Using co- production within mental health training when working with refugee or migrant community groups

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Abstract

This paper will discuss examples of mental health training developed and co-produced in active partnership with two communities, one in Britain and one in Sri Lanka. This work has taken place in community settings, not within the consulting room.   The learning had a bi-directional flow; through these partnerships, both partners/groups shared and developed their understanding of diverse cultures, idioms of distress, explanatory mental health models and ways of dealing with these. This expanded everyone's knowledge, understanding and repertoires of practice. The work in Britain was audited through a range of psychometric tests and that in Sri Lanka through questionnaires. Semi-structured interviews also took place with both groups as did meetings with a range of key informants.

Working beyond the clinic can benefit people, who have obliquely been labelled, as 'hard to reach' groups and who may find it difficult to access mental health services or who find services inappropriate. Therefore, community groups may be well positioned to bridge this gap in non-stigmatising, accessible and culturally appropriate ways. Evidence has begun to emerge suggesting that mental health services developed in conjunction with service users and the wider community may lead to better usage, more appropriate and accessible services, and to an improved sense of inclusivity. The implications of this for the global mental health debate will be briefly considered as will health pluralism and the importance of language and using a mother tongue.

Key words: Global mental health; relevance; migrant; community; psychology; Bidirectional, health pluralism

Introduction

> *"Fear of being labelled or being called mad. I think a lot of people when they say 'we'll refer you to a psychiatrist' or something like that, then you think 'well I'm not mad, I'm not crazy ..and the word 'psychiatrist' it puts the fear into you, you think 'well I must be losing my mind or why would they say that' you know and I think it's got to be approached in a different manner I think you know to stop people being frightened..."*
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> *A refugee from Zimbabwe*

It has been suggested that global mental health can be viewed as a form of neo-colonialism where ideas around mental health developed in high income countries are uncritically considered as being applicable to low income countries (Summerfield, 2012; Tribe, 2014). Historical and financial power dynamics have sometimes been ignored and racist undertones

may have been present (Fernando, 2014). The decolonisation of psychiatry and psychology is increasingly being considered and the important contribution of diverse cultures to our understanding of mental health recognised (Mills, 2014; British Psychological Society (BPS), 2018, 2019).

There has been an increasing range of counter-flows from low and middle income countries to high income ones (White & Sashidharan, 2014). For example, mindfulness has been part of Buddhism for thousands of years, yet since the 1980s it has been extracted from this context and adapted for use in western mental health and wellbeing (Kabat-Zinn, 2003).

However, control of resources means that influence flows mainly from high and middle to low income countries (Mills, 2014). In a review of articles in the highest ranking psychiatric journals, Patel & Sumathipala, (2001) found that only 6% of academic papers that are published in top psychiatric journals come from people living in low or middle income countries. Whilst the position may be slowly changing, this historical legacy has affected theory and practice (Fernando & Moodley, 2018).

This paper will briefly consider the relevance that global mental health may have in relation to the work conducted when working with community groups in the UK and internationally. There are approximately 22.5 million refugees worldwide, more than at any time during the past 20 years (UNHCR, 2017) and 250 million migrants worldwide (UN, 2017). They may hold explanatory health models of psychological distress and relevant interventions from their countries of origin (Mills, 2014). Therefore, in line with good practice guidelines and equal opportunities legislation, all clinicians will need to consider these issues if they are to try and meet the needs of all member of their communities and offer appropriate and accessible services. Clinicians may find that they can learn a lot from these groups which may challenge and enrich their repertoire of understanding and practice within this area (Bhugra, 2019). Clinicians can reach different groups if they are prepared to step outside the clinic when appropriate (Tribe & Tunariu, 2018). Community groups may be seen as playing a role bridging cultural differences in relation to mental health (BPS, 2018).

Social prescribing is gaining an increasing role in health care (it is a way of linking patients who are using health and care services with sources of support within the community). The London Assembly Health Committee, (2018) has called for more consideration of this and more rigorous research into social prescribing. It is potentially a very significant tool in relation to refugee and migrant community groups. The reasons for this include the fact that they may be less familiar with available mental health services, (Miller, 1999) and that they themselves often bring a wealth of relevant experience (Williams, 2018). The therapeutic services team at the Refugee Council are actively considering ways of using social prescribing in their work (Jalonen, 2019).

Cultural difference was the main challenge I would say, because for me, to be able to seek help I should admit that there is a problem … even if you have the problem, the last thing you can do is to go and seek help, because in my culture you don't wash the dirty laundry in public, so even if you are suffering in any way personally, I would not go and tell a stranger or professional about my problems.

A recent migrant from Asia

Rather than just considering the individual or family, clinicians may benefit from working with communities sharing knowledge and undertaking partnership working (BPS, 2018). Many community groups are undertaking exceptional work within mental health and wellbeing on a miniscule budget and with little support (Williams, 2018) .Visiting them may not carry the stigma that is frequently associated with mental health facilities, particularly for people where the stigma of having mental health issues is negatively constructed (Miller, 1999). In addition, support can be obtained in a culturally appropriate way and with people who have developed coping strategies, having themselves been through similar experiences. This can provide a normalising and shared experience as illustrated below by a refugee from Southern Africa.

> *I did prefer … help as some of them went through what l went through, which gave me some sense of belonging because when you are talking to someone who went through similar position with what I went through, it made me feel not alone because they knew exactly what I was going though because we were in the same boat.*

Statutory mental health systems will have a role to play for some people. Health pluralism where a diverse range of explanatory health beliefs, interventions or rituals and coping strategies or help-seeking behaviours, as well as a varied range of designated healers may be a helpful way forward for global mental health practitioners to consider and which may benefit service users (Tribe, 2007).

Understandings of mental health are likely to differ across countries (Fernando, 2014) and many cultures and religions possess sophisticated traditions of dealing with mental health issues (Somasundaram & Sivayokan, 2005). In community partnerships, cultural understandings of psychological distress can be shared and community partnerships developed which can lead to the co-production of resources and mutual learning (BPS, 2018). This could be viewed as a form of bidirectional training of both community workers and western trained clinicians. Through these partnerships, both groups develop their knowledge of diverse cultures, explanatory heath models and psychological distress. Clinicians are often hesitant to undertake community engagement (Bhugra, 2019; Lane & Tribe, 2010), although there are NICE guidelines stressing the importance of this (NICE Guideline on Community Engagement, 2017). The BPS (2018) guidelines on community engagement stress the need for co-production in health care as well as proactive engagement with communities and community groups, noting that this may improve services, reduce stigma and discrimination and help develop more equitable access to services. There is a developing literature which notes that where mental health services are developed in partnership with the wider community it may lead to services that are viewed as more suitable and accessible and to an improved sense of belonging (Bhugra, 2010).

Language, mother tongue and mental health

Where the clinician and service user are from different communities, issues of culture, religion and language require consideration. Not being able to use your 'mother tongue' can be a considerable loss and barrier to self-expression (Antinucci, 2004). The quote below illustrates something of what it may be like to live in a country where your mother tongue is

not widely spoken and how this can be alienating, distancing and frightening and may prevent people from seeking help with mental health issues.

> *A refugee living in Britain*
>
> *The main thing for me was my own mother tongue.   Even if I am still in this country, for the rest of my life I won't be able to express myself, my emotions and everything you know., I remember they used to talk to me about depression ....even though I speak English; l was not able to fully express myself in a manner that I should do, when l am using my own mother's tongue.*

Migrant and refugee community groups can provide services in mother tongue languages which can be used by people who may have difficulty accessing conventional services.

Several examples of global mental health work conducted by the author with community groups are detailed below.

 A Refugee Community Centre

The author was approached by the co-ordinator of a refugee community centre used by people of many nationalities (a registered charity) because the community workers felt that they needed further training in mental health. The centre is run by community volunteers and provides a one-stop shop for approximately 3000 people a year. A significant proportion of people using the centre were defined by the staff as having mental health issues in the widest sense of the word. After a series of meetings, the author and two colleagues (a psychiatrist and two psychologists) and the community workers co-produced a programme of 12 training sessions which took account of local, cultural and situational factors. Volunteer community workers from the community centre attended, along with a number of clinicians/trainers who hoped to gain knowledge and understanding of cultural and refugee issues from the volunteers. Topics covered included: traumatic experiences and surviving as an asylum seeker, refugee or migrant (including self-care); children and families; gang awareness; somatisation; adapting to cultural change and a different country; postnatal depression; addiction; and tree of life (nurturing resilience and strengths). Related, but non-mental health topics were also covered, including using statutory services, referral processes and a review of the programme.

The work was formally and independently evaluated (Tribe & Tunariu, 2018) and appeared to have had benefits for both the community workers and the external clinicians. This shared learning can only benefit the users of services, whether it is those at the community centre or those of diverse heritage who access NHS services provided by the external clinicians.

One session that was deemed particularly valuable, was one where mental health professionals from the local area were invited to come and meet with the staff team. It provided time to consider wider issues at the micro, meso and macro level, to discuss issues where problems appeared to arise for service users, an improved understanding of each other by both parties, and better communication and pathways to care (Tribe & Tunariu, 2018).

The co-ordinator of the centre has since spoken at a variety of mental health conferences and training events about this joint work and the centre.

A Psychological intervention with academics working in a civil war zone

A Sri Lankan psychiatrist wanted to establish an international mental health training partnership. The team from Britain, had all worked in Sri Lanka for numerous years, most had links of heritage to the country and all were members of the UK: Sri Lanka Trauma group (www.UKSriLankatraumagroup.org). The reason behind this proposed partnership was that university academics (who were at the time living in the theatre of the Sri Lankan civil war) had requested help in assisting students who were distressed and often overwhelmed by all the issues associated with living in a war zone. These included the fear for themselves and their families of being killed or injured, or being targeted by either or both sides in the civil war). These issues also affected the academics. Somasundaram & Sivayokan, (2005) have written extensively about mental health in the Tamil community, as well as on developing community resilience (Somasundaram & Sivayokan, 2013).

Funding was secured from the World Bank, in partnership and with the support and logistics provided by Samutthana a Sri Lankan mental health charity. A five-day residential workshop for the academics took place away from the theatre of war. This gave the academics some respite to think, review and participate in a workshop. Within our partnership group were two psychiatrists based in Sri Lanka, four psychologists, two counsellors and two people who practiced Siddha medicine (a type of traditional medicine used in Sri Lanka). The twenty academics came from the departments of medicine, arts, science, agriculture, business and commerce, and medicine. There was detailed discussions in advance of the workshop between the Sri Lankan and UK organising group to try and co-produce an outline of what the five days should cover, though we all wanted to be flexible and prepared to change the content and respond to the requirements as they arose.

The traditional ceremony of the lighting of the lamp to ensure an auspicious start to the event and locate the event within the cultural context took place. A wish list relating to the content of the next five days was developed by everyone present. Experiential small group work with intensive discussions and presentations on psychological well-being took place. Topics included looking after yourself/stress management, trauma, mental health, boundaries and counselling skills using a range of training methods including role plays and multi-media. An important artefact of this piece of work was that the participants decided to develop a support group to meet regularly once the training was over. This continued to meet for several years.

Several quotes from the workshop participants are given below.

"All the skills (relating to mental health) are very useful to identify the problem of the students as well as us."

"Through this I am able to understand other problems, their bad experiences and these effects. Owing to that I started to make empathy to others. But I had some bad experiences in my life. Sometime it may disturb me. So I feel like some more training in this field."

"Communication types and the effective communication skills were elaborately exhibited through examples. I understand the listening and communication skills still I need to know more on this. Such training program could be repeated in future to strengthen knowledge and skills."

"I was able to understand 'what is trauma?', the effects of trauma, ...I learned about how to respond after a trauma, common responses after trauma in children and adults. I was given an opportunity to understand the "scared mind". Trauma is about fear of death. I understand well about "trauma" and its reactions after this training."

Three follow up programmes were subsequently undertaken, after six months and at one and two years following the initial training. We collected data on each session within the workshop which rated the knowledge and well-bring at each follow up. The measures showed improvement on a variety of measures. When the war finished, a number of the academics moved, but our partnership has continued and developed in new ways, which have include further shared learning, setting up courses, helping with the establishment of a wellbeing centre and a range of other projects.

This paper has reviewed how co-production and partnership working and community engagement with groups in the UK and internationally can make effective contributions to knowledge and practice. The bi-directional sharing of experiences and knowledge enriched understanding and repertoires within mental health across communities and cross culturally took place. It has shown how community groups and clinicians may be able to offer services which are culturally and linguistically appropriate and accessible, may be less stigmatising and can play an important role. In addition this partnership working may in itself be viewed as a form of social prescribing which may make a useful contribution to refugee and migrant community groups.

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