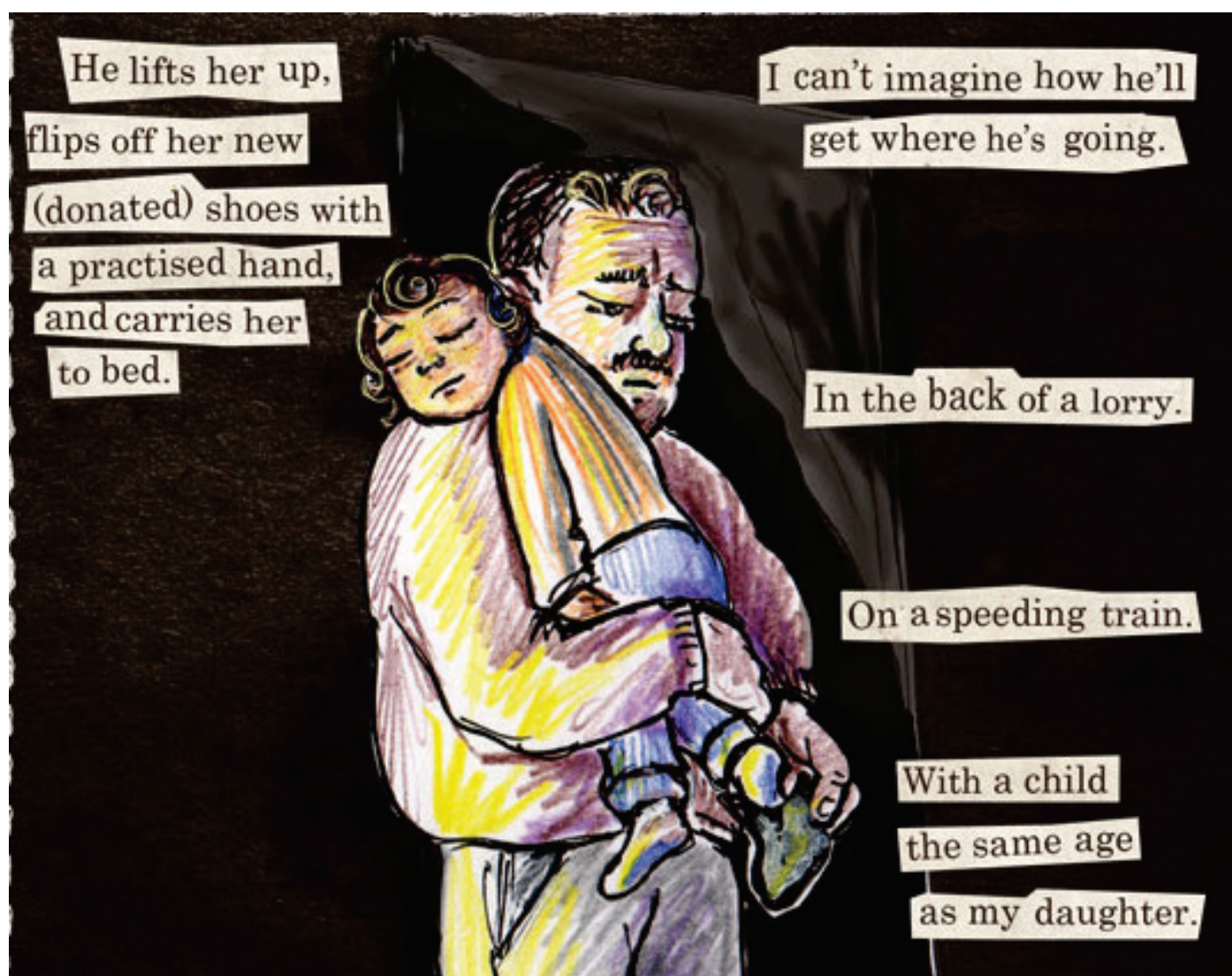


The Student Associate Newsletter

# future $\Psi$ Psych



**Winter 2016 Edition**

Mental Health and Migration

Cover image: Kate Evans is a cartoonist and activist. These cartoons are based on volunteering in the Calais refugee camp. Read the rest of the cartoon and request free copies to sell for fundraising purposes at [www.cartoonkate.co.uk](http://www.cartoonkate.co.uk). Our thanks to her for allowing us to reproduce her work here.

## Reporting Centre

I remember  
the white and black of that day.  
White posters, black print,  
the red doors,  
  
screens coming down  
shutting off faces of workers,  
and us waiting.

A man at the cubicle shouting,  
a man crying,  
white handkerchief fluttering.

Men slumped, heads bowed.  
You with sweat on your brow.

I remember the official in khaki  
with papers leading us through  
the red door  
to a room without windows.

A room without windows.  
Screens coming down.

A poem by Kate Adams

This poem is taken with kind permission from 'The Cheering Rain' by Kate Adams; The Conversation Paperpress. This book of poems draws on her experience with refugees as a volunteer for Kent Refugee Help.

## Editorial

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**The world is experiencing the biggest refugee crisis since The Second World War.**

The vast majority of refugees, an estimated 7.2 million, are fleeing war-torn Syria. The way in which the UK government has responded is inadequate and shameful, accepting only 20,000 of the millions of refugees. Stories, photos and statistics from the current refugee crisis are shocking and distressing.

Psychiatry and mental health is not always the first consideration in relation to humanitarian work. This edition of FuturePsych takes a global perspective and describes some of the local and international efforts of inspiring students, doctors and other health care workers, to improve the mental health of refugees. It highlights how humanitarian-focussed psychiatrists are involved in voluntary projects both around the world and here in the UK. Most importantly, it aims to give an insight into some of the struggles faced by refugees and the consequences that this has for their mental health.

Many thanks to our contributors and thanks to you for reading. If you would like to get involved with the next edition of FuturePsych - *Art and Psychiatry Edition*- please get in touch! **Amy & Laura**

## Meet the team

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**Amy Darwin, Co-Editor**

Amy is a medical student from Leeds University who is currently intercalating in MSc International Health. She is a Student Associate Representative on the RCPsych's Psychiatric Trainees' Committee (PTC).



**Laura Middleton, Co-Editor**

Laura is a Manchester graduate currently working as an F2 Doctor in Bristol. She is also a Student Associate Representative on the PTC.



**Chris Boyce, Features Editor**

Chris is an F2 Doctor working in Bristol. He graduated from UCL medical school in 2014 with an intercalated BSc in Psychology.

Our thanks to Tom Costelloe, fifth year student from Newcastle University, for illustrations

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# Get Involved!

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The next issue will focus on art and Psychiatry.

Have you been involved in an arts and mental health project? Do you know an inspirational individual working in this field? Do you create art in your spare time? Tell us all about it! We are looking for written contributions of 500-1000 words. This can be anything from an interview to a reflective piece to research or literature reviews.

We would also like to feature art work from medical students and foundation doctors, so send us photos of your artwork!

You can submit your pieces to: [FuturePsych@RCPsych.ac.uk](mailto:FuturePsych@RCPsych.ac.uk)

Become a student associate at RCPsych here: [rcpsych.ac.uk/discoverpsychiatry/studentassociate](https://rcpsych.ac.uk/discoverpsychiatry/studentassociate)

## Interview: Dr Peter Hughes



*Dr Peter Hughes is a psychiatrist who has worked in Haiti, Sierra Leone, Iraq and Syria to name but a few! He has worked for the WHO on their mhGAP program and is current chair of RCPsych's VIPSIG. Here he discusses his experiences, getting involved and successful early intervention in disaster.*

### **What attracted you to medicine?**

I had some relatives in medicine and my family had a background in charity work with mental health. I was interested in mental health before I even got into medical school. I was also familiar with learning disability and had formative experiences in this area.

### **How does your work in international psychiatry compare with that in the NHS?**

I absolutely love my job in the NHS and I love my job internationally as well. It sounds like a cliché, but it does feel that little bit more rewarding when working globally. Working in the NHS is both rewarding and fantastic; working globally transforms you.

### **How do you juggle the two?**

That is the biggest tension. I use up all my annual leave, unpaid leave and study leave on

international work. I haven't had holidays in years, but I don't mind that as I just love international work so much and having a complete break from the NHS is like a holiday!

### **Is mental health culturally relative?**

This is an interesting question. Psychiatry is transnational. In our Somaliland project, we put spirituality into the undergraduate curriculum. We have lectures about spirits - we know that religion is so important to people. It is part of the treatment, investigation and management because this is their reality. When I worked in Haiti, I knew nothing about Voodooism, but it was important it was respected. I remember the interpreter once said, 'I'm sorry I couldn't come in yesterday. I had a dream that I shouldn't come into work.' That is something you couldn't say in the UK, but we accepted it.

### **How do you manage working in disaster relief if you do not know the people and their culture?**

I feel very comfortable in some cultures, such as Islamic cultures, where I have spent a lot of time. Haiti was a culture that was very new to me, but it is a two way process. You learn as you go along and always question, 'could I be wrong?', and think about other hypotheses on reality. If someone believes that they are possessed by a spirit or a voodoo zombie or whatever, I am not going to say that is not reality. In training in Haiti, there was discussion about different classes of zombies. I couldn't take part in it, but it was interesting to hear how concrete that belief was.

### **Should we work with traditional healers?**

I think it is a difficult relationship. I know that some traditional healers beat, starve and burn people, for example to try and get rid of spirits. I can't work with those people. But for others, you can form a useful relationship. In Sierra Leone, so many traditional healers had died, and it was an opportunity to work with people who had maybe lost their customers or their prestige.

## **Is bearing witness to human rights an important role in international psychiatry?**

It is really important and talked about more and more. Some might say, thinking of cultural relativism, it is not for me to say that something is wrong. But I am ready to say that domestic violence is wrong, that FGM is wrong – it's not acceptable. But do I say to people that polygamy is wrong? How do I deal with people that are tied up or chained up? In one place I have worked in in Somaliland, they began a process of de-chaining people; within a short space of time, 8-10 people had broken their legs trying to jump over the walls. It's not black and white. I saw one lady chained in her home, but every time she was unchained she would run into the war zone, so they were really protecting her. Human rights can be nuanced; you need to protect peoples' autonomy. If there is a breach of human rights, work with that family and community to try and work towards resolution and safety.

## **How did you find working in Sierra Leone, considering the prevalence within sub-Saharan Africa of attitudes perceiving mental health as a punishment from religious forces? [question from Marilia Gougoulaki]**

I am thinking of an anecdote. I was in a faith based hospital in Sierra Leone in the worst month of the Ebola crisis where there were hundreds of cases a week. The head of the hospital said, 'We are safe from Ebola, because of our faith'. It was a very uncomfortable situation as it was unsafe Ebola practice.

I think that Sierra Leone has been through so many terrible times, such as war and the scourge of Ebola, that I never felt people were blamed for getting it, but there was a lot of stigma. People who were working with Ebola were stigmatised and people who had survived Ebola were stigmatised. It might have been my imagination, but I used to have dinner with the same people every evening. When it became known that I had direct contact with Ebola, I suddenly found myself

eating alone. It really brought it home to me what it is like to be a victim of stigmatisation and I felt horrible.

Much of my work in Sierra Leone was not linked with mental health but more with psychological distress and how Ebola affected people mentally from a public health perspective. The increase in mental illness such as bipolar and schizophrenia that you expect after disasters was not something that you saw. In Haiti, we saw a classical response to disaster - a 5% increase to mania, distress etc. Clinics were busy, but that was only one side of it. The other was psychological distress in the community. That was where the community came together and resilience was through families and religion was incredibly important and a real binding factor. I suspect this is why we saw little PTSD, as there was such a protective factor in religion and community.

## **What one early intervention in this setting is the most effective? [Question from Lins Michelle]**

I honestly think it is telling people, 'You're doing really well. You may be having palpitations, anxiety feelings, but you are not seriously mentally ill'. This is where I differ from some people, in saying 'you have a disorder' as I say, 'you're actually doing really well' and spend time doing relaxation techniques and breathing exercises, reassuring them that their physical symptoms were due to stress rather than anything else.

## **How can professionals who are themselves in a traumatic environment best be supported and how can they best look after themselves? [Question from Lins Michelle]**

I think immediately of the Assidi camps that I visited in Iraq earlier this year- a tough and painful experience. You could see how stressed and pained people were, they had been displaced from their home villages, they had seen terrible things. There were sexual assaults, beheadings, murders. When we spoke to the health workers

about mental health and psychological distress, I think they found it a bit hard to take as they were so committed to helping their colleagues and fellow villagers. They were burying themselves in work, but it wasn't healthy because you could see that it would break down. I have seen as well, with the volunteers in Haiti in particular, that as they got stressed, accidents happened e.g. needle-stick injuries.

The ways we can help people with are the principles of psychological first aid; a way of people dealing with disasters or difficult situations. It is a practical, supportive and humane approach. For example, the practical side - in Haiti, if I saw a person in distress and they had no shelter, or no money I might need to see where we could get a tent for them or some money so that they could get some accommodation. Or if they had been raped where they were living, could we organise alternative accommodation for them and PEP in case of HIV risk. The humane side - in Sierra Leone we told people in the treatment centres, try and call people by their name, make sure their food is next to them, not in a tray on the floor. The supportive side is about listening to people, spending time with them. Not as a clinician, just as a human being.

For health workers as well, they need to get this kind of support from each other and have a healthy work life balance. In Haiti, some of the volunteers from the US and Canada got very distressed when we told them their shift was finished and they should go home. The reality was that people probably did die because they weren't there, but you have to protect volunteers as well. We as doctors think that we are immortal and infallible and that we need to work all hours.

### **Is being humane, practical and supportive the best advice when thinking of helping Syrian and other refugees in the UK?**

I think that absolutely. If you think of what you need when you move to a new country, it is the

practical things, kindness, patience. People who are under stress may do things that get on the nerves of others, so people should remember to step back and remember that they have been on a long journey to get here.

### **Describe your experience at the World Health Organisation.**

This has been a really great experience for me and has given me a lot of opportunities. I have been able to meet great people around the world. Being in the Geneva centre when Ebola was at its height was something amazing, I have never seen anything like it. It was like a space system - so many experts, cameras and TV screens. I am impressed at the amount of materials they produce and I have learnt so much about their public health perspective. I have moved from being a psychiatrist, to being able to take skills of psychology, occupational therapy, social work and nursing. I have had to expand my repertoire and be so aware of cultural factors. There have been negative factors as well. It is such a big organisation that it can be slow and frustrating. It is really important to work with the WHO though, as they have the ears of the governments of where you are going to be. This can make doors open and affect change.

### **How can students get involved in global mental health research, particularly if you don't speak another language? [question from Vicky Wing]**

The example I can give is our project in the UK where we link students with people in Kashmir and Somaliland. Intercalated degrees are another way of studying global mental health and the projects that come out of that. Research is a strong interest area in global mental health and medical students should get involved by doing the donkey work of collecting data. Try and get a good supervisor involved who can make it an interesting experience. For medical students, there are also possibilities during electives.

*Interviewed by Amy Darwin.*





**The Royal College of Psychiatrists is pleased to announce the return of Medfest for its 6th year.**

Medfest is a medically themed film festival run by UK psychiatry trainees. Every Spring, medical schools around the UK and Ireland hold evening events. A selection of short films, clips and animations are shown and discussed by a panel of distinguished or famous faces before the floor is opened for audience comments. The dual aims of MedFest are to increase interest in psychiatry and to inspire people through film.

**The theme of Medfest 2016 is: 'Framing Trauma: Conflict and Medicine'**

This year the films will aim to consider the depiction of trauma in film and its relationship with healthcare and medicine. We will seek to encourage audience opportunity to reflect on the impact of conflict in a variety of contexts on both physical and mental well-being and to discuss the role of both medicine and mental health care in these situations as well as considering positive coping mechanisms and resilience in face of difficulties.

**Where does it happen?**

In 2015 a total of 46 events were held globally, comprising of over 25 medical schools in UK. Further successful events were held in Ireland, Portugal, Pakistan, India, Canada, South Africa, Australia and the US, reaching a combined audience of more than 3,000. Keep checking the site for updates on which areas MedFest is reaching in 2016!

**Who can come and how much does it cost?**

Anyone and nothing– the majority of our audiences tend to be medical students, though our events are relevant to all health professionals and film fans. Members of the public are most welcome.

MedFest is largely funded by the Royal College of Psychiatrists, with additional funding being accrued from both national and local sources. So there is no entry fee. Most events also carry free refreshments. MedFest does not receive funding from pharmaceutical companies.

**Events confirmed so far include:**

London (KCL, Bart's, St George's, UCLU), Birmingham, Cambridge, Keele, Dundee, Nottingham, Lancaster, Bristol, Oxford, BSMS, Edinburgh, Leeds, Sheffield, Southampton, SWD, UEA, Belfast, Galway, Limerick, Cork, Surgeons of Ireland, UCD with more to follow.

**Please see <http://www.medfest.co.uk/> and @medfest for further details and local contacts information. Event details will be updated as they are finalised. If your local PsychSoc is not yet involved we would love to hear from you at [medfest2016@gmail.com](mailto:medfest2016@gmail.com) as there is still time to get in touch and bring an event to your area!**

Dr David Bell ST4 GAP/Medical Psychotherapy (Belfast, Northern Ireland)

Medfest 2016 Lead

## Farasat's Story



*"Everybody has the same rights at the start and at the end. So why do people discriminate against each other?"*

Farasat was born in 1994 in a small town in Pakistan. He was living in a very peaceful environment with his family, until 2012. At the time he a student in the same high school that his father was a teacher, and also the president of the local council's department of education.

*"We never thought about leaving our homes. We are still in love with our country, but we have no options".*

*Due to discrimination between religious groups, his family was forced by the government to leave his posts and give up all his finances and properties, and was eventually imprisoned as well.*

*"Lots of people tried to encourage my father to escape. But, he didn't want to, and went to his job every day until he was arrested".*

*"We are Muslims, too. Only God can judge people in our religion. But our community is excluded*

*from the society because of the differences in our beliefs. My father dedicated himself to teaching children, and he became a very important person. But he was blamed for teaching Muslim children, and my siblings and I were blamed for playing with them..."*

*"The main common rule in every religion is respect. And our own people weren't respectful to us... We didn't have any hopes for our future in the country".*

Farasat stopped studying, and when his father finally finished his sentence, they began to look for possibilities to leave the country.

*"We didn't want money, we didn't want power. We only wanted to save our lives..."*

It was difficult for them to decide to leave a country that they were so committed to. Farasat said they were ready to give everything for their country. It was too risky to bring the whole family at the same time because all of them were being threatened. They moved city to city until they came to London in December of 2012.

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***"Everybody has the same rights at the start and at the end. So why discriminate against each other"***

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He still remembers exactly the conversation between his father and the UK border police. His father said: "Do you think that I am a wrong person? I spent all my life in Pakistan and I am 55 years old now. If you send me back, they are going to kill us. And if I am going to die anyway, you can kill me here in UK. It doesn't matter where I die." And they received refugee status at the border. The UK helped them to reunite their

family in September 2013.

*"I found my life at the last point of it. Hope is never finished".*

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**"I had to start my life from zero in a new country. New culture, new language, new people"**

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Farasat had many barriers when he came to UK. At first he was living in a very small town and it was difficult for him to learn English there.

*"My dream job was to become a scientist, but life didn't allow me to progress towards that dream. I had to start my life from zero in a new country. New culture, new language, new people... But I am happy for what I have accomplished in the last 3 years in UK. I really worked hard to improve myself".*

*"Firstly, I started going to a charity every day which helps young people. Although I couldn't understand the language at first, I tried to communicate with them through body language. After a while everything changed. I began to understand, I began to talk, I began to be more involved... And now I am the ambassador for the Prince's Trust [a UK charity] and I became the finalist for 'Young Ambassador of the Year'".*

He found a part time job and he started to study again. In 2014, he was able to go to college again and he is a 2nd year student in a Business Law programme at the University of Greenwich this year.

*"I respect the UK and I will never forget what it has done for my family. Our past is finished, and a new life is beginning. Now we are here, and this is*

*our country. They are great people in this country that's why the name of the country is Great Britain. Most of the people are well educated here and they can understand the situation of migrants. They want to help".*

He is now very worried for the Syrian people, as he has lived through similar experiences as well.

*"All countries should help the Syrian people because they have lost everything. No family, no city and no country left for them... Because of that they are taking a huge risk in the Mediterranean to reach a safe place. European people please, please respect your neighbours ".*

He said he will continue his studies as much as he can and fight for peace, dedicating himself to solving the problems of other peoples.

*"Everybody in this world is an immigrant, except those living in their country of birth. And every baby is the same in the beginning, except for where they are born. The countries, the people and the circumstances shape them during their lives. And in the end, everybody dies. Everybody has the same rights at the start and at the end. So why do people discriminate against each other? I don't understand this! This is my question to the whole world".*

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**"Our past is finished and a new life is beginning. Now we are here, and this is our country"**

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**Fasarat's Story is printed with kind permission from *i am migrant*: a global campaign to challenge the anti-migrant stereotypes and hate speech in politics and society.**

<http://iamamigrant.org/> @iamamigrant

## Interview: Dr Mina Fazel



*Dr Mina Fazel is a Psychiatric Research Fellow working in Oxford, who has a special interest in refugee mental health.*

### **How did you come to be involved in psychiatry and refugee mental health?**

I studied social anthropology in the middle of my medical degree as I was interested in the influence of culture and how people live. One of the topics covered was cross-cultural psychiatry, and I found this particularly fascinating. I found psychiatry the most interesting aspect of medicine because the best way to manage a problem was not always that clear and we needed to think together as a group of practitioners with the patient and the family as to what might be the best way to manage the presentation. With psychiatry there are so many factors at play – the interplay of family, society, cultural influences - not just a disease to diagnose.

After graduating I took jobs in a range of specialties, including neurology, neurosurgery, and A&E. I still found psychiatry the most interesting part. I was always drawn to the most

complex patients, who often had significant psychological aspects to their illness. I returned to Oxford for training but never rushed anything. I took years out to conduct research and worked for a time with aboriginal populations in Alice Springs. After completing core training I fortuitously fell on my feet to work with refugee populations in Oxford, as Professor Stein had been approached by a charity that wanted to set up a school-based service for refugee children.

Meeting such an incredibly resilient, amazing group of individuals treated so badly in their country of origin, and even in the UK, captivated me. I felt it was very important work and tried to continue working with them as much as possible by directing my research interests and questions around the topic of refugee mental health. My main job now is as an NIHR post-doc, though I also work with physically unwell children in the Children's Psychological Medicine Services in the Children's Hospital, Oxford University Hospitals NHS Foundation Trust. My research is oriented towards clinical service delivery, and how services can access the most vulnerable populations.

### **What are the mental health needs of refugees arriving in the UK?**

The main need of this diverse group is to find ways to integrate easily. The host population needs to think about what we can do to welcome these individuals into our lives. Their main mental health need is to feel accepted: to be able to earn a livelihood and feel they deserve to do so; to access education and look after themselves and their families. Every refugee population is incredibly different, though research shows that a 30% will have either depression, PTSD, or both.

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*"Each refugee group is a unique group with its own challenges and difficulties"*

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## **How do the services provided in Oxford compare with those offered elsewhere, say in London?**

Refugees are not the only vulnerable population group in Oxford, and there is lots of work that still needs to be done in improving service provision for these populations. Resources are incredibly stretched across the board when compared to parts of London, which have dedicated trauma services for migrants (though also larger migrant populations). There is a need for both specialist knowledge and general knowledge amongst clinicians, as the majority of needs will present to primary care.

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## **"Increasing use of detention and threats of repatriation, may clearly be detrimental to wellbeing"**

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### **Have any lessons been learnt from previous waves of refugees and migrants to the UK?**

Each refugee group is a unique group with its own challenges and difficulties. Though science may have improved with time – we have a better evidence base for what works – that doesn't necessarily mean that changes have been implemented and that services have improved.

The way that immigration law is changing is not particularly advantageous - the increasing use of detention, and increasing threats of repatriation, may clearly be detrimental to refugee wellbeing.

### **What can be done to overcome barriers to accessing mental health services for refugees?**

New routes for delivering services need to be established, with a greater focus on community-based services. Working closer with primary care and charities that deliver incredible services to these populations, as well as working hand-in-hand with social services and education services can open up access to mental health services. At the moment these are very separate services, but

populations need all of these things in one place to ease access.

A sizeable portion of refugee populations are unaccompanied minors, with no parents or primary caregiver travelling to the UK with them. Helping these groups of individuals - many of whom come from countries that simply don't have mental health services like we do - is a challenge. Mental illness is often highly stigmatised in many populations, and refugees might often fear that any contact with services might cause them to be deported, or negatively impact on their asylum application.

### **Is there any charitable or non-governmental support available?**

Humanitarian and charitable organisations traditionally fill in these massive gaps, playing a very important role. These include the Medical Foundation for Victims of Torture, the Helen Bamber Foundation, Medical Justice and Refugee Resource in Oxford. Some needs are met by these groups, but it will be interesting to see how clinicians and psychiatrists can work with these services to better standardise and improve accessibility to services.

### **How could students and doctors get involved in helping refugees with mental health issues?**

There are lots of ways to get involved. For example, here in Oxford, we are in the early stages of trying to set up an Oxford Refugee Health Initiative. We hope to develop an enhanced service run by medical students. Students often have the commitment and time to be able to develop relationships with newly arrived migrants. We are at the early stages of trying to bring this forward, but this shows the potential impact that medical students can have!

*Interviewed by Lauren Passby, 5th year medical student, Green Templeton College, Oxford.*

## Psychiatry in Conflict

*Patrick Strong is a psychiatric nurse who has held various posts in the NHS - in clinical, teaching and management roles. He was attracted to the psychological and speculative aspects of psychiatry and has been fortunate to work on development projects with international NGOs.*

I have worked in capacity building in Eastern Europe and Armenia following the political changes in those countries. The aim was to strengthen their management skills and introduce democratic styles of management in contrast to the autocratic system under communism. An understanding of political ideology was key as concepts of initiative, trust and enthusiasm in the workplace could seem alien. People were relieved at some of their new found freedom, but worried about their precarious economic situation and thus depression and anxiety was common.

I also began a project in Kenya and Uganda teaching counselling skills and mental health awareness for seminarians; mental health was highly stigmatized and there was a mixture of traditional beliefs and traditional medicine.

I was a member of the Geneva Initiative in Psychiatry which sought to strengthen human rights in Eastern European countries and pave the way for more enlightened legislation, safeguarding the rights of people with mental health problems

I worked at a Territorial Army field hospital and for a time was the officer in charge of the Department of Military Psychiatry. This led me into an intensive study of psychological trauma.

My involvement in mental health in disasters was principally in Bosnia and Albania where there was a large influx of refugees from Kosovo following the conflict there. Many refugees were traumatized by their experiences and the NGO I

was working with endeavoured to provide post trauma counselling. There was also a need to debrief staff who had experienced a degree of psychological trauma themselves and needed support.

Immediate medical needs take priority in disaster settings and much depends on the nature of the disaster. However, where this is prolonged and conditions are chaotic and sometimes accompanied by violence, it is necessary to ensure staff get adequate rest and are able to pace themselves. In these situations, people easily burnout.

I know that students have a lot of pressure and time constraints, but I recommend joining relief work societies in the university or the local city such as Oxfam, Cafod and MSF.

I think it is important to be familiar with supplementary nutrition and therapeutic feeding because in a refugee situation this is a likely intervention. A basic insight into tropical diseases would be useful. Other skills might include negotiation skills and conflict resolution, for example those available at the Headington Institute. Aid workers need to know how to safeguard their own health.

The current refugee situation in Europe is very serious for many reasons, not least the challenge of accommodating a large number of people and supporting them financially. It is particularly serious in the countries where refugees first set foot.

I am not sure what purpose would be served by medical students going to work with refugees in Calais. I believe there is adequate support in Calais already from a variety of organizations. I can see medical students working in the UK with the groups who support refugees and those who are held in detention centres. Find local organizations that are involved with refugees and approach them with offers of help.

It is vitally important for aid workers to avoid being partisan, not criticise the government and to be aware of one's prejudices. Otherwise effectiveness is compromised and the lives of aid workers may very well be put at risk. It would be unethical to take sides and this must be appreciated by all concerned. At the same time it is difficult not to get involved, especially when gross abuses of human rights are seen.

My skills were most tested when dealing with the mass movement of people such as refugees. It is a question of knowing where to start. Another challenge is managing a team of disparate people who may sometimes challenge or undermine the authority of the leader.

Bureaucracy can also be irritating in the extreme: trying to get things done urgently when no one else seems to acknowledge the urgency of the situation. It was also a challenge working in an extremely hot climate and dealing with basic hygiene factors!

The most satisfying part of my career has been my clinical work, supporting and counselling

people in distress. I have also greatly enjoyed teaching and instructing. It is great to see people develop and gain confidence. I continue the counselling part through my membership of the mental health Charity MIND.

It is sometimes the case that people come around to viewing the disaster in a positive light and change their values and priorities accordingly.

I believe we should use every opportunity to encourage a positive take on mental illness and dispel some of the misconceptions around the subject.

There are always limits on what we can achieve and this is the basis of humility. Flexibility is important and personal insight. In times of pressure and stress it is important to be open about one's feelings and avoid a stiff upper lip or macho attitudes. This means being prepared to talk about one's feelings and admit the need for help if this is warranted.



Refugees arriving in Lesbos, Greece. Photo by Fiona O'Malley

## Interview: Dr Niall Campbell

*Dr Niall Campbell is a GP and associate specialist in public health and psychiatry. He is involved with the NHS Trust Chester and Wirral Partnership which has an ongoing link to SW Uganda where mental health services are being developed. He has volunteered for the Medical Foundation for Care of Victims of Torture, MS and the Red Cross, amongst others. He has also worked across the globe in places as diverse as Nepal, Zimbabwe and Ethiopia. Here he talks about some of his experiences, how he became involved in global mental health and provides some tips for aspiring psychiatrists.*

### **What triggered your interest in global mental health?**

I had an interest in international health and psychiatry early on but needed a springboard to translate these interests into a career. Whilst I was studying for my diploma in tropical medicine in Liverpool we had a number of inspirational speakers including Dr Rowan Wilkinson. He spoke on mental health in Malawi, where I had spent my elective as a medical student. I remember feeling it was music to my ears to have mental health being addressed, even if sandwiched between lectures on malaria.

### **How did you go on to become more involved?**

My diploma had exposed me to a variety of people, interests and connections but the Royal College boards for volunteering have been very useful. They're keen to get people involved early. Through this I took part in the WHO's mental health GAP Action Programme which is active all around the world.

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*"Whilst the same diagnostic criteria form the backbone, the boxes may change, and it's easy to be blinkered"*

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I spent some time mentoring asylum seekers in Glasgow and gained a lot of experience about the finer details of psychological assessment through volunteering for the Medical Foundation for the Care of Victims of Torture.

### **Have you come across anything surprising during your trips overseas?**

The attitude of health professionals, and often churches, towards mental health and the level of stigma that still exists. Many people are still kept in chains but, if those around them have no means of caring for them, alternatives are challenging and few. One woman I met was psychotic and had been kept in a cave for 14 years, mute and severely emaciated. She was released intermittently only so she could become pregnant by her husband and provide children. We were able to provide her daughter with a sewing machine so that she could be a dressmaker and stay at home to care for her mother.

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*"Traditional healers often have a wealth of knowledge and experience. Many have excellent psychotherapy skills"*

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### **How do cultural differences affect practices in different countries?**

We tend to ask the same questions but must use a different template of understanding, even sometimes within the same country. Whilst the same diagnostic criteria form the backbone, the boxes may change, and it's easy to be blinkered. A trance-like state may be catatonic schizophrenia but it may equally be induced by traditional healers or be a dissociative mechanism. Expression can vary greatly across cultures so self-harm may not be to do with a personality disorder but instead associated with releasing evil spirits. To practice effectively you can read up on the culture and talk to the village



chief but ideally we need to be collaborating with traditional healers.

They have a wealth of knowledge and experience and are often very good at identifying the problem. In addition, many have excellent psychotherapy skills and, crucially, are believed by the local population.

### **Have your experiences altered your practice in the UK?**

Here we tend to see the disease process as opposed to the person and deal less well with uncertainty. I now view the spectrum of normal human behaviour as much wider and hopefully am less quick to label patients with a diagnosis. Grief is a useful example. It is a varied experience and in certain situations prolonged grief and mourning clothes are common, sometimes with brief psychotic episodes. Whilst our tendency might be to section someone, often care by extended family is the norm elsewhere. I also think it's important for medical education to include exposure to a diverse ethnic mix and to move away from teaching too formulaically.

### **What place does global mental health take in your current practice?**

I volunteer with the Royal Colleges of General Practice and Psychiatry. Through my NHS trust I am involved in developing mental health provision in South-West Uganda. There is a small psychiatric ward we have visited with OTs, nurses and psychiatrists. We help set up community groups, look at liaison work on the wards and have a scheme where patients are educated as mentors on discharge. We are also working on a nurse-led community alcohol screening programme. Recently we had a young boy who had been labelled possessed, tied up and abandoned. We were able to diagnose and treat epilepsy and contact relatives for his rehab in Kampala. Cases like this also increase awareness within the hospital and help to change attitudes.

### **What hopes do you have for the future of mental health and your career?**

Reduced stigma - both at the grassroots level and a change in the political climate. I also plan to be more involved in prison work and I'm heading to Uganda in April to pilot a screening programme for mental health within prisons.

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*"Here we tend to see the disease process as opposed to the person and deal less well with uncertainty"*

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### **What tips would you give to students or doctors looking to get involved?**

It's always important to get some experience of general medicine under your belt. If you're heading off on an elective make an effort to explore the mental health services on offer. I remember handing out mood questionnaires on a mother and baby unit and the returned forms demonstrated the often hidden need that you won't see portrayed in the media. Many organisations are keen to recruit enthusiastic individuals such as THET (Tropical Health and Education Trust) so ask around. Special interest groups of the royal colleges are helpful and for me, studies in tropical medicine opened a lot of doors. There is, however, no straight path.

*Interviewed by Kirsty Coombs, 3rd year medical student, University of Dundee.*

## Research

**Barriers to accessing and using mental healthcare services for Palestinians with mental health problems residing in refugee camps in Jordan: a qualitative study. Authors: C Mckell, A Hankir, M Omar, I Abu-Zayed**

### Aim

Our aims were to identify the barriers to the access and usage of mental healthcare services by Palestinians with mental health problems (MHP) residing in the Baqa'a refugee camp in Jordan and to formulate recommendations to overcome such barriers.

### Background

The United Nations Refugee Agency (UNHCR) reported that there were approximately 19.5 million refugees worldwide in 2014 of which 5.1 million are Palestinian. 2.1 million Palestinians are reported to be residing in Jordan, of which 370,000 live in refugee camps. The Baqa'a refugee camp is the largest in Jordan, home to some 104,000 Palestinians.

Refugees experience external displacement and this combined with other stressors such as conflict in their territory of origin, the way that they are received by their host nation, dilapidated and squalid living conditions in refugee camps (as a result of overcrowding and underfunding), poverty and unemployment can all contribute and conspire to rendering these people vulnerable to developing MHP. MHP are overrepresented in refugee groups compared with the general population. Indeed, recent research has revealed that up to 43% of refugees have experienced some form of mental illness or distress. The United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA) are 'Painfully aware of the lack of mental health care provision' for Palestinians in refugee camps in the Middle East. Compounding this issue further are barriers to accessing and using mental health services. Barriers to the use of mental health services in Arab-refugees are

well documented in the literature however few studies have been conducted hitherto to identify barriers for Palestinians with MHP residing in refugee camps in Jordan.

### Methods

16 qualitative, semi-structured interviews were conducted with healthcare professionals working at health centres for Palestinian refugees in Jordan in May 2015, 14 of which were in health centres at Baqa'a refugee camp and the remaining two at the headquarters of UNRWA in Amman, Jordan. All the interviews were recorded and transcribed and thematic analyses conducted. Written informed consent was obtained from participants and the study was ethically approved by UNRWA and the University of Leeds.

### Results

Resource and financial deficits were the most common barriers reported by interviewees (16/16, 100%). Sex (15/16, 94%), stigma and religion (12/16, 75%) and culture (10/16, 75%) were also major barriers to the access and usage of mental healthcare services by Palestinians with MHP in Baqa'a refugee camp as reported by participants.

### Discussion

Notwithstanding the limitations of our study our results have revealed that there were numerous major barriers for Palestinians with MHP in the Baqa'a refugee camp accessing and using mental health services. This, we feel, has important implications for policy and provision of mental healthcare services for Palestinians residing in refugee camps in Jordan. Recommendations to overcome such barriers include increasing resource allocation for mental healthcare provision, education to challenge mental health stigma and encourage help-seeking behaviour, and better communication and improved understanding between healthcare professionals and faith healers/Imams.

## Nepal Elective May 2015



*Karthickkumar Selvakumar graduated from the University of Leicester and is now a Foundation Year 1 Doctor working in Blackburn.*

I had the privilege of carrying out my medical elective in the department of psychiatry in a teaching hospital in Nepal. Before leaving the UK I wondered about the quality of care that I was going to see and was worried there could be a fair amount of unethical practice given how neglected mental health care is across the world. Growing up in India I came across some of the media portraying mental health issues in a derogatory manner and have family who have experienced the stigma associated with mental illness.

To my surprise, there were a lot of experiences I particularly enjoyed during my time in the department. The team of doctors and psychologists were friendly and welcoming. They followed an impressive evidence-based approach integrating both DSM and ICD-10 in assessment and management of the patient. I was also amazed by the extent of involvement of psychologists in the treatment of patients. Each ward round consisted of a team of doctors led by

the consultant with the presence of a team of psychologists assessing each patient and reviewing the current condition and treatment.

Overall I was impressed with the care being provided despite limited resources affecting confidentiality in the clinics and privacy in ward rounds. Aside from staffing issues due to budget allocation, there weren't enough rooms to do individual consultations with each patient and the wards were laid out in the same layout as regular medical wards, with no privacy for patients and potential safety risks to other patients and staff. There was also inadequate follow up of patients in the community due to a lack of community services. Moreover, patients had to buy their own medication which was often discontinued due to monetary problems.

The most appalling experience I had during my elective occurred one morning when I arrived on the psychiatric ward. On this occasion, there was a trolley in the office and about 8 doctors standing around talking. One of them told me I was going to witness something I would definitely not get the chance to see anywhere else today. I was really excited until I realised it was use of unmodified ECT on a patient. This was a patient that had treatment resistant schizophrenia that I had seen many ward rounds previously.

Although these problems paint a poor picture of mental health care in Nepal, it seemed to me that the doctors really did do their best with what they had. The senior registrars were earning the equivalent of £150 per month and the consultants £300 per month. Without question, I was concerned about the quality of care given to patients when the doctor had been working for 14 plus hours, but it did seem to me that the care provided was still very good. It was inspirational to see the amount of passion these health professionals had.

## Interview: Dr Hugh Grant-Peterkin



*Dr Hugh Grant-Peterkin is a Psychiatric Registrar in East London. He is a member of the Board of Trustees for both Medact and Medical Justice. He is also a member of the Royal College of Psychiatrists Working Group on Mental Health of Asylum Seekers.*

### **What does your work with refugees involve?**

I became involved in this area as a core trainee through the charity Medical Justice (MJ). I heard about MJ because my housemate at the time, a trainee paediatrician, had visited an 'Immigration Removal Centre' to assess the health of a detainee. He said it was the most important piece of work he had done as a doctor. I did the basic training with MJ and have been doing visits and medico-legal reports since then. The deficiencies in healthcare in IRCs remain one of my main concerns in relation to mental health and asylum seekers. British courts have found six article 3 breaches (of Human Rights Act - the prohibition of torture) in relation to mental healthcare in IRCs which demonstrates severe deficiencies in care. In 2012, some other psychiatrists and I successfully petitioned the Royal College to create a working group on mental health of asylum seekers and refugees. I am now part of the working group under Prof Katona. Since then

we have published an editorial in the BMJ and delivered training on the subject e.g. treating complex PTSD, writing legal reports and explaining the asylum system. The group has also submitted an application to the RCPsych to include trauma, migration and asylum-seeker related matters within the curriculum. We have also responded to the government on related issues - for instance responding to changes in the benefits system and most recently preparing a briefing document for MPs for a debate on the deficiencies in healthcare in Yarl's Wood IRC. It is fascinating, complex and fulfilling work.

### **What are the common mental health problems experienced by refugees?**

Refugees are individuals who have had their claims for asylum granted, whilst asylum seekers are people who have claimed asylum due to fear of persecution in the country of origin and are awaiting a result for their claim. Individuals in both groups will have been exposed to trauma and there is a higher incidence of PTSD in these populations; asylum seekers have the added stress of uncertain immigration status so often have higher levels of anxiety. Both groups also have an increased risk of depression and anxiety. There are numerous psychosocial stressors - forced migration, exposure to violence, social isolation, often a language barrier, inadequate housing and welfare support, and difficulty understanding the complex asylum process.

### **Do mental health problems present differently in the immigrant population compared to the native UK population?**

Psychiatric trainees will be well aware of the dynamic and fascinating interaction between an individual's culture and the psychopathology that emerges. There are phenomena we all share as humans as well as those that are unique to ourselves - an emergence and merging of our genes, family milieu and environment. I would not suggest that we are unable to understand such difficulties. However, the extreme stressors

do lead to trauma-related psychopathology - presenting as much with emotional blunting and withdrawal as with hyperarousal/avoidance type pattern.

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## "Deficiencies in healthcare in IRCs remain one of my main concerns"

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### **Are there any myths surrounding refugees that have repeatedly come up in your practice that you would like to dispel?**

I think that there is an increasing and widespread antagonism towards refugees and asylum seekers which can be played out in a healthcare setting. I do think we are not very good at addressing the psychological consequences of sexual violence against women which is commonly used as a weapon of war and is not often addressed; it is a difficult subject to question an individual about but ought to be part of an assessment when seeing someone who has fled persecution.

### **What are the current mental health services available to refugees? Are they fit for purpose?**

There is wide variation across the UK. Where I work in East London there is an excellent unit called the 'Institute of Psychotrauma' who offer psychological interventions specifically geared towards victims of extreme trauma. They can move a person through the three stages of psychological treatment for PTSD. Stage one is to achieve patient safety, reducing symptoms and increasing competencies. Stage two involves review and reappraisal of trauma memories. Stage three then consolidates the gains before discharge. Alongside specialist trauma units, well-equipped CMHTs with experience of working with translators and trauma victims are required - again this is evident in East London but likely not across the UK. Given dispersal arrangements for Syrian refugees this is something the government needs to address coherently and promptly.

### **How could the NHS improve its approach towards refugee mental health?**

More training! It's the cry of anyone who is passionate about what they do, specifically training for how best to use interpreters and the psychological sequelae of trauma. All mental health workers would benefit from this training - the whole MDT if possible! There should also be specific, albeit brief, training on the basics of the legal system pertaining to asylum seekers.

### **What can we do to document the problems with the current service?**

I would strongly encourage writing to your MP if you feel that there are insufficient services in your area and also if you have concerns about an IRC where you live - MPs do listen!

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## "Sexual violence against women is commonly used as a weapon of war and is not often addressed"

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### **What can students do to help refugees?**

Explore what is available in your local area in terms of charities/NGOs. Read up on NICE Guidelines on treatment of PTSD. Stay in touch with global events so as to have awareness of what patients have fled. For example, I felt I did not know enough about the situation when I recently saw a patient who had fled the conflict in Ukraine. If you are a keen volunteer with a charity/NGO, students can do great work. Have a look at Medact and Medical Justice to start with. You can make a big difference! As a wider piece of advice, I would follow your passion as a medical student and doctor. Get involved in what you care about and your career will remain exciting and interesting while opening up new connections and opportunities. Be guided by head and heart, and the CV will follow!

*Interviewed by Laura Middleton and Christopher Boyce.*

# i am a migrant



3,953 km from home

Current Country:

**United Kingdom**

Country of Origin:

**Syrian Arab Republic**

**"Despite the difficulties they are facing, Syrians are able to prove their abilities & contribute to development of host societies."**

**Weeam**

## **CHALLENGE**

ANTI-MIGRANT HATE SPEECH

## **CELEBRATE**

MIGRANTS

## **SHARE**

MIGRANT STORIES

JOIN THE CAMPAIGN



[iamamigrant.org](http://iamamigrant.org)  
[facebook.com/iamamigrant](https://facebook.com/iamamigrant)  
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## They Pressed Me Down...



A piece based on the experiences of Dr Ikenna Ebuenyi. He is from Nigeria and currently studying MSc Global Mental Health at the IofPPN.

The resonating buzz of the surrounding outpatient clinics seemed shy of the psychiatric clinic. Dr Ibe, my consultant, was typing on his phone while I hunched over my jotter trying to sort out previous notes I could barely decipher.

We were waiting for patients and, sometimes, the wait paid off. Our radio sensitization of the populace about mental health had met with mixed success. People continued to hold on to beliefs on the spiritual aetiology of mental illness.

I was jolted out of reverie when the door was opened by a male nurse. 'We have a patient', he said, and at the same time placed a folder on the table. I reached out for it and saw the brief entry of the general outpatient doctor. '?Psychosis. Refer to psychiatry.'

A brief smile spread across my face as I passed on the folder to Dr Ibe. He peered at the folder, and nodding his head in disapproval. 'We would see the patient', he said to the waiting nurse. Dr Ibe's efforts to encourage the medical officers in general outpatients to take a brief history before referral have failed so far and today he was unwilling to remind them again.

In less than a minute, the nurse came back and ushered in a middle-aged lady with two other men. One of the men was our old patient Pastor Timi, while the other was unknown to us.

'Good afternoon, how are you today madam?', greeted Dr Ibe. The woman appeared uneasy on her seat and turned looking towards the pastor and the other man that came with them.

'I was greeting you madam, not them'. Dr Ibe tried once more to reassure the woman. He understood the gesture of the woman turning to the relatives, but tried to encourage patients to talk themselves rather than relying on others.

'Gooday Doctor', Pastor Timi greeted. 'They attend service in my church and he is her husband', he said pointing at the second man who beamed with a muted smile.

'For over six months she has been having bad dreams during which she says evil spirits hold her and she is unable to move. Because of the dreams, she now refuses to sleep. I have prayed for her but remembering how you people helped me when I was sick, I decided to bring them.'

'Thank you, Pastor', Dr Ibe said. He turned to the woman and requested her own side of the story. She turned once more to her husband and the Pastor as if to ask for permission, then back to Dr Ibe. 'It's my neighbours. They entered my dreams and pressed me down. I tried to run or stand but could not. The litany of blames was endless.

'Madam, what you have is called sleep paralysis. We would give you some medications and you would be fine. I hope you would take the drugs we give you?', Dr Ibe asked after his explanations to the Pastor and the husband. 'Yes, sir, I would take them', the woman replied in a shaky voice.

As they left the clinic, I had my doubts but I also knew they came to the clinic because all the other options to access help had failed. Perhaps she would become an apostle, just like the Pastor...

