

Meeting the Mental Health Needs of Refugees, Asylum Seekers and Immigration Detainees

Stigma
Income
Work
Home
Family
Country
Loss
Identity
Discrimination

Social Perspectives Network is a unique coalition of service users/survivors, carers, policy makers, academics, students, and practitioners interested in how social factors both contribute to people becoming distressed, and play a crucial part in promoting people's recovery.

Meeting the Mental Health Needs of Refugees, Asylum Seekers and Immigration Detainees is a paper from a joint study day with the London Development Centre, National Institute for Mental Health in England aiming to share work and information looking at mental health from a social perspective.

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and Immigration Detainees

London Development Centre/Social Perspectives Network

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Foreword

Immigration into UK has a long history starting with the Romans, the Angles and people from Saxony. In more recent times, Britain has been a haven of refuge for people persecuted on the European mainland, such as the Jews who came here in the early twentieth century. With the break-up of Empire after the last world war, many people from the ex-Empire came here to settle. They were not always that welcome, but today most people accept them and their descendents as valuable members of British society – as black and minority ethnic (BME) communities, an integral part of a multicultural Britain. For various reasons, the UK government imposed strict immigration controls in the late 1970s, and, since then (apart from the influx of ‘guest workers’ from new EU countries in 2006) many of the newcomers to Britain who have arrived here in significant numbers are refugees and people seeking asylum. And mostly they have come from areas of conflict in Asia, Africa and South America and are viewed as ‘black people’ or as ‘Asian’ (unlike earlier refugees who were mainly ‘white’), falling into the category now described as ‘Black and minority ethnic’ (BME) communities.

The refugees who arrived in the 1970s and 1980s, such as the ‘Vietnamese boat people’ and people from Chile escaping Pinochet, were welcomed and treated with sympathy. They and their descendents have mostly either gone back or integrated well into British society. But something has happened in more recent times. More recent newcomers are all too often faced by antipathy and hostility. The media – and even the government – tend to focus on these recent newcomers as ‘problems’, rather than people. In fact much of the overt racism expressed openly in the late 1990s and the early 21st century takes the form of hostility to refugees and asylum seekers. They are being given much less leeway in seeking integration. Even worse, they are often pressurized to leave and even deported back to face the dangers they thought they had escaped from.

I shall not go into the reasons why I think this change of attitude has occurred among (at least) some sections of British public and in the media. I believe that deep down most people here do indeed still harbour positive feelings for people seeking asylum and safety, and an admiration for anyone seeking a better life for themselves. After all, this is a rich country with ample resources built up over hundreds of years of exploiting other places and other people. We *can* afford to welcome refugees as we did in the past. And a lesson from our history is that it is in our own interest to do this. Newcomers have proved to be the life blood of the future, economically, socially and culturally.

Until the mid 1990s, the idea that mental health services need to address the needs of refugees was rejected at many official levels. I recall going to the Department of Health (DH) in about 1996 to ask about financial support to enable a BME voluntary sector project that I was then involved in, to provide counselling services for refugees, only to be told that the DH did not see the need for specific projects for refugees because they were 'not here to stay'. Fortunately this extreme negative attitude within the DH has changed but it may not have changed enough. The underlying message as I see it of the study day organized by SPN is that this attitude is no longer tenable in any way at all. Refugees are among the most vulnerable, disconnected and isolated BME people within British society. Although facing similar problems to those faced by settled BME communities, these newcomers also present additional challenges for the mental health services such as ones concerned with personal torture and political persecution.

Clearly, we have a practical problem in meeting the health and social care needs of refugees. Health and care services must, I think, first and foremost – and that goes also for professionals working in them – try to understand what refugees and asylum seekers may be going through, the legal and social impediments they face, the fear and insecurity they live under, the sort of backgrounds they come from and so on. It is incumbent on us all to grasp the complexity of the problems faced by refugees, even if (as is often the case) we may never have experienced anything like the difficulties they face every day. Many have faced intense hardship just getting here and are terrified of being pushed out. Some have been through unimaginable traumatic experiences, often personal torture, rape and such-like and want to forge some security so that they can forget or come to terms with the past. As we try to understand better what problems refugees and asylum seekers face, we can be in a better position to organize services, meet needs, develop strategies to help them, hopefully always involving the users of services. Although facing similar problems to those faced by settled BME communities – statutory services that adhere rigidly to traditional models of mental health and social care that are often culturally insensitive, concepts of diagnosis and treatment that make little sense to people from non-western backgrounds, institutional racism at various levels, and so on - refugees and asylum seekers also present additional challenges for the mental health services and social care authorities.

The notes from the SPN study day presented in this publication form a valuable text for anyone who is concerned about the plight of refugees and wanting to play a part in developing mental health services that meet their needs. The poems are sensitive and evocative of feelings that few of us may have experienced but need to know about. They provide a feel of what exile and expulsion may be like from the inside; of what the treatment meted out to refugees in the UK actually feels like. Practical problems encountered by refugees when they seek work, try to integrate and attempt to contribute to British society, all these are well covered. And the impediments to integration and the perpetuation of exclusion – not least through government edicts, laws and public policies – come through as important themes that we must get to grips with if we are to even start to understand what refugees go through. The

accounts of workshops provide (a) a vivid picture of the complexity of problems that refugees face – in practical day to day existence, in obtaining assistance that they are entitled to and so on; (b) insight into the life-long traumatic consequences of being raped; (c) some idea of what ‘cultural competence’ in service provision may mean in practice; and (d) information on the prevalence of the practice of keeping immigrants in detention centres – a sure means of traumatizing people if ever there was one.

The publication of these edited notes taken on the day is most valuable and comprehensive. They provide a rounded picture of the basic information we need but more importantly, they should stimulate anyone who reads this document to find out more and even become involved in a branch of service provision that is seriously neglected. I congratulate SPN on bringing out the publication and add my thanks to everyone who participated in the study day.

Suman Fernando

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Author: Mental Health, Race and Culture (2002) Basingstoke: Palgrave

My Children – by Choman Hardi

I can hear them talking, my children
Fluent English and broken Kurdish
And whenever I disagree with them
They will comfort each other by saying
Don't worry about Mum – she's Kurdish
Will I be the foreigner in my own home.

Meeting the Mental Health Need of Refugees etc

Welcome by Melba Wilson, Director of Racial Equality, London Development Centre

Good morning and welcome to today's study day. Today's event is a joint one between the Social Perspectives Network and the London Development Centre. My colleague, Terry Bamford, Director of SPN, and I will be sharing the chairing responsibilities for today.

Today's event has been made possible by the dedicated and focused contributions of a diverse planning group, led by Dorin Varza at the LDC. They have helped to create a vibrant and we hope accessible programme with something for everyone. We have a programme which explores the issues but also one which celebrates the contributions of people from refugee and asylum seeking communities in relation to the mental health of refugees and asylum seekers and people who are detained on immigration issues.

We are pleased to see so many people here today, and also pleased to be able to celebrate London's diversity. And it's an indication of the strength of interest in the subject that we had to turn away as many as those attending – but we will be harnessing the energy of their interest in other ways.

The aim of today is to provide an opportunity for those who are responsible for commissioning, providing and delivering services to people from refugee and asylum seeking communities, including, importantly, the voluntary and community sectors, to explore practical ways of doing so and to do so within the political and economic environment which exists today. The starting point that service delivery must be in a context which people value and which meets their needs in respectful and accessible ways is a given.

We will be sharing good practice and information, as well as discussing practical ways forward in relation to:

- Eligibility/entitlement to services and the changing legal position
- Accessibility to services – e.g. looking at meeting mental health needs in generic services as opposed to having to set up specialist services
- The impact of racism and exclusion, including structural and institutional barriers
- Learning for professionals based on the experiences of refugees and asylum seekers i.e. in relation to trauma, rape as a tool of torture, violence; suicide and destitution.
- The implications of assessing needs/delivering a service – as health professionals who are often in the position of having to 'deliver services first and ask questions later'

We also want to look at the impact of:

- Stigma about mental health in communities and the need to balance this with culturally competent service delivery and a workshop will also focus on language support and interpretation.

If you live and work in London, it is clear that addressing issues which affect the lives of people from refugee and asylum seeking communities is, or should be, a necessary part of the capital's life – whatever the sector, whatever the discipline, whatever the agencies involved.

Refugees and asylum seekers are an important fact of life in London – they add to its rich diversity and bring needed skills and competencies. However, many experience great adversity, prior to arrival in London, and often once they get here.

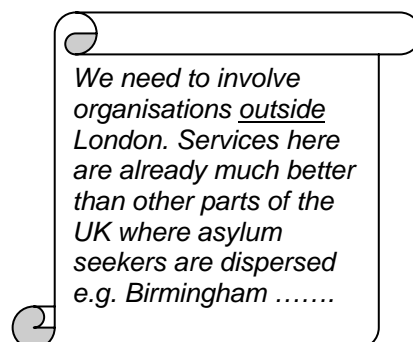
So the aim of today is to look at how we can collectively come up with strategies that can examine the barriers, and identify opportunities that can lead to better mental health service provision that people recognise as progress and improvement.

These are hopeful signs. The Mayor of London is about to launch his new Board for Refugee Integration (BRIL) in London. It is the result of agreement between the Mayor, the Home Office and the Association for London Government. BRIL will be launched later this month, and with it, the Mayor's new role will provide a strategic long term perspective on refugees in London, on their needs and on the opportunity offered to all Londoners by their presence.

BRIL will draw up a strategy to coordinate and promote such work across the city, and oversee its implementation. The Mayor will chair the Board and sign off the London strategy.

This work, today's event and other work underway, including that which many of you are doing, carries with it an impetus fundamental to address the barriers and challenges which adversely affect the mental health of refugee and asylum seeking communities in London

We have a varied mix in the programme – poetry, dance and personal testimony to bear witness. We hope you find the seminar enjoyable, informative and useful. But most of all, we hope you can take something away, which leads to change and good practice development in this key area.



We need to involve organisations outside London. Services here are already much better than other parts of the UK where asylum seekers are dispersed e.g. Birmingham

Poems – Choman Hardi

Choman Hardi was born in Iraqi Kurdistan just before the collapse of the Kurdish revolution and the flight of her family to Iran. She lived her early years in a small Persian town near Tehran and went to a Persian nursery. Following an Iraqi government amnesty for the Kurds, she returned to her hometown at the age of five and lived there until she was fourteen. After the Iraqi government attacked Halabja with chemical weapons in 1988, in tandem with the genocide campaign known as Anfal, her family fled to Iran again. She came to England in 1993 where she was educated at Queen's College Oxford (BA, philosophy and psychology), University College London (MA, philosophy) and the University of Kent in Canterbury (PhD, Mental health). Currently, she is conducting her post doctoral research with the widows of Anfal.

Choman has published three collections of poetry in Kurdish and her first English collection, *Life for us*, was published by Bloodaxe in 2004. Her second book in English will be a translation of *Butterfly Valley* by the renowned Kurdish poet, Sherko Bekes. She was chair of Exiled Writers' Ink! (2001-2003) which aims to support refugee writers and to provide a platform for their work. She works as a freelance writer and creative writing tutor. Her father Ahmad Hardi is a well-known and much respected Kurdish poet: "poetry started with my father," she says, "his regular recital of poetry at moments of anger, sadness, and laughter has had the greatest effect on me".

My Mother's Kitchen

I will inherit my mother's kitchen.
Her glasses, some tall and lean, others short and fat,
her plates, an ugly collection from various sets,
cups bought in a rush on different occasions,
rusty pots she can't bear throwing away.
"Don't buy anything just yet," she says,
"soon all of this will be yours".

My mother is planning another escape,
for the first time home is her destination,
the rebuilt house which she will furnish.
At 69 she is excited about starting from scratch
It is her ninth time.

She never talks about her lost furniture
when she kept leaving her homes behind.
She never feels regret for things,
only for her vine in the front garden
which spread over the trellis on the porch.
She used to sing for the grapes to ripen,
sew cotton bags to protect them from the bees.
I know I will never inherit my mother's trees.

Strings

From one branch of the fig tree
stretching to the window
a string made the line for our clothes

the strings we once had for swinging at picnic
used to hurt my bottom
and my mother made a special cushion for the swing-
once we hung it from the gate on a summer afternoon
and the neighbours came to have a swing too

The strings we use to tie our lives together,
the strings that stretch with us,
the strings that hold us back
and the strings that strangle our brothers

Roj was given back to his parents in pieces,
although his sentence was to be hanged

A blue string reminds me of travelling on a spring day,
watering the thirsty grass
and loving the sky
We spoke in clear blue at those times
a string was still a harmless thing.

The spoils, 1988

(For the 182,000 victims of Anfal, Kurdistan, Iraq)

Anfal came!
The little sparrows stopped practising their first flight.
The sheep died drinking from the water they trusted.
The caves were choked in gas.
The houses were flattened.

The villagers were taken, separated,
those who cried were shot because they cried,
those who didn't were shot because they didn't.
They were kept in the southern sands.
Those who survived the desert
were buried together, alive.

Anfal came!
The soldiers spoke a foreign language.
The villagers thought they were Muslim brothers,
but they spat at the Qura'an the imams held before them,
pissed on the engraved name of Allah,
bulldozed the village mosques.

Anfal came and some survived it.

Of those who survived,
some went back and rebuilt their houses.
They washed the roads, perfumed the air,
replanted the trees.

Some couldn't bear to return.
They left for unknown destinations
and started their lives in a new land,
speaking in a foreign language.
They got remarried, had new children, found jobs,
laughed and danced as before.

But sometimes, on very hot days,
when the land smelt a particular way,
listening to music
they would remember Anfal.

At the border, 1979

"It is your last check-in point in this country!"
We grabbed a drink-
soon everything would taste different.

The land under our feet continued
divided by a thick iron chain.

My sister put her leg across it.
"Look over here," she said to us,
"my right leg is in this country
and my left leg in the other".
The border guards told her off.

My mother informed me: *We are going home.*
She said that the roads are much cleaner,
the landscape is more beautiful
and people are much kinder.

Dozens of families waited in the rain.
"I can inhale home," somebody said.
Now our mothers were crying. I was five years old,
standing by the check-in point
comparing both sides of the border.

The autumn soil continued on the other side
with the same colour, the same texture.
It rained on both sides of the chain.

We waited while our papers were checked,
our faces thoroughly inspected.
Then the chain was removed to let us through.

A man bent down and kissed his muddy homeland.
The same chain of mountains encompassed all of us.

Two pages

1. Delivering a message

I was asleep in the middle of a pad
when he started writing on the first page.
The tip of his pen pressed down,
forcing pale words into the pages below.
He wrote many versions that night
some very lengthy, others brief.

When my turn came he paused,
He palmed his temples, squeezed his eyes,
and made himself a calming tea.

She received me early one morning
in a rush, leaving her flat.
She ripped the envelope. Then, gradually,
her steps slowed down,
her fingers tightened around me.

2. Not delivering a message

All my life I waited for words-
a poem, a letter, a mathematical puzzle.

On March 16th 1988,
thousands of us were taken on board-
you can't imagine our anticipation.

When they threw us out from high above
I was confused, lost in blankness.
All those clean white pages
parachuting into town...

Puzzled faces looked up
expecting a message, but we were blank.

Two hours later they dropped the real thing.
We had been testing the wind direction.
Thousands of people were gassed that day.

Managed migration, the *Depression Report* and the well-being debate

Rhian Beynon, Communications Officer for the Joint Council for the Welfare of Immigrants.

This paper offers a view on the implications of the immigration system for all types of well-being, including mental well-being, from the perspective of the migrants' rights non governmental organisation, the Joint Council for the Welfare of Immigrants, which has been giving immigration advice to migrants and campaigning for their rights since 1967.

The roots of JCWI are in the defensive, anti-racist movement of New Commonwealth migrants formed to combat the explicitly discriminatory immigration legislation, and the virulent Powellite climate, of the 1960s. Since the days of JCWI's inception, the tenor of the immigration debate has become relatively more progressive. The public expression of racism is no longer as widely acceptable as it was forty years ago and our immigration laws are not overtly racist in the same way as the 1962 Commonwealth Immigrants Act. In addition there is a recent cross-party consensus that some economic migration is helpful to the UK. However JCWI's experience is that the immigration system still places particular hurdles to the ability of migrants from the non-European, developing world to enter and remain in the UK legally. This policy is not intentionally racist but it does have the result of reinforcing global patterns of inequity and racial disadvantage in this country in ways that ought to be foreseeable. It is for these reasons, among others, that JCWI has recently published a major report making the case for a regularisation programme for irregular migrants and for a general opening up of legal migration routes for those from the non-EEA regions.¹

As it will be argued here, the immigration hurdles for non-EEA migrants are more likely to result in their employment precarity. The concept of employment precarity reflects absences of or deficits in stability and continuity of the employment relationship; stability of income; quality of working conditions; and access provided to social protection and social inclusion through the employment relationship². These conditions in turn have consequences both for the well-being new migrants from non- EEA countries and that of the communities who host them. Well- being is a notion which is worth locating these observations within given that a number of political players are attempting to shift political debate away from an explicit contest over

¹ *Recognising Rights, Recognising Realities: The Case for Regularising Irregular Migrants*, JCWI 2006 www.jcwi.org.uk

² As Jean Claude Barbier points out the concept of precarity is more widely appreciated on the Continent but even there is some disagreement on what it means. Barbier, Jean Claude et al, *Learning Employment and Welfare Policies in Europe, Cross National Research papers* 7 (3) May 2004, Economic and Social Research Council/ XNat Research and Policy, p7

ideologies of wealth distribution to ideologies of quality of life, of “happiness”,³ concepts which must be constituted in part by mental well-being. This is evidently why Professor Lord Layard and colleagues judged the political climate to be ripe for releasing their *Depression Report* earlier this summer.⁴ They argue that a significant contribution to the well-being of the UK lies in increasing access to basic psychotherapeutic counselling, primarily cognitive behavioural therapy. In turn they argue that increasing access to this time-limited, objective-orientated therapy is cost beneficial because it could increase economic participation. Just give more individuals £750 worth of CBT, runs the fundamental argument and we can expect commensurate numbers to peel away from the Incapacity Benefit statistics.

Well, that is a simple summary, and perhaps a little unfair. Arguably Layard and colleagues are only doing what any competent campaigners do when they are trying to argue for increased spending on a particular service, which is to show how their demands support the Government’s objectives, in this case the objectives on increasing economic participation. But the way in which the *Depression Report* asserts that mental health and well-being are requisite for participation merits scrutiny particularly given the authors’ declaration that well-being is not the result of material wealth, but mental outlook. In the first place this declaration is somewhat undermined by EU barometer research for the European Commission, which argues that the really important influencing factor on well-being is the experience of employment precarity.⁵ As I will seek to show the framework of the immigration system, while being more progressive than the system of the 1960s, still subjects new migrants from the non-European developing world to high degrees of precarity in the UK with potential consequences for well-being. In the second place the situation of the migrant worker also contradicts the assertions made by Layard and colleagues about well-being and its relationship to participation.

People migrate for all sorts of reasons, for an education, to marry, for economic reasons, to escape persecution and conflict, and in the case of some, usually people from the industrialised world, for the sheer sake of the adventure and knowing our planet. But people from the poorer countries of the developing world have particular incentives to migrate to the industrialised

³ *Tories Promise to Make Happiness a Priority* by Tania Branigan, The Guardian Tuesday 23 May 2006. David Cameron, the Conservative Party leader said: It’s time we admitted there’s more to life than money and it’s time we focussed not just on GDP but GWB General Well Being”. Government Minister Tessa Jowell reportedly said that “people were seeking greater contentment and happiness,” not just seeking to survive.

⁴ *The Depression Report: A New Deal for Depression and Anxiety Disorder*, The Centre for Economic Performance’s Mental Health Policy Group, London School for Economics, June 2006

⁵ Gallie, Duncan and Paugam, Serge, *Social Precarity and Social Integration, Report for the European Commission based on Eurobarometer 56.1*, October 2002

world for reasons of poverty, human rights abuse and conflict⁶. However, the UK immigration system makes it harder for them to migrate here. Firstly, the asylum system makes it more difficult for people to claim human rights protection here, for example by criminalising people for lacking documentation, or by narrow interpretations of human rights law which sharply limit the application of the concept of persecution, and more generally through the culture of disbelief and inability to access justice which pervade the whole asylum system⁷. In addition, the system of economic migration makes it more difficult for developing world migrants to enter and remain in the UK in a regulated immigration capacity. This is because the managed migration system presumes that most of the UK's migrant labour needs can be met from an expanded Europe and has as a specific objective limiting unskilled non-European migration. Among non-EEA migrants, highly skilled and skilled migrants from the developing world will find themselves made relatively welcome, with more legal migration routes open to them, more generous temporary leave to remain of five years and the eventual right to settle in the UK. However the vast majority of migrants from the developing world who apply for the unskilled categories will find the door shut to them and if they do obtain leave to enter they will be given sharply restricted temporary leave to remain – which in the case of migrant domestic workers accompanying to the UK employers who are foreign nationals may be as little as six months.

This is somewhat illogical when one considers the number of vacancies, including unskilled vacancies in the UK, which are not being fulfilled by the UK and regular migrant workforces⁸, and those vacancies overall will expand over the next ten years.⁹ In addition, many individuals from the developing world, despite having tertiary level qualifications,¹⁰ are desperate to earn money to remit home and will take any job that appears to afford some opportunity to remit money to their families in the poor sending countries. World Bank research shows that the remittances migrants send home outstrip by many times the money making its way to the developing world through overseas aid budgets.¹¹ Non-EEA migrants entering in the lower skilled categories enter on the basis of a sharply limited period of leave to remain – a maximum of twelve months - and consequently have little protection in the workplace as twelve months in post is needed to secure rights through the ability to challenge on

⁶ UN Global Commission on International Migration, 2005: *Migration in an Interconnected World: New Direction for Action*, www.gcim.org

⁷ *Working against the clock: inadequacy and injustice in the fast track system* by Bail for Immigration Detainees, July 2006

⁸ According to the Office of National Statistics, in the first quarter of 2006 a monthly average of 598,700 job vacancies remained unfilled

⁹ Sector Skills Development Agency (2006) *Working Futures 2004-2014*

¹⁰ 49 per cent of low paid migrant workers from the global south have obtained a tertiary level qualification before entering the UK according to one London study. For further details see Evans Y et al: *Making the City Work: Low Paid Employment in London*, Queen Mary University London, www.geog.qmul.ac.uk

¹¹ World Bank, *Global Economic Prospects*, 2006

grounds of unfair dismissal. This makes them particularly prone to workplace exploitation. Sharply limited leave also makes it more likely that they will remain in an unregulated¹² capacity after their visa expires which again increases the risk of workplace exploitation given that unions such as the Transport and General Workers' Union tell us that many employers find the ability to threaten migrant workers that they will inform the immigration directorate of their presence a handy mechanism of coercion. Some non-EEA migrants who are denied entry choose to enter the country at the hands of criminal traffickers and smugglers who require a period of forced labour as their fee for assuring transit, quite possibly putting those irregular migrants who have made use of their services in the worst situation of all.

It is not surprising that given the restrictive nature of the asylum and immigration systems, that the largest groups of irregular migrants are failed asylum seekers, visa overstayers and those who have entered illegally including the trafficked. Irregular migrants all share the same characteristics. Being at risk of deportation they are less able to enforce their employment, and other, rights by way of legal action and are more prone to work exploitation and criminal menace. Being disproportionately from visible minorities, certainly in so far as the failed asylum seeker group are concerned,¹³ they are more likely to be targeted for apprehension, immigration detention and deportation.¹⁴ Being irregular they will be denied all secondary NHS services other than certain urgent and compulsory treatment may be denied non-urgent primary services, and any social security benefits or help with housing. Following the Asylum and Immigration (Treatment of Claimants) Act 2004 they can now even be denied the right to be married in a civil ceremony.

This increases the levels of precarity that irregular migrants in particular face both inside and outside work and this can only impact on their well-being. We know that both job insecurity and poor task quality usually inherent in the type of jobs they do impact on psychological well-being.¹⁵ Yet migrants are some of the individuals with the highest levels of economic participation. Migrants from the global south, whether they originally entered legally or, not whether they came originally in the human right protection or work categories, are fulfilling job vacancies which cannot be fulfilled by the UK domestic or EU workforces,

¹² JCWI uses the terms unregulated and irregular because illegal implies an act which is criminal while the majority of the people to whom these terms are usually applied are law-abiding as most people would understand the word.

¹³ As evidenced by Home Office statistics which generally show the majority of the top ten nationalities to be failing in asylum claims to be from the Middle East, Asia and Africa. This is also the profile of most people detained under the immigration rules.

¹⁴ Beck A and Broadhurst K, *Policing the Community: the impact of national identity cards in the European Union*, Journal of Ethnic and migration Studies, Volume 24, Number 3, 413-431, July. Where immigration enforcement is founded on surveillance, ethnic minority groups are disproportionately targeted for action.

¹⁵ Gallie and Paugam, opinion cited.

mainly in the sectors which are considered “dirty, difficult and dangerous”. These are largely in agriculture and food processing, construction, cleaning and hospitality and the care industries. These are also sectors where use of recruitment agencies, subcontracting, long commissioning chains and deunionised workplaces are rife. Migrant workers, particularly those from the developing world are the flexibility in the flexible economy. They are bearing the brunt of areas of the economy where precarity, and hence the impact on well-being are highest.

This points us to the fact that, contrary to the *Depression Report's* assertions, for some groups such as migrants, participation is expected and obtained where all the factors are against well-being. Denied access to services, the capacity of irregular migrants to work in the jobs many of us do not want to do, will not be predicated on access to psychotherapeutic services, not even short term CBT, but on patterns of global inequity and an immigration system which is stacked against them. In turn their presence in utter precarity without recourse to rights, progressively excluded from health and therapeutic services, undermines the whole shift of political discourse toward quality of life and well-being. For patently the happiness of some is to be established on the foundation that it should not be a preoccupation for the new migrant groups.

This is not to deny that UK nationals and regular migrants also experience problems obtaining jobs with good employment conditions and accessing services. In fact it is to expose the underlying failing of the new political rhetoric on well-being and quality of life which is that it predicates them on access to resources and the labour market, but not on access to rights. This is a shift that is dangerous not just for the well-being of certain migrant workers divested of rights, but everyone. If one group is always more readily coerced and exploited in the workplace because of its irregular immigration status and consequent lack of employment rights how are regular domestic and migrant workers meant to organise to protect employment conditions, minimise employment precarity and thus optimise work life balance and well-being? In addition well-being if it is predicated on access to resource, including psychotherapeutic provision, is not properly served by some individuals' inability to access preventative provision, and their consequently increased likelihood to have to access costly emergency services at a point of crisis. This can only adversely impact on the availability of funds for preventative services such as cognitive behavioural therapy.

If we agree that well-being is a common objective for society it must be based on recognition of rights for everyone, whatever their immigration status, together a practical mechanism for accessing those rights. One way to achieve this would be for the UK Government to sign up to the international conventions which assert the rights of migrants. A more immediate way would be a programme of earned regularisation which awarded irregular migrants already present in the UK for at least two years, and who can satisfy other additional criteria such as employment or volunteering or family ties, a five-year period of temporary leave, with the chance to earn indefinite leave to remain. Migrants who can show they have experienced severe labour, including sexual, exploitation should also qualify for such a programme.

Asylum applicants and failed asylum applicants who cannot be returned should at least enjoy the right to undertake paid work. Incentives to irregularity should be reduced by ensuring the asylum procedure is not overly restrictive and that legal economic routes to migration with more expanded rights, not dependent on skills levels, are available to Non EEA applicants. Adoption of such policies which recognise the rights of everyone living as a member of UK society would tell us if the politicians are really serious about well-being and about the provision of services that support it for everyone.

Recognising rights, Recognising Political Realities: The Case for Regularising Irregular Migrants by JCWI is free to download at www.jcwi.org.uk



Refugees' common experiences of exclusion

Helen Murshali -Health Policy Adviser, Refugee Council

PowerPoint presentation

1. Government policies

a) The Government 5yr asylum and Immigration strategy published in 02/05

Refugees are given 5 years temporary leave to remain in the UK. This can be revoked during the 5 yrs. Permanent leave granted after review of country situation. This leads to:

- Fear of being refused to stay permanently
- Living in Limbo
- Uncertain future
- Contradicts the refugee integration strategy
- Hindrance to employment and further education such as Medicine, Architecture, and part time studies

b) The Nationality, Immigration and Asylum Act 2002

- Ends work concession for asylum seekers
- Excludes asylum seekers from job market
- Excludes professionals who need skill up date
- Job centre plus has no specialist training to deal with refugees
- Asylum Seekers live on low income and are therefore permanently in poverty

c) The NHS Charges for Overseas Visitors April 2004

This regulation denies hospital treatment for failed asylum seekers unless they can pay

- Failed asylum seekers are forced to access health care at end stages of illness.
- Failed asylum seekers are discharged from hospitals with long term illness to die because they are not entitled to treatment
- There is fear of seeking help from Health professionals on health issues. This has disturbing implications to public health
- Difficult to access information, which is only in English and not widely circulated

2. Local practices

a) Language and exclusion

Without English language refugees and asylum seekers are excluded from many aspects of life in exile

- Inappropriate English speaker of other languages (ESOL)
- Classes, inappropriate to learn certification
- Types of English training often inappropriate and not

- tailored to work
- Employment and education
- Access to services and social interaction
- Access to translation, interpreting and health advocates services are key but often these services are unavailable

b) Accommodation and exclusion

- Dispersal on no choice basis
- Choice of allocation
- Size of accommodation in relation to family numbers
- Appropriateness of accommodation e.g. young women in predominantly male environment

c) Education/training and exclusion

- Disruption of schooling through dispersal, removal etc..
- Lack of access to adult education especially if the asylum application is not determined
- Difficulties of paying Overseas fees for those who want to pursue further studies
- Refugee families see education as an important part of integration especially for their children, but often there is less support
- Lack of confidence for parents to become actively involved due to language and encouragement.

d) Employment and exclusion

- Refugees have higher unemployment rates
- Can not transfer their qualification readily to access work
- Lack of English skills act as a barrier to employment
- Earn lower wages
- Underemployment

e) Refugees documentation and exclusion

- Refugee status grants full family reunion
- Discretionary Leave (DL) allows family reunion only to those in full time employment. This prevents and discriminates against immediate family reunion

3. Effects on mental health well -being

- Refugees may present with a mixture of problems such as stress, anxiety, sleep disorder and depression
- Lack of concentration and feeling restless
- Physical symptoms (pains, dizziness)
- Nightmares, disturbed sleep
- Tired all the time and wanting to stay in bed
- Unable to form relationships (peers, adults)

- Consistent failure to function properly with daily tasks
- Feeling hopeless and talking about suicide
- Social withdrawal and self-neglect

Service providers' obligations towards refugees and asylum seekers

- The Refugee UN Convention 1951, UK is a signatory
- The European Convention of Human Rights incorporated into UK law 1998
- The European Union Council Directive 2003/9/EC.OF 27 January 2003, lay down minimum standard for reception of asylum seekers
- The Disability and Discrimination Act 2005

Poems – Houri Ghamian

Houri Ghamian was born in Iran, lives in Bristol. She is a mother, photographer, interpreter and an occasional poet.

OUR HOME NOW

My mother calls my sisters in my name
And cries
My little nephew keeps asking his mother, when is she coming back?
My bed-room is locked
The dusty mirror on the wall is still thinking of a young woman who used to
smile at herself a few times a day
And my lover passing our road whispers to his wife
“Here is where she lived”.

AS IF IT WERE YESTERDAY

The end of a pigeon is not the end of flying
You always hummed
Our mother was knitting you a woollen hat
I had bought you a torch, the sweet you liked
When radio announced your execution
As if it was yesterday
As if it was yesterday

MY BIRTHDAY

I've been detained in this hostel
For 3 months and 12 days
I begun wondering 8 months and 14 days ago
I haven't adored ARFAN's dimples
For 8 months and 14 days
I haven't pressed the NARENJESTAN'S bell
For 8 months and 14 days
The up-hill of ABIDAR hasn't taken my breath away
For 8 months and 14 days
I haven't seen his picture in their front door's frame
For 8 months and 14 days
I haven't stretched myself up to kiss OMID
For 8 months and 14 days
I haven't been followed by secret services agents
For 8 months and 14 days
Eight months and fourteen days in sanctuary
Not a familiar knock at the door
Nor a warm smile
And today is my birthday

ARFAN – a little nephew
OMID a nephew
NARENJESTAN – a
friend's house
ABIDAR – a mountain in
Kurdistan

Workshop - People without Access to Funds: Social Care: Destitution and Immigration

Olvia Fellas, Persons Team Manager, London Borough of Islington
Barney Wells – Focus Homeless Outreach Team, London Borough of Islington

Notes: Tom Thorpe

Community Care Law – Historical Overview

- Community care legislation and provision was initially developed in its current form, at the end of the Second World War.
- National Assistance Act (NAA) (1948) – *‘community care services for the ill, elderly and disabled people and anyone else who was in need of care and attention which is not otherwise available’*
- The significance of community care provision to people subject to immigration control has only really arisen since the Government attempted to restrict access to benefits to failed asylum seekers and asylum seekers who did not claim asylum at port of arrival.
- This meant that asylum seekers who were adversely affected turned to the local authorities for assistance under the NAA (1948).
- The Immigration and Asylum Act (1999) amended Section 21 NAA (1948) such that destitution alone was not enough to become eligible for assistance from the local authority.
- It excluded most asylum seekers from local authority assistance and the responsibility was placed on the National Asylum Support System (NASS), administered by the Home Office.

Who is entitled to Local Authority Support?

- The duty to assess a person’s community care needs arises under Section 47 of the National Health Service and Community Care Act (1990). This imposes a duty on the local authority to make an assessment of the person’s needs, irrespective of whether s/he requests the assessment. Where there is an appearance of need, the local authority must assess the applicant.
- *‘The obligation to make an assessment of community care services does not depend on a request but on the appearance of need’.*
- The duty to assess is not dependent on the person being ordinarily resident in the local authority’s area.
- Where the need for care and attention is **urgent** the local authority have the power, under Sec 47(5) of the NHSCCA (1990) to provide emergency accommodation and assistance without completing a full assessment.

Section 21

National Assistance Act 1948

- Section 21 allows for the provision of residential accommodation and support as part of an accommodation package.
Criteria:
- *Person is in need of care and attention which is not otherwise available to them and is:*

- a) *Over 18 years old and in need of care and attention due to age, illness, disability or any other circumstances; or*
- b) *Expectant or nursing mother*

The ‘not solely due to destitution test’

- In order to be eligible for assistance under Section 21 (1) (a) the need for care and attention must arise not solely due to destitution. This applies to asylum seeking and non-asylum seeking immigrants.
- Normally, asylum seekers are not eligible to assistance under Section 21 and are entitled to assistance from NASS. However if the asylum seeker has needs for care and attention that do not arise solely due to destitution then s/he will be entitled to assistance under Section 21.

Section 17

Children’s Act 1989

Assistance under Section 17 can include:

- Accommodation and support and any other support required to *“safeguard and promote the welfare of the child”* and
- *“so far as is consistent with that duty, to promote the upbringing of such children by their families”*.

Who is not eligible for support?

- Nationals of the European Economic Area (other than the UK);
- Those with refugee status from an EEA state;
- Persons unlawfully present in the UK (this includes people whose visa date has expired); and
- Failed asylum seekers who have refused to comply with removal directions.
- Paragraph 3, Schedule 3, Section 54 of the Nationality Immigration and Asylum Act (2002) provides that even if persons fall within ineligible classes, they can still be entitled to support if it is necessary for the purpose of avoiding a breach of:
 - a) A person’s Convention Rights; or
 - b) A person’s rights under the Community Treaties.

Case Study

Ahmed is a 45 year old Senegalese man who came to the UK in 1999 on a student visa. In 2002, he started an MA in Theology having already successfully completed two English courses. He had previously completed an MA in Philosophy and Psychology in France He is self supporting through work in catering and is part of a social network.

Soon after starting the course, he became increasingly preoccupied by a physical health problem, specifically halitosis. He perceived hostility and revulsion towards him as a consequence of this and dropped out of his course in early 2003. He believed his health problems were caused by a relative in Senegal placing a curse on him. The GP refused to sign a sick note and did not refer him on.

Ahmed left his previously rented accommodation and stayed with an acquaintance but he became suspicious of him and began sleeping rough. He did not renew his visa in March 2003. When sleeping rough, he made contact with St Mungo's street outreach workers and was referred to Focus. He was approached on the street initially, and subsequently attended appointments. Ahmed was assessed as suffering from a delusional disorder, ("Monosymptomatic hypochondrical psychosis") but was not eligible for benefits or support from the local authority housing dept. He was considered for voluntary psychiatric admission, but there was no bed available. He was prescribed, "Pimozide" and this led to a marked decrease in psychotic ideation, but severe, distressing, side effects developed.

A Community Care assessment was completed, and legal advice sought. The local authority agreed to fund Bed and Breakfast and provide subsistence (£35 per week) on the grounds that although ineligible under Sec 21 National Assistance Act (1948), continuing in his previous situation would be breach of Human Rights.

The Home Office were written to and informed of the situation. Weekly appointments were kept with a social worker and regular psychiatric reviews undertaken. Ahmed was prescribed Risperidone. CPA meeting and plan.

There were significant improvements in relation to delusional ideas and their impact on functioning, but ongoing, disabling, anxiety in relation to immigration status. He was given support in accessing legal advice.

In March 2005, the improvement in mental health was sufficient that Ahmed's previous college were written to. There was no response beyond formal notification that, "application not successful". Ahmed was referred to Islington Mind, where he continued to find social situations difficult, but was able to complete a computer course. He spent most of his time on his own in accommodation.

In September 2005, Ahmed developed side effects to Risperidone, and was prescribed Quetiapine. PWAF were in contact with Home Office about this case. In December 2005 he was referred for assessment to a trainee clinical psychologist. In February 2006, he developed increasing preoccupation with thoughts about past and family relationships. The intrusiveness of these thoughts, as well as some grandiose ideas suggested a relapse. It transpired that he had not been taking the medication as prescribed. Ahmed was restarted on Quetiapine and started attending Mind more regularly. Since April 2006, there has been a very significant improvement in relation anxiety, impact of delusional ideas and motivation. Social situations prove less difficult, as do following up interests in libraries and museums.

In June 2006, Ahmed completed a gardening course run by the Mental Health Trust and began voluntary work. He attends the gym under the "prescription for exercise" scheme.

In July 2006, application was made to the Home Office for consideration of exceptional circumstances, for leave to remain. The report from the mental health team refers to;

- a) Benefits of anti-psychotic medication but vulnerability to side effects;
- b) Difficulties to continue treatment in Senegal and receiving safe level of monitoring;
- c) Difficulties in returning to Senegal because of strains placed on family relationships when unwell;
- d) Return to previous level of functioning enabling potential to return to formal study and self support through work.

Exercise

Use the attached flowchart to advise on the case studies below.

Case Study A

A left Eritrea and came to the UK in 2000 seeking asylum. Her asylum application was refused in May 2005 and she became all appeal rights exhausted. In February 2006 she approached the local authority requesting housing, as she was homeless.

A stated that she was suffering from depression.

- *What action would you take in this case?*
- *Would her situation be different if her GP or treating psychiatrist diagnosed her with Depression?*
- *Would her situation be different if she had a child?*

Case Study B

B arrived in the UK from Ethiopia in 1999. B has received a negative decision on his asylum application. You receive a letter from B's solicitor's stating that you have a duty to provide services under Sec 21 of the NAA (1948), as their client is homeless and citing mental health needs.

- *What duties do you have to this person?*
- *Would the situation be different if you found out he was receiving regular counselling from the Medical Foundation for Victims of Torture?*

Case Study C

C is a 50-year-old woman from Grenada. She arrived in the UK in 1986 on a 6-month visa. She did not renew her visa and was living with her partner (a British Citizen) until 2005 when he unexpectedly passed away. They did not marry and she never renewed her visa or made any claims to stay in the UK.

C came to the attention of Social Services, as she was unable to pay her rent and she was referred by Housing. C was referred to a community care team for an assessment and she was diagnosed as suffering from paranoid psychosis and prescribed medication.

- *What support, if any, is she entitled to and what factors need to be considered?*

Case Study D

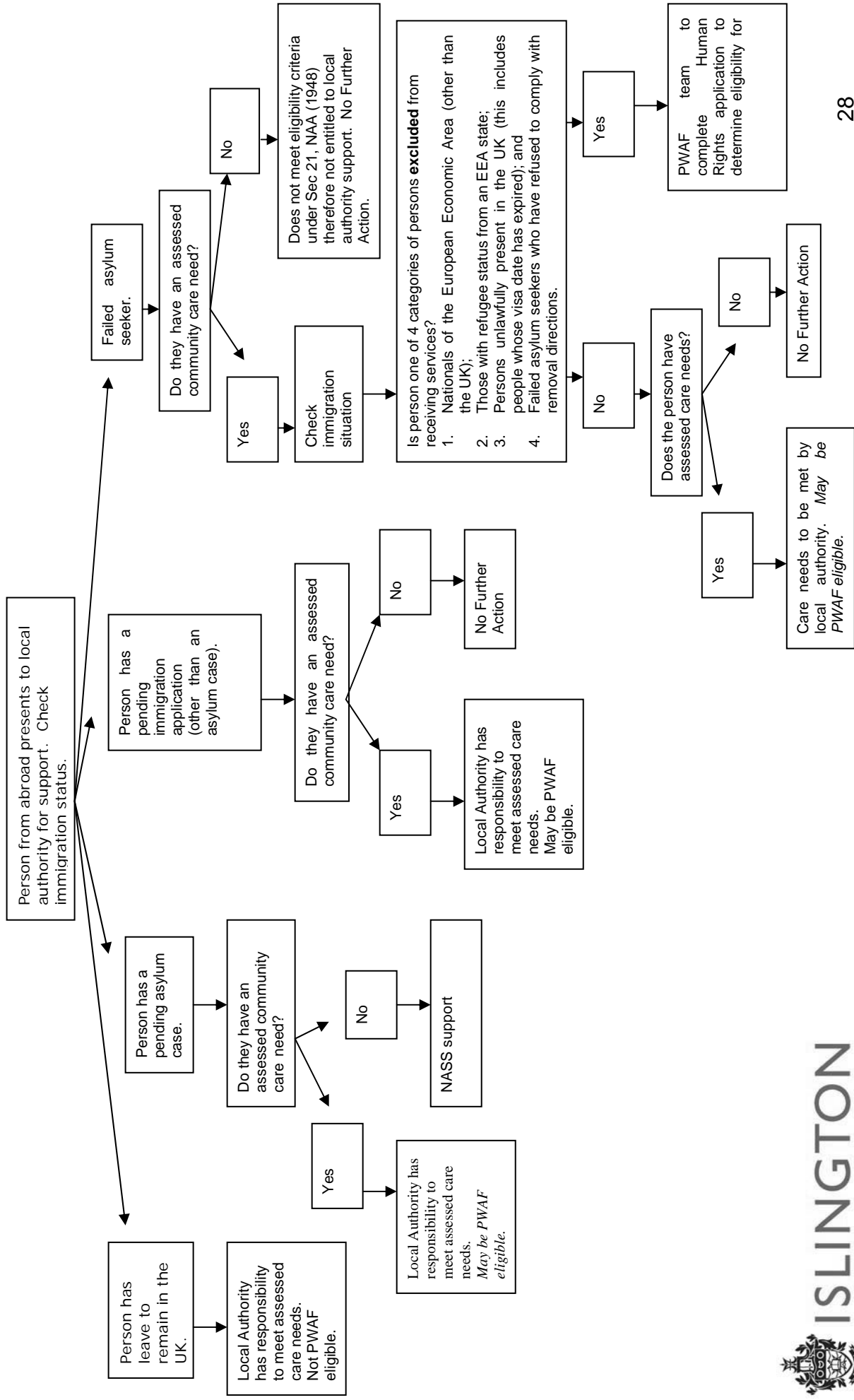
D arrived in the UK in 2002 from Somalia. He arrived and claimed asylum as a dependant on his mother's application.

In November 2004 he was detained under Section 3 of the Mental Health Act 1983. D's initial diagnosis is first Psychotic Episode and he is being treated with medication. D also has ongoing issues with cannabis and occasional alcohol misuse.

His application for asylum is still pending.

- *He approaches the Local Authority for support and accommodation. What are your obligations to him?*

London Borough of Islington – Persons Without Access to Funds (PWAFF) flowchart



Discussion

The workshop very much followed the presentation that was given and discussion mainly evolved around points of clarification on the presentation. The following points were also raised.

- The need for all social care professionals and those who deal with refugees and asylum seekers to be up to date with information and have a clear understanding of their legal obligations to make sure they do not act illegally.
- Olivia Fellas, Persons without Access to Funds Team (PWAF) from the London Borough of Islington was seeking to build a network of health and social care professionals throughout London to facilitate sharing of best practice, best practice and joining services up, statutory and voluntary sectors who deal with local authority statutory responsibilities towards refugees and asylum seekers. (check this for accuracy)

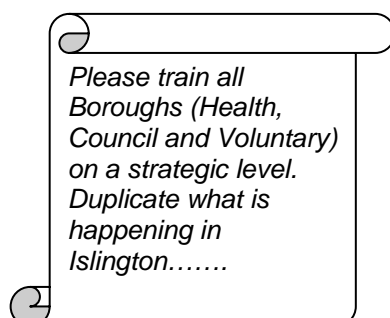
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Persons Without Access to Funds (PWAF)

What is PWAF?

The Persons Without Access to Funds (**PWAF**) service is Islington's response to managing people who are subject to immigration control and have no access to public funds. **Public funds** are welfare benefits such as, Job Seekers Allowance, Housing Benefit etc. Exclusions on public funds would also exclude access to public housing. Also, for this purpose, access to support from NASS is included as public funds. Social services spending is not included in the definition of public funds.

Who is eligible?

Local Authorities are increasingly being asked to provide services to **people from abroad that are destitute**. Typically these are failed asylum seekers or people with an application for leave to remain outside of the immigration rules. Individuals must be assessed as having **community care** and/ or **mental health needs** and be linked to a **community care team** and/or **mental health team**.

Community care needs may include people who have physical disabilities, people with learning disabilities or people with health issues, including people who are HIV+.

It is also important to establish that the individual is an **ordinary resident** of Islington before providing a service. According to the law where a Local Authority has placed someone in accommodation under **Section 21** of the **Nationality, Immigration and Asylum Act 1948**, in the area of another Local Authority, the original Local Authority remains responsible for the provision of community care services to that individual and also for undertaking reviews of **needs assessments**.

Community care and mental health teams are responsible for completing **Needs Assessments**, that cover areas such as personal care skills, living environment, emotional support and any other issues identified.

It is under **Section 21** of the **National Assistance Act 1948** that the Local Authority has a duty to provide residential support to individuals who have a need for care and attention that is not otherwise available. The Local Authority must be satisfied that the individual is **destitute plus**, that is, that the need for care and attention does not solely arise from being homeless.

Who is not eligible?

There are four categories of people who cannot be supported by Local Authorities. **Section 54** of the **National Assistance Act (1948)** had the effect of implementing **Schedule 3**, placing a duty on local authorities to either withhold or withdraw support from four categories of people subject to immigration control.

These include:

1. Nationals of the European Economic Area (other than the UK);
2. Those with refugee status from an EEA state;
3. Persons unlawfully present in the UK (this includes people whose visa date has expired); and
4. Failed asylum seekers who have refused to co-operate with removal directions.

Schedule 3 also states that support may continue where a breach of human rights would occur from the withholding or withdrawal of support.

If a client is assessed as no longer requiring community care support from a Community care or Mental Health Team, they are therefore no longer eligible for support under Section 21 National Assistance Act 1948, then the PWAF team will take steps to cease support. In these circumstances, individuals are encouraged to apply for NASS Section 4 support.

What support can individuals receive?

The PWAF service provides individuals with accommodation and **subsistence** (living allowance) support. We may also refer individuals to a community care team so they can access specialist support or liaise with other professionals to ensure that the individuals' care needs are being met.

The PWAF team co-ordinates the response for persons from abroad with no recourse to public funds throughout the borough, liaising with the relevant social care teams, the Local Authority legal services, the applicant's legal representatives and the Home Office.

Workshop – Immigration detention of asylum seekers and migrants

Sarah Cutler from Bail for Immigration Detainees (BID)
Harris Nyatsanza from Medical Justice

Notes: Jean Healy

The key issues covered in the workshop were:

- Who is being detained, why and where
- Medical Services in detention
- The impact of detention – research and evidence
- Challenging the use of detention and meeting the health and legal rights of detainees
- Sources of advice and support for detainees, including Medical Justice and BID

Key points:

- BID works with asylum seekers and migrants detained under Immigration Act powers.
- There are no official statistics available on how many people are detained over the course of the year.
- Detainees are held in one of ten removal centres in the UK. Six detain men only and the other four are mixed centres, 3 of which also detain children in families.
- Most are run by private companies contracted to the Immigration and Nationality Directorate (IND); however, three centres are run by the Prison Service.
- Detention is solely under Immigration Act powers. No court decision is necessary as it is an administrative decision by the Immigration Service.
- There is no statutory time limit on detention.
- The main reasons the Immigration Service gives for detention are that they believe the individual will abscond if released; that they need to establish a person's identity or that removal directions have been set. They can also detain them to make a speedy decision on their asylum claim, using a 'fast track' at Harmondsworth or Yarls Wood Immigration Removal Centre.
- Of the people in detention, 85% have claimed asylum at some stage. The remainder have other immigration issues, including having overstayed their visa, illegally working or have not returned when they should have done.

Harris – Medical Justice – had been detained himself for five months and is now working with detainees. His presentation included details of the work of the Medical Justice Network.

- MJN was formed because of problems in health care provided in detention centres and has been going for one year.

- The main theme they are working on is to move the provision of health care out of the hands of the detention centres.
- At present, detainees are experiencing failure to investigate evidence of torture before their arrival in the UK, failure to treat medical problems, poor documentation and obstruction of service. There is no opportunity for a second opinion unless it is paid for by the detainees or provided free of charge by the health professional.
- The reality is that more people are being detained and health care is paramount. The system is not equipped to deal with this challenge or the problems of the asylum seekers, which leads to mistrust amongst detainees, who are at present being moved from the community to the detention centre, and back to the community.
- The Home Office contract private companies who in turn sub contract medical care. There are issues about monitoring/transparency of contracts and access to secondary care. Detainees are taken to appointments in handcuffs and there are always escorts in room while they are talking about their health needs.
- When a person is locked up for no reason, it impacts hugely on their mental health. Ongoing health needs are disrupted by detention.
- During the workshop a question was raised about contact with or relationship with the Prison Ombudsman Service. At present, the Ombudsman, Stephen Shaw is investigating a death during time in detention, which was deemed to be self inflicted.
- There are categories of people who should not be detained according to Home Office guidance, including pregnant women, people with health needs and people who can show evidence of torture. Who defines these exceptional circumstances, and where is accountability?
- In many cases, when detention is challenged, the detainee is released on bail. There are elements of the detention centre rules which are not followed. There are no lawyers, or lawyers charging unrealistic prices, being given the wrong information and not being up to scratch on their subject.
- Other health issues are an increase of HIV, where there is disruption to medication, an increase in malaria, whereby after three months the immunity to Malaria is lost and when the asylum seeker is deported, they have lost their immunity, or in the case of young children being born in this country, if they are deported, they have no immunity at all to Malaria. TB is also rife, due to people being confined in small places. There is no testing for TB of people going into detention centres, and this is of major concern.
- Children being handcuffed going to hospital.

The workshop explored a number of positive actions that people could take to support detainees:

- Try to facilitate access to quality legal representation and advice, and make sure detainees have access to emergency numbers.
- If someone wants to oppose their removal, they can use the Legal Action for Women guide - free to all detainees - information distributed or in library

The workshop also discussed what changes need to happen to ensure basic rights are met:

- Ensure provision of health care is responsibility of Department of Health
- Protest at the fact that detainees are treated as criminals
- Push for existing guidelines to be followed: e.g. survivors of torture should not be there in first place

Comments from workshop participants:

- GP Dr Angela Burnett - Medical Foundation – perception that medical foundation has a long waiting list. This applies for counselling but not for a report. If someone has no access to Legal Aid, the Medical Foundations has the discretion to waive the fee for a report.
- Mayor of London - Capital Woman event – good place to raise women's health issues
- National Charities should join up and link in with refugee issues. They have good networks and campaigning skills.
- Suggestion – mental health in primary care uses validated diagnostic tools. Why can't these be used for people in detention to monitor decline of people detained for long periods of time. Powerful tool, has been done in Australia and helped change rules of detention
- Make the argument for cultural appropriateness in services – i.e. doctor of same sex

Workshop - Thinking about rape as a form of torture

Dr Abby Seltzer

Notes: Rowena Harding

Thirty people turned up for Dr Abby Seltzer's workshop on thinking about rape as a form of torture. The workshop is usually run as a full day training session. This much shorter workshop was to get participants to consider the consequences of rape as a form of torture.

Dr Seltzer pointed out the difference between rape as a criminal act, and rape as a form of torture.

Participants were asked to cite the aspects that they felt constituted an action as torture. Responses were:

- Deliberate humiliation and suffering
- Group activity (though there was some discussion that torture could be a one-to-one activity)
- Systematic and pre-meditated
- Humiliation, pain and suffering is the aim of the activity not a by-product
- Power and control dynamics are at play
- Serves as a lesson to others.

The legal definition of torture is set by the UN and has implications for asylum seekers. It is very specific.

“any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions.”

UN Convention against Torture (1984)

Three essential elements:

- The infliction of severe mental or physical pain or suffering
- By or with the consent or acquiescence of the state authorities
- For a specific purpose, such as gaining information, punishment or intimidation.

Legal sanctions prohibiting torture include:

- The UN Convention – International Treaty
- The Geneva Conventions – humanitarian law governing armed conflict
- Human Rights Law

The legal definition of torture can often be at odds with our own personal or professional definition. This causes a dilemma for us as professionals.

Participants were asked to consider what conditions allow torture to happen.

- Lack of state supervision
- Authoritative regime
- Turning a blind eye
- Breakdown of the state / rights of the individual
- Lack of protection / help and nowhere else to turn
- Absence of political /social /economic equality

In some states, torture was seen as a useful and effective way of governing. Even in the UK, in the light of recent terrorist attacks, the UK government had considered the legal admissibility of information acquired under torture.

Rape rarely happens in the absence of any other violence or action. It can include a whole spectrum of sexual torture from forced nakedness to rape. Rape can happen to men as well as women.

Dr Seltzer then presented three vignettes and asked Is it rape? Is it torture?

Vignette 1

A is a 30 year old woman whose husband participated in a political demonstration. He was arrested but managed to escape. On three occasions, soldiers came to her home, searched for her husband (whom she had not seen since the demonstration), questioned her as to his whereabouts, and beat her and her children. On the last of these occasions, three of the soldiers held her down and raped her in turn, threatening to kill her and her children if she protested.

Vignette 2

B is a 21 year old woman whose husband was killed when rebels attacked and burnt their village. She ran off with her two small children towards a refugee camp. When she got there, the children were in dire need of food. The camp commander told her that he would only give her food if she had sex with him. Every night, she and a group of other women waited outside his tent to be called in. If she was chosen, the next day she would be given extra rations. She lived like this for three months until some family members arrived at the camp and helped her to leave.

Vignette 3

C is a 19 year old man who was arrested at a student demonstration. He was taken to a police station in a different region, where he was beaten, then released later the same day and told to leave the area and not come back. He had no money to get home, but a clerk from the police station recognised him in the market place, and offered to give him the money for the bus ride home, provided he had sex with him. Initially C refused, but the clerk said he would tell the police that he was still in the area. C was still suffering from the after effects of the beating, and agreed so that he could get home.

Vignette 1 was easily classed as rape. In the other two cases, where the subjects were forced to have sex upon threat of greater harm, there was much debate as to whether the act constituted as rape. Sometimes, the act of rape

was not the torture – in the case of Case B, the torture was mental as the woman was regularly forced to make a decision to feed her children or be raped by a soldier.

It was clarified that if a subject was co-erced into sex (i.e. threatened with greater violence) then the element of consent was removed and the act was considered rape.

Rape makes a physical (e.g. HIV, pregnancy), psychological (e.g. disabling mental health), and social / economical impact on an individual. It is often the final straw that sees an individual seek asylum. Not all who are raped live, and Dr Seltzer said it was important not to forget these people.

Participants were asked to think of things that could act as barriers to talking to someone about their rape:

- Stigma
- Misinterpretation / discomfort / perceptions
- Lack of resources
- Language
- Talking about it makes someone feel worse
- Investigation process e.g. courts and police
- Lack of cultural insight

Interventions should consider:

- Does this person need an intervention?
- Who delivers the intervention?
- How long do they need?
- What will the outcomes be / what will the intervention achieve?

There are many models of mental health intervention:

- Psychodynamic (e.g. humanistic, counselling which looks at the unconscious)
 - Cognitive behaviour therapy (thoughts, feelings, behaviour and actions)
 - Medical model – bio psychosocial “
 - ‘Disease’ model within the person
 - Social model – the problem is with society.
 - ‘Indigenous’ model
 - Cultural models
- None of the models fully cover the issues that go with rape:
- Partners / relationships / family issues
 - Bearing children / health
 - Shame / guilt
 - Systems/Social networking / stigma / community taboos
 - Socio-political e.g. moving country for asylum

We have to take aspects of the different models to find something that works to cover all the outcomes of the experience.

Dr Seltzer explained a model she used call the Empowerment Model.

1. Minimum intervention – sometimes someone wants to talk to you and tell you that they are going to work through the problem on their own.
2. Maximum functionality – e.g. helping with practical things such as learning a language, housing.
3. Restoring self respect –e.g. therapy, listening, warm reception, treating people as someone who matters – because they do.

Applying the Empowerment Model – Formulating Needs and Planning Intervention.

Vignette

D is a 25 year old married Turkish Kurdish woman with two small children, a boy aged 4 and a girl aged 2. The family arrived in the UK five years ago. Initially her husband claimed asylum, but his claim has failed. Last year she claimed asylum in her own right, on the grounds that she has been persecuted on the grounds of ethnicity. As part of her evidence, she cites the fact that she was raped by police when held in custody overnight for questioning. She is terrified of being questioned in court – her husband does not know she was raped. Although her children were conceived and born here, she tries to find excuses not to have sex with him. She sees it as her 'duty' to bear children but 'freezes' when he is intimate with her. He is patient but bemused. She has constant headaches and struggles to eat enough. She is always tired. She worries about her daughter, who is small for her years and not a fluent speaker. She can't remember when she last had a full and satisfying night's sleep. To make matters worse, they have just been moved to a new neighbourhood, and although they now have a two bedroom flat, it is over a pub and noisy. Sometimes she wishes she could go to sleep and never wake up.

- 1) list her needs
- 2) Formulate some possible interventions, relating them to the principles of an empowerment model.

The key to assisting someone who had been raped was to realize that there are no right answers, but as professionals we know many different approaches that can be employed to create the right intervention for each person.

Workshop - Cultural Competencies – Interpreters as a medium for Refugee and Asylum Seeker Service Users' Empowerment

Dr. Lucy Williams and Dr. Eleni Hatzidimitriadou, European Centre for the Study of Migration and Social Care, University of Kent

Notes: Fran Goddard

This workshop discussed the role and responsibility of interpreters in mental health and social care services in relation to refugees and asylum seekers.

Psychologists and Mental Health professionals use interpreters regularly. The interpreter is often seen as a mediator and has to use his/her judgement on how much to translate on both sides. Refugees and Asylum Seekers often see the interpreter as an ally as the interpreter will speak the same language and have an understanding of the individual's culture. Consequently, the service provider can feel threatened by the refugee/interpreter relationship. The service provider can also feel disempowered by the amount of dialogue that transpires between the interpreter and the client, particularly if it results in a one word answer. Sometimes people will use a member of their family to translate which can increase the service provider's levels of disconcertion.

There are two different models of interpreting.

- 1) Linguistic model that entails making a direct, literal translation
- 2) Community model that entails translating for meaning rather than word for word.

There is a need to consult refugees and asylum seekers on their perspectives of who makes a good interpreter.

The same pool of interpreters tends to work across lots of different services, so they will know how other refugees and interpreters have responded to certain questions. The interpreter can sometimes be used as a scapegoat for both parties' frustrations, particularly when problems arise from the client and the service provider not understanding one another's cultures. The interpreter role can also be very emotional as many refugees and asylum seekers have been through traumatic experiences.

There are questions around who the interpreter is working for and whether professionals should take time to get to know the interpreter. Also, do interpreters need specialist knowledge of the sector that they are working in? There is an argument that immigration interpreters should be part of a separate service, as it is a particularly gruelling role and one which requires interpreters to hear stories that might prejudice their work in other (particularly health and social care) services.

Interpreters are not entitled to employment rights as they are freelancers. The nature of the work also means they struggle to get training or to meet other interpreters. If interpreters are seen not to be impartial in any way, they are unlikely to be recruited again.

Recommendation was made that better professional support is offered to interpreters. It is also recommended that more effort is put into explaining to

the users of interpreting services the benefits of using professional interpreters, rather than friends and family members. These benefits include confidentiality, skills, experience and adherence to professional codes of conduct.

PowerPoint Presentation

Outline for the workshop

- Interpreters in services
- Translating words / Translating meaning
- Service providers, service users and interpreters
- Cultural Mediation

Interpreting for refugees – a special case?

- Issues of trust
- Refugee services
 - Automatic outsiders
- Vulnerability
 - Because of 'status' and entitlements
 - Lack of information
 - Health status
 - Vulnerability to forms of abuse
 - Institutional discrimination

Interpreters in services

- Different models of interpreter service provision
 - Staff members, freelance, bicultural workers?
- Understanding power relationships in services
 - Outsiders and insiders
 - Who is the 'user'?
- The interpreter is expected to “make things beautiful” Kosovan woman
- When refugees come, first meeting with the social worker is a cultural shock. Sometimes I wonder how much the client grasped?” Albanian man
- “If people trust you its (informality) good, better than someone from an agency coming in and doing the job. In some cultures refugees need the connection to feel comfortable.” Eritrean woman

Translating words / translating meaning

- Linguistic models of interpreting or Community models?
- Trusting interpreters
 - Getting to know your interpreter!
- Meaningful communication

- Negotiating 'truth'

"You say I am not here to help you, I'm here to interpret so don't wait in the middle of the interview to say 'Oh, what shall I say?' don't expect me to say 'Don't tell them that'. I make sure they know I will interpret word by word so if there is something you don't want me to tell them, don't say it because I'm going to say it and I won't feel guilty - that's what I am paid to do!" Kurdish man

Service providers, service users and interpreters

- Codes of practice
 - Agreeing ways of working
 - Confidentiality
- Training and qualifications
- Recognising interpreters as fellow professionals and as experts

"Qualifications are important if you are looking for a job but don't mean that they are professional - experience is more important." Tunisian woman
 "First you have to be trained and have experience of interpreting, get people appreciating the work that you are doing." Somali woman

Cultural Mediation

- Interpreter or Advocate?
 - Keeping the balance
- Involving users in the choice of interpreters
 - Active users!
- Interpreters a bridge or a barrier?
- Promoting inter-personal mediation

"In the case of the Doctor who wanted to be very quick, the client wanted to talk about himself, he wanted to explain that the tablets weren't helping. He was very angry and almost started screaming - it's like calm him down and explain the situation - that she is here to try to help you so you must calm down and we explained again." Turkish man

"I had to bring her together as well as her case." Kosovan woman

Choosing a Good Interpreter

- A 'professional'
 - Accreditation, qualification, experience
 - Language skills
 - Specialist knowledge
 - Non-judgemental
 - Dispassionate
 - Independent
- A credible interpreter

- Acceptable to the user and the provider
- Linked to the community
- Separate from the community

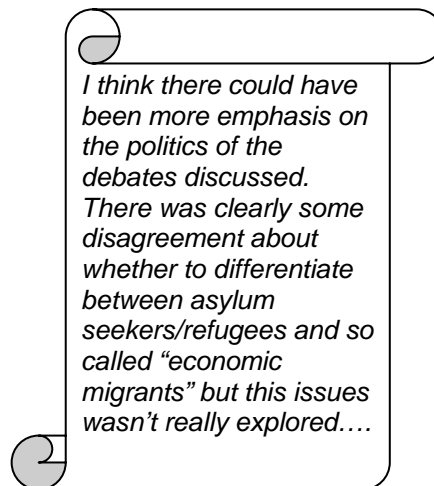
The Views of Users of Interpreting Services

Alexander C., Edwards R. and Temple B. 2004 – Joseph Rowntree Foundation

- The user wants to decide who they need
- An empathetic person
- User's lacked knowledge about 'professional' interpreters
- Family is preferred

The Challenges for Services Working with Interpreters

- Developing skills and ways of working across culture and language
- Engaging with refugee service users on ways of working with interpreters
- Agreeing on how to work with interpreters
- Developing relationships with interpreters



Al Zaytouna

Project 24eight, established with the help of Capital Volunteering, is committed to promoting mental well-being through music and performance. It supports a number of arts projects in north London including Al Zaytouna. This is a London based Palestinian Dabke dance group which aims to provide diverse audiences the opportunity to experience Palestinian Dabke in a variety of performances, workshops and classes.

The members of the group are a mixture of Palestinian and other backgrounds who reside in the U.K and feel the necessity to promote Palestinian culture to the West.

Dabke is a good means to show Palestinian culture because of its artistic presentation of Palestinian life and celebrations especially in weddings, harvests and other symbols of regeneration.

The performance brought zest and energy to the day and got a very enthusiastic response from the audience.



Workshop - Mental health, destitution and asylum seekers in the South East of England

Hildegard Dumper

South East of England Refugee and Asylum Seeker Consortium (SERASC)
National Institute of Mental Health in England (NIMHE)

Notes: Rowena Harding

The aim of this presentation was to provide a flavour of a piece of research that at the time of the workshop was still work in progress, and to stimulate discussion. The presentation consisted of notes summarising some of the initial research findings. The final report is due in September and will be made available to all conference participants.

Main Outcomes

- Provide a tool for community development workers and to inform their work plans
- Provide an insight into the experiences of destitute asylum seekers in the region
- Raise awareness amongst mental health providers of the service needs
- Identify areas needing further research

Methods

- 1-2-1 interviews with 40 destitute asylum seekers identified through drop-in projects for destitute asylum seekers. Two of these drop-in centres were based in a church.
- Group interview with nine Kurdish males not accessing services – relying on their compatriots and rough sleeping.
- Interviews with key service providers
- Group discussions with service providers as focus groups

Top Nationalities of those interviewed

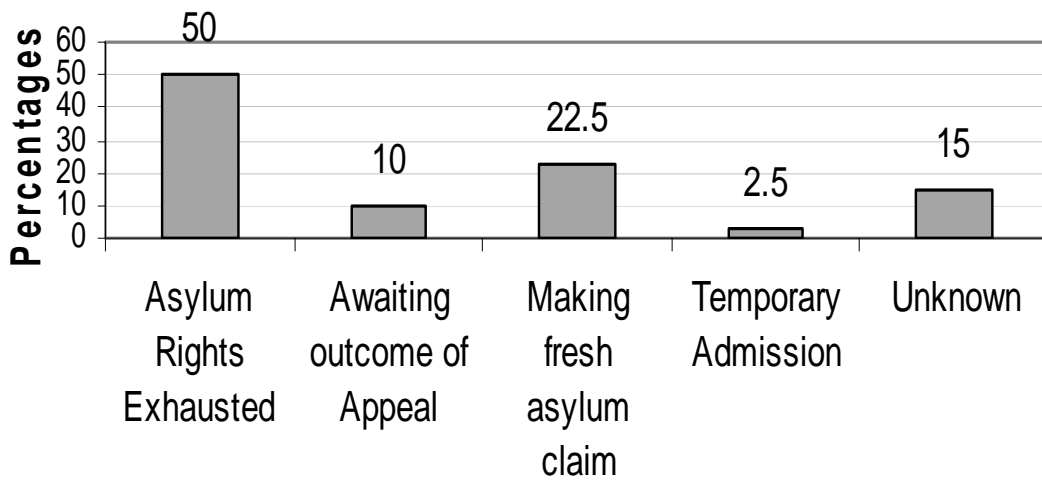
- Democratic Republic of Congo
- Sudan
- Zimbabwe
- Afghanistan
- Algeria
- Ethiopia
- Ivory Coast

There are a large number of refugees and asylum seekers from China, Vietnam and Jamaica but perhaps as there are more established communities in the UK from these countries, there was not as much representation in the drop-in centres.

Some demographics

- 78% from 21 – 40 years (representative of national figures)
- 29% female (compared to 30 % nationally)
- 78% single (representative of national figures)

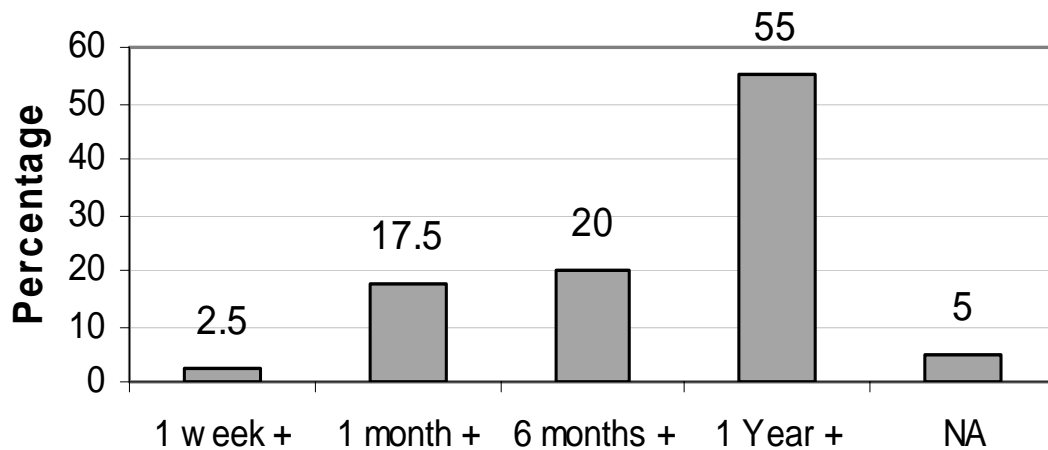
Current immigration status



Asylum rights exhausted = they have no other options

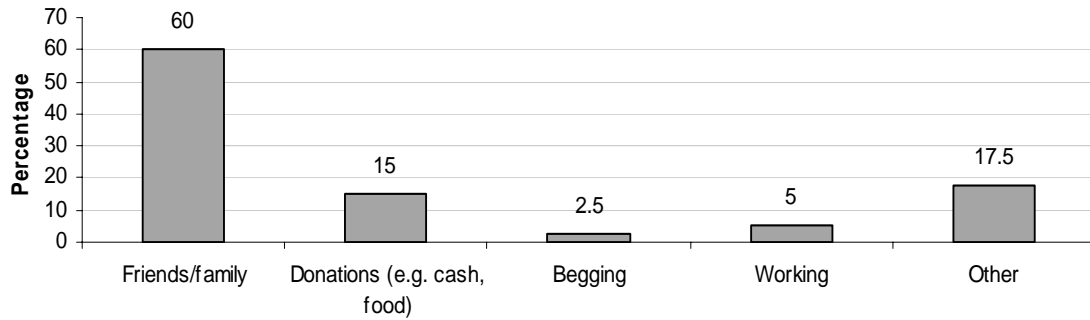
Unknown = people are not always sure what their status is. Their lawyer does not always explain it to them or they need proper legal advice to know what is going on.

How long have you been destitute?



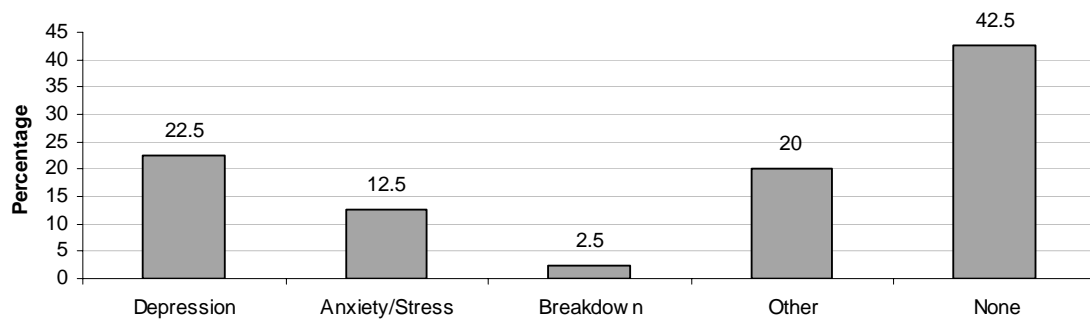
Those who have been destitute for over one year have possibly given up. They don't know what their rights are anymore and have lost touch with proper advice services.

How do you survive?



Friends, in this situation often refer to acquaintances, people they might have met in NASS accommodation, people in the community or churches, or people simply from the same community.

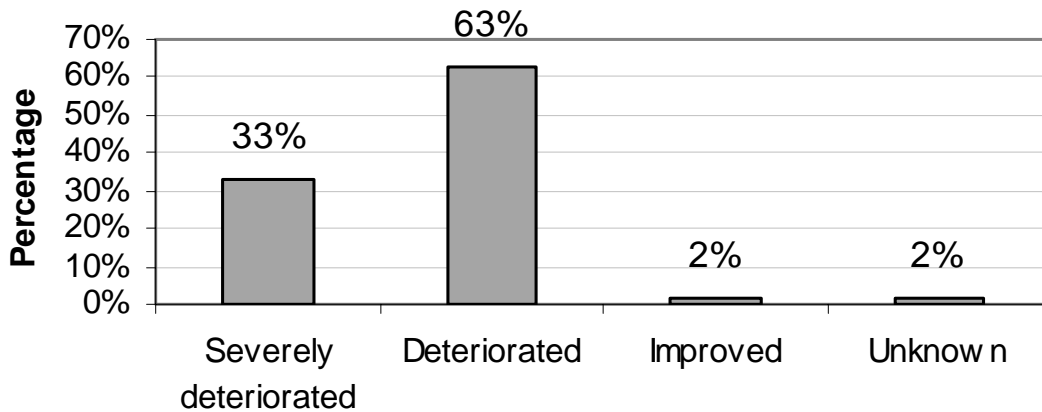
Mental wellbeing before coming to UK



Interviewees were asked to self assess.

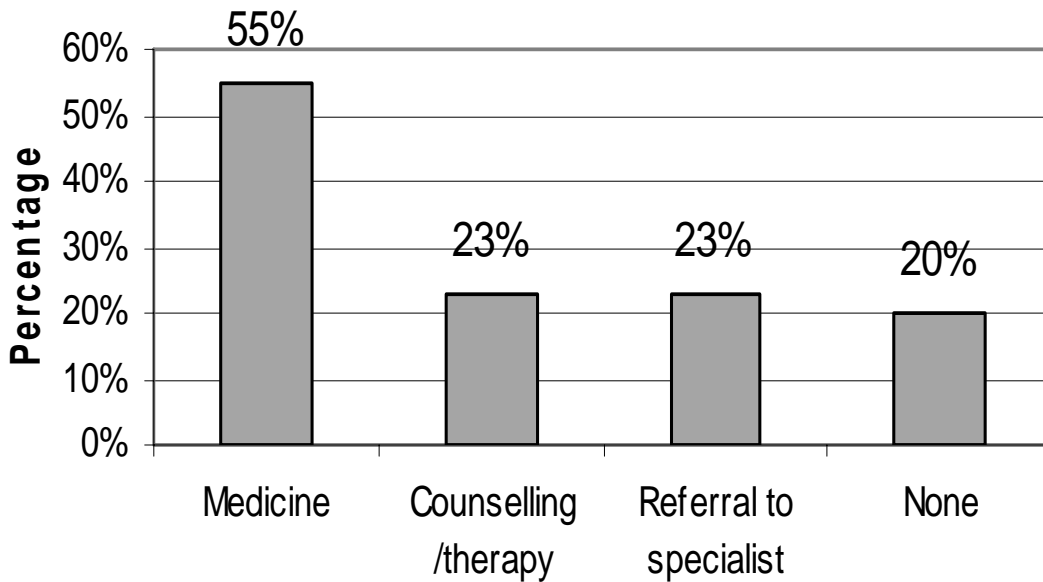
It's worth remembering that the presentation of mental health issues for example, depression, will differ from culture to culture.

Mental health since coming to the UK



Again, the responses were based on self assessment and must be guided by cultural awareness.

Are you receiving any help?



Help that a person received also depended on cultural understanding. People not familiar with counselling may feel that someone isn't helping because they "just talked to me".

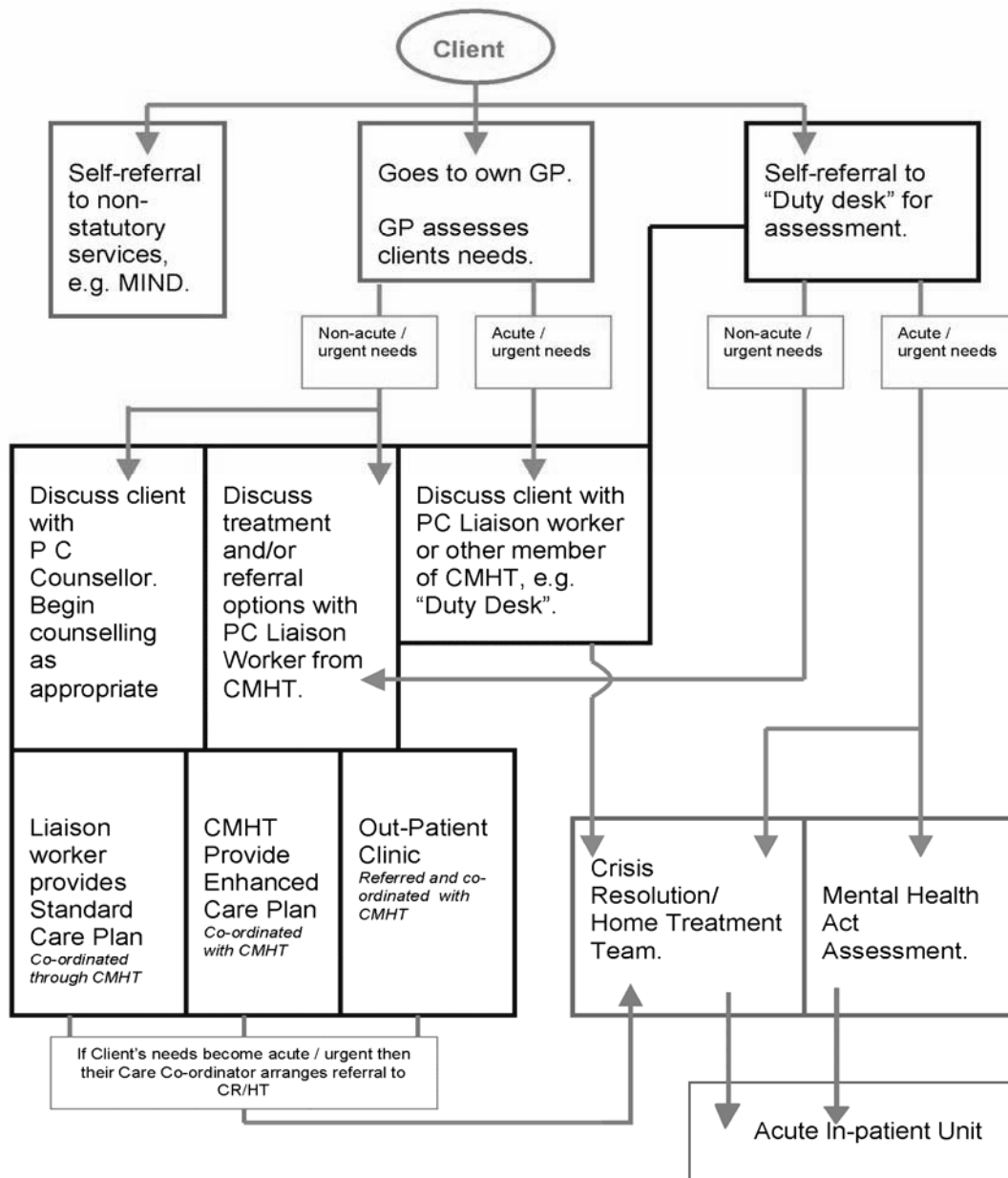
One of the participants suggested that lawyers sometimes encourage counselling because it helps bring out elements which might improve someone's status, i.e. identify them as destitute plus.

Only one interviewee accessed counselling through their GP. The others were referred by a solicitor or specialist agency e.g. rape crisis centre, the police.

Pathways to Mental Health care

This chart emphasizes the role of the GP. If a person is not accessing a GP, then it can impact a range of other services that they might need. It was pointed out that a GP will quickly refer someone onto medication but not as quickly refer them onto the Community Mental Health team.

The chart does not include access through hospital.



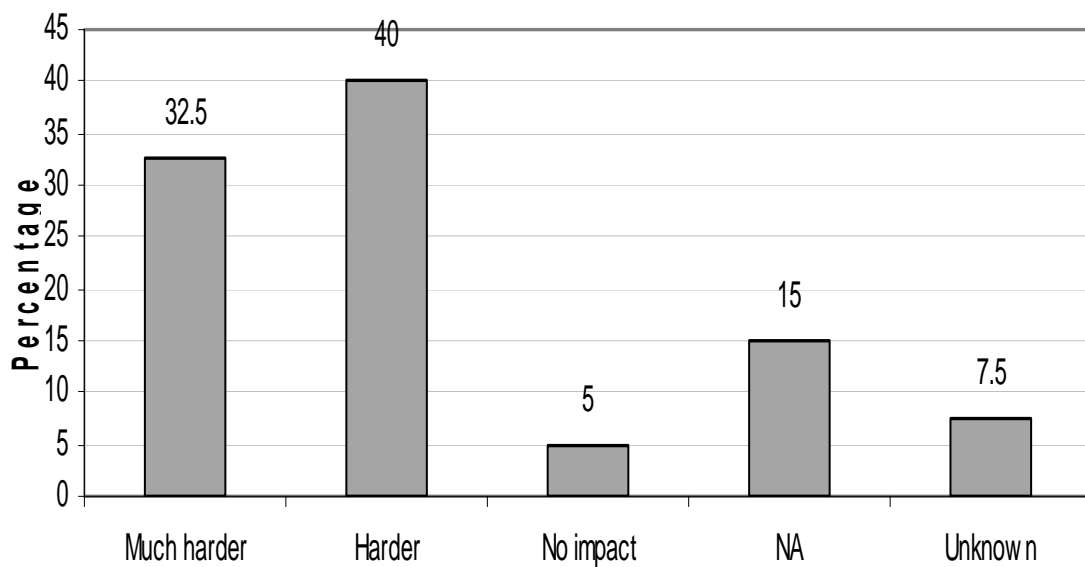
Routes to counselling

- 9 received counselling or therapy
- 1 accessed this through their GP
- 2 in detention
- 2 through a drop in centre
- 2 through their solicitor
- 1 referred by the police
- 1 by a specialist agency.

Demonstrates the problems people have accessing a GP.

People are often worried to show a prescription as they feel they could be challenged.

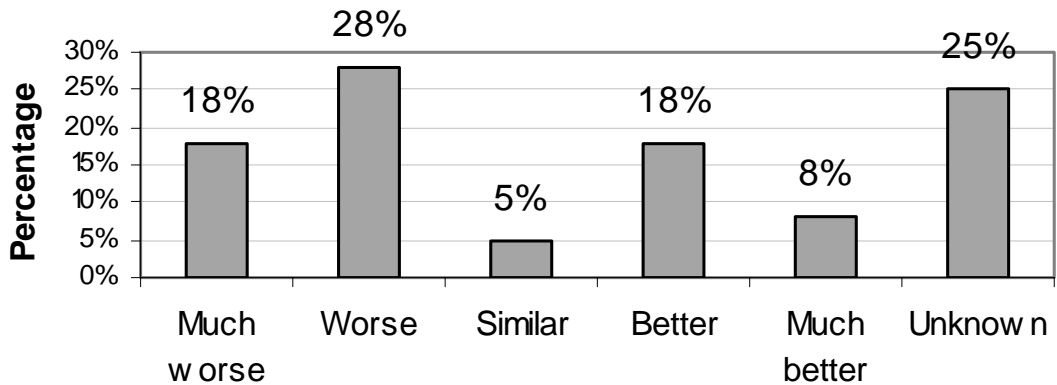
How did destitution affect access to getting help?



Medical receptionists are key because they are gatekeepers to GPs.

Having to pay for medication or relying on people to donate medication is an issue.

Would you have been given better help in your country of origin?



There is a cultural perception from some that you would not “go to strangers to talk to them” about your problems.

Ability of services to respond

- Confusion around eligibility for primary health care.
- Lack of information between NASS and other support services
- Response varies between regions
- No overall strategy

Some Recommendations

- Improved coordination needed between key players: social services, health, housing, NASS, refugee agencies etc.
- Asylum seekers who are unable to return should be given some form of status which allows them to work and support themselves
- Health services should take a moral stand and continue to provide health care to failed asylum seekers

Workshop– Detention – Support Groups- stigma, suicide, discrimination and re-traumatisation

Gill Butler – Chair of Befrienders Group – Yarls Wood Immigration Detention Centre

Heather Jones – Co-Coordinator, Yarls Wood Befrienders

Notes: Jean Healy

Gill is a retired psychiatric nurse with a special interest in mental health issues of asylum seekers and how we can help people in detention, all of whom will have some sort of mental health problems.

Yarls Wood is a purpose built detention centre. The women share (two to a room) and facilities are very basic. There are limited activities, a basic library and a gym. It is well maintained and decorated. There is a separate unit for children and an outdoor play area.

The Befrienders were set up in 2001 – and have been going since, apart from the time of the fire which was in 2002 when the centre was closed for the year. It used to house 900 men and women. Since reopening after the fire, it houses 405 single women and families. There are a large number of beds for fast trackers whose case should be heard within two weeks. 99% are refused when their case is heard, and they have a huge turnover of people. A vast majority of these women are depressed, having fled their countries, after being persecuted or raped. There are very few economic migrants.

When the women arrive in the country, they are amazed that they are detained. Many are suffering from post traumatic stress disorder and they are re-traumatised by detention. Every detainee is examined. They should be asked if they are victim of torture, but often this question is not asked. Even if it is, and the response is yes, often nothing is done about it. Cases are referred from Yarls Wood to Management of Detained Cases Unit (MODCU) but nothing happens. This leads to mistrust amongst those who are detained.

One of the delegates asked what was the big problem with being here – after all the women had a bed to sleep in and food to eat .Two Ugandan women attending the workshop were on bail release from Yarls Wood and were understandably very upset, reporting that it was worse than a prison. There was no privacy. If they had visitors they had to be taken through at least 10 locked doors, being searched on the wing in which they are held and again before the visit's room where they were supervised during visitation. Their visitors were also searched. There is inadequate education for their children and no opportunity to earn money. Mariam (one of the asylum seekers) made the point that “poverty with freedom would be far better than living in prison with no sense of when you would be released”

The detainees receive no compassion from staff after physical and mental torture received in their own countries. They are traumatised and cannot sleep at night. Often fellow detainees are removed in the middle of the night – taken to the airport for their flight home. This is to take advantage of cheap flights

and less traffic on the road. Often women are taken away from the centre at 1am in the morning for a 10am flight. They can be held in a cell at Colnbrook (near airport). Contrary to the myths, they are not given money to go back to their own country.

Mental Health Services within Detention Centres.

Gill related a case study from a year ago of a Ugandan victim of torture. Her husband had been involved in a rebel group and was hiding arms in their home. Her husband escaped. She was imprisoned and subjected to horrendous torture, including being raped daily. She escaped with the help of a relative who was a prison officer and came to the UK. Her three children were left behind and her father died from the shock of her imprisonment.

She entered Yarl's Wood and went on hunger strike, even refusing fluids and wrote a letter to Gill asking her not to read the letter until she got home, Gill read the letter and realised that the woman was going to take her own life, and contacted the Chaplain. After 45 days on hunger strike, she was admitted to Bedford Hospital. Despite the fact that she had collapsed and was vomiting blood, the daily comment from the medical providers was that there were no medical concerns. Gill made the point that the Medical Centre had no idea about how to re-feed hunger strikers.

During time in hospital, the victim was subjected to a bogus removal, where escorts came in and told her she had half an hour to get her things ready. She was unfit to fly, suffered total collapse, couldn't speak and was disorientated and hallucinating and eventually was taken back to hospital.

Three independent medical reports were undertaken. The lady was taken into the locked forensic unit at Luton. The point was made that the victim's story was not heard properly early on. She was eligible for a fresh claim, as evidence of torture had not been presented originally.

Gill told another story of a man who had been living with his wife and two sons in Leeds. His wife and younger son went home and were never heard of again. He and his other son were taken to Yarl's Wood. The father committed suicide as he realised that it was the only way that his son would be able to stay in the country. Members of his church family in Leeds camped outside Yarl's Wood until the boy was allowed to return with them.

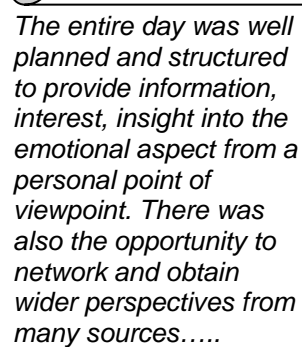
Suicides are common. There had been two attempted suicides that week (out of 60 women).

The situation is hard as mothers and children are separated from fathers. The children don't eat as they don't like the food, their lives are disrupted as they are taken out of school with no explanation. This has a terrible effect on the children who become either introverted or hyperactive, and in turn is hard on the mothers, as they are told to "control their children"

There is one counsellor who attends the centre on 3 days per week, for 4 hours each time. The detainees are very vulnerable women who desperately need counselling and this service is woefully inadequate.

In discussion, the following points were made:

- The Home Office claim that it does not detain people who are mentally unwell is bogus.
- There is a lack of adequate medication
- Duties under the Mental Health Act are not being fulfilled. Self Harm is a major problem. The statement by the Royal College of Psychiatrists should be used to bring pressure on detention centres.
- Mental health workers and social work assessments should be introduced and carried out. Clear legal duties are mandatory under the Mental Health Act. These should be applicable in all detention centres.



The entire day was well planned and structured to provide information, interest, insight into the emotional aspect from a personal point of viewpoint. There was also the opportunity to network and obtain wider perspectives from many sources.....

Workshop – Specific Mental Health Issues – Turning Post Traumatic Stress Disorder (PTSD) on its head – Medical and non Medical Model.

Dr Felicity de Zulueta and Dr Hosein Djalilian, SLAM Specialist Trauma Team

Notes: Fran Goddard

This workshop presented the case of a young man who was referred to SLAM's specialist trauma team two years ago. The anonymized case is detailed below. The subject has been given the pseudonym Z.

Z is a 20 year old male from a troublesome part of Africa that had undergone 20 years of conflict. He suffered outbursts of anger and seizures triggered by reminders of his traumatic experiences. These triggers included his family and people in uniform. Z's father was a policeman and his mother was a housekeeper.

When Z was 6 years old, his father was kidnapped and murdered. Z discovered his father's mutilated body and consequently froze and went mute. He was not comforted by his family and since his father had been the only person who had openly loved him, Z became doubly incontinent, suffered nightmares and became scared of daylight. Z's mother sought medical help for him. Z's older brothers often beat him to punish him.

Z's family then fled the country for London and Z was left in Africa in the care of a family friend. During this time, Z was arrested, imprisoned and tortured, both physically and mentally. When Z was released, a trip to England was arranged for him and Z was reunited with his family. Whilst working with his family, a cousin insulted him and this was a trigger for Z's anger. Z thought of killing his cousin, but changed his mind and seriously damaged himself. He broke all links with his family at this point.

During Z's treatment for his post traumatic symptoms, which involved recalling his personal experiences, he would suffer dissociative seizures. This is a common reaction to recalling a traumatic memory. Z's psychotherapist used grounding techniques and close support to help him reduce his dissociative episodes. He also helped Z to learn breathing exercises and thereby soothe the right hemispheric arousal through the vagus nerve. These breathing exercises helped his patient to modulate his emotions. Psycho-education also helped him.

In addition to trauma focused psychotherapy called 'narrative reprocessing', Z was prescribed an antidepressant according to the NICE guidelines, a Selective Serotonin Re-uptake Inhibitor (SSRI) which can be used to reduce flashbacks and co-morbid depression.

A diagnosis of Post Traumatic Stress Disorder can help carry weight with the authorities to justify why an asylum seeker should be allowed to remain in the country if treatment is not available in their own country.

A member of the workshop referred to a book called 'Tears of my Soul' which is the story of a traumatised individual who tries to undergo self-therapy.

Workshop - Mental health perceptions, experiences and challenges faced by refugees and asylum seekers in London. Findings from research on Somalis in Camden, London and from a research audit on mental health needs and provision for refugees and asylum seekers in London.

David Palmer & Ermias Alemu

Notes: Tom Thorpe

Abstract: Refugee groups experience issues that can affect any community, however research and data available has highlighted that refugees are particularly disadvantaged in relation to mental health experience and access as a result of political, administrative, language and cultural factors. Discourses on mental health in the context of western interpretations are not sufficient to understand refugee's interpretations of their own needs, perceptions and experiences of mental health in the UK. This workshop examines issues of assess and perceptions of mental illness and some of the barriers to accessing and utilising services. The presentation is based on research undertaken on the Somali community in the London Borough of Camden and on qualitative research undertaken on mental health provision for refugees and asylum seekers for the Commission for Public Patient Involvement on Health. The results indicate that refugees and asylum seekers make considerably less use of mental health services on the basis of cultural factors and due to pre-occupation with post migration stressors including immigration status, housing, social and socio-economic factors. The presentation will place these findings within the context of the structures and organisations of the mental health system and in turn adds to the knowledge base on good practice and service delivery.

PowerPoint Presentation.

Introduction

- Case Study: Somalis in Camden, London and references to Unheard Voices (PPI London research report)
- Refugees, a heterogeneous group, often have complex and multiple needs
- Mental health experience and access
- The migration process
- Stigma
- Mental health varies between cultures and behaviour can be interpreted in different ways

Somali Context

- Forced migration linked to collapse of the Somali state in 1991 and civil war
- In total over 300,000 Somalis lost their lives

- Largest refugee community in Camden
- Community with strong religious and cultural traditions
- Social exclusion

Map of Somalia



Mental health care issues

- Access to health care
- Prevalence of mental health needs
- High level of needs, access to services low
- Mental illness considered to refer to madness and not applied to depressive disorders

Research Methods

- Multi-faceted approach
- Project statistics from refugee centre
- Interview data
- Semi-structured interviews

Findings (Somali paper)

- Low use of secondary services (n=5 total n=37)
- Majority living in temporary/insecure housing
- Pre-migration trauma reported by 11 users not accessing services including rape, seeing friends/family members killed, beatings
- *“Everything is lost and broken. So many were killed, beaten and shot. Women raped, beaten and shot. Men killed, missing, wives and children missing. I can’t think about it but I do and cry all the time. It’s the reason why we are here in UK.”*
- Fear and mistrust of the system
- Language difficulties

- Pre-occupation about immigration, housing and income outcome
- Trust
- Lack of support and stigma
- *“The stigma attached to mental ill health attaches to the whole family of the sufferer; they only seek help when the problem reaches a critical stage”*
- Rising concern about the high suicide rates – anecdotal evidence
- *“People are losing ideals and thoughts with no future and are hiding it. Young men are drinking and spending time feeling so useless and are killing themselves.”*
- *“People keep everything inside. They cannot communicate or talk about the problems, they try to kill themselves. Suicide is rising in the Somali community”*

Different cultural understandings

- Difference in perception and interpretation around mental illness in country of origin
- *“The Somali vocabulary for distress is very limited”* (Somali community worker)
- *“Depression doesn’t exist in our language* (Somali Community Leader)
- *“Stress doesn’t exist in Somalia”* (Somali Community Leader)

Stigma

- Importance of recognising the stigma that may be attached to mental health.
- *‘We had difficulties reaching the Somali community and so I decided to search for a Somali interpreter. She did some outreach but no Somali’s 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’* (NHS worker ‘Unheard Voices’)
- 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 undesirable.
- Negative consequences of stigma
- Complex process of labelling which has many causes and is maintained by various structures and can occur at an individual, community and at a service delivery level

Combating stigma

- Multi level community education and training – community members provide positive role models and counter negative beliefs.
- Strategies need to be multi-faceted and have a co-ordinated approach to ensure that they reach community members, individuals and institutions.

Challenge of the system

- Institutional racism embedded within psychiatry?
- Adherence to Eurocentric forms
- Social factors not perceived as primary causes of mental illness
- The NHS – an incomprehensible system?

Cultural Competence: Klienman's explanatory Model

- What is the problem
- What do you call it?
- What can you do about it?
- How responsive will it be?
- Can Doctors do anything about it?

Segal Cultural Competence: 9 domains

- Values & attitudes
- Cultural Sensitivity
- Communication
- Policies and Procedures
- Training and Staff development
- Facility characteristics, capacity & infrastructure
- Family and community participation
- Monitoring, evaluation and research

Making Changes-Recommendations

- Holistic approach to health
- Assistance and advice with practical issues
- Promote an inclusive multicultural strategy addressing distinctive cultural and linguistic needs.
- Work towards the re-establishment of trust
- Sustained empathy and a flexible approach with an awareness of an individual's culture.
- Effective training in trans-cultural awareness

Recommendations for Service Providers

- Inclusive and solution focused approach that seeks to empower users and work in partnership with community and voluntary groups
- Addressing language barriers
- Engage with Refugee and community groups
- User Involvement

Suggested reading

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Discussion facilitated by Dr Angela Burnett (the Sanctuary Practice, Hackney)

Notes: Tom Thorpe

The workshop discussed perceptions and labelling of mental health and how issues relating to stigma impact on wellbeing and access to service provision. We discussed the findings of the study undertaken on the Somali group in Camden which highlighted that this group make less use of mental health services on the basis of cultural factors and due to pre-occupation with post migration stressors including immigration status, housing and socio-economic factors. We discussed the role refugee community groups have in combating stigma. It was pointed out that members may be reluctant to use community groups in case their mental health issues are relayed to their friends, family and wider community. Someone working in a community setting pointed out that many refugees are keen to speak to people about their mental health problems who are from their community and who do not share the negative

stereotypes of mental illness which impacts on community engagement and access.

It was agreed that social networks have a major role in promoting better health education and improving access and by addressing issues such as stigma, community groups could influence and further support their members and therefore be in a better position to action on issues impacting on the well-being of their members.

We also discussed the disadvantage that minority ethnic groups face in relation to health care access population due to the experience of migration, the stresses of racism and misdiagnosis due to the existence of institutional racism. Concerns about rising suicide rates in the Ethiopian and Somali communities were raised, which may be as a result of some of the factors highlighted above.

It was generally agreed that mental health services need to promote an inclusive multicultural strategy addressing distinctive cultural and linguistic needs. It is therefore necessary to take a wider, holistic perspective of mental health. If service provision was approached in this way the inevitable implication would be the adoption of a variety of treatments, and adopting a more appropriate and radical approach to combat the multitude of legal, social, economic and practical difficulties experienced by refugees. In this way much of the labelling of problems as 'mental illness' and subsequent medical interventions will in fact be shown to be an unnecessary and inappropriate response.

Community groups need to address issues relating to stigma and mental health so that they can represent their members and work with mainstream providers to promote a more inclusive approach for those suffering from mental illness

Testimony Interview with JN from Uganda

MW – I'd like to introduce you to JN who has very graciously agreed to be interviewed to share her story with us in the Conference today. It is important to hear the personal testimony of people who have actually undergone these experiences because it then becomes real for all of us. JN has kindly said she would be interviewed and tell us a bit about her experience. She comes from Uganda. She was a student there. I wonder first of all if you could just begin by telling us something about your life in Uganda.

JN – In Uganda I lived a normal and good life together with my family. I got involved in a political party at the age of 15, influenced by my father, not knowing what effect it would have on me later in life. My problems began when I was 17 years old in 2002. Unfortunately, I didn't get a chance to complete my education. My Dad was active in a political party of the opposition side, and when the opposition leader lost the election, supporters became victims of torture by Government soldiers. We were raided by the government soldiers and taken into captivity. As a result, I lost my parents and my brothers.

MW – When did you come here?

JN – I came in 2002.

MW – And what is your status now?

JN – I haven't got a status at the moment. When I came, I was granted exceptional leave to remain for one year and then after that I applied for an extension, and that is what I am still battling with the Home Office.

MW – And can you tell us something about your experience with the asylum seeking process?

JN – When I came here I thought I came looking for protection. Not just me but many came, targeted by political dictators. They come here with a plea for help and protection. It's very sad running away from persecution, coming to this country to be again punished. In 2005, I got pregnant. At 2 ½ months, I was told by the Home Office to start signing on but on my second visit I was arrested. The only crime I've ever committed was seeking asylum in this country. They detained me in Yarl's Wood. It was so hard. I was sick all the time, became anaemic. The food was poor. At times I went to bed on an empty stomach. The only medication prescribed is Paracetamol. I even reached to the point of taking my own life. It was so hard for me, but probably women and children, being put in that detention centre kind of situation, it's not fair on them. Innocent people are paying a high price to be allowed to have freedom. The Government should look back into people's cases and create fair laws instead of tightening them and focusing on numbers of deportation. All the cases have been turned down. You come here and you go to a lawyer and you don't know if he's good or bad, it just costs a lot of money.

You can't afford to appeal. We are afraid of being rejected by the Home Office. Many of the women are suffering from trauma and their health and mental wellbeing are not very good. The Home Office does not recognise the pressure of the institution, of waiting and being turned down.

MW – So you are effectively in a kind of limbo while you are waiting to find out what your status will be.

JN – Yes. Every single day I am afraid of being put back in the detention centre. It's always in my mind. I can't face detention any more. It has damaged my life, I have to depend on anti-depressants to cope with the situation. I have to sign every Friday and that is when I am frightened of being taken back to the detention centre. You don't know whether you will be coming back home or not, my heart beats very fast until I get out.

MW – And you have been able to find accommodation and get help and you have a beautiful young baby, how was that experience for you?

JN – When I came out it was very hard for me. I went to a friend and stayed there a couple of days. Some nights I wondered where I will sleep next because I did not have a home any more. It was destroyed the day they arrested me unaware. I contacted the Refugee Council and they told me that they don't provide accommodation for asylum seekers any more. I contacted the National Asylum Support Service and they told me that they are going to deport me, even though I was 8 months pregnant.

A lot of women are destitute, they have nowhere to go. They are sleeping on the streets, sleeping anywhere. I was advised by a lawyer who had to go to Court. Luckily the Judge issued an order to be given accommodation and support, but I still have very little income, not enough for my child to live on. My child and I are denied public funding yet I am not allowed to work to provide for my baby and myself.

MW – And access to health care- are you registered with a GP and able to get services.

JN – Yes I am very lucky in that when I got the one year exceptional leave to remain, it gave me a chance to register with a GP, unlike a lot of women who can't find a doctor. But when I moved to London, most surgeries deny asylum seekers treatment. One time I was humiliated by a receptionist to told me to go where they treat asylum seekers. We are undermined.

MW – Well it might be a funny kind of question, given the circumstances, but what are your dreams, what are your hopes for what you want to do for the rest of your life?

JN – To be honest, I am hopeless. I don't have any hope because everything's falling apart. We don't have hope. We are just hanging on, not knowing what's coming next.

MW – And you have a room full of people who are able to either provide services or purchase services, what would you like to say? If you had one or two things to say to Professionals about making your story slightly easier to bear, what would it be?

JN – Probably, especially for the doctors and the lawyers to come forward and volunteer to help us in a good way and to help us as any other person in this country. I would very much like other people to volunteer by taking part in visiting detention centres as well as contributing towards demonstrations.

MW – Is there anything else you would like to say to us?

JN – the Home Office do know that countries like Uganda and Iraq and other countries are affected by war and as a result, mainly women are paying a high price. When they come to this country they are very much traumatized. Some are victims of torture and rape, but yet the Home Office turn down our claims and put us on fast track process. We are being threatened by detention and deportation orders and as a result, some people have taken their own lives while in detention centres here in the UK instead of being deported back home where they could face mistreatment and death.

Many thanks to all those people who try their very best to support us.

JN

Concluding Remarks- Terry Bamford

It almost seems like an impertinence to say anything after JN's interview. It was very courageous of her to share her experiences and painful for us to hear them.

It has been a painful and emotional day. We shared the pain of Houri's poem written on the anniversary of her brother's death. We shared the acute sense of loss of homeland reflected in Choman's poems and throughout the day we have been reminded of the stark reality of the problems faced by asylum seekers and refugees in our society.

Asylum seekers and refugees share many common experiences. Some are shared with economic migrants but I wholly reject the equation with asylum seekers and refugees as suggested in Rhian Beynon's paper this morning. The experience of persecution does make a difference and we should not undervalue the distinctiveness of the asylum seeker experience.

First there is a loss of identity- the identity which stems from a shared language, a shared homeland, a shared culture and a sense of one's place in society. Second so many of the stories we have heard today describe the experience of rape, torture, death of loved ones and constant threat of politically motivated violence which leaves many traumatised by the time they reach these shores. Third is the stigma hostility and discrimination which they experience as asylum seekers- a stigma which is even more acute when there are mental health issues whether resulting from trauma or pre existing conditions.

We now have a situation of state-imposed destitution and detention without Trial or charge as an instrument of public policy. I was struck by the pertinence of Ann Neill's remark that we have lowered the threshold of what is acceptable in our society. What would have been deemed wholly unacceptable ten to fifteen years ago in terms of vouchers, denial of access to health and failure to provide accommodation is now accepted as the price of deterring asylum seekers.

It is no good for those of us in the mental health field to talk the talk of social inclusion, choice, quality of life and dignity and collude in the denial of those rights to asylum seekers.

The London Development Centre is not a political organisation, nor is SPN. But there are things which we can do to build on today' event:

LDC will ensure that all those here today have the chance to join in future events to share and disseminate best practice in work with asylum seekers and refugees

We can support as individuals and as organisations the Refugee Council's campaign on health care entitlements.

We can build a shared understanding of those rights and entitlements so that we can challenge injustice born of ignorance

We can build both as individuals and as agencies links with community groups like the Migrant and Refugee Communities Forum in Kensington and Chelsea and Westminster to improve our cultural sensitivity but also to draw on their support networks.

And through the publication of today's conference proceedings we can spread awareness of the gravity of the plight facing so many asylum seekers and refugees.

Yet our society has been enriched by the diversity which refugee groups have brought. The vibrancy and enthusiasm of the Palestinian dance troupe which enthused everybody at lunchtime was a vivid illustration of the resilience of so many refugee communities and how they derive support from their culture. Hope and resilience are important components in recovery for people with mental health issues.

JN spoke of her lack of hope. She is in a very dark place at present but I was struck in the workshop on trauma by the analogy of the garden. Seeds are planted in the dark damp ground. They remain there for weeks even months before breaking through and eventually coming to flower. And every asylum seeker has demonstrated extraordinary resilience to get to this country- a quality which does offer hope.

SPN will ensure that the proceedings today are captured because it has been a rich diet with many contributions meriting further thought which many will want to read and reflect on at their leisure.

I want to thank on your behalf the administrative staff of LDC splendidly marshalled by Dorin Varza, Rowena Harding and Jean Healy from SPN and all the workshop leaders and speakers who have contributed to this important day.

