Exploring how different organisations provide psychosocial support; with a focus on suicide prevention for the refugee and asylum seeker population.

Yuriko Matsukawa
Churchill Fellow, 2019.

WINSTON CHURCHILL MEMORIAL TRUST

SAMARITANS

Acknowledgements

The Churchill Fellowship has given me the opportunity to spend around four weeks visiting exciting projects in Montreal, Vermont, Melbourne, Brisbane and Adelaide during which time I learnt a great deal from enthusiastic people while developing personally and professionally. Undertaking the project exposed me to very different health systems and furthered my understanding of the health needs of a population who have needs not always met by mainstream support services. I would like to thank all those involved at The Listening Place; where I have spent time as a supervising volunteer, who have supported me in pursuing this fellowship through a desire to continually develop the service for all the clients who access it.

I would like to thank the organisations that welcomed me with open arms. I met an enthusiastic and forward thinking workforce who reaffirmed to me that despite the constant challenges faced in this field, is is possible to make positive change happen.

Finally, this would not have been possible had it not been for the support of the WCMT staff and without Winston Churchill himself. I would like to thanks the John Armitage Charitable Trust for co-funding my fellowship and The Samaritans who were a partner for the Suicide Prevention category out of which my project was born.

Contents

About the Author

Professional work

Yuriko Matsukawa graduated in 2009 with BA in Biblical Studies after studying at the University of Sheffield. After working for several years in marketing, she decided to pursue a life-long passion of hers to work with people in a therapeutic setting. Yuriko began volunteering with The Listening Place in 2016 and she thrived in an environment where she was able to put her listening skills to good use. As she spent more time at The Listening Place, she realised how much she loved the organisation and all that it stood for. As she became more confident in the role she was asked to be a supervisor, a role she found very rewarding.

In 2018, Yuriko began studying for a master's degree in Integrative Counselling and Psychotherapy at the University of Roehampton in order to realise her ambition to work as a therapist. As she continues to study, moving towards her final year, her enthusiasm continues to shine through. She is always looking for opportunities to develop professionally leading her to apply for the Churchill Fellowship, with a view to harnessing those learnings to implement change at The Listening Place.

Personal

Yuriko is a proud mother to an 11-month old boy called Ezra and an 9-year-old dog called Pia. When she is not being given the run around by one of those, she is an active member of her local community and hosts a feminist book club.

Disclaimer

Executive Summary

What was researched?

The overall aim of my fellowship was to visit Montreal, Vermont, Melbourne, Brisbane and Adelaide to explore how different organisations provide psychosocial support to the refugee and asylum seeker population, particularly those experiencing suicidal ideation. This was with a view to utilise the learnings to provide educational support to those volunteers at The Listening Place so they are better equipped when seeing this population group. Additionally, to work with the senior members of The Listening Place team to develop a pathway which better suits the refugee and asylum seeker population to allow them to be able to maximise the benefit they are able get from The Listening Place service.

Major Findings:

- The practical barriers to accessing support need to be addressed in advance of commencing any therapeutic work, these include financial, language, confidentiality, geographical and lack of understanding of UK systems.
- There are huge benefits to integrating advocacy as part of counselling
- Lived experience should be utilised when developing a service or training to ensure it addresses the needs of its target group.
- Involving individuals from within a community for cultural competency
- It is possible to utilise non-clinical figures to provide many aspects of support in this setting.
- There is a need for wider social integration in addition to mental health support services

Recommendations:

- All volunteers or staff delivering any form of psychological support to the refugee and asylum seeker population need to have a basic understanding of the barriers this cohort face when trying to access services. This could be delivered by face-to-face teaching or through educational materials. Specifically, in relation to The Listening Place; this could form part of the existing structures providing periodic training to the volunteers.

- Contact details for locally available advocacy services or community based projects targeting the refugee and asylum seeker population should be provided to those attending The Listening Place. A 'hub' of information providing contacts for services such as language courses, faith meetings and network groups could be made available for all those of a refugee and asylum seeker background visiting The Listening Place. Where possible volunteers can integrate advocacy into the sessions and then use signposting to the any allied services.

- Involving members from within different cultural communities to connect the clients attending The Listening Place to the comforts of their own community, to ensure that everything provided is culturally relevant and serves to form authentic connections for the individual. Utilising those with lived experience to inform both the training of volunteers and the future development of the service to ensure it is trauma-informed.

- Ensuring that cultural competency through reflective work is at the core of training and supervision at The Listening Place.

Introduction

Background to this project

The author of this project volunteers as a supervisor at The Listening Place (TLP) and so has first hand experience of providing a supportive space for those adults experiencing suicidal ideation. TLP offers a one-to-one, face-to-face 'listening' service to people who feel that life is no longer worth living. It is run by an entirely voluntary team supervised by professionals, with periodic training events provided by mental health specialists. TLP partners with a number of organisations including NHS trusts such as King's College Hospital, as well as charities such as British Red Cross and Hestia. Referrals are taken from across the Greater London area with service users hailing from all over the world. The presentation and experience of each service user is very different, but all are struggling and in need of supportive listening. During my time at TLP I spent time with several suicidal refugees and asylum seekers from different areas of the world. I found that although these individuals had very distinct stories to tell, collectively the group had a unique set of difficulties setting them aside from other service users attending TLP. The prevalence of traumatic experience and the lived experience of the refugee and asylum seeker population requires a supportive approach which accounts for the impact of this on the client's mental health. This group also face many practical challenges, such as an asylum application, which can be a very difficult and testing process to navigate. Many barriers prevent this population from accessing support, such as not being English speaking, a lack of knowledge about the structure of the healthcare system or fear of deportation.

To illustrate some of the challenges facing the refugee and asylum seeker population I have used an anonymised case vignette:

During my time at The Listening Place, I spent several months with a Tamil gentleman from Sri Lanka. He had spent over 10 years unable to move beyond Asylum Seeker status and prior to being referred to our service, the Home Office had decided to revoke this due to the end of the civil war. This gentleman faced being deported and had bounced between deportation centre and home office housing. Failed, forgotten or cheated by various immigration lawyers he was hopeless, angry and terrified. His life had been on pause, his prime had passed him by. Unable to build a life, create an identity, without purpose or a future, it seemed life was not worth living. The gentleman had made several attempts to end his life. He had moved beyond desperation into apathy, unable to recognise himself, he could not bear the constant threat of deportation. Navigating the punitive system with little or wavering support had left him feeling that Britain did not want him and never would. Nor did it care that he may face death or worse at the hands of his oppressors, should he return to Sri Lanka. He reached a point where he felt death was the only option. Often this gentleman would come to me frightened and frustrated clutching piles of letters threatening him or demanding things he couldn't understand. I was unable to help him. It was hard to move beyond the very real, circumstantial sources of his distress. He struggled to pay to travel to our meetings. He was often hungry. He was forced to steal things which left him feeling unbearable self-contempt. He was mistrusting and sad. We communicated with the help of a non-tamil Sri Lankan volunteer. This was particularly difficult for everyone in the room but it was the best that we

could do. Whilst offering legal advice on immigration is far beyond my ability or remit, it struck me that listening, bearing witness and really honouring his experience was beneficial. However, something was still missing. It struck me that asylum seekers or refugees were experiencing a complex set of difficulties, both historical and situational. Offering support to aid suicide prevention needed to be tailored and mindful of this.

At the time of planning the project, limited resource and a large number of service users meant that TLP could not provide a tailored service to those from a refugee and asylum seeker population. TLP is an incredible organisation of devoted professionals who coordinate dedicated volunteers to deliver a service which for many clients is a source of comfort and stability when there is otherwise none. The current pressures within primary care and secondary mental health services in the NHS is such that individuals experiencing suicidal ideation may not be able to access the support they need and this is where TLP fills a much needed gap. TLP is a forward thinking organisation, whose leaders are continually looking to improve the already amazing service that is provided and so it was with their support that I approached this project looking for a way to improve the service for our refugee and asylum seeker population.

Why this is important?

The UN Refugee Agency report an estimated 79.5 million forcibly displaced people worldwide at the end of 2019, this forms approximately 1% of the world's population. 26 million of these are refugees and 4.2 million are asylum seekers.[1] Many have experienced genocide, violence, trauma, imprisonment, war bereavement or other tragic circumstances. People escaping this and embarking upon the hazardous journey of seeking asylum are often faced with further inhuman conditions, detention, separation or fear of death. Even after migrating to an entirely new place, people then are met with discrimination, hostility, denial of right to healthcare or to work and an often extremely protracted and needlessly bureaucratic process of claiming asylum.[2]

In the face of this extreme adversity, it is then no surprise to hear that research evidence reports a higher incidence of suicide amongst refugees and asylum seekers compared with the general population. Estimates of suicidal behaviour in this population range from 3.4-34%.[2] Psychological and sociocultural factors contribute to this higher prevalence of suicidal behaviours. Underlying mental heath conditions such as depression, alcoholism or Post-Traumatic Stress Disorder are all associated with higher rates of suicidal ideation.[3] Trauma, loss, abuse and economic loss, all of which are commonly seen in the refugee and asylum seeker population are associated with suicidal behaviour.[4]

Despite the clear need to minimise social risk factors and facilitate societal integration for this population and despite the need for equitable access to health, social care and legal support, there continues to be a lack of top down government funded support programmes for refugees and asylum seekers. It is for this reason that charity sector organisations often find themselves at the heart of providing care for this population. Ensuring that this group

have equitable access to suicide support through TLP is incredibly important to me, and I know the organisation as a whole is in great support.

Aim and Objectives of the Fellowship

The overarching aim of the Fellowship was to learn about how various organisations around the world are supporting refugee and asylum seeker communities, particularly those experiencing mental health crises, with a view to better understanding the holistic needs of this group so that a tailored service and education program can be developed for those accessing and providing support The Listening Place.

The objectives for the Fellowship were:

- To better understand the barriers that limit refugee and asylum seekers from accessing the necessary mental health and psychosocial support and how these are overcome.
- To explore how different models of care are implemented across organisations from different sectors to understand how a charity sector (TLP) is able to provide support to this group.
- To use case studies of exemplary service provision to highlight the potential of what can be achieved and to guide future service development.

A further purpose of the Fellowship was one of personal professional development. Having found myself drawn to trying to improve the experience for the refugee and asylum seeker population accessing care, I hope to make lasting relationships with those who have created change and improved the care for this group.

Fellowship Approach

The approach of the project was to identify organisations across Canada, the US and Australia which offered a service tailored towards the needs of the refugee and asylum seeker population. The organisations were from all different sectors but were unified by a commitment to providing focussed support to this group. These countries were chosen not because they provide a nationwide high-level service, but because at a local and regional level organisations had sprung up to fill gaps in this nationwide delivery, fuelled by a passionate workforce. Many of the organisations had a different focus to their care provision, but all focussed upon delivering support to the refugee and asylum seeker population.

Canada, but specifically Montreal, was chosen as its home to SHERPA. SHERPA brings together university researchers and clinicians from multiple disciplinary backgrounds

(psychology, social work, anthropology, nursing, cross-cultural psychiatry, etc.) as well as research practitioners, research professionals, students and trainees from different sectors.[5] Additionally while in Montreal, I reached out to Programme Régional D'accueil et D'intégration des Demandeurs D'asile (PRAIDA) a regional organisation supporting asylum seekers in Quebec.[6] Geographically it then made sense to travel to Vermont to visit New England Survivors of Torture and Trauma (NESTT) and Connecting Cultures who work directly with the refugee and asylum seeker population and had some very relevant approaches to training their work force.[7]

From here the Fellowship headed further afield to Australia. Australia as a whole is not known for its person-centred immigration procedures with the island of Nauru regularly making international news as a detention centre with notoriously poor conditions. However, out of situations such as this can come amazing projects and organisations seeking to better the experience and support the refugee and asylum seeker population. First stop was Melbourne to visit CatholicCare, who focussed on re-integration of refugees and asylum seekers into society, with support provided by leaders of the different cultural communities.[8] Next I headed to Brisbane to visit Queensland Programme of Assistance to Survivors of Torture and Trauma (QPASTT), who I had been incredibly impressed by when reading about the work they undertake.[9] I spent a week with the organisation and their partners to really immerse myself in the service they are providing. When in Brisbane I also visited the World Wellness Group and The Queensland Transcultural Mental Health Centre.[10,11] Finally, my Fellowship took me to Adelaide where I joined the Professor Nicholas Procter and the Mental Health and Suicide Prevention Research Group at the University of South Australia.[12] Professor Procter has led on some amazing projects and is one of the leaders in the field and his group kindly allowed me to join for one week, culminating in a Suicide Prevention Symposium where I was invited to be a speaker. Finally, while in Adelaide I also visited Survivors of Torture and Trauma Assistance and Rehabilitation Service (STTARS) and the project lead of Fostering Future at HOST International.

For each of the organisations visited I focussed on trying to understand the points below:

- The size, structure and staffing of the organisation.
- What models of support they use.
- How they ensure the needs of their service-users are met.
- How they are funded and how they link to other sectors.
- How they train and educate their staff.
- If they are involved in any wider research or partnerships.
- What they feel are the main barriers refugee and asylum seekers face in accessing care.
- How they have overcome the barriers.
- The current focus of their work.
- What they see for the future for the organisation.

In addition to this information and partly supplemented by online materials, information about the organisations history, principles and scope were gathered. Below is a list of the organisations visited.


WORLD WELLNESS GROUP
EQUALITY
EQUITY
JUSTICE
#healthequityjustice


PRAIDA
PROGRAMME RÉGIONAL D'ACCUEIL ET
D'INTÉGRATION DES DEMANDEURS D'ASILE


QPASTT
Queensland program of assistance
to survivors of torture and trauma


Queensland
Transcultural
Mental Health
Centre

General policy information:

Asylum is the protection that is granted by country to a refugee. A refugee is someone who has left their home country to escape persecution. The United Nations 1951 Convention Relating to the Status of Refugees defines a refugee as a person who, "*owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and unable or, owing to such fear, is unwilling to avail himself of the protection of that country*". An asylum seeker or 'asylum applicant' is a person who has applied for recognition as a refugee under the Refugee Convention.[14]

The UK asylum process:

A person seeking asylum in the UK must first get to the UK. There is no asylum visa, which means that a person seeking asylum must either arrive irregularly or have a visa that has been issued for another purpose, such as tourism. Applicants will not be granted asylum if the government believes they represent a danger to the UK.

An initial asylum application has three possible outcomes.

1. An applicant can be recognised as a refugee and granted asylum with five years' leave to remain in the UK, after which they may apply for indefinite leave to remain (ILR).
2. The applicant can be granted an alternative form of protection, known as 'humanitarian protection' (HP), or an alternative form of leave: either 'discretionary leave' (DL), leave under family and private rules, 'Leave Outside the Rules', or 'Unaccompanied Asylum-Seeking Child (UASC) leave'.
3. The asylum application can be rejected. The applicant can appeal against the initial decision.[15]

The Australia asylum process:

Australia's detention policies are considered some of the harshest in the world. Detention is mandatory for those without a valid visa and is indefinite with no independent review. Anyone who is not an Australian citizen and does not have a valid visa can be detained and this continues until they are granted a visa or leave the country. It has particularly affected people seeking asylum coming by boat. There is no time limit for detaining a person in Australia under immigration laws meaning a person could be detained even for life, unless the Australian Government decides to grant them a visa, or they agree to leave the country. Since 2014, there has been an increase in the average length of detention, with it reaching over 545 days in 2020 and it is this lack of certainty which causes stress, anxiety and suicidality.[16]

Australia uses two other options to closed detention; community detention and bridging visas. For community detention, the person lives in the community but is required to sleep at a defined destination and during this time they cannot work, and are also subject to

curfews and other supervision and reporting arrangements. A bridging visa is given under the Migration Act and allows a person to be given lawful status to live in the community while their visa is being processed, however during this time they are not provided with accommodation. People are detained in different types of places in Australia; Immigration Detention Centres, Immigration Transit Accommodation, Immigration Residential Housing and Alternative Places of Detention (for example those needing medical treatment). There are several Immigration Detention Centres that have received worldwide attention due to the poor conditions; two of which are on the islands of Nauru and Christmas Island.

The US asylum process:

There are two primary ways in which a person may apply for asylum in the United States: the affirmative process and the defensive process. The affirmative asylum process is for a person who is not subject to removal proceedings may affirmatively apply for asylum through U.S. Citizenship and Immigration Services (USCIS), a division of the Department of Homeland Security (DHS). If they are not granted the asylum application and the applicant does not have a lawful immigration status, he or she is referred to the immigration court for removal proceedings, where they may request for asylum through the defensive process and appear before an immigration judge.

The defensive asylum process is for a person who is undergoing removal proceedings. They may apply for asylum defensively by filing the application with an immigration judge at the Executive Office for Immigration Review (EOIR) in the Department of Justice. In other words, asylum is applied for as a defense against removal from the U.S.

Asylum seekers who arrive at a U.S. port of entry or enter the United States without inspection generally must apply through the defensive asylum process. Both application processes require the asylum seeker to be physically present in the United States. Asylum seekers must apply via either of these two processes within a year of arrival to the US otherwise will face deportation.

The application process itself can be extremely lengthily, with delays of up to four years. Asylum seekers and family members waiting to join them are therefore left in limbo with the backlogs causing extensive periods of separation for families. The delay also makes it difficult to access free legal aid, as it is required for such an extensive period of time. In some circumstances, once a person's application has been pending for more than 150 days, they can apply to be able to work.[17]

The Canadian asylum process:

Individuals can make an asylum claim in Canada at a port of entry or at an inland Immigration, Refugees and Citizenship Canada (IRCC) office. Officials will determine if an individual is eligible to make a claim considering whether the claimant has committed a serious crime, made a previous claim in Canada, or received protection in another country.

Asylum claimants are different from resettled refugees. Asylum seekers make a refugee claim in Canada whereas resettled refugees are screened from abroad in advance and when they arrive in Canada, they are permanent residents. All eligible refugee claimants receive a hearing at a tribunal and each case is decided on its merits, based on the evidence and arguments presented.

Under the Immigration and Refugee Protection Act, a person in need of protection is a person in Canada who would be subjected personally to a danger of torture, a risk to their life, or a risk of cruel and unusual treatment or punishment if they were returned to their home country. If determined as eligible to claim asylum, a refugee claimant they may have access to social assistance, health services, legal aid, education and emergency housing while a decision is pending. Most individuals can also work during this period. Except for health services, which are funded by the Government of Canada (Interim Federal Health Program), provision of all these supports is the responsibility of provinces and territories. Municipalities or non-profit organizations also provide some supports.

Refugee claimants are not eligible for federal settlement services until they receive a positive refugee determination. Once they do, this means that individuals can stay in Canada and apply to become a permanent resident in most cases. If a claim is rejected, individuals may be able to appeal the decision.[18]

Case Study One: New England Survivors of Torture and Trauma (NESTT)

NESTT was founded by Dr Fondacaro in response to child protection services referrals to connecting cultures. The organisation set up educational resources in reaction to the key problems their clients were encountering e.g. domestic abuse, drug and alcohol misuse amongst specific communities.

My first meeting was in Vermont, USA with Dr Lauren Dewey, psychologist at NESTT and Connecting cultures, operating clinically and academically at Vermont Psychological Services within the University of Vermont. I was interested in the variety of services offered by the organisation, but also the training provided to staff. Connecting Cultures have published work on a training model used in the provision of mental health support to the refugee and asylum seeker population. I wanted to understand what the training and cross cultural community outreach, education and communication looked like. Unfortunately, the director and founder of the NESTT Dr Karen Fondacaro and author of publications on refugee psychological services was on sabbatical and unable to speak with me.[19] However, I spent time with Dr Dewey, director of youth services and clinical supervisor who was standing in for Dr Fondacaro and delivering ongoing training to the staff.

An interesting training resource was the provision of refugee resettlement webinars for associated staff, which was definitely something I felt could translate well to The Listening Place, particularly given the time restraints of the volunteer staff base to attend organised training events.

NESTT offers CBT, CPT and ACT acceptance and commitment therapy as well as working alongside social workers, legal services, advocacy and medical teams. Monthly multi-disciplinary meetings are held involving these groups to ensure there remains up-to-date holistic needs planning. In order to ensure that staff maintain cultural competency, NESTT reaches out to the different communities, and has senior figures from within the cultural community work with the organisation to educate staff and ensure that the organisation remains fully relevant to the community it serves.

At the time of visiting, the clinical and research focus of NESTT was a to develop and test a multi-disciplinary assessment programme. This was intended to reduce the number of referrals on the waiting list, streamline processes and improve access to different services. As part of this a new assessment framework had been introduced, which was delivered by a clinical team made up of trained psychology doctorate students at university of Vermont. The questionnaire included suicidality measurements and pulled information together with a therapeutic treatment plan and diagnostic summary to be shared with the social worker, legal and physical health teams. This meant, these groups were then better placed to understand the needs of each individual and offer them support quicker whilst working more collaboratively with each service involved.

It was really helpful for me to understand how the organisation upskilled and trained its staff to be competent in supporting the refugee and asylum seeker community in their needs and NESTTs work on developing a training model provided me with important pointers for what will be required when implementing my recommendations in the UK.

Case Study Two: ***Queensland Programme of Assistance to Survivors of Torture and Trauma (QPASTT).***

Background

I arrived in Brisbane, very excited to meet the team at the Queensland Program of Assistance to Survivors of Torture and Trauma (QPASTT) organisation. They had been incredibly receptive to my visit and had kindly made me a schedule to maximise my 4 days with the organisation. My research prior to arrival showed me that there had been some changes at an organisational level with the introduction of a co-CEO and a new strategy and framework which I was excited to learn more about.

QPASTT offer a range of culturally sensitive services and activities to support physical, psychological and social wellbeing, with counselling forming a large component of the organisation. I wanted to understand how this was delivered, if there were any thresholds to accessing counselling, what the common problems and presentations and how were staff supported, trained and supervised.

QPASTT is a member of the Forum of Australian Services for Survivors of Torture and Trauma (FASSTT),[20] a national network of eight specialist services for migrant survivors of trauma. FASSTT members support survivors who have come to Australia as refugees or humanitarian immigrants, to recover and rebuild their lives after having been tortured and traumatised in their countries of origin, as part of the migration journey or in refugee camps. FASSTT is a non-profit whose members receive state funding along with resources from the Program of Assistance for Survivors of Torture and Trauma (PASTT),[21] who are funded by the Commonwealth Department of Health. PASTT provides interventions and support for survivors of torture and traumatic experiences who present with complex needs. The FASSTT member agencies such as QPASTT deliver specialised services including:

- Direct counselling and related support services to individuals, families and groups who are survivors of torture and trauma. This includes advocacy and referrals to mainstream health and related services.
- Education and training to mainstream health and related service providers.
- Community development and capacity building activities.
- Rural, regional and remote outreach services to enable survivors of torture and trauma to access comparable services outside metropolitan areas.
- Resources to support and enhance the capacity of specialist counselling and related support services to deliver effective services to survivors of torture and trauma and to respond to emerging client needs.

I was lucky to spend time with Dr Ignacio Correa-Velez, Co-CEO of QPASTT as well as his senior team. Ignacio shared with me the new work in progress strategy and framework for QPASTT which takes into account the wider social and political context of the persecution suffered by the survivors accessing the organisation. Centred around Garcia-Ramirez's 2011 'A Liberation Psychology Approach to Acculturative Integration of Migrant Populations', the framework plots the journey towards the below recovery goals:

1: To restore safety, enhance control and reduce the disabling effects of fear and anxiety.
2: To restore attachment and connections to other human beings and a sense of belonging.
3: To restore meaning, identity and justice.
4: To restore dignity and value and reduce shame and guilt.

Much of the work done at QPASSTT aims to work through the memory of oppression and persecution throughout each individual's experience whilst simultaneously building the foundations of liberation by supporting people's knowledge, strength and values. The new framework also calls on Chavez's 2016 work 'Unifying Liberation Psychology and Humanists Values' as a tool for counsellors to promote social justice and healing. This reminded of the Power, Threat and Meaning Framework I had studied as part of my Psychotherapy masters. It is regarded as a new way to diagnose/assess/understand distress or responses (symptoms) to the misuse of power in people's lives. The philosophy of 'heal, belong and thrive', allows refugees to understand their trauma humanistically while developing critical thinking to arrive at a sense of belonging and empowerment in their new home. Individual,

family and group counselling is offered amongst a holistic framework of outreach services within the community.

QPASTT gets bipartisan support from Refugee Health Network Queensland in the form of clinical and mental health guidance. They hold a quarterly meeting for the Multicultural Mental Health Group and share self-harm and suicide rates alongside other FASSTT member agencies to develop a wider view for learning.

During my time at QPASTT I met with the senior team to discuss the range of services offered, which included the NEXUS suicide prevention program. The NEXUS program is an Australian Department of Health initiative that aims to reduce risk factors for suicide and self-harm and to promote protective factors among young people from refugee backgrounds. The program focusses on belonging, identity and social network. The work is considered early intervention and draws on guidance from the NEXUS Suicide Prevention Program 2002 framework developed by the Australian Department of Health for those between 12-25 years old. Identifying that young people from refugee backgrounds are at greater risk of suicide due to exposure to torture or trauma, acculturation distress and systematic vulnerabilities (including loss, discrimination and disruption to systems) the programme focuses on three pillars:

1. *Prevention* - Community outreach, engagement activities, relationship building and risk identification.

2. *Early intervention* - working with specific suicide risk factor such as trauma symptoms, transcultural identity formation, bullying, addiction and building healthy relationships and social cohesion.

3. *Crisis Management* - providing culturally safe and trauma informed supports at critical times.

The NEXUS project objectives are to decrease suicide risk in young people from refugee backgrounds who have attempted suicide or are at high risk of attempting suicide by increasing the support available to manage trauma symptoms. The pillars set out above increase and strengthen the connections these individuals have with other people, places and culture to create wellbeing and connectedness. All youth workers are bicultural which I noted was a huge part of building trust and safe, quality relationships to support suicide prevention. The project also sets out to improve community attitude, understanding and awareness to better identify and help at risk young people. Reporting is recorded every 10 sessions using the Kessler Psychological Distress Scale (K10).

I was fortunate enough to spend one-to-one time with Amy Burkett, Clinical Services Manager to talk about the psychological support format. Most interestingly, the service provider / practitioner roles are ‘Counsellor - advocates’ as opposed to just counsellor. The scope of the role allows for an hour of advocacy, a crucial part of sharing information, resources and support, alongside an hour of clinical work. QPASTT understands that the refugee experience calls for a holistic and broader approach that allows support throughout

a complex recovery process. Based in a human rights framework, the Counsellor Advocate model (existing throughout all services offered at QPASTT) is common practice within FASSTT member agencies. Advocacy allows for each client's experience, with clear permission, be shared beyond the walls of QPASTT to ensure that decision makers hear when a community's human rights have been violated or help build understanding of the refugee experience, increasing empathy and understanding from the people around them.

It is important to differentiate this from case management. Advocacy is not something that is built into the format of the service at The Listening Place, yet I have found myself trying to carve out extra time to communicate on behalf of a visitor, particularly for those in whom English is not their primary language or those receiving support from other services (legal, physical health etc).

The frequency of therapy is dependent on need, with most clients receiving fortnightly sessions. The provision can be reactive to stressors or positive events, but each session is for one hour with the assessment being one and half hours. On top of this there is 1 hour of time allowed for advocacy work. There is a review of symptoms every 10 sessions and a review of goals. Counsellor Advocates employ tools such as psycho-education, address self-destructive behaviours (including self harm and suicidal ideation), establishment of safe physical environment and grounding techniques. They focus on recovery goals which aim to restore trust after prolonged socially and psychologically damaging experiences. There is an understanding that the recovery process is not straightforward or linear and flexibility is available around length of sessions. The fear and trauma-informed counselling offered, centres around recovery process support with five principles:

- safety
- trustworthiness
- choice
- collaboration
- empowerment

With a person-centred approached in mind, QPASTT is clear that the therapeutic journey for each person is unique and personal. The nature of working with trauma means that a timeframe or set ending can be too concrete especially as there is an emphasis placed on creating a safe space where a therapeutic alliance can develop to deal with the individual traumatic reaction and experience.

A Risk Assessment Tool recording current and historical behaviours and events such as sexual assault, impulsivity and any current support forms part of the assessment. From this and the wider history, a treatment plan is developed collaboratively. This will incorporate personalised safety planning.

As restoring control through dignity and respect is a crucial part of the recovery process, transparency and understanding of the QPASTT support available and how their data is used, stored and shared forms part of the initial discussion.

Staff development

Staff all receive a clinical induction including training in the trauma recovery model as well as cultural and clinical understanding of the refugee experience. There is ongoing capacity building including internal meetings, sharing information, training, cultural competency and clinical supervision. Clinical supervision also allows the counsellor advocate to engage in their own reflexive practice, self-learning and reviews. Drawing inspiration from Daphne Hewson and Michael Carroll's Reflective Practice in Supervision, a reflective space is created allowing for critical focusing.

Cultural competency is made up of five components (APA, 2013):
- Self-assessment: about one's own identity, values, prejudices, biases
- Humility: about the limits of one's assessment and treatment of knowledge/skills
- Valuing diversity: via awareness of and sensitivity to cultural differences
- Vigilance: towards the power dynamics that result from cultural differences
- Responsiveness: to cultural differences via adaptation of assessment and treatment

QPASTT prioritises and encourages reflection on our own culture and cultural understanding of mental health.

The service user facing roles which deliver the counselling support are set up to allow for dual function, asserting that counselling and advocacy are fundamentally intertwined. Each qualified practitioner takes on a remit which includes both aspects of support. In line with the client-centred approach, this allows the counsellor to take a holistic view of the client's reality and circumstantial distress alongside psychological pain. This allows the counsellor to advocate for their client, often marginalised, to help them navigate a system to allow them to have their basic needs met alongside addressing their sense of belonging and trauma recovery. This however, is not case management support and referrals and signposting is part of advocacy.

Three times a year QPASTT counselling staff take part in an 'offline week'. No clients are seen during this time which is considered a period of development for staff. This can include speaker visits, case studies with the overarching aim of developing a good understanding of the refugee experience and up to date knowledge of common presentations or torture experiences. Clinical induction also includes incidental counselling with particular focus on vicarious trauma and self-care with guidance around compassion fatigue and burnout. In the instance of a successful suicide a staff care process is in place. This includes internal and external support of the staff member working with the client and an individual debriefing.

As a member agency of FASTT, annual data pooling is compulsory. This is gathered every 10 sessions and includes details of demographic data, symptomology including suicidality and torture trauma experiences. FASTT is a data sharing network providing the International Rehabilitation Council for Torture Victims (IRCT) torture related information.[22] The IRCT is

the world's largest membership-based civil society organisation specialised in the field of torture rehabilitation.

Counsellor advocates calculate risk including child safety, domestic violence and suicidality. This includes disclosure management including self harm behaviours or suicidal ideation which prompts a risk assessment and crisis management responses contained within therapeutic work e.g. safety planning.

QPASTT counselling bases it's approach from a client-centres framework. Cognitive based ways of working do not work as well addressing prolonged and sustained traumatic injury. CBT or Trauma Focussed CBT work within a 'top down' approach, relying on the client's ability to communicate well around cognitive functioning. Counselling within an integrative approach at QPASTT allows for more somatic based work. Being with the client, being a holding presence and bearing witness, versus solution giving is promoted at QPASTT.

Barrier's include client expectations and an understanding of mental health and what counselling is. Community suspicion and gatekeeping is a common barrier to overcome and this is why the counselling team will work closely with the community relationships team.

QPASTT is a fantastic organisation from which I learn a great deal during my time with the staff there. Much of what I experienced there will inform my future practice and has supported my project recommendations, but the concept of counsellor advocates really struck a chord with me and this is something I will continue to explore in the UK. Although advocacy roles exist in the UK, I am unclear whether any organisations utilise the counsellor as an advocate, as for me this is invaluable for the service user.

Case Study Three: Mental Health and Suicide Prevention Research Group at the University of South Australia.

My final visit was the University of South Australia in Adelaide to meet with the Mental Health and Suicide Prevention Research Group, led by Professor Nicholas Procter. Throughout my time in Australia, the people I had met from the variety of organisations had recommended I try to meet Professor Procter as his group were prominent researchers in the field. The Mental Health and Suicide Prevention Research Group includes a team of multidisciplinary academics from across the University of South Australia. A focus of their work is lived experience, and they produce research influencing the future of mental health care and suicide prevention in Australia and more widely.

The team had been kind enough to make a schedule for the week I spent with them, which culminated in a Suicide Prevention symposium. A number of academics and clinicians from across the region attended, with several short presentations on a variety of pertinent topics followed by a presentation by myself. I was incredibly lucky to have meetings with several people within the group as well as with individuals from partner organisations.

Their current research project is '*Development of Lived Experience workforce to examine and describe how Lived Experience advocacy and leadership embedded within the mental health system can be defined, recognised and utilised in South Australia*.'[23] This project aims to review how Lived Experience advocacy can help recovery from mental health issues and to integrate this into communities and the South Australia health care system. 'Lived Experience' refers to the ways that people with a personal experience of mental illness, service use and recovery are participating in the design and delivery of mental health services.

Of particular relevance to my work was a previous project led by Professor Proctor in 2017 to 2018, 'Suicide prevention education for NGO caseworkers'.[24] As discussed above, in Australia asylum seekers who are established to be be refugees are only granted a temporary residency visa, and at the time of the project there were approximately 30,000 asylum seekers living in Australian communities classified in this category. The uncertainty surrounding these temporary visas can contribute to significant mental distress, which can be seen as increased levels of anxiety and potentially suicidality. This interesting project delivered and later evaluated training to NGO caseworkers to address the particular vulnerability and mental deterioration seen in the asylum seeker and refugee population.

A 2013 article by Professor Procter et al published in the Medical Journal of Australia discusses suicide and self-harm prevention for people in immigration detention.[25] The article suggests that knowledge of cultural background is important and that support should promote an understanding of the factors that heighten self-harm and suicide risk, identify factors that protect people from self-harm and suicide and support access to external community mental health services that provide culturally and linguistically appropriate care and coordination and continuity of care. These recommendations remain pertinent for the asylum seekers and refugees accessing TLP services. Professor Procter and the current team at the University of South Australia were able to talk me through some of the research undertaken which has impacted on Australian policy and wider conversation, much of which although specific to the Australian situation, is generalisable to UK service provision.

The extensive research that Professor Proctor and his team have published will continue to support the development of my project. Their work looking at suicide prevention for individuals in detention centres was a distressing read but fuelled my motivation to work within this sector. I found the idea of using a Lived Experience workforce particularly poignant and this is something that can integrated into The Listening Place service.

Overview of some of the other organisations visited:

PRAIDA

Lastly in Montreal, I spoke with Alexis Jobin-Theberge, Senior advisor to the Programme régional d'accueil et d'intégration des demandeurs d'asile (PRAIDA) partnership, an organisation allocated by the provincial department of health and social services to meet the relevant psychological, medical and social needs of asylum seekers upon arrival in Quebec.

PRAIDA gives information on immigration and settlement support such as housing needs, obtaining work permits, requesting social assistance and signposting to immigration lawyers. Services are available in French and English and a bank of inter-regional interpreters are used. PRAIDA also has 2 temporary shelters where some eligible asylum seekers can stay for up to 3 weeks and are provided with 3 meals, healthcare including free vaccinations and a safe environment.

Primarily at PRAIDA, asylum seekers have access to a social worker, who evaluates their needs and ensures the appropriate follow-up and can also meet with a nurse. Social workers receive fortnightly external clinical supervision. I asked about when a servicer user presents as suicidal or is referred to PRAIDA from another service due to exceeding their capacity for care what happens. I was told that at PRAIDA suicide risk is established at reception of clients. A standardised tool is used and mandatory training to use it is provided. Regular file audits are arranged to ensure the use of up to date tools and material.

In terms of training, staff members receive 3 days of Montreal Action suicide training (the same training is consistent across the network of front of line services). Anyone at risk of suicide is made aware of 24/7 crisis services and those with concrete suicidal ideation or with a history of suicide attempts are taken care of by the emergency department.

CatholicCare

I visited CatholicCare in Melbourne, based in Dandenong, a culturally rich area with many migrant communities. CatholicCare offered a low to medium intensity counselling service, referring complex need cases to mental health specialists such as Foundation House (VFST), a non-profit supporting health, wellbeing and human rights for people from refugee backgrounds who have experienced traumatic events. They also have access to a drug and alcohol programme.

An intake assessment form to allow for care planning and referral is shared with the government as they provide funding to the organisation, this information includes mental health needs although not suicidality. It is possible that some people may not want to access service if information is being shared that they think might impact their immigration application. Due to funding allocation, refugee and asylum seeker programmes were separated into different teams and areas of the organisation. The asylum seeker arm was operating with almost no budget and relying on philanthropic support. The settlement programmes received government funding for humanitarian refugees.

CatholicCare believe a big alleviator of distress is community-based group activities, where people from refugee backgrounds can gain skills, enjoy spending time and create a support network of people with similar experiences. Isolation is a huge problem for many refugees and asylum seekers and activity groups create a space to talk in a way that isn't stigmatised or seen as specific mental health support. Such groups include needs-focused programmes such as literacy and English language or social wellbeing activities such as a weekly group for women from Myanmar where food is provided and cooking classes are held and childcare is provided. The activities are facilitated by volunteers from the general population and the relevant community and all receive training. All programmes ran by CatholicCare are set up collaboratively with members of the relevant migrant community to ensure everything is culturally appropriate.
CatholicCare employ permanent members of staff known as "cultural workers" who advise on programmes, activities, and internal and external training. Training and supervision is provided to staff, including suicidality awareness and cultural competency. This includes a suicide prevention seminar named 'Suicide to Hope' by Livingworks. A number of resources are made available in multiple languages including the SafeTalk book which includes mental health psychoeducation such as how to talk to someone that may be struggling and self care. A full range of crisis service contact details for Victoria plus translation services are also shared with service users.

World Wellness Group

In Brisbane I met with Annette Puzicka, Program manager of the Multicultural Psychological Therapies Group at World Wellness Group (WWG). World Wellness group offers care for physical and psychological needs and is a social enterprise, receiving no government funding. WWG was founded by 5 health workers from various disciplines in 2012 during a time of asylum seeker initiative defunding due to policy change. Thanks to the support of crowdfunding in 2013 a drop in community clinic was set up offering basic health care to marginalised populations.

The clinic offers pro-bono work with the support of donations and paying patients from the local community wanting to contribute to people unable to pay for their healthcare as part of a 'pay it forward model'. The presence of a clinic rather than a charity, NGO or public service encouraged visitors who might be put off seeking support for fear or stigmatisation or gossip within their community.

Mental health care provisions include focus on prevention through PM+ Program, problem management designed by the World Health Organisation) offer to those who are considered at risk due to their experience of adversity. Assessments and closing sessions are conducted by mental health practitioners, however the 7 sessions of support are delivered by peer support staff. These 'lay people' help make sense of overwhelming problems and offer advice on goal setting and self care. Referrals come from the community for those experiencing mild anxiety from a refugee background. The outcomes are measured using the K10+ Kessler Psychological distress scale.

WWG also offers 'Culture in Mind'; psychosocial community-based support for low, medium and high level mental health needs. Culturally responsive support is given by Welling

Support Coordinators and Multicultural peer Support Workers. This program is funded by the Queensland Department of Health.

All of the support offered at the WWG to people from migrant backgrounds operates within a 'culture based model' which embeds mental health and spirituality. A respectful and non-judgemental approach are core to the delivery, normalising each person's experience. There is a focus on education including signposting and empowerment, championing feedback.

Anecdotally, 40% of the clinic's visitors are considered at risk. Shifting Minds, launched by the Queensland Mental Health Commission, provides a suicide prevention strategic plan including targeted interventions for asylum seekers and vulnerable refugees.

Multicultural Psychological Therapies at WWG use the social factors surrounding each person with mild to moderate needs, embracing spirituality and religion as a protective factor. WWG seems to explain both mental health and each person's experiences and struggles in a way that personalises and honours the personal narrative by centering the person and their culture. I was struck by two things in particular during my trip to the World Wellness Group: how one location offers physical and mental health support and how they address the immediate situational needs with the inclusion of a small food bank. I believe it's important to address basic needs to reduce immediate stressors. I was also moved to learn that donations from the community go towards paying for healthcare including medications for asylum seekers. My biggest takeaway was the use of Multicultural Peer Support Workers (MPSWs). WWG employ around 50 trained community workers speaking 45 languages in total. Often gatekeepers to their communities, MPSW's draw on their own culture and experience of eleven issues including migration to work alongside health practitioners to offer cultural sensitivity and support.

Conclusions

I am truly grateful for the opportunity afforded to me by the Winston Churchill Memorial Trust, without which I could not have travelled far and wide to visit awe inspiring examples of suicide prevention for asylum seekers. I would like to share that I have been moved by the incredible commitment and dedication, on a variety of (mostly shoestring) budgets in varying political climates, where humanitarian care for those seeking asylum is heavily agenda-ed. It has struck me that working in this area often demands a level of self-sacrifice and requires consistent self-care and awareness around vicarious trauma and maintenance

of wellbeing. The people; leaders and providers, I met in each service from clinical settings to academia, were incredibly generous with their time, spirit and wisdom which they offered me in vast amounts. I believe this was in the hope that learning and sharing leads to a global improvement in how the world supports people in need from migrant backgrounds.

Achieving effective care can be a challenge due to service delivery difficulties the barriers existing to refugees and asylum seekers accessing treatment. Often service users have wide-ranging and complex needs, which are difficult to 'house under one roof'. Lack of funding and an ever-changing landscape which is dependant on government policy add to the challenge. Funding cuts to the NHS and privatisation of services has led to longer waiting times which in turn can result in deterioration of mental health in would be service users.

There is also an understandable reluctance to engage with services, in particular mental heath services, due to the stigma in various cultures and communities. There is perceived burdensomeness amongst individuals and there are practical barriers to accessing support e.g. money to travel to appointments. All of these things need to be overcome by a service offering tailored suicide prevention for asylum seekers and refugees.

I have taken home tangible ideas for The Listening Place and how to provide training for listening and supervising volunteers. Firstly, the importance of advocacy and the role this plays within The Listening Place. Advocacy is crucial to empower those who are often marginalised and left to navigate complicated and punitive systems with little support. They are then unaware and/or unable to access their rights and entitlements. Offering proactive, collaborative and informed decision making is incredibly important.

How would this work within the current format of The Listening Place service? There will need to be consideration given to the time needed for both face to face sessions and advocacy and how this will impact on the amount of visitors that can be seen. Perhaps rather than the two hours divided per client between counselling and advocacy as seen at QPASTT, advocacy can be integrated into the counselling role. It is worth mentioning that often to some degree advocacy is already happening on an informal basis. Service wide, data is collected to provide evidence for further funding and investment in suicide prevention. On an individual level, signposting and liaising with other service is common practice. It is routine to listen to a visitor's dilemmas so they can come to a decision in a safe space with no external influence. Amplifying an individual's voice who has no agency, and is painfully aware of this disadvantage.

Secondly and particularly relevant to The Listening Place, I have learnt about the value of non-clinical volunteers from migrant backgrounds as support service providers. As part of this, I have also considered about the use of volunteers with Lived Experience and what the implication of this is. I was inspired by the way that the services I met with worked closely with migrant communities and gatekeepers as 'consultants' to service offering and programme structure. I was particularly impressed by how people with migrant or lived experience with no clinical background provide support directly to service users. I draw on the Multicultural Peer Support Workers at the World Wellness Group. There, community workers with an expertise in languages and cultural experience, are trained to work across various programs including counselling, health management and prevention. Multicultural

Peer Support Workers in this setting are staff members, rather than volunteers. I believe that volunteers with lived experience can offer first hand understanding and wisdom, but it is important to consider how to ensure specific support is provided to these volunteers.

Considering Maslow's Hierarchy of Needs and the basic needs of physiological necessities such as food, shelter and safety needs such as security. These fundamental necessities are often not able to be accessed by the asylum seeker and refugee population and this needs to be addressed alongside their emotional needs. It may be the case that persecutory regimes rob people of these crucial elements to life, without which it is incredibly difficult to maintain motivation. The extensive uncertainty and the feeling that they cannot live a meaningful life lead to feelings of burdensomeness. Professor Procter describes the asylum seeker community feeling mentally trapped and helpless and this along with all the factors discussed in this report contribute to lethal hopelessness. It is therefore important to consider a full psychosocial holistic approach to supporting these individuals.

Perhaps the most important of all of my learnings is the idea of cultural competency. This had a particular impact on me, especially in the context of the current climate of rightly uncovering the veil on bias, privilege and systemic racism. It is crucial to accept the global and socially constructed system of racism that perpetually creates power, superiority and domination in the hands of white, often western people and retains and maintains this privilege by supressing, marginalising and mistreating ethnic minorities. This attitude is experienced often through the entirety of many asylum seekers and refugees lives.
This system of implicit bias is built into every aspect of society which a service user will encounter. Therefore, it is crucial to understand this and learn a new attitude of anti-racism and work reflexively in practice and in supervision.

When we consider what belonging, home, identity and race means to our clients, it's also vital to consider what these constructs means to us. Any training created must generate volunteer self-awareness, knowledge and critical. I am drawn to the importance of checking cultural bias as a service provider and divisor and considering how bias maintains the elements of identity listed above. At the core of the historic and situational suffering of suicidal visitors is the hopelessness created by the dehumanising treatment of asylum seekers and refugees. How can we empathise with this? How can we contain bearing witness to this? How do we care for those who have experienced such oppression and those that support them, particularly if they have lived through similar or the same trauma (themselves or generationally)? The trauma that is created by arriving at supposed safety or requesting basic safety to be met with institutionalised contempt. The distrust and pain that this leads to and the impact this has on mental health. The perception or self, shame, burdensomeness and cultural stigmatisation are large problems to engage with in a voluntary, non-clinical setting. The client is in a period of incredible uncertainty which must be held whilst acknowledging the limitations of The Listening Place. It should be considered what impact this has on both the visitor and the listener, as the listener too may feel helpless in the face of this complexity.

Recommendations:

When visiting the different organisations across Canada, USA and Australia I at all times had in mind how my findings could be interpreted to ensure they were relevant for practice in the UK, in particular at The Listening Place. Ultimately, there needs to be drastic change to the way the world treats some of its most vulnerable individuals. Policy and public health strategies are beyond the scope of this project, but the incredible work I have witnessed during this trip has provided me with a greater understanding of what changes can be made at a local level, at The Listening Place, and how this can be used as a blueprint for other services who make it their ambition to improve the support provided to the asylum seeker and refugee population.

- **Ensure volunteers and staff are informed of the issues faced by asylum seekers.**

  All volunteers or staff delivering any form of psychological support to the refugee and asylum seeker population need to have a basic understanding of the barriers this cohort face when trying to access services. This could be delivered by face-to-face teaching or through educational materials. Specifically, in relation to The Listening Place; this could form part of the existing structures providing periodic training to the volunteers.

- **A 'hub' of information.**

  Contact details for locally available advocacy services or community based projects targeting the refugee and asylum seeker population should be provided to those attending The Listening Place. A 'hub' of information providing contacts for services such as language courses, faith meetings, network groups etc could be made available for all those of a refugee and asylum seeker background visiting The Listening Place. Where possible volunteers can integrate advocacy into the sessions and then use signposting to the any allied services.

- **Connecting with cultural communities.**

  Involving members from within different cultural communities to connect the clients attending The Listening Place to the comforts of their own community, to ensure that everything provided is culturally relevant and serves to form authentic connections for the individual. Utilising those with lived experience to inform both the training of volunteers and the future development of the service to ensure it is trauma-informed.

- **Ensuring that cultural competency through reflective work is at the core of training and supervision at The Listening Place**.

Supervision structure already exist in The Listening Place, and so supporting junior team members spend time reflecting on the case work, and offering support groups and group working during the training days to link this in with information delivered from experts in the field.

What Next?

Now I have looked back at my time with the fantastic organisations in Canada, the USA and Australia, I will share what's next back home here in the UK. After taking time away from The Listening Place to give birth to my son, I will be returning once Covid restrictions are lifted. My plan is to deliver volunteer training format and material to develop a specific care pathway within the charity for asylum seekers and refugees. Whilst it's important to remember the voluntary and non-clinical element to The Listening Place, I would hope to equip listeners to hear and hold the interpersonal and intrapersonal struggles of each visitor to ensure attunement at a listening and an advocacy level. I will also put protocol in place to ensure that each volunteer is supported in their role, not just to ensure safe, ethical delivery of support, but also listener wellbeing. I hope to create space for multicultural and social justice to meet the needs of the individuals presenting. My aim is to build an environment where asylum seekers and refugees can be respected for their strength, resilience and skill. I will be drawing on existing literature to do this. In particular I have found 'Multicultural and social justice counselling competencies' very informative.[26]

Finally, I circle back to the foundations of the service I'm proud to be a part of. I ask myself; what is listening? For me, it is truly hearing someone and in doing so honouring them as a person and their experience. The outcomes data from The Listening Place show that listening as an intervention provides relief and improvement from suicidality. For this population group, after a lifetime of being dehumanised, what could be more powerful than being heard. Speaking with Bernadette McGrath, CEO of Overseas Services to Survivors of Torture and Trauma (OSSTT) who with kindness questioned my use of the word 'just' when referring to the non-clinical listening service at The Listening Place. When sharing the experiences of the counsellors she organizes at Nauru and Manus island detention centres, she explained that what they offer detainees is listening. Not a specific therapeutic modality. Simply an empathetic, non-judgmental and present ear. Listening is the most powerful service that can be given.

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