

**An Evaluation
of
the provision of a holistic therapeutic
service for vulnerable women refugees
and asylum seekers**

Shpresa Programme and the Women's Therapy

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Executive Summary

- Women from refugee communities, if they are supported in accessing culturally sensitive, skilled psycho-analytic psychotherapy services, find that talking about painful experiences brings feelings of relief and a reduction in their feelings of isolation.
- Women from refugee communities are better able to access mental health services if they are near where they live and if they receive practical support with childcare and travel to enable them to attend therapy sessions.
- Women from refugee communities have frequently grown up in societies where there is considerable stigma attached to mental ill health. This can be reduced if women receive information and support.
- Domestic violence is a serious problem within the Albanian community and women fear for their lives while also fearing that they will be judged if they try to leave a violent partner.
- Effective partnership working between two agencies with dissimilar cultures can be achieved if staff are committed and willing to be flexible and creative.

S. 1 Introduction to the Evaluation

In September 2008 Comic Relief awarded Shpresa Programme a grant of £123,501 over three years to fund a partnership project to be jointly delivered by Shpresa Programme and the Women's Therapy Centre. This project proposed to develop accessible culturally sensitive services for refugee women addressing complex issues of violence, sexual assault and ethnic identity by:

- Providing practical support and a signposting service to women seeking to access psychotherapy to enable them to take up and continue to attend therapy.
- Providing culturally sensitive mother tongue therapy or therapy with a skilled and experienced interpreter for women refugee survivors of rape and sexual violence.
- Evaluating this work.

The positive changes the project is seeking to deliver are:

- Albanian speaking women who have survived rape and sexual violence will have clear, mother tongue information about where they can access help.
- Albanian speaking women will get the practical support / signposting they require to enable them to access therapy sessions.
- Albanian speaking women will learn more about therapy and be able to ask questions about therapy which will give them the information they need to decide whether they want to start therapy.
- Albanian speaking women will receive culturally and gender sensitive therapy which will help them to identify / express painful emotions and learn less damaging ways of managing fear / distress.

Madill Parker Research and Consulting was commissioned by Shpresa Programme to undertake this evaluation. Both consultants who contributed towards the evaluation are women who have considerable experience of working with refugee community groups and evaluating a range of health and social care services. This evaluation took place during October and November 2009. It is an interim evaluation of the first year of the partnership project. The evaluation will identify to what extent the positive changes have been achieved and will make recommendations for the subsequent two years of the project.

The evaluation report starts by describing the methodology used in section 2 and then includes a Literature review in section 3. Section 4 provides some background information on the project being evaluated. The bulk of the findings are in sections 5 to 7. The report concludes with recommendations for future practice by both Shpresa Programme and Women's Therapy Centre, as well as other NGOs seeking to provide accessible, culturally sensitive mental health services to women refugees and asylum seekers.

S.2 Methodology

A literature review was undertaken identifying the evidence base for best practice in therapy provision for refugees and asylum seekers. The review focused on the following key issues:

- access
- language needs
- practical support
- cultural sensitivity
- recommendations from the literature.

The consultants then interviewed the following staff members:

- Project Director of Shpresa Programme (face to face interview)
- Women's Development Officer, Shpresa Programme (face to face interview)
- Chief Executive Officer, Women's Therapy Centre (telephone interview)
- Psychoanalytic Psychotherapist, Women's Therapy Centre (telephone interview)

A guided interview structure was used, please see Appendix A for a list of the questions asked.

The consultants also facilitated a focus group for eight Albanian speaking women. This was to seek feedback from the women on the impact on them of their contact with the joint Shpresa Programme and Women's Therapy Centre Project. The focus group was semi structured (see Appendix B for the questions that were used). The discussions were taped (with women's permission) and transcribed. All quotes taken from this focus group have been anonymised. All those women taking part in the group gave permission for anonymised quotes to be used in this report.

As well as the documents contained in the literature review, in preparing this evaluation report, the consultants also drew on:

- the original application submitted to Comic Relief
- presentations made by staff from Shpresa Programme and the Women's Therapy Centre at a joint conference to mark the end of the first year of this project.

The consultants would like to thank all those who contributed to the evaluation, particularly those women who took part in the focus group and shared often very painful experience in order to inform future service development for them and for other women. It is hoped that this report reflects their courage and strength.

S.3. Literature Review

Best Practice in Working with Refugee Women Survivors of Rape and Sexual Violence

Though there is no data on the use of therapy or psychiatric admission rates of refugee and asylum seekers compared with the rest of the population (Summerfield, 2001), that refugees and asylum seekers have a need for targeted, mental health services is clear. This review summarises the literature on best practice in therapy provision for refugees and asylum seekers is reviewed.

Overall, there is a clear need for culturally appropriate services which can recognise and accommodate each client's background and language. As important as the therapy itself, however, is the need to provide such services alongside or after the client has been able to receive effective practical support.

This review discusses the general thematic issues of:

- access
- language needs
- practical support
- cultural sensitivity

and finishes with a few general recommendations from the literature. Before this, however, there is a brief discussion of the experiences and needs of refugee women.

Experiences and Needs of Refugee Women

Refugees flee their countries of origin for a number of reasons, including war, abuse of their human rights or persecution on grounds of their political belief and actions, their religion, ethnicity or their gender. This means that they have experienced significant multiple losses in their lives – of people, their possessions, family and friends, their country and their hopes for the future (Tribe, 2002).

Because of this experience of conflict, violence, loss and possibly sexual violence prior to their flight they have a high risk of developing mental health problems. Turner et al write that potential problems for refugees include

- 1) Post traumatic stress disorder – “related to direct exposure to (often malicious) violence”
- 2) Depression – “related to associated loss events”
- 3) Somatisation¹ – “for example where physical violence has been used to achieve psychological change”
- 4) And the ‘existential dilemma’ of a person “whose core beliefs have been challenged” (Turner et. al, 2003:446)

Until relatively recently the trauma experienced by refugees was attributed only to their experiences in their country of origin and their reasons for seeking refuge in another state. However, it is now widely accepted in the literature that experiences

¹ Somatisation is defined as “The process by which psychologic distress is expressed as physical symptoms. Somatization is an unconscious process” (MedicineNet, 2009)

prior to flight, the experience of flight and a person's situation once within the host country can all add to the trauma of a refugee's situation (Turner et al, 2003; Tribe, 2002). When reviewing evidence of post-flight stressors, Silove, Steel, and Watters (2000) argue that "salient post-migration stress facing asylum seekers adds to the effect of previous trauma in creating risk of ongoing posttraumatic stress disorder and other psychiatric symptoms" (cited in Watters and Ingleby, 2004). Post flight stressors, often linked to a policy of deterrence, include detention, lack of access to services such as housing and education, not being allowed to work, isolation, boredom and discrimination (Watters and Ingleby, 2004:550; Watters, 2001). The separation of families in conflict – with some members still in the country of origin is a particular source of anxiety for some refugees (Tribe, 2002).

Though exact figures are not known, many refugee and asylum seeking women have experienced rape or sexual violence at some point. The proportion of women raped in some conflicts is high:

"Up to half a million women were raped during the Rwandan genocide; more than 90% of women and girls over the age of three suffered sexual violence in parts of Liberia, while three out of four women have survived sexual violence in parts of Eastern Congo" (Refugee Council, 2009:4)

With the rise of internal civil conflicts and violence, rape has been used as a weapon of war, "institutionalised" highly traumatic, often including gang rape and violence (USAAI, 2007; Refugee Council, 2009).

Women seeking asylum are also at risk of rape or sexual violence in their journeys to seek refuge – from security forces, border guards, smugglers, detention personnel and other refugees (AIUSA, 2007; Refugee Council, 2009). For women from some cultures disclosure about rape can be extremely difficult. They may feel intense shame and fear rejection from their spouse, family or community (Refugee Council, 2009).

The asylum process can be particularly hard for women that have experienced sexual violence as they have to report what are often highly traumatic memories repeatedly (AIUSA, 2007; Refugee Council, 2009), and failure to disclose straightaway can be a reason for a claim being deemed as untrue².

Once in the UK refugee women are more likely than women in the host community to be poor, living in areas of social deprivation, head of single-parent households and victims of domestic violence – all of which make them more likely to be at risk of rape and sexual violence (Refugee Council, 2009). These factors mean that a high

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'A Kurdish Turkish woman had been persecuted on account of her husband's membership of the PKK and claimed asylum on this basis. However, in Turkey she had also been raped by a neighbour and then blackmailed by the rapist. Her husband had murdered the man responsible and then attempted to murder his wife in an honour killing. The woman had not disclosed any of this to her representative until three weeks before her appeal hearing because she had been under pressure from her male relatives not to "dishonour" her family any further. Her representative was able to obtain court documents from an independent source in Turkey which were submitted in support of additional grounds for appeal. However, the adjudicator refused to accept her account as credible because she had not disclosed it at the outset.' (Asylum Aid, 2004).

number of refugee and asylum seeking women have experienced rape or sexual violence and thus require culturally and gender sensitive interventions.

Facilitating Access and Uptake of Therapy

The literature on good practice in mental health provision for refugees recognises the need to make facilities accessible (Watters and Ingleby, 2004; LeTouze and Watters, 2003).

In their report LeTouze and Watters (2003) present the following questions about access and promotion:

- What are the ways in which information about the service are disseminated to potential users? How are barriers to the discussion of mental-health issues overcome?
- Range of languages in which literature on the project is available; numbers of multi-lingual staff/ availability of interpreters
- Geographic/ physical location – is the project/organisations sited in such a way as to be easily accessible by public transport? Is there disabled access?
- Financial – what is the cost of the service?”

(LeTouze and Watters, 2003:22)

As well as language and cultural issues (which will be discussed further below), there is a need to ensure that women are able to attend sessions, especially if they are on a low income, have childcare needs or come from a culture where travelling alone to a new place will not be acceptable for a woman.

Language Support

Not all refugees will have sufficient English-language to be able to take part in therapy without an interpreter. Even those with good English language skills may prefer to talk about their experiences in their mother tongue. The provision of a well resourced interpreting service has been described as “the most quickly achievable means of raising the standard of mental health services for this population” by one commentator (Summerfield, 2001:161).

Where possible professional, trained and experienced interpretation services should be used. The British Medical Association recommends that “The use of family, friends and other asylum seekers as informal interpreters should be discouraged as it denies patients the right to confidentiality within their family or community” (2002:11).

Tribe recommends the following in relation to the use of interpreters in therapy:

- That the therapist spends some time before and after the session with the interpreter to clarify objectives and review.
- That the same interpreter is used throughout all the sessions.

- That some thought be given to matching the interpreter to the client with regards to gender, age and religion.
- That more time may be need for interpreted sessions.
- The therapist should avoid specialist terminology.
- That interpreters are trained and experienced whenever possible.
- The therapist needs to be aware that they are talking to someone from another culture and they may understand things differently.
- Remember that health beliefs about psychiatry vary in different cultures.
- Bear in mind that some words don't translate in an exact way.

(Tribe, 2002)

Practical Support

Refugees are often in a difficult position in the UK. Even once refugee status or leave remain has been granted and they have access to employment and benefits, many remain on low incomes, in unsuitable housing or unsure of how to access basic services. This might be because they are unfamiliar with the UK systems, or they may lack confidence or language abilities to make the most of any opportunities. They also face discrimination and misunderstanding from the host population. They may be struggling to overcome ongoing psychological difficulties caused by events they witnessed and the hardship and uncertainty caused by a long and complicated bureaucratic process to hear about their asylum claim.

For asylum seekers, the situation is even harder – they cannot access work, they may have been dispersed to an area where they don't know anyone and there are inadequate support networks (Griffiths, Sigona and Zetter, 2005). For those who have been refused asylum but have not been deported they have no access to any public funds and many become destitute and reliant on charity (Refugee Action, 2006).

Because of this, most best practice guidelines strongly emphasis the need for therapy work with refugees to be done alongside or after the provision of robust practical support (Tribe, 2002; Rees et al, 2007; Watters, 2001; Watters and Ingleby, 2004; Summerfield, 2001).

Watters summaries the need for this practical support succinctly:

“An asylum seeker with grave concerns regarding communication with family members in another country, or who does not know where resources to feed her family will come from, is unlikely to be receptive towards treatment in the form of counselling or psychotherapy” (Watters, 2001:1713).

Helping a client to improve their situation may also make it easier for them to trust their therapist and so help with the clinical aspect of the interaction (Rees et al, 2007).

Some therapists may not be in a position to offer support themselves, either because of a lack of knowledge about advice and information or other restrictions. This could be overcome by working in partnership with other agencies. In their review of UK best practice LeTouze and Watters highly recommended multi-agency linkages – including links between health authorities/trusts, statutory bodies and other agencies in order to avoid repetition of service, to tackle multiple need and to pool skills and resources, including information (LeTouze and Watters, 2003:26). It is important not to leave voluntary organisations from this list. Refugee-led community organisations are often a vital source of information and support on a whole range of issues (Griffiths, Sigona and Zetter, 2005). Tribe writes that community-based mental health initiatives via such organisations have a number of advantages over traditional therapy routes – including access to a range of practical services in the same agency, but also, taking up therapy provision within a refugee-led community organisation may be more culturally acceptable to the client (Tribe, 2002).

Cultural Issues

In the literature it is clear that for refugees from cultures that are different to those in the West, engaging in therapy may be an odd and unappealing concept.

“The idea of talking to a psychiatrist, who is a stranger, about feelings may be an extremely alien and culturally incongruous concept, particularly given the association with ‘madness’ and different cultural positioning around these issues.” (Tribe, 2002:242).

There is a high frequency of somatisation in refugees presenting at their GP surgeries (Summerfield, 2001) and Tribe believes that cultural differences are one reason for this, saying “physical pain may be much more acceptable than psychological pain” (2002:242). She also notes that for a person who has been persecuted or tortured for discussing their beliefs “the idea of a talking cure may seem initially not only unlikely but frightening” (2002:244).

Best practice guidelines therefore recognise the need for cultural sensitivity (British Medical Association, 2002; LeTouze and Watters, 2003) as “a lack of cultural understanding can offend clients and staff and hinder adequate care” (LeTouze and Watters, 2003:20). LeTouze and Watters (2003) in their review of good therapeutic services in the UK raise the following issues as important.

- User involvement – in order to develop culturally appropriate services for refugees, then refugee services users from different cultures need to be involved.
- Flexibility – over time communities will change and services need to be able to reflect that.
- Gender appropriate services – they ask “is the environment sufficiently non-threatening for women? Is there any record of the number of female clients and reflexivity regarding any special needs that such clients may have?” (LeTouze and Watters, 2003: 26-7)

In regards to refugee women that have experienced rape and/or sexual violence there is a particular need for therapists to be aware of their client's background cultural view of women and sexual violence. This is because in some societies rape may be condoned and women might be blamed for sexual violence against them (Refugee Council, 2009).

In some parts of the literature, culturally sensitive practice involves more than practical issues, however. Watters and Ingleby argue that a good service needs to include "cultural sensitivity, an integrated approach, political awareness and accessibility." (Watters and Ingleby, 2004:567) Accessibility, cultural sensitivity and an integrated approach have already been discussed. But what is meant by 'political awareness'? In other work, also involving Watters, this is defined as 'advocacy' and involves the use of "knowledge on the ground to push for changes in the larger policy arena" (LeTouze and Watters, 2003:27). This would also involve ensuring that clients are aware of their rights to services (LeTouze and Watters, 2003), which touches on the integrated approach combining therapeutic provision and practical support.

It has been argued that services for refugees with mental health problems need to go beyond a simple recognition of the different cultural background of refugees, and also beyond just developing culturally appropriate services (e.g. employment of workers with the same cultural background of the refugee) (Watters, 2001; Summerfield, 2001). Watters believes that in order to go beyond this service providers need to question categories used in diagnosis. He writes:

"The labeling of refugees is supported by a system in which tabulation of numbers with psychiatric labels forms a crucial basis for the mobilisation of broader social supports. This may operate within contexts in which refugees are rarely given opportunities to articulate their own needs or play active roles in the development of mental health or social care services" (Watters, 2001:1716)

Watters' solution to this problem of definitions is grounded in the need, as discussed above, to help refugees to address their practical economic and social situations. His alternative is worth quoting at length:

"a three-dimensional model for the analysis of refugee mental health is proposed. The aim of the model is to highlight the interrelationship between the treatment of refugees in mental health services and the broader social policy contexts in which services for refugees and refugees themselves are located. It is also to suggest that emerging holistic approaches to the treatment of refugees exercise a critical reflexivity in respect to the institutional contexts in which refugees are located and the stereotypes and assumptions that may underpin professional practices" (Watters, 2001:1717).

Summerfield believes that a more appropriate approach might be "one that assumes some background knowledge of the political landscape from which a particular client has fled" (2001:162). He thinks function-focused approaches, rather than the typical emotion-focus therapy approaches may be more appropriate and this, again, links to the need to prioritise practical support (Summerfield, 2001).

Tribe also writes about the need to engage in the kind of therapy that is appropriate to the client. “The major models are the linguistic or literal interpretation; the psychotherapeutic model...or the advocacy model...Explanatory health beliefs and constructions of psychological health or well-being for a refugee may bear little resemblance to those held by psychiatrists trained and practising in the West” (Tribe, 2002:244) and thought needs to be given to this. She also writes that therapist needs to be aware of any assumptions made about their clients’ needs and the underlying reasons for the mental health problems. As an example she recounts the story of a client who had been tortured by the authorities in his country of origin. Initially she thought his distress was because of the trauma of his experiences and of exile. In fact it was due to the loss of his political belief which now meant he perceived his past behaviours as meaningless and as the reason for his torture and why he could not return home (Tribe, 2002).

Other findings

As well as the above thematic issues arising from the literature there are other, more practical concerns that arise in the literature. These don’t fit neatly into the general discussion and so are included here in a list format:

- It is recommended by one practitioner that refugees from the same country are not placed in the same therapy group. Though practitioners may believe this will make the session more culturally relevant, there might be from very different backgrounds and this may cause problems with trust and fears about information getting into the wrong hands (Tribe, 2002).
- Assessment should include domestic violence, child protection and suicide risk and should be done in a transparent and collaborative way (Rees et al, 2007).
- Assessment of mental health needs should occur at an early stage of the asylum seekers application (Watters and Ingleby, 2004:567).
- “Mental health and social care services should be responsive to the stages of the asylum process and provide support at key phases during which clients may be most vulnerable ”(Watters and Ingleby, 2004:567-568).
- There should be continuity of service – “...the problem with short-term funding is that when it ends, refugees are at risk of isolation” (LeTouze and Watters, 2003:26)

Conclusion

This literature review has discussed the general needs of refugees and asylum seekers in regards to mental health provision. This has shown a need for services to be accessible, to involve service users, to use interpreters appropriately, to take the culture of the client and any beliefs they may have about therapy into account. Overall it has been shown that refugees and asylum seekers need to have mental health provision alongside holistic support services, or after their practical needs have been addressed, at least in part.

The specific needs of refugee and asylum seeking women have also been reviewed. This has shown that a high proportion of women in this group have experienced rape or sexual violence either in the conflict or persecution which they fled, in transit, in the process of seeking asylum or in the UK. There is a particular need for therapy provision to take into account the difference in culture. The client may have experienced extreme shame and fear over what has happened to her, and may be very uncomfortable in disclosing their experience to a therapist and/or interpreter.

S.4 Background to the project

Shpresa Programme is a Refugee Community Group founded by women who fled the Balkans conflicts in 1997. When the conflicts in the Balkans, led to human rights violations across many communities Albanian speakers found asylum in the UK. However they experienced real difficulties integrating and establishing a new life for themselves while living in exile. There was no significant Albanian community presence before this in the UK and community resources were sparse.

Shpresa Programme was founded in 2002. From the outset it sought to enable Albanian-speaking refugees and migrants to become active citizens and contribute to UK society. The key areas in which Shpresa works are reflected in the projects that it runs:

- Albanian Supplementary school
- Services for children and young people
- Support for women to promote their health and well being
- Advice and advocacy
- Volunteer training and support – including access to employment
- Campaigning

The ethos of Shpresa Programme has always been to develop user led, family focused services by working in partnership with others and sharing the learning.

The needs of isolated and traumatised women, including survivors of sexual violence had always been high on Shpresa's agenda, however in 2007 the Project Director of Shpresa described how:

'We were working with women on really hard issues and we did not have the capacity to tackle them. We did not have the skills.'
Project Director, Shpresa Programme

The 'hard issues' included depression, isolation and domestic violence, as well as loss of identity and conflicts arising between children who had grown up in the UK and their mothers who had been brought up in Albanian.

Shpresa Programme managed to secure £1,500 from an existing funder to pilot, with the Women's Therapy Centre, a therapy taster session for women experiencing emotional and psychological distress.

The Women's Therapy Centre had been providing psychoanalytic psychotherapy to women for more than 30 years and in 2003 had secured funding to broaden access to psychotherapy for women from refugee and asylum seeking communities. The Chief Executive of the Women's Therapy Centre describes how they were aware that women from refugee communities faced specific barriers to accessing therapy services so they began to leave the therapy room and take therapy into the community:

'...(it was) a very new model of actually going out and trying to establish why women wouldn't come through and what information and support women needed to break down the stigma.'

Chief Executive, Women's Therapy Centre

The Women's Therapy Centre met with Shpresa Programme to identify what their needs were and after the pilot session, which was well received by Albanian women, both agencies decided to develop services which could be delivered to meet the needs of women coping with complex and painful life experiences. The model would involve a two pronged approach whereby Shpresa Programme would provide practical advice and community based support and signposting while the Women's Therapy Centre would deliver therapeutic services. Early on in the development of this model it became apparent that:

'.. staff and volunteers at Shpresa were dealing with and carrying a lot.'

Chief Executive, Women's Therapy Centre

As a consequence it was agreed at an early stage that the project would include the Women's Therapy Centre providing an element of support for frontline staff and volunteers at Shpresa.

So far 104 women have attended quarterly workshops and taster sessions to get information. Seventeen women have been referred to therapy at the Women's Therapy Centre. Of these 17, seven were assessed and four were offered therapy. A further seven women are currently attending the psycho-educational group therapy.

S.5 Findings

The findings are grouped in accordance with the aims of the project – so there are four sub sections to cover each of the four aims. In addition a fifth section has been added to address domestic violence as this issue arose repeatedly in interviews and the focus group. Throughout this section on findings the evaluator refers back to the good practice guidance identified in the literature review.

S.5.1 Albanian speaking women who have survived rape and sexual violence will have clear, mother tongue information about where they can access help.

The evaluator saw two leaflets produced in Albanian and English which described this project and provided information on how to access service. While the provision of mother tongue information is important, and identified as such in the literature, (LeTouze and Watters, 2003:22), it is frequently the case for many refugee community groups that word of mouth is an equally if not more important way of communicating information about services.

‘It works mostly when you talk to them. We have produced some leaflets with ...some information about the project, but mostly..we introduce the idea and talk to women.’

Women’s Development Worker, Shpresa Programme

The women attending the focus group were adamant that they had sufficient information to enable them to access services:

‘We found out from X (the Women’s Development Worker) and the Shpresa Programme. We had enough information before we started.’
Albanian speaking woman.

S. 5.2 Albanian speaking women will get the practical support / signposting they require to enable them to access therapy sessions.

The literature notes that

‘... there is a need to ensure that women are able to attend sessions, especially if they are on a low income, have childcare needs or come from a culture where travelling along to a new place will not be acceptable for a woman.’

The model for this project was developed in recognition of the fact that to enable women from refugee communities to access therapy at the outset information about and access to therapy services has to be delivered from a community based setting, where women are already accessing services.

Women attending information sessions, therapy taster sessions and the psycho-educational group do so at Shpresa Programme’s venues. This means that women do not initially face many of the access issues highlighted in the literature:

‘Well it is local here we just get one bus.’
Albanian speaking woman

‘The approach (at Shpresa) is the family holistic approach, they come to the group and the children go to Albanian School or dance classes. They are being looked after.’
Woman’s Development Worker, Shpresa Programme

Early on there was a recognition that the distance from where many of the women live to the Women’s Therapy Centre (a distance which would involve up to 1.5 hours travel each way) was presenting a barrier to women accessing therapy services themselves. This would mean that women who had accessed information sessions, therapy taster sessions and a psycho-educational group at Shpresa and who then felt that they would benefit from psychotherapy may not then take up a therapy appointment because of the distance.

‘People were not prepared to travel – some don’t know how to travel and could not go alone.’
Project Director, Shpresa Programme

‘...travelling that distance is hard.’
Woman’s Development Worker, Shpresa Programme

‘The distance proved a real challenge – we are based in different parts of London.’
Chief Executive, Women’s Therapy Centre

However, those working on the project quickly adapted to this challenge by providing assessments to therapy at Shpresa Programme.

‘..we decided we needed to be a bit more creative and flexible about how we deliver.’
Chief Executive, Women’s Therapy Centre

This change in how assessments are provided is a big cultural shift for psychotherapy agencies but it has been recognised as a very positive move by all those involved in this project:

‘Us therapists we are used to our lovely rooms and familiar settings, this means we are out of our comfort zone.’
Psychotherapist, Women’s Therapy Centre

This therapist went on to explain how during assessment she develops ‘a bond’ with women and as a consequence one woman assessed at Shpresa now attends therapy regularly at the Women’s Therapy Centre in spite of having to travel over 1.5 hours each way.

The Women’s Development Worker at Shpresa described another instance where a very distressed woman had been advised by her GP to attend therapy but had never taken up the services offered locally. However after attending assessment sessions

at Shpresa she made the long journey, which she acknowledged was hard, to the Women's Therapy Centre to access regular therapy sessions there.

However, distance is not the only barrier to accessing services. The literature has highlighted that the provision of a well resourced interpreting service is "the most quickly achievable means of raising the standard of mental health services for this population" (Summerfield, 2001:161). The literature goes on to draw attention to the need for a professionally trained service and the inappropriateness of using family and friends when interpreting during therapy sessions. This project took the provision of trained and skilled interpreters seriously from the outset and interviewed all interpreters to assess their understanding of the complex issues involved interpreting during psychotherapy for women who have experienced complex losses and abuses.

'... interpreting is more than just the language in this setting.'
Chief Executive, Women's Therapy Centre

In the literature review 'most best practice guidelines strongly emphasize the need for therapy work with refugees to be done alongside or after the provision of robust practical support'. This was a cornerstone of the model for this project, where Shpresa Programme staff saw accessing therapy as part of 'community engagement' to take place alongside access to a range of practical support services.

'We do referrals, signposting for practical support, if they need help completing forms, we contact agencies, translate, interpret, signpost...'
Woman's Development Worker, Shpresa Programme

'Shpresa staff would support and link women who wanted to attend for therapy.'
Chief Executive, Women's Therapy Centre

S. 5.3 Albanian speaking women will learn more about therapy and be able to ask questions about therapy which will give them the information they need to decide whether they want to start therapy.

This project has sought to provide women with information about therapy in a number of ways:

1. Information sessions cover mental health in general, psychotherapy and the services offered by the women's therapy centre. These sessions seek to challenge some of the misconceptions – the idea that to seek help to promote positive mental well being is to be 'mad' or crazy.

The literature identifies how:

"The idea of talking to a psychiatrist, who is a stranger, about feelings may be an extremely alien and culturally incongruous concept, particularly given the association with 'madness' and different cultural positioning around these issues." (Tribe, 2002:242).

Staff working on this project were also aware of this very concrete barrier:

'Back home (if you seek help) you are crazy, mad, you have no support, no one in your family would want to be known with you. .. Don't forget, we are Albanian – we judge for therapy.'

Project Director, Shpresa Programme

'We never knew these things back home... we think they are crazy. We use bad words we say they need psychiatrist.'

Albanian speaking woman

But the provision of information has changed the attitudes of staff and women using the services at Shpresa:

'Y (a member of staff from the Women's Therapy Centre) has had a major impact on us. We are helping women to go to the therapy centre.'

Project Director, Shpresa Programme

One woman attending the psycho-educational group explained that when she lived in Albanian she just thought people were mad and crazy, now with the knowledge she has gained from her contact with the Women's Therapy Centre she realises:

'Lots of Albanian women are depressed... yes, yes they are very depressed...everything builds up one thing after another and they never have a chance to open up like what we are doing now in a group (the psycho-educational group).'

Albanian speaking woman

2. Therapy taster sessions

These sessions provide women provide women with a taste of the therapeutic process and encourage women to express opinions and feelings.

Women taking part in the focus group valued this opportunity greatly as they explained their life here can be hard, confusing and isolating.

'It is hard to go to another country. It is hard to integrate in a short time.'

Albanian speaking woman

'I lost identity...where are you going to fit into this new society?'

Albanian speaking woman

'I can't stop worrying.'

Albanian speaking woman

'We lived in a masculine society a very strong masculine society, everything was dominated by the man and things are changing there now but we have grown up in that way and for us it is very difficult to change and that is why this Women's Therapy Centre is a very interesting thing.'

Albanian speaking woman

For some women there has been a loss of any place they can call home:

'We don't find it easy here. We don't find it easy going back.'

Albanian speaking woman

Women recognised the need to find a place where they can express some of these feelings:

'It is you need to talk...sitting at home makes you more depressed.'

Albanian speaking woman

'.. and if you don't tell anyone how are you going to find a way to, you know, find the right person to talk to...to open up.'

Albanian speaking woman

3. The Psycho-educational group

The psycho-educational group runs for six weeks and seeks to offer women a sense of belonging and support while also in a therapeutic setting. The women attending the focus group described how the boundaries and structure of the psycho-education group enables them to talk safely about their feelings, often for the very first time:

'It is hard yes it is hard yes it is because we are a small community and we know each other more or less. When we started the group therapy (psycho-educational group) it was difficult and everyone was staying quite because we was thinking if I say anything this she is going to judge me and that is the point at which everyone will stay quiet. But the second session was interesting as everyone took part... Well the person who came (the therapist) she made us realise that nothing will go out you know she said everything will be private here. She made you confident to talk. That is why you are in the session you need to open up, to bring all your feelings up.'

Albanian speaking woman

By basing the psycho-educational group at Shpresa Programme and adapting it to meet the needs of the women as they explore the concepts of therapy and learn to speak about some of their experiences for the first time, this project is working in line with best practice as identified in the literature. The literature tells us that 'Refugee-led community organisations are often a vital source of information and support on a whole range of issues' (Griffiths, Sigona and Zetter, 2005) and that community-based mental health initiatives via such organisations have a number of advantages over traditional therapy routes. These advantages include access to a range of practical services in the same agency, but also, taking up therapy provision within a refugee-led community organisation may be more culturally acceptable to the client (Tribe, 2002).

It was apparent to the evaluator that the information sessions, therapy taster sessions and psycho-educational group, which have been accessed by 71 women to date, are an innovative and responsive ways of providing women with the information and experiences they need to decide whether to start therapy or not. What is more, women evidently valued these sessions and groups and found them helpful in and of themselves. Section 8 identifies in greater details the positive outcomes experienced by women attending these services.

S. 5.4 Albanian speaking women will receive culturally and gender sensitive therapy which will help them to identify / express painful emotions and learn less damaging ways of managing fear / distress

In the first year of this project ten women accessed assessments for therapy and four of these women then attended weekly psychotherapy sessions. While the nature of the psychoanalytic relationship means that it would be inappropriate to interview these women the therapist and staff at Shpresa were able to identify how for these women therapy is providing a safe space where they can begin to express painful emotions for the first time and find less damaging ways to cope with their distress.

‘(these) women themselves felt already empowered and motivated for change.’

Psychotherapist, Women’s Therapy Centre

‘If I can take one woman who has been receiving therapy, her feedback has been very, very positive...people are able to recognise the need for therapy.’

Woman’s Development Worker, Shpresa Programme

More information on the impact of therapy on the lives of these women is in section 8 on outcomes.

S. 5.5 Domestic Violence

Addressing the issues raised by domestic violence within the Albanian community was not a stated outcome for this project. However, the evaluator has identified the work that has taken place in this area during the first year of the project has been innovative and is potentially a model that can be transferred to other communities.

There is little variation of domestic violence rates across ethnic groups (Walby and Allen, 2004). However, women have come to the UK seeking refuge from persecution or armed conflict, who subsequently experience domestic violence, have complex needs which require specialist consideration and support, (Refugee Council, 2005).

‘There is an issue with domestic violence. It is very complex.’

Woman’s Development Worker, Shpresa Programme

‘Domestic violence is a big issue in our community. It does very much. We have to open up about it. It is hard...It is true what they say. They (parents and cousins) would judge you (if you left). Not the man.. you are bad.’

Albanian speaking woman

For staff at Shpresa Programme, the issue of domestic violence, was a very strong factor in their engagement with the Women's Therapy Centre. Before they began to work with the Women's Therapy Centre a service user from Shpresa was killed by her husband when he found out that he had consulted a solicitor with a view to divorcing him.

Staff at Shpresa realised that this was an issue women were reluctant to discuss for fear of being judged, or because they felt culturally this was the norm.

'So is the issue people try to hide, put a brave face, deal with it. They feel they can manage...'

Woman's Development Worker, Shpresa Programme

They decided Shpresa Programme should run some workshops to provide women with information and advice. But this was not well received by some male members of the Albanian community:

'..one husband said to me: 'What are you doing to our women? Teaching them to separate us?'

Project Director, Shpresa Programme

'There are risks that exist...I can't say everyone will be happy (we are addressing the issue of domestic violence). Some people don't accept these things are domestic violence, some people say it is good.'

Woman's Development Worker, Shpresa Programme

Staff at Shpresa Programme discussed these issues with staff from the Women's Therapy Centre and it was agreed that the Centre would run sessions on domestic violence as part of the joint project. This had a number of benefits, which included protecting staff and providing women with expert support from outside their community:

'It helps having an agency at outside comes to deal with these issues. It is like bringing specialist in on the issue...they give women a sense of security. They say it is not just in our country (that domestic violence takes place).'

Woman's Development Worker, Shpresa Programme

'.. did women feel ok about raising this with women from their community. Plus there was an issue for staff having to hold all this and risk that they would be attacked – not necessarily physically but via disapproval from others in the community. By having the Women's Therapy Centre come into Shpresa it took the focus away from Shpresa staff, to enable women to deal with it in less complicated ways.'

Chief Executive, Women's Therapy Centre

S. 6 Partnership Working

Partnership working was not mentioned as an outcome for this project but throughout the evaluation process it was apparent that key to the success of this project in delivering high quality services to women who usually do not access such services, has been the development of a unique partnership. The Women's Therapy Centre and Shpresa Programme in many ways are very different in terms of the services that they deliver. Shpresa Programme provides flexible services delivered seven days a week and in a family focused manner. As a community and user led organisation the focus is on flexible needs led services and taking the services to the user.

The Women's Therapy Centre is rooted in the psychoanalytic tradition, where they develop a safe space for women to work through painful experiences and identify their own resources to addressing past losses and trauma. The emphasis is on providing boundaried, structured therapy sessions which are time limited and without distractions.

This project has been repeatedly described by staff from both agencies as requiring them to move 'outside their comfort zone'. This has been hard at times. One woman was assessed by the Women's Therapy Centre as not being in a position to benefit from therapy. For an agency like Shpresa Programme turning someone away from a service runs counter to their ethos. For the Women's Therapy Centre the priority has to be acting on the clinical assessment's findings in order to protect the safety of the client and therapist. Shpresa staff discussed their concerns and were relieved that staff at the Women's Therapy Centre understood the issues:

'X (a member of staff at the Women's Therapy Centre) gets this. She really, really understands'

Project Director, Shpresa Programme

The Women's Therapy Centre has now provided Shpresa with information on where else they can refer women seeking psychological support.

Staff at Shpresa have not always understood why timing for therapy sessions have to be kept to so rigidly and they have also questioned why services cannot be provided at weekends. Staff from the Women's Therapy Centre agreed to run some weekend end sessions and have sought to explain the importance of boundaried therapy sessions.

Staff at the Women's Therapy Centre have provided assessments in the community for the first time and have embraced this shift to making their services more accessible. They have also relied on Shpresa staff to assess women for acceptance on the psycho-educational group and have been impressed by the skills shown by Shpresa staff in assessing the mental health needs of vulnerable women.

Both agencies know there will be differences that arise in the future but there is a strong sense that the partnership is strong and valuable:

'We learn from them and they learn things.'
Woman's Development Worker, Shpresa Programme

'It has worked well. There is a lot of common ground. We are both trying to adapt and make it ok. They have done adaptations as well. We know from talking to X (therapist) they went out of their comfort zone.'
Project Director, Shpresa Programme

'What I personally appreciate is the mutual respect from the organisations. We listen to each other... this is two cultures meeting. For two cultures to find something mutually satisfying and comfortable there needs to be a lot of trying. What has made it worth it is the sincere wish of both organisations to make it work and believe it will work.'
Psychotherapist, Women's Therapy Centre

'Working together is something that is quite lively... for both organisations, you end up going outside your comfort zone. It can be a bit threatening and weird but ultimately enlightening... it is possible to be able to share and develop services together.'
Chief Executive, Women's Therapy Centre

S.7 Outcomes

Women were very clear about the outcomes of developing an understanding of the therapeutic process and learning to talk about their feelings and fears:

‘You feel relieved....All the weight is from you....You don’t feel alone...You want to go again and again...You open up and share with a relief...At least you feel proud of yourself – you have spoken that day...The weight has gone...We don’t feel alone. We feel we can find people to deal with our problems.’

Albanian speaking women

Staff from both agencies can also recognise the impact of the work on women:

‘People are talking about therapy. There is less stigma... Women are confident to talk and go for it and have a try. They know what it is now.’

Project Director, Shpresa Programme

‘I do think women have begun to raise issues that have been quite a bit out of bounds. They are discussing domestic violence, their relationship with their children and young adults who are not from their culture and the challenges and stresses this poses for them as mothers, living in this country...and the big issue is their relationship with their husbands and how women have changed in a different way to men...’

Chief Executive, Women’s Therapy Centre

However the impact of this project goes beyond the outcomes for individual women. Both agencies have developed and gained knowledge and experience which will feed into all their future work.

Staff at Shpresa Programme have learnt not to be afraid of not meeting targets – in new and risky pieces of work it can take time for numbers to build and for targets to be met but the quality and impact of the work is important, not just the quantity of service delivered. The real shift however is more fundamental: it involves learning to discuss and address topics which were culturally taboo, such as domestic violence. It also goes beyond that and include an acknowledgement of the importance of women’s mental health and of a woman’s right to take her own mental well being seriously:

‘We are more positive about the process. This is a new project for us and we are out of our comfort zone – it is something we have not gone through so we are trusting other people. We are doing something very, very hard. We normally would not do...’

Project Director, Shpresa Programme

Staff at the Women’s Therapy Centre have also come on a journey which has resulted in them being more aware of the external realities of life in the UK for refugee women. They have also developed an understanding of how to provide

psychotherapy services in such a way that refugee women can engage and benefit from such services. This has been at times a very unfamiliar journey but is best explained in the words of a member of staff herself:

‘When I went into my first information session I was not sure what to do with women interrupting me and each other to ask for milk or sugar, children crying in the corner and people walking in and out of the room. Soon I realised that these were not my tidy sessions in a quite consulting room. I had to develop a different approach, in fact a different mindset. Now, when I go in, I become part of the setting and I might even enjoy a piece of cake!’
Psychotherapist, Women’s Therapy Centre

S.8 Recommendations

That mental health services for women refugees and asylum seekers are delivered in conjunction with refugee community groups and other agencies women RAS access and trust.

Services should be delivered locally where possible and agencies should assist in transport and childcare to enable women on low incomes to access services.

Women can best make use of therapy if their immediate practical support needs are being addressed. Therapy services should be provided alongside practical support services.

The provision of accurate information on mental health enables women to change the way they think about mental well being, breaking down the stigma and barriers which exist to prevent women accessing services.

Women who have fled situations of conflict and war frequently struggle to adjust to the host culture and can experience a loss of identity, feelings of depression and anxiety and a fear they will be judged as they struggle to reconcile their past with their future. These women value a space where they can talk about these experiences and feelings.

It is important to identify very clear boundaries in therapeutic group work, to enable women to share their experiences and fears with other members of their community.

Agencies should develop culturally sensitive domestic violence services for women RAS as their lack of knowledge about services and sources of support places these women at great risk.

Staff from refugee communities can be at risk themselves if they tackle issues raised by domestic violence. It can help protect staff and make it safe for women to discuss their problems if domestic violence services are provided by the host agency.

Partnership working can be challenging but is essential if RAS women are to be able to access therapeutic services which can work for them. When drafting a project plan sufficient resources should be devoted to planning and project meetings which can help the partnership to develop effectively. Both agencies need to be flexible and willing to move out of their 'comfort zone.'

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Appendix A

Semi structured interviews for staff

Questions for Shpresa – Co-ordinator

1. What practical support and signposting services to women seeking to access therapy to you provide?
 - Publicity? - Information
 - Childcare, travel, signposting, liaison with health professionals? – Practical Support
 - Taster sessions – Knowledge
 - Therapy – impact?
 - Numbers?

2. How do you evaluate your work?

Questions for Shpresa CEO

1. Why this service? – Need
2. How has the partnership been?
3. What are outcomes for women?
4. What are outcomes for Shpresa
5. Challenges? What would you have done differently?

Questions for CEO WTC

1. Why this service? – Need
2. How has the partnership been?
3. What are outcomes for women?
4. What are outcomes for WTC
5. Challenges? What would you have done differently?

Questions for therapist

1. What services are you providing for women?
2. Numbers?
3. Impact?

Appendix B

Focus Group guided questions for Albanian speaking women

1. What services have you accessed?
2. Do you have the information you need? If yes / if no in what way?
3. Do you have practical support that you need? If yes / if no in what way?
4. Do you have knowledge and understanding of therapy to make choice? If yes / if no in what way?
5. How has service had impact on your life?
6. What could have been done differently / improved? What would you change if you were managing / funding this service?
7. Is there anything else I should have asked but did not ask or anything else that you would like to tell me?