



**The British  
Psychological Society**  
Promoting excellence in psychology

# Guidelines for psychologists working with refugees and asylum seekers in the UK: Extended version



February 2018

## **Acknowledgement**

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## Foreword

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The number of refugees and asylum seekers in the United Kingdom (UK), across Europe and across the world has increased dramatically since 2015. This developing worldwide crisis has resulted in headlines about thousands of people experiencing traumatic events, crisis and disaster with alarming frequency.

As a discipline and a profession, psychology has a wealth of knowledge, experience and talent to apply in this area to help improve the lives of those who have fled their countries and are seeking safety. Psychological evidence and practice can help to equip individuals, organisations and communities with the knowledge, skills and understanding that they need in order to help them navigate challenging experiences in a complex world.

This guidance document is important, not only for frontline psychologists and others working in the field, but also for practitioners in related disciplines. It is an important resource for directors, managers and practitioners of organisations working with refugees and migrants and providing services to this population, at home and abroad. This guidance will help everyone who is working with these vulnerable populations to access evidence-based psychology, which can help them to improve the lives of individuals and communities that have been affected by the ongoing crisis.

The guidance was prepared by the British Psychological Society's Presidential Taskforce on Refugees and Asylum Seekers – a group of experts including academic and practitioner clinical, community, counselling, educational and occupational psychologists. I initiated the taskforce, the first in the Society's history, upon becoming President in 2015, to create a forum through which to disseminate this expertise.

Between them, the taskforce members have many years of first-hand experience of supporting vulnerable populations. They have spoken out on a number of occasions on key policy issues, for example, on best practice for the child refugees arriving in this country via Calais, and have compiled this guidance to disseminate this expertise further and share best practice.

It is for these reasons that I hope that as many people as possible will read this guidance document and that the recommendations it contains will prove valuable to all who read it, resulting in improved practice and more effective services for all those who we have the privilege of working with.

Thank you for reading and disseminating this guidance. I hope that you find it extremely useful.

**Professor Jamie Hacker Hughes**

*BPS Vice President 2016–2017*

## Executive summary

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Since October 2015, there has been a mass movement of refugee people of whom a (small) percentage have come to the UK. There were 32,414 applications for asylum in the UK in 2015, and 64 per cent of asylum claims were initially refused (Migration Observatory, 2016). Children are a key part of this group; in 2015, there were 3253 unaccompanied asylum seekers children in the UK (Refugee Council, 2016).

While the issue of supporting and protecting asylum seekers and refugees in the UK is not new, the intensification in conflicts means this will continue to be a pressing area for psychologists working with children, families, in educational settings, the workplace and amongst communities and volunteers.

Refugees and asylum seekers who come here have often done so at very short notice, and via a perilous journey, which can mean they have not emotionally processed many of their experiences, losses and changes. They may assume arrival in the UK signals an end to their difficulties, when it is frequently not the case and this can have a severe psychological impact. These groups may also come from a cultural background where accessing mental health services is stigmatised.

Most asylum seekers and refugees are extremely resilient having devised different coping strategies. However, poverty, being denied access to work, uncertainty about their right to remain, and the hostility they can face from the community where they are settled can have psychological impacts.

Psychologists will encounter refugees and asylum seekers in many different settings. The recommendations below are some of the most important points drawn out in the report for these specific areas, linked to the specific chapters. It's worthwhile pointing out though that there are many that overlap. For example, the need for professional interpreters, who are well briefed by the psychologist is key, whether it is a child, adult, or family being spoken with (see *Working with interpreters: Guidelines for psychologists*, BPS, 2017).

Those working with refugees and asylum seekers should take a holistic approach so that other valuable services – whether community volunteers, Non-governmental organisations (NGOs), those who can support these families with their legal journey – are accessed quickly and effectively. There must be rapid and evidence-based assessment so that the particular traumas these clients have gone through can be addressed. But equally psychologists should not fall into the trap of psychologising or pathologising their suffering; for the majority of families, their current situation can be understood in terms of being a normal response to abnormal circumstances.

By producing this extended guidance, the BPS hopes to inform and help those working in this particular field, in what appears to be a growing area.

A shortened summary of this document is also available at [www.bps.org.uk/policy-research-guidance](http://www.bps.org.uk/policy-research-guidance).

# Guidelines: A summary

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## **Supporting adults**

1. Show respect for clients and make sure clear information is given about meetings.
2. Always use professional interpreters.
3. Maintain good contacts with other services to avoid duplication of services.
4. Ensure professional boundaries are kept between you and the client, and make sure you have regular supervision to reflect on your work and avoid vicarious traumatisation.

## **Supporting children, young people and unaccompanied minors**

5. Children must never be asked to be an interpreter, especially when their parents are being examined or seen by a psychologist.
6. When assessing children, interview them separately, as they may not want to upset their parents.
7. For unaccompanied minors, be aware that turning 18 is a crucial age – both in terms of whether they have leave to remain, and the support they receive from social services if they stay.

## **Supporting nurseries, schools and colleges**

8. Swift access to education and well-planned school-based assessments help these children integrate successfully.
9. Assess such children in their home language and correct dialect.
10. Don't automatically place children in lower-attaining groups if English is not their first language; assess them on their previous schooling, ability and needs.
11. Engage the community and whole school so that these children and young people can be quickly integrated.

## **Supporting families**

12. Assess families not just in terms of their needs, but also their strengths and abilities.
13. Signpost sources of support for securing appropriate, sound and reliable legal representation.
14. Be sensitive as to which is the appropriate community for these families, rather than what is assumed to be.

## **Supporting communities**

15. Develop mutually supportive relationships with community organisations, sharing experience and knowledge rather than acting as an 'expert'.
16. Set up methods of evaluation for any work from the start as this can produce helpful feedback and wider use.

**Intersectionality**

17. Refugees should not be seen as a homogenous group, but offered specialist support if needed on terms of race, gender or sexuality. See changes in extended document.

**In the workplace**

18. Coaching, language skills, clarity of job advertisements can all help refugees and asylum seekers get into work.
19. Formal inductions and buddy systems can help the transition and may welcome workers in.
20. Encourage employers to align their commitments to diversity with their other goals and objectives.



# 1. Introduction

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For decades, armed conflicts, persecution and violations of human rights have led to people being forced from their homes to seek safety. The majority of those forcibly displaced tend to flee to neighbouring countries and regions. Many others remain within their country, but are unable to return to their homes, while some will have sought refuge in other countries, like the UK.

Since October 2015, with the intensified conflicts particularly in the Middle East and the resulting humanitarian crises, we have seen a mass movement of refugee people. The vast majority of the responsibility to provide humanitarian assistance and protection to these people has been shared by Turkey, Lebanon, Jordan, Germany and other European countries. In the UK, we have taken proportionally few.

Historically, many people from different countries have sought and will continue to seek asylum in the UK. So, the issue of supporting and protecting asylum seekers and refugees is not new for us. There are a significant number of organisations and psychologists who have specialised in this area, working both in civil society organisations and statutory services.

This Guidance seeks to provide basic information and resources for psychologists beginning to work with asylum seekers and refugees, although it may also be of relevance to more experienced colleagues. It is not intended as a detailed, comprehensive resource, or guidelines on specialist psychological interventions.

The Guidance has been written by members of the Taskforce, and includes a range of perspectives. Amongst the many key issues we would like to draw attention to, four are key:

- 1 The need for professional support and supervision of colleagues working with asylum seekers and refugees.
- 2 The need for professional interpreters, and developing appropriate competencies to work with interpreters when working with asylum seekers and refugees.
- 3 The need to address context, past and current, which may include experiences of poverty, homelessness, racism, hostility and hate crimes that asylum seekers and refugees face.
- 4 The need to take a holistic perspective, recognising the diversity and the resilience of asylum seekers and refugees and the survival strategies they possess.

## 2. Terminology

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Here, we define some key terms. These definitions are important because they may have different legal consequences and legal obligations, which in turn also have psychological, social, economic and other impacts that are relevant to psychologists and others.

The legal framework, which determines these definitions and obligations, is comprised of international law and domestic UK law.

### Legal framework

The UK has legal obligations under international refugee law, specifically the United Nations Convention on the Status of Refugees 1951 and the 1967 Protocol (together referred to as the 'Refugee Convention') which requires States to:

- Not return asylum seekers to countries they have fled from and where their life or freedom would be threatened because of their race, religion, nationality, membership of a particular social group or political position.
- Have in place national mechanisms to consider claims for asylum.
- Have fair and efficient asylum procedures to ensure they can live with dignity and in safety whilst their asylum claims are being considered and processed.
- Not penalise an asylum seeker for illegal entry when the purpose of their entry is to claim asylum.

The primary responsibility for protection lies with the State receiving refugees.

The United Nations High Commissioner for Refugees (UNHCR) is the UN agency with a mandate to protect refugees globally, including those internally displaced. The UNHCR's role is to advise and support states in implementing their responsibilities.

The UNHCR recognises that during mass movements of refugees, for example where there is persecution, violence or armed conflict, it is not always possible or necessary to conduct individual interviews with every person who crosses a border. These people are often referred to as 'prima facie' refugees. Currently, there are an estimated 60 million displaced people globally, including those who cross international borders and those displaced within their own countries.

### Asylum seeker

Internationally, asylum seekers are people who have moved across international borders to seek protection.

In the UK, an asylum seeker is someone who has applied for protection under international law, specifically on the basis of the UN Refugee Convention or Article 3 of the European Convention on Human Rights, which prohibits torture or inhuman or degrading treatment or punishment and prohibits the return of a person to a country where the person may suffer a violation of their rights under Article 3.

## **Refugee**

Under international law, the United Nations Convention on the Status of Refugees, 1951, defines a refugee as a person who 'owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion is outside the country of his nationality and is unable, or owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence, as a result of such events, is unable to or, owing to such fear, is unwilling to return to it' (Article 1 (A) (2)).

In the UK, refugee status is given to a person recognised by the Home Office as a refugee as defined by the Refugee Convention. Hence, refugees are those who have been granted protection in the UK.

## **Unaccompanied minor**

Internationally, the UNHCR defines an unaccompanied minor as a person who is under the age of 18, unless, under the law applicable to the child, majority is attained earlier and who is separated from both parents and is not being cared for by an adult who by law or custom has responsibility to do so (UNHCR, 1997).

In the UK, an unaccompanied minor is a person who at the time of making an asylum application is under the age of 18; and who is seeking asylum in their own right; who is outside their country of origin and separated from both parents or previous/legal customary primary care giver; and without adult family members or guardians in the UK to whom they could turn.

## **Separated children**

A separated child is someone under 18 years of age; who is outside their country of origin and separated from both parents or previous/legal customary care giver. Separated children are typically asylum seekers, but the Home Office may dispute their age.

An 'age-disputed child' is someone who has claimed asylum as a minor but where the Home Office and/or the local authority asked to provide support does not accept the date of birth claimed by the applicant. The person is then treated as an adult by the Home Office and/or the local authority. This has significant implications for the way in which the person's application for asylum is assessed and for the welfare and educational support that they receive.

## **Internally displaced person (IDP)**

An internally displaced person is someone who is forced to flee their home for safety but who has not crossed a border, and therefore remains within their country's borders. They remain under the protection of their government. Their reasons for fleeing may be the same as for those who have crossed international borders to seek asylum and protection in other countries, but they are not considered legally as refugees. IDPs are also sometimes called 'internal refugees' although they do not have the same legal protection as refugees who cross country borders.

## **Migrant**

A migrant is a person who chooses to move not because of threat of death or persecution, but to improve their lives, to seek family reunion, education or employment, etc. Migrants are those people who do not face threats to their lives or their safety if they returned to their country, and they could receive the protection of the government in their country. The distinction can be blurred since many seeking asylum are fleeing from war and violence and may also seek to improve their lives. Typically, migrants is a term used for foreign nationals resident in a country but who move for family, education or employment reasons.

## **Torture survivor**

A person who has experienced torture is described as a torture survivor. Many asylum seekers and refugees (adults and children) may be torture survivors, but not all. The definition of torture is a legal definition enshrined in the United Nations Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment 1987, which states in Article 1 that:

*‘Torture means 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.’*

The Human Rights Act and the European Convention on Human Rights both enshrine the prohibition against torture.

## **A person who is trafficked**

In international law, trafficking under Article 3 of the Protocol to Prevent, Suppress and Punish trafficking persons (‘Palermo Protocol’) is defined as:

*‘The recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation can include different forms of sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude or the removal of organs.’*

Additionally, the Council of the Europe Convention on Action against Trafficking in Human Beings entered into force in the UK in 2008. In the UK, the Modern Slavery Act 2015 criminalises offences of human trafficking and slavery and encompasses trafficking for all forms of exploitation.

## **Statelessness**

Statelessness in international law refers to the lack of citizenship. A stateless person is someone who is 'not considered as a national by any state under the operation of its law' (article 1 of the 1954 Convention relating to the Status of Stateless Persons). Some stateless people are also refugees, and some people become stateless or some are born stateless. Without citizenship or official identification papers to prove citizenship, a person who is stateless cannot vote, obtain travel documents or access government-provided services.

## **Refugee status**

Once a person is recognised as a refugee they are normally given refugee status, known as 'leave to remain' which entitles them to stay legally in the UK for five years. At the end of this five-year period, the person can apply for the permanent status of refugee, called 'Indefinite Leave to Remain'.

## **Indefinite leave to remain (ILR)**

Indefinite leave to remain is a form of immigration status granted after consideration of an asylum application by the Home Office. ILR grants permission to stay in the UK on a permanent basis.

## **Temporary admission**

Temporary admission is notice of a liability to be detained. Asylum seekers applying for asylum at the port of entry may be given this status by the Home Office.

## **Discretionary leave**

Discretionary leave is a type of immigration status granted to a person who the Home Office has decided does not qualify for refugee status or humanitarian protection but where there are other compelling reasons why the person is recognised as needing to stay in the UK on a temporary basis.

## **Humanitarian protection**

Humanitarian protection is a form of immigration status. It is granted by the Home Office to a person who they have decided has a need for protection but who does not meet the legal criteria for refugee status.

## **Quota or programme refugees**

People brought as refugees to a host country usually through the UNHCR with the support of the government and whose arrival is planned and who therefore may receive additional support and services



### 3. Key principles

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The British Psychological Society's Code of Ethics and Conduct 2009 applies to all aspects of work with refugees, asylum seekers and migrants.

In addition, there are key principles, based on professional practice and consensus amongst health and social care specialists in this field, which should inform all psychological work with these groups:

#### **Key principles in working with refugees and asylum seekers**

1. Do no harm in all activities, interventions, research and other psychological work.
2. The best interests of the individual must be the primary consideration, while endeavouring to address the differing needs of the family or primary caregivers.
3. Swiftly identify those who are particularly vulnerable to harm or exploitation, or mental health difficulties, so that they can receive prompt access to health and social care services and education.
4. Be aware of context –and take into account the social, economic legal and political contexts, which can impact on both individual and the family.
5. Adopt a rights-based approach, which upholds the human rights of every individual and ensures their dignity and safety.
6. Adopt human rights principles of inclusivity, non-discrimination, participation and cultural and gender appropriateness in all aspects of psychological work.
7. Ensure access to professional interpreters, qualified and skilled in working with children and/or adults.
8. Collaborate and work in partnership with other professionals and agencies to ensure psychological, physical, social welfare, educational, vocational and legal needs are addressed as holistically as possible.

## 4. The impact of becoming an asylum seeker/refugee

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The impacts of becoming an asylum seeker or refugee are many and diverse and are dependent on a range of factors. Many people have shown immense strength and resilience in fleeing from their country of origin and making the journey to their current country.

Yet the terms ‘asylum-seeker’ and ‘refugee’ are frequently used in negative and derogatory ways in the media and by some politicians (Tribe, 2010). Use of words such as ‘scrounger’, and narratives of blame can obscure the reality of who refugees are, and why they seek asylum abroad, when most would not want to leave their home country (Refugee Council, 2017). People who have been forced to become refugees include Nobel Prize winners, Sigmund Freud, Carl Djerassi, and many scientists, writers, artists, sports people and entrepreneurs, who have gone on to make a significant contribution to the UK or another host country.

The number of asylum applications within the EU in 2015 was 1.3 million, (Eurostat, 2016) although the UK’s share has declined from approximately 11 per cent in 2008 to approximately three per cent in 2015. There were 32,414 applications for asylum in the UK in 2015; 64 per cent of asylum claims were initially refused (Migration Observatory, 2016). In early 2015, there were estimated to be over 38 million IDPs worldwide (up from 33.3 million in 2013; UNHCR, 2015) of which 51 per cent of refugees are children. In 2015 there were 3253 unaccompanied asylum-seeking children in the UK (Refugee Council, 2016).

Most do not seek out statutory mental health services, but some will benefit from access to a psychologist or other mental health services for issues relating to their experiences of different traumatic experiences and losses.

### 4.1 The journey to safety

Asylum seekers differ from immigrants because they have usually been forced to flee their country at short notice, in fear of their lives or those of their family – and often not knowing where they are going. Reasons for their flight include war, human rights abuses (such as organised violence and torture) and/or persecution because of their politics, beliefs, gender, ethnicity or sexuality. They may have had to escape because they had become involved in political activity, promoting human rights or democracy – and this was seen as a threat by governments or officials (Amnesty International, 2017). Those who try to claim asylum in another country often risk being arrested within their country of origin or subjected to organised violence or torture (Refugee Action, 2016).

During their flight to safety, families are often split up. Their long and perilous journeys are filled with dangers such as arrest, theft, kidnap and sexual violence. The financial cost is also great: many pay agents significant sums to help them cross borders and may sell everything they own to help a family member at risk to flee. Some clinicians believe that those stressors refugees encounter during their flight and on arrival in a host country may be as influential as what happened before they had to leave (Gorst-Unsworth & Goldenberg, 1998; Pernice & Brook, 1996).

This short notice that asylum seekers have to flee may mean they have not had time to emotionally process many of their experiences, losses and changes – which psychologists working with them should be aware of. In contrast, immigrants generally make a positive choice to change their country of residence and can plan their move practically and make a psychological adjustment over time.

### **What to be aware of**

Asylum seekers may assume that you are familiar with the politics and the human rights record of their country of origin. This may mean that they do not immediately disclose their experiences of human rights abuses, including torture, and you may need to ask about this, when appropriate. You may find it helpful to be aware of this context, as it is highly likely to impact on refugees' and asylum seekers' states of mind, and their sense of wellbeing and safety. A useful variety of work conducted by psychologists working with asylum seekers and refugees in the UK can be located at Tribe and Patel (2007a, 2007b); German and Ehntholt (2007); Herlihy and Turner (2007).

Of those refugees registered with the UNHCR, 86 per cent were living in low and middle-income countries not in high income countries (UNHCR, 2015). Most psychological research has been conducted on asylum seekers and refugees living in high income countries; therefore this is a rather skewed and unrepresentative sample. Families are often split up and the journey is frequently fraught with risk and numerous dangers including arrest, theft, kidnap and sexual violence.

## **4.2 Arriving in the UK**

Many asylum seekers expect that their arrival in the UK will signal an end to their difficulties. In reality, this is frequently not the case, and the psychological impact of this realisation can be significant. While some local communities show support, many others may show a lack of interest or worse, show hostility or racist attitudes.

Someone who has to seek asylum in another country is likely to encounter multiple losses – loss of home, culture, family, profession, language and friends, as well as their plans for the future. Getting to the country may involve trauma. Once they arrive in the UK, they may experience a lot of stresses such as homelessness, social exclusion, stereotyping and overt discrimination. Asylum seekers are likely to experience poverty, as they receive only minimal financial support, and those who have been refused asylum receive nothing. There will be a range of psychological and practical adjustments – some expected and some not.

Most asylum seekers and refugees are extremely resilient, and have developed a range of survival and coping strategies. Unaccompanied children form part of this group and they face a particular additional set of challenges and may require a range of support (see sections 6 to 8 for further details).

Miller (1999) suggests that the mental health needs of refugees in high income countries might be better served by supplementing clinic-based treatments with a range of community-based initiatives, which also may be viewed as more culturally acceptable. These may have the additional benefit of providing opportunities for support in a culturally familiar manner, and may be able to assist refugees to deal with the many exile-related stressors that exist, but are

sometimes seen as outside the remit of the psychologist (see section 9 for further details). In addition, they may not carry the stigma sometimes associated with using mental health services. A number of psychologists have also run successful groups with refugees and asylum seekers (see section 5).

When asylum seekers arrive in the UK they are usually given a short screening health assessment, which has physical and psychological components. This helps identify those who may have been tortured (Patel & Granville-Chapman, 2010), those who have injuries or illnesses from experiences during flight, or who suffer from transmissible diseases such as tuberculosis. The NICE guidelines on post-traumatic stress disorder (PTSD) suggest screening asylum seekers at high risk of developing PTSD as well as programme refugees. There is also an extensive critique of how PTSD is classified, both cross-culturally and specifically when applied to asylum seekers/refugees (Summerfield, 2001; Bracken, 2001; Patel 2003, 2010). For example, Bogic et al. (2015) in their systematic review found enormous differences in prevalence rates of depression (a range of 2.3 to 80 per cent), rates of PTSD (4.4 to 86 per cent), and unspecified anxiety disorder (20.3 to 88 per cent). Lower rates were found in higher quality studies, and there were also differences between ethnicities. In line with other studies the importance of socio-economic and contextual factors for refugees were identified, as well as the need for further rigorous research to be conducted.

### **What to be aware of**

The NICE guidelines for PTSD have a three-phase model as follows:

1. Stabilisation and safety;
2. Trauma-focused interventions;
3. Integration.

The first is not always possible to achieve with an asylum seeker who may be deported at any time. The second requires psychologists to give people with PTSD sufficient information about effective treatments so they can have their preference for treatment taken into account. You should always discuss with service users how they understand their distress, and how it may have been dealt with in their country of origin. The NICE guidelines specifically state that due attention should be paid to cultural and language issues and that these should not preclude interventions. You should familiarise yourself with the cultural background of the service user, and use interpreters or bicultural therapists if required.

The third phase – integration can include engaging in activities and making links with communities. It is worth bearing in mind that asylum seekers may be anxious about meeting compatriots (who may of course represent the ‘other side’ in the conflict they have fled from) and who may have no legal right to work. It may also be difficult and even counter-productive to ‘integrate’ when asylum seekers do not know if they will be allowed to remain. For those with full refugee status the situation may be different.

Nosè et al. (2017) found that psychosocial interventions for asylum seekers and refugees who had PTSD resettled in high-income countries had significant benefits in reducing their PTSD symptoms. Earlier studies had complex findings (Crumlish & O’Rourke, 2010; Nickerson et al., 2011) and further research is needed. Given that poverty, destitution and

not being able to work can all be detrimental to the mental health of asylum seekers, a range of other interventions with colleagues and partner organisations are important, and should not be underestimated or ignored in favour of only PTSD-focused interventions.

In the UK, the Refugee Council provides hardship support at all their offices, and the London office offers access to food, laundry and washing facilities. The Refugee Council also provides a list of services for those who find themselves destitute. Since asylum seekers are not allowed to work in the UK, unless they have been waiting for a decision for over a year, there can be additional economic and psychological strain for many, willing but unable to work. The legal position on working for asylum seekers can be subject to change and this should be kept under review.

The health systems asylum seekers are used to, the way they understand distress and how they seek help in their country of origin may be different to how the NHS operates – and you could find it helpful to explore and understand this. The BPS Division of Clinical Psychology's good practice guidelines on psychological formulation (DCP, 2011) includes explicit mention of culture and the wider social/societal context as being a building block in the process of clinical assessment and formulations). The idea of talking to an unknown psychologist about thoughts, feelings and experiences may initially be seen as a bizarre and culturally incongruous notion for many – even before thinking about the issue of stigma surrounding mental health in many communities. Trust may also be a problem – for those who have lived in a repressive regime or within a civil war, secrecy becomes a functional strategy (Tribe, 2007). You should make clear to an asylum seeker that a psychologist is not part of the asylum process.

An additional challenge is the government dispersal policy, (Section 95 support of the Immigration and Asylum Act, 1999) whereby asylum seekers may be required to move to a different area which may affect engagement and disengagement with services.

If an asylum seeker you are working with is at risk of detention, psychologists may wish to consider contacting the client's lawyer (with the client's consent) or signpost the person to appropriate assistance for securing legal advice (see section 4.4 below). The lawyer may then sometimes request a psychological or medical assessment.

### **4.3 Immigration detention in the UK**

In 2015, 32,400 people were held in immigration detention in the UK. The reasons that were given for this include their applications being refused; the border agency believed that there were reasons to question/clarify their identity; the basis of their asylum claim was unclear or the authorities believed they might abscond. People can be detained on arrival in the UK, or from within the country, once a formal decision for their removal has been issued and after arrest by a prison officer, or a prison sentence being given. Most people who are detained are held for less than six months (Migration Observatory, 2016).

Being detained has many adverse effects on people's psychological wellbeing, and the impacts may continue way beyond release (Silove, Austin & Steel, 2007). A systematic review on the impact of immigration detention on the mental health of children, adolescents and adults noted elevated rates of mental health issues among detainees, and detailed some evidence to suggest an independent adverse effect of detention on mental health (Robjant, Hassan & Katona, 2009). For those asylum seekers held in immigration



detention centres, their access to mental health services and assessment is limited by issues of trust and language barriers. The Tavistock Institute (2015) undertook a review of mental health issues in the Immigration Removal Centre and made a series of recommendations, mostly accepted by the Home Office. These included better screening and identification of mental health issues; the need for further training and more qualified staff including multi-disciplinary teams; better working relationships between detention and health care staff, and the need for a culture change.

Torture survivors, detainees with suicidal intentions and someone whom a medical practitioner believes their health is likely to be injuriously affected by continued detention, are a particular subgroup of asylum seekers and may have additional needs for psychological work relating to their experiences. The Home Office has particular agreements relating to them, for example, Rule 35 if they are detained (see [www.gov.uk](http://www.gov.uk)).

#### **4.4 The asylum process in the UK**

An asylum seeker is required to formally apply for asylum, and needs to find a lawyer experienced in asylum law to assist with preparing the legal documentation. The Immigration Law Practitioners' Association (ILPA) provides a list of advisors, which can be searched by geographical region. There is also a telephone helpline, which will provide a list of firms, and organisations, which provide free immigration advice. Some firms offer legal aid, whereby their services are free to the user. These are funded by the Legal Services Commission, the Scottish Legal Aid board or the Northern Ireland Legal Services Commission.

Most lawyers on this list would be happy to work with an interpreter if the asylum seeker does not speak English. The lawyer will meet with the asylum seeker several times and prepare the relevant documentation, which includes details of the asylum seeker's history and set out the legal grounds for their asylum application. Psychologists may think that legal matters are not their concern, but if an asylum seeker does not follow the legal protocols, they may be removed from the country without their asylum claim being appropriately processed. Psychologists also need to be aware that the asylum process is likely to impact psychologically on the asylum seeker. The pressures associated with the asylum process are many, and asylum seekers frequently live in a culture where their credibility is under constant scrutiny and suspicion. Psychologists also need to be aware that asylum seekers live with the constant anxiety of being returned to their countries of origin and potentially to a traumatic situation; it is therefore difficult to feel stable or secure.

The Border Agency (part of the Home Office) states that an applicant should apply for asylum as soon as possible upon arrival in the UK, as waiting is more likely to lead to refugee status being denied. Even if someone enters the country illegally, once they apply for asylum they are no longer deemed illegal.

The period of time between an asylum application being submitted and receiving an answer can be anything between a number of days up to several years, depending on the complexity of the application. The UK Border Agency states that it tries to reach a decision within six months. Some asylum seekers will need to report regularly, either in person or by telephone to the local Border Agency. Most asylum seekers will also be asked to undertake a 'screening' interview either at the Border Agency in Croydon, Surrey, or in another

large city. They will then have a more substantive and detailed interview within the next few weeks. If after a brief screening interview, the asylum seeker's application is deemed not to be worthy, they may be 'fast tracked'. This means that they will be taken straight to an immigration removal centre, where they are held until a decision is made, which will be within seven to nine days. If an asylum seeker is refused asylum, they have the right of appeal, but once the process has been exhausted and their asylum application has been refused, they will receive formal notification and can be picked up by immigration officials (or those employed by them), taken to an immigration removal centre and removed back to their country of origin. They also may not receive any asylum support.

Psychologists will find it useful to be familiar with the progress of any asylum seeker's application that they are working with, as this is likely to affect their psychological health. The issues for children, families and unaccompanied minors require special mention (see sections 6 to 8).

## 4.5 Writing medico-legal reports

Writing medico-legal reports (MLRs) for asylum seekers is a highly complex and specialist area. It requires highly specialist skills, and the implications and outcomes of this can be life changing for an asylum seeker.

If a report is requested, you should speak to the legal representative of the asylum seeker to be clear about exactly what is required before agreeing to write the report and ensure you have the necessary skills, training and information to do this. You may get drawn into the dynamics of an asylum seeker's desperation and anxiety about the asylum process and feel that you want to do something to help. But writing a poor report may be counter-productive.

Sadly, lack of access to funds, restrictions in legal aid and other factors may mean that most asylum seekers cannot access medico-legal reports. If you are undertaking therapeutic work with an asylum seeker, you may decide that it is better that another psychologist or psychiatrist conducts an assessment for an MLR, as this task, the time-scales involved and the requirement to be an objective expert witness for the courts can make it difficult to write such reports.

Sometimes, you may write what is known as a professional report, noting the psychological effects of your client's experiences, current concerns, their current mental state, risk profile and how these may interfere with their ability to negotiate the asylum process and give evidence. Although the caveats mentioned above would still apply. Psychologists may sometimes be required to write letters or reports to document that they are seeing someone for therapy or to lend credibility to the events that the asylum seeker reports for other agencies, but this is different to producing an MLR.

Further information on expert witness reports for asylum seekers can be located at Rees et al., 2007; Bogner, et al., 2007; including conducting psychological assessments and writing reports for those in detention settings (Patel, 2017a).

## 5. Supporting adults and developing healthcare services

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Asylum seekers, refugees and trafficking survivors may present themselves, or be referred to a wide range of health services from primary care to community mental health teams, specialist services such as forensic or in-patient psychiatric wards. They may also seek help from Accident & Emergency departments, or be referred to other health services such as pain clinics.

### 5.1 General principles and good practice

#### 1. Respect

Clients should be treated with respect by all staff from their initial contact with reception to their face-to-face meeting with the psychologist. It is particularly important as an asylum seeker or refugee client, as they may have experienced the opposite in their home country prior to fleeing, and then the conditions during their journey to the UK, where they currently live or lack of employment, may add to the feeling of not being valued. Dealing with officialdom can often seem unpleasant and hostile. To be welcomed with a smile, and ushered to a seat in the waiting area, and perhaps offered a drink of water requires only a little thought and perhaps some additional training for reception staff.

#### 2. Accessibility

Accessing mental health services can be difficult particularly for asylum seekers and refugees who may face additional barriers such as a lack of understanding of the UK health care system, adverse perceptions about mental health care based on stigma in their home country or anxiety about being involved with any official government agency (Lamb & Smith, 2002; Majumder et al., 2015). So, it is vital that the psychologist considers the health service from the client's viewpoint and makes it as accessible as possible. This may be achieved in a number of ways.

#### **The appointment card/letter**

Try to send this in the client's own language. But also send the appointment card in English, in case the person has to ask for help to find the centre.

#### **Travel directions**

Use drawings or prints of digital photos to show key points on the route to the appointment location (e.g. a supermarket, underground/train station, bus stop)

#### **Your name**

Write out your full name – e.g. Dr Rosemary Clark rather than Dr Clark. Clients may want to find out the background or gender of the psychologist they are going to see, for cultural reasons or because of traumatic events, for example, experiences of rape or torture.

#### **Book an interpreter**

Always book an interpreter for the first meeting – and thereafter if required. Each centre will have different arrangements but, in general, if you work in an inpatient setting, make sure there is an interpreter who can attend regularly throughout the week and not just

for ward rounds. Your non-English speaking client should be able to communicate with nursing, medical and psychology staff. Reassure your client that the interpreter has a code of conduct and will keep their information confidential. More detailed information may be found in the BPS Guidelines *Working with interpreters in health settings*.

## **Gender**

Wherever possible your client's preferences should be respected. Sometimes, clients may find it easier to speak to a psychologist of their own gender with an interpreter of their own gender. As a general rule, female clients prefer female interpreters although this may not always be the case. Similarly, men may prefer male interpreters however, on some occasions, for example, when talking about sexual torture, men may wish to have a female interpreter.

## **Time of outpatient appointments**

Think carefully about timings of outpatient appointments – so that clients are more likely to turn up. For example, try to avoid times that clients have to sign on at the Immigration Office, or avoid Friday afternoons for Muslim clients. A single-parent mother may prefer an appointment that means she can get her children to and from school. This is particularly important for people who have newly arrived and may not have built up community support to help with childcare.

## **Preparing for your meeting with the client**

Carry out background reading on your client's home country before the first appointment. It is respectful to understand what the main political concerns are and any on-going violation of human rights, and useful to know what religions/languages are common. Familiarise yourself with the country's health service, particularly mental health service.

### **Example**

A clinical psychologist was having difficulty engaging Biyu, a teenage Chinese girl in therapy. Biyu came from a rural part of China, and she said there, if families wanted to get rid of a troublesome relative they simply took them to the nearest psychiatric hospital where they would be locked up. Sending Biyu detailed information in Mandarin about the outpatient clinic, and a photo of the community clinic building reassured her about the differences in mental health provision between rural China and Scotland.

The following websites are useful to understand the client's country background:

- Home Office Country of Origin information service
- <https://www.gov.uk/government/collections/country-information-and-guidance>
- BBC country profiles: [http://news.bbc.co.uk/1/hi/country\\_profiles/default.stm](http://news.bbc.co.uk/1/hi/country_profiles/default.stm)
- Amnesty International: [www.amnesty.org](http://www.amnesty.org)
- Human Rights Watch: [www.hrw.org](http://www.hrw.org)

## **Your office**

Try to see your room through the eyes of someone who may have been confined in a prison cell and/or travelled to this country crammed in the back of a truck. If you have a window in your office, place the chair so your client can see out. If your room faces a brick wall, wire fences or barbed wire, think about making sure the client faces into the room.

## **Travel costs**

Check before the meeting whether your client qualifies for reimbursement of travel costs. If they are reluctant to accept money, it can be helpful to say, 'It is your right' and explain this is common practice in the service for people in their situation.

## **Holistic approach**

Be aware of any on-going problems with the person's health, housing, finance and legal situation or asylum application process, etc.

## **Physical health**

Be sensitive to any on-going physical health problems so your client can be signposted to the most appropriate service. Asylum seekers and refugees may come from a country where they did not have access to health care and they may have chronic or acute physical illnesses that need addressing. Physical health problems may also be a direct result of the trauma, including torture that the client has survived.

A history of head injury with loss of consciousness was reported in 58 per cent of clients attending a Psychological Trauma Service (Craig et al., 2014). Screen for such a history, and identify any problems as they may impact on education, work and therapy. Clients who have been raped will worry about the possibility of sexually transmitted diseases but may not have managed to raise this concern with their GP. Female clients may also have undergone FGM (female genital mutilation) with accompanying physical and psychological consequences (Mulongo et al., 2014) that they may never have been able to discuss. You should enquire sensitively about a history of FGM. Also, be aware of the National Department of Education and Department of Health multi-agency statutory guidelines on FGM (2016).

## **Network with colleagues from social work and the third sector**

Be aware of the wide range of agencies that may be working with your client. If there are agencies that can support your client's practical needs (e.g. English courses, befriending schemes, community groups), signpost your client to them. Otherwise your client may look to you as a general resource – for example, inadequate housing, translating legal letters. With basic needs, such help can assist building up the therapeutic relationship, but if it's not appropriated, you need to discuss it sensitively with the client to minimise distress and ensure they understand your rationale.

## **Engaging with the client**

Remember your client may make assumptions about your religious or political background, ethnicity, gender based on your general appearance, clothing, jewellery and objects in the consulting room.



### Example

A psychologist who wore a hijab greeted a woman in the waiting area who looked shocked to see her. The woman came from a country with a predominately Muslim population. In the assessment, however, it emerged that the client (who came from a Christian minority group) had been sexually assaulted by men who identified as radical Islamists. It was important for the psychologist to spend time checking if the person felt able to work therapeutically with her.

### 3. Asylum seeking process

You need to ask the asylum-seeking client what stage s/he is at in the asylum process at some point in the assessment interview. Explain that this is necessary so that you can understand the current legal pressures for your client. It also means that you may not choose to start exploratory or trauma-processing work if the person has been refused refugee status and is facing an *imminent* return to their country. You can, however, outline what trauma-focused intervention would entail and jointly make a decision as to whether to proceed. But a negative asylum decision should not be used as a reason to stop therapy, as this is often a time of great distress and where the client can benefit from psychological support and interventions.

Listen carefully to the client's account of what troubles them, and to resist the temptation to squeeze all of their difficulties into a trauma narrative. The person may be most concerned about separation from and the wellbeing of relatives.

Look out for all opportunities to affirm the person's identity, as your client may feel perceived as the negative stereotype of an asylum seeker. You can achieve this by discussing the person's profession, studies, family and home country as well as how they are spending their time in the UK (Douglas, 2010).

### 4. Family tracing

Inform those who have been separated from or lost all contact with their families during conflict in their country or on their journey to the UK that the British Red Cross has a Family Tracing Service. Not everyone will wish to pursue this immediately, or at all, for fear of finding out the worst.

### 5. Take careful notes

Your client's narrative about events in their home country may be central to their asylum claim. You may also be the first person to hear a disclosure, for example, of rape or torture. It is crucial therefore to take careful notes as you may be asked for these to contribute to a legal report in the future. Inform your client what the purpose of your notes is – and that these are not part of the initial asylum application. This is important as clients sometimes assume that seeing a psychologist is part of the asylum process, and what they say may be used as part of the initial decision-making process.

### 6. Boundaries

When working with asylum seekers, it can be distressing and worrying to see someone who is destitute, or surviving on very little money and with often very few personal possessions. Each service will develop their own protocol for coping with these challenges. However,

it is important for you to avoid being the person who directly gives money, presents or clothes to your client. Instead, signpost your client to relevant agencies and colleagues.

Many asylum seekers will have lost their family either through forced separation or death. They may feel very isolated in their host country and regard you as part of their new family. Clients often say things like: 'you are my mother now' or 'you are my new daughter' or when referring to the team, 'this is my family now'. While this may be appropriate it can be helpful if the differences between the professional helping relationship and those with a member of the family are thoughtfully explained. Your professional relationship with your client will end eventually, and it is kinder and more ethical to gently explain the boundaries and limitations of this professional relationship.

## **7. Working with survivors of human trafficking**

Victims of human trafficking can be asylum seekers, though not all. They also face insecurity with regards to their immigration status. Many may be terrified of being returned home, fearing contact with the traffickers from whom they have escaped. They may face lengthy immigration detention and court processes, and may be involved in parallel legal processes in the UK. They may have asylum claims and also be referred to the National Referral Mechanism (NRM), which is 'a framework for identifying victims of human trafficking or modern slavery and ensuring they receive the appropriate support' (National Crime Agency, 2016).

They have experienced severe violations of their human rights, and can suffer many mental health problems but recognising survivors and providing support can be complex (Doherty & Morley, 2013, 2016). Survivors may fear reprisals from those involved in their exploitation both in the country of origin and in the UK, fearing being found, recaptured or harmed. They may continue to perceive that they 'owe' their traffickers money even after their escape and that they must 'work' in order to pay this money back.

Traffickers often warn those they exploit that they will be arrested if they seek help from authorities as they do not have passports or secure immigration status. Shame and fear because of their experiences may also prevent full disclosure. Survivors may also have been made to swear oaths, which can include ritualistic abuse, and believe that if they disclose their true experiences they will die as a result of the oath they have sworn.

You should always seek advice from immigration solicitors. Survivors may need to be accommodated in safe houses and receive support from organisations such as the Salvation Army. You and other healthcare professionals may encounter survivors who are still controlled by traffickers. Be vigilant about unidentified interpreters and those accompanying their clients to appointments who may prevent the client from revealing they are under duress. You should therefore always ensure that you see your clients alone, or with professional interpreters, for at least some part of the session, where any concerns can be explored, and emergency services notified. Those who have escaped trafficking remain at risk of re-trafficking.

Always follow up missed appointments and fill in missing person's reports where necessary. During therapy appointments, it can be helpful to enquire about your client's current social network and the nature of any new relationships in order to monitor this risk.

## 8. Trauma-focused psychological intervention

Many, though not all, asylum seekers and refugees will suffer from psychological difficulties, with some diagnosed with PTSD or complex PTSD. Your assessment should consider these psychological difficulties and use evidence-based interventions.

As outlined earlier, a phased based model of intervention (Herman, 1992; Robertson et al., 2013) is often used in working with those diagnosed with PTSD:

- (a) Safety and stabilisation;
- (b) Processing of traumatic memory;
- (c) Re-integration into family and community.

This work doesn't have to follow a strict sequential order through the phases but should be responsive to the particular needs of your client. Both culturally-sensitive Trauma-Focused Cognitive Behaviour Therapy and Narrative Exposure Therapy are seen as effective interventions with refugees (Slobodin & de Jong, 2015).

For example, group work can be used in Phase One where clients can learn techniques for coping with nightmares, relaxation techniques or mindfulness. Activity groups using creative art therapy or occupational therapy techniques such as cooking or gardening are often highly valued in reducing isolation, providing distraction from distressing memories and helping people re-connect with others.

Groups also sometimes provide the opportunity for people to share with others their traumatic experiences with a view to bearing witness to the suffering of others, decreasing their sense of isolation and offering a safe place to discuss current stresses. These therapy groups may employ psychodynamic and/or cognitive-behavioural techniques (Drozdek & Wilson, 2004). There is currently less evidence for the efficacy of group interventions compared to individual therapy, although emerging work showed that trauma-focused day treatment groups interventions led to a significant decrease in psychological distress compared with out-patient supportive psychotherapy and a waiting list control (Drozdek & Bolwerk, 2010).

## 9. Supervision for therapists

It is essential to have regular supervision where you can share the traumatic stories you have heard from clients and reflect on your therapeutic work (van der Veer, 1998). Supervision is also important in preventing vicarious traumatisation in the therapist.

## 5.2 Good practices in developing services in healthcare

The following section is likely to be most helpful for Psychology Managers. The NHS mental health service response in any geographical area will depend on a number of factors:

### (a) The client groups

Your client group may be asylum seekers (adults and/or children), or alternatively, people already counted as refugees on arrival, such as those relocated under a refugee resettlement programme, for example, The Syrian Vulnerable Person Resettlement Scheme. Your service may also be for people who have been trafficked. There may be some

overlapping needs between these groups, but also major differences. For example, those seeking asylum will be constantly aware of the precariousness of their status and the fear of being denied refugee status. Refugees may have many similar mental health issues to the asylum seekers but will have other pressing concerns, such as integration with the local community and finding suitable work.

### **(b) The numbers of clients**

Service design for a population of 10,000 asylum seekers in an area will differ from that developed for only a small number of families. What is central is whether clients should be seen in mainstream psychology services, for example, in community mental health teams; whether a stand-alone service should be contemplated – or something in-between such as a liaison team? Develop different models according to local need and context and any service needs to be flexible in order to respond to changes in the client group over time. All services should adhere to the key principles described in section 3.

#### **Example**

The service design agreed on in NHS Greater Glasgow and Clyde (now NHS Glasgow) (2000) in preparation for the dispersal of 10,000 asylum-seeking people to Glasgow was of a mental health liaison team that became known as the Compass team. Dr Anne Douglas, Consultant Clinical Psychologist, led the multi-disciplinary team and other members were an art therapist, an occupational therapist, other clinical psychologists and trainee psychiatrists, clinical and counselling psychologists. The team was located organisationally with two other specialist psychology-led trauma teams.

#### **The aims of the Compass team:**

- To ensure that asylum seekers and refugees of all ages in Glasgow receive the most appropriate mental health care, delivered in a culturally sensitive and holistic manner.
- To help build the capacity of other staff (in statutory, voluntary and other agencies) to provide mental health care to this client group through consultation, teaching and liaison.
- To provide a range of culturally-sensitive therapeutic interventions for asylum seekers and refugees with complex post-traumatic stress disorder or culturally-complicated problems.
- To work with partner agencies to promote the integration of asylum seeking people and refugees in Glasgow.

The specialist work for people with complex traumatic experiences continues to the present day with the asylum seeking and refugee strand now sitting within the NHS Glasgow Psychological Trauma Service known as The Anchor which also provides therapy to survivors of childhood sexual abuse, domestic violence and trafficking. Referrals are made through community mental health teams.

**(c) Gender and age of clients**

When designing your service, recognise the main age groups and gender backgrounds of your clients. For example, the Compass team was set up as a systemic service that crossed all age bands so as to be responsive to families, as these were the kinds of people initially dispersed to Glasgow.

Plan a monitoring system so you become aware of any changes in the backgrounds of the people coming to the area and, their ages, gender and nationalities. You can achieve this through collaboration of those who screen new arrivals, for example, the UK Borders Agency, Migrant Help.

**(d) Service provision for refused asylum seekers**

Think about whether your service will help those who have had their asylum claims refused and have exhausted all avenues for seeking asylum. Some of these clients may have become destitute as a result. In part, this will depend on the area's health board or NHS Trust policy. In some regions caring for these clients is restricted to emergency health care. But this can be a time of major mental health crisis and so wherever possible, it is important to continue to provide psychological support, as well as linking the client with other relevant agencies.

Focus of therapeutic work is likely to change in this period, and you may need to prioritise prevention of self-harm, ensuring clients continue with medication and ensuring the client carries the information about their mental health care with them, including the name of their psychologist and/or psychiatrist, in case the Home Office suddenly detains them.

**(e) Know what services other agencies are providing in the area**

Ensure joined-up service delivery and avoid duplication by knowing what other agencies are providing. For example, Freedom from Torture, the Red Cross and a range of other non-governmental and community organisations may be providing services which are similar or complementary to those, offered by the NHS. Think about setting up regular multi-agency meetings to ensure collaboration and to provide mutual support.

**(f) Helping the Health Board/Trust to understand the needs of your clients**

You may have to assist the NHS Trust, commissioners, or Health Board to understand the range of psychological and social care needs of this client group. Provide briefing documents with information about the impact of experiences of refugees and asylum seekers; the prevalence of mental health problems and the effective, evidenced-based therapies that psychologists can provide. Outline the importance of accessible, culturally-relevant services and the need for professional interpreting services. It can be helpful for psychologists to attend health board or commissioners' meetings, deliver presentations and address questions in person.

**(g) Consulting to other services**

Try to develop the skills of other colleagues to help ensure that the varied needs of asylum seekers and refugees can be addressed. On-going consultation, supervision groups or training placements are all good methods.

#### **Example: Consultation to initial health screening team**

In NHS Greater Glasgow & Clyde the lead psychologist for asylum seeker and refugee mental health provides regular consultation to the NHS Asylum Health Bridging Team. This team (made up of a community psychiatric nurse, dedicated midwife, nurses trained in working with children and families and an administrator) aims to screen all newly arrived asylum-seeking people of all ages to identify their current health status and any mental health needs.

#### **Example: Monthly consultation to GPs**

The lead psychologist also provided monthly consultation to a group of GPs who regularly worked in this area. This served the dual function of providing mutual support and giving them a space to reflect on the mental health issues in their patients.

#### **Example: Consultation to refugee community organisations**

Psychologists can offer support and consultation to colleagues in refugee community organisations; and facilitate the referral of those in need of specific psychological or mental health service (see section 9).

### **5.3 Conclusion and recommendations**

Providing health care for asylum seekers, refugees and trafficked people will always sit alongside the requirements of the local population. Service providers may initially channel your clients through existing services, which may be appropriate if there are only small numbers. However, if there are large numbers, then you may need a more bespoke service.

Identifying those with mental health needs early and getting them access to appropriate services can prevent more chronic problems. You should not feel under pressure to provide all the psychological health care but you can play an important role in supporting, training and enabling others to feel more confident in working in this area.

- Show respect for clients, and bear in mind that you may be the first person to hear details of their trauma.
- Make sure clear information is given, and that appointments are scheduled at suitable times.
- Use professional interpreters, especially if trafficking is suspected.
- Maintain boundaries, and ensure the client understands you are not part of the asylum decision.
- Maintain good contacts with other health services and NGOs to ensure a holistic approach and avoid duplication of services.
- Ensure supervision for yourself to avoid vicarious trauma and to reflect on the process.



## 6. Supporting children, young people and unaccompanied minors

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In addition to the points raised around adults, there are some particular issues around children. Supporting children, young people and unaccompanied minors requires you to be aware of the legal framework for their protection. However, always remember that these are children first, and asylum seekers or refugees second. These young people have to face all the usual challenges of living through childhood and adolescence, but with the added strain of living in a different culture, country and different context.

### 6.1 The relevant legal framework

In addition to all other legal frameworks, children are subject to the UN Convention on the Rights of the Child (United Nations, 1987). These rights remain whether the children are displaced, seeking asylum or with or without other family members. Among the most relevant articles of this are:

Article 9	The right not to be separated from their parents.
Article 24	The right to access health care.
Article 28	The right to education.
Article 34	The right to protection from sexual exploitation and sexual abuse.
Article 35	The right of protection from abduction, sale and trafficking.
Article 38	The right to be protected from war and armed conflict, and for under 15s not to take part in war or join the armed services. 'States parties shall take all feasible measures to ensure protection and care of children affected by armed conflict.'
Article 39	States parties shall take all appropriate measures to promote physical and psychological recovery and social reintegration of a child victim of .... armed conflict.

In summary, the legal framework makes clear that it is the duty of the state to protect the children, keep them with their families as far as possible, provide education and health care. In particular, the state should provide interventions to ameliorate the effects of the traumatic experiences the child or young person has been exposed to.

### 6.2 Key considerations

#### Experiences of children and young people

Children who are asylum seekers or refugees will often have experienced many different traumas. They may have witnessed killing, violence, and their homes being destroyed. Their journey from their country to the UK is often hazardous and full of hardships, especially if the family has paid agents substantial amounts for their crossings.

When they arrive, their family may be granted temporary leave to remain while the legal issues are sorted out. Current government policy is to disperse families to areas where

there is accommodation available, however sub-standard that may be. This can mean that they are separated from other families who share their culture and language, despite the well-established finding that social support provides a buffer against the worst aspects of the stresses they have been under. This policy ignores the psychological need for people under stress to seek support from others who have had similar experiences. It is well documented that good social support is one of the best buffers against exacerbating debilitating reactions (Udwin et al., 2000; La Greca et al., 2010; McDermott et al., 2012). The Home Office has issued guidance to local authorities and others concerning the Syrian Vulnerable Person Resettlement (VPR) Programme (Home Office, 2015) and for prospective sponsors (Home Office, 2016).

So, children (and adults) face living in a new community with different customs. Most will have to learn English – and because children often learn this faster than their parents, they may end up being the mediator with the outside world. However, you must never ask a child to be an interpreter when their parents are being medically examined or seen by a psychologist.

Studies show that children who are refugees or asylum seekers are at higher risk of mental and physical health problems (Fazel & Stein, 2003). Early studies found that following exposure to war one-third of Central American refugee children met criteria for PTSD (Arroyo & Eth, 1985), and a 50 per cent prevalence was reported in adolescent Cambodian refugees five years after reaching the USA (Kinzie et al., 1986). Higher rates of depression and anxiety have been reported for children who have experienced war (Mghir et al., 1995; Zivcic, 1993) and persistent psychiatric symptoms and disorders for some reported in one study (Sack et al., 1999).

A study of Kosovan Albanians who were admitted under a time-limited programme to the UK in 1999 found that while many of the adults were resilient, it was estimated that 39 per cent of them met criteria for PTSD, and 19 per cent for major depression (Turner et al., 2003). An unpublished study of their children found that over 50 per cent met criteria for PTSD (Yule et al., 2001, unpub). In other words, even though these child refugees remained with their families throughout their ordeal and relocation, around still half showed serious psychological stress reactions. Equally, half did not show evidence of serious mental health problems.

### **6.3 Good practice in supporting children and young people**

Many children and young people will have suffered psychological and other problems. All child agencies need to be aware of this, and put in place proper monitoring procedures. At a time when Child and Adolescent Mental Health Services (CAMHS) are under great strain, this implies that any centrally-funded support should include adequate resources to meet these needs.

Parents and children need to be made aware of the services available, and how to access them. GPs, schools and others, as well as voluntary support groups need to have up-to-date accurate information.

## 1. Interpreter

At least in the initial stages, you need to have professional interpreters present. Ensure the interpreter is acceptable to the family (and does not come from a feared group or perceived enemy, even though they speak the same language). Your aim for the consultation should be discussed with the interpreter beforehand. When it comes to working with a child therapeutically, you usually need to have an interpreter who can give verbatim translations of the child's responses, rather than their interpretation of what is going on. Good supervision of all mental health workers offering help to such young people is vital.

## 2. Educational support

Even children arriving with their families may have missed schooling during their journey. They need appropriate educational support to ease them in to school (see section 7). The whole ethos and rituals of local schools may be different from anything the child has seen before, and the parents also may need explanations of why things are done in the way they are. Many children value education highly and will work hard in school. But teachers need to be alert to difficulties in sleeping, concentration and so on, which may flag up problems. Forming good relationships with children may help ensure that difficulties can be identified early.

## 3. Legal issues

Even with families admitted under special programme conditions (Home Office, 2015), there are likely to be on-going legal issues. It is vital that families can access legal advice when needed. There are a number of immigration and legal charities that can help, but the family needs to know how to contact them. (See the 'Useful resources' section.)

## 4. Psychological assessment

With regards to psychological assessment, there are a number of widely used assessment tools that can be used to complement a standard psychological consultation interview. The same principles of conducting interviews with adults apply with children and young people (see sections 3 and 5). Whilst there are a number of tools that can be used for children aged 7 and over who can read – or even can have questions read to them (many are available in a variety of languages), they may not always be culturally appropriate, or validated.

For younger children, the screening measures available from the Children and War Foundation ([www.childrenandwar.org/resources](http://www.childrenandwar.org/resources)) assess stress, anxiety and depression. For adolescents, the measures developed by Bean (2006) in the Netherlands to assess unaccompanied minors give both English and some local language versions side by side. This can be helpful for both adolescents who can read their own language and for interpreters.

There are very few interventions supported by evidence of effectiveness (for details see NICE guidelines for depression, anxiety and PTSD). One key step has to be supporting parents to support their child. This can start with explaining why children may be behaving in a different way to before. Treatment will depend on the nature and severity of their problems. In addition, the Children and War Foundation has written clear procedures for group interventions to help young people develop coping strategies to deal with

stress. These have proven effective in a number of randomised controlled trials (Yule, Dyregrov, Raundalen & Smith, 2013). Unstructured counselling has little place in the set of interventions that can be recommended (NICE, 2005). In general, young people will benefit socially as well as emotionally from participating in a variety of groups from formal therapeutic ones to informal, leisure-oriented ones, some of which may be organised by other refugees.

Make sure you interview a child separately from their parents, as often children will not talk about what is troubling them, because they know that it upsets their parents to hear it. As part of early interviews, the child should be given time to tell their story with little prompting. Many adults (including parents, teachers and inexperienced mental health workers) worry that this will ‘re-traumatise’ the child. But learning that one can talk about horrific things, may be upset while doing so, but ultimately feel relieved at having shared in a safe context with a supportive adult is often a powerful part of any intervention.

## 5. Bereavement

One difficult issue to explore is bereavement. Children may have witnessed fighting and seen people being subjected to violence and killed. Some may have lost family members. There may have been little opportunity to grieve and participate in family mourning rituals. Check if this is the case and if so, ensure that the bereavement is properly acknowledged. Participating in belated funeral arrangements can be helpful. Where the child has developed a traumatic bereavement reaction where they cannot think of the dead person without reliving the killing, then using a protocol such as the Children and War’s Grief Manual (Yule, Dyregrov, Straume & Kraus, 2011) may be appropriate.

## 6.4 Supporting unaccompanied minors

In July 2016, the House of Lords (HoL, 2016) reported on the plight of unaccompanied migrant children in the EU. The report detailed the failure of EU governments to follow through good intentions with actual actions. Much of the factual evidence given below comes from that report.

The needs of unaccompanied minors are more complex than those who entered the UK with their families. Children may have fled their homes with other family members, only to be separated *en route*. More often, the family perceived that the children were targets of malign forces and so paid for others to get them to the UK. Occasionally, children will fly to the UK, but be abandoned in an airport. More usually, children trek over people-smuggling routes that avoid borders. Children from Afghanistan, for example, will travel on foot, by cars, trek over the mountains to Turkey, cross by boat to Greece and make their way through Europe to the Channel. There may be long periods hiding until it is safe to move on. These journeys, full of hazards can take a year or even longer. Throughout this time, vulnerable children are exposed to adults who do not always have their best interests at heart.

In 2015, 88,245 unaccompanied children applied for asylum in the EU – 3045 of them in the UK. An unknown number perished *en route*. These numbers have overwhelmed member states and so previously considered plans have not been implemented. The authors of the HoL report detected ‘a culture of disbelief and suspicion’ whereby adolescents were often not believed about their age, and made to feel unwelcome.

According to one EUROPOL estimate (HoL, 2016), 10,000 such children have gone missing within the EU and are vulnerable to trafficking. Another study by Save the Children (McNeill, 2016) found that 50 per cent had sexually transmitted diseases, confirming suspicions that many children are sexually abused during their journeys. As always, it is vital that the physical health of young people is properly assessed and appropriate treatment given where needed.

When these children reach the shore of the UK, far from feeling safe, many are taken to police stations where attempts are made to judge how old they are. This is crucial for the support they will receive. Under current rules, where a child is deemed to be under 17 years old, they are accepted by social services and placed in foster care. If they are 17 to 18 years old, they may be placed in semi-independent living, sharing accommodation with others of the same age and with some support from social services. Where they are deemed to be over 18 years old, they are treated as adults and taken to detention centres or released into the community while their fate is decided.

It is difficult to judge a young person's age from just looking at them, and yet that is what happened for many. Inevitably, many mistakes were made. Youngsters whose ages were disputed often report that their dreams were shattered and the experience was more traumatic than the original reasons they had to flee. In recent years, there have been slight improvements in policy, and age now has to be determined by two specially trained social workers following the Merton guidelines (ADCS, 2015).

Social services currently say that all children should be cared for in families – hence the focus on fostering. However, there are simply not enough foster carers available to meet current requirements, including meeting the needs of traumatised children from war-torn countries. While it is heartening that many people were moved by the plight of children recently seen on their televisions, the selection of foster carers often takes over six months. Increasingly there is good training of foster carers to meet 'ordinary' needs, but those working with unaccompanied minors will need additional training, as well as on-going support

If an unaccompanied child has applied for asylum, they are usually given the legal status of 'leave to remain' – but only until they turn 18. Then, or shortly after that, they are considered for asylum – and if it is not granted they may be sent back to their original country. The anxiety surrounding the wait for this crucial decision is not made any easier by the fact that it coincides with having to take important decisions about whether to continue education, or seek employment. They are also being moved from child to adult mental health services.

It is particularly important that teenagers who are receiving help from CAMHS continue to receive it. The move to considering young people up to the age of 25 as adolescents is welcome, because a sudden break in care can be devastating.

There have been cases where some mental health workers will not even begin appropriate interventions if there is a possibility that the young person may be removed from the country. That appears to be unethical practice.

At 18, much direct support from social services may be reduced or even removed. Those who have been in semi-independent living frequently lack the skills to look after themselves – because cooking, cleaning, shopping, budgeting all differ greatly from what they may have experienced in their country of origin. Indeed, understanding normal everyday tasks

are likely to differ greatly between their country of origin and the UK. Carers, teachers and others have an important role in helping young people learn the rules of everyday living that they may otherwise take for granted. Again, regular, professional interpreters have a big role to play in such socialisation.

Attitudes towards sex and people of the opposite gender can also lead to misunderstandings unless specifically discussed. This should be easier among those in foster care. But issues around contraception and equality need to be raised.

All unaccompanied minors will have dealings with the law, and these are far from easy to understand for the young person or those supporting them. There are organisations dealing with the laws surrounding refugees and asylum seekers. How to access help and how to understand the law needs to be discussed from early as arriving in the UK (see section 4).

## 6.5 Conclusion and recommendations

Young people must be seen as children first and refugees second but they have particular needs which must be catered for. While many prove resilient in the light of their ordeal, you should be aware of the pressures upon them. GPs, schools and CAMHS should work together with psychologists to ensure the child has the support they need.

- Agencies should work together to monitor children and young people for mental health issues.
- Children must never be asked to be an interpreter, especially when their parents are being examined or seen by a psychologist.
- When assessing children, interview them separately, as they may not want to upset their parents with distressing detail.
- If relevant, think about delayed bereavement rituals in order to give children a chance to grieve.
- For unaccompanied minors, be aware that turning 18 is a crucial age – both in terms of whether they have leave to remain, and the support they receive from social services if they stay.



## 7. Supporting nurseries, schools and colleges

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Nurseries, schools and colleges are likely to be a universal feature for newly arrived children, young people and families. With the right support, these places have the potential to help refugees and asylum seekers integrate socially. Psychologists, particularly educational psychologists are likely to be key professionals in providing this support to schools and other educational settings.

### 7.1 Key issues

This is a hugely complex area, fraught with social, cultural, religious, legal and political minefields, as well as offering opportunities for creative and innovative work. You may wish to reflect on the following issues:

- Swift access to education and well-planned initial school-based assessments are key in helping these children integrate successfully.
- Be aware of local political, cultural and religious issues as well as wider geopolitical and national ones. You should understand, and work with the community the refugees and asylum seekers are coming into, as well as the schools, nursery or colleges.
- Challenge dichotomous thinking. Not all children will have experienced traumatic events, although most will have experienced some key losses.
- Remind teachers that English as an Additional Language is not a special educational need. However some children and young people may experience both needs.
- Consider the impact of socio-economic facts, age, and language skills to make sense of educational, social and psychological outcomes.
- Be mindful that some children and young people may distrust interpreters because of past experience or specific cultural interaction between the child and the interpreter.
- Be aware that a young person's leave to remain could be revoked at the age of 18 (as mentioned in the previous chapter). This is a key developmental and educational transition point, and may impact on their life and their ability to complete/attain formal qualifications.

### 7.2 A role for psychologists

Despite these challenges, there is much that psychologists can do in terms of improving outcomes for these children and young people. This contribution can be viewed at a multi-systems level; supporting local authorities, working in the nursery, school or college system and working at the individual level.

#### 1. Supporting local authorities

Psychologists should seek opportunities to work at a strategic level so that there is psychological consultation when decisions are made at local authority (LA) level. The following areas are suggested as a particular focus:

- Find solutions and provide specific training for the LA and educational settings to ensure that they are ready to receive these children and young people. This support could span neighbouring LA and work towards developing partnerships where good practice can be shared.
- Reminding the LA that swift entry to education is consistently cited as a protective factor for refugees and asylum seekers. Psychologists should advise LAs that long-term community social inclusion is maximised where over-concentration of refugee and asylum seeker communities is avoided (Crul et al., 2012, 2016).
- Support newly-arrived families entering the educational system. Where possible, placements should be sought in settings as close as possible to where the young person is staying.
- Remind the LA and schools that they are required to publish their Local Offer (i.e. provision made for children with special educational needs and new arrivals (SEN&D Code of Practice Part 4: 2014)).
- Psychologists should remind the LA that children might not require additional resources beyond the setting's Local Offer (which is for children and young people with special educational needs and/or disabilities). Psychologists can support schools, colleges and nurseries to reflect on how their existing resources and skills might meet the needs of their new arrivals.

### 7.3 Supporting schools and educational settings

Psychologists have a long tradition of working with schools, nurseries and colleges. They are, therefore, well placed to support schools prepare for the arrival and successful inclusion of children who are refugees or asylum seekers.

#### 1. Preparing the school, nursery or college system

In many cases, a school, nursery or college system may have to welcome a new arrival with very little notice, and this may impact on already stretched resources. Psychologists are well placed to work at a whole-system level and with the staff to explore and support the arrival. Setting up psychologist-facilitated staff/pupil discussion groups can provide opportunities for teachers to express and explore anxieties and thus enable teachers to develop solutions that will ensure the social inclusion of new arrivals. Specific social inclusion tools such as MAPs: Making Action Plans (O'Brien & Forest, 1989); and PATHs: Planning Alternative Tomorrows with Hope (Pearpoint et al., 2001) have been successfully used to work toward successful social inclusion. This should not be a one off. Continuous intercultural and diversity education is important for staff and pupils and the wider community.

You can support schools to develop whole setting provision maps to detail the resources that they already have, could develop and may require in order to meet the needs of refugees and asylum seekers. This should include adaptations of existing welcome packs into relevant languages. Welcome packs should also specifically reference how families can seek support to address common issues such as enuresis and sleep issues. Families will also benefit from information about how they can support their children to learn at home.

Use school displays or share cultural experiences and strengths at school events. This will help represent the home culture of newly arrived children and research suggests that this aids a sense of belonging which helps successful inclusion (e.g. Fazel, 2015).

Buddy/friendship schemes in schools and colleges can help promote friendship formation. If these have already been set up, your role may be to remind teachers of the importance of using these approaches.

## **2. Removing barriers: English as an Additional Language (EAL)**

Psychologists are experienced in working to remove the barriers to social inclusion that EAL can cause and problems with accessing the academic curriculum. Psychologists can work at a whole-school level to review and modify existing systems and strategies. Work in this area might include: training throughout the educational setting to remind and reinforce best evidence approaches; developing initial language assessments and structures to provide continuous host language support both within after school; working in collaboration with teachers to ensure home language instruction is valued and facilitated.

### **Academic support**

Swift curriculum access is a key feature of successful social inclusion and working towards ensuring positive outcomes for refugees and asylum seekers. Psychologists could work with schools to develop a good initial assessment of children and young people's educational background in their home language. These should include an assessment of curricula concepts and dynamic factors such as learning behaviours. On-going assessments and tracking of these children should draw on principles of Assessment Through Teaching (see Raybould & Solity, 1988).

Importantly you should avoid these children being automatically placed in lower attaining groups. Instead, psychologists should advise schools and colleges to place children and young people in classes based on an assessment of their previous schooling, ability and needs. Develop individual pupil and family profiles that focus on strengths and resources. There should be particular focus on Key Stage transition points in order to ensure that these children and young people remain in education. Finally, consider how teaching assistants and learning mentors who may have second language skills are deployed to greatest effect.

One of the most important things can be to recast the narrative around EAL from being one of special needs to that of additional language. Some settings have re-constructed their EAL teachers and support as a curriculum area within the languages faculty rather than locate them as part of special needs or student support (see Case Study 1).

## Case Study 1

### **Recasting the narrative around refugees and asylum seekers: The Faculty of English as an Additional Language**

A large eight-form secondary school in a culturally diverse area was approached by the LA to place a group of refugees and asylum seekers. Many of the young people were new arrivals who had come unaccompanied and some were from countries where there was conflict. To respond to this challenge, the existing EAL department was moved in to the Faculty of Languages. The existing learning mentor team was increased, with recruits from communities with home language skills suitable for this group of children. The school commissioned the LA Educational Psychology Service to provide additional consultation support. This support included:

- Training teachers in EAL;
- Updating diversity training for teachers;
- Facilitating staff discussions groups as a means of exploring concerns and seeking solutions;
- Developing peer mentoring to assist new arrivals;
- Training and supervising learning mentors to use narrative-based approaches for assessment and intervention.

### **Involving the refugee and asylum seeker community**

Engaging and involving the family and the community is key in ensuring the longer-term social inclusion, and improved outcome for children from refugee and asylum-seeking families. Psychologists can work with educational settings to ensure that schools provide detailed information about themselves and LA systems through bilingual mentors and advisors.

Schools should be encouraged to use such mentors and family support workers, to encourage parents and the wider newly-arrived community to engage in nursery and school life. Find solutions that promote contact and communication between home, other children and families, and work to develop understanding between refugee and asylum seeker communities and schools, nurseries or colleges where there are clashes of constructs, beliefs or attitudes (see Case Study 2).

## Case Study 2

### Anti-bullying week: Diversity in families

#### *'Can we put up that display in the entrance hall?'*

A primary school in an area where there had been a recent arrival of migrants from south Asia who identified as Muslim, sought the support of their educational psychologist. The school wanted to know how it might address the issue of diversity in families during Anti-Bullying Week. Previously, a wall display featuring pictures of single-sex families had elicited an extremely negative response from some parents. This year, the school invited families to a range of sessions that were co-facilitated by the educational psychologist to explain the importance of valuing diversity within the context of the United Nations Charter of Human Rights, British values and the aspiration of the school to further develop their wider social inclusive ethos. Although a challenging meeting, with a range of differing views expressed, anxieties were contained and the purpose and importance of the curriculum was made clear and demystified. Anti-bullying week was delivered at a whole school level with most pupils attending sessions in the week.

## 7.4 Direct work with children and young people in educational settings

Most newly arrived children and young people do well at school, and do not need intervention (Rutter, 2006, 2015). However, for some children and young people, their experiences in their country of origin and/or the journey itself may have been traumatic. Some children and young people may also experience additional educational needs; others may have neuro-disability resulting from Traumatic Brain Injuries (TBI) due to their experience of war and/or torture. In some cases, these experiences may present schools with significant challenges to help these children integrate quickly, and settle down to schoolwork. In these cases, educational settings may seek specific advice and guidance from psychologists. For a small minority of these young people, their needs may exceed the provision usually available within the Local Offer. This policy ignores the psychological need for people under stress to seek support from others who have had similar experiences. It is well documented that good social support is one of the best buffers against exacerbating debilitating reactions (Udwin et al., 2000; La Greca et al., 2010; McDermott et al., 2012).

In these cases, there should be evidence that the child or young person's needs remain persistent, and require further provision despite the implementation and careful review of specifically-targeted additional provision over time. Where this is the case, you may advise the school, parents/carers or young person to request that the LA consider an Educational Health and Care Assessment. (Children and Families Act, 2014).

In some cases, the needs of the child or young person may require further in-depth clinical or therapeutic assessment. Where this is the case, you may recommend that schools seek support from CAMHS. If therapeutic work starts you should support schools to maintain

close contact between clinicians and educational professionals. This should ensure that the team around the child are sharing information and good practice.

You should seek opportunities to ensure that the child, young person, and parents/guardians are included in any planning interventions and review procedures. Ensuring the voice of the pupil is heard is a priority. Language barriers should not limit the involvement, participation and agency of children, young people and their families.

## **7.4 Educational psychological assessments of special educational needs**

In conducting individual assessment work, psychologists should comply with the guidance set out in the HCPC Standards of Conduct, Performance and Ethics (2016) and the Code of Ethics and Conduct (BPS, 2009). In addition to their usual assessment considerations, psychologists should be mindful of the key principles as set out in section 3, and the following considerations:

### **1. Challenges with gaining informed consent**

You should reflect on how issues related to English as an Additional Language may impact on gaining informed consent. Some refugees and asylum seekers may not have come in to contact with psychologists, or may hold differing ideas or understanding of what psychologists and other professionals do. Consider as well the possible impact that diversity related to culture, religion and gender may have when seeking informed consent. Psychologists should also be mindful that for some children and their families, their experience of some people seen as ‘officials’, including LA Officers may have been experienced as abusive and traumatic.

### **2. Assessment approaches**

The voice of the child and young person and family should be at the centre of any assessment. Be aware of cultural interpretations and social construction of trauma, diagnostic labels, treatment and help-seeking behaviours

You should consider the ecological validity of your choice of assessment methods. Establishing a developmental history is essential in informing the decisions you make on assessment in the future, and avoiding anti-oppressive practice. Assessment through teaching (e.g. Raybould & Solity, 1988) and approaches from Dynamic Assessment (e.g. Haywood et al., 2007), rather than standardised assessments of cognitive ability will be more valid and yield more helpful data regarding learning strengths, needs and subsequent interventions

Where at all possible, conduct direct assessment in the child’s home language and correct dialect using qualified, professional interpreters. Think about whether interpreters will be viewed positively by the child, young person or family. As stated earlier, other children or young people should never be used as interpreters.

When doing assessments, focus on the child’s strengths. Refugees and asylum seekers and their families bring with them a wide range of strengths, skills and resources and identifying these can form the basis of subsequent interventions in both educational settings and the family.



Assessments drawing on narrative psychology may also enable the voice of the child or young person to be heard. These assessments, in the home language, can also be used to explore what sense they make of their personal and physical journey. (e.g. Hulusi & Oland, 2010).

Some refugee and asylum seeker children and young people may not have a school place. If you are making assessments in these cases, draw cautious conclusions and recommend further assessment once the child or young person has secured a nursery, school or college place.

As with all assessments of children and young people, your recommendations and interventions should seek to target specific outcomes for the child or young person. Ensuring that swift social inclusion and curriculum access are suggested as key outcomes.

### **3. Seeking supervision**

Where necessary, you should always use professional supervision to reflect on your practice and formulation. Some psychology teams may have designated psychologists who have developed specialisms in this area. They can be an important source of professional support, supervision and may also provide consultation and training.

## **7.5 Conclusion and recommendations**

Many of these children and young people will have had their education disrupted as part of their journey and relocation. Psychologists have a very valuable role to play liaising between local authorities and schools, nurseries and colleges in order to help these children be assessed correctly, and integrated as soon as possible. Simple but effective approaches can make this transition much smoother, such as ensuring that children are assessed in their home language, and categorising 'English as an additional language' as an educational issue not a special needs one. In particular:

- Swift access to education and well-planned school-based assessments help these children integrate successfully.
- Assess such children in their home language and correct dialect.
- Don't automatically place children in lower-attaining groups if English is not their first language; assess them on their previous schooling, ability and needs.
- Engage the community and whole school so that these children and young people can be quickly integrated.

## 8. Supporting asylum seeking and refugee families

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Undeniably, the best support system for individuals, in times of distress, is the family – provided that the family is not separated by events, or choice and is not ‘dysfunctional’. Refugee and asylum-seeking families often undergo an arduous, disorienting and painful process, as a result of which family members may experience many changes, with many different implications. It is important for psychologists to be aware of these implications and ideally try to provide appropriate support to all members of the families, as well as to those who work with them. This support should maintain a sensitive balance of interventions which respect and address families’ suffering and losses, different cultural backgrounds but avoid pathologising them.

### 8.1 Key considerations

The family, with all its different forms and structures, is the most important unit to potentially provide the best conditions for humans to develop positively. But realising this potential depends on many factors, both internal to the family and external.

Even when dreadful things happen – events that force people from their homes or where they consider to be safe – the family can still help each other. Under these circumstances a greater emphasis should be placed on the importance of family, as it could be a vital source of support for its members in the following ways:

- Offering support and stability which helps family members tolerate their experiences of, and reactions to these adverse events, however difficult, painful or unbearable they may be.
- Providing ways of coping with these experiences.
- Offering ways of giving appropriate meaning to these experiences, by helping them not to get overwhelmed. The family needs to maintain the right balance between not ignoring or underestimating such experiences, but also by not over-estimating them and their destructive nature.
- Enabling them to survive, and to make the best possible use of these experiences- regardless of how difficult, painful or disruptive these experiences may be.
- Offering them ways of maintaining connections with people outside the family as well as with relevant outside bodies, organisations and services.

However, when caught up in difficult situations that mean they have to leave home or country, families can undergo radical changes with negative consequences. Therefore, you need to appreciate the complexity and uniqueness of these families’ experiences, so that appropriate interventions are aimed at not only minimising the destructive effects of adversity on the family, but also reinforcing specifically the family’s own positive potential to address these effectively.

When they have to flee their home country, families may lose sight of the importance of processing potentially overwhelming experiences because of the sheer burden of real and pressing needs of survival. As a result, they can neglect or minimise the family’s internal dynamics, cohesion, difficulties and conflicts, which can cause more problems.

They may also be so preoccupied with issues such as the legal complexities of seeking asylum or political realities that they overlook or are unable to deal with the needs of a particularly vulnerable or traumatised member/s.

Finally, a common experience is to end up being separated from a family member or members during their flight and relocation. This may lead to the family members' experiencing their ordeal in radically different ways. The lack of shared experiences or discrepancy may cause conflict, and may create new divisions, new roles, new identities and new imbalances within the family.

It is important to be aware that not all of these new experiences necessarily have exclusively negative impacts on the family. These new experiences may rip the family apart or they may strengthen the family and bring its members closer together, like never before. Consequently, what is of paramount importance is that you should endeavour to discern the impact of these experiences thoughtfully, attentively and judiciously and always strive to minimise their negative effects and maximise their positive effects.

By supporting families, psychologists not only support their individual members but also are strengthening a unique unit in the extended system that can have considerably beneficial effects in the wider community.

You do not need to be a qualified family therapist to have a positive impact on families. By appreciating the complexities outlined here, any psychologist can play a beneficial role in attending to the needs of these families. Moreover, the psychologists' tasks should also include consultation with other professionals and non-professionals involved in the care of these families.

Importantly, the role of cultural differences between those of the family and its surrounding community/ies needs to be appreciated in an appropriate way. Differences do not necessarily imply problems, as they can be enriching. Your task as a psychologist is to discern the specifics of each situation and, as always, endeavour to minimise their negative effects whilst maximising their positive effects.

The role of community support is of paramount importance. Appropriate support from the extended family and community strengthens these families and reduces the negative effects. However, you need to be extremely sensitive in terms of considering which is the appropriate community for each family, and, for that matter, each family member. It is always strongly recommended that psychologists collaborate with the family in selecting their community of choice and not to assign to them a community that is assumed by others to be 'their community'.

The role of spirituality and religious affiliation is of vital importance for some families, at all times, but especially during the periods of dislocation and relocation. You should endeavour to be sensitive to families' spirituality and religious affiliation and not to minimise their importance. Instead, enable each family to have access to their preferred spiritual/religious community.

## **8.2 Assessment and interventions**

Assessment is an important part of every good intervention. It may be performed as a separate activity, which precedes the intervention, or in an on-going way that interweaves assessment with intervention in a mutually complementary fashion. Or alternatively it could be carried out in a cyclical form: assessment – intervention – re-assessment – intervention, etc.

In working with these families, there is a danger of compartmentalising the assessment process due to the specific pressures they may experience and the pressures psychologists have in addressing their multi-faceted predicament. Moreover, there may be difficulties in co-ordinating information from all workers and professionals involved, as these families tend to have contact with many different organisations and services, which often have no communication amongst themselves.

You should give particular attention to the way you conduct assessments and interventions. They should not be intimidating, condescending, or un-empathic. Instead, go out of your way to speak to these families in ordinary, everyday language (avoiding professional jargon). Remain constantly alert to the families' immediate concerns with regard to the difficulties they encounter in their everyday lives.

Assessment of these families often focuses on identifying their needs as a result of their multiple losses. However, which needs do psychologists need to focus upon? These are often multifaceted. Ideally, all assessments and interventions should be based on a sound psychosocial perspective, that is, not only limited to psychological factors but also include the actual realities of living, along with their financial, medical, spiritual, and other considerations. Ideally, your assessment and interventions should address the wide spectrum of:

- Intrapyschic factors;
- Interpersonal interactions;
- Wider socio-political and cultural parameters.

All these should be within the context of the actual reality of their everyday lives.

You should assess families within at least two types of histories: *their own family developmental cycle* (e.g. have they just married, do they have young children, have their parents died, is their main focus now the education of their teenage children?) and *their dislocation history* (e.g. is their current location the final destination of their journey or are they still planning to move to another country; are they expecting other members of their family to join them?). So you should appreciate the particular stage that each family is at that given time, as well as the stage in their process from dislocation to relocation.

Unfortunately, the assessment of these families is restricted to identifying their 'needs', and these needs are understood exclusively in terms of their multiple losses. This fails to take account of their complexity, uniqueness and strengths and abilities. If the focus is entirely on their 'needs' (defined only by their losses), in effect, only their deficits will be accounted for and nothing else – giving them a victim identity.

You should be extremely vigilant to avoid subtle forms of interactions that, unwittingly, reinforce the 'victim identity' in these families. A key distinction needs to be made between appreciating that families have been victims of various events, acts and circumstances, as opposed to developing a 'victim identity', which fosters helplessness, dependency and many other negative functions and processes.

A practical way of minimising this is to appreciate them in their complexity, uniqueness and totality. Specifically, this can be achieved by following three steps (Papadopoulos, 2007):

- (a) As well as identifying needs, pay particular attention to the existing strengths, assets and resources of the family and its members that they have succeeded in retaining before their adversity. Find out what these families are good at, what they can offer to others, despite their own difficulties.

- (b) Look for new strengths they have been able to acquire during their journey and relocation. These new strengths may not always be easily accessible because they tend to be so obvious, for example, they have more confidence in themselves because they were able to survive adversities they did not believe that they could, or that they now are more compassion towards others that they tend to do more community work, etc. Seek creative ways of integrating these strengths into their psychological interventions.
- (c) Traumatic experiences tend to distort the sense of time in multiple ways, for example, people end up with a sense of living either in the past or the future, or suspended in frozen time. So it's imperative that families are understood, and also are helped to understand themselves, *diachronically*, considering their past, present and future. You need to help them see themselves beyond the reality of the present – which may be miserable and hurting – but also enable them to reconnect with their past realities, identities, roles and sense of worth. You also need to convey, in an appropriate way, that they have a future, beyond the troubled times they are now facing. One useful tip is to suggest to them that one day, many years from now, they are likely to look back at their current ordeal and realise that it was, possibly, the worst time in their lives.

A particular form of time distortion caused by traumatic experiences is the recurrent re-living of those experiences; and often these are experienced with the same emotions and physiology as at the time of their original occurrence. The memories/experiences may be fragmented, confused, and easily triggered. Such types of recurring experiences can have distressing effects, and psychologists have an important role to play in helping the families and those working with them to understand the potential impact of such memory disturbances, including poor concentration and dissociative experiences.

Make sure you differentiate between 'normal distresses' and 'abnormal disorders'. Not all forms of distress are types of disorder; not all distress implies dysfunctionality. For the majority of these families, their current situation can be understood in terms of being normal responses to abnormal circumstances. It is very easy to psychologise and even pathologise their suffering. You should be extremely vigilant to avoid both.

However, it is important that you identify psychological problems experienced by family member/s, which may require specialist psychotherapeutic (and even psychiatric) attention. Familiarise and educate families with regards to symptoms, treatments options (including talking therapy) to increase their insight and understanding of these conditions, which in turn may help normalise families' reactions to traumatic events they may have experienced and help them cope with their distress.

### 8.3 Interpreters

It is of utmost importance to use reliable, sensitive and professional interpreters. You should endeavour to the best of your ability to develop a good working relationship with the interpreters you use. Ideally, you should be able to work with them as co-workers and ensure that they understand your goals, methods and overall approach (but, needless to say, without clinical responsibilities). Whilst selecting interpreters for the families, sensitivity is of paramount importance. In addition, pay special attention to differences

such as ethnicity, language sub-groups, culture, religion/spirituality, gender, age, LGBT, social class, and all other relevant parameters. Obviously, this sensitivity should not be limited to the selection of the interpreters, but it should be extended to the entire range of the psychologists' involvement with these families.

## 8.4 Additional factors

Additional specific factors need to be considered in working with these families. The most typical ones are the following:

**Legal status:** Signpost sources of support for securing appropriate, sound and reliable legal representation (see 'Useful resources' section).

**Social discrimination and marginalisation:** in particular, you should endeavour to identify subtle forms of these negative types of unacceptable pressures on these families. In addition to familiar 'anti-refugee' hostilities these families may experience, they may also be targeted by other forms of discrimination and marginalisation due to their social class, educational level, or appearance.

**Financial status:** these families need to have sufficient financial means to address at least their basic needs and realise their main reasonable aspirations, for example, appropriate living conditions, housing, access to health and education. Although your focus should be on providing psychological interventions, do not forget that these families may face serious financial constraints and poverty. You need to find ways of addressing these issues either directly (e.g. putting them in touch with relevant aid organisations) and/or indirectly (through advocacy). The value of any psychological or other psychosocial work you do with these families is limited, if they are living under dire and inhuman conditions.

**Realistic expectations:** make sure such families have realistic expectations in relation to all facets of their new lives; unrealistic expectations have a harmful effect on them.

## 8.5 Conclusion and recommendations

For many people, the family will be their strongest form of support and should be recognised as this. The strengths that a family can bring are manifold, and psychologists should be very wary of focusing on the damage and the needs that must be met at the expense of the resilience that such families can show. There needs to be rapid assessment to help keep these families in the best place, both mentally and physically, but also to ensure that the needs of all family members are taken on board. In particular:

- Assess families not just in terms of their needs, but also their strengths and abilities.
- Signpost sources of support for securing appropriate, sound and reliable legal representation.
- Be sensitive as to which is the appropriate community for these families, rather than what is assumed to be.



## 9. Supporting/working with refugee communities

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All psychologists, whatever their area of specialism, can support communities. Don't think that just because you do not view or label yourself as a community psychologist that this excludes you from forming mutually beneficial partnerships with refugee community organisations.

Given the inaccessibility of mainstream services to many refugees, psychologists may also work within statutory services to address some of the barriers to access. Refugee community organisations (RCOs) will have a wealth of ideas on how this could be done.

### 9.1 Key considerations

RCOs have always played an important part in helping refugees and asylum seekers settle into and live in the UK (or other host countries), with many providing a wide range of services. This can include assisting with wellbeing and mental health both directly and indirectly (often with little, short-term or no funding). They often help people who might otherwise have received no assistance. They may provide a form of triage or may assist people who might otherwise have accessed statutory services.

RCOs are set up for a range of purposes. They may provide a range of therapeutic activities; many will offer advice, referral and counselling. They may offer interpreting and translation services, classes in their mother tongue for children, organise cultural events, English classes or offer a befriending or counselling service or have a specific focus. They can also provide a wealth of understanding and shared experience, which can be extremely helpful to an asylum seeker or refugee. Their experience of having lived experience of being an asylum seeker or refugee and the sharing of information and coping strategies can be invaluable. Some will have been established for many years and others may have been established more recently.

Psychologists can often provide very helpful and cost-effective services by working in partnership with RCOs. You can find helpful information around developing partnerships within the *Guidance on Working with Community Organisations for Psychologists* developed by the London Community Psychology Network (2017). Details of RCOs are available from The Refugee Council or Refugee Action. In Scotland or Wales, information can be obtained respectively from the Scottish or Welsh Refugee Councils, whilst the University of East London mental health and refugees web portal also provides a list of organisations (as well as additional resources). Your local NHS Trust, voluntary or local civil society organisation may also have information about the numbers and composition of people within their geographical area including refugees and asylum seekers.

### 9.2 Engaging and working with diverse community organisations

There are many opportunities for psychologists to work effectively in collaboration with refugee communities in ways that can assist with capacity building (both for statutory services and RCOs). Working together can help provide services in an appropriate, accessible and culturally sensitive manner, as well as developing skills in co-production and partnership-working. Some psychologists may feel that they have not received sufficient training in community partnership (which is qualitatively different to consultancy work).

This work though can provide important opportunities to undertake, innovative and useful psychological work, and contribute to social justice and service provision.

The key elements of any community partnership in this context include (but are not limited to) the following. You should develop a mutually respectful relationship with an RCO, by learning about their work and objectives. You should take a collaborative stance, with the aim of mutual learning and sharing of expertise, experience and knowledge – which may differ significantly from a consultancy relationship. When working with RCOs, you may need to move away from an ‘expert’ stance, into a co-operative partnership.

Issues of power, racism and who has access to which resources will also require consideration and open discussion. Developing a relationship takes time if it is to become an effective and long-lasting one, and both parties need to be clear about what they hope to contribute and obtain from the partnership. Prioritise openness and transparency, seek clarity about objectives and keep possible outcomes under review.

Even if you do not know all the details of a country, culture and its history, don’t let that prevent you from considering undertaking work with RCOs. What is essential is to recognise the expertise of the RCO, and not assume that they lack the skills, knowledge and professionalism of the statutory sector. The workers there are experts on their country, region or group and will usually be happy to ensure that psychologists are familiar with the relevant detail. A little research should provide much of the relevant information (for example, via United Nations High Commission on Refugees, Amnesty International, or Human Rights Watch websites).

Examples of a range of work undertaken by psychologists working with RCOs can be found at Harris and Maxell (2000); Byrne and Tungana et al. (2016); Tribe and Tunariu (2017).

You might be involved in providing information about the role of psychologists, statutory provision and when to refer to psychologists or mental health services. RCOs have a wealth of expertise in the cultural, social and political context of a country, the experience of seeking asylum, language and ways of thinking about and providing mental health support. They can also provide useful information about cultural ways of understanding psychological distress and ways of dealing with this and culturally appropriate and accessible services in the language of the asylum seeker or refugee.

Working in partnership can also involve mutual exchange of training. RCOs can provide training to statutory organisations on the asylum process, cultural issues, and effective ways of working with their client groups. Many RCOs are already providing a range of mental health support and may want some training on a specific issue for their workers, for example, addiction or suicide.

It is good practice to develop and co-produce methods of evaluation of any work undertaken with RCOs from the start, as this can provide helpful feedback and show the tangible effects of being involved in this work which can also contribute to the wider body of knowledge and can provide useful information for managers, commissioners and funders.

Finally, it is worthwhile remembering that people from many cultural backgrounds have a wealth of ways of dealing with psychological distress or mental health issues and you may find that there are a range of other ways of considering mental health and wellbeing (Fernando, 2014; Tribe, 2014).

There are arguments over the field of 'global mental health' (Summerfield, 2012; White, 2013). This is a highly complex area and the following is a brief and simplified summary of the debate. Some mental health professionals argue that the issues largely remain the same regardless of culture and context (Patel & Prince, 2010) but others contest this view and see the imposition of concepts developed in high income countries as a form of neo-colonialism which may undermine long-standing practices (Mills, 2014; Summerfield, 2012).

What is clear is that psychologists are increasingly being encouraged to work in a more inclusive and participatory manner. Issues of power need constant consideration in this situation.

The concept of health pluralism, where concepts developed in both low or middle and high-income countries are weaved together may also prove beneficial (Tribe, 2007) and has also been suggested as a possible way forward. You may find that this work encourages reflective practice and enriches your entire clinical repertoire in a range of ways.

### **9.3 Working with and supporting volunteers in communities**

Most RCOs have a mixture of staff who are paid, as well as unpaid volunteers. As with any volunteering, there will be a range of reasons for doing this, which may include, but are not limited to altruistic reasons, wanting to assist other members of their community, developing skills to assist with employability and social capital (Yap, Byrne & Davidson, 2011).

While refugee volunteers have a wealth of knowledge, skills and experience to offer, they may also need support because of the impact of working with issues such as abuse and injustice that they themselves might have suffered, or be continuing to suffer.

Many people working at RCOs will be volunteers, who often work under immense pressure for the good of their community. Providing some reflective space, support or clinical supervision may also be appreciated, if that is what the workers at the RCO require. It is important to be respectful and culturally sensitive to ensure that you do not inadvertently further disenfranchise members of a particular community by speaking only to certain vocal representatives of that community. Ageism, sexism and discrimination on grounds of sexuality or disability may be present in both mainstream services and some RCOs. The NICE guideline (Ng44, 2016) on community engagement provides some information and there exist practical guides for psychologists and other professionals (e.g. Lane & Tribe, 2010).

Refugee community organisations are unfortunately sometimes excluded from strategic decision-making in service provision, although they may be able to make a valuable contribution. Some local authorities have refugee integration projects, although these are becoming increasingly rare.

### **9.4 Intersectionality and the experience of being a refugee**

Taking an intersectional perspective points up the importance of not seeing refugee people as a homogenous group and the experience of being a refugee will differ depending on factors such as gender, sexuality, race or other relevant factors. People may choose to connect with an organisation that focuses on a particular group, for example, women or LGBT asylum seekers, rather than a specific cultural group or generic refugee organisation. For some groups of people, it can be very important that they receive specialist support

through the asylum process, for example, from legal representatives, organisations and support groups that understand the specific issues of LGBT asylum seekers (UKLGIG; Stonewall, Out & Proud Diamond Group, etc.). Working in partnership with RCOs can also involve contributing psychological perspectives and research to activism and policy development, which many of the organisations are actively engaged with.

Just because someone comes from a particular country, it does not mean that they will want to link up with a refugee community organisation. These organisations are sometimes organised around ethnic or political groupings, though some are not. A guide to working with refugee community organisations, a guide for local infrastructure organisations can be located at [www.cses-vol.org.uk](http://www.cses-vol.org.uk).

The constitution of the UK refugee population is subject to change as world politics and events will influence this. The Evelyn Oldfield Unit ([www.evelynoldfield.co.uk](http://www.evelynoldfield.co.uk)) aims to provide, develop and coordinate specialist aid and support services for established refugee and migrant organisations and individuals in order to assist them in increasing their capacity and potential for meeting the needs of their communities.

## 9.5 Conclusion and recommendations

There are often well-established community groups who are working hard to help those who have arrived recently, or offering long-term support. Psychologists may in the past have acted as ‘consultants’, but by sharing information and experience, they can develop a more mutual relationship. Be aware that those who you work with may be under pressure themselves, and that for some new arrivals, there may be complications or a lack of desire to integrate with communities, particularly if there are ethnic or political groupings.

In particular:

- Develop mutually supportive relationships with community organisations, sharing experience and knowledge rather than acting as an ‘expert’.
- Set up methods of evaluation for any work from the start as this can produce helpful feedback and wider use.
- Refugees should not be seen as a homogenous group, but offered specialist support if needed in terms of race, gender or sexuality.

## 10. Good practice in the workplace<sup>1</sup>

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Work is important – in its broadest sense, it is an activity that involves mental and or physical effort to achieve some result. While paid work has important economic value to individuals and their dependents, work generally is often central to our identities and for our wellbeing. The relationships that work can provide may be useful in providing local social support and anchors, but also in enhancing human capital for both the individual and the wider community. Work has value to both refugees and the societies they are located in. This section focuses on the role work might play for refugees in helping them restore who they are, and in them integrate into UK society.

### 10.1 Key issues: legal

Those who have applied for or are seeking asylum in the UK are not allowed to work (Home Office, 2017a, p.4). The right to work is permitted only where asylum claims extend to more than 12 months, and only to those roles that are listed on the occupational shortage list (Home Office, 2017b). Access to any type of paid work is only permitted once the right to remain in the UK has been granted. The reason for these rules is to protect access to the UK's labour market, and to deter economic migrants.

However, refugees and asylum claimants are able to volunteer, and its value to enhancing their integration is recognised by the Home Office. Volunteering is defined as unpaid work that benefits the environment, individuals or groups, but excludes working to support close relatives (Home Office, 2017a). Volunteering can include charities or public-sector organisations. The Refugee Council offers useful support to help employers (Refugee Council, 2014).

### 10.2 Key issues: psychological

Aside from the economic benefits of work, it may have important social and psychological advantages, enhancing the wellbeing of individuals and their families (McKee-Ryan & Maitoza, 2014). In the case of refugees, a work identity may offer a sense of continuity and distinctiveness about *who they are* (e.g. a professional person with a rich array of skills and experiences, such as an engineer or a baker) and who they are not (e.g. unemployed, reliant on welfare). Work can be a critical component of self-esteem.

For most people, the loss of a job and the struggle to get back into the labour market can be very difficult. Evidence from unemployed nationals shows a negative and pernicious relationship between the length of time without work and the subsequent reduction in the chances of finding work. Periods out of work may not only erode individuals' job-skills, but also reduce their motivation and job-related networks (Koen et al., 2012).

In the case of refugees this is likely to be magnified in two ways. First, many refugees and asylum seekers are not allowed to work, and so suffer from state-imposed worklessness (lack of activity involving mental and physical effort to achieve results- as defined by the

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<sup>1</sup> Prepared with inputs from the special BPS DOP international working group event on Integrating refugees into work: multiple perspectives 26 September 2016

*Oxford Dictionary*). This feeds directly into certain media-driven narratives of refugees as welfare recipients. Second, and compounded by the first, their self-identity is further threatened in four distinct ways – through a decline in self-worth, distinctiveness, continuity and control (Eilam & Shamir, 2005). This erosion of self-identity may be perpetuated by the challenge of trying to get back into work in an unknown context without any organisational and network support except potentially from family and friends.

Critically, other than having an application rejected, some refugees and asylum-seekers may have little insight into the nuances and differences involved in accessing work in their new context – a process that may be significantly different from their prior experiences. Such periods without insight into why they cannot get their careers back on track may intensify their sense of discontinuity (Ibarra & Barbulescu, 2010), making it difficult for self-narratives to be successfully revised and reconstructed. As a result individuals' previous career trajectories and identities may become dislocated, making it hard for them to adjust and adapt to a new and often subtly different context (Zikic & Richardson, 2015). As a result, it is possible that they may hit a personal crisis.

### 10.3 Examples of good practice and challenges

Psychological research has identified a multidimensional concept of employability which consists of components concerning an individuals' human and social capital, their work-related identity, and their personal adaptability (Fugate, Kinicki et al., 2004) (see Figure 1).

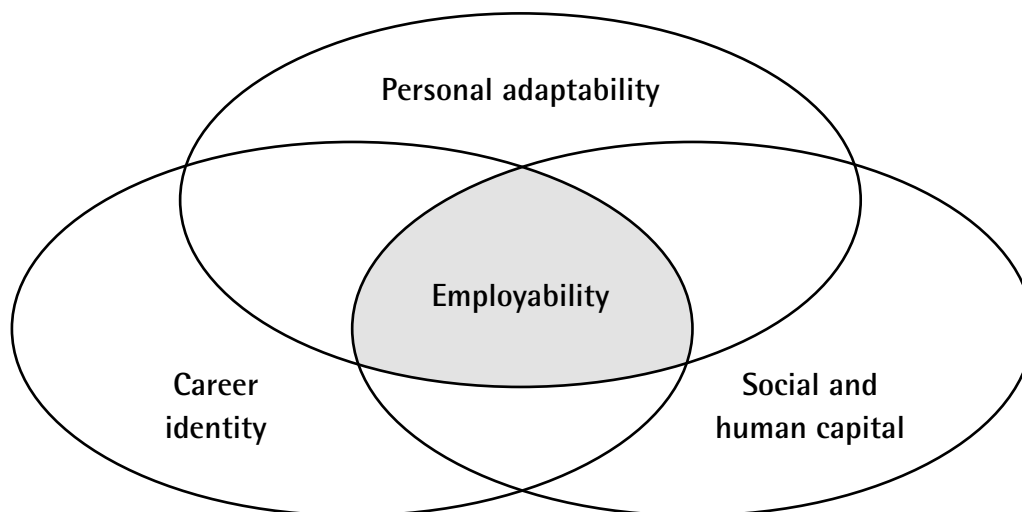


Figure 1: Heuristic model of employability.

Importantly, closer examination of practices that would enhance the integration of refugees into work shows they are not distinct, but instead a continuation of good practices that have value to all staff. These are: recruitment and selection, induction and 'onboarding', and diversity management.



## (a) Recruitment and selection

- **Access to work** is a vital way of supporting people to feel they have some element of control back over their lives. Given the current government-imposed restrictions on employment for asylum seekers, other routes into gaining experience of working in the UK context may be important.
- **Volunteering** (as stated earlier) may be one route to allowing refugees to gain some UK-based work experience, which is important for their CVs, but also in providing some acculturation about work in the UK context, and in broadening individuals' social networks.
- Attention to gaining work should include **career self-management**, which concerns proactive management of careers (e.g. De Vos et al., 2009). Evidence shows these skills can be taught and are effective for both the long-term unemployed as well as new job seekers as has been seen in the Netherlands and the USA (Michigan Prevention Research Centre, 2003). Such programmes creating a clearer vision of realistic career goals can focus individuals to gather more relevant information for their careers and to better plan and solve career problems. A more informed search process, rather than a scatter-gun approach, will reduce identity dislocation and provide a sense of being in control.
- **Language skills** can be an overarching challenge for some refugees. Literacy is a key component of employability<sup>2</sup>. There is often no priority given to refugees for state-funded provision and some people seeking asylum may not have the tenacity or understanding of provision to navigate successfully between agencies and providers to secure a place. There are also examples, such as from the National Literacy Trust<sup>3</sup>, of the additional spillover value for literacy programmes run as part of library support for under-fives years to adult refugees.
- **Coaching:** Evidence for skilled immigrant professionals shows the positive impact of coaching in enhancing their understanding of local career routes and qualifications (Zikic & Richardson, 2016). Coaching also helps refugees navigate different recruitment processes. **Job Coaching** models from Greece have shown benefits for young jobseekers; their approach matches an individual to a local professional who then helps them to apply for the kind of work they want through developing CVs, identifying training needs, and by offering job shadowing. This approach could increase refugees' human and social capital, and show potential employers what skills and talents are available to them.
- **Company support:** Refugees are often highly motivated, resourceful and resilient individuals who want to get their lives back on track. They can offer a rich skills source to organisations. In Germany, state support is currently provided to employers who take on refugee workers. In Norway, Stormberg (a sports retailer) has a deliberate policy of employing refugees as 10 per cent of its staff. These provisions are likely to vary and change overtime, as states seek more effective ways to manage the current and future levels of migration. More attention perhaps, needs to be paid to changing the narratives by persuading organisations to employ refugees and then communicating the on-going benefits.

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<sup>2</sup> For information on ESOL see: [www.refugeecouncil.org.uk/assets/0001/5845/DWP\\_and\\_ESOL.final.pdf](http://www.refugeecouncil.org.uk/assets/0001/5845/DWP_and_ESOL.final.pdf)

<sup>3</sup> For more information and resources visit: [www.literacytrust.org.uk/early\\_years](http://www.literacytrust.org.uk/early_years); [http://www.literacytrust.org.uk/early\\_words\\_together](http://www.literacytrust.org.uk/early_words_together); and for older adults: [www.literacytrust.org.uk/resources/free-resources](http://www.literacytrust.org.uk/resources/free-resources)

- **Wording of job vacancies:** Making the requirements of a job clear is an important part of any recruitment process. Transparency about the role and selection processes makes the procedure fair. Further, vacancies which draw attention to diversity could make refugee applicants feel they might be welcomed; adding that refugee applications are welcome would signal that this is an open employer.
- **Assessment and equivalence of qualifications and experiences** can be a critical challenge for refugees and the organisations seeking to employ them (Zikic & Richardson, 2016). A Swedish project for refugee doctors has worked constructively with refugees who do not have their formal paper qualifications; using clear job requirements for medical roles, they appoint strong teams to work alongside refugee candidates to enable an on-going work-based assessment of these refugees' competences. Several mentoring projects for health professionals operate in Britain.
- **Bias awareness training:** Selection processes can at times perpetuate bias. Selectors should be adequately trained to be aware of their inherent biases and prejudices, and to explicitly discuss any potential biases that emerge. Such a component should be part of any selector training, to help improve diversity more generally. Specifically, recruiters need to be sensitive when questioning refugees about why they have gaps in their formal work experience.
- **Monitoring** of applicant to recruitment rates for refugees would enhance accurate insight into unfair practices. For large-scale recruitment processes, generalisability theory (Brennan, 1983) and partition selection score variances for multi-stage and multi-assessor selection processes into distinct estimates of error variance (Brennan, 2001) could help reveal whether biases are due to distinct recruitment exercises, raters, or factors related to refugee candidates themselves.

#### (b) Induction and 'onboarding'

**Induction:** Good practices improve retention for all staff through the inclusion of the following elements (Bauer, 2011): *compliance*, focusing on the rules and legal requirements of each role; *clarification*, making transparent the tasks and duties of a specific role and ensuring new staff can be effective in their performance; *culture*, raising awareness of the organisation's formal and informal norms and approaches; and *connection* attending to the social connections and relationships important to sustaining longevity with an employer, e.g. buddy systems. Although organisations may informally induct staff, this process can be far from effective even for those from established communities. With refugee populations *standardisation of provision* to all may perhaps mitigate against simple misunderstandings.

- **Buddy-systems:** Identifying a good worker as a buddy can help any new employee, regardless of whether they are a refugee or not. They provide a clear point of social contact in the new organisation, someone who is tasked to get to know and keep an eye out for them, and they are invaluable for speedy clarification and checking, helping defuse potential misunderstanding.
- **Labelling staff:** Designating new staff members as being from a distinct group can become a burden, singling them out for greater attention and scrutiny. Evidence from affirmative action shows how easily such efforts can backfire (Bobo, 1998), exacerbating minority groups' discrimination and reducing their overall wellbeing (Deitch al., 2003).

Sensitivity is therefore required where labels – such as refugee staff – might be applied, and should always include an on-going review and evaluation.

### (c) Managing diversity

- **Clarity in the organisational vision:** Firms which have alignment between their diversity mission and their other goals and objectives are more effective in benefiting from such approaches. Organisations should be clear about how refugee employment fits in – is it part of their corporate social responsibility? Or to attend to a skills gap? Further, articulating their perceived benefit enables new staff to be clear about how they can contribute to the new employing organisation.
- **Supporting small employers:** Recruitment and retention of staff from non-traditional backgrounds can be hard for small employers who may not have experience of the expertise to navigate employment requirements for refugees. Attention on creating resources that identifies what documents an employer needs might help reduce the reluctance to take on refugee recruits.

## 10.4 Conclusion and recommendations

Refugees and asylum seekers often experience problems around self-esteem and self-worth because they are prevented from working while their claim is assessed. Afterwards, because of the gap in their work history, language skills or different qualifications, they may find it difficult to find work. Thinking about how job vacancies are worded to get over the hurdle into employment and how best to support those who do succeed in finding a job will help those who are allowed to stay to play a valuable role in society and in supporting themselves and their families. In particular:

- Coaching, language skills, clarity of job advertisements can all help refugees and asylum seekers get back into the workplace.
- In the workplace, formal inductions and buddy systems can help the transition and welcome workers in.
- Encourage firms to align their commitments to diversity with their other goals and objectives.

## References

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- Amnesty International (2017). *What we do*. Retrieved 22 May 2017 from [www.amnesty.org/en/what-we-do/](http://www.amnesty.org/en/what-we-do/)
- Annie E. Casey Foundation (2006). *Undercounted. Underserved. Immigrant and refugee families in the child welfare system*. Retrieved 22 May 2016 from <https://folio.iupui.edu/bitstream/handle/10244/115/IR3622.pdf?sequence=1>
- Arroyo, W. & Eth, S. (1985). Children traumatized by Central American warfare. In S. Eth & R. Pynoos (Eds.) *Post traumatic stress disorder in children* (pp.110–120.) Washington DC: American Psychiatric Press.
- Association of Directors of Children's Services (2015). *Age assessment guidance: Guidance to assist social workers and their managers in undertaking age assessments in England*. Retrieved 22 May 2017 from: [http://adcs.org.uk/assets/documentation/Age\\_Assessment\\_Guidance\\_2015\\_Final.pdf](http://adcs.org.uk/assets/documentation/Age_Assessment_Guidance_2015_Final.pdf)
- Bauer, T.N. (2011). *Onboarding new employees: Maximizing success. SHRM foundation's effective practice guidelines series*. Retrieved 22 May 2016 from: <https://www.shrm.org/foundation/ourwork/initiatives/resources-from-past-initiatives/Documents/Onboarding%20New%20Employees.pdf>
- Bean, T.M. (2006). *Assessing the psychological distress and mental health care needs of unaccompanied refugee minors in The Netherlands*. Doctoral dissertation: Leiden University. Retrieved 22 May 2017 from <https://openaccess.leidenuniv.nl/bitstream/handle/1887/4921/Thesis.pdf;sequence=1>
- Bobo, L. (1998). Race, interests, and beliefs about affirmative action: Unanswered questions and new directions. *American Behavioral Scientist* 41(7), 985–1003.
- Bogner, D., Herlihy, J. & Brewin, C. (2007). The impact of sexual violence on disclosure during Home Office Interviews. *British Journal of Psychiatry*, 191, 75–81.
- Bogic, M. Njoku, A. & Priebe S. (2015). Long-term mental health of war-refugees: A systematic literature review. *BMC International Health and Human Rights*, 15, 29.
- British Psychological Society, Division of Clinical Psychology (DCP) (2011). *Good practice guidelines on the use of psychological formulation*. Available from [www.bps.org.uk/system/files/Public%20files/DCP/cat-842.pdf](http://www.bps.org.uk/system/files/Public%20files/DCP/cat-842.pdf)
- Byrne, A., Tungana, J. Upenyu, M., Devota, Janet, Fay, Rose, Rukia, Wonderful, Patience, Becky, Mary, Hope, Lizzy, Linda, Barbie and Uwamaria of Re:Assure Women's Project at Positive East (2016). Women can build a nation: Our disease, HIV, cannot stop us to be mothers because we are the mothers of the nations: A liberation approach. In T. Afuape & G. Hughes (Eds.). *Towards emotional well-being through liberation practices: centralising dialogues*. London: Routledge.
- Children and Families Act 2014 (2014). Retrieved 22 May 2017 from [www.legislation.gov.uk/ukpga/2014/6/pdfs/ukpga\\_20140006\\_en.pdf](http://www.legislation.gov.uk/ukpga/2014/6/pdfs/ukpga_20140006_en.pdf)

- Craig, R., Doherty, S.M. & McMillan, T.M. (2014). Head injuries in asylum seekers and refugees: Hidden within a complex picture? *Division of Clinical Psychology, Scotland Review 10*, 22–25.
- Crul, M., Schneider, J. & Lelie, F. (2012). *The European second generation compared: Does the integration context matter?* Amsterdam: Amsterdam University Press.
- Crul, M. (2016, 18 September). Early education is key to helping migrant children thrive. *The Guardian*. Retrieved 18 September 2016 from [www.theguardian.com/profile/maurice-crul](http://www.theguardian.com/profile/maurice-crul)
- Crumlish, N. & O'Rourke, K. (2010). A systematic review of treatments for post-traumatic stress disorder among refugees and asylum seekers. *Journal of Nervous and Mental Disorders*, 198, 237.
- Deitch, E.A., Barsky, A., Butz, R.M. et al. (2003). Subtle yet significant: The existence and impact of everyday racial discrimination in the workplace. *Human Relations* 56(11), 1299–1324.
- Department for Education (DfE) and Department of Health (2015). *Special educational needs and disability code of practice: 0 to 25 years*. London. DfE and DoH.
- De Vos, A., Dewettinck, K. & Buyens, D. (2009). The professional career on the right track: A study on the interaction between career self-management and organizational career management in explaining employee outcomes. *European Journal of Work and Organizational Psychology*, 18(1), 55–80.
- Douglas, A (2010). Identities in transition: Living as an asylum seeker. *Advances in psychiatric research*, 16, 238–244.
- Doherty S. & Morley R. (2013). Recognising and responding to victims of human trafficking. *British Medical Journal*, 2013, 346, f2657. doi:10.1136/bmj.f2657
- Doherty S. & Morley R. (2016). Promoting psychological recovery. In M. Malloch & P. Rigby (Eds.), *Human trafficking the complexities of exploitation*. Published to Edinburgh Scholarship Online: January 2017. doi:10.3366/edinburgh/9781474401128.001.0001
- Drozdek, B. & Bolwerk, N. (2010). Evaluation of group therapy with traumatised asylum seekers and refugees – The Den Bosch Model. *Traumatology* 16(4), 1–9.
- Drozdek, B. & Wilson, J.P. (2004). Uncovering: Trauma focussed treatment techniques with asylum seekers. In J. Wilson & B. Drozdek. (Eds). *Broken spirits. The treatment of traumatized asylum seekers and refugees, war and torture victims* (pp.243–276). Brunner-Routledge: New York.
- Eilam, G. & B. Shamir (2005). Organizational change and self-concept threats: A theoretical perspective and a case study. *The Journal of Applied Behavioral Science* 41(4), 399–421.
- Eurostat (2016). *Asylum Statistics*. Retrieved 22 May 2016 from [ec.europa.eu/eurostat/statistics-explained/index.php/Asylum\\_statistics#main\\_statistical\\_findings](http://ec.europa.eu/eurostat/statistics-explained/index.php/Asylum_statistics#main_statistical_findings)
- Evelyn Oldfield Unit (2015). Working with volunteers: A management guide for Refugee Community Organisations. Retrieved 22 May 2016 [www.evelynoldfield.co.uk/wp-content/uploads/2015/04/refugee-volunteering.pdf](http://www.evelynoldfield.co.uk/wp-content/uploads/2015/04/refugee-volunteering.pdf).

- Fazel, M. & Stein, A. (2003). Mental health of refugee children. *Archives of Diseases in Childhood*, 87, 366–370.
- Fazel, M. (2015). A moment of change: Facilitating refugee children’s mental health in UK schools. *International Journal of Educational Development*, 41, 255–261.
- Fernando, S. (2014). *Mental health worldwide: Culture, globalization and development*. Basingstoke: Palgrave Macmillan.
- Finney Lamb, C. & Smith, M. (2002). Problems refugees face when accessing health services. *NSW Public Health Bulletin*, 13(16), 1–3.
- Fugate, M., Kinicki, A.J. & Ashforth, B.E. (2004). Employability: A psycho-social construct, its dimensions, and applications. *Journal of Vocational Behavior* 65(1), 14–38.
- German, M. & Ehntholt, K. (2007). Working with refugee children & families. *The Psychologist*, 20, 152–155.
- Gorst-Unsworth, C. & Goldenberg, E. (1998). Psychological sequelae of torture and organised violence suffered by refugees from Iraq. *British Journal of Psychiatry*, 172, 90–94.
- Michigan Prevention Research Centre (2003). The jobs project for the unemployed. Retrieved 22 May 2016 from: [www.isr.umich.edu/src/seh/mprc/jobsupdt.html](http://www.isr.umich.edu/src/seh/mprc/jobsupdt.html)
- Multi-agency statutory guidance on female genital mutilation (2016). Retrieved 22 June 2016 from: [www.gov.uk/government/publications/multi-agency-statutory-guidance-on-female-genital-mutilation](http://www.gov.uk/government/publications/multi-agency-statutory-guidance-on-female-genital-mutilation)
- Harris, K. & Maxwell, C. (2000). Needs assessment in a refugee mental health project in North East London: Extending the Counselling Model to Community Support. *Medicine, Conflict & Survival*, 16, 201–215.
- Haywood, C.H. & Lidz, C.S. (2007). *Dynamic assessment in practice: Clinical and educational applications*. New York: Cambridge University Press.
- Herlihy, J. & Turner, S. (2007). Memory and seeking asylum. *European Journal of Psychotherapy & Counselling*, 9(3). 267–276.
- Herman, J.L. (1992). *Trauma and recovery*. Basic Books: New York.
- Home Office (2015). *Syrian Vulnerable Person Resettlement (VPR) Programme: Guidance for local authorities and partners*. London: Author.
- Home Office (2016). *Full community sponsorship: Guidance for prospective sponsors*. London: Author.
- Home Office (2016). *Family reunion: For refugees and those with humanitarian protection*. Available from: [www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/541818/Family\\_reunion\\_guidance\\_v2.pdf](http://www.gov.uk/government/uploads/system/uploads/attachment_data/file/541818/Family_reunion_guidance_v2.pdf)
- Home Office (2017a). *Permission to work*. Available from: [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/583192/Permission-to-work-v7.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/583192/Permission-to-work-v7.pdf)
- Home Office (2017b). *Immigration Rules – Appendix K: Shortage occupation list*. Available from [www.gov.uk/guidance/immigration-rules/immigration-rules-appendix-k-shortage-occupation-list](http://www.gov.uk/guidance/immigration-rules/immigration-rules-appendix-k-shortage-occupation-list)



- House of Lords (2016). *Children in crisis: Unaccompanied migrant children in the EU: European Union Committee, 2nd Report of Session (HL 2016–17 (34))*. London: The Stationary Office.
- Hulusi, H.M. & Oland, L. (2010). Making sense of transitions through narrative-supporting newly arrived children and young People. *Journal of Emotional and Behavioural Difficulties*, 15(4), 341–351.
- Ibarra, H. & Barbulescu, R. (2010). Identity as narrative: Prevalence, effectiveness, and consequences of narrative identity work in macro work role transitions. *Academy of Management Review* 35(1), 135–154.
- Kinzie, J.D., Sack, W.H., Angell, R.H. et al. (1986). The psychiatric effects of massive trauma on Cambodian children: I. The children. *Journal of the American Academy of Child and Adolescent Psychiatry*, 25, 370–376.
- Koen, J., Klehe, U.-C. & van Vianen, A.E.M. (2013). Employability among the long-term unemployed: A futile quest or worth the effort? *Journal of Vocational Behavior*. 82(1), 37–48.
- Koen, J., Klehe, U.-C. & van Vianen, A.E.M. (2012). Training career adaptability to facilitate a successful school-to-work transition. *Journal of Vocational Behavior* 81(3), 395–40.
- Lane, P. & Tribe, R. (2010). Following NICE 2008 – A practical guide for health professionals: Community engagement with local black and minority ethnic (BME) community groups. *Diversity, Health & Care*, 7(2), 105–14.
- McKee-Ryan, F.M. & Maitoza, R. (2014). *Job loss, unemployment, and families. The Oxford handbook of job loss and job search*. Oxford: Oxford University Press.
- Klehe, U.-C., van Hooft, E.A.J. & McNeill, K. (2016). *Evidence to House of Lords Committee (Q34 in HL 2016 (34))*.
- Majumder, P., O'Reilly M., Karim, K. & Vostanis, P. (2015). 'This doctor, I not trust him, I'm not safe': The perception of mental health and services by unaccompanied refugee adolescents. *The International Journal of Social Psychology*, 61(2), 129–136.
- Mghir, R.W., Freed, W., Raskin, A. & Katon, W. (1985). Depression and post-traumatic stress disorder among a community sample of adolescent and young adult Afghan refugees. *Journal of Nervous and Mental Disease*, 183, 24–30.
- Mills, C. (2014). *Decolonizing global mental health: The psychiatrization of the majority world*. Routledge: London & New York.
- Migration Observatory briefing Report (2016). Retrieved 22 May 2016 from: [www.migrationobservatory.ox.ac.uk/wp-content/uploads/2016/04/Briefing\\_Asylum.pdf](http://www.migrationobservatory.ox.ac.uk/wp-content/uploads/2016/04/Briefing_Asylum.pdf).
- Mulongo, P., McAndrew, S. & Hollins Martin, C. (2014). Crossing borders: Discussing the evidence relating to the mental health needs of women exposed to female genital mutilation. *International Journal of Mental Health Nursing*, 23(4), 296–305.
- National Institute for Clinical Excellence (NICE) (2005). *Post-traumatic stress disorder: The management of PTSD in adults and children in primary and secondary care*. London: Gaskell and The British Psychological Society.

- NICE Guidelines (2005). *Post-traumatic stress disorder management*. Available from <https://www.nice.org.uk/Guidance/cg26>
- Nice Guideline (2016). *NG44: Community engagement*. Available from: [www.nice.org.uk/guidance/ng44](http://www.nice.org.uk/guidance/ng44)
- Nickerson, A., Bryant, R.A., Silove, D. & Steel Z. (2011). A critical review of psychological treatments of posttraumatic stress disorder in refugees. *Clinical Psychology Review*, 31(3), 399–417.
- Nosè, M., Ballette, F., Bighelli, I. et al. (2017). Psychosocial interventions for post-traumatic stress disorder in refugees and asylum seekers resettled in high-income countries: Systematic review and meta-analysis. *PLOS One* 12(2), e0171030. doi:10.1371/journal.pone.0171030
- O'Brien, J. & Forest, M. (1989). *Action for inclusion*. Toronto: Inclusion Press.
- Papadopoulos, R.K. (2007). Refugees, trauma and adversity-activated development. *European Journal of Psychotherapy and Counselling*, 9(3), 301–312.
- Patel, N. & Granville-Chapman, C. (2010). *Clinical guidelines for the health assessment and documentation of torture*. London: Medical Foundation with the Department of Health.
- Patel, N. (2003). Clinical psychology: Reinforcing inequalities or facilitating empowerment? *The International Journal of Human Rights*, 7(1), 16–39.
- Patel, N. (2017a). Psychological assessment and documentation of torture in detention. In J. Beynon & J. Payne-James (Eds.), *Monitoring and documenting conditions of detention, custody, torture and ill-treatment: A practical guide* (in press). London: Taylor-Francis.
- Patel, N. (2017b). The mantra of do no harm in international healthcare responses to refugee people. In B. Drozdek & T. Wenzel (Eds.), *The health of refugees: An interdisciplinary perspective* (in press). Rotterdam: Springer.
- Patel, V. & Prince, M. (2010). Global mental health. A new global health field comes of age. *Journal of the American Medical Association*, 303, 1976–7.
- Pearpoint, J., O'Brien, J. & Forest, M. (2001). *PATH. Planning Alternative Tomorrows with Hope. A work book for planning possible futures*. Toronto: Inclusion Press.
- Pernice, R. & Brook, J. (1996). Refugees' and immigrants' mental health: Association of demographic and post immigration factors. *Journal of Social Psychology*, 136(4), 511–9.
- Raybould, E.C. & Solity, J.E. (1988). More questions on precision teaching. *British Journal of Special Education* 15(2), 59–61.
- Rees, M., Blackburn, P., Lab, D. & Herlihy, J. (2007). Working with asylum seekers in a Clinical setting. *The Psychologist*, 20(3), 162–163.
- Refugee Council (2014). *Employing refugees guide*. Available from: [www.refugeecouncil.org.uk/assets/0003/4097/Employing\\_Refugees\\_-\\_Guide\\_to\\_documents\\_required\\_Dec\\_2014.pdf](http://www.refugeecouncil.org.uk/assets/0003/4097/Employing_Refugees_-_Guide_to_documents_required_Dec_2014.pdf)
- Refugee Action. (2016). [www.refugeeaction.org.uk](http://www.refugeeaction.org.uk)
- Refugee Council (2017). [www.refugeecouncil.org.uk](http://www.refugeecouncil.org.uk)

- Refugee Mental Health & Wellbeing Portal (2016). Available from [www.uel.ac.uk/Schools/Psychology/Research/Refugee-Mental-Health-and-Wellbeing-Portal](http://www.uel.ac.uk/Schools/Psychology/Research/Refugee-Mental-Health-and-Wellbeing-Portal)
- Robertson, M.E.A., Blumberg, J.M., Gratton, J. et al. (2013). A group-based approach to stabilisation and symptom management in a phased treatment model for refugees and asylum seekers. *European Journal of Psychotraumatology*, 4, 10.3402/ejpt.v4i0.21407.
- Robjant, K., Hassan, R. & Katona, C. (2009). Mental health implications of detaining asylum seekers: Systematic review. *British Journal of Psychiatry*, 194(4), 306–312.
- Rutter, J. (2006). *Refugee children in the UK*. Buckingham: Open University Press.
- Rutter, J. (2015). *Moving up and getting on: Migration, integration and social cohesion in the UK*. Bristol: Policy Press.
- Sack, W., Him, C. & Dickason, D. (1999). Twelve-year follow-up study of the Khmer youths who suffered massive war trauma as children. *Journal of the American Academy of Child and Adolescent Psychiatry*, 38, 384–391.
- Silove, D., Austin, P. & Steel, Z. (2007). No refuge from terror: The impact of detention on the mental health of trauma-affected refugees seeking asylum in Australia. *Transcultural Psychiatry*, 44(3), 359–93.
- Slobodin, O. & de Jong, J.T. (2015). Mental health interventions for traumatized asylum seekers and refugees: What do we know about their efficacy? *The International Journal of Social Psychiatry*, 61(1), 17–26.
- Summerfield, D. (2001). The invention of post-traumatic stress disorder and the social usefulness of a psychiatric category. *British Medical Journal*, 322, 95.
- Summerfield, D. (2012). How scientifically valid is the knowledge base of global mental health. *British Medical Journal*, 336(7651), 992–994.
- Tribe, R. (2007). Health pluralism: A more appropriate alternative to Western models of therapy in the context of the conflict and natural disaster in Sri Lanka? *Journal of Refugee Studies*, 20(1), 21–36.
- Tribe, R. (2010). Mental health of refugees and asylum seekers. In D. Bhugra, S. Cross & R. Bhattacharya (Eds.), *Cultural topics in clinical psychiatry* (pp.27–38). London: Royal College of Psychiatrists Press.
- Tribe, R. (2014). Culture, politics and global mental health: Deconstructing the global mental health movement: Does one size fits all? *Disability and the Global South*, 1(2), 251–265.
- Tribe, R. & Patel, N. (2007a). Refugees and asylum seekers. *The Psychologist*, 20(3), 149–151.
- Tribe, R. & Patel, N. (2007b). The mental health needs of refugees and asylum seekers. *Special Edition of The Psychologist*, 20(3), 149–166.
- Tribe, R. & Tunariu, A. (2017; in press) Psychological Interventions and Assessments. In D. Bhugra & K. Bhui (Eds.), *The textbook of cultural psychiatry*. Cambridge: Cambridge University Press.

- Turner, S., Bowie, C., Dunn, G. et al. (2003). Mental health problems in a large community study of Kosovan Albanian refugees in the UK. *British Journal of Psychiatry*, 182, 444–448.
- United Nations (1987). *Convention on the rights of the child CRC*. New York: United Nations.
- UNHCR (1983). *Guidelines on reunification of refugee families*. Available from: [www.unhcr.org/uk/protection/globalconsult/3bd0378f4/unhcr-guidelines-reunification-refugee-families.html](http://www.unhcr.org/uk/protection/globalconsult/3bd0378f4/unhcr-guidelines-reunification-refugee-families.html)
- UNHCR (1994). *Refugee children: Guidelines on protection and care*. Available from: [www.unhcr.org/uk/protection/children/3b84c6c67/refugee-children-guidelines-protection-care.html](http://www.unhcr.org/uk/protection/children/3b84c6c67/refugee-children-guidelines-protection-care.html)
- van der Veer, G. (1998). *Specific issues in working with refugees: Counselling and therapy with refugees and victims of trauma* (pp.161–168). John Wiley & Sons: Chichester.
- Welsh Refugee Council (2017). [www.welshrefugeecouncil.org](http://www.welshrefugeecouncil.org)
- White, R (2013). The globalisation of mental illness. *The Psychologist*, 26(3), 182–185.
- Yap, S.Y., Byrne, A. & Davidson, S. (2010). From refugee to good citizen: A discourse analysis of volunteering. *Journal of Refugee Studies*. 24(1),157–170.
- Yule, W., Dyregrov, A., Raundalen, M. & Smith, P. (2013). Children and war: The work of the Children and War Foundation. *European Journal of Psychotraumatology*, 4, 18–24.
- Yule, W., Dyregrov, A., Straume, M. & Kraus, F. (2011). *Children and grief: Teaching life skills*. Bergen: Children and War Foundation.
- Zikic, J. & Richardson, J. (2016). What happens when you can't be who you are: Professional identity at the institutional periphery. *Human Relations* 69(1), 139–168.
- Zivcic, I. (1993). Emotional reactions of children to war stress in Croatia. *Journal of the American Academy of Child and Adolescent Psychiatry*, 32, 709–713.

## Useful resources

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**Refugee Mental Health Portal** has a range of information for practitioners and refugees and asylum seekers extensive list of resources and services for refugees and asylum seekers. The portal is updated regularly.

[www.refugeementalhealthportal.org.uk](http://www.refugeementalhealthportal.org.uk).

[www.uel.ac.uk/Schools/Psychology/Research/Refugee-Mental-Health-and-Wellbeing-Portal](http://www.uel.ac.uk/Schools/Psychology/Research/Refugee-Mental-Health-and-Wellbeing-Portal)

**Refugee Councils** provide a range of useful information, which would be helpful to both service users and psychologists, much of it is available in a range of languages. This includes information about seeking asylum in the UK, for unaccompanied young people and helpful advice for people working with asylum seekers and refugees as well as support for some asylum seekers and refugees who sadly become destitute.

**Scottish Refugee Council** [www.scottishrefugeecouncil.org.uk](http://www.scottishrefugeecouncil.org.uk)

**The Refugee Council** [www.refugeecouncil.org.uk](http://www.refugeecouncil.org.uk)

**The Refugee Council** also provides a therapeutic service at its London office, (london.therapeutic@refugeecouncil.org.uk). The work they undertake includes individual counselling of up to 12 sessions, gender-sensitive services for women who have suffered sexual or domestic violence, individual counselling for men, psycho-educational therapeutic workshops, mother and toddler groups, support for young people, culture and language skills groups and educational classes. They also provide a range of services and training for people working with refugee and asylum seekers. The children's team can be contacted for email advice on [children@refugeecouncil.org.uk](mailto:children@refugeecouncil.org.uk) and the website contains an online referral form for advisers.

**Welsh Refugee Council** [www.welshrefugeecouncil.org](http://www.welshrefugeecouncil.org)

**UK Visas and Immigration** [www.gov.uk/government/organisations/uk-visas-and-immigration](http://www.gov.uk/government/organisations/uk-visas-and-immigration)

**British Red Cross Family Tracing Service:** [www.redcross.org.uk](http://www.redcross.org.uk)

**ICAR (Information Centre about Asylum and Refugees in the UK)** [www.icar.org.uk](http://www.icar.org.uk)

**Immigration Lawyers Practitioners Association** [www.ilpa.org.uk](http://www.ilpa.org.uk)

**National Crime Agency National Referral Mechanism** – for supporting survivors of trafficking [www.nationalcrimeagency.go.uk](http://www.nationalcrimeagency.go.uk)

**Refugee Assessment and Guidance Unit (RAGU)** offers training for people working with refugees and asylum seekers, though this is focussed largely on employment issues ([www.londonmet.ac.uk/ragu](http://www.londonmet.ac.uk/ragu))

**Refugee Action** [www.refugee-action.org.uk](http://www.refugee-action.org.uk)

## Additional resources

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**BPS Guidelines on Working with interpreters in health settings**

[www.bps.org.uk/policy-research-guidelines](http://www.bps.org.uk/policy-research-guidelines)

Working with interpreters in mental health training film: [www.youtube.com/watch?v=k0wzhakyjk](http://www.youtube.com/watch?v=k0wzhakyjk).



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