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**Report on the
General Refugee & Asylum Seeker Project
(GRASP)
Update 2004-2005**

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Setting the Scene

The Refugee Council's information centre guide provides a comprehensive list of the different types of immigration status, as they are legally defined in the UK. These range from that of Asylum Seeker, as laid down by the 1951 Geneva Convention, to unregistered immigrants. The use of the terms in this report relate to the official definitions.

The abbreviated 'RAS' (refugees & asylum seekers) has been used in the report to refer to this population generally in Hackney and 'New Arrival' refers to any refugee or asylum seeker, irrespective of their legal status, who has been in Hackney for less than 5 years. It includes those who may have been dispersed to other parts of Britain when they first arrived in the UK but have now come to join communities in Hackney.

It is worth noting, however, that in the course of working on the General Refugee & Asylum Seeker Project (GRASP), it quickly became clear that the term 'refugee', is much more loosely used locally than its official definition suggests. It is commonly used to define an identity, either current or past. It may include, for example, those who have lived in the UK for many years and are British Citizens and any ethnic minority and/or settled community who may see themselves as refugees, in some sense at least, or in particular circumstances. Or the term may be used – sometimes derogatively - as a 'catch-all' for different groups of people including asylum seekers and any other type of immigrant or new arrival.

It is often difficult to distinguish between the diverse uses, or to know where to draw the line, when attempting to collate local demographic data and other information. Future work may need to identify more precisely which groups of people (e.g. asylum seekers/those recently given refugee status/failed asylum seekers/newly arrived EU nationals etc) there is a need to understand better, at what levels (e.g. tackling health inequalities in general or planning specialist services?) and how this can be sensitively achieved.

Nevertheless, what is significant, as others have pointed out, is the common health and social care needs among refugees and asylum seekers, rather than their immigration status¹. In this sense, GRASP has been more generally concerned with those who are living in unstable circumstances, who are poorly integrated into mainstream services and who share a similar range of needs derived from their particular experiences. Notably, those experiences of conflict and trauma, displacement, social and familial disruption and transience, as well as those of facing the many challenges of integration into a new and often unfamiliar way of life.

As pointed out in GRASP's first report (February 2004), many of the health and other issues facing RAS are not specific to their immigration status. They overlap with those of other deprived or excluded groups, ethnic minorities, long settled immigrant communities and other new arrivals. In general, these issues relate to the wider determinants of health: to poverty, unemployment, poor housing, language barriers and lack of 'know-how'; poor access to and use of services and frequent experiences of hostility and racism. Despite the overlap with the needs of other minority or excluded groups in the community and the recognition that RAS themselves comprise a very disparate group, several significant pointers have been highlighted over the years. These help in identifying and understanding RAS health & social care needs but also have important implications for service delivery.

There is now a substantial body of information on the health issues and problems identified as specific to RAS². These include the more obvious physical after-effects of conflict and displacement; the greater risk of certain communicable diseases and chronic conditions for specific groups as well as the risks of *deteriorating* health after settlement; mental health concerns and a range of social and psychological issues resulting from the experiences of dislocation and, not least, from the uncertainties of one's immigration status.

Over recent years, both as a result of increasing levels of asylum applicant's to the UK³ and since dispersal⁴ to areas throughout Britain with previously little or no experience of RAS,

¹ See Feldman R (2004) who makes this distinction

² Appendix 3

³ Numbers peaked in 2002 and have since continued to drop

expertise in providing health care for asylum seekers has grown. There is now substantial documentation of the experience of health providers working with RAS and the development of appropriate services as well as a range of guidelines, standards and resources which can be used in providing such services⁵.

Government legislation, notably Section 55 of the Nationality, Immigration and Asylum Act (2002)⁶ and the more recent Proposals to Exclude Overseas Visitors from Eligibility to Free NHS Primary Medical Services (2004) as well as the Government's new Five Year Asylum & Immigration Strategy (February 2005) are already having -or are likely to have if implemented - a profound impact on the experiences of both RAS and service providers, on local communities in general, on recent public health and health promotion policies and on how services are delivered both nationally and in Boroughs such as Hackney. If nothing else, they threaten to add to confusions about entitlements to health care, increase fear among refugees in seeking medical help and undermine integration policies.

Some TERMS

CHtPCT	City & Hackney teaching Primary Care Trust
BEMWG	Black & Ethnic Minority Working Group
GRASP	General Refugee & Asylum Seeker Project
NRF	Neighbourhood Renewal Fund
RAS	Refugees and Asylum Seekers
RCO	Refugee Community-based Organisation

⁴ The 1999 Immigration & Asylum Act removed responsibility for providing support from Local Authority's and the National Benefits system. The Act became operational in April 2000 when a national asylum seeker support system (NASS) was setup providing support and accommodation to asylum seekers but mainly in 'dispersal areas' outside London

⁵ E.g. see Feldman (2004) & Burnett & Fassil 2000 for references

⁶ Since its implementation in January 2003, Section 55 of the Nationality, Immigration and Asylum Act significantly altered the asylum support system and RAS' access to accommodation and financial benefits through NASS. For many asylum seekers this added to the hardships of not being allowed to work until they receive a positive decision on their claim. However, a Court of Appeal judgement in May 2004 led to a less draconian interim approach to support pending an appeal by the Home Office to the House of Lords due in July 2005

Executive Summary

- ❖ There have been important changes since GRASP's first report in February 2004
- ❖ These include significant reductions in the number of National asylum applicants and those supported by NASS in Hackney. At the same time, however, there has been an increase in the number of locally reported cases of 'undocumented' and/or destitute migrants, poorly integrated into mainstream services in the Borough. This is thought to be partly due to the effects of Government legislation on asylum seekers and immigration.
- ❖ Much more local demographic data, new Borough profiles and sources of information have become available in Hackney over the last year. This seems to have been matched by a growing awareness of the need for better evidence-based and shared research, including on refugees and asylum seekers, to underpin effective community & health strategies.
- ❖ The voluntary sector and Refugee Community-based Organisations have an invaluable part to play in the drive for and compilation of better information.
- ❖ Concurrently, there have also been a number of new initiatives or improved service developments for refugees and asylum seekers in Hackney.
- ❖ Over the last year, GRASP has also aimed to further explore the needs of less known-about refugee groups in Hackney.
- ❖ There has been a notable rise in the number of Congolese and Latin American school children. The needs of young asylum seekers and refugees, including Vietnamese and Chinese, are beginning to be identified, although there is still not a lot known about Eastern European refugees & asylum seekers or new accession EU nationals in the Borough.
- ❖ By and large, however, GRASP's updated qualitative findings continue to underscore what is already known about refugee experiences and their likely health and social care needs, although different aspects are reflected by different refugee groups
- ❖ . The wide-ranging mental health concerns of the refugee population in general continue to be highlighted.
- ❖ Key features, shared in different ways by other minority groups in Hackney and which continue to impact on mental health, include access to all levels of healthcare as well as to stable housing and the experience of racism and hostility.
- ❖ Language barriers and communication remain at the heart of refugee needs and the delivery of effective health and social care services. Language needs are also closely linked to opportunities for learning and employment and there is a feeling that such opportunities are not properly supported for many refugees.
- ❖ The lack of knowledge and understanding about 'the system' occurs at many levels but also reflects the continuing absence of available or appropriate information, a factor which affects refugees and service providers alike and presupposes, among other things, a need for more training & education.
- ❖ Planning health & social care services to meet, or include, the needs of local refugees and asylum seekers depends on understanding the changing characteristics of local refugee communities as well as on involving those communities. It also depends on identifying the goals of provision for new arrivals to the Borough, so they are not just 'ad hoc and reactive' and on evaluating different potential models of service delivery.

Report on the General Refugee & Asylum Seeker Project (GRASP) Update 2004-2005

I) Introduction

Since GRASP's initial work during 2003-2004⁷ there have been significant changes. These span both the impact of Government legislation concerning asylum and immigration and local developments in Hackney relating, conversely, to some improved services for refugees and the availability of potentially more useful data and sources of information about refugees and asylum seekers (RAS) in the Borough.

The report briefly outlines some of the changes and what are seen as the implications for future demographic and other investigative work, aimed at better understanding and providing for the needs of refugees and asylum seekers in Hackney. It summarises findings resulting from the project's updated qualitative research work, highlighting some of the service implications, and concludes with its recommendations⁸.

II) Summary of Project's Background & Aims

The main aim of GRASP's work over the last year (2004/05) has been to update the research aspects of its work on the 'mapping' and the health of refugees and asylum seekers in Hackney. In this respect, its main objectives have been:

- (a) To revisit key sources of data and identify possible links to them for sustainable ways of updating demographic information on the Borough's RAS for future service policy developments and planning.
- (b) To undertake further qualitative research, especially among those refugee community based organisations (RCOs) or groups not well represented and harder to reach to further explore health and social care needs.
- (c) To link to existing and developing data sources and relevant local research initiatives (e.g. LBH's Better Information Group)

A further objective of the project was to develop the information resource, the 'Welcome to Hackney Guide', and produce it in five community languages⁹. GRASP (through BEMWG) has now secured funding to update, develop & translate the

⁷ See interim GRASP Report February 2004

⁸ The project has concentrated on mapping some changes and potential sources of data. It has not attempted to update and collate figures as before. It was felt that should be the focus of a proper, multidisciplinary and fully resourced research project rather than such a small single-handed one which at best could only provide generalised estimates (see below p.13).

⁹ A booklet was produced in English : 'Welcome to Hackney: a guide to health and social services for new arrivals ' April 2004

Guide and, as a result of consultations, produce it as a PDF targeted at Refugee Community-based Organisations (RCO's) rather than at individual new arrivals to the Borough.

In addition, GRASP has continued to contribute to NRF (Neighbourhood Renewal) and Public Health (DoH) Floor targets linking to existing activities related to local health and social care strategies and aimed at tackling health inequalities¹⁰.

Although GRASP's earlier, more experimental, development work (the Community Champions initiative) was not re-funded over the last year, the project retained some of its developmental aspects¹¹. By and large, these have taken the form of:

- (a) Supporting both statutory and voluntary sector agencies to widen health & social care access by supporting developments such as the Refugee Schools Outreach Project (provided by Social Action for Health through NRF), maintaining links with the Learning Trust (EMAS) and exploring other related initiatives (e.g. Social Services/Young Refugee Project; LBH Homeless Unit/Turkish community support initiative)
- (b) Making referrals to mainstream services where appropriate and between services
- (c) Supporting the development of the Hackney Refugee Forum (HRF) and the Refugee Health Planning Group (Sanctuary PMS Practice);
- (d) Supporting relevant emerging developments (eg. ESOL classes for refugees; capacity building support to smaller RCOs);
- (e) Promoting work in Refugee Week (June 2004) and other activities linked to making services more accessible to RAS and reducing health inequalities.

III) Methods

GRASP has continued to use a multiple data source approach, adopted in the first year. However, the approach was revised in the light of both the changes to GRASP itself (the loss of the 'Community Champion' /development aspect) and other methodological concerns¹², and notable changes in the local availability of data and data sources (see below).

¹⁰ See Appendix 1 for summary of NRF target measures & GRASP project outcomes

¹¹ Full Details on the background to GRASP and the Community Champions initiative are provided in the interim GRASP report of 2004

¹² See Appendix 4 for summary of methodological issues.

This year, GRASP's approach comprised the following elements:

- (1) Revisiting relevant information sources – (desk/web/literature based research and links to key local individuals and Fora/sources)
- (2) Face-to-face semi-structured interviews with key informants
- (3) Focus groups

The driving aim in the face-to-face interviews was to 'map' (i.e. discover where minority groups might be accessed) and approach harder-to-reach and less visible RAS /RCOs and/or those who work with them, for further qualitative data on health. In total nine (9) individuals were interviewed each representing a RCO or service.

These included: 6 voluntary sector groups/services

Three of these were 'generic' (i.e. accessing a range of African, Asian, Eastern European, Latin American and Middle Eastern RAS, including 'unregistered') though they offer distinctly different services (therapy/counselling/employment & training/wide range of advice, education, drop-in sessions etc.); and three represented Ugandan, Somali and Turkish/Kurdish RAS respectively.

In addition, interviews were carried out with LBH's Youth Service (the Young Refugee Project – YRP includes young RAS from China & Vietnam) and two counsellors (therapists) at Sanctuary PMS Practice (includes work with RAS from Uzbekistan/Belarus/Afghanistan & Jamaica) and a GP.

Two focus groups were arranged by the project. One, with the help of the African Support and Project Centre (ASPC), was attended by up to 40 men, women and young people/children representing a range of French-speaking mainly Congolese African RAS. The other Focus group comprised 8 Somali women refugees.

Opportunities were also taken to discuss health issues with RAS attending an ESOL class (John Scott Health Centre) originally set up by GRASP; to attend a health economy advice and employment drop-in session (Shoreditch SPA) and a refugee parent's drop-in (De Beauvoir Primary School)

IV) Changes

1 Update on General Figures

1.1. The most notable change that has taken place over the last year has been the sharp reduction of asylum applicants and their dependents coming to the UK (up to a third fewer). According to recent Home Office figures there has also been an almost 50% drop in the number of Somali's applying for asylum to the UK (although they remain among the top three applicant groups) and Turkish/Kurdish nationals are no longer in the top 10 applicant nationalities, factors which are likely to have implications for Hackney¹³.

1.2 Concurrently, there has been the expected sharp drop in NASS supported asylum seekers coming to Hackney (the result of dispersal policies). There was a 43% reduction in asylum seekers supported in NASS accommodation in Hackney between December 2003 and December 2004 - and as is well known the notorious Pembury Hotel closed last year. There was nearly a 60% reduction of asylum seekers on NASS subsistence only in Hackney over the same period.¹⁴

1.3 It could be argued, that these general changes have been matched by changing patterns of GP registration throughout Hackney with reduced overall net changes and a drop in turnover from up to 27% during 2003/04 to just less than 16% in 2004/05,¹⁵ marking an overall downward trend since 2001.

1.4 The north western parts of Hackney (CHNW) appear to have the highest turnover, suggesting greater mobility in those areas (and the likelihood of a less settled population). 'N' postal districts in general had the greatest net additions (of GP registrations) during both 2003/04 and 2004/05, confirming GRASP's earlier findings that refugees are probably still more likely to be resident in those parts of Hackney. Although, these findings remain inconclusive.

1.5 School figures for Hackney, also recently made available, suggest large increases between 2003 and 2005 in intake of, especially Congolese, Kurdish and Turkish, Latin American, Somali and White Eastern European pupils – all groups with a high probability of being RAS.¹⁶ The figures also show high mobility rates (based

¹³ Home Office figures see Appendix 2 for sources

¹⁴ See Appendix 2. In terms of the soundness of national figures, another development this year has been the National Audit's Office examination of the reliability of the Home Office's quarterly asylum statistics (May 2004) which concluded that they were 'in most respects reliable', although some weakness remained.

¹⁵ C&HPCT see Appendix 3

¹⁶ Learning Trust Research Brief No 1/05 Pupil Level Annual School Census (PLASC) introduced more detailed ethnic in January 2003 which has made it easier to describe and chart changes over time in ethnic mix and match them against other available information/guidelines, such as from Refugee Council, work done on language & refugees etc.

on pupils being at the same school during primary school years 3, 4,5 and 6) of between 62% and 77% among particular ethnic groups. The latter include Albanian and White Eastern European, Angolan, Sierra Leonean, Somali and Latin American among those most likely to be RAS. Overall, 12% of all Hackney Primary school children and 13% of Secondary school pupils seem likely to be from refugee and asylum seeking families,¹⁷ higher than GRASP first estimated.

1.6 The numbers and the changes (in ethnicity and turnover) are not distributed evenly among local schools so individual schools and different neighbourhoods are likely to be differently affected. Primary schools in 'N' postal districts have tended to have higher numbers of 'first wave' RAS intake but not exclusively so (Compare with GP turnover above)¹⁸

1.7 A snapshot insight provided by a recent report on advocacy and interpreting services provided or accessed by C&HPCT, shows that out of 160,000 outpatient appointments at Homerton Hospital per year over half (53%) do not have English as a first language¹⁹. Given that four out of the five most frequently used languages – for which there is the highest demand for advocacy/interpretation – are currently Chinese, Spanish, Turkish and Vietnamese points to a strong likelihood that many of these users are RAS.

1.8 Obviously, estimating the size of the refugee population both nationally and locally remains problematic. The numbers of those with refugee status (or other forms of protection) who subsequently leave the UK (or more locally, Hackney) are not recorded; figures for the numbers joining those granted settlement through Family Reunion schemes are not available; there are no figures for the number of 'overstayers' or 'failed' asylum seekers who remain in the country (or Borough) or, indeed, who leave voluntarily without participating in a government deportation scheme; and there are no reliable estimates of 'illegal' entrants or undocumented immigrants.

1.9 However, a survey commissioned by the Home Office is now being undertaken on the 'illegally resident population in detention in the UK', which is providing some indicators for estimating numbers²⁰. In addition, the Joseph Rowntree Social Cohesion and New Immigrant Programme is undertaking research on mapping the Serbian community, including in Hackney.

1.10 Virtually nothing is known about the numbers of those dispersed who subsequently return to Hackney. Anecdotally, this frequently recurs as a 'normal'

¹⁷ Learning Trust /private correspondence Jan 2005

¹⁸ Learning Trust Briefing 1/04

¹⁹ Lucas G 2004 (draft report)

²⁰ Sussex University Migration Centre. See Home Office Report 20/05 online

feature when talking to local RCOs and refugees themselves. On the other hand, there is still not a great deal known about how well or badly refugees fare after they have been accepted for settlement in the UK.²¹ The anecdotal evidence that does exist suggests that there are acute (i.e. especially at the point of transition from asylum to refugee status) and continuing difficulties especially in terms of stable housing and integration into mainstream services.²²

2 Local Research Developments

2.1 Locally, the most significant change since GRASP's work during 2003/04, is the growing availability of more robust and indicative sources of demographic and related data and/or sources of information which are being both 'pooled' and shared across statutory agencies and, to a lesser extent, across all sectors.

2.2 This includes a body of growing local knowledge provided through Hackney Council (Research & Statistics Team/Better Information Group), such as the results of the Household Survey (BMG Research Dec 2004), the updated London Borough Profile (April 2005) and the Ethnicity Profile update (based on a reworking of standard ethnic monitoring schemes to better reflect local communities and their concerns BIG 2004/05), all of which provide a potential framework within which to begin collating more specific demographic information about RAS.

2.3 At the same time, there seems to have been a growing awareness in the statutory sector of the need for more research and sound 'evidence-based' information on which to build more effective public and community policies in Hackney and in order to prioritise, plan and deliver services more appropriate to local needs and consistent, among other things, with 'modernising local government' agendas.

2.4 This is being recognised in a number of ways. Firstly, in commissioning/proposing new work, like for example, recent proposals for research on 'mobility', (related, for instance, to the availability of housing), and its impact on service provision and community cohesion. The work is linked to that of the wider London Population Mobility Reference Group (GLE/URBACT). More significantly, perhaps, there is a recognition of the need to build up sounder foundations for undertaking more meaningful local research (e.g. work being done on neighbourhood-based indicators & data sets and exploring the Indices of Deprivation

²¹ These points are made by ICAR February 2005 update

²² A range of community-based organisations and service providers make this point. There is a generally agreed estimate that the first 6 weeks after receiving ILR may be particularly difficult, both requiring emergency intervention and impacting adversely on health (discussion with Sanctuary and local GP)

for Hackney) as well as, importantly, in creating a framework for 'good practice research'²³ which includes sharing information more widely.

2.5 LBH 's Better Information Group (Policy & Regeneration Division) brings together different Council directorates and /or services, including Education (The Learning Trust) and Social Services, as well as other statutory agencies, such as Health (CHtPCT). This has opened up possibilities for researching links between, for example, GP and schools data or household profiles and hospital admissions.²⁴

2.6 The Better Information Group has also commissioned work from the voluntary, university and other sectors, making it an important single port of call for accessing information, sharing information across sectors, identifying gaps in information and proposing further research.

2.7 Other linked changes, since the first period of GRASP, include the recent work done by the Learning Trust on collating RAS schools information based on PLASC.²⁵ CHPCT, too, is reviewing related data (e.g. on homeless families in temporary accommodation to develop the 'notification' system) and its existing databases relating to refugees (e.g. NASS). It is also possible that the recent Quality Outcomes Framework (QOF) assessments may provide added and more easily accessible data, including relevant user information through the patient surveys.

2.8 Despite these developments there are still gaps. The possible information that could be provided by Social Services remains unexplored. Among other things, Social Services are in place to yield important information on younger RAS and unaccompanied asylum seeker children with cross service implications.

2.8 Reportedly, for instance, there has been an unexpected rise in unaccompanied Vietnamese school aged children over the last year under the care of Social services²⁶. The Young Refugee Project (Hackney's Youth Service) works with 50-60 young people a month (the number has apparently increased since dispersal²⁷). Mostly, they are not in school, are poorly skilled/educated and have few links to statutory services. Yet they are likely to be significant service users, being both sexually active (sexual health issues) and of child bearing age (there are a number of young parents), not to mention part of the future workforce.

2.9 Given the changes that are taking place relating to research and improved sources of information, GRASP has not attempted to estimate or update figures for

²³ See BIG briefing papers on Camden Strategies Research Team (2004); Creating a Hackney research network (2005); Local Knowledge – web-based application (2005);

²⁴ Discussed in BIG meetings. See also Eversley J work on Woodberry Down Estate

²⁵ i.e. Pupil Level Annual School Census. See Learning Trust Research Brief No 1/05.

²⁶ Private correspondence from Learning Trust requesting any information on Vietnamese RAS

²⁷ Interview with YRP worker (9/04)

2004/05 on RAS in Hackney. Rather, it is hoped that LBH, the Learning Trust, Social Services and CHPCT can jointly support - in partnership with other specialists - more major research on the demography of RAS – including undocumented migrants - in the borough. These should be linked to the planning and policy implications and, if necessary, on how Government regulations (e.g. the Eligibility proposals or 5 year strategy) might impact on the ethnically diverse local community, public health, health service providers and even the local health economy²⁸.

2.10 Finally, links should be established with neighbouring initiatives, such as Islington Refugee Integration Service (IRIS) and Camden & Islington Mental Health Trust, to help identify good practice in both research and mapping exercises and refugee pilot projects.

3. Local Initiatives

This year has also seen the start of other relevant developments, many directly relating to RAS in Hackney.

3.1 These include dedicated work with RAS school children through the Ethnic Minority Achievement Team (EMAT) at the Learning Trust, which has led to the collating of school statistics linked specifically to RAS, as mentioned above. EMAT has also convened its own Refugee working group, is now linked into the Hackney Refugee Forum and closely supports the Refugee Schools Outreach Project.

3.2 The latter is an NRF project being delivered through a voluntary organisation, Social Action for Health. The project was set up to support mainly Turkish/Kurdish refugee parents/carers initially in four local primary schools and has recently recruited a Somali worker.

3.3 Over the last year CHPCT has also supported a number of related initiatives. The Early Intervention Child Mental Health Service was set up by CHPCT for children and families registered at John Scott Health Centre. Although not specifically targeting RAS children any additional mental health resources for children are likely to be of assistance to schools.²⁹ Sanctuary PMS Practice also acquired two counsellors to work with refugees and now provides on site legal services and the Refugee Therapy Centre in North London is now being contracted by CHPCT as well as Islington and Haringey PCTs. Other initiatives include a housing advice service for people with TB; a health improvement adviser for cervical screening and an ante & post natal support

²⁸ Such work has been proposed in neighbouring Boroughs

²⁹ The urgent need for more mental health resources for primary school children was identified in GRASP's previous report.

service for RAS at Homerton Hospital; a scheme for qualified health professionals from abroad to work as care assistants.

3.4 Sanctuary Practice itself is extending and developing its services which, crucially, will also be available to RAS who have lost their rights or been dropped by NASS, as well as other homeless and vulnerable groups in general. Another important development at Sanctuary is its piloting of a more flexible approach to using advocacy services. It no longer uses CHPCT advocacy services but is able to contract other community-based providers to meet the high demand for different languages (64 recorded languages).

3.4 Obviously, many voluntary sector, community organisations / RCOs continue to work with and provide services to 'refugees' whatever their immigration status.

4. The impact of Government legislation on immigration & Asylum

4.1 The impact of Section 55 of the Nationality, Immigration and Asylum Act (2002) which was implemented in January 2003 has been felt locally in Hackney as well as nationally, although it has been all but suspended since May 2004.

4.2 In 2003 the Inter-Agency Partnership (IAP)³⁰ documented the experiences of 154 asylum seekers refused support under Section 55. Among other things, it found that over 60% were sleeping rough and a further 8% were faced with imminent homelessness. 70% experienced great difficulty in getting food on a daily basis. The lack of shelter and food was found to be having a pronounced effect on the health of over 57% in the survey³¹.

4.3 Anecdotal evidence in Hackney from front-line workers, including GPs and refugee community based organisations, also expressed concern over the impact of Section 55 and it is likely that before its interim measures were introduced it forced some asylum seekers into greater poverty and destitution placing an additional burden on both the local voluntary sector and refugee communities³². Local voluntary sector groups, nevertheless, increasingly report having to 'act as a safety-net' for the destitute and individual GPs and Practices, indicate an increase in cases

³⁰ IAP was formed in 1999 and comprises 6 established refugee agencies including the Scottish & Welsh Refugee Councils. IAP was established before NASS was set up but is now contracted by NASS to provide advice and support to asylum seekers in dispersal accommodation and emergency accommodation to newly arrived asylum seekers.

³¹ Interviewing & assessments of eligibility under Section 55 were suspended in May 2004 following a Court of Appeal's judgement. The effect was that NASS should not refuse support unless it is positively satisfied that the asylum seeker in question does have some alternative form of support which should include night shelter and adequate food. The Home Office is appealing the court's decision. Meanwhile, an interim approach to Section 55 was introduced in June 2004.

³² See also Refugee Council Report April 2004

of destitution or reported cases of destitution³³ and particular among new accession EU Nationals.

4.4 One of the lasting impacts of Section 55, however, even since its suspension, has been the confusion it has engendered about the availability of health services for asylum seekers falling under its provisions. In some cases this atmosphere of confusion has led to added difficulties for RAS in registering with GPs, a difficulty which is still reported.

4.5 As is well understood, the Government's 'Proposals to Exclude Overseas Visitors from Eligibility to Free NHS Primary Medical Services' (2004), if introduced later this year, is also likely to have knock-on effects in a Borough such as Hackney where there are already marked health inequalities resulting from multiple deprivations.

4.6 A major concern has been how these proposals will impact on Hackney's existing culturally and linguistically diverse immigrant and refugee communities and particularly on the more vulnerable groups among them such as children, the elderly or sufferers of chronic and/or communicable diseases. Given the complex nature of identifying immigration status and the undisputed existence in Hackney of 'failed' asylum seekers, 'overstayers' and undocumented immigrants, as well as refugees and asylum seekers, BME communities in general are far more likely to be challenged on eligibility and encounter problems, seemingly undermining the Government's own policy trends relating to community cohesion and inclusion. Other serious concerns relating to public health & surveillance of communicable diseases, immunisations, and the health economy have been highlighted during the consultation period and some modified.³⁴

4.6 The Government's more recent Five-Year Strategy for Asylum & Immigration (Feb 2005) proposes to add even more far-reaching measures to the earlier legislation. In particular, the 'cessation clause' (measure 1) which gives refugees (i.e. asylum seekers accepted for settlement) only temporary leave to remain in the UK for 5 years while *'the situation in their countries is kept under review'*, seriously undermines integration strategies. Equally, the moves to maximise the return of unaccompanied asylum seeking children (measure 4) is causing wide-spread disquiet and fears of growing child protection issues (Save the Children 2004).

Whatever the outcomes of these bits of legislation, there are likely to be continued changes linked to asylum and immigration with resulting effects on the health and health care of numerous refugees in Hackney.

³³ From personal discussions with Dr MB and at Sanctuary PMS Practice

³⁴ See for example Response of Joint Council for Welfare of Immigrants August 2004

5. The voluntary sector role in providing data

5.1. The voluntary/community sector remains a potentially significant, but still untapped, source of both demographic and other data on RAS. As GRASP reported last year, the demographic picture drawn from a questionnaire sent out to 102 voluntary/community organisations in Hackney, proved inconclusive. This was partly because of the diverse forms of monitoring and other difficulties concerning documentation/data sources. These included lack of consistent recording (e.g. whether on a weekly/monthly or annual basis); the fact that many such organisations see RAS from other Boroughs as well as those resident in Hackney and the undifferentiated nature (i.e. same/different individuals) of levels of contact activity.

5.2 Finding appropriate and sensitive ways to access this information remains a priority. It is this grass-root level which can provide a range of significant data on access to healthcare, gaps in services, effectiveness of delivery (e.g. poor take-up/high DNAs etc). The potential as a data source is particularly true for building up a clearer demographic picture of 'undocumented' /new arrivals/refugees/new EU nationals and so on.

5.3 As one voluntary organisation has shown³⁵, for example, annually collated simple data can provide invaluable insights into the key needs and service requirements of different RAS groups, as the Table below suggests.

Table 1

Service accessed	Adult education	Children's education (including school placement/literacy support)	Advice	Children's Play (play group/outreach)	Health	Women's Group
ETHNICITY						
Angolan	40	144	2	4	0	0
Iranian	32	25	83	3	4	11
Other African	98	47	111	76	44	43
Somali	19	20	297	28	8	0
Turkish/Kurdish	4	10	111	61		
Other White	0	52	67	30	0	74

The ethnic groups chosen are the most likely to be RAS – the organisation works with any vulnerable/homeless family, including British White and other settled BME communities, such as Bangladeshis. Shaded cells represent the highest numbers (among all groups even those not shown here) accessing that service.

In addition to the potential for providing more detailed demographic data (i.e. numbers/ages/gender etc), including about 'undocumented' migrants, the greater availability of this kind of information can add to the picture of actual service

³⁵ Finsbury Park Homeless Families Project – Annual report 2002/03

provision, to how well certain groups may or may not be accessing statutory services as well as a range of other information.

5.4 Such data may also suggest what kind of service delivery may be most effective for different groups. For example, in the above table, Angolan RAS's marked use of 'children's education services' may highlight a number of factors: difficulty in accessing schools; poor performance/difficulties at schools or priority given to children's education. The exceptionally high need for 'advice' among Somalis seems to be consistent with findings elsewhere that there are no specific Somali CAB workers elsewhere in Hackney and the community has reportedly, persistently high levels of difficulties with housing, utilities, loss of benefits and debt. Similarly, the low rate of use of the organisation's 'health services' (except among some Africans), could - among other things- point to good access to local NHS services for most users. High participation in the women's group for one group of women ('other white') could suggest that this form of intervention works best for that particular group of users and so on.

5.5. Such interpretations remain hypothetical, or unexplored, in this case, but serve to underline the need for and potential usefulness of this kind of data from the voluntary/community sector and RCOs.

5.6 Finally, Table 2 summarises key demographic and other features useful in understanding more about refugees in Hackney. It indicates available and potential sources of data and their main points of access. Potential sources of useful information also suggest areas where work may be usefully developed.

TABLE 2: SUMMARY OF POTENTIAL OR AVAILABLE SOURCES OF DATA ON REFUGEES & ASYLUM SEEKERS

	Demographic/Other Features	Main Sources of Information	Other Sources		Not known/Not available
GENERAL LEVEL	UK Figures on asylum seekers <ul style="list-style-type: none"> ▪ No. of Applicants ▪ No. of dependents ▪ Nationalities ▪ Gender/ages ▪ NASS supported ▪ Dispersal areas & no.s ▪ No. granted asylum etc. ▪ No. appealing/refused etc. 	Home Office Immigration Research & Statistics Service (Quarterly)	ICAR – regular summary of key statistics Sussex University Migrant Centre <small>👉</small>	HOME OFFICE NATIONAL FIGURES	<ul style="list-style-type: none"> ⊙ How many join by Family Reunion later on ⊙ How many applicants/those granted status then leave UK ⊙ No. of failed/overstayers who leave voluntarily /not through Govt. schemes ⊙ How many illegal entrants
	Hackney Figures (& other LAS) <ul style="list-style-type: none"> ▪ NASS supported ▪ No. dispersed ▪ No. granted refugee status in Hackney ▪ No. unaccompanied children ▪ By ethnicity/age/gender 	LASC (updated quarterly)	Hackney Asylum Unit LBH Social Services Police statistics? <small>👉</small>		<ul style="list-style-type: none"> ⊙ How many existing undocumented/illegal/overstayers etc. who join existing communities ⊙ How many of existing communities returned from dispersal and after how long (Any patterns/trends) ⊙ No. 'trafficked'

HACKNEY DIRECTORATES	HOUSING <ul style="list-style-type: none"> ▪ Refugees/New arrivals in temporary accommodation/waiting lists ▪ Ethnicity/age/gender/single families ▪ Types of housing/housing requirements ▪ Households in Temporary Accommodation ▪ Likely areas to be placed ▪ Housing support needs ▪ Language needs ▪ Turnover /mobility trends? 	Housing & Homeless Unit statistics		LONDON BOROUGH OF HACKNEY	
	CARE & YOUTH <ul style="list-style-type: none"> ▪ Unaccompanied children ▪ Profile + trends ▪ Special needs/disability among RAS ▪ Update on NASS ▪ No. young RAS ▪ Ethnicity/gender/age ▪ Support needs ▪ Housing status + areas 	Social Services Asylum Unit Youth Service (YRP)	Sure Start		(Assumed that figures for features on left are available)
	EDUCATION <ul style="list-style-type: none"> ▪ Ethnic profile of Hackney pupils (Primary & Secondary) ▪ Likely numbers of RAS ▪ Schools with largest no. of likely RAS ▪ Mobility by ethnicity ▪ Achievement by ethnicity ▪ Exclusion by ethnicity ▪ Waiting Lists by ethnicity 	Learning Trust (PLASC) (Not available yet?) (Not available yet?)	EMA Team Sure Start		

HACKNEY COMMUNITY DATA	<ul style="list-style-type: none"> ▪ Contact no/activities ▪ By ethnicity/age/gender ▪ Immigration status: ▪ Refugees just granted settlement ▪ Affected by Section 55 ▪ Returned from dispersal (after how long?) ▪ Undocumented etc ▪ Trends in 'destitution' ▪ Areas in which living (how many from Hackney) ▪ Housing status ▪ What services accessing ▪ Referral patterns ▪ Health & social care needs ▪ Trends in accessing existing provision 	Voluntary Sector/RCOs	<p>(Need to differentiate between same & different individuals Need to standardise how collected (p/w or p/m - collate annual figures etc) How faring after settlement Needs to develop 'safe, appropriate/sensitive ways of collecting data + standardise as far as possible)</p>	VOLUNTARY /COMMUNITY SECTOR	GAPS IN ALL INFORMATION
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V) Health & Social Care: Update on findings

*'Illness can be a sign of missed integration – therefore refugee health is an important factor of integration'*³⁶

1 Increasing Inequalities

Over the last year of work, GRASP aimed to follow up on less visible or known-about RAS groups in Hackney, in order to shed further light on refugee health and social care issues. This included contact with francophone African groups and Ugandan, and with organisations likely to be accessing harder-to-reach groups such as Eastern Europeans (e.g. Kosovan, Bosnian, Albanian) and other nationals likely to be part of – albeit a minority - the larger refugee community in Hackney (e.g. 'other African', Iranian, Eritrean, Afghanistan & from Uzbekistan). It has also included further work with Somalis who, despite their likely numbers in the Borough, remain poorly integrated into mainstream services and, seemingly, into the community. Some follow-up work was done with the Turkish community which highlighted special needs and disability issues among refugees.

One result which came about in the process of identifying relevant groups - has been to shed light on young RAS as well as on mental health issues and special needs among the refugee population. A great deal more detailed work, however, needs to be done on young RAS in particular – including unaccompanied children – to provide a sounder understanding of both their needs and the future service implications.

Most of the population involved in the groups mentioned above are NASS/Social service supported asylum seekers; those with Indefinite Leave to Remain (ILR) who have been in Hackney less than 5 years as well as refugees who have been here for more than five years and may be part of more settled communities.

However, as mentioned already, a significant feature which emerged during the work this year has been the growing concern expressed among service providers across sectors about 'destitute' RAS and/or 'undocumented' migrants, including new EU nationals with uncertain status. These people may include asylum seekers who had support withdrawn under Section 55 and even asylum seekers who are granted ILR *'who can have their benefits and housing cancelled the same day they receive ILR'* (Sanctuary 10/04). They also include new accession EU members.

³⁶ See [www. Refugeenet.org/health/index.html](http://www.Refugeenet.org/health/index.html)

One Hackney Practice reported the case of a young Polish woman brought to them by another asylum seeker. The Polish woman was 9 months pregnant and living rough on the streets. She had previously been brought to the UK by a gang master and although entitled to work could not receive benefits or housing. She was then unable to find work for a number of reasons (culminating in her pregnancy). As a result of the intervention of the Practice, LB Hackney agreed to house her in temporary accommodation until the birth of her child. After that, she was told by Housing if she remains in the UK the child will be taken into care³⁷. The woman had been too frightened to go to a hospital when she was brought to the Practice. Eventually, she gave birth to her child and returned to Poland (Sanctuary 9/04).

Although perhaps an uncommon case, reports of mounting difficulties affecting individuals with different immigration status, including refugees and asylum seekers, have been increasing. On the one hand, this makes it harder for those providing for those RAS entitled to health care. As one therapist put it, *'It is very hard to stay within the boundaries of provision i.e. just give counselling or medical care, in this context of need'* (i.e. where basic means survival are lacking, housing, etc.).

On the other hand, the growing concern has highlighted the need for a 'one-stop' or central information point and referral service for RAS presenting, for example, to health care providers. A number of Primary Care providers as well as teachers and other front-line workers have expressed frustration at not knowing where to turn for support, to whom to make wider referrals or whether or not support for particular language groups already exists in the community.

2 Continuing concerns

Clearly, aspects of both social care and health are based on the experiences of being an asylum seeker or refugee. Such needs are perhaps most vividly expressed among young refugees who may have witnessed, experienced and even participated in any number of traumatic events.

As a result of what they have been through, the inner worlds of some young refugees and asylum seekers may be populated by thoughts of abuse and horror repugnant to people around them in the host country. The inner worlds dominate their responses and can prevent them from settling into their new environment.....young people.. can frequently start acting out aggressively³⁸ getting into increasing trouble at school, for example, and with the law.

³⁷ It should be noted that there have been no reported cases of this happening in Hackney and Social Services have been at pains to avoid such eventualities.

³⁸ Refugee Therapy Centre, Clinical Director's Report 2003-2004 (p4 & 6)

Social and health needs, however, are also integrally related to conditions in the host country: unhealthy accommodation, prolonged inactivity, as well as adaptation difficulties which can undermine any integration (or recovery) process. The same key issues relating to the health and social care needs of refugees - identified through GRASP's earlier survey - continued to surface in the interviews and focus groups undertaken this year.

By and large, and as is widely known, these relate to difficulties in accessing services, language and communication problems, lack of information, poor knowledge and little 'know-how' about the function of the system. As pointed out before, these issues have long been emphasised in both practice and in the literature about refugees - not only in the UK, and indeed Hackney, but throughout Europe.³⁹

The following features have been highlighted in the belief that they can be tackled in different ways both at the community and policy development levels in Hackney.

2.1 ACCESS

GRASP's findings point to the fact, that 'access' is related, above all, to both housing and health care provision. Although access is about reaching and being able to use a required service in this sense, it is also often expressed as an 'attitude' or barrier.

(a) Housing

Poor housing continued to be identified, especially by the providers GRASP spoke to, as having a direct impact on both the physical and mental health of RAS.

Poor housing encompasses many issues like noise, dirt; people can't wash properly, in these circumstances depression worsens. Some refugees have told us "this is worse than in my country, my life has no meaning now" (Sanctuary 10/04)

The lack of space in poor accommodation doesn't allow for children to develop and grow properly and parents get no respite – we have to work very hard to prevent mental health issues (FPHFP 9/04)

NASS pays the rents and inspects accommodation but asylum seekers are not moved even when the premises are totally unsuitable, such as mothers about to give birth in totally unsafe and unhealthy conditions. After an asylum seeker is granted ILR things can get even worse especially for families. You can find yourself without home or income in a moment. There does not seem to be much support from the Housing department and landlords can be terribly exploiting. (Sanctuary 10/04)

Housing was obviously identified as a major preoccupation for both refugees themselves and RCOs in different ways. The uncertainties of poor temporary

³⁹ Report of Refugee Panel , Health Working Group, Dalfsen, Netherlands July 1999

accommodation clearly remains a priority issue among Somalis, for example. One Somali family, with six children, had moved twenty times in just 3 years! *'After that it is difficult to settle and it affects integration at every level, schooling, continuing health care, family and community links...'* (KH 2/05). The women in the Somali focus group also highlighted issues often associated with high mobility and instability and compounded by language barriers and low levels of literacy: difficulties with utilities (GAS/Electricity/etc), loss of benefits and mounting debt (SF3/05)

A refugee from the Ugandan community spoke about housing and integration in another sense,

The Housing system is such that it does not allow refugees to integrate and this is having its affects; for example here on this Hackney estate about 64% are non-white, non-English. In this way ghettos are created which doesn't help integration at all. It increases fear of refugees and asylum seekers and they too remain frightened and the stigma increases (URWA 6/04)

The lack of permanent and often poor quality of housing adds to other uncertainties that many RAS face further increasing the risks of deteriorating health.

For example, one family member may arrive as an asylum seeker and get Indefinite Leave to Remain. Then he is joined by his family but their status remains uncertain. Or asylum seekers arrive having been forced to leave their children behind; then they have to stay here while their applications are processed. Some become very depressed because they feel trapped and cannot see their families. Families are very important to most of the people we see. (Sanctuary 10/04)

Mental health problems have become rampant in our community and this is directly due to the uncertainties of immigration status, low incomes and housing issues (URWA 4/04)

A youth worker, poignantly described, how the uncertainty can affect young RAS, often leaving them very unmotivated and inactive, *'(the worry of uncertainty) suppresses them, it is all over their minds and they become lethargic and unmotivated'* (RYP 9/04)

(b) Health care

The most widely reported recurring feature relating to access to health services at the Primary Care level, remains continued difficulties with GP registration.

A number of refugee respondents said that they were unable to register with GPs without producing documentation on their immigration status and that the proposed legislation on Eligibility *'had already created a lot of trouble for us as people - receptionists and medical people- just don't know'* (CF 10/04). Numerous Congolese respondents in particular talked about such experiences in the Focus Group. Several people said they had tried between 7 and 10 Practices before they were accepted. One said, a GP readily accepted him but he was asked to pay for consultations

(though it was not clear that any of these cases had been in Hackney). As another respondent put it,

The difficulties in access have a profound impact on health – one refugee I knew had TB but he was unable to access a GP where he lived so he became a danger to himself and those around him. (URWA 6/04)

Waiting lists & referrals were other key 'access' factors identified by respondents across the whole of GRASP's sample. Frustration about waiting lists was particularly acute among Francophone African RAS – it is possible that this is linked to a greater fear and/or higher risks of HIV/AIDS

When you are seriously sick you have a dialogue between doctor and patient leading to a diagnosis. When you know the diagnosis you start to treat it. But the English system gives you an appointment 6 or 7 months later... this can lead to complications. If a disease is not treated as soon as possible it may cause another problem. (Congolese Nurse CF10/04)

I was offered an appointment in one year's time!. After the year was up, they (hospital) extended the appointment, so I went two years without medical care (CF10/04)

I had a very bad pain in my neck, I was worried I had a serious infection, but I was given an appointment for 18 weeks time. I was so worried that they (the doctor) would find it had become worse.. (CF10/04)

Others GRASP talked to, felt that it was extremely difficult to get hospital referrals or to see a specialist or consultants. This was sometimes seen as directly related to being a refugee and seemed especially acute among Somalis,

GPs don't seem to want to make referrals to consultants or specialists for Somalis they look at you and say 'oh a refugee that's the problem' until it's too late. I have heard of many women presenting too late with cancer (KH2/05).

I had no problem registering with a GP who also referred me to a consultant. At first the hospital said there was a 65% chance that surgery would be successful but then they changed their minds and won't do anything,. They say surgery won't make any difference, I think it is because I am a refugee (SPA10/04)

At other times, lack of referrals was related to not understanding the health system,

It is hard for us (refugees) to penetrate the health services. There is a lack of knowledge, information and direction. For example, how does one move from a GP to getting a hospital referral? – Many find the system hard to understand as back home we went straight to hospital for everything (URWA6/04)

(c) Attitudes

Access is also about attitudes. A youth worker with young RAS in Hackney described the importance of first contact with providers, *how they (young RAS) are first greeted*

sets the tone for any following partnership (YRP 9/04) and by implication, compliance and self-management in health.

However, worrying incidents and/or of racism were also repeatedly reported. Different workers and refugees themselves mentioned that they are,

Persistently being told by the medical profession that they are 'only pretending', 'there's nothing wrong' and non-one will complain because they are too terrified. (SF&KH 05) These attitudes seem to extend to para-medics and other NHS staff.

When encountered such attitudes undoubtedly create an underlying fear of bad treatment and suspicion among many RAS which was evident in some interviews. Among other things, it makes it difficult for people to talk openly about any aspects of health because they *'often feel dismissed by GPs being told 'these problems are normal' (RWCA 7/04.) Or they feel they are not listened to,*

When I go to see the GP, they don't take time to listen. I want to explain to the doctor but they haven't got time to listen and you can't express what you want.... In the end whatever disease you suffer from they give you paracetamol (CF10/04)

Worst of all such attitudes can lead to preventable misunderstandings,

A diabetic woman came to the group saying she couldn't make an appointment with her GP for three months. They (her Practice) introduced 'same day appointments' and she was told to phone at 8.30 in the morning. The woman had not been told about the change of appointment system and didn't understand it. The receptionists got annoyed, then the woman shouted and they told her she was not welcome at the Practice. She thought they were against her because she was a refugee and that's why they were making it difficult for her to see a doctor (SF3/05)

In respect to 'same day appointments', a worker also added,

Same day appointments are not working for the community: when people are given an appointment for say 10.30 the same day, they cannot go because it is too short notice for them to arrange for an interpreter (KA2/05).

2.2 LANGUAGE & COMMUNICATION

Language issues remain at the heart of both needs and provision for RAS. As one refugee worker put it, *'(language barriers) leads to so many misunderstandings but (not sharing a language) also means people cannot tell their stories which might help in so many ways' (FPHFP 9/04)*

(a) Advocacy

GRASP findings last year underlined the fact that language and communication in health care have many aspects. A major aspect is the availability and/or provision of advocacy/interpreting services. A report this year on advocacy and interpreting

services provided by C&HPCT, points to the urgency of assessing community language needs on a multi-stranded, Borough-wide level and for a strategic development programme to meet the huge, complex and changing nature of demand in a Borough like Hackney⁴⁰. Needless to say, such developments need to include specially trained advocates to work in counselling and psychological support services.

(b) Opportunities for Learning

Many have mental health problems. They come as refugees, they are stuck at home looking after young children. They find it difficult to learn English but there are also no opportunities for learning. They Feel very isolated. (RWCA 7/04)

Another aspect of language and communication, which emerged from the interviews and Focus groups, had to do with opportunities for RAS to learn English and related opportunities for employment.

Unexpectedly, numerous respondents felt strongly about the lack of success of available ESOL classes. A number expressed the view that

In my experience, many ESOL classes are not good enough or appropriate. I met a woman when I went to my first ESOL class after coming here; she had been doing it for 8 years and still couldn't speak English! ESOL seems a waste of resources and often makes you feel dumb and useless... feeling 'passive' is part of the problem... (KH2/05)

Again, a great deal of frustration was felt by others that higher levels of English learning, even EFL or that linked to professional qualifications were unavailable to RAS. Many RAS are highly qualified and educated and they find ESOL too basic. Many also complained of the lack of availability of classes or that classes were always full and difficult to access.

Many Congolese refugees at the African Focus group also felt deeply frustrated at not being able to find work to match their qualifications. They spoke of many in their community being qualified doctors, midwives and nurses and other medically related staff (e.g. lab technicians) 'who could help people' as well as those with other qualifications and experience, such as in sport. Often the resources required for having documents translated as well as verified, doing obligatory English courses or conversion/re-training courses are simply not available and too expensive. This view was repeated in respect to Ugandan refugees, *our qualifications are not recognised but there are only a few very expensive courses for re-qualifying (URWA 6/04)*

⁴⁰ Lucas G CHtPCT, 2004 (draft report)

Language was obviously also linked to 'lack of knowledge' about the system. As one refugee recognised, *'for you to understand the system you need to first understand the language'* (AF1/04)

2.3 KNOWLEDGE AND UNDERSTANDING

The lack of knowledge & understanding about the system also occurs at many levels and it includes both RAS themselves and service providers. It can mean not understanding the difference between primary and secondary care, not being aware that a cervical smear test can be undertaken by a female health professional, or simply not grasping how an appointment system works. One, professional and English speaking refugee told the following story,

I myself did not know when I could call an ambulance, what degree of sickness must it be? We are never told. I broke my leg and walked to Bart's Hospital (from Hackney) because I decided it was not serious enough to call an ambulance. (URWA 6/04)

As another refugee explained, lack of knowledge can also lead to other kinds of misunderstanding,

For example, when GPs ask them (RAS) about their 'family or medical history' they often have no idea as this has never been asked about back home or been taken before. When they say they don't know, then the GPs think they are being deliberately non-compliant or hiding something (KH2/05)

Lack of understanding also refers to providers, who may be confused about entitlements or, for example,

Like reception staffing asking for passports or even a driving licence which is often totally inappropriate, confuses people and leads to misunderstandings all round (KH2/05)

Finally, lack of knowledge goes hand-in-hand with a concomitant dearth of available information. Obviously, providing appropriate information spans wide-ranging needs targeted, among other things, at different requirements, diverse language groups and levels of understanding. It became clear, for example, that among more vulnerable – and especially non-literate RAS groups – there is not just a need for appropriate and accessible information but a parallel need to empower people to *want* to know. One woman, for instance, when asked what she had been told about her condition, said *I have no need to know the GP knows. I have diabetes I just have to do what they tell*

me. (KH 2/05). Her understanding of diabetes amounted to not taking sugar in her tea.

At other end of the spectrum there are those RAS who are eager for information that does not exist (e.g. it was not possible to find any suitable promotional materials on HIV or sexual health in French in Hackney). More importantly, there are those who feel they can contribute to meeting the information needs of their communities but are not asked to participate. The overriding message from the Focus group held with French-speaking Africans, for example, was that *it was first time anyone had come to talk to us about these issues (Health) and hear our views*(AF 10/04.

2.4 A Note on MEDICAL CONDITIONS

GRASPs earlier work (2003/04) attempted to identify key health conditions among different RAS groups. Some of the medical conditions identified by respondents in GRASP's work this year (albeit through a very small sample) and as being characteristic of their communities are summarised in the table below.

TABLE 3

Refugee Community	Main Concerns		'Surfacing' Conditions
Congolese	MENTAL HEALTH PROBLEMS	HIV/AIDS Sexual Health Teenage Pregnancies	Diabetes
Kosovan & Albanian ⁴¹			
Others ⁴²		Domestic violence Trauma	
Somali		Anaemia Arthritis & Rheumatism Disability	Diabetes HBP Cholesterol Asthma
Turkish/Kurdish		Domestic violence Special Needs & disability (among children)	
Ugandan		HIV/AIDS TB Teenage pregnancies	
Young RAS		Poor nutrition Sexual health	

Mental health concerns were given priority in every case. Otherwise, some distinction was made between likely RAS conditions and 'surfacing' conditions, referring to typical conditions after a few years of settlement.

⁴¹ Seen at Refugee Therapy Centre

⁴² As prioritised by FPHFP

VI) Conclusions: service implications

A recent report reviewing Primary Care services for refugees and asylum seekers throughout the UK summarises a number of recommendations highlighted by providers as essential in facilitating the planning and delivery of health services appropriate to meeting the needs of this population.⁴³ Significantly, these include

- (i) Improving systems for collecting demographic and other data on RAS in local PCT populations
- (ii) Involving local refugee communities in the planning and delivery of services, and
- (ii) Providing better information across the board (including through training)

GRASP's more limited findings can be said to reflect these recommendations. Significant changes have taken place over the last year in Hackney in respect to the availability of data and the identification of potential sources for further information on local refugee populations. There are, however, still numerous gaps and substantial work still to be done. Systems for data collection need to be improved to reflect the changing needs of such communities and in such a way as to directly inform local policy developments in health, community strategies and service delivery.

The voluntary/community sector remains an untapped source of vital information on refugees. Finding appropriate and sensitive ways of accessing and collating this information depends, above all else, on involving the sector as equal partners in such a venture. This would include allowing – and resourcing - RCOs/ community organisations to develop their own validated methods and measures and, of course, enabling greater participation in the planning and delivery of services.

The development of information resources, including health promotion materials, seems to be another repeatedly emphasised and crucial area of need. It is obviously linked to increasing knowledge and understanding both about the system and individual self-management of health and well-being. The development of knowledge is also integrally related to meeting language needs, dealing with access issues, promoting better use of services as well as changing perceptions and attitudes all round. Developments in health promotion would, however, have to be balanced against increased demand for services and the danger of raising unrealistic expectations.⁴⁴

⁴³ Feldman 2004

⁴⁴ See Lukes. S among issues raised through telephone survey with refugees in Finsbury Park area between March-May 2005

Nevertheless, involving local refugee communities/RCOs in the development of their own information resources seems equally essential, partly because of the diversity of the community with its different requirements and its obvious awareness of needs and how they can be appropriately met.

In respect to information needs GRASP has recommended possible developments including both a 'Healthy Literacy' programme for refugees, combining English language learning with learning about different aspects of the health system, at different levels (of both English and knowledge). It has also recommended close working with different refugee groups to develop their own health promotion and/or other information materials. Updating the 'Welcome to Hackney' Guide also involves such work with RCOs in identifying their information needs.

Obviously, any such developments need to be complemented by information for service providers about support for refugees in the community; their entitlements and so on. This could take the form of a single point of contact or dedicated post, as mentioned above. However, it also raises issues about the needs for staff training in refugee issues.

Finally, the same review of PCT services for RAS mentioned above, concludes that in developing such services there is often 'little conceptual clarity about the goals of many different types of Primary Care provision for refugees and asylum seekers' (p3) or they are 'ad hoc or reactive responses to the demands placed on PCTs by the needs RAS' (p25) The Review, therefore, proposes a framework to help in planning 'integrated' services but also, importantly, for identifying goals and evaluating models of service delivery.

The framework distinguishes between (i) 'gateway services' which emphasise access to (ii) 'core' or mainstream PC services and (iii) 'ancillary' or specialised (eg mental health service for RAS) services which may supplement core provision where necessary. Which models are adopted or considered appropriate will depend, among other things, on understanding the (changing) characteristics and needs of the local refugee community.

VI) Recommendations: Ways Forward

The mapping exercises undertaken by GRASP, both in terms of identifying demographic features of refugee and asylum seeker communities in Hackney and in terms of attempting to further explore their health and social care needs, seem to point to two main recommendations.

1) A Need for Proper Demographic Research: Creating a baseline of information

- A wide-ranging and substantial piece of research should be commissioned/undertaken by Hackney to provide robust baseline demographic data on refugees and asylum seekers in the Borough.
- Such a piece of work should bring together information from the different Council Directorates, including Education and Social Services, as well as City & Hackney Health Services and include related epidemiological data.
- It should also link to other pieces of research taking place in the Borough, such as that on mobility and the development of advocacy services, and should be widely shared and easily accessed.
- It should be undertaken in collaboration with a relevant academic unit (for example, University of East London's Refugees Study Centre)
- Such a baseline could provide the foundations on which to build further information, reflecting likely changes and trends in Hackney and informing policy and service developments at many levels.
- The Voluntary Sector and Refugee Community Organisations in particular, should participate in such work as specialist partners. They should be supported and resourced to develop their own sensitive and appropriate methods and measures for collecting data which could also be widely used as a model of good practice.
- Smaller pieces of research or needs assessment work in different RAS communities would continue or be encouraged, adding to the wider picture and ensuring that the actual needs of RAS were understood, fed into and action taken to meet them.

2) Time for Action: Development Work in Meeting Information Needs

Many of the health and social care issues concerning RAS have been highlighted again and again by research and for some years. The need for action, based on what is now known, seems all the more imperative. It is in this spirit that the following recommendations are made.

- Lack of information and knowledge appear to affect all levels of health and social care needs and service delivery, for both refugees themselves and providers, and there remain huge gaps in appropriate resources to meet such needs.
- A series of, mostly low cost, developments could make significant inroads into filling these gaps. These include
 - The development of a single information centre or key post as a reference point for service providers to access information on RAS (including about their entitlements) acting as a two-way bridge between available support in the community (including language provision and meeting emergency needs etc.), and existing statutory service provision for RAS (in health & education, for example).
 - Such a 'reference point' could be developed within an existing agency, such as the Hackney Refugee Forum or as part of the PCT, such as Sanctuary's developments, for instance.
 - A programme of 'Healthy Literacy', targeting different levels of requirement - as already suggested (a pilot has been proposed by GRASP)
 - Collaborating with different RAS groups throughout the community to jointly develop the information resources they require, in appropriate forms
 - Development and implementation of a programme of 'refugee issues' training for providers/NHS staff

All these can be linked to existing local initiatives spanning adult education, professional development (training), community arts projects and so on.

APPENDICES

APPENDIX 1 NRF End of Year Review	
Organisation: BEMWG Co-ordinator: Aliya El Agib	Project Title: General Refugee & Asylum Seeker Project Project Manager: Anna Collard

Project Performance SUMMARY			
Outputs	Outputs per Year	Achieved to Date	Project Performance & Explanation of Variance
Increase number of refugee and asylum seekers receiving health advice, promotion and access support	2080	1760 Achieved	<ul style="list-style-type: none"> ▪ Target achieved mainly through: <ul style="list-style-type: none"> a) Distribution of 'Welcome Guide' b) Continuing & new contacts with RAS groups & those working with RAS c) Continuing involvement in diverse Fora etc. ▪ This year's work in particular targeted: French-speaking African groups, Somalis & Eastern European - as well as other African groups (Ugandan/Sudanese), Turkish/Kurdish and Latin American. ▪ Two main focus groups were arranged by GRASP (a) mixed French speaking African at ASPC (b) Somali women's health group. Opportunities were also taken to use (i) parents drop-in at Primary school (ii) advice centre drop-in and (iii) ESOL class as 'focus groups'. However, See Report for difficulties with Focus Groups ▪ Some referrals were made in the course of work (e.g. to advocacy services; to Youth Services; to Training & Employment Services & to ESOL classes) and requests for referral help continued to be made to GRASP (mainly by education for possible support for asylum seeker children/their families) However, See Report target measure not appropriate for research project ▪ 'Welcome to Hackney: a guide to health & social care for people recently arrived in Hackney'. Available in English ▪ (Funds secured for development of updated PDF version of
BME organisations supported to widen health and social care access in their communities especially around information and access	25	26 Achieved	
No of focus groups (10-15 people each)	8	5 Not achievable	
Referrals to front-line organisations or services	75	27 Not achievable	
Publication of information guide for new arrivals focussed on health	1	Achieved	
No of languages information guide published in	5	5 in process	

No of copies (in 5 languages and English) produced of information guide	2000	PDF to be developed	<p>Welcome Guide)</p> <ul style="list-style-type: none"> ▪ (Funds secured from SCP to translate into x 5 languages) ▪ Continuing support given to Learning Trust, Teachers as well as different health professionals <p>Now Working Group set up and taking HRF through process of getting constituted. Also has secured SCP/CEN funds</p> <p>Continues to meet and ensured that plugged into service planning via Public Health/ Health Improvement etc.</p> <p>(During June 2004)</p> <p>See Report: difficult to achieve: represents significant gap in information which needs to be addressed. Experience suggests that GPs also have significant information needs regarding RAS & voluntary sector support etc.</p> <p>Links maintained through Learning Trust (EMA team) & NRF <i>Refugee Schools Outreach Project</i> rather than directly with schools. Although individual schools also visited and links with named teachers maintained. Target considered achieved</p> <p>GRASP made a number of presentations about its work throughout the year: including to BEMWG members; to the HRF & HISG</p>
Activities to support professionals accessing appropriate information on refugees or asylum seekers	1	5 Achieved	
Hackney Refugee Forum maintained and supported	1	Achieved	
Refugee and asylum seeker health planning group maintained and supported	1	Achieved	
Work promoted during Refugee Week	1	Achieved	
No of GP's contacted for follow up work	6	4 GAP	
Presentation at GP forum	1		
Follow up at schools (primary and secondary)	8	4 Achieved	
Create contacts and links with new groups, including East European, French speaking African, and other African orgs	5	7 Achieved	
No of activities / awareness raising events	3	3 Achieved	

APPENDIX 2

References, Sources & Resources

The following is a limited selection of references and useful resources used by GRASP. Some of the references quoted, themselves provide more comprehensive bibliographies. GRASPS earlier report (Feb 2004) provides additional resources which have not been repeated here (except for Burnett & Fassil).

1. Burnett A & Fassil Y (2000) Meeting the health needs of refugees and asylum seekers in the UK, Directorate of Health & Social Care, DoH ([contains comprehensive bibliography /resources etc.](#))
2. Feldman R (2004), Primary Care Services for Refugees & Asylum Seekers: A Review, Report commissioned by Hounslow PCT, Research & Development Dept. ([contains comprehensive reference list including reports & audits consultant](#))
3. Learning Trust (2005) Ethnicity of Pupils in Hackney Primary Schools: 2003-2005, Research, Statistics, Evaluation; Research Brief No.1/05
4. Lucas G (2004) Mapping & Appraisal of Advocacy & Interpreting Services Provided and Accessed by City & Hackney TPCT, Report commissioned by CHtPCT
5. Refugee Council (2004) Hungry & Homeless: the impact of withdrawal of state support on asylum seekers, refugee communities and the voluntary sector
6. Refugee Council (April 2005) A study of asylum seekers with special needs
7. Refugee Panel (EU) Health Working Group, Report Dalfsen, Netherlands, July 1999

Immigration & Asylum Statistics

www.homeoffice.gov.uk/rds/immigration1.html

Recent statistics

Quarterly stats on Asylum Seekers

Briefing on statistics that are covered

How & where they are collected

Related information

National Audit Office

www.nao.org.uk/publications/nao_reports/03

Provided report to Government on accuracy of immigration & asylum figures

Immigration & Nationality Directorate

www.ind.homeoffice.gov.uk

Legislation and changes in law/rules re immigration & asylum seekers
Integration Fund
All info on coming to/working in Britain/nationality etc.
Research statistics

Office of National Statistics (ONS)

www.statistics.gov.uk

All national stats & trends
Mainly figures on international migration

London Asylum Seeker Consortium (LASC)

www.westmintser.gov.uk

Stats on refugees and asylum seekers on individual Local Authority basis.

Refugee Council

www.refugeecouncil.org.uk

Comprehensive info service on RAS & UK laws and processes
Latest on health entitlements
Support for RAS
World statistics on RAS
Publications/research reports (eg. On RAS and special needs/disability/poverty etc.)

Health for Asylum Seekers & Refugees Portal

www.harpweb.org.uk

Consists of three websites, each developed in collaboration with health professionals working with asylum seekers and refugees in the UK. They are designed to access a wealth of information, practical tools, and articles that have been written by health care professionals, NGOs, academics and research bodies with expert knowledge of working with asylum seekers and refugees, both in the UK and other countries.

Information Centre about Asylum and refugees in the UK (ICAR)

www.icar.org.uk

Analysis of gov stats
Update son other useful sites
Resources & publications & links to projects/institutions etc.

Network of Refugee Organisations within the EU

www.refugeenet.org.

Database of good practices throughout EU in receiving and integrating refugees
WHO Declaration of cooperation in mental health of refugees, displaced & other populations affected by conflict (Geneva 2001)
Rapid Appraisal of Mental Health (RAMH) needs of Refugees (WHO Geneva 2001)
Guidelines for health services
A number of relevant publications

Joint Council for the Welfare of Immigrants

www.jcwi.org.uk

Campaigning body

Responds to all Gov legislation etc. on RAS

Paper on 'eligibility to free NHS services' (DoH May 2004 – JCWI response Aug 2004)

Links to global statistics (www.unhcr.org.uk) & others.

Immigration & Asylum information

www.asylumpolicy.info

Wide ranging information on RAS, immigration, legislation, human rights & related

Responses from different bodies/institutions to government legislation on immigration & asylum etc.

Migrant & Refugees Community Forum

www.mrcf.org.uk

Wide ranging umbrella organisation

Newsletter

Refugee Arrivals Project

www.refugee-arrivals.org.uk

See photographic publication 'The Lives in Our day' -

Refugee Council Archive at East London University

www.uel.ac.uk

Go to website for contact details.

Archive not available on-line

Accommodate: Refugee Housing Partnership Project

www.hact.org.uk

Started August 2004

www.medact.org.uk

Report 'Fit to be detained' challenging detention of RS with health needs.

www.refugeeyouth.org

Network of refugee youth groups across London & the UK.

www.londonmet.ac.uk

Provides training in PTSD/trauma for professionals working with child/adolescent mental health issues

LBH: Better Information Group

For information on recent research, reports, proposals and so on.

Janis Grant
Policy & Regeneration
London Borough of Hackney
Hackney Town Hall, Mare Street
London E8 1EA
T: 020 8356 3387
F: 020 8356 3118

APPENDIX 3 Summary of Trends (figures)

General UK trends⁴⁵

	2003	2004	2005 (Q1)
Applications for Asylum (excluding dependents)	49,405	33,930 (-31%)	7,015 (-17% from previous Q4/2004)
Applications for Asylum (including dependents)	60,045	40,200 (-33%)	
Applicants granted asylum (excluding dependents)	16%	Estimates not available	
Granted ELR/DL/HP	12%		
Refused	72%		
NASS applications for support (includes reapplications)	37,000	33,790	
Total supported by NASS	80,125	61,625 (-23%)	

Top 5 applicant nationalities applying for Asylum in UK in 2004: Iran (+20% from 2003), Somalia (-49%), China (-31%), Zimbabwe (-38%) And Iraq (-57%). The top 3 applicant nationalities in Q1 2005: Iranian, Iraqi and Somali

Hackney Trends⁴⁶

	2003	2004
AS in NASS accommodation (Dec 03 & Dec 04)	175	75
NASS subsistence support only (Dec 03 & Dec 04)	1,195	700

⁴⁵ Home Office/national Statistics Q4 2004; ICAR statistics Paper 1 February 2005 update

⁴⁶ Home Office/national Statistics & LASC

Other Figures for Hackney show:

	Dispersed	Disbenefitted (taken over by NASS from LA)	Subsistence only	Interim arrangements (supported by social services)	Unaccompanied children	TOTAL
2005	50	25	700	662 (258 children)	65	1,502
2004	55	125	1445	1116	73	2,814

First line shows: NASS/end 2004 & LAsFeb2005⁴⁷
Second line: figures from previous GRASP report

Turnover in GP registrations⁴⁸

	Total List	additions	deductions	Net change	turnover
2003/2004	261,474	35,341 13.52%	34,528 13.21%	813 0.31%	69,869 26.72%
2004/2005	261,194	20,923 8.01%	20,205 7.74%	718 0.27%	41,128 15.75%

⁴⁷ Quoted by Lukes.S briefing paper for Finsbury Park Partnership 25 May 2005

⁴⁸ C&HPCT

APPENDIX 4 A NOTE ON METHODS

The overall purpose of the 2 Focus Groups was to explore refugee experiences of 'health' in the widest sense.

The schedule for the two Focus Groups included the following prompts

- Registering with a GP (including, what were the differences in going to the doctor here/back home?)
- What kind of issues do you face when going to the doctor? (Including, what is it like seeing a doctor who speaks another language?)
- What do you think are the main health issues for your community?
- What are the health issues for young people and parents and /or others in your community?
- What do you think can be done to help? (Including, what would you like to tell a room full of health professionals)
- How do you cope with stress?
- Do you have any other concerns?

A number of methodological issues were raised in the process of setting up and running the focus groups which are listed below.

- 1) The difficulties of controlling size (40 was too big!) as it is often not possible to 'exclude' people for a number of understandable cultural, functional (the host organisation does not want to appear selective) and practical (childcare) reasons.
- 2) The costs to a small project such as GRASP are disproportionate in terms of venue hire/interpretation etc. and not least because GRASP felt that those attending should at the very least be offered adequate refreshment. The invaluable help provided by key workers (who 'interpret' in another crucial sense) could not be recognised at all.
- 3) The success of a Focus Group is very largely dependent on such key workers and your relationship with them -especially where the researcher's knowledge of the community is limited and crucially can also help in allaying suspicions
- 4) It became clear that there are often, again naturally, considerable expectations raised in holding Focus Groups. Again as small project, GRASP did not have the resources to do follow-up work and strictly speaking this is not part of research aims. This is also difficult for the key refugee workers involved who may have expected support in follow-up developments. In general, this element is often not taken into account when doing research.
- 5) A pre-requisite, it seems to me, is knowing how a particular community 'asks questions' (within their own community). Time should be taken to work with key workers/informants prior to the focus groups to explore this aspect. Questions can appear meaningless to people at one end of the spectrum and terrifying at the other if not appropriately put. Given the limitations of GRASP, it was not possible to spend more time on such preparatory work.

Points 1-4 informed the decision not to organise further focus groups.

An added difficulty has been with accessing GPs (including through a simple questionnaire). It is recommended that this work forms part of the proposed larger body of research, as it was felt too time-consuming for a small and wide-ranging project (i.e. not focused on GPs) to spend more time on getting access.