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"Our role as mental health professionals is not only to help overcome the suffering but as clinicians and human beings to advocate for more openness and humanity in this matter" Moussaoui et al (2021, p. 8)

Title: Guidance for Clinicians when working with refugees and asylum seekers

Parts of the good practice guidelines presented here are based on those developed for the British Psychological Society (BPS) on Working with refugees and asylum seekers. The authors would like to acknowledge and thank the BPS for giving permission to use elements of these within this paper and to the psychologists who contributed to the parts of the guidelines included here, specifically Angela Byrne, Anne Douglas, Halit Halusi, Renos Papadopolous, Nimisha Patel, and Bill Yule

Abstract

The contribution and role of psychologists, psychiatrists or mental health practitioners in working alongside forced migrants may take many forms. The guidance on which this paper is based, came about when several members of the British Psychological Society (including those with lived experience insight and those who had set up services); became aware of the need for good practice guidance for psychologists working with refugees, asylum seekers including forced migrants across Britain. These guidelines cover a range of areas where psychologists work with individuals in clinical contexts, schools, nurseries, colleges and within community organisations.

Context and statistical data

For decades, armed conflicts, persecution and violations of human rights have forced people to flee their homelands and seek safety in other countries (Tribe & Jalonen, 2021). There were 84 million forcibly displaced people in mid-2021 (UNHCR, 2021). Five countries (Turkey, Colombia, Uganda, Pakistan & Germany) host 39 percent of refugees and 35 million forcibly displaced are children under 18 (UNHCR, 2021). The majority of those forcibly displaced, flee to neighbouring countries and regions. Eighty-five percent of forced migrants are hosted in low- and middle-income countries (UNHCR, 2021). While, forty-eight million people remain within their country of origin, they are internally displaced to another part of this country (UNHCR, 2021) and are unable to return to their homes.

Legal framework

The UK has legal obligations under international refugee law, specifically the United Nations Convention on the Status of Refugees 1951 and the 1967 Protocol (together referred to as the 'Refugee Convention') which requires States to:

- Not return asylum seekers to countries they have fled from and where their life or freedom would be threatened because of their race, religion, nationality, membership of a particular social group or political position.
- Have in place national mechanisms to consider claims for asylum
- Have fair and efficient asylum procedures to ensure they can live with dignity and in safety whilst their asylum claims are being considered and processed
- Not penalise an asylum seeker for illegal entry when the purpose of their entry is to claim asylum.

The primary responsibility for protection lies with the State receiving refugees.

The United Nations High Commissioner for Refugees (UNHCR) is the UN agency with a mandate to protect refugees globally, including those internally displaced. The UNHCR's role is to advise and support States in implementing their responsibilities.

The UNHCR recognises that during mass movements of refugees, for example where there is persecution, violence or armed conflict, it is not always possible or necessary to conduct individual interviews with every person who crosses a border. These people are often referred to as 'prima facie' refugees.

Definitions

Asylum seeker

Internationally, asylum seekers are people who have moved across international borders to seek protection.

In the UK, an asylum seeker is someone who has applied for protection under international law, specifically on the basis of the UN Refugee Convention or Article 3 of the European Convention on Human Rights, which prohibits torture or inhuman or degrading treatment or punishment and prohibits the return of a person to a country where the person may suffer a violation of their rights under Article 3.

Refugee

Under international law, the United Nations Convention on the Status of Refugees, 1951 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 is unable, or owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence, as a result of such events, is unable to or, owing to such fear, is unwilling to return to it*" (Article 1 (A)(2)).

In the UK, refugee status is given to a person recognised by the Home Office as a refugee as defined by the Refugee Convention. Hence, refugees are those who have been granted protection in the UK.

Unaccompanied minor

Internationally, the United Nation High Commissioner for Refugees (UNHCR) defines an unaccompanied minor as a person who is under the age of 18, unless, under the law applicable to the child, majority is attained earlier and who is separated from both parents and is not being cared for by an adult who by law or custom has responsibility to do so (UNHCR, 1997).

In the UK, an unaccompanied minor is a person who at the time of making an asylum application is under the age of 18; and who is seeking asylum in their own right; who is outside their country of origin and separated from both parents or previous/legal customary primary care giver; and without adult family members or guardians in the UK to whom they could turn.

Separated child/ren

A separated child is someone under 18 years of age; who is outside their country of origin and separated from both parents or previous/legal customary care giver. Separated children are typically asylum seekers, but the Home Office may dispute their age.

Age-disputed person

An age-disputed person is someone who has claimed asylum as a minor but where the Home Office and/or the local authority does not accept the date of birth claimed by the applicant and therefore, asks the applicant to provide support. The person is then treated as an adult by the Home Office and/or the local authority. This has significant implications for the way in which the person's application for asylum is assessed and for the welfare and educational support that they receive. What is known as a Merton assessment (ADCS,2015) may need to be carried out with the young person. Recently, Hamdoud & Bunn (2022) detail the use of biological methods in age assessments, as well as documenting some of the difficulties associated with these.

Internally displaced person

An internally displaced person is someone who is forced to flee their home for safety but who has not crossed a border, and therefore remains within their country's borders. They remain under the protection of their government. Their reasons for fleeing may be the same as for those who have crossed international borders to seek asylum and protection in other countries, but they are not considered legally as refugees. IDPs are sometimes referred to as 'internal refugees' however, they do not have the same legal protection as refugees who cross country borders.

Migrant

A migrant is a person who chooses to move not because of threat of death or persecution, but to improve their lives, to seek family reunion, education or employment etc. Migrants are those people who do not face threats to their lives or their safety if they returned to their

country and they could receive the protection of the government in their country. Typically, migrant or voluntary migrant is a term used for foreign nationals resident in a country.

Refugees and Mental health

The escalation in conflicts around the world means people will continue to be forced to flee and that this will continue to be an important area of practice for mental health professionals and others working with children, families, in mental health, educational settings, amongst communities, in places of worship, as volunteers and in other relevant contexts. Refugees and asylum seekers who flee have often done so at very short notice, and via a perilous journey, which can mean they have not emotionally processed many of their experiences, losses and changes (Farsimadan, 2021; Douglas, 2010). They may assume arrival in another country signals an end to their difficulties, when frequently this is not the case and this can have a psychological impact. Fazel et al (2012) conducted a systematic review of individual, family, community, and societal risk and protective factors for mental health in children and adolescents who were forcibly displaced to high-income countries They noted that a significant risk factor was exposure to violence whilst social support and stable settlement provided protective effects. They also stressed the importance of asylum claims being dealt with quickly as well as active integration for refugee children. Although, many refugees and asylum seekers choose never to access formal or statutory mental health services (Bhugra & Gupta, 2011; Desa et al, 2021), they may access a range of services which they may find therapeutic, for example cultural, religious, sporting or artistic projects. While some will benefit from access to a clinician for issues relating to the traumatic experiences and losses they endured (Bhugra, 2020; Blackmore et al 2020).

Displaced people and forced migrants may also come from cultural backgrounds where accessing mental health services is not within their traditional help-seeking repertoire or may be viewed as stigmatising (Bhugra, 2020; Baarnhielm et al. 2020; Hammad & Hamid, 2021). It is important to realise that refugees are a diverse and heterogeneous group of people with individual needs and requirements. On occasions, clinical services can inadvertently be reductive by focussing only on a person's experience of being a refugee and whilst this is an important event in anyone's life, it is part of a wider life.

The impact of becoming an asylum seeker or refugee are many and diverse and are dependent on a range of factors. Most asylum seekers and refugees are extremely resilient having developed helpful coping strategies and have shown immense strength and fortitude in fleeing from their country of origin and making the journey to their current country (Tribe & Jalonen 2020). However, poverty (Bhugra, 2020) being denied access to work (Searle, 2017), uncertainty about their right to remain (Jannesari, et al, 2020) and the hostility they can face from the community where they are settled can all put a psychological strain on them (Bhugra et al, 2021).

What to be aware of:

- Getting to a new country may involve traumatic experiences including when families are often split up and the journey is frequently fraught with risk and numerous dangers including arrest, theft, kidnapping and sexual violence.

- Asylum seekers may assume that you are familiar with the politics and the human rights record of their country of origin. This may mean that they do not immediately disclose their experiences of human rights abuses, including torture, and you may need to ask about this, when appropriate. You may find it helpful to be aware of this context, as it is highly likely to impact on refugees' and asylum seekers' states of mind, and their sense of wellbeing and safety. A useful variety of work conducted by clinicians working with asylum seekers and refugees can be located at German & Ehntholt, (2007); Tribe & Patel (2007); Bhugra (2020); Moussaoui et al, (2021); Boyles, et al, (2022); Papadopolous, (2022).

- Someone who has to seek asylum in another country is likely to encounter multiple losses including loss of home, culture, family, profession, language and friends as well as their plans for the future.

- Many asylum seekers expect that their arrival in the new country will signal an end to their difficulties. In reality, this is frequently not the case, and the psychological impact of this realisation can be significant. While some local communities show support, some may show a lack of interest or worse, show hostility or racist attitudes. Asylum seekers may experience a lot of stresses such as homelessness, social exclusion, stereotyping and overt discrimination.

Clinicians will encounter refugees and asylum seekers in many different settings. These best practice guidelines outline key recommendations for clinicians working in and across these settings. Practitioners may choose to take on a range of roles, these may be restricted to work as clinicians and may or may not include human rights work, community psychology or advocacy.

Summary of key guidance

Supporting adults

1. Show respect for service users and make sure clear information is given about meetings.

2. Always use professional interpreters.

3. Maintain good contacts with other services to avoid duplication of services.

4. Ensure professional boundaries are kept between you and the service user and make sure you have regular supervision to reflect on your work and avoid vicarious traumatisation.

Supporting children, young people and unaccompanied minors

5. Children must never be asked to be an interpreter, especially when their parents are being examined or seen by a clinician.

6. When assessing children, interview them separately, as they may not want to upset their parents.

7. For unaccompanied minors, be aware that turning 18 is a crucial age – both in terms of whether they have leave to remain, and the support they receive from social services if they stay.

Supporting nurseries, schools and colleges

8. Swift access to education and well-planned school-based assessments can help the children integrate successfully.

9. Children should be assessed in their home language and correct dialect. Children should not be placed in lower attaining groups as a matter of course if English is not their first language, but they should be assessed on their abilities, previous schooling and needs.

10. Engage the community and whole school so that refugee & asylum seeking - children and young people can be integrated in a timely manner

Supporting families

11. Assess families not just in terms of their needs, but also their strengths, abilities and coping strategies.

12. Signpost sources of support for securing appropriate, and reliable legal representation if they need to apply for asylum.

13. Be sensitive as to which is the appropriate community for these families, rather than what is assumed to be.

14. Avoid assuming you know what is best for the family and involve them in any decision-making.

15. Clear pathways to support including relevant organisations and appropriate practical support should be made, if the family requires this.

Supporting communities

16. Develop mutually supportive and collaborative relationships with community organisations, sharing experience and knowledge rather than acting as an 'expert'.

17. Set up methods of evaluation for any partnership work from the start as this can produce helpful feedback and increase knowledge.

Intersectionality

18. Refugees should not be seen as a homogenous group, but offered specialist support if needed in terms of, age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation, religion, all of

which are protected characteristics as defined by the UK Equality Act (2010). Other equal opportunities legislation should also be adhered to.

Supporting adults

Asylum seekers, refugees and trafficking survivors may present themselves, or be referred to a wide range of health services from primary care to community mental health teams, specialist services such as forensic or in-patient wards. They may also seek help in Accident and Emergency Departments/ emergency rooms or be referred to other health services such as pain clinics.

Accessing mental health services can be difficult for asylum seekers and refugees who may face additional barriers such as lack of understanding of health care systems in their new country, adverse perceptions about mental health care based on stigma in their home country or anxiety about being involved with any official government agency as reported by Majumder et al., (2015) in relation to adolescents and Schina & Zanghellini, (2021) regarding adults.

Clinicians who receive such a referral are encouraged to follow the guidance provided below:

1. **Show respect for service users and make sure clear information is given about meetings.** Dealing with officialdom can often seem unpleasant and hostile. So, it is vital that the clinician considers the health service from the service user's viewpoint and makes it as accessible as possible. This may be achieved in a number of ways such as: sending a written invitation in the individual's own language as well as language of the new country, providing your full name, including travel directions, considering the time of the appointment, the lay out of your office etc.

Service users should be treated with respect by all staff from their initial contact with reception to their face-to-face meeting with the clinician. It is particularly important as asylum seekers or refugee service users, may have experienced unfriendly and hostile behaviours in their home country prior to fleeing, during their journey to a different country, or where they currently live. Lack of employment may also add to the feeling of not being valued.

2. **Always use professional interpreters.**

Always book an interpreter for the first meeting – and thereafter if required. Each trust will have different arrangements but, in general, if you work in an inpatient setting, make sure there is an interpreter who can attend regularly throughout the week and not just for ward rounds or assessments. Your non-English speaking service user should be able to communicate with clinicians. Reassure your client that the interpreter has a code of conduct and will keep their information confidential. More detailed information may be found in The BPS guidelines on *Working with interpreters in health settings*, (2017).

3. **Maintain good contacts with other services to avoid duplication of services.**

Ensure joined-up service delivery and avoid duplication by knowing what other agencies are or could be providing. If there are agencies that can support your client's practical needs (e.g., courses, in the new language, befriending schemes, community groups), signpost your client to them. For example, the Red Crescent/Cross and a range of other non-governmental and community organisations may be providing services, which are similar or complementary to those, offered by mainstream services. Otherwise, your service user may look to you as a general resource for – e.g., inadequate housing, translating legal letters. Although, assisting the service user with their basic needs, can assist building the therapeutic relationship, you should be mindful of the boundaries and if this becomes problematic you need to discuss this with them sensitively to minimise distress and ensure they understand your rationale.

Think about setting up regular multi-agency meetings to ensure collaboration and to provide mutual support.

4. **Ensure professional boundaries are kept between you and the service user, and make sure you have regular supervision to reflect on your work and avoid vicarious traumatisation.**

When working with asylum seekers, it can be distressing and worrying to see someone who is destitute or surviving on very little money and with often very few personal possessions. Each service will develop their own protocol for coping with these challenges. It may be helpful to be able to signpost your client to relevant agencies and colleagues.

Many asylum seekers will have lost their family either through forced separation or death. They may feel very isolated in their host country and regard you as part of their new family. Clients often say things like: 'you are my mother now' or 'you are my new daughter' or when referring to the team, 'this is my family now'. While this may be appropriate it can be helpful if the differences between the professional helping relationship and those with a member of the family are thoughtfully explained. Your professional relationship with your client will end eventually, and it is kinder and more ethical to gently explain the boundaries and limitations of this professional relationship.

Supporting children, young people and unaccompanied minors

In addition to the issues listed above there are some particular issues that must be considered in relation to children.

Supporting children, young people and unaccompanied minors, requires awareness of the legal framework for their protection. However, it is also primarily important to remember that these are children first and asylum seekers or refugees second. These young people have to face all of the usual challenges of living through childhood and adolescence, but with the added strain of living in a different culture, country and without the support of family.

The legal framework:

In addition to all other legal frameworks, children are subject to the UN convention on the Rights of the Child (United Nations, 1987). These rights remain whether the children are displaced, seeking asylum or with or without other family members. Amongst the most relevant articles of this area:

Article 9 – the right not to be separate from their parents

Article 24 – the right to access health care

Article 28 – the right to education

Article 34 – the right to protection from sexual exploitation and sexual abuse

Article 35 – the right to protection from abduction, sale and trafficking

Article 38 – the rights to be protected from war and armed conflict, and for under 15's not to take part in war or join the armed forces.

Article 39 – States parties shall take all appropriate measures to promote physical and psychological recovery and social reintegration of a child victim of any form of neglect, exploitation, or abuse; torture or any other form of cruel, inhuman or degrading treatment or punishment; or armed conflicts.

In summary, the legal framework makes clear that the duty of the State is to protect the children, keep them with their families as far as possible, and provide education and health care. In particular, the State should provide interventions to ameliorate the effects of traumatic experiences that the child or young person has been exposed to.

5. Children must never be asked to be an interpreter in formal settings, especially when their parents are being examined or seen by a clinician.

Children (and adults) face living in a new community with different customs. Most will have to learn the language of the new country – and because children often learn this faster than their parents, they may end up being the mediator with the outside world. However, you must never ask a child to be an interpreter in formal settings (including when their parents are being medically examined or seen by a clinician).

6. When assessing children, interview them separately, as they may not want to upset their parents.

Make sure you interview a child separately from their parents, as often children will not talk about what is troubling them, because they know that it upsets their parents to hear it. As part of early interviews, the child should be given time to tell their story with little prompting. Many adults (including parents, teachers and inexperienced mental health workers) worry that this will 're-traumatise' the child. However, although speaking about traumatic experiences with a professional in a safe environment may be initially upsetting, it may also be cathartic and therapeutic.

7. For unaccompanied minors, be aware that turning 18 is a crucial age – both in terms of whether they have to leave or remain, and the support they receive from social services if they stay.

Under current rules, where a child is deemed to be under 17 years old, they are accepted by social services and placed in foster care. If they are 17–18 years old, they may be placed in semi-independent living, sharing accommodation with others of the same age and with some support from social services. Where they are deemed to be over 18 years old, they are treated as adults and taken to detention centres or released into the community while their legal status is decided.

It is difficult to judge a young person's age from just looking at them, and yet that is what happened for many. Inevitably, many mistakes were made. Youngsters whose ages were disputed sometimes report that their dreams are shattered and the experience was more traumatic than the original reasons they had to flee. In recent years, there have been slight improvements in policy, and age has now to be determined by two specially trained social workers following the Merton guidelines (ADCS, 2015) in the UK. This process will vary depending on the system in the new country. More recently, Hamdoud & Bunn (2022) detail the use of biological methods in age assessments, as well as documenting some of the difficulties associated with these.

If an unaccompanied child has applied for asylum, they are usually given the legal status of 'leave to remain' within the UK, although the legal framework and language used will vary depending on the new country – but only until they turn 18. Then, or shortly after that, they are considered for asylum – and if it is not granted, they may be sent back to their original country. The anxiety surrounding the wait for this crucial decision is not made any easier by the fact that it coincides with having to take important decisions about continuing education, or seeking employment. They are also being moved from child to adult mental health services. It is particularly important that teenagers who are receiving help from Child and Adolescent Mental Health Services (CAMHS) continue to receive it.

Supporting nurseries, schools and colleges

Some clinicians work with schools, nurseries and colleges. They are, therefore well placed to support schools prepare for the arrival and successful inclusion of children who are refugees or asylum seekers. In many cases, there may be little notice of a new arrival and this may stretch limited resources. It is useful to devise a whole setting provision map to detail resources available, including those that could be developed and those that are required.

8. Swift access to education and well-planned school-based assessments helps refugee & asylum-seeking children integrate successfully.

Swift curriculum access is a key feature of successful social inclusion and working towards ensuring positive outcomes for refugee and asylum-seeking children.

9. Assess refugee & asylum- seeking children in their home language and correct dialect. Children should not be placed in lower attaining groups as a matter of course if English is not their first language, but they should be assessed on their abilities, previous schooling and needs.

Clinicians can work with schools through the provision of initial assessment of children and young people's educational background in their home language. This should include an assessment of curricula concepts and dynamic factors such as learning behaviours. Ongoing assessments and tracking of these children should draw on principles of Assessment Through Teaching (National Institute of Economic and Social Research, 2019).

Assessments drawing on children's narratives may also enable the voice of the child or young person to be heard. These assessments, in the home language, can also be used to explore what sense they make of their personal and physical journey. (e.g., Hulusi and Oland, 2010).

10. Engage the community and whole school so that refugee & asylum seeking - children and young people can be integrated in a timely manner

Engaging and involving the family and the community is key in ensuring the longer-term social inclusion, and improved outcome for children from refugee and asylum-seeking families. Clinicians can work with educational settings to ensure that schools provide detailed information about themselves and Local Authority systems through bilingual mentors and advisors.

Schools should be encouraged to use such mentors and family support workers, to encourage parents and the wider newly-arrived community to engage in nursery and school life. Find solutions that promote contact and communication between home, other children and families, and work to develop understanding between refugee and asylum seeker communities and schools, nurseries or colleges where there are clashes of constructs, beliefs or attitudes.

Supporting families

This can be helpful for refugees at difficult times, although the experience of flight, seeking asylum and obtaining legal refugee status can put tremendous stress on families. These experiences may affect family members in different ways and can lead to changes for one or more family member which can affect all the family. Clinicians needs to bear this in mind and offer support to all family members, who may have had very different experiences or been affected differently by these. Refugee families are often separated on a temporary basis due to the experience of flight, seeking asylum and obtaining refugee status.

11. Assess families not just in terms of their needs, but also their strengths, abilities and coping strategies.

Clinicians may need to consider the way they carry out assessments or interventions. They should reflect upon the cultural assumptions and architecture of these processes and work with the family to understand their meaning making and how they understand their distress. Explanatory health models and idioms of distress are culturally located. It is important to listen to what families understand as their difficulties and not to make assumptions about

these or that their psychological distress is their primary concern. Clear and accessible language should be used.

It may be helpful to understand the family's developmental history as well as their refugee history and where they are in the latter process, as this may affect their feelings of security, stability and psychological safety. For example, an asylum seeker at risk of deportation is likely to feel very differently to someone who has full refugee status. Understanding if other family members are hoping to join the family you are working with and what is happening to these family members may also be useful.

As stated earlier, it is important that strengths and abilities including coping skills, resilience and survival skills shown by many refugee families are recognised as well as their needs. It is easy to consider refugees as victims and to overlook the totality of their lives and the strengths they possess.

12. Signpost sources of support for securing appropriate, and reliable legal representation if they need to apply for asylum.

Families may be in touch with a variety of services and agencies, in which case it would be useful when possible and appropriate and with the family's consent that there is coordination between these agencies.

Families admitted under specific programme schemes by receiving countries, for example, recent schemes for people from Afghanistan or Syria in a number of countries, may still have legal issues. It is vitally important that families can access good legal advice when needed. There are a number of immigration and legal organisations that can help, but the family needs to know how to contact them. The Immigration Law Practitioners' Association (ILPA) in the UK and comparable organisations in other countries will be able to help.

13. Be sensitive as to which is the appropriate community for these families, rather than what is assumed to be.

The role of community support is of paramount importance. Appropriate support from the extended family and community strengthens families and reduces the negative effects. However, you need to be extremely sensitive in terms of considering which community is appropriate for each family, as well as each family member. It is always strongly recommended that clinicians collaborate with the family in selecting their community of choice and not to assign to them a community that is assumed by others to be 'their community'.

14. Avoid assuming you know what is best for the family and involve them in any decision-making.

Ensure that family members are involved in any decision making. Asylum seeing families are often labelled as vulnerable and as victims, rather than as survivors with agency (although of course they can be both) who have already shown immense resilience and courage in fleeing

their country of birth and often setting out on a perilous journey to a new country. The family are experts by experience on their own lives, they may have experienced significant disempowerment on their journey towards refugee status and clinicians should not add to this by making decisions about them rather than with them.

15. Clear pathways to support including relevant organisations and appropriate practical support should be made, if the family requires this.

There are refugee, third sector and governmental agencies which can provide support and practical help. There may have been different arrangements and agencies in the family's country of origin and providing information about relevant organisations in the new country can be helpful and contribute to a sense of agency for refugees.

Supporting communities

All clinicians whatever their specialism, can support communities. Given the inaccessibility of mainstream services to many refugees, clinicians may also work within statutory services to address some of the barriers to access. Refugee community organisations (RCO's) will also be key to providing such support and signposting specific needs.

16. Develop mutually supportive relationships with community organisations, sharing experience and knowledge rather than acting as an 'expert'.

All clinicians, whatever their area of specialism, can support communities therefore, they should refrain from thinking that because they do not view or label themselves as a community clinician, this excludes them from forming mutually beneficial partnerships with refugee community organisations.

Clinicians can find helpful information around developing partnerships within the *Guidance on Working with Community Organisations for Psychologists* developed by the London Community Psychology Network (2018).

There are many opportunities for clinicians to work effectively in collaboration with refugee communities in ways that can assist with capacity building (both for statutory services and Refugee Community Organisations, RCOs). Working together can help provide services in an appropriate, accessible and culturally sensitive manner as well as developing skills in coproduction and partnership-working. Some clinicians may feel that they have not received sufficient training in community partnership (which is qualitatively different to consultancy work). However, this work can provide important opportunities to undertake innovative and useful psychological work, contributing to social justice and service provision.

The key elements of any community partnership in this context include (but are not limited to) the following:

• Clinicians should develop a mutually respectful relationship with an RCO, by learning about their work and objectives.

• Clinicians should take a collaborative stance, with the aim of mutual learning and sharing of expertise, experience and knowledge – which may differ significantly from a consultancy relationship.

• When working with RCOs, clinicians may need to move away from an 'expert' stance, into a collaborative partnership.

17. Set up methods of evaluation for any work from the start as this can produce helpful feedback and wider use.

It is good practice to develop and co-produce methods of evaluation of any work undertaken with RCOs from the start, as this can provide helpful feedback and show the tangible effects of being involved in this work which can also contribute to the wider body of knowledge and provide useful information for managers, commissioners and funders.

Intersectionality

18. Refugees should not be seen as a homogenous group, but offered specialist support if needed in terms of, age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation, religion, all of which are protected characteristics as defined by the UK Equality Act (2010). Other equal opportunities legislation should also be adhered to.

People may choose to connect with an organisation that focuses on a particular group, for example, women or LGBT asylum seekers, rather than a specific cultural group or generic refugee organisation. For some groups of people, it can be very important that they receive specialist support through the asylum process, for example, from legal representatives, organisations and support groups that understand the specific issues of LGBT asylum seekers. Working in partnership with RCOs can also involve contributing psychological perspectives and research to activism and policy development, which many of the organisations are actively engaged with.

Just because someone comes from a particular country, it does not mean that they will want to link up with a refugee community organisation which may have links to that country or any refugee community organisation. Sometimes these organisations are organised around ethnic, religious or political groupings, which may not be desired by some refugees and asylum seekers who may have been persecuted for their ideology or life style in their home countries.

The constitution of the refugee population worldwide is subject to change as world politics and events will influence this.

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