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Rethinking Access to Mental Health Services for Refugees in Norway: A Fundamental Right to Health

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Declaration

I, Fatoumatta Jarra Dabo, declare that this thesis is a result of my research investigations and findings. Sources of information other than my own have been acknowledged and a reference list has been appended. This work has not been previously submitted to any other university for award of any type of academic degree.

Signature……
Date……

Dedication

This work is dedicated to all Refugees specifically in Norway and all over the world in general with Mental Health issues. I would also like to dedicate it those migrants who continue to pursue perilous journeys to secure a better life especially those who lost their lives during their journey in the African desert and the Mediterranean Sea.

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ABSTRACT

Migration is not a new phenomenon as humans have been migrating for centuries. The world's international migrant population is experiencing a rapid increase in both the global North and South. Europe's attempts to protect its borders against migration flows, has recently become a focus of migration discourses especially with images in the media of men, women and children attempting to cross the Mediterranean Sea with thousands losing their lives. Of those who make the journey, stories of resilience and gross human rights abuses emerge with calls for European Nations to do more to assist these migrant. Of the migrant groups refugees are considered as one of the most vulnerable groups of migrants as they are forced to flee due to some form of persecution. Whilst migration itself does not cause mental distress, pre-migration, migration and post-migration factors can contribute to mental distress in vulnerable groups. For those refugees who need psychosocial assistant, further challenges of access to health services, particularly mental services are presented post-migration. Policies and conditions in the new country often dictate the allocation of resources as well as how refugees are received and assisted. Acculturation and navigating the new health systems also poses more problems for refugees, with many being unaware of their rights and entitlements in the often culturally alien environment. As expressions of emotional distress varies from culture to culture, mental health practitioners and refugees are faced with added challenges in language, culture and treatment in mental health service provision. The purpose of this study is to revisit the accessibility of mental health service for refugees in Norway. The main aims are to ascertain if the current service provisions are adequate and whether culture is an important consideration when providing mental health services for refugees from non-Western backgrounds. The right to health is also explored to determine whether service providers view the right to health as a human right in service provision. This study was conducted by interviewing 27 professionals working with immigrants and refugees in Norway in the form of focus group interviews, semi-structured one-to-one interviews and the use of secondary data. The results of the research concluded that specialist mental services are needed in Norway in order to provide services that are culturally appropriate and accessible for refugees in order for them to realise their right to health and integration into the larger Norwegian Society.

Key words: refugees, immigrants, mental health services, culture, Norway, right to health, acculturation, integration

ABBREVATIONS

CAM	Cultural Accommodation Model
DPS	District Psychiatric Services
EU	European Union
GP	General Practitioner
HDI	Human Development Index
ICESCR	International Convention on Economic Social and Cultural Rights
IOM	International Organisation for Migration
IMDI	Norwegian Directorate for Integration and Diversity
NAKMI	The Norwegian Centre for Minority Health Research
NKVTS	Norwegian Centre for Violence and Traumatic Stress Studies
PHM	The People's Health Movement
PTSD	Post-Traumatic Stress Disorder
RHA	Regional Health Authority
RVTS	Regional Resource Centre for Violence, Traumatic Stress and Suicide
SSB	Statistics Norway
UDI	The Norwegian Directorate of Immigration
UN	United Nations
UNDP	United Nations Development Programme
UN (ESA)	Department of Economic and Social Affairs
UNHCR	United Nations High Commissioner for Refugees
WHO	World Health Organisation

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CHAPTER ONE

INTRODUCTION

This thesis is about mental health service provision in Norway for refugees from a perspective of a rights based approach to Health. Statistics Norway, suggests that at the beginning of 2014, there were 633 100 immigrants and 126 100 Norwegian-born to immigrant parents in Norway, with background from 221 different countries and independent regions (Statistics Norway, 2015). This also means that the immigrant population in Norway would be approximately 759,000 people. Immigrants now make up almost 15% of the population.

However, this number is expected to increase. The United Nations High Commissioner for Refugee, UNHCR (2014) remarks that Norway's current quota of UNHCR resettlement refugees was 1,620 refugees for 2014. Norway pledged an increase in its 2015 resettlement quota to 2, 120 places, of which 1, 500 places are allocated to refugees affected by the Syrian crisis (UNHCR, 2015). Despite this remarkable openness of the Norwegian immigration policy, unfortunately migration also seem to carry its mark on people with symptoms of the problems relating to stress and trauma. There is growing evidence of the impact of post-migration factors on the mental health of refugees (Carswell, Blackburn and Barker, 2014).

A substantial number of studies of immigrant health status in Norway have been undertaken, mainly within the disciplines of psychology, medicine, anthropology, sociology, and social work (Attanapola, 2013). Out of 62 peer-reviewed published articles and brief communications on immigrant mental health, focusing mainly on original articles that reported prevalence and or associated risk factors for mental health problems among immigrants in Norway between 1990 and 2009, thirteen studies were found addressing adolescent mental health problems and the rest on adult immigrants (Abebe, Lien and Hjelde, 2012) The main measured outcomes include psychological adaptation, anxiety, depression, psychological distress, hyperactivity and conduct problems (ibid).

However, despite this collection of studies conducted in the area of immigrant's mental health conditions, not enough work has been dedicated to the study of migration and its psychological factors in regards to the mental health issues of adult immigrants, as well as their development and integration into Norwegian society. The aim of this study is to look at

this missing gap in immigrant mental health literature in the context of Norway. The study will rely on secondary data from previous similar studies in the area, and primary data that were collected specifically for this study. The first chapter will present the research background focusing on the mental health issues of in Norway. It explores mental health issues of migrants in Norway. It will look at how theory and existing research has addressed the problems of mental health issues of immigrants, and then the gap this research intends to make a contribution to. The chapter proceeds to present the aims and objectives of the research, and the questions it wishes to answer. The outline of the preceding chapters is presented thereafter.

1.1 RESEARCH BACKGROUND

The United Nations (UN) suggests that one third of the world's population can be defined as migrants (UN, 2015), with 232 million migrants worldwide as of 2013 (International Organisation for Migration, 2015). This figure can even be regarded as a good estimate, but might be even more as the criteria for defining a migrant varies between countries including differences in citizenship criteria, birthplace or previous residence.

Migration has become a constant factor in the economic and social landscape, with most OECD countries becoming net immigration countries, and the share of immigrants has been rising in almost all of them, close to four million annually (OECD, 2014), refugees accounting for 7% of all international migrants (UNHCR, 2014). There are now more than 115 million immigrants in OECD countries, about 10% of the population, a further 5% of the native-born population has at least one immigrant parent. Although, the migrant number in the South has been growing more rapidly than in the North, the North between 1990 and 2013, has experienced a larger number of international migrants in comparison to the South (UN, 2013).

Asylum Trends 2013 reported a sharp rise in asylum claims in 44 industrialized countries over the course of the last year, primarily due to the crisis in Syria. The increase in 2013 in asylum applicants by region was in the 38 countries of Europe which together received 484,600 claims (an increase of a third from 2012). Germany experienced the largest single recipient with 109,600 new asylum claims, followed by France 60,100 and Sweden 54,300 (UNHRC, 2015). Italy's Ministry of the Interior reported that in January 2015 alone, 3,528 migrants had

crossed the Mediterranean into mainland Italy. From the 1960s, Norway has also seen a steady increase in its immigrant population (Statistics Norway, 2014).

Statistics Norway, for instance suggests that at the beginning of 2014, there were 633 100 immigrants and 126 100 Norwegian-born to immigrant parents in Norway, with background from 221 different countries and independent regions (Statistics Norway, 2015). This also means that the immigrant population in Norway would be approximately 759,000 people. Immigrants now make up almost 15% of the population.

Migration can be triggered by different issues including wars and political unrest in the migrants' home country. Never has the issue of migration been so poignant than in the last few decades as a result of increased civil wars, natural disasters and poor economies driving migrants from the countries of origin in search of a better life (Bhurga and Gupta, 2011). They take different routes of getting away from such trouble areas to safety. People narrate horrific stories of gross human rights abuses through the trafficking and exploitations of vulnerable people trying to escape troubled regions. According to UNHCR, a high number of people have also perished during their efforts to reach safety suggesting that around 3,500 people for instance have died whilst attempting to cross the Mediterranean Sea to reach Europe in 2014. During the same period, more than 200,000 people were also rescued.

The magnitude and complexity of the issues arising from the flow of asylum seekers and refugees globally poses huge challenges for the world's destination countries (Phillips, 2011, Bhurga 2010), including Norway. The European countries regionally struggle to maintain a balance between controlling national borders and offering protection to millions of displaced people.

The Norwegian Health Directorate views the increasing number of immigrants in Norway as a public health challenge to the health care system. The view is that this group has different health challenges compared to Norwegians because of the differences in culture, beliefs, expectations and their lack of knowledge of the Norwegian health care system (2009). This is backed by a study carried out by the Norwegian Center for Minority Health Research (NAKMI, 2010), on the mental health of immigrants in Norway. This study found that even though there is uncertainty on whether adolescent immigrants in Norway have a greater burden of mental health problems than their Norwegian peers, they are at an increased risk for

mental illness when compared to their Norwegian counterparts. This is linked to several factors such as having a higher risk for acculturative stress, high levels of perceived discrimination and identity crisis as well as parental war experience. The report also found that the prevalence rates of mental health problems in immigrant populations have been consistently higher among adult immigrants, especially among women and those from low and middle income than Norwegians and the general population. The risk factors contributing to this trend include poor social support, disadvantaged socioeconomic conditions, multiple negative life events, experiences of discrimination and traumatic pre-migration experiences. In NAKMI'S study, refugees were highlighted as being at a greater risk as a result of their life experiences hence increasing their vulnerability. Psychological disorders were found to be more prevalent in refugees and asylum seekers. In addition to this, the effect of traumatic experiences for refugees was found to be long lasting (ibid). In a survey on the mental health of immigrants in Norway carried out by National Statistics Norway (2005), the prevalence of mental health problems to be threefold higher in the immigrant compared to the general population.

This research will draw examples from the Norwegian experience, with a long history of accepting refugees for resettlement including thousands during and immediately after World War II. However, despite this long-term commitment, there seem to be a great deal of concern concerning the mental health condition of vulnerable immigrants. In addition to brutal and traumatic conditions experienced by some of the immigrants, some of the risky routes taken to safety include crossing seas, and exposure to mistreatment, abuse, or torture among people who make the journey by smugglers boats (UNHCR, 2015). A large number of these refugees are said to make their journey to safety, generally by foot, hiding in bushes and awkward places. They include women and children feeding on plants or anything edible. Many suffer hunger and exposure, losing family members on the way, or being subjected to torture and abuse (UNHCR, 2015). Incidents of extortion, exploitation, violence and sexual abuse perpetrated against refugees, asylum-seekers and migrants are often reported (Ibid). Norway has around 40,691 such people, including, 12,983 asylum applicants in 2013, an increase of 22 per cent from 2012 (Norwegian Refugee Council, 2015). With the arrivals of these migrants, horrific stories of gross human rights abuses, exploitations of vulnerable people, psychological traumas are endured to make it to a place of safety.

According to (Grønseth, 2009), two groups of are at risk of suffering distress. They include those who live in isolation and exploitative conditions, as well as those who seek refuge from conditions of starvation, violence and political turbulence. In the context of migration and mental health, a similar pattern is established in that migration does not in itself cause mental ill health but some migrants may find it harder to cope with the stress of migration because of their potential to be exposed to unemployment, poor housing, inaccessibility to health care, racism in the country of settlement, different understanding of health, language barriers and other political or cultural reasons (Bhurga, 2010). These can lead to serious poor mental health conditions for such migrants. Vulnerable migrants such as refugees become more at risk in the migratory process as they are at a higher risk when compared to the rest of the general population of suffering from psychiatric disorders related to their exposure to either war, violence, torture, forced migration and exile (Bhurga,2004). In the efforts to help migrants integrate into Norwegian Society, the Norwegian Government provides through the Directorate for Integration and Diversity, (*Integrerings-og mangfoldsdirektoratet*) a variety of programmes targeted at migrants; such as the two year Introductory Programme for newly arrived migrants who have come either through family reunification or as asylum seekers (www.imdi.no) This gives them some entitlements including housing, learning Norwegian language, culture and understanding Norwegian society. It also gives access and entitlement to health. In developing the healthcare model in Norway, emphasis is placed on equal opportunities for all including all members of the immigrant community such as refugees. The policy is based on principles such as integration and inclusion (Lie et al, 2014). The Ministry of Social Affairs in 1986 set up the Psychosocial Team for Refugees in Oslo to meet the public health challenges with a plan to come to an end in 1989. However a need was established for the team to continue their work. This led to the establishment for the Psychosocial Center for Refugees in 1990 at the University of Oslo (ibid). The work of this center included the promotion of human rights providing assistance to both refugees and professionals working with them (Lie et al, 2014).Currently, the Norwegian Government has incorporated immigrant healthcare as part of its national strategy focusing on the general rights of all to access healthcare. However, since the Government closed down the Center responsible for providing clinical support to severely tortured refugees, there remains still reluctance on the part of the Government to reopen other specialised clinical services for this

group. For instance other Nordic countries such as Denmark and Sweden have specialised clinics that provide clinical support for traumatized refugees (Lie et al, 2014).

Even though the Norwegian Center for Violence and Trauma (NKVTS), makes provision for mental health research, development and teaching, guidance and counselling to practitioners working with refugees, they do not offer any clinical services (www.nkvts.no). The approach adopted by NKVTS is an interdisciplinary perspective, including several aspects such as medical, psychological, social, cultural and legal aspects (ibid).In addition to NKVTS's activities, the Norwegian Center for Minority Health Research, *(*NAKMI), also provides research as well as training for health care personnel working with immigrants in Norway including mental health care workers (ww.nakmi.no).

There is no doubt that there is a need to provide psychosocial support for refugees and it is this gap in health care provision that this study seeks to explore and highlight both as a human rights issue and an essential ingredient to a successful integration into Norwegian society. This gap is supported by clinicians working with refugee groups who make a critique on the current healthcare system by citing that the current set up does not cater for specialised focus on refugees but rather focuses on integrating them into the general healthcare services (Lie et al, 2014).

1.2 Research questions

1. To what extent is the current mental healthcare provision in Norway appropriate for refugees from non-Western backgrounds?
2. How relevant is culture in the understanding of mental health care provision in Norway?
3. To what extent is Human Rights to Health regarded as a mental health need for refugees in Norway?

1.3 Research objectives

The main objectives of this research are;

First to places emphasis on the plight of refugees especially those suffering from mental ill health. Refugees have been chosen as a group they undergo added challenges when compared

to other migrant populations. In addition, they are 'becoming an endangered species', with fewer individuals being officially recognized under the 1951 Refugee Convention. The permanent protection they traditionally received are now being replaced by temporary protection. In addition, there appears to be a decline in these being written on refugees specifically or on specific groups of refugees (Voutira and Dona, 2007).
The second objective is to develop an understanding about the effect of migration on the mental health of migrants particularly refugees.

Third, to analyse and discuss ways to incorporate immigrant's cultural, social and religious contexts to facilitate improvements in mental health services in Norway.

Finally, the research seeks to investigate whether the mental health of refugees is regarded as a human right to health.

Chapter two will look at the literature on Mental Health services and its contributions specifically in the mental health conditions of immigrants in Norway. It will discuss migration and mental health as well as the cultural dimensions of mental health. Finally, the chapter will discuss the relevance and connections between mental health and key Human Rights theories and concepts such as the right to health and development.

Chapter three is a critical overview of mental health services in Norway with the view of understanding the general history and present state of mental health services. The chapter will also look at what services are provided for refugees as well as their use and accessibility of the services in order to understand and contextualise my research objective and questions.

In chapter four, focus will be on justifying the methodology chosen and present a discussion on its applicability, reliability and transferability.

The research findings and discussions will be presented in chapter five.

Chapter six will be the conclusion and recommendations focus as well as research implications and contributions to mental health services for immigrants in Norway.

CHAPTER TWO

LITERATURE REVIEW

2 Introduction

This chapter will look at the literature on mental health and mental health care in terms of providing care to refugees and immigrants with non-western backgrounds living in western societies. It will explore the migration and refugee discourses and common health issues they are confronted with, drawing on promising examples and initiatives taking place in western countries to address the mental health problems of refugees and immigrants coming to their countries. It will look at barriers created by language and cultural differences that threaten good care. The aim here is to create a foundation that would lead to a possible step towards studying the mental health services and care for refugees and immigrants living in Norway. The chapter will then provide its evaluation and conclusion.

2.1. Migration and Mental Health

There is a growing literature and academic research investigating mental health with focus on three areas: social determinants, the rate of mental illness and barriers to and facilitators of care (Centre for Addiction and Mental Health, 2009). Much of the works are also geared towards improving services and outcomes for immigrant, refugee, ethno-cultural and racialised groups, as a common challenge for mental health systems in high income countries.

Several studies have been conducted in Norway on migration and mental health especially with special focus on the mental health status of immigrants with refugee backgrounds. The general picture is that several factors influence why some refugees develop mental illness. Van der Veer (1994) opined that this could be as a result of past experiences from their home countries such as political oppression and persecution, severe traumatic experiences such as imprisonment, torture, murder of friends and family members. The actual process of exile and flight also have an impact. Varvin (2003) also state that the waiting period for asylum cases to be considered impacts adversely on the mental health of refugees.

Norway has welcomed refugees and immigrants and has become a more diverse country as immigrants add to the drivers for population growth in the country. However, immigrants are dissatisfied with the health care they receive as a result of poor communication between them and the health workers differences in language, culture and differing views of workers' role (Naess, 1992). Refugees come with complex problems which pose a challenge for primary and secondary health care (Varvin, 2009). Some of these problems tend to emanate from barriers created by language and cultural differences which may cause difficulties for the doctors in understanding the symptoms and ailments of their patients. As language tends to be a large part of psychiatry, careful considerations need to be made by psychiatrist when communicating with individuals from different cultures and languages. The size of the population, the rate of increase, and specific issues may differ but all jurisdictions will have to meet the challenge of providing mental health services to their multicultural population, and develop health promotion strategies that improve the health status of this group (Centre for Addiction and Mental Health, 2009).

For instance in Norway, poor economic status, marginalization and discrimination have been identified as accounting for the high prevalence of mental health problems among adult immigrants that come from low- and middle-income countries (Dalgård et al. 2006, Thapa & Hauff 2005, Thapa et al, 2007).Once refugees are settled in Norway, post-migration challenges sometimes develop that influences their mental health. These could be as a result of the lack of acculturation as well as experiences of racism and discrimination (Abebe et al, 2012).

The international Organisation for Migration (IOM) defines migration as:

> The movement of a person or a group of persons, either across an international border, or within a State. It is a population movement, encompassing any kind of movement of people, whatever its length, composition and causes; it includes migration of refugees, displaced persons, economic migrants, and persons moving for other purposes, including family reunification.

People migrate for many reasons and experts give two broad categories for it; the pull and push factors. People leave their own countries based on two main factors; because of 'pull' factors that encourage migration, including those forced to migrate; the 'push' factors. (Bhui et al, 2010), broadly divide the migration process into three stages:

1. the first stage is pre-migration in which the individual makes the choice to migrate,
2. the second stage is the actual process of migration itself whereby the individual physically moves from one location to another and
3. the third stage is known as post migration.

(Bhurga and Gupta, 2011).

Whatever the reasons for migration, it is arguably one of the most stressful experiences people face especially for vulnerable groups such as refugees and other minority groups. There are many forms of migration; however, in the context of this study, it will be limited to refugees. As migrants are often lumped and presented as on homogeneous group, it is perhaps useful to make a clear definition of the terms;

Asylum seeker is defined by UNHCR a**s** someone who says he or she is a refugee, but whose claim has not yet been definitively evaluated.

Immigrant is a person who has crossed an international boarder and moved away from their home country, sending country, or country of origin to a host, receiver, or destination country. Reasons for migrating can be voluntary or forced. Immigrants are categorised into one or more groups: irregular, illegal, or undocumented immigrants; asylum seekers, refugees, work migrants or family members (International Organisation for Migration, 2010).

Refugee is described by The Geneva Conventions 1951 as someone 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 nationality, and is unable to, or owing to such fear, is unwilling to avail himself of the protection of that country."

One might say that based on the Geneva Convention definition of a refugee, refugees are forced to flee because of unfavourable and unsafe condition hence can be seen as forced migrants. The label *refugee* is a highly contentious and politicized term making it problematic especially with the currents trends in globalization and migration from the South to the North.

This has according to Zetter (2007), has led to the overextension of the term 'refugee' to include any group of migrants whether it is as a result of environmental or development reasons. Zetter argues that the labelling of refugees is not only a highly instrumental process, but also a powerful explanatory tool to explore complex impacts of humanitarian intervention on the lives of refugees With the flow of refugees to the North as opposed to the traditional trend of South-South migration, the North is faced with challenges on how to manage 'different people on the move.' This trend has driven contemporary policy making discourses on refugees as well as migrants in general (ibid). The effort to manage the flow of people has led to stricter and tighter border controls in the West leading to the creation of 'fortress Europe.' This has in turn has also led to the creating of bureaucratic measures and categories which further render access to the term refugee (Zetter, 2007).

With the politicalisation of the label refugees, repercussions arise which can further alienate this group of people making their experience even more problematic as the politicalisation does not necessarily capture the true experience of refugees nor does it conceptualise the migratory process of refugees (Zetter, 2007). For instance, the generalisation could make refugees undesirable in host countries where the issue of migration is at the center of political discussions. The label can also become a part of a 'social compact' between the state and its citizen in creating convenient images designed to keep refugees at a distance. (Zetter, 2007)
Castles and Loughna (2005), add that the category 'refugee' now sidelined to be replaced with alternative labels such as asylum seeker, irregular migrant or undocumented migrant. These negative imagines can adversely affect the refugee experience by adding to existing stress encounters during the stages of migration with the most challenging being the resettlement phase- This phase is when the immigrant tries to adjust to the new framework of society by learning the new political, economic, social and cultural order (Bhurga and Gupta, 2011). Upon resettlement, refugees often continue to face challenges in the form of discrimination and exclusion from 'mainstream' society. Some of these challenges may be that in host countries they are often seen as the 'other' and any cultural or social differences they may show may be magnified as a reason to be concerned. The need then arises for them to be homogenised through assimilation, integration and citizenship (Bosworth & Guild, 2008). This may impact on some immigrants especially refugee populations who tend to have higher rates of trauma-related disorders due to their past exposure to violence and trauma (Bhurga, 2010, Kirmayer et al, 2011, Bhurga and Gupta, 2011).

Moreover, their specific health needs do not seem to be generally understood by health care providers for reasons including poor communication and ill prepared health care systems to respond to their needs. The challenges include the fact that many refugees are not generally aware of their human rights of access to health and other basic services; as well as holding low paid positions in society. These problems are compounded within the risk group of migrants such as undocumented migrants, asylum-seekers and those who have been victims of trafficking (Rechel et al, 2011). In addition to these challenges, the migratory process could also lead to stress caused by the majority culture represented by the host nation as well as in the minority culture of the migrant groups. This type of stress produced by migratory process is called 'acculturative stress.'(Berry 1999; Ruiz, 2004).

In spite of the growing interest on immigrants, the study of migration has largely bypassed the impact of migration on the mental health of refugees. Yet, the literature often reveals that there is mounting evidence that the migration process involves several stressors which can potentially have a negative impact on the mental health of migrants (Bhugra and Jones, 2001).

2.2 Women and Migration

According to. The United Nations, (2013) 111 million of the world's international migrants are women making up 48% of the world's migrant population. An estimated 59% of international migrants live in the North and half of the world's 15 million refugees are women (UNHCR, 2015). Poverty is the given as the primary reason for women migrating compounded by other factors such as pervasive gender bias and social prejudices especially against single mothers or widows in their country of origin, the systematic discrimination in education, health care, employment, and control of assets. In addition, throughout the migration process, women are at risk of exploitation through forced labour, sexual violence, gender based violence, human trafficking and threats of intimidation (International Organisation for Migration, 2014). The difficulties women face in migration continues once they have reached a place of safety as they are more likely than men to be exploited in the work environment and are also likely to be employed in as unskilled or domestic workers further isolating them from integration into the host society (Guruge et al, 2012). Migration to a new country has also been identified as a contributory risk of intimate partner violence

against women, further increasing their risk of poor psychical and mental health (Guruge et al, 2012).

In spite of their numerical importance and important role women play in migration there remains a general absence of gender in migration studies and even where women and gender are discussed, women tend to be portrayed predominantly as dependents, followers of men (Pedraza, 1991, Hondagneu-Sotelo, 2003, Llacer, 2007, King et al, 2006). It was not until the 1970's and early 1980s that women and gender began to feature in migration studies followed by waves of research in the 1990s and 2000 when the stereotypical roles of men and women in the migration process was challenged (King et al, 2006) for the assumption had been that that women are too traditional and culture-bound or that women migrate only as family followers or associational migrants based on androcentric biases (Hondagneu-Sotelo, 2003).

Through the feminisation of migration flows women became recognised as not being 'followers' but as equally important as their male counterparts. This in essence meant that the role women played was both quantitative and as social actors with increased agency and independence in migration. Further, contrary to the common perception of them migrating as dependents, migration streams have showed that women have always been active in migrating sometimes on their own; as independent individuals (King et al, 2006, Hondagneu-Sotelo, 2003). The early efforts to include women in migration research is both applauded and critiqued by Pedranza (2015) as during those first steps women were merely 'added as a variable' and compared with men's employment patterns in an 'add and stir' approach. This approach with research focusing solely on women excluding men, proved to be unhelpful as this did not only produce a skewed women only portrait if immigration but also further marginalised women. Furthermore, this women-only approach limits the understanding of 'how gender as a social system contextualizes migration processes for all immigrants, men and women' (ibid:114:2015).

Hondagneu- Sotelo eloquently sums up the importance of incorporating gender into migration by observing that;

> basic concepts such as sex, gender, power, privilege, and sexual discrimination only rarely enter the vocabulary or research design of immigration research.'' This is puzzling. Gender is one of the fundamental social relations anchoring and shaping

> immigration patterns, and immigration is one of the most powerful forces disrupting and realigning everyday life (2000:3).

Hondagneu-Sotelo makes a compelling argument as it is vital that to highlight and discuss the relationship between women's social position and migration as this will help fill the gap regarding our knowledge of women as immigrants as well as contribute to a greater understanding of the lives of women. Further, it will also be useful in explaining the process of migration that were neglected by the exclusive focus on men (Perdraza, 2015)

Looking at the literature and studies focusing on Norway on immigrants particularly refugees, there is a limited focus on women and gender. This is not to imply that it absent as some studies do exist such as Dalgard and Tappa's (2007) study focusing on gender differences in immigration and social integration and mental health. In other studies in Norway, gender plays a significant role in immigrants' mental health. For instance (Dalgård & Thapa 2007, Dalgård et al, 2007) indicate that women are more vulnerable to mental health problems than men. Some of the explanations given for this is the lack of acculturation and poor social integration as. This is compounded in cases where there is a significant difference in culture between women and the host society in areas such as gender roles and expectations. In these cases it is reported that the women feel marginalised and powerless adding to their mental distress (Dalgård & Thapa 2007, Thapa & Hauff, 2005). Abebe et al. (2012) also identify other risk factors such as the poor employment status, language difficulties, and lack of social network in the host society.

2.3 Cultural Dimensions of Mental Heath

Race, culture and ethnicity have never been as important and relevant in the mental health as now. This new conceptualization of psychiatric care is relevant to both the North and South (Ruiz and Bhurga, 2010). With immigration, many societies have become more culturally plural with individuals of multiple cultural backgrounds living together in a diverse society. They often form cultural groups which are not equal in power be it numerically, economically, or politically. These power differences have given rise to social science terms such as "mainstream", "minority", "ethnic group" to name a few (Berry, 1997). This 'mainstream' model equates to mainstream approaches to contextualizing culture and illness.

This is starkly evident in "mainstream'' western psychological approaches of conceptualising mental health provisions to migrant population. Hence, the value of cross-cultural psychology is becoming more and more popular in the attempt to understand among other things how migration impacts on mental health as opined by both Berry (1997) and Parker (2009), highlighting the important links between an individual's cultural context and the individuals' behavioural development. Consequently, there seems to be an increased emphasis on cross-cultural psychology where focus has been on looking at what happens to people who have developed in one cultural context when they try to re-settle in another one. According to Spering (2001), the subjective view includes a multidimensional array of shared beliefs, norms, and values of a particular group that are instantiated in everyday social practices and institutions, and that have been historically cultivated, transmitted, and deemed functional across time.

In the simplest terms, acculturation can be defined as a culture learning process experienced by individuals who are exposed to a new culture or ethnic group. While this process can occur among individuals who travel briefly abroad, this research is primarily concerned with acculturation as experienced by individuals with post traumatic syndrome exposed to a new environment to learn a new culture over lengthier periods of time. The approach of this research is grounded on the assumption that acculturation is a complex learning process occurring in culturally diverse environments. Its main components are: (i) getting conceptual knowledge, symbolic understanding, and behavioral skills in multiple cultures (Berry 1997); (ii) negotiating conflicts, coping with stress, overcoming ethnocentrism resulting from intercultural interactions and (iii) molding psychological changes as products of the two previous factors. (Bennett and Bennett, 2004).

Migrant populations deal with these in different ways including the tendency to either; integrate into the majority culture, assimilate, reject the majority culture or become marginalised themselves in the host society (Ruiz and Bhurga, 2010). Some of the challenges faced by migrants and especially refugees and asylum seekers include strict immigration policies designed to keep them out. The hostile reception from host countries in combination with experiences can adversely impact on the attainment of good mental health. Migrants seem to bring challenges to health care systems in their host countries probably due to the cultural and language differences they come with. In the case of refugees this also poses

additional challenges as a consequences of having been exposed to conflict and prosecution (Bhui el al, 2010, Berg et al, 2009). In addition the lack of preparation, attitudes of the host country, their poor living conditions, disadvantages of employment and other variable social support add to their vulnerability (Bhurga et al, 2011). For those individuals who find themselves in need of psychiatric assistance, additional challenges tends to be presented such as understanding and accepting the western medicalised model of care and treatment, adopting a new culture, new identity as well as understanding a new set of social norms.

Despite this emphasis on cultural understanding in mental health care provision, western countries have faced criticism for not incorporating this dimension in the provision of mental health services. For the purpose of this this thesis, western here, reference is made to Europe and America and non-western for people not of European or American origin. By assuming that western approaches are applicable to everyone as being 'superior' to other non-western approaches to psychiatry, an argument is presented that migrants' cultural and religious contexts are often overlooked or subjected to reductionist ideas leading to treatment models that are inappropriate (Summerfield et al, 1995, Honwana, 1997, Hubbard and Pearson, 2004).

Increasing cultural connections entail the phenomenon of hybridisation, which is based on the premise that intercultural processes lead to the recombination of existing forms and practices into new forms and practices (Ferdman and Horenczyk (2003), thus resulting in a transformation of cultural practices and multiple identities. A balance can be found that can be negotiated constantly for "if culture is recognized to be non-homogenous, non-static, and interactive, and if the importance of culture is integrated with rival sources of influence, then culture can be a very positive and constructive part in our understanding of human behavior and of social and economic development" (Sen, 2004:9). Culture is hence an important component for the understanding of mental illness as culture is very important to individuals and groups in issues of self and group identification. According to Calhoun (2003:559) 'culture plays a necessary role in making persons- that is, enabling biological humans to be psychological and sociological humans. It also enables our access to each other and to the rest of the world'

Acculturation is used as focus of reference throughout this thesis. Berry's Acculturation Model describes psychological acculturation as;

> the changes that an individual experiences as a result of being in contact with other cultures and as a result of participating in the process of acculturation that one's cultural or ethnic group is undergoing (1990:460).

He states that psychological acculturation is influenced by different group-level factors both in the society of origin as well as in the host country by key factors such as immigration policies of the host country, acculturation policies, social support and the attitudes of the dominant society (Berry, 1997). Studies conducted in Norway reveal that most Norwegians are tolerant to immigrants and feel that they contribute to Norwegian society. More people also think it should be easier for refugees and asylum seekers to get a residence permit. However, more people also felt that it should be more difficult to obtain a residence permit (National Statistics Norway, 2014). Communities that are supportive of cultural pluralism are more likely to provide social support from institutions and society as a whole (Berry, 1997). Acculturation is however not its critiques. Rudmin (2003), opines that having a fixed focus on the acculturation of minorities insinuates that acculturation is a phenomena that occurs only to minority people and that the cultures of dominant groups are somehow 'monolithic, immutable, and without acculturative origins'. In addition to state that minority are psychologically reactive to intercultural contact and that the mainstream groups are not seems to imply that minority people are a different species of psychological being that is distinct from that of the mainstream group. Rudmin argues that with increased globalization, all humans beings everywhere are subject to acculturation processes. Whether consciously or unconsciously. Hence, it is ''scientifically and ethically wrong to presume otherwise in our theories, in the performance of our research, or in the presentation of our theories and research to the public'' (2003:6). Horenczyk (1997), stresses that it is important that closer attention is given to the level at which the host country's attitudes are being assessed and expressed as there might be some inconsistencies which may make immigrant think that they are accepted in the host country only to find that their expectations are based on ideological attitudes as opposed to day to day experiences from the host society. These less favourable treatment carries the risk of feeling disorientation and distress. He further critiques Berry's adaptation and acculturation theory as being 'fixed dimensions' along which immigrants move during their process of transition though suggest that acculturation can bring about significant

changes in the immigrant's construction of the majority and their own minority culture. They argue that behaviour and attitude changes of immigrants are generally interpreted by researchers to be evidence of weakening of prior cultural allegiances but in fact what might actually be occurring is that the original culture is reconstructed in a manner where the new norms and behaviour become part of this reconstruction with no changes in the intensity of allegiance or culture (ibid). This thesis is not intended to imply that the 'dominant group' is immune from acculturation but rather suggests that it is a two way process and by making reference to acculturation here is to shift focus on one group (refugees) in the acculturation process. This thesis views acculturation as a dynamic process that is under constant change. Furthermore, it is hard to ignore the vast literature presented here on how acculturation through migration affects the mental health of migrant populations. (Bhurga, 2001). The long-term psychological consequences of this process of acculturation tend to be highly variable as this often depends on social and personal variables that reside in the society of origin, the community of settlement and phenomena that both exist prior to, and arise during, the course of acculturation (Berry, 1997). Acculturation is, arguably, one of the most frequently mentioned constructs or concepts in ethnic psychology, and indeed, researchers often include some measure of acculturation in their research to analyse differences within ethnic groups and to understand the relationship of acculturation to psychosocial adjustment and health (ibid).

Acculturation is used as focus of reference throughout this thesis but it is not without its critiques. Rudmin (2003), opines that having a fixed focus on the acculturation of minorities insinuates that acculturation is a phenomena that occurs only to minority people and that the cultures of dominant groups are somehow 'monolithic, immutable, and without acculturative origins'. In addition to state that minority are psychologically reactive to intercultural contact and that the mainstream groups are not seems to imply that minority people are a different species of psychological being that is distinct from that of the mainstream group. Rudmin argues that with increased globalization, all humans beings everywhere are subject to acculturation processes. Whether consciously or unconsciously. Hence Rudmin contends, it is ''scientifically and ethically wrong to presume otherwise in our theories, in the performance of our research, or in the presentation of our theories and research to the public'' (2003:6). This paper however is not intended to imply that the 'dominant group' is immune from

acculturation but rather suggests that it is a two way process and by making reference to acculturation here is to shift focus on one group (refugees) in the acculturation process. This thesis make views acculturation as a dynamic process that is under constant change. Furthermore, it is hard to ignore the vast literature presented here on how acculturation through migration affects the mental health of migrant populations. (Bhurga, 2001). In addition acculturation is, arguably, one of the most frequently mentioned constructs or concepts in ethnic psychology, and indeed, researchers often include some measure of acculturation in their research to analyse differences within ethnic groups and to understand the relationship of acculturation to psychosocial adjustment and health (Berry, 1997). The long-term psychological consequences of this process of acculturation tend to be highly variable as this often depends on social and personal variables that reside in the society of origin, the community of settlement and phenomena that both exist prior to, and arise during, the course of acculturation (Berry, 1997).

The literature presented above, has focused on the importance of culture and identity in the understanding of the mental health of refugees. However, an alternative approach is also presented in other literature which states that the emphasis on culture can be a problematic as it is hard to put a definition on the terms. Culture, it is argued, is neither uniform, nor fixed or immutable. Culture, according to Nadeau and Measham (2006) is not the only, or even the most important part of identity, because people do have multiple identities such as, education, gender etc. This point of view does carry merit as culture is a subjective term in itself which is not only socially construed, fluid and ever changing, but also individual in its construction. Sen (2004:4) adds that cultural contexts are important but "…influential as culture is, it is not uniquely pivotal in determining our lives and identities. Other things such as class, race, gender profession and politics matter also". Furthermore, he opines that our cultural identity is one of the aspects of our self-realisation and it is one of many of our influences that can inspire what we do or how we do it. Using the 'culture' and 'ethnicity' term can still further be problematic. Fangen et al (2010) stated that 'ethnicity' is used by individuals to both describe themselves and others belonging to a specific ethnic group but as there is no precise definition of an ethnic group, it is diverse, contextual and relational from person to person or group to group. Hence this 'diversity' can be a challenge in itself.

However, culture and ethnicity remains a powerful tool used by people and society on a daily basis to gain understanding of themselves and the sense of belonging. Ethnicity is important in empowering individuals within the dominant field of social organisations (Calhoun, 2003) and in the case of migrants and refugees this is of particular relevance as it allows them to maintain their identity in the face of 'mainstream' beliefs and practices. It is therefore hard to ignore cultural as the reality is that we individuals come into contact with one another, it is inevitable that our cultural influences, beliefs and practices also meet. People from different cultures interact with each other all the time hence culture cannot be seen as an insulated structure. It is not helpful to see culture as something that works all on its own, rather what is worth considering is the integration of culture in wider framework where it is viewed as something dynamic and interactive (Sen, 2004).

2.3.1 Challenges of Culture in Mental Health

Refugees' understandings of psychopathology may at times differ from those common in their countries of resettlement. In some countries of origin, perceived mental illness may be viewed as being a personal weakness, physical complaints and spiritual causes (Muneghina et al, 2010). For example, in one study in Norway, it was reported that patients and health professional had a difference in understanding what depression meant. They revealed that there were cultural differences with immigrants and refugees being more in favour of self-help types of treatments such spirituality or other methods when compared to native the Norwegians. The study also found that health workers decided who deserved treatment and who was overreacting based on the person's culture and social circumstances (Erdal et al, 2011). Thus, Western countries have faced some criticism in the way they view and interpret the mental health of refugees by assuming that Western approaches are applicable to everyone and as being 'superior' to non-western approaches to psychiatry. Migrants' cultural and religious contexts are said to be overlooked or subjected to reductionist ideas leading to treatment models that are inappropriate (Summerfield et al, 1995, Honwana, 1997, Hubbard & Pearson, 2004). Post-Traumatic Stress Disorder (PTSD) is often cited as an example. Refugees' understandings of psychopathology may at times differ from those common in their countries of resettlement. In some countries of origin, perceived mental illness may be viewed as being a personal weakness, physical complaints and spiritual causes (Muneghina et al,

2010, Bhurga et al, 2010). Refugees' understandings of psychopathology may at times differ from those common in their countries of resettlement. This is the most common mental health problem diagnosed among refugees. The diagnosis has however, in the past decade been under scrutiny in its application to refugee populations. There has been a sociological critique of the way in which the numbers of 'victims' of PTSD may be inflated to support the programmes of humanitarian aid organizations. (Watters 2011, Summerfield et al, 1995), opine that there is often an assumption made with refugees by western mental health professionals that anyone fleeing a conflict zone *must* be suffering from psychological ill health. As a result, they are given the label of PTSD and being in need of western treatment interventions. This approach may in fact be an alien concept to majority of non-western societies. Summerfield (1995) argues that Western-based therapies, disregard what is most important for this group of people which is the political dimension of suffering after torture. Instead, the therapy they are prescribed by psychiatrist, are largely focused on 'core syndrome', which do not address their real needs. In other words they make use of solely psychodynamic approaches to intrusion and denials, which largely ignores the political and cultural context in which these phenomena occur and have proven to be inadequate to this group of peoples. Bhurga, (2004) also observes that there is a misdiagnosis of mental illness in migrant groups or in cultural and ethnic groups whose cultural are not easily understood by Western practitioners. Hence a blanket approach by the West can at times culturally inappropriate and may lead to more harm than good when working with minority populations. (Parker, 2009). However, there are some positive signs in the Norway. Heath care professionals and researchers have stressed on the importance of working in a diverse culture. To this end, there have been calls for incorporating cross cultural understanding (Goth et al. 2010, Høye and Severinsson, 2010).

2.4 The Right to Health, Development and Mental Health Care Provision

The WHO (2013) states that migrants' enjoyment of the right to health is often limited simply because they are migrants. This is compounded by other factors such as discrimination, language and cultural barriers, or their legal status. Hence migrants are at risk of not being able to realise their right to health. According to the Norwegian Health Directorate (2009) in looking at migration and health trends and challenges faced by Norway for instance, the

challenges faced by Norway and many other countries is that both the right to health as provisions of the declaration are not itemised, not quantified and proves difficult to enforce. International human-rights law also recognises that the right to the highest attainable standard of health cannot be achieved readily overnight as it is expressly subject to both progressive realisation and resource availability. What is of most importance is that there is steady improvement in a country's human-rights performance. The right to health is hence seen as a novel concept even by health professionals who have the tendency to focus more on equity as a foundation for a just health care system (Tobin, 2012).

The right to health includes access to timely, acceptable, and affordable health care of appropriate quality. An individual's right to health should have four key elements according to the WHO definition and guidelines for governments. First is ***Availability*** whereby a sufficient quantity of functioning public health and health care facilities, goods and services, as well as programmes are made available to all. Second *Accessibility***;** in which health facilities, goods and services are accessible to all. This accessibility has four further dimensions; non-discrimination, physical accessibility, economical affordability and information accessibility. Third, *Acceptabilit*y**.** All health facilities, goods and services must be respectful of medical ethics and culturally appropriate as well as sensitive to gender and life-cycle requirements and finally, *Quality:* Health facilities, goods and services must be scientifically and medically appropriate and of good quality. Mental health is also a fundamental part of health and well-being, and is defined in the Constitution of the World Health Organisation as, "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'' (WHO) Protection for persons with mental illness is recognised in both local and international laws. Internationally for instance, The Convention on the Rights of Persons with Disabilities protects and promotes the rights of all persons with disabilities, including persons with mental and intellectual impairments, and also promotes their full inclusion in international cooperation including international development programme (ibid). This is binding on States Parties that have ratified or acceded to it and Norway is a signatory to this convention as well as to International Convention on Economic, Social, Cultural Rights (ICESCR) The focus of discussion here is not look at the right to health in terms of litigation but rather to 'center' its relevance in discourses about mental health of migrant refugee in the Norwegian context in.

The link between the right to health and mental health care seems to be absent both in literature and discourses on service provision for refugees in Norway. The WHO (2013) states that migrants' enjoyment of the right to health is often limited simply because they are migrants. This is compounded by other factors such as discrimination, language and cultural barriers, or their legal status. Hence migrants are at risk of not being able to realise their right to health. According to the Norwegian Health Directorate in looking at Migration and Health trends and challenges (2009) the challenge faced by Norway and many other countries is that both the right to health as provisions of the declaration are not itemised, not quantified and proves difficult to enforce. International human-rights law also recognises that the right to the highest attainable standard of health cannot be achieved readily overnight as it is expressly subject to both progressive realisation and resource availability. What is of utmost importance is that there is steady improvement in a country's human-rights performance. The right to health is instead seen as a novel concept even by health professionals who have the tendency to focus more on equity as a foundation for a just health care system (Tobin, 2012). However, the right to health can also be seen as an inalienable right that cannot perhaps be easily ignored as it adds power to campaigning and advocacy; not to perhaps be seen as merely being just a slogan because it has a concise and constructive contribution to make to health policy and practice (Hunt and Backman, 2008).

In the past 20 years, we have seen a keen interest develop in right to health litigation. (Flood & Gross, 2014 and Tobin, 2012)**.** The right to health however is not a 'new' right for it has been provided for under international law; found in the 1948 Universal Declaration of Human Rights and has seen progress since its development. In 1996, the right to health was adopted in the general comment of the International Covenant on Economic, Social and Cultural Rights (ICESCR). In addition, the first Rapporteur on the right to health was appointed in 2002 by the Commission on Human Rights giving it a mandate to develop a collaborative understanding of the procedures required to promote as well as protect the right to Health. These developments occurred simultaneously with other groups such as practitioners and academics attempting to investigate the link between health and human rights (Tobin, 2012).

In addition, the WHO Constitution also enshrines the highest attainable standard of health as a fundamental right of every human being. Other organisations such as. The People's Health Movement (PHM), a global network of health and human rights organisations have strived to put into practice a human rights-based approach to improving health, particularly in the area of economic, social, and cultural rights. Despite this positive outlook, we have not witnessed a clear picture according to Tobin (2012) that the right to health has in fact moved to the *centre* of political debate or social policy worldwide According to him, the empirical evidence seem to suggest that the status and the relevance of the right to health is far less secure and marginalised than thought.

On the international stage, efforts continue to be made to safeguard the right to health as seen with the World Health Organisation (WHO) and the Millennium Development Project, focusing on the right to health by incorporating it in their promotion, such as in the goal to develop a Global Partnership for Development. Health and human rights however, are not generally linked in an explicit manner except perhaps in discourses related to access to health care, in spite of the fact that health and human rights are both powerful tools in defining and advancing human well-being (Mann et al, 1994). To enhance the right to health of refugees, it is perhaps justifiable to apply it with the right to development as a framework. In 1986 a 'right to development' was adopted as a UN General Assembly resolution stating that:

> The right to development is an inalienable human right by virtue of which every human person and all peoples are entitled to participate in, contribute to, and enjoy economic, social, cultural and political development, in which all human rights and fundamental freedoms can be fully realized.

The justifications for the value of rights in development can be categorised into three broad areas; normative, pragmatic and ethical. The normative justification is a framework that has its basis in international covenants and conventions. This approach is contended to be effective as it relies on internationally agreed legal documents hence providing a greater legitimacy and perhaps a more powerful approach to development as it encompasses greater participatory style of development that enables individuals to exercise agency. The pragmatic reasons for the use of rights talk makes new demands for ensuring greater accountability on the part of recipient states. The state in this approach is bound by international law to be the

principal duty-bearer to respect the human rights of the individuals living within its jurisdiction. The ethical reason for adopting the rights based approach is mainstreaming to make a critical linkages between participation, accountability and citizenship (Nyamu-Musembi and Cornwall, 2006). The approach this thesis seeks to consider is to emphasise and contrast a rights-based approach with other approaches such as the needs-based approach as a development framework (Nyamu-Musembi and Cornwall, 2006) for refugees to realise their human right to health. The adoption of the rights-based approach would involve existing resources to be shared more equally by assisting the marginalised groups such as refugees to assert their rights to resources.

In addition, we often observe development and human rights are seen as two opposing factions where "development" is seen mainly as the terrain of economists and "human rights", the terrain of lawyers and activists (Alshot 2005, Uvin, 2007). Yet the two are intricately interwoven as development is in fact a human right. Perhaps this polarised view is unsurprising given that the right to development is fairly a new concept. The right to health, or health as a human right though emphasised in the majority of fundamental United Nations such as; the UN Charter, the Declaration of Human Rights and the International Covenant on Economic, Social and Cultural Rights can be a challenging framework as there is no clear-cut definition of what institutes basic health care or how it can be guaranteed for everyone. The right to development as a framework can also be problematic especially when it comes enforceability for it is a resolution adopted by the UN hence non-binding on states carrying non resource-transfer obligations (Uvin, 2007). However, even though there is a general lack of legal sanctions to compel states to meet their human rights obligations, Norway like other nations are increasingly monitored for their compliance with human rights norms by other states, nongovernmental organizations, the media as well as private individuals. The importance of health as a pre-condition for the capacity to realize and enjoy human rights and dignity must hence be appreciated. (Mann et, el 1994).

Amartya Sen (1999) contributed in providing some clarity in international development discourses. In 'Development as Freedom', Sen defined development in terms of capabilities of a person when he said that development is the expansion of capabilities or substantive human freedoms, 'the capacity to lead the kind of life he or she has reason to value' (Sen

1999: 87). He make a case for the eradication of factors that limit freedoms such as poverty, poor governance, economic opportunities social deprivation. When the rights based approach to development is discussed, focus often is on countries in the South. Sengupta (2000) to this effect is of the view that development assistance ought to be linked to states demonstrating that they promote participatory development, demonstrate that they are accountability, and transparent. This thesis though seeks is to adopt a broader and less traditional view of development, one that reconceptualises beyond the narrow understanding of development as a Western intervention allowing for the exploration of new aspects of migrants contributions to societal transformations in both countries of origin and residence. (Sinatti and Horst, 2012) Hence, a claim is made that development does not only happen in the Southern region but also in affluent and democratic countries such a Norway where marginalised groups such as refugees face added social, economic and health challenges. When looking at studies in Norway on the mental health of migrants, many health disparities as a result of ethnic, genetic, cultural or linguistic factors emerge. However, these are also largely influenced by other factors including the length of education of an individual, financial and social circumstances (Norwegian Health Directorate, 2009, Elstad et al, 2015). Refugees in Norway are at an increased risk of developing health problems particularly those from non-Western immigrants when compared to immigrants from countries in the West (ibid, 2009). In a 2012 study (Teodorescu et al, 2012) on resettled refugees in Norway, several complex factors were identified to contribute to poor mental health and quality of life such as poor social support and poor social networks. Being in employment was one of the most important markers of achievement for the majority of refugees as it was seen as being related to a sense of identity as well as to a feeling of self-worth and a means to financial independence. Unemployment on the other hand, is viewed by many refugees as a major source of post-migration stress which has profound negative implications for both health and quality of life posing a risk factor for the development of mental health problems in immigrants and refugees. In addition, learning a new language was identified as hindering social integration and increased acculturated stress. The above criteria can be argued to be related to development measuring tools hence the justification for claiming that development occurs not only in the South but in the North. In addition, the relationship between migration and development has since 2000 returned to the forefront as a major development-policy issue. European policymakers and practitioners now put emphasis on capacity building as an essential component of diaspora engagement

policy and practice focusing on the incorporation of migrants into the development industry by providing them with the required skills or frameworks, rather than to strengthen development outcomes for countries of origin (Sinatti and Horst, 2014).

2.5 Conclusion

The grave and long term effects of trauma induced displacement is generally accepted but in providing services to persons affected by migration, forced or otherwise, has been on tangible things such as housing, providing safety and communicable diseases. Mental health service provision has however has not received much focus despite the facts that refugee populations suffer high rates of psychiatric problems (Lin et al, 2010). This chapter has focused on some of the literature on the psychosocial effects of migration on the mental health of refugees as well as literature on the relevance of culture in mental health. It has highlighted the mental health of refugees as a human rights and development issue that needs to be brought to the forefront of discourses on the right to health. The Right to Health, development and ICESR were introduced as a theoretical framework for the rights based approach to mental health making an argument for the need to look at adequate mental health provision for refugees as a human right; one that would incorporate their full realization to enjoy cultural and social rights.

CHAPTER THREE

AN OVERVIEW OF MENTAL HEALTH SERVICES FOR REFUGEES IN NORWAY

Introduction

This chapter will present an overview of Mental Health Services in Norway. It is largely accepted that the Norwegian population enjoys good health. The United Nations has consistently been ranking Norway as number one out of 187 countries and territories in its Human Development Index (HDI) report including 2013 and 2014 (UNPD. 2015hdr.undp.org). Norway, like other Scandinavian countries, is regarded as a leader in human rights promotion, gender equality, democracy and health. With its free healthcare and education for all, one can easily see the appeal from the world's perspective. However, averages can conceal major systematic inequalities and there is still inequality and poverty in Norway (Guribye and Overland, 2014). One area where challenges occur is in the work with refugee where Norway struggles like other Nordic countries to balance the obligation to protect this group in ensuring social integration and national legitimacy (ibid). In a study carried out by Dalgrad and Tapa (2007) on immigration, integration and mental health, it was revealed that in Norway, non-western immigrants showed higher level of psychological distress in comparison to immigrants from western countries. In some of the explanations given in the case of men from non-Western backgrounds, there was a combination of less social integration, less employment, lower income, less social support and more conflicts in intimate relationships. This chapter will present a picture of the health care policy in Norway with focus on refugees. It will take a brief look at the historical development of mental health services for this group as well as the challenges faced by them in accessing health care services in Norway

3.1 Mental health care policy in Norway

The Norwegian health care policy is controlled centrally but the responsibility for the provision of health care is decentralised. The central Government has overall managerial and financial responsibility for the hospital sector and the local authorities at municipal level organise and finance primary health care services according to local demand. Norway has

four regional health authorities who are responsible for the provision of specialised health service. The Norwegian health care system's core value is based on the principles of universal access and everyone has the free choice of service provider.

All residents of Norway who have a national identity card are able to register with a General Practitioner (GP) who can provide referrals to specialists should the need arise. With the exception of emergency cases, those experiencing psychiatric problems in Norway are referred by their GP.

The Directorate of Health estimates that rate of mental disorders in Norway varies significantly, according to methods and diagnostic criteria used. It is however estimated that 15-20 percent of the population has some kind of mental problem, and 3 percent has a serious mental illness. Of the population between the ages of 16-67, 3.1 percent receive disability pensions due to a psychiatric diagnosis. An additional 0.6 percent of the population is said to be on long-term sickness leave as a result of a mental health condition. Three percent of the adult population in Norway visit a mental health outpatient clinic while 0.8 percent receives treatment on an inpatient basis at least once a year (Directorate of Health, 1999-2008). With regard mental health services, Government guidelines say that specialised mental health services are to be integrated in service provision and run according to the same principles as other specialised health care services. As of 2002, the responsibility for specialised health services was transferred to central government who established five regional health authorities They are now responsible for providing specialised health services including mental health services (ibid). However**,** even though immigrants and refugees have access to free healthcare there are still challenges as these entitlements do not equate adequate mental health care provision. Other factors including, communication, culture, literacy levels and even social differences pose barriers (Hansten, 2005). The Directorate of Health in 2009, published a report on Migration and health looking at the Challenges and trends and expressed that the current systems are not equally effective for everyone in Norway. Hence it was recommended that health services be adapted more extensively to the diversity of the population, more so that more people would benefit from the health care available.

3.2 Mental Health Care for Refugees in Norway

Norway adopts a public health care model with a policy of giving equal opportunities to immigrants and refugees alike. The core principle is based on integration and inclusion (Lie et al, 2014). The first government White Paper was adopted in 1996 which made specific reference to immigration and multiculturalism. It also highlights equal opportunities for them akin to Norwegians where all would have equal services (ibid)

In 1986 a National Psychosocial Team for refugees was established in Oslo to meet the challenge with the influx of refugees to Norway. The project was to operate for 3 years but a need to continue was established and the Ministry of Social Affairs gave the mandate for the Psychosocial Center for Refugees to open at the University of Oslo in 1990. The team who had been working at a National Level, now in addition worked with other regional teams that had been established in other parts of the country to meet the demand of more refugees. These teams provided training, teaching and counselling for other professional but also provided clinical service for severe traumatised refugees (ibid).

According to Lie at this point there were guidelines or policies for working with immigrant health issues until 1993 and 2003 when a comprehensive set of guidance was finally provided for health professionals (2003)

In 2002 new reforms were introduced which resulted in the partial closure of the services providing specialized clinical services for refugees to be replaced by new centers that did not provide any clinical care. Furthermore, they now functioned as specialist services focusing on refugees only. Other fields were added in their targeted group. An additional change was that now the work they did, was focused not on clinical work for refugees but focus was on training and supervision.

This reform is the gap this study seeks to bridge and highlight as a case of concern. The argument to be investigated here is that by closing down of specialist service, a vacuum was created in mental health care provision for refugee many of whom are traumatised. These services had been making very meaningful contributions to the refugees who needed the service as those working there were specialist in the area, who were aware of the value in

incorporating cultural understanding in their work with this group (Lie, et al, 2014). For example can be cited from a research carried out by Lie which provided evidence of the importance of early clinical intervention in this population upon arrival in Norway (2002). In practice however, the assessment provided for refugees especially the newly arrived in Norway does not make provision for this service. This has as a result had a fair amount of criticism levied against it. For example Norway has still not ratified international guidelines provided by the Istanbul Protocol for the assessment of Persons who are allegedly tortured (Lie et al 2014, Bailliet 2009). Under the current system, the assessment of refugees is conducted by the Directorate of Immigration (UDI) by individuals who are not experts in the field of mental health. This 'administrative processing' of asylum cases fails to address testimony affected by psychological stress or cultural misunderstanding. Bailliet (2009) suggested that a holistic approach is adopted that includes input from persons with a law and psychology training in determining asylum cases. By adopting a' medical-legal' report that contains assessment of whether psychological findings are expected and typical reactions to extreme stress within the cultural and social context of the individual, a broader picture would be captured (ibid, 2009).

3.3 Challenges to Mental Health Care in Norway

International statistics demonstrate that when people migrate to a new country, they may experience higher rates of morbidity and mortality when compared with their indigenous counterparts because existing health care systems fail to address the needs of such groups (Albarran, et al, 2011). Having said that, international studies generally show a positive relationship between migration and health. However in Norway though a different picture has emerged where researches have indicated that the negative effects of migration are higher than the 'healthy migrant effect' for immigrants (Attanapola, 2013). For example (Dalgård et al. 2006, Thapa et al, 2007) state that immigrants from low-income countries who have been exposed to war suffer from more mental health problems than ethnic Norwegians and immigrants from high-income countries. Some of the explanations given poor health status amongst immigrant populations are lack of social integration, acculturation and social networks. (Attanapola, 2013) This research in turn implicitly blames immigrants' cultural practices for exposing them to risk factors. However, other complex considerations associated with migration such as the adaptation process, the roles of institutions in the host society are not taken into account. (ibid) It is hard to capture all of the challenges faced by immigrants in

Norway in using health care facilities. However some of these problems faced by refuges presented below.

3.4 Access to Mental Health Services

A Report on (Migration and health in the European Union, 2011) make mention of important reasons for focusing on migrants' access to health services in European health systems. Some of these reasons are also applicable in the Norwegian context such as the fact that migrants now form a substantial proportion of the population in Europe making it vital that health professionals and politicians acquire more knowledge on migrants' health and ability to access care in order to make informed choices. Secondly, as illness may limit the integration processes in host countries as ill health affects the ability to engage in education, work and activities in society in general. This the report highlights this may lead to further marginalization and social isolation, which have a negative impact on their health. A further reason given is the legal duty of nation states based on the WHO Constitution of 1946 (WHO 1946) which guaranteed "the right to the highest attainable health".

A study conducted by NAKMI (2010) reported that immigrants in Norway reported that they were unsatisfied with health care provision in Norway compared to Norwegians. This is in spite of The Oslo Immigrant Studies revealing that that immigrants visited their GPs and specialists less than Norwegians (2008). According to Goth et al. (2010), general practitioners' experience is that migrants often seem helpless in dealing with the public health services because of language difficulties, differences in expectations, as well as systematic failures in the co-ordination of care services. Perhaps this is not so surprising if it is contextualised. Access to health care is not limited to physical or geographical access alone but also other complex categories such as that of culture, language, religion, immigration status, familiarity with services, (Powel, et al., 2004). Access to services is often linked with the status of a migrant (Bhui, et al., 2010) ranging from full access to health services, part access or emergency access. In Norway all permanent residence and including those who have been grant refugee status have full enjoyment of health services. For asylum seekers entitlement is given treatment is provided after an application has been made to remain in the country or those in held in asylum centers. For undocumented migrants, and those who have had their asylum claim rejected only emergency care and treatment for communicable diseases is provided (Norwegian Directorate of Health, 2009). In this same report, (2009) on

'Migration and health' stressful events refugees were exposed to prior to securing asylum in Norway are said to be precipitated by worse by the adverse effects of extended stays at reception centres as well as the difficulties of life in exile. It states that several studies also identify a number of circumstances of the application process itself as being especially stressful. Hence, ill mental health among asylum seekers and refugees are associated to a great extent with the diverse mental stress factors they were exposed to in their home country as well as various potential adversities of life in exile. When refugees do present to a professional, other limitations to access surface especially in the case of traumatised refugees. Professionals may for instance be regarded as 'authoritative figures' that symbolise oppression in their country of origin. This might make it hard for them to be honest or open up to the professional charged with helping them. In addition, those held in detention centers might experience it to be a type of imprisonment which can all add to their mental problems (Norwegian Directorate of Health, 2009, Bhui, et. al., 2010).

3.5 Language and Differences in Culture

Culture appreciated as that which aggregates individuals and processes as opposed to a social fact existing outside the minds of individuals or that which overly determines people's lives and neglects their agency. As a process therefore culture is open-ended, dynamic and fluid (Albarran et al, 2011).

Within health care, it is accepted that culture has a vital impact on health and illness beliefs, health practices and care Cultural factors are very influential in maintaining the mental health of individuals in many ways (Gupta and Bhurga, 2009).

An important cultural challenge and a major concern for immigrants in Norway is that of language barriers. Studies have shown that the best outcomes are seen in those who are able to preserve their own cultural background, while possessing the resources for acculturation in their new country of residence (Norwegian Directorate of Health, 2009). According to Goth et al. (2010), general practitioners' experience is that migrants often seem helpless in dealing with the public health services because of language difficulties, differences in expectations, as well as systematic failures in the co-ordination of care services. Varvin and Aasland (2009) carried out a study looking at doctors' experiences of their patients (refugees) and found that both groups were occupied with language barriers. This affected the quality of treatment as the doctors felt that their patients intentionally withheld information about their pre-migration

experiences even though such information is often relevant for the identification of the cause of their illness. Worryingly, the doctors usually did not know whether they were dealing with patients with a traumatic background or not.

This concern is supported by literature in Norway and elsewhere (Naess, 1992) showing that many immigrants are dissatisfied with the health care they receive as result of poor communication between them and the health workers due to differences in language, culture and differing views of workers' role. A leading psychiatrist working with refugees in Norway, Sverre Varvin (2009) in looking at the attitudes of physicians treating refugee patients, opines that refugees come with complex problems which pose a challenge for primary and secondary health care. Some of these problems are that of language and cultural differences which may cause difficulties for the doctors in understanding the symptoms and ailments of their patients. As language is a large part of psychiatry, careful considerations need to be made by psychiatrist when communicating with individuals from different cultures and languages. This is even important when using interpreters as they, the patient and the psychiatrist may all hold differing understanding in health models in relation to mental health. These might have been developed from within their own cultural paradigms and may be present in consultation meetings (Tribe, 2011).

However, cultural competence and transcultural care is not without its critics. Many of the well-known transcultural refer to cultural groups primarily in terms of ethnicity. This results in a rather narrow, essentialist and limiting view of culture, as opposed to the more fluid constructionist view espoused above; it defines patients and clients as "the other" in opposition to the "non-other" society and care giver (Albarran et al, 2011)

3.6 Lack of awareness of Rights

One of the most important barriers for migrants in accessing health services in Europe according to (Rechel et al, 2003) are the lack of legal entitlements and systems for ensuring that these rights are known and respected in practiced. It is often the case that even where entitlements exists, they are often disregarded.

John Rawls' principle of justice (1971), proposes that a fair society must make sure that those in the most disadvantaged positions are not treated fairly and not discriminated against so that they and can potentially access all positions. If this is applied to health service the minority

groups such as refugees could perhaps be prioritised in the same fashion as other members of society where their rights would be enhanced and promoted in health care provision. Yet knowledge of rights continues to be a mind field for refugees. Domenig, (2004) believes that there are various inequalities for migrants and refugees to access health services in the West where they are discriminated against based on their origin, beliefs and way of life. Many migrants are not well informed about their treatment or do not understand their diagnosis placing them at a disadvantaged position. (ibid)

The Norwegian Health Care system positions the principles of equity in the centre of operating system. However, ensuring that these rights are guaranteed have proven to be a challenge. In an attempt to address this problem The Norwegian Directorate for Health in looking at Migration and Health recommended that *all* employees of the Norwegian health service be made aware of the health rights, status of asylum seekers and refugees. Adaptation of medical care is also essential for persons of immigrant origin in order to achieve equitable health care provision according to the Directorate of Health, Norway (2009). It is also government policy that organisations try to reach out immigrant origin in order to provide information about rights, diagnoses and activities. (ibid) This however it reports, proves to be problematic due to poor coordination and many GPs feeling under-qualified to deal with the problems of these patients as well as finding it difficult to obtain the as well as assistance of the mental health care services. This the report says, raises challenges in both the expertise and framework conditions for treatment.

Conclusions

The discussion in this chapter has been on looking at health care provision in Norway and services for refugees were investigated. The chapter also attempted to capture some of the challenges faced by refugees in using health services in order to gain a clear picture on the gaps in service provision as identified by literature and some of the interviews conducted as part of this thesis.

The Norwegian healthcare system makes provision for all including immigrants. However, there are inadequacies and areas of concern in terms of the quality and appropriateness of services for this group. Currently there appears to be a lack of commitment to develop or re-introduce specialist clinical services for refugees. Other Nordic countries such as Denmark, Sweden and Finland all have such clinics whose work is to provide specialist care and

rehabilitation for this vulnerable group (Lie et al, 2014). Compelling arguments have been put forward to support the need for specialist services for refugees as the current system does not cater adequately for their needs especially if this is looked at from a human rights point of view by Lie (et al, 2009) Attempts have been made to meet some of the needs identified such as the establishment of the Centre for Violence and Stress Studies (NKVTS) in 2004 as well as setting up of five Regional Resource Centres for Violence, Traumatic Stress and Suicide (RVTS). These resource centers offer competency building for professional agencies but fall short of providing clinical support to refugees themselves. The Directorate of Health acknowledges that the needs of immigrants are not being adequately met based on a health survey carried out also showed that persons of non-Western origin were less satisfied with their GP for example than the others. In addition, the current health services are not functioning equally well for everyone, and that more people would have had greater benefit from health care provisions if the services had been more extensively adapted to meet the diversity of the population. (Norwegian Report on Migration and Health, 2009).

CHAPTER FOUR

RESEARCH METHODOLOGY

Introduction

In this chapter the research design and method used to investigate the research questions are presented. The chapter covers the research method adopted (qualitative), the research design, sample selection, the research methods used to collect data as well as the methods used to analyse and interpret the data. It also discusses the reliability and validity of the finding of the research as well as the limitations of the research and ethical considerations.

4.1 Research Design

The aim of this research is to explore immigrant mental health care issues in the context of Norway. The research design adopted was a mixed method in data collection through the use of Sampling, Individual Interviews, Focus Group Interviews and Secondary data. Once the data had been collected, a content analysis method was adopted to transcribe the content of the interviews and analysed to generate themes which were analysed and interpreted. The participants were selected for the individual and focus group interviews based on their professional experience of working with immigrants and refugees in Norway. The participants were from different professional settings such as clinicians, mental health services providers, school advisers working with refugees, social workers and organisations that work with immigrant health, integration and human rights.

A qualitative method was chosen as a research methodology for this thesis as it was beneficial in developing a better understanding and analysis of core issues from the perspectives of the group of people charged with providing mental health care for the migrants including refugees. Qualitative data collection gained momentum in the 1980's as result of dissatisfaction with quantitative methods for research. Reason and Rowan (1981) say of this;

> there is too much measurement going on. Some things which are numerically precise are not true; and some things which are not numerical are true. Orthodox research produces results which are statistically significant but

> humanly insignificant; in human inquiry it is much better to be deeply interesting than accurately boring.

Hence qualitative research has many advantages as with the use of a qualitative approach did not only allow the development of in depth understanding about the research subject but by using a qualitative method the experience of the participants were better captured in determining the challenges faced by both service users and service providers. As the qualitative approach involved the use of interviews as opposed to a questionnaire, opportunity was used to ask more questions that perhaps a questionnaire for instance would not have been able to capture. According to Coolican (1990), 'the principle of qualitative analysis is that casual relationships and theoretical statements be clearly emergent from and grounded in the phenomena studied. The theory emerges from the data; it is not imposed on the data.' Hence, an inductive approach was adopted whereby from the ground up as opposed to be handed down only from theory.

Generally, a positivist framework has been adopted in Norway when conducting research on mental health of immigrants with the use of quantifiable data to generate results. This has its limitations according to Attanapola (2013) as most research tend to focus on generally on results such as exposure to war and conflict environments or the lack of integration into Norwegian society are the main risk factors for mental health problems among non-Western immigrants in Norway. This Attanapola (2013), contends, does not take into account other the categories of experiences of immigrants with mental illness and how their illness affects their everyday life. What is useful though is a use of qualitative methods that focus on addressing the questions of why people behave in such manner and how they perceive their ill-health situation. Using qualitative methods would explore the immigrants' subjective understanding of being sick, capture their experiences and perceptions of health care personnel and services available to them. Furthermore, the use of qualitative methods such as interviews would help health care personnel to understand their patients better (ibid)

Hence, a constructivists approach was used in favour of the positivists approach. Bryman says of constructivism social phenomena and their meanings are constantly being accomplished by social actors. In other words, social phenomena and categories are produced through social interaction and are always being revised. In this approach he adds, the researcher's own

interpretation of social reality is what is presented and this is not necessarily definitive (2008). Guba, (1990) contends that it is neither possible nor desirable to have context free genralisations as research is value-bound hence problematic to fully differentiate causes and effects. However, as one of the objectives this study was to investigate whether the mental health services in Norway are culturally appropriate for refugees, it was important to understand their cultural contexts and interpretations of culture. As culture is not fixed, it would be problem to understand it in the context of it being value bound and prescriptive. The contrasting view of a quantitative approach requires social science inquiry should be objective, time, and context-free generalizations in order to be viewed as reliable and valid (Johnson and Onwuegbuzie 2004). However, as discussed throughout this thesis, issues of culture and health as not context free as they are often determined by the person experiencing the phenomena hence difficult to remain emotionally detached.

In addition an exploratory approach as recommended by (Veal, 1998:84) was adopted for the investigation. In other words, focus was on seeking to discover existing issues which might throw light on specific questions on immigrant mental health care concerns in Norway. In addition, a cross-cultural psychology approach was used as a framework in establishing links between an individual's cultural context and the individuals' behavioural development (Berry 1997, Parker, 2009). This approach is similar to that used in Leong (2007) referring to it as the cultural accommodation model (CAM) of cross-cultural psychotherapy (Leong and Lee, 2006). The dual goals of cross-cultural psychology model were and continue to be, to discover the universal and the culture-specific factors in human behaviour (Leong and Brown, 1995). This was modified to understanding the challenges faced by Norwegian mental health services in providing care for immigrants.

4.2 Sample

It is difficult to interview the entire population in Norway that work with mental health and human rights issues of migrants in Norway. Hence a quota sample was drawn from this group of professionals. The quota sample, used in this survey is one of non-probability sampling which is where the elements in the population do not have any probabilities attached to their being selected as a sample for the research. This sample design, according to Sekaran (2000:279), is best when generalisability of the findings to the whole population is the main objective of the study. Fowler, (2010) states that how well a sample represents a population

depends on a number of factors; the sample frame, the sample size and finally, the design of selection procedure. Hence making the decision as to who to sample the researcher chooses people and sites to study that can purposefully inform a good understanding of the research problem as well as the central phenomenon in the study (Creswell, 2013). The respondents in this research were not randomly selected but rather research as conducted on the public organisations and institutions that work with immigrant populations in Norway and then contacted via phone followed by email to discuss the research and requests put in formally for interviews. Public organisations and institutions were chosen as the research was looking at state provided mental health facilities for refugees. Hence for the purpose of this research, it was important to carefully select participants who could help with understanding the issues being explored. The sample comprise of 27 participants, which included 12 individual interview and 3 focus groups comprising of 5 participants each. Gender was not a determinant in selecting the participants as the main focus of this thesis was to investigate adult mental services in general. When contact was made to the organisations and institutions to request an interview, they recommended the individuals they felt were in a position to deal with the issues raised in the research questions a point of contact. However, for some of the interviews participants were selected as a result of the research conducted as part of the literature review. These were individuals who had carried out studies and published articles on topics of migration, health of migrants, refugees and mental health services in Norway.

4.3 Research Method and Data Collection

Both primary and secondary data sources were used in this study as a multiple data collection strategy is more advantageous than single data collection strategy when conducting a research work (Creswell, 2010). As there are strengths and weakness to any single data collection strategy, using more than one data collection approach gives the researchers an opportunity to combine the strengths and correct some of the deficiencies of any one source of data (Teshome, 1998, Creswell, 2013).

4.3.1 Primary Data Collection

The following methods were applied to collect the primary data

4.3.2 Individual Interviews

All the interviews conducted for this research were held in Oslo, Norway, through semi-structured interviews with the help of an interview guide. This allowed the researcher some level of flexibility to be able to vary the sequence of questions to allow the flow of conversation and to also allow my participants to engage fully in the discussion. The one on-one interviews I conducted were semi-structured in nature, lasting generally an hour each in the office of my participants. In these one to one interviews, with the help of my interview guide, 10 out of the 12 participants allowed me audio record my conversations with them which I later transcribed. I respected the views of the two of the participant who did not want to be recorded but allowed me to take notes during the interview. Two focus group interviews were also conducted in a formal office setting arranged by the organisations I had contacted. Two of the groups lasted an hour and one lasted one hour and thirty minutes. All the settings were private and free from distractions.

Kvale (1996) say that qualitative research interviews the researcher understand the point of view of the participants, to unfold the meaning of individuals' experiences, to uncover their lived world. This was evident during some of my interviews especially when it came to understanding the way my participants viewed culture and its impact on service provision to those from non-Western contexts. A further strength in using qualitative date collection is that it allowed me to understand the open-ended responses that I could not have understood from for instances the use of only questionnaires. This is because qualitative methods is adopted in order to gain a deep understanding of complex issues which can only be achieved from talking directly to people and allowing them to tell their experiences without restrictions (Creswell, 2013) such as ticking of boxes in a questionnaire not allow room for further expansion by my participants.

However, this is not to imply that qualitative methods are faultless and perfect. One limitation levelled at qualitative research is the criticism that qualitative research in itself is flawed and unscientific. It is also said to be often open to interpretation by the researcher (Bryman, 2008)

especially when transcribing information gathered from interviews whether it is from notes taken during the interview or from tape recordings. It is argued that it does not attempt to eliminate all influences by the researcher and the researchers views might not necessarily be that of the research participants'. However, Kvale (1996) refutes this and opines that interviews can be free of bias as well as have the ability to provide objectivity and mechanically measured reliability by the amount of agreement among independent researchers. He goes on to say that qualitative interviews can also be objective in the meaning of 'letting the investigated object speak', in expressing the true nature of the subject. Thus qualitative interviews are neither objective nor subjective in nature as its method is inter-subjective interaction. As an added safeguard to ensure quality in the enquiry Guba and Lincoln's (1994) criteria of credibility, transferability, dependability and authenticity were adopted

4.3.3 Focus Group Interviews

As mentioned earlier, 3 focus groups were conducted with each group having five member. There was a gender mix in all of the groups as well differences in position of the group members. For example in two of the groups, students of mental health were present as they were on placements at the time of the interviews. This was unexpected but an interesting development as I was able to see the differences in their experience which added value in understanding the issues better.

A focus group research is said to have three components. It is used for firstly as method devoted to collecting, secondly, interaction as a source of data, and third it involves the active role of the researcher in creating group discussion for data collection. Over the past century or so, focus groups have been used for many purposes, and can be traced to Emory Bogardus, who in 1926 described group interviews in his social psychological research to develop social distance scale (Wilkinson, 2004).

In addition to one to one interviews, focus group interviews were used as part of the data collection in order to gain deeper understanding in capturing the common perceived issues from the point of view of my participants as it allowed the participants to recount their experiences. Focus groups are useful where a researcher is interested in in the individuals discuss and view issues as a group and respond to each other's point of view (Bryman, 2008., Creswell, 213).. Focus groups can be good tools if handled by a skilled researcher. However,

as focus group interviews involves talking to more than one person as a time, facilitating the group in a safe and open manner, challenges do at times appear. Millward (1995) opine that the most appropriate type for a focus group is low control and high process. In this approach control over content is minimal but the facilitator should make sure that all relevant issues are covered in depth. This was the approach adopted facilitating the groups. For example one challenge was that in one of the groups, an individual appeared to be more assertive and expressive than other members of the group. The danger of this is that perhaps this may be influence by the general feelings from less vocal participants in the group. It was hence important to be mindful of this during that group and ensuring that the group was steered efficiently, boundaries maintained. My past experience of group work facilitation came in handy in holding the focus groups as I was equipped with understanding how group processes work as well as how dynamics of a group influence its outcomes.

4.4 Secondary Data Collection

A further method of data collection used was the use of secondary data as part of this research. References were made from previous literature presented on in the area of migration, mental health, culture, refugees, integration and acculturation. Statistics were used primarily from National Statistics Norway. Furthermore, references were made to Government publications and white papers in Norway as well as referring to International Policies on Migration, Mental Health and Refugees.

Ghauri et al, (1995) suggests that researchers usually start their investigation by examining secondary data to see whether their problems can be partly or wholly solved without collecting costly primary data. The information needed to conduct this research requires both secondary and primary data. Primary and secondary data sources were thus used as a multiple data collection strategy, which is more advantageous than single data collection strategy when conducting a research work (Creswell, 2010). This consists of information that already exist, having been collected for other purposes generated from a variety of sources such as academic text books, research articles, periodical journals, the internet, international organisations, public institutions and so forth.

As there are strengths and weakness to any single data collection strategy, using more than one data collection approach gives the researchers an opportunity to combine the strengths

and correct some of the deficiencies of any one source of data (Teshome, 1998; Creswell, 2013). With the exploratory nature of this study, coupled with time constraint, the primary data source, which is generally collected specifically for the pursuit of this particular research (Clark, et al, 1998) to answer the objectives of this research a qualitative survey was chosen as the appropriate instruments for the study facilitated through individual interviews and focus groups narrating their professional experiences of mental health services in Norway.

4.5 Data Analysis

Qualitative content analysis has been described by Hsieh and Shanon as 'a research method for the subjective interpretation of the content of text data through the systematic classification process of coding and identifying themes or patterns' (2005:1278). Content analysis is adopted as it is regarded by researchers to be a flexible way of analysing text data. Hence focus in qualitative content analysis is on the content or contextual meaning of the text (Hsieh and Shannon, 2005). Content analyses method was also used to fit responses into a model of communication in accordance with the research aim and objectives. This "method uses a set of procedures to make valid inferences from text" (Weber, 1990:9), and examines textual data for patterns and structures, singles out the key features to which researchers want to pay attention to, develop categories, and aggregates them into perceptible constructs in order to seize text meaning (Gray and Densten, 1998). A content analysis of responses from 27 participants helped facilitates a critical examination and comparison of the content of the responses from the interview identifying issues that shed light and expand on the findings providing a clear idea of the perceptions of respondents on the research questions.

The text data in this case was gathered from tape recordings of the individual and focus group interviews. Once the interviews were conducted, the content of the audio recordings were transcribed through text. For those who did not wish to be recorded, notes were taken during the interviews and later transcribed for content analysis. One key critique of content analysis is misunderstanding the context hence failing to identify key categories and findings not representing the data (ibid). Credibility was reassured through repeatedly listening to the text and coding of key terms based on the research question. As data was mainly collected through interviews, it facilitated the use of some open-ended questions allow respondents to explore

and share their experiences. This was then followed by targeted questions about the predetermined categories

In addition, the cross-cultural psychology approach in regards to links between an individual's cultural context and the individuals' behavioural development (Berry, 1997, Parker, 2009) was the core concept that was adopted to help understand the challenges faced by Norwegian mental health services in providing care for immigrants. This was useful to gain insight knowledge of the research problem in hand. As Primary data was obtained from the narratives of individuals and focus groups, meaning that the data is descriptive and cannot be measured numerically.

4.6 Reliability, and Validity

Reliability is of a measure of a concept that is concerned with the issue of whether the result of study are repeatable and validity here is concerned with the integrity of the conclusions that were from the research (Bryman, 2008). The criteria used to select participants this research is based on the professional background of the participants working in mental health services for refugees and migrant populations in Norway. The findings are hence limited to their perceptions on mental health care for immigrants in Norway.

A critique might be that the participants in the research might be claiming to have the ability, and knowledge of challenges affecting the mental health care services in their dealings with immigrants and refugees. However, based on knowledge that has now been gathered from this research, and with support from the literature on cross-cultural psychology approach in regards to links between an individual's cultural context and the individuals' behavioural development (Berry, 1997, Parker, 2009), this research can claim reliability and validity.

Of the mental health care services available within the Oslo Metropolitan area, 5 of them (71%) were used as focus groups. This is quite representative for the sample in the research and also seems to be showing the reliability of research instrument used. However, in taking into account of the critique of qualitative methods being open to interpretation (Kvale, 1996), was aware that as a researcher of her own theoretical and philosophical assumptions coming into the study as a form contribution to enrich the research. In axiological assumption, a researcher acknowledges that research has multi-faceted and value-laden. Hence biases may

be present. However to limit this, the researcher discusses these values that shape the narratives including the researchers' own interpretation (Creswell, 2013). This has somehow been the case that the author with more than 10 years professional work experiences in mental health care services who is also an immigrant, once a refugee, with a non-western origin, brings something of value to the study based on such background, experience and knowledge. The results could not have been much different in similar situations. The findings will provide similar findings if the research is to be repeated elsewhere in Norway.

4.7 Generalisability and transferability

The findings reflect the answers generated from responses of 27 participants who are all experienced professional health care service providers in Norway. The number of participants in the research is quite representative comprising of a focus group of (71%) of mental health care service providers in Oslo Metropolitan area. Despite this limitation, there is still possibility for generalisation of the findings to the mental health care service in Norway.

The conclusion is that, the results seem to be applicable within the group studied, referred to as internal generalisability (Maxwell, 2005; Flick, 2008), and can be applied in similar settings that were not directly observed by the study referred to as external generalisability. The facilities and professionals that are used as focus groups are similar in other parts of Norway. It is thus possible to generalise the findings to situations in other parts of Norway and can be representative in similar situations. This is referred to as transferability of the findings to other contexts (Miles and Huberman, 1994). The procedure used in this research thus ensures the generalisability of the findings, meaning that the findings are applicable to formal sectors operating in mental health care services in Norway.

4.8 Limitations in the Research

Performing studies on migrant populations is not without challenges. One principle challenge has been that many studies have the tendency to portrayed immigrant populations as a homogenous group despite their differences in ethnicity, culture and traditions, socioeconomic status, religious background, their places of origin and reason for migration, generation and length of stay (Abebe, 2010). Refugees studies is no different in this regard as one of the challenges is that in typical studies conducted on this group, they have often been

treated as a homogenous group. This is far from the reality as refugees like any other group in society differ in culture, religion, beliefs and so on hence refugees experience complex and multitude challenges in any given society. These methodological and conceptual challenges do not however diminish the validity of the study findings. (ibid, 2010)

In taking into account the critique of qualitative methods being open to interpretation (Kvale, 1996) I was aware that as a researcher, I would have theoretical and philosophical assumptions. In axiological assumption, a researcher acknowledges that research has multi-faceted and value-laden. Hence biases are present. However to limit this, the researcher discusses these values that shape the narratives including the researchers' own interpretation (Creswell, 2013) I was aware that I was bringing some of my values; as an immigrant who was once a refugee, as a person from a non-western origin and as a trained mental health professional ad service provider. I see this as bringing something of value to the study as it made me aware of the issues this research sought to highlight.

4.9 Ethical Considerations

Guba and Lincoln (1994) opine that ethics is an 'intrinsic' part of constructivism paradigm because if the inclusion of the 'participant value in the inquiry'. This is important as concealing the inquirer's intent is destructive to the aim of uncovering and improving constructions. However, there is also the danger that the closeness of the personal interactions needed by the methodology can adversely impact confidentiality and anonymity. To safeguard this risk, all participants were assured of confidentiality and even where they did not object to not remaining anonymous, all participants in this research have been given anonymity for the sake of consistency as some did not want to be identified. The researcher must ensure that all participants are informed about the reasons for the study and informed that they can pull out at any point of the exercise in line with the Nuremberg Code which states that participants should know '...the nature, duration, and purpose of the experiment; the method and means by which it is to be conducted; all inconveniences and hazards reasonably to be expected; and the effects upon his health or person, which may possibly come from his participation in the experiment.' Bryman (2008) outlines four broad areas for ethnical consideration for the researcher; to ensure that there is no harm to the participants, to secure informed consent and protect participant's privacy and to deceive the participants when carrying out the research.

No interviewed with any service users or patients form part of this research. As the participants are various professionals working with immigrant populations including refugees. None of them are classified as 'vulnerable' as such no approval for the research was only necessary from the academic Institution. All the participants were informed and reassured that any information given would be treated with utmost confidentiality. The rights of those who did not wish for the interviews to be recorded was respected and notes were taken in these instances and later transcribed in the same way as the tape recorded conversations. Even though some of participants expressed that they did not object to their names being, to enhance confidentiality, all names were left out.

4.10 Conclusion

This chapter discussed and provided justification for the choice of research strategy, the research design and ethical considerations. It presented the advantages of using a qualitative method and contrasted it with a quantitative methodology. A constructivist approach was adopted in order to provide opportunity to explore the phenomena and understand meanings from it. Throughout the process I was aware that values can and do affect the research but measures were taken to ensure reliability and validity. Data was collected through the use of primary date and secondary data a content analysis of the data was conducted thereafter. Limitations of the research were also presented as a well as the ethical issues that were considered throughout the research process.

Some issues of methodical challenges were experienced as this research in the same way a significant number of studies are presented with numerous methodological and conceptual challenges. This is also so for studies on immigrant population. One such challenge is that diverse immigrant populations being portrayed as a homogenous group and inadequate control of pre- and post-migration variables (Abebe, 2010). This limitation was acknowledged, and accurate as it may be, it does not necessarily discount the importance of carry out research on immigrants and refugees in particular especially where in Norway, only few studies investigated issues relating to their use and access of healthcare. (ibid).

CHAPTER FIVE

FINDINGS AND DISCUSSION

This research was carried in Oslo, Norway. The process involved me meeting and interviewing my participants in order to collect data for the study. In this chapter, the findings of the chapter will presented with discussions based on the narratives from individual and focus group interviews. For capture the opinions and perceptions of my respondents, I will use some of their quotations from my in the text. During one of the focus group interviews, the issue of culture and integration was discussed by the respondents even though this was not the main objective of this research. Their perceptions added value to the research and have hence been incorporated as part of the findings and discussion. The discussions and interviews will be presented first followed by further discussions of the findings in the sections that follow in relation to my research questions.

5.1 The Relevance of Culture in Mental Health; Perceptions and Opinions

In the interviews I conducted the issue of the relevance of culture in mental health of immigrants from non- western backgrounds was discussed with the participants. The general view was that culture is relevant and important component of a person and needed to be considered when working with this group of individuals. One of the focus groups I had was composed of mental health workers in various capabilities such as a nurse, psychologist, outreach worker and one trainee student. One member of this group (Group A) is from a non-western background, from Africa. The entire group felt that culture was relevant in mental health but also mentioned the importance of ethnicity. The members of group A, were individuals from a Western and non-Western background. They felt that the different ethnicities in their team was an advantage for them in terms of cultural understanding and access or use of their service by their non-western patient group they worked with. One member of this group, A, said

> *If we did not have someone from x's ethnicity in our team in, it would make it very difficult for the current Service users to come to us. They can identify with our current worker and he adds to the quality of our team. This is to do with Language and culture. With Language we could also use an interpreter but we cannot get that for*

cultural understanding. Of course we need other qualities too for example open mindedness etc but the culture and cultural contexts of our service users is very important...

They felt that people with mental health difficulties were stigmatised in certain cultures and this affected who accessed their service in some communities and as a result more males used their services as stigmatisation of mental illness was worse for the women from that community. When asked why this was, the response was that this was mainly because the outreach worker was male and culturally more men will talk to him than females. Another member of the group also added:

I think this is so because I think women are more social than the men but they don't come to us as much. Maybe they hide because the stigma affects the women more than the men especially in the service user's cultural context. Also culture prevent some of them coming to our offices we meet them outside. They feel if they are seen, people will think they are crazy. Also immigrant women at home taking care of kids, they have to remain strong because of kids so they don't come to us. Those (women) who do are usually come to us are referred by their doctors.

One member of this group A,'s perception is that that cultural interpretation and understanding was not the same for Ethnic Norwegians and those service users from non-Western countries:

In terms of our users the Norwegians and non-Norwegian see their illness differently. Their trauma is different. With the Norwegians it is usually not war related e.g sexually violence. But with the non-Norwegians it usually is war related. Their understanding of psychiatric problems is also different. For example someone from Somalia they might think it's related to jinns, evil eyes, or cursed by parents for being a bad child. We have to try teach them the Western diagnose system not to say we are right and they are wrong. We try to understand their cultural understanding.

Another participant in Group A explained that their team was aware of the different culturally expressions and interpretation of mental health illness so they adopted a flexible way of working with individuals from non-western backgrounds to accommodate their cultural diversity. When asked if this was so in other places they had worked at, the response was that

they believed their approach was not widely used but because some of the members of their team had worked in non- western countries in Africa and elsewhere for many years, they did not see the strangeness. One gave an example to demonstrate how they achieved this.

> *Some might want to combine their treatment to include alternative remedies like herbs, or want to use religious leader like Imam to pray on them to take away the jinns. We are generally supportive of this as long as it doesn't harm them and they comply with their medication that stabilises them. So there is a combination of traditional and medical model. So their response we get from them is more positive. They feel listened to and understood.*

In one of the one-to-one interviews I had, I interviewed Respondent 5 who came from a non-western background who was a mental health professional from a leading Organisation in Norway. They revealed that they come to Norway as a refugees and had used mental health facilities in Norway when first arrived. Respondent 5 wanted to share their experience of having used mental health services in Norway and said:

> *My observation as a professional is that when people of ethnic backgrounds seek help for their addiction or for their mental distress, they cannot relate to the psychologist. This is because this setting is alien for immigrants or refugees. It is difficult to contact and communicate with them as the culture is alien. Culture is deeply ingrained in our heart, in our brain in our life. The psychologist I saw was not culturally relevant to me. Our ways of dealing with mental distress is different. We may not even call it mental illness. I do not recall a psychologists ever asking me my culturally context or showing interest in my culture. This affected how I communicated my difficulties with him*

When asked why this was important the response was that many refugees are not used to talking to psychologist as they did not have them in their country or had never visited one before. According to respondent 5, their experience as professional proved that this is so for a lot of with young boys and youth in general particularly for those who come as unaccompanied asylum seekers to Norway. Some individuals from this group report to him that they do not get the help they need because of lack of cultural understanding. For example for many of them, religion and spirituality is central to their lives but they drink and smoke contrary to their religious beliefs to cope. As a consequence, they believe this has affected

their natural contact with the God they believe in. This has deep psychological impact on them yet psychologists do not talk about this the respondent reports.

In further discussion on how this related to culture, the respondent 5 replied:

> *The treatment models in therapies (family or otherwise) was all done with the West with the west in mind. There is nothing that is not culturally neutral and when you are stigmatised we cannot ignore the power of culture. Had my therapist shown interest in my cultural context, it would have been very different for me. I would trust him better as he is showing interest in me. I would open up more. Even simple question lie how is my experience in Norway? If my culture is ignored, I would not open up.*

Respondent 6 was a Norwegian Caucasian who works in education providing support to immigrant young immigrants. They shared their experience as being that individuals with mental health problems from non-Norwegian backgrounds in Norway faced a multitude of problems;

> *People of all backgrounds have mental health issues but it is harder for those who are not ethnic Norwegian to express their needs in Norway. This is because of cultural differences. Norwegian society is more open in talking about mental health as they believe that it can be cured with medicine. But the difference in understanding is not only cultural but also religious. Sometimes talking to those from non-western backgrounds about religion makes communication easier. The religious perspective makes the problem tolerable as it is seen as a temporal problem and would go away with time.*

Respondent 6 talked about acculturation and expressed that some of those they worked with struggled with their cultural understanding as some of them were living in one culture and when a new culture is introduced, they many end up with three cultures or more. This would be theirs, the Norwegian and a third one combining the two. This he said makes them stuck making them sick mentally and some start using drugs, alcohol etc. for relief adding to their mental health illness or difficulties.

The second focus group (Group B), consisted of individuals working in an institution that provides support to immigrants as part of their role. Two participants in this group were students and all were of Caucasian Norwegian background I interviewed. One of the

participants in this group had a perception on the relevance of culture in mental health. They said:

> *I do not see culture as relevant today in Norway. Maybe 10 years ago, it was relevant but not anymore. This is because in Norway everyone is treated the same*

When asked to clarify, they replied that all human beings are the same and it did not matter where a person came from. They must all be treated the same way. When asked if in their work, they considered the cultural contexts of those immigrants from non-western background that came for support and modified their approach, they answered no as it was not necessary to do so. This was an interesting perception in that other members in the group did not share this view and one of them vocalised their opinion by saying that they worked in an emergency psychiatric unit that catered everyone but those who were brought in from non-western backgrounds, presented differently. For example they did not necessarily see their illness as a medical condition. They also had difficulties in speaking the language and expressing their symptoms and problems to the professionals providing care. This respondent added that it was their experience that the ethnic Norwegian were able articulate their illness better and accept that they suffered from a mental illness.

Respondent 4 worked in a public institution that worked with immigrants and also provided support to other state facilities on working with immigrant populations in Norway. This respondent had a broader answer on whether culture was important. They expressed that they did not believe culture to be the most important factor when providing mental health services to immigrant but rather to other barriers such as affording to see a GP, paying GP related fees, the Introductory Programme for newly arrived refugees, working with interpreters and language barriers needed to be the focus of interest. Focusing on culture they felt was not helpful.

A similar view was expressed in one of my one to interviews with a health professional who felt that the use of the world culture was not helpful in their work as it then made it the dominant focus when working with immigrants. They said;

> *We abandoned the use of the term 'culture' in our work. We now focus more on migration and health. The term culture is very limiting us because the use of*

culture makes culture dominant… the term 'migration' as it is inclusive or intra-cultural

5.1.2 Findings on the Relevance of Culture in Mental Health

Culture was seen as important in understanding the mental health of refugees by the majority of my participants. One however, two of the participant held a different view. One felt it had no relevance and one felt that it did but must not be the focus when working with refugees. From the responses from my interviews and discussions, perhaps it is not surprising that the respondents construed culture differently. For instance respondent 4 who felt that focus ought to be on language amongst other things, perhaps did not share the view that language was considered by some as 'culture' such a respondent 5 did. As discussed in preceding chapters, the term culture has many meaning as it often socially construed. A broad definition of the term is adopted here from Mezzich et al. (2009: 384) who said ''Culture has been defined as a set of meanings, behavioural norms, values and practices used by members of a particular society, as they construct their unique view of the world. As such, culture deeply informs every aspect of life and health.'' However, medical literature takes a narrower view of the meaning of culture where focus has been mainly on "racial and ethnic disparities", omitting socioeconomic dimensions of cultural concerns (Rechel, 2011). Hence even though culture is as an important factor in the use of health services, caution must be exercised so as not to make sweeping generalisation about immigrants as culture is not the determinant, or even the most important part of identity (Rechel et al, 2011). Individuals possess many other identities, such as age, gender, education and professional background. In addition, culture is not uniform, fixed or immutable. This said, one cannot over-emphasise the importance for health service providers to have a good awareness of culture. This is because poor awareness and lack of competence amongst health professionals seriously affects the quality of service given and received. According to Rechel et al (2011), refugees and asylum-seekers may have a different understanding of how to express mental illness from those providing care. (ibid). In many part of the world, mental illness still carries a lot of stigma and some might see it as being attributed to the spirits, a sign of weakness, punishment of a bad deed done, defeat etc. (Hubbbard and Pearson, 2004). This may lead to stigmatisation for not being able to cope and

the loss of a person's cultural network (Vaage, 2014). What different cultures consider to be mental illness and their recognition of such disorder affect behaviour, and cognition in turn influence their willingness and desire to seek professional assistance for these problems (Leong, 2007, Ingleby, 2011). Hence cultural influence according to the cross-psychology framework, is a powerful tool in determining how refugees access and utilise services. Furthermore, cultural variations in the conceptualisation, expression, and recognition of what is normal or abnormal behaviour can serve as both a filter and a threshold for help seeking. Where cultures vary in the conceptualisation of what is perceived as abnormal, they also exhibit differences in the levels of psychological distress. This is also the case even when cultures agree on what is abnormal. In this instance, they may still exhibit differential thresholds for when to consult outsiders or professionals (ibid). Perhaps a cross-psychology approach as framework might capture some of these contentions and discourses of culture mental illness (Berry et al, 1997, Parker 2006, Leong and Lee, 2006). Cross cultural psychology (Berry et al, 1997) is influenced by psychological processes. He contends that human beings are ethnocentric. We all grow up in a specific culture(s) that influences us and the principles, standards and perspectives that we acquire from that culture is *the* way to view the world. Hence when psychological theories are constructed, the more the subject matter moves from biological and physiological phenomena and the more culture intrudes in shaping the theories we construct.

In emphasising on the cross cultural approach, a Cultural Adaptation Model (CAM) is presented by Leong & Lee (2006). According to this framework, the gaps in and limitations of the existing models of western counselling and psychotherapy can be abridged by incorporating culture-specific variables into an accommodated model to make it more relevant and useful for culturally diverse populations (Leong, 2007). This involves three stages: first is to identify cultural gaps or cultural blind spots in an existing theory that limit the cultural validity of the theory. The second step is to select current culturally specific concepts and models from cross-cultural and ethnic minority psychology with the view to fill in the cultural gaps and accommodate the theory to culturally diverse populations (2006). The third step is to test the culturally accommodated theory in order to determine if it has incremental validity above and beyond the culturally unaccommodated theory. This is demonstrated during the research. In a focus group interviews, the respondents' unit works with individuals

predominantly from the horn of Africa and several of the service users were reported by the respondents were reluctant to take prescribed anti-psychotic medication but would be willing to do so if they could take the medication alongside herbs or talking to a spiritual leader. As this team is experienced and interested in incorporating culture in the work, they are willing to allow the patient to use both approaches. They report to have had good outcomes. Here the cultural gaps were recognised i.e. the patients rejecting traditional medical approach of taking medication. Their views were accommodated to fit their cultural contexts and 'fill the cultural gaps from a culturally diverse group' and finally they had positive outcomes demonstrating 'incremental validity above and beyond the culturally unaccommodated theory'- theory based on western medicine and science and understating. One could perhaps also observe that in this unit, there is good 'match' or 'fit' between the professionals and service users which is important an important ingredient in ensuring good use and access of services (Ingleby, 2005 & 2011). This in essence refers to appropriate services for this group whereby service are matched to the service users' needs. From the responses of several of my respondents, there is a reluctance at Government level to provide specialised services for refugees as from the point of view of the policy makers, their needs should be provided for by the same mental health services as the rest of the population. This is in line with the social welfare model of the Nordic countries. However, there is a danger of further isolating this vulnerable group. To ignore the diversity of service users through the one size fit all is critiqued as being discriminatory as discrimination can also occur when different people with different needs are treated the same identically (Ingleby, 2011).

5.2 Mental Health Services in Norway for Immigrants and Refugees: Perceptions and Opinions

In the focus groups interview with Group A, a mental health team, the feeling was that there are gaps and inadequacies in the current mental health systems as there was no specialised group for immigrant groups in Norway. They reported that this concern had been highlighted to the Health Directorate, but these concerns have not been acknowledged as yet. When asked why they felt this was, the response was that this is it is difficult to say as there used to be a psycho-social Center for treatment for refugees in Oslo but that got closed down. They have tried to establish a new center with the same ethos but with no success. Further, the feeling

was that perhaps the government is not prioritising refugees. Yet the migrant community is growing rapidly in Norway and there is a need for such a center.

Participant 3, a mental health practitioner held a similar view and said that there was a center that used to receive refugees with psychiatric problems who found it difficult for them to communicate their problems with their general practitioners. However, the center closed. This was not necessarily negative but worries have arisen that refugees in particular are not getting the assistance they need.

When asked about the role of NAKMI the response was that NAKMI still had the responsibility to train and give information to the District Psychiatric services (DPS) and give them advice on the type of things they should be looking at when providing service for refugees. However they report this to be challenging as it was hard to maintain the knowledge in the DPS as employees do move on, hence there is always the need to build new competence. This affects the quality of service the respondent reported.

Other problem according to respondent 3 with the current services is that it up to the specific DPS to priorities refugees and not all do. This was said to be worrying especially compared with another Nordic country, Denmark where specialised services are provided for this group.

Respondent 4 a professional who worked with immigrants, expressed disappointment with the current services saying that

> *The government has disregarded the views and concerns of professionals that specialist services for refugees are needed. The Department of Health made that decision without talking to those of us who raised concerns or without referring to the research that had been done by other organisations calling for specialised services for refugees to be made*

Respondent 3 a mental health practitioner however made mention of one clinic in Stavanger called 'Transcultural clinic' who try to provide a specialised service for refugees. Respondent 4 felt that there was also a reluctance for certain professional in working with refugees.

> *The general feeling is that some people do not want to work with refugees especially traumatised refugees as the thinking is that they are too much trouble, they have too many problems and they have this as a policy. The arguments given are that there is lack of cultural knowledge, understanding etc.*

This affects service provision but according to them, the reality is that the exact situation and status in Norway is not known but and what exists are impressions about the services for refugees. "*What is clear though impression is that refugees do not receive adequate care and attention in Norway right now"*

This respondent went on to say that they were some improvements in the current mental care provision for immigrants and refugees in the sense more practitioners now in psychiatry come from ethnic minority backgrounds such as Iran, and the Balkan countries but only a few from African countries and not many from Asian countries. If there were more people from non-western backgrounds the respondent felt, more positive impact would be seen.

The same respondent also made reference to the use of interpreters in working with refugees. They felt that when one looked at the Government policy guidelines in treating refugees, the section making reference to cultural is very short and the main focus was on use of interpreters. This affects the way professionals work with refugees. The respondent felt

> *It does not need to be complicated but the Government seem reluctant because they say it would expensive, it will take a lot resources, and they would have nowhere to refer people. But I say there are a lot of psychologist looking for work. And it wouldn't take too much training. It is very difficult as I have been to the health authority and explained this many times. I don't know what they thinking.*

Respondent 3 felt that **"**good specialised service" can make a big difference for people who have been through hardship. According to this respondent:

> *Everything changes when you have been through torture. Nothing stays the same. For traumatised refugees, they find it difficult to relate to loved ones for example. So for me early intervention is important to help this group.*

Respondent 5 who worked with immigrant youths said that they did not know of any mental health centers for immigrants. There are projects and so on but the mainstream do to not cater of minorities. This respondent felt that the there was a need for the establishment of more specialised service. They gave an example of a service they had visited in Chicago for refugees.

> *Most of the workers at the center spoke at least 3 languages. When a refugee comes in the food is not strange, the smell is not strange. From the food they eat to the paintings*

on the wall, makes it easier for the person to feel more included. Newly arrivals in particular especially those with mental illness. This is needed in Norway.

Respondent 5 went on to say that the current services mental health services needed to be specialised or adapted and address issues such as **"**acculturation" when working with refugees.

> *Questions need to be asked about how living in Norway affects them as some refugees integrate in some areas and not in others. Others choose to assimilate. The acculturation process is different from person to person. This at times causes mental distress especially for those who learn the Norwegian language, change their names in order to fit into mainstream Norwegian Society yet society sees them as a second class persons. Their identity is constructed, reconstructed all the time. Identity is not stagnant it changes all the time. We adapt without even knowing it. It's only when we encounter others of different thinking that we realise how much we changed.*

Another respondent who works in an organisations working with immigrant health made reference to the problems that some refugees faced in accessing mental health care. They said

> *Some of the people cannot read so when their doctor sends them an appointment letter, they are unable to understand and do not show up. In some cases they get penalised for failing to show up and this means more cost. As many cannot afford it, they then stop going to the doctor altogether and their illness become worse.*

5.2.1 Findings on Mental Health Services for Immigrants and Refugees in Norway

The findings on the mental health services for immigrants and refugees are not adequate nor satisfactory according to my respondents. There were no specialised services in Norway that worked specifically with this group. The findings indicated that there is a need culturally adapted services to address their mental health needs. Based on literature and research this view is shared elsewhere in Europe.

Rechel et al (2011), in an European Union (EU) Report on Migration and Health in EU state that there continues to be an increasing ethnic diversity of populations in Europe which has

influenced and changed to a large extent the delivery of health care and the habits of health professionals. (Dauvrin and Laurent, 2014) add that professionals are obligated to adapt to specific demands by migrant patients in order to minimise linguistic or cultural barriers which can prevent these groups from accessing adequate care. To realise this objective, a broad approach of strategies is adopted including health policies, the use of interpreters and intercultural mediators, and the development of culturally-specific health services or ethnically sensitive health promotion campaigns. All these approaches concern the larger society on different levels such as the individual, institutional, and political levels which all interact in order to reduce the gap between migrant and non-migrant populations Although the organisation of health services and health systems do differ from one country to country, what seems to be a common denomination is that migrants and ethnic minorities still have lower levels of access to health promotion facilities and health prevention (ibid). In the Norwegian context, Norway was ahead of many countries with the development of services for refugees in the 1980s when integrated services were set up to accommodate arriving refugees in the form of psychosocial teams. This with the public health model of care provided advanced services that were meeting the needs of refugees. However, in the new millennium, this center was closed down through radical government reforms and refugees no longer had access to specialised clinical services. The reforms were a major setback for mental health services for refugees in Norway with great costs to service provision (Guribye and Overland, 2014). Whereas internationally there is evidence of a growth in the use of trauma-informed approaches in care services, this knowledge is not adopted much in the Nordic region including Norway. This is in spite of knowledge that evidences the importance of 'care and cultural and social institutions in resilience towards traumatic events. .' (ibid, 2014:7).

It is undeniable that Norway has also made efforts to meet these demands. However, based on this research and other literature presented herewith on Norway, there appears to be a feeling of apathy from professionals working with refugee populations who express concern and call for specialised mental health services that meet the specific needs of this vulnerable yet resilient group. From the interviews and focus group conducted as part of this project, all of the participants bar one felt that the current provisions in Norway for refugees and immigrants in general do not adequately provide for their mental health needs. The reasons given are varied including a perceived lack of commitment from policy makers and

practitioners alike, a perceived lack of resources, a lack of tailored and culturally sensitive services, disregards of human rights in regards to right to health, lack of professional competence in working with this group and the politicisation of the terms 'refugee, asylum seeker and immigrant in Norway. Sveaass, one of the pioneers of psychosocial services for refugees in Norway, questions the use of rehabilitation based on the medical model especially when working with victims of torture (as in the case of a large number of refugee). This medicalised model of rehabilitation has limitations where she argues that it is both misleading and politically wrong to approach political actions and abuse of power with the use of medical terminology (2014). Health care professionals in Norway have knowledge (Albaek et al, 2014) of what is regarded as good and health promoting care for refugees but it is argued that this knowledge is seldom used or implemented by the Norwegian professionals in the Norwegian asylum centers, institutions refugee and social services. Some of the poignant questions proposed for this phenomenon of services in Norway not being tailored to include the core principles of health promoting trauma informed care are that; it might perhaps paint an unflattering image of refugee service, or there is a lack of research in this area or the lack of commitment due to the believe that having specialised services have to be earned and not given out to non- Norwegians. Such services should perhaps be reserved for their own 'in-group.' Or could it be that this approach will involve a genuine recognition of the refugee. This recognition occurs 'when the individual is made visible to the extent that we are able to know the person' as opposed to mere cognition of another's existence. This makes the individual (refugee) invisible which then allows 'society to maintain a practice where strangers encounter different rules and regulations, rights, sympathies and expectations than those we apply to others in our group'' (ibid 2014: 139) These interesting explanations were in line with some of the responses from the respondents in this study where respondent 1 who worked with issues related to human rights of refugees said:

> *Everything in Norway is determined by cost all institutions clamouring for funding and that if the Norwegians don't spend on their own adults why would they spend on those who are not a part of the society i.e. refugee. Adding culturally expertise for mental health of refugees means extra costs*

This, one can imagine, will affect service provision especially mental health services.

5.3 Mental Health Care as a Human Right to Health: Perceptions and Opinions

During the interviews and discussions with the respondents the right to heath was not mentioned specifically. However, with further content analysis of the responses, the respondents made references to topics such issues of culture, employment (or lack of), discrimination, religion and access, (or lack of) to health care. All of these topics are covered by various Human Rights Instruments dealing with the right to health including mental health care. For example, the Universal Declaration of Human Rights gives everyone the right to a standard of living adequate for health and well-being, including medical care and necessary social services. The WHO Constitution 1946, and the International Covenant on Economic, Social and Cultural Rights (ICESCR) safeguard the right to the highest attainable standard of physical and mental health. In addition, the Declaration on the Rights of Disabled Persons which gives the right to the best available mental health care for all including dignity and respect regardless of disability.

One such response was from a health professional in one of the individual interviews who said:

> *My observation as a professional is that when people of ethnic backgrounds seek help for their addiction or for their mental distress, they cannot relate to the psychologist. This is because this setting is alien for immigrants or refugees. It is difficult to contact and communicate with them as the culture is alien*

This quotation makes reference to someone not getting access to adequate health care because of their culture.

Further, one health personnel in one of the one-to-one interviews said:

> *The general feeling is that some people do not want to work with refugees especially traumatised refugees as the thinking is that they are too much trouble, they have too many problems. And these professionals they have this as a policy. Argument is lack of cultural knowledge, understanding etc.*

This quote is an example of some refugees being denied access to health because they are seen as ‘too difficult’ or ‘too much trouble’’ based on their history and cultural difference.

Some participants though did refer specifically to legal frameworks such as respondent 1, who works with matters concerning the rights of refugees.

Respondent 1 felt that the right to heath as a legal framework is problematic for asylum seekers in Norway as their status is are often downgraded to humanitarian help giving them less legal protection. The respondent perception is that;

> *There is a political resistance to look at trauma or mental health as it means that the person may need long term help and hence be a burden on the state. Immigration case workers make errors and look at health only instead of right to protection hence the person's right to protection from persecution is overlooked. They see it as this person needs care downgrading their asylum claim. This means less protection in Norway.*

Also; *Everything in Norway is determined by cost with all institutions clamouring for funding and that if the Norwegians don't spend on their own adults why would they spend of those who are not a part the society i.e. refugee.*

In addition, respondent 1 felt that there was a lack of cultural expertise in the Directorate of Immigration (UDI) in working with refugees. This respondent felt that the current systems needs to be changes and make provision for psychological evaluation of all asylum applicants to address unaddressed mental health issues. Often the case is that an asylum seekers is evaluated by an UDI employee who is neither medical trained nor aware of the cultural contexts of the asylum seekers. This they felt had human rights implication. The respondent added

> *Adding culturally expertise for mental health of refugees means extra costs. UDI do not have their own anthropologist or psychologist. It is often up the lawyers to look for elsewhere for this. NGO such as NOAS help refugees. In Norway, very few refugees make it to the courts as cost is an issue.*

Respondent 7 a mental health personnel in another interview though felt that cost is not the issue in Norway and said:

Financial resources is not a reason from my point of view. In any society if a Government is prepared to give equitable health service and can provide for majority, why not the minority? That is a human right. Access to equitable health care is necessary to all. The right to health and health services includes all types of health but what kind of health care is there in Norway?

During one of the focus group discussions with a mental health team, it was felt that when their service used to be was a "specialist" service working with refugees but a government reform of services changed this. In the past the rights of refugees were seen as a priority and these rights were protected. However, their services now is required to work with all groups and not just refugee, the rights are no longer a priority. As there is now there is a call for refugees to be part of larger mental health system no specialised services are provided for them.

Participant 3 who works for an organisation fighting discrimination in Norway for minority groups such as refugees, said:

When we talk to organisations, they tell us they do not focus on the right to health as such. This is a problem as people with psychiatric problems do not have the same strong voice as other groups who get heard

Participant 3 also felt that in many of the cases, the refugees themselves were not fully aware of their legal entitlements to health. The recounted a story they had worked with saying;

The status of being a refugee is a special group making their experiences difficult. In one case, a refugee came to us for help because she had been raped and was severely traumatised because she had become pregnant as a result of the rape by those wanting to punish her for her husband's political affiliations. When she sought to have an abortion the doctor she saw asked what she would do if she was made to have the baby. She replied she would take care of it. She was refused abortion even though abortion is legal in Norway. It was her right to have this if she wanted. We had to refer her case formal and a ruling was eventually made to allow her the abortion. By then, she was well into the pregnancy and subjected to re-traumatisation. Her problem was made worse as

she was depressed, frail and did not have an interpreter. Her friend was interpreting for all. This in itself can be a problem.

Respondent 3 also highlight the issues of fighting discrimination and added;

Another problem is that it is a competitive environment when different groups fighting discrimination and they all are competing to be seen. Some of those people who have been discriminated against have often been waiting a long time to be heard and when they get the opportunity to speak to people with power, they do not want to lose their own focus. Indirectly the policy makers think why should we focus on refugees? We have the national level to consider. They are in the minority. Why priorities? I think we need to be diplomatic in our approach.

Respondent 7 who worked in an institution that deals with immigrant health said that the human rights to access to health was not a focus for refugees in Norway. Their perception was that;

Now services have been combined and as a result violence and trauma are seen as one thing and refugees as another. There was a fear that the human rights of refugees would be ignored as a result of combining services. And this is what happened. Refugees are no longer the focus.

In addition, this respondent expressed concerns for the rights of asylum seekers whose claims had failed and exhausted their rights to appeal and undocumented migrants. They felt that these groups of people now had limited rights in Norway including that of health care. They said:

Undocumented migrants and asylum seekers whose claim failed are having their rights being eroded. These asylum seekers are in limbo. Rights to health care is limited to emergency health cases only.

5.3.1 Findings on Mental Health Care as a Human Right to Health

The picture I had from my participants on whether mental health care is viewed as a human right to health was a mixed picture. Three of my participants made specific reference and saw

the link between mental health care and the right to health and felt that this right needed to be provided for in service provision. However the other respondents did not make specific reference to the right to health but discussed it indirectly. Hence for this group of participants, a clear link between the right to health and human rights, was absent. Based on some of the responses presented in the discussions, it would appear that this in some cases did affect the quality and access to mental health care. Perhaps if it is explicitly stated in policy documents or working practices, this might impact on service provision. Having said that, the finding on respondents failing to see the link between human right and mental health may not be unusual. Mann et al (1996) state that health and human rights have seldom been linked in an explicit manner. This is in spite of the importance of the intersection of health and human rights providing practical benefits to those engaged in health or human rights work and may also help reorient thinking about major global health challenges as well as contribute to broadening human rights thinking and practice (Mann et al, 1996). In the case of refugees, the first refugee mental health services of the modern era were initiated about 30 years ago and during this phase, human rights and medical concerns came together in giving strength to this movement. However, this link appears to have been lost and human rights and medical domains have become increasingly viewed as two opposite philosophical groups (Silove and Rees, 2010). This is despite the fact that the right to health for all are explicitly enshrined in various International as well as European Instruments such as in the WHO constitution and the International Covenant on Economic, Social and Cultural Rights (ICESCR) Article 12 also sets out "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health." In the case of the European Union, the Charter of Fundamental Rights sets out the right of everyone to access preventive health care and to benefit from medical treatment. The European Convention for the Protection of Human Rights and Fundamental Freedoms of the Council of Europe and the European Social Charter also guarantee the right to health. When one talks of a rights-based approach to mental care, emphasis is on integrating principles that include adhering to international treaties and conventions as well as promoting participatory development models. It is encouraging that Norway has ratified several international human rights conventions and treaties govern international standards providing access to appropriate mental health services some of which are; The Universal Declaration of Human Rights, which gives everyone the right to a standard of living adequate for health and well-being, including medical care and necessary social

services. The WHO Constitution 1946 and The International Covenant on Economic, Social and Cultural Rights, (ICESCR) which states that all individuals have the right to 'the highest attainable standard of physical and mental health (United Nations 1966). It also emphasises on the importance of making health care services accessible; meaning that facilities, and services must be physically accessible, economically accessible and also be accessible to everyone without discrimination. Information on health matters must also be accessible (that is, people have the right to seek, receive and impart information and ideas concerning health issues). Finally, the Committee stresses that health facilities must be acceptable and of good quality. In other words, health facilities should be sanitary, respect medical ethics and the right to confidentiality, be culturally appropriate and have medical personnel that are adequately skilled (WHO, 2007).

Norway has also ratified The Convention on the Rights of Persons with Disabilities, which puts emphasis on the importance of accessibility to health services for persons with both psychical and mental disabilities. The principles have important linkages to the rights addressed in the International Covenant on Civil, Economic Social and Political Rights (ICESCR) and the Declaration on the Rights of Disabled Persons which guarantees all individuals the right to the best available mental health care. It also protects individuals with mental illness and states that they like everyone else, should be treated with humanity and respect for the inherent dignity of the human person. ICESCR's framework is however not without its limitations and challenges. The framework is based on the principles availability, accessibility, acceptability and quality. On the issue of accessibility, the ESC Committee makes mention of four areas; non-discrimination, physical accessibility, economic accessibility and information accessibility. When one looks at for example the provision for non-discrimination, protection is given to all and no individual should be discriminated against on the basis of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status. This criteria however is critiqued on the basis that it does not make specific mention of certain vulnerable groups such as refugees or those suffering from mental ill health. This has been raised as an issue of concern by ESC Committee who highlight that this leads 'unjustifiable limitation to their ability to access health care services' because of their status (Tobin, 2012, Watters, 2010). Other problems of access can be down to language barriers which undermine both the accessibility of health

services for migrants and their quality. In addition, refugees are often unfamiliarity with their rights, and entitlements as well as the overall health system. This combined with gaps in health literacy, social exclusion, and direct and indirect discrimination can pose difficulties in accessing health care (Rechel et al, 2013). Access to health care are affected by additional challenges related to the process of migration, including health and socioeconomic status, self-perceived needs, health beliefs, health-seeking behaviour, language obstacles, differences in culture, trauma and newness (Rechel et al, 2011). Some of these difficulties were observed by the professionals I interviewed for this and during one of my interviews where one respondent felt that cultural boundaries were not the primary challenge for refugees but rather problems of language and the inability to afford a visit to their general practitioner.

Likewise the 'acceptability and quality' can also be problematic in interpretation and enforcement. The ESC Committee says that all health facilities must take regard of medical ethics and be culturally appropriate. For this to be affective services should incorporate the views of the medical profession and that of cultural groups that access health services. However, the ESC's formulations is ' too narrow if the health services made within a state are to be considered acceptable by those persons who provide such services and benefit from their delivery' (Tobin, 172:2010). Hence a failure in not providing health services that are not acceptable to those meant to benefit from these services will result in undermining a state's capacity to provide an effective enjoyment of the right to health (ibid).

IOM (2010) reports that refugees and asylum seekers have a low utilisation of mental and psychosocial due to several barriers relating to ethnicity, culture and health systems. Waters (2010) in a study conducted on mental health services for migrants and refugees in several European Countries, noted that the right to access mental health services for refugees and migrants were influenced political and legal implications. In some cases refugees could only access services through what he refers to as 'secondary level' care, through a 'professional gatekeeper' because of lack of knowledge. For example, in these instances access was gained through an intermediary such as a GP or others within the locality that the refugees lived. The lack of knowledge however according to this research is not only from the refugees about accessing the services but also from the specialist who may not be culturally competent to deal with the case. He cites the case of the UK where some GPs may feel that they do not

have the time nor the resources to treat a refugee and in some cases, they may an explicit decision not to treat refugees. This shows not even where there is a legal entitlement, access to services are either limited or absent. The phenomenon was present in other European countries (Rechel et al, 2011). From a right to health perspective, one could argue that the rights of the refugees affected are being disregarded raising concern. If however a rights based approach is perhaps adopted in cases such as this, where focus is on the *fundamental right to health* of refugees more concerted efforts could be made. Focus is often made high rates of mental illness when compared to the general population but to people from ethnic minority groups have a right to appropriate and effective services whether or not that they have increased vulnerability to mental illness. Hence there is a need for a *qualitative change* not just a *quantitative* increase in existing services (Ingleby, 2011).

5.4 The Integration of Immigrants into Norwegian Society: Perceptions and Opinions

In one of the focus groups interviews, (C), the issue of integration was discuss heatedly at great length by the respondents. The group consisted of individuals working in different public institution with refugees and immigrants in Norway. Amongst them was a mental health support worker, social worker and an adviser working for the state on integration and minority issues. All of them were from non-western countries. This group felt that it was difficult for immigrants from non-western countries to integrate into mainstream Norwegian society as many structural boundaries prevented them accessing health and employment. The group as a whole felt that individuals they worked with were discriminated based on differences in their background. The social worker in the group gave some examples his perception of the relationships between his Norwegian colleagues and some the African services users saying that they found it hard to relate due to differences in culture. He also spoke of services users finding difficulty in accessing the labour market even where they had the necessary qualification. This respondent felt that this impacted adversely on the individuals' mental health. Another member of the group who works with issues of integration, gave examples of the lengths some individuals went to try to 'fit in' such as changing their names to more Norwegian sounding names. This respondent's perception was that this affected individuals' sense of identity and self and at times led to them suffering depression.

In the one to one interviews, Respondent 6 appeared to share similar views with respondent 3 and 5 said that there needs to be more willingness from professional in Norway to look at alternative approaches:

> *Their truth might be different. They have different realities. Norwegians cannot ignore globalisation. In the future this will changes as the Norwegians will be backed into a corner when you look at the number of immigrants in Norway. Western diagnosis when compared to 100 years ago is very different. Now there are more categories of mental illness. Modern psychology is about ticking boxes. It is taken in the context of meaning. Where I work there 1000 people and many are from ethnic minority groups but we do not have any psychologist to cater for their needs.*

Immigrants says respondent 6 went on to say that immigrants in Norway should not be asked to choose either one or the other culture.

> *Those helping them tell them if you want to be helped you have to understand it 'our way' and if not they are not willing to integrate they will not get help. The way professionals are makes these immigrants less likely to vocalise their views for fear of not being helped or culture not being understood because the power balance very unequal.*

Respondent 5 a mental health professional in our one to one interview said that the integration policy for immigrants in Norway is lacking as the emphasis is more on assimilation as opposed to integration. To this effect he said:

> *In Norway there a 2 types of integration. One is assisted integration e.g. I got an apartment, pocket money, Norwegian course. What is lacking is making people independent to work not to depend on state. The second type is the Social dimension which is lacking. For example you have an immigrant living and working in Norway for 20 years yet does not know any Norwegian family. The acculturation process must also be looked at by mental health service providers and professionals. Questions need to be asked such as how is living in Norway affecting you? Have you adopted your culture to fit in? Some people integrate in some areas and not in other areas. Others choose to assimilate. The*

acculturation process is different from person to person. This at times causes mental distress especially for those who learn the language, change names, etc. yet society sees them as a second class person. Their identity is constructed and reconstructed all the time. Identity is not stagnant. It changes all the time. We adapt without even knowing it. It's only when we encounter others of different thinking that we realise how much we changed. For example when I went home after 15 years of living in Norway, I was chastised by siblings for the manner in which I spoke to my parents as I was more direct, open etc. This was wrong in my culture. I had changed as part of my acculturation process.

This respondent felt that the psychologist need to let patient lead and be more interested in the person and be tolerant. The respondent felt that individuals from the west countries also go to other countries with different cultures too:

Question need to be asked such as; how does this affect you as a person on a psychological level. This should be part of their professional curiosity. Look, human beings will never stop moving or migrating. Mental health facilities everywhere will be forced to adapt and become more tolerant. There will come a time when we will find western people with mental health problems in China, India etc. Hence everyone must adapt

5.4.1 Findings of Integrations of immigrants into Norwegian Society

Valenta and Burna (2010), say that categories used for reflecting and measuring the achieved level of integration within society's structures both by individuals and groups are used in literature to conceptualise the integration processes. They illustrate this from Durkheim's (1933) classical sociological position where the concepts of mechanical and organic solidarity were used to understand the relationship between divisions of labour, social bonds, and the maintenance of a functional society. Valenta and Bruna (2010) however add that even where theories of general integration processes still generate valuable insights, it was in fact through a series of refugee and immigration studies that the concept of integration gained theoretical and analytical momentum.

The general perception from the focus group (C) that constituted of individuals from non-Western backgrounds, working with immigrants, was that immigrants found it hard to integrate into Norwegian society and the expectation was that they assimilate or compromise on their culture to fit into Norwegian society. In focus group C interviews with the health and social work participants, it was interesting to observe the dominance of issues relating to integration in Norway as their primary focus. This was an interesting development as it raised some key questions such as; did their ethnicity influence how they saw the issues? Were they influenced by their personal experiences of having lived in Norway for more than 20 years each? Were they biased? Did the lack of focus on mental health reflect their cultural background where mental health is seen as taboo? These questions show that this is an area needs to pursued further.

The WHO emphasizes the importance of actively promoting social integration among and expanding the social network of persons with mental health problems in order to enhance their wellbeing (WHO 2005). Yet poor social continues to be challenge for many countries including Norway as seen in numerous researches on adults carried out in Norway. Dalgard et al (2006) to compare the level of psychosocial distress between Norwegian born and immigrants, (Dalgard et 2007) to investigate the relationship between social integration and psychological distress (Hauff and Vaglum, 1993,1995,1997) looking a mental health status during and after settlement. (Granerud & Severinsson 2006). Integration between individuals with mental health problems and other groups of people can counteract segregation in the community

Albaek et al (2014) opine that Norwegian society often fails to see refugees as individuals and refer to them based primarily on their group identity expected to assimilate to become as Norwegian as possible and abandon 'alien' religious practices in favour of Norwegian codes of conduct. Hence if this is how society views refugees, it will inevitably affect the type of mental health services given to this group. Similar observations are made elsewhere by Ingleby (2011) who opines that as mental health services have been developed to tackle illness as experienced by people from the west, the services provided may not be appropriate for those from other cultures and if nothing is done to address and adapt services that 'fit', there is a danger of 'institutional discrimination.' If attention is drawn to the lack of appropriate services, and nothing is done, it then becomes 'active discrimination'. This he

continues is unfortunately a common occurrence in a large number of mainstream health services in the west.

Bosworth and Guild (2008) view that cultural and social differences are routinely being presented as a cause for concern, to be homogenised through assimilation, integration or citizenship with the establishment of both internal and external barriers to create decisive differences foreigners and citizens.

In the Norwegian context, it was only in the 1990s that further development was carried out on its integration policy. This focused on economic integration and anti-discrimination. This was undertaken through two key policies; the Governmental proposal on refugee policy and its proposal on immigration and multicultural Norway. These two key policies are critiqued for their coercive nature which impacted on immigrants and refugees (Valenta and Burna, 2010). One illustration is that it is mandatory for all newly arrived refugees to take part in the Government's introductory programme meaning that their freedom of choice is limited. The Introductory Programme makes it compulsory for all municipalities which have received refugees have to set up introductory programmes. It also makes it compulsory for all newly arrived refugees to attend the full-time introduction programme which lasts for up to two years (IMDi 2008a: 37). The Norwegian Directorate of Integration and Diversity (IMDI) say that they provide tools for integration such the free Introductory Programme which offers courses in Norwegian Language and Norwegian life and society courses. (www.imdi.no). Norway is seen (Valenta and Bunar, 2010) to be ahead of their Europeans and other counterparts in developing extensive state sponsored integration programmes and housing and employment assistance are the two major foundations of refugee integration policies. Norway like other Scandinavian countries is also often applauded for their liberalism in refugee admission policy including tolerant attitudes and appreciation of cultural diversity at the political level when dealing with the effects of forced migration. Even though Norway's integration policy is based on the principle of a strong welfare state, which provides extensive resettlement and integration assistance to refugees yet, refugee integration policies have not succeeded in equalizing the initial inequalities between refugees and the rest of the population. (Fangen et al 2010).

At the heart of the government's Integration Policy is the mandatory introductory programme as stated. This is critiqued by Fangen et al (2010) who say the compulsory nature of the

introductory programme is in itself problematic from a political liberalism perspective and that integration policies often have the tendency to focus on issues related to economic integration. Refugees who fail to take part in the programme are penalized through withdrawal of cash benefit and failure to attend the programme also has negative consequences for refugees' judicial status in Norway (Valenta and Bunar, 2010). This strict application according to one of my respondents who works in providing legal support for refugees is often problematic especially in the cases where a woman become pregnant or has a baby. In these instances, they lose their place and face financial problems which may lead to further isolation, defeating the purpose of the Programme which is to 'integrate' the refugee.

The participants in this thesis expressed concern about discrimination refugees and other immigrants face in finding employment. It is their perception that lack of employment opportunities affect the integration of refugees into mainstream Norwegian society. They gave examples of individuals having to prove that their university education is at the same level as Norwegians or having to re-train to prove their competency. Studies carried out in Norway and elsewhere appear to support that poor employment opportunities has an impact on poor mental health. For instance, study carried out on young immigrants living in Sweden report high levels of mental health problems that was likely to be connected with detrimental employment. In the addition, in the Norwegian context, studies have also supported the theory that poor integration has an effect on and mental health. In a study on immigration, social integration and mental health in Norway (Dalgard and Tapa, 2004) immigrants from non-western backgrounds were found to exhibit a higher level of psychological distress when compared to those from western countries. Some of the reason that contributed to this were poor social integration, unemployment and poor social support and income. Good social integration was shown to have a positive effect through access to employment and income.

Further still, findings from an Oslo study in 2006 also showed an increased prevalence of psychological distress among immigrants from Africa, Asia, East-Europe when compared to those from Western countries including Norway. Dalgard and Tapa (2007) in explaining possible reasons the high prevalence of mental distress in this group is that in spite of the country's public policy focusing on "integration" rather than "assimilation", Norwegian society is not a pluralistic society but assimilationist with pronounced pressure on immigrants to adopt Norwegian language, culture and customs. This in the short term is likely to create stress and mental health problems among those who are least able to acculturate (ibid).

Norway's' purported focus on assimilation appear to be supported by. Valenta and Burna, (2010) who say that Norway did not officially have any integration policies before 1970 nor did it have any defined ambitions on how to develop good ethnic relations. This is said to still be ideologically reflected with the focus being on the assimilation approach, whereby the assumption is that immigrants adopt the cultural traits of the majority as they are already granted equality in basic rights. Fangen (2006) carried out a study on the Somali community in Norway and reports that the perception they have of Norway is that of being discriminated against and humiliated in the country based on their ethnicity and differences from both individuals and the authorities in Norway. Fangen (2010), contends that refugees in many regards start at the bottom rung of the new social hierarchy where they come to realise that their competence is not recognised and are instead their entire being is reduce to being only to one thing.- a refugee. This diminishment she opines, is at the core of the concept of humiliation. In explaining the word 'humiliation' from that study terms such as feeling stigmatized; reduced in size, feeling belittled, put down, or humbled; being found deficient, i.e., feeling degraded, dishonoured, or devalued; being attacked were used. This 'othering' is perhaps not unique to Norway as it is reflected by many other Western countries many other immigrant groups struggle with the 'Otherness' attributed to their ethnic group by institutions such as the media, politicians as well as the majority population in general. (ibid) These attitudes can have grave repercussions for individuals as seen in Fangen's study in Norway where it was reported that as a result of feeling 'humiliated', many became withdrawn and distanced themselves from everything resulting in a kind of mental disease (2006). This is supported by Klein (1991), who opines that the experience of being humiliation and the fear of being humiliation are inferred in different types of mental illnesses.

These observations are very poignant in context of this thesis given the perceptions of my respondents about the difficulties surrounding the integration of the refugees and immigrants they work with.

Conclusion

This chapter presented the findings of this research by presenting the perceptions and opinions of the participants on the relevance of culture in mental health, the suitability of mental health services in Norway for immigrants and refugees from non-western backgrounds, the link between the right to health and human rights as well as the impact of

poor integration on mental health. Based on these findings, culture is seen as being relevant in the understanding and contextualisation of expressing mental distress in the group studied. The participants are generally of the view that the cultural contexts of refugees need to considered and incorporated into mental health services in Norway for a more meaningful engagement and access. Another finding is that the current mental health services are seen to be inadequate in addressing the mental health challenges face by refugees. This is as a result of the closure of the Psychosocial Center in Oslo that catered for refugees with trauma. The participants of this study believe specialist mental health services provide a good resources for those refugees needing psychological input as such as center provided professionals that are trained and have experience of culturally adapted services. The findings on the link between the right to health and human rights was not explicitly made by all the participants however this was inferred from the references made to international frameworks determining and governing the right to health such as such ICESCR and the right to access adequate health care including mental health care. Poor integration into Norwegian society was perceived to be as a result of discrimination, lesser access to employment were also seen by the participants to be a contributory factor to poor mental amongst immigrants and refugee populations in Norway.

CHAPTER SIX

RECOMMENDATIONS AND CONCLUSION

6.1

Recommendations

Migration is a conundrum for many clinicians because not all migrants go through the same experiences and or settle in similar social contexts. The process of migration, cultural and social adjustment also have an important impact on role in the mental health of these individual. Hence it is very vital that those working with immigrants mental health consider a range of these factors into consideration when assessing and planning intervention strategies aimed at the individual their her social and cultural context This is even more important in the case of refugees who have the propensity of developing mental illness due to past their past experiences. (Bhurga and Jones, 2001). These challenged are cumulated with the growing evidence that immigrants but especially asylum seekers and refugees undergo discourses of criminalisation in both government policy and legislation, the media and the general community. Furthermore, there is also a tendency to lump all immigrants into category effectively erasing any differences thy might have. This can have serious consequences for vulnerable group such as refugees as such perceptions have policy implications on how refugees are treated (Bosworth and Guild, 2008).

Services provided to refugees in western health care settings is often the same as those offered to the indigenous population (Bhurga et al, 2010) as seen in Norway. Yet studies have shown that expressions of psychological distress do vary in cultures. Recommendations arising from this research are that there is a compelling argument to provide specialised mental health services for refugees, one that is appropriate to their cultural contexts and their understanding of how their illness affects them. Accessibility, not just physical accessibility should be a core component of such services based on the legal entitlement to use health services in order for them to realise their right to health. This would include the developed of culturally adopted services with the use of qualified interpreters as well as psychosocial support and sensitising services providers on the right to health of refugees. Cross cultural psychology approach may perhaps be one way of ensuring the incorporation of cultural differences in treatment plans. As refugees at times present with a multitude of difficulties and challenges in addition to

mental health problems, another option could be the use of a comprehensive psychosocial assessment approach (Bhurga et al, 2010) which would incorporate the practical challenges of employment, housing social integration, language and so on to create a holistic response.

The WHO Action Plan (2013) incorporated human resource development as one of its targets. This emphasised on the need for nation states to develop the knowledge and skills of their general and specialised health worker so as to deliver evidence-based, culturally appropriate and human rights-oriented mental health and social care services. The problems of using interpreters was discussed on numerous occasion during this research and general dissatisfaction was observed. This lack of qualified translators particularly for new refugees is an important barrier to health care. There is a need to use of interpreters for obtaining the medical history and also explaining the cultural context of a patient's symptoms to service providers.

Migrants are not a homogeneous group and nether is their experience of migration. Hence it is key for those working with them and policy makers be educated on their needs as well as the meaningful contributions they make to society. As Norway comes more and more multicultural, cultural tolerance and understanding is imperative in order for refugees to have a successful integration into the larger community. More active and visual efforts should be made to raise awareness and protect the rights to these individuals. Not all refugees are traumatised or suffer from mental illness. For those who do need the service, early intervention has been highlighted by those working with them as a key determinant in long term stability. Clinicians in particular could gain a lot from structured training as part of both their education and clinical training in order to capture some of the issues faced by refugees.

The terms 'refugee' and 'asylum seeker' are highly politicised in Norway and with this comes the danger of scapegoating and marginalising them. Asylum seekers often spend a protracted amount of time in asylum centers awaiting a decision on their claim. This can have detrimental impact on their mental well-being as seen in Denmark where an association was found between the period of stay and referrals for mental disorder. (Hallas et al. 2007). The proposal that all asylum seekers be assessed by a qualified health professional is an appealing approach as it would ensure early intervention, treatment and rehabilitation should the need arise.

The rights based approach to health and development is also recommended that would focus on empowerment and human rights of refugees. There are varying degrees of inequality for migrant groups to access health services in the west leading to violations in their human rights (Domenig, 2004). This is compounded by the lack of awareness of their rights and entitlements. Perhaps these can incorporated in introductory programmes to better inform them and orientate them on the health systems in Norway with the view of enhancing access.

6.1 CONCLUSION

This thesis adopted a broad approach to look at the impact of migration n the mental health of refugees and migrants. The purposes of this thesis was to look at the Mental Health Services in Norway to determine whether the current service provisions are appropriate for individuals from non-Western backgrounds with special focus on refugees. It also investigated whether tths issue of culture was viewed as an important ingredient in service provision and whether the cultural contexts of refugees was incorporated in service provision delivery. An additional purpose of the research investigate whether the right to health was seen as a human right in service provision for refugees. One of the main finding is that no specialised mental health services existed in Norway at the time of doing the research. Those respondents interviewed as part of this thesis felt that there is a need to have separate specialised services particularly for refugees. Culture was seen as an important part of understanding the mental health of refugees as it affects whether services are appropriate or not. The relationship between the right to health and the human right of refugees was explicitly made by some of the respondents whereas some did not make implicitly reference but made strong reference to it. The respondents in this study believe that the integration of refugees was an important consideration in service provision.

It used to be the view in mental health that service users are expected to adapt themselves to the services offered to them as medical professionals were regarded as being the experts and best determinants of what is best for service users. There has however been an international shift now, away from the ‘top down’ approach to be replaced with the bottoms up approach where service users are given a voice and agency to determine what best works for themselves. This is evident in the governing principles of international and humanitarian aid and development work. Today however, a response to local values and cultures based on

consultation and implementation with active participation to recipients is favoured for good outcomes (Ingleby, 2011).

A rights based approach to health was also studied in order to gain understanding of the right to health and how it is linked to mental health service provision. The respondents were asked about their perceptions on the right to health as human right was investigated as a part of this thesis. Most of my respondents did not explicitly see the two to be connected but made reference to several international conventions and laws governing the right to health. Global Mental Health (2007), provides evidence that mental health is an essential component of health that cannot be separated. This is because problems associated with poor mental goes well beyond their effect on mental health. Poor mental is a risk or a consequences of other health problems and they directly have an effect on the progress toward achievement of many of the Millennium Development Goals. Mental disorders everywhere is often associated with poverty, marginalisation, and social disadvantage. Evidence points to the importance of emphasising on the developing systems for the treatment of mental disorders. Yet globally challenges are continue to be faced in developing mental health systems and protection of the human rights for individuals enduring poor mental health. Issue of integration of refugees and immigrants into Norwegian society was also explored and a connection was established between poor integration and mental health. Modern community mental health care regards social integration as an essential ingredient for improving mental health however, on the contrary, reports suggest that efforts to socially integrate people who suffer from mental health problems have not been as successful. (Granerud and Severinsson, 2006). The findings from this thesis support the view that specialised culturally adapted services are needed in Norway and could perhaps address some of the problems associated with integration and mental illness. Perhaps the use of a cross cultural psychology approach might influence the refugee and immigrant experiences of alienation as their cultural contexts would be better captured. Another argument is that could have a positive effect on their integration into Norwegian society.

In the age of globalisation individuals will continue to migrate whether as a result of pull or push factors. They bring with them different values, cultures, religions and other identities as part of the migratory process. It is important that these differences are appreciate or even embraced in in order to develop more tolerant societies. For refugees and other vulnerable groups, it is important that their cultural contexts are understood in providing accessible

health care provision especially where cultural expressions of illness varies from place to place. It is important that mental health service provisions incorporate their differences in norms to allow them opportunity to develop and realise their aspirations. The right to health is a fundamental human right and failure to incorporate cultural contexts into mental health care provision raises human rights concerns.

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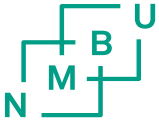

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