

Community Engagement Project
The NIHME Mental Health Programme

**Report of the community-led research project focusing on
the mental health needs of refugees and asylum seekers in Manchester**

By



Community in Manchester

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with

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*National Institute for
Mental Health in England*

PERSONAL PROFILES

Elaine Dixon

I am the Chief Executive of HARP (Health, Advocacy & Resource Project), which provides services to people with mental health problems, and I have responsibility for the Community Engagement Research Project. I have held this position for five years and have extensive experience in managing mental health services, both in the statutory and voluntary sectors. I also have experience in setting up and managing a reception centre for Kosovan refugees which gave me first hand experience of working with refugees and asylum seekers and the impact that the war had had on their mental health. I am a qualified social worker and graduate in psychology.

HARP has, over the last few years, seen increasing numbers of refugees and asylum seekers seeking help with housing, benefits and accessing services. We now have a dedicated worker at our young people project working with young asylum seekers. This led to us making a successful bid to carry out this important research, which will be an influential document in terms of shaping mental health services for refugees and asylum seekers. I have particularly enjoyed working with our research volunteers and supporting them throughout the research.

Dan Gratton

I was encouraged to get involved in the Community Engagement Project by HARP Chief Executive Elaine Dixon due to the varied role I hold at HARP of Advice Team Assistant, Administrator, PA to the Chief Executive and Company Secretary of our catering social business Good Mood Food. My interest in this project not only stems from my eagerness to play an active role in all parts of our organisation, but was also encouraged by the mental health aspect of the project, as I initially joined HARP as a volunteer and have personal experience of this area beyond my role at HARP. Prior to and during my time at HARP, I have worked as a volunteer both at Samaritans & Mood Swings Network in Manchester.

I have taken great pleasure from my involvement in this project, having had the chance to meet and work with individuals with a diverse range of experiences, and at the same time further my knowledge of issues facing refugees & asylum seekers. It has also given me the chance to expand my leadership & management skills. I am both impressed & delighted with the enthusiasm shown by all the research volunteers, and am hopeful that the report will prove to be as significant as it was originally hoped.

Aqila Mansoor

I am from Pakistan, where I was a teacher, and have a Masters Degree in Economics. I have done some useful courses since I came to this country, e.g. Esol, community interpreting, classroom assistant, Urdu (A level), clait (computer course), word processing in Urdu, and a parent survival course. I have also undertaken a Certificate in Community-based Research & Mental Health at the University of Central Lancashire.

I work as a volunteer with different refugee-oriented organisations such as ROUTES Project (Black Health Agency) and British Red Cross. I was able to communicate well with many asylum seekers & refugees and get the input needed to give policy-makers an overview of the complex situation of mental health in the community.

Burhan Fatah

I am of Kurdish ethnicity from Iraq; I am now a British citizen. I am one of the researchers and I am 34 years old. I have a degree in Psychiatry and I am the Chairman of Federation of Iraqi Refugees (Manchester).

I was always interested in, and wanted to do, research, especially around mental health. My interest began when I started running the Federation of Iraqi Refugees office twice a week. I found out that my community is in big need of mental health support, information and guidance. There is a huge lack of knowledge about mental health within this most vulnerable community. I will not stop researching and I hope to pass my message through to the NHS and other authorities about the user's movement and our involvement. We hope to work together so we can change the stigma around mental health.

Wadiha Ahmed

I have lived in Manchester for a few years, and during that time I have been involved with a wide variety of organisations and projects. I am an active member of the GMCDP (Greater Manchester Coalition of Disabled People), initially through their refugee project, and am now an executive member. I intend to extend my knowledge and involvement in projects and work that support disabled people and refugees and asylum seekers in Manchester.

Georgina Caswell

During my time as a researcher, I have been studying for an MA in Development Studies as well as working for charities within the HIV sector. I was attracted to this research because I have had several homes and I am aware of the challenges involved when adapting to new environments. However, I could only imagine that as an asylum seeker, these difficulties are even more pronounced because people have not 'chosen' to move, but rather have 'been forced' to do so.

Being involved in this study has taught me many things about mental health and the impact it has on our daily lives. The other researchers have shared with me their personal stories, which reflect courage and determination in the face of enormous challenges. Their positive attitudes motivate me in my everyday work and in my personal life.

Shabana Baig

I graduated as a textile designer and worked freelance for some years but then went on to work in housing for the city council and then community development work. In my current role I work as a project worker and also co-ordinate the volunteer programme for the Routes project (the Black Health Agency). As a project worker my work is providing initial support to asylum seeking and refugee families newly arrived in Manchester. I provide practical and emotional support and help families access relevant support services.

My work also includes the development of a women's group in east and south Manchester. This includes developing activities and awareness projects, which contribute in a positive way to the well-being and mental health of asylum seekers and refugee families, e.g. delivering a 12-week parent survival course for asylum seeker mothers. In my role co-ordinating the volunteer programme I support and work with volunteers to help deliver the

service and also to develop their skills and opportunities. I am currently doing a counselling course to enhance my work and hope to be qualified in the near future.

Molly Ondoga McLelland

I am an hotelier by profession; I worked with Sarova international hotels in Uganda and Kenya Marasa ltd in Uganda. I am a personal assistant to Wadiha Ahmed and I also do part-time work with adults with learning disabilities in the community. I am also a volunteer with Manchester Evens volunteers and I have volunteered at the George Trust too. I am currently taking a course in youth studies diploma level 3 at North Trafford college.

I got involved in this project to support Wadiha Ahmed with her university work and research. Having been involved in this project, it has given me a wider and broad knowledge of mental health issues among refugees and Asylum seekers and ethnic minority. Hopefully this will help improve services offered to them.

David Jones

My name is David Jones and I am 34 years of age. I am from the United States of America and a resident of the state of California. I have been living in the United Kingdom for 12 months. I am the treasurer of the Federation of Iraqi Refugees and serve on the management committee. I also help to run the Federation office in Manchester. I have helped organise meetings and events for Iraqi refugees and asylum seekers.

I have been helping Burhan Fatah with the research questionnaires, and think it is a vital means of assessing how good the mental health services are locally. I have helped with the research questionnaires by interviewing asylum seekers and refugees along with Burhan Fatah who interpreted for me. I also assisted with the evaluation of the results and helped draw up some Pie Charts. I found helping out with this research study very interesting and it is something I would consider doing again in the future.

Sabrina Nutter

My name is Sabrina Nutter and I am age 31. I am a resident of the United Kingdom and live in Manchester. I have been assisting Burhan Fatah with his research papers. I have hopes that the research that we have done will benefit asylum seekers and refugees in and around Manchester. I hope that the research has been beneficial.

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EXECUTIVE SUMMARY

HARP is a mental health charity and voluntary sector organisation based in Manchester and is one of 11 projects from around the country selected to research the mental health needs of black and minority ethnic communities. These research projects are intended as pilot projects aimed at formulating a direction for a larger investigation in the near future. The project was funded by the Department of Health via NIMHE (National Institute for Mental Health in England), and has been overseen by UCLAN (University of Central Lancashire). Training was provided by UCLAN and the project took place between March 2005 and April 2006.

HARP's particular area of focus for the project was 'the mental health needs of refugees and asylum seekers in Manchester'. This gave us great scope for the research as we have extensive connections within statutory and voluntary sector services and have also experienced a growing number of asylum seekers and refugees utilising our advice and advocacy services. This meant that we could easily access individuals from our target community to not only be interviewed, but to actually do the research. Therefore, all the researchers involved in this project were recruited from the BME communities, 3 of who were from asylum seeker and refugee communities, enabling improved access to those people whose opinions and experiences we needed. A steering group was also set up, which included representatives from both community organisations and individuals working in statutory and voluntary sector services.

The difficulties faced by asylum seekers and refugees living in Manchester had become more apparent by what we were being told by people from these communities when they accessed our advice services. It was clear that these difficulties were exacerbating the mental health problems of refugees and asylum seekers, a view that was also held by representatives of the numerous refugee and asylum seeker organisations with whom we had contacts. Primarily, concerns centred on the barriers to accessing mental health services and on the lack of information reaching asylum seekers and refugees.

With this in mind, and following a period of training in Community Research & Mental Health, a questionnaire was designed to gain an insight into the lives of people living in these communities, and to get a clearer picture of the issues facing refugees and asylum seekers in Manchester. We also wanted to collate the opinions of those interviewed in order to formulate some solid recommendations, in the hope that service providers would implement them.

Our results come from 117 face-to-face interviews with asylum seekers and refugees living in Manchester.

Major findings and recurrent themes were as follows:

75% were aged between 25 and 44. Only 7% were aged 55 or over.

Only 30 of the respondents spoke fluent English, with even fewer (24) able to write English fluently.

62 had not been granted status.

82% were Muslim.

Only 16% were in employment, even though 40% were legally allowed to work.

50% or more of the respondents had experienced one or more of the following : Separation from family & friends, Violence, Financial problems, War, Family problems.

A similar number (between 40% and 50%) had experienced the following : Bereavement, Local Displacement, Torture, Persecution, Destruction of home.

98 respondents had experienced depression.

89 had experienced mood swings.

87 had experienced anxiety.

69 had experienced memory loss.

27 had experienced suicidal thoughts.

98 had experienced language difficulties.

78 had experienced unemployment.

71 had experienced racism (44 of whom stated it had had a negative effect on their mental health)

Respondents had little or no knowledge of local services nor of what 'mental illness' actually was.

Respondents stated that 'Support from Family & Friends' was the most important thing in maintaining good mental health, however, the most common experience was 'Separation from Family & Friends'.

When this is compounded by mental health difficulties, racism and discrimination, language difficulties and lack of information, the result (as stated by the respondents) becomes obvious - Isolation.

In light of this information, we formulated a set of recommendations aimed at service providers, in the hope that they will be discussed further and implemented as soon as possible. The report therefore requests that the following be considered in the future planning and implementation of mental health service provision :

1. Education

- o **Service providers** : There is need for people to be aware of the issues facing asylum seekers and refugees and implementation of staff training to gain knowledge of their rights and different cultural needs.
- o **Asylum seekers & refugees** : Community Development Workers would be vital in helping asylum seekers and refugees to access education, particularly with regard to mental health. Respondents repeatedly spoke of mental health in religious terms and linked it with superstition, myth and even magic.
- o **Wider community / public** : Racism and discrimination becomes more prevalent in socially deprived communities and in predominantly white communities. Improvements could be achieved through increased community interaction and integration via activities centred on community involvement.

2. Appropriate and responsive services

There needs to be more development of appropriate mental health services to help refugees and asylum seekers to deal with the mental health difficulties highlighted in the research i.e. depression, anxiety, mood swings, nightmares, flashbacks etc.

The development of these services needs to acknowledge the research findings on what the refugees and asylum seekers found to be most useful e.g. counselling, support workers and places to meet to reduce isolation.

3. Trained mental health link workers across the city will help these people settle in their local communities they live in so that they are not excluded or isolated. When separated from the families there is a big impact on Asylum seekers and refugees due to inappropriate language.

4. Trained community support workers would be culturally sensitive and articulate to the specific and different needs of service users, and would be able to support and orientate newly arrived asylum seekers, ensuring they know about local services and can access them.

5. More Community Development Workers both from within and outside the communities of asylum seekers, community development workers would educate people about mental health. This would contribute to removing the stigma around mental health and would improve understanding around the different types of mental health issues and the services available.

6. Access to information in different languages

Asylum seekers have little information about the mental health services available in their local area. Whilst leaflets may be available, they are not accessible in the languages of asylum seekers. Statutory services need to set up information for asylum seekers / refugees by printing leaflets in their own languages to help them to access mental health services. A directory of services should be made available.

7. Right to work

Not working means that many people feel inadequate and useless, as they want to contribute to society and to be able to support their families. Not allowing asylum seekers to work leads to an increase in the instances of people having no option other than to work illegally, in order to maintain some semblance of an ordinary life. Many asylum seeker families find it impossible to survive on benefits and so choose this option, despite the fact that they will be exploited and forced to work in conditions with poor health and safety and for very low pay.

8. Availability of activities as part of mental health services

Community Living Services in Manchester provided by the Mental Health Care Trust need to consider the needs of refugees and asylum seekers providing appropriate and culturally sensitive services where people can meet and get support. Consultation needs to take place within the community of refugees and asylum seekers on how this can be developed. The voluntary sector mental health forum is well placed to consider the recommendations

contained in this report and to look at ways of taking them forward through its involvement with the development of the mental health commissioning strategy.

9. Services for women

Outreach workers are a particularly important need for women as they are often isolated and cannot access support. Projects working with women who have experienced sexual and / or domestic violence should also ensure that they are trained on the particular needs of refugee and asylum seeker women.

10. Accommodation

There should be provision of appropriate accommodation as unstable or inadequate accommodation impacts adversely on mental health.

11. Advice & Advocacy

An advocacy scheme could be developed to help refugees and asylum seekers access the services they need. Advocates including paid workers and volunteers should be recruited from the refugee and asylum seeker communities. Dedicated multi-disciplinary teams should be set up to work with refugees and asylum seekers. This should include addressing the needs of refugees in relation to work opportunities, training, education as well as leisure opportunities.

12. National Service Framework

Standard 1 of the National Service Framework for Mental Health (Department of Health, 1999) requires health and social services to: promote mental health for all and work with individual and communities and combat discrimination against individuals and groups with mental health problems and promote their social inclusion. Mental health interventions that are sensitive to the needs of refugees and asylum seekers need to be developed in partnership with this community. They should be an integral part of designing sensitive services.

13. Delivering Race Equality

We would like to recommend that further examination of this research in line with the action plan contained in Delivering Race Equality is conducted so that the development of appropriate services for refugees and asylum seekers can be properly informed.

INTRODUCTION

The Centre For Ethnicity and Health's Model of Community Engagement

Background

We often hear the following words or phrases:

- o Community Consultation
- o Community Representation
- o Community Involvement/Participation
- o Community Empowerment
- o Community Development
- o Community Engagement

Sometimes they are used inter-changeably to mean the same thing. Sometimes the same word or phrase is used by different people, in the same meeting, to mean different things. The Centre for Ethnicity and Health has a very specific notion of Community Engagement, and this paper is an attempt to describe it. The Centre's Model of Community Engagement evolved over a number of years as a result of its involvement in a number of projects. Perhaps the most important milestone however came in November 2000, when the Department of Health awarded a contract to what was then the Ethnicity and Health Unit at the University of Central Lancashire to administer and support a new grants initiative. The initiative aimed to get local Black and minority ethnic community groups across England to conduct their own needs assessments, in relation to drugs education, prevention, and treatment services.

The Department of Health had two key things in mind when it commissioned the work; first, the Department of Health wanted a number of reports to be produced that would highlight the drug-related needs of a range of Black and minority ethnic communities. Second, and to an extent even more important, was the process by which this was to be done. If all the Department of Health had wanted was a needs assessment and a 'glossy report', they could have directly commissioned a number of researchers who could have gone into local Black and minority ethnic communities, talked to them about their needs, written up a report, and produced yet another set of reports that potentially do not have any long term impact.

This scheme was different however. The Department of Health was clear that it did not want researchers to go into the community, to do the work, and then to go away. It wanted local Black and minority ethnic communities to undertake the work themselves. These groups may not have known anything about drugs, or anything about undertaking a needs assessment at the start of the project; what they would have is proven access to the communities they were working with, the potential to be supported and trained and the infrastructure to conduct such a piece of work. They would be able to use the nine-month process to learn about drug related issues and about how to undertake a needs assessment. They would be able to benefit and learn from the training and support that the Ethnicity & Health Unit would provide, and they would learn from actually managing and undertaking the work. In this way, at the end of the process, there would be a number of individuals left behind in the community who would have gained from undertaking this work. They would have learned about drugs, and learned about the needs of their communities, and they would be able to continue to articulate those needs to their local service providers, and their local Drug Action Teams. It was out of this project that the Centre for Ethnicity and Health's model of community engagement was born.

The model has since been developed and refined, and has been applied to a number of areas or domains of work. These include:

- o Substance Misuse
- o The Criminal Justice System
- o Sexual Health
- o Mental Health
- o Regeneration
- o Higher Education
- o Asylum

New communities have also been brought into the programme: although Black and minority ethnic communities remain a focus to the work, the Centre has also worked with:

- o Young people
- o People with disabilities
- o Service user groups
- o Victims of domestic violence
- o Gay, lesbian and bi-sexual people
- o Women
- o White deprived communities
- o Rural communities

In addition to the Department of Health, key partners have included the Home Office, the National Treatment Agency for Substance Misuse, the Healthcare Commission, The National Institute for Mental Health in England, the Greater London Authority and Aimhigher.

The Key Ingredients

According to the Centre for Ethnicity and Health model, a Community Engagement project must have the community at its very heart. In order to achieve this, it is essential to work through a **host community organisation**. This may be an existing community group, but it might also be necessary to set a real or virtual group up where one does not exist already. The key thing is that this host community organisation should have good links to the target community¹ (whoever this is) such that it is able to recruit a number of people from the target community take part in the project and to do the work (see section on task below). It is important that the host community organisation is able to provide a co-ordination and infrastructure (e.g. somewhere to meet; access to phones and computers; financial systems) for the day-to-day activities that will be undertaken once the project is underway. One of the first tasks that this host community organisation undertakes will be to recruit a number of people from the target community to work on the project.

¹ The target community may be defined in a number of ways – in many of the Community Engagement Projects that we have run we have defined it by ethnicity. We have also worked with projects where it has been defined by some other criteria however, such as age (e.g. young people); gender (e.g. women); sexuality (e.g. gay men); service users (e.g. drug users or mental health service users); geography (e.g. within a particular ward or estate) or by some other label that people can identify with or rally around (e.g. victims of domestic violence, sex workers).

A Host Community Organisation	With Good Links To The Target Community	To Provide Basic Infrastructure For The Project (Recruit And Co-ordinate Project Team; Provide Office Space, Phones And Computers; Look After The Finances)	To Recruit A Number Of People From The Target Community To Do The Work
A Task	Time Limited Meaningful Manageable	A Piece Of Research Into Key Needs/Gaps/Issues For The Community	Learning And Development Of Key Individuals; Access Hard To Reach Groups; Raise Awareness and Debate; Community Ownership
Support	Financial (Typically Up To £20,000)	Training And Workshops; On-Going Support And Guidance; Personal Tutor	Statutory Partnerships; Steering Groups; Sustainability

The second key ingredient is the **task** that the community is to be engaged in. According to the Centre for Ethnicity and Health model, this must be something that is meaningful, time limited and manageable. Nearly all of the community engagement projects that we have run have involved communities in undertaking a piece of research or a consultation exercise within their own communities. Sometimes we have been met with an initial resistance to doing ‘yet another piece of research’, but this misses the point. As in the initial programme that we ran on behalf of the Department of Health, *the process (i.e. of getting ordinary people involved in doing the work) is as important, if not more important, than the report that they produce at the end of the day.* The task or activity is something around which lots of other things will happen over the lifetime of the project. Individuals will learn and new partnerships will be formed. Besides, it is important not to lose sight of the fact that it will be *the first time that these individuals have undertaken a research project.*

The final ingredient, according to the Centre for Ethnicity and Health’s model, is the provision of appropriate **support** and guidance. We do not expect community groups to become involved for nothing. Typically we would make in the region of £15-20,000 available to the host organisation. We would expect that the bulk of this money would be used to pay people from the target community as community researchers². We then allocate a named member of staff from our Community Engagement Team as a project support worker. This person will visit the project at for at least half a day once a fortnight. It is their role to support and guide the host organisation and the researchers through the project. We also provide a package of training – typically in the form of a series of accredited workshops. The accredited workshops give participants in the project a chance to gain a University qualification whilst they undertake the work.

The support workers will also assist the group to pull together a steering group for the project³. The steering group is an essential element of the project: without one, it is difficult to see who the community are engaging with and it is unlikely that anything out of the project will be sustained in the longer term. The group will be doing a needs assessment or a consultation exercise, but for what purpose? It is the role of the steering group to ensure that the work that the group undertakes sits with local priorities and strategies, and that there is a mechanism for picking up the findings and recommendations that the group may make. It is

² This is not always possible, for example, where potential participants are in receipt of state benefits and where to receive payment would leave the participant worse off.

³ Very often we will have helped groups to do this very early on in the process at the point at which they are applying to take part in the project.

also their role to help to pick up the key individuals who are developed through the project process to help them to take their 'next steps'.

The Community Engagement Team

The Community Engagement Team comprises of 25 members of staff. They work across a range of Community Engagement areas of specialism, within a tight regional framework.

National Programme Directors			
Northern Team	Midlands Team	Southern Team	Senior Programme Advisors
Senior Support Worker	Senior Support Worker	Senior Support Worker	
Support Workers X 3	Support Workers X 3	Support Workers X 6	Drug Interventions Programme
			Regeneration
			Mental Health
Teaching And Learning Team			
Administration Team			
Communications Officer			

Programme Outcomes

Each group involved in any of our Community Engagement Programmes is required to submit a report detailing the needs, issues or concerns of the community that it consulted with. The qualitative themes that emerge from the reports are often very powerful, particularly when taken together with other reports produced by groups involved in the same programme. Such information is key to commissioning and planning services for diverse and 'hard to reach' communities. Often new partnerships between statutory sector and hard to reach communities are formed as a direct result of community engagement projects.

The capacity building of the individuals and groups involved in the programme is often one of the key outcomes. Over 20% of those who are formally trained go on to find work in a related field.

The Focus Of This Particular Report

Since 2000 over 200 community groups have taken part in one or other of the Centre for Ethnicity and Health's Community Engagement Work Programmes.

HARP is a voluntary sector organisation providing services to people with mental health needs living in Manchester. We are one of the Community groups who are taking part in the National Institute for Mental Health in England's Community Engagement programme in 2005/2006. The objectives of the programme are to deliver and improve equality of access, experience and outcomes for Black and minority ethnic mental health service users by:

- Building capacity in the non-statutory sector

- Encouraging the engagement of Black and minority ethnic communities in the commissioning process
- Ensuring a better understanding by the statutory sector of the innovative approaches that are used in the non-statutory sector
- Involving Black and minority ethnic communities in identifying needs and in the design and delivery of more appropriate, effective and responsive services.
- Ensuring greater community participation in, and ownership of, mental health services
- Allowing local populations to influence the way services are planned and delivered
- Contributing to workforce development, and specifically the recruitment of 500 community development workers.

The focus of our work is the mental needs of refugees and asylum seekers living in Manchester.

The views expressed in the report are those of the group that undertook the work, and are not necessarily those of the Centre for Ethnicity and Health at the University of Central Lancashire.

Manchester is the regional capital of the north west of England, the UK's largest economic region outside London. The region comprises some 2.5 million households, has a population of over six million and a GDP of £50 billion.

Manchester is a city of startling contrasts and significant challenges. It is the northwest's regional centre for finance, commerce, retail, culture and leisure, home to a major international airport and one of the largest student populations in Europe. It is transforming itself from an industrial city dependent on manufacturing to a thriving, modern, dynamic, international city. Whilst manufacturing remains important, Manchester has attracted growth in the knowledge - based economy and is in the top ten of European cities for business location. But the economic success of the city centre is in sharp contrast to surrounding communities which suffer some of the highest concentrations of crime, poor health and poor housing in the country with 27 of its 33 wards among the most deprived 10% nationally and at 9.1% an unemployment rate nearly twice the national average.

The past decade has seen the growth of an increasingly strong service sector, while even devastating bomb damage to the city centre could not stem the accelerating process of dynamic change and renewed confidence. One of the largest metropolitan authorities in England, Manchester City Council has 26,000 employees and an annual budget of over £500 million. The Council's central purpose is to reverse the cycle of decline and build a strong, sustainable city of the future for the benefit of its entire people.

Refugee & Asylum Statistics

The top 5 asylum applicant nationalities in 2005 were Iran (3140), Somalia (1770), Eritrea (1760), China (1735) and Afghanistan (1585).

Including dependants, the number of applications fell by 25% from 40,625 in 2004 to 30,460 in 2005.

27,495 initial decisions about asylum were made in 2005, 40% lower than in 2004, but more than the number of applications (25,720). 7% of initial decisions were granted asylum, 10% were granted humanitarian protection or discretionary leave and 83% were refused, compared with 3%, 9% and 88% respectively in 2004.

13,080 principal applicants were removed in 2005, 4% higher than in 2004 (12,585). Including dependants, 15,055 asylum seekers were removed in 2005, 1% higher than in 2004 (14,905).

The five nationalities accounting for the highest number of removals (principal applicants) were Iraq, Serbia & Montenegro, Turkey, Afghanistan and Pakistan.

Even though the standard of proof needed to get refugee status is very high, in 2002 more than one in three asylum seekers were found to be in need of protection or were allowed stay on humanitarian grounds. One in four appeals were successful. In 2003, 23% of initial decisions resulted in asylum seekers being given permission to stay in the UK and one in five appeals were successful.

The press often suggests that asylum seekers are coming to Britain for economic reasons, failing to recognise refugee movements as a distinct form of international migration. A report published in June 2004 showed that three out of four asylum seekers were fleeing countries in conflict. Afghanistan, Iraq and Somalia have been in the top five refugee-producing countries for the past three years. War, human rights abuses and the repression of ethnic minorities are common to all these countries.

In 2003, there were 1,396,000 overseas workers in the UK, compared with 49,370 asylum applications.

Asylum seekers cannot claim mainstream welfare benefits. If destitute, they can apply to the National Asylum Support Service (NASS), the Government department responsible for destitute asylum applicants, for basic food and shelter. A single adult is eligible for £38.96 a week, equivalent to 70% of basic income support.

In December 2003, around 80,000 asylum seekers were receiving Home Office support, compared with 15.5 million Britons on benefits (excluding retirement pensions), meaning that 0.5% of those claiming government support were asylum seekers.

From January 2003 to June 2004, government policy denied even this basic support (under Section 55 of the Nationality, Immigration and Asylum Act 2002) to thousands of asylum seekers. The Government was forced to reinstate support, after an appeal court judge found the policy in breach of asylum seekers' human rights. The Home Secretary is likely to appeal against the Court's decision.

A joint study by Oxfam and the Refugee Council (2002) showed how the asylum system institutionalises poverty. The report revealed that 85% experience hunger, 95% cannot afford to buy clothes or shoes and 80% are not able to maintain good health. Many asylum seekers do not receive the basic support they may be entitled to, because the system is badly designed, extremely bureaucratic and poorly run.

A Home Office report shows that people born outside the UK, including asylum seekers, contribute 10% more to the economy in taxes and national insurance than they consume in benefits and public services - equivalent to a boost to the economy of £2.6 billion in 1998/99.

Refugees bring with them a wealth of skills and experience. According to a recent research commissioned by the Department for Work and Pensions, 53% of refugees have academic qualifications, 23-33% of parents of asylum-seeking and refugee children have a first or postgraduate degree and most possess the relevant work experience to pursue careers in their field.

The Aims & Objectives of HARP's Community Engagement Research Project

Aims

- Assess the needs of the local asylum seeker and refugee communities in Manchester.
- Inform future service development in partnership with the statutory sector, other voluntary organisations and commissioners.
- Identify the mental health needs of asylum seekers and refugees.

Objectives

- Recruit 3-6 volunteers from the local asylum seeker and refugee community to carry out the needs assessment.
- Provide volunteers with training and support (including a support worker) through The University of Central Lancashire.
- Provide support to volunteers to enable their attendance at the workshops provided.
- Set up and establish a local steering group.

Our advice workers at the Zion Centre in Hulme, and at our young people's support project in Levenshulme, are working with many refugees/asylum seekers, particularly from African countries such as Somalia and Mozambique. They are also seeing increasing numbers of Iranians and Iraqis. Many of them are experiencing severe mental health problems associated with their experiences prior to arriving here, which include loss and bereavement, post trauma stress, separation from family and experiencing the horrors of war. Once they arrive in England they are experiencing poverty, discrimination, culture shock and isolation. Many find it difficult to cope with the benefit and housing systems and are often totally ignored. One of our workers has built up a really positive relationship with the Somali community and works closely with them.

The Community Engagement Project aims to assess and identify the mental health needs of the local asylum seeker/refugee communities. We want to ensure, through the research carried out by volunteers from the asylum seeker and refugee community, that results will be fed into strategic developments across the city and will influence Manchester's commissioning strategy

Outcomes

- Pathways to support improved
- Gaps in the service identified and addressed
- Long-term funding secured
- Capacity developed within the identified communities to access help and support sooner
- Improved awareness of asylum seeker and refugee rights with regard to access to healthcare, appropriate housing and benefits.

METHODOLOGY

Steering Group

A multi agency steering group was formed which included membership from people who were involved in mental health services and from organisations providing support to refugees and asylum seekers.

The purpose of the steering group has been:

- o Monitoring
- o Support
- o Development
- o Inform strategy and development
- o Inform commissioning

Recruitment, Roles and Responsibilities of Individuals

The researchers were recruited in the following ways :

- o we approached HARP service users from the refugee and asylum seeker communities who we thought might be interested in being involved in the research;
- o we prepared a recruitment poster and circulated this to HARP service users;
- o we sent this recruitment poster to agencies we have worked with who we knew were working with refugees and asylum seekers;
- o we circulated the recruitment poster through the e mail groups we are members of and which we have close links with i.e. Manchester Voluntary Sector Mental Health Forum, Manchester Race Equality Forum, Manchester Advice and Information Network and the Multi Agency for Refugee Integration in Manchester Forum.

The key points required of the researchers to enable them to carry out the research, are listed below.

- o Ability to work on own initiative
- o Some knowledge and understanding of issues facing Refugees and Asylum seekers
- o Good communication skills
- o Access into asylum seeker and refugee communities
- o Team work
- o Ability to analyse and feedback information.

The researchers were involved in designing the research instrument, piloting, selecting the sample group, undertake the fieldwork, input data, analyse data, write up of final report, attend steering group meetings and dissemination of findings.

Effectively Delegating Tasks

There were various tasks throughout the project: by effective teamwork these tasks were delegated to each member of the team and were carried out by the relevant member.

There were regular steering group meetings held in order to monitor the researcher's progress and raise any problems that arose. This meant that any problems were dealt with quickly and effectively.

The training sessions provided the researchers with useful information and beneficial skills that would help them carry out the research project effectively. Training was also received on how to analyse data and how to compile this into the report and how to evaluate the research findings.

The researchers have also met fortnightly, then weekly from January 2006 to discuss the development of the project, support each other in the research and to produce the research report. These meetings have been attended regularly by Mary Carradice from the university.

Access To The Community

The researchers through their own strong links approached the asylum seeker and refugee communities.

They asked members of these communities to take part in the research. They informed those taking part of the nature of the research and the purpose of it.

The researchers gained a broad knowledge of the issues facing asylum seekers and refugees especially issues relating to mental health.

Action Planning

An action plan was drawn up in order to assist the project. The plan outlined the aims and objectives of the project and consisted of tight deadlines, meetings and targets that needed to be met. A work plan was also submitted to UCLAn's ethics committee for approval before fieldwork commenced.

Analysis of Data

In order to reach our conclusions and publish our findings we took the following steps:

- o We analysed the quantitative data (numbers and figures) by inputting the data into Microsoft Excel and converting the data into pie charts and graphs.
- o We analysed the qualitative data (detailed answers to specific questions) by manually reading through each questionnaire and noting down any remarks and comments made by the interviewees.

Target Groups

The target group were refugees and asylum seekers aged 18 and over living in Manchester.

Methods of Data Collection

We agreed that we would use questionnaires to collect data. The questionnaires were compiled using the researchers own knowledge of issues relating to refugees and asylum seekers and mental health.

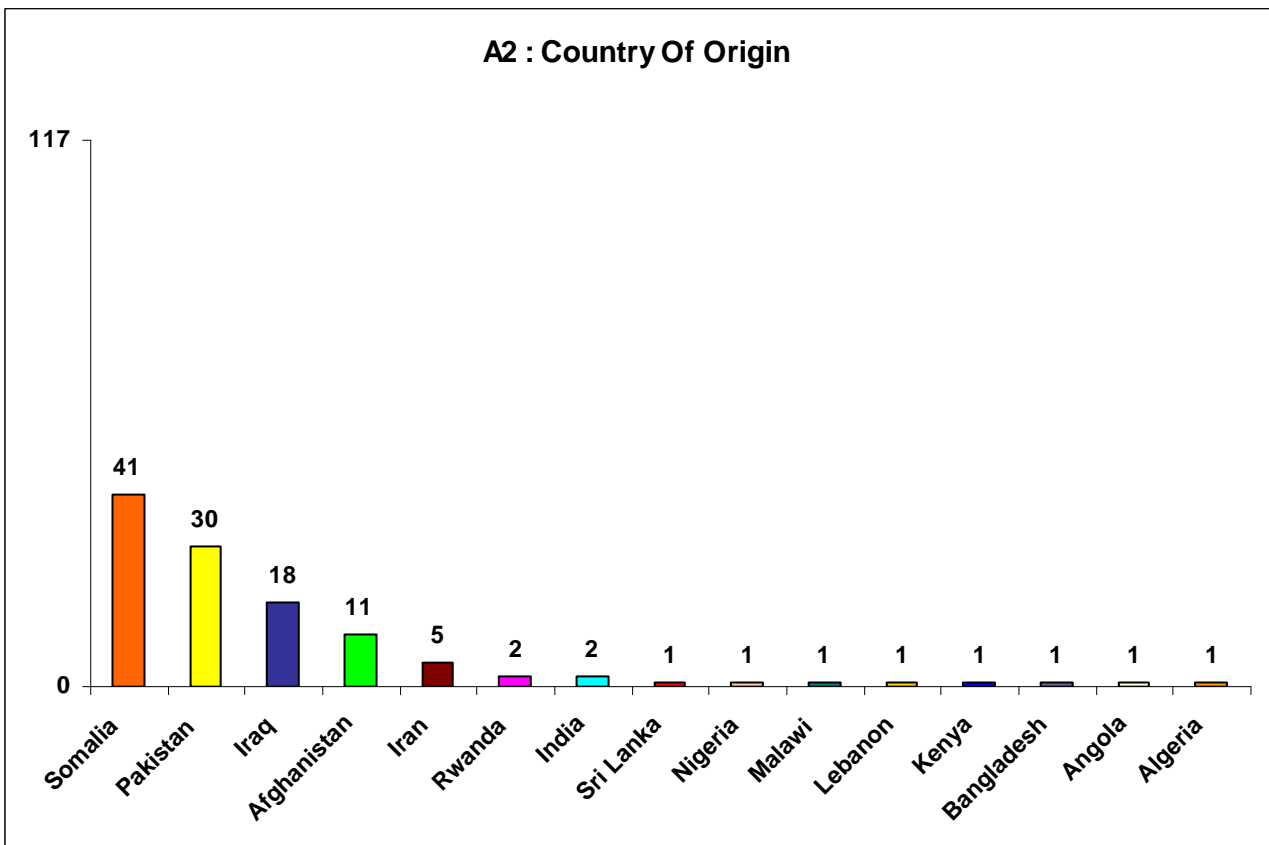
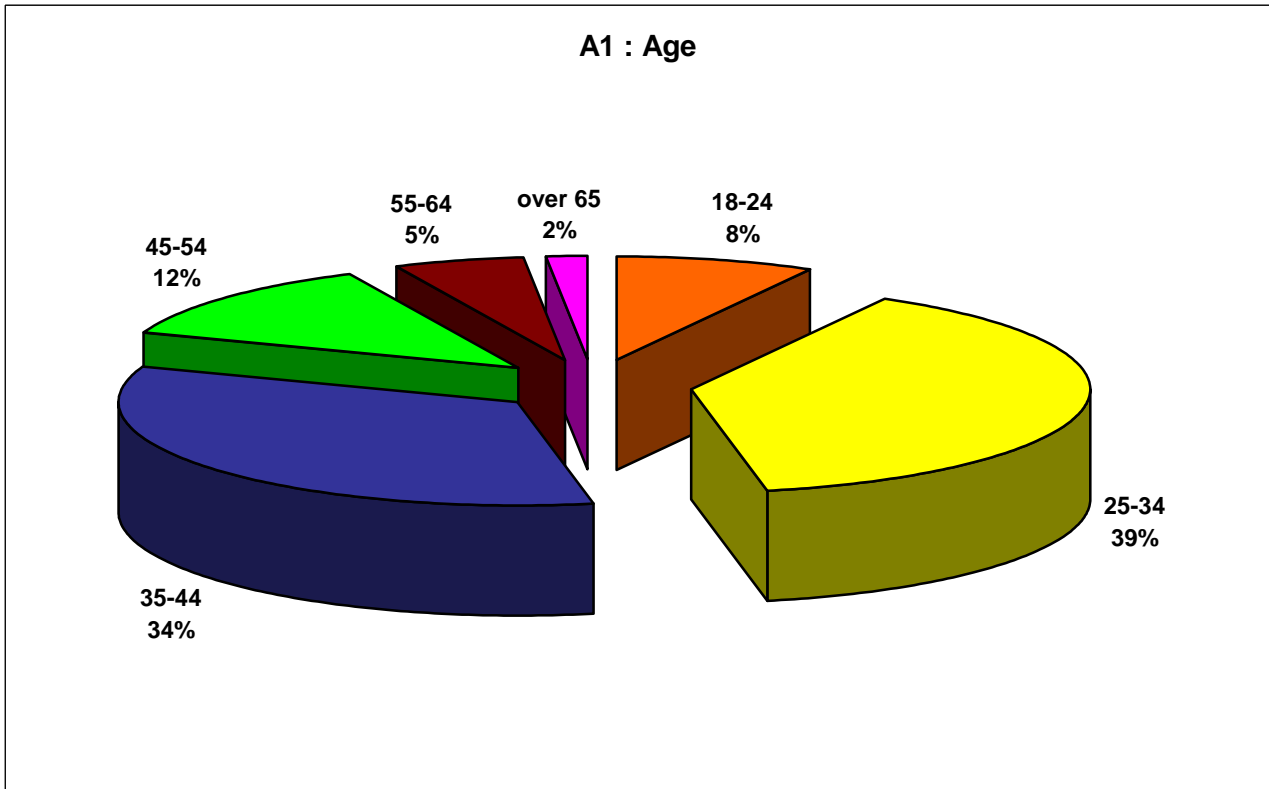
We used both the cluster and purposive sampling method. The cluster sampling method is a random sample drawn from part of the population i.e. One geographical area, in this case Manchester. The purposive sampling method is used to select people who had the information we needed i.e. refugees and asylum seekers.

The interviews were carried out on a one to one basis and the researchers fully informed people about the research project, it's purposes, aims and objectives. The researchers reassured the interviewees that all the information collected was confidential and would only be used for the purpose of this research project. The researchers went through the questionnaires with the interviewees and recorded their responses.

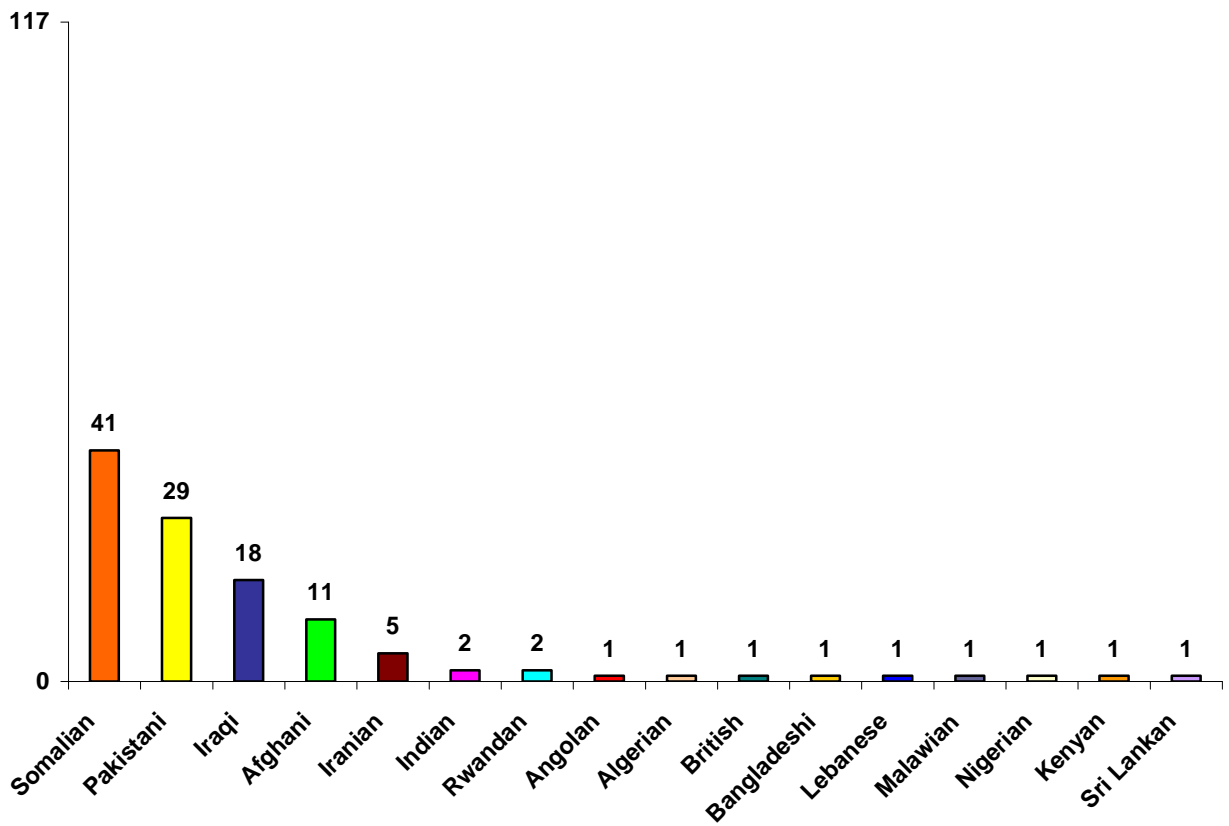
RESULTS

The total number of completed questionnaires was 117 (see appendix for copy of questionnaire)

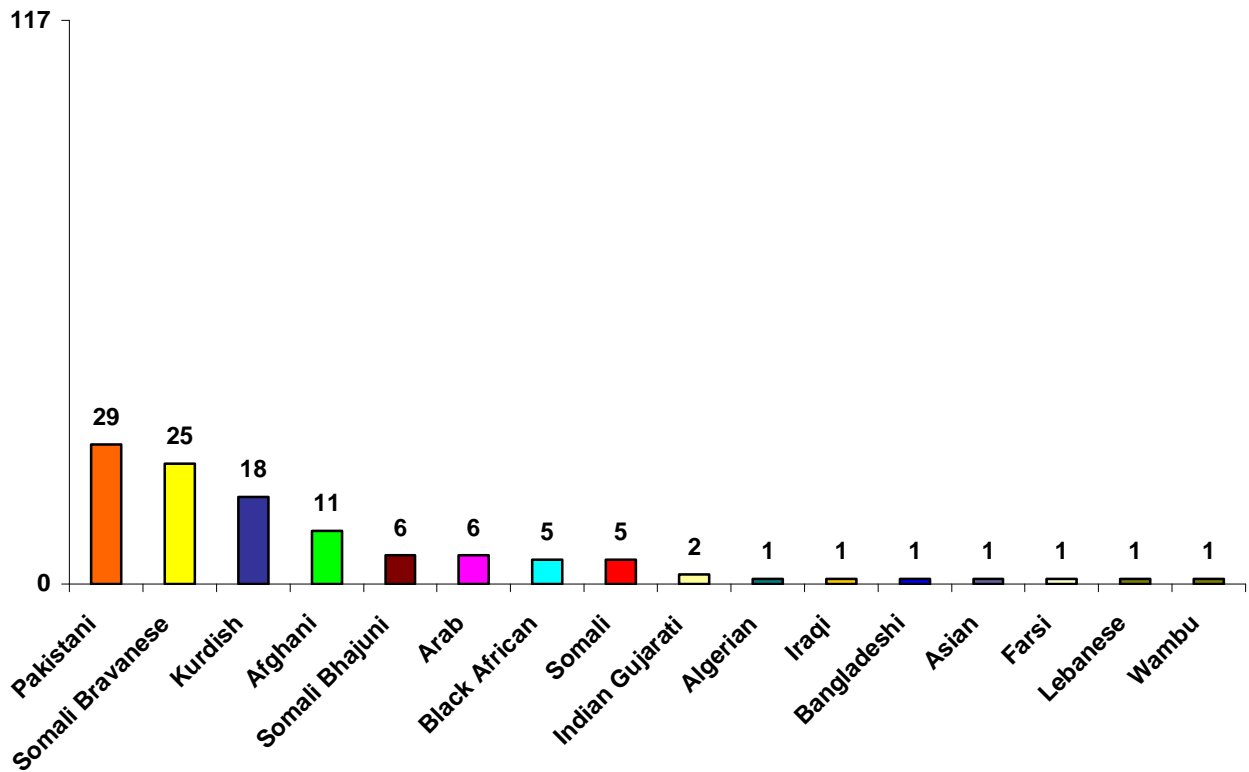
Section A : Core Questions



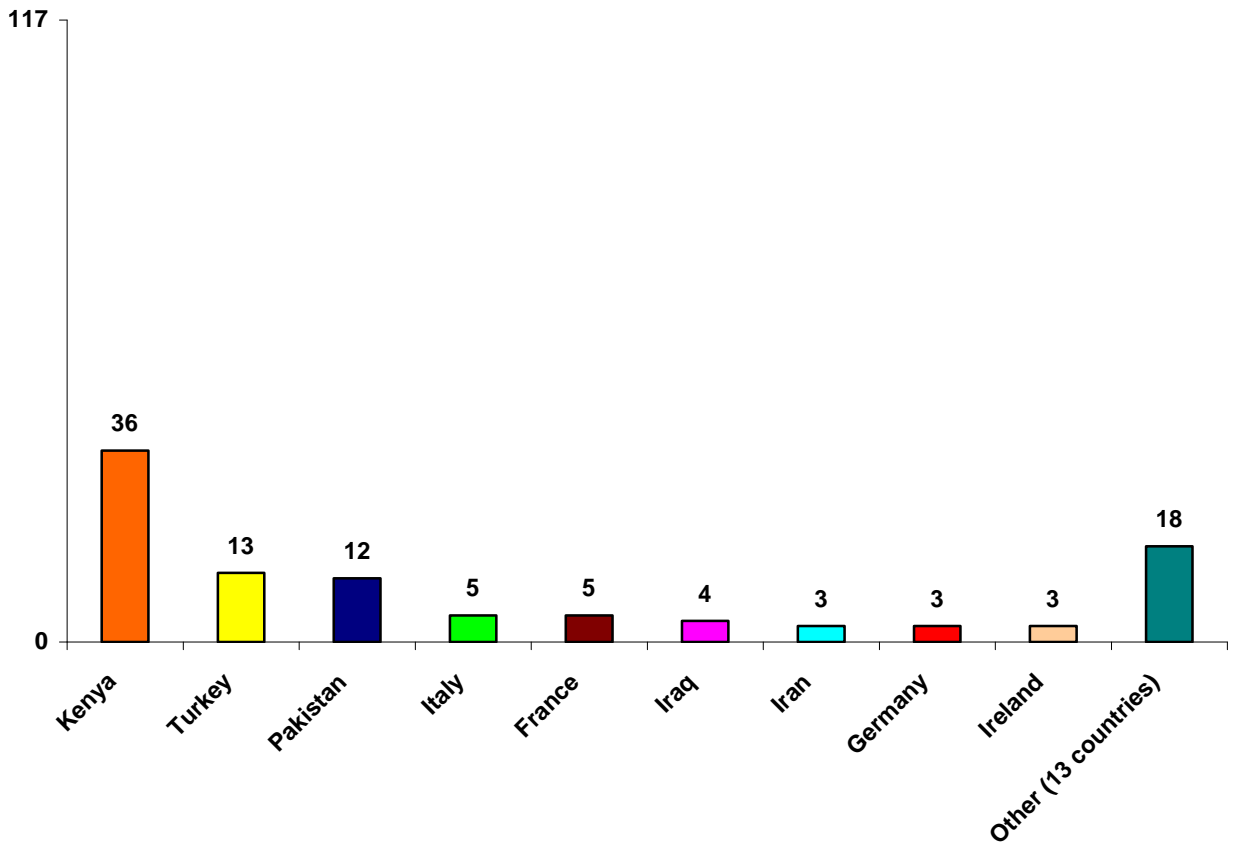
A3 : Nationality



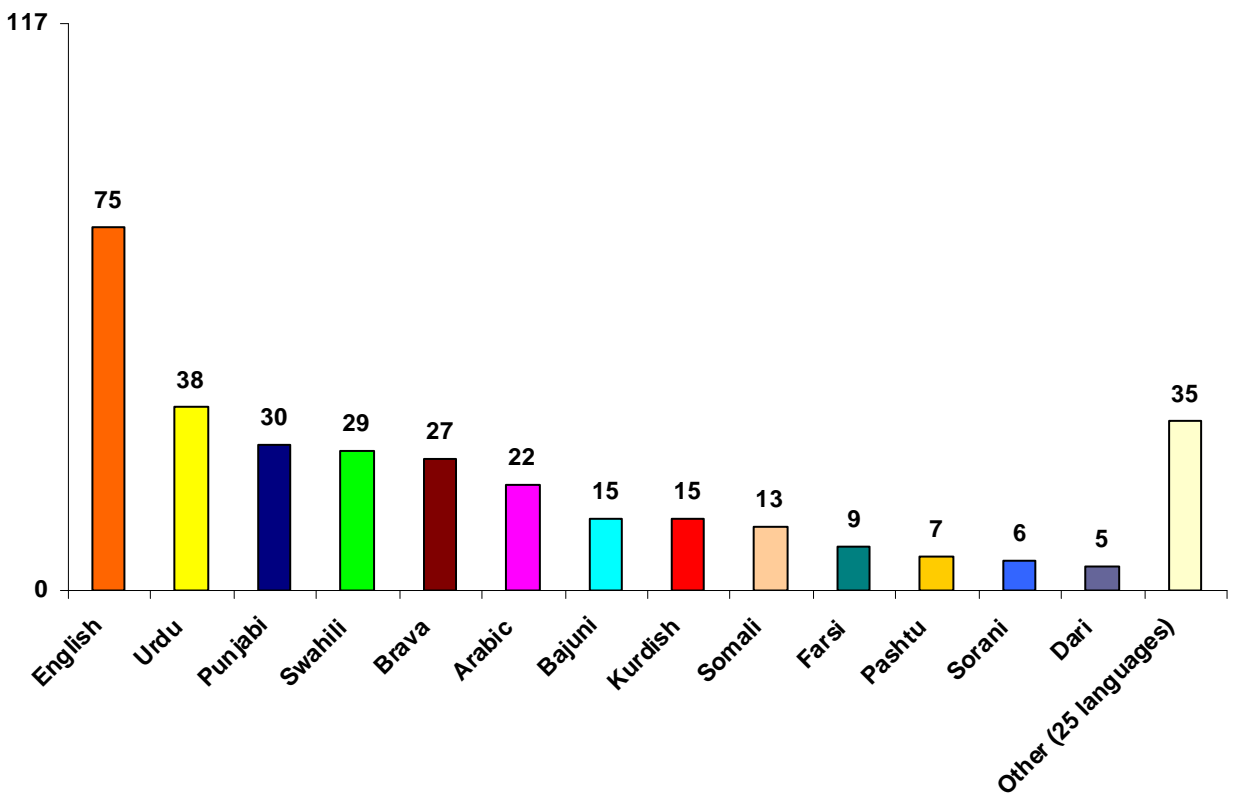
A4 : Ethnic Identity



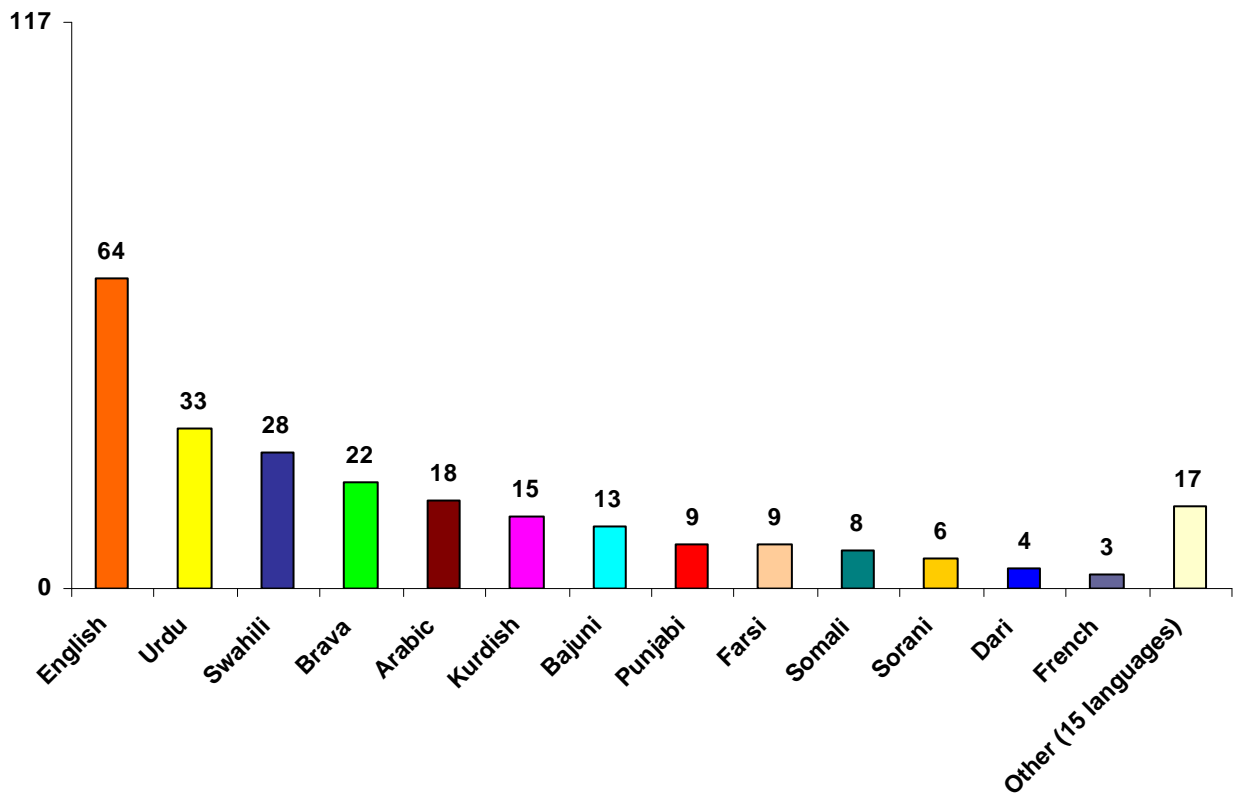
A5 : What other countries have you lived in?



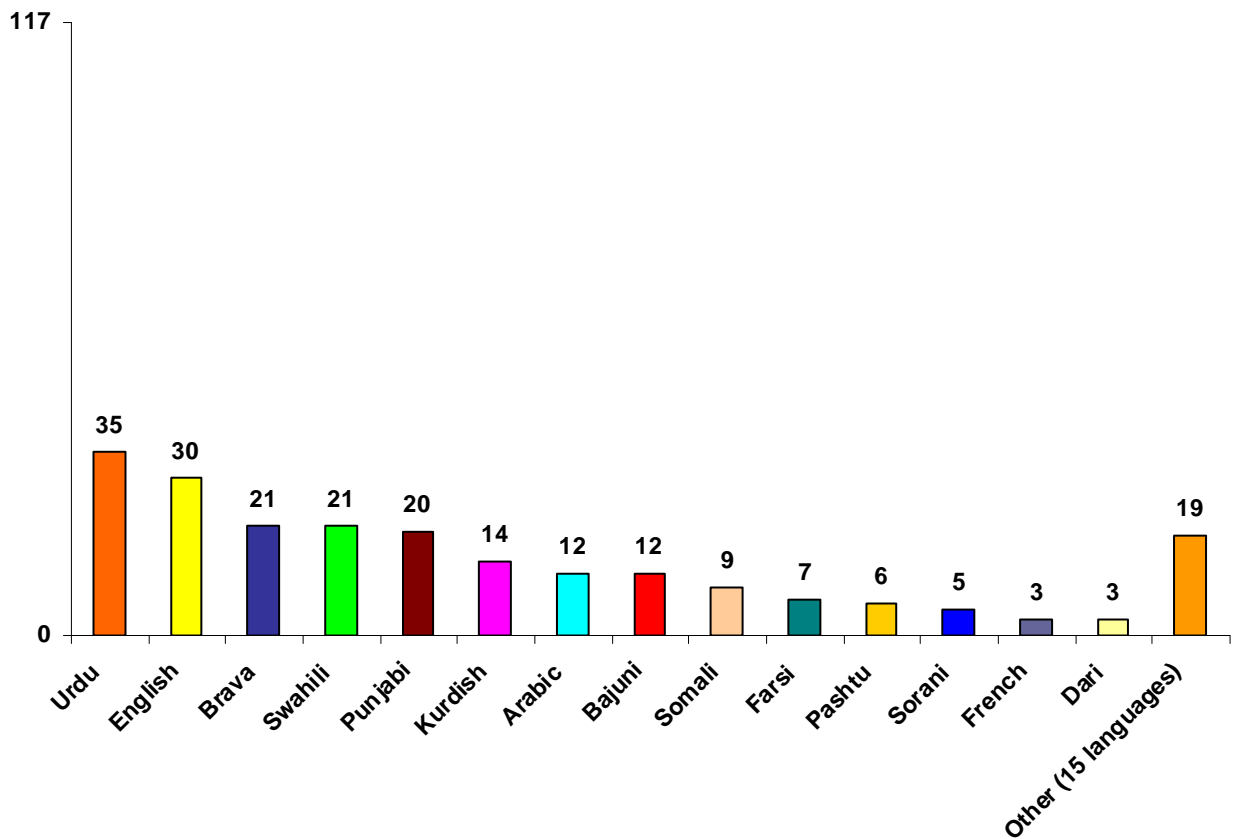
A6(a) : What languages can you speak?



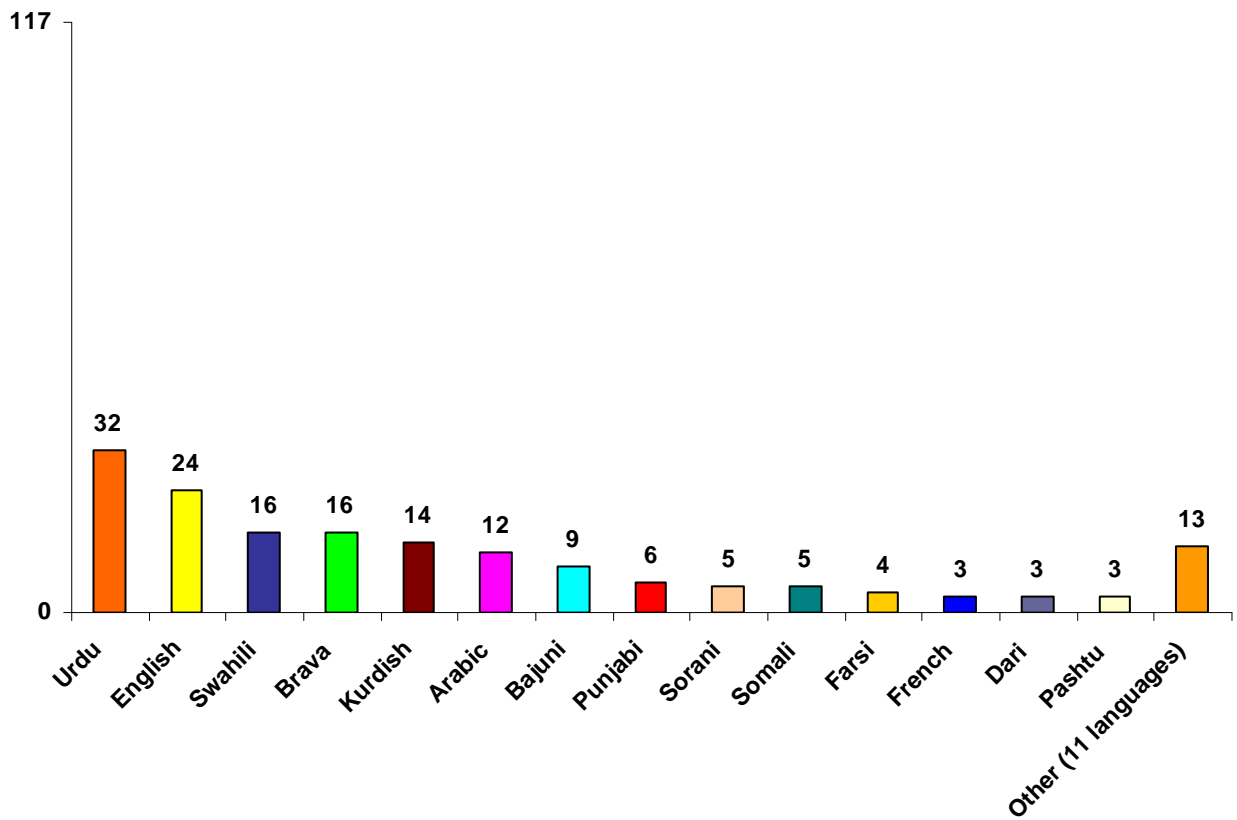
A6(b) : What languages can you write?



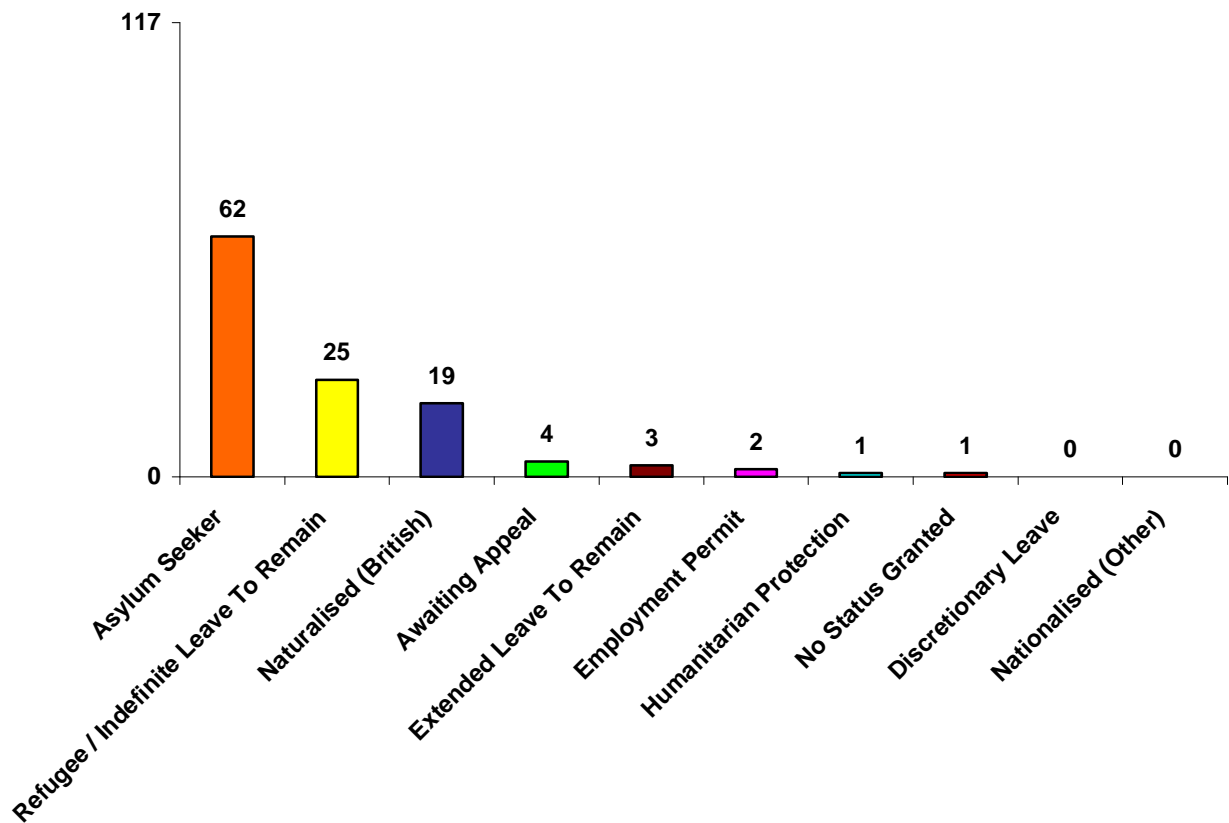
A7(a) : What languages can you speak fluently?

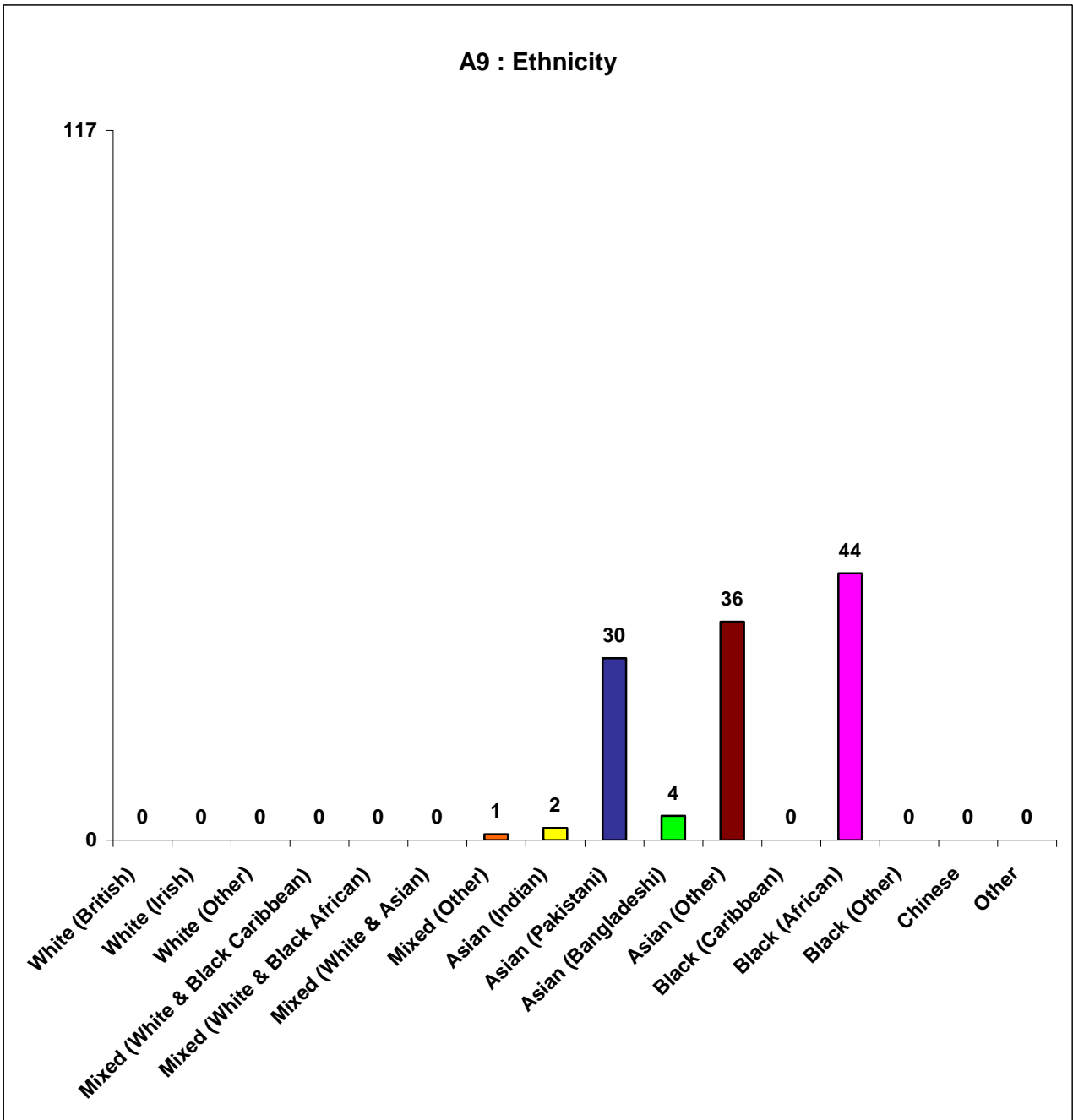


A7(b) : What languages can you write fluently?



A8 : Status





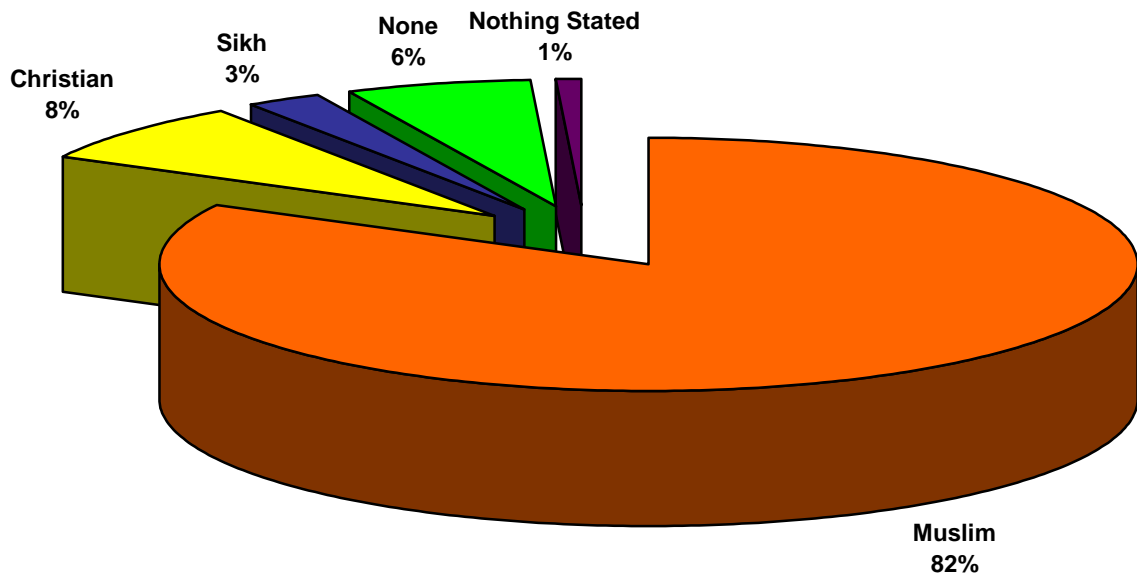
A9 : 'Other' explanations

1 : Mixed (Other) : Algerian

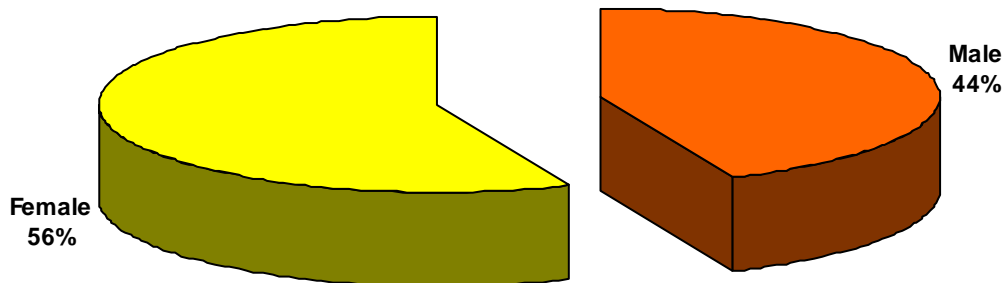
36 : Asian (Other)

- 11 : Afghani
- 10 : Iraqi Kurd
- 5 : Iraqi
- 4 : Iranian Kurd
- 3 : Iraqi Arab
- 1 : Iranian Fars
- 1 : Sri Lankan
- 1 : Lebanese

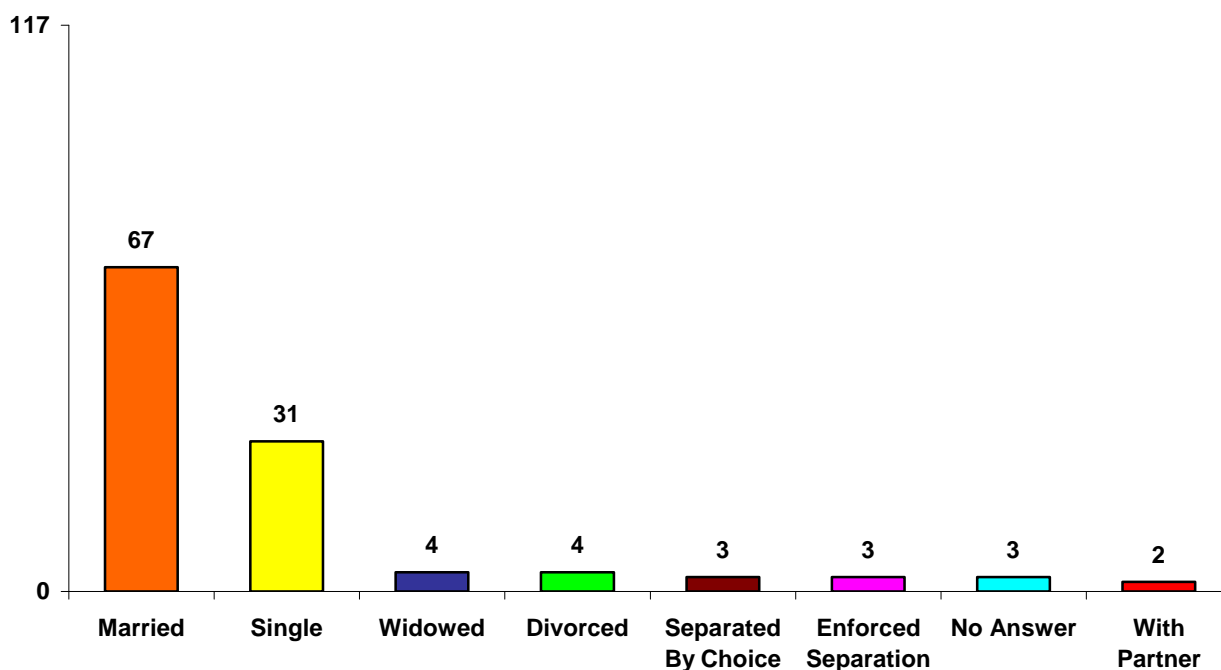
A10 : Religion



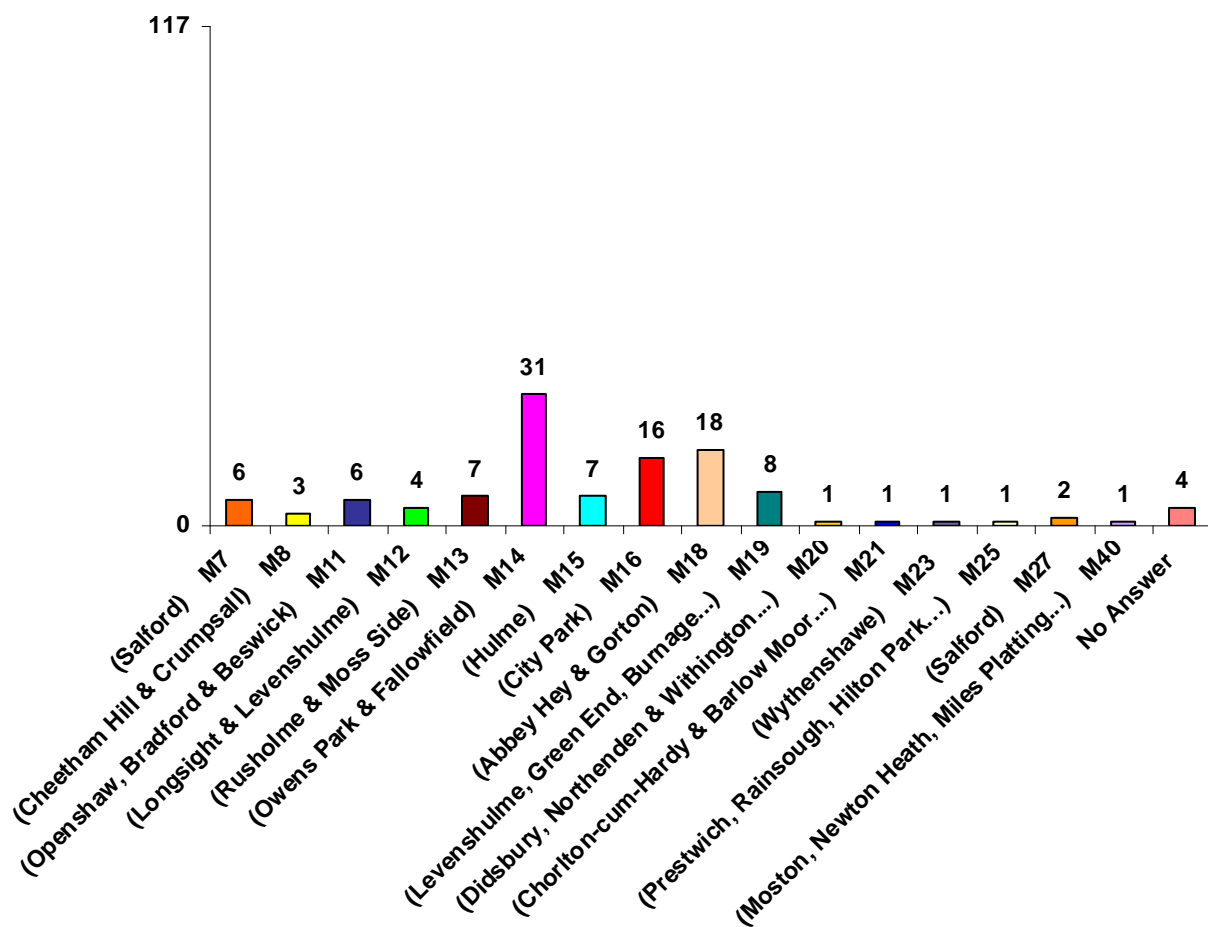
A11 : Gender



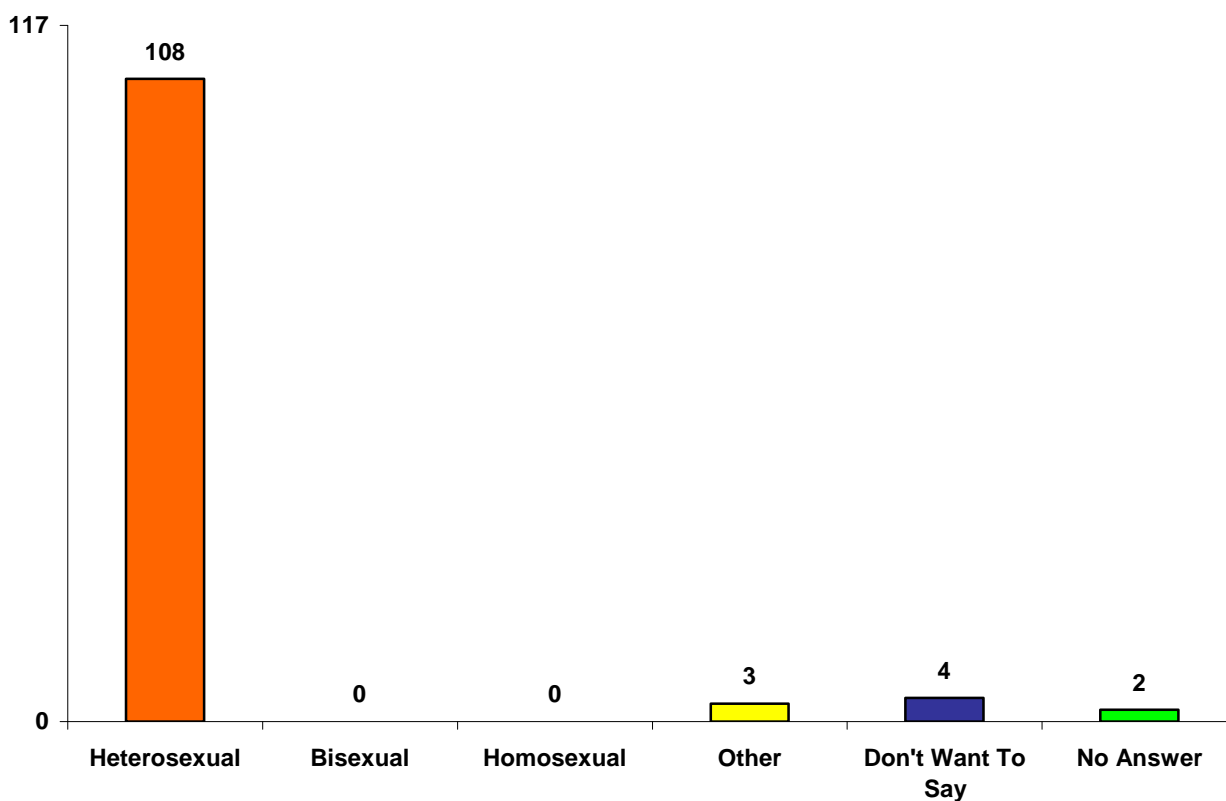
A12 : Marital Status



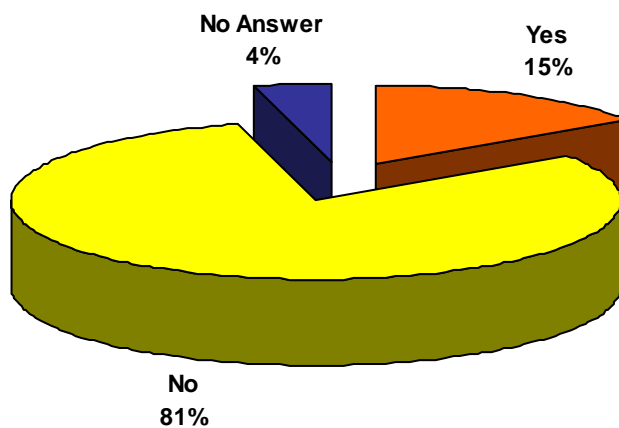
A13 : Location



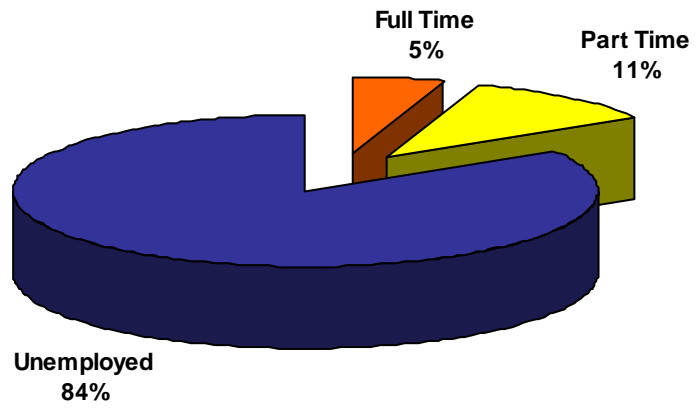
A14 : Sexuality



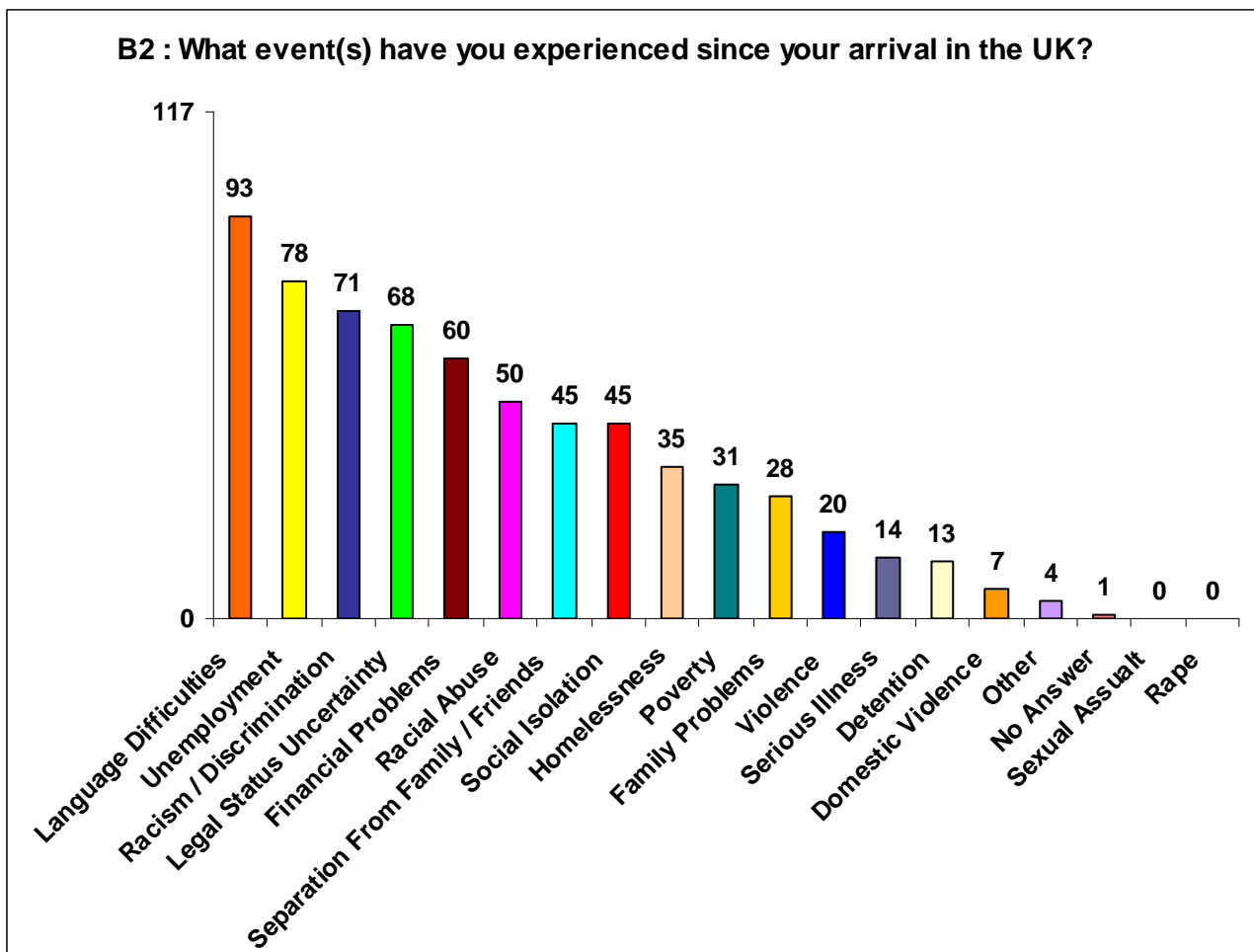
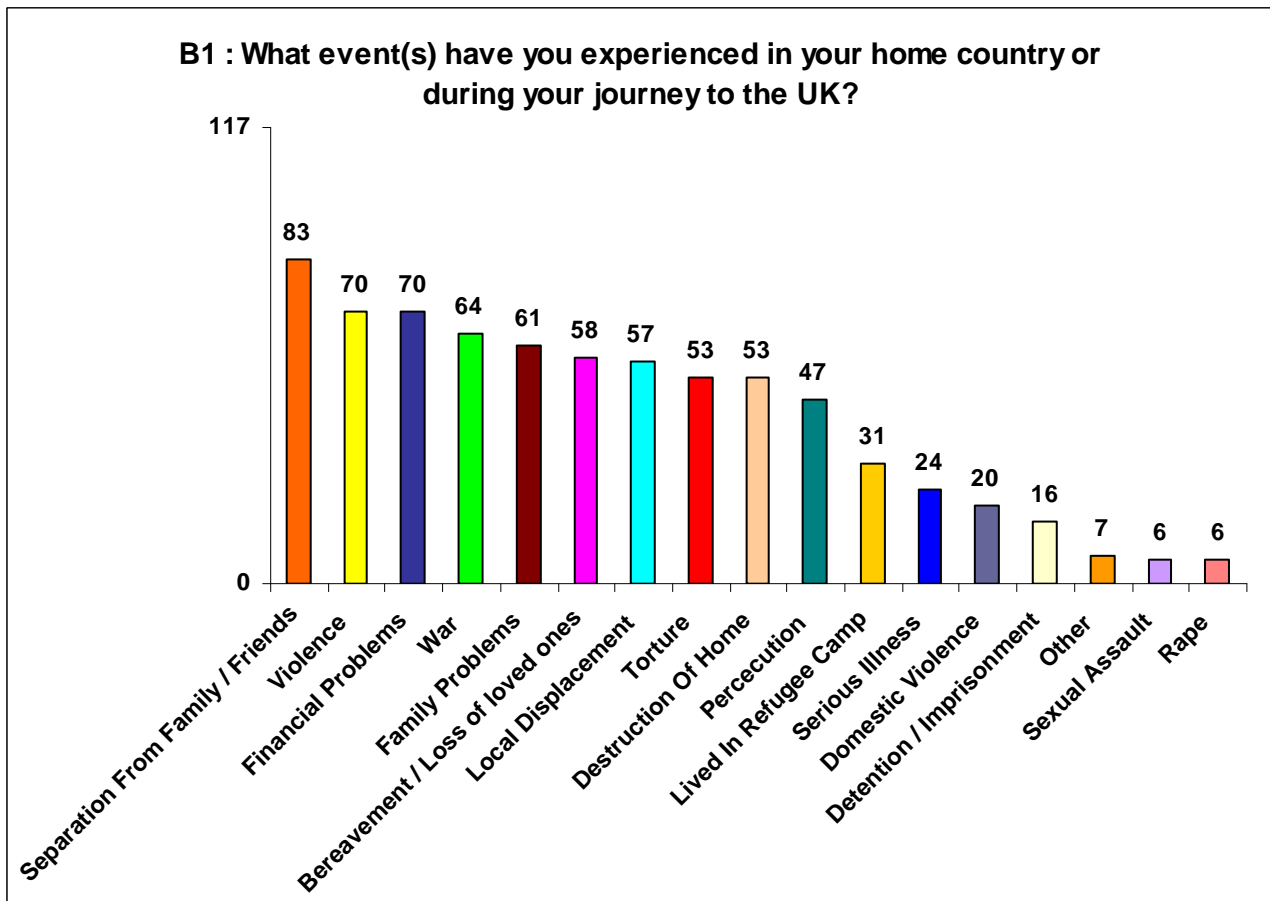
A15 : Do You Have A Disability?



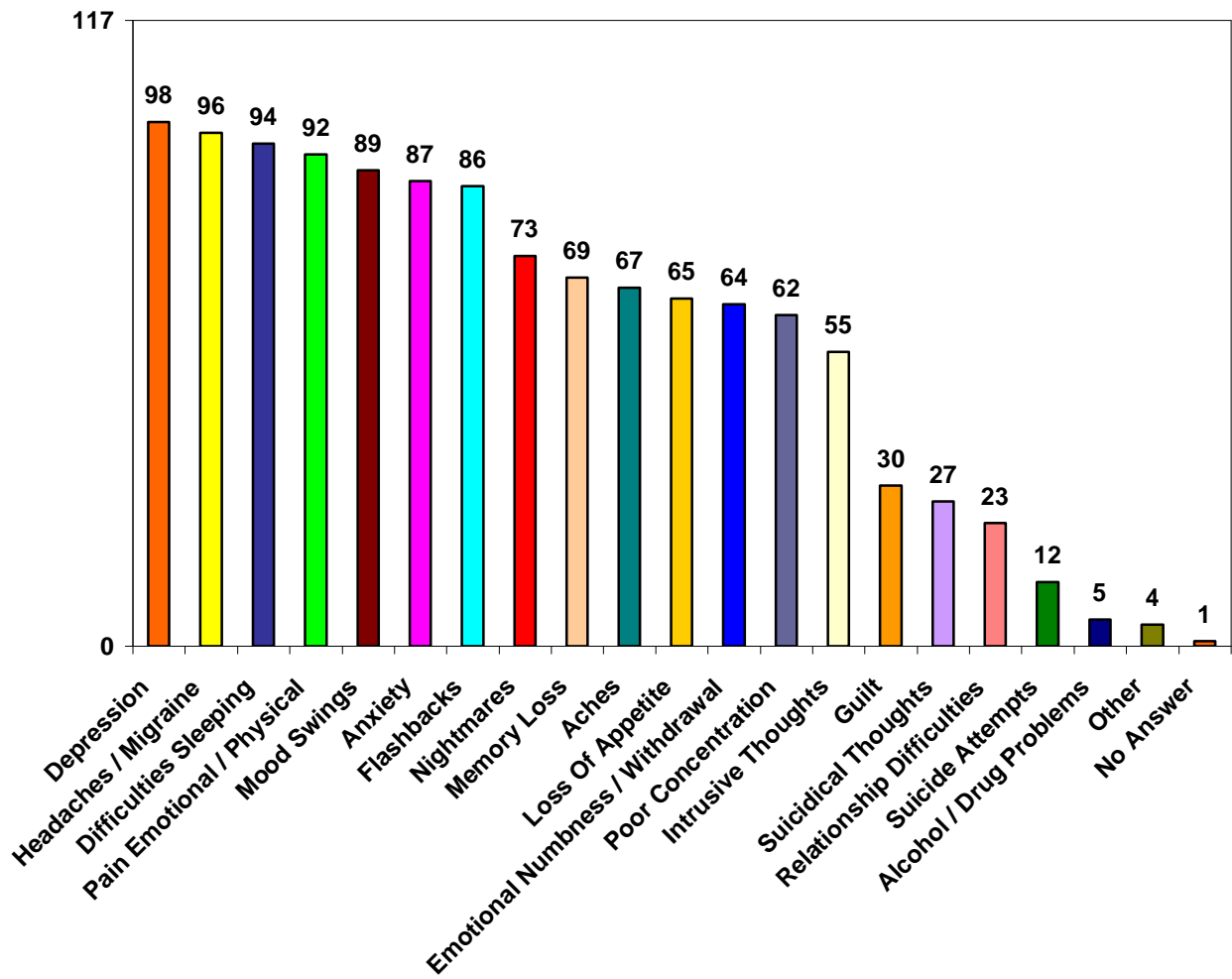
A16 : Employment Status



Section B : Your Experiences



B3 : Have you experienced any of the following, either before you left home and/or since you arrived in the UK?



B4 : What do you understand by 'mental health'?

Recurrent Responses : Crazy, Madness, Depression, Don't know, Don't understand.

The majority of responses focused on the negative side of 'mental health'. Here are some examples :

"Someone who cannot do something correct. A person who is not conscious. He or she doesn't understand what he or she is doing." (Bhajuni, Female)

"Someone's head is not working." (Bhajuni, Female)

"One losing his or her head, e.g. crazy, lunatic (African, Male)

"Someone who is not able to do anything." (Brava, Female)

"It's worse than physical illness by ten times." (Kurd, Female)

"When wanting to harm others but not intentional." (Black African, Female)

"To allow past events to affect you today." (Pakistani, Male)

"I think it is like madness. People are making others mad." (Pakistani, Female)

"Confused. Don't remember things. You can't remember where you are going." (Malawian, Female)

"Full tension. More depression. You feel like it's a brain haemorrhage." (Pakistani, Female)

"To be abnormal and get angry quickly and not able to look after your family." (Afghani, Female)

"When you are sick in any form e.g. fever (Brava, Male)

"It's like madness and people like that need to be treated seriously." (Kurd, Male)

12 responses out of 117 indicated a broader understanding of the term 'mental health'.

"It's internal feelings. Change of thoughts." (Pakistani, Male).

"What's going on with the brain." (Algerian, Female)

"All things are related to our thoughts. Sometimes it's good memory. Mental health is related to memory." (Pakistani, Female)

"Things or thoughts related to brain." (Pakistani, Female)

"The state of your mind." (Pakistani, Female)

"To do with your brains." (Brava, Female)

"Things related to brain. Thoughts." (Pakistani, Female)

“My behaviour, reactions, happiness or sadness. Feeling anger. Mood swings.” (Arab, Female)

“People who live happily, their mental health is good and those who are unhappy. It also means bad mental health, mental peace and calm, and mentally depressed.” (Pakistani, Female)

“Mental health is the situation related to the brain.” (African, Female)

“To do with psychological way.” (Brava, Female)

“Like physical health there is mental health and it is related to our brain, e.g. thoughts, stress etc .” (Pakistani, Female)

B5 : How has this affected you and how does this interfere with your everyday life?

Recurrent responses : Don't know, No comment, Isolation, Depression, Lack of concentration.

"Don't feel like working and want to sit quietly away from people." (Pakistani, female).

"Affects family, relationships, difficulties looking for work." (Pakistani, male).

"I'm stressed all the time and I feel lonely. The future does not look bright to me at all." (Africa, male).

"Sometimes lose my confidence. I'm sad. Sometimes I feel like there is no hope. I feel like I'm nothing." (Africa, female).

"I'm always indoors I don't meet with others. My self-esteem is low." (Brava, female)

"I'm not free to do things that I want or like to do. Can't concentrate." (Bhajuni, female).

"Sometimes I feel like my brain is going to burst and I cannot do anything." (Bangladeshi, female).

"I feel very angry with myself." (Brava, female).

"My life is not very good one; stress is a very strong problem. I eat not so well." (Kurd, male).

"I'm going upstairs, I'm crying and then I pray to god. I say to god 'please listen do some thing for my children'." (Pakistani, female).

"I don't want to cook or do any work. I hate my children when I'm in that situation." (Pakistani, female).

"Depressed can't eat or sleep, some times feel suicidal." (Arab, male).

"Always feel scared, don't know what the future holds, makes me feel depressed." (Kurdish, male).

"I don't think straight; my memory is affected, thinking what will happen to me tomorrow." (Afghanistan, male).

"I feel angry, I don't want any body to come near me, I don't want to see anyone." (Pakistani, female).

"I don't feel like doing anything, I feel like I'm useless." (Bhajuni, female).

"Hard to get relationships, hard to have a job because of not sleeping, feeling tired." (Kurdish), (male).

"Shaking of my legs because I'm worried and scared." (Pakistani, female).

"Couldn't go to work." (Somali, female).

"Sometimes I don't want to go out or even open the front door." (Lebanese), (female).

"I'm not happy because I can't work I'm always worried about what's going to happen to me."
(Bhajuni, female)

"To fight or argue with family members and not be able to concentrate on everyday activities." (Afghani, female)

"Sadness. Bad headaches, too many negative thoughts, this makes me feel angry. I loose control; spend for no reason, calling children constantly to see if they are safe, crying a lot. Feeling lonely." (Arab, female)

"I don't like any thing, don't feel hungry, northing interests me. Don't like TV, arguing with partners, life is bad, atmosphere at home becomes bad; feel like relationship will break down. Stops me looking after children, washing my face." (Pakistani, female)

"Angry, want to do nonsense things and actions." (Pakistani, female)

"This is affecting my children because I don't do the things they need and also I'm shouting."
(African, female)

"Feel frustration, don't want to talk or become annoyed." (Pakistani, female)

B6 : How would you have dealt with this at home?

Recurrent responses : Sleeping, Going Out, Praying, Talking to Friends & Family, Medication, No Comment, Watching TV, Being alone, Suicide.

"I could not deal with it, which is why I left my home." (Pakistani, male).

"Killed myself." (Afghani, male).

"Beating up children." (Pakistani, female).

"I don't know, I'm confused." (Somali, male).

"Look for doctors." (bhajuni, male).

"Talking to friends, have a walk out, cry about it." (Female)

"Wanted to kill myself in my own country." (Brava, female).

"My family would have been there for me." (Black African, male).

"Medication and support of others." (Kurd, male).

"It's quiet different, some are isolated and depends on group if you have money you can get treatment if not you will end up in stress until you die." (Somalia, male).

"I would have gotten worse; I would have become more mental." (bhajuni, female).

"I will not get proper support education or treatment." (bhajuni, female).

"Be left alone, go to parents, got comfort from them or go to a group that can help." (black African, female).

"Friends help, talking to me, telling me nice things." (Lebanese, female).

"Family and friends support helped me to survive." (Kurd, female).

"I would be angry, crying, praying to god and not talking to my kids." (Pakistani, female).

"I used to think I couldn't survive with out my husband, i'm all the time in bed crying." (Pakistani, female).

"I would lie in bed and start crying waiting to see what my husband will do to me i'm unable to do anything." (Pakistani, female).

"Keep busy in self-created work." (Pakistani, male).

"Would get help from support groups go to hospital." (Malawian, male).

"Went to family members and out with friends." (African, female).

"If I was in Somalia I would not have had education, no working for female and no money to support my self as a person be forced to stay home cook and look after family at large." (bhajuni, female).

"I fight with my self and then I start fighting with god. Then I got message from god just control yourself ." (Pakistani, female).

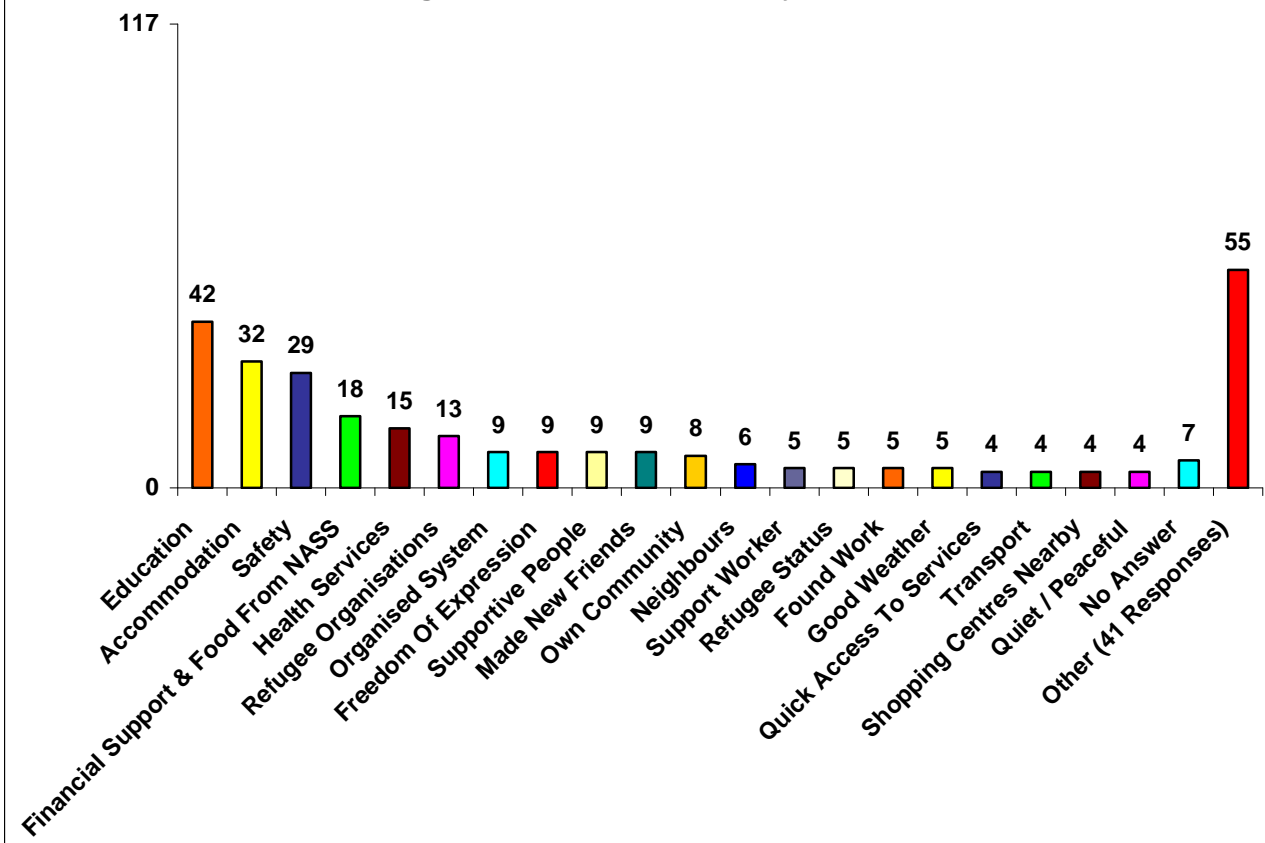
"Used to go out and see friends and go out side to have coffee." (Algerian, female).

"Usually I went out in the park or usually meet up with my friends." (Pakistani, male).

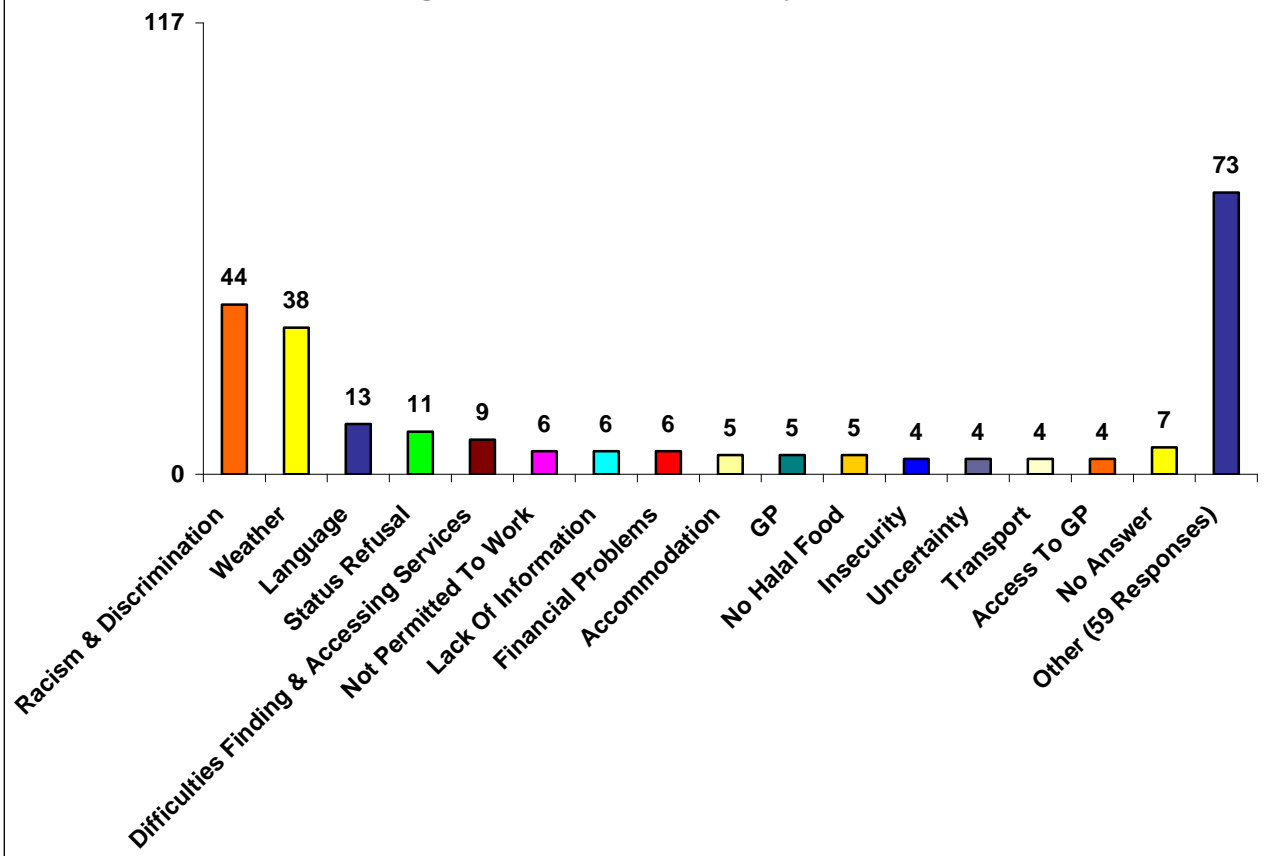
"I went to the doctor and took the medication of depression." (African, female).

"I used to call my mum but I got no support from her. Mum used to tell me to bear the problems coz you have children I used to cry I have no help." (Pakistani, female).

B7 (Positives) : Upon your arrival in Manchester, what 3 things had the most effect on your mental health?



B7 (Negatives) : Upon your arrival in Manchester, what 3 things had the most effect on your mental health?



Section C : Services & Support

C1 : As a refugee or asylum seeker, what do you need to support your mental health?

Recurrent Responses : Certain immigration status, Employment, Activities, Personal attention from GP, social worker, Peace of mind, No response.

“Permanent good house; good and suitable job; good education for children.” (Female, Pakistani)

“No harassment by racists, they need to be educated; permission to work.” (Female, Pakistani)

“To bring my daughter here because she is back at home; permission to work.” (Female, Algerian)

“Support worker, permission to work, stay busy, more money, benefit very low, further education.” (Female, Malawian)

“Meetings/programmes or functions for asylum seekers to keep them busy; permission to work.” (Male, Pashtun)

“I need to feel I am equal like other human beings and able to work for me and for my family.” (Male, Asian Pakistani)

“Sense of belonging, status, permission to work.” (Female, African)

“I need someone to look after me, I need a carer, bus pass, interpreter. The doctors don't believe I have a disability.” (Male, Afghani)

“Have contact and support from own community and to be able to live close to them.” (Female, Iraqi)

“Status - should be given quickly. Accommodation provider makes me feel bad about being an asylum seeker.” (Female, Pakistani)

“I just want to get work permit. I don't want benefits. I am a man, I can work.” (Male, Afghani)

“Counselling, talk about problems with people in the community, information and access to mental health services.” (Female, African)

“A place where people of my age meet.” (Female, Brava x 3)

“Community groups working together.” (Female, Brava)

“Leisure centres.” (Male, Brava) (Female, Brava x3) (male, brava)

C2 : What forms of mental illness do you know?

Recurrent Responses : Do not know, No response, Depression, Madness, Stress, Memory loss, Headaches, Talking to oneself, Schizophrenia

“High blood pressure, it can cause brain damage, frustration, cannot understand things.”
(Female, Pakistani)

“Tumour, madness.” (Female, Gujarati)

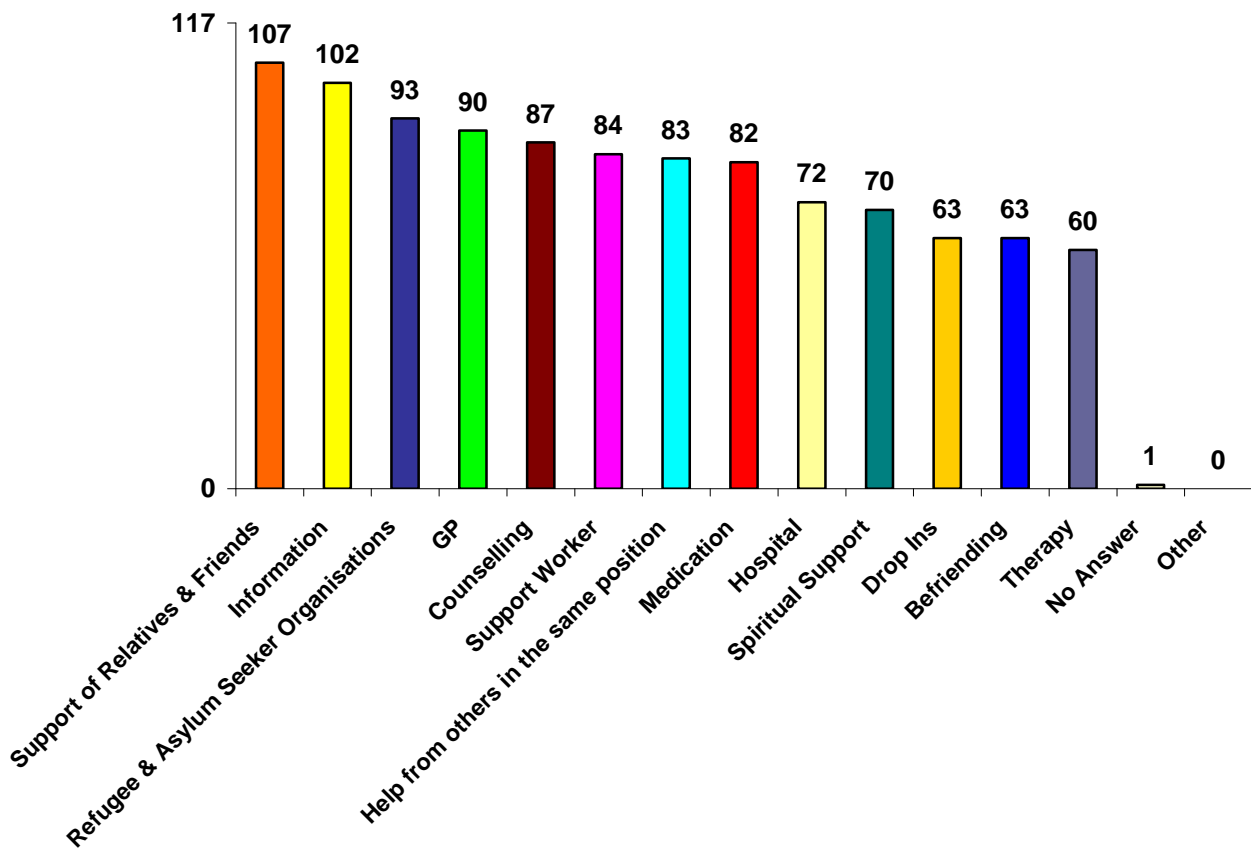
“Migraine, loss of memory, feeling dizzy.” (Female, Pakistani)

“Depression, when nobody wants to listen to the children, it’s noisy, I feel like killing them, I need space of my own.” (Male, Afghani)

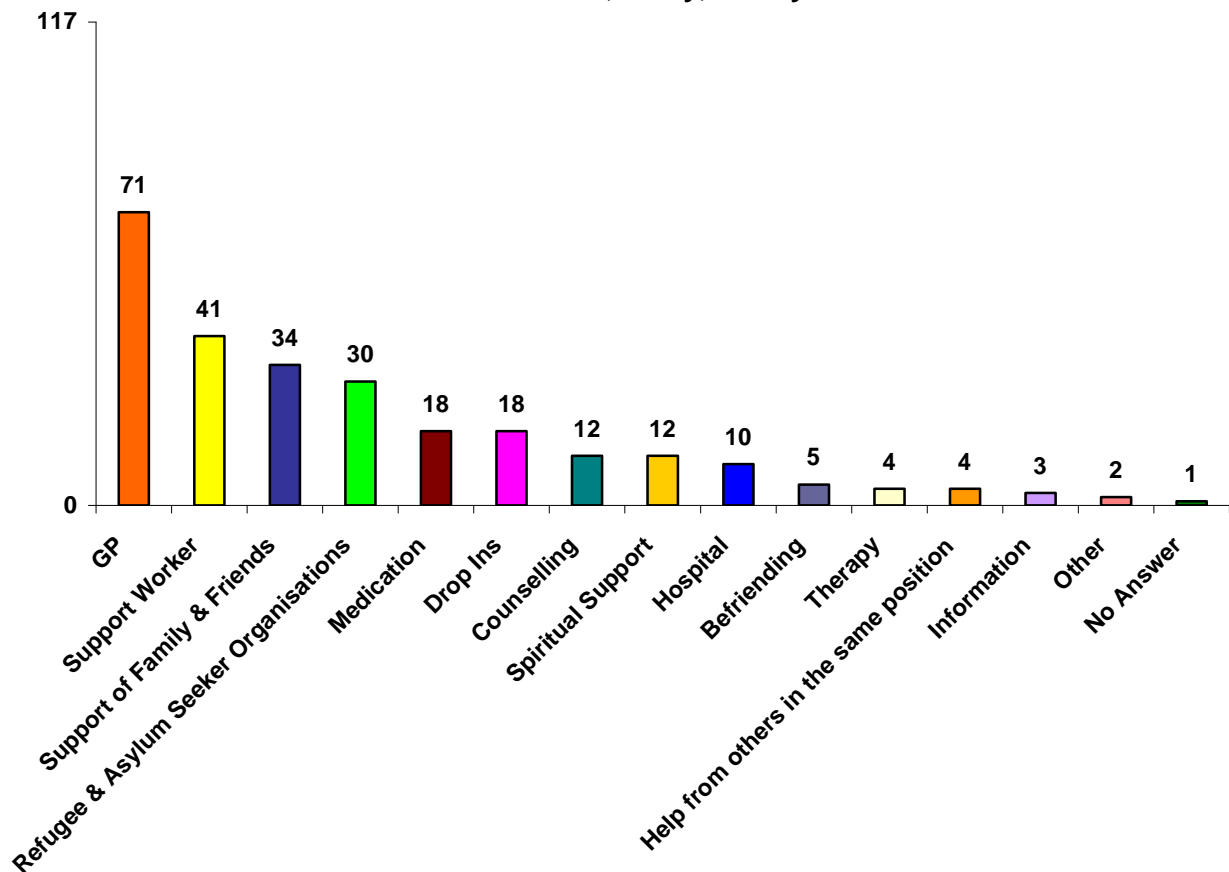
“Depression, taking drugs.” (Female, Fars)

“Some people go out to look for problems like fighting others. Staying in house in silent. Some talking all the time.” (Male, Kurdish)

C3 : What kind of help do you think refugees and asylum seekers with mental health problems need?



C4 : Which of these, if any, have you used?



C5 : What did you find helpful about the help or support you received?

Recurrent Responses : No response, I don't know, GPs provided medication, Support worker helped access services, Drop-ins were an opportunity to meet people in a friendly environment.

"Friends make me able to move towards life." (Female, Pakistani)

"These (medication, therapy, G.P. and hospital) are all very important to me because using these can make me active or able to think. So these all are very effective and useful and give me strength." (Male, Pakistani)

"Support worker came through a refugee organisation and she helped me to get access to all the services; doctor gave medicines." (Female, Pakistani)

"Support workers are very good help with everything I ask. I feel better because they support me. For example, going with me to hospital." (Female, Pakistani)

"GP gave medicines and I felt relaxed; refugee organisation provided me support worker and support worker got services for us." (Female, Gujarati)

"Counsellor treated me like a friend and became a confidant; I am meeting with people in drop-in and they are helping me if I need help." (Female, Algerian)

"In drop-in people meet each other and discuss the problems together; refugee organisation set up my campaign; G.P. gave medicine." (Female, African)

"Drop-ins are very useful because there I make friends and people in drop-in are solving all my problem and get support for me." (Female, Bangladeshi)

"GP gives medication; support worker organised services and access to services." (Female, Malawian)

"Friends and family support you make sure you are not lonely; support worker helped with filling in forms." (Female, Pakistani)

"Support worker was very helpful; she done all the work I needed and I got access to the services. Counselling helped me to come out of depression." (Female, African)

"Refugee organisations helped with getting a house, helped with campaign, any issues; very helpful with giving peace of mind and good advice." (Female, Pakistani)

"Counselling and Drop ins: Helped with reassuring us. Support agencies: Helped whenever we had problems, mediated for us, schools, etc." (Male, Afghani)

"Support worker was the best- we know nothing and he helped with everything e.g. schools, job centres, laws in England, getting children to school." (Female, Iraqi) (Male, Pakistani)

"Advice not to chew 'chad', which is part of a drug." (Male, black African)

"It made me feel relaxed. If the services deal with you nicely it makes you feel better." (Female, Pakistani)

"I find everything helpful, when my support worker came to see me she made life easier, she enrolled my kids to school and gave me all the information on service." (Female, Pakistani)

"Sharing and discussing problems with friends. Refugee groups supported and encouraged me to push myself and not to give up." (Female, Black African)

"Talking to someone." (Female, Brava)

"GP is supportive; he makes mistakes but he is human." (Male, Somali)

"People who knew that mental health is not a sin." (Female, Arab)

"It helped to have someone to talk to in my own language." (Female, Arab)

"Able to talk about experiences." (Male, Kurdish)

C6 : What was less helpful?

RECURRENT RESPONSES : No response, Nothing, GP only provided medication, Leaflets were in English so could not access information due to language barriers

“Home Office took my clothes out & accommodation providers vacated me from the house.” (Male, Bhajuni)

“Doctor only helps me sometimes.” (Female, Algerian)

“No dentist, no doctor, no health worker. I don’t have access to services, only the GP.” (Female, Pakistani)

“Befriending was not helpful.” (Female, Pakistani)

“GPs not very helpful, not committed, don’t listen, don’t care.” (Female, Pakistani)

“Sometimes I find it difficult because of the language barrier.” (Female, Pakistani)

“GP was very bad; bad attitude. I changed.” (Male, Pakistani)

“Takes a long time for services to come through.” (Female, Pakistani) (Male, Somali)

“I didn’t get a suitable house, problems in college and GP is the biggest problem.” (Male, Kurdish)

“NASS support is less helpful. Heating breaks down. No hot water, no heater and they take their own sweet time to come to repair it. They don’t care.” (Female, Bhajuni)

“I don’t have carers to look after me, I am homeless and live in a hostel.” (Male, Afghani)

“They were not patient enough to listen to me and I would end up keeping quiet; feeling sad; because nobody is taking any interest in listening to me.” (Male, African)

“GP can only treat you with medication but you cannot share every problem or talk to them about the past which is disturbing me.” (Female, Bhajuni)

“When interpreters could not understand me well and the GP did not sympathise with my concerns.” (Female, Kurd)

“Leaflets were written in English.” (Female, Brava)

C7 : Which mental health services are you aware of in your area?

Recurrent Responses : No response, None, I don't know, GP, MRI

"Sure Start." (Female, African)

"St. Mary's." (Female, Brava) (Female, Brava) (Female, Brava) (Female, Brava) (Female, Brava)

"Levenshulme Health Centre." (Male, Kurdish)

"Hospital, GP, refugee support organisation." (Male, Kurdish)

"Local health centre." (Male, Iran)

"Kath Locke Centre." (Male, black African x 2)

C8 : What might make it hard for you to access services?

Recurrent Responses : No response, Language barriers, Lack of information about services, Transport difficulties.

"Distance because this is what I am experiencing myself. For example, mosque is too far away to take my children; shops are too far away so have to use taxis." (Female, Pakistani)

"Language, people, strange behaviour because of different communities." (Female, Algerian)

"We don't know about services." (Female, Pakistani)

"Slow service, waiting for a long time for appointments because I have experienced this." (Male, Pakistani)

"Legal status, language because many agencies discriminate against asylum seekers." (Male, Pakistani)

"Not enough information, not easy to get to places." (Female, Pakistani)

"Not knowing where services are." (Female, Afghani) (Female, Pakistani)

"Lack of information- because if we don't know about the places of the services we cannot reach there." (Female, Pakistani)

"I can't understand addresses, bus routes." (Female, Pakistani)

"Not knowing where they are and how they work or what they do." (Female, Lebanese)

"Lack of information, language, embarrassment of not being able to communicate – I have experience this." (Female, Afghani)

"Being an asylum seeker stopped me from opening a bank account." (Female, Black African)

C9 (a) : Have either yourself / partner / family member / friend been prescribed drugs in the last 2 years for mental health?

Yes : 37

No : 70

No Answer : 10

C9 (b) : If yes, please explain. What was the experience like?

“Sometimes I got side effects but sometimes it was useful.”

“It was like floating on the water.”

“Sometime she couldn't sleep. I felt sorry for my friend.”

“He takes injections once a month and takes tablets twice a day he is very good man and I feel sorry for him.”

“I was given them but did not take them. The G.P prescribed them for me to sleep- but id didn't want to get addicted.”

“After using those medicines I felt peace and calm because those were for the tension.”

“Helped my mood, made me feel better but also made me gain weight.”

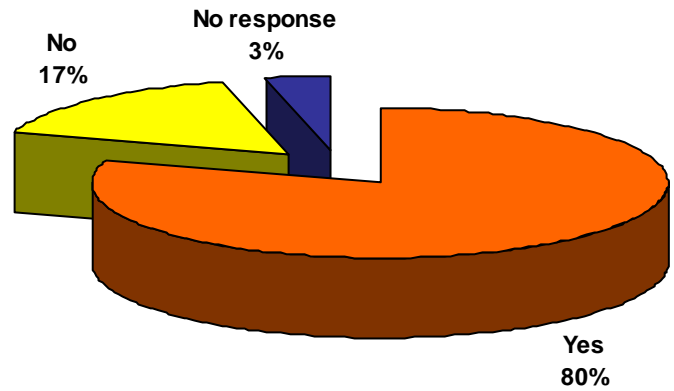
“Shocked.”

“I feel better when I take my medicine. I am very sad when I don't take my medicine.”

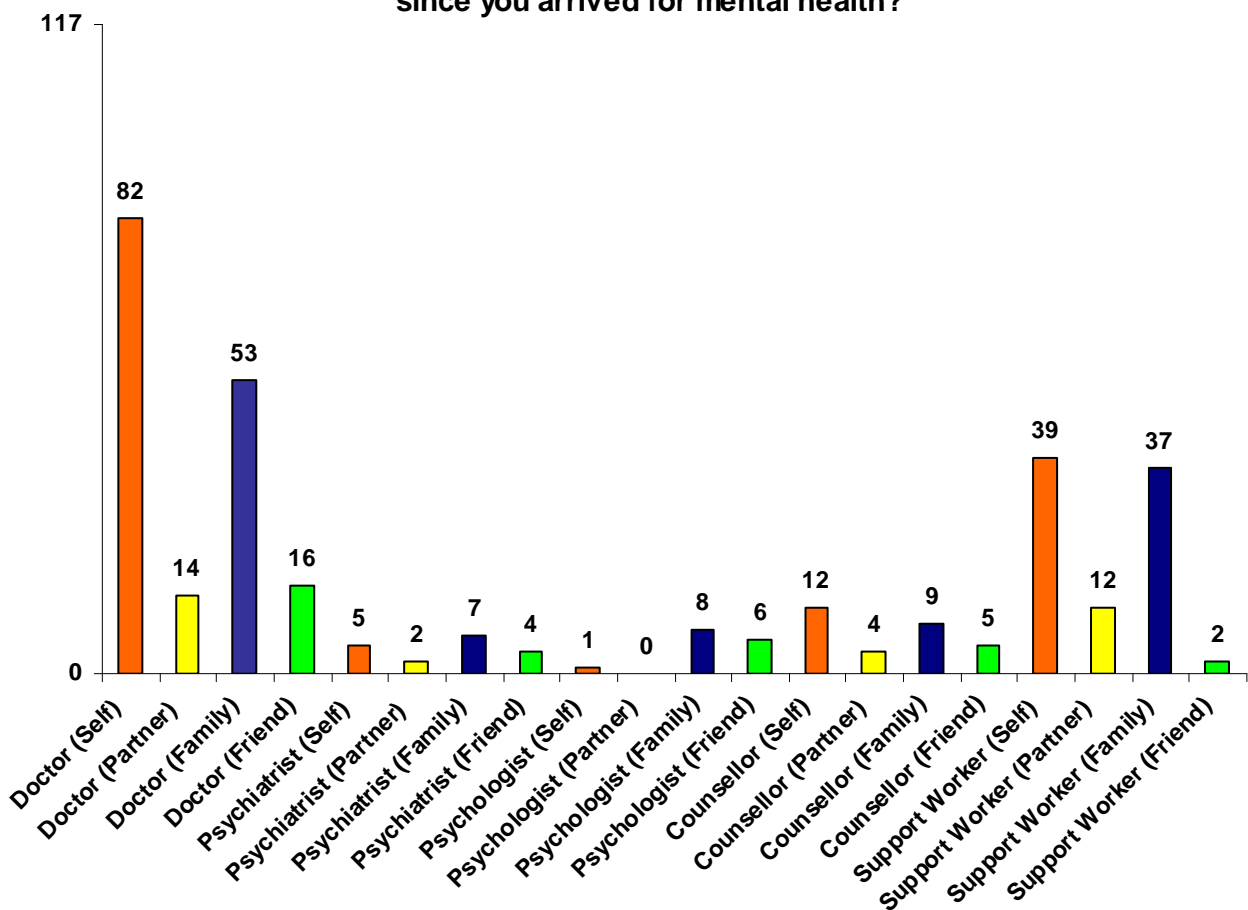
“I was scared to know that person is using medicine will kept away from her I was scared.”

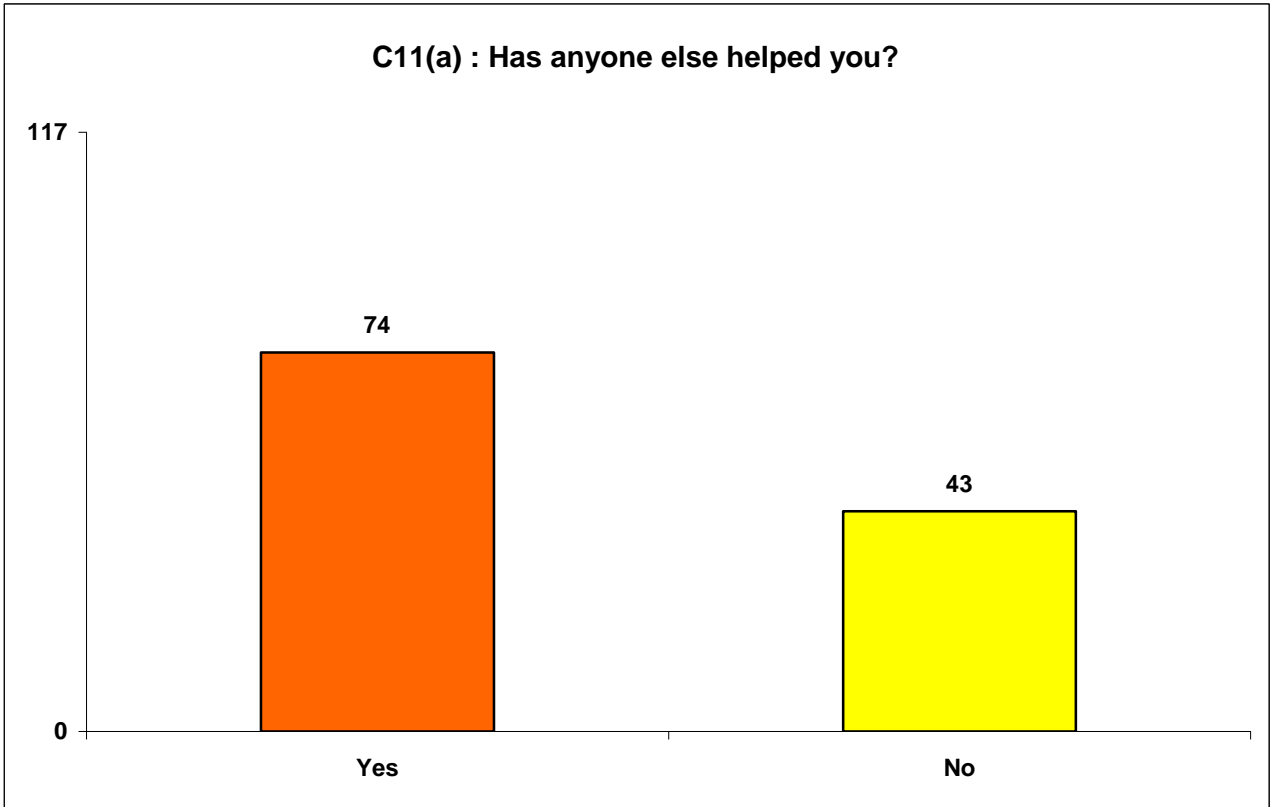
“I had hallucinations. Once I thought the police is going after me to harm me.”

C10(a) : Have either yourself / partner / family member / friend visited a doctor / psychiatrist / psychologist / counsellor / support worker / health worker since you arrived for mental health?



C10(b) : Have either you / partner / family member / friend visited a doctor / psychiatrist / psychologist / counsellor / support worker since you arrived for mental health?





C11 (a) : Has anyone else helped you?

43 : No

19 : Female

Ethnic Identity

- 8 : Bravanese
- 4 : Pakistani
- 2 : African
- 1 : Algerian
- 1 : Bangladeshi
- 1 : Bhajuni
- 1 : Gujarati
- 1 : Sri Lankan

24 : Male

Ethnic Identity

- 6 : Bravanese
- 3 : Iraqi
- 3 : Kurdish
- 2 : Afghan
- 2 : Pakistani
- 2 : Somalian
- 1 : African
- 1 : Arab
- 1 : Black African
- 1 : Bhajuni
- 1 : Gujarati
- 1 : Iranian

74 : Yes

46 : Female

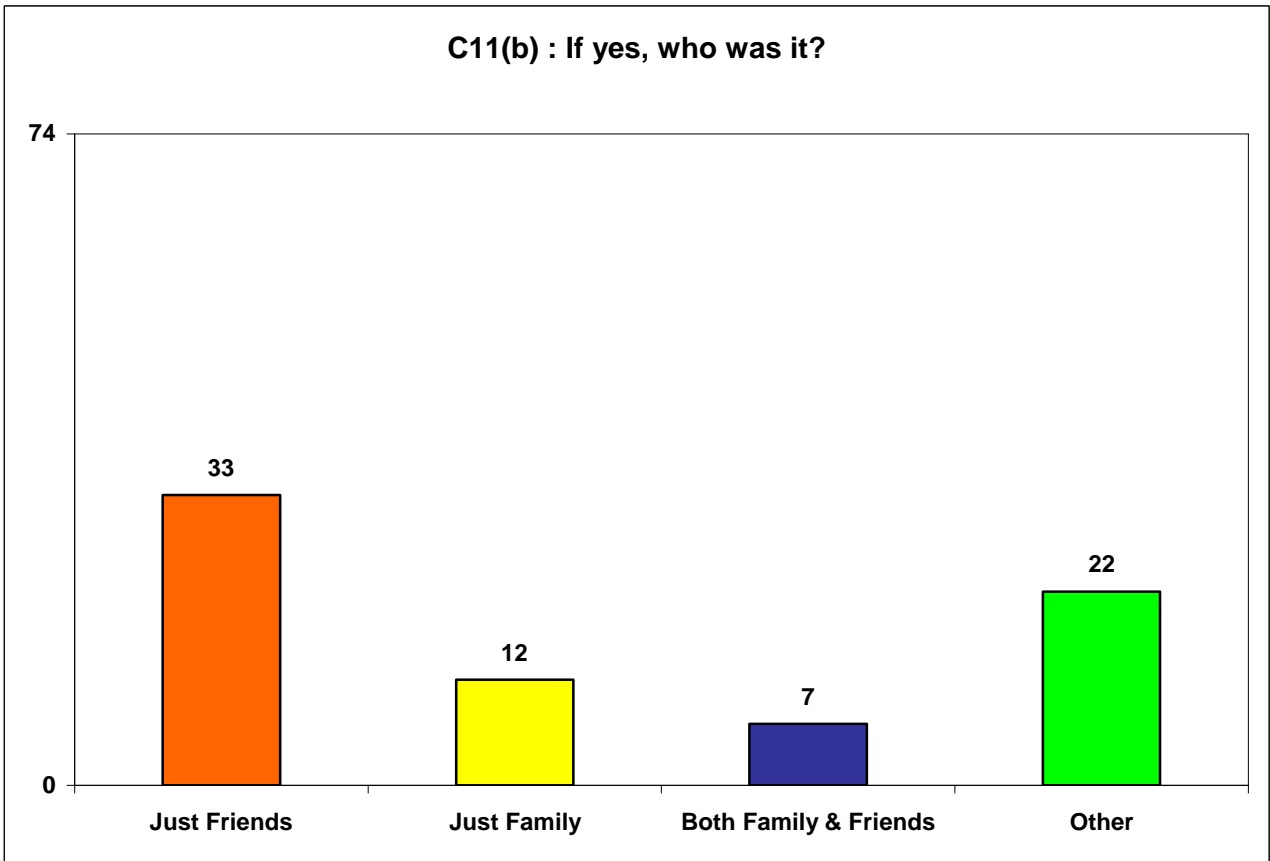
Ethnic Identity

17 : Pakistani
8 : Bravanese
4 : Afghani
4 : Bhajuni
3 : Arab
2 : Unknown
1 : African
1 : Black African
1 : Lebanese
1 : Fars
1 : Somalian
1 : Kurdish
1 : Malawian

28 : Male

Ethnic Identity

5 : Afghani
8 : Kurdish
2 : Bhajuni
2 : Bravanese
5 : Pakistani
1 : Black African
2 : Arab
1 : Somalian
1 : Punjabi
1 Wambu Angolan



C11 (b) : If yes, who was it?

33 : Just Friends

24 : Female

9 : Male

Ethnic Identity

- 13 : Pakistani
- 2 : Afghani
- 2 : Bhajuni
- 1 : Bravanese
- 1 : African
- 1 : Black African
- 1 : Lebanese
- 1 : Arab
- 1 : Fars
- 1 : Unknown

Ethnic Identity

- 3 : Afghani
- 4 : Kurdish
- 1 : Bhajuni
- 1 : Bravanese

12 : Just Family

9 : Female

Ethnic Identity

5 : Brava
1 : Pakistani
1 : Somalian
1 : Arab
1 : Unknown

3 : Male

Ethnic Identity

1 : Pakistani
1 : Brava
1 : Black African

7 : Both Friends & Family

3 : Female

Ethnic Identity

1 : Brava
1 : Bhajuni
1 : Kurdish

4 : Male

Ethnic Identity

2 : Kurdish
1 : Pakistani
1 : Arab

22 : Other

10 : Female

Ethnic Identity

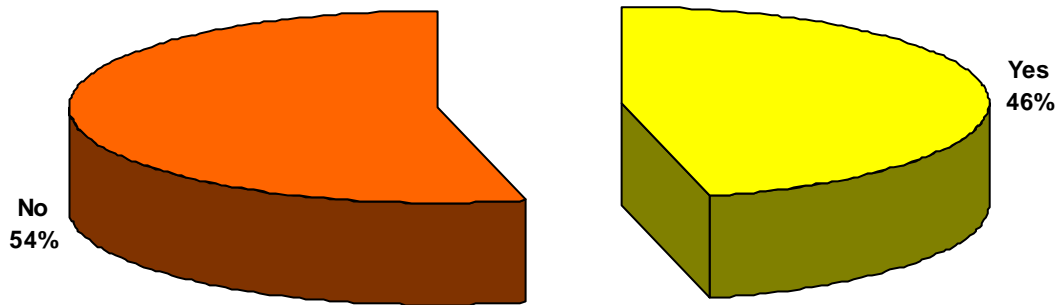
3 : Pakistani (Solicitors) (CAB) (Friends, Family & Carers)
2 : Afghani (Friends & Neighbours) (Contact at Gudwara)
1 : Arab (CAB)
1 : Malawian (Friends & Midwife)
2 : Bravanese (Support Worker) (Social Services)
1 : Bhajuni (Red Cross, RAPAR)

12 : Male

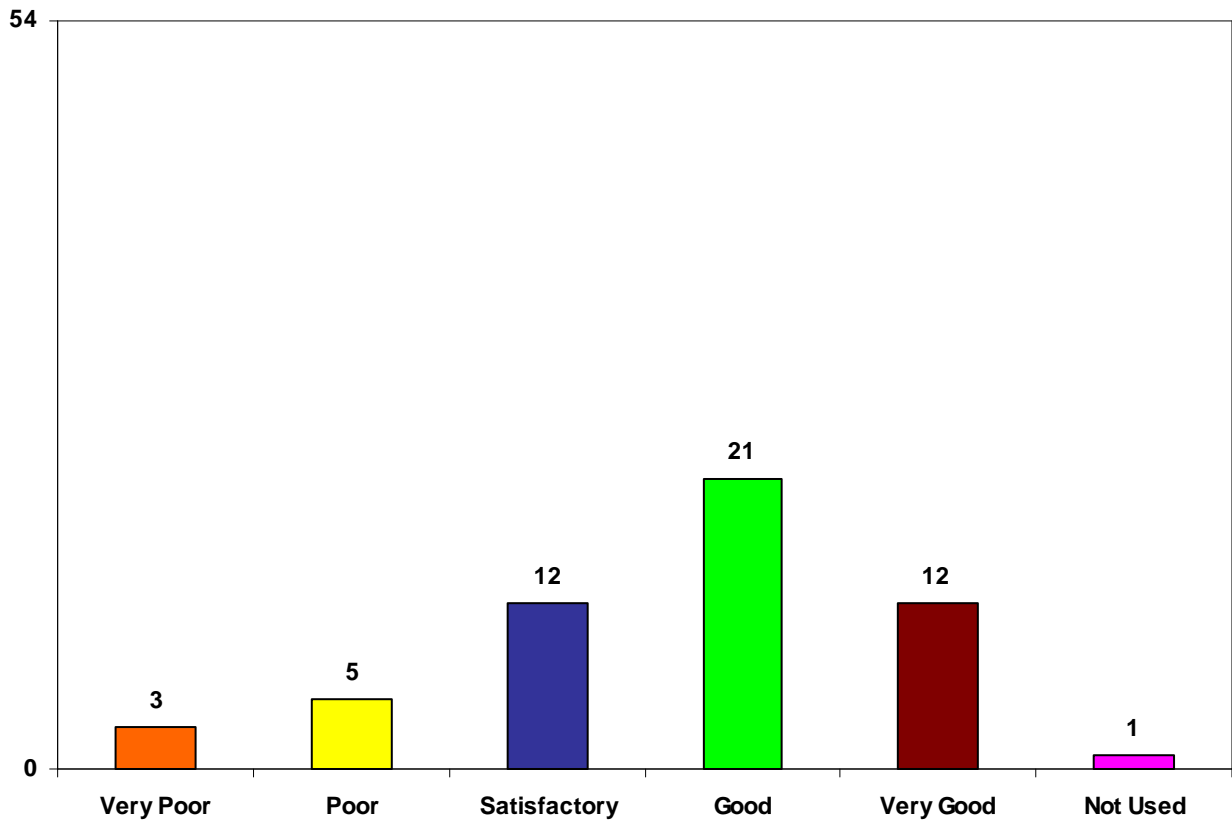
Ethnic Identity

3 : Pakistani (Housing Worker) (Colleagues, Trade Union) (Mosque, People In Community)
2 : Afghani (Neighbours) (School, Routes, Wood St. Mission)
2 : Kurdish (Friend, Nurse) (Friends, Other Refugees)
1 : Arab (CAB)
1 : Punjabi (Counsellor)
1 : Wambu Angolan (GMCDP)
1 : Bhajuni (Red Cross, RAPAR)
1 : Somalian (Friends, Family, Carers)

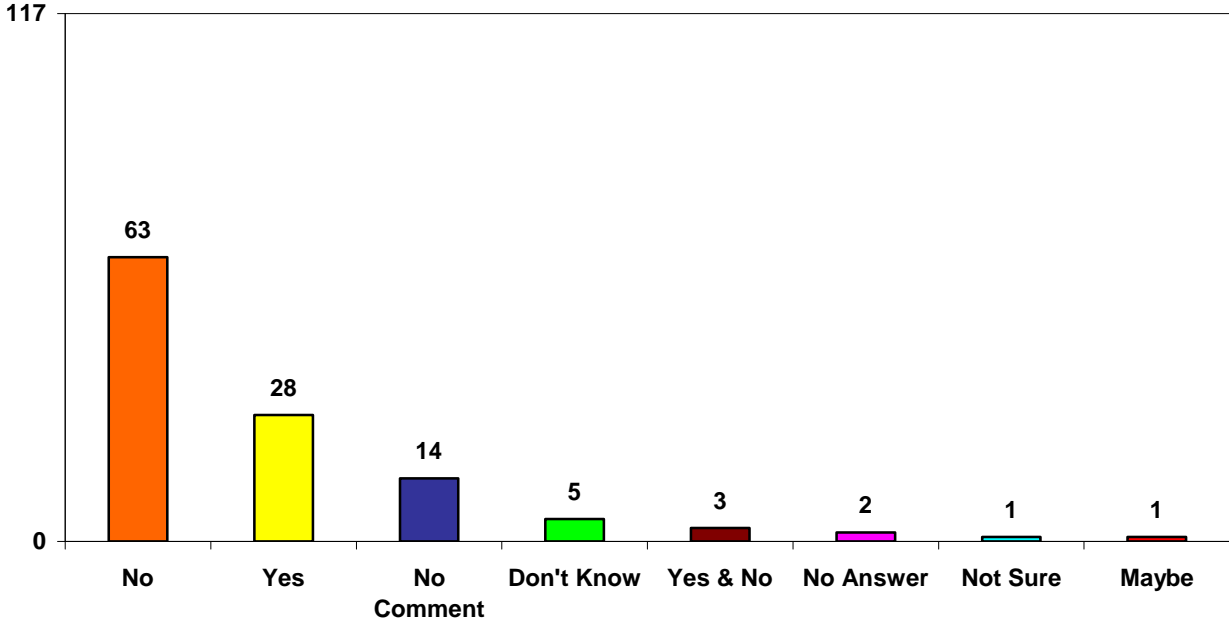
C12(a) : If you have received help, were you offered interpreters or translation services?



C12(b) : If yes, how do you rate the quality of the service(s) offered?



C13 : Do you feel that refugees & asylum seekers with mental health needs seek advice or treatment?



C13 (Comments) : Do you feel that refugees & asylum seekers with mental health needs seek advice or treatment?

28 : Yes

“If someone has problems they have to seek advice about it to get better.” (Kurd, male)

“Because some have no family or friends to support them.” (Iraq, male)

“Because when they are mentally ill they need doctors, psychologists. They are humans and need help.” (Somalian, male)

“General practitioner usually refers towards these services.” (Afghani) (female)

“Because they have no choice they have to help themselves.” (Arab)(female)

63 : No

“They feel ashamed about their mental issues.” (black African) (male)

“Because many of them don’t know where they can get the service they need.” (black African) (male)

“Scared.” (Bhajuni) (male).

“Lack of information, we don’t know where to go for help.” (bhajuni) (male).

“People look at refugees and asylum as people increasing nhs cost’s. That’s the impression we get.” (African) (male).

“They don’t know what is wrong with them.” (Kurd) (male)

“Not listened and heard and no one is interested to know any problems about them we are also humans.” (Afghanistan) (male).

“Doctors and people don’t care about people with mental health. How can they care about people refugees, asylum seekers or disabled people.” (Kurdish) (male).

Section D : Appropriate & Responsive Services

D1 : How could things be made better for your community?

Recurrent Responses : No response, I don't know, More information, More activities, Education, Leisure, Social, Education about mental health, More/better services for refugees and asylum seekers.

"Amenities, shops, mosques should be local because everywhere I go I have to take two buses." (Female, Pakistani)

"Meeting and chatting with the people about the services and then maybe we can make some things better." (Male, Gujarat)

"People should understand the problems of the asylum seekers and then make the services easy for them and service providers should be friendly." (Female, Bangladeshi)

"Services should follow up to see if we are okay. It would be better because sometimes I don't have the confidence. For example, G.P. should check and see how I am doing on my medication for depression." (Female, Pakistani)

"There should be some office where locally based people should go and explain their problems." (Male, Pakistani)

"Governments, politicians and media can play a vital role in this." (Male, Asian Pakistani)

"By educating people about different communities and cultures to help with getting on better." (Male, Pakistani)

"Clean neighbourhoods; children should be educated and made better in their behaviour; crime stopped- no racism/ no violence towards asylum seekers." (Male, Pakistani)

"More education and integrating into society." (Female, Pakistani)

"Multinational community centres within areas." (Male, Bhajuni)

"A system like the Routes Project has of linking families." (Female, Afghani)

"More information about the services and educating people about exactly what the services will do for them." (Male, Asian Pakistani)

"There should be interpreters to avoid the language difficulty. People should be helpful to each other. Services should be near." (Female, Pakistani)

"If we had status it would be better for us to integrate and be better members of the community." (Female, Pakistani)

"Regular events for my own community to find out what is going on and pick up information." (Female, Pakistani)

"More information in my own language; easier to access support; better interpreter services." (Male, Arab) (Male, Kurdish)

“We will help each other. I will go to the adult education centre and learn proper English to help my community. I like helping others.” (Male, Afghani)

“We should educate the communities who are ignorant to understand us also being human like them. We aren’t giving them pain, why should they give us pain?” (Female, Pakistani)

“If services are accessible then many of the asylum seekers can get benefits. Adult education centres can play the role to improve the mental level of people to think positive.” (Female, Pakistani)

“Get together, different training programmes, give awareness to people about services.” (Male, Asian Pakistan)

“Giving money to organisations run by refugees.” (Male, Iraqi Kurd)

D2 : What would make it easier for refugees and asylum seekers to use services?

Recurrent Responses : No response, Interpreters, leaflets in own language, advocates, accessible, Local, Places to go for advice

“Services should be advertised better about what the rights of asylum seekers are- so they are more aware.” (Male, Pakistani)

“Learn English.” (Female, Pakistani)

“Ongoing communication about what is happening around them. For example, law and rules changing. Free crèche for children.”

“Good interpreters who are qualified.” (Female, Iraqi)

“Access to advice centres within the community dealing with mental health problems.” (Female, Bhajuni)

“More advertisements, local signing centres, more support from solicitors and local authorities.” (Male, Iraq)

“More meetings, leaflets in own language and educational courses.” (Female, Kurd)

“Interpreters, but they need more education about mental health, leaflets in my own language and educate hospital staff.” (Male, Arab)

D3 : Would you like to be involved in the development and planning of services?

Recurrent Responses : No response, No, Yes, I don't know, Yes, by providing people in my community with information, Yes, by providing advice and suggestions on the needs of my community

"Yes, by volunteering and giving suggestions." (Female, African) (Male, Asian Pakistan)

"If there is a new service, I would be happy to give my views and ideas if I was consulted." (Female, Pakistani)

"I can be on the steering group, would like to attend any briefing but how it will be possible because these forms are anonymous? How will you know who is interested?" (Male, Asian Pakistani)

"Yes, depending on what it is." (Male, Pakistani)

"Yes, to participate in discussions, seminars, decision making." (Male, Afghani)

"No, because this time I have language difficulty so if I am not able to speak I can't involve myself in the phoning and development of services." (Female, Pakistani)

"Yes, as an interpreter, help the community, to make sad people happy, to help people who cannot access services (disabled people, older people) to give all the support." (Male, Afghani)

"I would like to suggest some things which can be helpful for refugees seeking asylum in this country e.g. that services should be local and accessible and should have good standards." (Female, Pakistani)

"No, I don't want tension in my head. I have a lot to deal with at the moment." (Male, Somali)

"Yes, to encourage people to accept their disability and live with it positively." (Male, African)

"No, we cannot change anything whether we are involved or not." (Male, Kurd)

"Yes, I want to be heard and I want to voice my concerns." (Female, Kurd)

"No, it needs specialist people to be involved." (Male, Iraqi Kurd)

"Yes, by making everyone who is involved in mental health services educated about barriers and the respect of human rights." (Female, Arab)

"Yes, we need to say what we think is good for us through a representative." (Female, Fars)

EXTRA NOTES (Not attached to specific questions)

- o Facing racism (Male, Brava)
- o Violence on the road; burglary (Male, Brava)
- o Need operation every 2 years; I don't know the name of my disability; I'm not getting help with my benefits, carers and housing; I'm homeless (Male, Afghani)
- o My benefits have been stopped; I live with my daughter, her husband and kids; I survive on their benefits which is £35 and we are struggling a lot; I had a knee replacement operation, my daughter's house is not adapted for my needs, I am very much stressed and not happy; life is not worth living for, I wish I had died in that war; client was crying (Female, Bhajuni)
- o My daughter and mum's benefits were stopped and we are a family of eight; NASS accommodators came to my house and told my mum and daughter to leave the house as they have been refused stay. I told them that where will my mum and daughter go they are not going anywhere, we came here as a family of eight people so how can two people be refused? NASS people were rude and left; sometimes we don't have heating for weeks and we end up getting portable heaters from friends; I had operations twice women problems, I have other health issues like lack of blood, balance problems and use mediation for depression; my mum uses a lot of medication because she has got a lot of health issues such as blood pressure and diabetes; client was in tears when carrying out the interview (Female, Bhajuni)
- o No-one to help me (Female, Brava)
- o One day I was walking with my mum and someone drove beside us and threw cans of cokes on us, which was all over our head, scarf and tops; I went home in tears; my neighbours teenage boy was beaten up by white people passing on the road and no-one helped them; a black guy passed by and stopped his car and helped the black boy; and the white people passing were looking and laughing (Female, Bhajuni)
- o I was walking with my sisters. We were coming from college and boys on bikes started pulling off my sister's headscarf. There is also a group of teens who come close to me, call me names and swear languages- I can't even tell you because it is not nice. I'm always thinking I don't know what to say or think anymore. I'm tired. (Male, Somali)
- o I have a lot of health issues, problems. I am not getting enough support with housing and benefits (Male, Kurdish)
- o Questionnaires are long. Can I stop, interview stopped as requested (Male, Brava)
- o I was with my grandma taking her out for a walk because she was having knee operation. We were stoned with bottles thrown at us and we had to go back in the house. My grandma was so scared that we had to put her back in her wheelchair and push her quickly back to the house. Till today she doesn't want to leave the house (Female, Bhajuni)
- o Racial abuse. Our house was stoned on the windows and windows are broken. We are called names like Paki. I have been refused and live on my mum's and sister's benefits. It is not easy but what can I do. Sometimes we were spit on the bus. We then had to be moved to a different house because of stoning problems- at the windows (Female, Bhajuni)
- o Questions were distressing. Client stopped and requested to stop the interview (Female, Brava)
- o Racism in hospital. I was attacked by a group of boys and called names. They also stole my purse. It all happened at the market. Domestic violence (Female, Brava)
- o Client didn't want to discuss his past problems. He wants to forget it all. He wasn't cooperative (Male, Afghani)
- o I was beaten on my face and back by English people. Money was stolen from me (Male, Afghani)
- o Racism in hospital. I was attacked and someone stole my bag in the market. Domestic violence (Female, Brava)

- o Client arrived, suffered a lot with his benefits. Financial problems, financial support e.g. job seekers allowance
- o Burglary in my house (Female, Brava)
- o First time when I came I had a lot of problems. I had to go to sign and it was very far. I am always scared (Female, Somali)
- o When I phoned the G.P., I didn't get the appointment on time. Neighbours are bad (Female, Brava)
- o Burglary in the house, Lack of interpreters, Education issues, I'm not aware of any adult education (Female, Brava)
- o My neighbours were bad. Area was not good. Client's son has mental health issues. Sometimes he becomes very aggressive, breaks down everything in the house, hits wall and doesn't want to see his mother at all. Aged between 18 and 26, client refused to give the exact age and more information for security reasons (Female, Somali)
- o Car accident and some white guy called me black and said go to your home (Male, Somali)
- o My mobile was stolen and someone tried to con my family (Female, Brava)
- o Language barrier. Housing problems the first time I arrived. My first G.P. services were not meeting my needs (Female, Brava)
- o Given a small dirty house. It is over-crowded- 6 people for 2 rooms (children ages 15, 14, 9 and 3 wks); They had no washing machine, nor Hoover; client started crying so had to stop the interview (Female, Brava)
- o When I arrived at first, I felt safe and well-taken care of; I miss my country; I had a beautiful farm that I enjoyed looking after; I miss the hot weather and eating from my farm (Male, Somali)
- o My benefits were stopped; I had no food and nowhere to go; I used to be given food vouchers which can only be used in Asda (£35 every week) to go and get myself food – the money is not enough so I end up returning some food; I am struggling in life and sometimes I think it is not worth living for; I am always indoors because I don't have a single cent to spend on transport and if I need to go out then I have to walk; I feel like I am isolated from others and that it is my problem and no-one else's.
- o I stopped interview because the children were crying and the client looked stressed, unhappy and absent-minded (Female, Brava)
- o Client had problems with housing because housing refused to do repairs, for example, draft on the winds; I was taken far away from my relatives (Female, Brava)
- o The lady's children were crying and fighting; the lady looks very tired and depressed; she looks absent-minded (Female, Brava)
- o My mum has a brain tumour; I would like to travel back and pay my respects; I am very depressed; sometimes I don't know what to think anymore; I feel tired mentally (Female, African)
- o Was refused twice; under section 4, they have given me shelter and money vouchers; I am expected to go to court; I don't have any cash with me, only food vouchers for Asda- and I can't buy halal meat in Asda; I can't buy toiletries; life is not worth living for; I wish I wasn't in this situation; I feel very scared and low; on medication (Male, Bhajuni)
- o Language difficulties (Male, Bhajuni)
- o Had problems finding a house and registering with a GP. There were long waiting lists (Female, Brava)
- o Diabetic, pressure, cholesterol, epileptic; this guy was talking non-stop, repeating himself; worried and scared of the Home Office; he has isolate himself from people because of fear; he is epileptic, when an ambulance is called to help him, he refuses help thinking the doctors will return him to his country Somalia (Male, Somali)

DISCUSSION

Section A : Core Questions

A1 : Age

73% of interviewees were between the ages of 25 and 44. This could be because this is the most likely age that someone will be politically active and / or most physically affected by war and repression.

Only 7% of respondents were 55 or over. People in this age bracket are most likely to be more attached to their homes, particularly if they have a large family. If a family has means to fund an escape to another country, it is usually the youngest and strongest who will be given the chance to go, in order to continue the family line.

A2 : Country Of Origin

This indicated the limitations of our research, as we could only access those communities with which we had links and / or shared languages. There are many other communities within Manchester that could be researched which may provide a different set of results due to differing personal experiences.

A3 : Nationality

Results simply indicated that the vast majority of respondents lived in the country in which they were born.

A4 : Ethnic Identity

We cannot just label people by their nationality, which is why it is very important to ask a person's ethnic identity, particularly as we are researching people from refugee and asylum seeker communities with very diverse backgrounds. This information is vital when planning and implementing services e.g. a Somali community centre would not work as effectively as it could if it did not recognise the separate ethnicities coming from Somalia. Bravanese and Bhajuni communities, both from Somalia, would have different cultural and social needs.

A5 : Other countries you have lived in

The European countries identified by this question were 'passing points' as most asylum seekers and refugees have been smuggled here via other countries as they have no passports. We discovered by talking to the respondents that people were smuggled to other countries first, stayed there to earn more money, and then paid to be smuggled here. Turkey, the second biggest response to this question, is known as the 'Gateway To Europe' from the Middle East.

Many people from Africa, particularly Somalia, were crossing into Kenya. This was so they could get into refugee camps, obtain passports and then travel to the UK

A6 (a), A6 (b), A7 (a) & A7 (b) : What languages do you know? (Spoken & Written)
What languages are you fluent in? (Spoken & Written)

The results of these questions support the claims of language difficulties faced by refugees and asylum seekers repeated continually throughout the research.

Of the 117 interviewed only 75 could speak English, with only 30 speaking fluently. Similarly, only 64 could write in English, with only 24 able to write fluent English.

The fact that many interviewees could speak a variety of different languages, some up to 7 different languages, indicates that it is not an inability to learn a new language that is holding people from asylum seeker and refugee communities back, but rather a lack of encouragement and availability of English language education.

It is therefore no surprise that problems arise when trying to access services, as respondents have found it very difficult to get information in their own languages.

A8 : Status

Results show that 62 out of the 117 respondents are still without status and spoke of the anxiety that comes with the uncertainty over what the future will bring.

A9 : Ethnicity (Results generate no discussion)

A10 : Religion

The results indicate a large percentage (82%) come from wholly or predominantly Muslim countries. However, as discussions with respondents indicated, not everyone who classes themselves as a Muslim is actually a practising Muslim. This information would prove important if setting up services, as assumptions cannot always be made regarding a person's requirements based on their religion e.g. not all Muslims would require Halal food.

A11 : Gender (Results generate no discussion)

A12 : Marital Status

The results to this question proved to be quite a surprise as we were expecting a lot of the respondents to be widowed or victims of enforced separation. This was not the case.

Many of the respondents were married and few living with partners, indicating compliance with strict religious or cultural expectations and /or norms.

A13 : Location

Results indicate that dispersal of asylum seekers and refugees in Manchester is quite wide, although significantly the majority of respondents came from larger communities within centralised areas.

We must recognise, however, that this may just be a result of holding interviews in more centralised locations, in order to attain a higher number of completed questionnaires.

A14 : Sexuality

The fact that not a single respondent said they were lesbian, gay or bisexual is very unusual.

The chances of this being the truth is extremely improbable and it is likely that many interviewees were unwilling or scared to admit to their true sexuality, either due to previous bad experience or the constraints of religion.

A15 : Do you have a disability?

Although the figure of 15% seems high, this may be yet another limitation of where the interviews were held, particularly those that took place at the Disability Coalition and the Horn Of Africa Disability Association.

A16 : Employment Status

Although over 40% of respondents have been given status to remain in the UK, only 16% are in work.

This is further indication that language barriers are preventing people from accessing information that would lead to employment.

It may also indicate that employers are discriminative and are unwilling to employ someone with refugee status and / or does not have a firm grasp of the English language.

Section B : Your Experiences

B1 : What events have you experienced in your home country or during your journey to the UK?

A large number of problems were experienced by a high percentage of respondents, the greatest of these being 'Separation From Family / Friends'. This statistic alone reinforces many statements given by respondents throughout the research regarding feelings of isolation, which have contributed significantly to the occurrence of mental health difficulties.

The combination of this with other experiences (Torture, War, Persecution, Bereavement, Destruction Of Home etc.) paints a chaotic picture of what the lives of refugees and asylum seekers were like before they reached the relative safety of the UK. This amount of disruption to people's lives is obviously going to increase the incidence of mental health difficulties, and the need for a solid community within which their lives can progress as their individual needs dictate.

The complexity of needs indicated here calls for an accessible and adaptable provision of services.

B2 : What events have you experienced since your arrival in the UK?

Most of the respondents have experienced racism in many different forms, which has left a lot of asylum seekers and refugees living in fear, especially following the July bombings of last year. The people in these communities feel excluded by this. The distress caused is increasing mental health problems within these communities.

"Our house was stoned on the window and it broke. We had to be moved to another house. Then we were spat on from a bus and called 'Paki'."

Homelessness was also experienced by a large number of the respondents. This is a significant area of concern for asylum seekers as they are unsure as to what the situation will be like upon arrival in the UK. Many asylum seekers and refugees are given emergency or temporary accommodation by NASS. Some of the respondents said that some of the accommodation they are placed in is in an appalling state, with no heating facilities in some of the properties (nor health & safety procedures). Many respondents stated that they had had to stay at friend's homes.

"Given a small house. It is overcrowded; 6 people (including children aged 15, 14, 9 years, and 3 weeks) in 2 bedrooms." They had no vacuum cleaner or washing machine. This interview was terminated at this point due to the emotional state of the interviewee.

Uncertainty over status was also mentioned by most of those interviewed as a major contributor to their poor mental health, particularly with anxiety and depression. They felt that their future was on hold as it takes the government between 2 and 5 years in some cases to decide their fate.

Unemployment is forcing some of the respondents to work illegally, especially when benefits have been stopped and they have no other means of survival. This work is usually underpaid. All respondents wanted to have their status sorted so that they are allowed to work. This would enable them to contribute to the economy, support

themselves and their families and reduce the incidences of depression caused by being stuck at home with nothing to do. This is exacerbated further if the person is a skilled worker and has a lot to offer.

“My benefits were stopped. I had no food and nowhere to go. I used to be given food vouchers of £35 per week, which can only be used in Asda. The money is not enough and I end up returning some of the food. I am struggling in life. Sometimes I think it is not worth living for. I’m always indoors because I don’t have a single cent to spend on transport and if I need to go out then I have to walk. I feel isolated from others and that is my problem and no-one else’s.”

B3 : Have you experienced any of the following (mental health difficulties) either before you left home and / or since you arrived in the UK?

The occurrence of mental health difficulties indicated by this question was even greater than anticipated and demonstrates the extent of the mental health needs of refugees and asylum seekers. It shows a clear link with the horrific experiences of the respondents and the resultant psychological problems.

13 of the categories were experienced by over 50% of respondents.

The most common of these was ‘Depression’ although other notable mental health difficulties experienced were ‘Anxiety’, ‘Mood Swings’, ‘Nightmares’, ‘Withdrawal’, ‘Flashbacks’, ‘Memory Loss’ and ‘Loss Of Appetite’.

B4 : What do you understand by ‘mental health’?

Responses to this question showed a very limited understanding and / or knowledge of mental health, with the vast majority of respondents focusing on the negative side of mental health, naming physical symptoms or illnesses such as ‘fever’, or simply stating that they didn’t know and / or understand the term.

The terms ‘Depression’, ‘Madness’ and ‘Crazy’ were used repeatedly, though with very little understanding indicated by the interviewees, even of these broad terms.

Only 12 respondents indicated a broader knowledge of the term ‘mental health’.

This indicates that many interviewees are from countries where education about mental health is either very limited or not existent, compounded further by a lack of information within communities here in the UK. Mental health problems are often severely stigmatised in the countries respondents had lived in, with much of it surrounded by superstition and with religious connotations.

Many respondents mentioned being possessed by a ‘Jin / Ginn’ (evil spirit) as being associated with mental health in their home countries in both Africa and the Middle East. A lack of education about mental health has led to communities trying to explain mental illness in spiritual terms. These views are still held by many people arriving as asylum seekers in the UK.

B5 : How has this (your experiences) affected you and how does this interfere with your everyday life?

Although many did not want to comment on this particular question, the most common recurring theme was 'Isolation'. However, we cannot assume that this is based entirely on mental health difficulties, but must consider it in conjunction with other respondent experiences such as 'Separation From Family / Friends' and 'Language Difficulties', both raised in different questions.

Respondents are seemingly experiencing very similar things and a theme emerges as we combine responses :

Bad experiences leading to depression and other mental health difficulties – Separation from family and friends leading to a lack of support within new community – Isolation leading to lack of access to information (worsened further by poor knowledge of English) and progression of mental health problems.

Other difficulties caused by mental health problems primarily centred around relationships with family, and difficulty working due to poor concentration and lethargy brought on by depression.

B6 : How would you have dealt with this at home?

The most prominent responses to this question tell us just how important religion and socialising are to refugees and asylum seekers. The difficulty is, however, that as so many have been separated from those they know and love, they are less able to go out and socialise. Talking problems through with another person, particularly someone with similar experiences, is viewed as extremely important for helping people to overcome their social difficulties and to cope better with any mental health difficulties they may have. **Sharing information with other individuals or through community groups is seen as vital by almost all respondents in ensuring that you gain proper access to services and any information they may need, with particular regard to mental health service provision.**

B7 : Upon your arrival in Manchester, what 3 things had the most effect on your mental health?

Positives

No particular areas gained a high percentage of agreement as being a great help with regard to respondent's mental health, with the exceptions of 'Education', 'Accommodation' and 'Safety'.

The fact that there were over 60 different positive areas mentioned would be very encouraging but for the fact that so few interviewees actually identified the same positive experiences. This indicates that refugees and asylum seekers are not all receiving the same information, access to services or treatment by authorities upon arrival in Manchester.

This goes some distance in explaining why a lot of refugees and asylum seekers feel very confused as to their future, their rights and the availability of different services.

Negatives

One of the most disturbing result in Section B appears here, as we see that over a third (44 out of 117) of respondents view the racism and discrimination they have suffered as having a negative effect on their mental health.

The number of those who suffer racism is of course much higher, but it indicates that the responses and actions of others in the community has much more impact on refugees and asylum seekers, than the failures of services to respond to their social needs.

'Weather' (38 out of 117) was the only other area mentioned prominently as having a negative effect.

Over 70 different responses in this category indicates, in paradox to the 'positives' category, that there is no inherent problem (excepting 'Racism & Discrimination') experienced by the majority of respondents that has a worsening effect on mental health.

However, it may be the case that respondents are not actually mentioning everything that has worsened their mental health, only those issues most prominent.

Section C : Services & Support

C1 : As a refugee or asylum seeker, what do you need to support your mental health?

Most respondents expressed a desire to have a *certain immigration status*. As an asylum seeker, ones life comes to a stop when one cannot access benefits or work.

'Legal status to be sorted; a fair investigation of my case; permission to work' (Male, Pakistani)

'Making of quick decision on the asylum case will help my mental health, without knowing what my status is it makes me panic and worried all the time' (Female, Bhajuni)

'Status should be given quickly. Accommodation provider makes me feel bad about being an asylum seeker' (Female, Pakistani)

Linked to this, respondents stated the importance of *employment and activities*. This would help keep them busy, enable them to build on their skills, provide them with a means of contributing and getting to know their communities and offering them a means of taking their mind off their circumstances.

'To be able to work and study; to keep busy' (Female, Pakistani)

'To keep myself busy and educated e.g. going to the library' (Male, Afghani)

'Freedom to work and earn' (Male, Somali)

Respondents also stated the need to receive more *personal attention from their GP and social workers*.

Some respondents mentioned a *'peace of mind'*.

Few respondents felt they needed *medication*.

C2 : What forms of mental illness do you know?

A significant majority responded 'depression'. This was followed by 'madness', 'stress' and 'memory loss'. Other responses included 'headaches', 'schizophrenia', 'nightmares' and 'talking to oneself'.

A few individuals stated some extreme responses including the following :

'Tumour, madness' (Female, Gujarati)

'Suicidal thinking, anxiety, forgetting things' (Male, Asian Pakistani)

'Mental torture' (Male, Afghani)

'Paranoia, flashbacks, alone, talking to oneself' (Male, Somali)

'Depression, amnesia' (Female, Brava)

This highlights the traumatic experiences that some of the respondents have experienced.

C3: What kind of help do you think refugees and asylum seekers with mental health problems need?

Most respondents stated that they felt that refugees and asylum seekers with mental health problems needed the support of relatives and friends (107 responses). This was closely followed by the need for information (102 responses) and the need for support from refugee and asylum seeker organisations (93 responses). Most respondents felt that refugees and asylum seekers had multiple needs and this is reflected in the large number of responses under each category.

The need for support of relatives and friends reflects the background of the respondents. Most of the respondents came from countries where community life is highly valued. When asylum seekers and refugees arrive in the UK, they also seek the support of community members because they feel that people from their communities would be able to identify with their situation and offer support on how to live in England. Similarly, the need for information reflects the language barriers that refugees and asylum seekers face when accessing services. Materials may exist in English but this information is not accessible if it is not translated to them into their own languages. Refugee and Asylum Seeker organisations are also viewed as vital in their role of guiding and helping people access services.

C4: Which of these, if any, have you used?

The majority of respondents stated that they have used a GP (71 responses). This is followed by support workers (41 responses), support of family and friends (34 responses) and refugee and asylum seeker organisations (30 responses).

Although respondents in Question C3 felt that refugees and asylum seekers with mental health problems need a range of services, many respondents themselves had not accessed the services. This indicates that the respondents *either* did not place themselves in the category of those who may need help or have mental health problems *or* they simply did not have access to services they felt would be useful.

C5 : What did you find helpful about the help/support you received?

For the majority, *support workers* were helpful because they helped the respondents organise their lives, in particular accessing services.

'Support worker came through a refugee organisation and she helped me to get access to all the services; doctor gave medicines' (Female, Pakistani)

'Support worker helps, advises and listens to me' (Male, Pakistani)

'Support worker was the best- we know nothing and he helped with everything e.g. schools, job centres, laws in England, getting children to school' (Female, Iraqi) (Male, Pakistani)

GPs were also helpful in providing medication, which respondents felt they needed.

'G.P. gave medicines and I felt relaxed; refugee organisation provided me support worker and support worker got services for us' (Female, Gujarati)

'Support work gave me moral support and helped me to access the different services. Doctor gave medicines which helped me to remain healthy' (Female, Pakistani)

'Doctor gave me medication and I felt good' (Male, black African)

In addition, *drop-ins* were an opportunity to make friends and stay busy in a friendly environment.

'In drop-in people meet each other and discuss the problems together; refugee organisation set up my campaign; G.P. gave medicine' (Female, African)

'Drop-in is good because the environment is friendly' (Female, Asian)

'Drop-ins are very useful because there I make friends and people in drop-in are solving all my problem and get support for me' (Female, Bangladeshi)

Some people *did not respond* to this question.

C6 : What was less helpful?

Many of the respondents (42 people) *did not respond* to this question.

Others responded that the *GP* was not helpful because they only provided medication.

'GPs not very helpful, not committed, don't listen, don't care' (Female, Pakistani)

'GP can only treat you with medication but you cannot share easy every problems or talk to them about the past which is disturbing me' (Female, Bhajuni)

'When interpreters could not understand me well and the GP did not sympathise with my concerns' (Female, Kurd)

Some felt that *leaflets* were in English so they could not access information due to language barriers.

C7 : Which mental health services are you are aware of in your area?

Most of the respondents (56 people) responded that they did not know of any mental health services in their area. They know of health services where they have access to GPs. However, they do not know of 'mental' health services. This is due to lack of awareness and information.

Among the services that were known is the Manchester Royal Infirmary.

Some respondents referred to the MRI while others called it St. Mary's. Some simply stated 'hospital'.

C8 : What might make it hard for you to access services?

Most reported that they found it hard to access services because of language barriers.

'Language, because if we don't know language we cannot get any service' (Female, Pakistani x 5) (Female, Asian) (Female, Bangladeshi) (Female, Asian Pakistani) (Female, Bhajuni) (Female, Brava) (Male, Afghani) (Female, Brava) (Male, Kurdish) (Male, Arab) (Male, Kurdish) (Male, Iraqi Kurd) (Male, Arab) (Male, black African)

'Language difficulties, because I could not explain everything to my GP' (Male, Kurd)

'Not enough information, not easy to get to places' (Female, Pakistani)

Others described the lack of information about services available.

'Lack of information- because if we don't know about the places of the services we cannot reach there' (Female, Pakistani)

'Lack of information, language, embarrassment of not being able to communicate – I have experience this' (Female, Afghani)

A number *did not offer any response*.

C9 (a) : Have either yourself / partner / family member / friend been prescribed drugs in the last 2 years for mental health?

Most respondents stated that neither themselves nor their partners, family members and friends have been prescribed drugs in the last 2 years for mental health (70 responses).

About a quarter of respondents (37 responses) answered 'yes', demonstrating that mental health problems are an issue within refugee and asylum seeker communities.

A small number of respondents did not answer. This is probably because they were not comfortable admitting that either themselves or someone they knew were taking drugs for mental health. This is due to stigma attached to mental health.

C9 (b) : If yes, please explain. What was the experience like?

Amongst those who responded 'yes' (37 responses) about half of them provided negative comments about their experience. Problems faced include side effects, lack of sleep, an increase in weight, fear of the medications, and dizziness.

One respondent stated that as a result of the drugs, "I had hallucinations. Once I thought the police are going after me to harm me".

About another half of the respondents who said 'yes' stated that the drugs helped them feel better, relaxed them, brought some peace, helped their moods and helped them sleep.

C10 (a) : Have either yourself / partner / family member / friend visited a doctor / psychiatrist / psychologist / counsellor / support worker since you arrived for mental health?

A large majority of respondents said 'yes' (80 responses). 17% of respondents answered 'no' and 3% of respondents did not offer a response. This response highlights that, in general, refugees and asylum seekers are accessing some type of health or support service. The next section would throw light onto what services they are accessing.

C10 (b) : Have either yourself / partner / family member / friend visited a doctor / psychiatrist / psychologist / counsellor / support worker since you arrived for mental health?

More specifically, respondents stated that they had visited a doctor for mental health (82 responses) and that a family member had visited a doctor as well (53 responses). Respondents also declared that they had visited a support worker (39 responses) and a family member had also visited a support worker (37 responses).

A lesser number of respondents stated that either themselves or someone they knew had visited a psychiatrist (collectively 18 responses), a psychologist (collectively 18 responses), and a counsellor (collectively 30 responses).

The information from this question reinforces the response in question C4, showing that most respondents have access to a GP and to support workers. About a quarter of respondents had stated that they prescribed drugs (Question C9a). They receive these prescriptions from their GPs. The support workers provide information about services and facilities available for the families of refugees and asylum seekers. Psychiatrists, psychologists and counsellors, who are visited less by the respondents, do not offer practical support to the same extent that support workers do.

C11 (a & b) : Has anyone else helped you? If yes, who was it?

About two-thirds of the respondents stated that they had someone else helping them (74 responses). Forty-three respondents said that they do not have anyone else helping them. Most of the people who replied 'yes' were women (46 responses, as opposed to 28 responses from men). The women indicated that the people who had helped them were predominantly friends (33 responses) and 'other' (22 responses). Most of those who commented that they did not have anyone else helping them were men (24 responses, as opposed to 19 responses from women). Information gathered about the ethnicity of those who had someone else helping them shows that these respondents are from diverse ethnic groups. Ethnicity is therefore not an explanatory factor in terms of who has additional support from friends, family or others.

C12 (a) : If you have received help, were you offered interpreters or translation services?

Over half of the respondents (54%) responded that they were not offered interpreters or translation services; while 46% stated that they had been offered these services. This finding shows that there are many respondents who do not have access to interpreters or translation services. This has an impact on their ability to access certain services because of language and communication barriers.

C12 (b) : If yes, how do you rate the quality of the services offered?

Amongst the 46% that had accessed interpreters and translation services, the majority of respondents (21 responses) stated that these services had been of a 'good quality'. Twelve respondents felt the services had been satisfactory and another twelve respondents felt that they had been very good. A lesser number felt that the services had been poor (5 responses) and very poor (3 responses).

Since most respondents who had accessed interpreters and translation services view them positively, they should be extended to a greater number of refugees and asylum seekers. Some respondents were not satisfied with the quality of the service they received. This reflects the need for qualified experienced interpreters. Some interpreters also did not speak the specific dialect of the respondents, which leads to miscommunication and confusion.

C13 : Do you feel that refugees and asylum seekers with mental health needs seek advice or treatment? Please explain why you say so.

Most respondents felt that refugees and asylum seekers with mental health needs do not seek advice or treatment (63 respondents, in comparison with 28 respondents who felt that they did). Those who felt that refugees and asylum seekers with mental health needs seek advice or treatment, have substantiated their response with comments including the following:

“Because some have no family or friends to support them” (Iraq, Male)

“If some one have problems they have to seek advice about it to get better” (Kurd, Male)

Because when they are mentally ill they need doctors and psychologists. They are humans and need help” (Somalian, Male)

“Because they need to express all their anxieties and issues they want to live a normal life again” (Pakistani, Female)

The majority of respondents replied ‘no’. The reasons they gave about why refugees and asylum seekers with mental health needs do not seek advice or treatment includes the fact that they feel ashamed, they do not know where these service are, they face language barriers, they are stigmatised and they are not aware that they have mental health problems because they are trying to focus on resolving their day-to-day problems. Comments from respondents include the following:

“They feel ashamed about their mental issues” (Black African, Male)

“Because many of them don’t know where they can get the service they need (Black African, Male)

“People look at refugees and asylum as people increasing NHS costs. That’s the impression we get (African, Male)

“Don’t know where to go for help, embarrassed or ashamed about mental problems” (Kurdish, Male)

“I’m saying that because they have lots of problems to sort out before they realise they suffer from mental health problems” (Bhajuni, Female)

“I’m a disabled and I don’t get proper help and support” (Afghani, Male)

A lesser, though still significant, number of respondents either stated that they did not know whether refugees and asylum seekers who have mental health problems were seeking advice or treatment or they did not respond to the question. Most of these respondents were from the Bravanese community. Members of the Bravanese community are often newly arrived within the UK; and they therefore may not yet have a full enough understanding of the extent to which refugees and asylum seekers are seeking advice or treatment.

Section D : Appropriate & Responsive Services

D1 : How could things be made better for your community?

The majority of respondents stated that *more information* would make things better.

'More information about the services and educating people about exactly what the services will do for them' (Male, Asian Pakistani)

'By getting education, information, help from friends to make it easy for newcomers' (Female, Pakistani)

A significant number felt that *more activities* would be useful.

'Youth clubs for children, community groups, health centres' (Female, Bhajuni)

'Day centres, drop ins, children's playing groups, gyms, health centre' (Female, Bhajuni)

Others felt that there is a need for *more and better services for refugees and asylum seekers*.

'More information provided; specialist help for asylum seekers and refugees' (Male, Kurd)

'More support needs to be given to refugees and asylum seekers; professionals from ethnic backgrounds or volunteers to be involved in giving out information to the community about these services' (Male, African)

A number felt that there is need for *education about asylum seekers and mental health in order to contribute to a positive community spirit*.

'People should understand the problems of the asylum seekers and then make the services easy for them and service providers should be friendly' (Female, Bangladeshi)

'By educating people about different communities and cultures to help with getting on better' (Male, Pakistani)

'We should educate the communities who are ignorant to understand us also being human like them. We aren't giving them pain, why should they give us pain?' (Female, Pakistani)

D2 : What would make it easier for refugees and asylum seekers to use services?

Most respondents (74 people) felt that *interpreters, leaflets in their own language, advocates, accessibility and local services* would all contribute to making services more accessible and useful for refugees and asylum seekers.

Some respondents referred to the importance of qualified *interpreters*.

Others specifically stated that *leaflets* would make it easier for refugees and asylum seekers.

**D3 : Would you like to be involved in the development and planning of services?
If yes, in what way?**

Many of the respondents felt that they did not want to be involved. Some of them are mothers and feel they need to be at home to care for their families. Others feel they cannot communicate adequately. They do not read or speak English. Some have low self-esteem and cannot imagine how they can contribute.

A significant number stated that they would like to provide advice and suggestions on the needs of their communities.

Some stated that they would like to provide people within their communities with information, particularly newcomers.

Extra Notes

The extra notes provide contextual information that helped to explain the responses of interviewees.

RECOMMENDATIONS

Asylum seekers in Manchester live in fear of being returned to their home countries. Their anxieties are compounded by their inability to work while their asylum cases are being dealt with. In addition, the lack of activities in their local areas does not enable them to develop their skills and contribute positively to their communities. Services are rarely designed to meet the needs of asylum seekers who often find it difficult to access information and support in their own languages. There is also little attention paid to the fact that asylum seekers and refugees have fled from their home countries in an attempt to escape war and trauma. The special needs of asylum seekers requires a targeted approach based on an agreed strategy, which is holistic in nature.

The recommendations below offer some ideas of how the mental health needs of refugees & asylum seekers in Manchester can begin to be met.

1. Education

Service providers : There is need for people to be aware of the issues facing asylum seekers and refugees and implementation of staff training to gain knowledge of their rights and different cultural needs. This applies to those working in both statutory and voluntary sector services. Many respondents stated that they had witnessed discrimination and a lack of professionalism within services e.g. CPNs discussing their status, which is completely irrelevant to their job.

“ The GP told me to my face that he was refusing my access to a wheelchair because I was an asylum seeker. I also couldn’t get adaptations to my accommodation for 9 months. I was forced to crawl around my house, as the chair I had did not fit through the doors. The ‘asylum seeker’ label follows you around.” - Wadiha Ahmed (HARP CEP Researcher)

Asylum seekers & refugees : Community Development Workers would be vital in helping asylum seekers and refugees to access education, particularly with regard to mental health. Respondents repeatedly spoke of mental health in religious terms and linked it with superstition, myth and even magic. This lack of education leads to people (even upon arrival in the UK) using non-medical treatments, including what can best be described as ‘exorcisms’ to remove what are perceived as ‘bad spirits’.

“African families fear the stigma of the ‘mental health’ label.” - Wadiha Ahmed (HARP CEP Researcher)

“Mental health is hidden within families, particularly if the affected person is female.”
- Molly Ondoga McLelland (HARP CEP Researcher)

Wider community / public : Racism and discrimination becomes more prevalent in socially deprived communities and in predominantly white communities. Increasing education in these communities, which is where a lot of refugees and asylum seekers are being placed in accommodation, is vital to improve community relations and decrease the effect of racism on the mental health of asylum seekers and refugees. Most respondents were optimistic that this could be achieved as they view the racism and discrimination they suffer to be borne out of fear, misinformation and media indoctrination. Improvements could be achieved through increased community interaction and integration via activities centred around community involvement, such as environmental improvement schemes and regular neighbourhood meetings facilitated by Community Development Workers.

2. Appropriate and responsive services

There needs to be more development of appropriate mental health services to help refugees and asylum seekers to deal with the mental health difficulties highlighted in the research i.e. depression, anxiety, mood swings, nightmares, flashbacks etc.

The development of these services needs to acknowledge the research findings on what the refugees and asylum seekers found to be most useful e.g. counselling, support workers and places to meet to reduce isolation.

3. More qualified community workers / interpreters

Communication is crucial when expressing ones' needs. In order to accurately translate the needs of asylum seekers, interpreters need to be qualified in the different languages.

- o **Trained mental health link workers** across the city will help this people settle in their local communities they live in so that they are not excluded or isolated. When separated from the families there is a big impact on Asylum seekers and refugees due to inappropriate language.
- o **Trained community support workers** would be culturally sensitive and articulate to the specific and different needs of service users, and would be able to support and orientate newly arrived asylum seekers, ensuring they know about local services and can access them.

4. More Community Development Workers

Both from within and outside the communities of asylum seekers, community development workers would educate people about mental health. This would contribute to removing the stigma around mental health and would improve understanding around the different types of mental health issues and the services available. The mental health organisation needs to train more community workers from the Asylum/ Refugees/ ethnic minority so as to gain trust and build a relationship which will help the mental health organisation gain an insight of providing services and at the same time understanding them better.

Most respondents emphasised how important support workers were in helping them access services and deal with their everyday concerns. Respondents spoke to researchers about the support they received from workers at ROUTES, HARP, YASP and the Red Cross.

5. Access to information in different languages

Asylum seekers have little information about the mental health services available in their local area. Whilst leaflets may be available, they are not accessible in the languages of asylum seekers. Information in the different languages and dialects of asylum seekers would enable them to better access services. Statutory services need to set up information for asylum seekers / refugees by printing leaflets in their own languages to help them to access mental health services. A directory of services should be made available.

6. Right to work

Refugees and asylum seekers are desperate to work. Not working means that many people feel inadequate and useless, as they want to contribute to society and to be able to support their families.

Not allowing asylum seekers to work leads to an increase in the instances of people having no option other than to work illegally, in order to maintain some semblance of an ordinary life. Many asylum seeker families find it impossible to survive on benefits and so choose this option, despite the fact that they will be exploited and forced to work in conditions with poor health and safety and for very low pay.

“It feels like a human rights violation when you are not allowed to work and must wait for status to be confirmed.” - Burhan Fatah (HARP CEP Researcher)

“When my husband is going to collect our weekly benefit and I ask him where he is going, he responds with ‘I’m going begging’.” - Aqila Mansoor (HARP CEP Researcher)

“Kids from asylum seeker families develop low self-esteem as they cannot join in the same activities as their peers. Even small things such as a trip to the cinema. The family can’t afford it.”

- Molly Ondoga McLelland (HARP CEP Researcher)

7. Availability of activities as part of mental health services

Asylum seekers want to be active within their communities. This would enable them to meet others, to share their problems and find solutions together, and to engage in constructive and positive activities. This includes, for example, activities provided by the ‘Well-Being Project’.

Community Living Services in Manchester provided by the Mental Health Care Trust need to consider the needs of refugees and asylum seekers providing appropriate and culturally sensitive services where people can meet and get support. Consultation needs to take place within the community of refugees and asylum seekers on how this can be developed.

The voluntary sector has a vital role to play in the provision of appropriate services to asylum seekers and refugees. There are some good examples cited in this report where refugees and asylum seekers have benefited from help available. The voluntary sector mental health forum is well placed to consider the recommendations contained in this report and to look at ways of taking them forward through its involvement with the development of the mental health commissioning strategy.

The commissioning strategy for mental health in Manchester needs to include plans for meeting the needs of refugees and asylum seekers. This should be focussed on the provision of appropriate and accessible services for them.

8. Services for women

For the women from the Asylum and the Refugees communities there is a special need for people from their ethnic background to work with them because of their cultural and belief there is need to carry out further research in domestic violence and sexual assault because of the fear that if they spoke about the above they would be rejected by their communities. Outreach workers are a particularly important need for women as they are often isolated and

cannot access support. Projects working with women who have experienced sexual and / or domestic violence should also ensure that they are trained on the particular needs of refugee and asylum seeker women. The setting up of crèches, most likely within community centres, is also necessary, as many women need access to childcare, especially if they are doing voluntary work or in education.

9. Accommodation

There should be provision of appropriate accommodation as unstable or inadequate accommodation impacts adversely on mental health.

10. Advice and advocacy

An advocacy scheme could be developed to help refugees and asylum seekers access the services they need. Advocates including paid workers and volunteers should be recruited from the refugee and asylum seeker communities.

Dedicated multi-disciplinary teams should be set up to work with refugees and asylum seekers. This should include addressing the needs of refugees in relation to work opportunities, training, education as well as leisure opportunities.

11. National Service Framework

Standard 1 of the National Service Framework for mental health (Department of Health, 1999) requires health and social services to: promote mental health for all and work with individual and communities and combat discrimination against individuals and groups with mental health problems and promote their social inclusion. Mental health interventions that are sensitive to the needs of refugees and asylum seekers need to be developed in partnership with this community. They should be an integral part of designing sensitive services.

The research has highlighted key mental health issues for refugees and asylum seekers including racism, stigma, language barriers, poverty, unemployment, isolation, lack of knowledge about services, problems accessing services, experience of traumatic events and anxiety and depression. The National Service Framework also highlights in all its standards the need for primary and secondary mental health services to be established and that these services should be accessible to all. The design and development of any service needs to be sensitive to certain groups including refugees and asylum seekers. All staff need to be aware of those needs in order to offer appropriate services. The current review of mental health services in Manchester needs to make sure that new services are sensitive and accessible to refugees and asylum seekers. There needs to be effective consultation and extensive community involvement in the planning and implementation of services.

12. Delivering Race Equality

Delivering Race Equality (Department of Health, 2005) is an action plan and focuses on three building blocks: appropriate and responsive services, engaged communities and better information. It outlines a five-year vision of improved mental health services and lists a set of characteristics many of which match some of the responses in this research. For example: the need for increased satisfaction with services, an increase in the proportion of BME

service users who feel they have recovered from their illness, a more balanced range of effective therapies such as peer support services, psychotherapeutic and counselling treatments, as well as pharmacological interventions that are culturally appropriate and effective, a more active role for BME communities and BME service users in the training of professionals, in the development of mental health policy and in the planning and provision of services. We would like to recommend that further examination of this research in line with the action plan contained in delivering race equality is conducted so that the development of appropriate services for refugees and asylum seekers can be properly informed.

Final Note

Since the start of our involvement in this Community Engagement Project, we have collectively gone on to achieve the following :

- o Passed CLAY computer course
- o Passed I.T. course
- o Passed English Literacy Level 1
- o Passed MA in Development Studies at the University of Manchester
- o Completed Disability training carried out by Break Through UK
- o Completed Assertiveness training with YASP
- o Gained Certificates in Community Research & Mental Health at the University of Central Lancashire
- o Became a Board Member at Manchester Social Services
- o Become a Director of GMCDP (Greater Manchester Coalition of Disabled People) and worked as a volunteer for their refugee project
- o Become a Secretary of Horn of Africa Disability Society
- o Become a Steering Group member for a women's refugee project
- o Continued volunteer work at British Red Cross, ROUTES and the Federation of Iraqi Refugees - Manchester
- o Gained employment at Refugee Action as Asylum Advice Caseworker
- o Gained employment at African HIV Policy Network as Policy & Community Engagement Officer

APPENDIX

HARP Community Engagement : Research Questionnaire

Date : _____

Section A : Core Questions

1. How old are you?

- 18-24 25-34 35-44 45-54 55-64 over 64

2. Your Country of Origin

3. Your Nationality

4. Your Ethnic Identity

5. Other countries you have lived in

6. What languages do you speak?

a. Spoken

b. Written

7. Which languages are you fluent in?

a. Spoken

b. Written

8. Status

- Naturalised / British
- Refugee / Indefinite leave to remain
- Humanitarian Protection
- Asylum Seeker
- Extended leave to remain
- Discretionary leave
- Naturalised - other European country (please specify)
- Awaiting appeal
- No Status Granted
- Other

9. Ethnicity

White

- British
- Irish
- Other (please explain)

.....

Mixed

- White and Black Caribbean
- White and Black African
- White and Asian
- Other (please explain)

.....

Asian or Asian British

- Indian
- Pakistani
- Bangladeshi
- Other (please explain)

.....

Black or Black British

- Caribbean
- African
- Other (please explain)

.....

Chinese or Other Group

- Chinese
- Other (please explain)

.....

10. Religion

Religious Identity:

OR

- None
- Christian
- Buddhist
- Hindu
- Jewish
- Muslim
- Sikh
- Other (please state)

.....

- Not stated

11. Gender

- Male
- Female
- Transgender

12. Marital status

- Married
- With Partner
- Single
- Divorced
- Separated by choice
- Enforced Separation
- Widowed

13. Location

Postcode (first three letter and numbers only e.g. M14)

Please note you don't have to give postcode, and all information will remain confidential

.....

14. Sexuality

- Lesbian or gay woman
- Homosexual or gay man
- Heterosexual or straight
- Bisexual
- Other
- Don't want to say

15. Do you have disability?

- Yes (explain what)
- No.

16. Employment status

- Full time employment
- Part time employment
- On Emergency support
- NASS
- Voluntary work
- Student
- Disabled - working
- Disabled - not working
- Retired
- Not permitted to work
- Other

Section B : Your Experiences

1. What events have you experienced in your home country or during your journey to the UK?

- War
- Torture
- Violence
- Destruction of your home
- Sexual assault
- Rape
- Domestic violence
- Persecution
- Bereavement and loss of loved ones
- Separation from family or friends
- Lived in refugee camp
- Detention/imprisonment
- Family problems
- Serious illness
- Financial problems
- Local displacement
- Other

2. What events have you experienced since your arrival in the UK?

- Detention
- Homelessness
- Family problems
- Poverty
- Separation from family /friends
- Violence
- Racial abuse
- Unemployment
- Uncertainty about your legal status
- Social isolation
- Racism and discrimination
- Language difficulties
- Sexual assault
- Rape
- Domestic violence
- Serious illness
- Financial problems
- Other

3. Have you experienced any of the following either before you left home and/or since you arrived in the UK?

- Depression
- Guilt
- Anxiety
- Mood Swings
- Suicidal thoughts
- Suicide attempts
- Headaches/ Migraine
- Intrusive thoughts
- Flashbacks
- Nightmares
- Difficulties sleeping
- Emotional numbness//withdrawal
- Loss of appetite
- Drinking too much alcohol or taking drugs
- Relationship difficulties
- Poor concentration
- Memory loss
- Aches
- Pain Emotional Physical
- Other

4. What do you understand by mental health?

5. How has this affected you and how does this interfere with your everyday life?

6. How would you have dealt with this at home?

7. Upon your arrival in Manchester, what three things had the most effect on your mental health?

Positives

- 1.
- 2.
- 3.

Negatives

- 1.
- 2.
- 3.

SECTION C : Services and Support

1. As a Refugee or Asylum Seeker, what do you need to support your mental health?

2. What forms of mental illness do you know?

3. What kind of help do you think Refugees and Asylum Seekers with mental health problems need?

- Support of relatives and friends
- Medication
- Counselling
- Therapy
- Information
- Spiritual support
- Drop-ins
- Help from others in the same position
- Help from refugee and asylum seeker support organisations
- General practitioner
- Befriending
- Hospital
- Support worker
- Other (*please give details*)

.....

4. Which of these, if any, have you used?

5. What did you find helpful about the help / support you received?

6. What was less helpful?

7. Which mental health services are you aware of in your area?

8. What might make it hard for you to access services?

Please explain why you think so.

9. Have either yourself / partner / family member / friend (*delete as necessary*) been prescribed drugs in the last 2 years for mental health?

- Yes
- No

If yes, please explain. What was the experience like?

10. Have either yourself / partner / family member / friend (*delete as necessary*) visited a doctor / psychiatrist / psychologist / counsellor / support worker / health worker since you arrived for mental health?

- Yes
- No

(Researcher to tick each relevant box in the table)

	Self	Partner	Family Member	Friend
Doctor				
Psychiatrist				
Psychologist				
Counsellor				
Support Worker				

If yes, was this helpful and in what way was it helpful?

If no, why was it not helpful?

11. Has anyone else helped you?

If yes, who was it?

12. If you have received help, were you offered interpreters or translation services?

If yes, how do you rate the quality of the services offered?

VERY POOR	POOR	SATISFACTORY	GOOD	VERY GOOD
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13. Do you feel Refugees and Asylum Seekers who have mental health problems seek advice or treatment?

- Yes
- No

Please explain why you say so.

SECTION D : APPROPRIATE AND RESPONSIVE SERVICES

1. How could things be made better for your community?

2. What would make it easier for refugees and asylum seekers to use services?

Use prompts: e.g. Interpreters, leaflets in own language, advocates, accessible, local,

3. Would you like to be involved in the development and planning of services?

If yes, in what way?

Thank you for your time, it is greatly appreciated 😊

References

National Service Framework for Mental Health (Department of Health, 1999)

Delivering Race Equality (Department of Health, 2005)

Manchester City Council : Council Wide Information : City of Manchester
(www.manchester.gov.uk/corporate/thecity/, accessed 01.02.06)

Home Office : Asylum Statistics : 4th Quarter 2005
(www.homeoffice.gov.uk/rds/pdfs06/asylumq405.pdf, accessed 01.02.06)

Refugee Council : Press Myths
(www.refugeecouncil.org.uk/news/myths/myth001.htm, accessed 01.02.06)