Bridging the Gaps

An Evaluation of the Women's Therapy Centre's Community Development Psychotherapy Service for women refugees and asylum seekers

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Thanks go particularly to all the women refugees and asylum seekers who took part in this evaluation. This evaluation would not have been possible had they not had the courage to talk through frequently very painful and distressing experiences.

Foreword

The Women's Therapy Centre has offered psychoanalytic psychotherapy for over 30 years. Throughout this time the service has continually evolved and developed in order to address the needs of diverse groups of women. At the heart of the service the core values have remained intact: providing high quality psychotherapy to women in a women only setting and making psychotherapy accessible.

By actively engaging with refugee and asylum seeker communities this project promoted an understanding of mental health, gave women the opportunity to have an understanding of psychotherapy and developed access to psychotherapy. This reflected the Women's Therapy Centre's commitment to making therapy accessible for diverse groups of women. This report demonstrates the effectiveness of the community development psychotherapy model and the positive outcomes for refugee and asylum seeker communities.

The report concludes with a number of recommendations for policy makers and commissioners, for psychotherapy training organizations and for the Women's Therapy Centre. We believe the recommendations, if implemented, will result in significant improvements in the quality of services offered to women from refugee communities and would urge that these recommendations are taken forward.

Ann Byrne
Chief Executive

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Executive Summary

There is a severe short fall in accessible psychotherapy suited to the needs of women refugees and asylum seekers.

Refugee and asylum seeking women face many barriers to accessing therapy, including: language and communication barriers, stigma, practical and economic problems, a lack of understanding of the needs of refugee women among providers of therapy, and a lack of understanding and trust on the part of therapy providers and of women from refugee communities seeking to access therapy.

To improve access to psychotherapy for women from refugee communities it is essential that agencies recognise, and, where possible, seek to address the practical barriers women face, including poverty, homelessness, social isolation and domestic and other gender based violence.

Psychoanalytic psychotherapy can help women who have been through very traumatic experiences and who feel that they cannot be healed. This model of therapy can provide support over a long period of time and does not seek to offer a 'quick fix' to women who are very vulnerable.

Cognitive Behavioural Therapies and other short term interventions may not be the most appropriate models of therapy for women who have survived torture, trafficking, exile, detention and gender based violence. For these women psychoanalytic psychotherapy can 'hear the unhearable' and allow them to 'speak the unspeakable', beginning a long process of recovery.

Psychoanalytic psychotherapy can help women, over time, to find their own solutions and identify their own strengths. For women who have been stigmatised and demonised both as asylum seekers and as survivors of gender based violence, to be treated in this way can be a uniquely powerful experience and one that offers them hope for the future.

There are few if any support services available specifically for front-line staff working with refugees and asylum seekers.

Staff who are themselves refugees can face a range of practical and emotional difficulties when delivering services to women from their own communities.

Specialist services aimed at improving access to therapy for women refugees and asylum seekers by taking therapy out into the community can improve access to, understanding of, and trust in therapy for women refugees and asylum seekers and are well received by refugee and asylum seeking women and staff working with these women.

Mainstream providers of mental health and psychological support services indicate a high level of interest in a community development model of providing psychological support services to asylum seekers and refugees.

Services aimed at improving access to therapy for women refugees and asylum seekers need to take into account how alien the concept of therapy can be to women from other cultures, as well as addressing issues such as stigma, language and cultural barriers, in a flexible manner.

Domestic violence within refugee communities can threaten the physical and psychological well being of both women refugees and asylum seekers using and providing services. Women with no recourse to public funds face greater threats to their physical and mental well being.

Chapter One
Introduction

Since 1976 the Women's Therapy Centre, a registered charity based in North London, has provided high quality individual and group psychotherapy for women facing complex issues, including depression, low self-esteem, violence and abuse, eating problems, racism, trauma, exile and loss. The Women's Therapy Centre has a reputation for the development of gender and culturally sensitive psychotherapy for women (and is cited as an example of good practice in the Department Of Health's publication Women's Mental Health: Into the Mainstream 2002).

The Women's Therapy Centre has developed its services for women who have traditionally not had access to psychotherapy including Black and minority ethnic women and refugees and asylum seekers. The Centre explicitly takes into account women's social and political circumstances and has sought to facilitate access for Black and minority ethnic women and other marginalised groups.

In 2006, the Women's Therapy Centre secured funding from Connecting Communities Plus a government funding scheme which sought 'to reduce race inequalities and tackle extremism'. This funding scheme was aimed at organisations committed to delivering projects and services to promote race equality and foster strong community relations. The Women's Therapy Centre secured three years funding from this scheme (due to a delay in funding being allocated to agencies, funding ran from July 2006 – March 2009), in order to develop and manage a Community Development Psychotherapy service and in so doing to:

- Employ a Community Development Psychotherapist, who speaks at least one community language or has experience of working with interpreters.
- Produce information (in community languages) about local mental health services and about the WTC's services, for refugee and asylum seeking women.
- Provide Information sessions for women using Refugee Community Organisation, which would give women information about mental health and services for women in London, including the services provided by the Women's Therapy Centre.
- Provide Therapy Taster sessions, to allow women an opportunity to explore their feelings and fears about using mental health services, and to offer them some insight into psychoanalytic psychotherapy and the benefits of such therapy.

- Provide six week Staff Support sessions for front-line staff and volunteers working in Refugee Community Organisations, many of whom are refugees themselves, who will have experienced some of the losses and traumas described by those to whom they are providing support.
- Develop a toolkit for agencies seeking to offer high quality services to women refugees and asylum seekers experiencing mental and emotional distress and to staff and volunteers working with them.
- Evaluate the impact the Information and Therapy Taster sessions and Staff Support sessions have on the numbers of women refugees and asylum seekers accessing mental health services and their attitude to these services.
- To disseminate the findings about what works with different community groups.

The Chief Executive of the Women's Therapy Centre when asked why the Centre had chosen to develop this service, replied there was "**a real sense that if we did not develop this service we would be excluding women from refugee and asylum seeking communities from accessing therapy**." She cited the following reasons:

- Many women from refugee and asylum seeking communities do not have the knowledge of services or the confidence and self esteem required to approach therapy services themselves. The need to develop routes into therapy by working alongside Refugee Community Organisations is therefore urgent.
- The stigma relating to all types of mental health problems among these communities is great and there is an urgent need to challenge the stigma by reaching out to community groups with information and support.
- While not everyone will necessary benefit from therapy at this moment in time it is important that women from refugee and asylum seeking communities have access to information about mental health and therapy services, information which is very rarely available to them.
- There is a strong sense in the literature and in the Women's Therapy Centre's work with other community groups that staff in Refugee Community Organisations are under considerable pressure and urgently need support to help them acknowledge and address their own needs. Only then will they be able to look after both their own mental health needs and that of their clients / service users.
- Agencies like the Women's Therapy Centre need to work with Refugee Community Organisations and other frontline agencies to ensure that the services that they offer women to help them manage their internal worlds, are informed by the realities of

women's external worlds, including the experiences of detention, persecution, gender based violence[1] destitution and severe isolation. Only then it will be possible for the Women's Therapy Centre and other therapy providers, to deliver services appropriate for and sensitive to the needs of women refugees and asylum seekers.

The Connecting Communities Plus funding was used to employ a Turkish speaking Community Development Psychotherapist from a refugee background, for the three year period. Initially she provided:

- Information sessions for service users
- Information sessions for staff
- Therapy Taster sessions for service users

In response to the needs identified during the first year of the project the following additional services were provided:

- The growing demand for therapy from the Women's Therapy Centre which arose as a consequence of this project resulted in the Women's Therapy Centre re-negotiating with A4E, who were managing the Connecting Community Plus funding programme. A4E then agreed that some of the grant awarded to the Women's Therapy Centre could be used to cover the cost of therapy for women refugees and asylum seekers. As a consequence, the Community Development Psychotherapist provided four hours of therapy each week, as well as delivering the outreach sessions from November 2007.

- Having identified some of the support needs of staff and volunteers working with refugee and asylum seeking women the WTC began to offer Reflective Practice sessions, in the second year of the project. These sessions were targeted at front-line staff and volunteers working in Refugee Community Organisations, many of whom were themselves refugees, who had experienced some of the losses and traumas described by those to whom they were providing support. The sessions provided women with a safe space where they could learn about the emotional and psychological impact of seeking asylum, explore their own responses to the loss and trauma that they faced in their work and identify how more supportive structures could be developed in their places of work.

[1] By gender based violence we are referring to crimes such as domestic violence, honour crimes, forced marriage or female genital mutilation.

All these services funded by the Connecting Communities Plus funding complements and enhances the Women's Therapy Centre's existing initiatives to improve access for women from refugee communities and other women living in exile including:

- The provision of mother tongue therapy
- The use of trained and experienced interpreters
- A Link Worker who supports women who are accessing therapy at the Women's Therapy Centre by assisting them with practical problems and signposting them to other support services in relation to housing, benefits and immigration issues.
- Support with child care and travel costs for refugees and asylum seekers.

In April 2007, the Women's Therapy Centre commissioned Madill Parker Research and Consulting to undertake an independent evaluation of the Community Development project in order to:

- review the aims and objectives of the Bridging the Gap Community Development Psychotherapy service for refugees and asylum seekers and of achievements in relation to these aims and objectives
- assess the impact of the service on the ability of women refugees and asylum seekers to access services at the Women's Therapy Centre
- assess the impact of the service on the outcomes for women refugees and asylum seeker's
- assess the impact of the service on women refugees and asylum seekers confidence in mental health and other therapeutic services
- review the impact of the service on community cohesion
- make recommendations for the future development of this service, including specifically what the Women's Therapy Centre could learn from this project and use to inform the scheme in future years.

This report is the final evaluation report. Chapter One consists of an introduction to the work of the Women's Therapy Centre and the project being evaluated. Chapter Two reviews the literature concerning women refugees and asylum seekers and their access to therapy. Chapter Three outlines the Methodology used. Chapter Four contains the findings of the evaluation and Chapter Five makes recommendations based on these findings.

Chapter 2

The Literature Review

This literature review seeks to identify:

1) Barriers to accessing therapy experienced by Refugees and Asylum Seekers.
2) Models of good practice to facilitate access to therapy by Refugees and Asylum Seekers.
3) Models / references in the literature to providing support to staff working with Refugees and Asylum Seekers, particularly staff who are themselves from RAS communities or living in exile.

The review was undertaken during May 2008 and draws on the UK and international literature.

Executive Summary

- A number of studies identify a severe shortfall across the UK of psychoanalytic psychotherapy, and other mental health services, that are specifically targeted at, and designed to meet the needs of, refugees and asylum seekers (RAS). This is identified as acting as a major barrier to access by RAS.

- It is noted further that RAS women have very specialised needs in the context of therapy provision, and that cultural factors and other specific circumstances need to be taken into account if therapy provision is to attract such women and then continue to meet their needs.

- Funding for and training of good-quality interpreters is widely identified as a vital factor in the success or otherwise of take-up of therapy by RAS.

- Funding for and training of bi-cultural therapists is also widely identified as being an important factor in attaining, and successfully retaining, RAS participation in psychotherapy provision.

- Psycho-social support, in the form of provision of practical help and social activities, including appropriate childcare provision, assistance with immigration matters, housing problems and broader health issues has been identified as contributing to the likelihood of RAS, particularly female RAS, being able to participate in a therapeutic environment, including psychotherapy provision.

- There is a substantial literature that addresses the fact that many cultures from which RAS originate stigmatise mental health issues, to the extent that all mental health issues are equated with ‘madness’. This stigma must be overcome, the literature suggests, if RAS are to feel comfortable accessing mental health services, including psychoanalytic psychotherapy provision.

- Models of good practice for overcoming such stigma have focused on recruiting volunteers from RAS communities, who can then liaise with community members in order to make inroads into changing attitudes to psychotherapy among RAS.

- There is a smaller literature on models for providing support to staff working with RAS, particularly staff who are themselves from RAS communities or living in exile

1) Barriers to accessing therapy, including psychoanalytic psychotherapy, experienced by RAS

The need to provide targeted therapy services, including psychoanalytic psychotherapy, to refugees and asylum seekers has been widely recognised across EU states in recent years. This growing awareness is reflected in a substantial literature relating to barriers to accessing therapy and models of good practice for facilitating access. However, the literature that relates directly to the UK is smaller, reflecting the comparative paucity of provision of therapy services in the UK. There is a subsection in the literature that focuses on the specific barriers to accessing therapy faced by female refugees and asylum seekers.

The existence of extensive barriers preventing the take-up of therapy provision by RAS has been identified by NGOs, public institutions, practitioners, refugee community organizations and refugees themselves. The literature identifying what constitutes the principal barriers, as well as literature outlining models for overcoming barriers to take-up, thus comes from diverse sources and is presented in a variety of academic and non-academic contexts.

The barriers to accessing therapy by RAS identified by the organisations and individuals outlined above can be summarized in the following manner[2]:

- Language, communication and cross cultural barriers
- Economic and administrative problems
- Lack of training/awareness by providers of refugee and asylum seeker issues and their specific needs
- Lack of understanding on both sides
- Lack of trust on the part of refugees and asylum seekers.

Language, communication and cross cultural barriers

Greater participation from RAS as therapists or other mental health care providers, or as participants in the therapeutic environment in an advisory role, has been identified as offering a path to improving communication between therapy providers and refugees and

[2] European Council on Refugees and Exiles, *Good Practice Guide on the Integration of Refugees in the European Union. Health*, September 1999. Online. UNHCR Refworld, available at: http://www.unhcr.org/cgi-bin/texis/vtx/refworld/rwmain?docid=4652feff2 [accessed 10 June 2008]

asylum seekers.[3] However, in the UK and in many other EU states, such participation is hindered by the fact that refugees from a professional background are frequently not allowed to practice in EU countries because of their immigration status or because their qualifications are not recognized.[4]

The literature identifies the shortage across the UK of interpreting services and cultural mediators as being an important factor hindering RAS access to therapy provision. The literature identifies an increase in funding for and training of such staff as being a key factor in improving the accessibility of available therapy services.[5] The literature suggests further that communication problems are not limited to a therapist and client speaking a different language.[6] Rather, nuances of expression, particularly relating to emotions, may be obscured in the context of a white British therapist seeking to engage with an RAS client. This failure of communication on a more abstract level can act as a barrier to RAS continuing to attend therapy sessions.[7]

Moreover, in some cultures from which RAS originate, there exists a fundamental hostility to a 'talking therapy'.[8] Specifically in relation to psychoanalytic psychotherapy, many RAS in the UK come from cultures in which the "detached introspection" of psychotherapy is an alien activity: The poor regard in which therapy and psychotherapy is held by RAS is illustrated by a recent survey in which out of 759 respondents in London, 76% of those offered counselling or psychotherapy rated it as poor or very poor solution to the problems that they were experiencing.[9]

This might be addressed, it is suggested in the relevant literature, by offering counselling and other forms of therapy that assumes some background knowledge of the political landscape from which a particular client has fled, is "eclectic and streetwise", and acknowledges that practical advice and advocacy is of itself psychologically supportive. Moreover, therapy provision specifically targeted at RAS might benefit from including an

[3] ibid
[4] European Council on Refugees and Exiles, *Good Practice Guide on the Integration of Refugees in the European Union. Health*, September 1999. Online. UNHCR Refworld, available at: http://www.unhcr.org/cgi-bin/texis/vtx/refworld/rwmain?docid=4652feff2 [accessed 10 June 2008]
[5] Summerfield, D, (2001) Asylum Seekers, Refugees and Mental Health Services in the UK, *Psychiatric Bulletin* 25: 161-163.
[6] Van Tienhoven, AH, Van Waning, A and Veen, G Culture, Trauma, Transference and counter transference: a working model for the complex interaction between refugee client and therapist, Pharos Foundation for Healthcare and Refugees, see http://www.ishhr.org/conference/articles/tienhoven.pdf
[7] Burchell. S (July 2007) Counselling Asylum Seekers and Refugees, BACP Information Sheets. See http://www.bacp.co.uk/
[8] Patel, N and Mahtani, AThe politics of Working with Refugee Survivors of Torture, The Psychologist, Vol 20, No 3, March 2007
[9] Baluchi, B (1999) *Beyond Urgent: Towards a Strategy for Mental Health*. London: Kimia Institute.

acknowledgment that a recounting of traumatic experience is an option but not a necessity. [10]

The literature that addresses the potential communication gap between therapist and client recognizes that such alterations to a traditional therapeutic environment may mean attending more to function-focused and problem-focused coping styles. (For example: 'How are you doing?' and 'What do you need to do?' rather than the emotion-focused: 'How are you feeling?') [11]

The literature also identifies the focus on the individual within the therapeutic environment as acting as a barrier to take-up for people from cultures in which the role of family and social networks in providing support and nurturing problem-solving strategies is of paramount importance.[12] The literature suggests that this cultural resistance to stepping out of the family or community enclosure and into a therapeutic situation can be at least partly overcome by recruiting volunteers from within refugee communities who can act as go-between from the western psychiatric model into RAS communities.[13]

The literature refers to a widespread ignorance of cross-cultural factors found across mainstream mental health services in the UK. This has meant that RAS patients have often been given inappropriate diagnosis, and this has hindered the take-up of more appropriate services, such as psychotherapy, for treating conditions such as depression and anxiety.[14]

An important strand of the literature identifies a fundamental mismatch between mental health services offered in the UK, including psychotherapy and other forms of therapy, and presentations by refugees and asylum seekers from cultures where Western psychiatry has little purchase. This can hinder people from such cultures from accessing services that may be available to them.

A further cultural factor that has impacted on take-up of therapy by RAS identified in the literature is the widely held notion in some cultures that mental health issues are associated with madness. (For example, a study of Somalis in London showed that all Somalis consider all forms of mental disorder to be 'madness'.) Accordingly, people are afraid to reveal their

[10] Summerfield, D, (2001) Asylum Seekers, Refugees and Mental Health Services in the UK, *Psychiatric Bulletin* 25: 161-163.
[11] Ibid
[12] Ibid
[13] Palmer, D and Ward, K (March 2005) Mapping the Provision of Mental Health Services For Asylum Seekers and Refugees in London: A Report, ICAR, Scholl of Social Science and Public Policy, King's College, London
[14] Summerfield, D, (2001) Asylum Seekers, Refugees and Mental Health Services in the UK, *Psychiatric Bulletin* 25: 161-163.

experiences for fear of being labelled mad. This acts as a strong disincentive for individuals to seek help. In addition, 'madness' is seen as bringing shame to the community.[15] For this reason, RAS are reluctant to approach mainstream services to address mental health issues, turning instead to community or the broader family network.

Economic and administrative problems

Access to services that aim to provide therapy for refugees and asylum seekers can also be hindered, according to a number of sources, by the existence of a range of broader practical problems facing people arriving in the UK from repressive regimes and war zones. For many RAS there is an enormous and ongoing battle with the immigration services in the UK to remain in the country, and thus to have the possibility of being physically able to continue to access therapy. For example, it is generally accepted that therapists need to create "safe spaces", often through relationship, before clients can fully engage in the work. [16] Asylum seekers, by definition, do not yet know what will happen to them. Threats of deportation or fear of being 'dispersed' to another part of the country are significant barriers to therapy. It may be a reality that therapists cannot guarantee, even from one session to the next, being able to meet again, let alone complete a planned series of meetings.[17]

Even those who have successfully overcome initial immigration battles, including the right to remain in the UK or the right to take up paid work, may face an ongoing struggle with a range of dilemmas that are rooted in broken social world-disrupted trajectories, loss of status and cultural alienation. [18] The literature therefore suggests the implementation of strategies that aim to combat the physical barriers to accessing therapy, such as financial problems, immigration problems, shortage of childcare, unfamiliarity with the location of the therapy provider. It is suggested that such problems could be countered by offering a range of psycho-social support provisions – in the form of practical help and social activities – in tandem with therapy provision. Such services could act to diminish some of the barriers to accessing psychotherapy through first addressing the practical problems that RAS perceive as constituting their most pressing and insurmountable problems.[19]

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[15] Palmer, D and Ward, K (March 2005) Mapping the Provision of Mental Health Services For Asylum Seekers and Refugees in London: A Report, ICAR, Scholl of Social Science and Public Policy, King's College, London
[16] Burchell. S (July 2007) Counselling Asylum Seekers and Refugees, BACP Information Sheets. See http://www.bacp.co.uk/
[17] Ibid
[18] Summerfield, D. (1998) Sociocultural dimensions of war, conflict and displacement. In *Refugees. Perspectives on the Experience of Forced Migration* (ed A. Ager), pp. 111-135. London: Pinter.
[19] Summerfield, D, (2001) Asylum Seekers, Refugees and Mental Health Services in the UK, *Psychiatric Bulletin* 25: 161-163; European Council on Refugees and Exiles, *Good Practice Guide on the Integration of Refugees in the European Union. Health*, September 1999. Online. UNHCR Refworld, available at: http://www.unhcr.org/cgi-bin/texis/vtx/refworld/rwmain?docid=4652feff2 [accessed 10 June 2008]

Negative perceptions of the effectiveness of therapy in the face of apparently insurmountable practical problems have also been identified as acting as a barrier to RAS accessing therapy. For some RAS, psychotherapy and psychiatry more generally may not appear to offer solutions to the enormity of their practical problems and to the very fact of their dislocation and profound loss (of home, livelihood, often friends and relatives).[20]

There is, it is argued, a perception by RAS that psychoanalytic psychotherapy, and other forms of 'talking cures', are unable to offer solutions to the reality of the practical problems and the difficulties presented by their new circumstances. For this reason, therapy is not taken up because the perception is that the mental anguish and depression experienced is caused by the specific circumstances in which RAS have found themselves.

The specific circumstances nominated as often leading to RAS experiencing mental health problems such as depression include poverty, homelessness, loss of social status and problems with the immigration system. The literature suggests that a barrier to RAS accessing therapy lies in a widespread perception that the solution to their problems lies in changing their circumstances, rather than talking about their circumstances.

Shortfalls in the provision of services catering to the specific needs of RAS and gaps in training/awareness by providers of refugee and asylum seeker issues and their specific needs

Given the specific practical and mental health problems experienced by RAS, it is noted in the literature that the shortfall in services specifically designed for this group constituted a significant barrier to RAS accessing therapy services. For example, only five of the eleven mental health trusts in London provide services that are specifically designed with the needs of refugees and asylum seekers in mind.[21]

In relation to the shortfall in provision of targeted therapy services, it has been noted that with the exception of a handful of PCTs , there appears to be a general lack of awareness that refugees and asylum seekers are a group with distinct needs that are multiple, complex and require specialist knowledge. This lack of awareness is manifest in a failure to put in place adequate training for therapists dealing with RAS clients. There are, the literature

[20] Ibid
[21] Palmer, D and Ward, K (March 2005) Mapping the Provision of Mental Health Services For Asylum Seekers and Refugees in London: A Report, ICAR, Scholl of Social Science and Public Policy, King's College, London

notes, only a small number of 'specialist' organisations outside the NHS that provide culturally appropriate services to this group.[22]

Conversely, there is a lack of awareness on the part of RAS about what therapy is, what it can treat, the importance of regular attendance, etc. As explained earlier in this paper, RAS often see a Western mental health model as an alien concept and psychiatric treatments such as psychotherapy are unfamiliar to them.[23] Moreover, many RASs who fit this model do not understand the treatments administered. This lack of awareness on the part of the RAS has meant that even when some form of therapeutic treatment has been available, there has been a failure on the part of the RAS to continue to attend therapy and/or other mental health services.[24]

The lack of awareness on the part of RAS about therapy and other mental health services can be overcome, the literature suggests, by implementing schemes by which people from within the RAS community are recruited to carry knowledge of the therapy provision available, how it works and what it involves directly to community members. A model of good practice in overcoming the barrier to access caused by lack of knowledge is found in the work of the Bromley PCT Refugee Service. This service has a team of three specialist heath visitors who promote refugee mental health by training volunteers from the RAS community so that these volunteers can impart their knowledge directly.[25] This is particularly important if women, the elderly and those who do not speak English are to be made aware of therapy services available.

Lack of trust on the part of refugees and asylum seekers

A further barrier to RAS accessing therapy lies in a widespread concern among RAS about issues of trust and confidentiality. Such concerns have meant that many refugees and asylum seekers are extremely anxious about providing information to outsiders. The specific concerns about confidentiality experienced by RAS are a further reason why services that are designed with the particular circumstances and requirements of RAS patients are vitally important if take-up of services is to be increased.[26]

For example, it may have become a habit for clients who have spent many years in repressive regimes to keep feelings and thoughts hidden as a form of protection. It is

[22] Ibid
[23] Ibid
[24] Ibid
[25] Ibid
[26] Ibid; Burchell. S (July 2007) Counselling Asylum Seekers and Refugees, BACP Information Sheets. See http://www.bacp.co.uk/

possible that figures in authority, including the therapist, trying to gain their trust will be treated as though they are 'agents of the state'.[27] The issue of divulging personal information is of particular pertinence when considering the incidence of women RAS taking up psychotherapy and other forms of therapy provision. A significant number of RAS women have been sexually abused as a result of the wars and conflicts from which they have fled. These women commonly experience fear, shame and guilt about the sexual abuse they have suffered – and such emotions may prevent them from seeking or continuing with therapy, if such therapy touches on their abuse.[28]

Cultural sensitivity to meetings between men and women are a further potential barrier to RAS accessing therapy. This is the case because rules for private meetings between men and women differ around the world. In some instances it is forbidden for an unmarried man and woman to meet without a chaperone. It is therefore good practice for therapists to inform themselves about an RAS client's comfort with gaze, proximity and intimacy and how this will impact on their experience of, and response to therapy. Furthermore, clients who have suffered sexual abuse or torture may experience discussion of this early in therapy as abusive.[29]

2) Models of Good Practice to facilitate access to therapy by RAS

Summary of recommendations for increasing take-up of therapy services, including psychoanalytic psychotherapy, by RAS contained in the literature include:[30]

- Strengthening the capacity of organisations by providing advocacy services to members of community organisations

- RAS communities need to be given mental health awareness training so that it is easier for them to recognise the symptoms of mental ill health

- It is necessary to respond to mental health issues by taking a holistic approach, and by taking into account the social factors that impact significantly on mental health

[27] Burchell. S (July 2007) Counselling Asylum Seekers and Refugees, BACP Information Sheets. See http://www.bacp.co.uk/
[28] Kastrup, M,(Jan 2006) War and Women's mental health, World Cultural Psychiatry Research Review, WCPRR, Jan 2006, 29:33
[29] Ibid
[30] Palmer, D and Ward, K (March 2005) Mapping the Provision of Mental Health Services For Asylum Seekers and Refugees in London: A Report, ICAR, Scholl of Social Science and Public Policy, King's College, London

- Statutory and other mainstream organisations need to acknowledge that RAS community organisations are key players in providing services to the community and should support them by funding them and involving them in service planning and delivery

- There is a need for mental health awareness training programmes for primary and secondary care providers on RAS communities and the migration on process

- Funding needs to be made available for therapy, counselling and other culturally specific services so that they can be provided within community organisations

- More information needs to be provided on how to access services and on the mental health system

- There needs to be greater links between community groups and mental health services, including services offering psychoanalytic psychotherapy

- There is a need for bi-lingual workers, interpreters and advocates. Interpreters with training in or understanding of counselling skills are more likely to assist the process, although it must be noted that any three-way dialogue requires careful monitoring.

- Providers of therapy services to RAS need to ensure that the psycho-social needs of clients are being met, by providing the necessary additional services themselves or working in partnership with other organisations

- Specialist mental health care provision needs to be provided where necessary, for example, for victims of torture, ethnic cleansing or systematic rape

- More bi-cultural therapists need to be trained and recruited

- There should be a campaign to allow trained bi-cultural therapists to work in the UK

- More and better interpreter services would also increase access of RAS to therapy services.

Models of good practice in action

As noted earlier in this literature review, an important strand of the relevant literature focuses on the extent to which approaches to mental health vary between cultures, and the impact of this dichotomy on RAS access to therapy. It is noted that different cultures have different models and frameworks for dealing with mental health crisis, depression, anxiety etc. In some cultures from which RAS in the UK are commonly drawn, therapy and counselling have no place. 'Emotional safety' is instead sought in religious or traditional practices. For this reason, it is good practice to ensure that adequate training in cross-cultural awareness is given to therapists and associated support staff. However, a more effective strategy for lowering barriers to therapy experienced by RAS, particularly RAS women, involves the recruitment and training of bi-cultural therapists and support workers, including the integration of those who have been trained in the country of exile. Such therapists not only speak the same language as clients, but they are also cognisant of cultural differences and subtleties.[31]

The literature further demonstrates that it is good practice to provide more services for RAS within a community-based setting, particularly at the stage when the initial assessment of the client takes place. One of the benefits of providing more community-based therapy services is that clients are likely to feel less intimidated than they would if they were required to attend mainstream therapy services. This is particularly pertinent given that many refugees and asylum seekers have a distrust of 'authorities' due to their experiences in their countries of origin.[32] As such, the location, environment and support staff they encounter should be designed to minimise the sense of an encounter with officialdom and maximise informality. The need for RAS to seek treatment in settings in which they feel comfortable and secure means it is crucial that therapy services work in partnership with RAS community organisations, so that a more culturally sensitive therapeutic environment is made available.

The preceding section of this literature review outlined important barriers RAS experience in accessing, and continuing to attend, therapy. A number of organizations across the EU have sought to address such barriers by:

- analyzing obstacles to RAS use of therapy provision
- proposing solutions/ways of improving accessibility of therapy services, and tailoring policies to RAS' experience and cultural background

[31] Palmer, D and Ward, K (March 2005) Mapping the Provision of Mental Health Services For Asylum Seekers and Refugees in London: A Report, ICAR, Scholl of Social Science and Public Policy, King's College, London
[32] Burchell. S (July 2007) Counselling Asylum Seekers and Refugees, BACP Information Sheets. See http://www.bacp.co.uk/

- devising innovative ways of dealing with traumatic events in order to increase take-up of therapy services.

An example of an organization that has followed this model and put in place innovative solutions to address poor take-up of mental health services, including psychotherapy provision, is The Pharos Foundation for Refugee Healthcare, in Utrecht, the Netherlands. The organization was created in 1993, with the aim of acting as a bridge between RAS and mainstream healthcare services in order to promote mental and social wellbeing of RAS.[33]

The foundation has sought to overcome barriers to therapeutic encounters experienced by RAS by first considering refugees and asylum seekers as 'ordinary people with extraordinary experiences'. In this way, the Foundation avoids labelling them as mentally ill people, which can contribute to overcoming the stigma attached to seeking help for mental health issues found in many RAS communities.[34] On a practical level, Pharos aims to increase the take-up of therapy and other mental health services by RAS by providing advice, information and training courses to health professionals, and by promoting the creation of networks of communication between RAS communities and the mental health service providers.

A further example of organizations implementing good practice is The Portobello Project, at Omega, in Graz, Austria, which provides individual and group counselling and psychotherapy to refugees and asylum seekers. This organization has targeted its attempts to increase take-up of therapy and other services at women, with the justification that in many cultures women are responsible for the wellbeing of all family members.[35] This project attempts to overcome the practical problems that may inhibit RAS take-up of psychotherapy provision by offering a wide range of psycho social care giving activities, in addition to therapy provision.

The additional activities, and the overall 'feel' of the project has been specifically designed to help to overcome the fear that refugees and asylum seekers might feel at going to private or public institutions that offer 'mental health' services. This is achieved by locating the project in a second-hand shop that also serves as a meeting point for women. Eight women from different countries are employed

[33] European Council on Refugees and Exiles, *Good Practice Guide on the Integration of Refugees in the European Union. Health*, September 1999. Online. UNHCR Refworld, available at: http://www.unhcr.org/cgi-bin/texis/vtx/refworld/rwmain?docid=4652feff2 [accessed 10 June 2008]
[34] Ibid
[35] Ibid

3) Models / references in the literature to providing support to staff working with RAS, particularly staff who are themselves from RAS communities or living in exile

It is noted in the literature that therapists working with RAS are very likely to come into contact with people who have been severely traumatized. It is held to be good practice for the therapist working with such trauma to be aware of the particular models that exist for such work. This often involves some additional training or education, for which funding should be made available.

There is a large and growing body of literature that explores all aspects of transcultural counselling, trauma and displacement. When working therapeutically with asylum seekers and refugees, the socio-political context from which their problems arise needs to be recognised.[36] The literature notes that it is good practice for therapists from different geographic and cultural backgrounds to their RAS clients to read additional materials relevant to the particular context and client group. [37]

Further, the literature refers to the "particularly horrific" nature of the experiences often recounted by those fleeing persecution, coupled with the need to be flexible and creative with boundaries.[38] These special circumstances can be extremely challenging for the therapist. Both factors call for close attention to the quantity and quality of supervision of the therapist working with RAS. It is therefore good practice to carefully monitor the supervision and support networks available to therapists working with RAS.[39]

An example of this issue in action involves clients who have been tortured wanting to show their therapist the injuries or scars.[40] It is good practice for the therapist to have devised a plan of action in the event of this or similar circumstances. Refusal to look at them or a visible sign of revulsion might cause hurt and feelings of rejection and even result in the client terminating therapy. This issue should thus be considered in order to avoid such an encounter acting as a barrier to RAS and the therapy provision.

The literature recounts the existence of therapists working with traumatised clients experiencing 'secondary trauma'.[41] This is a form of 'negative counter-transference', one

[36] Van Tienhoven, AH, Van Waning, A and Veen, G Culture, Trauma, Transference and counter transference: a working model for the complex interaction between refugee client and therapist, Pharos Foundation for Healthcare and Refugees, see http://www.ishhr.org/conference/articles/tienhoven.pdf
[37] Burchell. S (July 2007) Counselling Asylum Seekers and Refugees, BACP Information Sheets. See http://www.bacp.co.uk/
[38] Ibid; Patel, N and Mahtani, A The politics of Working with Refugee Survivors of Torture, The Psychologist, Vol 20, No 3, March 2007
[39] Burchell. S (July 2007) Counselling Asylum Seekers and Refugees, BACP Information Sheets. See http://www.bacp.co.uk/
[40] Ibid
[41] Ibid

aspect of which also been called 'compassion fatigue'. The findings explain that therapists may experience a wide range of responses including, ‘similar physical responses to those of the client; feelings of extreme rage towards individuals or organisations responsible for the client's plight or welfare; feelings of overwhelming helplessness in the face of the work to be done; and even antagonism towards the client’.[42] Burchell argues that it is good practice for therapists to take extra time and care to ensure that their own wellbeing and restorative supervisory needs are being attended to. Furthermore, increased time between client sessions, additional support from colleagues and the processing, in supervision, of uncomfortable reactions, are often essential in avoiding secondary traumatisation or burnout. However, supervisors are themselves not immune to the effects of vicarious or secondary trauma. For this reason, the literature suggests that group supervision could be useful in helping to reduce the impact of disturbing therapeutic encounters on therapy providers.[43]

[42] Ibid
[43] Ibid

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Chapter 3
Research Methods

The methods used to evaluate this project were as follows:

- A Literature review: reviewing literature in the UK and international literature to identify:
    - Barriers to accessing therapy for RAS
    - Models of good practice in the provision of services to encourage access by RAS
    - Models of good practice in the provision of support to staff working with RAS, particularly staff who themselves come from RAS communities or are living in exile.
- Careful reading of the anonymised case notes of women RAS who have accessed therapy via this project.
- Observation of two Therapy Taster sessions provided by the Community Development Psychotherapist – one in 2007 with Turkish speaking women and one in 2008 with Albanian speaking women.
- Observation of the Women's Therapy Centre's User Forum.
- Observation of a Reflective Practice Session at the Women's Therapy Centre for front line staff from across London.
- Observation of a meeting between staff from the Women's Therapy Centre Community Development Psychotherapy project and staff from the Refugee Council working with vulnerable women seeking asylum in the UK.
- Participation in a Seminar facilitated by the Women's Therapy Centre on the interim findings of the Bridging the Gap project Community Development Psychotherapy for Refugees and Asylum Seekers, November 2008.
- Participation in the launch of the Bridging the Gap Toolkit, develop during the course of this project providing guidelines and models of good practice for those working with women refugees and asylum seekers, March 2009.
- Participations in a series of meetings to identify how the Women's Therapy Centre can raises awareness of, and addresses, the needs of women whose immigration status includes the requirement that they do not 'seek recourse to public fund[44]'.
- An interview with a staff member at a Domestic Violence project in North London.

[44] Home office, 'No Recourse to Public Funds', Immigration and Nationality Enquiries Bureau, www.ind.homeoffice.gsi.gov.uk

- An interview with the facilitator of a community organisation providing support and signposting service to Turkish speaking women, including Kurdish refugees and asylum seekers.
- An interview with the co-ordinator of a Refugee Community Organisation supporting Albanian speaking refugees and asylum seekers.
- Interviews with the Chief Executive, the Clinical Director, psychotherapists, the Community Development Psychotherapist, the Link Worker, the Administrator and staff from the Appointments and Referrals Team at the Women's Therapy Centre.
- Questionnaires completed by women attending outreach sessions. (Please see Appendix A for a copy of the questionnaire).
- Questionnaires completed by staff members attending staff support and training sessions. (Please see Appendix B for a copy of the questionnaire).

There are a number of limitations in terms of the methodology which need to be born in mind when reading this report:

In psychoanalytic psychotherapy the relationship between the client and therapist is crucial. Through the course of therapy, the therapist provides a confidential and private setting which enables the client to become aware of unconscious patterns of behaviour based on their inner world. These patterns are reflected in the client's relationship with the therapist via a process of transference. Because of the importance of the setting and the client–therapist relationship it is not appropriate for therapy sessions to be observed.

However, while the evaluators did not observe therapy sessions, they were able to meet with women who had taken part in the range of outreach sessions provided by the Community Development Psychotherapist as well as women in therapy at the Centre who attended the Women's Therapy Centre's User Forum. Evaluators also consulted the case files of those women from refugee community groups who had been referred into therapy as a result of this project. Finally, the evaluators were also able to read accounts of refugee and asylum seeking women's experiences of therapy including Discovering Bits and Pieces of Me – research exploring women's experiences of psychoanalytic psychotherapy (Women's Therapy Centre, 2005).

Another limitation placed on this evaluation is the dearth of research into the experiences of refugees and asylum seekers accessing psychoanalytic psychotherapy. A great deal of what the Women's Therapy Centre is currently offering women from refugee and asylum seeking

communities has never previously been offered to women from these communities, so the evaluators have had to look outside the UK for models of good practice and have had a limited literature to draw on in evaluating this work.

Chapter 4
Findings

Reviewing the aims and objectives of the project

One of the primary tasks of the evaluators is to review the aims and objectives of this project and success in relation to these aims and objectives.

What became apparent early on in the evaluation process was the appropriateness of the aim of developing access to psychoanalytic psychotherapy and other psychological support services for women from refugee and asylum seeking communities. The literature review clearly identified:

> '**a severe shortfall across the UK of psychoanalytical psychotherapy and other mental health services that are specifically targeted at and designed to meet the needs of, refugees and asylum seekers**.'

The review also identified a number of barriers facing women from refugee and asylum seeking communities wishing to access existing therapy services, specifically:

- Languages and cross cultural communication barriers
- Economic and administrative problems
- Lack of awareness by providers of therapy services of the needs of women from refugee communities
- Lack of understanding on both sides and a lack of trust.

This shortfall in services was reflected in the focus groups with women from refugee and asylum seeking communities, who articulated the uniqueness of the service provided by the Women's Therapy Centre:

> '**If not here, where else would I go? Where?**'
> Albanian speaking refugee

> '**There is no where else.**'
> Albanian speaking refugee

In one focus group with Turkish speaking Kurdish and Turkish refugees and asylum seekers, the evaluators encountered women who had been on a waiting list for therapy (at agencies other than the Women's Therapy Centre) for up to three years.

> '**The waiting lists are a problem. Women feel so frustrated… (they) really need to be seen urgently.**'
> Staff member at a Refugee Community Organisation for Turkish speaking women.

Staff from Refugee Community Organisations and a Domestic Violence project noted that due to their experiences of detention, torture, gender based violence, trauma and exile, many women require a long period of therapy in order to begin to trust the therapeutic relationship and their own ability to find the strength to talk about their experience and move forward with some hope for the future. However, most women think that they can only access six sessions as this is all they are offered by agencies other than the Women's Therapy Centre.

One woman described how she interpreted the shortfall in services:

> '**It feels like a judgement on us. We feel these services are not for us.'**
> Turkish speaking refugee

The barriers identified in the literature were very real for the women taking part on the focus groups. The language and cross cultural communication problems were referred to frequently:

> **'You need more staff, more Turkish speaking staff. It is not just the language, knowing the culture is very important.'**
> Staff member at a Refugee Community Organisation for Turkish speaking women.

Women also spoke of the practical barriers to accessing services. Many of the Albanian women who took part in the evaluation described how difficult they find it to negotiate childcare during, and transport to, the sessions. For them, it is only the support provided by the Refugee Community Organisation in conjunction with the Women's Therapy Centre that makes it possible for them to attend therapy.

The women's lack of awareness of what psychoanalytic psychotherapy is and of their potential to access this support was very evident, as was their appreciation of this project

which provided them with information which had not been made available to them from any other source:

> **'They are not used to the language of psychotherapy and mental health.'**
> Staff member form an umbrella agency supporting refugees and asylum seekers and Refugee Community Organisations

> **'It (Information session) was helpful to help us to understand different therapy systems and what system she is using... we did not have that information.'**
> Turkish speaking refugee

> **'They (staff from the Women's Therapy Centre) understand how we work. They worked really, really well with us. They understood the need to take in information step by step.'**
> Staff member at a Refugee Community Organisation for Albanian speaking women.

The fact that the Women's Therapy Centre identified the need to work with Refugee Community Organisations and thus together to provide practical support to enable women facing complex and frequently intractable problems to make the space to deal with their emotional problems, reflects a need identified by staff and service users in Refugee Community Organisations.

> **'We ran workshops on education and domestic violence, mother tongue teaching etc, and through talking and having that relationship with women we identified that they needed more than we could provide. They needed counselling and more support.'**
> Staff member at a Refugee Community Organisation for Albanian speaking women.

Challenging the stigma faced by women refugees and asylum seekers seeking to access therapy was one of the primary reasons for establishing this project and the evaluators quickly uncovered evidence of stigma and an urgent need to overcome this stigma in the interests of the mental health and well being of women from these communities:

> **'People still think you are crazy if you have therapy. The community needs to be educated to realise that going for therapy is helping yourself and not a sign of madness.'**
> Turkish speaking refugee

‘(in our country) to go to therapy is if you are really, really mad.’
Staff member at a Refugee Community Organisation for Albanian speaking women.

‘A lot of people need help but they don’t want to be labelled.’
Turkish speaking refugee

‘To seek therapy in some of their communities means that you are really not well... The stigma is great. They need a safe space where they can get to know and trust someone.’
Staff member form an umbrella agency supporting refugees and asylum seekers and Refugee Community Organisations

The literature review identified the importance of ensuring appropriate support for those working with refugees and asylum seekers but the evaluators found no literature on the impact of working with refugees and asylum seekers for staff and volunteers who have themselves sought asylum. One of the pioneering aspects of this project is the manner in which it explicitly seeks to support staff who are themselves refugees.

The evaluators found many examples of how much the Reflective Practice sessions are valued by staff and volunteers. One member of staff attending Reflective Practice sessions described how staff and volunteers never have the opportunity to reflect on their work or the impact it is having on them because of the great demand for their service and the pressure of meeting client’s needs:

Some days it feels like a conveyor belt. When you think you have heard the worst case scenario of abuse someone else comes in and we hear more…if we didn’t have it (support from the Women’s Therapy Centre) I don’t know… we wouldn’t be able to cope sometimes. It’s the only time we have to sit down and off load sometimes. At Reflective Practice sessions for the first time someone else …asks me what are my concerns and frustrations.’

One worker at a meeting facilitated by the Women’s Therapy Centre for staff working with vulnerable women, described in detail her powerless when faced with:

‘…women who fall through the safety net of all sorts of provision.’

The evaluator was struck by how much emotional distress this staff member was carrying and by how the staff from the Women's Therapy Centre had managed to create a safe space for this women to acknowledge the profound impact of her work on her own emotional well being and begin to look at how to take care of her own needs.

Another example of the crucial importance of this area of work was described by a staff member from the Albanian speaking community, herself a refugee. Domestic violence had been raised by a number of women in their community and this staff member had sought to provide Albanian women with information and support, but

> **'… I got lots of grief from husbands in our community.'**

She approached the Women's Therapy Centre for support having heard about this project and the Centre then facilitated Reflective Practice sessions, to explore issues of domestic violence with the staff team.

> **'Through the Women's Therapy Centre it is much better. I don't get the blame as an Albanian…Having the Women's Therapy Centre protects our workers. Otherwise we are to blame for bringing in these ideas.'**

While this is a graphic example of how the project has potentially made staff physically safer, the same staff member described parallel emotional and psychological support which staff members have received via regular Staff Support sessions:

> **It's been good (the Community Development Psychotherapy project)…They understand how hard it is for us and the difficulties we are facing in our community. Staff now cope with stress much better.'**

The evaluators have evidenced a need for a project with the aims and objectives set out above, as well as evidencing the positive impact that the project is having on those women accessing support both as service users and as staff members.

Assessing the impact of the service on the ability of women to access services

Over the three year life of the project, 458 women attended Information sessions, 137 women attended Therapy Taster Sessions, 26 women took up therapy at the Women's Therapy Centre and 32 women attended Reflective Practice sessions.

It is apparent from the evaluation that women highly valued the information given:

> **I found out about the Women's Therapy Centre and available services, what therapy involves and expectations.**
> Comment on an evaluation form completed by a Turkish speaking refugee

> **It was very helpful. D explained all available services, thinking behind therapy sessions, group sessions, expectations etc.'**
> Comment on an evaluation form completed by a Turkish speaking refugee

> **D explained the services quite well. What to expect from therapy sessions, how to refer, thinking behind the therapy, what and how you might feel during, before and after etc.**
> Comment on an evaluation form completed by a Turkish speaking refugee

What is apparent from the focus groups, is that while accessing therapy is greatly stigmatised within the refugee community groups in contact with this project, accessing therapy via the Women's Therapy Centre was made possible for these women because they knew and trusted the Refugee Community Organisations that the Women's Therapy Centre was working with.

> **(It was) not difficult to come. We came gradually because we knew Shpresa (the Refugee Community Organisation). We have been with Shpresa.**
> Albanian speaking refugee in response to a question about how hard it was to access the Women's Therapy Centre's services.

Other women were even more direct:

> **'I've heard about the Women's Therapy Centre previously, but after meeting with D (the Community Development Psychotherapist) I called and put my name on the waiting list.'**
> Turkish speaking refugee

At one focus group six of the eleven women explained that after they attended the taster sessions with D they had telephoned the Women's Therapy Centre to refer themselves for therapy.

At another focus group for Albanian speaking women, staff described how two women had referred themselves for therapy following their attendance at the Therapy Taster sessions. Staff described this as '**a very big step'**, and they went on to talk about the huge stigma that usually surrounds access to mental health services within their community.

Accessing the anonymised case files at the Centre, the evaluator found evidence of work with women from a range of Refugee Community Groups

One woman was aged 31 at the point of referral. She was an ethnic Kurd who had fled Turkey to seek asylum in the UK. She had experienced physical and sexual assault as a child, when she was raised by her grandmother. She was accessing mother tongue therapy at the Centre at the time the project evaluation took place.

All the evidence that the evaluators identified points to the fact that this project is making psychoanalytic psychotherapy accessible to groups of women very unlikely to access therapy via any other referral routes.

Assessing the impact of the service on the ability of women refugees and asylum seekers' to achieve positive outcomes

In completing feedback forms, following outreach sessions and in speaking with the evaluator both service users, staff and volunteers gave universally positive feedback about the impact of therapy on their lives. Comments included:

> **'The service was very helpful because I can see a way to deal with my problems.'**
> Comment on evaluation form completed by an Albanian refugee

In the focus groups women expanded further on the impact these reflective therapy taster sessions were having on their lives:

> **'We speak about our problems. I never had a place to talk.'**
> Albanian speaking refugee

‘We speak about stress and how to manage stress.’
Albanian speaking refugee

Some women explained how having time to reflect made them conscious that they could take decisions and make changes in their lives:

‘Prior to meeting D I always considered blaming others as a problem. After meeting with her here I think maybe there is a problem in myself and I can do something.’
Turkish speaking refugee

‘**We have learnt to take some more responsibility…’**
Albanian speaking refugee

For some women there was a strong sense that they would never fully recover from their experiences but that psychoanalytic psychotherapy had offered them some stability in a life with very little else that is stable:

‘I am not fixed. I will never be fixed...the (therapy) group was stability, it helped me tremendously... Yes from the group that was stability. I had never had that. It was very powerful for me.’
North African woman

Another woman asylum seeker who spoke for the first time about her childhood experience of sexual abuse while in therapy described a process of transformation:

‘All my life I was ashamed of who I am…I felt guilty and humiliated. Now I feel (as) if I am a new person…’

The evaluator also gained a sense from listening to service users, staff and volunteers that psychoanalytic psychotherapy works with women who have often had very little power and control over their lives in a way which enables them to discover that they can make changes and find the strength to move on. This is consistent with a recent expert review of over 280 projects working with women survivors of abuse, including women who had been trafficked and who had experienced gender based violence, which found that short term Cognitive and

Behavioural therapies (CBT) alone were insufficient to meet the needs of these women[45]. During the course of the evaluation concern was expressed by women using psychotherapy services (at the Women's Therapy Centre's User Forum) and by staff working with these women (at the launch of the Bridging the Gap Toolkit) that recent shifts in statutory funding towards supporting CBT as opposed to longer term psychological interventions may make it less likely that very traumatised women will find the specialist help that they require.

Evidence of the impact of psychoanalytic psychotherapy on women survivors of torture, gender based violence and trafficking was identified by the evaluators in many of the interviews and observations. The following is a snap shot of some of the findings:

One member of staff from a Domestic Violence project described the impact that therapy at the Women's Therapy Centre had had on one of their clients:

> **'…she felt that therapy had helped so much. She described how it gave her time to talk and express and heal herself. She found that she herself has the solutions.'**

Elsa, who is currently in therapy at the Women's Therapy Centre, was one of seven children who had been physically abused from early childhood. She welcomed the prospect of a better life when traffickers offered to take her to Germany. In Germany she was put to work as a prostitute. She was then taken on to the UK, she was assaulted by traffickers and her son conceived as a consequence of rape. She tried to escape but was subjected to death threats, beatings and mock drowning. She was held hostage in a flat until a client helped her to escape. At the time she was pregnant with her son.

An issue that came up in one of the focus groups highlights the very significant impact this project has had on the lives of some of the refugee women accessing outreach services:

D has been providing reflective Therapy Taster session to members of the Albanian speaking community in conjunction with a Refugee Community Group working across North and East London with members of the Albanian speaking community. A member of the Albanian community was killed soon after D started working with the group and the women used the time with D to explore the impact of domestic violence on their lives and their own

[45] Psychoanalytic Psychotherapies in the Treatment and Care of Individuals who have experienced Sexual Abuse, Violence and Neglect in Childhood, D. McQueen et al, 2009, Karnac

responses to this violence. Women described to the evaluator how profoundly their thoughts and feelings had shifted through working with D.

> **'I come here and I see we can never say yes to domestic violence. I realise there are people who can help. It can stop.'**

> **'We were unhappy about what had happened. To talk after was good. To think about looking for the signs (of domestic violence) and talking to someone.'**

In assessing the impact of this project on the outcomes for refugees and asylum seekers, the evaluators also chose to explore the impact on staff, many of whom also came from refugee communities.

Even when considering staff not from refugee community groups, the evaluators start from the premise that staff are better able to support service users if their own emotional and psychological needs are being met, for as is evidenced in the literature review:

> **'… therapists may experience a wide range of responses including "similar physical responses to those of the client; feelings of extreme rage towards individuals or organisations responsible for the client's plight or welfare; feelings of overwhelming helplessness in the face of the work to be done; and even antagonism towards the client"'**

The Women's Therapy Centre provided Information sessions both for staff from refugee community groups and for other staff. Staff who attended these Information sessions in completing the feedback forms described the most useful parts of the workshop in the following ways:

> **Analysing what therapy is and how it works. Make us understand how to access it.**

> **Discussing about what stops people to go for therapy.**

> **Hearing other people's experiences and backgrounds and how it may impact perceptions to therapy.**

I reconnected with the therapist in me and also see how amazing the inter-cultural model is for psychotherapy.

One to one interviews with staff working in refugee community groups enabled the evaluators to gain a greater insight into the impact of Staff Support sessions. One woman staff member, L, from the Albanian speaking community vividly described her own feelings and that of other staff members on hearing that a woman who had been using their service had been killed by her husband. For L the hardest part was hearing about the grief experienced by the murdered woman's children who were in the care of social services. She described how the Women's Therapy Centre offered both practical and emotional support. In practical terms they delivered information and support sessions to women in the Albanian community, removing the focus of blame from the female Albanian staff members, who were being accused by Albanian men of breaking up families and encouraging women to divorce. At the same time, the Women's Therapy Centre offered staff support sessions, which were based on an understanding of '**how hard it is for us and the difficulties we are facing in our community.'**

Observation of a meeting between staff from the Women's Therapy Centre's Community Development Psychotherapy project and staff from the Refugee Council working with vulnerable women seeking asylum in the UK, gave the evaluators another example of the value of the staff support provided by the Women's Therapy Centre. At the very start of the session the staff member from the Refugee Council described how hard her work can be, when there is very little she can do for women

'…there is not much I can provide in terms of emotional support.'

She gave a number of examples of women who are very sick with HIV but facing deportation and there is no hope that she can offer them. She also spoke about women who are experiencing domestic violence but they are dependent on their husbands asylum claim, and to leave the violent relationship means destitution or deportation. It was evident to the evaluator from this meeting that having the time to reflect on how hard the work is and having a space where her own feelings could be acknowledged was very important for this woman.

The evaluator also observed a Reflective Practice in which one woman from a refugee community described the process of staff and volunteers attending the session as a form of:

'…feeding each other….taking responsibility for what you do and how you feel.'

Assessing the impact of the service on women refugees and asylum seekers' confidence in mental health and other therapeutic services

The most telling example of the impact this service has had on the confidence of women refugees and asylum seekers in mental health services and other therapeutic services, is the referral rate of refugee women into therapy: 26 refugee women have accessed therapy at the Women's Therapy Centre since the start of the project, and 137 women have attended Therapy Taster sessions. Given the barriers to accessing therapy as described in the literature review, in the words of an Albanian speaking staff members, **'this is a very big step.**'

Staff members reflected very positively on how the Women's Therapy Centre had broken down barriers to access and women's fear of mental health services. They felt that the reason why women were not afraid to engage with D the Community Development Psychotherapist, was because of her flexible and informal style, which was not what they expected from a therapist.

'The Women's Therapy Centre introduced ideas to women informally – they have got a way of talking which is not just the professional view. She, D, is someone who talks about a range of issues not just counselling – that is just one of the themes.'
Albanian speaking staff member

Staff from the Albanian speaking community also described how they had identified a need for counselling and therapy support for women but they did not know how to introduce this into their agency. The Women's Therapy Centre enabled them to introduce the concept of mental health support in a non-threatening and non-stigmatising way.

Staff from the Turkish speaking community described how some of the Turkish speaking refugees and asylum seekers were suspicious of therapy and others had tried therapy before but believed that it was only possible to access six sessions of short term therapy, the amount usually offered by NHS therapy services. For women from this community the Women's Therapy Centre's project has clarified what therapy is and how different

therapeutic models offer women different types of services. This in turn has reduced misunderstandings and increased confidence in therapeutic services:

> **'I like it more now when she (D) comes. I understand more what therapy is.'**
> Turkish speaking refugee

The staff member from an umbrella organisation for refugees and asylum seekers and agencies working with them, described how the fact that the Women's Therapy Centre goes to their centre, where women refugees already feel safe, and delivers Information sessions and Therapy Taster sessions in an environment they trust, helps them to develop confidence in the therapy services themselves. She felt strongly that women who had no confidence in mental health services in the first instance would not travel to a dedicated mental health or psychotherapy service. By delivering outreach sessions, the Women's Therapy Centre is helping refugee women to get over their fear of mental health service provision and develop confidence in services like the Women's Therapy Centre.

Staff members from more than 45 organisation attended the launch of the Bridging the Gap Toolkit and in the question and answer session after the Toolkit was presented, very positive feedback was given about the Women's Therapy Centre's approach to taking therapy out into the community. Staff from refugee communities themselves were quick to identify that in their view women from refugee communities would not have developed the trust and confidence in the services offered by the Centre if they had not been able to find out about it from the safety of an agency they already knew and trusted.

Reviewing the impact of the service on community cohesion

The development of community cohesion is defined by the government as:

'.. the attempt to build communities with four key characteristics:

- a common vision and a sense of belonging for all communities;
- the valuing of diversity;
- similar life opportunities for all and;
- strong and positive relationships are being developed between people from different backgrounds and circumstances in the workplace, in the school and within neighbourhoods.'
  (www.neighbourhood.gov.uk accessed on 2 July, 2008)

This project has contributed to these four key characteristics in the following ways:

1. Communities, including those communities of refugees and asylum seekers, cannot belong if they feel that essential services, such as mental health services, are, to quote from one of the refugees interviewed during the course of this project, **'not for us'**.

   The Independent Asylum Commission[46] states that: **'People seeking sanctuary should be treated fairly and humanely, have access to essential support and public services…'** Talking therapies are essential support for many women who have survived the journey into exile, fleeing detention, persecution and gender based violence.

   This project has helped break down barriers and develop among some refugee communities a sense that services such as therapy services are 'for them' and are services that are there for members of all communities. The Chief Executive of the Women's Therapy Centre described the shift among one group of refugees:

   `We have gained an idea of the complexities some groups face and how it can be really hard (to see therapy as being for them). For some women it is an achievement just getting them to an information session. But some communities we have developed our work with…now…jump at the chance of a therapy space.'

   By developing access routes to therapy and enabling refugee women to feel that they belong and have a right to use mainstream services, this project has contributed to community cohesion.

2. This project has been driven by the Women's Therapy Centre's commitment to valuing diversity at every level. The project began by recruiting a therapist from a refugee community group, who herself had arrived in the UK as a refugee. The message to women from refugee communities wishing to access services at the

[46] A team of independent commissioners which aimed to take a fresh and impartial look at the asylum system and make credible recommendations for reform that will ensure that we continue our proud history of sanctuary while restoring public confidence in the system. See http://www.independentasylumcommission.org.uk/

Centre, was that this project does not simply pay lip service to diversity, but seeks to develop services founded on a real commitment to diversity.

The commitment to providing an accessible service to refugee women appeared to be shared by staff through-out the Women's Therapy Centre. Those staff members working in the Appointment and Referrals Team at the Centre, responsible for delivering the appointments and referrals services described the extensive measure that they had taken to facilitate access for women from refugee communities. This included sending out mother tongue leaflets through to holding information sessions at refugee community groups and compiling a database of agencies working with refugees and asylum seekers who could support women in therapy at the Centre. These staff members clearly recognised that their role was crucial in ensuring access to women from marginalised communities.

While recruiting staff with a personal and therapeutic understanding of the experiences of exile and loss, the Centre also strove to make links with Refugee Community Organisations and work with them to develop the project. Staff from the Women's Therapy Centre did not develop an idea as to how the project should be delivered, instead they liaised with diverse community groups, valuing their expertise and taking their advice regarding the development of access routes to therapy. This resulted in a number of changes to the original work plan:

- It became apparent after offering a number of Therapy Taster Sessions to the Turkish speaking community that women from this community urgently wanted to access therapy. The Chief Executive at the Women's Therapy Centre realised at that point that: '**We can't just create access routes, we need to provide therapy if that is what women need.'** As a consequence, the Chief Executive liaised with the grant manager for the Connecting Communities Plus programme and negotiate a change in the grant so that some funds could be used to provide mother tongue therapy.

- After a member of the Albanian community was murdered by her male partner, it became apparent that both staff and service users required ongoing support. The Women's Therapy Centre have responded flexibly, not limiting their input to a block of six sessions and instead focusing on developing capacity within the organisation to hold emotional distress and

support staff in so doing, while also developing referral routes into therapy for vulnerable women.

- Referrals to the Centre via this project included women who had been trafficked and others whose immigration status included the requirement that they have no recourse to public funds. At the same time staff members from refugee community groups spoke eloquently of the limits of what they are able to offer women experiencing domestic violence, but whose immigration status is dependent on their male partners, the choice therefore being to be deported to a country where they face persecution or to stay in a violent, abusive relationship. The Centre chose not to ignore the fact that while there is a policy of zero tolerance to domestic violence for the majority of women living in England and Wales[47], women who are foreign nationals with no recourse to public funds do not benefit from equal protection and in fact face retribution and or destitution in seeking to escape domestic violence[48]. In February 2009 the Women's Therapy Centre launched a paper on this issue[49] and is actively seeking support to change policy and practice and ensure that these women are not excluded from access to life saving practical and psychological support.

3. Similar opportunities for all is one of the primary aims of the Women's Therapy Centre which seeks to make therapy services available to refugee women who face the following barriers to therapy, as identified in the literature review:

- Language, communication and cross cultural barriers
- Economic and administrative problems
- Lack of training/awareness by providers of refugee and asylum seeker issues and their specific needs
- Lack of understanding on both sides
- Lack of trust on the part of refugees and asylum seekers.

This project has sought to address all these barriers by:

[47] Department of Health Guidance Domestic Violence: A Resource Manual for Health Care Professionals , 2000
[48] Amnesty International and Southall Black Sisters (March 2008) 'No Recourse' No Safety, the Government's failure to protect women from violence
[49] Women, Domestic Violence and the No Recourse to Public Funds Rule, the Women's Therapy Centre November 2008

- Employing mother tongue therapists and therapists and Link Worker staff from refugee community groups and by using skilled and experienced interpreters.
- Providing childcare and travel costs and referring women to the Refugee Link Worker, a member of staff based at the Women's Therapy Centre whose role is to provide a practical support and sign posting service to women refugees to enable them to access therapy.
- Developing a specific project for refugees and asylum seekers, ensuring that the Women's Therapy Centre recognises and responds to the specific needs of this community.
- Working with existing Refugee Community Organisations and umbrella organisations for refugee groups and delivering outreach sessions at these venues, in order to start to engage with women in a space they already trust and feel safe.

The Chief Executive of the Centre explained:

'**We really had a sense if we did not do this work we would be excluding Refugees and Asylum Seekers**.'

As one staff member of a mental health charity working with refugees in east London commented after attending the launch of the Bridging the Gap toolkit:

'I came to your seminar last year (on the interim findings of the Bridging the Gap project Community Development Psychotherapy for Refugees and Asylum Seekers, in November 2008) **and we have been using your model and it is inspirational. It really works. We are now seeing refugee women and are really able to work with them.'**

4. It was apparent throughout the evaluation process that strong and positive relationships are being developed between people from different backgrounds and circumstances through this project. Employing a therapist with personal and professional experience of exile has, in the views of the evaluator, facilitated the development of strong and positive relationships between Refugee Community Organisations and the Women's Therapy Centre. Staff in Refugee Community Organisations can see that the Centre is not bring in expertise from outside but building on the skills and strengths of Refugee Community Organisations themselves and helping to protect their mental well being.

Staff from Refugee Community Organisations spoke very positively about both the Community Development Psychotherapist:

'A session with D is never enough. All day with D would not be enough, she is so good at what she does, she has so much knowledge and information.'
A Turkish speaking staff member

And about the work of the Women's Therapy Centre in general:

'Through the Women's Therapy Centre it is much better…so far it has been good… they worked really, really well with us…'
An Albanian speaking member of staff

But it is not just the relationship between Refugee Community Organisations and the Women's Therapy Centre that has been strengthened. The Women's Therapy Centre has shown a remarkable commitment to sharing its learning with voluntary and statutory agencies with a view to improving services for vulnerable women across the country:

- The Community Development Psychotherapist's outreach programme reached more than 458 refugee and asylum seeking women during the life of the project, while also providing support to 32 staff members from a wide range of agencies.

- More than fifty one agencies attended the seminar on the interim findings of the Bridging the Gap project Community Development Psychotherapy for Refugees and Asylum Seekers, in November 2008. These agencies included the Medical Foundation, City and Hackney MIND, East London NHS Trust, The Domestic Violence Intervention Project and Islington PCT.

- Forty six agencies were represented at the launch of the Bridging the Gap Toolkit in March 2009. Participants included commissioners, funders, local councillors, the London Probation Service, the local Member of Parliament and staff from statutory and voluntary sector mental health providers.

- More than 200 copies of the Toolkit have been disseminated to agencies ranging from Chairs of PCTs and Psychotherapy Training Organisations, the Refugee Council and MPs through to local refugee projects and community support services.

After the seminar on the project in November 2008 and the launch of the Toolkit in March 2009 agencies from across London requested full copies of the evaluation report, advice on developing similar services and copies of the Women's Therapy Centre's leaflets and publicity materials. The Centre has sought to develop further opportunities to share its learning and build community cohesion in addressing the complex and often hidden mental health needs of women refugees and asylum seekers by planning future seminars to address these topics.

Chapter 5
Recommendations

For service commissioners and policy makers:

- **That more research is funded into the emotional and psychological support needs of women refugees and asylum seekers**

- **That funding is provided for more dedicated services to improve access to therapy for women refugees and asylum seekers**

- **That funding is provided for long term talking therapies which have been demonstrated over time to have an impact on the quality of life of even the most vulnerable and traumatised survivors of the asylum process, journeys into exile and persecution and gender based violence.**

- **That more research is undertaken into the needs of frontline staff from refugee communities who are themselves providing a range of support services to refugees and asylum seekers, including research into the impact of this work on the mental well being of staff**

- **That a range of models of providing support to frontline staff from refugee communities are piloted and evaluated with findings being widely disseminated to commissioners and providers of services for refugees and asylum seekers.**

- **That consideration is given as a matter of urgency to how best support can be offered to women refugees and asylum seekers experiencing domestic violence. Such consideration should include action on the lack of choices available to women who have no recourse to public funds and are dependent on their partners' application for asylum.**

For agencies that train psychotherapists

- **That the issue of the recruitment and training of staff from refugee communities is considered urgently, with solutions for improving access being developed, including bursary places.**

- **That the training of all psychotherapists includes modules on the needs and experiences of refugees and asylum seekers**

- **That a code of practice for the recruitment, training and use of interpreters is developed and adopted by all psychotherapy training agencies.**

For the Women's Therapy Centre:

- **That the Centre continues to develop, deliver and evaluate both therapy and outreach services to promote access to therapy for women refugees and asylum seekers and support services for front-line staff from refugee communities.**

- **That the Centre develops a training programme for interpreters working with refugees and asylum seekers drawing on their unique experience and body of knowledge in this area.**

- **That the Centre develops and delivers a training programme for psychotherapists working with refugees and asylum seekers, drawing on their unique experience and body of knowledge in this area.**

- **That the Centre continues to work with other agencies, including those working with women fleeing domestic violence to considers as a matter of urgency how best to raise awareness of and respond appropriately to the needs of women refugees and asylum seekers experiencing domestic violence, including those whose asylum claim is dependent on their husband's or partner's application.**