'Unheard voices': listening to Refugees and Asylum seekers in the planning and delivery of mental health service provision in London.

A research audit on mental health needs and mental health provision for refugees and asylum seekers undertaken for the Commission for Public Patient Involvement on Health (CPPIH).

Researched and written by David Palmer & Kim Ward

For information contact: david@mrcf.org.uk

Commission for Patient and
Public Involvement in Health

London Region
Ground Floor
163 Eversholt Street
LONDON
NW1 1BU

T: 0207 788 4900
F: 0207 788 4988

Contents

List of tables		3
Acknowledgements		4
One	**Introduction**	5
	Context:	
	Key concepts and issues	10
	Mental health of refugees and asylum seekers	17
Two	**Research**	
	Methodology	22
	Findings	27
Three	**Good Practice Guide**	
	Emerging themes and priorities	46
	Partnership working	47
	Working holistically	50
	Accessibility and Engagement	55
	Cultural sensitivity and understanding	59
	Care provision	64
	Evaluation, consultation and planning/funding future services	66

SUPPLEMENTARY SECTION: Mental health provision for asylum seekers detained in Immigration Detention Centres. 68

Appendices:

1: Interviewee information
2: Questionnaires/topic guides
3: Information on Advocacy
4: Alternative treatment options
5: Consultation event

Bibliography

List of Tables:

Table 1: Health Entitlements for Refugees and Asylum seekers 13-14

Table 2: Service users: demographic data 27

Table 3: Service users: range of difficulties experienced 28

Table 4: Service providers: organisation data 36

ACKNOWLEDGEMENTS

The research for and writing of this study was undertaken by David Palmer with Kim Ward. The project was very much assisted by the advice of a steering committee consisting of:

Rosie Newbigging – London Region CPPIH
Mike Loosley - South London and Maudsley MH PPIF
Maurice Hoffman - Central and North West London MH PPIF
Judy Lever - Hillingdon PPIF
Doplih Burkens and David Hindle - Barnet, Haringey and Enfield MH PPIF
Jane Barratt, Ruth Appleton and Karen Clark - Camden and Islington MH PPIF
Nick Nalladorai - South West London and St George's MH PPIF

In addition to some of the above, the following people also contributed to the consultation:
Maureen Brewster - Voluntary Action Camden
Nursel Tas – Derman
Puck de Raadt – the bail Circle/Churches Commission for Racial Justice

We would like to give thanks to the following organisations who participated in the study:

Derman
Ethiopian Health Support Association
Health Support Team, Lisson Grove Health Centre
Iranian Association
Kurdish Association
Migrant Refugee Community Forum
MIND in Harrow
Refugee Support Service
Traumatic Stress Clinic
Vietnamese Mental Health Service

A special thank you to the *St. Pancras Refugee Centre* for assisting with the study and for allowing access to service users.

Thank you to all the service users who participated in this research, for supporting the project and for sharing so much information. Confidentiality has been maintained.

A big thank you to Deborah Haylett and Finn, Ermias Alemu, Sasha Rozansky and Mahi Salih and Ben Gatty of Islington Metamporhis and Paul Burns of Mind in Harrow for advice, support and so much patience.

If wish to make any comments on this report, please contact david@mrcf.org.uk

PART 1: INTRODUCTION

Research into the mental health needs of asylum seekers and refugees has shown that they are likely to experience poorer mental health than native populations[1] and are amongst the most vulnerable and socially excluded people in our society.[2] In terms of known factors that might predispose an individual to develop mental health issues, including serious and enduring problems, refugees are a group with high indicators of mental health need. Refugees are likely to have experienced war, persecution or inter-communal conflict, resulting in multiple losses including: family, friends, home, status and income.[3] Reports have also highlighted the continued difficulties this group may experience in exile.[4] The Department of Health has identified Post Traumatic Stress Disorder (PTSD) as the most common problem amongst asylum seekers and refugees and has also reported that because of these mental health issues the risk of suicide amongst asylum seekers and refugees is raised in the long term.[4] However, PTSD is controversial and has been criticised for not taking in to account the ongoing difficulties of individuals; for focusing too much on a limited range of reactions; for undermining traditional coping strategies; and for ignoring the role of culture in shaping meaning.[5] Whilst recognizing the limitations of PTSD as a diagnostic category it is not the aim of this guide to specifically add to this discourse.[6]

Researching the mental health needs of Refugees and Asylum seekers

In recent years interest in the provision of mental health services for refugees and asylum seekers in the UK has increased.[7] Previous research conducted for the Commission for Public, Patient Involvement in Health (CPPIH) demonstrated the lack of service provision

---

[1] Tribe, R. (2002) Mental health of refugees and asylum-seekers. *Advances in Psychiatric Treatment*, **8**, 240–247.
Burnett, A. and Peel, M. (2001) Asylum seekers and refugees in Britain. Health needs of asylum seekers and refugees. *BMJ*, **322**:544-547

[2] Ibid.

[3] Warfa, N. and Bhui, K.(2003) Refugees and mental health care. *The medicine Publishing Company Ltd*. pp26-28

[4] Burnett, A. and Peel, M. (2001) Asylum seekers and refugees in Britain. Health needs of asylum seekers and refugees. *BMJ*, **322**:544-547
Burnett A, and Peel, M. (2001). Asylum seekers and refugees in Britain: The health needs of survivors of torture and organized violence. *BMJ*, **332**: 606-609
Carey-Wood, J., Duke, J., Kar,V. and Marshall.T. (1995). *The settlement of refugees in Britain*. Home Office Research Study 141. London: HMSO Books.

[5] Burnett A and Thompson K. (2005) Enhancing the psychosocial well-being of asylum seekers and refugees. In Barrett K, George B (eds). *Race, Culture, Psychology and Law.* California: Sage Publications.

[6] Eastmond, M. (1998) Nationalist discourses and the construction of difference: Bosnian Muslim refugees in Sweden. *Journal of Refugee Studies*, **11**, 161–181.
Gorst-Unsworth, C. and Goldenberg, E. (1998) Psychological sequelae of torture and organised violence suffered by refugees from Iraq. *British Journal of Psychiatry*, **172**, 90–94.
Kirmayer, L. and Young, A. (1998) Culture and somatization: clinical, epidemiological and ethnographic perspectives. *Psychosomatic Medicine*, **60**, 420–429.
Summerfield, D. (1999) A critique of seven assumptions behind psychological trauma programmes in war-affected areas. *Social Science and Medicine*, **48**, 1449–1462.
Summerfield, D. (2001) The invention of post-traumatic stress disorder and the social usefulness of a psychiatric category. *BMJ*, **322**, 95–98.
Tribe, R. (2002) Mental health of refugees and asylum-seekers. *Advances in Psychiatric Treatment*, **8**, 240–247.

[7] Burnett, A. and Peel, M. (2001) Asylum seekers and refugees in Britain. Health needs of asylum seekers and refugees. *BMJ*, **322**:544-547
Burnett A, and Peel, M. (2001). Asylum seekers and refugees in Britain: The health needs of survivors of torture and organized violence. *BMJ*, **332**: 606-609
Burnett A and Thompson K. Enhancing the psychosocial well-being of asylum seekers and refugees. In Barrett K, George B (eds). *Race, Culture, Psychology and Law.* California: Sage Publications.

available to Refugees and Asylum seekers within London.[8] Only five of the 11 mental health trusts in London provided specialist services that were specifically designed with the needs of refugees and asylum seekers in mind. However, some trusts provide generic trauma services of which around 50% of their clients were refugees and asylum seekers. PCT (Primary Care Trust) specialist services for refugees and asylum seekers were very difficult to locate. Equality and diversity managers were often unaware of individuals or departments with a special responsibility for refugees and asylum seekers. Some commissioning departments also seemed to be unaware of services that the PCT itself was funding. It was also very hard to locate individuals, such as health visitors, whose remit was to work with refugees and asylum seekers but who were not attached to a particular specialist team.

With the exception of a handful of PCT's, there appeared to be a general lack of awareness that refugees and asylum seekers are a group with distinct, multiple and complex needs that requires specialist knowledge on the part of professionals and others working with them. The research found only a small number of specialist organisations outside the NHS that provided culturally appropriate services to this group.

This research provided important findings for practitioners and mental health commissioners. Other research has also highlighted that access to appropriate treatments may be less frequent for refugees.[9] The issues are manifold and most seem to be fundamentally related to a lack of mutual understanding of mental health care needs and how the services designed to meet those specific needs are organised and accessed. Discrimination on the basis of cultural differences, as a factor that contributes to exclusion from and non-use of mental health care services for refugees, is a wider current area of interest for those working with or providing health and social care to this group.

The growing body of research on the challenges presented to mental health services by refugee and asylum seeking populations is increasingly necessary, however, such research focuses mainly on organisational or institutional processes rather than user perceptions and beliefs concerning health care. Very little is known about refugee and asylum seekers user involvement in mental health services and the impact on the accessibility to care among this user population. The experience of the refugee service user in mental health is conspicuous by its virtual total absence from research and the few studies dealing with black and minority ethnic experience of mental health do not specifically refer to refugees or asylum seekers.[10]

Limitations

It is necessary to acknowledge the limitations of this study. The timescale for the completion of the research, including writing up, was 11 weeks in total. This inevitably impacted upon the availability of many interviewees. A total of 31 interviews were undertaken. It could be contended that the information gained from such a small sample cannot be generalized to a wider population of asylum seekers and refugees. However analysing the specificity of different individuals is seen as significant and the views and opinions will hopefully allow

[8] Ward, K. and Palmer, D. (2005a). *Mapping the provision of mental health services for asylum seekers and refugees in London*. London: Commission for Public Patient Involvement in Health

[9] Tribe, R. (2002). Mental health of refugees and asylum seekers. *Advances in Psychiatric Treatmen,* **8**: 240-247.
Warfa, N. and Bhui, K.(2003). Refugees and mental health care. *The medicine Publishing Company Ltd*. pp26-28
Watters, C. (2001) Emerging paradigms in the mental health care of refugees, *Social Science and Medicine*, **52**, 1709-1718.

[10] Barnes,M and Bowl, R.(2001) *Taking over the Asylum*. Basingstoke, Palgrave.

for some level of exploration on mental health and service provision for the wider refugee and asylum seekers population.[11]

Why this research is innovative

This research intends to provide an insight into the views of potential and actual service users. It also explores the views of service providers including community groups and the voluntary sector, and the priorities of commissioners in order to draft a good practice guide on mental health provision for asylum seekers and refugees.

- The purpose and structure of this research is highly innovative, primarily as it begins to redress the balance between service provider and user by prioritizing the user perspective.
- The practical relevance of this study is also significant. The NHS is confronted with the need to organise accessible, adequate health care for culturally diverse populations. This is not only a question of human rights, but also a pragmatic necessity for the proper allocation of resources.
- In terms of broader, long-term implications, health care provision for refugees and asylum seekers is in its infancy and there is a great need for research studies, such as this, with the users' perspective as key, which can guide its development.

This research indicates that all professionals involved in the planning, delivery and funding of services need to acknowledge the range of problems and issues experienced by those living in exile. By taking a wide perspective of mental health needs, providers can plan intervention, which takes account of the multitude of practical, social, cultural, economic and legal difficulties, which can act as contributing factors to the long-term mental health of refugees and asylum seekers. The fundamental challenges faced by service providers in the mental health and social care sector is to incorporate the views, and whenever possible the users themselves in the planning and delivering of services.

Ultimately the aim would be for adequate long term funding being available to refugee and asylum seekers self-help, community and voluntary sector organisations in order for them to deliver local services to local communities. Treatment and service options would therefore be more easily controlled and chosen in accordance with the context of refugee and asylum seekers lives and therefore the actual needs and choices of the individual. This approach requires a truly radical re-organisation potentially encompassing changes not only in healthcare but in welfare, housing, employment and immigration policy. Local community groups, ideally managed by committees containing members with first-hand experiences of the pre and post migratory realities as well as experience or knowledge of the mental health system, are well placed when compared to large monolithic government organisations to understand and meet local refugee needs, offering and delivering alternative and more appropriate options.

[11] Holloway, W (1989) Subjectivity and method in Psychology: Gender Meaning and Science. London: Sage

How the guide works

This guide is intended for use by a wide range of stakeholders. The guide will be useful for health providers, service users, local authorities and other key statutory and voluntary agencies in the development of inclusive, evidence based services that meet the needs of refugees and asylum seekers. Specifically, it is intended to be a useful reference for interested and relevant parties to gain an understanding of the mental health needs of this group and an aid to the development of strategies to improve mental well-being,

The guide has been organised into three main parts.
PART ONE is the INTRODUCTION. This includes an outline of the CONTEXT and main themes, the motivation and purpose of the study - the why and how.
PART TWO is THE REASEARCH - METHODOLOGY and FINDINGS.
PART THREE is the GOOD PRACTICE GUIDE - the recommendations.

The basic structure is as follows:

PART 1: The introductory section provides information on the main themes in research on refugees and mental health and establishes the importance of the research undertaken for this guide.

It also provides a context to the discourse.
This context is extremely important as it establishes and explains the main concepts and issues. Research is never carried out in a vacuum, it is important to provide as much relevant information to contextualize findings and to ensure that the complexity of the situation is fully represented and understood.

The CONTEXT is organised in two sections. Firstly, it includes an explanation of the key concepts and issues, which are

- Mental illness
- Access and user involvement
- Service providers
- Legal Status and Entitlements
- Attitudes: Public and the Media
- Political and Legal context
- Health entitlements

Secondly, a more comprehensive explanation of the central themes concerning the mental health of Refugees and Asylum seekers follows. This section makes specific reference to the importance of acknowledging and responding to pre and post-migratory experiences as contributory factors in mental health. It also includes a section on the response of transcultural health care and the specific relevant government policy related to mental health service provision for this group.

PART 2: The next main section is THE RESEARCH; this is also presented in two sections.
The first part provides an outline of the METHOLOGY and the following section provides an analysis of the FINDINGS from the interviews undertaken with service users, providers, a refugee community forum and a commissioner.

The first part of this section is the METHODOLGY.

What we cover here is:

- Research framework
- Literature review
- Qualitative study
- Topic guide development
- Sampling and recruitment
- Consumer involvement
- Ethical considerations

The FINDINGS section is a key part of the guide as it represents the user perspective, much of it in their own words, and provides the shape and themes for the good practice guide. These themes are:

- **Partnership working – statutory, refugee and voluntary sector community groups: Addressing social care needs by working holistically – combating social, economic and political factors**
- **Accessibility and engagement – Advocacy, befriending, and user participation in service planning and delivery**
- **Cultural sensitivity and understanding – perception, stigma, language, education and training**
- **Care provision – Talking therapies, alternative therapies, user-led services and possible solutions**
- **Evaluation, consultation and planning/funding future services**

PART 3: The GOOD PRACTICE GUIDE is the last section.

This provides a discussion of the main themes as they emerged in the service user interviews (as listed above in the 'Findings' section). It breaks the themes down into manageable parts so as to provide an accessible resource for stakeholders. A fundamental part of this section are the recommendations as these provide practical information and possible solutions to meeting the mental health needs of refugees and asylum seekers in London.

There is also a supplementary section at the end of the Good Practice guide entitled: '**Mental Health provision for Asylum seekers detained in immigration detention centres (IDC's)'.** Details of which can be found in both the Context and the introductory section of the Good Practice Guide.

Context

EXPLANATIONS OF KEY CONCEPTS AND ISSUES

Mental Illness

Mental illness is a general term for a group of illnesses**.** A mental illness can be mild or severe, temporary or prolonged. Mental illness can come and go in episodes through a person's life. Some experience their illness only once and fully recover. For others, it is prolonged and recurs over some time. It is necessary to acknowledge and recognise the different models of mental illness that are expressed by individuals and communities from diverse cultural contexts. Failure to recognise and incorporate diverse cultural understandings can lead to negative consequences, including misunderstanding and poor or aversive treatment outcomes.[12] In this study, we have used the words of the respondents rather than applying our own interpretation.

For more information on mental health refer to www.mind.org.uk

Access

Facilitating access is concerned with assisting people to command appropriate health care resources in order to improve or preserve their well-being. If services are available, then a population may 'have access' to health care provision. The extent to which access is gained can depend on administrative, political, social and cultural factors and barriers. The services available must be relevant and effective if people are to gain access to improved health outcomes. Barriers to services and utilisation have to be evaluated in the context of the differing perspectives, health needs, and cultural settings and change.

There has been recognition that service user involvement particularly amongst black and minority groups is central to tackle inequalities and disparities in the current health system.[13] A better understanding of the views of service users and greater user involvement has become increasingly relevant in facilitating access to culturally appropriate mental health and social care service provision and for the role of services to meet user's individual and specific needs.

Service providers

Those individuals in organisations which provide a services these may include, but are not limited to, health care workers, psychiatrists, psychologists, social workers, counsellors, policy officers, and refugee specific community groups.

The service user

A precise definition of a 'service user' is a complex and problematic area. Barnes and Bowl (2001) highlight the distinct categories of users namely that of the patient, public and carer, the most vocal of which will inevitably be the most influential.[14] This has important and

[12] Fernando, S (2002) *Mental Health Race and Culture* (2nd ed) Palgrave: Basingstoke
[13] Keating, F., Robertson, D., and Kotecha, N. (2003) *Ethnic Diversity and Mental Health in London.* London: Kings Fund Working Paper.
[14] Barnes, M and Bowl, R.(2001) *Taking over the Asylum.* Basingstoke: Palgrave.

necessary implications for the asylum seekers and refugee communities who maybe disadvantaged in terms of language, access, knowledge of institutional procedures and racism.[15] For the purpose of this research the 'service user' refers to both individual refugees and asylum seekers at the point of service e.g. patients accessing primary, secondary, and specialist mental and social care services and those accessing voluntary therapy support groups and Refugee Community Organisations (RCO's). The 'potential' service user is defined as those who reported as suffering from various forms of mental distress, who are registered with practioners at a primary level but are not accessing any specific mental health support services.

How important is service user involvement in service provision?

In order to establish how important service user involvement is in good quality mental health and social care services it is necessary to explore the emergence and reasons for such user involvement. Barnes and Bowl (2001), Pilgrim and Rodgers (1999) and Campbell (1999), site that the user movement emerged in response to the emergence of the political right and consumerist ideology in 1980's. Such a growing consumer power base can be seen to have *"undoubtedly added to current willingness for service providers and purchasers to consider the views of people with a mental illness diagnosis"*.[16] However, they also discuss how it is important to recognise that the power demonstrated by consumer groups with financial influence in a consumer capitalist marketplace is very different to the needs and demands of users of mental health services and this also inevitably impacts on the influence such users may have in shaping their own services.

In the last few decades there has been a growing criticism of the mental health and social care services available to users, this includes those from minority ethnic and refugee groups in the UK. This has resulted in the rise of user groups and forums to put forward their agenda's and challenge the very structure and provision available. It is important to note that such movements remain very much in their infancy and consequently a thorough exploration of the current situation is extremely difficult especially as literature available on the user movement is conspicuous by its absence.[17] However it is possible to report that since the 1980's users of mental health services have had a greater contribution to health service provision and more services are requesting the views of the mental health user in order to provide culturally appropriate services with a focus on the individual, considering them as participants in their own care programmes. By the mid 80's within London, forums were emerging in Camden, Islington and Hackney and by the mid to late 80's the movements used the media more effectively in order to highlight their agenda.[18] User groups have now become increasingly widespread and organisations such as MIND have served as advisors to local authorities, health advisors and to Central Government. However, although acknowledging the influence of such user groups, Barnes and Bowl (2001) question "*the extent to which they represent a 'users' voice"*.[19] This is especially important when looking at the extent of individual user involvement and Barnes and Bowl

[15] Pilgrim, D. and Rogers, A. (1999) *A Sociology of Mental Health and Illness.* (2nd ed.) Birmingham: Open University.
Raleigh, V.S. (2000) Mental health in black and ethnic minorities: An epidemiological perspective in Kaye, C, and Lingiah, T.(eds.) *Race, culture and ethnicity in secure psychiatric practice : working with difference*. London: Jessica Kingsley Publishers (pp 29-46).
[16] Campbell, P (1999) The service user/survivor movement in Newnes, C., Holmes,G and Dunn,C. *This is Madness: A critical look at psychiatry and the future of mental health services.* Ross-on Wye, PCCS Books p220.
[17] Barnes, M and Bowl, R.(2001) *Taking over the Asylum*. Basingstoke, Palgrave.
[18] Ibid.
[19] Barnes, M and Bowl, R.(2001) *Taking over the Asylum*. Basingstoke: Palgrave p37

(2001) remain critical of the small number of groups which are actually run by service users; in fact they reported having difficulties finding examples of any organisations that were actually user lead.[20]

User involvement in health service development has been established as a legal requirement, as set out in the 'Community Care Act 1990'. The Department of Health states that all mental health service provision must be planned and implemented in partnership with local community groups, and involve service users and their carers.[21]

For further information on service provision for refugees and asylum seekers in London, please refer to: Ward, K. and Palmer, D. (2005). *Mapping the provision of mental health services for asylum seekers and refugees in London*. London: Commission for Public Patient Involvement in Health

Legal Status and Entitlements

The legal definition of a refugee is someone who has made a claim for asylum in the UK under the 1951 Refugee Convention. The Convention defines a refugee as:

> *'A person who has a well-founded fear of persecution for reasons of race, religion, nationality, membership of a particular social group or political opinion. Someone who is outside the country of his/her nationality and is unable or, owing to such fear, is unwilling to avail himself/herself of the protection of that country; or who, not having a nationality and being outside the country of his/her former habitual residence is unable, or owing to such fear, is unwilling to return to it'.*[22]

An asylum seeker is someone who has made a claim under the Refugee Convention and is awaiting a decision on their case.

On the whole, asylum seekers are only entitled to apply to NASS (National Asylum Support Service) for support and accommodation. They are not allowed to work while their claim is being decided. Refugees are able to work and they are covered by housing and community care law. They are also entitled to apply for mainstream welfare benefits and family reunion.

Until April 2003 applicants whose circumstances did not merit a grant of asylum under the Refugee Convention, but whom the Home office felt should be given leave to remain in the UK on humanitarian grounds or compassionate grounds were granted 'Exceptional Leave to Remain'(ELR). Since 30th August 2005 refugees are no longer granted Indefinite Leave to Remain (ILR). They are instead only granted limited leave, initially for five years. At the end of those five years cases will be subject to a review. If the situation in a country of origin has changed, and the individual is no longer in fear of persecution, they may face removal. If their review is successful then they should get ILR.

In some circumstances an asylum application may be refused and Discretionary Leave or Humanitarian Protection (HP) is awarded instead of refugee status. HP is awarded when an individual faces a serious risk to life or person for one or more of the following reasons: death penalty, unlawful killing, torture, inhuman or degrading treatment or punishment.

---

[20] Ibid

[21] Department of Health. (1999). The National Service Framework for Mental Health. Modern Standards and Service Models. London: Department of Health.

[22] Article 1(A)2 of the 1951 Convention Relating to the Status of Refugees.

Discretionary leave (DL) is granted outside the immigration rules in very limited circumstances.

HP is awarded for five years and individuals have the same entitlements as refugees. After five years the case is reviewed and HP may be extended, ILR awarded or the applicant will have to return home. Individuals with DL have the same entitlements as refugees but are not eligible for family reunion. DL is normally granted for three years and reviewed at the end of this period to see if protection is still needed. If it is then another award of three years can be made. It is only after six years that individuals with DL can apply for ILR.

Asylum seekers whose applications have not been successful are no longer entitled to support from NASS unless they agree to return to their country of origin. They are also excluded from community care law and are therefore not the responsibility of social services. Additionally, they are not entitled to welfare benefits and are not eligible under housing law.

Asylum seekers, refugees and individuals with humanitarian protection and discretionary leave are all entitled to NHS treatment. Individuals who have been refused asylum and do not have an outstanding application are, with some exceptions, only entitled to emergency treatment.

Entitlement to primary and secondary care services

National Health Service(NHS)	Primary care	Secondary care
Asylum seeker	Yes	Yes
Asylum seeker at any stage of appeal	Yes	Yes
Asylum seeker awaiting a judicial review	Yes	Yes
Unsuccessful asylum applicants receiving 'hard cases' grant	Yes	Yes
Unsuccessful asylum applicants awaiting deportation	Discretionary	From 1st April 2004, amended regulations came into force which mean that unsuccessful asylum seekers at the end of the asylum process have to pay for non-urgent in-patient NHS hospital care
Unaccompanied children and young people under 18	Yes	Yes

People granted ELR or HP	Yes	Yes
People with refugee status	Yes	Yes

(Refugee Council 2006 www.refugeecouncil.org.uk) Table 1: Health Entitlements

Public attitudes and the media

Various opinion polls have found that immigration, asylum and race are considered by the public to be one of the most important current issues in the UK.[23] The general findings are that:

- People are very concerned that immigration is not under control.
- People question the genuine-ness of asylum seekers.
- Asylum seekers are associated with illegality and deviance and are perceived to be economically motivated.
- The perceived numbers of asylum seekers are seen to be a great problem.
- This, together with concern about genuine-ness of asylum seekers, constitutes a threat to British society including religion, values, ethnicity and health and to the British economy through criminality, increased competition and an economic burden.
- People feel that asylum seekers are given preferential treatment and are better off than the average white Briton.[24]

A recent report has found that public attitudes to asylum in the UK have reached new levels of hostility.[25] Some politicians have responded to perceived public concern over asylum and immigration by emphasising restrictive policies.[26]

The media has a key role to play in the formation of public attitudes and observers have argued that the UK press has encouraged negative attitudes towards asylum seekers.[27] There have been a number of studies, which have noted the way in which particularly the newspaper media construct asylum seekers as threats or problems.[28] There is also a tendency for coverage to be inaccurate and unbalanced and terminology is often confused.[29] Although often specific reference is made to asylum seekers, such coverage often includes refugees, ensuring that they are seen as a homogenous group and therefore elicit the same negative responses.

[23] Finney, Nissa (2005) *Public Attitudes to Asylum.* Navigation Guide. London: ICAR
[24] Ibid
[25] Lewis, M. (2005) Asylum: understanding public attitudes. London: ippr
[26] Hansen, Randall (2000) *Citizenship and Immigration in Post-War Britain.* The Institutional Origins of a Multicultural Nation Oxford: Oxford University Press.
[27] Greenslade, R (2005) *Seeking scapegoats. The coverage of asylum in the UK press. London: ippr*
[28] Article 19 (2003) What's the story? Results from research into media coverage of refugees and asylum seekers in the UK. London: Article 19
[29] ICAR (2004) *Media image, community impact. Assessing the impact of media and political images of refugees and asylum seekers on community relations in London.* London: ICAR.

The political and legal context

Political issues

Over the last two decades the issue of asylum in the UK has become increasingly controversial and emotive, successive governments have focused on reducing the number of asylum applications in the UK and on increasing the number of asylum seekers who are removed because their applications are unsuccessful.[30] Policies include visa sanctions, air-carriers liability, the increased use of detention, anti-smuggling operations, the deployment of UK immigration officers beyond UK territories and the use of airline liaison officers.

Some policies are designed to remove perceived 'incentives' for asylum seekers such as the termination of support once a claim has been refused and the restriction of support whilst a claim is decided.[31] Section 55 of the Nationality, Immigration and Asylum Act 2002 aimed to remove support for those who do not register their claim for asylum 'as soon as reasonably practicable' after arrival in the United Kingdom. After a legal challenge the government is now not able to withhold support from NASS if it will result in a breach of Article 3 of the European Convention on Human Rights. Nevertheless, the legislation is still criticised for contributing to the destitution of asylum seekers and being a significant obstacle to accessing support.

Another piece of legislation designed to increase the number of individuals voluntarily returning to their country of origin is Section 9 of the 2002 Act. Under Section 9, families whose claims have failed and who do not take active steps toward voluntary return can have their support terminated (and only the children will be provided with support).[32] Section 4 of the 1999 Act enables the government to provide support, (in the form of accommodation and vouchers), for those applicants who have been refused asylum but are willing to return to their country of origin and those who have made a fresh claim for asylum. Research has shown that one of the consequences of legislation that limits support is increasing levels of destitution amongst asylum seekers whose claims have not been successful.[33]

Legal issues

Fixed caps on publicly funded immigration work were introduced in April 2004 which means that legal representatives are now only able to carry out five hours of work on a file before applying for an extension. There has been speculation that some of the more competent legal advisers are leaving the sector because they do not believe they can operate effectively within these new restrictions. It has also been noted that a significant proportion of asylum seekers reaching the end of the asylum process lose their case because they have not received proper advice but are unable to secure the legal representation needed to ensure a reconsideration of their case.[34] This can also lead to destitution because they will only be entitled to support in exceptional circumstances.

---

[30] The number of asylum applications peaked in 2002 at 84, 300 and have fallen since then; to 33, 930 in 2004. Heath, T., R. Jeffries, and J. Purcell (2005) *Asylum statistics: United Kingdom 2004,* 13/05, 23 August 2005. London: Home Office.

[31] It should be noted that research in to the decision making of asylum seekers has not found that the prospect of receiving benefits was a major factor influencing their choice of destination country. Vaughn Robinson and Jeremy Segrott (2002) 'Understanding the decision-making of asylum seekers' Home Office Research Study 243.

[32] Pilot projects have been running in Manchester, Leeds and London.

[33] Richard Malfait and Nick Scott-Flynn (2005) 'Destitution of asylum-seekers and refugees in Birmingham', Restore of Birmingham Churches Together and the Churches Urban Fund, Stoke Citizens Advice Bureau (2003) '*Mind the gap: failed asylum seekers and hard case support*'.

[34] 'Into the Labyrinth: Legal advice for asylum seekers in London' (2005) Greater London Authority.

Integration policy

The Home Office has developed a refugee integration strategy in which eight indicators of integration are identified:

- employment,
- English-language attainment,
- volunteering,
- contact with community organisations,
- take-up of British citizenship,
- housing standards,
- reporting of racial, cultural or religious harassment,
- access to education.

The mental health of refugees has been recognised as an important component in the integration process:

> *'The first step towards the integration of refugees must be to identify and help with their most pressing needs. Finding and settling them into safe and appropriate housing, accessing employment or social security support, addressing any health concerns, and getting children settled in school are crucial to enabling refugees to focus on the longer-term aspects of integration. Some refugees may arrive in poor health, and some health conditions may not become apparent until after they have been in the UK for a period of time – not least because some refugees may be apprehensive about discussing their health while their status in the UK is uncertain. And refugees who have experienced trauma and suffering before their arrival in the UK will require long-term support.'*[35]

Mental Health provision for Asylum seekers detained in immigration detention centres (IDCS)

In the timescale available, it has not been possible to give this very important area of work the coverage and attention it so clearly needs. However, the Commission for Public Patient Involvement in Health have requested that this issue is explored to some extent in this research and also to highlight that this is an area that requires further research. The good practice guide therefore contains a brief outline of some of the central issues and importantly provides some recommendations.

[35] Home Office (2004) 'Integration matters: a national strategy for refugee integration'. London: Home Office. Available at http://www.ind.homeoffice.gov.uk/ind/en/home/laws___policy/refugee_integration0/a_national_strategy.html.

MENTAL HEALTH OF REFUGEES AND ASYLUM SEEKERS

Understanding the Migration Experience

Pre-Migration Experience:

Often neglected in the psychiatric evaluation of refugees is their history prior to arriving in the UK.[36] Backgrounds among refugees are extremely variable, often current psychiatric problems can be related to traumas, losses and injuries that occurred or existed prior to migration.[37] People migrate because they are forced or 'pushed' out of their former location while 'pull' factors may make another place seem more attractive and therefore influence the decision to move.

The two 'push' factors identified are ethnic problems and economic problems in the country of origin. Refugees migrate because of 'push' factors; these can include disease, human right abuses, famine, wars, and civil conflict. According to Zolberg (1989)

> *'Refugees are generated in the first instance by the generalised violence and dislocation that typically accompany the onset of the revolutionary upheaval process itself, regardless of outcome'.*[38]

Jeremy Hein in 'Refugees, Immigrants and the State' purports that

> *'The significant fact about refugees is that they break their ties with their home, state, and seek protection from a host nation'.*[39]

An understanding of the pre-migratory experience is essential if providers of health and social care services are to establish the link between such experiences and subsequent mental health issues.

The flight experience:

Acknowledging the pre-migratory and flight stages in the over-all migratory experience is important for providers of health and social care services. It is a necessary basis for a more thorough understanding of the complex needs of individuals and will inevitably affect the type, and way in which the service is offered. Being forced to flee represents a major life event and the emotional trauma may be exacerbated by other dangers, such experiences represent a risk factor for mental illness. Shresth (1998) links Post Traumatic Stress Disorder (PTSD) to the degree of trauma exposed.[40] He provides an example with the Bhutanese refugees in Nepal stating the prevalence of psychiatric disorders is associated with the degree and severity of trauma to which these refugees had been exposed. Bhugra (2004) argues that the nature of 'push' and 'pull' factors, the impact of forced migration, will

[36] Harris K and Maxwell C. (2000) A needs assessment in a refugee mental health project in north-east London: extending the counselling model to community support. *Medical Conflct and Survival*;**16**(2):201-15

[37] Westermeyer J, Wahmanholm K (1989) Assessing the victimised psychiatric patient. *Hosp Community Psychiatry* **40**(3):245-249.

[38] Zolberg, A. (1989) 'The Next Waves: Migration Theory for a Changing World'. *International Migration Review,* **23**(3): 403-430. p414.

[39] Hein, J. (1993) Refugees, Immigrants and the State, *Annual Review of Sociology*, **19**: 43-53 p44.

[40] Shrestha NM, Sharma B, Van Ommeren M, Regmi S, Makaju R, Komproe I, Shrestha GB, de Jong JT. (1998) Impact of torture on refugees displaced within the developing world: synpomatology among Bhutanese refugees in Nepal. Jama 280 (5) 443-8.

influence the stressors and response in the individual: *'the preparation for the act of migration is a significant factor in the outcome of migration'*.[41] Escaping these pre-migratory experiences may involve further trauma including the actual physical dangers of crossing borders, malnutrition, assault and other forms of violence. During flight the separation of family or friends may also occur with some individuals or groups being left behind. The reasons for this separation can vary according to individual situations. In addition, hunger may be widespread and health can be compromised by a lack of, or shortage of, medicine and facilities. Furthermore, some may rely on unscrupulous professional smuggling operators or human traffickers who help potential migrants cross boarders. Most face long journeys which may include dangerous modes of transportations such as being packed into small unventilated containers to cross boarders or reach ports. Psychological conditions may be attributed to the fact of fleeing as the realisation that possessions, family members and native culture are lost.

To provide appropriate health care to this group GPs and health professionals must be aware of the pre-migratory and 'flight' experiences. An understanding of the patients' history is essential if an appropriate response is to be formulated. For example in the case of victims of torture, medical professionals need to develop the ability to recognise physical signs which would indicate that torture has occurred. In addition to this it is important to acknowledge the emotional state victims of torture present with, special consideration is required when dealing with torture victims; healthcare professionals need to build trust: *'It is likely to take time as well as special expertise to engender sufficient trust for many torture survivors to be able to describe the abuse they suffered'*.[42] It is estimated that up 30% of asylum seekers have experienced some form of torture; however, it is possible that this number may be higher due to victims unable to disclose information due to shame, or possible cultural factors.[43] In summary: *'professionals need to know what has happened in the countries from which refugees have fled if any credibility is to be maintained'*.[44]

Post Migration Experience:

Van der Veer (1998), states that each stage of the migration process is a risk factor for mental illness.[45] The stresses and challenges at different stages of the migration process can lead to psychological distress and physical ailments. Bhugra and Cochrane (2001) in 'Psychiatry in Multicultural Britain Acculturation' have observed that deculturation as a process of settling down in a new and alien culture will also produce psychological distress and can *'lead to the development of mental illnesses such as adjustment reactions, eating disorders, affective illness, paranoid reactions and common mental disorders'*.[46] In addition issues such as lack of familiarity about services, low income, racism, and isolation, dietary requirements that may differ from the host nation, housing difficulties and dispersal can add to psychological stresses. Studies suggest that exile related stressors maybe as powerful as events prior to flight and therefore impact hugely on health. In a study of Indochinese refugees in the USA Rabaunt (1991) established that family loss was a

[41] Bhugra, D.(2004) Migration and mental health. *Acta Psychiatr Scand*; **109**: 243-258 p247
[42] Keating, F., Robertson, D., and Kotecha, N. (2003). *Ethnic Diversity and Mental Health in London.* London: Kings Fund Working Paper. P10
[43] Burnett, A. and Peel, M. (2001). Asylum seekers and refugees in Britain. Health needs of asylum seekers and refugees. *BMJ*, **322**:544-547
[44] Aldous, J., Bardsley, M., Daniell, R., Gair, R., Jacobson, B., Lowdell, C., Morgan, D., Storkey, M., Taylor.G. (1999). *Refugee health in London: key issues for public health*. London: Health of Londoners Project.
[45] Van der Veer, G (1998) *Counselling and Therapy with Refugees and Victims of Trauma*. John Wiley & Sons Ltd: Chichester
[46] Bhugra, D.& Cochrane, R.(2001) *Psychiatry in Multicultural Britain*. London: Gaskell p129.

significant factor of distress in the resettled environment.[47] This concept has been established by a variety of researchers and theorists.[48] Burnett and Peel (2001) state: *'Post-traumatic stress disorder consigns the traumatic experiences to the past, implying that trauma was something experienced before or during the flight, but much of the trauma that refugees experience is in their country of resettlement through isolation, hostility, violence, and racism'*.[49]

<u>Transcultural mental health care: responding to cultural factors</u>

The debate on trans-cultural mental health dates back to the 1960's.[50] The first discourse in the UK tried to explain the substantially higher rates of schizophrenia diagnosed primarily among the second generation black African-Caribbean community compared to the population as a whole. The evidence offered two main strands of explanation: either a very large number of people were being misdiagnosed, or environmental factors were a much more significant causal factor in schizophrenia than had previously been acknowledged by psychiatrists. Psychiatric theory acknowledges a number of social and environmental factors that are associated with mental ill health in both a contributory and consequential way. These include poverty, unemployment, poor housing, social isolation and extreme mental stress and trauma.[51] However these are not perceived as the primary causes of the major mental illnesses rather as secondary contributory factors. The data on the diagnosis of schizophrenia in young African-Caribbean men laid this open to question. A discussion of the epistemological problems presented by psychiatry is beyond the scope of this research. Nonetheless it is important to consider some of the issues as they occur in the debate on trans-cultural psychiatry. Trans-cultural psychiatry is concerned with the relationship between culture and mental illness and explores normal and abnormal behaviour within different cultural contexts by examining the cultural meanings and the social contexts of distress. [52] The main focus of trans-cultural psychiatry is the study and analysis of beliefs, practices and cultural values and their influence in shaping beliefs and practices with respect to illness and health care rather than the focus on the often negatively weighted term 'cultural difference'.

While well entrenched in medical theory[53], psychiatric presumptions have been accused of being epistemologically flawed as definitions of mental illnesses are frequently circular and make reference, overtly or covertly, to a culturally subjective notion of 'normality' against

---

[47] Rumbaut, R.G.(1991) 'The agony of exile: a study of the migration and adaptation of the Indochinese refugee adults and children'. In F.L Ahern Jr and J.L. Athey (eds), *Refugee Children: Theory, Research and Services,* pp.53-91. Baltimore; John Hopkings University Press.

[48] Summerfield, D. (1999) A critique of seven assumptions behind psychological trauma programmes in war-affected areas. *Social Science and Medicine*, **48**, 1449–1462.

Summerfield, D. (2001) The invention of post-traumatic stress disorder and the social usefulness of a psychiatric category. *BMJ*, **322**, 95–98.

Tribe, R. (2002) Mental health of refugees and asylum-seekers. *Advances in Psychiatric Treatment*, **8**, 240–247.

[49] Burnett A, and Peel, M. (2001). Asylum Seekers and Refugees in Britain: The health needs of survivors of torture and organized violence. *BMJ,* **332**: 606-609

[50] Kiev, A (1965) Psychiatric morbidity of West Indian immigrants in an urban group practice. *British Journal of psychiatry*, **111**: pp51-56

Sharpley, M.S., Hutchinson, G and Murray,R.M. (2001) Bringing in the social environment – understanding the excess of psychosis among the African-Caribbean population in England. *The British Journal of Psychiatry.* **178**: 560-568

[51] Raleigh, V.S. (2000). Mental health in black and ethnic minorities: An epidemiological perspective in Kaye, C, and Lingiah, T.(eds.) *Race, culture and ethnicity in secure psychiatric practice : working with difference*. London: Jessica Kingsley Publishers (pp 29-46).

Pilgrim, D. and Rogers, A. (1999) *A Sociology of Mental Health and Illness.* (2nd ed.) Birmingham: Open University.

[52] Kleinman, A (1977) Depression, Somatisation and the 'New Cross-Cultural Society'. *Social Sciences and Medicine*, **11** : 3-10

[53] Crow, T. J, (1995) A continuum of psychosis, one human gene, and not much else- the case for homogeneity, *Schizophrenia Research* **17**: pp135-145

which illness or deviance is judged.[54] The presumption is of an innate physiological propensity. Psychiatric diagnosis requires doctors to make judgements based on their understanding of their patients' mental states and emotional processes, and relate these to a 'normal' or 'healthy standard'. Clearly this exercise is (at the very least) much more difficult where doctor and patient do not share a language, a set of concepts around the nature of mind and emotion, and an understanding of what behaviours fall within and without each others' cultural norms.[55] Psychiatrists, Littlewood and Lipsedge (1997), comment on the level of misunderstanding and misinterpretation, regularly occurring between psychiatrist and patient, leading to situations where substantially more harm than good may arise from treatment. This raises the question of whether Western psychiatry is inherently culturally specific, and if so, is not equipped to make judgements on the mental health or illness of people from non-western cultures.[56]

Government Policy: tackling health inequalities

The issue of disparity and inequalities between black and minority ethnic groups and the majority white population in rates of mental ill health and equality of service in terms of experience and outcomes has figured in government policy since Labour took office in 1997. The death of an African-Caribbean patient named David Bennett in a secure psychiatric unit whilst detained under the Mental Health Act (1983) and the subsequent inquiry report published in 2003 found the NHS to be "institutionally racist". The report was unequivocal in its condemnation of the NHS for its failure to protect a patient in its care and called for a commitment to eliminate institutional racism. The report was not the first to highlight inequalities and racism as reasons for poor engagement of BME communities with mental health services. In 1999 the Department of Health's report ***'National Framework for Mental Health: Modern Standards and Service Models'*** aimed to address inequalities in health with a particular focus on BME communities. As a response to this it published ***'Inside/Outside'* (2003)**[57] which set out three objectives and recommendations to improve the mental health of minority groups, these were to:

- reduce and eliminate ethnic inequalities in mental health experience and outcomes
- develop the cultural capability of services
- to engage with the community.

An important implication of this was that the training of mental health workers '*should include service users and /or voluntary organisations working with black and minority ethnic groups in their programme*'.[58]

In reaction to community consultation, the government subsequently published ***Delivering Race Equality: A Framework for Action*** (Department or Health 2003)[59] again placing greater emphasis on community engagement, calling for voluntary and community services to be more effectively and substantially involved in planning, commissioning and delivering

[54] Fernando, S (2002) *Mental Health Race and Culture,* (2nd ed) Palgrave: Basingstoke
[55] Littlewood, R. and Lipsedge, M. (1997). *Aliens and Alienists: ethnic minorities and psychiatry.* (3rd ed). London: Routlege.
[56]Pilgrim, D. and Rogers, A. (1999) *A Sociology of Mental Health and Illness.* (2nd ed.) Birmingham: Open University.
Littlewood, R. and Lipsedge, M. (1997). *Aliens and Alienists: ethnic minorities and psychiatry.* (3rd ed). London: Routlege.
Fernando, S (2002) *Mental Health Race and Culture,* (2nd ed) Palgrave: Basingstoke
[57] Sashidaran, S.(2003) Inside/Outside: Improving Mental Health Service for Black and Minority Ethnic Communities in England. National Institute for Mental Health in England (NIMHE) Department of Health.
[58] Ibid p31
[59] Department of Health. (2003) *Delivering Race Equality; A framework for Action.* London: Department of Health

services. Both reports had only focussed on the large established minority communities – African-Caribbean and south Asian. Following further consultation responses the most recent report, ***Delivering Race Equality: an action plan for reform inside and outside services*** (Department or Health 2005) makes some reference to refugees and works to establish its broad understanding of the term 'black and minority ethnic'.

This action plan is seeking positive outcomes for members of BME communities many of which include combating the issues raise in the trans-cultural health debate, such as:

- Reductions in disproportionate inpatient admissions
- Compulsory detention
- Use of seclusion
- Interpretation and investigation of violent incidents
- Monitoring and investigating death in mental health services
- Reducing imprisonment and fear of mental health services
- Increased satisfaction and sense of recovery
- More involvement in training, policy and planning.

It is positively stated that users need access to:

'Peer support services, psychotherapeutic and counseling treatment, as well as pharmacological interventions that are culturally appropriate and effective, [and] a workforce and organisation capable of delivering appropriate and responsive mental health services to BME communities'.[60]

In addition, the report recommended that the Department of Health should identify relevant funding streams for minority ethnic groups to ensure access within mainstream performance management.

For statutory bodies, this is a major and worthwhile challenge, however, consulting with organised lobbies is one thing, but as Werbner (1991) shows, treating BME communities as homogeneous entities is a dangerous error.[61] Different ethnic groups and individuals within those groups variously integrate and / or assimilate in different ways and at different rates and have different cultural treatments for mental distress. The government, it seems, is well aware of the deficiencies in the quality of mental health care provided to BME groups. There is a clear political agenda to redress these issues in respect of major established ethnic minority communities, especially the African-Caribbean and south Asian communities. However, the recent policy documents continue to give very little reference to the particular and specific needs of the refugee community within the BME category. This is a significant problem which considering the issues concerning access and utilisation will potentially lead to their continued marginalisation and exclusion. This notwithstanding, the NHS is now required to engage with all minority ethnic communities, by whatever means available, in the course of providing mental health services.

[60] Department of Health. (2005) Delivering race equality in mental health care – An action plan for reform inside and outside services. London: Department of Health.
[61] Werbner, P. (1991) 'The Fiction of Unity in Ethnic Politics', in P. Werbner and M. Anwar. (eds), *Black and Ethnic Leaderships in Britain*. London: Routledge

PART 2: THE RESEARCH - METHODOLOGY AND FINDINGS

Methodology

Research framework
This piece of research has been carried out within the framework of participatory action research.[62] Participatory action research is a style of research rather than a particular method. The approach is particularly suited to practitioner-led research as it encourages participants to problematise existing practices and develop potential solutions.[63] The clear-cure demarcation between 'researcher' and 'researched' is not as apparent as it may be in other forms of research as issues are addressed in a more collaborative manner.[64]

Methods
This study was carried out in two iterative phases: a literature review and a qualitative study of mental health services and refugees and asylum seekers, as detailed below.

Literature review
A literature search was carried out on the issues of refugees, asylum seekers and mental health using academic databases, Harpweb, service provider web sites and general internet searches. Literature from the following topic areas was identified: transcultural psychiatry, service user involvement, the accessibility of mental health services and the provision of appropriate services for refugees and asylum seekers. A range of material was identified and included journal articles, books, practitioner guides, service guides and annual reports.

Qualitative study
A total of 31 people were interviewed for this study: 21 service users, 8 service providers, a director of a migrant refugee community forum and 1 Primary Care Trusts commissioning mental health services commissioner. The main aim of this study is to better understand the experiences and views of mental health service users. However, to develop an understanding of the context of mental health service use, it was also felt necessary to explore the experiences of refugee community groups, multicultural (non-NHS) services, NHS services and commissioners working with services for refugees and asylums seekers. By looking at the full range of stakeholders (from the level of commissioning through to service providers, community involvement and on to the experience of service users) it is felt that a comprehensive picture of service delivery is achieved.

[62] Stringer, E. (1996) *Action Research: A handbook for Practitioners* Thousand Oaks: Sage.
[63] Greenham,F and Moran,R.(2006) Complexity and community empowerment in regeneration in Temple,B. and Moran, R(eds) *Doing Research with Rrefugees*. Policy Press: Bristol. (p111-143)
[64] Meyer, J. Qualitative research in health care: Using qualitative methods in health related action reserach. *MBJ* 2000;**320**;178-181

Topic guide development

Topic guides were developed by the researchers. They were informed by the findings of a mapping exercise, and literature on the provision of mental health services for refugees and asylum seekers.[65]

The following broad and overlapping issues are reflected in the topic guides for service users and service providers:

- the role of culture and language in mental health service provision
- stigma and mental health
- knowledge of western mental health concepts and systems amongst service users
- the accessibility and appropriateness of services
- the role of the service user in the development of services
- improvements to existing services

For the service user topic guide phrasing was discussed at length to ensure validity and reliability in the context of cross-cultural research. The topic guide for service providers was designed for a range of services and so not all questions were relevant for every service. The topic guide for commissioners focuses on the funding of services and issues around resource allocation. All topic guides were extended by a number of prompts and probes to ensure greater inter-interviewer consistency. And a number of demographic questions were also included in the questionnaires.

Limitations

The complete research project was undertaken over a limited 11 week period. Due to time size limitations and resource constraints it places the emphasis on a small number of respondents however the sample selected possess relevant characteristics for the question and themes being considered.[66] In addition, our research acknowledges that the size of the sample base will not be completely reflective of the refugee community as a whole, however the use of both qualitative and quantitative sources will hopefully allow for some level of extrapolation of how the issues may impact upon the wider refugee population.

Sampling and recruitment

Service users

The researchers aimed to obtain a maximum variation sample. This technique enabled the researchers to purposefully select a set of individuals that exhibited maximal differences in terms of nationality, religion, culture, current location in London, age, class and immigration status. A balance between male and female interviewees was also sought. Whilst this technique does not allow an in-depth exploration of issues affecting a particular client group, with common backgrounds, it does serve to identify important common patterns that cut across variations.

[65] Ward, K. and Palmer, D. (2005a). *Mapping the provision of mental health services for asylum seekers and refugees in London.* London: Commission for Public Patient Involvement in Health

[66] Brown, C.S.H and Lloyd, K. (2002) Comparing Clinical Risk Assessment using Operationalised Criteria, *Acta Psychiatrica Scandinavica*, Vol **106**, 412 p148

Service users were recruited through contacts at a refugee centre in central London. The centre provides holistic support and advice (including housing, health, welfare and social care issues) to refugees and asylum seekers from a range of backgrounds. The service is not targeted at one particular community and although it is based in the London Borough of Camden it has clients from across London.

The centre was chosen for reasons of access and because the researchers already have a relationship with the staff and clients at the project. This meant that the research could be carried out in a more trusting and collaborative manner.

The researchers applied exclusion criteria when considering potential interviewees. Client vulnerability, capacity to provide informed consent and the possibility of the interview resulting in distress (i.e. 're-traumatisation'), were issues discussed with the centres' staff before a decision was made on whether an individual would be invited to participate. Where there was doubt about the capacity of a given client to participate, the client in question was not approached.

The authors searched the database at the refugee centre to identify potential interviewees that did not fall within the exclusion criteria and that were from a range of nationalities from across London. Potential interviewees were then approached confidentially by one of the researchers the next time that they were in the project.

Service providers

The researchers aimed to cover a range of services across London including: refugee community groups, specialist NHS services, primary care services and multicultural (non-NHS) services. Potential service providers were identified using research that had been previously undertaken on mapping available mental health services in London.[67]

Service commissioners

The authors aimed to obtain an interview with a commissioner from each of the Strategic Health Authorities. However, this was not possible due to time limitations and availability of the commissioners. As a result only one interview was obtained. However it was felt that this participation provided a valuable and important insight and was therefore included in the research.

Potential mental health commissioners had been identified via contacts at the Commission for Patient and Public Involvement in Health and through contacts established as a result of the initial mapping exercise.[68]

Data collection

Interviews were conducted by both Palmer and Ward. Interviews with service users were carried out confidentially in a private room at the St Pancras Refugee Centre (SPaRC). Interviews with service providers and commissioners were conducted as their premises in a

---

[67] Ward, K. and Palmer, D. (2005a). *Mapping the provision of mental health services for asylum seekers and refugees in London.* London: Commission for Public Patient Involvement in Health

[68] Ibid.

setting of their choice. In two cases the interview questions were completed via email and forwarded to the researchers. The interview with the commissioner was undertaken by telephone.

Ten of the 21 interviews with service users were carried out using an interpreter. Interpreters were briefed on the aims of the study and were instructed to take care when they translated concepts and terms from one language to another and to make sure that they did not imbue the responses of interviewees with their own meaning and terminology. In some cases the interpreters had previously worked with the clients and could therefore build upon their trust relationship.

Interviews lasted between 30 minutes and 1 hour and 30 minutes.

Data Analysis

All interviewees were asked if they would allow for the exchange to be tape-recorded, however, all but two declined and these interviews were carried out with hand note-taking only. All interviews were carried out with informed-consent and transcribed. The researchers charted the data for thematic analysis according to the principles of the Framework method. [69] Data arising from the interviews with services users and that from interviews with service providers and commissioners were analysed separately, though the resultant frameworks developed for charting and interpreting data were compared. Codes and frameworks were rooted in the aims of the project and guided by the nature of the interview data generated.

Consumer Involvement

A draft version of the report and a summary were sent to various parties including all of the participants who were involved in the study and they were invited to provide comments. Over 70 invites were sent out inviting various stakeholders to a consultation event to discuss the draft findings. In addition, service users who participated in the research were also invited to take part in a consultation event where a summary of the findings of the report were discussed as part of a focus group. Four service users attended the St. Pancras Refugee Centre on 17th March and participated in a discussion on the findings. Four people attended the event on 24th March held by the Commission for Patient and Public Involvement in Health. Responses and contributions from both consultations were treated as data and incorporated in to the final report.

Ethical considerations

Ethical issues were considered in-depth by the research team and discussed with stakeholders, as detailed above. We note the particular ethical issues arising from research into mental health. Great care was taken to ensure that this study was non-obtrusive and supportive. Voluntary participation, and confidentiality were emphasised and researchers made it clear that interviewees could withdraw at any stage.

---

[69] Ritchie.J and Spencer,L.(1993) Qualitative data analysis for applied policy research. In Bryman.A. and Burges.R (eds) *Analysing qualitative data*. London: Routledge.

All individuals approached to participate received a study information sheet, detailing parameters of participation, confidentiality and anonymity, allowing individuals to make an *informed* decision about participation.

A particular ethical consideration for this study was that the professional involvement of the researchers in the refugee project. One of the researchers is the project manager and the other researcher has worked at the project as an advice worker on a part-time basis. As a result, there were concerns that the uneven power relationship between the researcher and 'the researched' would be exacerbated by the fact that the interviewees may also be clients of the interviewers.

The researchers addressed this concern by ensuring that service users were given detailed information on the study and plenty of time to think about their involvement. They were also informed that their participation, or non-participation, would in no way affect the services that they were receiving from the centre. As noted in the previous section, clients identified as particularly vulnerable or dependent by any of the staff at the centre were not approached. The fact that some potential interviewees declined when approached suggests that the invitation to participate was not coercive. Interviewees were also given the choice of which researcher they wanted to be interviewed by in case they did not feel comfortable being interviewed by someone who had also worked with them in an advisory capacity. All interviewees preferred to be interviewed by the researcher that they knew the best.

Findings

SERVICE USERS

We interviewed a total of 21 people. As indicated in the methodology, this study aimed to recruit participants from a range of nationalities, ages and locations in London. We also aimed to achieve a roughly equal split between men and women and to also include both asylum seekers and refugees. The demographic data for this study is shown in a table below:

Nationality/Ethnicity	Age	Borough	Time in country
Ukrainian	50	Westminster	10 years
Somali	54	Camden	6 years
Iraqi	37	Camden	4 years
Somali	46	Islington	3 years
Rwandan	40	Wandsworth	6 years
Colombian	34	Islington	4 years
Somali	46	Tower Hamlets	9 years
Iranian	36	Islington	4 years
Ethiopian	33	Kensington and Chelsea	10 years
Kurdish (Iraqi)	65	Hounslow	6 years
Congolese	35	Hounslow	18 months
Bosnian	28	Barnet	6 years
Somali	62	Islington	12 years
Somali	41	Hounslow	2 years
Ethiopian	21	Camden	3 years
Iranian	27	Camden	6 years
Russian	26	Haringey	4 years
Kosovan	21	Haringey	3 years
Iranian	27	Islington	3 years
Azeri	26	Enfield	5 years
Ethiopian	61	Camden	8 years

Table 2: Demographic data

Six of the interviewees were asylum seekers, one was without status[70], one had ELR[71], one had British Citizenship and the rest had been awarded refugee status. Eleven of the interviewees were men and ten were women. Fifteen of the interviewees were accessing mental health services provided by the NHS and charitable organisations. None of the sample were currently accessing counselling provided by a Refugee Community Organisation (RCO). Six of the interviewees were not accessing any mental health services.

[70] Asylum application refused on appeal.

[71] Exceptional Leave to Remain (ELR) Until April 2003 applicants whose circumstances did not merit a grant of asylum under the Refugee Convention, but whom the Home office felt should be given leave to remain in the UK on humanitarian grounds or compassionate grounds were granted 'exceptional leave to remain'.

The results of this study have been grouped by the themes identified when analysing the interview transcripts.

Range of difficulties experienced

All of the interviewees reported experiencing some form of mental health problem. Only one of the interviewees indicated that their problem was not current. The nature of these problems is recorded in the table below. We have used the words of the respondents rather than applying our own interpretation or checking their medical diagnosis.

Complaint	Number of participants
Sleeping problems	15
Anger/bad temper	10
Panicky/panic attacks	5
Tearful	5
Depressed	4
Nightmares	4
Stress	4
Tired	4
Sad	2
Nervousness	2
Distressed	2
Bad memories	2
Breathing problems	2
Easily upset	1
Hates noise and crowds	1
Feel worse	1
Worry	1

Table 3: Mental health symptoms

Interviewees also indicated difficulties with a number of social issues. Everyone mentioned that they have had problems with housing at some stage. Seven of the interviewees stated that they have had problems with immigration and six have had problems with benefits or with finding enough money to live on. Six people indicated that they felt isolated and a further three that they missed their family. Two individuals highlighted barriers to finding employment as an issue. Racism, language difficulties, family conflict and loss of status in society were all cited at least once as a difficulty.

Trauma and mental health

Twelve of the interviewees highlighted traumatic experiences in their countries of origin as being either one of the reasons, (nine people), or the major reason, (three people), for their mental ill health:

> *'Everything is due to Somalia. You can't forget it. Any second you think that you will die'*
> (Somali male).

> *'I was in the war in Bosnia and saw lots of horrible things'* (Bosnian female).

‘It is all down to what happened in Rwanda….Everything will never go away’ (Rwandan female).

Reference was made by the interviewees to beatings, imprisonment, torture and witnessing brutality and killings.

Two of the interviewees identified traumatic experiences in London as the source of their mental ill health.

Psycho-social issues and mental ill health

Interviewees also noted the affects of social difficulties on their mental well being, and that of their communities. Again, housing was cited as one of the biggest difficulties with ten people commenting that the lack of adequate housing or homelessness had impacted their mental health negatively:

‘Homelessness made me feel dark and useless’ (Ethiopian female)

'I don't have housing and money. Not many could live like me. I am out of humanity. I am rejected. What am I? One of the human people but I am out of humanity and rejected here' (Somali male)

‘Bad housing has made my depression worse’ (Kurdish female)

'I was experiencing stress here. The stress was because I didn't have a place to stay or support. I was feeling to kill myself. I was sleeping in the streets. I was sick, very sick with TB. I didn't have support. I was crying, crying, thinking all the time, headaches and couldn't sleep. I would get lost and frightened' (Somali male)

‘I would say that 70% of my problems are from housing.’ (Iranian male).

The Immigration process

Immigration was cited by eight of the interviewees as having a negative affect on their mental health or the mental health of their community.

'I felt that I was going to be sent back. I couldn't sleep and eat Saturday to Sunday. It was very stressful and I was losing my hair. I had no iron. I had lots of headaches. I was very worried about being deported. It has also affected my daughter. She gets very hyper and hates noise, bangs and shouting' (Bosnian female).

‘*Delays in Immigration, waiting for the decision. Its taken so long. I feel my rights are not protected, this is bad for me, makes me sad and causes me much stress with no outlet’* (Russian Male)

Two individuals observed that because of the stress around immigration problems suicide was an issue in their communities:

'The first two refusals from the Home Office caused big problems. I was not able to sleep. I know many people from Somalia that have stress. I know one lady who got refused three times and then one day she became like mad. She jumped from a very high building and died. This was in Glasgow. I knew her from Somalia. We were in contact' (Somali male).

'There is a problem with people keeping things to themselves. There is a problem with suicide. One person from the church jumped in the water. They hang themselves, jump in to train because of immigration, housing. Most are men. They feel helpless. They don't know the way or speak the same language. I think that about 10 or 12 have committed suicide' (Ethiopian female).

Two of the interviewees observed that it was not just the worry about their immigration status that was affecting them but that if he had status then he would be able to work which would help him forget his other problems more easily.

'I have no rights. I can't work and can't start a career. If I could work I would feel happier.' (Russian male)

Other social issues were identified by four of the interviewees and include money problems, inability to find work, interpreting, studying and benefits issues.

'Some people in my community get distressed because they have problems with housing, money, working and interpreting'. (Ukrainian male)

The gap between people's expectations about the UK and what they actually experience once they are here is highlighted as a reason for depression and stress:

'Here they think things will be easier but then you can't find job or money or housing, study, national insurance number and there are all these problems that they didn't know about. You loose hope and this causes depression' (Somali male)

'People come here for hope, freedom and a better life. When this doesn't happen they get stressed. The system isn't fair' (Iranian male)

Referrals and waiting time

Of the interviewees seeing a specialist mental health professional four of them had been referred by the refugee centre (SPaRC) and the rest had been referred by their GP. The majority of interviewees felt that they had waited for too long before their referral had come through; there was a maximum wait of six months. One person indicated that they were waiting for a year before they felt able to approach their GP and another person was looking for help for six months before they were referred.

Appointments

The appointments for the secondary and specialist services varied in frequency. Some individuals went once a week, others once a month and one person went once every three months.

Duration

Again, how long individuals had been seeing a mental health professional varied dramatically; from four months to ten years. Most individuals were unsure how long they would be seeing someone for and were not aware of any time limits on their sessions.

Conceptions of mental health

Another issue that emerged during the interviews was the difference between the UK understanding of mental health and the way in which mental health is understood in the interviewee's countries of origin. Five interviewees observed that the concept of stress or depression did not exist in their country of origin and that according to their culture; individuals were either 'mad' or 'sane'.

> *'Inside Somalia people are crazy but they don't have depression. They (Somali community) didn't know about depression… I didn't want to publicise. Depression doesn't mean anything in Somalia'.* (Somali male).

> *'In Iran there are only crazy people who are in hospital. Not people who are stressed. Here everyone talks about stress. No one says 'I have stress' in Iran. Even people who have had bad things happen to them. If you talk about stress a lot, like here, then you get stressed'* (Iranian male).

> *'In Somalia people have problems and have stress but there is no record or investigation because there are no doctors out there. The whole country has been stressed for 14 years. People from Somalia use a different language about stress. When I came here I learnt the word stress because it is not well known in my country. Somalian people who are having stress thinks that he is okay but other people see that he is not. Educated people know that they have a problem but people who are not, don't. If someone is stressed they say 'Waa waa she' which means mad. It is quite extreme, there is nothing in between. Stress is less than mad but Somalians talk about being mad'* (Somali male).

Confidentiality and stigma

Fifteen interviewees expressed concerns around confidentiality and about the community finding out that they had mental health problems.

> *'I don't talk about my problems with people. Instead of helping I think that they will talk. It is not confidential'* (Ethiopian female).

> *'I tell a little but not the full story. They gossip a lot, Bosnians; I think that they are born with it. I hate it, really'* (Bosnian female)

> *'I go to socialise and forget. I don't talk they all gossip'* (Kurdish female)

All indicated that they experienced some level of anxiety about their situation and some indicated that they felt ashamed that they had mental health issues:

> *'Some things are very special and I can't say them when there is someone else there. I feel ashamed and nervous. With my doctor it is a safe place and with an interpreter I*

can't feel that. If it is through the telephone it is better for me but is it is in front of me it is difficult. This is because they are from the same country as me' (Iranian female).

Eight people explicitly stated that there is stigma around mental health:

'Interpreters take time and they maybe he doesn't say exactly what you feel. For example he might say that I feel mad when I feel depressed. It's not good for confidentiality as they talk too much in the community' (Somali male)

'I don't trust any of those groups. They say that 'this man is crazy'. Somalis talk too much' (Somali male).

'They make signs. They say that people are mad. They like to talk' (Somali female).

Another interviewee observed that:

'People do not want to be with you if you are mad' (Somali male).

What helps?

Interviewees were asked what makes them feel generally less distressed. Some interviewees cited several different factors. Ten individuals highlighted the importance of friends and family and said that they make them feel better. Eight people stated that medication helped them to feel better, (three people said that medication didn't help). Seven people stated that talking to their doctor helped. Socialising (six people) and keeping busy (four people) were also identified. Praying (two people), artwork, music groups, sport, and user-led groups such as sewing (three people) and breathing exercises or alternative therapies (four people) were also highlighted as useful coping strategies. The need for practical solutions was identified by most of the interviewees:

'When you get good things, accommodation, you have comfort'. (Somali female)

'A new house would make me feel better. If I had money to live on I would feel better' (Iranian female).

'If the situation here is good then it is a good life but is not then it is bad. If someone gets housing then their life is good. My friend is relaxed in his accommodation so he is happy. If I had my housing I would feel better'. (Iranian male)

'I like coming to the sewing group. I meet some people and it helps me forget. I can make things and it helps for not to think about all my problems. (Ethiopian Female)

Emotional Support

When asked who they turn to for specific support when they are feeling emotionally distressed nine interviewees indicated that they go to their psychiatrist or counsellor. Five people stated that they go to an advice centre (SPaRC) for emotional support. Another two mentioned their GP and three more said that they turned to their family. Two interviewees said that they did not go to anyone and only one said that they went to their community.

Community
Six of the interviewees are in contact with their own community groups. They went to the community groups for practical help or to socialise. One person turned to the community group for direct emotional support. All of the interviewees attended the Refugee Centre (SPaRC) for holistic support and advice.

The individuals who were not in contact with their community indicated that this was because the community group was not helpful (three people), they did not like mixing with people from their country because of the war (one person), it is too far to travel (one person), they do not trust them (five people) and they do not have the time (one person). Interviewees also observed that their communities have their own problems and don't have the capacity to help them (Three people):

> *'The majority of the community need help themselves and so I can't get help from them'* (Ukrainian male)
>
> *'Every Somali has a problem. No one is able to get help from Somali people. Everyone speaks about their own problems and I feel worse'* (Somali male)
>
> *'The community can help one or two times but they can't do more than that. The UK is a very developed country so people are thinking: 'why aren't the government helping?'* (Somali male)

One man felt unable to go to his community because his accommodation is inadequate and he can not take care of himself properly:

> *'The hotel is too dirty to prepare myself properly. I feel too ashamed to go like this'* (Iranian male).

Talking therapies
There were diverging opinions amongst the interviewees on the efficacy of talking therapies for them. Seven interviewees found talking therapy to be very beneficial:

> *'It's is very good for me. He lets me talk freely. He helps organise my thoughts, puts me back on track which I wouldn't get unless I was there'.* (Colombian male)
>
> *'She(therapist) has really helped me. She saved my life. I talk to her about everything. She helps me focus, think about breathing and to take control when I have nightmares.* (Azeri Male)
>
> *'Talking helps solve some problems. My counsellor gave me some confidence. She helped with breathing and solved many problems. She wrote letter for the housing problem. They were good for me. It was perfect'* (Ethiopian female)
>
> *'I like it a lot. Talking helps. Makes it less'.* (Congolese male)
>
> *'My counsellor helped me so much. They gave me advice and guidance. They were experienced and helped me stay calm.'* (Somali male)

Some (four) were more ambivalent about the benefits of talking about their problems:

> *'Talking helps a little but I can't sleep without medication. It helps me forget things…it's nice to talk sometimes but I want to forget''* (Somali male).

> *'I don't want to talk about it but the psychiatrist makes me talk. I am not happy but she says it will help me….She helps me when I feel hopeless. She gives me hope'* (Rwandan female)

> *'It's just talking but I am fed up with it. They do give me help with breathing though for when I am distressed'* (Iranian female).

> *'I have too many problems. I want to be happy. I want my children to be happy. I understand that they help but they don't make everything okay'* (Kosovan Female)

Others were very sceptical about how effective they felt talking was:

> *'I went to the counsellor but I feel even worse when I leave because he makes me talk and remember' 'They ask me about things that happened in my childhood but I don't know the use of that'. 'Talking just reminds me more and more. I want more community activities and social activities'.* (Kurdish female)

> *'What use is talking? It is a waste of time. You need to forget. The Koran, that's the duty'* (Somali female)

> *'He is helpful. He gives me sleeping pills. Talking about my problems doesn't help. It is accommodation I need'* (Iranian male).

One woman was pleased with her psychologist because she had helped her with her immigration problems.

Suggestions for improvements

Interviewees were asked what could be done to help people experiencing emotional distress in their community. Some interviewees gave more than one suggestion. The most common suggestion was the creation of more advice centres. Seven people observed that there was a need for more places giving advice on housing, immigration, health and offering help with forms and language. Another four people identified the benefits of general community centres where people can socialise. Four interviewees stated that there should be more generic services on offer to help them express themselves or develop skills such as art, music and sewing groups. Five interviewees also felt that they benefited from services that provided relaxation opportunities and techniques such as Indian head massage and complementary therapies. One person talked about the benefits of coffee mornings.

Three people stated that the services offered by mental health professionals could be improved by translating their letters and questionnaires in to the appropriate languages. Two people identified the need for more ethnic minority staff or people from their community to

be employed by mental health services. More outreach work by advice centres was identified as another possible improvement. The need for more advertising of the mental health services available was highlighted by one individual and another person thought that there should be more health visitors. One interviewee also felt that research should be conducted into the effects of housing and income support levels on refugees. Finally, one person observed that there needed to be more education in his community about UK culture and the meaning of stress:

> *'Most Somalis don't understand what is going on in Britain. They get the Home Office paper and most don't have the chance to study the difference in cultures. The Somalis who speak English and know the culture can educate the people about the knowledge that they have learnt. Lack of knowledge is the problem that this community has right now'* (Somali male).

SERVICE PROVIDERS

The service providers and community forum interviewed were from a variety of organisations. As outlined in the methodology the aim was to cover a range of services across London as identified in previous mapping research.[72] The relevant data for this section is listed in the table below.

Table 4: Service Provider data

Organisation	Percentage of Refugees /Asylum seeker users	Service provided
Traumatic Stress Clinic (NHS)	70%	Psychosocial assessment and treatment for PTSD
Kurdish Association	100%	Holistic and social support
Ethiopian health Support Association	100%	Counselling and holistic support
MIND Harrow	95%	Refugee advocacy and befriending project for mental health sufferers
Iranian Association	100%	Counselling and advice
Vietnamese Mental Health Service	100%	Counselling service, outreach, support for carers and for children of mentally ill parents.
Derman	(Majority are Kurdish, Turkish and Cypriot refugees and asylum seekers)	Counselling, support work, advocacy and outreach.
Health Support Team, Lisson Grove Health Centre	35%	Holistic service, multi-disciplinary health visitors.
Refugee Support Service	100%	Counselling, psychotherapy, social support and complimentary therapies for refugees and asylum seekers with mental health issues
Migrant Refugee Community Forum	60%	Capacity building, advice and support, employment training and advice for overseas health professionals, bilingual advocacy and resource centre.

[72] Ward, K. and Palmer, D. (2005a). *Mapping the provision of mental health services for asylum seekers and refugees in London.* London: Commission for Public Patient Involvement in Health

Complexity of the issue

All of the interviewees indicated that their clients did not just suffer from trauma but that there were often a number of complicated and interlocked issues:

> *'The problems in our community are very complex. They come for relationship or bereavement or trauma but you will see that there are layers of problems. Long standing problems'* (Community based worker).
>
> *We do not provide therapy but we notice that all our advocacy clients experience additional stress because of their problems. This leads to further disempowerment.* (Community Forum)

Social issues and mental health

All interviewees noted that most of their clients needed support in addition to talking therapies.

Seven people highlighted the impact of social issues on mental health.

> *'A holistic approach is needed. Counselling by itself doesn't work. Yes, they need counselling but they also need housing advice and a welfare service. If the client doesn't have these basic needs met how can they concentrate on their emotional problems? 'It is no good having just the NHS provide services, there also needs to be a plan from the beginning involving different agencies and covering all aspects of the case'* (Community based worker).
>
> *'It's impossible to provide proper counselling without focussing on the social issues as well'* (NHS worker).
>
> *'Our clients also need advice on benefits, asylum matters, housing, English classes, community support groups, family reunification & tracing, activity groups eg sewing classes, cooking classes, exercise classes, massage and stress management, help with sorting out travel documents, financial advice and small grants. These additional needs impact on client's mental health and can exacerbate depression and anxiety. They can also create uncertainty and be a threat for clients – leads to instability which makes therapeutic work difficult and sometimes impossible in cases where this is the primary preoccupation. Can exacerbate symptoms of PTSD as well'* (NHS worker).
>
> *'We need to look at the issue in a holistic way. Look at the family, benefits, housing etc. It is better if all issues are dealt with by the one agency. Once trust has been built up it is better for us to help our clients with all of their issues….Social issue impact the mental health of clients'* (Community based worker).

Immigration, housing, benefits, language problems and family conflict were all identified as social issues impacting the mental health of the interviewees' clients.

One interviewee observed that some people feel that the only way that their social problems can be resolved is by accessing support from the mental health system.

'Client's main problem can be housing or immigration rather than trauma. Sometimes clients feel that they have to exaggerate mental health symptoms in order to get help' (Community based worker).

One interviewee reported that older members of their community are particularly vulnerable and that providing a social space helps counter isolation.

'By providing day centre for elders helps those particularly over 50 to socialise with each other and share their loneness and experiences in the host country'. (Community based worker)

Family conflict was identified as being particularly important by four of the interviewees. Two of them identified problems around men feeling as though they have lost their status and power and three highlighted conflict between the parents and children.

'The children who are born here and grow up here are very different from their parents and there are identity problems. The parent's often can't speak English and don't know the system…They are stricter and there is a big struggle between the first and second generation. There are many problems between couples. There is a lot of pressure on the couple relationship…Children become more dominant because they learn the language and the mother and the father lose their roles. The boundaries and the hierarchies are changing. Children interpret for their parents, they know everything' (Community based worker).

One interviewee noted that it was too much of a burden on counsellors to expect them to deal with the social needs as well as the counselling.

Client-centred work

One interviewee noted that it is not always possible to predict what will be important to the client:

'Sometimes their childhood experiences come up. What someone has been through in a prison in Iraq may not be as important to them as not having a relationship with their mother or the fact that they were abused as a child or a whole range of issues. It is important to be lead by the client' (NHS worker)

'The client is more important than the therapy model as the framework doesn't always fit the situation...you can break a client in pieces trying to get them to fit a model' (Community based counsellor).

In the initial assessment the client will chose the type of counsellor that they want. For example, do they want the same language? Do they want a male or female? Do they have strong views about religion? It is important to match with what the client wants otherwise the process will not work and they will stop coming'.
(NHS worker).

‘Sometimes clients don't want counselling. They don't want to unleash the lid and want to suppress things…it can take months of support before people feel ready to access mainstream services or counselling’ (NHS worker).

One service provider gives their client a break from counselling during Ramadan as they know that many Muslim clients do not want to talk about difficult things during this period.

User involvement

User involvement was discussed both in terms of involvement in the planning and delivery of services and in terms of direct involvement or access for clients receiving support or treatments.

Three service providers reported that positive attempts had been made to involve users in the initial stages of a service being set up. However, it was noted that involvement tended not to be long-term or consistent and often involvement was limited to infrequent consultations. One provider reported that they relied mainly on informal ‘chats’ or ‘meetings’ to obtain feedback. Two providers stated that they ascertained feedback in the form of questionnaires at the end of each course of therapeutic treatment. The refugee forum reported that all projects are based on consultation with group members.

‘All projects are set up based on consultation with members (users) and they are invited to join steering groups. Members are also involved in governance of the organisation as well as in strategic planning. We also have regular consultation meetings with members where they set the agenda.’ (Community Forum)

‘When the service was set up there was a lot of consultation with users.’ (NHS worker)

‘Treatment is collaborative. To date have not involved service users in developing service but it is something that we are currently exploring. We do elicit feedback from clients at the end of treatment and use this to develop our service.’ (NHS Worker)

One community group who provide services to Refugees also commented on the problem of a lack of sufficient time/warning and a lack of understanding of language needs and by the Department of Health when organising consultation meetings:

‘No one is going to read a 100 page policy document in English. When the Department of Health hold a meeting locally they want the Vietnamese (users) to attend but without someone there to help them understand no on will turn up. It takes time to prepare people. 'The format of these consultations is inaccessible and it is unfair to ask them to do this’ (Community based worker).

Accessibility

Three service providers reported that mainstream service provision was not very accessible for this group.

> *'Mainstream service provision is not very accessible – barriers include language, GPs not having the time to talk to people and find out what the problems are, lack of knowledge of mental health services in refugees and asylum seekers, long waiting lists for treatment. Mistrust and fear is another barrier and lack of supportive counselling agencies'* (NHS Worker).

> *'The mainstream mental health system is not accessible. The GP doesn't refer them for counselling and keeps them on tablets. It is only when they are desperate that the GP refers them to a psychiatrist but the waiting list is too long.* (Community worker)

One interviewee discussed the institutional factors that can act as a barrier to accessing appropriate secondary services:

> *'The mainstream mental health system is not accessible. The GP doesn't refer them for counselling and keeps them on tablets. It is only when they are desperate that the GP refers them to a psychiatrist but the waiting list is too long.'* (Community based worker)

Cultural and language barriers were also highlighted by two providers:

> *'If people aren't forthcoming about how bad they are feeling because of cultural reasons then they aren't going to access the services'.* (Community based worker)

> *'Language is the main problem for clients to access mental health services.'* (Community based worker)

Language and interpreters

All interviewees commented on the importance of using the users own language whenever possible.
Two community workers commented on the need for leaflets and information to be available in community specific languages.

One interviewee commented on the possible difficulties that can occur when working through interpreters in a secondary mental health setting.

> *'If you are seeing someone for a mental health problem language is incredibly important and you can miss so many things through interpreting'.* (NHS worker)

However, others recognised the effective use of training interpreters, and having access to consistent interpreters to allow for the building of trust.

> *'We have access to nine community languages in house and also have allocated budget for interpreting in advocacy casework. We use community interpreting agency. All our workers are bicultural. The advantages are in better understanding of different cultures and having access to languages.'(Community Forum)*

'Interpreters can work well if you have good relationship with interpreter and they are trained in working with mental health – we have access to very good interpreters whom we have been working with over a long time.'(NHS worker)

Cultural Factors

All interviewees emphasised the importance of cultural knowledge in the counselling process in order to provide appropriate services. For instance one interviewee commented on the importance of understanding cultural preferences when planning care and placing clients with particular workers:

'Some people only want to work with people who know their culture, and some don't want to work with people who know their culture' (NHS worker).

Understanding cultural factors is essential if care is to be appropriately planned and delivered:

'You can work cross culturally but you need to know the culture. There are so many people coming from rural areas where there are arranged marriages. This is an issue so the class of the client is important as well as the culture…we had a phone call about a man who had been sectioned unnecessarily because he had lost his teenage son he was extremely devastated and he was pulling his hair, banging his chest and grieving. In hospital he became worse because people were visiting his home and there were lots of ceremonies which were all part of the grieving process and he wanted to be at home to be able to do that. Something appropriate for one culture is not for another. In this case he was behaving in the normal way for our culture' (Community worker).

One service provider stated that they would obtain cultural knowledge about their clients from colleagues.

Conceptions of mental health

All of the interviewees identified the impact that culture has on the understanding of mental health amongst their client group:

'There are still people who think that they are mad or crazy when they are referred to counselling and they do not say anything to relatives or friends because there is a perception that counselling is equal to acute mental health' (Community based worker).

'The concept of mental health is different than in the UK. People don't realise that it is a social problem and see it as something magical or mysterious. They think of it as madness and see it as something uncontrollable. In Europe or the US people are more accepting of mental health problems' (Community based worker).

'The western model of therapy is fairly new for most of our clients. Speaking to a stranger about their lives is new. Many see mental illness as a type of madness. Some say that depression is not a mental illness but that it is just about 'feeling bad' (NHS worker)

'A lot of people don't want to engage because of shame or because of their perception of the situation. Clients have said "I'm not mad, I don't need counselling'. (NHS worker)

'A lot of people don't want to engage because of shame or because of their perception of the situation' (NHS worker)

'Counselling and talking therapies are not part of our culture. If we have emotional or personal problems it is not part of our culture to talk to a strange or professional. When you are talking about mental illness and mental health in the UK context these are two separate issues but in the culture they are one' (Community worker)

Stigma

All those interviewed commented on the importance of recognising the stigma that may be attached to mental health within different cultures.

'We had difficulties reaching the Somali community and so I decided to search for a Somali interpreter. She did some outreach but no Somalis came. When they did begin to come they asked for an English speaking counsellor. They feel free to speak to her without feeling shame because she doesn't know the structure of the country. A Somali counsellor will know the structure and this is difficult for the client because they come from a society that sees their position as shameful' (NHS worker).

'There is stigma attached to mental health in the communities that we work with' (Community based worker).

'Many communities have a very poor understanding of the system because it is so complicated and also because of the stigma attached to the mental health both in the UK and in the country of origin'(Community Forum).

'We talk about 'health issues' to women's group and elderly club rather than mental health issues because of the stigma attached' (Community based worker).

'I feel that our service is more accessible than NHS services but some still don't come because of stigmatisation' (Community based worker).

'We spend quite a lot of time doing psycho education and explaining concepts and exploring cultural beliefs and attitudes. Many male clients feel ashamed about seeking help' (NHS Worker).

Limited resources

Interviewees that provided a counselling service commented on the difficulties that occur due to limited resources, in particular they stated that they would like to be able to offer counselling that wasn't time limited.

Community based services stated that there wasn't enough support from the NHS and that they couldn't provide training to staff or pay them a reasonable wage.

> *'We can't cope with demand and are having to limit referrals'.* (Community based worker)

Suggestions for improving service provision

All interviewees recognised the need for health promotion and education in communities about the meanings of mental health and the mental health system in the UK.

> *'Health promotion is important. We need to raise awareness about how the system works so that they know who to contact and where to go'* (Community based worker).

> *'Awareness raising and training amongst professionals and refugee communities, more resources, better partnerships between NHS and voluntary services'* (NHS Worker).

There were many other suggestions for improving services and service delivery for refugees and asylum seekers. The central concerns were for reforming the way that the institutions and systems of the health care service worked, acknowledging the significance of cultural and social factors and improvements in the asylum process. In summary, the following suggestions were made:

- The need for more contact between community and NHS services. Recognizing the experience and knowledge of communities and creating more services that are based in the community, and with increased numbers of community link workers.
- Improving the asylum processes to make them faster and fairer, and working more with destitute asylum seekers by providing them with accommodation and at the very least basic living standards and access to full health care provision.
- The need for culturally appropriate services, to include publications in community languages, increased use of interpreters, and increasing numbers of ethnic minority staff.
- The fact of primary health staff morale was also raised. This is an important consideration, the health; motivation and professional development of staff working in this setting will inevitably contribute to the level of service provided and access to secondary and specialist services.
- Looking at innovative projects to combat health inequalities and developing funding strategies to allow for long-term planning and implementation.

COMMISSIONER

Although attempts were made to contact commissioners from Primary Care Trusts commissioning mental health services in various parts of London, we were only successful in obtaining one interview.

Specific services for Refugees and Asylum seekers

The issue of specific services for Refugees and Asylum seekers with mental health services was discussed. The commissioner indicated that are no specific funded services for this group.

> *'There are no specific services for refugees and asylum seekers although; there are service level agreements with three BME organisations focusing on issues of communication and access'*

> *'There is also a BME sub-group which links up people from primary care and health promotion with the BME organisations so that representatives from these organisations can be assisted in their work. The idea is to employ three BME support workers to assist with access issues in the BME community.'*

Looking at services that have Refugee and Asylum seeker clients

The commissioner reported on research that had been undertaken to identify possible needs:

> *'A mapping exercise idenitfied a need to make services more accessible. We have begun to talk about the problems but there is a need for more solutions.'*

The mapping exercise identified some of the main achievements of services that were available. The most important achievements of these services we identified as interpreting and literature:

> *'At the moment we offer interpreting and literature in different languages and we have a complaints system in place but there is a need for more than this.'*

The commissioner commented on the problem of ensuring Refugees and Asylum seekers access the services that were available to them. He recognised the impact of culture and acknowledged the importance of understanding cultural factors:

> *'Issues around stigma have been identified and groups have said that individuals are wary of accessing services and often want to access them out of the borough'.*

The problem of gaps in service provision

Asked why the provision of mental health services for refugees and asylum seekers in London is inconsistent the commissioner replied:

> *'In Bromley it is a bit further out from the rest of London and there aren't as many problems as with places close in. But people are still receiving lower levels of treatment and some none at all.'*

The need for user involvement and working groups was identified as a way forward

The commissioner identified the need for partnership working:

> *'Minority groups need to be empowered to be able to contribute and influence service provision.*
> *We are hoping to set up a working group made up of senior managers from the local authority, PCTs and the NHS Trust along with BME groups. This will help everyone to join up their resources'* (Bromley Commissioner).

Future Funding

When asked "What do you think can be done to encourage commissioners to fund mental health services for refugees and asylum seekers?" The Commissioner replied:

> *'People need to be forced to act. There is a need for a specific target in the NSF. This will help to move things forward. However, you have to be careful as when people are forced to act is does not necessarily mean that the services developed are robust. It is best when it grows organically from within.'*

The commissioner also reported that the NHS is likely to fund the mental health work of community organisations if:

> *'They can help with early intervention, needs assessment, Information & communications, preventative work and social inclusion bridge-building. Also where the impact of their service can demonstrate that they are keeping people out of mainstream MH services*.'

PART 3: THE GOOD PRACTICE GUIDE - THEMES AND RECOMMENDATIONS

Emerging Themes and Priorities

Identifying the criteria for what constitutes as good practice is problematic. Different stakeholders will have different interpretations of, and criteria to measure, good practice. For instance mental health professionals may assess good practice as being demonstrated by clinical outcomes, refugee community groups and voluntary sector organisations may measure good practice in relation to funding criteria whilst the 'service user' may value the interrelationship with the clinician, including the extent to which s/he feels respected, has a voice and participates in service design and evaluation. Whist being aware of this context to our good practice guide is based specifically on the findings from our research. We will however draw upon much of the related prevailing literature in the area of refugee and asylum seeker mental health care.

This section acts as a guide for service users, health providers and commissioners and examines the ways in which primary, and other health care professionals can promote socially inclusive mental health services for refugees and asylum seekers.

We have drawn out emerging themes, priorities and implications from the interviews carried out with all participants. Many of these themes overlap and are linked on significant points and significantly with the subsequent recommendations. We have tried to avoid repetition of specific recommendations; however, we are also aware of the need to present each area as a distinct section which could be read without reference to any other section if necessary. We have therefore negotiated this complex issue and identified six main areas for consideration, these are:

- **Partnership working – statutory, Refugee and voluntary sector community groups: Addressing social care needs by working holistically – combating social, economic and political factors**
- **Accessibility and engagement – Advocacy, befriending, and user participation in service planning and delivery**
- **Cultural sensitivity and understanding – perception, stigma, language, education and training**
- **Care provision – Talking therapies, alternative therapies, user-led services and possible solutions**
- **Evaluation, consultation and planning/funding future services**

This section will explore each of these areas and include recommendations for good practice. There is also a supplementary section at the end of this guide entitled: '**Mental Health provision for Asylum seekers detained in immigration detention centres (IDCs)'.**
Although not specifically about provision within London, the Commission for Public Patient Involvement in Health requested that it be included. The situation and experiences of detainees will inevitably impact on their mental health, it is therefore imperative that health

care providers in London are informed about this issue, particularly as it may result in them accessing health care provision within the London area. This area warrants comprehensive future research.

KEY RECOMMENDATIONS – RELEVANT TO ALL AREAS:

Health providers need to offer a 'holistic' response to the needs of refugees, providing advice and advocacy, social and emotional support, and access to education and training.

Promote and fund 'One stop shop' services. Such multi-agency services can provide comprehensive advice and support dealing with the multi-faceted needs of the refugee and asylum seeker communities. This model facilitates partnership working, improving communication between organisations and providing a service base which aims to be all-inclusive and adopting preventative measures thus improving health outcomes.

Partnership working – statutory, Refugee and voluntary sector community groups: Addressing social care needs by working holistically – combating social, economic and political factors

One of the most significant themes to emerge from our research has been the need for a holistic way of working with refugees and asylum seekers with mental health care needs. The implications for such a method of working are far-reaching, moving beyond a medical model of the causes and effects of ill health.

The alternative is a social model which acknowledges the socially political and culturally constructed definitions and arrangements/experiences that determine an individual's expectations, knowledge and circumstances. It therefore follows that health is a holistic concept embracing an individuals social, physical and mental well-being and influenced by social, economic, political and environmental experiences. In this way the solving of mental health 'problems' becomes an issue beyond that of the individual, rather encompassing the challenge of working with the organisation of key aspects of social life (to include housing, employment, legal status, education and training).

This produces challenges at all levels – from strategic, to operational planning, to service delivery. Providing holistic care can be difficult to co-ordinate across many disparate services. A truly holistic approach would also need to involve social services, refugee community organisations, mental health providers and a range of providers in the both the voluntary and statutory sector.

Social Support Networks

The need for 'community setting' and support networks in order to reduce isolation was identified as one of the main issues improving and impacting on mental wellbeing for those interviewed. The UK has been significantly influenced by ideas of multiculturalism, and the perception of a 'community' therefore plays a vital role in the individual's incorporation into the rest of society. Kelly (2003) argues that *'this model has been used for the incorporation of refugees into society and informs current legislation and policy.'* [73].

Whilst the role of traumatic experience should not be overlooked when determining the psychological illness patterns of refugees, the potential effect of the contextual circumstances of the asylum seekers and refugee experience in the host country was identified by all those who participated in our study. Those interviewed placed much emphasis on a need for social support networks and users from certain communities such as the Congolese community, expressed a huge need for a community which would accommodate their specific culture and traditions.

Partnership working

Efforts to establish and maintain cross agency partnerships should be a priority in providing mental care provision for refugees and asylum seekers. While acknowledging some successful alliances, there is still room for developing effective co-working. Much can be achieved at local levels through forums and encouraging marginalized communities to access and contribute to service planning and delivery. It is essential that refugee and voluntary community groups are encouraged to participate in multi-agency forums working with both statutory and non statutory agencies in order to work together on the issues of mental wellbeing, resulting in specific knowledge being shared and contacts being forged and established.

There is very little available literature on refugee community organisations and their role in dealing with mental illness. In the case of refugees, Refugee, voluntary and community organisations would seem to be the only available point of engagement.[74] Many refugee groups form community and voluntary organisations to promote their language and culture and to counter isolation; it also allows them to meet the outstanding needs in their community and to supplement the work of the statutory sector. Mutual support within a community can sustain the health of its members in otherwise unfavourable conditions.[75] Refugees use statutory and voluntary groups, but it has been identified that their main links tend to be with community groups.[76] Refugee Community Organisations can play a large, positive role in helping refugees come to terms with their new life and studies have show that access to a refugee community group can reduce the severity and likelihood of mental illness.[77]

---

[73] Kelly, L. (2003) *'Integration Policies in the UK'*. Intpol-United Kingdom.
Burnett, A. and Peel, M. (2001). Asylum seekers and refugees in Britain. Health needs of asylum seekers and refugees. *BMJ*, **322**:544-547

[74] Keating, F., Robertson, D., and Kotecha, N. (2003). *Ethnic Diversity and Mental Health in London.* London: Kings Fund.

[75] Aldous, J., Bardsley, M., Daniell, R., Gair, R., Jacobson, B., Lowdell, C., Morgan, D., Storkey, M., Taylor.G. (1999). *Refugee health in London: key issues for public health*. London: Health of Londoners Project.

[76] Harris K and Maxwell C. (2000) A needs assessment in a refugee mental health project in north-east London: extending the counselling model to community support. *Medical Conflct and Survival*;**16**(2):201-15

[77] Carey-Wood, J., Duke, J., Kar,V. and Marshall.T. (1995). *The settlement of refugees in Britain*. Home Office Research Study 141. London: HMSO Books.

RECOMMENDATIONS

- Recognition, support and investment in incorporating Refugee community and voluntary organisations into the development and implementation of mental healthcare provision for refugees and asylum seekers. These organisations have the expertise, specific knowledge and experience to contribute at a strategic level such as planning and design and additionally they need to be strategically supported to provide and develop the services that they offer.

- Many support services are voluntary projects which survive on short-term or little funding. While this may be appropriate when services start, it is important that local authorities and government departments look to 'mainstream' services and funding to allow them to be more widely and more permanently available.

- Capitalising on community knowledges and understandings in terms of building on existent projects and ideas. This can be achieved through formal consultation structures and informal networks (such as newsletters and cultural events).

- ‘Signposting’ – ensuring that service users are directed to other services available to them in both the voluntary and statutory sectors.

- Information sharing between partners providing specific and relevant details and resources in order to meet health and social care needs.

- NHS Trusts and the PCT should be pro-active and liaise with Refugee community and voluntary organisations in order to raise awareness on particular and relevant available services.

- It is necessary for those commissioning and planning services to be clear of the specific needs of refugees and asylum seekers. There is a need to develop clear commissioning protocols that promote co-ordinated care.

- Processes need to be flexible to recognise local needs and to identify agencies and Refugee and voluntary community groups that are best placed to provide services in a given area. For these communities to be effectively integrated this expertise must also be integrated into mainstream discussions on issues affecting the lives of asylum seekers and refugee communities.

- Commissioners need to sustain involvement of Refugee, voluntary and community organisations at planning and service delivery level by encouraging the formation of regional and local networks and partnerships.

Addressing social care needs by working holistically

Housing

All of those interviewed reported that factors such as housing and poverty and adverse social circumstances played a major role in their mental health problems. Studies have highlighted that Ethnic minorities (with refugees inevitably included in this group) actually experience higher levels of housing deprivation than other citizens in the host nation.[78] According to Brown and Harris (1978) poor housing conditions can be linked to depressive disorders and metal ill health.[79] Pilgrim and Rodgers (1999) further examine the relationship between health inequalities, housing and ethnic minority groups and conclude that ethnic groups are overrepresented in poor housing and that housing deprivation clearly affects the behavioural and psychological processes of individuals.[80]

A significant proportion of the service user group interviewed presenting as homeless, living with friends or residing in temporary hostel accommodation. Previous research undertaken for Shelter LONDON and NCAB (National Citizens Advice Bureau) indicates that temporary B&B and hostel accommodation is unsuitable and impacts on mental illness.[81]

[78] Blackburn, C. (1991). *Poverty and Health*. Milton Keynes: Open University Press

[79] Brown, G. and Harris, T. (1978). *Social Origins of Depression*. London: Tavistock Publications.

[80] Pilgrim, D. and Rogers, A. (1999) *A Sociology of Mental Health and Illness*. (2nd ed.) Birmingham: Open University.

[81] Palmer, D., Scott, M., and Murphy, C. (2001). *Far From Home : A report on suitability of temporary accommodation provided by London Local Authorities*. London: National Homeless Advice Service-NACAB

RECOMMENDATIONS:

- Planning the supply of housing needs, including NASS accommodation in LONDON, needs to be based on extensive consultation in order to ensure that it meets the needs of local refugee communities.

- Stronger partnership working between housing organisations and Refugee community organisations (R.C.O's) should lead to more culturally-sensitive services, related more closely to people's needs. R.C.O's are keen to be involved in influencing and in some cases providing support services.

- Housing departments, support teams and refugee communities should work in close partnership to help refugees settle and sustain independent living.

- Housing providers including NASS must establish a effective protocols and a regular method of inspecting accommodation, emergency, temporary and long-term, to ensure that accommodation providers are meeting adequate standards in terms of amenities and environmental health standard.

- Some refugees may prefer to be accommodated in an area hugely populated by their own community where services are geared to address their distinct cultural needs.

- Local authorities should seek to keep 'out of Borough' placements to a minimum and carefully assess the potential risks associated with placing individuals away from their community and support networks.

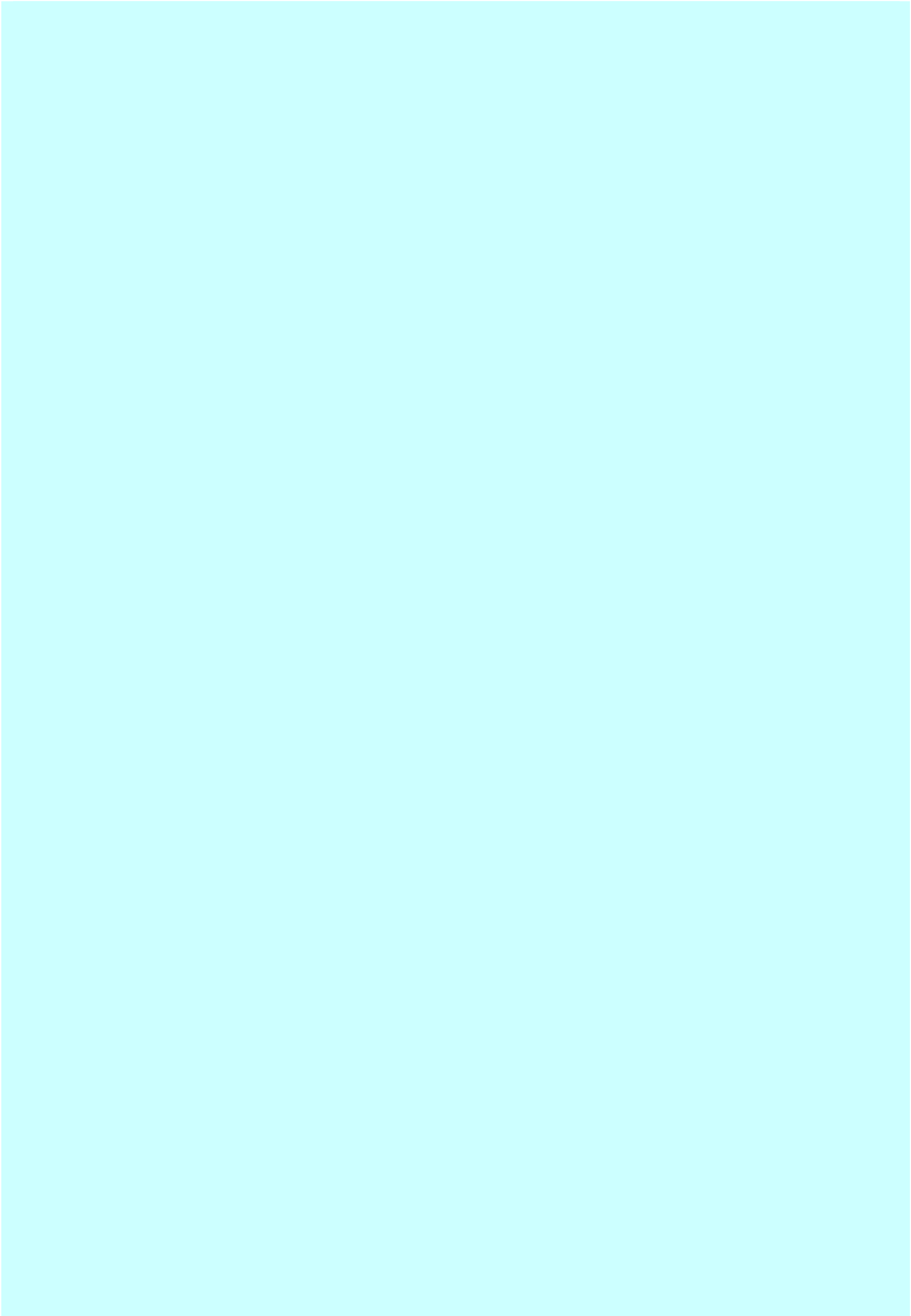
- Some refugees may have mental health needs that require specific care and should therefore have access to specific support services. There is a need to develop housing stock, which accounts for specific requirements.

- Refugees and asylum seekers with a disability should be allocated to suitable and where appropriate supported accommodation.

- The use of temporary accommodation for refugees and asylum seekers should be kept to a minimum.

- Partnership services need to organise to provide extensive support to enable users to move quickly from temporary to secure permanent accommodation.

- It is essential that local authorities provide assistance to those moving from temporary to permanent accommodation. Given that some may have difficulties with the English language, are not familiar with the welfare benefit system, may have few family members or friends in the UK, may be fearful of racist attacks and are generally a vulnerable group more attention and expertise needs to be devoted to helping refugees settle into their new residencies.



Sustainable living

Townsend (1979) in his seminal study 'Poverty in the United Kingdom', defines poverty as 'a concept of relative deprivation' and examines contributing aspects to poverty which include homelessness, ethnicity, low income, age, ill health and housing deprivation, amongst others.[82]

This research has established that the issues and impact of deprivation are crucial when developing mental health service provision for refugee and asylum communities. It is apparent that economic deprivation can impact negatively on mental health. Socio-economic adversity, destitution and lack of occupational opportunities were significant factors contributing to the poor mental health of the service users interviewed. In contrast there is wide recognition that the quality of life for vulnerable people and their mental health and well-being can be dramatically improved through increased income.

Summerfield (2001) and Tribe (2002) argue that poor social support is a greater predictor of depression in the long term than trauma.[83]

Evidence suggests that refugees suffer high levels of unemployment and are disadvantaged in the labour marked. There are many factors which contribute to this inequality (as discussed in the previous section – CONTEXT); perhaps the most significant however is the issue of language.[84]

It is significant that none of the service users interviewed are in employment despite some being very proficient in English and some possessing high levels of education in their country of origin.
All are in receipt of welfare benefits, NASS support or Social services Support or are destitute without any financial support.

---

[82] Townsend, P. (1979) *Poverty in the United Kingdom, a Survey of Household Resources and Standards of Living*, London: Penguin and Allen Lane.

[83] Tribe, R. (2002). Mental health of refugees and asylum seekers. *Advances in Psychiatric Treatmen,* **8**: 240-247.
Summerfield, D. (2001). Asylum seekers, refugees and mental health in the UK. *Psychiatric Bulletin,* **25**: 161-163.

[84] Ward, K. and Palmer, D. (2005a). *Mapping the provision of mental health services for asylum seekers and refugees in London*. London: Commission for Public Patient Involvement in Health

RECOMMENDATIONS

- A 'One stop shop' model is again extremely relevant to solution planning in this area. Such a model would help facilitate income maximisation on many different levels to include negotiating the welfare system, education, training and careers advice.

- Minimising the number of contacts users need to have with the benefit system in order to secure the right outcome.

- Awareness training for professionals on the importance of securing entitlements and recognising need and referring users on to appropriate sources of help.

- Systems and processes to ensure equality of access and provision, for example - access to a home visiting service for especially vulnerable refugees, to ensure that they are not lost or forgotten or excluded from mainstream support systems.

- Improving public awareness of entitlements and availability of support – advertising campaigns and benefit checks focused on specific entitlements for specific communities.

- Improving forms and leaflets, less jargon, multi-language formats and a simpler application process.

- Refine the process of those moving from NASS support to mainstream welfare support.

- Financial assistance for those who are destitute, refused asylum or outside immigration rules.

Legal, Political and Institutional factors

Another important factor impacting upon the mental health of those interviewed was the complexity and great uncertainty surrounding their legal status.

The experience of uncertainty means that for many months and sometimes year's individuals live with a fear that they may be returned to their country of origin. Daily and persistent anxiety over the possibility of deportation and dealing with the complex legislation and decision making process has resulted in an increased level of mental distress and demoralisation for many of those interviewed. This inevitably impacts on integration, mental wellbeing and emotional and behavioural responses. In addition this experience was also acknowledged by mental health professionals to have a major impact on the ability of individuals to engage with treatments.

It is important to note that professionals working within the Refugee and health sectors have had to work within an ever-changing complex legal framework. It remains a priority to understand the implications of these changes and the subsequent impact on Refugees and Asylum seekers in the UK.

The challenge of dealing with the monolithic institution of the immigration system can encourage feelings of helplessness and despair most likely due to a lack of control over the situation. This lack of control can impact of an individual's self esteem, perspective, and self confidence and consequently individuals can be locked in an internal pattern called 'learned helplessness'. Learned Helplessness is understood as a motivational issue whereby failure or lack of control over a situation or situations makes the individual believe that they are incapable of doing anything to improve their situation and consequently can have a detrimental effect on an individuals well being.[85]

RECOMMENDATIONS

- Training needs to be provided for all relevant parties working with refugees and asylum seekers to ensure that they are able to face the challenge of understanding and adapting to the frequent changes in current legislation and policy.

- Improving the immigration process so that claims are decided equitably and as fast as possible, therefore mitigating against anxiety, fear, demoralisation and destitution.

- Refugee and Asylum seeker organisations, faith and voluntary organisations need to expand their remit in terms of acting as pressure groups lobbying the Government, particularly the Department of Health, NASS and the Home Office to improve policy related to refugees and asylum seekers.

- NASS administrative systems should be expanded and improved in order to avoid the numerous delays and failures in payments that currently occur.

- NASS to work with health care professionals and communities to ensure continuation of care is provided and consequently not to disperse those with mental health care needs and thus disrupt their vital care and support provisions.

- Permission to work immediately should be granted to those who have submitted and application for asylum in order to give the opportunity to support themselves and not remain dependent on state support.

- The UK Government should be pro-active in educating health providers and the public so they have a full and accurate understanding of the reasons why people claim asylum in the UK and the actual level of state support to which they are entitled. In this way, discrimination and hostility can be reduced, and the public support for providing adequate levels of assistance can be improved.

---

[85] Peterson, C., Maier, S. F., and Seligman, M.E.P (1993). *Learned Helplessness.* Oxford: Oxford University Press.

Accessibility and engagement – Advocacy, befriending, and user participation in service planning and delivery

This research has explored the issues of accessibility and engagement both in terms of access at the service provision interface and in relation to access to the important decision making and planning mechanisms.

The importance of service user involvement in good quality mental health provision has increasingly become part of the mainstream social and political agenda. Recent UK Government policies have aimed to shift mental health service ideology from a hierarchical culture to a participative, inclusive and solution focused approach that seeks to empower users and work in partnership with community and voluntary groups in order to improve mental health services.[86]

Accessibility and engagement

In reality there are many potential barriers to accessing mental health services (refer to the related section in the 'CONTEXT' for a more detailed outline and discussion of these factors). The most significant of which are noted from our research to include language, cultural factors, institutional factors to include how services and systems are organised, a lack of information about services available, and pressure from limited resources/funding. It is therefore important that partner agencies collaborate on issues and solutions to the problems of access to ensure that those in need of help, support and treatment receive the service they require.

In particular our findings show that the majority of service users interviewed felt that access to secondary and specialist services was either limited, time restricted or delayed. Once access was gained however, most users were satisfied with the time and regularity of appointments. The service provider interviews, particularly the community groups, highlighted the issue of funding. It was reiterated that there remained a need to pressure for appropriate and relevant services to receive adequate funding if they were to be able to offer services which could be relied upon in terms of consistency and longevity.

Advocacy and Befriending

Advocacy was identified in the research as a comprehensive and successful way in which to engage service users and to eventually result in effective participation in the processes of planning and service delivery. An advocate, who both listens and when appropriate speaks for a user, works to enable users to express themselves, access and explore relevant

[86] Department of Health. (1999). *The National Service Framework for Mental Health. Modern Standards and Service Models.* London: Department of Health.
Department of Health. (2000). *National Service Framework for Mental Health: Modern Standards and Service Models.* London: Department of Health.
Department of Health. (2003). *Delivering Race Equality; A framework for Action.* London: Department of Health.
Department of Health. (2005). *Delivering race equality in mental health care – An action plan for reform inside and outside services.* London: Department of Health.

information and service options and be empowered to promote and secure their rights and responsibilities.

'Mental health advocacy has been developing in the UK over the last decade as one way of challenging the discrimination faced by users and survivors of the mental health system. Advocacy in all its forms seeks to ensure that people are able to speak out to express their views and defend their rights.' www.mind.org.uk

There are many different types of advocacy and it may be appropriate to adopt only one or a mixture of approaches at different times and in different circumstances. The main types of advocacy are – self, group, peer, formal, professional or paid, citizen, legal and best interests (non-instructed). A full definition and discussion of each of these types can be found in Appendix 3 as offered by MIND in Harrow, LONDON, also refer to www.mind.org.uk .

Befriending is a strategy which involves helping users and/or potential users to make choices about their lives, and to particularly support them during important transition points to enable them to rebuild their lives in the UK.

User involvement

'For people who already experience discrimination and exclusion having a mental health problem creates another barrier to social inclusion and can make voicing opinions, wants and needs almost impossible' www.mind.org.uk.

The issue of user involvement presented itself in a complex and seemingly contradictory way. Whilst the service providers and the Commissioner interviewed acknowledged the potentially important contribution service users can have in the planning and delivery of services, when asked about user involvement the service users themselves, particularly during the consultation exercise, responded with ambivalence. Interestingly, the service users interviewed and those involved in the Focus group consultation evidently appreciated the opportunity to contribute to the research; however, they then placed very little value in user participation in general. It is important to note that their priorities lay very much with sustaining their mental and physical health and consequently their political life in this context took second place. It is evident that a healthy democracy requires a healthy population on all levels, for individuals that are preoccupied with basic survival will feel unable to contribute to important decisions that affect their lives. In essence they have become disengaged and disempowered and therefore the formal structure of consultations, forums and user-led meetings may be so far removed from their everyday reality.

It is important to reiterate that this research is based on a small scale and although valuable in itself and to some extent able to be generalized in terms of the wider community, it is not fully representative of all refugee and asylum seeker individuals and communities. Individuals will inevitably occupy different positions and have had different experiences which may be less likely to mitigate against participation. Consequently it should not be concluded that user participation is unimportant or irrelevant, rather that these findings emphasise the importance of holistic working in order to combat the practical barriers which may prevent users from feeling able to make a valuable and necessary contribution to their own and their communities mental health care provision. It remains an important strategy to whenever possible encourage and support service users to contribute to service planning and

delivery in whatever way they feel possible. Such an approach will inevitably require innovative and creative thinking in terms of engaging with users to ensure that it is itself user led in terms of appropriate strategies informed by cultural understandings and practical considerations.

RECOMMENDATIONS

- It is essential to prioritise holistic working and 'one stop shop' agencies (see recommendations for partnership working).

- Comprehensive, consistent and professional development training for mental health service providers to increase knowledge of cultural factors and explore different approaches to encourage engagement (the significance of cultural factors and training is outlined in more detail in the following section 'Cultural sensitivity and understanding')

- Primary care trusts need to facilitate health promotion events to raise awareness of services available.

- Refugee, voluntary and community organisations need to liaise with primary care professionals to ensure that the most vulnerable clients are given the most appropriate treatment or referred to secondary or specialist services as quickly as possible.

- Flexible use of interpreters at the service interface, where necessary providing a choice of interpreter and double appointment slots at surgeries and clinical settings to allow for translation time and correct understandings of diagnosis, prognosis and treatment.

- Funding community advocate and befriending programmes (in all the many different forms as appropriate) in order to improve access, social inclusion and equitable health care provision. The benefits for advocates could include experience, skills, training in recognised mental health qualifications, references and enhanced job prospects.

- Formal, Professional or paid advocates would need to be trained in mental health issues so that they are then able to offer education and training and work with volunteers and mentors from asylum seeker and refugee communities in order to ensure users are better informed.

- Develop innovative ways of engaging with users that may be less formal than traditional forms of consultation; engagement is therefore on their terms rather than through a pre-set format. Some possible suggestions are:
    - use cultural events to promote services and develop relationships
    - use newsletters to both inform and represent views
    - consultations can be carried out in community settings or during home visits
    - encourage users to use a diary to record positive and negative views on their experiences of service provision, this could also be tape recorded or video recorded if the written word is an inappropriate format
    - day trips can be organised which provide a non-threatening and relaxed

opportunity to canvas views and feedback (obviously with informed consent)

- encourage and promote user-led informal groups which provide alternative mechanisms for individuals to discuss their experiences in an informal setting, examples of such groups could be sewing, art, music, poetry, creative writing and cooking.

- Encourage and obtain feedback from partner agencies via third party reporting. This may mean that if a client is referred by a partner agency their views and opinions may be obtained by the referred to agency via their own innovative method and reported back to the original agency.

Cultural sensitivity and understanding – perception, stigma, language, education and training

Cultural sensitivity and understanding

Recognizing the importance of culture and recognizing that culture is not static and understanding how the dominant culture within a society shapes and influences all aspects of institutional service provision and development is essential to any discourse on the challenges facing both service users and the systems and institutions comprising health care provision. The health of refugees and issues of accessibility for certain groups can be underpinned by culturally specific understandings of mental health, stigmatisation of mental health issues and the role of treating illnesses. Many societies and cultures stigmatise mental health and the diagnosis of mental illness may be unreliable cross culturally. Cultural interpretations about psychological distress, trauma and mental health maybe viewed differently in different parts of the world particularly given associations with 'madness'.

Whilst the role of traumatic experiences should not be overlooked when determining mental illness, the cultural context within which the refugee operates is highly important. Burnett and Peel (2001) described Refugees as a heterogeneous people who have different cultural expectations of healthcare.[87] This view is echoed by Ackeman (1997) who adds that there is great variation in health and psychological issues as well as cultural beliefs.[88] Symptoms of psychological distress are described as being common but they do not necessarily signify mental illness.

The problem of perception

One of the most significant challenges facing both users and service providers is the problem of perception. The perception of mental illness within certain culture, in addition to narrow western interpretations can result in a barrier to accessing mental health services. Our research has highlighted differences in perception and interpretation of mental health in certain communities, with community workers reporting that mental ill health is generally understood as a binary function: people are either sane or are mad. Unless cultural interpretations of distress are taken into consideration, communities will not access services and misdiagnosis may occur and everyday mental distress can be mistaken for mental pathology.[89]

A culturally sensitive approach is therefore necessary if users are to receive appropriate care. Understanding how these cultural interpretations may impact on potential access and use of Western health care is essential if service providers want to ensure those needing help are getting the help they need.

Stigma

Mental illness has traditionally involved a high degree of stigma for sufferers and their families. Stigma has been described as negative outcomes that result from any physical attributes, behaviour or character, which deviates from the norm and is perceived as

---

[87] Burnett, A. and Peel, M. (2001). Asylum seekers and refugees in Britain. Health needs of asylum seekers and refugees. *BMJ*, **322**:544-547

[88] Ackerman, L. K. (1997). Health problems of refugees. *The Journal of the American Board of Family Practice*, **10** 337-348.

[89] Fernando, S. (1995). *Mental Health in a Multi-Ethnic Society*. London: Routledge.

undesirable.[90] There are many negative consequences of stigma, many of which operate to perpetuate the existence of negative attitudes, feelings and behaviour directed towards those suffering from mental illness. Stigma is a complex process of labelling that has many causes and is maintained by various structures and can occur at an individual level, community level and at a service delivery level.

Language

Perhaps the initial principal barrier refugee's and asylum seekers face in accessing any service is that of language. Any service seeking to respond to this group must have a range of language skills available in a highly flexible way. Without interpreters, service users are denied access. The Health of Londoners Project identified language *"as the biggest single obstacle to access and as a major issue for providing healthcare to refugees"*.[91] Inability to speak English is not only problematic during the clinical encounter but makes accessing services and appointment making difficult. Other studies have identified that many minority ethnic groups are unaware of services available for reasons primarily to do with language.[92]

The issue of language was mentioned by all three groups of interviewees and was given a high priority in terms of changes and improvements required. Interestingly the problems and solutions were not as straightforward as simply improving the availability of interpreting services, three of the service users interviewed expressed a dislike for the use of interpreters from their countries of origin, fearing that they would be judged or become the subject of gossip. The recommendations for improvements in this area therefore need to take into account these specific cultural factors.

Education and training

The questions and discussion from the interviews represented education and training both in terms of the professional development of mental health care workers and also in terms of the needs of the refugee and asylum seeker as a way to facilitate successful integration.

It has been widely accepted that material deprivation can impact negatively upon mental health. It is therefore imperative that service users are encouraged and supported where appropriate to undertake education and training or conversion courses (allowing them to utilise qualifications obtained in their country of origin) in order to begin their journey into employment (paid or voluntary) in the UK.

Two service users talked about the need for them to feel 'normal' in terms of going to work and earning their own money again. Another user talked about how a recent computer course they attended made them feel better about themselves and helped them to meet other people and allowed them to feel more positive about their future.

The need for the appropriate education and training of all those working with refugees and asylum seekers in supporting their mental health needs was recognised by all the service providers interviewed.

---

[90] Weiner,B.,Perry,R., Magnusson,J.(1988) An attributional analysis of reactions to stigma. *Journal of Personality and Social Psychology*, **55**, 738-748

[91] Aldous, J., Bardsley, M., Daniell, R., Gair, R., Jacobson, B., Lowdell, C., Morgan, D., Storkey, M., Taylor.G. (1999). *Refugee health in London: key issues for public health*. London: Health of Londoners Project. P50

[92] Harris K and Maxwell C. (2000) A needs assessment in a refugee mental health project in north-east London: extending the counselling model to community support. *Medical Conflct and Survival*;**16**(2):201-15

RECOMMENDATIONS

Cultural sensitivity and understanding

- Agencies need to address the lack of cultural understanding of the dynamics of refugee communities and the cultural, political and social background of refugees. Relationships need to be developed between Refugee, voluntary, faith and community organisations and mainstream agencies, developing good practice standards for wide implementation, such as always providing refugee clients with appropriate advocates
- Services need to work in partnership with refugee and asylum seeker community groups and voluntary organisations to ensure that the services provided are responsive to the client group.
- Innovative approaches need to be employed to empower communities such as through the 'Refugee Doctors programme' a national initiative, whereby refugee doctors are encouraged and supported to resume their medical careers in the UK and work towards developing culturally appropriate services within mainstream provision. Such programmes can act as a forum in which individuals and organisations can exchange information, share experiences and work on specific health projects with members of their community. These events can also highlight issues and gaps in service provision for which lobbying is needed.
- Service providers need to ensure equal opportunities for BME individuals to be represented in the workforce, thus making services more culturally competent.

Stigma

- In order to combat stigma there needs to be a multi level community education and training process where members of the community provide positive role models and demonstrate the possibility of positive outcomes and counter the possible negative beliefs within the community and institutions which stigmatise those suffering from mental ill health.

- To reduce stigma surrounding mental illness, strategies need to be multi-faceted and have a co-ordinated approach to ensure that they reach community members, individuals and institutions.

Language

- Partnership work between public, private and community groups needs to be developed in order to combat the difficulties related to linguistic and interpretation needs. For instance community organisations have access to interpreters who are able to represent the needs and desires of the individual refugee within a user participation forum or at a service provision level.

- Funding is required for Refugee, voluntary and community organisations to provide training programmes for refugees to act as paid interpreters or translators for their own communities, empowering them to help others and potentially address the issue of trust if the interpreters themselves have had experiences and understanding of mental distress.

RECOMMENDATIONS (CON'T)

- The NHS needs to ensure the availability of appropriate trained interpreting and advocacy services. Ideally access to a consistent interpreter would allow for the building of trust.

- It is important that service users have access to a choice of interpreter, one perhaps not from their own culture, if they do don't feel comfortable or secure with an interpreter they are unlikely to be open about their situation.

- Service providers must ensure the availability of a range of health promotion literature/information that is aimed at refugees and asylum seekers in relevant languages and culturally sensitive.

- Health providers need to develop a system of translating letters, forms and appointment cards into relevant languages and formats.

- Health providers should have targeted written/video information in community languages produced in partnership with Refugee, voluntary and community organisations on health service provision and steps on accessing these services.

Education and Training

- Health providers need to share information about education and training opportunities available to asylum seekers and refugees.

- Access to Learner Support Funds and other funding streams for asylum seekers and refugees is necessary to increase participation and retention on education and training programmes.

- Refugee, voluntary and community organisations need to be adequately funded and supported to allow them to provide good quality ESOL classes that are differentiated and specialised to maximise opportunities for progression, and IT class, and creative classes such as storytelling and developing self-esteem/confidence building classes.

- Health providers need to conduct education programmes at a community level, ensuring that users are informed about accessing services and where to access information and treatment options.

- Health providers and commissioners need to ensure effective training in trans-cultural awareness for mental health professionals and community groups. This would need to include information and training on ethnicity and mental health which should cover understanding of language, culture and racism and the implications on mental health service provision. Ideally, training would be built into qualifying courses and continue throughout a professional career.

- All NASS staff dealing with applications for support should receive awareness training on relevant issues including mental health and disability.

RECOMMENDATIONS (CON'T)

- Training needs to recognise the importance of health awareness programmes that focus on mental health issues.

- Staff in community groups would need specific training so that they were able to recognise the symptoms of mental ill-health and importantly to work with refugees in a supportive environment to combat any negative attitudes and stigma associated with mental illness.

- Refugee Community organisations must be consulted and involved in the delivery of education and training programmes to communities and individuals that they have a professional expertise of working with.

- Refugee and Asylum seekers organisations, voluntary and community organisations need to be aware of the different career pathways available to their service users, and make links with local education and training centres to improve access to appropriate courses; in addition to liaising with The National Academic Recognition Information Centre so that correct advice can be given on the comparability of overseas qualifications.

- Health Authorities should play a more active role in assisting conversion training for refugee mental health professionals (e.g. for people who are doctors in their country of origin).

Care provision – Talking therapies, alternative therapies, user-led services and possible solutions

Fernando (2002) Littlewood and Lipsedge (1997) have reported that once patients from minority ethnic groups are incorporated into the mental health system they are likely to have access to inferior kinds of therapy such as physical treatment methods, mainly in the form of drug treatment, at the expense of alternative forms of treatment such as psychological and cognitive-behavioural interventions.[93] The reason often given for this difference in access is the perceived unsuitability of patients from minority ethnic groups to use them comprehensively. Fernando (2002) argues that this is a racist practice, which discriminates against minority groups in their access to mental health services and consequently disadvantages them severely.[94] This is important research to consider and warrants further exploration, particularly with regards to refugees and asylum seekers. The implications of such limited and controversial treatment options have been considered when formulating our recommendations.

Refugees and asylum seekers are a diverse group each with distinct identities and with different perceptions about mental wellbeing and how to treat mental 'illness'. Both the service users and providers commented on the usefulness of alternative approaches to mental distress. There were diverging opinions (see 'Findings') on the usefulness of talking therapies, however it can provide an important support for some (7 service users in this research reported the positive impact that talking therapies had had for them), and should therefore be available, if appropriate, as central to, or part of, care provision.

This research has highlighted the importance of providing more services for refugees and asylum seekers, including looking at alternative treatments, holistic treatments, providing alternative services and services within a community setting.

[93] Fernando, S (2002) *Mental Health Race and Culture* (2nd ed) Palgrave: Basingstoke
Littlewood, R. and Lipsedge, M. (1997). *Aliens and Alienists: ethnic minorities and psychiatry.* (3rd ed). London: Routlege.

[94] Fernando, S (2002) *Mental Health Race and Culture* (2nd ed) Palgrave: Basingstoke

RECOMMENDATIONS

- It is essential for health providers to work at a client-based level, exploring the individual understandings and specific beliefs relating to mental 'illness' and to address and incorporate where possible issues which they believe will be relevant to their mental health and that will promote their wellbeing

- Strategies should be in place to recruit qualified and ethnically diverse staff at all levels, and services need to liaise with religious, faith and community leaders in order to understand all the possible treatments being undertaken and what they regard as effective interventions.

- Care providers can learn from or incorporate coping mechanisms that may have been used in the country of origin, in this way the best elements of both Western and indigenous methods and techniques can be combined to provide the most appropriate care package.

- Treatment options need to be broad and flexible in order to adapt to the specific needs of individual users. This will mean a variety of options are available when necessary throughout a course of treatment, one approach may be used to complement another (e.g. medication with talking therapies, or talking therapies with homeopathy) or a completely different course of treatment opted for on its own. This would require an exploration of alternative therapies and traditional treatments such as meditation, massage, aromatherapy, homeopathy, herbalism and acupuncture, and the securing of funding for such provision (A brief outline of some of the alternative treatment options can be found in Appendix 4)

- Care packages need to respond to, and attempt to overcome the potential barriers in accessing services, for example to help overcome stigma and isolation, language specific telephone support, outreach strategies, clinics and information sessions in community settings should be provided to promote wellbeing.

- Services should be welcoming and include information which is user friendly and available in community languages.

- Services should be developed in consultation with refugee, community and voluntary groups and where possible users should be encouraged to participate in the design and planning in order to establish effective access and provision.

- Health providers need to promote a culture in which users are encouraged to participate fully in their care plan and evaluate the services they receive.

- User- led services such as sewing, music; creative writing and art groups should be funded in order to improve access, health promotion and user-initiated interactions

- Services should use innovative approaches to reach isolated refugees and asylum seekers such as and cultural events, coffee mornings, relaxation and stress management classes.

Service providers should undertake outreach work to develop links and establish trust with community groups. This would enable both professional and non-professional community members to be involved in supporting users who are experiencing emotional difficulties.

Evaluation, consultation and planning/funding future services

The need for, and positive impact of effective and relevant evaluation and consultation processes has been established (see 'User involvement' sections in the 'CONTEXT' and GOOD PRACTICE GUIDE). It is therefore important that all service providers regularly review their evaluation and consultation procedures in order to make services more user-friendly, culturally competent, more accessible and more effective and therefore successful in terms of the long-term health of refugees and asylum seekers. If carried out in consultation with stakeholders and users services can tailor their provision in order to effectively meet the specific needs of their client group.

The lack of funding and sustainability was stated as a serious issue for Refugee, voluntary and community organisations. In order to effectively meet the diverse needs of refugees and asylum seekers funding needs to be made available for the many relevant, different and potential care services for this group. One service provider discussed the commissioning of services and highlighted the need for funders to be aware of the long-term gains many 'first point of contact'; holistic, innovative/alternative and preventative services can have on the mental health of refugees and asylum seekers. It is important to 'factor in' these potential long terms gains when deciding the value of less 'traditional'/ 'medical' services, for often what appears to be an expensive initial outlay requiring some form of consistent follow up support, can result in cost savings in the long-term.

RECOMMENDATIONS

Evaluation, consultation and planning

Mechanisms should be in place to incorporate user feedback into services. These mechanisms need to allow for innovative ways of engaging with users that may be less formal than traditional forms of consultation; engagement is therefore on the users' terms rather than through a pre-set format and consequently more likely to encourage participation (see recommendations for user involvement for possible suggestions).

Ensure that refugee, faith, voluntary and community organisations are effectively involved in the commissioning, planning and delivery of services.

The evaluation process for service providers needs to be regular and thorough, with specific consideration of the refugee and asylum seeker user. A good evaluation process should include the following:

- feedback from service users, community groups, carers and families
- confirm that the service is effective and meets the needs and wishes of the service user
- review language provision and bi-lingual needs including ethno-specific counselling
- collect and maintain accurate and detailed ethnic monitoring in both primary and secondary care
- incorporate recommendations for service improvement based on the information obtained

RECOMMENDATIONS (CON'T)

Service providers should encourage independent and external evaluation.

Working with refugees and asylum seekers with mental health care needs is both complex and intensive staff should therefore receive regular supervision, positive and constructive feedback, and adequate non-contact time.

Funding

Local Authorities, including primary care trusts need to work in partnership as part of the Local Strategic Partnership's (LSP's) to develop a more comprehensive, long-term approach to funding services for refugees and asylum seekers.[95]

Local Government Authorities need to provide capacity building, training and practical assistance for refugee, voluntary and community organisations with funding applications and finding sources of funding (e.g. from both statutory and charitable sources.).

Innovative support services and projects need to be funded in order to provide a wide range of care provision and support and all those working with and caring for those with mental health needs. This is also to include support for family members and friends, such as drop-in sessions, access to information and advice and a therapeutic space for both users and their families to give and receive support.

[95] A Local Strategic Partnership (LSPs) is a single non-statutory, multi-agency body, which matches local authority boundaries, and aims to bring together at a local level the different parts of the public, private, community and voluntary sectors. The main source of funding associated with is the Neighbourhood Renewal Unit which is a targeted grant that can be spent in any way that will tackle deprivation in the most deprived neighbourhoods. The grant is intended as time-limited funding to facilitate the more effective, long-term targeting of mainstream resources. The Single Community Programme is designed to assist Local Strategic Partnerships and Community Empowerment Networks to take forward Local Neighbourhood Renewal Strategies at neighbourhood level. It is a streamlining of the NRU's three Community Participation programmes (Community Chests, Community Learning Chests and Community Empowerment Fund) For more information: http://www.neighbourhood.gov.uk

SUPPLEMENTARY SECTION:

Mental health provision for asylum seekers detained in Immigration Detention Centres (IDC's)

Many asylum seekers are detained in one of 10 IDC's up and down the country. As of November 2005, the capacity in the "detention estate" was 2,755, including 456 places for families. Figures for February 2006 indicated that 37 children were held in detention at Yarlswood IDC in Bedfordshire. As a result of campaigns in Scotland and a positive response from Scottish MPs, there are no children held in detention in Scotland anymore. These centres are designed to keep the detainees from getting out into the community; Yarlswood IDC has a security system equivalent to a Category B prison.

The Medical Justice campaign is a network of ex-detainees, doctors, other experts and concerned citizens who are working on a voluntary basis to improve health care for asylum seekers who are or have been detained. Medical Justice has identified that health care for asylum seekers often fails to meet acceptable standards and examples of this provided by two recent cases highlight the issues around mental health care in IDC's. In October 2005, the Institute of Race Relations published a roll call of death of the 34 asylum seekers who had committed suicide in the previous five years including the tragic case of Angolan asylum seeker, Manuel Bravo. Manuel Bravo, a detainee at Yarlswood, hung himself the day before he and his teenage son were due to be deported back to Angola. In February 2006, the Immigration Minister agreed to an inquiry into how a Ugandan woman detained at Yarlswood was reduced to a state of severe mental health distress during 7 months in Yarlswood. The woman concerned is now an in-patient at the Maudsley Hospital in South East London. The inquiry will investigate "healthcare provision at Yarlswood with specific reference to mental and traumatic stress disorders and to the treatment of Sophie Odogo."

In summary, the findings of the Medical Justice campaign include evidence of:

- Failure by health care staff to investigate that a detainee has been tortured;
- Failure by IDC staff to investigate and appropriately treat or refer a detainee with significant medical problems;
- Detainees being obstructed in accessing a doctor of their choice;
- Unsympathetic attitudes of some health care staff towards detainees, regarding the detainees' own assessment of their health as just a ploy to avoid deportation;
- Failure to comply with policies which prevent the detention of vulnerable people. Asylum seekers who are suicidal are not supposed to be detained in IDCs, there is clear evidence that this has happened such as the case of Manuel Bravo at Yarlswood and the enquiry which is currently being conducted into the care and treatment of a female detainee, Sophie Odogo at Yarlswood.

Healthcare in the majority of IDC's is not provided by the NHS or regulated by the Healthcare Commission, the inspector and regulator of NHS provided or commissioned services including with the private sector. Healthcare in most IDC's is provided by private agencies under contract with the Home Office. If referred to hospitals or other services outside the IDC then the provision is NHS.

RECOMMENDATIONS

- The responsibility for medical care of detainees should be transferred from the Home Office to the NHS. This would mean that:
  - All healthcare provision accessed by detainees would be registered, regulated and inspected by the Healthcare Commission;
  - Patient and Public Involvement Forums would have the legal right to monitor the provision of healthcare in IDC's;
  - Detainees would have rights of redress through the NHS complaints procedure if they had concerns about their care or treatment or access to care;
  - Detainees would be able to access the Independent Complaints Advocacy Service which supports people who have concerns or complaints about their health care.

- Detainees should have the right to access a doctor of their choice, rather than have one imposed by the IDC.

- The Operation Enforcement Manual policies that apply to vulnerable individuals, such as children, torture survivors and people with severe mental health problems, that state that they should not "ordinarily be detained" should be rigorously complied with.

Appendix 1:

Information on services who participated in the research

Traumatic Stress Clinic
73 Charlotte Street
London
W1T 4PL

Tel: 020 7530 3666

Service: Psychologists, offering assessment and specialist trauma therapy. Most of the work is carried out in English with the help of interpreters. The team has a cognitive behavioural approach to trauma that includes dealing with the guilt, shame and fear associated with their ordeal. The therapy helps them to develop coping strategies, and talking to them about how they are going to cope with their situation. Where appropriate clients are linked in with outreach services for help with psycho-social issues including immigration, Housing, Welfare Benefits and Community Care. The Traumatic Stress Clinic also run training workshops for other NHS mental health professionals, as well as some voluntary organizations on managing the mental health needs of refugees and asylum seekers.

Refugee Support Services
4D Shirland Mews
London
London W9 3DY

Tel: 020 89686451

The service provides brief counselling, psychotherapy, social support and complimentary therapies (massage & acupuncture) for refugees and asylum seekers with mental health problems living within the London boroughs of Westminster and Kensington & Chelsea. Many of the therapists are bi-cultural therapists with a wide range of languages available. Referrals are accepted from both Primary Care and Secondary Care Services ie GPs, Community Mental Health Teams and other agencies working with refugees and asylum seekers in the catchment areas. Clients have to be over the age of 16.

The Health Support Team (HST)
Lisson Grove Health Centre
Gateforth Street
London
NW8 8EG

Tel: 020 7479 8805

Service: The team was established to work with refugees, asylum seekers, homeless individuals and families and people living in temporary accommodation in North Westminster and North Kensington & Chelsea. The key principle of the team is to provide additional support for vulnerable groups with gradual integration into mainstream services. he role of the team is to

provide health care, support and advocacy by identifying the needs of clients through an individual comprehensive health assessment.

Referrals: The HST responds to referrals from other health care professionals, statutory and non-statutory organisations and self-referrals for any individual or family who come under the team's remit.

St Pancras Refugee Centre
Holy Cross Centre
Cromer Street
London
WC1H 8JU

Tel: 020 72784223

The St Pancras Refugee Centre (SPARC) aims to benefit and ensure access to services for refugees resident in Camden, Islington or Westminster, improving health care and social inclusion and quality of life. Through a range of services provided both by the project itself and a number of partner agencies, the project impacts on health, housing, benefits, community care, education and employment. The project provides psycho-social support through casework and advice. Counselling is provided in non-direct ways such as art workshops, sewing groups, health workshops, and twice-weekly drop-in sessions.

Ethiopian Health Support Association
Kings Gate Place
London
NW6

Tel: 020 7419 1972

Service: The project provides a holistic service for Ethiopians with particular attention to mental health, HIV/AIDS, sexual health, women and young people's health through the provision of advice and information, advocacy, interpretation and translations, visits and befriending and culturally sensitive counselling in Amharic..

.
Iranian Association
241 Kings Street
Hammersmith
London
W6 9LP

Tel: 020 8748 6682

Service: Holistic project offering advice and guidance for the Iranian community in London, including refugees and asylum seekers. Issues covered include education, employment, immigration and benefits access to education and training and health services. The project also

has a women's project offering support and advice to refugee women in order to improve their quality of life and it refers them to legal advice on matrimonial, divorce, domestic violence and custody issues. In addition, the Iranian association offers a bi cultural counselling service for its client group.

Kurdish Association
241 Kings Street
Hammersmith
London
W6 9LP

Tel: 020 8563 7918

Service. The project provides information and assistance on immigration, housing, benefits, interpreting, translation, referral service, employment and training and access to health care provision. The project runs a children's and elders project.

Refugee and Asylum Seekers Befriending Scheme: MIND
8 Havelock Place
Harrow
London
HA1 1LJ

Tel: 020 88863 6255

Service: Advocacy, bi-lingual befriending and mental health support for Refugees and Asylum Seekers.

For further information contact: Paul Burns refugeeslink@btinternet.com

Vietnamese Mental Health Project
Thomas Calton Center
Alpha Street
London
SE15 4NX

Tel: 020 7639 2288

Service: Project provides bilingual and intercultural support to mainstream services. Education and training to Vietnamese people about mental health issues and health social care systems. Also provide training to mainstream health services. The project also provides an outreach service, support for carers and for children of mentally ill parents, supported housing. Access to these services is available through referrals from the health and social services and other agencies, from Vietnamese community groups, and self-referrals.

Derman
The Basement
66 New North Road
London N1 6TG

Tel: 020 7613 5944

Service: Part funded by City and Hackney Primary Care NHS Trust. The aim of the mental health service is to help and support the Kurdish and Turkish speaking communities to overcome their emotional and practical difficulties which they face as immigrants. The mental health service comprises counselling, mental health support and mental health outreach work. The project also provides an advocacy service which includes interpreting, improving the appropriateness of health services and improving health outcomes, providing information and expertise to health professionals to facilitate the bridging of the cultural and language gap.

Migrant and Refugee Communities Forum (MRCF)
2 Thorpe Close,
London,
W10 5XL

Tel: 0208964 4815

Service: The Migrant and Refugee Communities Forum (MRCF) is a West London based migrant and refugee-led community development organisation with over thirty member organisations from diverse migrant and refugee communities in North West London. MRCF has a successful track record in delivering community development support, assistance and advice to migrant and refugee communities in the UK. The project provides community-based accredited training programmes, conducts consultations and research, and develops employment and health and welfare support projects, with the ultimate aim of developing self-sustainable communities. MRCF works to strengthen the development of migrant and refugee groups by establishing effective partnerships with statutory and voluntary agencies to ensure access to services and opportunities. The ethos of the Forum is to advocate for these rights and to develop support services to migrant and refugee communities to empower them to access services on an equal basis.

Appendix 2:

Questionnaires

Service providers

<u>The service</u>

1. Can you describe the service that your organisation offers?

2. What percentage of your caseload is made up of refugees and asylum seekers?

3. What regions/countries are your clients from?

4. What type of ethnic monitoring records do you keep?

5. How long has your organisation been providing services for refugees and asylum seekers?

6. Where do you receive referrals from?

7. What sort of training do you and your colleagues receive?

8. Do you offer any training to other organisations? [Prompt: please give details]

9. Who is your service funded by? [Probe: How secure is your funding?]

10. If you were able to secure more funding, which areas of your work would you like to expand?

11. What systems do you have in place to monitor/evaluate the service?

12. Can you describe ways in which your service users are consulted and involved in the development of your service?

13. Are service users offered a specific number of sessions? If so, are they referred to other services when the treatment comes to an end?

14. Do you use interpreters? If so, where do you recruit them from and do you provide them with any training?

15. How do you find working with interpreters? [Probe: Are there any challenges? How do you deal with them?]

16. Do you use bicultural workers? If so, can you describe any benefits or drawbacks associated with using bicultural workers?

<u>Support needs</u>

17. What sort of support needs do your clients have in addition to talking therapies? [Prompt: immigration, housing, benefits etc]

18. What percentage of your client group needs additional support?

19. How do these additional needs impact your client's mental health and the therapy/counselling that you provide?

20. In what circumstances do you refer your clients to other organisations? [Probe: How often do you refer clients to other organisations?]

21. How well do you feel that your clients understand the mental health system and mental health concepts in the UK? How much does this vary amongst clients? Which factors affect their understanding? [Prompt: cultural background, education, class, gender etc]

22. How accessible do you feel mainstream mental health services are for refugees and asylum seekers? [Prompt: What sort of barriers can they encounter?]

23. How well do you feel that the mental health needs of refugees and asylum seekers are being met?

24. What can be done to improve services?

25. What sort of understanding or knowledge do you feel refugee community organisations can offer mainstream mental health services? [Probe: how do you see these two sectors working together?]

26. I have come to the end of my questions. Is there anything else that you would like to add in

relation to the issues that we have discussed or maybe something that has not been mentioned?

Service users

Background

1. How long have you been living in the UK for? [Probe: Have you been in London all of this time? Whereabouts do you live in London? What sort of housing do you have?] [Prompt: Family/friends, privately rented, council, hostel, flat/house, NASS accommodation, temporary/permanent]

2. Where are you from? [Probe: What is your nationality/ethnicity?]

3. What is your immigration status?

4. What family do you have with you here in the UK? What friends do you have in the UK?

5. How old are you?

6. What do you do with your time? [Prompt: study, work, socialise, exercise, childcare]

Experiences

7. How do you find living in the UK? [Probe: Can you describe any good things about living here? Can you describe anything that you may find difficult about living here? [Prompt] immigration, financial support, housing, benefits, NASS, employment, racism].

8. Can you describe any *emotional distress you* may experience*? [Focus on experience of distress rather than causes]* (if necessary, explore this term with interviewee and if they use an alternative term then use this for the rest of the interview).

9. What do you feel are the reasons for your emotional distress: the experiences that you had before you arrived in the UK or your situation here?

10. What makes you feel less *distressed*? [Prompt: talking, medication, exercise, socialising]

11. When you are experiencing *emotional distress*, who do you turn to for support? [Prompt: Is there anyone else that you speak to about your *distress*, (If something other than a mental health service is mentioned ask: In what ways does this person/organisation help?)

Questions relating to interviewees accessing a mental health service

12. How often do you see _____ *(insert term used by interviewee)?* How long have you been going?

13. How did you find this person/organisation? [Prompt: Who suggested that you go there? How long were you looking for help before you were referred to this person/organisation?]

14. How far do you have to travel far to get there? How long did you have to wait for an appointment?

15. How long will you be seeing this person /organisation for? [Prompt: have they said what will happen at the end of the sessions?]

16. Have you been referred by this person/organisation to anyone else? If so, who and for what reason?

17. Do you speak the same language as this person/organisation? [Probe: Are there any benefits to this? Are there any difficulties to this?]

18. In what ways do you find seeing this person/organisation helpful?

19. How do you think that this person/organisation could improve their service?

Ask these questions for each service used by the interviewee.

Community

20. Are you in contact with your community (members of the same nationality/ethnic group) here in London? [If no, Probe: Are there any reasons why you are not in contact?]

21. [If yes, Probe: Can you describe how your community helps you when you feel distressed? [If interviewee does not access help from community: Are there any other ways in which the community supports you? What are the reasons that you do not receive support from your community on this issue?]

22. Can you describe what other people from your community (who live in London) do when they are experiencing emotional distress?

23. What advice would you give to another member of your community if they were experiencing emotional distress?

24. Are there any ways in which people from your community experiencing emotional distress can be helped more?

25. Thank you for taking the time to answer these questions. Is there anything else that you would like to say?

Questionnaire – Commissioners

1. Can you describe the mental health services that you provide for refugees and asylum seekers? Roughly how many people do these services cater for?

2. How long has the Trust been providing these services?

3. How did you come to fund these services?

4. What do you see as the most important achievements of these services?

5. Why do you think that the provision of mental health services for refugees and asylum seekers in London is patchy?

6. What do you think can be done to encourage commissioners to fund mental health services for refugees and asylum seekers?

7. In what ways do you think that the NHS and community organisations can work together more?

8. In what situations do you feel that the NHS is likely to fund the mental health work of community organisations?

9. In your opinion, do you think that mental health services are likely to become more community-based?

Appendix 3:

Types of Advocacy (obtained from Paul Burns MIND in Harrow)

Self-advocacy
Self-advocacy is about the user speaking up for her or himself. It is important for other advocates to be thinking about how to develop independence and support the skills and confidence for increasing self-advocacy.

Group advocacy
Group advocacy is where a group of people with similar experiences meet together to put forward shared views. Local user groups, support groups and patient councils are all examples of group advocacy. There are also larger, national groups, such as those campaigning and advocating about issues raised by their membership.

Peer advocacy
Peer advocacy is support from someone with experience of using mental health services or drawing on some other shared experience. Peer advocates can draw on their past to understand and empathise with the person they are working with. Working with a peer advocate often makes it easier to have an equal relationship between the advocate and user.

Formal, professional, or paid advocacy
Many voluntary organisations develop advocacy services where some, or all of the advocates are trained and paid to work with anyone who wants to use their service. Although not always the case, this kind of advocacy is usually focused on short-term or 'crisis' work, rather than providing long-term support. Many of the advocates working for formal advocacy services are also users/survivors.

Citizen advocacy
Citizen advocacy matches people with partners who are members of their local community. Citizen advocacy partnerships tend to be long-term,
supportive relationships. Most citizen advocacy schemes have paid coordinators who train and support unpaid volunteer partners. As well as helping with specific situations, citizen advocacy partnerships are intended to support vulnerable people in taking a fuller part in the life of their community.

Legal advocacy
People with specialist knowledge and training, such as lawyers and advice workers, are sometimes called 'legal advocates'. Legal advocates differ from other mental health advocates in that they represent people in formal settings such as courts, tribunals or complaints processes. A legal advocate will often give advice and express their own opinion about the best course of action.

'Best interests' (non-instructed) advocacy
'Best interests' advocacy is where an advocate represents what he or she feels a person's wishes would be if they were able to express them. 'Best interests' work is not generally appropriate in mental health advocacy when people are well able to express their needs and opinions directly. Some mental health advocates working with older adults are trained to do 'best interests' work with those clients with dementia who are no longer able to communicate clearly.

Appendix 4:

Alternative Treatments

What is meant by "alternative therapies?"

Alternative therapies are those not normally offered by conventional medical personnel. They include but are not limited to, nutrition, herbal medicine, spinal manipulation and body work medicine, ‘energy medicine’, spiritual attunement, relaxation training and stress management, biofeedback and acupuncture.

Acupuncture

Acupuncture is a treatment which can relieve symptoms of some physical and psychological conditions and may encourage the patient's body to heal and repair itself, if it is able to do so.

Acupuncture stimulates the nerves in skin and muscle, and can produce a variety of effects. We know that it increases the body's release of natural painkillers - endorphin and serotonin - in the pain pathways of both the spinal cord and the brain. This modifies the way pain signals are received. Modern research shows that acupuncture can affect most of the body's systems - the nervous system, muscle tone, hormone outputs, circulation, antibody production and allergic responses, as well as the respiratory, digestive, urinary, and reproductive systems. Typically, fine needles are inserted through the skin and left in position briefly, sometimes with manual or electrical stimulation. The number of needles varies but may be only two or three. Treatment might be once a week to begin with, then at longer intervals as the condition responds. A typical course of treatment lasts 5 to 8 sessions.

Homeopathy

Homeopathy is a form of medicine which treats the whole individual. It is equally concerned with maintaining good health and aiding recovery from ill health, and like all forms of medicine - even those which use powerful drugs and high technology surgery - relies for its effects on the body's own powers of self-regulation and self-healing. Since its development nearly two hundred years ago homeopathy has benefited millions of people, young and old, from all walks of life, in countries all over the world.

A homeopathic remedy is one which produces the same symptoms as those the ill person complains of, and in doing so sharply provokes the body into throwing them off. 'Like may be cured by like', also expressed as similia similibus curentur, is the basic principle of homeopathic therapeutics. The opposite therapeutic approach is 'allopathy', which is defined as a system of therapeutics in which diseases are treated by producing a condition incompatible with or antagonistic to the condition to be cured or alleviated. The idea that remedies and symptoms sharing certain key features might interact in such a way as to banish illness, and the implied corollary that two similar slates of discomfort cannot eldest in the same body, was not new even two centuries ago.

Homeopathy is a naturopathic form of medicine - it seeks to assist Nature rather than bludgeon her, to assist the body's own healing energies rather than override them. The 'disease' is not only the virus or the bacteria - these are merely the organisms which move in when the body's defences are low. The discovery of legions of micro-organisms since Hahnemann's time has done

nothing to alter this fundamental truth. The fever, the inflammation, the diarrhoea, the headache - these are not the disease either, but the body's attempt to return to normality. Such ideas may be difficult to adjust to if one been brought up in the belief that both attack and cure come from the outside, but they are ideas which have been accepted by humanistic physicians since the time of Hippocrates.

Another tenet of naturopathic and therefore of homeopathic philosophy is that every person is different. The same remedy, the same diet, the same general advice does not necessarily help everyone with the same ailment. Indeed there is no such thing as the same ailment; the course of a particular kind of cancer in one person will not be the same as that in another. Accordingly, homeopathy has the most flexible system: of remedy prescribing of any system of therapeutics, as this book demonstrates. The most effective remedy is always the one which matches three things: the physical symptoms, the mental and emotional symptoms, and the general sensitivities of the person concerned. It is also taken in the least possible dose for the least possible time.

If homeopathy is, or becomes, your line in health care it is strongly advised that you consult a professional homeopath. Indeed his or her skills should complement and guide your own. Homeopathy is also a rational system of medicine. If the body's defence systems are handicapped by poor diet, bad habits, destructive emotions, and environmental stresses, it stands to reason that homeopathic remedies, of themselves, will be of limited benefit. If you consult a homeopath, he or she may suggest al change of diet or lifestyle before prescribing any remedy.

Homeopathy is not a system for those in search of instant, easy answers, although it can act: very swiftly in acute conditions. It requires careful self-monitoring and a willingness to stick to a course of action. The prize is higher vitality and greater resistance to all disease processes.

Yoga

The ancient Yogis recognised long ago that in order to accomplish the highest stage of, yoga, which is the realisation of the self, or God consciousness, a healthy physical body is essential. For when we are unwell, our attention is seldom free enough to contemplate the larger reality, or to muster the energy for practice. The masters of yoga also teach us that personal growth is possible only when we fully accept our embodiment and when we truly understand that the body is not merely skin and bones but a finely balanced system of energies.

Essential oils

Essential oils is a kind of are the subtle, aromatic and volatile liquids extracted from the flowers, seeds, leaves, stems, bark and roots of herbs, shrubs and trees through distillation. It is a form of vibrational healing. They are the oldest form of medicine and cosmetic known to man and were considered more valuable than gold. Science is only now beginning to investigate the incredible healing substances found in essential oils.

Massage Therapy

Human touch can have a profound effect on physical and emotional wellbeing. Massage therapy is the therapeutic use of touch, by hands, elbows or feet. Through the use of a variety of techniques a bond forms between the client and the therapist. Massage can be comforting and

soothing, letting go of toxins from tissue and dispersing lactic acid. Endorphins, the body's natural feel good factor are released from muscles during massage.

Indian Head Massage

Treatment normally begins with a deep kneading and probing of the neck and shoulder muscles. The head is then worked with the scalp being squeezed, rubbed, gently tapped and prodded. The hair is briskly tussled and gently combed.

Pressure points are gently worked on and the ears are tugged and pressed. Lastly the practitioner moves to the face, working with acupressure points to help relieve any sinus pressure, stimulate the circulation and increase alertness. The face is also very gently stroked.

Once a massage has been complete the client should remain at rest for at least 20 minutes.

Music Therapy

There are different approaches to the use of music in therapy. Depending on the needs of the client and the orientation of the therapist, different aspects of the work may be emphasized. Fundamental to all approaches, however, is the development of a relationship between the client and therapist. Music-making forms the basis for communication in this relationship.

As a general rule both client and therapist take an active part in the sessions by playing, singing and listening. The therapist does not teach the client to sing or play an instrument. Rather, clients are encouraged to use accessible percussion and other instruments and their own voices to explore the world of sound and to create a musical language of their own. By responding musically, the therapist is able to support and encourage this process. The music played covers a wide range of styles in order to complement the individual needs of each client. Much of the music is improvised, thus enhancing the individual nature of each relationship. Through whatever form the therapy takes, the therapist aims to facilitate positive changes in behaviour and emotional well-being. He or she also aims to help the client to develop an increased sense of self-awareness, and thereby to enhance his or her quality of life. The process may take place in individual or group music therapy sessions.

Herbalism

Herbalism, also known as phytotherapy, is folk and traditional medicine practice based on the use of plants and plant extracts.

Finding healing powers in plants is an ancient idea..Plants have an almost limitless ability to synthesize aromatic substances, most of which are phenols or their oxygen-substituted derivatives such as tannins. Most are secondary metabolites, of which at least 12,000 have been isolated, a number estimated to be less than 10% of the total. In many cases, these substances serve as plant defense mechanisms against predation by microorganisms, insects, and herbivores. Many of the herbs and spices used by humans to season food yield useful medicinal compounds.

The use and search for drugs and dietary supplements derived from plants have accelerated in recent years. Pharmacologists, microbiologists, botanists, and natural-products chemists are

combing the Earth for phytochemicals and leads that could be developed for treatment of various diseases.--Dr M Tariq Salman 19:06, 30 January 2006 (UTC)The use of herbs to treat illness is almost universal among non-industrialized societies. A number of traditions came to dominate the practise of herbal medicine in the Western world at the end of the twentieth century.

Reflexology

Reflexology is a complementary therapy, which works on the feet to help heal the whole person not just the prevailing symptoms. Reflexology can be used to help restore and maintain the body's natural equilibrium. This gentle therapy encourages the body to work naturally to restore its own healthy balance. Reflexology is suitable for all ages and may bring relief from a wide range of acute and chronic conditions. After you have completed a course of reflexology treatment for a specific condition, many people find it beneficial to continue with regular treatments in order to maintain health and well-being.

While many people use reflexology as a way of relaxing the mind and body and counteracting stress, at the same time many doctors, consultants and other health care professionals recognise reflexology as a well established, respected and effective therapy. Reflexology helps us to cope on a physical, mental and emotional level thereby encouraging us to heal and maintain health in all areas of our lives. The reflexologist will then use their hands to apply pressure to the feet. The application and the effect of the therapy is unique to each person. A professionally trained reflexologist can detect subtle changes in specific points on the feet, and by working on these points may affect the corresponding organ or system of the body. A treatment session usually lasts for about one hour. A course of treatment may be recommended depending on your body's needs.

For further information contact:

www.homeopathy-soh.org

www.ainsworths.com

www.**flower**society.org

www.**acupuncture**.org.uk

www.**reflexology**.org

www.nimh.org.**uk** (for herbalism)

www.bwy.org.**uk** (for yoga)

www.bsmt.org (for music therapy)

www.**massagetherapy**.co.**uk**

Appendix 5:

Consultation event on a draft best practice guide on mental health service provision for refugees and asylum seekers.

Research undertaken for the Commission for Public Patient Involvement on Health by David Palmer & Kim Ward

At London Region CPPIH -163 Eversholt Street, London NW1

Friday 24th March 10am

Agenda

9.45am	Registration, Tea and Coffee
10.00am	Introduction to event, background on research, purpose of consultation: David Palmer
10.15am	*David Palmer: Presentation of draft* ***'Hearing voices': listening to Refugees and Asylum Seekers in the planning and delivery of Mental health service provision in London'.*** (A research audit on mental health service provision undertaken for the Commission for Public Patient Involvement on Health) Summary-aims and objectives, methodology, limitations of study, findings, guide on good practice, recommendations. Questions and answers Information exchange
11.15am	Break
11.30am	The way forward: A discussion/seminar on research findings, guide and recommendations Conclusion
12.15pm	Feedback End

Bibliography

Ackerman, L. K. (1997). Health problems of refugees. *The Journal of the American Board of Family Practice*, **10** 337-348.

Aldous, J., Bardsley, M., Daniell, R., Gair, R., Jacobson, B., Lowdell, C., Morgan, D., Storkey, M., Taylor.G. (1999). *Refugee health in London: key issues for public health*. London: Health of Londoners Project.

Article 1(A)2 of the 1951 Convention Relating to the Status of Refugees.

Article 19 (2003) What's the story? Results from research into media coverage of refugees and asylum seekers in the UK. London: Article 19

Barnes, M and Bowl, R.(2001) *Taking over the Asylum*. Basingstoke: Palgrave.

Bhugra, D. and Cochrane, R.(2001) *Psychiatry in Multicultural Britain*. London: Gaskell

Bhugra, D.(2004) Migration and mental health. *Acta Psychiatr Scand* ; **109**: 243-258

Blackburn, C. (1991). *Poverty and Health*. Milton Keynes: Open University Press

Brown, C.S.H and Lloyd, K. (2002) Comparing Clinical Risk Assessment using Operationalised Criteria, *Acta Psychiatrica Scandinavica*, Vol **106**, 412

Brown, G. and Harris, T. (1978). *Social Origins of Depression*. London: Tavistock Publications.

Burnett A and Thompson K. Enhancing the psychosocial well-being of asylum seekers and refugees. In Barrett K, George B (eds). *Race, Culture, Psychology and Law*. California: Sage Publications.

Burnett A, and Peel, M. (2001). Asylum Seekers and Refugees in Britain: The health needs of survivors of torture and organized violence. *BMJ,* **332**: 606-609

Burnett, A. and Peel, M. (2001) Asylum seekers and refugees in Britain. Health needs of asylum seekers and refugees. *BMJ*, **322**:544-547

Campbell, P (1999) The service user/survivor movement in Newnes, C., Holmes,G and Dunn,C. *This is Madness: A critical look at psychiatry and the future of mental health services.* Ross-on Wye, PCCS Books

Carey-Wood, J., Duke, J., Kar,V. and Marshall.T. (1995) *The settlement of refugees in Britain*. Home Office Research Study 141. London: HMSO Books.

Crow, T. J, (1995) A continuum of psychosis, one human gene, and not much else- the case for homogeneity, *Schizophrenia Research* **17**: pp135-145

Department of Health. (1999) *The National Service Framework for Mental Health. Modern Standards and Service Models*. London: Department of Health.

Department of Health. (2003) *Delivering Race Equality; A framework for Action.* London: Department of Health

Department of Health. (2005) Delivering race equality in mental health care – An action plan for reform inside and outside services. London: Department of Health.

Eastmond, M. (1998) Nationalist discourses and the construction of difference: Bosnian Muslim refugees in Sweden. *Journal of Refugee Studies*, **11**, 161–181.

Fernando, S. (1995) *Mental Health in a Multi-Ethnic Society*. London: Routledge.

Fernando, S (2002) *Mental Health Race and Culture* (2nd ed) Palgrave: Basingstoke

Finney, Nissa (2005) *Public Attitudes to Asylum.* Navigation Guide. London: ICAR

Gorst-Unsworth, C. and Goldenberg, E. (1998) Psychological sequelae of torture and organised violence suffered by refugees from Iraq. *British Journal of Psychiatry*, **172**, 90–94.

Greater London Authority (2005) Into the Labyrinth: Legal advice for asylum seekers in London. Greater London Authority.

Greenham,F and Moran,R.(2006) Complexity and community empowerment in regeneration in Temple,B. and Moran, R(eds) *Doing Research with Rrefugees*. Policy Press: Bristol. (p111-143)

Greenslade, R (2005) *Seeking scapegoats. The coverage of asylum in the UK press. London: IPPR*

Hansen, Randall (2000) *Citizenship and Immigration in Post-War Britain*. The Institutional Origins of a Multicultural Nation Oxford: Oxford University Press.

Harris K and Maxwell C. (2000) A needs assessment in a refugee mental health project in north-east London: extending the counselling model to community support. *Medical Conflict and Survival*;**16**(2):201-15

Heath, T., R. Jeffries, and J. Purcell (2005) *Asylum statistics: United Kingdom 2004,* 13/05, 23 August 2005. London: Home Office.

Hein, J. (1993) Refugees, Immigrants and the State, *Annual Review of Sociology*, **19**: 43-53 p44.

Holloway, W (1989) *Subjectivity and method in Psychology: Gender Meaning and Science*. London: Sage

Home Office (2004) ‘Integration matters: a national strategy for refugee integration’. London: Home Office. Available at :
http://www.ind.homeoffice.gov.uk/ind/en/home/laws___policy/refugee_integration0/a_national_strategy.html.

ICAR (2004) *Media image, community impact. Assessing the impact of media and political images of refugees and asylum seekers on community relations in London.* London: ICAR.

Keating, F., Robertson, D., and Kotecha, N. (2003) *Ethnic Diversity and Mental Health in London.* London: Kings Fund Working Paper.

Kelly, L. (2003) *'Integration Policies in the UK'*. Intpol-United Kingdom.

Kiev, A (1965) Psychiatric morbidity of West Indian immigrants in an urban group practice. *British Journal of psychiatry*, **111**: pp51-56

Kirmayer, L. and Young, A. (1998) Culture and somatisation: clinical, epidemiological and ethnographic perspectives. *Psychosomatic Medicine*, **60**, 420–429.

Kleinman, A (1977) Depression, Somatisation and the 'New Cross-Cultural Society'. *Social Sciences and Medicine*, **11** : 3-10

Lewis, M. (2005) Asylum: understanding public attitudes. London: IPPR

Littlewood, R. and Lipsedge, M. (1997). *Aliens and Alienists: ethnic minorities and psychiatry.* (3rd ed). London: Routlege.

Malfait.,,R. and Scott-Flynn,N/ (2005) 'Destitution of asylum-seekers and refugees in Birmingham', Restore of Birmingham Churches Together and the Churches Urban Fund,

Meyer, J. Qualitative research in health care: Using qualitative methods in health related action research. *MBJ* 2000**;320**;178-181

Palmer, D., Scott, M., and Murphy, C. (2001). *Far From Home : A report on suitability of temporary accommodation provided by London Local Authorities*. London: National Homeless Advice Service-NACAB

Peterson, C., Maier, S. F., and Seligman, M.E.P (1993). *Learned Helplessness.* Oxford: Oxford University Press.

Pilgrim, D. and Rogers, A. (1999) *A Sociology of Mental Health and Illness.* (2nd ed.) Birmingham: Open University.

Raleigh, V.S. (2000). Mental health in black and ethnic minorities: An epidemiological perspective in Kaye, C, and Lingiah, T.(eds.) *Race, culture and ethnicity in secure psychiatric practice : working with difference*. London: Jessica Kingsley Publishers (pp 29-46).

Ritchie.J and Spencer,L.(1993) Qualitative data analysis for applied policy research. In Bryman.A. and Burges.R (eds) *Analysing qualitative data*. London: Routledge.

Robinson.,V and Segrott,J. (2002) 'Understanding the decision-making of asylum seekers' Home Office Research Study 243.

Rumbaut, R.G.(1991) 'The agony of exile: a study of the migration and adaptation of the Indochinese refugee adults and children'. In F.L Ahern Jr and J.L. Athey (eds), *Refugee Children: Theory, Research and Services,* pp.53-91. Baltimore; John Hopkings University Press.

Sashidaran, S.(2003) Inside/Outside: Improving Mental Health Service for Black and Minority Ethnic Communities in England. National Institute for Mental Health in England (NIMHE) Department of Health.

Sharpley, M.S., Hutchinson, G and Murray,R.M. (2001) Bringing in the social environment – understanding the excess of psychosis among the African-Caribbean population in England. *The British Journal of Psychiatry*. **178**: 560-568

Shrestha NM, Sharma B, Van Ommeren M, Regmi S, Makaju R, Komproe I, Shrestha GB, de Jong JT. (1998) Impact of torture on refugees displaced within the developing world: synpomatology among Bhutanese refugees in Nepal. Jama 280 (5) 443-8.

Stoke Citizens Advice Bureau (2003) '*Mind the gap: failed asylum seekers and hard case support*'. CAB: Stoke

Stringer, E. (1996) *Action Research: A handbook for Practitioners* Thousand Oaks: Sage.

Summerfield, D. (1999) A critique of seven assumptions behind psychological trauma programmes in war-affected areas. *Social Science and Medicine*, **48**, 1449–1462.

Summerfield, D. (2001) The invention of post-traumatic stress disorder and the social usefulness of a psychiatric category. *BMJ*, **322**, 95–98.

Summerfield, D. (2001). Asylum seekers, refugees and mental health in the UK. *Psychiatric Bulletin,* **25**: 161-163.

Townsend, P. (1979) *Poverty in the United Kingdom, a Survey of Household Resources and Standards of Living*, London: Penguin and Allen Lane.

Townsend, P. and Davidson, N. (1982) (eds.) *Inequalities in Health. The Black Report,* Harmondsworth: Penguin.

Tribe, R. (2002). Mental health of refugees and asylum seekers. *Advances in Psychiatric Treatmen,* **8**: 240-247.

Van der Veer, G (1998) *Counselling and Therapy with Refugees and Victims of Trauma*. John Wiley & Sons Ltd: Chichester

Ward, K. and Palmer, D. (2005a). *Mapping the provision of mental health services for asylum seekers and refugees in London*. London: Commission for Public Patient Involvement in Health

Ward, K. and Palmer, D. (2005b). 'Reaching out to refugees' *Mental Health Today*, Pavilion **5** (10)

Warfa, N. and Bhui, K.(2003) Refugees and mental health care. *The medicine Publishing Company Ltd*. pp26-28

Watters, C. (2001) Emerging paradigms in the mental health care of refugees, *Social Science and Medicine*, **52**, 1709-1718.

Weiner,B.,Perry,R., Magnusson,J.(1988) An attributional analysis of reactions to stigma. *Journal of Personality and Social Psychology*, **55,** 738-748

Werbner, P. (1991) 'The Fiction of Unity in Ethnic Politics', in P. Werbner and M. Anwar. (eds), *Black and Ethnic Leaderships in Britain*. London: Routledge

Westermeyer J, Wahmanholm K (1989) Assessing the victimised psychiatric patient. *Hosp Community Psychiatry* **40**(3):245-249.

Zolberg, A. (1989) 'The Next Waves: Migration Theory for a Changing World'. *International Migration Review,* **23**(3): 403-430.

Some useful links:
www.neighbourhood.gov.uk
www.mind.uk
www.ind.homeoffice.gov.uk
www.icar.org.uk
www.refugeecouncil.org.uk
www.irr.org.uk
www.asylumaid.org.uk
www.asylumrights.net
www.asylumsupport.info
www.jcwi.org.uk
www.ncadc.org.uk
www.medicaljustice.org.uk
www.dh.gov.uk
If wish to make any comments on this report, please contact david@mrcf.org.uk