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Birmingham New Communities Network and
Community Resource and Information Service

"They do not understand the problem I have"

Refugee well being and mental health

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JOSEPH ROWNTREE FOUNDATION

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Executive Summary

Introduction

The *Making a Difference* project was developed in response to a call from the Joseph Rowntree Foundation (JRF) to work with Migrant Community Organisations (MCOs) to help develop and use evidence to work towards change in policy. Mental health was one of the areas identified by the project as a major issue for refugees.

Methodology

Leaders from 16 MCOs were trained, as part of an accredited community research programme, in social research and interviewing skills. Part of the training entailed each community researcher to undertake a range of in-depth interviews with members of their community to explore refugees' experiences of mental health. In total 138 interviews were undertaken. These were analysed by CURS using a systematic thematic data analysis approach. The community researchers also undertook 17 in depth case studies with refugees who had experienced mental health problems. A further fifteen interviews were undertaken with service providers

Findings

The issues facing asylum seekers and refugees were found to be multi-faceted, interlinked and complex. In the absence of a clinical diagnosis many respondents discussed symptoms rather than a particular illness. These included anxiety, insomnia, depression and feeling suicidal.

A range of factors were found to have impacted on mental health. These include:

- Past experiences of war, persecution, torture, sexual violence and flight
- Concern around continuing political problems in their country of origin
- The asylum system and often the length of time it took for a decision to be reached. In particular there were issues around the questioning of stories which were difficult to tell, uncertainty about the future, being detained, being criminalised, stigmatisation and respondents developing a mistrust of the state
- Discrimination, feeling unwelcome and being harassed or bullied
- Isolation, loss or separation from friends and family and ethnic community
- Unemployment and skills downgrading, concerns around inability to be self-sufficient
- Culture shock and difficulties understanding how to conduct themselves in UK society.
- Difficulties accessing services, in particular housing
- Gender issues
    - Isolation from traditional child rearing and social support networks
    - Sexual and domestic violence
    - Increased difficulties accessing services, ESOL and work
    - The belief by some that women are inherently weak
- Community specific issues
    - Qat use amongst Somali men
    - The impacts of chemical warfare of the Kurdish community

Support

Few respondents knew how to access support and many believed there were no services they could access. Those who had referred to a GP found that medication was the main means of treatment. Whilst some were provided with anti-depressants many were given paracetamol or sent away. Others were put off clinical treatments by the waiting list. Counselling was offered sparingly and generally had little relevance to the scale of problems refugees experienced. Women were reluctant to speak to white male GPs about their experiences of sexual violence. Of the thirteen service providers interviewed in Birmingham only two provided a specialist refugee service and both of these were experiencing funding problems. One of them was threatened with closure. Other providers occasionally dealt with a refugee but felt they lacked the knowledge, expertise and resources to provide the service required.

Importance of community

Ethnic, and in some cases faith, communities fulfilled a key role in supporting asylum seekers and refugees with their mental health problems. Not all respondents were able to locate a community but those who did found support provided in terms of advice, empathy and understanding to be critical in their recovery. Refugee Community Organisations (RCOs) were however overwhelmed by the needs of their community and there was often a lack of social space or resources to attend to the needs of all of their members

Conclusions

Much more work is needed to help asylum seekers and refugees with mental health problems. This category of people present a particular challenge to providers because of the sheer scale of problems that they face. A holistic approach is required together with some consideration of how the asylum system can be made more humane and how service providers might work together. The provision of health promotion for asylum seekers and refugees may be a more realistic approach in the short term.

Suggestions

A number of suggestions were made by refugees and service providers:

Suggestion	Suggested by
Health Promotion	
Increase the number of community centres and other spaces for socialising and sharing to reduce isolation	Refugees
Provide support to help new arrivals to locate community organisation where established	Refugees
Improve guidance about how to access all services, learn English, access training etc	Refugees
Help refugees to gain work	Refugees
Arrange trips for adults and children, so that they can see how the systems work and feel less isolated	Refugees
Refugees should get involved more with community, agencies and schools. They should be more active in the activities organised by different institutions.	Refugees

Focus on causal factors	Providers
Take a holistic approach taking into account cultural background	Providers
Awareness and Education	
Provide training for GPs and counsellors on the nature of the refugee experience, their needs and problems	Refugees Providers
Undertake work to improve the image of refugees so that people realise they want to contribute to society	Refugees
Put on seminars highlighting mental health problems	Providers
Work to reduce the social stigma of mental health	Providers
Promote action at PCT and GP level	Providers
Outreach and Co-ordination	
Increase communication between different community groups so that they can share information and experience perhaps through development of a mental health network	Refugees
Support community organisations so they can act as a link between public services and their community (by providing funding and specialist training)	Refugees
Provide counselling in the community in refugee languages	Refugees Providers
Provide female friendly services for women who have experienced sexual violence	Refugees Providers
Improve ethnic monitoring	Providers
Train refugee communities about how the system works	Providers
Allocate someone at each practice to help refugees	Providers
Provide one to one support	Providers
Develop culturally sensitive services	Providers
Workforce Development	
Appoint some staff with the same ethnic origin or at least the same language in public services (such as in NHS, job centre and City Council)	Refugees
Train refugee health professionals to be mental health professionals	Refugees
Provide leaflets for professionals on refugees' mental health problems	Providers
Provide trained interpreters who understand mental health issues	Providers

> "Fitting into a new culture is like being born again… It doesn't happen in one day". (Kosovo, Male, 32)

1. Introduction

Birmingham has gained a reputation as one of Britain's foremost multi-cultural cities. In terms of ethnicity, it is now apparent that Birmingham will become Europe's first non-white majority city by 2011 (Birmingham Chamber of Commerce 2005). In the present day the city is home to a wide range of different communities from the descendants of the Jewish people who fled discrimination in Eastern Europe during the eighteenth and nineteenth centuries, those escaping conflicts and persecution in Chile, Indo-China and East Africa in the 1970s and 1980s (Dick 2004) and the Afro-Caribbean and South Asian economic migrants of the 1960s and 1970s. More recently people from Afghanistan, Bosnia, Iran, East Africa, Kosovo and Kurdistan to name but a few countries, have escaped from war, genocide and tyranny and have been sent to live in the city as part of the National Asylum Support Service's (NASS) dispersal programme.

Whilst Birmingham has provided a home to those who seek sanctuary or new opportunities and the city today sees its multi-cultural identity as one of its defining characteristics, new communities in the city have had to face a range of difficulties when striving to make a place for themselves. The majority of migrants move, or are dispersed to, multi-cultural parts of the inner city (Phillimore 2005) which have been associated with high levels of deprivation such as Handsworth, Aston, Newtown and Nechells. Recent research in the city has revealed that new communities face a range of obstacles to their successful integration in the city including the resentment of local people, high levels of homelessness, extreme levels of unemployment (over 60%) and under-employment, difficulties accessing education, poor quality ESOL provision and difficulties accessing appropriate healthcare (Phillimore & Goodson *et al.* 2003; 2005; Phillimore 2004; 2005; Goodson & Phillimore 2005; Bloch 2004).

Research undertaken in Birmingham has repeatedly recommended to policy makers that the role of Migrant Community Organisations (MCOs) in service provision be elevated. In addition the evidence base relating to migrants needs to be improved in order to demonstrate the extent of the challenges faced and new opportunities offered by new communities in the city and to begin to develop policies to address those challenges. At the current time there is little knowledge even about the numbers, ethnicities and geographical locations of new communities in Birmingham (Phillimore & Goodson *et al.* 2005). Despite the overwhelming evidence of the need for different approaches to evidence collection there have been few moves towards change. In particular the role of MCOs as both a source of evidence and expertise about new communities has been under-utilised. It was in response to this situation that the Joseph Rowntree Foundation (JRF) commissioned the *Making a Difference* project. The project was created through the joint working of the Centre for Urban Studies (CURS), the Community Resources and Information Service (CRIS), Birmingham New Communities Network (BNCN) and a number of their members. It was seen as a way of overcoming these difficulties and enhancing the role of MCOs. The aim of the overall project was to build the capacity of MCOs to use existing evidence and to gather new evidence and work collaboratively to use and

communicate this evidence. CURS have brought the JRF programme together with the ESF funded EQUAL project, *Progress GB*. This EQUAL project has been developing new ways of recognising and accrediting refugees' skills. Through building the capacity of MCO leaders to collect and utilise evidence and developing links between MCOs and stakeholders the project aimed to improve stakeholder understanding of the value and contribution of MCOs in supporting settlement and cohesion and work towards reviews of policy in several critical areas: the delivery of ESOL, young people's access to education, employment of skilled refugees and mental health services. These areas of activity were identified by BNCN because they were considered to be areas where refugees were experiencing particular difficulties. This report represents the culmination of months of work undertaken by BNCN community researchers (CRs) with the guidance of CURS. Having been trained in social research, interviewing and qualitative data analysis skills community researchers designed research tools and collected data about the mental health experiences of refugees. A team of researchers at CURS worked alongside the CRs to project manage the research programme, analyse relevant data and undertake supplementary research. The next section of this report sets out a brief discussion of the prevalence of mental health problems in the asylum seeking and refugee communities. This is followed by an account of the methodology utilised by the CRs before the main findings are considered in detail. The report concludes with a discussion of the implications of the findings for refugees in Birmingham and consideration of the ways in which mental health provision might be improved across the city.

1.1 Mental health, refugees and asylum seekers

There is a considerable body of research examining the mental health problems experienced by asylum seekers and refugees and broad agreement that the nature of the refugee experience brings with it particular psychological problems. Porter and Haslam's study (2001) comparing refugees with non-refugees from ex-Yugoslavia living in the USA demonstrated that refugees suffered significantly more mental health problems than their non-refugees counterparts. One of the causal factors in this increased susceptibility to mental health is the nature of the experience that precipitated an individual's flight from their country of origin. Silove *et al.'s* (1997) research on 40 asylum-seekers attending a community resource centre in Australia found that 79% of respondents had experienced a traumatic event such as witnessing killings, being assaulted, tortured and/or captured, and 37% had posttraumatic stress disorder (PTSD). Weaver and Burns (2001) found that most of the 58 asylum seekers they interviewed at a refugee centre in the US encountered insomnia and nightmares. Research with 480 Latin American refugees and 156 Middle Eastern refugees living in the Netherlands showed that 29% of the refugees had psychological complaints related to torture but 40% of them had psychological complaints related to their experience in the host country. Six percent of the Latin American refugees and 11% of the Middle Eastern refugees were diagnosed with PTSD (Hondius *et al.*, 2000).

Whilst the term asylum seeker or refugee implies homogeneity of experience the reality is that individuals who are categorised by these terms have a wide range of backgrounds and experiences. Findings around the subject of mental health depend on the methodology employed as well as the nature of the population being researched and the biography of the individuals within that population. Different

diagnostic criteria will also lead to different results. For example a survey of 322 Indochinese refugees attending a psychiatric clinic in the USA indicated that 70% of them had PTSD (Kinzie *et al.*, 1990). A study on 50 randomly selected Cambodian refugees in the USA showed that 86% of respondents had PTSD and 80% were suffering clinical depression (Carlson and Rosser, 1991). Weine *et al.*'s (1998) research on 34 Bosnian refugees compared rates of PTSD immediately after resettlement in the USA, and one year later. Twenty-five of these refugees were diagnosed with PTSD in the first survey but the number with PTSD symptoms decreased to fifteen after a year. Mollica *et al.*'s research (2001) on Bosnian refugees living in a refugee camp in Croatia found that 45% of the refugees had depression or PTSD. Murphy *et al.*'s research (1994) with Bosnian refugees screened by GPs in Ireland found that 14% of the refugees were diagnosed with psychiatric problems. The variation in incidence of PTSD may relate to different approaches to diagnosis, different methodologies or the difference between living conditions. Summerfield (2001) argues that mental health issues of asylum seekers and refugees must be considered in the context of their disrupted social life. Whilst studies suggest that symptoms of psychological distress are common among refugees, these symptoms may not necessarily signify mental illness (Burnett and Peel, 2001; Thompsell 2001). Indeed very few refugees and asylum-seekers surveyed by Summerfield (2001) saw themselves having mental health problems.

1.2 Refugees in the UK

There is less data on mental health issues of refugees and asylum seekers in the UK, although the Medical Foundation is notable as having been particularly active in this area. UK studies do re-iterate those undertaken elsewhere in that they indicate that refugees are more likely to experience mental health problems than the general population (Murphy *et al.*, 2002). Needs assessments in three London boroughs and Great Yarmouth found that depression, rather than PTSD was repeatedly cited as a common problem and was linked with racism, lack of opportunities, isolation, loss and culture shock (Webster & Roberston 2007). The predominance of depression is supported by (Murphy *et al.*, 2002). Burnett and Peel (2001) found that two third of refugees in the UK experienced anxiety or depression. Many also had panic attacks, agoraphobia, and poor sleep patterns. Research on 84 male Iraqi refugees found that 35% of the respondents had depression, 50% PTSD and 20% psychosis (Gorst-Unsworth and Goldenberg 1998). A survey of asylum seekers living in Newcastle area indicated that 11 % to 15 % of respondents had a form of mental illness (Crowley, 2003). There are gender differences in the refugee experience and propensity to mental health problems. Burnett and Peel (2001) argue that refugee women are more seriously affected by displacement and more vulnerable to physical assault, sexual harassment, rape and domestic violence and they are more likely to report poor health and depression than men. However their specific needs often go unacknowledged.

Whilst the trauma of the refugee experience has a clear impact on mental health, research also indicates that experiences within the UK are often viewed by refugees as more detrimental to their mental health than the atrocities they underwent in their countries of origin (Gorst-Unsworth & Goldenberg, 1998). Silove *et al.* (1997) found that a diagnosis of PTSD was associated with greater exposure to post-migration trauma, delays in processing refugee applications, difficulties in dealing with

immigration officials, obstacles to employment, racial discrimination, and loneliness and boredom. Further UK based research found that the legal uncertainty, cultural bereavement, isolation, poverty, racism, lack of occupational opportunities, unemployment and stress experienced in the host country had a negative impact on refugees' and asylum seekers' mental health (Crowley, 2003; Murphy *et al*., 2002; Gorst-Unsworth & Goldenberg, 1998; Silove *et al.* 1997; Burnett & Peel 2001). Detention has also been found to have an adverse effect on mental health (Cutler, 2004; Murphy *et al.*, 2002). Links have also been made between the negative images of asylum seekers and refugees circulated in the media and feelings of stigmatisation (Summerfield, 2001). Research for the Home Office (Carey-Wood, 1997), found that 50% of refugees experienced racial harassment. Hostility and racial discrimination have been found to impact on asylum seekers' and refugees' quality of life in the UK and their mental health (Crowley, 2003; Burnett and Peel 2001).

In addition to the impacts of the asylum process and public attitudes to asylum seekers in the UK, the dispersal system and levels of social and health support provided within the system, are also a factor that impact on mental health problems (Murphy *et al.*, 2002; Burnett and Peel, 2001; Summerfield, 2001). Data on patterns of utilisation of health services among asylum seekers and refugees is patchy (Crowley, 2003). Little is known about admission and treatment rates relative to the general population. Although the '*Count Me In'* census has expanded ethnic monitoring, it does not record immigration or asylum status. Whilst in theory refugees are entitled to access health care in the same ways as the local population, it has been difficult for them to utilise these services to the same level (Murphy *et al.*, 2002). Western constructions of mental health are not always appropriate in cultures where problems may not be viewed as being located within the individual (Watters 2001). Many refugees experience difficulties in expressing health needs and in accessing health care (Burnett and Peel, 2001). Counselling is a Western oriented concept and its usefulness depends on individual's socioeconomic background and cultural orientation (Burnett and Peel 2001). Webster and Roberston (2007) argue that many refugees are reluctant to use formal services and question whether clinic-based responses to mental health needs are appropriate (see also Miller 1999). The disproportionate distribution of asylum seekers and refugees across the UK means that in some areas services can be overwhelmed and they lack the capacity to provide therapy to all who need it (Webster & Roberston 2007; Crowley, 2003; Summerfield, 2001). Language barriers and the quality and availability of interpreting services are a further problem. Research conducted with 435 GPs in London found three-quarters of respondents were not satisfied with interpreting arrangements (Summerfield, 2001). Lack of interpreting services means the use of more informal methods such as voluntary interpreters, family members and children. Inexperience or familiarity can cause misinterpretation, embarrassment and concerns around confidentiality (Kelley & Stevenson, 2006).

Whilst an argument has been made for refugee specific mental health services it is important to note that it may be necessary to address wider social inequities by promoting social justice and social action as well as empowerment (Seedat 2001). Webster and Roberston (2007) argue that it's important to ask refugee communities to define their own mental health needs rather than externally imposing a service. They argue that community psychology offers an opportunity to "*provide services for refugees which are more congruent with the community's own constructions of mental*

health problems" (p156). However such arguments depend on the assumption that there is a refugee community. The reality is that there are many refugee communities. In Birmingham for example refugees come from over 100 different countries of origin (Phillimore & Goodson 2005). Mistrust and stigma around mental health may also militate against community engagement with mental health services.

Burnett and Peel (2001) argue that reducing isolation and dependence; providing suitable accommodation; spending time more productively through education and work offer much more to relieve depression and anxiety rather than medication. Although some of the refugees may not be diagnosed with any psychiatric illness, they may still require emotional, social and practical support (Crowley, 2003). Community organisations provide invaluable support in terms of reducing isolation, providing information and orientation. Much of the literature on refugee mental health favours the use of a mental health promotion approach to tackling problems. Suggestions include increasing self-sufficiency through provision of practical advice, language tuition (Murphy *et al.*, 2002), developing social support (Crowley, 2003), developing peer groups (Crowley, 2003), tackling racial harassment (Crowley, 2003), improving economic well-being including offering the right to work to asylum seekers and increasing the range of employment possibilities (Murphy, *et al*., 2002), improving housing (Crowley, 2003), facilitating communication with families in the country of origin (Crowley, 2003), providing a fully resourced interpreting service (Burnett & Peel, 2001; Summerfield, 2001) and making strong links between psychiatric services, Non Governmental Organisations (NGOs) and Refugee Community Organisations (RCOs) (Murphy *et al*., 2002).

2. Methodology

This research is based upon data collected in three sets of qualitative interviews. The first set of qualitative interviews was undertaken by Community Researchers with 138 members of refugee communities. In this phase of research interviews explored the range of mental health problems experienced by newcomer communities. The second set of 17 qualitative interviews focused on the mental health problems of particular individuals and were undertaken as in depth case studies by Community Researchers The final set of interviews were undertaken by the Community Resource and Information Service (CRIS) with 15 community mental health service providers, 13 based in Birmingham and two outside of the region.

The Community Researchers (CRs) received general social research training and specialised training in qualitative interviewing. The training taught the concepts of rigour and reliability, considered issues around bias, interpretation and a wide range of ethical issues. The interview training taught how to brainstorm issues, how to develop and ask open questions and how to probe. The training was based around a series of interactive workshops in which the CRs had opportunities to practice their new skills and receive feedback from their peers and tutors. They were also taught self-reflection skills. Working collectively with the guidance of the CURS research team, the 16 researchers identified the key issues and questions that were of most interest to them and their communities in respect of mental health. They then worked in small groups to create interview questions and develop a topic guide. CURS merged the topic guides created into one topic guide, which was then utilised by all the researchers when under-taking their interviews. This aided the comparability of interview data. Each CR was set a target of ten interviews to undertake with refugees and each was allocated a mentor to support and provide regular feedback during the process. The CR team located interviewees through friends, family and members of their community organisation. Interviews were undertaken between March and June 2006. The main topic guide consisted entirely of open questions. Issues covered included:

- The common problems that refugees experience that affect their well being
- The types of mental health problems that refugees experience
- The services used by people from migrant community organisations to support their mental health/well being
- Refugees' ideas about the kinds of services they need to help support them with mental health problems.

Each interview was accompanied by a short questionnaire to record basic background information including the age, ethnicity, gender, address and family situation of each interviewee.

It is important to note that the interviews were undertaken in a qualitative manner. That is refugees were encouraged to discuss their experiences in their own words. Apart from the socio-demographic data, the data is largely qualitative in nature. Further quantitative research is required to reveal the representativeness of the issues discussed here across different age, ethnic and gender groups. The interviews were mostly conducted in the original languages of interviewees, and, because of lack of funds to transcribe and translate the interview tapes, we were reliant upon mostly

hand-written summaries provided by the community researchers. The qualitative data is based on reinterpretation of the community researchers' summaries rather than being based on direct response to the refugee interviewees. Due to sensitivity of the issue, the minimum amount of amendments has been made and quotes are used as translated and summarised by the CRs. The majority of the data analysis involved systematic thematic analysis around themes selected by the CRs. CURS undertook the task of analysing the 138 interviews and whilst the CRs undertook their own analysis to produce a report for accreditation, this report is written by CURS and based on CURS' analysis of the CR data.

2.1 The Interviewees

Some 138 qualitative interviews were analysed in total. Twelve of the interviews were without any identification page (i.e. did not include basic socio-demographic information about the interviewee), documentation for two interviews was mixed up and three respondents were not refugees. Once these irregularities were taken into account there were 121 interviews to be considered. Of the respondents 44 (36.4%) were female and 77 (63.6%) were male. Some 68.7% of respondents were aged between 25 and 40 years of age (see Table 1 for full distribution).

Table 1: Age of Respondents

Age group		Frequency	Percent
	17-18	9	7.4
	19-24	19	15.7
	25-30	29	24.0
	31-35	29	24.0
	36-40	25	20.7
	41-45	6	5.0
	50-55	1	.8
Missing	**99**	**3**	**2.5**
	Total	**121**	**100.0**

The respondents came from a wide range of countries including Afghanistan, Albania, Burkina Faso, Burundi, Cameroon, Chad, Congo, Egypt, Ethiopia, Iran, Iraq, Iraqi Kurdistan, Ivory Coast, Kenya, Kosovo, Rwanda, Somalia, Sudan, Syria and Yemen. Majority of the respondents came from Afghanistan, Congo, Iraqi Kurdistan, Iran, Rwanda, Somalia and Sudan (see Table A1 in Appendix for further detail).

The majority of respondents (65) had no dependants. Some 23 had children, of those 15 had two children, five had three children, four had five children and one of them had seven children. The distribution of number of dependants can be seen in Table 2 below.

Table 2: The Number of Dependants

No. dependants	Frequency	Percent
0	65	53.7
1	23	19.0
2	15	12.4
3	5	4.1
4	7	5.8
5	4	3.3
7	1	.8
Missing 9	**1**	**.8**
Total	**121**	**100.0**

The distribution of the respondents according to their residence in Birmingham can be seen in Table A2 in the Appendices. The district name was not stated in some of the interviews. The first 3 characters of the postcode were used to identify the respondents' place of residence. Respondents came from across Birmingham with some based in the Black Country. There were clusters of respondents in the multi-cultural city centre areas of Handsworth, Ladywood, Edgbaston, Small Heath, and Hockley.

As can be seen from Table 3, only 25 of the respondents, which constitute 20.7% of the total, were employed. Two of them stated they were self-employed[1]. Some 91 (75.2%) were unemployed.

Table 3: Employment Status

Employment status	Frequency	Percent
Employed	25	20.7
Self-Employed	2	1.7
Unemployed	91	75.2
Missing	**3**	**2.5**
Total	**121**	**100.0**

2.2 In depth case studies

Seventeen in depth case studies were undertaken with refugees who had been identified as experiencing mental health problems. Some of these individuals were identified in the first phase of the research whilst others were identified at a later stage through community contacts. Of these interviewees six were female, and 11 were male, six were Iranian, three Kurdish, two Kenyan, two Congolese, one Burundian, two from the Ivory Coast, and one Zimbabwean. Four were currently employed, eight were married, two were single parents and the remaining seven were single. Some nine respondents had children with them in the UK.

[1]In the interview sheet there were only two categories, namely 'Employed' and 'Unemployed'. Those two interviewees particularly mention that they were self-employed. Therefore, some of the refugees who are included in the "employed" category may actually be self-employed.

2.3 Service provider interviews

These interviews were undertaken by CRIS as a basic mapping exercise to explore what services are currently available to refugees. Potential interviewees were identified by contacts gained via JRF, the Refugee Council, BNCN and other organisations. A snow-balling approach to identifying service providers was used so that each time an organisation was interviewed they were asked if they knew of any other service providers that should be interviewed. The full list of interviewees is provided in the Appendices. Interviewees were also asked about what they felt the main causes of refugees' mental health problems were and how they felt services should be provided for refugees.

3. Factors Affecting Refugee Well Being

During the interviews the refugees mentioned a wide range of problems that affected their well-being. In the first set of interviews respondents were not asked specifically what their symptoms were or what conditions they were suffering from. Due to sensitivity of the issues and in a bid to avoid causing additional stress to the interviewees, the questions related to refugees' well being and mental health were mainly focussed on the general refugee experience, rather than directly asking about their personal experience. Therefore problems stated in this section represent their opinions and experience of the common problems faced by refugees and asylum seekers. However, this does not necessarily mean that when they are expressing their opinion, they have not referred to their own experiences. In fact during the interviews' refugees gave valuable insight on mental health issue referring to their friends, communities and as well themselves.

This first phase of the research is not based on identifying clinical mental problems faced by refugees as we cannot expect refugees commenting on mental health issues to be able to make clinical diagnoses. As will be seen from the findings many refugees were reluctant to see a GP and discuss their problems. In some cases others who did see a GP did not receive a diagnosis. Refugees interviewed referred to stressful situations they found themselves in, in relation to well being issues. Some of these problems related to their current experience in the UK and others to their country of origin. Further research is needed to explore the direct relationship between refugee experiences and clinical mental health problems. The accounts given by refugees highlight the range of mental health problems that they experience. These included stress; depression; anxiety and fearfulness; mental trauma; post traumatic stress disorder, schizophrenia and in some cases feeling suicidal. The in depth case studies probed more specifically into the mental health problems that refugees experienced. Once again, in the absence of a diagnosis respondents were more likely to refer to emotional pain or their inability to sleep or concentrate than a specific illness. This way of referring to mental health problems echoes work undertaken by the Confederation of Indian Organisations in 1996, wherein the mental health symptoms of the Indian community were being presented, and treated, as physical pain. The recurrence of this approach ten years on, is a clear and worrying finding of this research and strongly suggests that GPs and other health professionals need support in the diagnosis and treatment of refugee and asylum seeker mental health issues. The ways in which symptoms are treated will be the subject of further discussion later in this report.

In the case studies respondents were asked about the impact their problems had on their lives and those of their families. Women spoke about the ways in which looking after their children became difficult because they were so depressed. They were concerned about their children because:

"*When Mum is stressed, they are stressed too.*" (Kenyan woman, 35)

Others spoke about feeling totally unable to relate to others, feeling unable to do anything including eating, feeling empty, argumentative or angry and a feeling that they were the only person in the world experiencing such problems. They found it

hard to maintain relationships of any kind or to build the new friendships they needed to make a place for themselves in the UK:

> *"Sometimes because of my mental health I will go mad, and people don't really understand why I am going mad and I can't really help myself in that situation, that is how I live my life and it's just quite like hell. It's not easy for some of my friends to understand why I am angry"* (Ivorian male)

Some individuals were clearly experiencing trauma related to their past experiences:

> *"I can no longer sleep well, I have insomnia, I dream that I am in war, I see what was happening and I have headaches. I am no longer able to concentrate on things as I used to be."* (Congolese male).

Several interviewees spoke of friends or relatives who had attempted, or committed suicide:

> *"I know a few who had committed suicide because of mental pressure and have been taken to hospitals or mental hospitals, lots have committed suicide with their problems."* (Iranian Kurdish male, 34)

Parents spoke of the mental health problems experienced by their children. Often these emanated themselves in uncharacteristic behaviour. This behaviour was sometimes interpreted as bad behaviour at school and could result in a child being suspended or excluded. Children who found themselves outside of school then became depressed and isolated because they had no other children to socialise with.

Others spoke of a change in personality, how they moved from being outgoing to inward looking, from confident to lacking self-esteem:

> "*I developed very low self esteem, which I never used to have. I have always been confident, I always had high esteem, I used to like challenges and look forward to the future"* (Zimbabwean woman, 40)

The symptoms expressed by the refugees related to, and were argued to have been caused by, a complex combination of factors. These included the experience of becoming a refugee, arrival and reception in the UK and current attitudes and experiences trying to settle here. The factors that impact on individual's well being are discussed here in turn but it is important to remember that it is the combination of these factors, the multi-faceted nature of refugees' problems and experiences that impact on their mental health. It is logical to begin with refugees' past experiences, but important to note that the factors impacting on mental health have not been prioritised either by the respondents or the authors. Different combinations of issues affect different people.

3.1 Problems Related to the Refugees' Past Experience

Some of the problems influencing mental health of refugees are related to their past experience. These included a combination of issues from the experience of being raped or tortured to having witnessed atrocities. Service providers noted the trauma

associated with the experiences which precipitated flight was a common cause of mental illness. Those who had few refugee clients considered trauma a major issue for those clients who did make it to their services. They were concerned that they did not have the knowledge to deal with these kinds of issues because they differed so much from the types of concerns presented by their usual client group. Refugee respondents linked their past experiences with their present mental health problems. The word stress was used frequently by respondents to express extreme trauma:

> "*People suffer post traumatic depression because of the war and the stress it caused. From ill treatments and abuse they have gone through."* (Albanian male, 30)

> *"I come from a country that was for thirty years war and we were hearing the sounds of guns and wars. It will take time to get used to the sounds of industries."* (Afghani male, 34)

> *"They (asylum seekers) already have problems from the country they come from. Some people have been tortured. Some bad experiences and coming here the government don't accept them."* (Chad woman, 18)

A further concern for service providers was how to deal with rape victims, particularly those who had 'rape babies'. Women found it extremely difficult to vocalise their experiences because it was both painful and culturally unacceptable to discuss them, even to a doctor particularly if they were male:

> *"There are many kinds of problems which you can not talk about in front of male, because culturally you can not talk to a male about a problem you experienced during the war. Then you choose to keep quiet, it means you live with your own problems. You can be angry inside and not talk to anyone"* (Burundian woman, 25)

Losing friends and family members in the conflicts in their home country or even witnessing the murder of their loved ones also had a profound affect on refugees' well being:

> *"The war took all of my life there and I lost my family and friends"* (Kurdish male, 29)

> *"Speaking about families, I can't really say I have got one, because from my background I have lost my family, my entire family"* (Ivorian male)

Continued problems in their country of origin meant that there was still an attachment to the past, which made it harder to focus on moving forward and building a future:

> *I think the political situation of Iran affects the well-being of Iranians living here because the people living here can not go back and are worried about the situation in their country"* (Iranian male, 38)

Other interviewees noted that the journey to a safe haven was also fraught with difficulty and some refugees became mentally ill because of the stresses of the actual

flight. Upon arrival in the UK pretty much all respondents expected their problems to be resolved but for many their lives were about to get even harder.

3.2 The impact of the asylum process on mental health

After fleeing from their home country to find a safe heaven, and arriving in the UK, refugees soon realised that they have another big battle to fight, to demonstrate that they are 'genuine' refugees and to gain their refugee status. Many did not feel safe as they knew at any point they could be detained and deported and that their status remained uncertain. For many having to re-tell their story was extremely stressful, their distress increased when they were told that they had made their stories up:

> "*First of all the war I went through, the way people have been killed, the way a body is opened up from the stomach, it is not a story, I have seen it myself. From what I have seen in my country and the way we are treated in this country it is double. I had all those immigration troubles to add to my experience of war. Then I felt mentally ill"* (Congolese male)

It seemed to refugees that immigration officers had no concept of what it was like to be persecuted and no understanding of the political situation in the countries of origin. They had to be convinced of every detail of a refugees' story no matter how traumatic.

Several respondents were traumatised by being detained on arrival. Being put in detention echoed experiences of detention and imprisonment in their countries of origin. It could also mean that families were split up:

> "*For instance, where I was back home, the reason that made me run away I was in a situation where I was hiding myself. And for me to go through that and come all the way here, again you are taken into detention."* (Kenyan woman, 39)

> *"When my family members came in, they were supposed to join me. But the Home Office did not do that. They took them to a detention centre, they stay there about three months. They could not see me. Just imagine with small kids"* (Kenyan male, 41)

Once they had been released from detention some respondents had to sign in at the police station every week. This made them feel as if they were viewed as criminals. The fear they experienced entering the police station was coupled with low self-esteem and impacted on their mental health.

Respondents all struggled with the uncertainty of their situation when going through the asylum process. Until arrival many had no idea that there was any question of them not being allowed to remain. The threat of deportation meant whilst they were awaiting a decision they lived in fear of returning to the situation from which they had made great effort to escape. Several respondents knew of people who had committed suicide rather than live in uncertainty any longer. Others related their uncertainty directly to mental health problems:

"*Were they going to send me back to my country after going through all this hardship or not? This caused mental problem and stress to me*" (Iranian male, 38)

"I was worried and anxious about my future in this country. I wondered if they were going to grant refugee status to me or deport me from this country. I will never forget the anxieties and the fears that I had when I was waiting for an answer and I will never forget those nights I could not sleep. All these things had negative effects on me" (Iranian male, 47)

"(Asylum seekers are in) fear of going back to the country they escaped from, stressed and depressed from what happened to them in their country". (Kosovan Male, 33)

Although for new arrivals the process has shortened in recent years, for some the asylum application is still a lengthy, long term struggle that can take years. One of our respondents had waited eight years to be granted a decision. During the wait asylum seekers faced difficulties that made them feel insecure and unwanted. They felt insecure having to report to the nearest immigration office weekly or monthly. In some cases individuals were said still to be doing this even after five years. They feared that their case would be refused, and they would lose NASS support. They worried that they would lose the roof over their head and the money to buy food for themselves and for their family. All these issues exacerbated mental health problems:

"People who come to live here have some kinds of trauma in themselves. Some people are living here more than four or five years, but they still have problems… Because they have no decision from the Home Office and they are living without any hope. They think everyday that they might be sent by force to their countries any day…I have some kind of mental health problem and my friend has the same sort of problems as me…. When I came to this country, I was given one year leave to remain. That was ended, but I received no response from the Home Office for more than one year. I don't know what is going to happen to me. That became a kind of trauma on me." (Afghani male, 19)

"I was 15 years old when I came to the UK. The doctors assessed my age and agreed that I was 15 years old, but the Home Office did not accept it. That caused me a big problem. They stopped my vouchers and I went to the court. Even the court didn't accept the doctors' age assessment. Now, I have no decision from the Home Office and I don't know what to do...I have lots of psychological problems. I have no documents. I cannot do anything. Not having any decision is itself is a kind of trauma. You don't know what will happen to you." (Afghani male, 17)

The lengthy legal process not only causes anxiety about their life in the UK, but also means that refugees have to put their lives "*on hold*". They cannot make plans, they cannot have hope for the future. Most cannot work because they are not allowed to so they spend their days with no purposeful activity and too much time to worry about the future and the well-being of their remaining family in their country of origin.

Whilst they await a decision they are unable to visit or be visited by their family so they have to go through the process without emotional support from their families:

> *"It was difficult, especially at the beginning, because I haven't been able to see my family for six years."* (Kosovan male, 33)

The trauma of their experiences going through the asylum system led to several respondents feeling very suspicious of authorities in general. This meant GPs, housing officers and Jobcentre Plus officers. The asylum system left them feeling, even after a positive decision, that they were unwanted. The continued discrimination against them, because of both their status and their race as well as in some cases their religion only served to increase the feeling of exclusion.

3.3 Discrimination

As well as feeling unwanted by the state refugees quickly became aware that they were not welcome by local people. There were a number of dimensions to the discrimination their experienced. Firstly the image propagated by the media of asylum seekers being criminals, terrorists and liars impacted further on their self-esteem:

> *"Refugees have been portrayed as people who come to take money. We are stressed because people don't like us. Our community stressed because of being refugee, black and African."* (Congolese male, 30)

Secondly they were not welcomed by the host population in the neighbourhoods to which they were dispersed. This situation made them feel isolated from society as well as disenfranchised by the state. The combination of institutional and societal discrimination excluded them from mechanisms that may have served to integrate them or at least provide support and advice:

> *"I was hoping to be welcomed and to be taken care of, because when you flee your country, you hope that you will get people to welcome you and understand and feel sympathy of what you went through. But I did not get that. It makes it difficult to integrate into society"* (Zimbabwean woman, 40)

This respondent had lived in South Africa and said she preferred living under apartheid than living in the UK because apartheid had clear rules dictating what Black people could do. Refugees living in the UK find "the rules" unclear. They feel unsure about what they are able to do because racism in the UK is hidden "*but it is still here killing people inside"*. Refugees felt that they were shunned by people in their neighbourhood:

> *"Some people see you differently as a asylum seeker and they would keep distance from us or being not friendly."* (Albanian woman, 32)

> *"There is racism among people. People don't accept refugees. White areas don't accept us."* (Iraqi Kurd male, 30)

> *"There are some fears. Some are being bullied. When the people are bullied, they think that they are not wanted in the community…When people are looking at you, you are thinking that you are not welcomed"* (Afghani woman, 25)

Some of the respondents stated that their children also suffered from mistreatment and discrimination. Being bullied at school, or in their neighbourhood, lead to feelings of fear within refugee families. It also meant that they felt that they needed to restrict the freedom of their children:

> *"My children are prisoners in their bedroom, because, I am afraid of the fact that they are racially abused by other children."* (Sudanese woman, 36)

An education survey undertaken by community researchers revealed that some refugee children were truanting from school because of the way they were treated by other students. Parents were keen that their children attended multi-cultural schools that had experience supporting refugee and asylum seeking children because they were so vulnerable. One of respondents interviewed as part of the mental health case studies described how her child was excluded from school for hitting another pupil. On examination she discovered that the "victim" had been racially abusing her son and that the teacher had taken no action against this individual despite being aware of the problem. Only after concerted action was she able to have the problem acknowledged.

Furthermore refugees suggested that discrimination is also a problem for those seeking employment and for those in work:

> *"Sometime people are racist. When you go to work somewhere and if you are black, they can fire you. But the white people can't be touched, even if s/he is not doing well."* (Rwandan, woman, 27)

The negative image of the refugees in the media and its influence on the British public exacerbated feelings of inferiority and rejection. Several refugees said they felt as if they were the "*lowest in the society*". Some were ashamed of their identity, being a refugee, and the stigma attached to it:

> *"People don't take refugees as human being. I am ashamed to say that I am a refugee."* (Rwandan male, 22)

> *"People see you differently as a refugee and it makes me sad, because of the stigma attached to the name refugee."* (Kosovan male, 32)

Inability to speak English, or the fact that they spoke English with an accent was a further factor that demarcated refugees as different and made it difficult for them to communicate with local people:

> *"How other people treat you especially when you do not speak English is not good."* (Chad woman, 18)

> *"First of all when you come to a different country, you don't speak English. When you cannot express yourself, the door is closed, the window is closed. So, there is a huge barrier between you and the community."* (Afghani male, 31)

The culmination of inability to communicate, feeling unwanted and being rejected as well as actively excluded and derided left refugees feeling extremely isolated.

3.4 Isolation

One of the common problems mentioned by refugees is that they feel isolated, excluded and lonely. Refugees suggested that these feelings, on top of discrimination, their past experiences and the impact of the asylum system have a severe affect on their life and their mental health.

The majority of refugees arrived in the UK alone. Even once a positive decision is made there is much work to do in order to gain permission and funds to facilitate family reunion. Asylum seekers are not allowed to leave the country to visit friends or family. Many refugees are unable to return to their country of origin to visit their family because they lack the funds or they still fear persecution. As a consequence they may not see their family for many years and perhaps wonder if they will ever see them again. They constantly feel the pain of missing their family combined with extreme loneliness:

> *"The fact is I am missing my family, friends, sisters, brothers, mum and dad, the environment."* (Ivorian male)

> *"It was terrible when I first came... Like I was in prison. I had no friends."* (Sudanese woman, 37)

Some feel so lonely that even a researcher coming to talk to them for a half an hour is a welcomed opportunity for interaction:

> *"Today I am very happy. Somebody (you) come to me and ask me my problems. That makes the pain to go away and releases me from it. I am happy, because someone comes to listen to what I have to say."* (Afghani male, 19)

Clear links were made between isolation, loneliness and mental health. Being alone meant more time to reflect and dwell on past experiences and the uncertainty of the asylum application. It also meant that there was no one to ask for advice or support:

> *"There is depression, Isolation. There is fear."* (Rwandan woman, 27)

> *"Mental health is a problem, because you are here alone. You do not have any communication with them (other people in the society)."* (Sudanese woman, 36)

> *"I came here and I didn't have family. I was lonely. I got sick and spent a lot of time in hospital."*(Somali male, 18)

3.5 The importance of employment

The importance of employment as a factor in integration is accepted by both academics and policymakers (cf. Home Office 2005; Bloch 2000). Numerous studies have demonstrated that unemployment levels among refugees are extremely high both nationally (Sargeant & Forna 2001; Feeney 2000) and in Birmingham (Phillimore & Goodson *et al.* 2003). Indeed the cohort of refugees interviewed for this study was predominantly unemployed. Unsurprisingly the refugees participating in this study mentioned that unemployment and underemployment were factors that affected their well being. Refugees wanted to be active, self-sufficient and to use the skills and abilities they brought with them. This is something that is echoed in several other studies focusing on refugees and employment issues (Phillimore & Goodson 2006). For many refugees the only thing of any value they have been able to bring with them is their skills and qualifications. Not to have those skills and qualifications recognised impacts on their individual identity and has a considerable effect on their confidence and self-esteem. Furthermore, being unemployed reinforces feelings of segregation and reinforces the image of refugees coming to the UK looking for support through state benefits. Several respondents spoke of how keen they were to make "a contribution":

> *"People take you as stupid, because you are not working. But, people should take you the way you are without judgement."* (Rwandan woman, 35)

> *"Getting a job would make me integrate more and thinking more positive about my life."* (Kosovan woman, 34)

> *"I would feel better if I had chance to do what I am good at."* (Congolese, woman, 34)

There were many factors reinforcing high unemployment levels among refugees, such as language problems difficulty transferring their qualifications, unwillingness of employers to hire refugees and lack of specialised welfare and advice services for employment for refugees (Phillimore and Goodson, 2001). Asylum seekers are not permitted to work. Because of the length of the asylum process some might wait several years for a decision and in the process become long-term unemployed making challenge of locating work even harder.

Some of the refugees link the reason for their unemployment to discrimination on the grounds of their religious or ethnic origin or merely because they are refugees:

> *"Give us the opportunity to get a job, whatever the colour of our skin."* (Cameroonian woman, 31)

> *"Whatever our colour, culture, religion, give us the possibility to get the job we deserve sometime."* (Cameroonian woman, 21)

Similar to other new migrants, many refugees face a skill downgrading, when they come to the UK. Either their qualifications are not accepted or they do not know how to locate employment that utilises their skills:

> *"They don't accept our qualifications here. If they want to help, they should provide training, work experience and job replacement. Send them to work. The governments should create more jobs for them. Not to give them welfare benefit, better to send them to work."* (Afghani male, 31)

Although refugees may feel safer and freer in the UK, some miss working and the associated income. This situation is especially valid for professionals who face unemployment or manual jobs as a result of skill downgrading. For some of the refugees the gap between their status in their home country and in the UK causes a loss of esteem. They feel as if they have lost everything and have been forced to completely start their lives again:

> *"Your reasons for seeking asylum are not taken genuinely, because they think that you came….for good jobs, in fact I was having a better job than I have now. I had a better life style than I have now"* (Zimbabwean woman, 40)

> *"When I first came, I wanted to go back. I missed my home, my family, my profession and my car."* (Yemeni woman, 42)

> *"We are educated back home, but here we are nothing."* (Kurdish Iraqi, Male, 23)

Refugees face barriers not only in terms of employment, but also in terms of their education. For some their education has been interrupted or they cannot meet their aspirations due to language problems, communication problems or because they lack knowledge about the opportunities available to them. Many of the problems are interlinked and combined impact upon refugees' emotional health:

> *"(When I first came) I couldn't see my family or complete my education and I became depressed… Newcomers can't see their family, can't study and can't work. So they become depressed and suicidal."* (Kurdish Iraqi woman, 26)

3.6 Culture shock

Another factor affecting refugees' well-being is the difficulty they experience adapting to new conditions. Some find it hard to adapt to the new culture, some to the food and some struggle with the very different weather conditions:

> *"It was very hard to fit into new culture, because everything is totally different…the culture and the food is different. Everything is different here."* (Chad woman, 18)

> *"The weather is horrible, but I coped well I put more clothes on."* (Rwandan woman, 27)

Predominantly though, it is the different systems and ways of living that are most disturbing:

> *"I am stressed, I can't feel comfortable, my head doesn't fit"* (Ivorian male)

> *"The way we live in my country it is very different"* (Burundian woman, 25)

> *"It is very hard to adjust to the people, community and to everything else…. It was very hard to adjust I can't do anything."* (Kenyan male, 41)

> *"Imagine when you go to a country where you are new and you don't know anybody and you don't have any relative and no friends. You don't know anything about their culture and nothing from the language. Would that be easy to live or hard?"* (Afghani male, 27)

Refugees did not have any route to find out about the ways to conduct themselves in society. Even after they learned some English they were still fearful of doing something wrong because often learning the way of life in the UK was the hardest task. Clearly this is a problem that caused a great deal of stress on arrival in the UK. Asylum seekers were particularly worried that they might inadvertently break the law and find themselves being deported. Some refugees felt that over the years they had become more at ease with the culture whereas others continued to feel that they were in the wrong place and unable to relate to society and institutions. Difficulty relating to UK organisational culture had a wide range of implications for a refugee's well being.

3.7 Accessing services

Refugees spoke of how they faced difficulties in accessing major resources including health, employment, benefits and housing. These difficulties related to a range of problems. They included not understanding the systems so not knowing how to apply for support or services, having nowhere to go for advice or receiving incorrect advice from peers, inability to communicate, and not knowing about their rights or entitlements. For some respondents the changes in the support systems once they

received a positive decision came as a major shock. At this point refugees have a maximum of 28 days to leave their NASS accommodation, locate housing and make applications for benefits:

> "*Another problem is to get a house when you are moving from the asylum to the refugee system. You go to this office, they ask you this paper, this paper and this paper and some papers you don't even know where to get them. You are stuck. You do not know because I was stressed"* (Kenyan woman, 35)

Previous research has shown that homelessness is a major problem for refugees. Only families or those deemed vulnerable are considered as priority homeless when they leave the NASS system. A shortage of family housing in Birmingham means that they are generally housed in temporary accommodation; a hostel or bed and breakfast. Families find living in these very cramped conditions stressful. Whilst in temporary accommodation it is very difficult for people to seek employment or for children to progress with their studies:

> *"It is difficult to live in a hotel with two kids"* (Rwandan woman, 32)

However the situation for families is better than for singles. There is no statutory obligation to house singles so they are automatically homeless. Refugees stated that the housing problems they experience after being evicted from NASS accommodation exacerbate their mental health problems. Research has indicated that it may take years for refugee singles and families to find secure accommodation (Phillimore 2004). The ongoing transience leaves a sense of insecurity which reinforces that already created by the asylum system. The system can also be very slow. A single parent with two young children (aged eight and three) expresses her problem:

> *"It was very hard. I have not received any support for 6 month. No house, no money."* (Rwandan woman, 35)

Some think that the problems they have encountered in services are related to their communication problems and lack of information about available resources:

> *"First of all when you come to a different country, you don't speak English. When you cannot express yourself, the door is closed, the window is closed. So, there is a huge barrier between you and the community. If you don't get the right support at the right time, it will affect you emotionally and financially. And you don't know what to do."* (Afghani male, 31)

Another issue that impacts on the well-being of refugees is the quality of housing. One community researcher describes the situation as follows:

> *"The social housing stock is dwindling, and refugees often find themselves in the oldest accommodation, plagued by damp and vermin… Somalis, particular suffer a particular problem of overcrowding. …Somali Muslims tend to have large families - to have six or seven children is not unusual. In addition, new arrivals often have difficulty finding somewhere to live, and*

take advantage of norms of family or clan obligations to move in with relatives. British housing is not designed for large households, and the health of members inevitably suffers." (Community Researcher originating in Sudan).

3.8 Community specific mental health problems

Interviewers attempted to explore whether there were any specific mental health issues faced by particular communities. Whilst most problems appeared to relate to refugees in general there were some issues raised by particular communities.

An example of a community specific problem raised in this study is that of "qat"[2] chewing in the Somali community. Research projects on Somali community in the UK reported health effects of qat use include sleeping difficulties, paranoia, depression, mood swings, suicidal thinking and hallucinations (Patle *et al*, 2005; Bhui *et al*., 2003; Griffiths, 1998). Further research is needed to explore whether qat causes mental health problems or exacerbates existing problems (Patle et al, 2005). However its consumption by refugees was viewed as something that at the very least exacerbated mental health problems by some of the Somali respondents in this study.

Also mentioned by refugees from Somali and Afghan communities was the pressure that they were experiencing being a Muslim in British society in the current political situation:

> *"Unfortunately the recent bombing in London has changed a lot on the mentality of the people. The refugees are thinking it is their fault and the society is also thinking it is their fault. The newcomers felt mentally not happy. We shouldn't put the blame on people who are totally irrelevant to that. For example, if I am an Afghan refugee and if I have created a problem, it shouldn't affect all the Afghans. It is not their fault."* (Afghani male, 40)

> *"I do not feel I have a community here. I escaped from war and Al-Qiadah, but I still hear from different people that we are from Al-Qiadah. Even I hear from people from Pakistani background. They say that Afghanistan is a sh... country. I heard that many times."* (Afghani male, 18)

Refugees coming from Iraqi Kurdistan had a particular problem relating to the impact of chemical warfare on their communities:

> *"Lots of people suffer from insanity, due to chemicals dropped on Kurdistan and it affects people differently. Some have schizophrenia or other forms of mental illnesses."* (Kurdish Iraqi male, 30)

The same Kurdish refugee also stated that it is common for women who have had contact with chemicals to give birth to deformed children. The needs of such children

[2] Qat is also known as 'khat', 'jaad', 'qaat' or 'chat'. It is a plant (Catha Edulis Forsskal) most commonly grown in Eastern Africa and the Middle East. Although, qat is legal in the UK, its two main ingredients are Class C controlled substance (Patle *et al*., 2005).

bring additional burdens and stress to women. Further research is needed to understand the extent of this claim.

3.9 Gender specific mental health problems

During the interviews, respondents were asked whether they thought that men or women were more prone to mental health problems and the reasons behind their opinion. Ninety seven refugees answered this question. Some 68 of the refugees (69.4 %) thought that women suffered more. Three refugees said men suffered more. Nine refugees (9.2 %) thought that they suffered equally. Some 17 refugees (17.3 %) were not sure. There were a variety of reasons that encouraged people to think that women were more prone to mental health problems.

Being a single mother with sole responsibility for children placed a considerable burden on women in addition to being a migrant or refugee. A female refugee with two young children expressed her situation:

> *"I am a lonely parent with two kids. It is hard to take care of them. It is a lot of works. I can not work."* (Rwandan woman, 35)

Previous research has revealed that single parents are more likely to be excluded from mechanisms associated with progression towards integration such as ESOL classes and work because of a lack of available and affordable childcare (Phillimore & Goodson *et al.* 2003). The stress of being solely responsible for children is intensified by the lack of extended family networks. In their home country many female refugees enjoyed the support provided by extended family members in helping to share their domestic responsibilities. These networks often formed the basis of their social lives. When they arrived in the UK they found themselves completely alone. Two refugees touched upon this issue:

> *"Women suffer more, because they have more traditional obligations. It is difficult to manage it with this new culture."* (Somali male, 38)

> *"(When I first came), It wasn't easy to deal with children and look after them compared to Africa"*. (Sudanese woman, 37)

The combination of domestic and child care responsibilities and cultural norms meant that women were restricted to the home much more than men so had fewer opportunities to socialise

> *"Women suffer more, may be as women stay most of the time at home."* (Somali woman, 36)

In the absence of social networks and with restricted access to ESOL women were less likely to know where to seek help and advice about how to access services. Certainly fewer female refugees (38%) compared to their male counterparts (15.6%) were aware of any mental health services available to them or the general public. In addition some respondents stated that they would not discuss a mental health problem with a male doctor.

Female refugees appeared to be more vulnerable to domestic violence in the UK, than in their home country. This again was linked to the fact that female refugees were separated from their social networks and extended family members who traditionally protected them against domestic violence. It is possible that women were not aware of the existing services to support them if they experienced domestic violence in the UK. Even if they were aware of some of these services, refugees tend not to trust authorities because of the negative experiences with statutory bodies associated with their flight from their country of origin (Phillimore *et al*, 2004). In addition, the legal process of applying for asylum reinforces refugees' mistrust of formal bodies, regardless of whether there is an actual link between organisations dealing with domestic violence and governmental institutions.

Refugees from Congo, Burundi and Rwanda also mentioned that female refugees' experiences of being raped in their home country was a significant cause of psychological stress both in coming to terms with the experience and fear of return:

> *"Those who were raped back home. They are afraid to go back home and face those who raped them."* (Rwandan woman, 27)

Those women were also reluctant to speak to doctors about their problems because of the shame associated with the experience.

A further reason why respondents felt that women refugees were more likely to experience mental health problems appeared to be influenced by the gender bias of the interviewee. Gender ideologies can involve defining women according to their domestic roles and their family. For instance, some of the male refugees suggested that women are more likely to suffer being away from their family than men because their "*place is in the family*". Some female refugees were also influenced by the view that women are "*weaker*":

> *"Women are depressed, lonely and isolated. We are more fragile"* (Congolese woman, 34)

> *"Woman is weak compare to a man. If anything happens to her. It affects her straightway emotionally"*. (Chad woman, 18)

Others argued the opposite case that women are stronger:

> *"No. Women do not suffer more. I think women have strong will."* (Sudanese woman, 30)

3.10 The positive side of the refugee experience

Not all refugee experiences are negative in the UK. Some refugees enjoyed living in a multicultural society. Once they received their refugee status, many celebrated feeling safe and secure and the freedom to be themselves:

> *"I feel comfortable because the law is executed fairly and I have become familiar with other nationalities and their culture and it has a lot of social, cultural and moral effects on me."* (Iranian Kurd male, 34)

"I feel safer in the UK now than I was in Sudan." (Sudanese male, 36)

"This country has law and freedom. It makes me feel safe and content." (Iraqi Kurd male, 23)

"I saw always fight and killing in my country. I learnt a lot of good things here. I become happy because I come from a war zone to a quite place. That is why I am happier." (Afghani male, 18)

Some feel that they have more opportunities in the UK:

"I received help and support from your system; help with financial costs and education." (Albanian male, 31)

Whilst some individuals progressed over time and felt that their achievements had a positive impact on their mental health others saw the opportunities but struggled to access them:

"Every step of my progress was a good point for me. When I passed my course I was happy. When I received promotion I became happy" (Iranian male, 47)

"You are free to grow up anything possible here. If you want to open a business, you are free to do the so. If some one wants to access to higher education, it is available. I am living about 5 years and four months here. I wanted to study, but I couldn't (He found it hard to adapt to the system). I searched for jobs in different places such as warehouses, factories and other places. I was working in some of them, but now I don't have any job." (Afghani male, 21)

3.11 Support available

A number of organisations exist in the West Midlands, which provide support for newcomers with mental health issues. Some of these such as the Immigrants Counselling and Psychotherapy were originally set up for specific communities such as for the Irish community or for Asian or Black African women more generally. Two services with a specific remit to support newcomers with mental health issues were identified in Birmingham. Both of these organisations were struggling to find sufficient funds to build their capacity to deal with the level of demand for their services. My Time offered pre-access confidence building, culturally and faith sensitive counselling services, drop-in with a language team, training for counsellors wanting to work with refugees as well as research into refugees' mental health needs. It receives no funding whatsoever from the Health Service despite providing the only specialist service for newcomers in the region.

ARCH was essentially a referral practice for newcomers providing help to register with GPs and offering advice on a wide range of health matters including mental health. ARCH was under review at the time of the study and was facing the

possibility that despite huge demand for its services, it may fold because the unit costs to treat ARCH clients are viewed as too expensive. This organisation was only funded to work with refugees and had to turn asylum seekers away. All the other eleven organisations, with the exception of two that had very specific client groups, had come into contact with refugees on an ad hoc basis. Two of these eleven organisations suggested that they would struggle to deal with refugees because they could only deal with people who spoke English. The remainder felt that they would like to do more for asylum seekers and refugees but lacked sufficient knowledge and understanding of their problems to feel that could support them effectively at the current time. They were open to attending training in order to help them widen their services to refugees.

Existing service providers generally agreed that there was insufficient support in the region for refugees and asylum seekers at the present time. Some recognised that there was a stigma around mental health within some communities, which needed to be overcome before it was possible to provide services effectively. They also felt that there was a lack of knowledge around cultural issues generally and a lack of language capacity within counselling and clinical services to provide an effective service. Providers showed considerable awareness about the multi-faceted nature of refugees' problems and argued that a holistic approach to dealing with those concerns was necessary. They also recognised that work was needed to improve the social standing and image of refugees within the community so that they would not be subject to the levels of racism they experienced at the present time. Service providers felt that some co-ordinated action was required to help them gear up to improve provision and that further funding was needed to help a wide range of organisations to provide sensitive, intensive, culturally appropriate services.

3.12 Accessing help and support for mental health problems

Respondents indicated that formal support for mental health was not adequate. The majority of the refugees either thought that there were no services to help refugees with their mental health problems (18.8 %), or they thought that the services were not good enough (38.5 % see Table 4). Some refugees suggested that long waiting lists were a problem. Some 29 of them (30.2 % of the valid responses) were not aware of any services. Only 8.3 % thought that the services were acceptable and 4.2 % thought that services were very good. A quarter of respondents have only received support from their family and ethnic community members (27.1 %).

Table 4: Quality of Mental Health Support for Refugees

Response		Frequency	Percent	Valid Percent
	0: No Service	18	14.9	18.8
	1: Very Poor or Not Good	37	30.6	38.5
	2: Acceptable or Good	8	6.6	8.3
	3: Very Good	4	3.3	4.2
	8: Don't Know or Not Aware	29	24.0	30.2
	Total	**96**	**79.3**	**100.0**
Missing	**9**	**25**	**20.7**	
Total		**121**	**100.0**	

There appeared to be a range of different approaches when it came to seeking support for mental health problems. Depending on the route taken treatments also varied. Some refugees went to their doctors. Eleven of the people interviewed as part of the 17 case studies did this. Two African women visited their doctor but did not tell him the full story behind their problem because they did not trust him and were reluctant to discuss their problems with a man:

> *"I can not tell him my problem, he is male and he is white. It is a woman's problem"* (Burundian woman, 25)

> *"The problems of doctors here, they are people from here who do not understand you. And I do not trust them sometimes. I never told them my story because I do not trust them"* (Congolese woman)

Both of these women had discussed with the interviewer severe mental health problems that were impacted on their ability to live their daily lives. These problems were related to their experiences of war and seeking asylum.

Many refugees went to their doctors and discussed their problems in some depth. Treatments varied. One respondent refused to go to the doctor despite being encouraged to by friends because he had heard that "*all they do is offer tablets*". Respondents repeatedly stated that they had difficulty explaining their problems to their doctors, whether or not they spoke English. Out of the 17 case studies some four were given painkillers and a further three anti-depressants and one was given sleeping tablets:

> *"The only medication I have had so far is paracetamol. I have 800 paracetamol at home. I have never had any treatment. I am not able to do anything, to get a job, to get a good education, I can't focus."* (Ivorian male, 30)

> *"They do not understand the problem I have, even if I explain to them they give me Panadol. They do not help me at all."* (Kenyan male, 41)

> *"They do not understand me. One thing you will only tell them is that I have a problem I did not sleep during the night. They will prescribe painkillers. They will give you a tablet to help you sleep. In fact those tablets make you lose your appetite."* (Congolese male)

One refugee had been told by his doctor to think positive. Three of the respondents had been hospitalised because of their mental health problems. The process by which they were hospitalised was unclear, it is difficult to say whether this was via their doctor or through an alternative route. Stays varied from a number of days to three months.

Three respondents had been referred for some kind of psychological counselling. One person received one hour of treatment and found the impact of such a short course of treatment to be completely insignificant. A further respondent was told that he was not eligible because he was an asylum seeker and a further respondent found the counselling technique used inappropriate:

> *"I had depression. I went to see somebody to do counselling. I went just once because I did not see it helping at all. What the counsellor was concentrating on was my background, whether I had a happy childhood which I thought was irrelevant because I had a very happy childhood, very happy life before I came here and the main problem was here."* (Zimbabwean woman, 40)

Many of the respondents expressed concerns that it was pointless seeking help from the doctor because waiting times were so lengthy:

> *"The only support available to the people with mental health problem is to send them to the doctor. To get a doctor appointment is a waiting list. It takes 6 weeks before you get one. It takes years (to see a specialist on mental health) and not good services available."* (Kosovan male, 32)

Concern about waiting lists was also mentioned by some of the case study respondents. There was a general view that accessing specialist support was too difficult because of a combination of language and cultural problems. Refugees did not trust professionals with their problems because of the difficulties they had expressing their problems to the medical profession. Two Iranian case studies sought a specialist Iranian psychologist to provide support for their children. One used his networks to get one treatment from a clinician working within the NHS and paid for the one off session. Another was still looking for a professional:

> *"We are still trying to find a psychologist. We watch the Iranian psychologist programmes on Iranian channels which are broadcasted (in Farsi) from America. We still got a big problem which has not fully been solved yet and trying to find a solution for that".* (Iranian male, 47)

Despite severe difficulties outlined in this report, the majority of the refugees did not receive any support. Only 17.1 % of them received support from formal organisations for their mental health. Although refugees are entitled to access health care on the same basis as other residents, there seems to be a disconnection between the existing

services and refugees' awareness of available health services and the way in which these services work:

> *"There is support. But, unfortunately there aren't any association to guide the refugees. Someone who could speak the same language and who can hold his/her hand and introduce to the services…. There are clinics about mental health, but we are not aware of it. We don't know if they charge or not."* (Afghani male, 31)

The most important support that refugees received which helped them with their mental health problems was having access to a community and the support networks that this provided.

3.13 The importance of community

For the majority of respondents the main source of support was their community. Whilst some were directly helped with their mental health problem through talking to friends or community members others did not talk about the problems they were experiencing, or the various issues underlying these problems, for example their housing, education or asylum application issues. When asked what it means to be part of a community there was general agreement that it meant being with people who spoke the same language, shared a culture where people can share information, talk about their problems and give each other advice. It also meant having somewhere that you were welcome and where you felt you belonged, a safe social space away from the rejection that many refugees had experienced upon arrival in the UK:

> "*I am with friends or people I speak the same language with, I have the same culture, we have to share."* (Ivorian male, 30)

> *"to be part of a community is to be welcomed, in that community, to be accepted and to be appreciated and you have a turn in taking part."* (Zimbabwean woman, 40)

For refugees being part of a community was about being able to give something to someone else, to feel as is they had some worth, as well as being in receipt of support. Mostly, community was about spending time together, often in an informal way because of the lack of space for formal social gatherings. While many defined their communities as a community organisation based around ethnicity, generally a Refugee Community Organisation, others saw community as being based around faith. This was particularly important for Christians from Africa. Faith communities were sometimes very mixed and based around well established churches. They might also be communities of Black Christian refugees, new churches that had emerged to meet the needs of new communities.

Refugees often struggled to locate a community in Birmingham. It could take over a year to find somewhere where they felt they were welcome. Not all refugees in the study felt part of a community. Some 118 interviewees responded to a question enquiring whether they felt part of a community in the UK. Some 82 of them (69.4 %) felt part of a community and eighteen of them (14.9 %) felt part of a community to some extent. Fifteen (12.4 %) said they did not feel part of a community at all and

three of them were not sure.[3] Most of them (110 refugees – 90.9 %) stated that their ethnic community was important for socialising and providing a support network. As described above ethnic communities tended to work as a support and information network, informally providing services and creating links between newcomers and public services. Ethnic communities also provided important financial (stated by Rwandan, Burundian and Chad communities) and psychological support, helping one another with distressing issues such as racial harassment.

> *"A community can help you in any problem you are facing. It is very important. For example, you don't have money, don't know where to go, want a house and stuff like that."* (Chad woman, 18)

> *"Community helps you to meet with others and the community can give you ideas. When you chat with other people, it helps your well-being."* (Rwandan woman, 27)

> *"I had no one to talk to, before Kurdish centre opened."* (Iraqi Kurd woman, 26)

Refugees outside these support networks were more vulnerable to mental health problems. One of the Kurdish refugees living in Wolverhampton, after discussing the importance of ethnic community networks for settling, stated that he had not received any support as there was not a Kurdish community organisation in Wolverhampton. Another refugee from Afghanistan mentioned the difficulties his family experienced not being part of a community when they were dispersed to Newcastle Upon Tyne:

> *"If there was community group available in Newcastle six years ago (when we came), we wouldn't have the problems we had. For example we didn't have someone who could help us and guide us for shopping cheaper, because we (my wife and me) were getting £30 per week. We didn't have anyone to help us to get a good solicitor or other legal advices."* (Afghani male, 27)

There was a consensus that whilst being part of a community did not resolve an individual's problems they certainly made them easier to bear. Respondents reported "feeling better" once they had located a community:

> *"The community helps me. I get counselling from them I get advices and financial help."* (Congolese woman)

> *"It will help you to remove stress and you may feel good."* (Burundian woman 25).

One of the reasons suggested for refugees' improvement in mental health when they were around their community was because people felt at home and more comfortable with people of the same culture. Certainly feelings of isolation decreased. Those in faith communities took their solace in shared belief and communal prayers. Being

[3] A further three do not give a valid respond to this question.

part of a faith community may also encourage interaction with non-refugees outside of an individual's ethnic group, provide opportunities for practicing English and allow people access to local residents with far more knowledge of British practice and culture than moving within an ethnic community.

4. Conclusions

Refugees experience high levels of mental health problems and are currently receiving very little support from the health service in relation to those problems. Whilst the 17 case studies were selected on the basis of participants having a mental health problem, the 121 interviewees contacted by Community Researchers were not selected on this basis. Despite this almost every interviewee had experienced a mental health problem or knew someone with a severe problem. Difficulties ranged from mild depression to totally debilitating trauma that prevented refugees from leaving the house and therefore from making social contact, seeking work or joining ESOL classes.

The fact that refugees experience these levels of mental health problems is perhaps no surprise. The problems and challenges they face are multi-faceted, inter-linked and complex. In the UK those who are unemployed, homeless, have experienced loss, been the victims of trauma and experienced discrimination are more likely to experience a mental health problem. Refugees often experience all of those problems at the same time. When they gain their refugee status they automatically become homeless and unemployed. Many have seen relatives killed in front of them, been persecuted or attacked in their country of origin and then had to go through a process that essentially criminalises them in the UK and undermines their identity as refugees by questioning the authenticity of their experience. Finally as they struggle to make a place for themselves in their city of sanctuary, many often find that they are not welcomed by the local population and experience discrimination and harassment in many different areas of their lives.

Evidence from this study indicates that despite having obvious symptoms of mental health problems, the support and treatment that refugees receive is inadequate. Few interviewees had received any treatment beyond painkillers or anti-depressants. Counselling is hard to access and does not seem to bear much relationship to the complex challenges faced by refugees. Services tend to be inappropriate for women who have experienced sexual violence. Many refugees struggle to communicate to their GPs and those that do get referred to specialists wait months to access services sometimes giving up before their appointment arrives. Findings suggest that some individuals do end up in hospital, others we were told commit suicide. Furthermore this study suggests that community mental health services or GPs are not equipped to deal with the complex nature of refugees' problems. Certainly further action is needed to deal with the level of difficulties experienced by refugees, leaving so many people without support can only lead to the a further deterioration in the mental health of some of the most vulnerable newcomers.

Ethnic, and to a lesser extent faith, communities act as a major support network for refugees including giving emotional, psychological and financial support; a space for socialising which helps them to reduce their isolation and loneliness; information on how to access services and resources. Whilst refugees value their community groups, it could be argued that expecting community groups to do the work of the social or health services is a risky strategy. Firstly those individuals in severe need are not getting access to the specialist health that they genuinely need. Secondly, expecting individuals to rely entirely upon their ethnic communities does little to promote

integration. Studies suggest that difficulties accessing housing and services and limited work opportunities, work against community cohesion (Temple *et al.* 2005). Refugee mental health problems are a symptom of a combination of refugees' past experiences and their current experiences trying to build a life in the UK. Whilst it is not possible to undo past experiences it is possible to improve the quality of experiences that refugees have once they arrive in the UK. Some of the problems cannot be overcome without a general change of the attitude towards asylum seekers and refugees.

In order to reduce mental health issues associated with uncertainty, the asylum system should be improved to process applicants more quickly to reduce the waiting times that are so stressful for refugees. In addition the whole system needs to be more open so that it is clear to refugees exactly what the process is, and what they can expect. In the interests of community cohesion there is a strong argument for making the system more humane so that it does not create a distrust of the system, the institutions and people within it, that still exists long after a refugee is given leave to remain. Refugees also need better access to housing, employment and education. Dealing with these problems requires changes in national policy and multi-agency working at local and regional levels. It is perhaps more realistic to think about the ways in which asylum seekers and refugees can be supported to deal with the challenges facing them. Greater emphasis on health promotion which capitalises upon the role of RCOs and helps to build safe social space for new communities is required. It is recognised that many of the challenges around the mental health of newcomers are beyond the scope of the mental health system. Having undertaken this research, the *Making a Difference* team, and BNCN in particular, hope that we have cast some light on the range and extent of mental health problems, as well as the issues, that impact on mental health, experienced by refugees in the West Midlands. We hope that as a result of this study some action will be taken to help to improve refugee mental health. Ideally that action would involve a holistic approach whereby refugees get assistance to resolve some of the problems that contribute to the deterioration of their mental health, as well as clinical support where needed. The last section of this report outlines some of the suggestions that respondents made about the ways in which they feel refugee mental health problems might be tackled.

Table 5: Suggestions for tackling asylum seeker and refugee mental health problems

Suggestion	Suggested by
Health Promotion	
Increase the number of community centres and other spaces for socialising and sharing to reduce isolation	Refugees
Provide support to help new arrivals to locate community organisation where established	Refugees
Improve guidance about how to access all services, learn English, access training etc	Refugees
Help refugees to gain work	Refugees
Arrange trips for adults and children, so that they can see how the systems work and feel less isolated	Refugees
Refugees should get involved more with community, agencies and schools. They should be more active in the activities	Refugees

organised by different institutions.	
Focus on causal factors	Providers
Take a holistic approach taking into account cultural background	Providers
Awareness and Education	
Provide training for GPs and counsellors on the nature of the refugee experience, their needs and problems	Refugees Providers
Undertake work to improve the image of refugees so that people realise they want to contribute to society	Refugees
Put on seminars highlighting mental health problems	Providers
Work to reduce the social stigma of mental health	Providers
Promote action at PCT and GP level	Providers
Outreach and Co-ordination	
Increase communication between different community groups so that they can share information and experience perhaps through development of a mental health network	Refugees
Support community organisations so they can act as a link between public services and their community (by providing funding and specialist training)	Refugees
Provide counselling in the community in refugee languages	Refugees Providers
Provide female friendly services for women who have experienced sexual violence	Refugees Providers
Improve ethnic monitoring	Providers
Train refugee communities about how the system works	Providers
Allocate someone at each practice to help refugees	Providers
Provide one to one support	Providers
Develop culturally sensitive services	Providers
Workforce Development	
Appoint some staff with the same ethnic origin or at least the same language in public services (such as in NHS, job centre and City Council)	Refugees
Train refugee health professionals to be mental health professionals	Refugees
Provide leaflets for professionals on refugees' mental health problems	Providers
Provide trained interpreters who understand mental health issues	Providers

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Appendices

A1: Country of Origin of the Refugees

	Frequency	Percent
Afghanistan	11	9.1
Albania	5	4.1
Burkina Faso	1	.8
Burundi	2	1.7
Cameroon	9	7.4
Chad	1	.8
Congo	12	9.9
Egypt	1	.8
Ethiopia	1	.8
Iraq/ Kurdistan	17	14.0
Iran	10	8.3
Iraq	4	3.3
Ivory Coast	1	.8
Kenya	1	.8
Kosovo	5	4.1
Rwanda	10	8.3
Somalia	14	11.6
Sudan	13	10.7
Syria	1	.8
Yemen	1	.8
Missing	**1**	**.8**
Total	**121**	**100.0**

A2: The Distribution of the Respondents According to their Residence

Area	Frequency	Percent	Area	Frequency	Percent
Alum Rock	1	.8	Newtown	3	2.5
Aston	3	2.5	Northfield	1	.8
Bearwood	1	.8	Quinton	1	.8
Balsall Heath	5	4.1	Ridge Way	1	.8
			Rowley Regis	2	1.7
Bordesley Green	2	1.7	Saltley	1	.8
Coventry	1	.8	Selly Oak	2	1.7
Bromford	2	1.7	Small Heath	6	5.0
Chelmsley Wood	1	.8	Smethwick	7	5.8
Darlaston	1	.8	Sparkbrook	4	3.3
Digbeth	1	.8	Sparkhill	1	.8
Dudley	1	.8	Tilecross	1	.8
Edgbaston	9	7.4	Tipton	1	.8
Erdington	2	1.7	Walsall	1	.8
Great Barr	1	.8	West Bromwich	8	6.6
Handsworth	11	9.1	Washwood Heath	4	3.3
Highgate	5	4.1	Winson Green	4	3.3
Hockley	7	5.8	Wolverhampton	2	1.7
Kingstanding	2	1.6	Yardley	3	2.5
Ladywood	6	5.0	**Missing**	**3**	**2.5**
Lozells	2	1.7	**Total**	**121**	**100.0**
Nechells	1	.8			

A3: Service providers interviewed

ARCH
Birmingham and Solihull Mental Health Trust
Birmingham Asylum Seekers Outreach Team
Chinese Community Centre
Immigrants Counselling and Psychotherapy (ICAP)
Main Street Community Health Centre
MANN (Sheffield)
MIND
MyTime
National Coalition of Anti-deportation campaigns
One Sketchy Close
Rethink
Sahil Asian Women's Project
Vietnamese Mental Health Service (London)
Walsall Black Sisters Collective

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