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Mental health, trauma and wellbeing of forced and other migrants: effective responses at times of crisis

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MENTAL HEALTH, TRAUMA AND WELLBEING OF FORCED AND OTHER MIGRANTS: EFFECTIVE RESPONSES AT TIMES OF CRISIS

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INTRODUCTION

IT IS widely recognised that the main impact of forced migrant experience involves serious distress and suffering which may escalate to psychosocial dysfunctioning, trauma and chronic mental health problems. These challenges are often affecting not only migrants' and refugees' own lives but also the wellbeing of their families and whole communities. In their majority, these are normal reactions to abnormal situations. To address the mental health needs of such populations, specific skills and approaches are required. The task becomes even more complex as health and mental health infrastructure in host countries are at best unprepared, or at worst non-existent, to respond to these needs. Assumptions, however, are repeatedly made that entire refugee populations become mentally disturbed and are in need of psychiatric care. In fact, psychiatric morbidity and psychosocial dysfunctioning depends on the nature and time span of the conflict, on level and rapidity with which resilience will emerge, based on socio-cultural factors and environmental parameters. Approaches to migrant and refugee mental health care are heavily influenced by Western models of care and not always culturally sensitive or responsive to the needs of these

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groups. Lack of appropriate care in the mainstream services means that often humanitarian organisations are becoming the main providers of care and support for these populations, posing challenges of dependency on this humanitarian aid and sustainability of support without dedicated funding and resources.

In this chapter, I will present a brief critical analysis of access to healthcare, social protection and welfare of forced and other migrants[1]. I will then consider how the concept of refugee trauma and the diagnosis of Post-Traumatic Stress Disorder dominate discussion on the mental health needs of forced and other migrants. I will present some key challenges in assessing needs of these populations and designing appropriate responses by mental health service providers at a time that most European healthcare systems are under pressure to curtail existing resources while being made accountable for compromising quality of care standards. Also, I will discuss innovative and integrated psychosocial models of care in the refugee mental health field, which still remain outside of the mainstream provision rather than embedded responses to the current refugee crisis. Finally, I will argue the necessity of identifying and eliminating existing systemic barriers to recognising the resilience and determination of forced and other immigrants as a key factor in coping with refugee mental health care needs in reception countries. To exemplify the issues addressed, I will draw on studies in relation to the situation of vulnerable refugee and migrant groups, such as women, older people and unaccompanied asylum seeking children in the United Kingdom and Europe.

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[1] I am using the term 'forced and other migrants' to include a wide range of immigrants; those who were forcibly displaced by war as well as by economic hardship; this is in recognition that different categories such as 'migrant' and 'refugee' have become deeply politicised in the context of Europe's 'migration' or 'refugee' crisis. For further discussion, see CRAWLEY, H. / SKLEPARIS, D. (2018) Refugees, migrants, both: categorical fetishism and the politics of bounding in Europe's 'migration crisis', *Journal of Ethnic and Migration Studies*, 44(1), 48-64.

ACCESS OF IMMIGRANTS AND REFUGEES TO HEALTHCARE AND WELFARE SYSTEMS OF THE HOST COUNTRY

A significant trend of contemporary times is that more people are on the move now than at any other time in history. The sheer volume of these migratory movements poses unprecedented pressures on existing state and international systems. According to the International Organization for Migration (IOM, 2015), in 2015 over 1 billion people in the world were migrants, or more than 1 in 7 people globally. The figure includes international migrants - people residing in a country other than their country of birth - whose number reached 244 million (from 232 million in 2013) and it was the highest ever recorded (IOM, 2015).

By the end of 2015, the EU as a whole received over 1.2 million first-time asylum claims, more than double the number registered in 2014, and almost double the levels recorded in 1992 in the then 15 Member States. The increase was largely due to higher numbers of asylum claims from Syrians, Afghans and Iraqis. The year 2015 was also the deadliest year for migrants. Increased levels of forced displacement globally were tragically accompanied by record-high numbers of people perishing or going missing while trying to cross international borders. Over 5,400 migrants worldwide are estimated to have died or gone missing in 2015. According to IOM's Missing Migrant project, migrant fatalities during migration to Europe increased by 15% compared to the previous year, reaching at least 3,770 (IOM, 2015). These trends in migration moves and asylum applications are putting states under a particular - and often controversial - position to reconsider their responses at policy and practice levels.

Forced displacement of populations is a worldwide phenomenon which presents a pressing need for governments and aid organisations to respond to, especially in terms of healthcare and welfare (Fazel and Betancourt, 2018). The mental health of displaced populations has been an important area of clinical work and research to understand how the intersection of biological, psychological, social, and cultural factors explains individual responses which vary on a spectrum from successful integration to chronic mental

illness. It is evident from existing research evidence in this area that forced migrants are highly unlikely to return to their origin countries and, in fact, they seek asylum and resident status as soon as they are able to do so. To do this, they enter a process of asylum application, often prolonged and quite stressful, that causes further mental agony and instability in their lives (Silove *et al*, 2017). A critical factor in this process is the state and international policies in migration and asylum management. Such policies are crucial to the mental health of the population.

Admittedly, the United Nations (UN) Refugee Convention (1951) and later Protocol (1967) put the foundations for a worldwide humanitarian approach, allowing people with "*a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion*" the undeniable right to seek asylum in signatory countries, the right to protection from refoulement or forced return to unsafe homelands and the right to receiving 'favourable' conditions including right to work, freedom of association and movement and appropriate services in the host country. Nonetheless, since the 1980s, forced migrants have received variable treatment depending on whether they were asylum seekers arriving without prior authorisation or "Convention" refugees who were granted residency visas prior to arrival (Joly, 2016). Policies of deterrence were implemented in European countries, North America and Australia, stretching the spirit of the UN Convention to allow differential treatment depending on the rate of inflow and ethnic difference of the received group. More recently, the phenomenon of terrorism pushed boundaries further by blurring the distinction between forced and voluntary migrants and caused additional pressures to loosen or, even worse, to dismantle the key provisions of the Convention for protection of refugee rights to fundamental healthcare and welfare systems (Silove *et al*, 2017). Yet, it has been well documented that refugees and asylum seekers who are resettled in the host country can be affected by a number of interconnected and complex post-migration stressors which is likely to exacerbate mental health problems for those already vulnerable populations (Li *et al*, 2016).

Socioeconomic and interpersonal difficulties, as well as stressors relating to the asylum-seeking process and immigration policy have been identified among those post-migration factors leading to poorer mental health outcomes. Commonly faced challenges by refugees and asylum seekers such as temporary visa status, discrimination in the host labour market, inability to find stable affordable housing, are leading to social exclusion and segregation. These negative experiences in the settlement environment may impact on psychopathology of these groups, compounded by pre-existing vulnerabilities and past trauma exposure (Hoare *et al*, 2017; Siriwardhana *et al*, 2014).

The process of migration, broadly occurring in three stages - pre-migration, migration and post-migration - can be a trying experience regardless of whether it is happening as a voluntary choice or a forced decision. Social and cultural norms and new roles in the host country may impact on the acculturation process and often there is a significant discrepancy between attainment of goals and actual achievement of them during this process (Bhugra *et al*, 2011). Pre-migration vulnerabilities could be precipitated by cultural bereavement at the migration stage and culture shock at the post-migration period. Cultural bereavement refers to the grief reaction due to loss of one's social structures, cultural values and self-identify (Eisenbruch, 1991). Grieving for this loss can be viewed as a healthy reaction and a natural consequence of migration; however, if the experience causes significant distress which lasts for a significant period of time, professional intervention may be needed. In such cases, the person lives in the past, and experiences flashbacks and feelings of guilt. Cultural bereavement may be misdiagnosed as a psychopathological condition due to language and culture barriers, and the application of Western psychiatric diagnostic criteria in non-Western populations. At post-migration, cultural changes in attitudes, family values, generational status and social affiliations could also cause distress and lead to low self-esteem and ill mental health. Contact between the migrant individual or community with the majority new community could result in assimilation, rejection, integration or deculturation (Berry, 2007). Rejection and deculturation are mainly linked to loss of cultural

identity, segregation and acculturative stress, including culture shock and conflict. Racist attitudes of the new society will trigger further feelings of depression, hopelessness and isolation.

The reality of migrants' new life can pose unsurmountable barriers to improved mental wellbeing as most of them will be faced with one or more of challenges such as unemployment, financial hardship, legal concerns, poor housing, separation from core family members etc. Acculturation has been identified as a way of enabling culturally bereaved migrants to achieve a more balanced wellbeing. As acculturation proceeds, a sense of belonging in the new country could be developed which would enable migrants to settle socially, culturally and emotionally, building new ties and support systems. This dynamic and reciprocal process of acculturation would also impact on the broader majority group and dominant culture, increasing opportunities for better appreciation and understanding of migrant physical and mental health needs (Bhugra *et al*, 2011).

Refugee Trauma and Post-Traumatic Stress Disorder

Despite the importance of post-migration experiences, as noted by scholars in the field of migration and refugee studies (Ingleby, 2005), most medical and psychological research concerned with refugees, until recently, was primarily focussed on the effects of past sufferings and little attention was paid to the effects of forced migration or the problems of readjustment in a new country. Most of this work is engaged with the concept of 'trauma' and the psychiatric diagnosis of Post-Traumatic Stress Disorder (PTSD). Ingleby (2005) observes that the popularity of the concept 'trauma' in relation to psychological aspects of the refugee experience rises sharply from the 1968-1977 decade when there are no references of it in relevant literature to the 2000-2005 period when almost half of psychological articles made reference to this concept.

'Refugee trauma' may be referring to a whole range of phenomena connected with the particular refugee reality and experiences (Alcock, 2003). For example, forced migrants are likely to have extreme experiences such as multiplicity of losses and torture,

while fleeing from their home countries (George, 2010); psychological and interpersonal difficulties if detained (Coffey *et al.*, 2010); as well as difficulties with disclosure in Home Office interviews regarding their asylum application (Bogner *et al*, 2010). However, Papadopoulos (2007) warns against refugee trauma being branded as psychological trauma, as the latter is focused on the psychological effect of being traumatised irrespective of external causes. He argues that the presupposition of all those having experienced an involuntary move will become psychologically traumatised, is not valid as not all refugees will be traumatised in a psychological or psychopathological sense.

Trauma, according to Papadopoulos (2000, 2001), is not necessarily a mark of pathology; it is in fact a neutral word indicating that '*a strong emotional experience has taken place and which has left some mark - either a mark of injury or of cleansing and renewal*' (2001, p. 413). People who experience adversity, such as forced migrants, find it difficult to return to previous ways of life and their adversity experiences may be too overwhelming and disorientating, being the cause of severe distress. All too often, the 'refugee trauma' is confounded with helplessness of refugees being traumatised and in need of being cared for. Nonetheless, it is important to understand how these traumatic experiences are managed by refugees and to avoid negative consequences such as learned helplessness or other iatrogenic effects of trauma. Indeed, people who experience a difficult and intense experience may respond by focussing on the renewing rather that the distressing effects of the experience (Papadopoulos, 2007). Thus, through pain, disorientation and loss, people may feel that the very same 'traumatic' experience made them to re-evaluate life priorities, changed their way of dealing with events and led them to acquire new values and meanings. This approach allows opportunities for alternative interpretations of refugee traumatic experiences, as paradoxically, despite their negative nature, such experiences may help people develop their resilience and emerge transformed.

Another concern of 'refugee trauma' being viewed in an exclusively pathological context, is the implied linear concept of a clear causal-reductive relationship between external events and intrapsy-

chic consequences. Such conceptualisation ignores the significant intersectionality of power, control, gender and class on traumatic experiences of refugees (George, 2010). So, it runs the risk of polarized positions and simplistic interpretive formulations in individual and group cases, stemming from the one-dimensional connection of events and psychological experience of the 'refugee trauma' discourse. The psychiatric diagnosis of PTSD can be considered one manifestation of such linear approach (Summerfield, 2001). Its construct was developed by psychiatrists in the United States in the wake of the war in Vietnam and reflected their concern to recognise the suffering of war veterans. When introduced in 1980, this new diagnosis was meant to shift the focus of attention from the details of a soldier's background and psyche to the fundamentally traumatogenic nature of war. There is no doubt that the introduction of PTSD diagnosis has enabled the identification of a distinct syndrome which was previously ignored. Nonetheless, it is mainly a medical concept and neglects the collective parameters of the experience as well as the wider socio-political context within which stressors have been developed.

Clinicians have highlighted the limitations of PTSD's applicability cross-culturally (Bracken and Petty, 1998; Eisenbruch, 1991) and its failure to acknowledge the socio-political events causing these psychological reactions, '*taking the pathological-sounding symptoms out of their context*' (Papadopoulos, 2002, p. 30). Summerfield (2001) makes a more salient point about the misuse of PTSD (over)diagnosis in pathologising distress and suffering, often attaching a psychiatric condition to social events and phenomena, and being an instrument '*by which a moral charge is fashioned into a medicolegal one*' (*ibid*, p. 96). This also raises concerns, according to Summerfield and other authors (Summerfield 1999; Angel *et al*, 2001), in relation to questionable therapeutic interventions involving '*working through*' for people whose cultures value stoicism and '*active forgetting*'. Irrespective of these justified critiques and the scepticism around its uses, all experts agree that PTSD is a useful diagnostic category which helps to identify acute reactions to traumatic events that require specialist attention to those most vulnerable to them.

The tendency to focus on refugee trauma and related psychiatric diagnosis distracts from the equally vital need to consider in more depth the appropriate assessment and response approaches of recognising and meeting the mental health needs of forced migrants. As highlighted above, there is a widespread assumption that whole forced migrant populations face serious psychological problems and require care by mental health services. While this is true for a small percentage of the population, the level of suffering and ill mental health varies on their particular circumstances and exposure to risk factors (Siriwardhana *et al*, 2014). The timely provision of mental health support becomes a critical component in recovery and management of mental health difficulties (Bradby *et al*, 2015).

Challenges in Assessing Needs and Designing Appropriate Responses

Understanding the impact of resettlement factors on forced migrants' mental health over and above the pre-migration trauma has substantial implications for care provision and service delivery. There are a number of challenges associated with assessing care needs and designing appropriate service responses for these populations. These challenges became more noticeable and pushed boundaries of state and other stakeholders involved in the latest crisis since 2015 in terms of efficiency and capacity to respond as well as stretching local mental healthcare resources (Hunter, 2016).

First, most theories, instruments and projects in refugee mental health care have been developed in Western countries and are often implemented without the necessary adaptations to account for other significant parameters of individual and group needs (Altschuler, 2016; Joshi *et al*, 2013). Yet, Bhugra and other well-known mental health researchers, in their 2011 article presenting World Psychiatric Association (WPA) guidance on mental health care of migrants, highlight the important role of culture in the presentation of distress and illness and note that '*cultural differences impact upon the diagnosis and treatment of migrant populations in part due to linguistic, religious and social variation from the clinician providing care*' (Bhugra *et al*, p. 2). They call for increased awareness by clinicians,

policy makers and service providers of the specific needs that migrants may have and urge that their mental health needs to be identified in a culturally appropriate way and services delivered accordingly. More recently, Pottie *et al* (2017) raise the need for humanitarian action and the World Health Organization (WHO) calls for health responsive systems worldwide as a response to the 'European migrant crisis' in 2015. Within the WHO framework, health system responsiveness is defined as "*the ability of the health system to meet the population's legitimate expectations regarding their interaction with the health system, apart from expectations for improvements in health or wealth*" (WHO Health System Responsiveness, online). Forced and other migrant populations may cause unexpected stress to local health and mental health systems. Systems may not be prepared to offer culturally appropriate services such as interpreter services and it may be required to care for conditions unfamiliar to the local health care system, such as PTSD. In Europe and North America, migration may increase pressure on local disadvantaged populations dependent on public social services if authorities do not take action to deal with increased demand (Pottie *et al*, 2017). Key policy priorities in building responsive health and other social systems include raising awareness of the challenges facing decision makers, monitoring health inequities, responsiveness for time pressures and limited local language proficiency.

The second challenge to consider is that, in the recent European refugee crisis, undocumented migrants and asylum seekers experienced lack of access to healthcare as a result of restrictions in social and health care policies. A significant number of them ended up in detention centres near international borders with inadequate and often unmonitored healthcare (Hunter, 2016). Humanitarian projects attempted to address gaps in service provision; however, the humanitarian urge of many well-intended people is not always associated with the needed research and evaluation of the service and care that is provided through these projects (Pottie *et al*, 2015). Indeed, approaches successful in one region do not always correspond to the needs, context and culture of other regions. Highly specialised clinical models may be aimed at the psychological needs of the few people who experience PTSD, while the majority of these

groups who experience psychosocial problems rarely receive adequate support. Moreover, such interventions are not sustainable as they increase the dependency of populations concerned as well as of services of host countries upon external support and hamper local capacity building (Garcia-Ramirez and Hatzidimitriadou, 2009; Kentikelenis and Shriwise, 2016). Acknowledging this challenge, responses need to be more holistic and multi-sectoral. In terms of capacity building, mainstream healthcare professionals need effective cultural sensitivity training, technical advice and support, in order to improve quality of work. Monitoring and evaluation tools need to be standardised and be culturally relevant to maximise impact of project efforts (Bradby *et al*, 2015).

Finally, a significant area which poses challenges for effective care management of forced and other migrants' mental health is the role of health and immigration policies in the host countries. At international level, efforts were made by the United Nations, Global Commission on International Migration, WHO, International Organization for Migration, European Public Health Association and other bodies, to re-orientate health policies for the better protection of migrant and refugee health (Suphanchaimat *et al*, 2015; Pottie *et al*, 2017). These international guidelines and policy directives have been acting as a catalyst between stakeholders in addressing gaps and shortcomings in the national and regional relevant policies. However, such calls for change of policy are competing with pressured policy process at times of crisis and are impeded by limited knowledge and financial resources. Efficient solutions to these challenges are yet to be explored. For example, experts suggest that providing universal healthcare coverage could be more cost effective than providing emergency health care, justifying the expansion and improvement of healthcare services for migrants. To highlight this point, a secondary analysis of national data on health expenditures for asylum seekers and refugees in Germany between 1994 and 2013 demonstrated that if all asylum seekers had the same access to the healthcare system, total spending for medical care over the past 20 years could have been cut by 22% (Bozorgmehr and Razum, 2015). Furthermore, in order to address lack of evidence-based decision making, the emergence of systematic reviews in the

field of migrant health has a significant important role to play in supporting policy development as it has done in other health system areas (Cochrane Methods Equity, online; Lavis *et al*, 2005).

EMERGING PSYCHOSOCIAL MODELS OF CARE

The refugee mental health field has been dominated by '*spirited and at times divisive debates in relation to theory and models of intervention*', broadly between 1970s and 2000 (Silove *et al*, 2017, p. 133). An emergent group of those advocating a critical transcultural perspective questioned and often rejected the dominant Western diagnostic categories such as PTSD and associated trauma-focussed therapies in favour of acknowledging culturally distinct environmental approaches to dealing with the distress and suffering of forced and other migrants. More recently, there has been an increased emphasis on holistic and interdisciplinary frameworks as a foundation for integrated, culturally appropriate, evidence-based, good practice models of care. Before discussing some of the most promising developments in this area, we should note that although very innovative and progressive, these models remain at the periphery of mainstream mental healthcare provision for forced and other migrants instead of being embedded responses in the current 'refugee'/'migrant' crisis.

Miller and Rasco (2004), influenced by social ecological models (*cf.* Bronfenbrenner, 1977), in which factors at multiple levels (individual, family, community and society) impact on human development, suggested a social ecological framework to capture the multitude of stressors affecting refugee mental health. Within that framework, refugee distress is understood as a result not only of violence and destruction of war, but also of stressful conditions linked to social and material everyday life following forced displacement. The ecological model includes risk factors at different points in time (pre-migration, flight and post-migration stressors) and at different levels of the social ecology (Miller and Rasmussen, 2017). Moving from individual to macrosystem level, specific risk factors might include first-hand experiences of traumatic stress; family conflict including interpersonal violence; community ten-

sions and limited resources within refugee camps; discrimination by host communities; and restrictive national policies. A social ecological model expands understanding beyond the field's historical focus on war exposure and its adverse psychological effects, by drawing attention to current stressors associated with life in exile or displacement-related stressors. It also involves mental health intervention strategies that extend well beyond traditional clinical psychotherapy and psychopharmacology. Based on this model, the emphasis of interventions is on supportive social environments to reduce daily stressors rather than on individual psychotherapy dealing with past trauma experiences.

Another multidisciplinary framework developed by Silove (2005, 2013) is the Adaption and Development After Persecution and Trauma (ADAPT) model for post-conflict and low resource settings. It identifies five core psychosocial systems disrupted by conflict and displacement, that is, systems of safety and security, interpersonal bonds and networks, justice, roles and identities, and existential meaning. To restore communal mental health and psychological recovery of forced migrants, interventions need to consider all five core systems. The refugee experience, which involves adversity, wears down the integrity of all five psychosocial systems, thereby weakening social structures and having damaging effects on the mental health of individuals. The ADAPT framework has been used as a conceptual foundation for formulating and implementing a comprehensive refugee mental health programme amongst Iraqi refugees in Syria (Quosh, 2013). This model too emphasises the overall social ecology of the refugee experience and contextualizes the array of interventions which may assist in repairing each damaged system, thereby creating the context for promoting mental health recovery and evaluating the work of such interventions.

At an individual level, having challenged the pathologisation of refugee trauma, Papadopoulos (2007) introduced the Adversity-Activated Development (AAD) model, which refers to the positive developments that are a direct result of being exposed to adversity. In order to systematize the variety of responses to adversity, Papadopoulos devised the 'Trauma Grid', acknowledging the vari-

ous combinations of trauma effects across different levels and perspectives (Papadopoulos, 2004). The grid offers a framework of three possible effects of trauma - positive, negative and neutral - and assists the therapist to consider the totality of each individual's experiences as they relate to the wider network of interrelationships across the different contexts. By focussing on adversity rather than trauma, AAD makes the important differentiation between being exposed to adversity and being traumatised. Resilience, which is deemed as 'neutral', refers to a person retaining qualities that existed before whereas AAD introduces new characteristics that developed as a result of experiencing adversity. The grid reminds therapists to explore the entire range of the refugees' functioning in order to discern the entire spectrum of possibilities at any given time. This means that refugees may exhibit different positive and different negative responses simultaneously. However, as Papadopoulos notes, the grid merely provides '*a useful framework to be utilized creatively in the therapeutic interaction with refugees*' (2007, p. 310).

Resilience, whether individual or community, has been recognised as a key protective factor associated with mental health outcomes in forced migration and its potential importance for reducing psychological distress and suffering through intervention development, especially in resource-poor settings. A recent systematic review by Siriwardhana *et al* (2014) on adult conflict-affected forced migrants, found that the role of gender and prolonged displacement are important factors associated with weaker or stronger resilience. Community resilience and its impact on collective negotiation of traumatic experiences by displaced communities, was also identified as a factor for reducing the overall burden of mental illnesses. The authors of the review propose an emerging theoretical framework of the social-ecological construct of resilience which echoes Miller and Rasco's and Papadopoulos' models by '*contextualising resilience as a product of supportive environments with sufficient resources that aid individuals (or communities) to overcome adversity*' (2014, p. 23).

As a step further into the discussion of resilience as a buffer and resource of mental health for forced and other migrants,

Hatzidimitriadou and Çakır (2009, 2013), in their research with Turkish-speaking migrant women in London, suggest that community activism and community empowerment of migrants are important in promoting meaningful service user involvement and giving a voice to those who may not be able to express and advocate for their needs for care. This could take the form of self-help and mutual aid groups which can assist migrants '*to communicate their needs to the host society, …improving their knowledge and skills as individuals and helping to build bridges with the host and other communities*' (*ibid*, 2009, p.44). Such activities, apart from opportunities to women to develop agency in promoting gender equality and advocate equality of access to healthcare systems - challenges faced by migrant and refugee women, especially those arriving from developing countries - they also present a mechanism to aid their successful integration in the host country. It is worth noting though that similar challenges of disempowerment and need for a synergic approach are highlighted more recently in relation to refugee fathers' mental health, whose needs tend to be overlooked in providing care and recognising gender complexities in supporting them (Papadopoulos and Gionakis, 2018).

Implementation of innovative models and concepts discussed above is evident in more recent examples of mental health interventions with forced migrants. One such example is the Sleep Project, introduced by a multi-disciplinary team working with unaccompanied asylum seeking children (UASC) in Kent, England, one of border regions which saw a dramatic increase of UASC in 2015. The Sleep Project was introduced as part of an early-intervention approach for the children's and young people's resilience and wellbeing (UASC Health, online). Sleep difficulties were identified as a major distress factor in conversations the team held with both the children and staff in reception centres where UASC were hosted. The team adopted a participatory action approach and co-designed an intervention consisting of: a sleep hygiene education, to help the children to understand better sleep mechanisms and implications from poor sleep habits; the sleep pack, devised by the team with the help of children, to give them symbolic and practical tools to have a good sleep; and, a circadian rhythm reset formulation, to help chil-

dren to reset their body clocks and sleep patterns and give them a 'sleep prescription' to use for sleep difficulties. An evaluation by Carr *et al* (2017) concludes that the intervention was very welcome by UASC and made a very significant positive difference in their mental wellbeing, empowering both staff and children to change their practices and normalise an issue which was key to the children's functioning and adjustment in their new life. This non-medical intervention also led to lesser use of mental health services and promoted practices of mutual aid among UASC who used the tools of the intervention to support other children and young people living in the reception centres.

Systemic Barriers to Providing Care

Notwithstanding mental healthcare good practices developed in the last few years, forced and other migrants still face substantial obstacles in accessing services (Giacco *et al*, 2014). Sound research evidence on how mental healthcare should be delivered to benefit these groups is still scarce. A number of systemic barriers preventing access to healthcare, experienced by very different immigrant populations, are identified - language barriers, different beliefs and exploratory models of illness, confidentiality concerns, stigma, reluctance to seek psychological help outside families, and social deprivation. Pathways to care for immigrants, different from those of the non-immigrant population, are mainly non-medical through self-referral, social services and non-governmental organisations. Community outreach activities of these agencies seem to be key in promoting access to care (Chtouris and Miller, 2017). Silove *et al* (2017) note the disjuncture between the breadth and complexity of existing ecological models of mental health and the more limited approach underpinning brief, symptom focussed interventions that are offered in a range of care settings, both statutory and voluntary. Lack of tailored approaches to particular subpopulations of interest and reliable longitudinal data of current use of services by them, continue to hinder needs-based care which also should provide for often neglected groups such as older refugees (Hatzidimitriadou, 2010), women exposed to domestic violence (Hatzidimitriadou and

Çakır, 2009), persons with alcohol and drug problems (Silove *et al*, 2017).

Given the importance of resilience for a positive mental health status of forced and other migrants, it is of vital importance to identify and eliminate existing systemic barriers to recognising the resilience and determination of forced and other immigrants as a key factor in coping with refugee mental health care needs in reception countries. As noted above, restrictive asylum and migration policies led to limited entitlement of continued protection, rights and resources of forced migrants, reinforcing dependency and pathologisation of the 'refugee experience' (Pottie *et al*, 2015). Yet, research evidence suggests that refugees endeavour to be proactive social actors and apply strategies and tactics to overcome these systemic restrictions and support each other (Williams, 2006).

A growing body of evidence is highlighting the need to conceptualise immigrants as co-providers and co-producers of care provision and welfare support. There are calls for the voice of the refugee communities to be heard in conceptualising needs, designing and providing mental health services (Silove *et al*, 2017). This is particularly important for the sustainability of the interventions introduced in the field, especially when these projects are confronted by austerity cuts and very low resources for mental health care in the host European countries and elsewhere (Bradby *et al*, 2015).

CONCLUDING THOUGHTS AND WAYS FORWARD

In conclusion, there is a growing global awareness of the impact of displacement on the mental health of forced and other migrants. While international commitment to help is increasing, greater international cooperation and information exchange is required to remedy the chaos of crisis situations. Given the impact of forced migration on large populations, care on individual basis is not realistic. Community-based psychosocial interventions have to be prioritised and integrated in the primary health care services to create sustainable responses. At the earliest opportunity, people with chronic mental disorders and severe trauma should be identified and cared for. Non-mental health professionals, given appropriate tech-

nical support, have been efficient and instrumental in responding to the psychosocial distress of refugees and migrants. Nonetheless, the development of long term mental health responses to crisis can lead to the reconstruction of relevant, effective and sustainable mental health services.

Forced and other migrants need to be able to access the same primary care services as the local population. Thus, all primary care services need to be prepared to deliver health care to refugees in their local area and some services should develop models of care specifically addressing the needs of refugees because of the demographics of their local communities. Those in receipt of care need to be able to transition into ongoing mainstream primary health care. At times of austerity, this poses additional challenges and requires more flexible care management models and more migrant-centred development which will allow effective maximisation of available limited resources.

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