An Exploration into the Impact of the Resettlement Experience, Traditional Health Beliefs and Customs on Mental Ill-Health and Suicide Rates in the Ethiopian Community in London

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Abstract

Forced migration and the resettlement experience combine to produce a set of social, cultural, economic and psychological challenges for forced migrants which may affect integration, mental and physical health, and access to health and social care. There is very little research on the resettlement experience of Ethiopian forced migrants in London, particularly on causes of mental illness and access to mental health care. Few studies have examined whether and how traditional beliefs and customs affect the experiences of this group in health care. The paper reports on a pilot study consisting of interviews with an Ethiopian priest, community leaders and Ethiopians working in the community health sector with the aims of improving our understanding of the issues, and to inform further study. Initial analysis suggests that this group faces multiple forms of disadvantage which affect mental health. A further interesting dynamic is the relation between lack of 'help seeking behaviour', due to cultural expectations and norms, and lack of access and engagement with Western treatments. Religious mechanisms and activities were also reported as bolstering coping mechanisms. Perhaps most significant was concern about the increasing suicide rate among this group, many respondents suggesting a direct causal link between suicide and maladjustment in exile.

Key words

resettlement; health beliefs; customs; mental ill-health; suicide rates; Ethiopian community in London

Introduction

The disadvantages that forced migrants experience are multi-faceted, being influenced by both pre- and post-migratory experience. Primary factors leading to exile are war trauma and displacement, and specific post-migratory socio-demographic variables include the wider experiences of unemployment, poor housing, poverty, poor health generally, access difficulties, discrimination and hostility (Watters, 2001; Summerfield, 2001). Although refugees are resilient and many appear to have made positive transitions and managed to integrate successfully, others have found the path between cultures to be filled with numerous economic, social and psychological obstacles. Duke (1996) has indicated that the predisposing factors for mental health problems in forced migrants include separation from family and friends, particularly the intense suffering when separated from children, language difficulties, difficulties in obtaining accommodation, a hostile host community, unemployment, suffering prior to exile, and new and unknown cultural traditions in the host country.

Studies have found that forced migrants are more disadvantaged in health care access than the white British population. The reasons include the experience of migration, the stresses of racism, and cultural, social and economic disadvantage. Specifically, they are more likely to experience misdiagnosis and unequal access to provision due to, among other issues, the existence of institutional racism and the unequal power relationships that exist between health care workers and the service user (Fernando, 2002; Bhui & Olajide, 1999). Forced migrants experience various practical difficulties, in addition to the personal and administrative migration process, and accessing services such as health care without knowledge

of the system and the English language can be daunting. They may face many additional barriers in both the initial stages and any subsequent participation. Approaches to, and understandings of, mental health inevitably vary between cultures and at different times throughout history. These additional barriers may therefore be due to a cultural hierarchy, which can be seen to operate in health care provision, where behaviours can be interpreted in different ways and subsequent treatments will vary in accordance with dominant understandings and practices (Fernando, 2002; Pilgrim & Rogers, 1999).

This study provides an investigation into the impact on mental health of resettlement experiences among Ethiopian forced migrants in London, and explores the possible reasons for their high rates of suicide. It attempts to improve our understanding, and it is hoped that it will inform further in-depth study (for a PhD on the subject). Among studies of forced migration, resettlement and traditional beliefs about mental ill-health and suicides are perhaps the least researched aspects, and it is hoped that this pilot study will inform the wider discourse on health care by providing new and valuable insights into the situation of forced migrants.

Due to size limitations and resource constraints, this research includes only a small number of respondents, but the sample selected possesses characteristics relevant to the questions and themes considered. In addition, this study acknowledges the possible limitations arising from significant regional issues which may affect the position of Ethiopian forced migrants. They include asylum seeker dispersal patterns, local economies, access to education and the settlement of earlier cohorts of Ethiopian individuals and communities. Although the size of the sample does not reflect the Ethiopian community as a whole, it does allow for some extrapolation of how the issues may affect the wider Ethiopian population.

Context

Studies of the demography of mental illness indicate strong links between social disadvantage, mental distress and suicide (Brown & Harris, 1978). Ethnic minority groups, among them Ethiopian forced migrants, can occupy the most disadvantaged strata in society and are therefore more vulnerable to the ravages of mental distress. Studies including McKenzie *et al* (2003) and

Ferrada-Noli *et al* (1995) have indicated that general risk factors for suicide in any population are:

- past psychiatric history and present psychiatric symptoms such as depression, schizophrenia, alcohol dependency and psychopathic personality disorder

- social factors such as social isolation and unemployment

- physical illness

- past history of suicide attempts

- labile mood (McKenzie *et al,* 2003; Ferrada-Noli *et al*, 1995).

Geographical studies (Gunnell *et al,* 1995) have indicated that people living in deprived areas generally have high suicide rates, and there is also evidence that living in a single-person household may be a predictor of suicide (Ashford & Lawrence, 1976).

Background information on suicide rates among minority ethnic groups in the UK is scarce, partly because death certificates do not record any details of an individual's racial or cultural identity. However, statistics from the National Coalition of Anti-Deportation Campaigns (NCADC) show that forty-six asylum seekers or migrants in the UK have taken their own lives since 2000 – thirty in the community, six in prisons and ten in immigration removal centres (www.ncadc.org.uk). The NCADC acknowledges that these statistics may not reflect the complete picture, and reports that detainees and campaigners believe the actual number to be much higher. Informal and anecdotal evidence also suggests high suicide rates among Ethiopians in London (Papadopoulos *et al*, 2003; Geberemikael, 2004; Palmer & Ward, 2006). Recording of ethnicity and nationality in government statistics on health and other areas has recently been introduced in Britain, but at present there are no current official statistics available, so it is unclear which groups are at increased risk, and why. Such information would be invaluable in development of targeted health care and prevention strategies.

The limited research on suicide among ethnic minorities does, however, highlight some significant

information. A report by Driessen and colleagues (1998) indicates that suicide rates are higher among migrant groups in areas where ethnic minority groups are in lower concentration, and they propose that this is due to a relative lack of support by people with similar social situations. Information from their report is limited, however, and more in-depth work is needed if we are to be able to explain why certain individuals and minority ethnic communities have high rates of suicide.

Most research on suicide and attempted suicide has focused on African Caribbean, Irish and Asian migrant communities. Studies by Merrill and Owens (1986) and Bhugra and colleagues (1999) found that Asian women were at increased risk of attempted suicide as a result of cultural conflict. The Merrill and Owens (1988) study on attempted suicide rates in Asian, West Indian, Irish and Scottish immigrant groups and an English-born sample concluded that the annual rates of self-poisoning in the immigrant groups exceeded rates in their countries of origin. Among the Asians and West Indians, males and older females were under-represented, but young females had rates similar to those of the English-born group. This research, although somewhat limited, indicates clear disparities between ethnic groups, and so further research (to include, but not limited to, statistical data) is necessary in order to deepen our understanding and inform policy.

Research on suicide rates specific to refugees and asylum seekers is also extremely limited. A study undertaken by the Institute of Race Relations (2006) found that suicide attempts by asylum seekers in detention are not infrequent. The rates of self-harm were high for people in the 26–35 age range, and self-harmers were predominantly men – it is important to note that most asylum seekers are men, who will therefore be over-represented in this group (IRR 2004. www.irr.org.uk). There is also emerging evidence that self-harm, suicide and suicide attempts may occur when an asylum seeker's application has been refused. The same report by the Institute of Race Relations (2006) indicated that hopelessness as a result of a negative asylum outcome may have been associated with the suicide of an Ethiopian in Liverpool. In October 2005, the IRR published a 'roll call of death' listing the 180 asylum seekers and undocumented migrants who have died either in the UK or while attempting to reach the UK in the past 15 years. Significantly, 34 of them died by their own hand

upon refusal of asylum; suicide was evidently a 'better' option than deportation. IRR statistics indicate that since the first immigration removal centre opened in the UK there have been 10 deaths from self-harm.

Ethiopian refugees in the UK

Ethiopia is in the Horn of (East) Africa on the Red Sea. The country was ruled by the Emperor Haile Selassie from 1930 until he was overthrown in 1973 by a military coup which established a repressive Stalinist military regime. In addition to the repression came drought, famine, a secessionist movement in Eritrea and other internal conflicts. Major cultural groups living in Ethiopia include the Amhara and, in Western Ethiopia, the Oromo. Conflict-induced displacement is the most significant form of migration from Ethiopia, but drought-induced and famine-induced displacements are chronic problems and are a contributing factor to displacement. The Ethio-Eritrean war, which erupted in May 1998, accounts for the largest number of displaced people since the current government, the Ethiopian People's Revolutionary Democratic Front (EPRDF), came to power in 1991 and established a federation of ethnic-regional states called The Federal Democratic Republic of Ethiopia (Muchie & Papadopoulos, 2002). During the last 25 years, more than a million Ethiopians have been displaced within the country, and an estimated 1.25 million have fled to neighbouring countries (McSpadden & Moussa, 1993). Before the 1973 coup there were very few Ethiopians living in Western countries. It is estimated that there are now 25,000–30,000 Ethiopian refugees in the UK, most residing in inner London boroughs (Papadopoulos *et al*, 2004; Geberemikael, 2004).

In 1990 there were 2340 Ethiopian asylum applications, 10% of the total applications, and by 2005 the number was 385, 1% of the total applications received (www.ICAR.org.uk). More recent asylum applications are made because of human rights abuses. Over the last decade, reducing the number of asylum claims lodged in the UK has been one of the top priorities for the Labour government. The drop in numbers claiming asylum illustrates the UK Government's comprehensive reform of the immigration system and in particular draconian policies which are designed to deter people from seeking asylum in the UK. A significant percentage (75%) of Ethiopian forced migrants in the UK are male and single (Papadopoulos *et al*, 2003). The majority of Ethiopian

forced migrants in London are Christians and belong to the Ethiopian Orthodox Church, which is closely related to the Egyptian Coptic Church and doctrinally similar to the Eastern Orthodox Church (Geberemikael, 2004).

Very few mental health studies have been undertaken on Ethiopian refugees in the UK. With a few exceptions, research on the Ethiopian community is contained in small, local studies often carried out by Ethiopian communities themselves, which are not distributed widely and are difficult to obtain. Most of the research that has been undertaken focuses on resettlement experience and outcomes in the United States (McSpadden, 1987; McSpadden & Moussa, 1993), Israel (Areili & Aycheh, 1994; Ringel *et al*, 2002) and Toronto (Fenta *et al*, 2004). The limited research available in the UK indicates that there are serious mental health problems that need to be addressed. Papadopoulos and colleagues (2003) have undertaken research on this group in the UK, and these studies indicate that Ethiopians in the UK present with a set of problems that are shared by many other refugee communities in British society. They experience high levels of unemployment, poor housing and racism, in addition to the stress caused by immigration status, separation from family, uncertainties about their future and the need to adapt to a new culture.

Most significantly, the studies provide some evidence that a larger proportion of Ethiopian refugees commit suicide and self-harm than other African communities from a similar geographical background (Papadopoulos *et al*, 2003). Similar findings were reported in Geberemikael's (2004) research dissertation, 'The role of refugee community organisations: the experience of the Ethiopian Health Support Association' (EtHSA). These findings highlight the worrying reality of Ethiopian suicide in the UK, with more than 40 such deaths in the UK between the mid-1990s and 2004, but the author does not identify the source of this figure (Geberemikael, 2004). This study undoubtedly adds to our knowledge of the resettlement experiences of Ethiopian forced migrants in the UK, and reinforces the need for a more thorough investigation of the mental health experiences of this vulnerable group.

Methodology

The main aim of this study is to understand better the impact of traditional health beliefs and customs and the resettlement experiences of Ethiopian forced migrants in London on mental ill-health and suicide rates. The first stage was a literature review of what is known about the experiences of Ethiopian forced migrants in the UK, to develop an understanding of the context and the problems of mental health and suicide. The main sources of information were gathered from a range of sources across London, and include the experiences of a variety of Ethiopian community leaders and groups, Ethiopian forced migrants working in multicultural (non-NHS) services, a community development worker for a primary care trust (PCT) in South London, an Ethiopian priest and an Ethiopian doctor currently studying for the PLAB exam. It is hoped that this broad range of sources will provide an insight into the wider and specialist experiences and knowledge of those involved with the Ethiopian community. In total, interviews were undertaken with ten key stakeholders. This study also draws on my own experience of working with this community in London over the last ten years.

Snowball sampling was used to identify potential interviewees. My work and research in this area, *Mapping Mental Health Services for Refugees in London* (Ward & Palmer, 2005), have allowed me to establish links with and knowledge of the Ethiopian community in London, giving me some initial contacts. These people were then asked if they could refer me on to individuals who they knew could provide information-rich cases, thus creating a chain or snowball of referrals. Whilst snowball sampling is an effective way of accessing hidden populations, it is important to be aware of limitations as there may be a high risk of selection bias as the sampling composition can be heavily influenced by the choice of initial contacts and because individuals may only know other individuals who are similar to them in terms of age, class, gender, ethnicity and religion. The interviewees selected had had a range of experiences, with variations in economic and social status, acculturation and length of stay in the UK. Ethical issues were given strong consideration when developing this research. Voluntary participation and confidentiality were emphasised, and it was important that interviewees gave informed consent and were made aware of their right to veto inclusion of certain information and to withdraw at any stage.

Most of the data was collected through in-depth semi-structured interviews; this approach was felt to be the most

appropriate, in view of the complex and sensitive nature of the research topic. An informal semi-structured approach is more likely to gain the interviewees' trust and elicit information than a formal approach or a questionnaire with limited response opportunities or potential for clarification. The interviews were based on a questionnaire topic guide. A number of core themes were addressed: post-migration factors, including Home Office status, housing and income, education and employment, the role of community groups, health care beliefs and issues of access, cultural differences between Ethiopia and the UK, the role of the church and suicide. Invaluable input was given by tutors from the University of Kent and colleagues at my workplace, which helped shape the topic guide.

Findings

I interviewed ten Ethiopian forced migrants, three female and seven male. The sample was made up of one PCT community development worker, one doctor studying for the PLAB exam in order to practise in the UK, one Ethiopian priest, five Ethiopian Refugee Community leaders and two community health workers. The results of this study have been grouped by themes identified when analysing the interview transcripts.

Mental health, migration and marginalisation

All the interviewees reported large numbers in their community experiencing some form of mental distress. Diagnosed depression, anxiety and post-traumatic stress disorder were reported as influenced by both pre- and post-migratory experience. Respondents also suggested that many have no contact with mental health teams and providers when they first contact the community. Interviewees reported increasing numbers of members presenting to community groups with khat and alcohol addiction.

'Many have anxiety and depression, [they suffer from] *loneliness, people feel helpless and no-one understands what life was like back home. It's the big disappointment when people come here. That is what also affects mental health. The main problem is that for Ethiopians, mental health services are unreachable. They don't understand the culture, they don't engage, they don't have a full understanding of mental health so they think services are for others not them.'*

Community group respondents said that members of their community are particularly disadvantaged in relation to their mental health experience, a disadvantage attributed to a wide variety of post-migration factors which included language difficulties, socio-demographic variables including experiences of unemployment, housing and poverty, lack of knowledge and understanding of services and systems, cultural disorientation, family separation, social isolation, stigma, insecurity about immigration status, racism and discrimination, and stresses caused by the situation in their home country.

'The cause of mental health problems among Ethiopians are mainly psychosocial in nature. Homelessness and unemployment, isolation and loneliness, homesickness, racism and immigration issues. Many, particularly the elders, struggle with English language. There is also increasing drug, khat and alcohol use among young men, which also causes poor mental health.'

'The community here is fragmented and the majority are single, young, male, who are very lonely and isolated.'

Distress was reported as more severe when asylum applications were refused, and as a result members generally struggled more with difficulties of day-to-day living.

'Frustration at the Home Office, that's the main problem. Early morning before you open the door you have to watch for that brown envelope. People are very worried about it in the community and we [the community] *are now sending information in white envelopes. Unemployment is high. Many are educated, unemployed and isolated. Lack of status affects everything. You can't plan, you can't study, and you don't feel part of society. It affects every aspect of daily living.'*

Community leaders reported that many frequently present with housing problems which include overcrowding, homelessness, sleeping on community members' floors, inadequate temporary accommodation,

poor location and destitution. These social realities were attributed to lack of immigration status and were contributing factors affecting poor mental health.

Another major barrier was the difficulty many Ethiopians have in communicating in English. Coming from backgrounds where English is neither the national language nor an established second language, it is hardly surprising that many Ethiopians face language barriers on arrival and resettlement in the UK.

Unsurprisingly, all participants said that there was a high level of unemployment in the community, and leaders reported considerable job dissatisfaction for those who had found employment. Three interviewees believed that this source of dissatisfaction and subsequent mental disorders were due to the very different social and economic situation they find themselves in as refugees, compared with their status in their home nation. Many such individuals had been professionals or academics in Ethiopia but have a low socio-economic position in exile, with limited opportunity to improve their situation. This drastic change in status and sense of loss was identified as having a negative impact on their sense of self and self-esteem. It was compounded by inability to adjust or find alternative pathways, and led to episodes of common mental disorders. One interviewee reported a high level of nostalgia among elderly community members, 'many looking inward' and not engaging with new or different experiences. This isolationist approach was also viewed as having a negative impact on mental health.

> *'It's difficult for elders to move on. They think back to the way things were. Their position is different as here they have nothing. They can't let things go. They are lost here.'*

Suicide

The respondents reported a high mortality rate from suicide among Ethiopians in London. The co-ordinator from one of the community groups reported that there had been eight suicides in 2004 and at least four suicides the following year. This is particularly worrying, given the decreasing percentage of Ethiopian asylum applicants, making this level of suicide significantly high in proportion to the total number of Ethiopians in the UK. This situation is even more worrying if the numbers quoted are accurate, because in the period 2002–4 there were 1923 suicides in London (8.3 suicides per 100,000), on average 641 deaths year (London Health Observatory, 2006).

On the basis of these statistics, the Ethiopian suicide rate is nearly four times the average for London. It is difficult to confirm the specific of suicides, as there are no readily available statistics and details of suicides are not currently kept by any community group. Some paper records are kept, but they are not organised or consistent and would require significant time to compile and analyse. The statements from participants should not be dismissed, for oral history and community knowledge are based on close network supports, activities and responsibilities. In addition, while no specific paperwork is kept, some records are available on monies raised to pay for the cost of burials back in Ethiopia, so a death rate can be extrapolated from these papers.

In addition, the participants demonstrated significant knowledge of particular incidences, and information about the level and type of suicide was quite detailed. Five participants reported that most cases of suicide were single men, although others also recalled cases involving females. The most common methods of known suicides were jumping from a height, self-poisoning and drowning, all of which are quite violent and definitive. The community is intimately involved in arrangements following a death of one of its members; it is responsible for taking care of the organisation, and community and church members pay for all details of the funeral. The community is also reliably informed by the police of any death of an Ethiopian, even if they are 'unknown' or 'unconnected'. This line of communication is especially strong in the London area, and ensures that the Ethiopian community is aware of the death of any of its members. Community and church leaders then help to notify the family back in Ethiopia.

> *'I think, from being involved in the church, about six people committed suicide over a two to three month period last year. The church contributes to the burial in Ethiopia. The causes are HIV, loneliness and neglect, depression and immigration. There are people jumping in the river and drinking bleach.'*

The importance of official documentation of the number and causes of deaths in the Ethiopian community was recognised, and one consequence of this research, following my recommendation, has been the decision of the Ethiopian community in Britain, in conjunction with the Ethiopian Health Support Association, to develop a co-ordinated database of such information.

Undoubtedly the most overwhelming, consistent response was the belief in the causal link between social factors and life events. A number of psychosocial risk factors were reported to be associated with high rates of suicide. All interviewees were unanimous that problems with immigration, particularly the threat of deportation, and destitution were the main factors affecting high suicide rates.

'Only last week, the neighbours tell us [the community group] *and we called the police and they find that a person has died. The cause is that the Home Office is threatening them with deportation, they have been here for many years, learning new skills and they fear that they will be killed when returned, mostly young single men. The community is very concerned. We try to give advice and support their claim.'*

One community leader spoke of the disturbing evidence from a few suicide notes discovered in London, Liverpool, Portsmouth and Leeds, such notes indicating distress over the refusal of asylum applications as the reason for suicide.

The impact of the immigration process on suicide rates was a high priority among respondents' concern. Participants spoke of the complexity and great uncertainty surrounding legal status, the experience of uncertainty resulting in individuals living with a terrifying fear that they might be deported back to Ethiopia. This inevitably affects integration, mental well-being and emotional and behavioural responses, and was cited by all respondents as the catalyst for suicide rates in the community. All respondents stated that a positive Home Office decision in the case of asylum applications might have prevented many suicides.

Other significant influencing factors mentioned were the impact of physical illnesses, including hepatitis and HIV/AIDS.

'Young people with HIV are so embarrassed. They don't see people for fear of stigma. They exclude themselves completely from the community and become depressed and alone. I know of three people who committed suicide.'

It was also noted that negative thinking and mental distress, including-self neglect, feelings of depression and hopelessness, were predictive of suicidal thoughts and actions. Isolation and living without family members and lack of religious and community support were also cited as possible reasons for suicidal inclinations. The experience of participants had led to the conclusion that less access to informal support was associated with a greater suicide risks.

'There is problem with the suicide – it's so different here. No family. Language, care for the elderly, culture, religion, the way of life is so different. Everyone is busy here, people are isolated, alone. They even drink coffee alone.'

One community leader reported that nearly all suicides in the community that he was aware of were of individuals living alone.

One interviewee discussed the lack of contact with mental health services as a major problem for the community. It was apparent from police reports and investigations that few of the individuals who had committed suicide were in contact with mental health services. The interviewee clearly suggested that there will be less potential for these services to prevent suicide in this particular group unless measures are taken to engage them further.

'It is well known in the community that an alarming number of young mainly male Ethiopians take their own life. The causes are asylum and immigration anxieties, financial worries, unemployment, guilt at not meeting the family's and relatives' financial expectations, homelessness, loneliness and isolation, HIV and

poor physical health. There is lack of support to these isolated individuals as there is a breakdown of the traditional mechanisms, which would have dealt with the problem at early stages. In addition there is a lack of access to an appropriate and sensitive health service.'

It was also suggested that improved communication between services, community leaders and churches, covering both health and social care needs, might help to detect early warning signs and in developing preventative strategies.

Health care beliefs, practices and cultural characteristics

Having a severe mental illness is a known risk factor for suicide. The problem for the Ethiopian community and service providers is the growing evidence that Ethiopians are not accessing mental health or social care support. All the respondents talked about the lack of engagement with statutory services. Individuals from rural parts of Ethiopia were even less likely to access Western remedies than those from urban areas. A significant influencing factor was said to be the difference in perception of 'mental ill-health' in Ethiopia.

'Mental health/illness is defined culturally, so Ethiopians have their own understanding, which is very different from the Western understanding. Many lay people would not understand the Western mental illness classification and the symptoms related to them.'

Interviewees said that mental illness carries a stigma in Ethiopian culture. Individuals are seen to be suffering from 'madness', which is not recognised as a medical issue but as a moral or spiritual one.

'Ethiopians are afraid of talking about mental health problems as there is a strong stigma attached to it in their culture. They are not open about it until it gets to a critical stage. They mainly associate mental illness with spiritual and religious beliefs. Many lay people with little knowledge of or exposure to the Western world or lifestyle are unable to express what is wrong with them in English. The usual

method of dealing with these problems is seeking help from traditional healers and through the church.'

'Traditionally it is believed that diseases can be caused because of cursing, and by evil spirit and germs. The remedies are medicinal plants, praying, healers and taking tablets.'

Illness is also considered to be a punishment for sins or due to the anger of spirits. 'Madness' was believed to be the work of *buda* (evil eye), evil spirits or the devil, and may be brought about by spirit possession. *Zar,* a form of spirit possession, is viewed as a cause of negative invisible forces, misfortune, bad luck and illness. Possession by a *zar* spirit is identified by psychological symptoms including headaches and lethargy, and therapy begins at a ceremony where the spirit is treated by a traditional healer, negotiating with the spirit and giving gifts to the possessed patients (Kahana, 1985). Participants reported that very few (if any) pursue this course in London. However, the belief in *zar* possession clearly highlights the different concept of illness held by many members of the Ethiopian community.

'One old person was involved and many used to visit her but she died. That was a long time back. It doesn't happen here any more but it's part of the culture back home.'

When people exhibit bizarre behaviour or thought patterns, they are liable to be stigmatised by their community. Treatment of mental illness is also approached differently in the Ethiopian culture. Sufferers frequently turn to the church or other traditional forms of treatment, including herbal remedies. Religion, strong beliefs, praying, going to church and participating in religious ceremonies and the use of holy water were all reported to be coping mechanisms thought to heal mental and physical ill-health. Treatment is also usually accommodated within the immediate family and community.

'The role of the church and traditional healers is very significant in Ethiopia. Family members are very much involved in the care of a relative back home. Members of the community pay visits and express support to the sick person.

People's initial belief is in traditional healers and the health care system is much simpler and less developed.'

'Most are religious with much emphasis on prayer. Ethiopians are not serious about depression or sophisticated sickness. We believe in religion and holy water as a cure.'

Interviewees indicated that many Ethiopians chose not to access or use Western medical services as they perceived them to be 'alien and stigmatising'. Such services are unknown and present mental distress in unfamiliar terms, and the treatments offered are not seen to be reliable or familiar. For instance, it was reported that Ethiopians generally do not understand the practice of withholding treatment until a diagnosis has been made. It is evident that, for many Ethiopians, engagement with Western mental health services involves accepting an entirely new belief system.

The relationship between the individual and the Orthodox Christian church was presented as a powerful one and a central part of Ethiopian identity, influencing beliefs and treatments with regard to illness and health care. Emotional well-being was seen to arise from participating in religious services and talking to religious leaders, and evidence suggested that the Ethiopian churches in London have over the years become an integral part of the support mechanism for those suffering from mental distress.

'Church plays a real importance. The Bishop tells us to visit each other in prisons, hospital or go to the houses. The church helps to reduce isolation. Most people don't talk about their problems but you can see them – crying, they come to pray that God will listen to her about her Home Office problems. The church gives them purpose and support. The church it gives some relief from all the troubles, a sense of belonging.'

Recognition of mental disorder also depends on careful evaluation of the norms, beliefs, traditions and customs of the individual's cultural environment. Community attitudes and beliefs play a role in determining help-seeking behaviour, access to medical facilities and successful treatment of those suffering from mental ill-health. Respondents in this research suggested that, in addition to the points highlighted above, Ethiopians are less likely to consult their general practitioner (GP) because of cultural characteristics and cultural norms. Ethiopians may feel 'awkward' and 'modest' about accessing health care, and have 'low expectations' about approaching their GP or health provider.

'Ethiopians are in general traditional, sociable, shy and introvert, religious and suspicious of unfamiliar circumstances and situations. Some of the negative traits like suspicion could be reinforced in exile. The absence of social life could create a gap and could lead to isolation and shyness and could be a barrier towards integration and accessing services.'

'Ethiopian character is shy, proud people we don't ask for help. They need help but don't ask for so many reasons. They feel awkward, as if they are devalued if they ask for help. The mentality is not to ask for help, feeling that they are begging and it's something we shouldn't do.'

It was pointed out by an interviewee that Ethiopian society operates a hierarchy of authority which dictates normative behaviours. 'No' is a rare response, especially to authority figures, and the culture inculcates emotional restraint. It was also highlighted by many participants that in general the cultural/behavioural code dictates that Ethiopians do not ask questions and are inclined to be more passive. 'Suspicion' is part of the culture, and would influence responses to and acceptance of information and advice. Several participants cited this behavioural code as a factor affecting access and engagement with mental health services. It was also noted that, even if sufferers had been persuaded and supported to attend initial appointments, the ingrained behavioural code might result in reluctance to attend follow-up appointments, adhere to medical advice or consent to procedures or conform to treatments.

Discussion

The central issues that emerged during this research were the concerns over the rate of suicide among the Ethiopian community, the perceived causes and predictive factors for

mental distress, and the possibilities and requirements for improving the situation for Ethiopian forced migrants.

It is evident from this research that the post-migration process has a negative impact on the mental well-being of Ethiopian asylum seekers and refugees, and is a significant risk factor for suicide. In particular, a number of psychosocial risk factors were reported to be associated with high rates of suicide and are consistent with other research in this area. Psychiatric theory acknowledges a number of social and environmental factors that are associated with mental ill-health, in both a contributory and a consequential way (Littlewood & Lipsedge, 1997). However, these are not perceived as the primary causes of the major mental illness, but as secondary contributory factors. The logical conclusion to medicalised categorisation of the causes of mental distress is a medicalised solution; physical treatments will therefore take priority over perhaps longer-term practical initiatives which would mitigate the social and political disadvantages mentioned above.

A distressing feature highlighted in this research was the link between lack of immigration status and high suicide rates for this group. The impact of negative decisions from the Home Office was acknowledged by all those interviewed to have a major impact on mental ill-health, and was regarded as one of the most important issues affecting suicide. Heightened hopelessness, low self-esteem and learnt helplessness were also associated with negative Home Office outcomes. A recent report (2007) by the Joint Committee on Human Rights (JCHR) concluded that the asylum system is over-complex and poorly administered, and offers inadequate information and advice about the support to which people are entitled, in some cases denying any support whatsoever to people who are desperate and destitute.

The Committee also notes the significant increase in detention of asylum seekers, and expresses serious concerns about the detention of vulnerable people such as children, victims of torture, pregnant women and those with serious health problems. The report concludes that, in refusing permission for asylum seekers to work and in operating a system of support which results in widespread destitution, the Government's treatment of asylum seekers in a number of cases reaches the human

rights threshold of 'inhuman and degrading treatment'. A recent ORB opinion poll, as reported in the *Guardian* (07/05/07), suggests public support for reforming the asylum process; two-thirds of those polled believed that asylum seekers should be allowed to work while they wait for their claims to be determined (Travis, 2007).

The Ethiopian Orthodox church emerged as one of the main support networks for those suffering from distress. Psychiatrists acknowledge that a mentally ill patient's strong religious beliefs can provide a solid platform for therapy. Studies have found evidence of a positive relationship between religion and good mental health (Janssen *et al*, 2006), and there is growing recognition of the importance of spirituality to people from black and minority ethnic communities (Copsey, 2001).

One issue that emerged as extremely important was the increasing concern over the impact of a diagnosis of HIV/AIDs on mental distress and suicide. An important related issue was the problem of lack of access for failed asylum seekers to primary care and therefore to appropriate medication. There has been considerable confusion about the rights of refused asylum seekers to register with a GP or to access free health care. Since 2004, guidance states that, when an asylum application is unsuccessful and all avenues of appeal have been exhausted, they lose their entitlement to free NHS care. Existing policies require hospitals to charge the above group for HIV treatment, but lack of information and clarification on the regulations increasingly has become a source of national debate. This situation is increasingly untenable, and needs urgent review by the Home Office and the Department of Health.

Conclusion

The information gathered in this study is both important and relevant for all those working with the Ethiopian community and other migrant groups. However, it is important to reiterate that the analysis is based on a small number of participants and in the absence of statistical data, particularly in relation to statistics on suicide. Given these methodological limitations, it is not possible to draw definite conclusions, but we can highlight the central issues, concerns and recommendations as identified in the research, and add to the developing understanding of health and well-being for forced

migrants. The extremely important nature of this research and the disturbing initial findings reinforce the need for further, comprehensive research into mental health and suicide in the Ethiopian community.

In conclusion, the key factors in reducing mental health and suicide were found to be provision of, and access to, advice, social and economic support, information, education, appropriate health services and reform of the asylum process. Priority also needs to be given to understanding the impact of social and economic variables, and mitigating these disadvantages is central to any preventative strategy.

Community attitude and beliefs also play a role in determining help-seeking behaviour, access to medical facilities and successful treatment of those suffering from mental ill-health. Such groups can assist with practical support in relation to language and interpreting needs and, most important, to working towards combating isolation. Development of health educational programmes is an essential aspect of any strategy to reduce suicide rates and improve access to and engagement with mental health services.

Service providers need to be aware of the cultural, social and political context within which individuals operate and are judged. Education and training programmes need to incorporate these understandings and allow for considered and sensitive exploration of the belief systems operating in the Ethiopian community. It would therefore be crucial to involve the community and religious leaders in a mutual exchange of information and practice in order to ensure that those suffering from mental illness are given the most appropriate and effective care. Treatment programmes would need to adopt a flexible, preventative approach based on different, complex, individual requirements, allowing for inclusion of traditional and alternative treatment options and longevity of treatment programmes. This approach would require continued multi-agency co-operation in planning, development and delivery of such educational programmes and services.

The Government and the Department of Health are well aware of the deficiencies in the quality of mental health care provided to BME groups (DoH, 2005). There is a clear political agenda to address these issues in respect of major established ethnic minority communities, but recent policy documents continue to make very little reference to the particular and specific needs of the refugee communities within the BME category. It is evident that 'BME' as a category can itself be problematic, as such groups are not homogeneous and services which treat them as though they are risk damaging the health and well-being of whole communities. Clearly there is much more work to be done.

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