Editorial/introduction for the IRP Edition on Forced Migration & Mental Health

Rachel Tribe, Farkhondeh Farsimadan & Claire Marshall

Forced migration is a well- known and understood but relatively poorly studied phenomenon. A forced migrant is a person who was subject to a migratory movement in which a degree of coercion is applied, whereas a voluntary migrant freely chooses to move to a different country. The term forced migrant, although contested, is generally understood to include refugees and asylum seekers, people who have been trafficked, survivors of modern slavery and may include those who have been part of a family reunification process. Reasons for having to migrate might include threats to life and livelihood (e.g., arising from natural or man-made causes) because of war, organised violence (including torture), persecution on grounds of ethnicity, sexuality, religion, gender, climate change or for another reason. For practitioners supporting people to prepare and negotiate the complex issues associated with becoming a forced migrant at the individual, familial, community, agency or organisational level, clinical knowledge and expertise can often be useful.

It is important to note that, issues relating to culture, religion, idioms of distress, explanatory health beliefs and the meaning-making of forced migrants require foregrounding. It is often assumed that models of psychiatric, psychological and psychosocial practice developed in high income countries are generalisable worldwide, this is not always the case.

Definition of terms

It may be helpful to briefly differentiate the terms 'asylum seeker' 'refugee' a 'stateless person' and an 'internally displaced person';

- an asylum seeker is someone who is applying for asylum in a new country,
- a refugee is someone who has been granted legal refugee status under the UN 1951 Refugee Convention.
- a stateless person refers to a person who is not a citizen of any country. Accessing any services for a stateless person can be extremely difficult. There are an estimated 43 million stateless people worldwide (UNHCR, 2021).
- an internally displaced person (IDP) is someone who has been forced to flee to another area within their country of origin.

Sometimes an asylum seeker will describe themselves as a refugee, as they are using the term generically. Whilst this might appear irrelevant to a clinician, the different legal status awarded will determine access to government services and support in some countries and therefore, access to mental health services. Very few refugees and asylum seekers are able to flee to high income countries. 73% of people flee to neighbouring countries, many of which are low- and middle-income countries. These countries end up hosting 85% of the total number of people fleeing their home country (UNHCR, 2022). Details about legal status can be located at www.help.unhcr.org/asylum/

One important factor to consider when undertaking mental health work is the time a person may have to wait or is waiting to discover if refugee status has been granted to them. Dealing with uncertainty and fears about the future with the possibility of deportation a constant concern, can be a very difficult and challenging time for people applying for asylum. The

time the individual may wait will vary between countries, in the UK it is likely to vary from between 6 months to several years (Refugee Council, 2022). Lack of perceived control over one's own life situation has been found to contribute to increased psychological distress in non-western immigrants, (Dalgard, 2010). The experience of temporary accommodation either whilst on the migratory journey (such as a refugee camp) or when arriving at the destination country (for example detention centres) may also contribute to the experience of 'waiting' and lack of control over one's situation (Marshall, 2021a; 2021b). Jannesari et. al.'s (2020) systematic review found that asylum seekers compared to refugees and other migrant groups, are at increased risk of mental ill health.

Geopolitics

International and national geopolitics will also determine to some degree, which countries people are forced to flee from. The burgeoning area of Geopsychiatry is highly relevant here (Castaldelli-Maia & Bhugra, 2022). Nationalities of people arriving will change over time. A person's nationality may mean they receive more favourable treatment by the governments of the receiving countries. For example, Ukrainians in the UK or some other European countries are currently treated differently, compared to people seeking refuge from other countries within Asia and Africa. There are a range of different schemes across Europe, but many governments have been extremely welcoming. In the UK, there are two schemes, the Ukrainian Family scheme and the Homes for Ukraine scheme. If Ukrainian refugees come to the UK under one of these schemes, they will be given a visa which entitles them to remain for three years in the first instance. They automatically have the right to work and to access public funds including welfare payments. Whereas asylum seekers from other countries have to apply for asylum, they cannot work unless their claim for asylum is outstanding for 12 months "through no fault of their own" and then they can only undertake jobs on the shortage occupation list published by the British Home Office (Home Office, 2022). Asylum seekers will be housed in hostels, bed and breakfast accommodation or a flat. They generally have no recourse to public funds (NRPF) (which includes access to mainstream welfare or housing benefits (Home Office, 2022). Each person (including children) currently receives £40.85 (less than 50 $ US dollars or 49 Euros) a week to cover clothing, food, and other expenses (Home Office, 2022).

Mental health Services

Many people forced to migrate will have experienced adverse experiences in their country of origin, as well as difficult and risky journeys. They may have experienced multiple losses and changes and may have had little opportunity to process these experiences. Some may benefit from the services of clinicians, whilst others may prefer to use different means including but not limited to community or familial support (Williams & Stewart-Brown, 2021); focused activities (Nattel & Juen ,2017); and religious or cultural practices (Hammad & Hamid, 2021). Refugee Community groups often offer a range of extremely helpful activities, undertaken from a position of understanding about the relevant culture, and frequently available in the mother tongue (British Psychological Society, 2018; Chase & Rousseau, 2018). They may also share an understanding relating to how mental health is understood and what help- seeking behaviour/s may be employed (Tribe, 2019; Lloyd et al, 2022). Thus, clinicians are recommended to undertake useful collaborative or liaison work with refugee community groups or charities when working with forced migrants (Tribe & Tunariu 2018; British Psychological Society, 2018). The British Home Office (2022) has

initiated the Asylum Seeker therapeutic Support grant to enable third sector organisations and others to bid for the delivery of trauma informed stabilisation and other services for vulnerable asylum -seeking adults.

People who have experienced forced migration may also face racism, discrimination, poverty, social exclusion, loss of professional roles and previous identity, other multiple losses and adjustments, whilst dealing with a new culture and language, all of which are likely to adversely impact on their psychological wellbeing and/or mental health, at least initially. Clinicians thus need to be aware of the role of culture and religion when offering clinical interventions, training, consultancy, support or supervision; to ignore or minimise this may lead to poor initial engagement or high drop-out rate from services and interventions

Mental health services may be viewed by some as not appropriate to their needs and not accessible for a number of reasons, including government restrictions on access to services, language barriers (Tribe & Thompson, 2022), prohibitions on access to secondary care (Boyles et al, 2022), different help-seeking behaviours or concerns about authorities and government systems (Satinsky et al, 2019 but also on their explanatory models). In a systematic review on women asylum seekers and refugees in high income countries, Desa et. al., (2021) found that there may be under reporting of mental health issues owing to the stigma associated with mental illness in some communities of people who have been forced to migrate. Evidence shows that people from ethnic minority groups tend to access mental health services less (Memon et. al., 2016). In a review of refugees and asylum seekers residing in Europe, Satinsky et. al. (2019) noted a much lower rate of utilisation of mental health and psychosocial services (MHPSS) compared to the host population in a number of countries.

Clinicians may need to be innovative and tailor their methods of engagement to the individual, taking into account their forced migrant client's ethnicity and culture. Although, culture can be viewed in an essentialist, reductionistic, reified and on occasions racist or stereotyped manner, which fails to account for the whole individual and their individualism as meaning making, especially within a cultural context, is fluid and not static. Mental health services exist in myriad and diverse forms, which may include innovative methods of group work or other creative, sporting, or 'social prescription' activities to engage or meet the needs of service users (Tribe &Tunariu, 2018; Summers, 2022). Accessing conventional mental health services may not be in the help-seeking repertoire of some people who have been forced to migrate (Miller 1999; Bhugra & Gupta, 2011; Desa et al, 2021). Social prescribing may be helpful in providing a number of benefits and has the potential to contribute to the development of a sense of social inclusion and social capital, as well as focussed and meaningful activity. Zhang, (2021) in a systematic review on social prescribing and international migrants, noted that after taking part, participants often described increased confidence and self-esteem, feelings associated with empowerment, and increased social connections. The outcome research on social prescribing is in its early stages and it is unclear what percentage of the migrants in this review were forced to leave their original home. Therefore, these findings need to be approached with caution as it is unclear if they are more widely generalisable.

Clinicians might fear they are ill-informed about the person's country and culture of origin, and any others that may be informing their experience (for example countries they may have

travelled through on the way to the destination country). No clinician can expect to know about the politics, history, culture etc. of all countries but being aware of some basic cultural conventions and norms around psychological and emotional distress and wellbeing and help-seeking behaviours often goes a long way in assisting understanding and communication between the parties. However, clinicians should not see the forced migrant person as a 'victim' and must try to recognise their strength and resilience. Clinicians should also guard against seeing all forced migrants as one homogonous group without appreciating the nuance of an individual's socio-political-culturally mediated experience.

Understanding forced migration and meaning-making

How an experience of forced migration is understood by an individual will be influenced by a range of factors. These may include, but are not limited to, whether they were forced to migrate alone or with family members, the current political situation in their home country, their sense of belonging and acculturation but also acceptance by the new country, their age, social support and resources, their personal and mental health history before they fled, their experiences pre, during and post flight, and any experiences of organised violence and torture. How an individual has understood the reasons for having to migrate may also be an important consideration when trying to understand their experience.

The prevalence of mental illness in forced migrant populations is a complex and contested area, (BHUGRA, 2021; Summerfield, 1999; Bogic, et al, 2015; Blackmore et al ,2020; FAZEL et al, 2012). While some important and informative studies have been conducted, there are also some contentious issues. For instance, a number of studies using various measures and populations have been reviewed, with some studies focussing on one diagnosis and how prevalent that is within a particular sub-group, some showing higher levels and others less so. Some studies report high levels of PTSD and complex PTSD diagnoses in adults, (DeSa et al., 2021) and in children (Blackmore et al, 2020). Other studies report high levels of depression and anxiety diagnosis in adolescents (Slodnjak et al, 2002). Many studies focussed largely on forced migrants in high income countries, a group who represent only a minority of forced migrants worldwide. There is also the issue of how researchers have measured psychiatric diagnostic categories as some have used checklists, others clinical interviews, some interviews and some have utilised measures validated with different populations often developed in high income countries. The diagnostic manual used (e.g., DSM or ICD) may also be a relevant consideration when interpreting the findings of such studies. Inevitably these measures will have incorporated the cultural norms of that society, which may not be applicable to all refugees.

Some studies have looked at one nationality (Tinghog et al, 2017), conflated asylum seekers and refugees into one group, or failed to account for a history of torture or organised violence. In addition, pre and post migration experiences have been frequently ignored in research. Furthermore, the figures relating to asylum seekers who are held in detention are complex, by this we mean that on occasions they are difficult to interpret; sometimes a range of mental health disorders are conflated, and finally the samples often contain mixed participant groups of those who are seeking asylum combined with other groups (Sen et al., 2018). Therefore, the findings and interpretations drawn from this research may, on occasions, be problematic and may not always be relevant to the service user in front of the

clinician. Using diagnostic categories may be problematic for the clinician, but some government agencies will use a formal diagnosis as a way of gate keeping access to services or to the granting of asylum. The issue of stigma, which is frequently associated with mental health issues, may also need consideration as this may be constructed differently around the globe (Hammad & Hamid, 2021). Whilst some refugees and asylum seekers will find any kind of diagnosis extremely stigmatising, some will welcome it. This can put the clinician in a complex position.

<u>The overarching narrative</u>

The overarching narrative about asylum seekers and refugees in any country may influence the refugee and asylum seeker as well as the clinician. Some refugees and asylum seekers will have experienced organised violence and torture, and some may have been trafficked. Details of these experiences may be difficult for a clinician to hear, which may need active consideration by the clinician to minimise potential avoidance or the possibility of vicarious trauma or distress. Clinicians should also try and avoid excessive labelling or pathologizing of the responses of forced migrants and consider the context and experiences which gave rise to these responses. Some forced migrants will undoubtedly require clinical assistance, and several of the papers in this special edition discuss various ways of responding to mental health needs and improving provision of mental health services for this group. For many people who have experienced forced migration, it might be helpful for clinicians to consider their distress in the context of their reactions as being normal responses to abnormal events. Nevertheless, clinicians should be mindful that how their forced migrant client's distress is presented and understood may be influenced by cultural and religious frameworks. Similarly, as mentioned above, idioms of distress and explanatory health models may also be culturally located. In summary, "*It's absolutely critical that we do not medicalise their distress and instead help refugees and asylum seekers to come to terms with, and eventually recover from, the trauma they've experienced. There will also be some refugees and asylum seekers that may develop a mental illness, and for those we will need to identify the additional specialist mental health support that is needed."* Adrian James, President of the Royal College of Psychiatrists, (2022)

This themed issue of the journal contains papers which have consistently considered the role of culture and religion to varying degrees as *well* as asymmetries of power. If services are perceived as inappropriate, inaccessible, or stigmatising by forced migrants themselves, they will be unable to benefit from them. Furthermore, if clinicians are not open and curious about not only how the individual understands their experience of forced migrant and distress but the cultures they come from, the clinical engagement may be affected. The experience of flight to a different country for forced migrants (frequently at short notice and sometimes to unknown locations) is likely to impact upon their wellbeing in the short term, (Tribe & Jalonen 2021) although in the longer term, this does not stop many forced migrants making significant contributions to their destination country in a diverse range of ways (Farsimadan, 2021). In this themed issue of the Journal, there are a variety of papers covering a number of issues relating to mental health and forced migration within the UK and internationally.

The special edition starts with a paper which provides guidance for clinicians when working with refugees and asylum seekers. These guidelines cover a range of areas where clinicians

work with individuals, couples, families and community organisations which may include clinical contexts, schools, nurseries, colleges and within community organisations.

The next paper is entitled Trauma and resettlement- lessons learned from a mental health screening and treatment program for Syrian refugees located in the UK. This paper details the importance of understanding the context of service users' lives and describes some of the challenges the clinic staff experienced as well as providing opportunities to reflect upon, explore and consider the context of their work, as well as making suggestions for future service provision.

This is followed by report commissioned by Lord Dubs (*former Chief Executive of the Refugee Council, a lifelong campaigner for refugees and sponsor of the "Dubs Amendment" to the Immigration Act 2016) on* Child Refugees, what are our responsibilities? This report was presented at the House of Lords and presents an overview of the importance of mental health services for unaccompanied asylum-seeking children in the UK.

The next paper is on Working with interpreters when working with forced migrants in mental health. If refugees and asylum seekers do not yet speak the language of the country they have fled to, or at a level that they can work with a clinician, they will be unable to access mental health services and an interpreter will be required, the paper provides some guidance on working effectively with an interpreter in mental health.

A paper looking at Latinx adolescent migrant challenges in reuniting with family members in the USA is then presented, which raises a number of important issues. Family roles and relationships may become fragmented or estranged, as family members experience and understand the process and reasons for becoming a forced migrant through different lenses and may acculturate or assimilate to the host culture at different rates due to factors including age, gender, language and other factors. In this paper some of the participants blamed their mothers for being forced to migrate. It appeared that although they may have had little choice in doing so, these mothers then had to deal with this blame, in addition to readjusting to changed family dynamics and roles. Furthermore, families may experience difficulties reuniting post-migration, particularly when the reasons for flight are not openly discussed or are understood differently by family members. This, combined with developmental challenges for young people and their parents/carers, and intergenerational differences in acculturation could give rise to family conflicts and discord.

This is followed by a paper on suicide prevention training programme in Syria which describes a suicide prevention training programme in Syria. Cultural and religious issues relating to suicide are relevant in many religions. However, whilst studying suicide among Muslim populations the impact of religion and culture on the behaviour being studied (e.g., suicide) needs to be fully incorporated into the study's design and methodology to yield more culturally informed findings. In many Islamic countries data on suicide rates is difficult to obtain as the religion proscribes the act, so faced with attempted suicide or self-harm behaviours the clinician as well as the researcher has to take the religious/spiritual framework into account in order to improve therapeutic as well as research engagement.

A second report which looks at learning for educators and learners when educating forcibly displaced students looks specifically at some of the structural barriers, including the absence of psycho-social and academic support which can make higher education access for forcibly displaced students challenging, as well as how some of these challenges can be met. This is

followed by a paper on Humanitarian interventions and Psychosocial Training Programmes, which notes the lack of evidence-based research examining the training of humanitarian professionals, as well as discussing the importance of decolonisation, before reviewing an on-line training programme which has participants from a range of countries.

The final paper provides a critique of The inter-agency standing committee (IASC) guidelines on mental health and psychosocial support (MHPss) in Emergency Settings, drawing attention to the uncritical use of a biomedical model and the cultural appropriateness of using a framework of psychopathology when working inter-culturally in emergency settings.

The Special Edition finishes with a Book review of the book entitled "When they came for me", which details the experiences of a group psychotherapist who was detained and tortured by the pro-apartheid South African authorities. During this time, the author kept a secret diary which the book includes as well as their reflections on this life-changing experience fifty years later.

Agencies working with forced migrants:

There are a range of agencies clinicians may find useful when working with service users who have experienced forced migration. These include:

The United Nations High Commission on Refugees (UNHCR)

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.

https://www.unhcr.org/uk/

Refugee Council

Many countries have national Refugee Councils which provide a range of information (often in a variety of languages) as well as local refugee community groups, who often provide a wealth of information and support to refugees and asylum seekers.

https://www.refugeecouncil.org.uk

International Commission of the Red Cross /Crescent (ICRC)

https://www.icrc.org/en

Royal College of Psychiatrists

https://www.rcpsych.ac.uk/news-and-features/latest-news/detail/2022/04/12/royal-college-of-psychiatrists-launches-new-resource-to-support-the-mental-health-of-asylum-seekers-and-refugees

University of East London Refugee Mental Health and Wellbeing Portal

University of East London hosts Refugee Mental Health and Wellbeing Portal can be utilised as a first stop resource centre by refugees and asylum seekers themselves and mental health and social care professionals, organisations and agencies working with them nationally and worldwide. The portal contains a variety of resources for children and adult refugees and asylum seekers which are updated on a yearly basis. The portal can be accessed via link below:

https://www.uel.ac.uk/our-research/research-school-psychology/refugee-mental-health-wellbeing-portal

References

Bhugra, D. & Gupta,S. (2011) (Eds) *Migration and Mental Health.* Cambridge: Cambridge University Press 263--275

Bhugra, D. (2021) Oxford Textbook of Migrant Psychiatry.: Oxford: Oxford University Press

Blackmore, R., Boyle, J. A., Fazel, M., Ranasinha, S., Gray, K. M., Fitzgerald, G., Misso, M., & Gibson-Helm, M. (2020). The prevalence of mental illness in refugees and asylum seekers: A systematic review and meta-analysis. *PLoS medicine*, *17*(9), e1003337. https://doi.org/10.1371/journal.pmed.1003337

Bogic, M., Njoku, A., and Priebe, S. (2015). Long-term mental health of war-refugees: A systematic literature review. *BMC Int Health Hum Rights*, 15(29). https://doi.org/10.1186/s12914-015-0064-9.

Boyles, J., Ewart-Biggs, R., Kazembe, J., Miller, J. & Oliver, K. (2022) Seeking Asylum in the United Kingdom in Maloney, C., Nelki, J. & Summers, A.(eds) Seeking Asylum and Mental Health A Practical Guide for Professionals. Cambridge: Cambridge University Press

British Psychological Society Guidelines for Psychologists working with Refugees and Asylum-seekers in the UK: Extended version. (2018). Leicester: BPS publications

British Psychological Society Guidance for Psychologists on Working with Community organisations (2018) Leicester: BPS publications

Castaldelli-Maia, J.M., & Bhugra, D. (2022) What is geopsychiatry? *International Review of Psychiatry, 34:1, 1-2,* DOI: 10.1080/09540261.2022.2031915

Chase, L.E. & Rousseau, C. (2018). Ethnographic case study of a community day centre for asylum seekers as an early-stage mental health intervention*, American journal of Orthopsychiatry, 88,48-58*

Dalgard , O. S. (2010). Immigration, psychosocial factors and psychological stress, with focus on perceived control and social integration. *In Immigration and Mental Health. L. Sher and A. Vilens (Eds). Nova Science Publishers.*

Desa, S., Gebremeskel, A.T., Omonaiye, O. Yaya, S. (2022) Barriers and facilitators to access mental health services among refugee women in high-income countries: a systematic review. Systematic Reviews, 11:62https://doi.org/10.1186/s13643-022-01936-1

Farsimadan, F. (2021) Therapy and therapeutic considerations with Refugees and Asylum Seeker. In D. Moussaoui., D. Bhugra, R. Tribe. & A. Ventriglio (2021) (eds) *Migration, Mental Health and Mental Illness. Springer:Singapore.*

Fazel, M., Reed, R.V., Panter-Brick C., Stein, A. (2012). Mental health of displaced and refugee children resettled in high-income countries: risk and protective factors. The Lancet, December, 266- 282

Hammad, J. & Hamid, A. (2021) Migration and Mental Health of Arabic-speaking communities in D. Moussaoui., Bhugra,, R. Tribe. & A. Ventriglio (2021) (eds) *Migration Mental Health and Mental Illness. New York: Springer.*

Home Office, (2022) https://www.gov.uk/government/publications/handling-applications-for-permission-to-take-employment-instruction/permission-to-work-and-volunteering-for-asylum-seekers-accessible-version accessed 24.7.22

Home Office, (2022) https://www.gov.uk/government/publications/report-on-review-of-cash-allowance-paid-to-asylum-seekers/report-on-review-of-weekly-allowances-paid-to-asylum-seekers-and-failed-asylum-seekers-2021 accessed 24.7.22

Home Office, (2022) https://www.gov.uk/asylum-support/what-youll-get accessed 25.7.22

Home Office (2022) Asylum Seeker Therapeutic Support grant https://bidstats.uk/tenders/2022/W22/775750114

Jannesari , S. Hatch, C. Prin, M. & Oram, S .(2020) Post-migration Social–Environmental Factors Associated with Mental Health Problems Among Asylum Seekers: A Systematic Review *Journal of Immigrant and Minority Health* 22, 1055–1064

James. A. (2022) https://www.rcpsych.ac.uk/news-and-features/latest-news/detail/2022/04/12/royal-college-of-psychiatrists-launches-new-resource-to-support-the-mental-health-of-asylum-seekers-and-refugees

Lloyd, A., Wattis, L., Devanney, C. Bell, V. (2022) Refugee and Asylum Seeker Communities and Access to Mental Health Support: A Local Case Study. *Journal of Immigrant and Minority Health* https://link.springer.com/article/10.1007/s10903-022-01367-z

Marshall C. (2021a) Social and Political Agendas: The Securitisation of Migration and Detention as a Spectacle in D. Moussaoui., D. Bhugra,, R. Tribe. & A. Ventriglio (2021) (eds) Mental Health, Mental Illness and Migration. Mental Health and Illness Worldwide. Springer, Singapore. https://doi.org/10.1007/978-981-10-0750-7_40-1

Marshall C. (2021b) The Psychological Impact of Residing in a Refugee Camp in D. Moussaoui., D. Bhugra,, R. Tribe. & A. Ventriglio (eds) Mental Health, Mental Illness and Migration. Mental Health and Illness Worldwide. Springer, Singapore. https://doi.org/10.1007/978-981-10-0750-7_33-1

Memon A, Taylor K, Mohebati, L.M., et al (2016) Perceived barriers to accessing mental health services among black and minority ethnic (BME) communities: a qualitative study in Southeast England BMJ Open m:e012337. doi: 10.1136/bmjopen-2016-012337

Miller, K. (1999) Rethinking a familiar model; psychotherapy and the mental health of refugees, Journal of contemporary psychotherapy, 29,283-306

Nattel , J & Juen, C. (2017) An emerging approach to supporting the mental health of refugee and conflict-exposed populations. Lancet Psychiatry, 4, 274

Refugee Council, (2022) www. *https://www.refugeecouncil.org.uk* Accessed 23.6.22

Satinsk . E., Daniela C. , Fuhr A , Woodward, A. Sondorp, E , Roberts ,B. (2019) Mental health care utilisation and access among refugees and asylum seekers in Europe: A systematic review . Health Policy 123, 851–863

Sen P, Arugnanaseelan J, Connell E, Katona C, Khan AA, Moran P, Robjant K, Slade K, Tan J, Widyaratna K, Youd J, Forrester A. Mental health morbidity among people subject to immigration detention in the UK: a feasibility study. Epidemiol Psychiatr Sci. 2018 Dec;27(6):628-637. doi: 10.1017/S2045796017000269. Epub 2017 Jun 22. PMID: 28637536; PMCID: PMC6999003.

Slodnjak, V. Kos, A., Yule, W. (2002) Depression and Parasuicide in Refugee and Slovenian Adolescents. *Crisis The Journal of Crisis Intervention and Suicide Prevention 23(3):127-32*

Summers, A. (2022) Formulation and Diagnosis in C Maloney,, J. Nelki, J.,, & Summers, A. (eds) Seeking Asylum and Mental Health: A Practical Guide for Professionals London & Cambridge: Royal College of Psychiatrists and Cambridge University Press.

Summerfield, D. (1999) A critique of seven assumptions behind psychological trauma programmes in war affected areas. *Soc sci med, 49,1449-1462*

Tinghog, P., Malm, A., Arwidson, C., Sigvardsdotter, E , Lundin, A., Saboonchi, F. (2017) Prevalence of mental ill health, traumas and postmigration stress among refugees from Syria resettled in Sweden after 2011: a population-based survey BMJ Open, 7, 12 http://dx.doi.org/10.1136/bmjopen-2017-018899

Tribe, R & Tunariu, A. D. (2018) Psychological Interventions and Assessments in Bhugra, D. & Bhui, K. *The Textbook of Cultural Psychiatry.* Cambridge: Cambridge University Press 458-471

Tribe, R. (2019) Using co-production within mental health training when working with refugee or migrant community groups, *International Journal of Mental Health, 48:4, 330-337, DOI: 10.1080/00207411.2019.1693087*

Tribe, R. & Jalonen, A. (2021) Working with refugees and asylum seekers in D. Bhugra, (eds) *Oxford Textbook of Migrant Psychiatry:* Oxford: Oxford University Press *281-290*

UN Convention on Refugees (1951) https://www.unhcr.org/uk/1951-refugee-convention.html" https://www.unhcr.org/uk/1951-refugee-convention.html

UNHCR (2022) www.help.unhcr.org/asylum/

Williams, B & Stewart-Brown, S. (2021). Physical and Psychological Resilience and Migration in D. Bhugra, Oxford textbook of Migrant Psychiatry.: Oxford: Oxford University Press pp.232 - 239

Zhang, C.X., Wurie, F., Browne, A., Haworth, S., Burns, R., Aldridge, R., Zenner, D., Tran, A. Campos-Matos, I. (2021) Social prescribing for migrants in the United Kingdom: A systematic review and call for evidence. Journal of Migration and Health 4 [100067[doi.org/j.jmh.2021.100067