own self-perception and their own world-view incorporates these attitudes'.

Whilst considering the impact of such patriarchal attitudes we should not forget the use of systematic rape by Serb troops as being the real evil.

The projects working with Bosnian refugees have done a great deal to better understand some of the values and expectations about mental health related matters that Bosnian people bring with them. A volunteer at a Bosnian project described for us what he saw as the key differences:

People from Bosnia, coming as they do from a culture which places great value on traditional life such as an extended family support network, find themselves isolated in the U.K. In Bosnia, the problems one faces are solved at kinship level. Family members keep together and help each other. Having left Bosnia, kinship no longer provides a safe ring of people that one can rely on. Families have been torn apart, with family members either dead, missing or scattered across Europe and throughout the rest of the world.

The Bosnian co-ordinator at Refugee Action described the framework of mental health services in that country. In Bosnia psychology is a recognised profession and there are mental health centres and psychiatric hospitals catering to the needs of people with mental health problems. However, they tend to cater to individuals who are at the more severe end of the spectrum. It is unusual for people to receive counselling in the Western way to work through everyday issues. It is usually only provided as a treatment for a severe and tangible trauma such as a car accident. There isn't much "middle ground" counselling. Counselling was not available generally and was not a recognised profession.

B6 REFUGEES AND PATHOLOGY

'refugees present perhaps the maximum example of the human capacity to survive despite the greatest of losses and assaults on human identity and dignity'.²³

We have already referred to the risk of seeing all refugees as mental health cases or as victims. The danger in a report of this kind which describes the appalling abuse and inhumanity that refugees have

²² B6 describes the work of Renos Papadopoulos with programme Bosnians.

²³ Papadopoulos Prof R – Multiple Voices 1997

suffered in their country of origin and the offensive and inadequate reception they are often greeted with here; is that it runs the risk of casting the refugee in the role of passive victim; object of charity; patient awaiting therapy.

Yet if we adopt that well meaning route, we ignore both the resources implicit in *the human capacity to survive*; the skills and ambitions of individual refugees and refugee communities; and the fact that positive mental health flows more from inner resources than external treatment (though, of course, at its best, the one can help unlock the other).

The second part of the report, which focuses on strategies for positive mental health, will draw on examples of good practice which have been developed by refugee organisations and others through building on this positive and skilled sub-strata of the refugee experience. It is our view that generic mental health services have much to learn from this process.

Here we want to explore the key aspects of the debate that perhaps help differentiate the subject of refugees and mental health from more traditional mental health practices in the UK and, at the same time, help outside professionals like ourselves better understand our most effective role. This discussion was substantially influenced by the interviews we undertook with Professor Renos Papadopoulos of the Tavistock and Portman NHS Trust and we quote from his publications a number of times.

'the objectification of refugees as a political class of excess people, and the reduction of refugee health to disease or pathology' is a major concern for Professor Papadopoulos. He feels that there is a danger that refugees will be pathologised by the NHS and that anyone directed into the psychology services is likely to have their problems medicalised. *'Psychologists have a kind of reverse Midas touch whereby every problem they encounter becomes pathologised'*.

This is a problem inherent in all professions – the car mechanic will look for and usually find problems with the car and so will the psychologist with the mind. We perhaps should not blame them too much for being good at their job. But of course if the mechanic is a BMW specialist and the car is an Alfa Romeo there may be problems. Similarly if there are problems in determining and correctly analysing symptoms for reasons of language or culture then inappropriate assessments can take place. Some of the agencies we interviewed would certainly argue this is so with some of the admissions into mental health units. The problem is simply that of misdiagnosis.

More fundamental, and this is the key issue to which Professor Papadopoulos refers, is the process whereby the psychologist or other mental health specialist ignores or fails to take into account the broader context. That context will include the language and cultural issues referred to above and may also include issues of political and religious commitment. It needs to take on board the refugee experience, the displacement, the 'broken world'. It certainly should not ignore the real world experience of the refugee in the country of exile i.e. all the issues of poverty and insecurity we have already referred to.

The mental health problems of refugees are mostly a consequence of massive upheaval in the country of origin and massive insecurity in the country of exile. An effective clinical response will at the very least take those factors into account and may further conclude that the clinical role needs either to be conjoined with other positive strategies or is inappropriate.

Professor Papadopoulos refers to 'positioning' whereby the psychologist or other professional sees themselves as working with a family or refugee community organisation to look for those positive strategies. The 'positioning' as such refers to the psychologist shifting their position from that of medical expert in a one to one with a patient seeking or needing help to that of someone learning from the user and adapting their skills to best support the self help process.

Part of this positive engagement is looking for the factors that predicate survival, coping, self help. So, for instance, some refugees seem to show greater 'resilience' and are less likely to experience problems.

Research shows that one key factor is their ability to forge relationships with supportive adults whether related or not. Part of therapy may, therefore, be helping to build up ‘resilience’.

Professor Papadopoulos is concerned that a traditional analytic examination of traumatic experience can be damaging and disabling. Instead he refers to ‘exploring narratives’ and bearing ‘testimony’ whereby users can talk through their experiences in their own way. This may include not talking about more extreme experiences. The recognition by both therapist and user that certain experiences are ‘there’ but ‘unutterable’ can be positive.

The therapist may need to learn from the ‘patient’ what matters to him or her and what processes can help bring comfort and assurance. Furthermore organisations working in this field have demonstrated that effective mental health practices are often only a part of a broader programme of social development work with refugee communities.

B7 PATHWAYS TO CARE

In considering the provision of appropriate mental health services for refugees a number of key themes are beginning to emerge which will help inform the second section on positive strategies. These key themes can be summarised as:

- Mental health problems amongst refugees may be much higher than previously recognised.
- Those mental health problems may be long standing; may be a consequence of torture and ill treatment in the country of origin; or may be brought about by the destabilising aspects of the refugee experience including the insecurity and sometimes poverty associated with being a refugee in the UK.
- Refugee communities may have different understandings of mental health conditions and what to do about them. This may include very profound concerns about stigma.
- They may not know about the mental health services that exist or may be reluctant to approach them. They may regard sorting out decent housing as higher priority.

A reasonable outcome to such an analysis would be a series of recommendations to do with better assessment of mental health conditions in refugees; better outreach and health promotion work targeted on those communities and a whole series of mechanisms aimed at linking refugees with mental health problems into existing mental health services.

We will certainly cover these considerations in the section on recommendations in D16 below. However, such recommendations in isolation would be fundamentally weakened unless we also address what has become described as ‘pathways to care’ and how these pathways to care differentially affect different communities in the UK.

This section draws on work undertaken by the Mental Health Foundation²⁴, the Policy Studies Institute²⁵ and Professor Raymond Cochrane²⁶ at the University of Birmingham and we are grateful for their permission to quote from that work.

Their work focuses on the treatment that black and minority ethnic communities receive from mental health services in the UK. It does not specifically refer to the situation of refugees but, in our view, the issues are very much the same.

All three reports consider whether:

²⁴ Mental Health Foundation – Mental Health in Black and Minority Ethnic People – The Fundamental Facts 1995

²⁵ Policy Studies Institute – Ethnicity and Mental Health 1997

²⁶ Cochrane Prof R. – Improving Services for People from Black and Ethnic Minorities – University of Birmingham 1997

- a) all communities in the UK get equal access to the full range of mental health services in the NHS;
- b) if the different communities do not get equal access why that might be;
- c) those communities perceive that process of access in the same way;
- d) the underlying social goals are perceived in the same way by the patient and the doctor.

The research that these reports rests on was usually prompted by a major concern about the higher admission of young African Caribbean men than white to psychiatric units following a primary diagnosis of schizophrenia. Statistics referred to suggest that the diagnosis of schizophrenia may be 3 to 6 times as high in the African Caribbean community than in the white community and that as a consequence compulsory admission rates are that much higher too. Are there simply much higher rates of schizophrenia amongst this group requiring compulsory detention or is something else going on?

The PSI study, very importantly and disturbingly, assessed symptoms of different mental health conditions amongst different ethnic communities rather than admission rates. It came to the conclusion that schizophrenia levels were only marginally higher in the black community and that this difference would certainly not explain or justify the number of in patients.

The MHF report then argues that one of the key differences in the way black and minority ethnic people experience mental health services has to do with what it calls '*pathways to care and treatment*'.

On the one hand the report describes the process of compulsory detention referred to above and on the other notes that African-Caribbean people are:

- less likely to be referred by their general practitioner;
- less likely to receive treatment and diagnosis at an early stage;
- less likely to receive non-physical treatments such as psychotherapy, counselling and alternatives to institutionalised care and more likely to receive physical treatments and strong medication.

The position with regard to Asian people seems to be:

- a higher usage of GPs than other communities but that this does not lead to early intervention or talking therapies as often;
- a very low take up of counselling and other early intervention services;
- a very low take up of after care services.

More traditional psychiatric and psychological out-patient type services seem to have only minimal take up by Asian and African-Caribbean people. Early intervention or rehabilitation and aftercare services are rarely used.

Professor Cochrane makes the point that psychiatrists may practice a 'white' model of psychiatry that disadvantages Asian and African-Caribbean patients. He then considers the overall role of psychiatry in this respect and comments:

*'its practice is not always seen as benign. There has been a long history of reinterpreting psychiatry as a way of legitimising the suppression of non-normative and subversive behaviour by applying labels of madness to activities which threaten the status quoPsychiatry also has a unique privilege the ability to forcibly detain and treat people against their will.....Add the ethnic dimension to this and a very potent brew of racial suspicion and distrust is created. What are we, and more significantly the community concerned, to make of the fact that young black men are twice or three times as likely to be brought to a mental hospital by the police and doctors and detained there compulsorily than are white men?'*²⁷

²⁷ Cochrane Prof R. – Improving Services for People from Black and Ethnic Minorities – University of Birmingham 1997

Given that their experience of mental hospital may be one of the forcible use of treatment at worst and rarely a matter of free choice, it is hardly surprising that there is an unwillingness to use aftercare services.

'If psychiatric services are perceived as coercive or repressive, they are less likely to be accepted or effective'.²⁸

The relevance of all of this is that in compiling this report we gained the impression that very much the same process may be affecting refugees. So, for example, we noted:

- very large numbers of refugees in the three mental health units we visited (certainly out of all proportions to the numbers of refugees in the local community);
- the concerns of local agencies that misdiagnosis was a common factor in these admissions;
- and, of course, a key concern of this report is that for a whole host of reasons refugees are not aware of or not using the range of counselling and therapeutic services that are available.

²⁸ Mental Health Foundation – Mental Health in Black and Minority Ethnic People – The Fundamental Facts 1995

SECTION C

FACTORS AND CONDITIONS

C1 SPECIFIC FACTORS

1 INTRODUCTION

The authors of this report are not psychologists or other mental health professionals and whilst much of our published and other work has been in the field of mental health, we would not pretend to have expert knowledge of the different mental health conditions that might affect refugees.

Technical papers on some of the syndromes and conditions exist and we have included reference to a number of these in the bibliography. C2 below includes an account of Post Traumatic Stress Disorder as it is such a central and disputed factor in the field of refugees and mental health and also briefly describes two other syndromes.

What we wanted to do here was rather different from attempting a kind of mental health dictionary. Instead we wish to attempt to summarise those key factors that are explicit or more often implicit in the case studies and the other material and that provide helpful indicators to what causes mental ill health and what may assist in bringing about mental well being.

2 KEY PROTECTIVE FACTORS

A number of specialists in the field have sought to identify those key protective factors that might assist a refugee achieve a new and positive life style in the country of exile. Dr Kate Harris from Forest Healthcare NHS Trust quotes from the work of Watters²⁹ who refers to the following factors:

- contact with family members and/or family reunification;
- social support and links with local community groups;
- a strong religious or political ideology;
- the refugee has a proactive problem solving style.

There is much evidence from work with the original group of Bosnian refugees of how beneficial it was to their mental health when positive and successful efforts were made to bring their families from Bosnia to join them in the UK. This should hardly surprise us but instead make us reflect on whether an active process of family reunification might help reduce the cost and demand on the NHS.

Similarly the best response to depression arising from isolation and boredom may be an active process of community development to link people into networks of those sharing the same culture, language and interests. At the Trauma Stress Clinic they regard one of the key predictors of refugees doing well in the receiving country as being the continuation of their cultural contacts, networks and practices.

A number of the case study interviews and the publications we reviewed referred to the fact that those refugees with a strong political or religious commitment often coped the best with their ordeals. A sense of political goals helped a number of refugees make sense of what had happened to them. It was not an arbitrary and inexplicable occurrence but instead part of the repressive processes of a state to which they were politically opposed.

²⁹ Watters C – Refugees & Asylum Seekers – needs and service development issues 1997

Religious commitment is more of a double edged sword. On the positive side faith may help sustain a person through suffering and as we will describe below use of prayer and other spiritual process may be a healing route out of suffering. The negative side is that faith may have been profoundly questioned and assaulted as the person struggles and fails to understand what has happened to them. How could God, Allah, Jehovah allow this to happen to us? A central plank of security and world understanding may have been taken away leaving the individual all the more bewildered and confused. Equally a sense of religious fatalism may affect some people's interpretation of what has happened to them. Somehow they have brought what happened to them on themselves.

3 RESILIENCE

The term used by Professor Papadopoulos to summarise these key protective factors is 'resilience' which also implies a combination of external support mechanisms and internal resources. He describes the process as follows:

There is an abundance of evidence as to how individuals (alone as well as in groups), under the circumstances of such 'profound life disruption', may not only survive but also (paradoxically) benefit from these experiences.

'Like any life crisis, exile represents a transitional period, one that has various potential outcomes. Deprivation and loss may chronically undermine mental health.... or else create the possibility for growth. Exile can potentially endanger or empower.'

Resilience is now understood in its wider context, as a product of a close collaboration and mutual co-construction between the individual and the collective. The resilient children, for example, were able to recruit, throughout their lives, people who acted as surrogate parents and mentors to them, thus ensuring that they always benefited from the safety and support of a secure base.³⁰

There is massive evidence that major diasporas of people – the Jews, the Palestinians and the Kurds for example – have led to an remarkable flowering of intellectual and artistic creativity and of entrepreneurial brilliance. No one would wish to lose their homeland and even the most successful of Palestinians cannot forget or forgive the loss of their homeland in 1948 and afterwards. Nonetheless despite and perhaps because of that upheaval they have had to employ huge ingenuity and resourcefulness to survive and, in some instances, to prosper and to lead in their chosen field.

4 KEY MORBIDITY FACTORS

Identifying key morbidity factors is the other side of the coin. What are the particular indicators that might predicate greater difficulty coping with refugee status?

Derek Summerfield³¹ suggests that *significant predictors of psychiatric morbidity include gender, younger age, previous education, extreme trauma, absence of a close confidant in exile, negative life events since trauma, and separation from close family.*

According to Dr Summerfield depressive features were more likely when lack of social support and activities is combined with racial attacks, isolation from political organisations and a history of severe physical tortures. Poor social support appears to be a much stronger predictor of depression in the long term than severity of trauma.

He concludes that *more effort should be directed towards family reunion where the survivor is separated from close relatives and that contact with political organisations is important to a group of highly committed individuals who may find life in exile somewhat meaningless without shared ideals and aims.*

³⁰ Papadopoulos Prof R.- Storied Community As Secure Base 1998

³¹ Summerfield D – Psychological Sequelae of Torture 1996

5 ACKNOWLEDGEMENT

A very simple distinction is drawn by workers at Refugee Action between those who recognise that they have been traumatised by their experiences and those who clearly demonstrate all the symptoms of trauma but deny this or otherwise fail to recognise it in themselves.

In other words some of their users are clearly able to identify for themselves that the flashbacks, the lack of concentration, the forgetfulness and the anger and are straightforward consequence of the trauma they have experienced rather than a series of problems that they deny or are only partially aware of or do not understand the origins of. This does not make the traumatic responses any less painful or disturbing but means that the individual is better geared to seek help and deal with them.

6 GET BUSY

Those who are active suffer less from mental health issues.

Dr Summerfield³² describes his experience of this in Nicaragua

In Nicaraguan war-wounded men, economic factors, work prospects and a sense of identification with wider social ideals was found to be important in the overall well-being of survivors.

In some instances, getting busy may represent a way to avoid problems, which will not last as the refugee becomes settled and is less occupied with sorting out his or her practical difficulties. Years later difficulties with mental health may be observed which appear to be linked to the experience of exile but which may be lain dormant. As a general rule, however, people often find keeping active a useful way to cope with the difficulties of being a refugee in a new environment. Later they may be interested and ready to seek support for any mental health difficulties they are experiencing. Given the already stretched resources of our mental health services interventions focusing on activity and resolution of practical problems may be the best initial focus.

C2 THE SPECIFIC SYNDROMES

1 INTRODUCTION

So far we have steered clear of any comment on or analysis of any of the different mental health conditions as they have been defined by the mental health professions over the years. However, in the field of refugees and mental health it is certainly impossible to ignore one – post traumatic stress disorder (PTSD) – as it is regularly referred to by different practitioners. In addition we have made passing reference to two other syndromes that get mentioned in the literature simply on the basis that those who are new to the field might be curious to know what they are.

Given our lack of professional competence in this area we have largely drawn on the writings of others both to describe the different syndromes and to illustrate the lively debate around PTSD in particular.

2 THE DEFINITIONS

³² Summerfield D – Psychological Sequelae of Torture 1996

Derek Summerfield³³ provides the following history and description of PTSD:

The successor to earlier formulations known as 'shell shock', 'concentration camp syndrome' and 'war neurosis', PTSD was officially classified around 1980 and applied to many US Vietnam war veterans. Criteria for a diagnosis of PTSD can be divided into three groups:

- *liability to re-experience aspects of the original events (in sleep or during the day),*
- *avoidance of reminders of the events (or diminished interest in things generally),*
- *and increased nervous system arousal (manifesting as sleep problems, irritability, poor concentration, excessive watchfulness, jumpiness etc.).*

The diagnostic criteria for PTSD contain symptoms that may be non-specific and associated with other diagnoses, for example major depressive disorder (MDD) and generalised anxiety disorder (GAD).

The point of a diagnostic tool is to provide the professional with a series of tips as to possible interpretations of different types of behaviour, which may otherwise seem inexplicable. PTSD then has arisen from the observation over many years that certain individuals who had a traumatic experience may demonstrate some or all of the symptoms described above

3 THE ASSESSMENT TOOL

Mental health professionals have then, with reference to a wide range of syndromes and conditions, developed a set of assessment criteria to determine the extent, frequency and severity of the different aspects of a particular condition. In this field one of the key assessment tools is STAR – the Survivor of Torture Assessment Record.

*The scale for this includes demography, current political status, family and personal history, medical and psychiatric history, history of political activities, detentions and methods of torture both physical and psychological, details of other organized violence, medical involvement in torture, questions related to change in attitude, mental state examination.*³⁴

4 REFUGEES AND TRAUMA

The first question that then concerns those engaged in this debate is:

Is the refugee experience necessarily traumatic?

Do all refugees automatically go through a traumatic experience and if, fairly reasonably, we accept that having to leave one's country unwillingly is a traumatic experience, are we using the word 'traumatic' relatively loosely to mean shocking, unwanted, unexpected or are we using it in its medical sense to mean leading to the kind of condition defined above as PTSD.

Here is Derek Summerfield again:

Since many now believe that exposure to, for example, rape or other criminal violence, childhood sexual abuse or even persistent bullying at school may all have enduring or lifelong psychological effects, it seems unthinkable that torture or atrocity should not do this and more to almost all those exposed to them. There is a rapidly expanding trauma field which... has familiarised the general public with its role as part of the standard response to events involving horror and loss of life. Psychiatric or psychological teams are mobilised after train or plane crashes; teams of counsellors now arrive almost routinely and immediately at schools if a pupil or teacher has died violently.

³³ Summerfield D - The Impact of war and atrocity on civilian populations 1996

³⁴ Summerfield D - Survivors of Torture and Organised Violence 1990

These notions have roots in western assumptions that very adverse events are bound to leave people with a psychological injury. There is no empirical basis for this narrowly pathologising generalisation, one that is capable of distorting the debate on the human costs of war, including those that legitimately relate to ill health and health services. Suffering or distress - observed or imputed - is objectified, turning it into a technical problem - 'traumatisation' - to which technical solutions are seen to be applicable. Yet, for the vast majority of survivors, 'traumatisation' is a pseudo-condition; distress or suffering per se is not psychological disturbance.

Whilst that danger of universal and inappropriate application of trauma concepts is obviously a real one, it was not our experience that that was what was going on with those working in and associated with trauma response services. So Stuart Turner, for instance, at the Trauma Stress Clinic which has pioneered much of the trauma related therapeutic work in the UK made it very clear that:

- in his experience the refugee experience was not automatically traumatic in the medical sense and that only a minority of refugees in the UK would experience PTSD;
- this applied to survivors of torture as well;
- some people clearly did have these symptoms and that by recognising them and working with them the practitioner was better equipped to help the user.

4 INTERPRETATION OF SYMPTOMS

We need to be sure, however, that we are not just recognising the symptoms but also evaluating their significance with reference to the refugee's sense of what matters:

For one person, recurring violent nightmares might be an irrelevance, revealed only by direct questioning; to another, they may indicate a need to visit a health clinic; to a third, they might represent a helpful message from his/her ancestors.³⁵

This is very much linked to the point we have made previously and will explore further below that effective assessment takes to take into account a whole host of cultural determinants about what constitutes common behaviour and what the person believes.

Having assessed this the practitioner may still conclude that the nightmares and other symptoms are not an irrelevance or even a benefit but are causing the person acute and avoidable distress.

5 WESTERN MODELS

Essentially then the line of challenge to PTSD is not just that it might be perceived as a universal normative reaction to trauma and be applied inappropriately but also that it is derived from an inherently Western model of mental health.

western diagnostic systems, primarily designed to classify diseases rather than people, are highly problematic when applied to diverse non-western survivor populations³⁶

And if the model is western and not universally applicable then so are the treatments:

There is debate as to whether treatments based on the retrieval and treatment of trauma are helpful to refugees. Whilst some studies....demonstrate therapeutic benefit, others suggest that recalling traumatic experiences causes psychological deterioration.³⁷

³⁵ Summerfield D - Survivors of Torture and Organised Violence 1990

³⁶ quoted in MRCF – Refugees and the use of mental health services 1996

³⁷ quoted in MRCF – Refugees and the use of mental health services 1996

Indeed those treatments may unhelpfully displace other healing mechanisms that flow from within a community.

many non-western cultures have little place for the revelation of intimate material outside a close family circle. Mozambican refugees describe forgetting as their normative means of coping with past difficulties; Ethiopians call this 'active forgetting'.³⁸

6 SUMMARY

The concerns about PTSD and the other syndromes strike at the heart of a much broader concern about effective understanding and treatment of mental health problems amongst refugees. Indeed there is considerable resonance between the arguments deployed here and those we have referred to throughout the report.

And yet how is it, if PTSD is such a dubious concept, that it is referred to so frequently not just by the trauma specialists but by a whole host of other practitioners and refugee community organisations themselves. Is this partly because it has helped focus the mind on the true extent of possible mental health suffering and helped many of us think in a more structured way about what to do about this? Is it partly because even when all the cultural connotations and possibilities are taken into account many, but certainly not all, refugees are suffering acute psychological reaction and do need professional help? And is it partly because the model of effective mental health that many would like to see emerge is neither Western nor Eastern but takes the best from both?

³⁸ Summerfield D - The Impact of war and atrocity on civilian populations 1996

SECTION D APPROACHES

D1 INTRODUCTION

The report so far has tried layer by layer to

- unpick the basic symptomology of refugee mental health;
- indicate the broad range of factors that may impact on a refugee's mental well being;
- and point to those positive and negative factors that may assist or hinder recovery.

We have described a place where some of the most extreme examples of individual human suffering meet head on the physical and psychological barbarity of which the late 20th century is still capable.

Some of the individual stories we were told by refugees and people working with them were acutely distressing. Pointless violence inflicted on women and children was common. All the best-written articles in the Guardian on current episodes of torture and brutality cannot convey the devastation one person has experienced. In just a few quiet words a refugee would describe how their whole world had been shattered.

And when that individual experience is multiplied on to a massive and systematic scale of abuse and repression in Kosovo, Bosnia, Somalia and elsewhere, then it is easy to feel defeatist and that all the little liberal gestures on which the West so much prides itself are hopelessly inadequate.

This is not the position of refugees. We found very little sense of self pity or futility amongst the groups and individuals we interviewed. Instead the experience was of an energetic and inventive outburst of activity aimed at resolving problems and creating new opportunities. Not only within the field of mental health but generally in the area of self help and organisation there are so many small refugee community groups in the UK working intently on making things better. Much of that activity is thwarted or at any rate less successful than it might be through lack of knowledge of things English. So for example we have a certain way of running and managing charitable activity and unless you pretty much conform to that mould then the chances of financial support, for instance, are limited. This is an argument for organisational development support for refugee community groups that we will come back to.

It appears as though very much the same line has been adopted on mental health too – either you conform to and engage with mental health services as we have traditionally run them or really you are not going to get much of a service. Conforming to UK charity law has a rationale to it. Conforming to UK models of mental health has far less rationale and one of the key thrusts of this report and many other recent publications on ethnicity and mental health is to argue that there is a fascinating and creative area of growth for mental health services when they explore different models, different cultures and different senses of what mental well being consists of.

We want, then, in this section to focus on the various positive initiatives and understandings that have emerged in the field of refugees and mental health. These are mostly borne out of the work of refugees and refugee organisations themselves but also of the work of pioneering individuals and organisations that have dedicated huge energy to this field.

D2 THE ROLE OF REFUGEE COMMUNITIES AND INDIVIDUALS

We referred earlier to a process called ‘positioning’ whereby the psychologist moves from the position of sole expert to something more akin to a team member working alongside refugees to help them improve their position and their health.

We have tried to emphasise that refugees are often skilled people and that those skills need to be deployed in this country rather than ignored. In a recent piece of work we did on African communities and HIV/AIDS in the UK, it was obvious that some communities – the Ugandans are a good example – have high level medical skills and qualifications as well as a very good understanding of how the disease affected their community. The point was not to provide a community based service for Ugandan people but to better enable them to do some of these things for themselves.

For some communities and for some individual refugees and refugee families this is also the case with mental health. It is important to emphasise that it is not uniformly so and there should not be an assumption that refugee communities can ‘cure’ themselves. The point here is that we should make best use of what expertise there is rather than ignore it.

Refugee organisations will also need to teach us about mental health and mental ill health. We need to understand what matters to the individual; what their value system is. The professional (who is not Bosnian or Somali or from one of the other communities) is going to need to experience a sharp learning curve if their intervention is to be effective.

Stuart Turner suggests that any approach needs to be based on:

- empowerment,
- cultural appropriateness and
- mutual education.

We need to recognise, where it exists, and build up, where it does not, the sense of the refugee as ‘active survivor’ rather than a patient receiving services:

the emphasis is on service provision, with the ‘expert’ and his or her expertise at the centre of things, and the war victim relegated to the role of consumer-patient. It is important to consider whether this may have the effect of increasing an individual’s sense of him or herself as passive victim rather than active survivor.³⁹

KEY POINTS ARISING	
1	Many refugees come with skills, including professional qualifications in mental health disciplines from their country of origin. It is important to utilise those resources.
2	There is, however, a danger in assuming that community resources are adequate to deal with the problems that they face. A major investment in primary and secondary health care in this field is essential.
3	We need to learn from the different communities how mental health is perceived and what they regard as effective interventions.
4	We need to promote the image of the refugee as ‘active survivor’ rather than passive victim.
5	The task is to work with refugees rather than for them.

D3 CULTURAL CONSIDERATIONS

³⁹ Summerfield D - The Impact of war and atrocity on civilian populations 1996

*The psychological concepts and practises which the expatriate-led psychosocial projects are importing into developing country settings are as western as Coca-Cola.*⁴⁰

The argument so far has been that to provide effective help the professional needs to have a reasonable understanding of what matters to the user and his/her family and community. There is really little point in providing counselling for someone experiencing nightmares if they are not that bothered about them in the first place. We may misinterpret behavioural traits if we assume they indicate a western type of behaviour or response whereas in fact they are telling us something different altogether.

A recent example is of a woman compulsorily admitted to a mental health unit for psychotic behaviour primarily based on the fact that during certain phases of her depression she failed to respond to the questioning of her doctor and appeared to be semi-delirious. The alternative diagnosis was to identify her as a committed Sufi engaged in a rhythmic prayer-song activity as her own means of coping.

There is of course a reverse danger of too easily believing someone who tells us something does not matter or that the behaviour we have noticed is communication with god, when, by any standards what is going on is symptomatic of uncontrollable and perhaps unrecognised psychological dysfunction.

Cultural understanding is, however, only one theme. The other is cultural appropriateness of the models of therapeutic intervention that are used. There is much literature⁴¹ that suggests that a number of the models of mental health intervention are ‘as western as Coca Cola’, are euro-centric’ and may be of limited efficacy in other contexts. Psychiatry and psychology are understood by writers such as Fernando to have evolved out of a western analysis of the way the mind works and the place of the mind in the trinity of body, mind and spirit that is not shared universally.

If treatment approaches can be described as ‘euro-centric’ it seems perfectly reasonable that the way communities experience mental health problems may also differ to some degree. It does not seem unreasonable to suggest that the way the Somali community, for instance, experiences and describes mental health problems may be quite significantly different from the Irish. Conversely there are behavioural norms in some communities that may be seen as bordering on mental ill-health in others. It does not take much imagination to perceive how the traditional British reserve, the lack of emotionalism, the stiff upper lip, might be construed as psychologically dysfunctional in some settings.

The danger is of operating on the assumption of a common language and repertoire of mental health conditions and seeking to interpret the behaviour of those presenting for services by reference to a tool kit of syndromes and solutions. More than one of the psychologists and counsellors who helped us with this report referred to the need for an ‘unlearning’ process; a need to ignore, to not apply, some of the models and assumptions in which they were trained and instead begin to structure a new understanding that flows from the person in front of them.

One of the main recommendations of the PSI report⁴² is that work should be undertaken

‘aimed at improving our understanding of the ways in which different cultures experience psychological distress.....Clinical practice that is rooted in western concepts of mental illness may fail to identify illness among those with other cultural backgrounds.’

The case studies provide many examples of this. So as a simple example according to the Somali Welfare Association many Somali users do not recognise stress and realise that they can receive help. They will not tell their GP about stress problems as they consider it to be a personal matter and not a medical problem. The Refugee Support Centre have noted that the particular characteristics displayed by people

⁴⁰ ditto

⁴¹ see for example Fernando S – Mental Health, Race & Culture 1991

⁴² Policy Studies Institute - Ethnicity and Mental Health 1997

from different countries can be very different. For example Ugandans tend to display emotional distress by stopping eating and drinking.

According to MFVT a service needs not only to understand the culture of the client but also to take on board the systems that may have been available to people in their own country. For example, women in India may have had the support of the women in their village in terms of someone to listen to their problems, help with child care, someone to speak up on their behalf, etc.

Refugee communities are not all the same in this respect and there are clear differences between particular refugee communities and their attitudes and awareness around counselling or talking therapies. An example of this from the work of Nafsiyat is the Turkish community which appears to engage more readily with “talking” therapies than the Zairean community. Different approaches therefore need to be adopted depending on the refugee group being worked with.

Building on innate strengths and other effective community based approaches are all a necessary part of the therapeutic tool kit. The Bosnian group at Refugee Action focuses on issues such as the value systems in different cultures, looking at Islamic ways of coping. The group reinforces culture and members tend to speak in Bosnian, write in their own language, etc.

There is, however, a danger of being too simplistic in this analysis. Inappropriate models of mental health, racism and a failure to communicate at even a basic level with refugee users, all undeniably exist. But so do the mental health problems of those users. Cultural understanding may help avoid misdiagnosis and may influence therapeutic intervention but is not a substitute for clinical services when those are needed. We need, therefore, to develop an effective strategy of intervention that is an adaptation, a reworking and not a replacement of Western mental health services drawing on the best elements of the different traditions and approaches.

KEY POINTS ARISING	
1	Assessment is based on an accurate understanding of symptoms and behaviour. This may require some familiarity with the language and cultural norms of the person assessed.
2	The mental health professional should then be in a better position to decide what is normative and what is dysfunctional.
3	Models of mental health understanding and intervention in this country are derived from Western concepts of mind and body. There are other approaches and interpretations of services need to learn from.
4	Different refugee communities may also experience and express mental ill health in different ways to each other and to the host community.
5	Mental health services can learn from and utilise coping mechanisms that would have been used in the country of origin.
6	An emphasis on and better understanding of cultural factors should not be allowed to obscure recognition of genuine ill health. Appropriate responses are likely to include the best elements of both Western and indigenous approaches.

D4 OUTREACH, HEALTH AWARENESS AND PREVENTION STRATEGIES

A key part of any mental health strategy is early intervention to avoid or reduce the risk of potential crisis and subsequent hospital admission etc. This is currently only a limited strand in mental health services in the UK generally which are still very much reactive and hospital based.

If we are slow to develop community based responses such as crisis helplines, respite and crisis accommodation facilities, self help and support services for the population as a whole; then inevitably refugees are unlikely to benefit much if at all.

It could be argued that the most effective role for refugee community organisations wishing to develop mental health services is precisely in this area of health awareness, early intervention and, where necessary, linking more severe cases into clinical services. Before considering that in detail, we need to explore some of the factors that affect the three themes of outreach, health awareness and prevention.

Outreach

We have already drawn reference to the under use of existing services. The key factors can be summarised here as follows:

- An unwillingness by some of those in need to come forward for help because of the stigma attached;
- A failure to recognise that the person is actually mentally ill;
- A lack of knowledge of services;
- A view that services may be unwelcoming or betray confidentiality;
- The inappropriateness of many of the services currently on offer.

The answer, as Asian and African-Caribbean services have already discovered, is a continuous process of outreach to community organisations, other places where community members meet and, in many instances, to people in their own homes. This is both about making contact with those who are isolated and of raising awareness so that community members generally are familiar with services.

There is one particular phenomenon that may especially affect the attitude of some refugees to using the services of health professionals. According to the Traumatic Stress Clinic users may be very scared of health professionals as there is research which suggests that 40% of those undertaking torture may actually be health care professionals.

Some very basic issues will need explaining to potential users if they are going to trust and access services:

- the issue of confidentiality has to be explained;
- people need to be told their rights in terms of what they can expect from the service and that what they talk about in the sessions will not be repeated to other clients, their family etc;
- the whole concept of counselling and confidentiality may be something which is new to them.

Health awareness

Health awareness traditionally has been through leaflets and other written information (usually displayed in great volumes and ignored in dentist and GP waiting rooms). Evidence suggests that written material is even less effective with black and minority ethnic populations than white.

The Refugee Support Psychologist in Waltham Forest asked her users whether they thought it would be useful to produce a brochure in refugee languages explaining what reactions are common when someone has been through difficult events and is exiled. The intention would be to reassure individuals about their feelings or behaviours while at the same time providing information on where to seek for help. All those asked thought that this would be useful although they pointed out that some communities have low levels of literacy and a leaflet may not be the ideal method of passing on information. Other forms of awareness raising were suggested : presentations or discussion groups in community centres and other social centres, drama and training programmes.

Training for professionals

Refugee groups may need training about mental health. Professional groups may need training about refugees. Awareness raising and possibly training is, therefore, key with groups of health professionals. Particularly important are those professions like health visitors and community psychiatric nurses who are likely to encounter refugee families in distress and play a key role in linking them into services.

KEY POINTS ARISING	
1	Early intervention and community based preventative measures in the field of mental health, are generally under-developed.
2	Outreach is a key tool in work with refugee communities both so as to make contact with isolated individuals and so as to raise awareness of mental issues throughout the community.
3	The role of our health care services may need explaining including access arrangements.
4	Confidentiality will need to be stressed.
5	Counselling will need to be explained.
6	Effective mental health awareness is more likely to be achieved through face to face contact than through leaflets and other written materials (though these are still needed).
7	Myths about mental health and misinformation about mental health services will need to be tackled.
8	Training for professional staff on refugee issues will be a key part of any strategy.

D5 PRACTICAL SUPPORT

Poverty is a key determinant of mental ill health. The stress associated with insecure asylum status, poor or no housing, inadequate or no benefits, unemployment or menial employment cannot be understated. The person who felt that it was the treatment received in the UK that was likely to lead to mental health problems as much as the torture experienced home, was only one of many we interviewed saying largely the same thing.

Poor housing, no job, no money, racial abuse are all good reasons for feeling depressed or even suicidal. Refugees are often contending with factors that would make anyone depressed. In so far as services can help ameliorate their poverty (which is often not very far) then they may be doing a great deal of good for their psychological well-being as well.

What all this means is that refugee counselling services cannot help but be involved, at least in the early stages, in attempting to resolve some of the practical issues that clients present. Doing so may also help the counselling process (and the counsellor) gain in credibility in the eyes of the user and may act as an opportunity for the counsellor to provide a better understanding of what counselling is.

The various projects have dealt with this issue of practical advice in a number of different ways. Some projects have most involvement with clients during their resettlement period when people are primarily concerned with obtaining material possessions, getting a job and establishing themselves in society. Mental health is very much neglected during this time unless it is an extreme problem. During this period people are highly motivated to get housed, obtain employment, ensure that their children are schooled, etc and the different agencies will help with all these issues.

Others argue that this is not the primary role of a psychologist but that they should attempt to link the person into other appropriate services so as to maximise the appropriate use of often limited resources. Efforts to trace family members can be made by the Red Cross; family reunification, which is only available to a small percentage of refugees with full refugee status, can be arranged via the Home Office; social support is provided to a greater or lesser extent by the refugee communities and so on.

According to this approach, it is only on the last point, helping clients to develop a proactive problem solving style, that the psychologist is working in familiar territory.

*Linking individual refugees to refugee networks is vital for all who work with refugees. Making sure that such groups are supported so that they can form the much needed bridge between the individual in exile and the host society is equally important. A proactive problem solving style is likely to develop collectively in communities whose efforts are sustained and integrated within the society where they live.*⁴³

KEY POINTS ARISING	
1	Factors like poverty and poor housing can all impact negatively on a refugee's mental health.
2	Helping ameliorate their physical and material circumstances may help improve their mental health.
3	Some agencies see this kind of practical help as a key part of the service they provide. Others prefer to link refugees up with other agencies who can assist them.
4	All seem to agree that encouraging a positive attitude to problem solving is an effective strategy.

D6 ASSESSMENT ARRANGEMENTS

There are two levels at which assessment is important:

- firstly as part of an overall health assessment which we would suggest is offered to every newly arrived refugee and their family;
- secondly a specific mental health needs assessment.

With regard to the former Kensington & Chelsea and Westminster Health Authority, for example, are notified by the port of entry of every refugee they are aware of intending to take up residence in the Health Authority's patch. The Health Authority then sends out a welcome pack with a host of information on the different health services including arrangements for registering with a GP and a letter encouraging the person to have an overall health check.

Barking, Havering and Brentwood Health Authority⁴⁴ were typical of a number of authorities who became aware relatively recently of a significant influx of refugees into their area. There were concerns by health professionals that these people may:

- have significant health needs
- not always present for assessment or to access treatment
- need specific help including interpreting as part of the assessment process.

The post of Public Health Nurse Specialist was therefore created to make contact with newly arrived refugees; help with initial health assessment arrangements and link them into different services as required.

As regards a specific mental health assessment there is often a basic problem in persuading people that this is necessary. One way, described by the Somali Welfare Association, of engaging with clients about their mental health is to talk with them about the other services that they can access and the help that they can receive if they face up to the problems that they have.

⁴³ Kate Harris

⁴⁴ Case Study D – Refugee Public Health Nurse - p---

Essentially the process is one of the community group acting as a link to support people to access mental health assessment services. There is a strong case, in the first instance, for that assessment to take place in a person's own home or a more friendly environment like a community centre. We came across few examples of this actually being offered during the review.

Training of community representatives in advocacy can also be a valuable tool for linking people in.

KEY POINTS ARISING	
1	Refugees should automatically be offered an overall health check shortly after arrival.
2	This will need promoting through welcome packs and through specialist post holders making home visits etc.
3	Mental health assessment will have to be approached sensitively because of the stigmas and myths that may be associated with mental health in the refugee's mind.
4	Refugee community groups can have an invaluable role acting as a link or advocacy members.

D7 CHILDREN AND YOUNG PEOPLE

Refugee children face some quite specific problems as we have previously described – they may have gone through traumatic experiences; they may have lost parents or other loved ones; they may have arrived in this country unaccompanied or with only a fragment of their family intact. The approach that is required in working with these children is often very different to that employed with adults.

The Nafsiyat service has specifically focused on children and younger people. They are aware of large numbers of children who are facing difficulties at school because of the trauma experienced in their early lives and teachers will often refer quite young children for therapy. Nafsiyat work with them and help them to work through their problems by using play therapy, art therapy, etc. There is a danger that if these children do not get picked up early on they get labelled later on as having learning difficulties or mental health problems.

The work with young people aged 13-17 years undertaken by Refugee Action, indicated that the teenagers were more concerned with the future than the past. As a consequence activity based therapy was used as a channel to address difficulties.

A factor for all services is to understand how the family works as a unit and the expectations of different members and roles. Where children are concerned in different communities there may be cultural differences in how childhood is perceived and the expectations that are made of children. They often act as “cultural brokers” for the family; linking the family through language and, perhaps, a greater openness into the outside world. The child may have a role as a carer and be expected to take on fairly onerous family duties at an early age. They are regularly used as an interpreter (though see D11 below for further thoughts on this).

A major concern amongst some communities – the Somali community – is a good example – is with regard to young men whose father may be missing. Many of these boys and men are regarded as being at extreme risk (NB the number of suicides of young male Somalis). One scheme has sought to recruit other Somali men as mentors providing guidance and advice.

KEY POINTS ARISING	
1	Children and young people may need separate services.

2	The focus is likely to be on activity based therapy such as art or drama rather than therapies.
3	The emphasis is likely to be on the future rather than the past.
4	The role of children in the refugee family may be different and professionals need aware that children may be expected to take on duties such as caring at a young age may also act as a link with the 'outside' world accompanying parents to appointments acting as interpreters. This latter role can be very problematic.
5	Some communities are considering strategies like mentoring to support fatherless

D8 COUNSELLING

Those community-based mental health services for refugees that have developed so far are, by and large, counselling services. Given the lack of familiarity with counselling for many refugee communities we need first to ask why this is so; secondly to consider what kind of counselling; and third to ask what are the expected outcomes?

The section above on the Bosnian and Somali populations referred to the fact that counselling was only available in very specific and limited circumstances in Bosnia and probably not at all in Somalia. Yet we have case studies describing targeted Bosnian and Somali counselling services in the UK.

We think there are a number of key factors that make counselling an acceptable and often effective method of early intervention and prevention:

- Little counselling takes place in a hospital setting. Usually it is provided in a more user friendly setting like an advice centre.
- Because many counselling services are linked into the giving of practical advice and assistance it seems likely that many users may be attracted by these roles in the first place and then only subsequently drawn into actual counselling.
- Even if the concept of counselling is unknown, the process of seeking advice and guidance from an elder or other trusted member of the community is not. The role of counsellor may well, in the early stages, be perceived in these terms.
- Staff do not wear white coats or carry syringes.

When counselling is also provided by someone speaking the same language and understanding the same issues of culture and family then it becomes especially user friendly (though as we will consider below this is only possible in a very few situations). If the counsellor is another refugee, albeit from a different community, then there is still a mass of shared experience.

Kate Harris explored exactly these issues with her users.

When asked to suggest which approaches might best help refugees with the problems of exile the overwhelming reply was "counselling". This tends to reflect the longer term nature of stay in the UK of most of the people approached for the needs assessment, as it is safe to say that "counselling" is an alien concept in many of the countries which produce refugees. Despite this, many cultures do use talking about problems to a trusted individual as way of coping.

Part of the process of providing effective counselling is explaining what it is and what it can realistically achieve. Much effort has to go into ensuring that users have a clear understanding of what is being offered and this may only develop over a number of sessions as counselling actually takes place. Counsellors will need to get informed consent at all stages to the actual process.

To express what hurts takes skill and may represent an achievement in itself. Simply to put words to what has happened or what one deeply feels is far from simple. Counsellors often find themselves gently nudging the user into unexplored territory. In cases, such as sexual abuse, the very words to describe what has happened are stained with guilt and shame. The task then is to build up the confidence of the user to express their unhappiness.

The Latin American Women's Rights Service refer to the fact that with women in particular there are often issues to do with getting their complete story. Women may find it excruciatingly difficult to divulge the whole truth about what they have been through.

Some projects refer to helping the person bear 'testimony'; to produce an account of their experiences and thereby gain some distance on them and some solace from them. Others will argue that some events have been so savage that they have to be acknowledged almost without words and left alone.

Perhaps we need at this stage to draw a distinction between counselling that is intended to help the user better cope with the consequences of past trauma and counselling that is intended to help the user better cope with current experience. The distinction is probably arbitrary and there is much overlap in practice but there is a decidedly different emphasis when the challenge is current experience. The task of the counselling in this respect is to build up personal resources to cope with the situation and then to look at ways of changing that situation within the individual's range of possibilities. For many users the key issues are to do with a personal sense of self-worth, of status and of problems within the family. Articulating and understanding these problems may bring a kind of power over them and an enhanced sense of self-worth.

The model of counselling has to be adapted in all kinds of ways which it would be impossible to cover here but have been dealt with to some degree in other publications.⁴⁵ Some of those interviewed felt that one almost had to start again from scratch and learn what was effective with and for the person in front of you. Aruna Mahtani at MFVT felt that they have to abandon traditional psychological models and try to respond empirically to what is being presented to them. She gave the example of a Sri Lankan woman who appeared to be mute and behaving in a child like way where a psychologist would normally assume some process of 'regression but where in fact the woman responded rapidly when spoken to in Tamil. In her view none of the usual models can be assumed to apply and therapists need to either abandon these or adapt them substantially.

This is very new territory and the case studies provide valuable material on the new models and approaches that are evolving.

The outcomes for the user then mostly fall into the following categories:

- Better skills in expressing themselves to themselves and increased self-awareness.
- Better skills in expressing themselves to others (particularly but not exclusively partners and children).
- Some degree of empowerment, of shifting from passive victim to active player.
- Some unscrambling of contradictions and sense of compromise as a positive route forward.
- Some redefinition, some enhancement of the role of a woman within the family or community.
- Some reworking of the role of the man particularly with regard to status issues.
- A more positive sense of self-worth.

From some perspectives this is not a lot. From the perspective of a user it can be life changing. From the broader perspective of the world outside the counselling centre we have to acknowledge that the influence that counsellors can have on the major themes of poverty, insecure asylum status, poor housing and racism are minimal.

⁴⁵ Shaikh Z and Reading J *Between two cultures* –1999; d'Ardenne P and Mathani A *Transcultural Counselling in Action* 1989

KEY POINTS ARISING	
1	Whilst counselling is often unknown or used on a very limited basis in the country there are a number of factors that make it a particularly appropriate tool for supporting refugees.
2	Counsellors speaking the same language or who have simply also been refugees may be particularly helpful.
3	The process needs to be explained and the user needs to understand and consent to the process.
4	There are various methods to help a refugee articulate painful experiences and take some control over and distance from them. Some experiences may simply have to be acknowledged as unspeakable.
5	Different types of counselling will need to be adapted and some counsellors may need to 'unlearn', to abandon traditional models.
6	At its best the process can lead to empowerment and an enhanced sense of self worth.

D9 SPECIFIC COUNSELLING APPROACHES

As part of developing new models of counselling when working with refugees, projects have explored which of the particular schools of counselling and counselling theory are most effective in this context.

The approach that is most commonly referred to is Cognitive Behavioral Therapy. According to the Traumatic Stress Clinic, for instance, who use this approach the aim of Cognitive Behavioural Therapy is to help individuals to cope by themselves, to work with their belief systems. The team has a cognitive behavioural approach to trauma that includes dealing with the guilt, shame and fear associated with their ordeal. In their view, when someone is traumatised they are not processing the event, and they need to be enabled to do this, to become "unblocked". This is done by directly questioning the shame and the guilt.

This approach can, however, be problematic if the belief system is linked to their trauma e.g. believing that they deserved whatever happened to them or that they are a bad person.

Kate Harris describes her approach as 'integrative' – 'starting from where the person is'. It tends to be a more emotion-based model. Part of her role is 'reinforcing existing forms of solace'; helping users develop their own resources. This may include linking a person into traditional healers and so she is developing a list of local healers.

In her view it is clear that there are cognitive behavioural techniques that might be used to combat some of the problems discussed above. Past experience indicates that some simple techniques can be easily learnt and used as tools by refugees themselves.

Many of the organisations interviewed referred to a need for there to be an emphasis in the counselling process on moving forward; on a forward looking focus. As a consequence a number of projects have limited the extent to which, at least in the early stages, that they dwell on or attempt to uncover past experiences. Instead the emphasis is on what has been called 'solution-focused' therapy which entails the setting by the counsellor and the user of a series of short term goals some of which are quite practical in nature.

Bayswater Family Centre, for instance, feel that it is essential to provide practical support alongside the emotional support. In their view counselling interventions need to be short term and the critical factor is to get people moving forward.

The area of effective counselling techniques for refugees would repay a detailed investigation.

KEY POINTS ARISING	
1	Experience suggests that certain approaches are more effective than others.
2	Cognitive behavioural therapy is often referred to as being effective insofar as it works with the user's own belief systems and encourages them to develop coping mechanisms.
3	Many of the approaches are based on helping the user develop their own resources.
4	Some of these techniques can be taught relatively easily to refugee groups.
5	Other approaches emphasise short term goals, solutions and moving forward.
6	Traditional and faith healers can also be enlisted to help.

D10 BICULTURAL AND TRANSCULTURAL COUNSELLING

Language is key to counselling in a number of different ways. Firstly it now seems obvious that, wherever possible, a person should be counselled in their mother tongue. To articulate the deepest emotions in a second language (assuming clients speak English in the first place) is beyond the ability of even the most skilled linguist. Even second and third generation refugees (who are usually fluent in English) will revert to their family language at times of emotion or stress. The language of childhood is the language of affection and projects often find that there is a dissociation between a learned language such as English and the emotions that a person experiences.

Languages are not parallel universes simply using different words. Instead they convey different philosophies, different priorities, different ways of living. The experience described is different, not the same. Recently attention has begun to focus on the fact that Eastern languages, for instance, may convey emotions in a different way to Western languages. The example of this that is regularly given is that mental processes may be described through physical attributes and analogies. The repertoire of language (and gestures and body language) used may be significantly different in Arabic compared to English.

The very basic problem of course is the sheer plethora of different languages that are involved. In the Royal Borough of Kensington and Chelsea (which has a large refugee population) they estimate that nearly one hundred first languages are spoken. So for other than the larger communities like the Bosnian and Somali the likelihood of being able to provide a same language trained counsellor is very limited.

Indeed there are dangers to be avoided in assuming that competence in language equals competence in counselling. The untrained and amateurish counsellor who is fluent in Farsi but tongue-tied in therapy, may appear to offer something which in practice they cannot deliver. The early experience of some culturally targeted services was of precisely this combination of linguistic / cultural competence and enthusiasm, but next to no knowledge of effective therapeutic interventions.

Equally some clients are nervous about being treated by members of their own community. According to MFVT this particularly applies to Iraqis and some of the other Arab communities who are concerned about problems with confidentiality and even physical threat.

The Refugee Support Centre (who provide same language counsellors) have described people who have turned back at the reception when they have realised staff are present from their own community. Nonetheless the experience of those culturally specific services such as the Somali counsellor in Tower Hamlets is that once their service is known about and trusted by the local community it is widely used and welcomed.

The Traumatic Stress Clinic have pioneered the idea of the bi-cultural worker who is likely to have been trained as a mental health professional in their country of exile. That person then operates as a therapist

with their own community but within the broader context of a clinical service and with clinical supervision.

In another model the Crisis Intervention Service⁴⁶ in Islington works jointly with different refugee communities so as to appoint a worker from that community who is based in a particular refugee organisation but who then receives management support from the central organisation.

Intercultural and transcultural counselling are another option. The critical issue seems to be that issues of race and culture are taken into account by the counsellor. As has been noted some users may prefer a counsellor from a different background. Particularly for those smaller and close-knit communities issues of confidentiality and trust may be as important as shared understanding.

The quality of interpreting then becomes a key factor.

KEY POINTS ARISING	
1	Counselling, wherever possible, should be in the mother tongue.
2	Given the huge range of refugee languages and the small size of some communities only going to be possible in a limited number of cases.
3	Professional skills are more important than linguistic ability.
4	Some users may be nervous about same race counsellors but generally the responses very positive.
5	Those counsellors need linking into a professional, clinical framework.
6	Transcultural or intercultural counselling, which takes into account issues of race culture, is the other option.

D11 INTERPRETING

There is little choice but to use an interpreter if there is no shared language. Some of the professionals we interviewed have actually learnt a language for this purpose so Renos Papadopoulos actually speaks Bosnian and Kate Harris has worked specifically with French-speaking African refugees for the self evident reason that she speaks French.

Many of the projects felt that the use of interpreters was problematic. One project complained that the level of interpreting available was inadequate, particularly when attempting to communicate medical terms. Another referred to the fact that there is a lot of non verbal behaviour in therapy sessions which does not get translated.

Refugee Action conduct most of their counselling through an interpreter. Issues which they feel need to be considered are:

- The level of training the interpreter has received in mental health issues.
- The level of trauma and experiences of the interpreter themselves. This is a particular issue if the interpreter is from the same community as the client and has maybe had some similar experiences to the client which they are still dealing with.

The Traumatic Stress Clinic undertook a survey of Somali and Kurdish groups where a number of people were interviewed and feedback obtained on important notions. One of the main findings was that no one liked using interpreters

⁴⁶ Case Studies A, T and U – Crisis Intervention Scheme; Islington Somali Community Association, Islington Zairean Refugee Group - p---

Some projects have their own training programmes for interpreters. Kate Harris has trained community workers from the Somali, Turkish, Tamil, Colombian, Congolese, Angolan, Algerian, Iranian and Lithuanian communities as interpreters. She wants interpreters to be as unobtrusive as possible and to speak in the first person. There is a danger otherwise that their relationship with the client will get in the way of her forming a direct therapeutic relationship and the interpreter will not focus as much as they should on clearly articulating what the user is saying.

KEY POINTS ARISING	
1	Interpreting generally is seen as inadequate.
2	Partly this is because interpreters may not be familiar with medical and mental health and partly because issues of gesture and body language will not be conveyed.
3	There is also a risk that the process of interpreting in a counselling session may bring to surface similar problems or experiences for the interpreter.
4	Some projects are training their own interpreters to ensure the process is more effective.

D12 GET BUSY

"Possibly the best way to promote mental health is to pay greater attention to helping refugees rebuild social and community links. Support of self-help groups (financially or through providing training and supervision if appropriate), activity groups, community centres and paid employment of refugee community development workers may all be the most effective responses in helping refugees build up their self-esteem and feel part of a community again."⁴⁷

We have described the obvious need that refugees have to deal with various immediate practical problems like getting a house and a job and how these practical concerns can, in some instances, lead to an effective postponement of a mental health problem much later.

But what if the net result of 'getting busy' is that the problem is diminished or disappears in the longer term as well. Isolation, boredom, poverty are key indicators of mental ill-health. Strategies to avoid or reduce them can be positive mental health strategies as well. Some refer to this as 'distraction' – shifting the mind and its preoccupations to other mundane tasks. It can also, however, be seen as a process of restoring meaning to a life that may have been so changed as to seem lacking in meaning altogether.

According to Kate Harris this may be a culturally sanctioned approach as well:

In many cultures the solution chosen may be to distract the sufferer by work, hobbies or socialising. This is not always recognised in this country as a strategy for good mental health, particularly as "avoiding" intrusive memories or difficult emotions can be seen as an impediment to the working through of traumatic experiences. However, if the key problem the refugee faces is isolation or boredom, rather than unbearable memories or emotions, the best approach is not "counselling" but linking up with other activities.

Refugee Action also see the value of an activity based approach in helping their users to preserve their sense of their traditions and themselves. The Bosnian group focuses on preserving handicrafts like sewing and lace making. The purpose of the group is to exchange ideas, recipes, patterns, etc. that have been in families for generations and have never been written down. This itself is therapeutic to a lot of women. There is a sense of "they couldn't get to my brain" – even though they may have been through terrible experiences there are aspects about their previous way of life that will never be taken away

⁴⁷ Reynolds J & Shackman J Partnership in Training and Practice with Refugees 1995

At Saheliya⁴⁸ the activity-based groups are used as a method of drawing women in to the service and then enabling them to access other facilities. Groups such as badminton, sewing, etc are an ideal introduction to many women because they do not rely on the women being able to speak a particular language or admitting that they have any other problems.

Some may argue that this is not therapy but those centres running such activities comment positively on the boost to the users' morale; on the confidence that it gives people to move on to access other services; and a whole series of other by-products like improved English etc.

KEY POINTS ARISING	
1	Distraction or getting a user involved in different activities may not only take their problems but even help reduce them in the long term.
2	In many cultures this is a preferred response to a mental health problem.
3	Activities can be linked into traditional arts and crafts as a way of sustaining these
4	Other activities have proven to be a useful way of drawing in women users.

D13 COMPLEMENTARY THERAPIES

Complementary and alternative therapies are currently very fashionable in the West and we need to be clear about their role and expected benefits before recommending them in the context of refugees and mental health.

In the context of counselling a number of modest but achievable expectations are beginning to emerge. Firstly there is no doubt that these are 'culturally acceptable' models. Most refugee counselling services will find that their groups for shiatsu, massage, reflexology, acupuncture and aromatherapy are in considerable demand. So at the very least they get people in the door.

At the Latin American Women's Rights Service, for instance, alternative and complementary therapies are very popular and, in particular, massage, aromatherapy and homeopathy. Herbal remedies are also popular and include remedies for reducing depression such as lemon verbena for calming and reducing anxiety.

Secondly and more seriously it is now clear that such therapies can have a role in reducing stress and improving how people feel about themselves. The body of the user with a mental health problem may be near contorted through stress and various subtle and not so subtle forms of self abuse. Alternative therapies are often the warm bath of the soul—they soothe and they relax. They may help stabilise a particularly stressed client and thereby help them engage with the counselling process.

There may also be particular ways in which specific therapies offer a precise tool (e.g. auricular acupuncture has a clear role in reducing the stress factors associated with addiction and craving) but generally the expectations are of a vaguer feel-good factor.

Saheliya regard complementary therapies as being effective when talking therapies may not be immediately appropriate, for instance, because the client is unable at that point to engage in the way required for counselling to be effective.

The complementary therapies often offer women a route into accessing other services such as support groups, learning groups, etc at their own pace i.e. when they feel ready to do so. The complementary therapies are concerned with making an individual feel better physically. It is only when this is achieved that an individual can then move on to participating in something which requires effort on their part to help themselves feel better emotionally and psychologically.

⁴⁸ Case Study Q – Saheliya p---

KEY POINTS ARISING

1	Many refugee communities are familiar with different models of what we call complementary and alternative therapy and may regard them as more acceptable, first instance, than psychiatric services.
2	The evidence on precise medical benefit, at present, is limited with one or two exceptions like the potential to reduce addictive craving.
3	However, many can have a more generalised effect in reducing stress and creating a 'good factor'.
4	Some groups may attend complementary therapy sessions and then be prepared to move into counselling etc.

D14 SPIRITUALITY AND RELIGION

With refugees you 'can't divorce the spiritual from the political' (MFVT)

Spirituality is a key dynamic for many refugees seeking counselling. Its influence may impact on counselling in a number of ways including:

- As part of understanding how the user sees their world and what their value system is;
- The impact the trauma or refugee experience has had on faith (which may lead the refugee to question their faith or to adhere to it more dogmatically);
- Providing the refugee with a more or less useful interpretation of what has happened to them (fate; their own fault; guilt etc);
- Most importantly its role in helping them move forward in a positive way.

Some clients may wish to see a same faith counsellor, though in the experience of the projects interviewed this is rare. It is far more common for them to want a Bosnian speaker or a Spanish speaker than for them to want counselling from a Muslim or a Saintist.

There are, of course, theologically based counselling services available and so, for instance An-Nisa in Brent offers advice and counselling from within a specifically Muslim world view in the same way as there are Christian counselling centres.

Two semi-spiritual strands are yoga and meditation which are widely used within a religious framework in the East as a means of achieving psychological and spiritual well-being. Prayer and meditation can flow effortlessly into each other. The techniques of prayer are usually intended to calm the mind as well as engage with the divine.

The starting point for counsellors is to understand the part that religion plays and incorporate it positively into therapy. At Nafsiyat counsellors see a number of people who are very ill, even psychotic where a common expression of their illness is stating that they are "possessed by spirits". They could choose to dismiss this as deluded or to work with it as explaining how the person understands what is happening to them. They feel it is important to incorporate these belief systems in any therapy.

At Bayswater Family Centre the counsellors do "bring god into the counselling sessions" as this is often a way of ensuring that what is being raised by the counsellor is taken seriously by the client because it fits into the frame of reference of the client.

Most of the people seen at the Latin American Women's Rights Service counselling centre are very spiritual. Many can be described as 'saintist' they believe in good and bad and that they have a "collective unconscious". The counsellor needs to understand this complex web of beliefs and traditions.

There are saints for hopelessness and lost causes e.g. alcoholics. The therapist is often seen as the ‘little angel’. There is even a saint for hopeless cases!

Kate Harris researched in depth the kinds of spiritual resources users were drawing on even in the UK.

All users came from cultures where traditional healers still played an important role. With probing, they were able to outline ceremonies and rituals used to combat what might be called mental illness by our society. Some of these revolve around the use of the Koran to purify and protect the wearer from evil spirits. There are also non-religious ceremonies, like the Saar ceremony used in Somalia or the rituals used by the Poosary spiritual healer amongst Tamils, in which the sufferer must dance and sing out the spirit or djinn inside them. Both the Sheikhs (Somalia) and Hojas (Turkey) who use the Koran against evil spirits can be found in the UK.

Anyone who has been round counselling for any time knows that ‘there are many routes to heaven’ and that no approach is going to work all of the time. Many of the projects we visited have developed an eclectic approach borrowing strands from many traditions and using the help of others like imam and priests.

KEY POINTS ARISING	
1	Religion will be a key factor in counselling for many refugees. The counsellor cannot leave it outside the counselling room.
2	It seems rare for a person to want a same faith counsellor. It is common, however, to want / need to explore issues of faith during counselling. This implies at least some familiarity with the religion in question.
3	Yoga and meditation come midway between complementary therapies and faith and have the same benefits of relaxation, stress reduction etc.
4	It may be helpful to link a user into traditional spiritual advisers and rituals where available in the UK.

D15 THE LINK BETWEEN COMMUNITY AND CLINICAL SERVICES

There are a number of dangers inherent in a process that sees community based mental health services as the primary response to the mental health needs of refugees and so in this final section we wanted to deal with some of these. Firstly, however, let us reiterate the strengths. Properly organised community based refugee organisations can:

- Make contact with otherwise isolated members of their community;
- Have far greater knowledge of the extent and nature of mental health problems in that community;
- Provide a friendly face to individuals who are hesitant or scared to use services;
- Provide befriending and emotional support to community members;
- Undertake health awareness work, peer and volunteer training and run support groups;
- If trained and skilled provide a range of preventative and counselling services.

All of this is a massive and inexpensive resource which is willing and able to be deployed in order to help its own members with mental health problems. Some Health Authorities (Camden and Islington, Kensington & Chelsea and Westminster, for example) are providing organisational development support services to help equip refugee groups to fulfil this role. The Evelyn Oldfield Unit⁴⁹ was set up for this specific purpose. But the dangers are also clear:

⁴⁹ Case Study M – The Evelyn Oldfield Unit p---

- The needs of refugees with mental health problems may become marginalised if the communities are perceived to be ‘doing it for themselves’;
- Refugee organisations cannot possibly provide the full range of services; those in crisis and more extreme ill health need access to NHS clinical services;
- Community based organisations need a clear sense of boundaries as to what they can appropriately provide and what they cannot.

All of which argues for a clearly structured interface between the mental health services that a community based refugee organisation can provide and the specialist NHS mental health facilities in the area. There are a number of very good examples in the case studies such as Healthy Islington placing ‘crisis’ workers in different community settings or the Refugee Support Psychologist in Waltham Forest seeing herself as having a support and advisory role to local groups.

In other instances this relationship has not been formalised or even properly considered. The Trauma Stress Centre were amongst many who were aware of criticism of community groups which took on the role of a professional service without having the skills and expertise and resources to deal with the problems presented.

KEY POINTS ARISING	
1	Community based organisations need to have a clear sense of boundaries as regards range of mental health services they can provide appropriately and effectively.
2	There is a critical need for formal links into mainstream clinical services.
3	A number of the case studies describe different approaches to creating a bridge between refugee community organisation and mainstream mental health services. This can be achieved by: <ul style="list-style-type: none"> • Placing trained and supervised workers into a community setting • Employing refugees with mental health training or qualifications in an NHS setting
4	The danger otherwise is that community based responses will become marginalised and those in acute need may not access the services they require.

SECTION E CASE STUDIES

E1 INTRODUCTION

A key part of the review was to undertake a large series of case studies. In all we undertook some 38 interviews with different projects providing services to refugees with mental health problems. 24 of these interviews have been written up as case studies. The format for the interviews and for the case studies as they are written up here was to:

- explore the history, what prompted the service to be set up in the first place;
- understand who the users were, which community did they come from; what were the presenting problems;
- describe the range of services that were being provided and the ways in which they differed from and linked in to main stream mental health services;
- encourage those interviewed to describe for us what they saw the particular key issues as being; what factors needed taking into account; what unmet needs were there, what strategies worked best etc.

The case studies are attached because:

- many of the projects describe innovative and imaginative models;
- they illustrate better than any other source the type and volume of mental health problems there are amongst refugees;
- we hope that those interested may make direct contact and that those considering setting up new services may learn from the experiences described here.

The position of some of these agencies is insecure, largely for funding reasons, and we understand that two services have closed down as a consequence of funding being withdrawn. This is very much to be regretted.

Case studies are organised on three levels:

- those services provided from within the NHS;
- specialist providers of mental health services to refugees;
- those services provided by refugee community organisations themselves.

E2 NHS SERVICES

A CRISIS INTERVENTION SCHEME HEALTHY ISLINGTON Monica Schwartz – Project Manager

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BACKGROUND

Healthy Islington is an inter sectoral agency addressing health inequalities. It grew out of a conference in 1982 on refugees and mental health. That led to a refugee working party being set up in Islington which

made a series of recommendations on mental health issues. They then produced a series of generic health needs assessment reports on different communities. In 1996 they received funding for a 'Refugees Crisis Intervention Scheme'

This is a mental health service but they don't use that term. It has negative connotations for a number of the communities and means that people would be less likely to use a service described as mental health. The term 'crisis intervention' is seen as less pejorative. They also monitor mental health trends in the different communities.

STAFFING

They now have 4 p/t workers (21 hours per week each) as follows:

- Eritrean (working mostly with single parents)
- Turkish (working with women)
- Somali
- Zairean

Each worker is seconded to a refugee community organisation. The community groups are involved in the recruitment of their worker jointly with the Co-ordinator of Healthy Islington.

The role of the worker needs careful defining as the groups may have unreasonable expectations and it is important to retain the focus which is on:

- Raising awareness of mental health issues
- Undertaking preventative work to reduce the likelihood of crises
- Linking people into appropriate specialist services.
- Co-ordinating care services.

They do not undertake interpreting. One or two of the crisis workers will provide counselling and group work. Each case must have a key worker from either Social Services or Health.

Group supervision is provided fortnightly by Nafsiyat (see case study O). They also have a Refugee Development Worker who monitors how things are going.

**B INTERCULTURAL REFUGEE COUNSELLING PROJECT
CAMDEN & ISLINGTON NHS Trust
Debbie Clark – Team Leader**

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BACKGROUND

The main service is a team of 10 psychologists/counsellors who provide sessional counselling services in a range of primary care settings. So the overall service is the provision of sessional counselling in GP practices for anybody who needs it.

Two years ago they set up a specific refugee project. This followed on from a course on refugees and mental health set up by Birkbeck College and Nafsyat. Clinical placements from the course were based with the team during the year that the course was run.

CURRENT SERVICES

They now employ two counselling assistants to work with refugees. Referrals come from:

- GP's
- Their own surgeries
- Health clinics

The aim is to provide structured support up to a maximum of 20 sessions. They do not provide family therapy. The basic approach is described as psycho-dynamic.

MAIN COMMUNITIES

The two counsellors are placed in different GP practices where there are substantial refugee populations. They will see whichever refugee presents rather than specialising in different communities.

Between them they speak Farsi and Turkish but also use interpreters. (They provide some training for interpreters and also some support after an interpreting session)

The main communities presenting currently are:

- Iranian
- Turkish
- Iraqi
- Latin American
- African

APPROACH

As well as the problems they bring with them their refugee clients will face substantial problems caused by being in this country. The team try to stay out of practical problems, especially housing problems which can be very time consuming and refer people elsewhere for this. Their main role is to have a bridging function into the clinical services provided by GP's and the NHS. They try to deal with what the client presents rather than digging into the past. A solution focussed brief therapy type approach is used to help clients have a sense of moving forward.

They feel that having counsellors who were refugees themselves means there is a common sense of “otherness”.

**C REFUGEE OUTREACH TEAM
LAMBETH SOUTHWARK & LEWISHAM HEALTH AUTHORITY
David Jobbins – Team Leader**

**Outreach Team
1 Lower Marsh
London SE1 7NT**

Telephone No.:0171 716 7000

HISTORY

The project was originally developed because of the low take up of health services by refugee groups and because very little was known about the local refugee population. A report was produced by LSL entitled “Stating the Obvious” (1995) which was a health needs assessment based on all the nationalities in the borough.

An outreach team was then set up in 1996 comprising one team leader and four part time outreach workers. All the outreach workers were from refugee communities themselves and included one West African, one Sudanese, one Somali and one Latin American worker. It proved relatively difficult in 1997 to recruit people from the different communities because although there were enough people applying for the jobs, the people applying did not necessarily have the experience or the skill required for the job.

WORK OF THE OUTREACH TEAM

The project aims to work with refugees and asylum seekers particularly new arrivals to the UK. It aims to improve access to health services as well as the quality of services offered to refugees living in Lambeth, Southwark and Lewisham.

The outreach team aims to:

- Identify and address difficulties preventing access to health services.
- Improve access to primary health care services for asylum seekers and refugees (e.g. GPs, dentists, community nursing, optician services).
- Influence the quality and appropriateness of primary health care services in the LSL area.
- Increase awareness amongst health providers of the needs of refugees
- Ensure that refugees are aware of their rights and able to exercise their rights to access NHS services.

The team covers a range of languages in addition to English that include Arabic, Italian, Spanish, Somali, Amharic and Tigrignia.

The activities of the outreach team include:

- Raising awareness amongst refugees and asylum seekers on primary health services and the rights of refugees to use these services and how to access them.
- Health education on basic health issues – through the organisation of workshops/seminars and training to health workers and refugees and asylum seekers.
- Production and distribution of leaflets on a range of health issues
- Working with GPs and Community Health Care Trusts to improve their understanding of why refugees and asylum seekers have difficulty accessing services and highlighting the major health issues.
- Working with local authority asylum teams to improve the ability of asylum seekers without access to welfare benefits to access health services.
- Co ordination and networking with other organisations and agencies across Lambeth, Southwark and Lewisham working with refugees and asylum seekers to improve co operation and collaborative working

The Refugee Outreach team is currently part of the Primary Care Directorate. This means that it has greater influence over ongoing work and ensuring that issues are picked up by the Health Authority as a whole. It is now in the process of transferring to one of the community NHS Trusts which should further strengthen collaborative initiatives with health professionals.

MAIN ISSUES

The level of counselling available to refugees is low and there tends to be an over reliance on medication in treatment. In the area of mental health there is a need for bilingual counselling services. Interpreting services should not be relied upon for this service.

There is usually a lower uptake of services amongst men than women and it is more common for men to wait until an issue becomes urgent before seeking help.

Due to other pressing concerns (such as legal status), health is often not considered a priority. There is concern that some refugees and asylum seekers feel that their GPs do not always take health concerns seriously and therefore fail to refer them on for treatment.

Confidentiality is still a major issue amongst refugee communities and can be a barrier to accessing services. Some refugees still experience problems registering with a GP. Some refugees and asylum seekers are unwilling to embark on the complaints process for fear that it will influence their application for asylum.

It is also difficult to predict the requirements of particular groups. For example the Somali community in Lambeth, who are primarily people from urban areas are very different from the Somali community in Southwark many of whom come from more rural areas and may be illiterate in their own language.

MENTAL HEALTH

Many acute mental health wards are being used by asylum seekers (the common pattern is that people get referred because their health deteriorates directly as a result of their application for asylum being turned down). There is a tendency amongst this group towards self-harm.

The three main presenting mental health issues are:

- Low level depression – there is a need to provide social/supportive environments for people who are feeling isolated and depressed.
- Children – there is a problem with family services not being aware of children in refugee families.
- GP registration -The service is looking at commissioning a practice to undertake a need assessment of patients in their practice.

**D REFUGEE PUBLIC NURSE HEALTH SPECIALIST
BARKING, HAVERING & BRENTWOOD HEALTH AUTHORITY
Sarah Savigar – Public Health Nurse Specialist**

**Gascoigne Road
Barking**

Telephone No.:0181 594 2242

BACKGROUND

The Health Authority became aware of a significant influx of refugees into their area. There were concerns that these people may:

- have significant health needs
- not always present for assessment or to access treatment
- need specific help including interpreting as part of the assessment process.

The post of Public Health Nurse Specialist was therefore created to make contact with newly arrived refugees; help with initial health assessment arrangements and link them into different services as required.

KEY TASKS

The post is joint funded through the London Improvement Zone arrangements to work with refugees and asylum seekers. She receives notification of all asylum seekers moving into the area. Each new family / individual will then get a home visit to help link them into health services and pick up on immediate health problems. It is often essential to use interpreters.

She also runs a drop in clinic and sees herself as having a community development role supporting health care initiatives by community groups themselves. The project is based in the Orchard Health Centre in the Gascoyne estate, a large council estate where many refugee families are rehoused.

MAIN COMMUNITIES SERVED

The main groups currently are Kurdish people and French speaking African people. She also has some contact with the local Punjabi community.

There is an increasing profile of mental health problems particularly since benefits were withdrawn. Out of 80 current clients the main issue is mental health. The risk of problem drinking is significant although there is only one case at present (combined with mental health).

Some GP practices are being very selective about their patient lists and are refusing to take asylum seekers.

**E REFUGEE SUPPORT PSYCHOLOGIST
FOREST HEALTHCARE NHS TRUST
Dr Kate Harris**

**Larkwood Centre
Thorpe Coombe Hospital
714 Forest Road
London E17 3HP**

Telephone No.: 0181 520 8971

HISTORY

The Trust has a refugee development worker whose role has been to identify health care needs. This led to the conclusion that mental health needs were sufficiently acute and wide spread to justify a dedicated post of psychologist.

The post is jointly funded by the Health Authority and the Single Regeneration Budget. Half of the work load is clinical and the other half is developmental.

CLINICAL WORK

The service does not accept self referrals. Considerable awareness raising has been undertaken with potential referral agencies. The Refugee Support Psychologist endeavours to get the referral agency to deal with any practical problems the person may be having and tries to ensure that the counselling session does not get 'polluted' by too much practical advice. The practical issues may feature as a route in to the underlying concern.

Many clients will present with somatic problems. Memory problems are common and some clients are distracted to a point where their behaviour puts them at risk. Anger is also very common (particularly from men who have been in prison).

Recently many cases have been either Algerian or Somali. The psychologist speaks French in which some users are fluent, but for many users it is necessary to use an interpreter. They have trained some Somali leaders as interpreters. They want interpreters to be as unobtrusive as possible and to speak in the first person.

The approach is described as existential – 'starting from where the person is'. Part of the role is 'reinforcing existing forms of solace'; helping users develop their own resources. This may include linking a person into traditional healers and she is developing a list of local healers. If a user wanted a counsellor from a particular background they would be referred on.

There is a waiting list of about six weeks though they will see someone more quickly if there is a crisis. The counselling programme is open-ended.

DEVELOPMENT ROLE

This consists of awareness raising sessions with different community groups using a range of mental health case issues so that the groups can think about different situations and consider their options for dealing with these.

They would like to develop a befriending scheme.

**F THE REFUGEE SUPPORT PROJECT
WILLEDSEN CENTRE FOR PSYCHOLOGICAL TREATMENT
Dr Judith Zur – Project Co-ordinator**

**Willesden Centre for Psychological Treatment
Willesden Hospital
London NW11 7BY**

Telephone No. 0181 451 0030

BACKGROUND

The Refugee Project is a two year initiative which began in January 1996, supported by Brent and Harrow Health Agency and LB Brent aimed at improving mental health support for refugees in Brent and Harrow who were not accessing services.

The Refugee Support Project has a broad definition of mental health work and provides a holistic service including asylum information, housing advice, welfare benefits advice, etc.

THE PROJECT OBJECTIVES ARE TO:

- Develop the capacity of mainstream mental health services for adults, children, adolescents and families and to provide suitable help for the special needs of refugees.
- Build upon the existing potential of refugee groups to provide mental health support, including counselling, through training and joint work.
- Provide direct mental health support for Brent and Harrow refugee residents at accessible outreach venues, where possible in the refugee's own language or through trained interpreters.

These objectives are met through a combination of individual and group counselling, workshops, training, consultation, seminars, community work and the provision of accessible information. The project draws on the expertise of refugees and organisations working with them, including users and providers of mental health services.

THE SERVICE

The following services are provided:

- Counselling and therapy for individuals of all ages.
- Family therapy for children and/or adults
- Advocacy work - report writing especially to the Home Office in relation to seeking asylum
- Consultation, supervision, joint working and training with community groups.
- Work with GPs

STAFFING

The project team includes a Project Co-ordinator and a Somali mental health worker, both based at Willesden Centre for Psychological Treatment. The Somali therapist was a doctor in his own country working in the mental health field.

REFERRALS

Referrals are obtained from GPs, Homeless Person's Units housing associations, hostels, internally within the Health Service, schools, Social Services, solicitors. In Brent 45% of the refugee population is Somali (approx. 15,000), in Harrow between 70-90% of the refugee population is Somali.

PROCEDURE FOR ACCESSING SERVICES

An assessment is made before the applicant is placed on a waiting list. The criteria for accepting someone on to the waiting list is that there should be a recognised mental health component to their presenting problem.

If the client is a child, the assessment may be done with a teacher. The project would work with other child development services if they felt that a referral needed to be made other more specialist services. When working with parents around their child's mental health there is often a lack of acknowledgement of the problem and a need to focus on more concrete concepts such as education.

A number of clients are referred by hospitals and are seen in hospital. Ward staff often call the project to help people who have been admitted and need help with asylum applications, etc.

ISSUES

Working through interpreters is very difficult. There are sometimes problems around levels of awareness regarding mental health issues. Training is needed in this area. There are also issues regarding the counselling time. If interpreters are used then extra time is required for those clients. There is a lot of non-verbal behaviour in therapy sessions which does not get translated. There is no way of knowing whether their interpretation of what the client is saying is what the client is actually meaning. There is an onus on the interpreter to often best guess what they think the client wants to express. All clients have a choice in terms of whether their interpreter is male or female.

PARTICULAR ISSUES WITH REGARD TO SOMALI REFUGEES

Somalis tend not to make a distinction between health and mental health. They are usually traumatised and in the process of seeking asylum. The mental health component of their condition sometimes presents itself as a physical component. Khat use amongst both men and women is causing an increase in mental health problems and broken families.

There are cultural differences in how childhood is perceived and the expectations made of children. They often act as "cultural brokers" for the family

The project works with Somali refugee groups in terms of health awareness so that they can recognise when clients need their help; explain the complex NHS service; what counselling is and when it might be appropriate for the people they are seeing. There is a reluctance to use health services and a caution around "who you discuss your problems with". Professionals are perceived as 'hostile hosts' and not to be trusted. Racism is a problem. For many Somalis they are experiencing racism for the first time.

HOW DOES THE COUNSELLING DIFFER?

The co-ordinator find that she discloses much more of herself with her Somali clients than she has ever done before, whilst maintaining her professionalism. She feels, however, that it is important to adapt and be flexible depending on the needs of the client and the cultural practices of the client.

Issues to be aware of include dependence. The service aims to help individuals to create their own support structure by tapping them into other agencies that can help. Clients are told that they can contact the project whenever they need to even when they no longer receive counselling.

The ritual of presenting counsellors with food and gifts as a sign their appreciation is something that happens a lot. This is accepted as much as possible as it is linked to cultural practice and issues around self esteem and pride.

No one particular model of counselling is followed. An eclectic mix of theories is drawn upon depending on the needs and experiences of the client.

**G SOMALI COUNSELLING SERVICE – PRIMARY CARE PSYCHOLOGY AND
COUNSELLING TEAM
TOWER HAMLETS HEALTH CARE TRUST
Amina Hussain – Somali Counsellor**

**Steels Lane Health Centre
384-398 Commercial Road
London E1**

Telephone No.0171 790 9619

THE ROLE

The role of the counsellor is to work with Somali refugees in Tower Hamlets, but she will also assess people from outside the area when requested.

Somali people are not aware what counselling is and so the counsellor needs to have an educative role. She also provides training for professionals on ‘what mental health is in the Somali community’. Finally she undertakes some joint working with other professionals (e.g. child psychologists) to help ensure a more effective service for Somali people.

MENTAL HEALTH AND SOMALI PEOPLE

A person is either ‘sane’ or ‘mad’ in Somalia, there are no degrees of gradation in between and there are no words for anxiety, psychosis, counselling etc. Basically lower level mental health problems are dealt with within the family (and anyway are not nearly so prevalent) and may not be regarded as requiring help.

Until recently the only facilities were asylums without treatment where the very seriously disturbed were incarcerated. As a consequence people are very frightened of mental health professionals over here and particularly of psychiatric hospitals. Symptoms are often presented physically e.g. headaches etc. Somalis are predominantly Muslim so may approach the imam to say prayers on their behalf. Also there is some sense of mental health being regarded as a punishment.

REFERRALS

Referrals often come from Somali welfare groups; they get lots of referrals from schools and some from GPs. The largest group is adolescents with behavioural problems, anger etc who may have lost parents and be living with other relatives. Many clients who attend have been seriously wounded including amputations.

Bereavement is a common problem; this can be particularly problematic when the body is not found. Marital problems are also common; in some instances roles will have changed and the man is no longer the provider. Suicide is unheard of in Somalia (there is no redemption in Islam for suicides). Over here there have been a number of very dramatic suicides – under trains etc. A number of cases are admitted to mental health units for apparently psychotic behaviour. In the counsellor’s view there is a clear problem of misdiagnosis.

ASSESSMENT AND COUNSELLING

It takes a long time for users to understand what counselling is. Somali people are not prepared to talk about their feelings, and are fearful when notes are being taken. The Trust also employs psychiatrists who can be involved as required. The counsellor runs two groups:

- A group for school age girls talking about identity; sexuality; family pressures etc
- A group for women dealing with loss and bereavement

They have produced relaxation tapes in Somali and will draw on a client's religious beliefs where these can be used.

BACKGROUND

The Tavistock Clinic was originally established to deal with soldiers experiencing shell shock etc after the First World War. It then developed as a training centre for post-graduate students in psycho-therapeutic techniques.

CURRENT REFUGEE PROJECTS

1. The Tavistock has a series of courses for people who work with refugees and mental health issues
2. They also provide external training on refugees and mental health e.g. for Westminster Social Services Department, MFVT etc.
3. Professor Papadopoulos undertakes clinical work at the clinic and elsewhere
4. There is a regular programme of consultation to other bodies e.g. GP practices, voluntary organisations etc.
5. and finally there is some international consultation

TRAINING

Working with refugees

The courses aim to assist those working with refugees to develop and enhance their understanding and skills in the context of their own experiences. Using systematic and psychodynamic approaches, it aims to create a facilitative space within which to consider the complexities of the refugee condition from a more global perspective including therapeutic, clinical, theoretical, organisational and political dimensions.

More specifically, the course is intended to offer participants the opportunity to:

- (a) explore theoretical issues pertaining to the refugee condition and the dynamics involved in helping them
- (b) develop practical skills in working with them
- (c) exchange ideas and share feelings about their work experience
- (d) present specific work issues for consultation.

Participants are substantially from refugee communities. They use case material so as to focus on specific circumstances.

Courses at Birkbeck College

A series of courses have been run at Birkbeck college for refugee communities themselves (some have been run jointly with Nafsiyat). These are specifically to do with mental health issues and include an introduction to basic counselling.

The courses are intended to

- help participants recognise boundaries of counselling or advice and the point at which clinical intervention may be required

- work within a realistic framework of the practical situation of the refugees
- also identify psychological issues presented practically e.g. obsessive behaviour.

CLINICAL AND PREVENTATIVE WORK

Professor Papadopoulos sees a small caseload of refugees at the T&P NHS Trust, primarily families. He refers to 'positioning' whereby the psychologist or other professional sees themselves as working with a family or refugee community organisation to look for positive strategies.

He is keen to work with refugees before they request professional health input so as to undertake preventative work. As an example he worked with the first group of Bosnian refugees endeavouring to help them identify coping strategies.

EXTERNAL CONSULTATION

Finally he is approached by external bodies wanting advice on a refugee strategy. An example is a GP practice in Paddington which was initially very open to refugees and rapidly became overwhelmed with a key member of staff getting burnt out. He worked with them to clarify criteria and working practices.

ISSUES

Some refugees seem to show greater 'resilience' and are less likely to experience problems. Research shows that the key factor is their ability to forge relationships with supportive adults whether related or not. Part of therapy may be helping to build up 'resilience'.

He is concerned that an analytic examination of traumatic experience can be damaging. Instead he refers to 'exploring narratives' and bearing 'testimony' whereby users can talk through their experiences in their own way. This may include not talking about more extreme experiences. The recognition by both therapist and user that certain experiences are 'there' but 'unutterable' can be positive.

Refugees can over emphasise practical needs as a way of avoiding emotional issues. The therapist needs to be 'sensitive to other dimensions'; needs to consider 'the meaning of the symptom'

BACKGROUND

The clinic provides a service for people with severe traumatic experiences. The clinic was set up after the Kings Cross Fire to help those involved deal with the trauma of their experience and has since developed services for refugees and other people who have been traumatised.

SERVICE USERS

The centre works with people including refugees with a range of conditions but who all exhibit severe trauma responses. Staff work with people who are experiencing depression, Post Traumatic Stress Disorder (PTSD). This accounts for approximately half of all the clients they see. The main responses are alienation, stress, acculturation, stereotyping, racism etc.

NEEDS

In a survey of local GPs on access to health care services for refugees and asylum seekers they found that language and psychosocial problems and the lack of co ordination between services were the greatest problem. There was some criticism by GPs of community groups who took on the role of a professional service without having the skills and expertise.

The primary needs of those coming to the centre are for a roof, food, a united family, money, dignity. Their refugee status is seen as a social loss. There are three basic steps a refugee needs to go through:

- Ensuring the safety and security of themselves and their family
- Access to any treatment that may be required
- Rehabilitation and possible integration into a new society

Often refugees do not go through these stages because they never complete stage one. They may only be given exceptional leave to remain which could change. There is therefore a great feeling of instability and insecurity.

COUNSELLING SERVICES

The therapy is provided through interpreters if necessary. The clients are then, wherever possible, linked into other services. A pool of interpreters is used with whom they have developed a good relationship. The therapy helps them to develop coping strategies, and talking to them about how they are going to cope with their situation.

The team has a cognitive behavioural approach to trauma that includes dealing with the guilt, shame and fear associated with their ordeal. When someone is traumatised they are not processing the event, and they need to be enabled to do this, to become “unblocked”. This is done by directly questioning the shame and the guilt. The aim of Cognitive Behavioural therapy is to help individuals to cope by themselves, to work with their belief systems. This can be problematic if the belief system is linked to their trauma e.g. believing that they deserved whatever happened to them or that they are a bad person.

ASSESSMENT

A detailed account of what has happened to the individual is obtained. There is sometimes somatisation presented as multiple pains which may relate to the original torture/injury (pain is more an emotion than a physical state) Users may be very scared of health professionals (there is research which suggests that 40% of those undertaking torture may actually be health professionals)

BACKGROUND

The Traumatic Stress Clinic undertook a survey of Somali and Kurdish groups where a number of people were interviewed and feedback obtained on important notions. The main findings were that:

- No one liked using interpreters
- There were clear barriers to accessing NHS services

One recommendation that came out of the research was the need for a bi-cultural therapist. This was acted upon and the Kings Fund supported the funding of a Bosnian Project, initially for one year. This has now been extended for the second year running. The aim of the project is to recruit people who are newly arrived and who have the skills (perhaps they have psychological backgrounds) but not necessarily the registerable qualifications to practice.

Two part time workers were chosen to train as bi cultural therapists. They sit in a professional team and are paid a professional salary.

Both have backgrounds in psychology. one has obtained BSc in Psychology and MSc in Mental Health Studies (UMDS Guy's & St Thomas' Hospital), both at the University of London. The other therapist has obtained a professional qualification in Psychology in Croatia, and is currently half-way through training as a Systematic Psychotherapist, for which she has been sponsored by the British Red Cross.

USERS

Most users are Bosnian adults, but they also see some users from other regions of Former Yugoslavia and more recently some people from Kosovo.

CRITERIA FOR ACCESSING THE SERVICE

The basic criteria are that the user

- have the symptoms of Post-Traumatic Stress Disorder
- or have experienced something traumatic in the Former Yugoslavia
- and there will be a degree of severity in all cases

THE PROCESS

The preliminary work for the Bosnian Project involved talking to organisations which were providing existing services, holding open meetings with community groups, targeting General Practitioners and others.

When individuals present, they undertake a full psychological assessment, but also ask about practical needs. Most of the referrals are from general practitioners. Most users come from rural areas; so they may only have a limited degree of understanding of counselling and other psychological services.

The key challenge is helping people understand what their problems are what causes the symptoms. It is very common for users' reactions to be confusion, fear and anger. A major problem is that they simply

do not understand what has happened to them. The approach is largely problem-focused. It is also possible to access the treatment service directly, via the telephone line, in Bosnian language.

TREATMENT

A key part of the process is producing a 'testimony' whereby individuals retrieve and write the history of what has happened to them. Testimony is a method treatment, whereby patients' audio-taped account of their traumatic experiences is produced. This is then transcribed and given to the patients, to check the text and add or delete, as they find appropriate. The amended text is re-typed, and the final version is given to the patient, to keep as their own document. This has been shown to reduce symptoms of Post-Traumatic Stress Disorder.

MEDICATION

Most users will also be on anti-depressants and will also be seen by the consultant psychiatrist at the TSC. Only one or two users are patients in MHU's. Some may come expecting a pill and drop out of counselling when medication is not forthcoming.

FURTHER DEVELOPMENT

They would be keen to participate in a service whereby counselling was provided for each newly arrived community using skills from within that community but based in a regional NHS service.

K TRAUMATIC STRESS SERVICE
Dr Ian Robbins – Consultant Clinical Psychologist

**Clare House
St George's Hospital
Blackshaw Road
London SW17 0QT**

Telephone No. 0181 672 1255

BACKGROUND

The Traumatic Stress Service focuses on treating victims of violence. Services offered include assessment, consultation and treatment in a variety of settings.

The project has only been in operation for three months. Next year the aim is to offer in patient treatment. There will be six beds attached to a larger unit working with clients with similar needs. To date the following clients from refugee groups have been seen:

2 Bosnian	1 South Asian
2 Sri Lankan	2 Iranian
1 Kurdish	1 Algerian
1 Ugandan	

The service aims to “reduce distress and facilitate recovery from post traumatic stress, allowing the individual to return to their previous level of functioning in the shortest period of time”. Treatment aims to promote effective coping and recovery and prevent the emergence of long term psychiatric problems.

FORENSIC SERVICE

This service is under the umbrella of the regional forensic psychiatric service and provides special expertise in the forensic aspects of post traumatic stress disorder and the preparation of medico - legal reports for criminal cases or civil litigation.

ASSESSMENTS

These are usually made on an out patient basis but in more complex cases this could be during a brief admission. More than one appointment may be necessary in more complex cases. A comprehensive report is provided at the end of the assessment with recommendations for treatment.

TREATMENTS AND SERVICES

Treatment is provided by a multidisciplinary team of clinicians. The service includes:

- Debriefing for acute reactions to trauma
- Cognitive behavioural treatments, including stress inoculation, desensitisation and exposure, anxiety management and anger management.
- Eye movement desensitisation and reprocessing (EMDR)
- Physical therapies e.g. relaxation, physiotherapy
- Individual and Group therapy

In addition to the above an in patient unit will be available in 1999 to enable more intensive assessment and therapeutic work. The service also provides training in assessment and management of acute trauma and PTSD.

TREATMENT APPROACHES

The approaches used include cognitive behavioural and cognitive analytic work. Group work can also be undertaken with particular groups e.g. women who have experienced sexual abuse.

The number of sessions depends obviously on the needs of the client. On average clients are seen for 15 sessions. More sessions are provided in more traumatic cases. After an initial 20–25 sessions they would need to go back to the funding authority to secure funding for further sessions. Initially clients are seen very regularly on a weekly basis or more regularly if necessary.

Most of the clients speak English, although interpreters have been used. Issues such as the gender and nationality of the interpreter are important. It is the practice of the service to allow the interpreter and client to spend half an hour with each other to gain familiarity and aid the therapy sessions. The interpreters used have experience of working in mental health services and on occasions have been trained social workers.

As the service develops and the numbers of clients from different communities increases, specific services will be set up for particular communities with specialist interpreters.

The sessions involve undertaking work which includes exposure to thinking of the event, developing the trauma story (not specifically in psychiatric terms), and providing information to the client on the range of responses that people have

Some medical treatment is provided but usually only around severe clinical depression. Tranquillisers are not generally used as they interfere with talking therapies. Some clients also present physical problems which may be psycho somatic or may require referral on to medical colleagues for further investigation.

Some therapy is undertaken with couples. However drawing in partners can be difficult. In the past couple counselling has been encouraged through presenting the situation as the wife being able to help the husband by attending the sessions with him. Children are not catered for by the service, as there are more appropriate specialist services available to them. The service does, on occasion, work in conjunction with the Child Department.

PRESENTING PROBLEMS

Depression, loss, grief, anxiety and arousal i.e. problems sleeping, loss of energy. Chronic pain – psychological and physical. Somatic complaints are often present and it is difficult to determine whether they are actually physical i.e. relating to torture or beatings that may have occurred. Often the initial presentation of the problem is somatic. However it soon becomes evident that there is deep psychological distress.

ISSUES

The Zairian and Somali community are gradually integrating into society but the links that have been built up are a poor substitution for what existed before in their home countries.

There are also obvious issues to do with the immigration status of the refugees. A lot of mental health issues are as a direct result of uncertainty about their status.

L THE BAYSWATER FAMILY CENTRE

Vickie Eves – Co-ordinator; Mebrat Deres – Counsellor; Latifa Gawi – Family Support Worker; Mahmoud Lobinet – Support Worker; Dr Najedha Majid – Counsellor

**14-18 Newton Road
London W2 5LT**

Telephone No. 0171 229 8976

BACKGROUND

The Family Centre is an NCH Action for Children project providing an open access service for refugee children and homeless families in the central London area of Bayswater. The area has the highest concentration of homeless families in the country. Over 80% are refugees and the majority are non - English speaking.

The Centre sees approximately 600 new households a year and provides a service for 1200 families. Information about new families is gained from comprehensive cross-information systems with local authority housing departments, asylum teams, health visitors and the local primary health support team.

They run a drop-in session every afternoon with supervised play and a kitchen where parents can cook and do their laundry and there is a daily, no-appointment advice and information service.

STAFFING

Staffing consists of:

- a social worker who works with more complex cases involving mental health, child protection and disability;
- two family support and outreach workers, both of whom speak a number of languages and are trained counsellors;
- a refugee advice and development worker linking statutory services with refugee community groups
- three part-time early years workers providing play and family support;
- two counsellors - one Arabic and one Amharic speaking;
- two art therapists who, have experience of working in Bosnian refugee camps
- a volunteer aromatherapist
- a nurse practitioner who provides therapeutic massage
- sessional interpreters who provide interpreting for three regular Arabic and Albanian sessions a week

Staff part-based at the Centre include

- health support workers consisting of a health link worker, a health, visitor, a community nurse and three nurse practitioners
- two primary mental health/ child and family therapists (who speak Farsi, Russian and Zulu) from St Mary's Child and Adolescent Psychiatric Unit

SERVICES

There are considerable services for children and families with children including a drop-in for young children and some under-5's learning provision. They provide lots of practical help for families and see themselves as working with the whole family wherever possible. They have a very strong community

outreach role with a family support worker and outreach worker who introduce families to the centre and help with access to other local services. They reckon to make contact with 60% of homeless families living in the area. In order to meet the diverse language needs of the client group information is available in eight languages and the languages spoken by the multi-lingual team of staff and volunteers are supplemented by regular interpreters.

A number of refugee and women's groups use the centre.

BACKGROUND

The family centre provides an open access service for refugee children and homeless families. The area has the highest concentration of homeless families in the country (of whom 85% are refugees). The majority are non-English speaking

They run a drop in session every afternoon with a small staff team, volunteers and interpreters from GRIP. They see a very mixed group of refugees. Recently they have been seeing more Iraqis. They try to help people as far as possible in their own language

STAFFING

Staffing consists of:

- an Iraqi woman GP as a counsellor on a sessional basis
- two art therapists (who previously worked in Bosnia)
- two volunteer counsellors (one Amharic and one French & Arabic speaking)
- one health worker seconded to the team to act as a link worker.
- There is also a nurse practitioner

SERVICES

There are considerable services for children and families with children including a drop in for young children and some under 5's learning provision. They provide lots of practical help for families and see themselves as working with the whole family wherever possible. They have a very strong community outreach role with a family support worker and a community outreach worker. They reckon to make initial contact with 60% of the families who use the service. They try to draw families into the centre and get them to use other services.

A number of refugee and women's groups use the centre

PSYCHOTHERAPY

There are two counsellors who undertake counselling and psychotherapy with clients. They see a number of refugees who have been exposed to war and are experiencing posttraumatic stress. Some have been hospitalised in mental health units in this country.

Presenting problems include:

- recurring nightmares, anxiety,
- not understanding the welfare benefit system,
- fear of stigmatisation – the community are not necessarily supportive and people can feel quite isolated
- often there are no links with doctors, social workers or community networks.

Counselling Issues

The issue of confidentiality has to be explained, people need to be told their rights in terms of what they can expect from the service and that what they talk about in the sessions will not be repeated to other clients, their family etc. The whole concept of counselling and confidentiality is something which is new to them. It is essential to provide practical support alongside the emotional support. Counselling interventions need to be short term – it is important to get people moving forward.

FAMILY SUPPORT AND OUTREACH WORKER

The Outreach Worker visits people in hotels, gets to know about them via Housing and Asylum Teams. There are approximately 600 new households seen per year.

She provides families with information about the Bayswater Centre and advice on how to access the welfare benefit/housing system. The worker speaks French and a range of Arabic dialects. Families are asked to come to the centre if they require interpreters. At the Centre they can also receive information on benefits via the team, and get help with food and clothing and a range of other services.

Clients are referred on to different organisations. Clients often don't have much confidence in statutory services such as social services.

There are often fundamental differences in practices such as child rearing, applying discipline, etc which are hard to explain and go against their own beliefs.

HEALTH/LINK WORKER

The Health/ Link Worker's job involves linking people in with GP's, dentists, interpreters, and advocacy work.

Presenting Issues

There is a general problem with misinterpretation of mental health issues, the interpreters used are not necessarily trained or qualified in mental health issues. This can mean that information is not necessarily presented to clients in the most sensitive way.

People do not like to be labelled as having mental health problems. It is therefore important to present the assessment of their condition in a way which is going to be acceptable to them and not offensive. Interpreters who do not have any mental health knowledge or training are not in the best position to do this.

There is also the whole issue of responsibility and status of parents in the family. Often with refugee families and minority ethnic families in general it is usual for the husband to accompany his wife on doctor's appointments and to attend appointments with children. This is something that may be seen as conflicting with confidentiality and frowned upon in the West.

COUNSELLOR

One of the counsellors is also a GP / nutritionist and so is also able to provide counselling for people with eating disorders. She is from the Middle East and has the language skills to work with clients from Iraq, Syria, Lebanon and the Sudan. She is trained in psychodynamic counselling.

Counsellors see clients once a week for an hour. An initial contract is drawn up with the client which is for 6-12 weeks. If during this time it is discovered that the client has a severe mental health problem they may be referred on to a psychiatrist. Referrals are made to the Medical Foundation for Victims of Torture and the Marlborough Family Service if more specialist help is required.

The need for a specialist resource for refugees has been recognised by the health authority and mental health refugee support team is currently being developed in the area.

Presenting problems

- People who are experiencing Post Traumatic Stress Disorder and have had no previous problems i.e. prior to becoming refugees.

- People who are experiencing PTSD and had prior complicating problems e.g. physical abuse, childhood problems.
- The most common problem is housing, lack of appropriate housing often leads to other problem such as child abuse and marital problems.

Refugees suffer from identity problems associated with losing their home, family and country – “broken world”. There is also the added complication of instability and uncertainty regarding their future; they live under the constant fear that they may be deported.

Religion can often be helpful in terms of enabling people to come to terms with their lives and what they have had to endure. There is often an element of “no blame” and “no control” over the situation.

The guilt associated with survival and escape is also a common issue for refugees.

The counsellors do “bring god into the counselling sessions” as this is often a way of ensuring that what is being raised by the counsellor is taken seriously by the client because it fits into the frame of reference of the client.

BACKGROUND

The Evelyn Oldfield Unit was set up in 1994 to provide specialist aid and support services to refugee community organisations to enable them to increase their capacity and potential to meet the needs of members of their own communities.

The services provided include a free professional advice, information, support and training service on specific managerial, organisational and legal issues focusing on areas such as:

- Financial management
- Roles and responsibilities of management committees and staff
- Personnel issues
- Managing organisational change
- Conflict resolution
- Legal accountability and structures
- Service contracts

SERVICE USERS

The unit works with formally constituted, well established service providing refugee community organisations which:

- Need help to resolve particular issues
- Need help in managing change
- Wish to further their services in relation to mental health or women's development.

Organisations can apply directly to the unit for support. Referrals can also be made from founders, resource agencies and others.

The unit does not work with recently formed groups and does not provide on going development support but will refer groups on to appropriate development agencies. The Unit operates by providing services directly, through its own staff, through external consultants and trainers and other resource agencies as appropriate.

MENTAL HEALTH

The unit offers two main areas of support in mental health services:

- Technical aid and support to groups developing counselling services
- Support for the Refugee Mental Health forum

THE REFUGEE MENTAL HEALTH FORUM

The Refugee Mental Health Forum was set up in 1995. This is led and managed by refugee communities. The Evelyn Oldfield Unit services the forum. The forum provides the organisations with the opportunity to network and talk about issues of concern.

The aims of the Forum are to:

- Lobby statutory bodies to provide better mental health services or refugees
- Educate refugee groups through appropriate training
- Introduce models of good practice
- Organise conferences and seminars on mental health issues affecting refugees
- Collaborate and co operate with counselling agencies and professionals.

A steering committee was established to develop guidelines to providers of counselling. A course has been set up with NAFSIYAT at Birkbeck college. Tutors are from ethnic minority communities.

The Evelyn Oldfield Unit has produced guidelines for refugee community organisations providing counselling services. The guidelines aim to give clear information to training providers and refugee community organisations on training and the provision of training and subsequently counselling to be accessed by refugees.

THE MEDICAL FOUNDATION

The Medical Foundation has been running for 12 years. The Foundation is a generic service and provides social and emotional support. The client group comprises political refugees with a history of torture. The counselling is very much linked in with practical and social help.

Approximately 12,000 clients use the service each year; there is a high turn over of users. Most refugees approach the service within one year of arrival. Advocacy Work is undertaken, this includes appeals on behalf of clients.

REFERRALS

Referrals are made by GPs; lawyers, mainstream mental health service professionals and community organisations. Some clients with a forensic history are also referred. There are a number of self referrals.

The core client groups are Kurds from Turkey, Iran and Iraq, Iraqi Shi ites, Sri Lankans, Tamils, Somalis, Zairians, Colombians and a small number of Bosnians.

According to the consultant psychiatrist the average refugee presenting at the service is distressed but not mentally ill. The pressures of their current living arrangements are as likely to lead to mental health problems as the torture they previously experienced.

There are some users who obviously had mental health problems prior to coming to this country.

STAFFING

Staffing consists of a full time psychiatrist, two part time clinical psychologists, counsellors, caseworkers, volunteer primary health workers e.g. GPs, case workers, visiting volunteer medical specialists (paediatricians, etc), volunteer psychiatrists and counsellors

THE THERAPEUTIC SERVICE

The service receives approximately 50 new referrals each week. The counselling services offered are much more long term than those provided by the NHS.

There is a walk in service available from Mon to Fri between 1pm and 4pm. A duty worker provides the client with basic information and completes a form which includes details on their background, the conditions under which they left the country and their presenting problems.

The case is then discussed at a multi disciplinary team meeting and classified as high, medium or low priority. Currently only people classified as high priority are being seen and there are approximately 50 people on the waiting list.

People are classified as follows:

- High priority have severe mental health problems, may be isolated, suicidal or highly vulnerable.
- Medium priority – they are linked into other services where possible and there is support available

The multidisciplinary team discusses each case to determine priority and general needs. There is a discussion around who is the best person to see them. The client is then offered an appointment. An assessment is undertaken and the concept of counselling is explained using plain language i.e. not the language of Western psychology and psychiatry. The psychologist may explain that ‘she is not a doctor’; that they provide ‘a talking kind of therapy’; that they will be able to offer some practical assistance and that the net result should be that the client is better able to cope with their difficulties.

Often practical support and advice is also offered for example in relation to housing and benefits.

THE PSYCHIATRY SERVICE

Much of the work is crisis intervention including ongoing liaison with mainstream mental health services. The Foundation does not undertake much out patient work.

The majority of the work is fairly short term. Medication can be prescribed if necessary. Out of approximately 600 clients seen by the psychiatrist since 1991, only 10 were admitted to psychiatric hospital, one attempted suicide and there were no deaths. Only four clients were seen for more than three years. The emphasis of the centre is not on longer-term work. Caseworkers may have longer-term connections with clients.

PRESENTING NEED

The most common presenting issues include depression, anxiety, fearfulness, Post Traumatic Stress Disorder (an unpopular label with clients and staff). Clients talk about being separated from their families – having a “shattered world”, sleeping problems, eating problems, loss of weight, mood changes, difficulties in coping with day to day demands as asylum seekers in a strange, insecure, environment.

APPROACHES TO COUNSELLING

Those with mental health problems often have a ‘complex presentation’ where there are a number of strands to the mental health problem. The assessment may therefore take more than one session.

“Suffering” is not a psychological disorder. Clients who have suffered torture do not necessarily have an increase in the need for mental health services. A short term measure is medication (mainly anti depressants). Some clients have had suicidal ideas i.e. tried to hang themselves.

The Foundation is not equipped to provide on going treatment of psychosis. There is no community arm to the service at all, therefore the service has its limitations. The NHS provides follow on treatment.

They then have a range of therapies to draw on, all of which are problematic to some degree (because they are Eurocentric).

The service needs to understand the culture of the client and take on board the systems that may have been available to people in their own country. For example, women in Sri Lanka may have had the support of the women in their village in terms of someone to listen to their problems, help with child care, someone to speak up on their behalf, etc. Even when an ethnno sensitive counselling approach is applied to counselling, Western concepts are being applied to people from different cultures and it should be considered that maybe it is not possible to transfer these concepts.

There are a number of themes emerging from the way counselling has developed:

- Much effort has to go into ensuring that users have a clear understanding of what is being offered; this may develop over a number of sessions as counselling actually takes place;
- They need to get informed consent at all stages to the actual process;

- Essentially they have to abandon traditional psychological models and try to respond empirically to what is being presented to them.
- None of the usual models can be assumed to apply and therapists need to either abandon these or adapt them substantially.

With refugees you ‘can’t divorce the spiritual from the political’ and they gave examples of how individuals combine religious and political persuasions (eg communist and Islam).

ISSUES

In their view statutory services as a whole do not provide a very good service to refugees. GPs are often not interested in refugees and refuse to take people onto their registers. Language and lack of interpreting services are often used as an excuse by statutory organisations not to provide a service to refugees.

Some clients are nervous about being treated by members of their own community. This particularly applies to Iraqis and some of the other Arab communities.

There have been some problems with different communities having difficulties with adapting to British culture. An example was given of Kurdish women living in Hackney where they were obviously not able, or wanting to adapt to this new way of life in Britain which was so different to their village life back home and were beginning to express this unhappiness in terms of “mental health” language. Social and economic factors contribute greatly to the mental health of the refugee and mainstream population; unemployment commonly results in mental illness.

Turkish Kurds are different from many other refugee groups as they are comprised mainly of rural people, farming communities from small villages. Most of the other refugees are from urban areas usually quite well educated. There is a degree of self-selection amongst many refugees, and it tends to be the most able and financially well off people who manage to flee their home country.

There is a higher incidence of khat usage in the young Somali population that can exacerbate an individual’s mental health situation. There is also an increase in suicide in young Somali men, as reported by community workers.

Unemployment is a major problem. An underground underclass is developing comprising refugees who are not linked into services. Many refugees are dealing with living in "limbo" whilst awaiting outcome of Home office applications.

HISTORY

NAFSIYAT is a registered charity and has been running for three years. The organisation provides counselling and therapy to people from black and minority ethnic communities. NAFSIYAT provides counselling for families, individuals and children.

A project for young refugees between the ages of 12 and 30 years was established because it was felt that a different approach was needed to reach young people and enable them to access the service.

STAFFING

The “young refugees” project has one full time paid worker and approximately 18 trained volunteer counsellors who undertake sessional work. All the counsellors are from refugee communities themselves.

SERVICES OFFERED

The services offered include:

Counselling

Counselling is provided from a culturally sensitive perspective. The types of counselling offered range from supportive counselling to psychotherapy. Clients have a choice of therapist, they may have someone from their own community (or not), same gender, etc.

Each client is initially given a short-term contract lasting 12 weeks after which time it is reviewed. Many people who approach the service are unaware of what counselling entails. This has to be explained to them at the initial assessment. Most people respond positively to the explanation and choose to proceed with counselling.

A counselling course has also been set up at Birbeck College by NAFSIYAT and the Evelyn Oldfield Unit.

Training

Seminars are run with community groups and the communities themselves often dictate the topics for these seminars. They cover a whole range of issues including intergenerational conflict in families, marital issues, isolation etc.

Outreach

Outreach work including work with children in schools. The outreach work involves raising awareness on counselling services and NAFSIYAT generally. Outreach work is undertaken in schools by workers who can speak the community languages and act as link workers between them and other services.

REFERRALS

These are obtained from GPs, teachers and community workers. A significant number of people are self-referrals. There is no geographical remit in terms of referring boroughs. Outreach work is undertaken in the boroughs of Islington, Camden and Haringey.

The service sees 500 clients per year. Each counsellor has a caseload of approximately 10 clients at present. They are mainly from Somali, Eritrea, South America, Iran, Iraq and Sierra Leone. The counselling service is seeing equal number of men and women.

CRITERIA FOR ACCESSING THE SERVICE

It is rare for a client to be refused access to the service. NAFSIYAT feel that if an individual is turned away from the service it is highly likely that they will not be seen by any other service.

Allocation meetings are held to discuss each case and an assessment is undertaken. The organisation has a policy not to work with people who are dependent on drugs or alcohol.

PRESENTING PROBLEMS

Young people, mostly teenagers, are presenting problems associated with dealing with conflicting cultures and issues around identity. Many of the young people are alone i.e. unaccompanied children and are finding it difficult to cope.

Children who are facing difficulties at school because of the trauma experienced in their early lives. Teachers often refer quite young children. NAFSIYAT will work with them and help them to work through their problems by using play therapy, art therapy, etc. There is a danger that if these children do not get picked up early on they get labelled as having learning difficulties or mental health problems.

Older refugees (over the age of 20 years) initially present very practical problems i.e. to do with housing, employment. However, after a period of time, when these needs have to some degree been met, people often look inward and want therapy to try and understand their experiences and the period of time and way of life that has been lost to them.

A significant number of people have experience of the mental health system and have been diagnosed as suffering from schizophrenia, depression, etc. There have been a number of suicides known to the organisation, which can directly be associated with the individual's refugee status, their resulting loss of personal status and not being able to cope with that loss.

It is often the case that the families of male refugees have enabled them to flee the country with the hope that they will be helped financially when they are settled. When this cannot be achieved there is an added burden on that individual which can result in psychological problems.

Counsellors see a number of people who are very ill and may even present as psychotic. A common expression of their illness is stating that they are "possessed by spirits". It is important to incorporate these belief systems in any therapy.

ISSUES

There are differences between particular refugee communities and their attitudes and awareness around counselling or talking therapies. An example of this is the Turkish community which appears to engage more readily with "talking" therapies than the Zairean community. Different approaches therefore need to be adopted depending on the refugee group being worked with.

Many people have practical problems with which they need help this need to be taken on board when counselling clients.

The service is often in the position of undertaking crisis intervention and there is a danger of overloading the service with high number of people who are experiencing severe distress.

There is a major problem with young people and alcohol and drugs, with a tendency for young men in particular to turn to drugs as a way of coping with their situation.

AIMS

The Refugee Support Centre aims to provide specialist multilingual counselling and psychotherapy service for refugees and asylum seekers and promote awareness of their psychological needs.

SERVICES OFFERED

A number of counselling sessions are usually offered after assessment. Specialist medical or psychiatric intervention can be provided if required.

All counsellors are fully qualified to at least BAC level and speak at least one other language. Interpreters are sometimes used. They all receive in house training and are often training to become counsellors themselves.

REFERRALS

GPs, lawyers, Social Services, other health professional and libraries make referrals to the service. There is a standard assessment form, which is completed for each referral. The main criterion is that the individual should have an emotional problem.

The service sees adults, not children although family work is undertaken. Unaccompanied children are not seen. (referred on to NAFSIYAT)

ELDERLY PROJECT

This was established in 1991 as the result of identified need for therapeutic provision for elderly refugees. The project works in particular with elderly women. The project lobbies on issues such as accessibility of health services to improve the well being of elderly refugees. It encourages people to speak for themselves and make decisions about matters which affect their lives.

THE COUNSELLING PROGRAMME

Most of the counsellors have been trained in counselling techniques that have a very eurocentric base. The counselling therefore has to be tailored to the individual clients needs.

All interpreters have feedback/discussion sessions after each session.

Long term counselling is offered to clients, a time limit is set e.g. three months after which progress is reviewed. The average length of time for which clients receive counselling is six months.

The elderly clients are provided with group sessions because this is what was originally requested. However any client can have one to one sessions at any time.

COUNTRY OF ORIGIN

The main groups of refugees using the centre are:

Somali, Ethiopian, Eritrean, Serbian, Bosnian, Arabs from Iraq, Algeria, Sudan and a whole group of Latin Americans from Chile and Colombia. (This is an older more established community in which the

older generations are now presenting symptoms which were previously buried because other more pressing issues such as employment, housing, etc were priority).

ISSUES

The particular characteristics displayed by people from different countries can be very different for example Ugandans tend to display emotional distress by stopping eating and drinking.

When does an emotional problem become a mental health problem? This is to some extent dependent on the counsellor's assessment.

Some users of the service have a previous history of mental illness. These clients are usually reluctant to register with a GP and are encouraged to go to hospital if the case is serious.

Refugees are often not prepared for the reality of being a refugee in a foreign country. Poor housing and bad conditions generally can often come as a shock to people who may be from quite privileged backgrounds.

Intergenerational conflicts, there is an issue concerning the change in power dynamic between children and parents. It is often the children who find it easier to learn the language and assimilate into the culture which sometimes results in a role reversal where parents are reliant on their children to access services. This can cause problems whereby parents feel out of control themselves and also feel that they are "losing" their children to an alien culture.

HISTORY

The Saheliya project was set up in 1992 as a result of research conducted by the community based mental health unit which identified a need for counselling services for black women. The organisation is a black/minority ethnic women's health project providing a safe and confidential service which supports the mental health and well being of women in Edinburgh.

USERS OF THE SERVICE

The service is women only and available to women from black and minority ethnic groups in Edinburgh.

SERVICES OFFERED

The following services are available:

- Counselling - 9 sessions are initially provided. Clients may receive counselling for as long as 18 months if necessary. The interval of time between sessions may increase and the sessions may change from counselling to support sessions. The organisation offers a total of 15 sessions per week and there is a waiting list of 4 to 8 weeks for new clients depending on the language in which they may require to be counselled.
- Group support sessions – these offer women a safe place in which they can participate in group activities or talk to other black women about their problems and receive mutual support. Activity based groups such as badminton, aerobics, yoga and tai chi are also run.
- One to one support sessions in variety of other settings e.g. hospitals, community centres, home visits.
- Complementary therapies such as massage art therapy, aromatherapy, reflexology and homeopathy.
- Befriending Scheme - The befriending scheme has been particularly well received by older women. The scheme provides training in befriending to volunteers many of whom have accessed other services provided by the organisation. Befrienders are matched in terms of language needs and may also have an advocacy role with their client
- Various therapy groups e.g. for young women to discuss particular issues of concern such as relationships, their role in society, identity.
- Transition/Learning groups – where women can learn English as a second language. A flexible/open learning scheme has also been set up with the local education college.

The counselling service on the whole tends to attract women under the age of 50 years, however younger women aged 16 to 18 years do not tend to use the service.

The service is needs led and users are involved in its development in various ways. There is an advisory group and a management group in which users are involved.

An alternative lifestyles group is also due to be set up to cover issues such as sexuality and mental health.

Saheliya has also set up training courses for women in conjunction with the local college where tutors from the college provide one to one tuition to clients at the centre. There is a crèche available and a course is also run on how to run a crèche. Training is important to users of the service as employment is a big issue for many women and gaining employment can play a key part in their recovery.

REFERRALS

Referrals are obtained from a variety of sources including social workers, GPs, hospitals, voluntary organisations, etc. Most are self-referrals who have heard about the service from other users.

The service does not work with acute cases. A good working relationship exists with the Health Authority (there is an Ethnic Minority Development worker in post) and a two way referral system is in operation which means that referrals are made by both parties and that clients receive the service most appropriate to their needs.

Clients may have a range of problems some of which may be acute i.e. schizophrenia, psychosis. In such case the counsellors would only take on clients who were on medication and stable. However, if their condition changed e.g. they missed prescriptions or refused to take their medication, the person would be referred back to statutory services.

Training/Recruitment of Black Counsellors

The service initially experienced problems when it was first set up, recruiting counsellors from black and minority ethnic communities who were appropriately trained or had the necessary experience to provide counselling. This dilemma was overcome by identifying 10 women volunteers who had the capacity and desire to train as counsellors and providing them with the necessary training.

All counsellors at Saheliya have a minimum of a diploma in counselling and experience of working for another agency. The Saheliya counsellors work to the British Association for Counselling code and receive regular support, supervision from the Senior counsellor and ongoing training both in house and from external trainers.

The staff attend a Black issues consultation group once a quarter aimed at exploring particular issues concerned with counselling and the way in which their clients' problems may affect them. This group provides counsellors with the opportunity to discuss issues raised by clients in counselling sessions such as racism, violence, abuse and acceptance and fatalism with which counsellors are presented, and the affect that this may have on the counsellors and the service they are providing.

THE ROLE OF COMPLEMENTARY THERAPIES

Complementary therapies are effective when talking therapies may not be immediately appropriate because the client is unable at that point to engage in the way required for counselling to be effective. A range of complementary therapies is offered e.g. art therapy, aromatherapy and massage. A course of six sessions is available each session lasting 45 minutes. The complementary therapies often offer women a route into accessing other services such as support groups, learning groups, etc at their own pace i.e. when they feel ready to do so. The complementary therapies are concerned with making an individual feel better physically, it is only when this is achieved that an individual can then move on to participating in something which requires effort on their part to help themselves feel better emotionally and psychologically.

The art therapy classes tend to be used mostly by younger women i.e. 16–25 years and were set up as a direct result of these women requesting such classes.

Other services such as aromatherapy, massage and the befriending service tend to be accessed more often by older women.

WHAT IS SPECIAL ABOUT THE SERVICES BEING OFFERED?

The service is run for black women by black women. This means that counsellor and client are more likely to have the same frame of reference with regard to familiar issues such as racism, pressures imposed by culture or family, etc.

The counsellors provide the clients with a positive role model. It helps that the person providing the counselling is also black and therefore the client has a positive role model with whom they can identify.

PARTICULAR ISSUES

Introducing clients to the subject of mental health has to be done sensitively because of the stigma associated surrounding mental illness or simply not being able to cope. It may be difficult for an individual to admit that they are experiencing difficulties or not coping with stress, family relationships or a change in circumstance. The subject of mental health is introduced initially, very gently through general health awareness sessions and activity based groups.

The activity-based groups are used as a method of drawing women in to the service and then enabling them to access other facilities. The activity based groups such as badminton, sewing, etc are an ideal introduction to many women because they do not rely on the women being able to speak a particular language (in any case the only common language is often broken English) or admitting that they have any other problems.

Confidentiality is still a major issue. It is often necessary to explain during the client's introductory meeting what will be offered in terms of counselling, what is meant by confidentiality, the occasions on which it may be necessary to break confidentiality, and the kinds of issues which might be talked about at counselling sessions. The senior counsellor conducts all the initial interviews and matches clients with a counsellor.

Access is another important issue. Clients may not wish to receive counselling at the organisation's premises for reasons of confidentiality and in such instances counselling can be provided in another setting e.g. community centre, health centre, GP surgery.

Racism is a common theme in many of the presenting issues. Issues such as isolation and abuse are compounded by the fact that clients also have to deal with racism in practically every aspect of their lives.

Self harm and mutilation is also an issue particular amongst women who have a history of being sexually abused.

Eating disorders are also present and various health awareness sessions have been organised on such topics.

Relationship problems are common amongst women using the service. Problems associated with mixed relationships i.e. between different religions and between black and white are also common.

(NB Saheliya's clients are not all refugees and they see a wide range of black women from different communities)

R THE BOSNIAN PROJECT (WELCARE)**Edina Fejzic – Co-ordinator****145 High Road
Willesden
London NW10 2QJ****Telephone No. 0181 459 2278****BACKGROUND**

The Bosnian Project is one of the projects run by Welcare Community Projects. **The Welcare Community Project** was started as a church based organisation for single mothers **was called Brent Welcare**.

In 1992 work with refugees began. In 1997, the post of Bosnian Project Development Worker was created. (The project did employ a mental health social worker, qualified in psychotherapeutic work, but the funding has now expired for this post).

SERVICES

The **Mosaic Centre** is going to set up advice sessions and group work with different refugee groups.

The current service provides counselling and therapy in a non direct way i.e. through play for children and tea and coffee mornings and drama workshops. The co-ordinator is currently seeing refugee children, Bosnian women, a mixed group of elderly clients and a Bosnian Youth group.

SERVICES FOR REFUGEE CHILDREN

An art group exists where children can express themselves through painting and drawing. The parents may also attend this group with their children. A volunteer artist works with the groups (children aged between 8-12 years). Six children currently attend the group. Other activities in the group include writing poems, doing homework.

BOSNIAN YOUTH GROUP

Young people using the service wanted more activity based work. They are currently rehearsing a play which covers issues such as identity, fears, etc

The group focuses on issues such as the value systems in different cultures, looking at **Bosnian** ways of coping. The group reinforces culture and members tend to speak in Bosnian, write in their own language, etc

BOSNIAN WOMEN'S GROUP

This group focuses on preserving handicrafts like sewing and lace making. The purpose of the group is to exchange ideas, recipes, patterns, etc. that have been in families for generations and have never been written down. This itself is therapeutic to a lot of women. There is a sense of “they couldn’t get to my brain” – even though they may have been through terrible experiences, there are aspects about their previous way of life that will never be taken away. The women **show** their products at fairs, etc.

ELDERLY GROUP

This group comprises mostly Bosnian men who are all detainees from two main concentration camps. All the members are aged between 50 and 65 years and have many health issues relating to pain from torture, arthritis, etc. There are two women who regularly attend the group. Initially all these people were being seen individually. Now they are mostly seen as a group with one to one sessions if needed. The groups cover issues such as “how to enforce culture” setting up social clubs etc. Once a month there is a social event. Once a week the group meets to talk about their experiences and also share “what it is to be a refugee in England” and provide support for each other.

Mental health problems are explained to the group as a normal reaction to the experiences they have been through. Everyone in the group has lost at least one member of their family in the war.

ISSUES

Many of the older members feel that they would like to go back to Bosnia and there is a reluctance to learn the English language. English classes **will be held from September** and members are more likely to come to these than go to education classes in a college.

The service tries to explain to members what is meant by counselling. The Refugee Action Project is **monitored by** a Bosnian coffee group which provides a low level of therapy/informal counselling as people feel they can legitimately talk through their problems at such a gathering.

In Bosnia psychology is a recognised profession. There are mental health centres and psychiatric hospitals catering to the needs of people with mental health problems. However, they tend to cater to individuals who are at the more severe end of the spectrum. It is unusual for people to receive counselling in the Western way to work through everyday issues. It is usually only provided as a treatment for quite severe tangible trauma.

The concept of psychiatric therapy is more familiar amongst more educated people.

Casework with clients is undertaken. If more serious problems present referrals are made to the Traumatic Stress Clinic or a bereavement project based in Brent. All the group work provides supportive counselling in a safe environment.

Clients are sometime referred on to **the Mental Health Teams** for assessment when it is felt necessary to do so. One person has been sent on for specialist counselling services because he was afraid to talk about his problems and needed more specialist help. Most people do not want to be perceived as needing in depth help. On the whole it is difficult to refer people on for specialist help. Most GPs just look at the physical condition and tend to prescribe. 25% of all members are on anti depressants.

BACKGROUND

The Chinese users of the service are mainly from rural areas and speak Mandarin not Cantonese. There has been an increase of users from Hong Kong since the handover.

The organisation has commissioned a National Survey on the mental health needs of the Chinese community which will be featured in the Journal of Public Health and is due to be completed in the near future. The survey included interviewing commissioners, purchasers, and directors of Social Services, community groups, and voluntary groups. A screening questionnaire was used which scored people on their mental health status. Those who scored positively were asked to participate in a more in depth questionnaire. The six largest concentrations of Chinese communities were focused upon. A total of 410 people participated in the general questionnaire, 74 participated in the in depth study.

MAIN FINDINGS

There are a large number of Chinese people who suffer from schizophrenia, depression and psychosis.

Many people were on medication and were experiencing side effects; did not have much information on their treatment but continued the treatment. Problems with language and not being able to explain their position to health professionals were given as the main reason for this. There was also a blind faith and respect for the medical profession amongst the Chinese community which means that it was not thought appropriate to challenge authority.

THE RESOURCE CENTRE

The aim of the centre is to assist the Chinese community to access mainstream health services through linkage with interpreters, registration with GPs, health promotion and other preventative work. The centre is also due to set up a national carers centre which will provide a range of services including advice and information, a drop in facility, counselling, training and education.

The objectives of the mental health project are to link together professionals working in the field of mental health which will ensure that an effective referral system exists and that services are accessed more directly. The Chinese Resource Centre is aiming to develop counselling services. This will be done in conjunction with The Marlborough Centre (which already has two Chinese speaking counsellors). The Resource Centre will refer clients to the service.

There is very much a stigma in the Chinese community attached to mental health. The subject of mental health has to be approached sensitively and counselling needs to be provided in an informal manner.

PRESENTING PROBLEMS

The following problems are presented by the Chinese community:

- Feelings of isolation and loss of links with family in Hong Kong and China. There are also a significant number of people from Vietnam.
- Issues of identity particularly for the younger generation. The survey did not cover Chinese people under the age of 18 years so the findings of the survey may not reflect this issue as it is mostly this age group that suffer from problems with identity.

BACKGROUND

This project was established as part of Islington's Crisis Intervention Scheme (see case study A). The post holder works part time three days a week specifically on mental health but also undertakes health advocacy generally. She was a surgeon in Somali, trained in a abdominal surgery and also did some training on mental health issues and counselling

TYPICAL USERS

She sees mostly younger people (including single mothers). Many of the single mothers are having problems bringing their children up. Depression is the most common diagnosis. She helps with diagnosis in mental health units including one female client who refuses to talk to doctors

Typical tasks include assessment of clients which may lead on to counselling. Depending on the severity of the problem she may refer on to specialist agencies. She will also try to sort out practical problems.

PRESENTING PROBLEMS

The main presenting problems include PTSD, acute depression and some users with psychotic problems. She has 6 or 7 schizophrenic users on her caseload and has worked with 21 clients in last 6 months

CAUSAL FACTORS

Key determinants of mental ill health include:

- lack of family members
- fear of being returned home
- concerns about legal status

Most clients are not working and it is noticeable that when they are working there are less problems

ISSUES

Counselling is very unusual in their culture and most users will be unfamiliar with the approach. A strong element of advice is required. Many users and their families are not clear about in between shades of mental health like depression. Users are worried about automatically being labelled as schizophrenic.

She estimates that 20 young Somali men have committed suicide. There is very little suicide in Somali

Women in particular often do not like taking medication and report side effects like their periods having stopped.

SUBSTANCE MISUSE ISSUES

Khat is not regarded as a drug. Its use is very common. There are also some cases of alcohol misuse and a few users are drinking very heavily

SERVICES PROVIDED

The Islington Zairean Refugees Group (IZRG) runs a range of front line services and activities around the following projects:

- Community Development (Welfare benefits, housing, referral on immigration issues, women issues etc)
- Health(HIV/AIDS Prevention, Primary Health care, Mental Health)
- Education and Training (Mother Tongue classes for children, ESOL and IT courses for Adults).
- Elderly support and advice

The health projects are serviced by two staff namely:

- HIV/AIDS Prevention Worker.
- Crisis Intervention Worker. (Mental Health)

CRISIS INTERVENTION PROJECT

The role of the Crisis Intervention Worker is to work with people who have mental health problems and with families in crisis

Overview of Mental Health Problems

These are mainly associated with worries around immigration status and poor housing (particularly overcrowding in bed and breakfast accommodation). Depression is the main presenting mental health problem. The majority of clients are women. They are currently seeing 12 clients of whom only two of are male. Five people are linked into hospital services. Two are in the psychiatric unit at Whittington hospital.

Many families approach the crisis intervention worker because of problems with their children. The worker states that some families have fostered other people's children because the parents are unable to cope and because the children do not wish to remain with their parents.

In cases where more specialist mental health work is needed the worker contacts Nafsiyat for counselling services. This is not necessarily a popular form of treatment.

ISSUES

There are problems in terms of cultural attitude towards people with mental health problems – there is still a lot of stigma attached. Many of the clients are on medication. Counselling and talking therapies are not really perceived as useful by clients.

Poor housing is seen as a major cause of mental health problems, secondary problems include uncertainty around immigration status and general poverty and lack of access to welfare benefits.

BACKGROUND

The LAWRS has been operating for twelve years providing advice and information to Latin American women who have often been here since the 1960's. Advice is provided in areas such as immigration, health, domestic violence, housing etc. The counselling service is a part of this service and has two counsellors and another two waiting to join.

There are approximately 70,000 Latin American people in London. Many do not engage with the establishment because of their immigration status. This population is made up of a combination of immigrants and refugees. Refugees take a 'moral' high ground against economic refugees.

PRESENTING PROBLEMS

Most women who approach the service are in crisis with problems such as depression, post natal depression, low sense of self-esteem, loss of cultural identity. Post Traumatic Stress Disorder is reasonably common mostly affecting people from Columbia, Equador and Peru. Symptoms include recurring nightmares, anxiety.

Some women have been admitted to Mental Health Units in connection with experiences of sexual violence, torture, etc. Second generation women face issues such as intergenerational conflict, cultural conflict. Young women often get pregnant to escape family pressures and get 'thrown out of home' so they can live independently.

THE COUNSELLING APPROACH

With women in particular there are often issues to do with getting their complete story for immigration purposes. Women may find it difficult to divulge the whole truth about what they have been through.

The models of counselling used, such as psycho dynamic and person-centred, work well with their clients and facilitate the understanding of situations where there appears to be obvious conflict e.g. a woman who is experiencing domestic violence having as her main goal, to make her marriage work. Group counselling is not held because this is not something that is culturally acceptable i.e. to expose your vulnerabilities in a group setting.

Alternative and complementary therapies are very popular and, in particular, massage, aromatherapy, homeopathy. Herbal remedies are also popular and include remedies for reducing depression, lemon verbena (calming, reduce anxiety), mint tea,.

ISSUES

In the 1970's there was an influx of political refugees. More recent refugees are from countries like Equador, rural communities who have been caught in the crossfire of civil war. These people are very different from previous refugees i.e. uneducated. They may not even have been to their own capital city and then find themselves in London.

Counselling has to be intuitive. How do you know what people believe?

Most of the people seen at the counselling centre are very spiritual, can be described as 'saintist' they believe in good and bad and have a "collective unconscious" the counsellor needs to understand this. There are saints for hopelessness and lost causes e.g. alcoholics. The therapist is often seen as the 'little angel'. There is a saint for hopeless cases!

HISTORY

The organisation was set up in 1992 to provide advice, information and support to the Somali Refugee community in West London (Kensington, Chelsea and Westminster). The local Somali population is estimated at between 1500 to 2000 people.

The work is focused on welfare benefits advice, housing health education and employment. In 1994 a Health Project was set up. A Family Support Worker was employed to undertake out reach work with elderly, disabled and mentally ill clients.

The two main groups that need help are young people and women. The women traditionally do not seek help, the men tend to rely on the women.

YOUNG PEOPLE

A Youth Project has also been set up as there was a need to develop a specific service for young men in particular who had originally entered the country as unaccompanied children, or young people who were isolated and did not have any contact with family. Many of the younger men are very frustrated, have language difficulties and low self-esteem. They are often living in poor quality bed and breakfast accommodation. There only escape from boredom may be chewing qat and some do this all night long, sleeping through the day.

A worker is employed to focus on issues affecting young people such as housing, employment, etc. One project is to train ten youth advocates to work with their peer group providing support and encouraging them to get involved in training etc.

The Youth Project also focuses on equipping men with life skills such as cooking, shopping, cleaning, etc which may be alien to them and certainly not something they would have had to do in their own country.

WOMEN

Most Somali women in this country are single parents (their husbands are either missing or dead). SWA estimate this could be as high as 70%. Many are illiterate in Somali, have very limited knowledge of English and may have never previously left their country. Large families are common and women may have 7-8 children to look after. Few will know anything about claiming welfare benefits and accessing health or education services.

Breakdowns are common. Few of these women will go to a doctor or a hospital for a checkup without encouragement from a worker. There have been a number of examples of children being taken into care and SWA are also aware of a high number who have been admitted to mental health units

OLDER PEOPLE

The elderly project runs a luncheon club every week. The club also functions as a much needed drop in centre and social club which prevents people feeling isolated and provides a space where they can raise issues of concern.

MEN AND ADDICTION TO KHAT

There are high levels of suicide amongst male Somali refugees. This has been linked to the use of khat and the long term psychological effects it has on users.

Khat was banned from use in Somalia in the late seventies and early eighties as it was becoming a major problem and causing family breakdowns and economical difficulties. In the UK it is both men and women who are chewing khat. The percentage of women is still low and usage is probably hidden.

In addition to using khat, use of other drugs such as alcohol, cannabis, etc is also on the increase. There is a sense of disillusionment resulting from having escaped the horrific conditions of civil war and their expectations of their host country not being met. There are cases of men not eating properly and a growing incidence of TB.

COUNSELLING

Many people have been through horrific experiences, which no doubt have taken their toll in terms of psychological damage. However, most refugees are more concerned with receiving practical help than engaging in “talking “ therapies”

One of the issues in terms of the responses from professionals is that any problem experienced by a refugee is automatically attributed to their past trauma and not to their current situation which may be pretty traumatic in itself.

MENTAL HEALTH

Ealing Hospital and Charing Cross Hospital are full of refugees in their psychiatric wards. Some are there because of misdiagnosis due to language problems. There have been horrific cases where children have been wrongly taken into care and where legal action has been taken against people or benefit stopped because they have not responded to correspondence, which they could not read.

The Somali Welfare Association sees a significant number of clients who have mental health problems. One way of engaging these clients (which needs to be done in a sensitive way because of the stigma attached to mental health) is to talk with them about the services that they can access and the help that they can receive if they face up to the problems that they have.

BACKGROUND

Refugee Action is mostly involved with clients during their resettlement period. During this time people are more concerned with obtaining material possessions, getting a job and establishing themselves in society. Mental health is very much neglected unless it is an extreme problem. People are usually highly motivated to get housed, obtain employment, ensure that their children are schooled, etc. After a period of two to three years mental health problems may emerge because other aspects of their lives are stable. Refugee Action was, therefore, involved in setting up a Bosnian Project to respond to these mental health needs.

THE BOSNIAN PROJECT

The aim of the project was to look at ways of mobilising the community and mechanisms that could be employed to do this.

The project workers contacted several community groups around the country and worked with the “leaders of opinion” (community leaders). These groups were set up in conjunction with community associations to test out what worked. Expertise was also brought in, in the form of external consultants (Bosnian or Bosnian speaking) trained in mental health or actually mental health professionals. There were also representatives from Refugee Action.

Two approaches were used in running the groups:

1. Informal therapy groups were set up which employed traditional methods of bringing people together e.g. coffee talks. Bilingual counsellors formed part of the group.
2. Approaching leaders of opinion i.e. community leaders. Medical professionals and representatives from Refugee Action provided basic training looking at the mental health system, symptoms, etc. for community leaders as a route into educating the communities themselves.

REFERRALS

Most of the clients seen by the project had been in detention centres in the UK and although the concept of therapy is not totally alien, it is still viewed with suspicion.

Their immigration status or uncertainty regarding it can contribute a great deal to mental health problems.

PRESENTING NEED

There have been a number of cases of Post Traumatic Stress Disorder.

Work with younger people aged 13-17 years indicated that they were more concerned with the future and so activity based therapy was used as a channel to address difficulties. With older people there was a more obvious focus on the past, with the need for a time of transition and adaptation to a new environment.

There appear to be two distinct ways in which people react to having been through traumatic experiences:

- Those that acknowledge that they have a problem and recognise they need help

- Those that don't acknowledge that they have any problems and in fact feel that because they have experienced such extreme situations as torture, war, etc and survived, that there is no reason for them not being able to cope after the event.

In Bosnia there used to be an established health service and some mental health concepts are known. However they are used differently and mental health services in particular tend to be accessed only in more extreme cases. There isn't much "middle ground" counselling. Counselling was not available generally and was not a recognised profession. However, it was always available for people who had been through traumatic situations such as car crashes as part of their treatment.

USING INTERPRETERS

Counselling is mostly conducted through an interpreter. Issues that need to be considered are:

- The level of training the interpreter has received in mental health issues.
- The level of trauma and experiences of the interpreter themselves, this is a particular issue if the interpreter is from the same community as the client and has maybe had some similar experiences to the client which they are still dealing with.

ISSUES

The reception centres should be more geared towards providing services around mental health and being able to pick up mental health problems earlier, before the individual develops more serious problems.

OUTCOMES

As a result of this project, there was an increase in the numbers of people wanting to become involved in mental health services i.e. approaching NAFSIYAT, etc to train as counsellors, etc. This in turn resulted in more referrals being made to health services.

APPENDIX ONE: ACCESS TO THE NATIONAL HEALTH SERVICE FOR REFUGEES AND ASYLUM SEEKERS

Introduction

Despite the restrictions on access to many services introduced through the Asylum and Immigration Act 1996 there has been, to date, no change in refugee or asylum seeker access to the National Health Service which is essentially the same as for any indigenous resident except in one respect which will be explained later.

Refugees, asylum seekers and those with exceptional leave to remain (ELR) are exempt from charges for medical treatment under the NHS. This is set out in Health Circular HC (82) I5 paragraph 20, and updated in Statutory Instrument No 306, NHS (Charges to Overseas Visitors) Regulations 1989 which offers guidance on circumstances in which an overseas visitor is liable to pay for treatment.

A person who has been accepted as a refugee, or who has documentation to prove that he/she has applied for refugee status, can be treated under the NHS. The spouse and any children (up to the age of 16, or in a UK school up to age 19) are also exempt. The documentation, should it be required, can be obtained from HM Government, a solicitor or from a recognised voluntary organisation such as the Refugee Council.

Registration with a General Practitioner

All refugees or asylum seekers have the right to be registered with a General Practitioner (or family doctor) free of charge. They can also receive NHS medical prescriptions for medicine and can be registered with a NHS dentist and optician (for all of which there is a charge unless the patient is in receipt of welfare benefits or has an exemption).

The GP has the right to decide who to take on to their lists. They are, however, expected to treat refugees, asylum seekers and those with exceptional leave to remain as NHS patients.

When registering, it is likely that a refugee will be asked what his/her immigration status is, although it is not necessary to show any documentation other than an official document showing their address. There is no requirement to show official documentation when registering with a GP.

Some practices, however, may be unwilling to register an asylum seeker or refugee without some form of Home Office letter. It is important to note that the practice has no right to demand to see a passport before agreeing to register a person.

Hospital services

Refugees and asylum seekers have the right to use all Accident and Emergency, Maternity and In-Patient and Out-Patient services. In other words they have free and comprehensive access to the whole range of services.

The only statutory check on access to the NHS applies when accessing hospital services, such as a waiting list for an operation, and is in the form of three simple questions relating to length of time in the country and intention to stay permanently. This registration procedure to determine free entitlement applies to everyone, not just refugees and asylum seekers, although it is not clear how consistently it is implemented around the country.

The three questions are:

Have you been living in the UK for the past 12 months?

On what date did you arrive in the UK?
What is the basis of your stay in the UK?

As refugees are in the UK for the purpose of settlement there should be no problem in providing answers which establish free eligibility to the NHS. Where further confirmation is needed the documentation listed in the previous section will suffice.

Funding of services for refugees

With regard to the funding of any treatment, whether it is with a GP, in a hospital or another NHS facility, this is the responsibility of the Health Authority of residence, except in the case where the GP is a GP Fundholder who funds all treatment from any health services for their patients from their own budget. Thus, refugees, asylum seekers and those with exceptional leave to remain have the same rights and access to services as the indigenous population and there is no special funding from the Home Office or anywhere else.

Changes for those no longer receiving Income Support

Those no longer able to access benefits following the introduction of the Social Security (Persons from Abroad) Miscellaneous Amendment Regulations 1996 after 5th February 1996 (which was later incorporated into the Asylum & Immigration Act 1996) will only be able to qualify, exempt from charges, for free medical prescriptions; dental treatment and checks; sight tests and "full-value" vouchers for glasses fares to hospital for NHS treatment by obtaining an HC2 exemption certificate. This is done by completing an HCI form. Affected asylum seekers will not, however, be able to obtain free baby milk and vitamins and free school meals.

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APPENDIX THREE:

CVS Consultants was established in 1989 as a policy, research and consultancy unit. We now have ten years experience primarily in the fields of social care, health care and housing. CVS provides high quality consultancy services tailored to meet the specialist requirements of individual agencies. Staff have a range of expertise including skills in service development planning, knowledge of service delivery issues and financial management and accountancy skills. CVS has provided management support and training for over 250 charities and other voluntary organisations in the UK.

CVS has also undertaken a considerable number of research projects ranging from needs assessments, to large regional and national studies which have a wide impact on operational policy. A wide range of publications have been produced. Some of these are technical guides to help agencies gain a better understanding of complex legal, financial and management issues and others are intended to influence policy and promote good practice. Included in this are two reports for the Department of Health on physical disability and learning difficulties.

The CVS philosophy of working is firmly based on the transfer of expertise to enable voluntary sector agencies to improve their skill base and organisational capacity. We have a strong record of working with black and minority ethnic community organisations in the UK and have undertaken over 100 projects for such groups.

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APPENDIX FOUR:

THE MIGRANT & REFUGEE COMMUNITY FORUM

The forum was formed in 1993 and is a strategic alliance of voluntary organisation working with migrant and refugee communities in Kensington & Chelsea.

Presently 30 organisations serving 17 migrant and refugee communities in the borough are members of the Forum. The member groups have come together to meet the common needs of their communities.

The Forum's ethos is Community Development and its work programme reflects it through the diverse provision of services, event activities, participation and facilitation, the centre resources, and networking activities and liaison.

The aims and objectives of the Forum are to:

- Strengthen migrant and refugee organisations to deliver effective services to their communities and form productive partnership with statutory and independent agencies
- Identify and articulate the needs of communities to policy makers and service planners
- Create joint activities between migrant and refugee organisations and develop shared services in response to the needs of their communities
- Build partnership with statutory and voluntary organisations to ensure access by minority ethnic communities to basic services and establish supplementary services where needed e.g. advice & counselling, education, training, and women's services
- Manage a Resources Centre for migrant and refugee communities
- Facilitate cross cultural understanding and integration on the basis of cultural diversity

The main activities of the Forum are:

- Community Development
- Organisational Development/Capacity Building
- Resource Centre Management – shared Offices, computers, meeting rooms, information resource materials
- Information
- Advocacy, lobbying, representation
- Cultural & Arts Events
- Projects: African Women's Health
Advice Training Programme
Vocational Guidance Training Programme

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