

SUPPORTING NEW COMMUNITIES:

A QUALITATIVE STUDY OF HEALTH NEEDS
AMONG ASYLUM SEEKERS AND REFUGEE
COMMUNITIES IN NORTH GLASGOW

Final
Report
2005

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FOREWORD

– IRENE GRAHAM

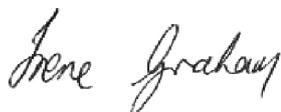
As the only council in Scotland to host asylum seekers through the Home Office dispersal programme, Glasgow City Council has taken pride in the fact that we have welcomed asylum seekers to the city and in the fact that many who receive leave to remain choose to stay in Glasgow. We know that one of the reasons many choose to remain in Glasgow is because there has been successful integration in communities and schools. In addition to the work of the Glasgow Asylum Support Service, local voluntary groups have worked hard to welcome asylum seekers and to fill gaps in provision. There are support services in ten areas across Glasgow as well as city wide services. The Council sees asylum seekers and refugees as being potential assets to the city. They bring a range of much needed skills and a range of different cultures both of which are positive for the city. The impact of children of asylum seekers in our schools has been extremely positive. They bring a dedication to and thirst for learning that have brought benefits to whole schools. There has been much work done to provide English classes both in colleges and community settings and there are a number of projects aimed at accrediting skills and qualifications, providing training and work shadowing.

Glasgow City Council welcomes this research, the first of its kind in Glasgow. The findings, whilst directly relevant to the Health Board, are also of significance for the Council, presenting us with some challenges. Despite the many good initiatives the Council has put in place, this research shows us there is still more to do. I wish to pick up on two of the findings.

Language and communication have been identified as key findings in this research. This is despite a massive investment in and development of translation services in the city. We have seen this service develop from providing translation in seven languages in 2000, to providing translation in over twenty languages now. In 2004, a freephone help line was introduced to provide translation in four languages and this has now grown to seven languages.

Racism and bullying are reported as daily aspects of the lives of asylum seekers and refugees. This is a sad reflection on Glasgow and is despite the programmes and support mechanisms in place across the city. Sadly too it reflects the experience of many people from our resident black and minority ethnic population. The research confirms the Council's view that the integration and anti-racism work done in schools is the best way to influence new generations, what remains is to transfer that learning experience into harmonious relations outside of schools. In our recent advertising campaign, "Glasgow, We're Every Kind of People", we presented Glasgow as a racially and culturally diverse population, all of whom, belong to Glasgow. The research gives weight to the need to run more such campaigns and to continue to look at how best to challenge racism in the city.

I congratulate all those who conducted the research and thank all the participants who shared their views which will inform service developments and hopefully result in improved accessibility for all asylum seekers and refugees. I will ensure that the findings of this research are presented to Policy & Resources Equalities Sub Committee for consideration and action where appropriate.



Councillor Irene Graham
Convener, Policy & Resources Equalities Sub Committee

FOREWORD – TOM DIVERS

The basic truth that lies at the heart of our efforts to improve public involvement is that the people we serve can in turn do the NHS a great service.

Whilst it is our task to protect and improve the health of the people of Greater Glasgow, we can only do that if we are responsive to their needs. We must listen to what people tell us about our services and use their opinions and observations to help us develop and improve the care we offer. This is especially vital to ensure there are no gaps in our care, or in determining where we must be especially sensitive to specific cultural needs and circumstances.

This research is an excellent, very real example of the process I have described. It shows what can be achieved by the power of partnership between the NHS and the public and will lead directly to more effective and relevant services.

For the very first time in Greater Glasgow, asylum seekers and refugees have acted as field workers in drawing together this health needs assessment. It proves once again how everyone in all of our communities has unique skills and abilities that must be cherished. The researchers have clearly done us a very great service – we now have much greater depth of insight into the issues that affect the community of asylum seekers. In return, the act of gathering the underlying data has fostered the abilities and confidence of those who took part and generated a real sense of ownership for the outcome.

It is said that many people see asylum seekers as a problem. Here, they have proved that they are in reality the solution to a problem – in this case, the problem of providing solid and perceptive information on which to plan and design services suitable for the diverse communities of the 21st Century.

I trust that others will learn from the achievements represented in this report.



Tom Divers
Chief Executive
NHS Greater Glasgow

ACKNOWLEDGEMENTS

This report was written by Naasra Roshan, Health Promotion Officer for Asylum Seekers and Refugees, North Glasgow and Drumchapel Geographic Team, Health Promotion Department, Greater Glasgow NHS Board. It would not have been possible to conduct and complete this research without the support and dedication of many contributors:

We would first of all like to acknowledge the support of the research steering group for contributing their advice and ideas on how to best conduct the research study and also their input to the research report. They included: Joe Brady – Scottish Refugee Council, One Stop Shop, Eric Duncan – GGNHSB, Ali Motie – Representative from Asylum Seeker & Refugee Community, Jac Ross – GGNHSB, Imran Shariff – NHS Greater Glasgow, Primary Care Division and Heather Voisey – North Glasgow Partnership. We are particularly grateful to both Eric Duncan and Heather Voisey for editing the report also.

Our thanks must also go all the asylum seekers and refugees in North Glasgow who agreed to take part in the research. We are also grateful to the community organisations in North Glasgow who helped us to facilitate the fieldwork. Thanks also to Vikki Hilton for facilitating the Participatory Appraisal training for the fieldwork.

Finally we are very grateful for the commitment and dedicated support of the nine peer researchers who assisted in conducting this research. Mohammed Abowe, Kishwar Ali, Abdul Badur, Francine Bucumi, Buyankhuu Davga, Mohammed Dara, Richard Darko, Dr Saad Al-Kamisi and Sai Saeed were an invaluable resource to the project and without them we would not been able to gain the same insight and depth from conducting the research.

GLOSSARY OF TERMS

ARTICLE 1 OF UN CONVENTION

Article 1 of the UN convention defines a refugee as:

“A person who is outside his/her country of nationality or habitual residence; has a well-founded fear of persecution because of his/her race, religion, nationality, membership in a particular social group or political opinion; and is unable or unwilling to avail himself/herself of the protection of that country, or return there, for fear of persecution.”

ASYLUM SEEKER

Is someone who is fleeing persecution, has arrived in another country, made themselves known to authorities and exercised their legal right to apply for asylum under the Convention (i.e. is someone who has made a claim to be considered for refugee status to a state which is party to the Refugee Convention).

REFUGEE

Under domestic UK legislation a refugee is someone who has a positive decision on their asylum application thereby giving them permission to stay in the UK because they fulfilled criteria laid out within the UN Convention that defines who is a refugee. However the term is also used generically to describe a person seeking sanctuary from persecution and those fleeing widespread conflict or natural disasters. People who do not qualify under the strict convention definition of a refugee, but who are recognised as having pressing humanitarian reasons not to be returned home, are given a form of subsidiary status (see other statuses, below).

UNACCOMPANIED OR SEPARATED YOUNG PEOPLE (UNACCOMPANIED MINORS)

An unaccompanied or separated young person is someone who arrives in the UK without a guardian or adult relative, has no adult relative or guardian to care for them within the UK, is under the age of 18 and makes an application for asylum. They will not enter the National Asylum Support Service (NASS) support system instead they will be referred to Social Work Services or their local authority. If they have not received a decision on their asylum claim at the time of their 18th birthday they will transfer to NASS support.

REFUSED ASYLUM SEEKER

Sometimes known as a 'failed' asylum seeker within the UK this applies to someone who has applied for asylum and has been refused a form of protection by the UK Government.

HUMANITARIAN PROTECTION

Since April 2003 this status has been awarded to people who have been refused refugee status, but cannot be returned to their country of origin as they face serious risk to life or person or inhuman or degrading treatment or punishment. It is awarded for a three-year period, at the end of this period the circumstances of the case are reviewed. If the circumstances are unchanged a person with Humanitarian Protection (HP) can apply for Indefinite Leave to Remain (ILR). People with HP status are allowed to work and access mainstream welfare systems.

INDEFINITE LEAVE TO REMAIN

This status is given when someone has applied for asylum in the UK and has been recognised by the Home Office as a refugee. Known as ILR this gives someone permission to settle permanently in the UK. Those granted this status are allowed to work and to access mainstream welfare system.

DISCRETIONARY LEAVE

Awarded to people who have been refused refugee status and who do not fulfil the criteria for Humanitarian Protection, but are allowed to stay in the UK for other reasons. It is only awarded in very limited circumstances, sometimes to separated young people (unaccompanied minors – under the age of 18 who have made an application for asylum in the UK).

BLACK AND MINORITY ETHNIC

In this instance someone who is from the indigenous South Asian, Chinese, Black African, Black Caribbean and Gypsy Traveller community.

EXECUTIVE SUMMARY

1. INTRODUCTION & BACKGROUND

In October 2003 Greater Glasgow NHS Board, Health Promotion Department and Planning and Community Care Directorate of Greater Glasgow NHS Board began an 18-month health needs assessment of asylum seekers and refugees. The work was funded by the Scottish Executive who provided funding to Greater Glasgow NHS Board to carry out a needs assessment of addiction issues within the asylum seeker and refugee community. Due to the sensitivity of this issue it was decided to contextualise the addictions component within a general health needs assessment. The study was conducted in the North Glasgow area as it had the highest number of asylum seekers and refugees accommodated through dispersal within Glasgow.

1.1 Aims and Objectives of the Research Project

The key aims of the research project were to:

- Identify the perceived health needs of asylum seekers and refugees in North Glasgow.
- Explore addiction issues in asylum seeker and refugee communities within North Glasgow.
- Identify barriers to accessing current services with a view to informing future service planning and service delivery.
- Enable the development of services that are sensitive and able to meet identified needs.

2. FINDINGS FROM LITERATURE REVIEW

Despite a paucity of research on the health needs of asylum seekers and refugees in this country a number of key themes and issues were identified from the literature review:

- The literature suggests that most asylum seekers and refugees arrive well and in apparent good health.
- There is evidence to suggest that health status of new entrants may worsen in two or three years after entry to the UK because of a complexity of pre-migration and post-migration factors.
- Mental health appears to be the biggest health issue affecting asylum seekers and refugees once in this country. Many studies have documented the high prevalence of trauma, post-traumatic stress disorder (PTSD) and depression within this community.
- There is very little information on the health needs of disabled asylum seekers and refugees.
- There is very little known about drugs and alcohol issues within the asylum seeker and refugee community; inaccurate figures from drug services and relatively low numbers of asylum seekers and refugees accessing addiction services prevents an accurate assessment of these issues. However, research suggests that this community is at risk of developing addiction problems because of unemployment, poverty and exposure to drugs and alcohol in the areas where they live.
- A number of studies have demonstrated that asylum seekers and refugees experience particular problems in accessing and using health services because of language and a lack of information.
- Asylum seekers and refugees are not a homogenous group, coming from different countries, cultures, religions and experiences, they have different health needs as a result.

- Asylum seeker and refugee women and children are particularly vulnerable to developing poor physical and psychological health. Women may have a specific range of health problems related to their experience of migration and possible rape or torture experienced in their home country.
- Children are at risk of undergoing physical and psychological disturbances due to malnutrition, exposure to violence, forced displacement and multiple familial losses.
- There are a number of key methodological issues which may arise when researching the health needs of asylum seekers and refugees related to the diversity of this community, trust and confidentiality.

3. RESEARCH PROCESS

3.1 Methodology

Three main methods were used to carry out the research study, which included a literature review, qualitative interviews with asylum seekers and refugees and a focus group discussion with professionals. In order to engage with members of the asylum seeker and refugee community in an effective and appropriate way it was decided to use a peer research approach to carry out the needs assessment.

3.2 Profile of Participants

Overall 113 asylum seekers and refugees participated in the research project, representing a total of 26 different nationalities with overall far more female participants (73%) than male (27%).

Despite using an inclusive approach to access the asylum seeker and refugee community, male participants were difficult to access as they were less likely to attend and/or participate in community group settings.

4. KEY FINDINGS FROM FIELDWORK

4.1 Access to Primary Care Services

Language and Communication:

From the views expressed by asylum seekers and refugees it was evident that difficulties in access were compounded by language and communication difficulties.

GP Registration:

Although registration amongst asylum seekers and refugees was high, there were a couple of cases which highlighted that some asylum seekers do still find it difficult to register with their GP.

Appointments:

Issues regarding appointment times generally were the most frequently cited problem by asylum seekers and refugees, and more specifically in relation to obtaining GP appointments.

Travelling to the Health Centre:

It appeared that many asylum seekers were allocated GP practices which were not within walking distance, so many felt that the 'health centre was too far away' for easy accessibility.

Attitude of Staff:

Some asylum seekers and refugees commented on the hostile reception they felt when accessing their health centre. Before they were given an appointment they tended to be openly questioned about their status which they feel unwelcome at the practice.

4.2 Quality of Care

Diagnosis & Treatment:

One of the most consistent issues to be raised by participants was inappropriate diagnosis of their problem or condition. Many asylum seekers and refugees felt that they were given only painkillers for all their health problems.

Experience of Secondary Care Services:

In general it seemed that asylum seekers and refugees in the study had little experience of secondary care services, largely as they appeared not to have accessed these to the same extent as they had primary care services.

Ongoing Health & Social Support:

Continuity of care is essential in maintaining the health of patients. However, it appeared that some female asylum seekers were not aware of how to access health visiting support, primarily due to ignorance of how the system works.

4.3 Mental Health Problems

Asylum Case:

As the future of many participants we spoke to depended on the outcome of their asylum case, it was not surprising that many of them spoke about the negative impact of their asylum case on their mental health.

Traumatic Experiences:

Professionals in the focus group observed that most of the families that they had come across appeared emotionally scarred due to their experiences of rape, torture and murder.

Loneliness & Isolation:

A number of asylum seekers and refugees we spoke to felt alone and extremely isolated. Related to this was the distress they experienced as result of dislocation from their homes and cultures.

Unemployment:

Many of the asylum seekers and refugees we spoke to were highly qualified or had actively worked back home and their inability to work in the UK as asylum seekers had led to them experiencing a loss of status and self-esteem.

Coping Mechanisms:

Many participants that we spoke to were finding it difficult to cope with their mental health problems. They said that they just wanted someone they could 'talk to' and share their problems with.

4.4 Environment and Neighbourhoods

Racism & Bullying:

Racism and bullying by members of the host community was a daily occurrence for most of the participants. As a result many developed a sense of fear and anxiety about the communities in which they were staying.

Accommodation:

It was evident from the views expressed by asylum seekers that poor housing and overcrowding was felt to be having a poor effect on their physical and mental health and well-being.

Lack of Basic Necessities:

It appeared that the health of asylum seekers was negatively affected by a lack of basic necessities such as money, food and electrical appliances.

Support from Agencies:

A further theme to emerge was that many asylum seekers felt that little support was given to them when they reported a problem or when they requested help from agencies.

4.6 Attitudes and Experience of Drugs and Alcohol

Prevalence of Drug Use:

The views expressed by asylum seekers and refugees suggested that there was very little direct experience of drug and alcohol use within the asylum seeker and refugee community. Some indication of the use of the drug Khat amongst Somali men was reported.

Exposure to Drug and Alcohol Use:

Although amongst participants there was very little direct experience, it appeared drug and alcohol use was something which most participants were exposed to on a daily basis in the host communities where they lived.

Addiction Services:

Asylum seekers and refugees were not generally aware of addiction support and treatment services. This was consistent with the views of professionals who felt that asylum seekers and refugees suffering from drug and alcohol abuse may be prevented from accessing addiction services because of a number of barriers.

5. CONCLUSION

Some of the issues affecting asylum seekers and refugees such as their asylum case, unemployment and dispersal policy clearly need to be addressed through legislative and policy changes. However, despite this there are issues which should more appropriately be dealt with on a local level. It appears that asylum seekers and refugees experience a multitude of problems which prevent them from promoting their physical and mental health and well-being. These problems also make asylum seekers and refugees vulnerable to developing other health related problems, including potentially problems linked to drug and alcohol use. It is therefore important that service providers address practical problems facing asylum seekers and refugees through providing a much more holistic and needs led approach.

01 INTRODUCTION & BACKGROUND

1.1 Introduction

One of the overarching principles of NHS Greater Glasgow is to reduce avoidable and systematic inequalities in health. Through providing thorough and up to date research the Greater Glasgow NHS Board aims to address inequalities suffered by excluded groups or communities within Greater Glasgow. It recognises that there is a requirement for comprehensive information on the health needs of asylum seekers and refugees due to their particular complexities of need. The requirements for health information on the needs of asylum seekers and refugees has also been highlighted by a number of commentators. For example, Ballini (1997) argues that despite growing recognition from service providers that asylum seekers and refugees have multiple health needs, there still remains very limited research on this topic. It has been argued that there is currently a lack of research on the experience of asylum seekers and refugees themselves and that research has primarily focused on the migration process, international comparisons and the implementation of legislation (Barclay et al, 2003). There has also been a tendency for the primary focus of health literature to be on the experience and needs of recognised refugees, rather than those seeking asylum (Johnson, 2003). Therefore it was felt important that an evidence base be developed on both these groups to effectively address their health needs and issues specifically in Glasgow.

In October 2003 the Health Promotion Department and Planning and Community Care Directorate of Greater Glasgow NHS Board were able to effectively respond to this need by beginning an 18-month health needs assessment. This work was funded by the Scottish Executive who provided funding to Greater Glasgow NHS Board to carry out a needs assessment of addiction issues within the asylum seeker and refugee community. However, due to the sensitivity of this issue it was decided to contextualise the addictions component within a general health needs assessment.

The study was conducted in the North Glasgow area as it had the highest numbers of asylum seekers and refugees accommodated through dispersal within Glasgow. Like most asylum seeker and refugee communities it is not a homogenous group and is made up of a diverse range of people with different cultures, religions, languages and experiences. Although not all the asylum seekers have had the same experiences, it is likely that the majority of them have experienced, either directly or indirectly horrific traumas such as rape, persecution and torture in the events leading up to them fleeing their country of origin. These harrowing experiences have contributed to many asylum seekers and refugees having a mistrust of strangers and those in authority. Due to this mistrust, it was thought that many asylum seekers and refugees living in North Glasgow would be reluctant to participate in a research study. Therefore to ensure maximum participation and sensitivity it was decided to use a method of research which would help overcome this and build trust and capacity. This was integral to the research project due to the sensitivity of the issues highlighted above and issues related to the refugee and asylum seeker status.

This report will document the findings and recommendations of the health needs assessment which was carried out. We also hope that this report will make a valuable contribution to the small body of research on asylum seekers and refugees in the UK and Scotland in particular. The findings and recommendations detailed in this report will be of interest to policy makers, service providers, local and national strategic planners and will contribute to the development of good practice in relation to the health needs of asylum seekers and refugees and supporting their integration into mainstream society. The timing of this report is also consistent with the recent 15-month extension by Glasgow City Council of the asylum contract, where the Council will provide a further 2000 units of accommodation to asylum seeker families until 2007.

This report will begin by providing a brief background to the research project; it will then go on to present the findings of the literature review as they informed the research methodology and research questions. An outline of the process involved in conducting the needs assessment will follow. The findings from the fieldwork will be presented thereafter including findings from a focus group discussion with professionals. This will be drawn together in a conclusion section which will also discuss merits and outcomes of research methodology. Finally a number of action points for future work with asylum seekers and refugees will be highlighted in response to the key themes identified from the research. Contributions by the asylum seeker and refugee participants and professionals in the focus group have been kept anonymous to protect confidentiality.

1.2 Background

(A) NASS & Dispersal Policy

The Immigration and Asylum Act 1999, created the National Asylum Support Service (NASS). National Asylum Support Service (NASS) has borne responsibility for the support of destitute asylum seekers until their application for refugee status is finally determined. NASS is a UK wide Home Office organisation with its headquarters based in Croydon. Asylum and immigration are reserved matters for the Westminster parliament and in practice decision making within NASS has remained centralised. The decision to disperse asylum seekers to cities out with the South East, particularly London, was planned to ease pressure upon them. However this dispersal of asylum seekers to other cities has presented challenges to many statutory and voluntary organisations across the UK, who may have had little previous experience in working with new communities (see appendix 1 for full analysis of the Asylum and Immigration Acts since 1993).

(B) Local Authority Response

In Scotland, Glasgow City Council entered into a contract with NASS in April 2000 to provide 2000 units of accommodation to families and 500 units to single people, running for 5 years from April 2000. Glasgow City Council 2001 Ethnic Group Data Analysis report (2004) states that 11,115 asylum seekers have arrived in Glasgow since April 2000. Being the main provider of accommodation for asylum seekers, the Council set up the Glasgow Asylum Seeker Support Project (GASSP) to provide a co-ordinated approach to the care of asylum seekers in Glasgow. The project has dedicated Education, Police and Health staff at its base to ensure that asylum seekers access Health and Education services and provide information and advice on local resources. It is also worth noting that the voluntary sector has played a pivotal role in supporting asylum seekers and refugees integrate into services in Glasgow.

(C) The Health Policy Context

The recent implementation of the Race Relations (Amendment) Act 2000 and the Health Development Letter (HDL) 51, Fair for All (2002) have required all Health Boards to meet the needs of black and minority ethnic communities. Furthermore, the Scottish Refugee Integration Forum Action Plan (2002, Scottish Executive) has advocated the need for more co-ordinated and integrated services for refugees: "Health Boards need to ensure that services planning takes full account of the particular needs of refugees". If the needs of asylum seekers and refugees are to be effectively met by Health Boards, then an accurate assessment of their health needs is required.

(D) Legal Entitlement to Health Provision

All asylum seekers and their dependents are entitled to free NHS treatment. In order for asylum seekers to be exempt from charges for these services they need to obtain an HC2 certificate by completing a lengthy form that is only available in English and Welsh. Just like any UK citizen, asylum seekers have to pay for some health services such as eye tests, certain prescriptions and some dentist treatment.

(E) Glasgow's Healthcare Response to Asylum Seekers

Health Services across Glasgow have endeavoured to provide access to a full range of primary and secondary health care services to meet the needs of the asylum seekers who come to the city. Upon arrival in the city, asylum seekers receive a welcome pack, which explains how they can access medical and dental services provided locally by the Primary Care Division. Included in this information is the name and address of the local designated GP who will already have been sent information about the asylum seeker. Asylum seekers are asked to attend their designated GP in the days after their arrival in the city. A number of additional services have been provided by Primary Care to accommodate the needs of asylum seekers, including a specific health visiting team, health check assessments, a mental health service called COMPASS and free interpreting service. (Further information on this is available from the Welcome Pack produced by the Glasgow Asylum Support Project, Glasgow City Council).

(F) North Glasgow

As the data below (1.3) indicates the majority of asylum seekers coming to Glasgow were accommodated in North Glasgow. North Glasgow is an area which has suffered prolonged deterioration in its economic, social and physical fabric. It has a population of approximately 70,000 people and spatially the area covers three Social Inclusion Partnership areas. The Draft Revised Scottish Indices of Multiple Deprivation, published in February 2003 reveal that there are four areas in North Glasgow listed within the most deprived local authority wards in Scotland; these are Keppochill, Royston, Ashfield and Milton. In addition there are 7 wards within the 40 most deprived wards, indicating that North Glasgow partnership area is the most concentrated area of deprivation in Glasgow. The area has itself suffered from poor health and high levels of substance abuse; concentration of poverty; low incomes and worklessness. One of new challenges facing the area has been to provide an effective response to the emerging needs of a new population of asylum seekers and refugees, and integrating these into the existing communities. To some extent this has been hampered by existing constraints on service provision in the North of Glasgow.

1.3 Profile of Asylum Seekers & Refugees in Glasgow

There appears to be little consistency in the data available on the number of asylum seekers and refugees in Glasgow. To allow an estimate of the size of asylum seekers and refugee population, two sources of information are presented. Firstly from the National Asylum Support Service (NASS) numbers and secondly from GP registration numbers.

(A) NASS Figures

Figure 1 – Number of Asylum Seekers in Glasgow

Figure 1 below depicts the number of asylum seekers living in Glasgow according to NASS. At the end of January 2005, NASS had calculated that there were 5798 asylum seekers in Glasgow. North Glasgow, specifically Springburn & Barmulloch (G21) had the highest number of asylum seekers followed by Shawlands (G43).

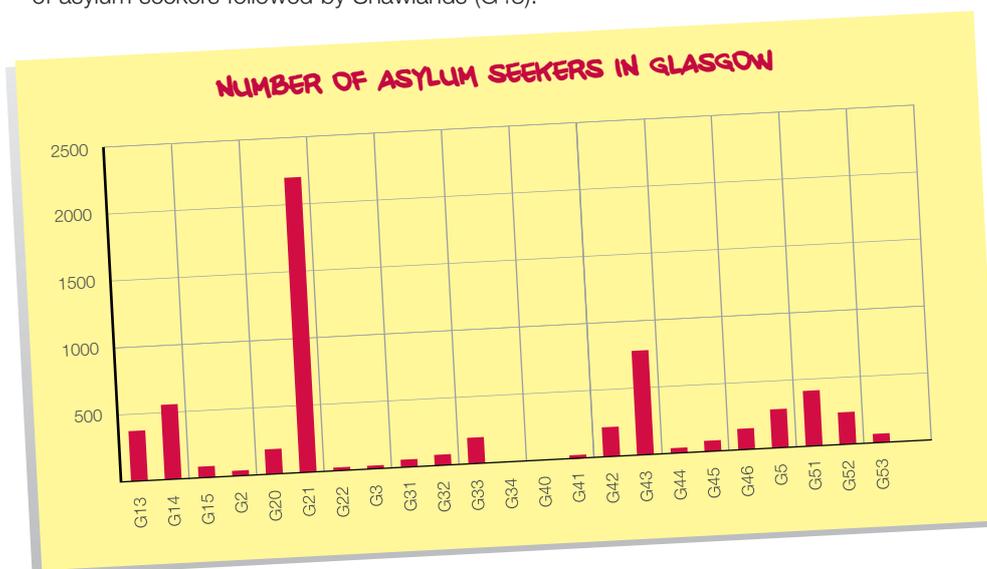
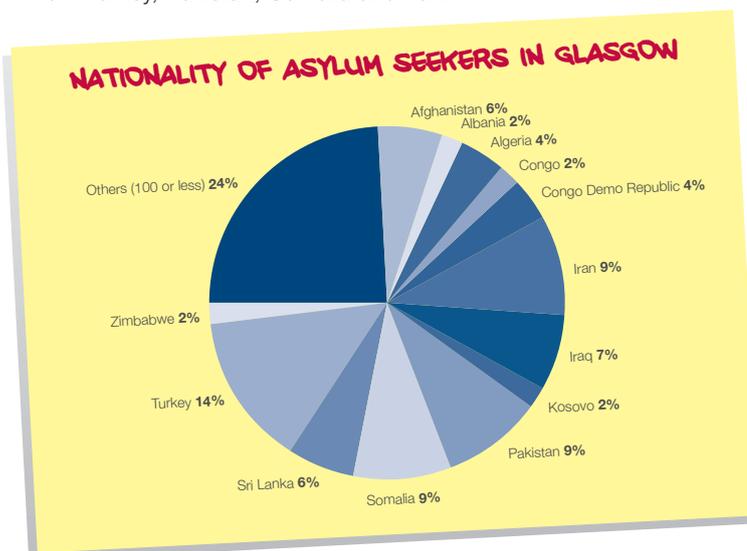


Figure 2 – Nationality of Asylum Seekers in Glasgow

Figure 2 depicts the different nationalities of asylum seekers staying in Glasgow according to NASS figures, August 2003. It appears that the majority of asylum seekers are coming from Turkey, Pakistan, Somalia and Iran.



(B) GP Registration Numbers

Figure 3 – Geographical Distribution of Asylum Seekers

Figure 3 depicts the number of asylum seekers in each Local Health Care Co-operative (LHCC) within Greater Glasgow according to GP registration numbers, November 2004. According to these figures the total number of asylum seekers was 11849. North Glasgow LHCC has the highest number of asylum seekers living in its area.

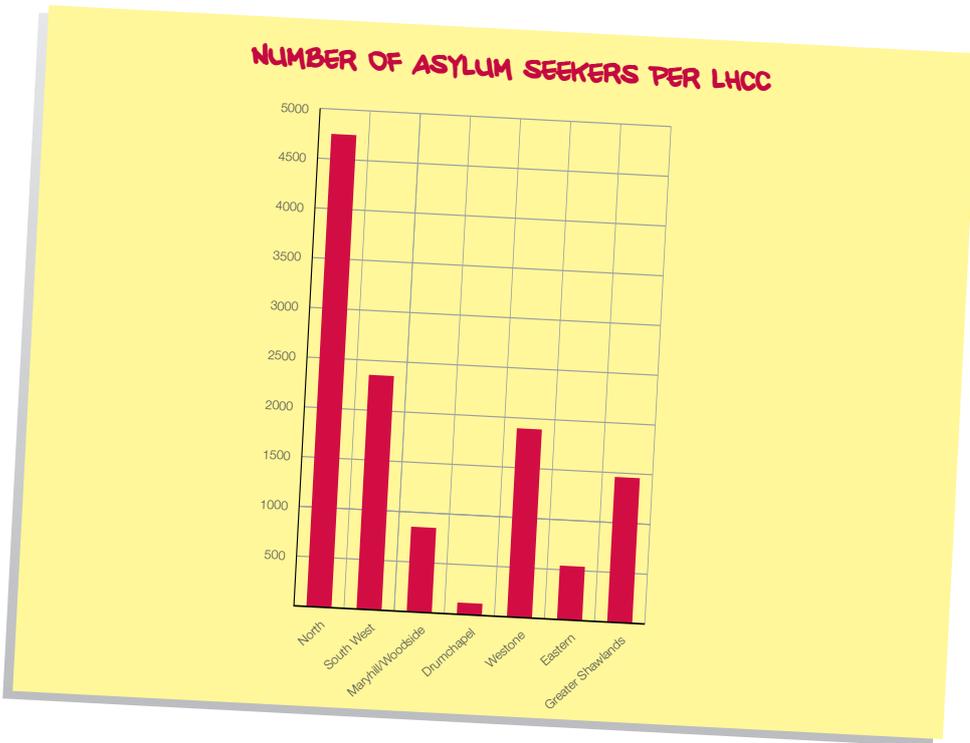
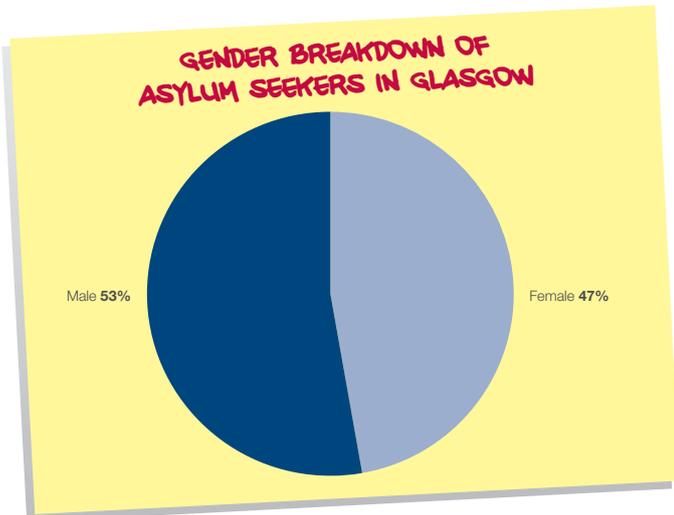


Figure 4 – Gender Breakdown of Asylum Seekers in Glasgow

Based on GP registration numbers November 2004, figure 4 below gives a breakdown in the number of male and female asylum seekers in Glasgow. It appears that there are more male asylum seekers arriving in Glasgow, than females.



(C) Disparity in Figures

There appears to be a 49% difference between NASS and GP registration figures. A combination of factors almost certainly contributes to this difference e.g. census dates and classifications. However, one of the most likely contributing factors lies in the way that GP registration figures are recorded. The Community Health Index (CHI) from which the GP population is drawn is known to be inflated as a proportion of patients who are on a GP's list no longer reside in that GP's catchment area. Generally a patient is only removed from a GP's list when they register with another practice and there is often a time lag between a patient moving away and registering with a GP in their new location. This inflation varies between 6 and 9% for the general population and is not unreasonable to assume that it is higher for the asylum seeker population.

The GP registration figures could be regarded as a measure of how many people have entered the system. The fact that the Glasgow City Council 2001 Ethnic Group Data Analysis report (2004) states that 11,115 asylum seekers have arrived in Glasgow since April 2000 underpins this assumption. Unfortunately, these data do not tell us whether these people are still in the system or have been given a decision and moved on. Therefore, the NASS figures could be regarded as a measure of the number of asylum seekers currently known in the population.

This disparity between NASS and GP Registrations highlights a real gap in our information on asylum seekers and there is a need to investigate this further. One possible method would be an audit of a GP list that contains a high number of asylum seekers.

(D) Rate of Positive Decisions

Glasgow also has an 81% positive decision rate¹, with an estimated 42% staying on in Glasgow. Glasgow city has decided to extend its asylum contract by 15 months to 2007, it remains unclear how this will impact on future decision rates or on numbers electing to stay on in the city.

1.4 The Research Project

(A) Development of Project

The research project was developed in response to concern amongst professionals over the lack of information on the health needs of asylum seekers and refugees in Greater Glasgow. It was anticipated that this research project would be instrumental in building a better evidence base on the health needs of asylum seekers and refugees as well as sensitively gathering information on addiction issues within this community. The research project was also perceived to be innovative as it would incorporate a dual approach in carrying out the research, which would not only provide health needs information but it would also build capacity and trust in the asylum seeker and refugee community.

(B) Project Co-ordination

The research project was managed by the North Glasgow and Drumchapel Geographic Team in Health Promotion, GGNHSB as the team covered an area which had the highest number of asylum seeker and refugees in its catchment area. Rather than commission the study to an outside research company it was agreed that it was more appropriate for a Health Promotion Officer to co-ordinate the research project. A clear aim of this approach was to help establish good links with the local asylum seeker and refugee communities and supporting agencies during the research phase and to create solid foundations on which the local health promotion team, planners and other health service providers could build upon.

¹ A positive decision is when asylum seeker is granted refugee status.

(C) Steering Group

The steering group played a pivotal role in developing the aims and objectives of the research project and agreeing on the research methodology. A core group was also set up from the steering group to assist with the more practical issues surrounding the research. Steering group members included representatives from Greater Glasgow NHS Board, North Glasgow SIP, Scottish Refugee Council One Stop Shop, Primary Care Division Multi-Cultural Health Team, North Glasgow Social Work Community Addiction Team, North Glasgow Alcohol Support Project, COMPASS² and North Glasgow LHCC. There was also representation from the asylum seeker and refugee community. It was felt that it was important to have representation from the key stakeholders in the development of the project to ensure effective implementation of research findings and to get a flavour of the sensitivities and issues in working with these communities.

(D) Aims and Objectives of the Research Project

The key aims of the research project were to:

- Identify the perceived health needs of asylum seekers and refugees in North Glasgow.
- Explore addiction issues in asylum seeker and refugee communities within North Glasgow.
- Identify barriers to accessing current services with a view to informing future service planning and service delivery.
- Enable the development of services that are sensitive and able to meet identified needs.

From these aims the following tasks were identified:

- Conduct a literature search to inform scope of research and methodology.
- Recruit and train peer researchers with a view of developing capacity building opportunities.
- Develop and devise appropriate research questions and methodology in consultation with steering group and peer researchers.
- Implement agreed methodological process to identify perceived health needs; explore addictions issues and identify barriers to accessing services.
- Analyse collected data and make recommendations for service delivery.

A key principle of the research project was that all stakeholders, including asylum seekers and refugees, would participate in developing, designing and planning the research project.

(E) Research Ethics

As the research study was not directly interviewing NHS clients and staff, the project was exempt from requiring ethical approval from the Primary Care Division in Greater Glasgow NHS Board. It was however anticipated that there may be some ethical issues arising from the sensitive nature of the topic area and the community involved. Therefore, the research project adopted the Code of Practice for Researching Black and Minority Ethnic Communities (see appendix 2) as developed by Greater Glasgow NHS Board Black and Minority Ethnic Research Strategy Group.

Ethical approval was also acquired from Social Work Services Department, Glasgow City Council, as a number of social work staff were participating in the professional focus group and also because we were intending to carry out interviews with asylum seeker and refugees who access North Glasgow Addiction Services.

(F) Literature Review

A literature review was conducted to draw on findings from wider research studies on the health needs of asylum seekers and refugees. The findings of the literature review would help to inform the primary research study and would also help to identify what methodological issues need to be taken into consideration when conducting the research. The literature review was conducted in December 2003 and updated briefly in July 2005. As the literature review informed the research methodology it will be presented here first.

02

FINDINGS FROM LITERATURE REVIEW

2.1 Introduction

This literature review draws on findings from research studies on the health needs of asylum seekers and refugees. In doing so it reflects current knowledge within this area, identifying key issues and themes. Although the main objective of the literature review is to inform the health needs assessment including review of literature research, it is hoped that this literature review will make a key contribution to understanding and raising awareness of the health needs of this vulnerable group.

The report will begin by describing the methodology used to select literature for this review. The report will then go on to present the key themes that arise from the literature. These will comprise of:

- Health status upon arrival
- Situational factors
- Mental health needs
- Communicable diseases
- Physical disabilities
- Addiction issues
- Women's health issues
- Children and young people
- Access to services
- Methodological issues in researching asylum seekers and refugees

These issues will then be brought together in a conclusion section and recommendations will be given in relation to the larger research project specifically the fieldwork.

2.2 Search Strategy

An extensive search of literature relating to the health needs of asylum seekers and refugees was conducted. To ensure maximum information a 'broad' definition of literature was used, comprising of published literature, grey literature (unpublished literature), reports, presentations and articles. In trying to identify literature for this research the following approaches were used:

- Electronic Database search, comprising of Medline, ASSIA, HIC
- Accessing documents through websites including Drug Scope, Home Office & Kings Fund website
- Personnel research reports on asylum seeker and refugees collected over the years
- Reports requested directly from health authorities and agencies working with asylum seekers and refugees

Documents and articles which were not available directly from the databases were requested through the British Library. Due to the limitations in the published literature, it was decided to incorporate unpublished 'grey' literature also. Although the methodology within the grey literature was not peer reviewed, it provided a valuable snapshot into the health needs of this group.

2.3 Health Needs of Asylum Seekers and Refugees

(A) Health Status Upon Arrival

A report by the Kings Fund (2000) revealed that most asylum seeker refugees arrive well and in apparent good health. This is consistent with other studies which indicate that the average physical health of asylum seekers on arrival is not especially poor (Johnson, 2003). However evidence from the literature also suggests that some asylum seekers do arrive in distress and with long standing illnesses and physical disabilities (Kings Fund, 2000). These physical and psychological problems may have been acquired as a result of the war, torture or rape they experienced in their home countries. For example a study Ceneda (2003) demonstrated that the majority of women who were claiming asylum on political grounds had suffered harm, beatings and rape in their own country. Many asylum seekers also appear to experience health problems as a result of travelling long distances, particularly pregnant women and the elderly (Johnson, 2003). Although pre-migration factors do impact on the health needs of this group, it is important to remember people seeking asylum are not a homogenous group as they come from various countries, cultures and experiences which impact on their health and well-being (Burnett et al., 2001). It is also been asserted that for many asylum seekers their health may not be a main priority for them and they may be more concerned about finding housing or getting employment (Aldous et al., 1999).

(B) Situational Factors

There is evidence to suggest that the health status of new entrants may worsen in two or three years after entry to the UK. There appears a general consensus that this is primarily due to the socio-economic and environmental circumstances which asylum seekers and refugees find themselves in. (Aldous et al., 1999; Burnett and Peel, 2001; BMA, 2002; Karmi, 1992). Mitchell (2002) reports that asylum seekers show similarities to other excluded groups such as black and minority ethnic community. Aldous et al. (1999) reports that these factors are going to have an even greater impact on their health in comparison to other disadvantaged groups as they more likely to arrive in this country without housing, money and adequate clothing. This is consistent with Karmi (1992) who suggests that asylum seekers not only suffer from psychological and physical problems due to persecution but also due to language problems, unfamiliarity with British systems and as a consequence of poverty and unemployment. The impact of the situational factors on the health of asylum seekers and refugees is evidenced in a number of key studies. For example:

- A recent base-line study (2004) found that asylum seekers and refugees were more dissatisfied with the area in which they live in comparison to residents in both North Glasgow SIP area and the whole North Glasgow partnership area. Ninety-three per cent of refugees and asylum seekers interviewed expressed the feeling of being unsafe in their neighbourhoods at night, compared to 29% of North Glasgow SIP respondents. Thirty-five per cent of asylum seekers had been victims of crime, compared to 13% in the North Glasgow SIP. Only fifty-four per cent lived in a household with central heating, lower than that of North Glasgow SIP residents (83%) and of the area as a whole (86%).
- A Social Inclusion Partnership base-line (2003) study conducted in Dumbarton Road Corridor in which 100 asylum seekers were surveyed, also revealed that 68% of asylum seekers felt that their household income was inadequate, in comparison to 25% of the general population. There was also a far lower rate of perceived safety amongst asylum seekers with 86% of asylum seekers saying that they would not feel safe going out at night.
- In a study conducted in Glasgow by Weaver (2003), key informants felt that social isolation; poor heating, poor water quality, no money and unemployment were having a negative impact on their physical and mental health.

- In a study conducted in Glasgow by Mojee et al. (2003) 24% of the asylum seekers surveyed identified the process of claiming asylum as the main contributing factor to their psychological distress, 12% found racism as factor contributing to their psychological distress and 29% found their living circumstances and feeling unsafe led them to feeling distressed.
- Findings from a Kings Fund Study (2000) reveal that the mental health of asylum seekers deteriorate within the first six months of their arrival in the UK.
- Key informants in Johnson (2003) study felt that employment restrictions led to associated health problems and low self-esteem.
- A recent study by Save the Children (2005) conducted in Glasgow revealed that asylum seekers had felt that poverty had eroded their sense of self-worth and esteem and affected how they interacted within the family. Some asylum seeker families felt that they were living in overcrowded situations and others felt they were not in a position to complain about their housing and that they were just grateful to be housed. The waiting period for a decision on their asylum application was experienced as mentally traumatic and parents were concerned of the impact it had on their children.

(C) Mental health

(C.1) Prevalence of Mental Health Problems

The literature suggests that mental health appears to be the biggest health issue affecting asylum seekers and refugees once in this country. Many studies have documented the high prevalence of trauma, post-traumatic stress disorder (PTSD) and depression within this group. For example:

- A base line study (2004) conducted in North Glasgow found that only 34% of asylum seekers rated mental and emotional well-being as positive, compared to 80% of residents of North Glasgow SIP and 81% of NGSIP Board area.
- A base line study (2003) conducted in Dumbarton Road Corridor found that 53% of the 100 asylum seekers surveyed had a negative perception of their mental and emotional well being.
- Mojee et al. (2003) reported 500 asylum seekers were referred to mental health services in Glasgow.
- A study by Silove (2002), found that high rates of trauma, PTSD and depression in asylum seekers.
- A study by Wilson (2002) found that mental health was the most frequently encountered health problem by asylum seekers.
- Carey Wood et al. (1995) claims that two-thirds of asylum seekers are likely to have mental health problems (cited BMA, 2002).
- A study by Gammell et al. (1993) on refugees and asylum seekers in Newham found a high prevalence of mental health problems and issues. The study revealed that one-third of refugees were depressed, (44% of women and 25% of men). One in five mentioned having experienced constant worrying, sleeplessness and intrusive memories in the previous two weeks.

De Long et al. (2000, cited Murphy et al.) found that the most common psychiatric disorder appears to be PTSD and depression in asylum seekers. Jensen et al. (1989; cited Silove, 2000) in a study found that 34 of 46 displaced persons referred for psychiatric care in Sweden experienced PTSD; the majority of these were asylum seekers. Silove (2000) argues that even though selection and other biases may have influenced prevalence rates of disorder in these populations, there is clear evidence of substantial psychological morbidity among asylum seeker groups.

(C.2) Factors Impacting on Mental Health

A number of studies have demonstrated the impact which pre-migration and post-migration factors have on the mental health of refugees and asylum seekers (Lavik et al.1996). Karmi (1992) reports that several factors have been identified as important in the development of mental illness in displaced people. These include language difficulties, family separation, and hostility from host population, social isolation and traumatic experience before displacement. A study by Lavik et al. (1996) explored the risk in an out-patient refugees sample by analysing the relationship between psychiatric symptoms and dysfunction, and between symptoms and the socio-demographic background and the stressors specific to this refugee sample. The study found that 46.6% of patients had post-traumatic stress disorder. Torture, emerged as an important predictor of emotional withdrawal. Also age, gender, and no employment or education predicted for anxiety/depression, while refugee status and no employment or school predicted hostility/aggression.

Past traumatic stressors and current existence in exile constitute independent risk factors.

A number of authors have suggested that the stress asylum seekers face in developed countries may exacerbate risk of ongoing PTSD and other psychiatric problems (Gorst-unsworth et al., 1998; Summerfield 1996; Burnett et al., 2001). In a study of 84 Iraqi asylum seekers living in the United Kingdom, Gorst-unsworth and Goldenberg (1998) reported that low levels of social support and financial difficulties after migration were associated with heightened levels of depression. Silove (2000) argues that although systematic research into the mental health needs of this group is in its infancy there is growing evidence that salient post migration stress facing asylum seekers adds to the effect of previous trauma in creating risk of ongoing PTSD and other psychiatric symptoms. Hauff & Vaglum (1995) add that although studies seem to confirm that refugees have an increased prevalence of mental disorder, one should be careful with generalisation, because of the great variation in background, degree of persecution and conditions in exile. They argue that it is important to take into account both the traumatising in the home country and the condition during exile.

It has also been claimed that asylum seekers and refugees share factors relating to depression with black and ethnic minority communities in general in the UK. Beliappa (undated) claims that depression in Asian communities is caused by factors relating to marital and family relationships, and socio-economic conditions such as employment, housing, low economic status and racism. As discussed earlier these are issues which asylum seekers and refugees are also particularly vulnerable to experiencing.

(D) Communicable Diseases

The literature suggests that many asylum seekers and refugees are at risk of developing communicable diseases and infections as a result of pre-migration and post-migration factors. This is likely to be determined by which part of the world they have fled from, with many asylum seekers coming from impoverished parts of the world where there is poor sanitation and no opportunity for vaccination (Aldous et al., 1999). Communicable diseases found to be prevalent in asylum seekers and refugees include, lice, scabies, intestinal parasites, tuberculosis, chronic hepatitis B, HIV/ Aids and syphilis (Aldous et al. 1999; BMA, 2002). Although the high prevalence of some of these diseases can be due to the country of origin, some communicable diseases such as tuberculosis can be further spread by the poor living conditions in which they may find themselves in this country. A study by the Kings Fund (2000) found that asylum seekers and refugees were struggling to maintain acceptable levels of personal hygiene, especially in overcrowded hostels. Aldous et al. (1999) raises a number of key points in relation to communicable diseases amongst asylum seekers and refugees. He stresses that many asylum seekers, and in particular children, may not have been immunised and this is further hindered by difficulties in accessing primary health care in this country.

A study by Callister (2002) found that the prevalence rate of tuberculosis (TB) in asylum seekers entering the UK through Heathrow Airport is high. The findings from the study suggest that approximately 101 asylum seekers with active pulmonary TB enter the UK every year, of which 25 would have smear positive disease (infectious). Callister (2002) reports that most patients with TB are from black and ethnic minority communities, with 38% being from the Indian subcontinent population and a further 13% from African populations.

Asylum seekers and refugees may also be at risk from developing sexually transmitted infections (STIs). Incidences of these diseases appear to be particularly high in some groups of asylum seekers and refugees as they come from countries that already have a high prevalence rate of STIs. Aldous et al. (1999) reports that rates of syphilis have increased due to the increase of refugees from Eastern European countries. Deaton & French (1997, cited Aldous et al., 1999) found increased numbers of Russian commercial sex workers attending genito-urinary medicine services in the UK. Aldous et al. (1999) recommends that consideration be given to sex education and effective outreach work to target those at most at risk of imported syphilis and other STIs. It is also reported that there are higher incidences of HIV/AIDS amongst asylum seekers and refugees from Africa. Chinoya et al. (2000) reports that migrants from African populations are the second largest group affected by HIV/AIDS. A report by the Kings Fund (2000) found that the issue of HIV is one of considerable personal and political importance. It suggests that most asylum seekers and refugees have not been tested and do not know their antibody status. The Kings Fund (2000) study suggested that this maybe due to asylum seekers and refugees fearing that it might hinder the asylum seekers application. It has also been suggested by Johnson & Akinwolere (1997, cited Aldous et al., 1999) that under-reporting may also be due to stigmatisation of people from particular areas. It was also reported that maternal HIV (transmission to the child) is common, this may be because breast-feeding is the only option available to asylum seeker and refugee mothers who are most likely to be living in poverty (Kings Fund, 2000).

(E) Physical Disabilities

There is very little information on the health needs of disabled asylum seekers and refugees. According to a Kings Fund (2000) report asylum seekers and refugees who are fleeing for safety may arrive with physical disabilities sometimes as a result of torture or conflict. A study conducted by the Joseph Rowntree Foundation (2002) revealed that disabled refugees and asylum seekers appear to find themselves isolated in Britain without any support specific to their needs. The study involved qualitative interviews with 38 disabled asylum seekers and refugees and social work staff. Over 100 organisations working with refugee community groups and disabled people organisations were also surveyed. The study revealed that:

- Although there were no official statistics on the number of asylum seekers and refugees in Britain, the survey in this study found that there were 5,312 individuals with physical disabilities in Britain known to 44 organisations.
- Disabled asylum seekers are a diverse group. For example one organisation had mostly men who attended whose impairments had resulted from torture. On the other hand there were older women's groups whose impairments were associated with age and chronic illness.
- Inadequate housing provision exacerbated personal care problems.
- Communication barriers, lack of social support and impaired mobility led to extreme isolation.

(F) Addiction Issues

There is very little known about drugs and alcohol issues within the asylum seeker and refugee communities. A Home Office study by Cragg (2003) reports that problematic drug misuse is rare, there being no reliable figures from drug services to suggest that a dependency problem amongst this community exists. However, he does go on to suggest that this may be because asylum seekers and refugees very rarely access services. This is consistent with findings from a recent literature review by Greater Glasgow NHS Board on drug and alcohol issues affecting black and minority ethnic communities which suggested that there is an under representation of these communities accessing drug services as they consider them to be inappropriate and inaccessible (Hay et al., 2001). Many asylum seekers may not access drug services, as they may not feel that their confidentiality will be respected. Sheikh et al. (2001; cited Fountain, 2003) points out that this may be a particular issue for refugees and asylum seekers who may be worried about their legal status or in hiding. Awiah (undated, cited Fountain 2003) points out that amongst the Turkish speaking community the concept of confidentiality in the context of drug services is simply not understood. Burnett and Fassil (2002) also report that there is a significant stigma around drug use amongst refugee communities, again this may prevent them from seeking help. The study also points out that because the refugee and asylum seeker communities are so diverse it is difficult to generalise about the existence of drug misuse within it.

Cragg (2003) study did find evidence of the drug khat³ amongst the Somali community. A recent literature review carried out by the University of Lancashire on drug use within the black and minority ethnic communities in England also found evidence of the prevalence of the drug amongst specific refugee communities. For example prevalence was found among the Somali community by a number of studies (Cunningham 1998; Fountain et al., 2002; Griffiths 1998 and Nabuzoka and Bdhade 2000; cited in Fountain 2003). A number of studies have also found prevalence of khat within the Middle Eastern and Ethiopian communities (Leroy 2000; Mohammed 2000; Fountain et al., 2002; cited Fountain et al., 2003). Fassil and Burnett (2002) have also stressed that there may be a potential for khat to be replaced by other drugs and alcohol.

Professionals interviewed in Cragg's (2003) study did feel that asylum seekers and refugees were particularly vulnerable to drug misuse due to the socio-economic position that they found themselves in. Patel (1997; cited Fountain, 2003) also argues that there is recognition that certain people may be at risk of developing drug problems where they are exposed to risk factors such as social deprivation, exclusion, isolation and exposure to drugs.

Evidence of drugs and alcohol being used as a coping mechanism has already been found in some studies. For example, a Kings Fund (2000) report found extensive use of unofficial self-medication such as alcohol and drugs to help cope with the psychological effects of torture and war. In a study by Ljubin (2000) a link was also found between PTSD and alcohol dependence in displaced people. The study found an increase in alcohol dependence associated with PTSD in adult males who were displaced. This dependence did not appear related to drinking behaviour before the war, suggesting the role of trauma in alcohol dependence comorbid with PTSD in men. There however appeared to be no increase in alcohol dependence associated with current PTSD in women.

There has also been concern regarding addiction to prescribed drugs. Cragg (2003) study found that asylum seekers from India and Pakistan were excessively prescribed drugs, mainly tranquillisers and anti-depressants. Members of a Turkish speaking community (Awiah, undated, cited Fountain et al., 2002) also expressed concerns about the use of prescribed drugs.

³ Khat is a green-leaved plant that has been used for its stimulant properties for centuries across parts of Africa and Arabia. The stimulant effects are often described as being somewhere between caffeine and amphetamine.

A recent drug and alcohol needs assessment by Hanley (2004) with black and minority ethnic communities in the Castlemilk area of Glasgow in which all the respondents were asylum seekers and refugees, found that although there was no identified use of drugs or alcohol within the research participants, there was concern about use within their communities and the effect that this may have upon their culture, family structure and safety. There was also concern regarding the high use of prescribed drugs within this community, considered by many as 'an addiction'.

Another recent study by the Centre for Ethnicity and Health (2004) on young refugees and asylum seekers in Greater London reported that very few of the young asylum seekers and refugees interviewed were problematic drug users. Cannabis use amongst them was not uncommon, but only a small number were involved in heroin or crack cocaine use, and even fewer in selling drugs. However, the study did find that the lives of young asylum seekers and refugees was characterised by risk factors such as high prevalence of mental health, high unemployment, lack of social networks, poor environment, separation from family, barriers to education and poor housing which made them vulnerable to developing potential drug problems.

(G) Women's Health Issues

Burnett and Fassil (2002) report that asylum seeker women may have a specific range of health problems which are often unrecognised. They claim that this is largely due to them having a low status within society. Migration can also have an impact on gender roles with some asylum seeker and refugee women having to take on new roles and responsibilities due to them losing or becoming separated from their spouses (Aldous et al., 1999). Many cannot speak English and this can have implications on their health (BMA, 2002). For example, Cenada (2003) reports that two-thirds of women in her study did not speak English. Gammell et al. (1993) study revealed that the inability to communicate in English, for women was associated with poorer self-assessed health and reported depression. It also been reported that females are much less likely than men to report ill health and mental health problems (BMA, 2002). The BMA (2002) have also pointed out that one specific problem which may occur in many female asylum seekers is female genital mutilation. This primarily affects women from Eritrea, Ethiopia and Somalia and can have implications on both childbirth and sexual health (BMA, 2002).

It has been reported that many women will experience both psychological and physical health problems as result of rape and torture. Almost all the women in Cenada (2003) study who had claimed asylum on political grounds had suffered three or more forms of harm including rape, beatings and detention. One in six in this sample had experienced sexual violence. Murphy et al., (2002) claims that women who have experienced rape fear ongoing victimisation. He also asserts that where rape has been rare or remains a taboo subject many women will have deep shame and be rejected by their families and community members. These they add are common responses and need to be contextualised and they should not be looked at as a psychiatric condition. In many cultures sexual violence is a taboo subject making many survivors uncomfortable speaking about them.

There is also evidence to suggest that many women asylum seekers are increasingly experiencing domestic violence. A study carried out by Murphy et al. (2002) revealed that that there were number of women who were caught up in either violent relationships or what they felt were inappropriate second relationships because of their vulnerable circumstances. A recent report by Save the Children Fund (2005) revealed that women had found their partners more frequently to shout and display aggressive behaviour towards them due to changes in their roles.

A qualitative study carried out by McLeish (2002) on behalf of the Maternity Alliance highlighted the particular difficulties facing pregnant asylum seeking women. The study revealed that conditions for asylum seeker women and their babies were not even meeting the basic requirements of food and shelter. In particular pregnant or breastfeeding women in emergency accommodation had to go without food. Many had been placed in temporary accommodation which was overcrowded or damp. Some had also been placed in all male hostels where they were subject to sexual harassment. Although some of the women were generally satisfied with both their antenatal and postnatal care, almost half had experienced racism, neglect and disrespect from the health professionals during the delivery or postnatal care. At the early stages of their pregnancy many had experienced sadness, loneliness, although none had been diagnosed with postnatal depression or been offered any help. No information was given to say what support services were available to them.

(H) Children and Young People

Asylum seeker and refugee children and young people face multiple disadvantages (Lynch et al., 2000). The literature highlights that asylum seeker and refugee children are at risk of undergoing physical and psychological disturbances due to malnutrition, exposure to violence, forced displacement and multiple familial losses (Fazel, M; Stein, A, 2003; BMA, 2002). Further evidence of this was found in a Kings Fund (2000) study which revealed that although children and young people have issues that are common to all young people, there are some which are specific to their status. The report revealed that they:

- Are less likely to be physically ill than adults but are more likely to be mentally damaged.
- Have experienced or witnessed torture.
- Might lack in social skills and have difficulties in making friends.
- Suffer from identity issues.
- Feel excluded and want to fit in and as a result get involved in street culture.
- Subject to harassment and attack.

A literature review by Thomas and Lau (2001) on the psychological well being of child and adolescent refugee and asylum seekers found that children and adolescents are vulnerable to the effects of pre-migration, most notably exposure to trauma. The review also highlighted that children and adolescents with extended trauma experience, unaccompanied or separated adolescents, and those engaged in uncertain process of sought asylum are most at risk. The authors also found that there were certain risk and protective factors such as family cohesion, parental psychological health, individual dispositional factors such as adaptability, temperament and positive self-esteem and environmental factors such as peer and community that tempered or aggravated poor psychological health. These issues were reflected in a recent comparative study of the mental health of refugee children by Fazel et al. (2003). The study examined the rates of psychological disturbances in a sample of UK children who were refugees and compared them with a group who were from an ethnic minority but were not refugees and a group of indigenous white children. The results revealed that a quarter of refugee children had significant psychological disturbance, greater than in both control groups and three times the national average. As the children had only limited access to clinical services, the authors of the study were concerned that the mental health needs of this group were largely being unmet. They recommended that the development of services should include collaboration with schools, primary health care, and community child mental health teams. Indeed many other commentators have asserted that promoting physical and mental health among these children deserves special consideration, extending beyond access to services (Lynch et al., 2000; Trang et al., 2002).

A recent research study by Save the Children (2005) exploring the experiences of children, young people and parent/adult carers seeking asylum who have compulsorily located in Glasgow revealed the following findings:

- Experiences of racism at school and in their communities were reported by the majority of young people with a range of strategies to deal with it.
- Young people were aware of the financial constraints on their parents and avoided making demands on them.
- Young men in particular did not trust authority representatives such as the police, NASS and Home Office officials, due to a number of bad experiences.
- Most children and young people were taking on more responsibility within the family and were also aware of their parents having new roles.
- Children and young people refrained from telling their parents about their problems to avoid worrying them.

(I) Access to Services

According to the Audit Commission (2000) refugees and asylum seekers receive poor healthcare in the United Kingdom despite their entitlement to free NHS treatment. The Kings Fund (2000) has stressed that insufficient resources have been allocated to the NHS in the dispersal areas in order to meet the special needs of this group. A number of studies have demonstrated that asylum seekers and refugees experience particular problems in trying to access and use health services (Ramsay et al., 1993; Hergreaves et al., 1999; Barnett Refugee Health Access Project, 1995; Mojee et al., 2003; Weaver, 2003; Johnson, 2003; Kings Fund, 2000; Aldous et al., 1999; Wilson et al., 2002). They have also highlighted that GP knowledge of asylum seeker rights and entitlements is poor which has led to asylum seekers and refugees receiving an inadequate service (Ramsay et al., 1993; Hargreaves et al., 1999; Barnett Refugee Health Access Project Study, 1995). These studies also suggest that one of the biggest barriers to asylum seekers and refugees accessing primary care services is language and interpretation support (Wilson 2002; Barnett Refugee Health Access Project 1995; Weaver 2003; Johnson 2003). Some respondents in Weaver (2003) study had not received any interpretation support when attending appointments. Informants in Mojee et al. (2003) study said that not being able to read their appointment letter in their own language prevented them from accessing services. Practitioners in Johnson (2003) study felt that both the cost and availability of interpretation and translation prevented them from providing language support to asylum seekers and refugees. Participants in Weaver's (2003) study felt that there was not enough health promotion material in their own languages. This is consistent with Mojee et al (2003) study in which asylum seekers who were accessing mental health services felt that they required information on their problem in their own language.

Evidence from a number of studies suggests that many asylum seekers do not know how their health care services work. The Barnett Refugee Health Access study (1995) revealed that although many GP practices had assumed that refugees and asylum seekers had knowledge of how the health care system works, refugees in this study said that they found it difficult to register with their GP practices. Asylum seekers who were accessing mental health services in a study by Mojee et al. (2003) felt that they were unsure what treatment they would receive and what to expect when accessing mental health services.

A study by Johnson (2003) examined the provision of healthcare services for asylum seekers in dispersed areas of Bedford, Coventry, Birmingham and Leicester. The study highlighted a number of key issues in relation to bureaucracy, cost and support systems. Most healthcare providers said that their principal problems arose from the number, diversity and irregular flow of asylum seekers. Health care providers were concerned that decisions about where to disperse asylum seekers were based purely on accommodation with the capacity of healthcare services not taken into account. Those interviewed expressed the need for appropriate training and more support to help staff deal with the needs of asylum seekers and refugees sensitively. Healthcare professionals were concerned to ensure that the health of asylum seekers and refugees remained stable and felt that health promotion work would be an important way of doing that. Overall, the healthcare professionals found poor co-ordination by NASS was the main barrier to effective and efficient delivery healthcare services to asylum seekers.

It is important to note that the above study was conducted in dispersal areas within England and these findings may not necessarily translate to Glasgow. Although there has been no formal evaluation of the Health Care Services in Glasgow, Redpath (2003) claims that the system in Glasgow is rated as amongst the best in the UK. Anecdotal evidence seems to suggest that Glasgow does have a better co-ordinated approach in responding to the needs of asylum seekers and refugees. However, there still remains a gap within services in Glasgow as demonstrated by Weaver (2003) and Mojee et al. (2003).

This is further evidenced by a recent baseline study in North Glasgow (2004) which found that 26% of asylum seekers interviewed experienced difficulties in accessing a GP compared to only 5% of North Glasgow SIP residents and 9% in the whole area. Another common problem was getting access to the dentist, and 23% said that they had difficulty obtaining an appointment. This was in comparison to only 2% of North Glasgow SIP residents who cited any difficulties in accessing their dentist and 3% who found difficulties in making appointment.

(J) Methodological Issues in Researching Asylum Seekers

A number of key issues have been identified in researching the health needs of asylum seekers and refugees. Aldous et al. (1999) points out that it is difficult to assess the health needs of this group as data relating to refugee and ethnic health is incomplete. In particular, due to asylum seeker communities being so diverse and heterogeneous it may also be difficult to get a representative sample from this group. It is therefore important that alternative strategies such as name spotting, affiliation listings, snowball sampling techniques are used to access this community (Aldous et al., 1999). The issue of trust and confidentiality may also be another problem encountered when trying to engage this community in research. Aldous et al. (1999) points out that for asylum seekers and refugees suspicion is a survival skill. He suggests that it is best to use an intermediary to gain access to asylum seekers and refugees as they may mistrust the researcher. Although methods such as case studies with informants, non-probability convenience or network sample recruitment techniques might limit the generalisability of the findings, such approaches are essential for maintaining the trust of individuals concerned (Bariso, 1997; cited Aldous et al., 1999). Muecke (1992, cited Murphy Lawless) points to the ethical problem of researching refugees and asylum seekers and says that it is essential that consent to participate is truly informed and that they are no way coerced. Problems for example may arise when asylum seekers and refugees are anxious about their application or legal status and therefore may feel obliged to co-operate with officials (Muecke 1992). Issues such as drugs and sexual health may be particularly difficult to discuss with these communities, so it is essential that the methodologies developed are sensitive to that. For example, a study by the Mayisha Project (2000) on sexual health found it difficult to recruit informants from social and commercial venues as they were regarded as family orientated. This project also points out that the high mobility within these communities can also impact the research outcomes. Thomas et al. (2003) stresses that it is important that the research is sensitive to the experiences of asylum seekers and refugees.

There have been a number of studies done with the refugee and asylum seeker community, which have utilised alternative approaches in trying to engage asylum seekers in research. These include:

1. Refugees (Political Asylum Seekers): Service Provision and Access to the NHS, Newham Health Authority, Gammell et al, 1993

The main objective of this study was to discover existing patterns of health in the refugee population of Newham, to identify how refugees accessed current health care provision, and to identify unmet needs of this population. A total of 1151 people were surveyed using a networking or snowball process. This process was used because of the difficulty in obtaining names and addresses of potential respondents, without comprising confidentiality of official records. The researchers noted that only a quarter of their sample could read and write when interviewing the respondents.

2. The Mayisha Study: Sexual Attitudes and Lifestyles of Migrant Africans in Inner London, Martha Chinouya et al, 2000

The aim of this study was to assess sexual attitudes and lifestyles of migrant Africans within inner London, by using a community participatory model. In this study 17 key workers from community-based organisations were employed as part of the Mayisha research team. A total of 748 people from this community were surveyed. The research study demonstrated that involvement of the local community in the research methodology helped them to become aware of the local research priorities as viewed by the communities themselves. It also helped them obtain suggestions from the key workers as to how to access and undertake research within their communities. The key workers also helped to develop methodologies and instruments which were appropriate to the communities being studied. Although there were limitations with the study, a number of successful outcomes such as continued engagement and developing ownership of the research by the communities was achieved.

3. Black and Minority Ethnic Community Drugs Misuse Needs Assessment Project, National Treatment Agency for Substance Misuse, University of Lancashire, The Centre for Ethnicity and Health, Dr Jane Fountain, 2003

This project was commissioned by the Department of Health in November 2000 and 47 projects were selected as being representative of a wide range of ethnic groups and communities and geographical spread. A diverse range of groups responded to the call for application, including groups where there was little known about their drug use. The project outcomes as reported by the Centre for Ethnicity and Health / Department of Health reveal that a total of over 12,000 BME community respondents participated in the needs assessment. Positive outcomes from the approach were mostly in terms of capacity building both between individuals and community group. For example some of the community researchers went on to gain employment within the drugs field. The project was also successful in raising awareness with communities, ensuring there was a firm link with local commissioners and the work was not perceived as ad hoc.

4. Missed Opportunities, A Skills Audit of Refugee Women in London from the Teaching, Nursing and Medical Profession, Mayor of London & Refugee Women's Association, Hildegard Dumper, 2002

This research was initiated by the Mayor of London to identify the skills and qualifications of refugee women in Greater London. A peer research method was used for the research, where refugee women were trained as researchers to conduct the research. The authors of the research study felt that this would help to empower all the refugee women involved in the research. This methodology was successful from a number of perspectives, as the peer researchers were able to feed their own experience into the research, and help shape the methodology and access the community. The authors of the study noted how much the peer researcher's confidence and self-esteem had increased as a result of interviewing the participants.

2.4 Conclusion

The aim of this review has been to identify key issues and themes in relation to the health of refugees and asylum seekers. Although there appears to be a paucity of information in this area, a number of key themes have emerged from the selected literature. It appears that the health of refugees and asylum seekers is compromised due to a complexity of pre-migration and post-migration factors. The evidence suggests that there are a variety of issues which seem to impact on their health. These issues include:

- Experience in home country
- Language & culture
- Gender
- Attitudes to health
- Displacement
- Socio-economic factors
- Environmental factors
- Access to services
- Attitudes of host community

In particular there is a high prevalence of mental health problems which tends to deteriorate once the asylum seeker is in the host community. Again evidence suggests that this is primarily due to isolation, lack of money and uncertainty regarding asylum application. In order to progress the impact of these factors further exploration of these issues is required in the health needs assessment.

There was also evidence to suggest that asylum seekers are at risk of developing communicable diseases. Although these physical illnesses may be a result of circumstances within their own country, it appears that the experience of poverty and disadvantage in the UK further exacerbates these illnesses. The health needs assessment should therefore take heed of the impact of poverty on the health of asylum seekers and refugees. The literature also highlighted that there is a lack of information on asylum seekers and refugees who have physical disabilities. Therefore, it is important that the health needs assessment investigates the need of this group, in order that this gap in information is filled.

The review also highlighted that there is a lack of research on drugs and addiction issues within this community. Evidence from the literature suggests that it is difficult to make an accurate assessment of addiction problems within this community as the figures from drug services are not reliable and that asylum seekers and refugees are unlikely to access drug services. However, the literature suggests that asylum seeker and refugee communities are at particular risk of developing addiction related problems due to unemployment, poverty and exposure to drugs and alcohol. The health needs assessment should therefore investigate the prevalence of addiction problems within this community and related risks factors.

The literature also highlighted that asylum seekers and refugees face barriers in trying to access health services due to unfamiliarity with the NHS system, language barriers and lack of information. Further exploration of these issues is required in the health needs assessment if these issues are to be addressed at a local level.

The review also demonstrated that asylum seekers are also not a homogenous group, as they come from various countries, cultures, religions and experiences. These issues obviously have an impact on their health, however further exploration of this is required within the health needs assessment to assess the real impact of this. The literature also highlighted that there are a number of sub-groups who have particular needs. Women and children appear to be particularly vulnerable to developing both poor psychological and physical health. Therefore, to ensure that future work is targeted at the needs of these vulnerable groups, further exploration of their needs is required within the health needs assessment.

The literature also raised a number of methodological issues in researching asylum seekers and refugees. It appears that researching the health needs of asylum seekers can be difficult due to the diversity of the community and issues surrounding trust and confidentiality. Methodologies need to be developed which actively involve asylum seekers in the research in order to ensure that they are sensitive and appropriate to their needs.

2.5 Recommendations

In view of the issues raised within the review the following recommendations have been made in relation to the health needs assessment:

- Further investigation of the needs of vulnerable sub-groups such as women and young people.
- Exploration of issues such as mental health, addiction issues & access to services.
- Assessing the impact of risk factors on the physical and psychological health of asylum seekers and refugees.
- Exploring the impact of culture and religion on the health of asylum seekers.
- Ensuring issues of trust and confidentiality are addressed within the methodology.
- Developing a code of practice in researching the health needs of this group.
- Developing methodologies which are appropriate and sensitive to the community.
- Ensuring asylum seekers and refugees are consulted on the development of the research study.
- Recruiting and training asylum seekers and refugees to carry out the research study.
- Developing ownership of the research by involving asylum seekers and refugees in the dissemination and implementation of the research study.

03 RESEARCH METHODOLOGY

3.1 The Policy Context

The theme of public involvement or public participation has appeared consistently throughout government policy and legislation. In 2001 the Scottish Executive, produced a framework called Patient Focus and Public Involvement. In it the Scottish Executive states *“we want to work with the NHS to ensure that a patient focus is embedded in the culture. To make this happen we will ensure that listening, understanding and acting on the views of local communities, patients and carers is given the same priority as clinical standards and financial performance.”*

One of the more recent policy drivers has been recent Scottish Executive white paper Partnership for Care (2003), which states, *“traditional forms of consultation on options for change or service development are no longer enough”*. It goes on to emphasise the need for *“modern methods of communication and involvement to ensure that the widest range of individuals and communities affected by change are reached.”* This has also been evidenced by the development of the Scottish Health Council, which will provide greater leadership in securing greater public involvement in NHS Scotland.

3.2 Participatory Appraisal Methodology

In order to engage with members of the asylum seeker and refugee community in an effective and appropriate way it was decided to use a qualitative method called Participatory Appraisal to carry out the needs assessment. Participatory Appraisal has been described as “a growing family of approaches, methods and behaviours that enable people to express and analyse the realities of their lives and conditions, to plan themselves what action to take, and to monitor and evaluate the results (www.ids.co.uk). It has widely used in developing countries in Africa, Asia and South America and has been recently used in Europe. One of the unique aspects of this method is that the tools that it uses are visual and vocal and do not necessarily require a high level of written or language skills. Participatory appraisal activities usually take place in groups, working on the ground or on paper. Visual techniques provide scope for creativity and encourage a frank exchange of views. Due to the potential language barriers and range of formal learning levels that exist within the asylum seeker and refugee community it was believed that this would be an appropriate method to use.

3.3 Peer Research Methodology

(A) Involving Asylum Seekers and Refugees

One of the main objectives of this research project has been to increase community capacity opportunities through recruiting asylum seekers and refugees as voluntary peer researchers. It was hoped that this approach would not only develop skills and confidence in this community but it would also help to foster a process which would enable ownership of the research project and allow the peer researchers to feed their own experience into the research design and methodology.

The literature review also identified a number of methodological issues arising when trying to engage with this community, which included trust, access, language, and understanding of cultural and political issues of this community. Utilising voluntary peer researchers to carry out the research ensured that some of the barriers arising out of general mistrust of strangers and people perceived to be in authority were likely to be overcome. The steering group also felt that the asylum seekers and refugees would be more open when discussing issues with their own peers, as they would know that they have been through similar experiences. Moreover, using peer researchers would mean a reduced use of interpreters to conduct the interviews meaning that the information was richer in context and less diluted through someone else's understanding. It was also anticipated that peer researchers would be able to assist with how to best access this community and thus ensure a much more inclusive process.

(B) Recruitment of Peer Researchers

The recruitment of voluntary peer researchers took place between March and May 2004. Flyers advertising the recruitment were drawn up in the 12 main community languages and were advertised in community venues in North Glasgow and asylum seeker and refugee agencies across the city. Potential peer researchers were also recruited through the Doctors and Nurses Refugee Programme in the Scottish Refugee Council. Informal talks were also given to community groups who had expressed an interest in the research study. One of the key criteria for recruitment was to ensure that the peer researchers reflected the wide variety of nationalities and languages spoken in North Glasgow. By the end of the recruitment process 16 applications had been received from the asylum seeker and refugee community in Glasgow. The majority of applicants had been from North Glasgow, although some had applied from outwith the area. Overall 11 people were recruited, which included 6 males and 5 females. There were no applicants from the Turkish community even though attempts were made to specifically recruit from this community. By the time the training programme was to commence two of the peer researchers left, as they were unable to undergo the training programme due to other educational commitments. The nationalities of the remaining 9 peer researchers ranged from Sri Lankan (1), Pakistani (2), Somali (1), Burundi (2), Iraqi (1), Mongolian (1), Ghanaian (1). It is also important to note that 7 of the peer researchers were asylum seekers and 2 were EU nationals. However, it was decided to recruit the 2 EU nationals as they met the language requirements and it was felt that they would be able to effectively engage and empathise with the asylum seekers and refugees from the communities in which they were staying. Due to employment restrictions on asylum seekers we were unable to pay the peer researchers. Instead all peer researchers were reimbursed for any lunch and travel expenses incurred as a result of carrying out the research project.

(C) Training of Peer Researchers

The training of the peer researchers took place shortly after the recruitment process in May. Many of the peer researchers were also participating in other courses during the week, so to ensure maximum turnout the training was held on Saturdays and weekday evenings. The training was conducted and facilitated by a freelance participatory appraisal trainer (See appendix 3 for objectives of the Participatory Appraisal training).

Three separate evening sessions were also conducted on health issues and addictions awareness. This training was delivered by staff from Greater Glasgow NHS Health Board Health Promotion Team. An essential part of the training was to develop teamwork skills and for the peer researchers to develop their own peer support. The facilitation and tools used in the training session helped to inform this team building process.

Before the fieldwork commenced, peer researchers developed their own objectives for conducting the fieldwork/community work. These included:

- To enable a wide range of people from the asylum seeker and refugee communities in North Glasgow as possible to share their knowledge, experiences, ideas and opinions about their health needs.
- To encourage participants to share their ideas about what affects their health, any barriers to accessing appropriate services and suggestions for change and improvements that could be made (implicit in this is self change and service provision changes).
- To remain neutral and not raise unrealistic expectations.
- To make the experience as enjoyable as possible for all involved (asylum seekers, refugees, the community).

A key focus of the training was to raise awareness in the behaviour, attitudes and ethos of participants through practical skills sessions. The training process ensured that the trainers increased their confidence and enhanced their team working skills. The peer researchers were also asked to think about how best to reach out to the asylum seeker and refugee community in North Glasgow. In doing so they drew a timeline of the fieldwork and highlighted which groups, events and venues that they could possibly target. This process helped to ensure that the consultative process reached a cross-section of the community and groups which were not engaged.

3.4 Interviews with Asylum Seekers and Refugees

(A) The community work (fieldwork)

The fieldwork was conducted between June 2004 and November 2004. Due to the additional addiction element of the needs assessment it was decided to conduct the research in two stages as it was felt important to explore generic health needs before going on to introduce the sensitive issue of addictions. Stage 1 focused on exploring the perception of health needs and service provision in the area, and stage 2 on the perception of the area and addiction issues (see appendix 4 for PA tools used). The fieldwork was conducted at a wide variety of venues and groups, including North Glasgow International Festival, Somali Refugee Football Team, local English classes, North Glasgow Framework for Dialogue Group, church drop-ins, the YMCA drop-in and women's groups (see appendix 5 for timetable of fieldwork). The drop-ins ensured that we were able to target people who did not normally utilise formal groups. It was difficult to reach some communities particularly the Turkish community. Despite making up the largest asylum seeker community in Glasgow this group appear reluctant to participate in community groups and activities. However, through liaising with a local church group we were eventually able to access one Turkish-speaking group. Men also were a difficult group to access, as they were generally less likely to attend community groups and drop-ins than females.

(B) Facilitation

The peer researcher facilitated all interviews. Once the peer researchers explained what they were doing the participants appeared to interact well with them. Some participants mentioned to the peer researchers that this had been 'the first time anyone had asked them how they felt' and that 'participating in the research gave them hope'. The PA tools were used in one-to-one discussions or in group discussions with the participants. On a number of occasions the peer researchers had to work with interpreters, which the peer researchers found difficult. Although the participants were asked to write on the sticky notes, sometimes they were not comfortable and the peer researchers recorded their comments for them. Sometimes the participants wrote their comments in their own language, requiring translation afterwards (See appendix 6 for an evaluation by the peer researchers of the training and the fieldwork).

(C) Support and Management

The peer researchers were supported and managed by the Health Promotion Officer throughout the research project. This was done through having regular team meetings or through one-to-one meetings with the peer researchers. It was important to provide this ongoing support throughout the research project, due to the sensitivity of the issues discussed in the interviews.

3.5 Strengths and Weakness of Research Methodology

It is evident from the evaluation carried out with the peer researchers that they gained both professionally and personally from participating in the research project. Since participating in the research project, two of the peer researcher (both EU nationals) have gained employment with Greater Glasgow NHS Board. A number of the other peer researchers have gained access to volunteering opportunities within the health field through participating in the research project.

Using a peer research approach ensured the data we received was much richer in context, and helped to ensure a much more inclusive process as we were able to access members of the asylum seeker and refugee community who may not normally have participated in research. However, it is important to note that this method can be both resource and time intensive. Furthermore, there is also a risk that the community members may feel inhibited when being interviewed by their own peers, although this was not a problem which we encountered in this study.

Also due to the limitations in the study we were not able to explore all the issues and themes arising from the literature review. Any future research with asylum seekers and refugees should be able to build upon the findings of this research study with minimum adaptation to their study.

3.6 Stakeholder Focus Group

A stakeholder focus group was held with organisations closely working with asylum seekers and refugees. The focus group included representatives from North Glasgow Community Addiction Service, Glasgow Asylum Support Project, Scottish Refugee Council, North Glasgow Alcohol Project and Strathclyde Police. The purpose of this was to identify what the main health issues affecting asylum seekers and refugees were from an agency perspective and also to check the participants findings with the peer researchers. There was also a focus on their experience of addiction issues within the asylum seeker and refugee communities. Stakeholders were also asked to give their view on how services could be developed to effectively meet the needs of asylum seekers and refugees. Key issues raised have been included in the report.

3.7 Case Study Interview

In order to explore the addiction element further in the research project an interview was held with an asylum seeker who was currently accessing North Glasgow Community Addictions Team within Social Work Services. Although it was our intention to interview more clients, it appeared that at the time of interview there was only one client from that background accessing North Glasgow Addiction Services. The purpose of the interview was to gain further insight into issues that asylum seekers and refugee may face in accessing addiction services. The findings of the interview have been presented as a case study (see appendix 7).

3.8 Data Analysis

The findings from both the community fieldwork and stakeholder focus group was analysed through a thematic analysis. This was cross-referenced by using a peer review of themes, with core members analysing data elicited from the fieldwork, ensuring a consistency of themes. The peer researchers also assisted in identifying main themes arising from the fieldwork. From this cross-referencing main themes to be identified were:

- Perception of Health Services
- Mental Health Issues
- Environment & Neighbourhoods
- Addiction Issues

04 PROFILE OF RESEARCH PARTICIPANTS

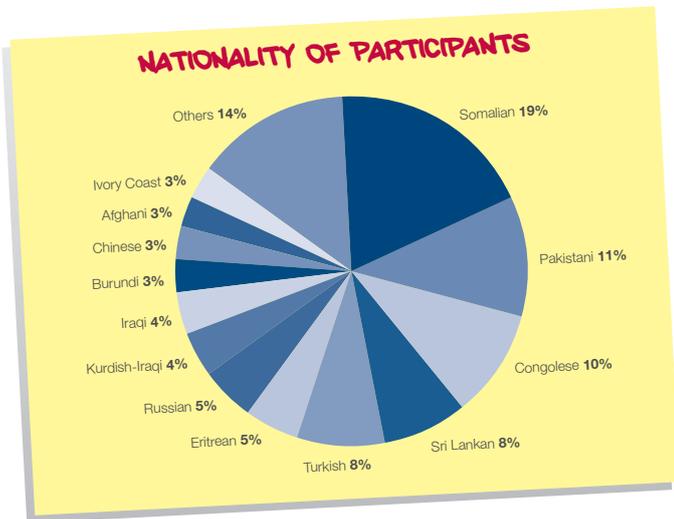
4.1 Profile of Participants

This section gives a profile of the 113 asylum seeker and refugees who participated in the research study.

(A) Nationality

A broad number of nationalities participated in the study, representing 26 different nationalities in all. The table below details the main nationalities covered.

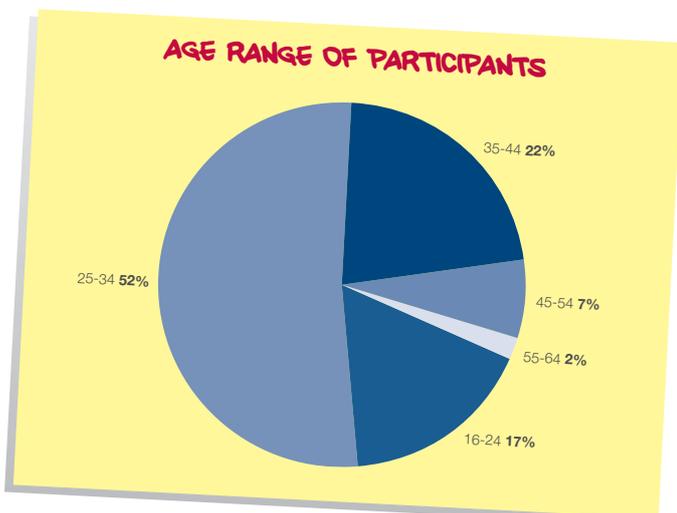
Figure 1 – Nationality of Participants



(B) Age Range

Figure 2 shows asylum seeker and refugee participants broken into age bands. Over half of those who participated were in the 25-34 year old category.

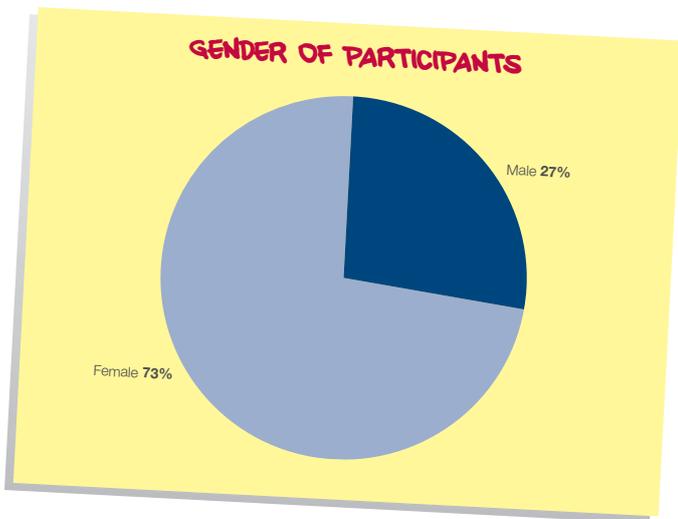
Figure 2 – Age Range of Participants



(C) Gender

The following pie-chart shows the gender split for asylum seeker and refugee participants. Overall there were far more females (73%) in comparison to males (27%) who participated in the research project.

Figure 3 – Gender of Participants



05

KEY FINDINGS FROM FIELDWORK

5.1 Perception of Health Services

This section gives asylum seeker and refugee views of health services in Glasgow. It also incorporates the views of professionals who have a remit for working with asylum seekers and refugees. These views suggest that there are considerable issues of inequality associated with use of health services by asylum seekers and refugees and there are difficulties in health service staff responding to these effectively. In response to issues raised recommendations are made to suggest how health services can become more responsive to the needs of asylum seekers and refugees.

5.1.1 Access to Primary Care Services

It is essential that asylum seekers and refugees have adequate access to primary care services as GPs co-ordinate services for individual patients and act as clinical gatekeepers to specialist services in the UK. However, the findings suggest that asylum seekers and refugees are still having difficulty in accessing GP and dental care services. This appears to be primarily due to communication barriers, difficulties in registering with a GP, attitude of staff, long waiting lists and difficulties in getting to the surgery.

(A) Language and Communication

From the views expressed by asylum seekers and refugees it was evident that access difficulties were compounded by language and communication barriers. Despite the provision of a quality assured service from Glasgow Interpreting services, this research uncovered a range of difficulties experienced by asylum seekers and refugees relating to communication difficulties. Problems arose from the point of enquiry to other subsequent stages in the process, for example some asylum seekers and refugees had difficulties in making an appointment with the receptionist due to language problems.

"It is sometimes difficult to make an appointment with the receptionist as you can't speak English, but you get there eventually."

A number of asylum seekers and refugees also complained that when they attended their appointment they had not been provided with an interpreter or that the interpreter was not able to adequately interpret in their language. This caused frustration and anger, as they were unable to adequately explain their problems to their GP to allow their problem to be effectively treated.

However, professionals in the focus group felt that interpreting provision within health services was better in comparison to other services as it was more structured, although they did stress that problems could occur especially in emergency situations. This was supported by comments made by asylum seekers and refugees who were unhappy by the delay caused by interpreters during emergency appointments.

"What I don't like about the health service is that when we have an emergency we have to wait for an interpreter."

Asylum seeker and refugees requested that 'communication services be improved' within practices. They also felt that it would be helpful if they were provided 'information in their own language'.

It is evident from these findings that barriers to access can be compounded by language and communication difficulties. Difficulties in accessing interpreting services in emergency situations can also lead to an unnecessary delay in treatment and can be frustrating both for the practitioner and the patient. It is important that these issues be addressed, as there is a danger that difficulties in communication and language may lead to misdiagnosis and inappropriate use of medication. As problems appear to occur from the point of enquiry it is important that language support mechanisms be put in place at this point, such as language line provision. Interpreting services could also be complemented by the development of culturally appropriate materials. An evaluation of interpreting services would also help to assess how well interpreting support is provided and accessed and produce wider recommendations for further language supports required to overcome any difficulties.

Recommendations:

- An evaluation is required on access and use of interpreting services within health service settings.
- Development of culturally appropriate health information.
- Exploration of possible language line provision to include provision from the point of enquiry.

(B) GP Registration

Registration amongst asylum seekers and refugees appeared to be high. However, there were a few cases which highlighted that some asylum seekers do still find it difficult to register with their GP. Reasons for not registering included not knowing where the GP practice was and that the practice was too full to take on new patients. There is a possibility that difficulties in registering may also be specific to non-NASS asylum seekers. Further exploration of this issue is required to overcome this problem.

Difficulties in registering meant that patients experienced a long delay in getting their health problems treated.

"I have a back problem, but I never saw a doctor, because I didn't know where the doctor was. I have been here a year, but I only registered last week with the doctor."

Participants indicated that although they had received their registration documents, they were not really sure what to expect when they attended their GP appointment. Some of them were not even sure where the surgery was and how they would get there. One participant said that she needed to know 'how the NHS worked' as she wanted to get the appropriate support from it.

Problems with orientation was also an issue highlighted by professionals in the focus group who felt that even though health services were co-ordinated for asylum seekers, it was still up to the individual to know how to appropriately access them. They also felt that difficulties might arise as asylum seekers and refugees can hold many different expectations of health care systems depending on their own backgrounds in the UK and that many are coming from countries where aspects of provision are better or different.

"Its all about expectations, some of these people are coming from countries where provisions are better, they work in different ways but the information is really important for awareness, at first we need to do a bit of explaining e.g. old firm game."

Difficulties also arise because asylum seekers and refugees can lack awareness of what their rights and entitlements are. In trying to address this health care providers can improve orientation to health services by providing information awareness sessions to asylum seekers and refugees. Closer links could be developed between the NHS, NASS and other key local voluntary and community organisations to disseminate this information and to ensure community-level support for asylum seekers and refugees as part of their integration into local communities. A part of the GP registration process could include direction to the health centre.

Recommendations:

- Newly arrived asylum seekers need to be provided with information on how NHS works and what their rights and entitlements are. This should also include directions on how to get to the health centre.
- Closer links need to be developed between NHS, NASS and other local community and voluntary organisations to disseminate this information and ensure support for asylum seekers at a community level.

(C) Appointments

Having to wait a long time for an appointment was the most frequently cited problem by asylum seekers and refugees. These were specifically in relation to GP appointments although some participants had also experienced difficulty in getting dentist and hospital appointments. Although appointment times appear to be a generic problem facing most people, asylum seekers and refugees felt themselves to be waiting much longer for an appointment than the host community.

"The doctor is okay when you get to see him... when you are sick you don't get to see a Doctor, it took five months before I was seen by a Doctor."

However, these delays may also be due to the fact that asylum seekers and refugees are not aware of how to effectively access the NHS. For example many of them may not be aware that in certain situations you are able to access emergency appointments.

"I had toothache and I had to wait 52 weeks for an appointment."

Participants also found the procedure for getting emergency appointments complicated and frustrating.

"Actually the problem we have is when we want an emergency appointment, it is always complicated. I mean there is a delay or something or sometimes they tell you to come back tomorrow or some other time and that is a thing which we do not like."

Difficulties in obtaining appointment times led to a perception amongst many of the participants that they were being given a lesser service in comparison to the indigenous community. It also appeared that these problems may also relate to expectations regarding the health care system, for example one participant commented that they do not have problems with appointment systems in Russia, as you are given an appointment immediately. Other participants were also not aware of how long it realistically took to get an appointment.

"I have a thyroid problem and I have been waiting 2 months for an operation."

Participants felt that appointment system should be 'reviewed' and they should 'not have to wait a long time' before seeing their doctor. It is evident from these findings there is a mismatch of expectations on how long it takes to obtain an appointment. Health care providers need to look at how can they manage this mismatch better by explaining the appointment system to asylum seekers and their inability to be seen at once does not mean that they are unwelcome at the practice or that they are receiving a lesser service. Further exploration by health care providers is also required to see why asylum seekers and refugees have to wait long periods before they are seen. This would both help clarify the issues and provide potential solutions to these. The provision of longer and quicker consultations during initial orientation might be one such solution explored.

Recommendations:

- Further information on how NHS works, in particular appointment systems.
- The provision of longer appointments during initial orientation.
- Further exploration on the length of time asylum seekers and refugees have to wait for an appointment.

(D) Travelling to Health Centre

It appeared that many asylum seekers were allocated to GP practices which were not within walking distance and as result many felt that the 'health centre was too far away' for easy accessibility. This was compounded by difficulties in accessing public transport to take them to the health centre.

"If you are late 10-15 minutes they say make another appointment and that's very hard to go by bus again and make another appointment. The local bus doesn't take a pram and that's why you have to wait in the cold again."

Asylum seekers felt that they would find it much easier to access their GP if they were allocated a practice which was nearby. Others suggested having a car or a minibus which took them directly to the health centre.

"If you didn't need to go far away for your appointment that would help."

Distance from services therefore provides a significant factor inhibiting asylum seekers from accessing primary care services. Health service planners need to review allocation of GP practices to asylum seekers and refugees as it may not always be based on accessibility, but rather is dependent on the capacity of practices to take on new patients. Transport links to health services need to be provided for all communities in North Glasgow, not just asylum seekers and refugees.

Recommendations:

- Improved transport links to health centres.
- Allocation of practices to be based on accessibility for the patient.

(E) Attitude of Staff

In addition to practical barriers in accessing primary care services other barriers appeared to be based on perceived attitudes of staff to asylum seekers and refugees. Some asylum seekers and refugees commented on the hostile reception they received when accessing their health centre. Before they were given an appointment they tended to be openly questioned about their status which made them feel unwelcome.

“Nothing is good about the health service... in front of everybody they ask you if you are an asylum seeker or a refugee, I find this offensive...”

Some positive comments were made also about health care staff, with them being described as ‘helpful’ or ‘sympathetic’ towards their problems’. Some asylum seekers also commented that they had a ‘good understanding’ with their GP. Many asylum seekers suggested that they wanted to be ‘treated equally’ when accessing health services. One participant also suggested that GPs needed training to address their negative attitude towards asylum seekers.

“The attitude of doctors should be addressed. Doctors also need to have a better understanding that they are dealing with human beings.”

It is also important that asylum seekers and refugees do not perceive health care staff as being hostile or prejudiced towards them, as it will lead to mistrust and reluctance to access health services with adverse consequences on their health. In view of the findings presented, there may be a need for frontline health care staff to attend refresher courses on how to work with asylum seekers and refugees. Current training provided to health professionals on this needs also to be re-evaluated to assess its effectiveness. Additionally refugees and asylum seeker could be used as a valuable resource for designing and delivering future training for health professionals. Health care staff also need to be better supported so that they are able to deal with asylum seekers and refugees sensitively.

Recommendations:

- Current training provided to health professionals on this needs to be re-evaluated to assess its effectiveness.
- Health care staff should attend anti-discrimination refresher courses as appropriate on how to work with asylum seekers and refugees.
- Asylum seekers and refugees should be involved in designing and delivering this training, this would also be a valuable resource, as it would help draw on their own personal experiences.

(F) Ongoing Health & Social Support

Continuity of care is essential in maintaining the health of patients. However, from the views expressed it appeared that some female asylum seekers were not aware of how to access ongoing health visiting support. This primarily appeared to be due to ignorance of how the system works. This in turn appeared to cause anxiety about the health of their children.

However it was apparent from the comments that some female asylum seekers perceived the health visiting service as being a positive aspect of the health service.

“The health visitor pays attention to our children, and that makes us happy.”

Many others felt that there was still a need for more health visitors and social workers in their area. It was evident from this that asylum seekers and refugee mothers required additional support and reassurance in how their children are developing.

The need for this additional support may relate to females within this community feeling socially isolated and detached from the host community. Therefore, it is not only important that asylum seekers and refugees are given additional information on how health visiting support operates but also that they are signposted to any other support available within the host community.

Recommendations:

- Asylum seekers and refugees need to be given additional information on how the health visiting service works and be signposted as to any other support available within the host community.

5.1.2 Quality of Care

A number of issues were identified in relation to diagnosis and treatment of conditions and their experience of secondary care services. These suggest that asylum seekers and refugees are still experiencing difficulties in using health care services. Due to the complexity of health problems suffered by most refugees and asylum seekers it is important that they are provided with a good quality of care when using both primary and secondary care services.

(A) Diagnosis and Treatment

One of the most consistent issues to be raised by participants was an apparent inappropriate diagnosis of their problem or condition. Many asylum seekers and refugees felt that they were given painkillers for their health problems; perceived by many as a quick fix solution whilst the actual problem or symptom was not being treated productively.

"I have a back problem and a leg problem and I feel that the GP does not care, he just gives you paracetamol and that does not help, I take five tablets everyday but that does not help."

Linked to this was the perception that GPs did not have enough time for them and that prescribing of medication was a quick way of getting them out of the surgery. Some participants felt that this led to their needs being misinterpreted and to misdiagnosis of their condition.

"My GP only gave me 5 minutes and when I told him my problems he only told me this answer what do you want, you want anti-depressants or anything else and then he only wrote me medicine so when I discussed my problem, your GP doesn't give time and doesn't sort out your problem."

There were also a number of instances reported by participants where no treatment had been given, leading to the view that their condition had worsened. This reinforced the perception that asylum seekers and refugees were not listened to. Many asylum seekers and refugees felt prevented from receiving specialist treatment and support. Again this led to the perception that they were not being listened to and that the doctor was not taking their problem seriously. These problems may have been exacerbated by issues around communication difficulties between the GP and patient, or by patients being given insufficient time to get to the heart of the problem. Some of the issues raised by asylum seekers and refugees are similar to those experienced by the indigenous community. However it is possible that the experience of asylum seekers and refugees is compounded by status. A minority of participants were happy with the treatment which they received, particularly the universal nature of health care in the UK.

"What I like about the health service is that it is good to get medicine without paying."

Overall, participants believed that treatment could be improved if they were given 'a chance to talk to the doctor' or that 'more time was taken to examine them'. It is important that GPs refer patients on to other services such as counselling as it may be a more effective way to deal with people's problems rather than just prescribing medicine. Patients should also be given a choice as to the types of treatment which are available, as they may not always be used to conventional forms of medicine. More culturally appropriate translated literature should be provided to give patients information on their conditions.

Recommendations:

- Asylum seekers and refugees need to be given longer consultation times.
- More referrals to other services such as counselling need to be made.
- Patients need to be informed as to what treatment options are available.
- Translated literature on common medical conditions is required.

(B) Experience of Secondary Care Services

Generally, there was not as much discussion by asylum seekers and refugees on experience of secondary care services, possibly because they had not accessed such services to the same level as primary care services. From those who did express comments on this, it appeared that there was a balance of views on their experience. Negative experiences appear related to emergency services where issues regarding their treatment, attitudes of staff and language emerged. Some had more positive experiences which related to the treatment they had received in hospital.

"The only thing I like about the health service is that my examination was very thorough and they are happy to see me again when my wife joins me."

One participant in the professionals focus group felt that in his experience asylum seekers are reluctant to access secondary care services due to a wide range of issues. He described an experience of a Kurdish male whose cousin had stitched his wounds himself rather than access emergency and accident services.

"...My cousin did the stitches here in the house... he felt that he would be left to stand in a queue, he would be disadvantaged because of his ethnicity, people would look down on him, and also it would bring shame on him as an individual within his own community if people thought he was a disorderly person who had been involved in fighting or violence or anything like that."

Some mixed views were also expressed by female participants regarding their experience of maternity services, with a few female asylum seekers commenting on how they were not given any support from some staff at the hospital and as result were left feeling quite isolated. Others had positive experiences and were happy with the care that they received from maternity staff.

"What I do like about health services is that when I had my baby the hospital took great care of me. The midwife took good care of me and that was nice."

It is evident from the comments that asylum seekers have differing experiences of secondary care services and that to some extent this may depend on what aspect of the service they are using. However, it is important to ensure that all aspects of the service are accessible and that all experiences of treatment and care are positive. Asylum seeker and refugees' experience of secondary care services is an area that probably requires further exploration. It is important that changes within primary care are also filtered up to a secondary care level.

Recommendations:

- Emergency & Accident services need to ensure they are able to provide interpretation support at a much quicker pace.
- Changes at a primary care level such as staff training, information on NHS need to include secondary care services.

5.2 Mental Health Issues

This section gives participants' views about their mental health. It also incorporates the views of professionals from the focus group discussion. Almost all participants mentioned having mental health issues making this a significant aspect of the asylum seeker experience. The discussion below highlights key issues surrounding the mental health of asylum seekers and refugees. In response to these, recommendations are made on how improvement of the mental health outcomes of asylum seekers and refugees might be achieved.

(A) Asylum Applications

As the future of many participants we spoke to depended on the outcome of their asylum case, it was not surprising that many spoke about the negative impact of their asylum case on their mental health. For the majority of participants the complexities and the wait involved appeared to cause anxiety, tension and in some cases depression.

"We have depression. We cry a lot due to our depression. Our asylum case depresses me. We feel helpless because we can't do anything about it."

Many participants spoke of the pressure that the home office were putting on them, their difficulties in getting adequate legal advice and their inability to do anything about it. It appeared that the process of claiming asylum had a disempowering role, as many were prevented from getting on with their life. Many also had a negative view of the future.

"I have depression as result of the home office decision. If home office stops support I am really worried about this, where will I go, future is very dark, so I am depressed."

Professionals too agreed that the complexities of asylum process were so great that it left asylum seekers feeling ill informed, unwell and depressed. Many asylum seekers felt that the impact of their asylum case not only affected their mental health, but also that of their children.

For many study participants, it appeared that settlement of their asylum case would help to improve their life as they felt that all their problems were due to this. Many participants felt that they also required adequate legal advice and help to see them through their case.

“Settlement of asylum process would help us all, all these problems are due to asylum process because when someone is in this process they must have tension, so I think settlement of asylum process helps the people.”

It is important that the process of seeking asylum is reviewed to make it quicker and that better legal representation be offered to asylum seekers. Professionals also need to develop holistic care packages and try to address practical problems facing asylum seekers such as their asylum case as well as concentrating on their perceived mental health problems.

Recommendations:

- The time taken to process asylum applications needs to be reviewed to make it quicker and more efficient.
- Asylum seekers and refugees should have access to adequate legal representation.
- Professionals should provide holistic care packages when trying to treat mental health problems facing asylum seekers.

(B) Traumatic Experiences

Professionals agreed that most of the families they had come across had been psychologically scarred as a result of rape, murder and torture. This was borne out amongst asylum seekers themselves, many of whom displayed physical and emotional scars.

“I have bone problems because of my body injury. I also have high blood pressure. My problems are talking inside my head, no good sleeping, stomach pains, left my family, my husband was kidnapped. ... bone problems gave me a lot of pains; a lot of people from Somalia appear to have this problem. Bullets caused my injuries and my burns caused by fire, I am crying in my sleep, I am screaming. When I wake up, I don't know what I am talking about. The doctor gave me cream for my burns. I also have problems with immigration, not treating us well, refusing us ... we need better treatment from the home office.”

It appeared that their experiences impacted on how they both perceived and presented their health problems. There was a tendency to present health problems brought on by these traumatic experiences in physical terms; such as inability to sleep, bad dreams, high blood pressure and palpitations etc.

“Low blood pressure, when I had low blood pressure I was not able to walk. I feel like lying on my bed. It is also due to depression and weakness. I have headaches. I feel there is a burden on my head, and I feel I put my head on the wall because it is so severe due to depression. I have depression, I feel alone, and darkness all around me, there is no future, negative thoughts. I don't sleep the whole night, I am so disappointed. I have an ulcer and my condition is getting worse and worse.”

It is important when asylum seekers and refugees are being treated for their problems, that GPs treat the patient in light of their whole experience. Furthermore, it should not be assumed that all ailments are a reflection of past experiences as they appear to be a combination of pre-migration and post-migration factors and they need to be appropriately treated as such. To assist in this a culturally sensitive assessment is required for treating asylum seekers and refugees for trauma to ensure that peoples own traditions are respected whilst ensuring appropriate treatments and supports are in place.

Recommendations:

- GPs and other medical staff need to ensure that asylum seekers and refugees are being treated in light of their whole experience, both present and past.
- Sensitive assessment is required for treating asylum seekers and refugees for trauma, as they may have their own culturally-appropriate way of dealing with their experience. GPs and other medical staff could be supported to gain the awareness required for this through specialist training on working with asylum seekers and refugees.

(C) Loneliness & Isolation

A number of asylum seekers and refugees we spoke to felt extremely isolated and alone. Some of them had become separated from their families back home and were worried about their well-being. Related to this was the distress they experienced as result of dislocation from their homes and cultures. Many appeared to be experiencing a culture clash, as they felt alienated from the culture and attitudes of the host community, a feeling compounded by difficulties in language and communication.

"I want to go back home, as I feel lonely here."

Many of them wanted to be housed where there were more people from their own community as they felt that they would be better supported.

"I would also like to live in area where there are more Chinese people, near China Town."

Others wanted to be near facilities such as mosques and temples so that they felt able to practice their own religion and culture.

It is evident from these findings that better mental health outcomes could be achieved by creating opportunities for refugees and asylum seekers to develop close links with their own community and the host community. Further provision for learning English is required as it is key to improving community capacity and integration.

Recommendations:

- Innovative programmes need to be developed which improve links between asylum seekers and their own communities and between host communities.
- Further ESOL provision is also required to help overcome language barriers and thus improve integration. This could be done through tools such as the Health Matters ESOL teaching pack developed by Greater Glasgow NHS Board.

(D) Unemployment

Many of the asylum seekers and refugees we spoke were highly qualified or had actively worked back home and their inability to work in the UK as asylum seekers had led to them experiencing a loss of status and self-esteem. Poor mental health was also linked to forced inactivity and dependency on benefits.

"Because I can't work, I feel stressed sitting at home all the time. Signing on is a big problem... It's embarrassing to get money."

Although there are no set restrictions on asylum seekers pursuing educational opportunities, some said that they found it difficult to access courses due to financial difficulties or lack of crèche facilities. Many female participants reported a need for crèche provision so that they could attend college or other courses within the community. Overall most asylum seekers and refugees felt that their situation could be improved if they were given permission to work. For many this was seen as a way for them to give something back to the community and to use their skills and qualifications.

"What would help me is if I were given permission to work... asylum seekers need to work at least four hours per week to exercise themselves. If I could stay, I could work and then my children would be happy."

These issues could be addressed through providing sufficient childcare support to asylum seekers and refugees. There is also a need to enhance volunteering and educational opportunities for asylum seekers, so that if they do get status they are in a much better position to secure employment. Agencies also need to look at the right to work as a holistic issue.

Recommendations:

- Asylum seekers and refugees should have access to childcare support in order to pursue further educational opportunities.
- Both educational and volunteering opportunities for asylum seekers should be enhanced.
- Agencies need to look at the right to work as a holistic issue and that it needs to be readdressed.

(E) Coping Mechanisms

Many participants that we spoke to were finding it difficult to cope with their mental health problems. Some felt that medication for their mental health problems only offered temporary relief.

"Medication deals with my problems sometimes but not all the time because when I had severe depression it doesn't help me. Staying busy also helps me to stay away from my problems, but as before when I had severe depression I don't want to do anything."

Many also said that they just wanted someone they could 'talk to' and share their problems with. It would therefore be beneficial to link asylum seekers and refugees to befriending and listening services where they exist. Service providers also need to consider holistic ways of responding to these mental health needs rather than only prescribing medication. This could be done through better resourcing of local stress centres so that they are able to respond more effectively to the needs of asylum seekers and refugees.

Recommendations:

- A holistic response is required from services to respond to the mental health needs of asylum seekers and refugees.
- Better resourcing of stress centres and Primary Care Mental Health Teams is also required so that they are able to respond more effectively to the needs of asylum seekers and refugees.
- Asylum seekers and refugees need to be linked up with befriending and listening services, to ensure that they are supported at a community level.
- Asylum seekers and refugees should be supported to enable them to act as volunteers for stress services or befriending and listening services.

5.3 Environment and Neighbourhoods

This section discusses participants views of their environment and neighbourhoods in which they were staying. It appears that poverty, racism and fear of crime characterise the experience of many asylum seekers and refugees living in North Glasgow. In response to this recommendations are made which might help to address these issues.

(A) Racism & Bullying

Racism and bullying by members of the host community was a daily occurrence for most of the participants. As a result many developed a sense of fear and anxiety about the communities in which they were staying. Many asylum seekers also felt that they needed to restrict their movements to protect themselves. They also felt too scared to go out after five in the evening. Some participants related incidents of being attacked in their own homes. Many believed that the host community did not want them to be integrated into the area.

“They start spitting at us, we walk slowly with our heads down, my daughter says she doesn’t feel safe going to the park...her hijab (scarf) was taken off. From the bus stop to the house we are scared, just a short distance. I don’t understand and why they don’t respect you, why do they call you a bitch when you are walking. You are scared going out of the house, children are hanging out of the flats like animals...some kids go about with lighters, why take the chance so we keep them indoors... living here affects your health. They call the kids black bastards...the children abuse you because they know you can’t do anything about it... parents as well. They say things will be better in three years time. Maybe all this is what is written by Allah. Sometimes you feel that you can’t live up to expectations of your daughter...we don’t want free money, we want to work, and this is what my daughter says... my health has got worse since we have got here.”

Many of the perpetrators of racism appeared to be local children and many asylum seeker and refugee parents were too scared to let their children play outside due to the risks.

“Too much time indoors gives us depression. I can’t go downstairs due to fear. You feel intimidated by local children and our children are therefore not safe. You are in high rise flats, there is no garden to relax and get some fresh air.”

The experience of racism had led to the confidence of these families being undermined and many felt too ill-equipped to challenge racism. Participants were also disturbed by the perceived racism and ill treatment they received from local bus drivers. These incidents had a negative impact on many asylum seekers and refugees who were dependent on using the bus service.

"The bus drivers do not want to stop when it is a black person and that affects me morally and emotionally."

The incidents of racism and bullying generally appeared to be specific to the Red Road and Sighthill area of Glasgow. Those asylum seekers who had been accommodated in Royston appeared to have much more positive view of their neighbourhood.

"Royston is nice, I feel safe here."

Many asylum seekers and refugees said that all they want was 'to live in peace' and they didn't want their 'children to be mistreated'. They felt that 'better police patrolling' was one of the ways of ensuring this. Others suggested better integration and understanding between themselves and the host community. They also felt that parents should be pro-active and address their children's behaviour towards asylum seekers.

"It would help if there was more understanding, mixing of people ... integration would help for example there was an African concert in School. If mothers improve, talk to their children."

In view of these findings it is essential that host communities be prepared by providing them with general information on asylum seekers. Also more creative approaches to community integration need to be developed. This could involve learning from the experience of areas where integration appears to have been much more successful. Significantly, asylum seekers and refugees perceive schooling as being a positive tool for improving integration and promoting anti-racism. Therefore, there is a need for further research on what schools are doing on integration and the impact of this. This is important, as a successful programme to challenge racism and promote community cohesion probably requires a sustained educational initiative.

Agencies with a responsibility for offering accommodation need to consider the suitability of the area before any accommodation is procured. Moreover, agencies need to work together to ensure that those who experience racial harassment are able to report incidents to police safely, and are provided with information to enable them to make full use of victim support schemes. A zero tolerance policy also needs to be adopted and promoted through the dispersal areas. Asylum seeker and refugee communities also need to be informed as to how they can use current legislation against abusive neighbours. All these issues could be addressed through developing an inclusive community safety strategy for the area; this would also ensure a partnership approach in trying to address these problems.

Recommendations:

- Further research is required on what schools are doing to promote integration and the impact of this.
- Learning from other areas where integration has been more successful.
- Asylum seekers and refugees need to be adequately supported to report racist incidents to the police.
- A zero tolerance policy also needs to be adopted and promoted in dispersal areas.
- Asylum seeker and refugee communities also need to be informed as to how they can take use current legislation against abusive neighbours.
- These issues could be addressed by developing an inclusive community safety strategy for the area.

(B) Accommodation

It was evident from the views expressed by asylum seekers that poor housing and overcrowding was felt to be having a poor effect on their physical health and well-being. They felt that their accommodation was poorly furnished, overcrowded and dirty. Some asylum seekers felt that poor housing conditions had resulted in them developing health problems such as sickness, depression and breathing problems such as asthma.

"The beds are very short and we get problems on our shoulders, and back problems and that make us depressed, because before we lived well. The bedrooms are not clean, as they do not change the sheet every week and that gives us breathing problems."

Some asylum seekers were staying in shared accommodation and they found it particularly stressful due to the lack of privacy and in some cases fear of their housemate.

"I don't like living with my housemate, her son always comes and eats my food and he is always asking me to prepare food for him. When I am sleeping the old woman wakes me up and because of this I am tired and depressed."

One of the frustrations for many asylum seekers and refugees was that they felt that nothing was done by agencies to improve their accommodation. Many asylum seekers said that they wanted to change their accommodation. It is evident from this that housing is clearly an issue which affects asylum seekers and refugees. In view of this housing providers need to assess the quality of their accommodation before it is provided to asylum seekers. Housing single asylum seekers with people that they do not know should also to be reviewed.

Recommendations:

- Housing providers need to assess the quality of their accommodation before it is provided to asylum seekers.
- The practice of housing single asylum seekers with someone they do not know needs to be reviewed.

(C) Lack of Basic Necessities

It appeared that the health of asylum seekers was negatively affected by a lack of money. Lack of money meant that they were unable to buy basic necessities such as food and electrical appliances. Many were experiencing levels of poverty which placed them at the very margins of society.

"The benefits do not provide enough for eating, travelling, clothing. If we get something to eat the money finishes."

Participants reported difficulties in sustaining themselves on the benefits which they received and said that if they spent their money on food they didn't have money for anything else. These problems led to feelings of dependency and lack of control over their lives. Some also felt inadequate, as they weren't able to sufficiently provide for their children. Many felt that their situation could be improved if they were able to work. Some felt that life would be easier if they had basic necessities such as a washing machine and a Hoover.

"What would help me is if I was allowed to install a landline phone and it would be cheaper and much easier to make our appointments with our solicitor and doctor. If I could get a washing machine, it would be a lot easier to cope with the washing."

As current NASS support (70% of income support) appears to be insufficient to support health and well being a review of current benefit legislation is required. The right to work for asylum seekers as a holistic issues needs to be reviewed. There is also a need for more locally funded poverty prevention projects to tackle poverty issues within asylum seeker and refugee community.

Recommendations:

- A review of benefit legislation for asylum seekers is required as current NASS support (70% of income support) appears to be insufficient.
- The right to work for asylum seekers as a holistic issue needs to be reviewed.
- There is also a need for more locally funded poverty prevention projects to tackle poverty issues within asylum seeker and refugee communities.

(D) Support from Agencies

Another theme to emerge was that many asylum seekers felt that little support was given to them when they reported a problem or when they requested help from agencies. The majority of these related to problems which they were having with their accommodation. Some felt that services overall were not adequately provided for them because they are asylum seekers and refugees. This led to disillusionment with service providers as asylum seekers felt that they were not responsive to their needs.

"The area is very dirty, services are not provided for us in good way, because we are asylum seeker and refugees. There are insects in my house and the officers don't do nothing about that."

However some did comment that they had received support from local community organisations and this had been very helpful and they needed more services like these. Asylum seekers and refugees also said that they just wanted to be treated equally and felt that there should be specific workers within the community to support asylum seekers and refugees. Many felt that as a community they should be enabling and supporting each other better.

"What I would like is the community helped each other, for example there was a young boy here and he was homeless and mentally upset and we put a small sum of money in to help him."

The views expressed by professionals in the focus group also highlighted that asylum seekers and refugees were still having problems accessing and integrating themselves into services. Many professionals felt that they sometimes did not have the resources or the capacity to overcome some of the barriers that asylum seekers and refugees faced. Due to the diversity of these communities some of them were just focusing their work on one or two communities, realising that it was at the expense of other community groups.

"Because there is only limited resources available and so much time you can devote, we're trying to work with SACRO at the moment, but we can't be dealing with them and be dealing with the Kurdish community, Somalian community or whatever, there is only 3 of us and I think most organisations are the same."

They also felt that constant changes in government legislation appeared to hamper this process. To ensure that agencies are able to better respond to the needs of asylum seekers they should be provided with proper support and training to understand the impact of legislation on the asylum seeker and refugee communities. Agencies should also be allocated sufficient funding and resources to undertake work with this community. A community development approach should be used when working with asylum seekers and refugees, to help ensure their fullest participation and to strengthen their ability to influence changes in service provision.

Recommendations:

- Training should be provided to all local agency staff. This training should focus on values and attitudes.
- Agencies in dispersal areas should be provided with sufficient funding and support in order to undertake work with asylum seeker and refugee community.
- A community development approach should be used enabling asylum seekers and refugees to influence changes in service provision.

5.4 Attitudes and Experience of Drugs and Alcohol

This section reports asylum seeker and refugees perception of drug & alcohol use within their own community and the communities in which they live. Views expressed by professionals in the focus group are also incorporated into this section. It highlights that although problematic drug and alcohol use is low amongst asylum seeker and refugee community, they are vulnerable to developing such problems. In response to this recommendations are made to address this.

(A) Prevalence of Drug Use

The views expressed by asylum seekers and refugees suggested that there was very little direct experience of drug and alcohol use within the asylum seeker and refugee community itself. Any real indication of drug use came from the Somali community, where there appeared to be a prevalence of khat use amongst Somali men. It is worth noting that Khat was not perceived to be a 'drug' by many people in this community, an attitude similar to that held by many of the indigenous community about cannabis and alcohol for example. The only other information regarding drug use came from a participant who was worried that her son had a drug problem, but she was too scared to seek help. Although this is only one incident it does highlight that drug use is still perceived as being taboo and that those who develop a problem may not necessarily know how to seek help. This may be because it is perceived to be shameful from a cultural and religious perspective within these communities.

"There is nothing to be happy about. My son is so depressed and I think he has a drug problem and I don't know who to talk to about it."

There were some indications of alcohol use amongst asylum seekers, however on the whole it appeared to be low and not problematic.

"Some Muslim people drink a little but they don't harm anyone."

This may indicate that exposure to alcohol may be influencing consumption. There is also a possibility that due to religious reasons there may be a underreporting of this issue. Levels of consumption within asylum seeker and refugee communities where alcohol is not forbidden also needs to be further explored.

Overall, the majority of participants did not think that drugs and alcohol was a problem which existed in the asylum seeker and refugee community, but in the indigenous white community in which they were staying. Some cited religion and/or culture for not participating in drug and alcohol use.

"I don't think there is a drug and alcohol problem. I am Indian so I don't have anything to do with drugs."

Professionals felt that problematic drug and alcohol use was an issue that they were recently coming across in the asylum seeker and refugee community. Again incidences of khat appeared to be well-documented among the Somali community, although it had not manifested into a policing problem. Some professionals said that they were coming across cannabis use amongst young asylum seekers and the problem was quite widespread.

Professionals also reported clients who appeared to be adversely dependent on prescribed medication. The high prevalence of mental health problems does suggest that dependency problems may exist amongst this community or at least that they may be vulnerable to developing such problems. It is likely that many asylum seekers that we spoke to did not perceive prescribed drugs used as something on which they could become dependent.

In view of these findings it is important that there is general targeting of information to appropriate communities such as the Somali community where specific drug use is reported. Asylum seekers and refugees should be made aware of drug and alcohol services in the area and that they operate a confidentiality policy. To support these activities it is important that agencies should also be aware of the specific types of drugs within the asylum seeker and refugee community. The issue of addiction to prescribed medication also needs further exploration to assess the extent of problem. Also due to the vulnerability of this community developing mental health problems a holistic and culturally appropriate approach is required to treating their mental health problems, rather than prescribing medication as the sole treatment option.

Recommendations:

- Targeting specific communities with addiction information appropriate to them.
- Alcohol and drug agencies need to be made aware of specific types of drugs within asylum seeker and refugee communities.
- Asylum seekers and refugees need to be made aware of drug and alcohol services and that they operate a confidentiality policy.
- Further exploration of addiction to prescribed medication within asylum seeker and refugee communities.
- A holistic approach is required to mental health problems within asylum seeker and refugee community, rather than prescribing medication.

(B) Exposure to Drug and Alcohol Use

Although there was very little direct experience reported it appeared drug and alcohol use was something which most participants were exposed to on a daily basis in the host communities where they lived. Many had witnessed their neighbours drinking or buying drugs from dealers. Some related incidents of being physically attacked or verbally abused by their drunken neighbours. This exacerbated their concerns for their personal safety and that of their children.

"There are many problems linked to drugs and alcohol and one of my neighbours had been frightened by this. There are people who take drugs and alcohol who come and knock at our doors and this really scares us. A drunk person has already attacked me while coming out of church and nobody came to help me."

"I have seen one of my neighbours give a syringe to another person and they gave them money. My neighbours always drunk and sometimes shouts at me."

The substantial presence of drugs and alcohol in their community meant that many asylum seeker parents were concerned about the influence it might have on their children. Due to the sheer size of the problem, many were concerned that their children may think that it is normal behaviour and as a result start to experiment with drugs and alcohol. Although some parents said that they knew what some of the drugs are, many others were concerned that they might not always recognise them if their children started taking them.

"I don't know what all the drugs are... this is concerning in terms of my children... one of my friends she lived in Italy and she started smoking in front of her mum but her mum didn't know what the drugs are."

Professionals also felt that parents were lately becoming concerned about the influence of drugs and alcohol on their children. However they felt that it was positive that parents were becoming aware of this problem and wanted to make sure that it was prevented.

"Yesterday I was speaking to some representatives from the black community and they are telling me that a lot of parents up there are concerned that their kids are starting to become involved in cannabis abuse, alcohol abuse, smoking, things like that, which in their country of origin had not been involved in, but due to the situation they find themselves in here and there's a real concern amongst the parents about that."

Professionals felt that exposure to drugs and alcohol is most likely to effect young asylum seekers and refugees as they will be under a lot of pressure to fit in and are desperate to have friends. However some professionals felt that the strong family structure within asylum seeker communities might prevent young people from developing a problem. They however realise that this wouldn't apply to unaccompanied asylum seekers.

"I do personally feel that parents are too scared to let their children at 16, 17 out of the house, there's maybe a wee bit more control there with parents."

Professionals felt that it was important that prevention work be done to ensure that the problem didn't escalate. They felt that asylum seekers and refugees were very vulnerable to developing a problem due to the circumstances that they found themselves in.

Most asylum seekers and refugees in the study felt that the best way to receive information on drugs and alcohol would be through their GP or their children's school. Others suggested that they would like someone to speak to them in their own language about drug use. Participants also suggested more visual methods such as drama and films to educate them on the dangers of drug and alcohol abuse.

“The best way of getting information and advice about drug and alcohol related problems would be through creating social activities where they can be active and can have plays and music on the subject and talk about it.”

As drug and alcohol awareness was low amongst asylum seekers and refugees it is important that both parents and young asylum seekers are targeted with information on the dangers of drug and alcohol use to help protect and prevent use. Again this could be done through more visual and interactive ways as mentioned above, rather than simply leaflets. Service providers and policy makers also need to address the potential risk factors which may lead to asylum seekers and refugees developing a drug or alcohol problem. Further targeted support is also required for single asylum seekers, they are more isolated, and without the same family support and may be more at risk of becoming involved in drug and alcohol use.

Recommendations:

- Drug and alcohol awareness is low amongst refugee and asylum seeker communities and more targeted information is required.
- Service providers and policy makers need to address the potential risk factors which make asylum seekers and refugees particularly vulnerable to developing a drug and alcohol problem.

(C) Addiction Services

Asylum seekers and refugees were generally not aware of addiction support and treatment services. Many said they would go to their GP if they had an addiction problem. This was consistent with the views of professionals who felt that asylum seekers and refugees who might be suffering from drug and alcohol abuse may be prevented from accessing addiction services.

“Because the way the services are designed, they are designed on a standard model, kind of mainstream, which is not going to be appropriate for everybody.”

They also felt that many asylum seekers were finding it difficult to access mainstream health services and that they face additional barriers in accessing specialist addiction services.

“I’m not intending to be critical any way of the health service but I think it’s just the way its set up there’s no doubt there’s difficulties for people to access mainstream health care let alone a specialist addiction care.”

Notably, some professionals working in the addiction field did not feel adequately prepared to work with the asylum seeker and refugee community. They felt that they did not have the language skills or the cultural understanding to respond appropriately and suggested that training for workers was required to address this issue.

“Equality issues have certainly been high on the agenda, but from the workers’ perspective you still don’t feel adequately prepared to approach, you don’t have the language skills or the understanding or awareness of cultural issues, when you don’t have that you feel unable to respond appropriately and I think that’s a training and development need for workers.”

In view of these findings it is important that asylum seekers and refugees be made aware of drug and alcohol services within their community. Agency workers also need to be provided with training on working with asylum seekers and refugees so that they feel competent in dealing with their needs.

Recommendations:

- Agencies need to be provided with training on working with asylum seekers and refugees, with a specific focus on drug types within this community.
- Asylum seekers and refugees need to be made aware of drug and alcohol services within their community.

5.5 Conclusion

It is evident from the research findings that asylum seekers and refugees experience an extreme level of health inequalities. Despite the diversity that exists in the asylum seeker and refugee communities there appears to be a number of issues which are specific and common to the experience of the asylum seeker and refugee communities in the North Glasgow area.

By far the biggest health issue is the high prevalence of mental health problems within this community. Although to some extent these are a manifestation of their pre-migration experience, it is evident from the findings that they are compounded by situational factors which asylum seeker and refugees find themselves in their host country. One of the main issues appeared to be waiting for a decision regarding their asylum case, which not only causes anxiety and stress but also has a disempowering role as many asylum seekers felt that they were not in control of their lives. If the home office processed asylum cases at a much swifter pace then this would help to alleviate this problem.

Staying at home all day and not being able to work also distressed many asylum seekers. Agencies therefore need to look at the right to work as a holistic issue and readdress it. The distress caused by dislocation was another problem as many asylum seekers and refugees felt isolated and cut off from their own communities and cultures. Better mental health outcomes could be achieved through improving links between them and their own communities and with the host community.

During their pre-migration experience many asylum seekers had suffered traumatic experiences. However they tended to describe these in physical terms such as lack of sleep, ulcers, and high blood pressure. It is therefore important that GPs treat their problems in light of their whole experience. Culturally sensitive assessments are also required as many asylum seekers have their own culturally appropriate way of dealing with their experiences.

Many asylum seekers and refugees were finding it difficult to deal with their mental health problems and felt that it would help if they could speak to someone about these problems. It is therefore important that asylum seekers have access to listening and befriending services at an early stage or their condition may deteriorate.

There is also a need for service providers to deal with the practical problems facing many asylum seekers and refugees such as the asylum case and not being able to work, as well as dealing with the symptoms of the mental health problem. This would involve providing a much more holistic care package and developing further inter-agency working to help reduce pressure on local GPs and resolve high use of prescribed medication within this community.

Another disabling factor was the fear and lack of safety in the communities where they live. Many asylum seekers and refugees had received a hostile reception from members of the general community and felt that they were not wanted in the area. For many racism was a daily occurrence and this had led to their confidence being undermined and many feeling too ill-equipped to challenge it. It is important that agencies work together to develop an all inclusive community safety strategy for dispersal areas.

The health of asylum seekers and refugees was exacerbated by poor housing conditions. A number of asylum seekers and refugees said that they had developed problems such as asthma since living here. Others felt sick at living in accommodation which was overcrowded and poorly furnished. Asylum seekers should be housed appropriately and should be provided with adequate and good quality housing. Many asylum seekers and refugees were living below the poverty line and reported not being able to afford basic necessities. As we are aware of the ill effects of poverty on health it is important that there is a review of benefits received by asylum seekers.

Through its co-ordinated approach, Primary Care Services in Glasgow have been successful in facilitating access to its services, particularly in comparison to health services within other dispersal areas. However, despite this it appears that refugees and asylum seekers face a number of difficulties in accessing health care services. These ranged from difficulties in accessing language support, transportation problems, attitude of staff and awareness about how the health care system works. It is important to note that the issues raised by asylum seekers and refugees are similar to those highlighted by the indigenous population. However, from the findings of the research it appears that their experiences are further compounded by their status and a lack of awareness of how the NHS works. This lack of awareness has led to a mismatch of expectations of the NHS. The NHS could manage this mismatch better through improving orientation to its services for asylum seekers and refugees.

Overall, there appeared to be very little evidence to suggest that there is problematic drug and alcohol use amongst the asylum seeker and refugee communities. There was some evidence to suggest that there is use of the drug khat within the Somali community and recently some cannabis use amongst young asylum seekers and refugees. Professionals have also suggested that some asylum seekers and refugees may be addicted to prescribed drugs due to the high prevalence of mental health problems within this community. Many parents appeared to be aware of the high prevalence of drug and alcohol use in their neighbourhoods and were concerned that their children would be at risk of developing a problem due to their exposure. This was reiterated by professionals who felt that if prevention work was not done at this stage the problem might develop among these new communities. It was also felt that the high prevalence of mental health problems and marginalisation of these communities might also make them vulnerable to developing such problems. Many asylum seekers and refugees appeared unaware of drug and alcohol services. Professionals working in this field felt that asylum seeker and refugees were prevented from accessing their services and they did not feel they were adequately prepared to deal with an influx of referrals from these new communities. It is important that prevention work is done with asylum seekers and refugees at an early stage to combat any potential problems. Asylum seekers and refugees also need to be made aware of drug and alcohol services within their area and agencies provided with training on how to work with them both in treatment and in prevention.

It appears that asylum seekers and refugees experience a multitude of problems, which prevent them from promoting their physical and mental well-being. The complexity of seeking asylum, poor living conditions, lack of money, racism and lack of control over their future appear to manifest themselves in many ways, particularly in mental health problems. Problems such as these could make asylum seekers and refugees more vulnerable to developing other health related problems including drug and alcohol related issues. It is therefore important that service providers address problems facing asylum seekers and refugees through a much more holistic and needs led approach. There is a need for service providers to ensure that intervention and prevention work with asylum seekers is done at an early stage to avoid any potential health related problems in the future. Community organisations also need to support the integration of asylum seekers and refugees in the community, as this integration is key to promoting their health and sense of well being and belonging.

One of the aims of this project was not only to gather information, but also facilitate a process which built trust and capacity with the asylum seeker and refugee communities. The peer researchers felt that they had benefited enormously by taking part in the project and felt they had gained new skills and they were able to use these in accessing further employment (see appendix 6 for full evaluation). All agreed taking part in the research helped them overcome their own problems and helped to increase their confidence. Since taking part in the research project two of the peer researchers have gained employment with Greater Glasgow NHS Board. Many of the others have started doing voluntary work in the community. The peer researchers have been a valuable resource to the research project, and without them we would have not been able to gain the same insight and depth from the fieldwork as we did. This approach also highlights the value in involving asylum seekers and refugees in projects such as this; not only does it empower them, it also helps to address the complexities arising from the diversity within this group. If agencies want to genuinely enhance the lives of asylum seekers and refugees then they should see them as a resource, rather than a problem and pro-actively involve them in their work.

5.6 The Way Forward

In response to the key themes identified from the research, those working with asylum seekers and refugees in the future should address the following action points:

- A NHSGG targeted action plan is required to tackle the main issues which impact on the health of asylum seekers and refugees. This should be part of the approach to reducing health inequalities in Greater Glasgow. A multi-agency working group is required to implement and monitor progress of this plan and should have a strong focus on developing a holistic approach to healthcare provision for asylum seekers and refugees. Mental health should be a core part of this plan.
- Community Health and Social Care Partnerships need to actively ensure that improving the health of asylum seekers and refugees is on their local health agendas.
- Healthcare providers need to ensure that strategic policies and processes aimed at improving the health of asylum seekers and refugees are acted upon at a local level.
- Community development approaches to improving the health of refugees and asylum seekers are also required. This needs to empower asylum seekers and refugees by directly drawing on their experiences and knowledge.
- There should be a stock take of asylum seekers/refugees in Glasgow, e.g. number of positive decisions etc to inform future planning needs.
- A co-ordinated approach is required between agencies to improve community integration between asylum seekers and refugees and the host community.

The above action points should always be based on consultation, integration and working with asylum seekers and refugees as a key resource.

06 APPENDICES

APPENDIX 1

LEGISLATION	WELFARE IMPLICATIONS
The Asylum and Immigration Appeals Act 1993	<ul style="list-style-type: none"> • Introduced the first changes which really affected local authorities, as it introduced a stricter test to assess whether homeless asylum-seekers were eligible for council housing
The Asylum and Immigration Act 1996	<ul style="list-style-type: none"> • Excluded asylum-seekers from any entitlement to local authority accommodation under homeless legislation. • Excluded access to child benefit, housing and other social security benefits from 'in-country asylum-seekers' and those who had had their initial claim refused • From October 1996 all asylum-seekers were prevented from claiming: child benefit, family credit, disability living allowance, disability working allowance, severe disablement allowance or attendance allowance • Excluding asylum-seekers from benefits was reported to have left 35,000 asylum-seekers destitute many of whom sought support from Local Authorities
The Immigration and Asylum (1999) Act	<ul style="list-style-type: none"> • The cost and responsibility of supporting asylum-seekers transferred from mainstream benefits to local authorities • Created the National Asylum Support Service (NASS) – asylum-seekers to receive 70% of income support and an offer of accommodation from NASS • Introduced 'no-choice' dispersal where asylum-seekers were dispersed to different parts of the country to alleviate the 'burden' on local authorities in the South East • Extended powers of search and arrest and detention • Introduced a controversial voucher scheme, which was withdrawn by the end of 2002 as a result of protests against it • Removed any separate right of appeal against deportation and introduced a bond scheme (later withdrawn) to guarantee the return of visitors to their own country
The Nationality, Immigration and Asylum (2002) Act	<ul style="list-style-type: none"> • Set up a system of induction, accommodation and removal centres • Introduced measures to tackle people trafficking and illegal working • Obligated Local Authority staff to report any failed asylum seeker who attempts to claim community care provision • Debarred children in accommodation centres from accessing mainstream education services • Introduced citizenship pledge • Section 47 excludes accompanied asylum-seeker children from receiving support under Section 25 of the Children (Scotland) Act 1995 • Section 55 states that in order to be eligible for NASS support, asylum-seekers must apply for asylum as soon as reasonably practicable. This provision has led to a number of asylum-seekers being destitute
The Asylum and Immigration (Treatment of Claimants, etc.) Act 2004	<ul style="list-style-type: none"> • Section 2 – made it a criminal offence to enter UK without a passport • Section 9 – withdrawal of support from failed asylum-seekers and power to local authorities to remove families who refuse to co-operate with removal instructions • Section 10 – 'hard Case' support for asylum-seekers who have exhausted their appeal rights • Section 12 – removes right to reclaim 30% backdated benefits withheld whilst awaiting claim outcome • Section 26 – creates single tier appeals structure, thus reducing the appeal rights of asylum-seekers • Section 36 – allows for electronic monitoring of asylum-seekers over 18

APPENDIX 2

Minority Ethnic Research Strategy Group Ethical Guidelines for Researching Minority Ethnic Communities

Background to Ethical Guidelines

The Race Relations (Amendment) Act (2000) widened and extended the anti-discriminatory provisions of the 1976 Race Relations act to the Police and other public authorities. It also added a new enforceable duty to key public bodies to promote race equality. In addition, Fair for All (2003) emphasised the need for a strategic approach to minority ethnic health and to provide local evidence regarding the health needs of minority ethnic groups.

In response to this the Minority Ethnic Research Strategy Group formed in order to develop a strategy for NHS partners to initiate and support research activities on minority ethnic communities¹. Due to the growing level of community based research being carried out, the Minority Ethnic Research Strategy Group has developed ethical guidelines for researching minority ethnic communities within Greater Glasgow.

The purpose of these guidelines is to ensure that culturally sensitive research strategies are developed which reflect the values and merit the trust of the minority ethnic communities being researched. While the remit of these guidelines is specifically for health it does not preclude other organisations from using them.

Core Principles

There a number of ethical principles that should underpin the conduct of all research undertaken by NHS Glasgow and its partners:

1. No Harm to Individuals

Researchers should take care to ensure that participants are not harmed as a result of participating in the research study.

Researchers should take appropriate measures to ensure that the privacy of participants is not invaded.

Researchers should be aware that some groups may be sensitive to certain issues and should therefore ensure that the research experience is not a distressing one. If issues are addressed that could lead to distress, then steps must be in place to minimise this.

2. Confidentiality & Anonymity

Researchers need to ensure that they maintain the confidentiality of the research participants².

Researchers need to ensure that individuals are not identified or identifiable when publishing research findings.

When research involves multiple participants, researchers must take precautions to ensure that confidential information about one participant is not revealed to another.

Specific consideration should be given when using peer researchers and interpreters in minority ethnic communities as some of these communities tend to be small.

¹ For the purpose of these guidelines minority ethnic communities will refer to people from the South Asian, Chinese, Black African, Black Caribbean, Gypsy Traveller and Asylum Seeker and Refugee Communities as these communities are designated within the remit of the Minority Ethnic Research Strategy Group. However, these guidelines are likely to be appropriate to groups not listed here.

² In certain circumstances confidentiality cannot always be guaranteed if there are circumstances where the potential for future harm is revealed. If so, this should be addressed in the information sheet.

3. Informed Consent

Researchers should provide participants with as much information as might be required to make an informed decision as to whether or not they wish to participate in a study. Researchers should consider issues around minority ethnic groups such as literal translations (see language below) and power issues.

4. Deception

Researchers and their collaborators should not deceive prospective participants about any aspect of the research study³.

Additional Considerations

When conducting research with minority ethnic communities the following issues should also be taken into consideration:

1. Understanding Race, Ethnicity & Culture

Researchers must be clear about the minority ethnic community being studied. Prospective interviewers should be appropriately matched where possible to the community being studied, as it may be improper to mix age, gender, ethnicity or religion. Researchers should consider implications of inter-ethnic and intra-ethnic mixing, particularly in focus groups.

2. Learning & Experience

Research teams need to ensure that have the cultural competency necessary to conduct research with minority ethnic communities.

3. Culturally – Sensitive Methodologies

Researchers need to ensure that appropriate and culturally sensitive methodologies are employed to research minority ethnic communities. Researchers should endeavour to actively involve the community being studied in the development of the research. Researchers should be aware of the potential impact of sensitive topics on the community being researched. Researchers should be non-judgemental and objective at all times.

4. Language Requirements

Information about the study must be explained either in verbal or written form in a language understood and preferred by prospective participants. Researchers should ensure that translated versions of consent forms are available. When necessary, researchers must use the services of interpreters who have the language and knowledge competencies necessary to ensure consent is informed, rational and voluntary. All research instruments should be translated into appropriate languages. Adequate provision must be made so that data collected in any language or dialect is not misrepresented, misinterpreted or interpreted (as opposed to translated) at the point of recording. Researchers should never use family members for interpretation purposes, especially children.

³ There are cases where it could be argued that accurate information cannot be gained without deceiving participants. However, the need for this information should be carefully weighed.

5. Remuneration

Researchers need to carefully consider the appropriate compensation for participants contribution and make sure that it does not affect their legal status for example in the case of asylum seekers.

6. Findings

When reporting their research findings, researchers should avoid using devaluing, racist or insensitive terminology.

Researchers should consider the appropriateness of generalising findings from one minority group to another.

Researchers should also be aware that findings from one minority ethnic group might not necessarily translate to a similar minority ethnic group in a different location.

7. Dissemination

Researchers should disseminate the findings to the wider community being studied, ensuring that it is presented in the relevant languages/formats.

The research findings should be disseminated to relevant organisations and agencies that have a remit for the community being studied.

These guidelines are not intended to replace any existing guidelines for conducting research. As a matter of fact, these guidelines draw heavily on pre-existing ones. Nevertheless, considering the amount of work planned regarding minority ethnic health research, we felt it was necessary to write down specific ethical considerations that may arise when conducting research with minority ethnic groups. We recognise that these are broad in nature but believe they form the basis for conducting ethically sound research with minority ethnic groups.

APPENDIX 3

Objectives of Participatory Appraisal (PA) Training

- Provide the participants with the background to the principles and some methods associated with PA.
- Provide the participants with the skills to use PA to conduct a real life participatory community engagement process for groups/individuals identified by the participants and project as relevant.
- Enable the participants to reflect on the strengths and weaknesses of PA, and the principles of PA process design
- Enable the participants to analyse the potential for, and ways to overcome the constraints to, using PA in the project
- Participate in the planning, implementation, and reporting of a PA exercise within the asylum seekers and refugee communities of North Glasgow
- Have the opportunity to analyse and reflect upon the use of PA within this project and how they might use the methods within their own area or setting (capacity building)

APPENDIX 4

Participatory Appraisal Tools

During the fieldwork four main PA tools used were:

H-Diagram

Respondents were given a flip chart paper, with the letter H drawn on it. On one side of the letter was a happy face and on the other side was a sad face. For the happy face they were asked to write on a pink sticky-note what they liked about the health service and for the sad face they were asked to write on a blue sticky-note what they didn't like about the health service. These were then appropriately placed on each side of the diagram. On a yellow sticky-note participants were asked to write what should be changed or improved about health services. This was then placed in the middle of the diagram.

Body Map: Health Issues

Respondents were given an outline of a body. They were then asked to write on a blue sticky-note what health problems they had and place them on the body. They were then asked to write on a green sticky-note how they cope with these health problems and place this next to the blue sticky-note. Finally they were asked to write on a yellow sticky-note what would make their health better for them and place this on the body also.

Mapping: Perceptions of Area & Addiction Issues

Respondents were given a map of their local area, with pictures of their local flats, shops, schools etc on it. On a pink sticky-note they were asked to write what they liked about their area and on a blue sticky-note they were asked to write what they didn't like about the area. Participants were then asked to write on a yellow sticky-note what they would like to change about their area. The mapping exercise was also used to explore addiction issues in the communities. Participants were also given trigger cards on drugs and alcohol, to stimulate discussion on this issue.

Venn Diagram: Addiction Issues

Participants were given a flipchart with a circle on it. In the middle of this circle a picture of drugs and alcohol was placed on it. If the participants felt close to the issue they were asked to place a sticky-note near the circle, if they didn't feel that close to the issue they were asked to place the sticky-note further away from the circle. They were then asked to record why they did or didn't feel close to the issue.

APPENDIX 5

Timetable of Community Fieldwork

GROUP/VENUE	DATE
North Glasgow International Festival	Saturday 12th June
St Rollox's Church	Tuesday 16th June
Operation Reclaim	Tuesday 22nd June
Tron St Mary's Church	Wednesday 23rd June
YMCA	8th July
St Mungo's Church	Tuesday 13th July
Framework for Dialogue Initiative	Wednesday 21st July
Rosemount Flexi-Centre	20th August
Red Road Women's Centre	1st September
Refugee Football Team	Friday 10th September
Rosemount Flexi-Centre	Thursday 7th October
St Rollox's Church	Tuesday 12th October
YMCA Glasgow	Wednesday 13th October
Red Road Women's Centre	Wednesday 3rd November
Somali Women's Group	Monday 8th November
Framework for Dialogue Group	Wednesday 24th November
Turkish Group, Tron St Mary's	Thursday 15th December

APPENDIX 6

Evaluation of Training & Fieldwork

During the fieldwork a half-day evaluation took place with the peer researchers. This was to assess and discuss how the peer researchers found the fieldwork so far and what they could improve.

After the fieldwork was complete the peer researchers took part in an evaluation of the training and fieldwork. The main purpose of this was to bring the peer researchers together to share, reflect, and record their experiences of undertaking the research project.

The peer researchers felt participants were very receptive to the PA approach, because they felt that it was *'not official'*, it was *'comfortable'* and that it gave respondents an opportunity to *'come out with their own views'*. Furthermore, they felt that the PA tools worked well because it *'helps to focus on the issues of mental and physical health'* and *'helped people to talk about these issues'*. They also said that *'asylum seekers and refugees are used to forms and these open methods worked much better'* and *'helped people to engage'* with process. They did feel that it was difficult to work with interpreters and that it was better to have direct contact with the participants. They suggested that maybe interpreters should be trained in PA methods and have it as a resource in the future.

The peer researchers made many comments on how the participatory appraisal training and community work has helped them. Listed below are some of their comments:

Future Skills

- "Using PA in other areas i.e. in research project and community health project."*
- "Having been involved has given us our dignity, confidence to go onto other things."*
- "Gave me more skills to get a job."*
- "Exposed me to more job opportunities to do community work."*

New Skills

- "Geography skills & mapping exercise of getting around Glasgow helped me to getting around Glasgow, helping me to get to know the place better and know more about organisations."*
- "Communication skills."*
- "Team work – learnt a lot about group work."*
- "Increased tolerance."*
- "Experience of communicating with people in this project will be helpful in the future."*
- "How to cope with peoples feeling."*
- "Overcame a fear of going out and talking to people."*

Benefits of Participating

- "Confidence, ability to do more in the community."*
- "Hearing other people's problems make you appreciate your own."*
- "I was very depressed but being part of this project, it changed by attitude and behaviour."*
- "Network of friends."*
- "Made me feel more equal."*

Value of Approach

- "Importance of doing things for/with people."*
- "How important it is to involve people in the changes they want in everyday life."*
- "Diversity and real beauty in listening to people, not telling them."*
- "Get more from the PA than straight interviews."*

APPENDIX 7

Case Study of a North Glasgow Addiction Service User

X is 38 years and is seeking asylum from Iran. Although he is seeking asylum, he recently got married to a Scottish girl, which makes his case a little more complex. He was referred to North Glasgow Social Work Addiction service through his GP and has been attending for the last 18 months. His drug use developed in Japan where he started smoking opium. When he was in Japan he says he was not taking a lot of opium, however since he came here he has been taken more as he has felt 'sad and alone' and he has had problems with his asylum case. He says that the pressure of his asylum case has made him feel suicidal:

"Having to go to court, having no evidence and getting the letter made me feel like killing myself. They always say I am lying; I would rather kill myself because I know my country. This country knows Iran, but they never believe my story. It is not paradise here, but having to go to Iran would be very hard."

He feels that the service he has received at addiction services has been good and his drug worker listens to him, however he feels that they do not have much power and authority to help him. His drug worker has recently arranged for him to get his methadone from the chemist every two weeks, this he feels is helpful, because he is ashamed of his problem and it means that people, especially his wife's family are less likely to see him. He says that he knows of another asylum seeker from Iran who is smoking opium and self-harming, because his wife is hiding in Iran and he hasn't seen her in three years. X says that asylum seeker and refugees are "not happy about smoking, some only smoke because they are sad and upset."

07

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