A Report on

SUICIDES IN TURKISH AND KURDISH COMMUNITIES

Developing appropriate approaches for recognising signs and prevention

Produced by DERMAN for the well-being of the Kurdish and Turkish communities

Report from the Derman Mental Health Conference
Held at Queensbridge Centre, 30 Holly Street, London E8 3XW

World Mental Health Day 2006
10th October 2006

SUICIDES IN TURKISH AND KURDISH COMMUNITIES

Developing appropriate approaches for recognising signs and prevention

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Introduction

To mark World Mental Health Day 2006, Derman has called this conference to address the growing concern about suicide among the Turkish and Kurdish communities, and especially suicide among men. Professionals from a range of disciplines applied their knowledge and experience to begin to find a way forward in improving the recognition of the signs in those at risk of suicide, and ways of improving our understanding of how to prevent suicide.

The key message from this conference is that suicide is *preventable*. Improved training in risk assessment, the development of better cultural competence among those working with the Turkish and Kurdish communities, better collaboration among practitioners, and the imaginative use of resources, are all crucial factors in bringing about prevention of suicide within these communities.

This report presents the talks and discussions that took place at the convenience, and the summary of recommendations that resulted. There were many calls for further action, research, events and collaboration to find solutions. We hope that this report will stimulate all these things.

Derman would like to extend warm thanks to

- Jules Pipe, the Mayor of Hackney for his opening address

- Professor Dora Kohen, Dr Begum Maitra, Dr Tricia Bohn, Ron Wallace, Brian Innis, Magella Nwimo and Cemile Kalkan for the their presentations and for leading the discussions.

- Kumru Baser for chairing the panel discussion

- And City & Hackney Primary Care Trust (tPCT) for funding this conference

And to everyone who attended and participated to make this a lively, challenging, and fruitful conference.

Algin Saydar
Executive Director, Derman

Conference Programme

9:00-9:30   Registration

9:30-9:45   Opening speech by the Mayor of Hackney

9:45-10:10   Keynote Speaker- Professor Dora Kohen

10:10-10:20   Research on "Epidemiology of Deliberate Self Harm"
                   Cemile Kalkan (BSc Psychol)

10:20-10:30 Research on Attitudes to Suicide and Derman Mental Health
                   Services-Nursel Tas

10:30-12:30 Panel Discussion – chaired by Kumru Baser from the BBC

12:30-12:40 Plenary

12:40:13:30 Lunch and Networking

Contributors

Jules Pipe, the Mayor of Hackney

Professor Dora Kohen MD FRCPsych, Consultant Psychiatrist and Professor of Women and Mental Health Lancashire Postgraduate School of Medicine

Cemile Kalkan (BSc Psychol)

Nursel Tas, Derman Mental Health Team Leader

Panel :
- Professor Dora Kohen (Consultant Psychiatrist),
- Dr Begum Maitra (Consultant Psychiatrist),
- Dr Tricia Bohn (GP from Barton House HC),
- Ron Wallace (Head of Mental Health Commissioning / City & Hackney tPCT)
- Brian Innis (Acting Deputy Head of Mental Health / LB Hackney)
- Magella Nwimo (Primary Care Psychiatric Nurse)
- Selma Altun (Derman Advocacy Team Leader)

Panel Chair: Kumru Baser, BBC Journalist and Broadcaster

Mayor's opening address

Each Year the World Federation for Mental Health has a World Mental Health Day to focus attention on and promote good mental health. This year the focus is on suicide. Mental illness is often hidden away & often subject of scare stories in the media, though it can affect one in four people. Suicide causes more deaths worldwide than murder or war. It is a tragedy that affects all communities irrespective of background. It is heavily stigmatised in the media. It is over-represented in Hackney compared to other boroughs, especially in the Turkish and Kurdish communities, and especially among men.

The basic aim of World Mental Health Day is to assist the worldwide effort in improving public awareness and to reducing stigma that continue to be barriers to the early diagnosis, intervention and treatment of people at risk of suicide. World Mental Health Day aims to promote responsible media coverage of the issue, and aims to promote service and policy changes within government in order to address the global impact that suicide has.

873 000 people die by suicide each year
For every death there are another 20 attempts made

In the last 45 years suicide rates have increased by 60%, and 90 % of people who die of suicide have a treatable mental illness or substance abuse disorder.

1 in 4 patients visiting a health service have at least one mental, neurological or behavioural disorder[1]. It is worrying for all that most are not diagnosed or treated.

The Turkish and Kurdish communities constitute the largest refugee and asylum-seeker communities in Hackney, and Turkish is the second most spoken language in Hackney after English. It is sadly recognised that there is a high level of psychological distress in this community and that suicide rates are higher, especially among men. In line with the statistics given, individuals who do commit suicide more often than not have a history of mental health problems.

People in the Turkish and Kurdish communities have often endured war torture, rape and other traumas. In fleeing oppression and coming to England, some of the horrors are not left behind, & many people go on to suffer mental health problems. Living in an alien culture among people who sometimes have an ambivalent view towards asylum seekers brings social exclusion, and great stress and distress. A disproportionate number suffer from severe poverty, and homelessness and overcrowding are very big issues in the community. Many have left families behind and this separation can lead to permanent family breakdown, with the consequent stress that this brings.

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[1] Source: WHO

Language barriers prevent the most vulnerable from accessing appropriate services, which is why the Council will continue to work very closely with Derman & other organisations that are committed to improving access. Early interventions are one of the strategies that City and Hackney Primary Care Trust (CHPCT) wants to achieve, aiming to make services more responsive to these particular communities. The Council is to fund, through community services, a number of specific Turkish Kurdish mental health support services – for example particular posts in the locality Mental Health Teams. The Council has established a Turkish Kurdish Mental Health Development Worker post based at, along with a drop in service, at Lee house[2]. In response to community feedback a simplified referral system has been established, enabling easier and *earlier* access to services, contributing to prevention of development of more severe conditions that require hospital treatment rather than community support.

The Mayor stated that it was his expectation that the early intervention work would be continued and developed, especially in the light of the Section 31 agreement with the Mental Health Trust and as mental health features more prominently in the social inclusion agenda.

> "Politicians have a duty to remind the general public that suicide is a mental health issue that deserves sympathy, understanding and compassion, and a determination to reduce the stigma that surrounds it. We can only achieve that through education and outreach, and the professional services working with the communities." Mayor of Hackney

The Mayor thanked Derman and all those present who "work tirelessly in raising the awareness of mental health issues".

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[2] See page...ref

Professor Dora Kohen MD FRCPsych

Introduction
Suicide is an index of deprivation: Suicide and deliberate self harm shows that there is poverty, personal problems, and psychological and mental health problems. These are a great public health issue. To understand the extent of the problem it you need to understand the epidemiology – i.e. the frequency and the distribution of the problem in world, in UK and in refugee populations.

Epidemiology of Suicide and Deliberate Self Harm
Presented by Cemile G Kalkan BSc Psychol

Suicide

- Suicide is the 10th leading cause of death worldwide.(WHO, Geneva,1996)
- In year 2000 approximately 1,000,000 people died of suicide worldwide (WHO, Global Burden of Disease, 2004)
- This is 16 deaths per 100,000 and one death every 40 seconds.(Anderson et al, Leading causes of death 2001)
- In the last 45 years suicide rates have increased 60% worldwide (WHO, Geneva 1996, 2001)
- Suicide is the 8th cause of death in the US accounting for 1% of all deaths (Krug et al, WHO, 2002)
- 30-35,000 people/year commit suicide in US.
- UK has one of the highest suicide rates in Europe.
- Each year around 5000 people take their lives in the UK (National Confidential Inquiry on Suicide, 2002)
- The Samaritans estimate that in the UK there is a suicide every 82 minutes.

Suicide and young people

- Each day 2 people under age 24 commit suicide
- At least 26 children kill themselves each year because of bullying at school.
- In 1999, the government reported that the number of young males who commit suicide each year in the UK doubled over the last 10 years.
- Males are 4 times more likely to die from suicide than females (NCIPC, 2005)
- Suicide rates are high in old age
- 40% of suicide victims are over 60. (National Mental health Association Fact Sheet, 2005)
- At age 75 the rate is three times higher than average.
- At age 80 it is 6 times higher than average.

Number of suicide by age in the UK (WHO, 2002)

Age	5-14	15-25	25-35	35-44	45-54	54-65	65-74	75	all
total	8	394	879	978	745	505	293	274	4066

Suicide attempts and Self Harm

- There are around an estimated of 100,000 – 170,000 general hospital admissions for self harm in the UK each year (Hawton et al, 1994, DoH 2002, NICE 2004, Gunnell et al, 2005)
- 19,000 of these involve teenagers (Females) (Depression Alliance, 2000)
- Women report attempted suicide 3 time more than men (Krug et al 2002)
- The ratio of attempts to completed suicide is 10 to 1.
- 30-40% of people who commit suicide have made previous attempts.
- The risk of completed suicide is 100 times greater than average in the first year after attempt

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Suicide and Suicidal Behaviour in Asylum Seekers

- In asylum seekers in Denmark: Period 2001-2003; the number of suicide attempts in 2001 was 3.4 times higher than in Danish population (Staehr, Munk-Andersen 2006).
- Psycho-social deprivation increases the repetition of self harm in Uganda (Kinyanda et al, 2005)
- Indigenous suicide in Australia, New Zealand , Canada is increased in comparison to white population (Procter, 2005, Fernandez, 2002)
- Asylum seekers are a high risk group:(Tamil refugees , 1998, Silove 2002)
- Bosnian refugees high risk for self harm(Mollica et al, 1999, Momartin et al, 2003)

Looking at the research findings, it is very clear that suicide is a major public health problem and is increasing in the world. The numbers are staggering: 1m people who lost their lives were designated as suicides, but there are at least 0.5m classified as 'open verdict' although these may well be actual suicides.

What is important about the problem is that it is *preventable[3].* We can make changes in our society and in our lives that will prevent so many people dying from suicide.

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[3] WHO-Euro Multi-centre Study, Crisis, 2006, NIMHE 2006

Recognising the signs

Suicide is strongly associated with 'social fragmentation'[4]. Social fragmentation is different to deprivation, and is a stronger predictor of suicide.

> **Characteristics of Social Fragmentation:**
>
> - **Isolation from meaningful relationships**
> - **Single parenthood**
> - **Unemployment**
> - **Lack of stability in all parameters of life (moves, refugee status, unable to plan for the future, unpredictability)**
> - **Lack of control over personal situations**
> - **High rate of turnover of neighbours, friends, support systems**
> - **Alcohol and Drug abuse**

Where there is social fragmentation the person experiences a lack of control – for example, the choice about where to live. With refugees this control has been completely lost. A high turnover of support systems brings an instability that cannot be controlled. Drug and alcohol abuse are significant factors in increasing social fragmentation, leading to isolation and often to suicide.

We can further understand the pressures that lead to a person committing suicide through a method called "Psychosocial Autopsy"[5]. Psychosocial autopsy means looking at every aspect of the social & psychological life of the person who committed suicide to try to understand the risks, and the issues as they happened. What the research using this method found was that when a person commits suicide there are three main issues present.

- Clustering of psycho-social problems

- Mental health problems

- Psychological problems

"These are recognisable problems, tangible problems, and problems that we as mental health services & voluntary organisations should be able to recognise and to address before it becomes a crisis". Dora Kohen

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[4] Ecological study of fragmentation, poverty and suicide, Whitley et al BMJ, 1999

[5] Reference? Ask Dr K

Demographics - who commits suicide?

Research shows that the following are characteristic of people who have committed suicide:

- **More males than females**
- **High rates of contact with mental health services**
- **Older age group**
- **Disturbed family background**
- **Psychiatric history in the family**
- **History of suicide in the family**
- **Death of a parent**
- **Sexual, physical, emotional abuse**

Some researchers say that up to 30% of those committing suicide have had contact with Mental Health services in the year prior to their death. These are people suffering, trying to help themselves, but do not get the support they need.

Those people who attempt, but not complete, suicide tend to show the following characteristics:

- **More females than males**
- **Younger age group**
- **Disturbed family background**
- **Unemployment**
- **Homelessness**
- **Lack of structure to their day or life**
- **Refugee status**
- **Criminal justice involvement**
- **Drug and Alcohol Abuse**

Many of these characteristics are identical with the indicators for social fragmentation. In addition to these, Refugee Status has now been included by the WHO as a factor linked to suicide attempts. Also, 6% of all suicides were people from Ethnic Minorities, and this is a higher proportion than in the general population as a whole.

Some studies say that 50% of all suicide attempts are linked to drug and alcohol abuse, and as such this is one of the most important factors in determining the risk. Cultural factors also play a very strong role and can lead to unwillingness to seek help: it is a stigma, leading to thoughts of shame or denial by the person that they are ill or under stress. This will block the vulnerable person from seeking help.

Psychosocial Factors.

The Key Psychosocial Factors are:

- Previous suicide attempts

- Easy access to lethal methods (guns, large amounts of paracetamol) (Gunnell, 2000)

- Modelling (others are doing it)

- A perception that attempts are an acceptable **'Cry for Help'!**

Psychosocial factors include access to the methods of attempting self-harm or suicide. One of the most famous examples is the change in practice in the dispensing of Paracetamol[6]. This drug used to be sold in packs of 100. This would be a lethal dose, and a person in crisis can kill themselves with this amount. The limit on the amount sold in single packs is now down to 12 in supermarket, or 16 in a pharmacy. Deaths have decreased (but not the attempts). This shows that practical interventions such as these will discourage people from obtaining lethal methods. The same would be true of access to weapons – self harm or suicide by weapon will not occur if there are no weapons, or they are very difficult to obtain.

Modelling is an important psychosocial factor. The knowledge that other people are doing it increases the perception that suicide is a possible course of action. Modelling contributes to the perception of suicide attempts as being acceptable as a cry for help.

Psychiatric & Psychological Issues

These issues include

> - **Psychiatric illness**
> - **Physical / medical conditions: Disability, chronic suffering, irreversible conditions, dependence 'being a burden'** *(EPSIS/WHO-EURO)*
> - **Divorced, widowed, elderly**
> - **Lack of structure to the day**
> - **History of self harm/ previous attempts**
> - **Bereavement in childhood**
> - **Personality traits; impulsive aggressive, labile mood**

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[6] Gunnell, 2000)

Psychiatric components
The psychiatric components include

- **Depression, chronic, untreated**
- **Schizophrenia**
- **Alcohol dependence**
- **Drug addiction (prescribed and non-prescribed)**
- **Personality disorders (borderline and anti-social)**
- **Organic disorders (epilepsy, brain injury, mild dementia)**

The most important psychiatric conditions that we need to address are:

Depression   10% of patients with depression will attempt suicide

Schizophrenia   10-15% of all patients will kill themselves.

Alcohol & Drugs   This is a MAJOR social problem – 50% of all attempts are made under the influence of alcohol or drugs.

In Hospital and post-discharge
12% of all suicides were In Patients – i.e. in hospital when they committed suicide. 23% of all patients that died of suicide died within 3 months of discharge[7]. These figures demonstrate a lack of risk assessment and a lack of understanding of the problems that are there.

Key Findings:

- 12% of all suicides were psychiatric inpatients

- 23% of patients died within 3 months of discharge from hospital

- 6% of all suicide were from ethnic minority background[8]

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[7] Confidential Inquiry into Suicide & Self Harm 2001 & 2004
[8] ibid

Psychological and psychiatric components especially relevant to migrants and refugees

- Trauma exposure (PTSD, 1999)

- Post-migration stressors (Silove et al, 1998)

- Post-Traumatic Stress Disorder

- Impact of Torture (Comprehensive psychiatry 2002)

- Loss of identity

What do we need to do?
The National Suicide Prevention Strategy aims to reduce suicide by   25% within the next 5 years[9].

Preventative Measures

First: It is important to take a *broad approach* to prevention, and not to 'pigeon hole' the issue and try to find a single solution. This means including as many different categories as possible, and as many different agencies as possible because the problem is very large and very diverse. Agencies range from psychiatric inpatients to voluntary organisation dealing with day-to-day care of the person who may have the problem.

Second: Promote awareness that this public health issue is *preventable.* Public education is of paramount importance.

Organisational and social issue forums are important in order to stress that this is a *psychosocial* issue and that therefore social factors will significantly inform intervention – the case study about change in dispensing practice of paracetamol is a clear example. These forums will enable the social issues to be addressed as widely as possible.

Training and sharing information. To recognise the problem we have to train people, and find effective ways of sharing this information. There are several successful interventions (the paracetamol example is one of the best known, and there are others). This is good practice that can be built on. These need to be promoted

We need safer clinical care, Safer Services – This means that services will be local, tiered, there will be statutory & voluntary organisations, there will be different teams dealing with the different needs of the 'at risk' population.

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[9] NIMHE National Suicide Prevention Strategy for England 2002
http://www.nimhe.csip.org.uk/our-work/-suicide-prevention.html

These would include crisis resolution, assertive outreach, and early intervention teams.

Risk assessment and management.
Concerning the high incidence of in-patient suicide, and post-discharge, risk assessment and management are key issues. In order to improve services, professionals need to find out what they can about the patient. Staff need to be trained in risk assessment and risk management. There are things one can do to learn about the person, to follow up and make some kind of classification of risk. It is important to train staff in the *management* of risk: intensive level of care if necessary, prompt access to other services, especially if the person is non-compliant and refuses to see a psychologist or psychiatrist, social worker, or not take medication. It is very important to have a multi-disciplinary approach.

It requires exercise of judgement on the part of staff, but training will increase awareness and the ability to spot problems earlier. Physical health & medical health facilities are very important. Recovery and rehabilitation facilities, for example, will be important elements in any prevention programme, since alcohol & drugs are such a major influencing factor.

Protective Measures
In the management of mental illness compliance with prescribed treatment is essential for the patient's recovery and well being. Non-compliance is a risk factor, and ensuring compliance will be a protective measure against the risk of a suicide or self-harm.

Protective factors include:
- **Family and community support**
- **ACCT (Assessment, Care in Custody and Teamwork)[10]**

These factors have been identified as being important in decreasing the number of suicides. Family support and community support cannot be 'prescribed' by health professionals, but there is the opportunity to encourage this support through other means, such as through the aid of community organisations.

Specific Skills training is an important factor in enabling people to deal with difficulties and helps to prevent a person reaching crisis point as a result of these difficulties. Specific skills include

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- **Skills in problem solving, conflict resolution and non-violent handling of disputes**
- **Culture, gender sensitive approach**
- **De-stigmatised approach**
- **An understanding of Social Inclusion**
- **Improved reporting of suicidal behaviour.**

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[10] ACCT is the prison service looking at addressing suicide

Introducing culture & gender sensitive approaches is very important in assessing the risk of the person, especially as women and men follow very different trajectories with suicide and deliberate self harm.

Social inclusion is part of the social fragmentation, inclusion being the positive protector from social fragmentations.

Reporting of suicidal behaviour – we know that only a third of incidents of self harm is reported into the hospital. Reporting is vital, because we know that those people who repeat attempts at suicide have a very high probability of completing the suicide.

> **"Suicide is preventable, and deliberate self-harm is preventable, and we will need to work together, all agencies together, to reduce the numbers"** *Professor Dora Kohen*

Nursel Tas

Suicide is a massive public health problem. From research findings worldwide there is a great recognition of the effects of mental illness and of depression in particular.

In the UK 50% of all suicides occur in current or former diagnosed psychiatric patients. Biological, psychological, social and cultural factors all have a significant impact on the risk of suicide. However mental illness stands out as the greatest risk factor for suicide.

Research suggests that refugees are at high risk of suffering a wide range of health problems, both physical or mental, and are unlikely to access mainstream health services.

As a result of immigration people move from one cultural setting to another, and research shows that immigration process is an extremely stressful process and can lead to 'cultural shock' and mental illness. The process of adaptation to a new culture is full of anxiety, frustration, confusion and depression. Trying to adapt to new patterns of life and leaving behind old values is very challenging. Unresolved issues of displacement may result in the symptoms of mental stress, psychological problems and illness. Symptoms can include post-traumatic stress, psychosomatic illness, as well as relationship problems, isolation and psychotic illness. In some cases these symptoms may result in self-harming activities or suicide attempts.

At Derman we help over 400 Turkish and Kurdish people with mental health problems each year. In the financial year 2005-06:

Number of referrals received	**482**
Number of sessions provided	**2787**

Of these 482 clients

- **384 were Female**   **(79.67%)**

- **98   were Male**   **(20.33%)**

This proportion may reflect the fact that it still more difficult for men to seek help than women.

Most of our clients are asylum seekers, refugees or immigrants, and second generation immigrants. These groups experience a high degree of psychological distress. Among the main problems presented by people who are referred to Derman's mental health service are:

Depression	**Psychosomatic symptoms**
Post Traumatic Stress Disorder	**Bereavement**
Relationship problems	

Almost half of all clients are suffering depression (**45.83%),** and almost a quarter **(24.24%)** had attempted suicide or have suicidal thoughts.

Suicide rates are substantially higher in the Turkish Kurdish communities and among men in particular. Four men from our communities committed suicide, last year.

Before this conference Derman sent out a questionnaire to 200 health professionals, and also conducted a brief study among the male population. The aim of the study was to obtain first hand information about suicide among Turkish and Kurdish people in Hackney. While there was a low return rate from the questionnaires (12.5% were returned), these responses can serve as at least a beginning in the understanding of the local picture from the health professionals experience.

Highlights from the survey:

- There was a high incidence of overdose as a method

- 66% had used a mental health service

- Of the 387 patients reporting suicidal thought, 66 (17%). actually attempted suicide.

On demographic information – there is no census category for Turkish or Kurdish, so it is difficult to clearly establish the actual number of Turkish Kurdish people in the UK. However the researcher suggests that there are at least 24 000 refugees from these communities in Hackney alone.

Key Findings:

- **Attempt rate is much higher among women, but more men lose their lives as a result of attempts.**

- **Cultural norms in these communities can inhibit the expression of emotions, e.g. sadness, fear, disappointment or regret is seen as being less acceptable for men than women. This is the same for Turkish and Kurdish societies.**

- **Immigration and immigration-related issues also make life difficult.**

The second part of the study involved a questionnaire and semi-structured interview. The participants were Turkish Kurdish males recruited randomly in Hackney - questionnaires were filled out by people that the researchers met in the community, in cafes, community centres, and in social clubs in the borough.

In total, 63 people completed the questionnaire. Two Kurdish refugees, one who had attempted suicide, were interviewed in depth in their homes using a semi structured interview methodology. The findings of these interviews are presented as case studies.

Respondents were asked about what they thought the main causes of suicide were. These answers reflect their own perceptions:

Main Causes

- **34.9 % hopelessness**

- **22.2 % family problems**

- **74.6 % not being able to go back to their own countries.**

33.3 % of participants thought about committing suicide at least once in their lives.

9.5 % declared that they are still thinking about committing suicide.

42 % personally knew people who committed or attempted to commit suicide (relative, neighbour or friends)

A striking finding was that 42 respondents reported that they know or have known people who have attempted or committed suicide. This finding suggests that 'modelling' is a significant risk factor in this community.

87.3 % of the participants believe that Turkish and Kurdish males do not openly share their emotions or talk about their psychological problems with others.

The main reasons for this
- **38%** embarrassment
- **31%** finding it difficult to express emotions
- **24%** it is not a 'male' thing to express emotions

What could be effective for preventing suicide?
52% Better psychological services
23% Improved economical circumstances
12% Having full refugee status

Case studies:

Both interviewees described traumatic journeys and difficulties in being able to disclose these stories for fear of undesirable consequences with their asylum applications. The journeys, coupled with the inability to recount these have contributed to their unstable psychological health.

Client X said:

"Our journey was very difficult; we escaped from death many times. They (smugglers) put us in a freight container and we were poisoned because of the chemicals. My wife and daughter fainted….they were dying in front of me. There were about 15-20 people in the container – most of them fainted. When we came here we had to stay in hospital for about a week…this journey affected us very badly. I still think about it, I can say that the journey mentally tormented me."

Client Y said:

"It was a very difficult journey; firstly we went to Bosnia-Herzegovina and stayed there for a short time. Then we moved to other places illegally by walking in the mountains, sometimes with a group of 50 people and sometimes only 10 people. During this journey at times we had nothing to eat and it was freezing cold...I find it very difficult to forget the negative effect of this journey on my mental health. When I arrived in France I was relieved but throughout the journey I was hoping to be caught and sent back to Turkey because I was so scared of losing my life... We came face to face with death so many times, like freezing...I lost a lot of weight and after arriving in France I had constant nightmares about the journey..."

While men in the Turkish Kurdish community may traditionally be thought of as being less emotionally expressive or open than women, in this interview they were asked about emotional expression and both talked about their feelings quite openly. This may have due to the encouragement they have received through the psychological treatment they have both received. Their conditions improved significantly during the period of treatment.

One of the interviewees had attempted suicide in 2003 and was hospitalised for a brief period. This person now has regular contact with psychiatrist and attends weekly group therapy sessions where he can speak in his own language. The other seriously though about it twice, but was able to manage these feelings, by calling on support from friends and professionals, and did not attempt suicide. The two people had different responses to their experiences – one attempted suicide, one got help:

"…I was going to kill myself, I decided to do it but at the last minute I called my friend and he helped me to overcome these feelings… Again the second time I decided to commit suicide I called my doctor. He wanted to see me immediately and I saw him for about an hour and my social worker and my GP helped me a lot. Knowing that there were people to support me during these difficult times helped me greatly…"

"…We had some bad times in this country…we lived in a room which was 3 metres long and 3 metres wide, without a toilet or a bathroom. We were four people in this tiny room. I used to fight with my wife everyday and started to harm my children. We were shouting at each other all the time and at the end it was unbearable for me and I attempted suicide…"

Conclusion

This brief study gives us a glimpse of how serious a mental health problem suicide is among Turkish and Kurdish male refugees and highlights the importance of understanding the cultural beliefs of people in order to provide better treatment/services. The findings also indicate where the focus for attention should be for protective and preventative measures to reduce the risk of suicide and deliberate self harm.

The training of health and mental health professionals about inter-cultural issues that may affect the mental health of immigrant communities is vital. The provision of advocacy within the health and mental health services may reduce distress caused by lack of English and information about mental health services. There is need to expand bilingual counselling and psychotherapy services and the provision of long term therapy. Also, specialist community based services accessible seven days a week with multi-disciplinary staff, are required to deal with the mental health problems in the Kurdish and Turkish communities.

"Our hope is that the brief research we have conducted will lead to a more in-depth research project into suicide attempts in Turkish Kurdish communities..

"It is well worth remembering that nearly half of the participants in this research stated that they knew someone who committed or attempted to commit suicide."

Nursel Tas

Panel Discussion

Recognising and assessing need

What are the issues from the GP point of view?

The instability of people's lives, different language and culture makes care very complex. A key issue is building confidence and trust. There is a natural reservation about how safe people feel. There is a fear of revealing their story, as the research case study revealed. In the worst cases, some Turkish and Kurdish clients do not want to use Turkish and Kurdish services for fear of being known, especially where domestic violence is present.

Risk Assessment and Cultural Understanding

Language and cultural understanding are key issues. Most people in these communities do not speak English, and most GPs do not have interpreters or Advocates. As a result family members are relied on too much for interpreting. This can present a serious obstacle, as the patient can be inhibited or discouraged from being honest and open about their story or the problem they need to discuss. Using family interpreters, or doing an assessment in the company of family members can be inhibiting (e.g. parents may be inhibited about talking very personally if they are with their children).

For Kurdish and Turkish people, problems are told in *stories*. The person will describe their issue in an indirect way, not in the direct terms that the GP or health professional would be expecting. Bi-lingual and culturally aware Advocates are trained to listen for the signs, and to pick up the signals.

> "One client used to say she was hearing a voice saying "go and jump off London Bridge". She was not telling me she was going to go to London Bridge and jump from there, but there is a very important message in that one sentence. Of all the many bridges in London, why did she say London Bridge? Because, whatever is going on, she is away from home for a long time, and she is feeling guilty, being away from home, leaving parents behind, leaving her culture behind, being away from everything. This guilt for refugees and asylum seekers is a very important thing – makes us live in hell in this world."
>
> *Selma Altun, Derman*

The client here needed counselling, long term. But under another diagnosis, may have been deemed suicidal and a crisis intervention made. Advocates are skilled and trained to pick up these nuances from the language and the culture that interpreters would miss. Many places do not use advocates who would be able to understand these issues.

Dimensions of a Risk Assessment
There are four main levels of Risk Assessment of the individual

- Has the person a psychiatric problem? - if the person has come to a psychiatrist, the presence of mental illness needs to be determined. And if so, are the symptoms treatable?
- Personal history and personal life – as important as the psychiatric background is what is happening in personal life that may be affecting mental health.
- Social life – finances, employment, interpersonal difficulties, social influences– including economic, structure of the day, social interactions. All these are important influences of the risk
- Psychological – identifying the psychological factors.

There is the issue of stigma associated with mental illness – the person does not want to talk because they do not want to be seen as having a mental health problem. Cultural issues, especially for men are a big influence, as indicated by the research findings. Men don't cry, it is not as acceptable for a man to express feelings in this way as it is for a woman. Added to this can also be a suspicion of the person who is offering the help – a lack of trust in a professional health worker can be a serious obstacle.

Risk assessment is not an exact science, but it does require some specific skills, and those who conduct it must be fully trained. Even then – it is not perfect, and risks will not always be identified. Perhaps it should be accepted that it will not provide total protection.

Risk Assessment in GP surgeries
One panel member described her experience of carrying out in-depth risk assessments in GP surgeries. These are often 1.5 hour assessments; the advantage is that the time given for the assessment allows the real story to emerge. It allows the assessor to listen to the person ''in the round' and includes examining the influence of the family (this helps to pick up on 'modelling' – if there is evidence of attempts or suicidal thoughts among family members). The result is a detailed report up to 12 pages long.

In conducting these assessments it is very important to understand how to ask the right questions, using probing and open ended questioning. It is very important to have the time and to use trained assessors.

There is research from the British Medical Journal (BMJ) into the kinds of probing questions that have been shown to be effective. Examples include:

"Is there anyone in the family you are afraid of?"
"Have you at any time thought that life is not worth living?"

This in-depth method of assessment is very thorough, but very intensive on time and resources.

Resources and priorities concerning Risk assessment

The panel identified the following as priority areas

- Need to improve training for health professionals

- Increase (where possible) the number of professionals

- Improve communication between professionals

- Ensure that the Locality Teams are properly equipped

Context and 'Medicalising' suffering

The Panel raised the issue of developing the understanding of what constitutes *well being*, and particularly *mental well being in specific communities*. It is important that risk is assessed in context – what constitutes well-being, mental health for that individual within their community? How do we support advocates? There are many risk assessment tools that are used in other disciplinary teams and areas that could be learned from.

In terms of entry into mainstream adult mental health services, we need to be able to ask: What is mental health? What is well being?

The panel asked: Is there a danger of " medicalising" human suffering? Human suffering does not necessarily need to be brought to mental health services. It is important to recognise where the problem is a psychiatric one, and where the social, personal, and psychological issues become the key issues. It is here that community services and social services are essential parts of the whole picture in the prevention of suicide.

The threshold of entry into adult mental health services is high. Medical services for those with serious mental health issues are expensive and the issues of cost and resources need to be recognised. A large proportion of the NHS budget goes towards supporting people with high dependency needs, in particular to forensic mental health – those in secure/semi-secure units. 20% of budget goes on this forensic mental health. Longer term there has to be scope for diverting some of this, as long as the fundamental issues are dealt with. About 20% of the Mental Health budget goes on the treatment of about 80 people.

Budgets have to be redirected according to need. In Hackney spending has increased by 10% per year over the last 10 years. The Mental Health Trust has had to make cuts to support other parts of the London Health service. As a consequence, some developments that were planned have not taken place, including mainstreaming Black and Minority Ethnic (BME) counselling for example (including part of Derman's work).

It has not been possible to appoint the four Community Development workers that the government sees as critical to communication between mental health professionals and ethnic minority community[11] . London Health economy is under pressure, there just won't be any more money.

City and Hackney Primary Care Trust (PCT) spends more than any other on mental health (but not enough) Statutory services are not going to be the full answer, we need a flexible solution:

- Funding as flexibly as possible - flexible investment

- Much more about enabling communities to address their own issues

- The PCT policy takes the "medicalising" approach seriously - a lot of what we're talking about are ordinary human problems, rather than medical problems requiring a medical response

Mainstream services have to become more culturally competent

Early Intervention and Community Services

Could work on Early Intervention be more emphasized, before the person gets into a crisis situation? I.e. given the pressure on resources at 'above the threshold' what needs to improve 'below the threshold'. Here we are looking at primary care and community services.

> **"For the NHS and Local Government , in terms of addressing equalities, equal opportunities employment is difficult. In practice, getting targeted recruitment in the NHS is not easy. But we have to encourage people from communities to join the NHS. If you're a Londoner, do as Londoners do – join the NHS".**
>
> *Ron Wallace City & Hackney PCT*

Like the NHS, Hackney Council also has to prioritise spending. The Council has to prioritise, informed by the need, and current priorities are directing resources towards 'meaningful daytime activities' – including employment, education and training, and looking at ways to ensure that people access these better.

Lee House, funded through Hackney Council, has run a pilot project to encourage more people from the Turkish and Kurdish communities to access mental health services, and is currently evaluating the effectiveness of the services that have been piloted.

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[11]For implementation of Community Development Workers in London boroughs see:
http://www.londondevelopmentcentre.org/page.php?s=1&p=2812

Cultural Competence

The panel considered the issue of cultural competence - what does it mean for mainstream services to become culturally competent? A key issue is training of existing mainstream staff to increase awareness, understanding of cultural and gender context and the ability to undertake risk assessment based on this knowledge. A summary of the key issues concerning cultural competency:

- **Language barrier**
- **Stigma**
- **Trust**
- **Cultural and gender issues**

However there is a dilemma – for those diagnosed with depression, behavioural problems or personality disorder the only possibility is short term cognitive therapy. People with these conditions need longer-term care, as evidenced by the pressure on Derman bilingual counselling services. It was perceived that a 'huge number of people fall between professional services'. And that there is a gap between primary care, secondary care & community care that still needs to be addressed.

Summary:

- Community mental health is not simply the problem for the community – the *system* should be **competent.**

- Assessment is key to early intervention – these needs to be competent, done by trained practitioners and in depth.

- Availability of in depth assessment is constrained by resources – imaginative responses are needed for early identification that could lead to referral for in depth assessment.

- Culturally appropriate day-care services need to be supported.

- Communication between rehabilitation and statutory services needs to be improved.

Floor Discussion

Follow-up after treatment

Follow-up is extremely important, as the high incidence of post-discharge suicide indicates. Both follow up action based on risk assessment, and post discharge 'community care'. Follow up can include activities such as relaxation- this is a simple but effective service that can help reduce anxiety. Follow up by GPS, especially if there has been indication of domestic violence.

Encouragement and making better use of existing services

- **Encouraging users**
  There are services that are available to people in the community, but are not well used. How do we encourage the use of the full range of services that are available? We need to educate people, and especially parents about what exists, how to go about using services and facilities.

  We need to encourage Kurdish and Turkish clients to use services that do exist. Language is a big issue, but so also is integration. There is a lack of integration and this can lead to insularity, and possibly to further isolation. How can we encourage people to become interested in better integration with the host community? We must encourage people to make the effort to integrate.

  Improving the perceptions of mental health services, and complementary services could help to encourage people to make better use of existing services. Work is needed to make using such services more acceptable, and reduce the stigma attached to being a service user.

- **Encouraging professionals**
  Cultural competency training is essential, so that BME issues are fully integrated into training, and are not an 'add-on'.

  Need to improve the focus on using existing professionals better.

Developing Community Services

Could there be more use of group support methods, e.g. the support group for women run by Derman that allows in depth discussion of issues (e.g. medicine?).

There is a Turkish and Kurdish mental health working group that has been running for 2 years now. Key issues identified by the group include:
Intergenerational conflicts
Poor understanding of mental health within the community

Concerning resources, creative thinking and learning is needed both on the part of community organisations and statutory health and social care providers. A large proportion of resources are invested in forensic mental health services for, mainly for BME, and African Caribbean users in particular. Until this is reduced, there won't be resources for other preventative work for the other communities.

In the NHS, there needs to be monitoring on recruitment from BME communities, and the creation of access arrangements for employment, especially in mental health services. The difficulty is that mental health services are stuck in 'firefighting'. 80% of the workload professionals are dealing with is schizophrenia, and conditions such as anxiety depression etc could be done via GPs commissioning rather than hospital based services.

Improving the management of high cost patients, especially those with long term conditions, is increasingly seen as an important strategy for improving health outcomes and controlling healthcare expenditure and is a key element of current NHS policy.

There are clearly tensions that need to be resolved.

There could be the potential for increasing investment in psychological services through GP commissioning.

Finding Solutions through Collaboration

There was the recognition that resources are finite, but that imagination and collaboration will be required to improve and to establish what the priorities are that we need to focus on.

There was a call from many participants to come together in some way to resolve issues and find solutions. Time is a pressure for everyone, but time must be made available to work out new ways forward.

Summary of recommendations

1. There needs to be an improvement in the training of workers in risk assessment. To build and maintain trust, risk assessments must be safe and confidential, and workers should be fully trained in risk assessment. Stress should be placed on understanding the problem, and on finding methods where people can have time, without inhibition, to open up.

2. There should be more focus on targeting and encouraging people from the community to come forward to train as professionals.

3. More can be done in training for frontline/mainstream workers to become culturally competent. More can be done to train people specifically in the cultural background of this specific community.

4. Statutory services will not provide the full answer, and so collaborative and imaginative approaches will be increasingly necessary.

5. There is a clear need to improve co-operation and collaboration. There needs to be more collaboration with community services post-discharge. Agencies must come together to find solutions and to bring these issues to the commissioning process.

6. There is need to expand bilingual counselling and psychotherapy services and the provision of long term therapy.

7. There is the need for an increase in meaningful daytime activities for this community. Some practical suggestions included setting a walking group (physical exercise) and a Turkish-speaking employment service.

8. The provision of advocacy within the health and mental health services may reduce distress caused by lack of English and information about mental health services. Translation services are inadequate and need to be improved, especially for people with complex needs.

9. Further research is needed, in particular on the needs of men in Turkish and Kurdish communities.

APPENDICES

Turkish, Kurdish Population in the UK   Appendix A

In recent history Turkey received a substantial amount of refugees from Bosnia, Kosovo and Iraq. Although, Turkey is a country which receives asylum seekers and immigrants, particularly from its neighbouring countries, a substantial amount of Turkish people and people from ethnic minorities leave the country for religious, economic, ideological and ethnic reasons. For example, in Germany, 8.9 % of the general population are non-Germans with people from Turkey comprising 26.6 % of the group (Lay, Lauber, Rossler)[12].

According to a 2001 census in the UK, 92.1% of the population are white and the remaining 7.9% people belonged to other ethnic minorities. In Great Britain the number of people who came from other non-white ethnic groups grew by 53 per cent between 1991and 2001, from 3.0 million in 1991 to 4.6 million in 2001. (www.statistics.gov.uk).

Since there was no census category for Turkish and Kurdish people in the 1991 and 2001 census it is very difficult to establish accurate statistics for the number of Turkish and Kurdish people in the UK. However, Mugerwa (1997)[13] estimated that there were 24,000 refugees from those communities in Hackney alone. Today it is estimated that the Kurdish and Turkish population in the UK is around 100,000.

There are three main Turkish-speaking communities in the UK, and the most recent group to arrive are people from the Kurdish community, the majority of who have come from Turkey. Kurdish people come from Turkey, Iraq, Syria and Iran, and the majority of Kurdish refugees and asylum seekers live in the boroughs of Hackney, Haringey, Enfield, Barnet and Waltham Forest.

Turkish Cypriots have been in the UK the longest; as the first immigrants came to England between 1930 and 1950. After this first wave of immigration a second group of settlers came between 1950 and 1970, after direct result of the political events in Cyprus. Many of the Turkish Cypriots worked in restaurants and textile factories in the UK. Turkish people from the mainland have been coming since 1971, after the Army coup in Turkey. During 1980's there was another military coup in Turkey and, as a result of political reasons a large number of people left Turkey. Turkish and Turkish-Cypriots reside mostly in Newington Green, Haringey, Hackney, Edmonton and Enfield. There are a large number of Turkish and Kurdish enterprises in these areas such as food shops, restaurants and cafés.

Mahir Guden, Derman Research Assistant

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[12] Lay, B. Lauber, C. & Rossler, W. (2005). Are Immigrants at a Disadvantage in Psychiatric In-patient Care. *Acta Psychiatrica Scandinavica,* 111: 358-366.

[13] Mugerwa, F. (1997). *Refugees in Hackney: A Study of Health and Welfare*. London: ELCHA-LIZ Programme.

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http://www.unhcr.org/cgi-bin/texis/vtx/basics

www.statistics.gov.uk

http://www.guardian.co.uk/race/story/0,,1660467,00.html

Some Useful Links   **Appendix C**

National Suicide Prevention Strategy for England:
http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/Mental
Health/MentalHealthArticle/fs/en?CONTENT_ID=4002199&chk=TR19FI

Centre for Suicide Prevention – links to the National Confidential Inquiry into
suicide and homicide by people with mental illness:
http://www.medicine.manchester.ac.uk/suicideprevention/

Suicide Prevention Training – including risk assessment, risk and crisis
management, crisis prevention:
http://www.medicine.manchester.ac.uk/storm/training/

Care Services Improvement Partnership (CSIP) National Website. Links to
new Suicide Prevention Toolkit
http://www.csip.org.uk/resources/publications/public-health-and-well-
being.html?keywords=Suicide%20prevention

National Institute for Mental Health in England (NIMMHE). Links to Prevention
strategies, early intervention, anti-stigma, mental health in BME communities:
http://www.nimhe.csip.org.uk/our-work/-suicide-prevention.html

National Institute for Health and Clinical Excellence (NICE) – Youth Suicide
evidence briefing:
http://www.nice.org.uk/page.aspx?o=503368

PAPYRUS - Voluntary organisation dedicated to the prevention of Youth
Suicide
http://www.papyrus-uk.org/

The East London and The City Mental Health NHS Trust website
http://www.elcmht.nhs.uk/aboutus/index.htm

Suicide Prevention – the Maytree approach, published by City Parochial
Foundation:
http://www.cityparochial.org.uk/cpf/publications/the_maytree_approach_suicid
e_prevention.html

Applied Suicide Intervention Skills Training – description & listing of contacts.
http://www.livingworks.net/AS.php

Paper by Derek Summerfield, Honorary Senior Lecturer, Department of
Psychiatry, St George's Hospital Medical School, in the Psychiatric Bulletin on
Asylum seekers and mental health services – issues concerning suicide
vulnerability and cultural competence in diagnosis and treatment
http://pb.rcpsych.org/cgi/content/full/25/5/161

World Mental Health Day
http://www.wfmh.com/wmhday/about.html

Appendix D

Comments and Feedback from Participants

There seemed to be many comments like "if only there were agencies providing this…" and whispers from the other end of the room – "but there are!" I' like to see an updated, comprehensive list of what services are available, how to refer etc. Otherwise an interesting conference, thank you

Thank you for bringing professionals and others together to highlight the issues within the community and with the services. There is a lot to be done still by the Government and local agencies, even though they think the services given are more than enough. I'm proud of Derman and their contribution to the community. Please keep up the good work.

Would like to see:
- Presenters explaining a little more about their history/experience
- More information on culturally specific interventions that could be used
- Asking/more involvement from the audience

Much more information of the cultural style of Kurdish and Turkish clients – the vast majority of information was true of any BME group which is a shame, since cultural competency must include specific information on a specific culture. Only two groups were given that related to Turkish people, and no specific mention of Kurdish people – culture, history, religion, and persecution. Better title should have been improving services in Hackney – that would better describe the conference. I work in Enfield.

I would like to have heard more about the Turkish and Kurdish Culture in relation to understanding and dealing with suicide and self harm. In our service a large number of young Kurdish girls take overdoses – I would like to try to understand why, so then we can know how best to help. More in-depth information specific to this community rather than general statistics on suicide.

Would have been nice to see some service users, to establish the access issue more clearly, and hear their views directly.

Would have been interesting to have less statistics and more personal stories or information about the cultural experiences and factors that the professionals encounter in this field.

A break was needed before the panel discussion. Questions in the panel discussion could have been better.

It could be better. It didn't give any chance for the rest to participate. There is no solution or proper conclusion. Didn't address the issues properly.

1. The panel discussion could have been more effective if each contributor had been given 5 minutes to state a view before questions and discussions
2. The discussion strayed off the <u>vital</u> issue of <u>suicide</u> too often.
3. <u>Well done</u> for organising the conference!

Thank you for concentrating on suicides and related issues in our community. I hope there will be more meetings like this.

I hope you continue to provide a regular event to develop debate, informing and finding solutions. Excellent introduction by Dora Kohen. Thank you.

In future meetings it would be good to have focus groups to discuss issues in primary care, counselling, CAMHS and have wider Council representation, e.g. housing, welfare to work.

Derman is doing excellent work

Well done Derman.

It has been a very well-organised conference. To hear the whole problem at once was good – thanks for that.

Conference Evaluation Sheet   **Appendix E**
Summary of Responses

1. Did our conference meet your expectations regarding raising issues on suicide in T/K communities?

| a lot	To some extent	not much	not at all
3	17	1	0

2. Has the conference enabled you to think about how you might respond to these issues in your work/practice?

a lot	To some extent	not much	not at all
2	16	3	0

3. Has the conference enabled you to link up with other people or agencies who share you concerns?

a lot	To some extent	not much	not at all
5	9	5	0

Quality Rating - one(low) to five (high)
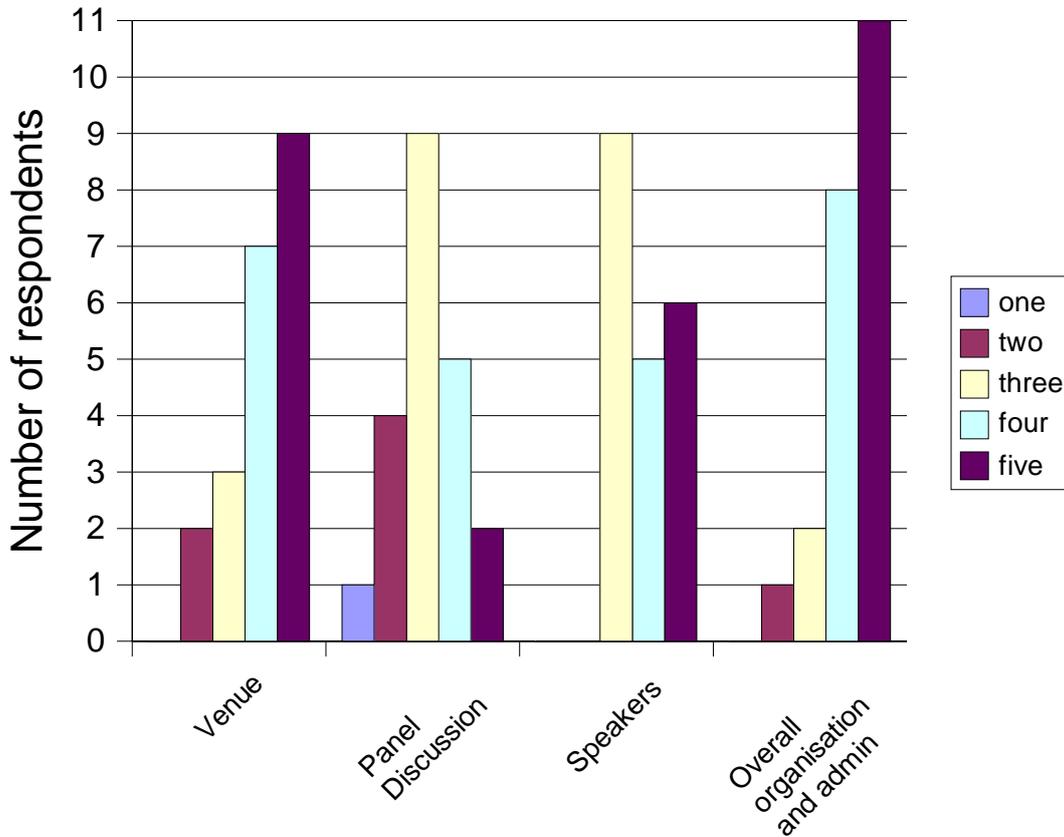
Appendix F

Attendance List

(Names in italics were unable to attend)

	Name	Organisation	Role
1	Algin Saydar	Derman	Director
2	Ali Kemal Sahan	Derman	Advocate
3	*Akgul Baylav*	*Hackney Community College*	*Equality Diversity Support*
4	Anousha Khan	CFCS Lower Clapton	Trainee Clinical Psychologist
5	Amanda Cheeseman	Homerton Hospital	Mental Health Nurse
6	Ayla Karalar	The NIA Project	Senior Refugee Worker
7	Aynur Karapinar	CHPCT	Health Advocate
8	Aysel Kirmizikan	City & Hackney Mind	Senior Counsellor
9	Aysen Dennis	The NIA Project	Refugee worker
10	Banu Aydin		
11	Berna Vardar	The NIA Project	Advice Worker
12	Brian Innis	Social Services	Acting Deputy Head Mental Health
13	*Cahit Baylav*	*Hackney Community College*	*Student Advisor, Counsellor*
14	Cemile Kalkan		Psychologist
15	*Cetin Alkan*		*Health Advocate*
16	Christine Achadeff	CFCS Lower Clapton	Psychotherapist
17	Dilek Karatas	Derman	Advocate
18	Dorian Cole	Haringey PCT	Primary Care Mental Health Specialist
19	Dr Beecks	Lower Clapton Health Centre	GP
20	Dr Begum Maitra	Lower Clapton CFCS	Consultant Psychiatrist
21	Dr Claire Davies	London Fields MC	GP
22	Dr Dora Kohen	Lancashire Medical School	Consultant Psychiatrist
23	Dr Monica Doshi	Barton House HC	GP
24	Cr Rhiannon England	Statham Grove Surgery	GP, Principle
25	Dr Geeta Patel	Latimer HC	Specialist GP in Mental Health
26	*Dr Jane Wilkinson*	*Lawson Practice*	*GP*
27	Dr Tricia Bohn		
28	Dr Robert Lyle	Lower Clapton HC	GP
29	Dr Margaret Wallace	Lower Clapton HC	
30	Elif Cenar	Derman	Advocate
31	Elif Sarikaya	CHPCT	Health Advocate
32	Elvin Titiz	South East Locality	Turkish/Kurdish Support Officer
33	Emel Hakki	Family Welfare Association	Project Manager
34	Faize Yakup	Derman	Counsellor
35	*G Leavey*	*BEH MHT*	*R&D Assistant Director*
36	Gulcin Caymaz	Somerford Grove	Advocate
37	Haleh Kazemian	Chase Farm Hospital	Bilingual Therapist
38	Hamdi Yazici	Derman	Welfare Rights Advice Worker
39	Ilkay Cetin	Derman	Counsellor
40	Jacqui Gratton	Enfield NHS Refugee	Clinical Psychologist
41	Jale Forrest	Statham Grove Surgery	Turkish Health Advocate
42	Janice Woodruff	HTPCT	Senior Manager, MH Commissioning

	Name	Organisation	Role
43	Jessica Garland	House of Commons	Researcher
44	*John Staines*	*CFCS (CAMHS)*	*Senior Nurse/Family Therapist*
45	Jules Pipe	London Borough of Hackney	Mayor
46	Julie Telvi	Chase Farm Hospital	Systemic Psychotherapist
47	Kathryn Allen	CFCS Lower Clapton	Clinical Psychologist
48	Kumru Baser	BBC	Journalist
49	Laura Marmion	ELCMHT	Occupational Therapist
50	Lauren Stock	City & Hackney PCT	Primary Care MH
51	*Louisa Jean Baptiste*	*Training Link*	*Director*
52	Magella Nwimo	Latimer HC	Primary Care Psychiatric
53	Mahir Guden	Derman	Research Assistant
54	Mathew Ijaopo	Lee House, Hackney Community Services	Team Manager
55	Mina Kakaiya	Locality Mental Health Team	CDW
56	Muyesser Tabanli	Derman	Advocate
57	Neriman Adiyaman	The NIA Project	Resettlement Worker
58	*Nese Erkan*	*City & Hackney tPCT*	*Refuge Link*
59	Nimet		
60	Nina Tungodden	St Leaoards CAMHS	Psychologist
61	Norma Johnson	St Ann's Hospital MH	Clinical Nurse
62	Nuray Cakmak	Minik Kardes	Community Outreach Worker
63	Nursel Tas	Derman	Mental Health Team Leader
64	Omer Genc	Haber Gazetesi	
65	Rachel Evans		
66	Ron Wallace	City & Hackey PCT	Head of Mental Health Commissioning
67	*Sander Kooj*	*Homerton Hospital*	*Consultant*
68	Sanem Yigit	London Turkish Newspaper	Journalist
69	Serhat Incirli	Toplum Postasi	Journalist
70	Sehriban Suyur	Derman	Advocate
71	Selma Altun	Derman	Advocacy Team Leader
72	Sevinc Aslan	Hackney Housing	Turkish Community Liaison Officer
73	Sheila Levi	Chase Farm Hospital	Clinical Psychologist
74	Sidika Alkan	Derman	Counsellor
75	Suna Guven	Derman	Counsellor
76	Tony Nickson	Derman	Funding Officer
77	Violeta Pelemis	Statham Grove Surgery	Med Receptionist
78	Zafer Kursun	Derman	Office Manager
79	Zehra Cam	Derman	Advocate
80	Guney Dillioglu	ELCMHT	Trainee Clinical Psychologist
81	Tom Ashmore		