Engage Project:

Breaking barriers and improving access to healthcare services for new & emerging communities.

PROJECT & CONFERENCE REPORT

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Preface

Engage (New and Emerging Communities):
“Engage, Challenge, Support”

Breaking Barriers and Improving Access to Healthcare for New & Emerging Communities.

The Engage Project is a time-limited initiative in response to the considerable challenges health service professionals are facing in meeting the health needs of an increasingly diverse population, and the difficulties encountered by people from new and emerging communities in accessing healthcare services.

The Project is funded by Heywood, Middleton and Rochdale Clinical Commissioning Group (HMR CCG) and aims to work with new and emerging communities, in particular refugees and asylum seekers, to raise awareness and promote access to health services. More specifically:

- Identify the needs of these communities and any gaps in service provision;
- Investigate whether (and how) these communities are engaging with health services or other service providers.

That is, identify the barriers they face in accessing services, and explore the following issues:

- **a)** Are service pathways obvious or easy to navigate?
- **b)** Language and interpretation needs
- **c)** How the experience and expectations associated with their status (new and emerging communities) can act as an additional barrier.
- **d)** Explore how best to engage effectively with these communities, and identify best practice to inform culturally sensitive service provisions.

The Project seeks to **engage** with new and emerging communities, **challenge** the barriers and stigma often associated with poor access and take up of services, and **support** people with knowledge and understanding of available services and how to access them.

The Project adopts a partnership approach in identifying the barriers in accessing healthcare services for Refugees and Asylum Seekers. It works with individuals and organisations who are
aware of the cultural needs and barriers that these communities are experiencing, and attempts to engage individuals in:

- **Identifying the barriers to accessing health services**
- **Identifying the needs people have for health care services / wellbeing**
- **Increase awareness of health services and how to access them**
- **Suggesting how to plan and deliver health services in new and emerging communities that are culturally sensitive, responsive and accessible.**

**Deliverables:**

The Project delivery plan includes:

- Six focus group sessions with individual targeted community groups
- Individual case studies of experiences accessing health care services.
- Deliver one awareness event (conference), specifically targeted at new and emerging communities and those who work with or support them, with the aim of:
  - Addressing issues around access and barriers to health services.
  - Increase awareness of health care services and pathways across the borough of Rochdale.
  - Identifying how to plan and deliver health care services with new and emerging communities that are culturally sensitive.

**Specific Health outcomes:**

A number of health outcomes have been identified, including:

- More awareness/understanding in new and emerging communities, in particular with refugees and asylum seekers, to reduce the pressure of stigma and lack of awareness for individuals which will lead to more people seeking help at an earlier stage.
- Reduce crisis situations developing
- Better assessment outcomes and treatment for individuals through effective communication and engagement – at primary and secondary care level.
- Health services developing more culturally sensitive approaches to meet the needs of these communities.
- Better engagement with health services to facilitate diagnosis and treatment (e.g. early diagnosis), and improve access to services - especially at primary care level

The Project aims to meet the following HMR CCG Strategic Objectives:

- **Strategic Objective 5:** To increase the number of people with mental and physical health conditions having a positive experience of hospital care and care outside of hospital (including General Practice and the Community).
- **Strategic Objective 7:** To develop integrated working and partnerships to ensure the best possible care for the borough.
- **Strategic Objective 8:** To be a high performing CCG, deliver our statutory duties and use our available resources innovatively to deliver the best outcomes for our population.

The Project also aims to meet the following local priorities – as outlined in the Locality Plan:
• **Programme 1: Prevention and self-care.** The project will improve and increase ease of access to preventative services, and help people from new and emerging communities feel more confident connecting with health and wellbeing services and networks.

• **Programme 2: Getting help in the community.** Ensuring that people with multiple and complex conditions (especially refugees and asylum seekers), are aware of, and able to receive coordinated and proactive help and support.

• **Programme 5: Mental Health.** Whilst many people from new and emerging communities, especially refugees and asylum seekers, may well arrive in the UK in relatively good physical health, health problems, including mental health, can rapidly develop whilst they are in the UK as a result of:
  - Difficulty in accessing healthcare services;
  - Lack of awareness of entitlement;
  - Problems in registering and accessing primary and community healthcare services, particularly if their claim has been refused;
  - Language barriers.

The project will seek to ensure that clear pathways to accessing mental wellbeing services are embedded in any programme of support with new and emerging communities. This will include using Five Ways to Wellbeing as a framework for prevention and sustainable recovery; ultimately leading to a reduction in the number of people accessing mental health or crisis services.

The project will also support the integration of new and emerging communities (including asylum seekers and refugees), enhance mental wellbeing.
Acknowledgements

We wish to express our thanks and appreciation to all delegates and representatives from the organisations who attended the conference and took part in the focus groups. We would also like to thank the following organisations for their contribution and assistance:

1. NHS HMR Clinical Commissioning Group
2. Castlemere Community Centre
3. Mind
4. NHS England
5. Nestac
6. British Red Cross
7. New Life Christian Fellowship, Rochdale

All keynote speakers and workshop leaders at the conference held on 17th May 2017:

- **Sally McIvor**, Integrated Commissioning Director, HMR CCG Trust, who gave the opening address ‘
- **Abdi Gure**, Somali Advocacy Worker, Mind in Harrow, who spoke on the theme "Health needs of refugees & asylum seekers, and implications for healthcare providers”
- **Peggy Molongo**, Cross-Cultural Mental Health Practitioner, Nestac, who spoke on 'Supporting people from new & emerging communities: Model of good practice from Nestac”
- **Estelle Worthington**, Regional Activism Co-ordinator North West, who addressed the “Barriers to Healthcare”
- **Phil Burton**, Engagement Lead, NHS HMR Clinical Commissioning Group, who facilitated the workshop on "Local services response: Working together to identify strategies to improve pathways for healthcare.”
- **Emily Danby**, Bridging Cultures Coordinator, Mind in Harrow, who facilitated the workshop on: 'Barriers to accessing healthcare: Overcoming the language barrier, stigma and taboo, and impact on mental health.”

All delegates and staff from Rochdale and District Mind who helped to make the conference happen on the day, and to make it a most successful and enjoyable occasion for everyone.
Executive Summary

1. Introduction

1.1 Engage Project: a time-limited initiative, funded by HMR CCG, in response to the considerable challenges health service professionals are facing in meeting the health needs of an increasingly diverse population, and the difficulties encountered by people from new and emerging communities in accessing healthcare services.

1.2 The Project adopted a partnership approach, working particularly with refugees and asylum seekers in identifying the barriers to accessing healthcare service. More specifically, existing needs and any gaps in service provision, and the barriers they face in accessing services.

1.3 The Project worked with individuals and organisations to draw on their knowledge and awareness of the cultural needs and barriers that these communities are experiencing, and engaged individuals, through selected Focus Groups discussions and a one-day conference, in:

- Identifying the barriers to accessing health services
- Identifying the needs people have for health care services / wellbeing
- Increasing awareness of health services and how to access them
- Suggesting how to plan and deliver health services in new and emerging communities that are culturally sensitive, responsive and accessible.

1.4 As well as meeting a number of HMR CCG strategic objectives and local priorities, a number of specific health outcomes were also identified, such as

- More awareness/understanding in new and emerging communities, in particular with refugees and asylum seekers, to reduce the pressure of stigma and lack of awareness for individuals which will lead to more people seeking help at an earlier stage.
- Reduce crisis situations developing
- Better assessment outcomes and treatment for individuals through effective communication and engagement – at primary and secondary care level.
- Health services developing more culturally sensitive approaches to meet the needs of these communities.
- Better engagement with health services to facilitate diagnosis and treatment (e.g. early diagnosis), and improve access to services - especially at primary care level.

2. Project Analysis.

2.1 Seven focus groups were held with participants to explore a range of issues impacting on their ability to access services across the Borough of Rochdale. A set of questions was used to engage participants in discussing their experiences of accessing healthcare services, their knowledge and understanding of the process, and what alternative arrangements they made to overcome any barriers or challenges they face. In addition, five one-to-one interviews were also held to explore individual experiences of accessing health care.
2.2 Over 60 people participated in the focus groups, which were held at various venues across Rochdale and at times to maximise attendance – including a Friday evening session at New Life Christian Fellowship Church, and a Saturday morning session at Castlemere Community Centre.

2.3 Participants also contributed to two case studies - drawing specifically on personal lived experiences. These are included in the main body of the report.

2.4 Profile of participants

2.4.1 Age and gender of participants: Sixty people took part in the focus groups, of which more than two thirds were female. The majority of respondents were within the age cohort 35–44 (30%, N=18), with those between 25-34 years old accounting for 27% (N=16), and those 18-24 years old, accounting for 18% (N=11).

2.4.2 Ethnicity of participants: The largest group that took part in the focus group were Black Africans, accounting for 45% (N=27), followed by those who described themselves as Arab, accounting for 22% (N=13); this category also include people from Syria, Iraq and Kurds. The third group of participants from ‘Any other Ethnic Group’, accounts for 13% (N=8), mostly of Iranian background.

2.4.3 Sexual orientation of participants: Ninety-three percent (N=56) of participants described their sexual orientation as heterosexual, and 6.7% as ‘questioning or unsure.

2.4.4 Health condition or disability of participants: Participants were asked whether they had any long-term health condition or disability, 78.3% (N=47) said they had ‘none;’ 8.3% (N=5) said they were experiencing a mental health condition (including long-term depression or stress), and 3.3% were experiencing a physical disability.

2.4.5 Religion or belief of participants: Participants were also asked about their religion or belief; 53.3% (N=32) said they were ‘Christians’, with 41.7% (N=25) say ‘Muslim’ and 4% saying they had no religion or belief, or preferring not to say.

2.4.6 First and second language of participants: Arabic was the first spoken language of the majority of focus group participants, followed by English. In terms of second language, English was stated for 41.7% of participants, followed by French (23.3%). The vast majority of participants (38.3%) stated English as their preferred language for receiving information; this was followed by Farsi and Arabic – both 6.7%.

3. Focus Group Summary Feedback and Analysis

3.1 Focus group sessions were held at various venues in Rochdale between February and May 2017. Participants were present with a set of questions about their experiences of accessing health care services in Rochdale. A summary of their responses is given below:

3.2 Questions about participants’ knowledge and understanding of health and wellbeing, and entitlement:
  - Some participants were accustomed to paying for health are in countries such Albania and Iran, and where access is often quicker.
• Most participants were generally aware of the range of health services available in the community, but some were unsure how to access them.

• There is a sense of the need to maintain one’s physical and mental wellbeing, but mental health was often viewed with stigma and cultural taboos. For example: not recognising or accepting that there is a problem, or anyway out: “I'm finish,” is how one might react to a diagnosis.

3.3 Questions about health seeking behaviours: How they currently access health services:

• For some, when confronted with health issues, “We just get on with it;” soldier on.

• Stigma and cultural taboos have a significant impact on families. Witchcraft is seen as a possible cause for serious health problems.

• Calling '999' in a crisis was seen by some as the most preferred option, or going to the GP – depending on the nature of the crisis.

• The out of hours GP service was not widely known, and waiting times can be onerous for some. Similarly, the lack of cultural sensitivity in dealing with patients.

3.4 Questions about difficulties experienced in accessing services and support. Whether the pathway is obvious, or clear to navigate.

• There is some awareness about the type and range of NHS services available, and the navigation pathways. However, some people were less clear about how to access services in an urgency, or where these services are based.

• One participant noted that the process for accessing services has become more complicated, due to the changes in some service provisions, and that there is a tendency to cancel your appointment, if you are running late. Another commented on the lack of flexibility for emergency appointment.

• Lack of language support at GP surgeries remain a profound problem for some; where this is provided, the service is sometimes poor and lack cultural sensitivity.

3.5 Questions about barriers encountered when registering with GPs and dentists

• “System is too rigid, I was struck off for missing one (dental) appointment.”

• Main barrier is language; makes it harder to get an appointment

• Had to take daughter to A&E when the ambulance took some time to arrive; I have never received information in Albanian about what to do when your child is ill.

• Some of us learned about registering with the GP from the Asylum Team at Serco...; but those of us who came before Serco did not receive any information from any organisation. We learned through friends.

3.6 Questions about communication: receiving information.

• I don’t speak good English but I should receive some care and respect.”

• We don’t know how to complain if we have had poor experiences health services. For example there is a receptionist at the GP service that is racist towards me. I don’t know what I can do with this.

• Information must be relevant; any leaflets must be on specific issues; via GP surgeries; Internet; Training / events; Word of mouth

3.7 Questions about Resilience and default mechanism: things that help their wellbeing.

• Work, Faith, Shared experiences
• Family – extended family especially, which gives a notion of community and a sense of belonging.
• Employing the five pillars of “Five Ways to Wellbeing.”
• **Default practices / alternative approaches:** When a health crisis arises, the tendency is to try and access emergency support from a GP or even A&E. When this is not available, or difficult to access the alternative is generally a resignation to the problem and just “Get on with it,” as one participant puts it.

3.8 Case Studies

3.8.1 Case Study 1: Male, age 22, Asylum seeker

**Q 1:** What is your knowledge and understanding of health and wellbeing?
When I arrived to Rochdale I didn’t know anything about the healthcare services. I was only told how to register with the GP that’s why I struggled a lot with booking an appointment; after that things became easier with time. I suffered many times with depression during the three years I’ve been here and I didn’t know what to do until things got serious and I tried to end my life. My mother told me about Mind Wellbeing Centre.

**Q 2:** Health seeking behaviours / How do you access health services in Rochdale?
Through GP, Dentist, Accident Emergency and Raid Team – mental health services

**Q 3:** What difficulties (If any) have you experienced in accessing services and support in Rochdale, are pathways obvious and clear to navigate?
I had some difficulties in booking appointments with the first GP because the line is always busy. But when I changed, the other GP sorted this problem. …lots of people are facing problems with the language as they aren’t English speakers.…

**Q 4:** Communication: How would you like to receive information about health services?
By Post

**Q 5:** Have you resulted in using: Cultural practices in meeting your health needs?
Yes, a little herbs for the stomach.

**Q 6:** If you had an ideal pathway or way of delivering health services what would this look like?
They should hire volunteers from the local community who could share the same language with the refugees or asylum seekers, and help them register with any of the health services they need.

3.8.2 Case Study 2: Male, age 28, Asylum seeker

**Q 1:** What is your knowledge and understanding of health and wellbeing:
The health services I had back home is different than here in the UK. For example, back home we did not call to book an appointment. We had two separate papers to submit to the office at the health centre. After that we could see a doctor straight away. There is more to say about the different between our health centre at home and now.
Q 2: Health seeking behaviours / How do you access health services in Rochdale?
Access health services in Rochdale by GP

Q 3: What difficulties (If any) have you experienced in accessing services and support in Rochdale, are pathways obvious and clear to navigate?
I had difficulties the first time I came to Rochdale to find a GP, but at last I found one through my house officer at SERCO. She gave me the address of the GP as well as the registration form.

Q 4: Communication: How would you like to receive information about health services?
I would like to receive information about health services by letters, if it is possible.

Q 5: Have you resulted in using: Cultural practices in meeting your health needs?
Yes, a little herbs.

Q 6: If you had an ideal pathway or way of delivering health services what would this look like?
The health service I am getting now is much better.

3.8.3 Case Study 3: Female, age 42, Asylum seeker

Q 1: What is your knowledge and understanding of health and wellbeing
I didn’t know about the services when I arrived in the UK. My manager told me about the GP and before eight months, booked appointment with Mind when she saw my situation. I was depressed and wasn’t feeling well.

Q 2: Health seeking behaviours: How do you access health services in Rochdale?
GP Service, urgent care, hospital and Psychiatrist

Q 3: What difficulties (If any) have you experienced in accessing services and support in Rochdale, are pathways obvious and clear to navigate?
It is not easy to see the GP when you need it; I mean my GP, you need to book appointment on the same day, but not every time I asked I got it.

Q 4: Communication: How would you like to receive information about health services?
By post or SMS

Q 5: Have you resulted in using: Cultural practices in meeting your health needs?
Yes, a lot because even when I go the urgent care centre they give me paracetamol for everything and it’s not all the time, so I prefer to use some herbs at home for stomach or cold and flu.

Q 6: If you had an ideal pathway or way of delivering health services what would this look like?
More stuff to covering all patients; more GP appointments
3.8.4  **Ralph** (Not his real name): **Age 37; from Sudan (refugee seeker)**

I came to England two years ago. The health service here is strange. I was told I can go to the doctor whenever I need to. Though I have only been to the doctor once since I came. That was the first time I went to register. They asked me questions, took my temperature and other measurements. Then they said everything was ok. They also took some bloods and said if there was anything problem they will call me. Since then I have not heard from them. I have not gone back to see them because I have not been sick...

The hospitals here and the doctors are good; ......healthcare here is definitely better than back home. I have a doctor but no dentists.

My health is ok. Things have not been easy. I have not been sick but sometimes I get headaches. But I think it is after the drinking. I drink every evening, and I smoke too. Well, I don't work and don't go to college so me and my friends we come to NESTAC when they're open, use computers and then go back home. We play cards and buy drinks and cigarettes. We talk about home and the war and family. You know?

Sometimes we try not to sleep at night because of the dreams. The bodies of people, especially the women and children and all the animals. Sometimes when I talk about it I can smell everything. It is not good. Makes me sad.

I have not seen a doctor or anyone to talk about these dreams. For now, I don't think I want to talk to anyone because some people will start thinking I am crazy... I don't need medicine but if I do I will go to the hospital. That's no problem.

I have no problems using services in Rochdale...I think I am a strong person. My family is Christian so I think that helps me. I believe that things will get better. Yes, very hopeful... I survived war in Sudan I can survive UK...

3.8.5  **Tim** (Not his real name): **Age 28; from Eritrea**

I came to England last year. I spent three months in London and then was sent to Liverpool before being sent to Rochdale... When I came to Rochdale I registered with a GP, which was strange to me that everybody has a doctor. It was a good thing because back home to see a doctor was very difficult. Though consultation was free, paying for medicine was expensive. Here consultation and medication is free...

I was diagnosed with post trauma [Post Traumatic Stress Disorder] by doctors in London. So I have medication from my doctor to help me sleep and also medication that I take when I go out, especially during the day time when I have to meet new people. I have panic attacks especially when I hear loud sudden noises. I also panic when I see police cars or people in uniform...

I don't have any health problems, except when I have panic attacks I have headaches. Or when I have nightmares too, I wake up sweating. The medication is helping....

The doctor and the NHs have helped me. So if I pay taxes and stay healthy they can be able help somebody else who needs help.... I don't have any problems going to hospitals... I don't go to accident and emergency. If I need help I go the doctor or sometimes I go to pharmacy and ask the pharmacy man what medication I can buy, if it is not expensive... The services I have used are good. There's nothing I want to change.
4. The Conference

4.1 The conference was attended by 80 delegates from Rochdale and partner organisations across Greater Manchester.

4.2 Conference: Profile of participants

4.2.1 Gender of Participants
Of the 80 people who attended the conference, only 40 (50%) completed the participant profile. Of these 67% were female.

4.2.2 Age of Participants
The majority of attendees fall within the age cohort 35–54, representing 57%, with those between 25-34 years old accounting for 18%.

4.2.3 Ethnicity of participants
Of those completing the profile questionnaire, the largest group that took part in the conference were those describing themselves as White UK and any other White background, accounting for 75%. The other 25% were those from Black, Asian and minority ethnic (BAME) backgrounds.

4.2.4 Sexual orientation of participants
Ninety percent of participants described their sexual orientation as heterosexual, and 7.5% not answering this question or ‘Prefer not to say.’

4.2.5 Health condition or disability of participants
Participants were asked whether they had any long-term health condition or disability, 75% said ‘none or prefer not to say;’ 15% said they were experiencing a mental health condition (including long-term depression or stress), and 10% were experiencing a physical disability or other experience of disability.

4.2.6 Religion or belief of participants
Participants were also asked about their religion or belief; 42.5% said they were ‘Christians’, with 45% saying they had no religion or belief, or preferring not to say.

4.2.7 Language of participants
English was the first, second and preferred spoken language of the majority of conference participants, and may have to do with the high percentage of those describing themselves as White UK/any other White background.

4.3 Conference Evaluation and Feedback

4.3.1 The feedback was overwhelmingly positive and encouraging (see feedback evaluation below; p.41). Some key discussion points from delegates and keynote speakers:
- In regard to mental health, people are being sectioned much earlier than they need to, and not getting the care they need.
- Gatekeeping in general practice remains a major issue regarding poor registration.
"The need for better information in understanding how the NHS will support people to register with a GP (Comment from delegate)."

- Lack of awareness as well as social and cultural factors tend to reduce help seeking behaviours.
- The need for a bilingual health advocate (cultural broker), or bridge between the two value systems;

**4.3.2 Language barriers faced by new arrivals and refugee communities when accessing public services:**

**a.** The following quote from one of the presentations highlights the serious language barriers people often face in accessing services:

"I asked if I could be referred to a Dari speaker so they could understand my issues better, but they referred me to an English speaker.

I went to the counselling sessions but it didn’t make much difference because I couldn’t explain everything. There was no interpreter... It was a waste of time because we couldn’t understand each other. This went on for a year."

**b.** Factors contributing to mental health stigma within refugee and migrant communities also featured throughout the focus groups sessions, and included comments such as:

- "If he is mentally ill he can never recover"
- "I’m finished"
- “It probably runs in the family”

Beliefs about what causes a mental health issue include Jinn possession, Saya and curses. These beliefs and myths about mental health often go unchallenged within a community.

There is therefore a feeling of being judged or labelled in the community if it was known that one was accessing mental health services. Such perceived negative attitudes act as another barrier and prevent or delay early and appropriate help seeking responses from a GP or other healthcare professionals. The default response is quite often treatment from spiritual healers, either locally or abroad, which is seen as a more effective solution. When a crisis occurs, presentation of the problem is often to A&E; at times to a GP.

**4.4 ‘Feedback from Table-top Discussions:**

**4.4.1 A** number of table-top discussions were held during the conference on a range of issues relating to healthcare pathways for refugees and asylum seekers. See below:

**a. Developing local services & responses:** "How can local agencies/organisations create a healthcare pathway for new & emerging communities that is culturally sensitive and responsive?"

- Know your demographic
- Co-production model – listening to issues
- Knowing/finding out about what barriers people face
- Developing and maintaining relationships with service users
b. Developing local services & responses: How do we help frontline services to better understand the range of issues asylum seekers and refugees may present with and provide better care?

- Training for organisations
- Finding out what services need to deliver to new and emerging communities
- Ensure providers are up to date with legislation
- Champions for the community to ensure their voice is heard

c. Breaking Barriers, Improving Access (1): What do you think are the barriers currently faced by people from new & emerging communities in accessing healthcare services; and what are some of the ways in which services can become better at responding to their needs?

- Recommendations – take opportunities to inform men/women about GPs, Walk-in and A&E. How to access them and enabling action by keeping them informed.
- Understanding of local area
- Complex, medical jargon, language barrier

d. Breaking Barriers, Improving Access (2): If language is one of the barriers that prevent people from new & emerging communities accessing healthcare services (and services generally), what are some of the ways in which services can become better at responding to their needs?

- Pictorial representation
- Simple pictures to make text more accessible
- Short paragraph saying 'hand this in to the Doctor or Dentist'
- Animated version of leaflet – speaks over recording in relevant language

e. Breaking Barriers, Improving Access (3): In the Focus Group Sessions with Refugees & Asylum Seekers, men were less likely to visit their GP. Some also raised concerns about the lack of clarity regarding access to interpreting and translation services when they visited their GPs, or getting services elsewhere in the community.

What can service providers do to encourage more men to access healthcare / general services in the community?

- Male role model
- Homes/family – build relationship even to extended family before men/trust
- Listening and talking

f. Breaking Barriers, Stigma and Cultural Taboos: People experiencing certain health conditions such as mental health and dementia sometimes lead to stigma, embarrassment and social isolation, and a reluctance to seek help; adopting instead the default position of 'tried and tested' cultural practices.

How might service providers tackle the issue of stigma and cultural taboos, and promote wider access to healthcare services?

- Reframing the language of mental health
- Present mental health in a more positive way
• Community engagement and relations
• More visible and accessible services
• Building capacity within communities (champions)

g. A Responsive Service (1): What would be an ideal healthcare service for new and emerging communities, including refugees & asylum seekers?
• For various groups to be involved
• To educate service providers and communities about good practice and entitlement until there is no inequality or stigma in healthcare

h. A Responsive Service (2): In the Focus Group Sessions with Refugees & Asylum Seekers, some participants believed faith played a major role in their recovery and wellbeing, and social networks also helped keep them well.

How can service providers tap into this resource to improve access to and take up of healthcare / general services in the community?
• Translators, interpreters
• Friendly GP’s and receptionists
• Simple language – visual aids, less lingo, user led diagrams
• Sensitivity to culture
• Awareness of Asylum procedures – the stress of this procedure
• Champion for Rochdale
• More bilingual peer mentors or befrienders – connectors

4.4.2 Summary of key discussion points:
5. Conclusion

1.1 Both the focus group sessions and conference have been very successful in capturing a good amount of data to make an informed judgement on the experiences of people from refugees and asylum seekers background, accessing health care.

1.2 Although most people stated their first language as Arabic, the majority stated English as a second language, as well as their preferred language for receiving information.

1.3 The majority of respondents (78%) stated that they had no long-term health condition or disability (including mental health). It is not clear whether this is a reflection of stigma and fear.

1.4 Most people have a fairly good knowledge of the health service, but not a good experience of it. Some viewed going to the GPs or hospital as unfriendly, lacking cultural sensitivity. Several participants have not heard of the ‘Out of Hours GP Service.’

1.5 There is a strong desire to maintain health and wellbeing, but discussions about mental health were often viewed with stigma and cultural taboos.

1.6 Access was, perhaps, the most used word in the Focus Group discussions. It surrounds the difficult people experienced getting to their GP, Dentist, or some other health service provision. For some, the pathway was unclear in a crisis, and the frequent changes made it even more difficult to know what is available or what your entitlement were. Where language is a barrier, it was even harder to get the right support when needed.

1.7 To maintain health and wellbeing, in the face of poor experience and access to health care services, people did not so much default to cultural practices, but indulged in a wide range of other activities. These include work, faith-based practices, or maintaining a sense of community and belonging with family.

1.8 There are several examples of people getting a good service from their GP or hospital, or another health professional. Yet, equally, there are also several examples where the same experience has not been positive for others.

1.9 Specific pointes noted by delegates and keynote speakers:

1. "I asked if I could be referred to a Dari speaker so they could understand my issues better, but they referred me to an English speaker.

2. The lack of understanding and the stigma attached to mental illness may prevent people from seeking help.

3. Language barriers, including the lack of professional interpreting services, may prevent people from receiving information about what is available and how to access help.

4. The need for better information in understanding how the NHS will support people to register with a GP (Comment from delegate).”

5. "I asked if I could be referred to a Dari speaker so they could understand my issues better, but they referred me to an English speaker.

6. The need “COMMUNITY CHAMPIONS,” to help improve access.
7. Health professionals must have an awareness of and sensitivity to the different cultural practices and spiritual beliefs that shape a person’s health and wellbeing.

1.10 This is a small population with very high needs, and it is important to recognize this as a key inequality issue that requires specific support and resources.

2. **Recommendations: Next Step Forward**

2.1 There seem to be a general need to work with other frontline services to help improve the experience of people from new and emerging communities, especially refugees and asylum seekers accessing health care services. A next step forward would be to set up a Task and Finish Group to lead this.

2.2 Community health champions were frequently cited as a way forward. This should be encouraged, with people within the refugees and asylum communities recruited to help raise awareness and improve access.

2.3 Training for frontline health professionals, including GPs and surgery/health centre staff would help to improve cultural understanding and sensitivity.

2.4 A programme of ongoing access to health care awareness is critically needed to ensure everyone can access services when needed, especially in times of crisis.

2.5 A programme of mental health awareness training, targeted at refugees and asylum seekers, is necessary to help tackle the evident stigma and taboo that prevent many from seeking help before a crisis occurs.

2.6 Refugees, asylum seekers and vulnerable migrants tend to present with complex issues – medical, psychological and social – as a result of experiences in their home country, and the process of adapting to life in the UK. Where language is also a barrier, it will require longer appointment times.

2.7 Patients from refugees, asylum seekers and vulnerable migrant communities be made more aware of their right to request a phone interpreter for appointments with healthcare professionals: this should always be offered at the time of making an appointment when it is clearly needed, including offering a choice of gender of the interpreter.

2.8 Similarly, patients should be informed of their right to make a complaint, if they are unhappy with any aspect of the service, and the procedure for doing so.

2.9 These recommendations will require resourcing of some sort, and HMR CCG must recognize the level of commitment and investment needed in order to meet the specific health outcomes identified in this report.
1. **Introduction**

1.1 Two main approaches were adopted for understanding the barriers faced by refugees and asylum seekers in accessing healthcare services. These were (1) Focus group setting, with participants drawn primarily from new and emerging communities, and (2) a conference type event, with participants to include frontline staff and organisations working with people from new and emerging communities.

1.2 Seven focus groups were held with participants to explore a range of issues impacting on their ability to access services across the Borough of Rochdale. A set of questions was used to engage participants in discussing their experiences of accessing healthcare services, their knowledge and understanding of the process, and what alternative arrangements they made to overcome any barriers or challenges they face.

1.3 Over 60 people participated in the focus groups, which were held at various venues across Rochdale and at times to increase attendance. For example, one focus group session was held at New Life Christian Fellowship on a Friday evening, at the end of their prayer Service. Another session was held on a Saturday morning at Castlemere Community Centre.

1.4 A number of 1:1 interviews were also carried out, from which some cases studies were drawn to look specifically at individual lived experiences, and explore any barriers to accessing health care. Profile and responses are given below:

2. **Focus Groups: Profile of participants**

2.1 **Gender of Participants**

Of the 60 people who took part in the focus groups, more than two thirds were female; see below:

**Fig. 1: Gender**
2.2 Age of Participants

The majority of respondents fall within the age cohort 35–44, representing 30% (N=18), with those between 25-34 years old accounting for 27% (N=16). The next significant age group were those 18-24 years old, accounting for 18% (N=11).

2.3 Ethnicity of participants

The largest group that took part in the focus group were Black Africans, accounting for 45% (N=27), followed by those who described themselves as Arab, accounting for 22% (N=13); this category also include people from Syria, Iraq and Kurds.

The third group of participants from ‘Any other Ethnic Group’, accounts for 13% (N=8), mostly of Iranian background.

2.4 Sexual orientation of participants

Ninety-three percent (N=56) of participants described their sexual orientation as heterosexual, and 6.7% (N=4) as ‘questioning or unsure.’

2.5 Health condition or disability of participants

Participants were asked whether they had any long-term health condition or disability, 78.3% (N=47) said they had ‘none;’ 8.3% (N=5) said they were experiencing a mental health condition (including long-term depression or stress), and 3.3% were experiencing a physical disability.

2.6 Religion or belief of participants

Participants were also asked about their religion or belief; 53.3% (N=32) said they were ‘Christians’, with 41.7% (N=25) say ‘Muslim’ and 4% saying they had no religion or belief, or preferring not to say.
2.7 Language of participants

Participants were asked to state their first and second language, and their preferred language for receiving information. Arabic was the first spoken language of the majority of focus group participants, followed by English. In terms of second language, English was stated for 41.7% of participants, followed by French (23.3%). The vast majority of participants (38.3%) stated English as their preferred language for receiving information; this was followed by Farsi and Arabic – both 6.7%. See tables 1a – 1c below.

Table 1a: First language

<table>
<thead>
<tr>
<th>Language</th>
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<tbody>
<tr>
<td>1 English</td>
<td>13.3%</td>
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<tr>
<td>2 Punjabi</td>
<td>1.7%</td>
</tr>
<tr>
<td>3 Farsi</td>
<td>10%</td>
</tr>
<tr>
<td>4 Arabic</td>
<td>23.3%</td>
</tr>
<tr>
<td>5 Kurdish Sorani</td>
<td>3.3%</td>
</tr>
<tr>
<td>6 Bengali</td>
<td>3.3%</td>
</tr>
<tr>
<td>7 Albanian</td>
<td>1.7%</td>
</tr>
<tr>
<td>8 Portuguese</td>
<td>6.7%</td>
</tr>
<tr>
<td>9 Other</td>
<td>10%</td>
</tr>
</tbody>
</table>

Table 1b: Second language

<table>
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</tr>
<tr>
<td>2 Urdu</td>
<td>1.7%</td>
</tr>
<tr>
<td>3 Kurdish Sorani</td>
<td>3.3%</td>
</tr>
<tr>
<td>4 French</td>
<td>23.3%</td>
</tr>
<tr>
<td>5 Creole</td>
<td>1.7%</td>
</tr>
<tr>
<td>6 Portuguese</td>
<td>5%</td>
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</table>

Table 1c: Preferred language

<table>
<thead>
<tr>
<th>Language</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
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<td>38.3%</td>
</tr>
<tr>
<td>2 Urdu</td>
<td>1.7%</td>
</tr>
<tr>
<td>3 Farsi</td>
<td>6.7%</td>
</tr>
<tr>
<td>4 Arabic</td>
<td>6.7%</td>
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<tr>
<td>5 Kurdish Sorani</td>
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<td>6 Bengali</td>
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<tr>
<td>7 Portuguese</td>
<td>6.7%</td>
</tr>
<tr>
<td>8 French</td>
<td>8.3%</td>
</tr>
<tr>
<td>9 Spanish</td>
<td>1.7%</td>
</tr>
</tbody>
</table>
3. Focus Group Feedback and Analysis

3.9 Focus group sessions were held at Deeplish Children’s Centre; Castlemere Community Centre, Mind Wellbeing Centre, St Andrews Church and Sudden Community Centre during February and May 2017.

3.10 Participants were asked to reflect on a number of questions to do with their experiences of accessing health care. The key issues raised during the focus group sessions are listed below:

Q.1: We asked about participants knowledge and understanding of health and wellbeing. We wanted to know how well people were acquainted with the following:

- Healthcare services in own country and UK
- Healthcare needs, and clarity about entitlement?

- In my Country Iran, you have separate specialist services (for back pain, heart etc.), and not just one central GP service. You can see a specialist health professional quickly in Iran but you have to pay.

- In my Country Albania, you have to pay for services and then you can access them quickly.

- In this country I have used GP services, A&E services and the Dentist. My health visitor explained and helped me to register with the GP.

- Most participants were generally aware of the range of health services available in the local community, this includes A&E, GP and Dentist, but some were unsure how to access them.

- There is a sense of the need to maintain one’s wellbeing – physically and mentally, but discussions about mental health were often viewed with stigma and cultural taboos. For example: not recognising or accepting that there is a problem, or accepting it as the end: “I’m finish,” is how one might react to a diagnosis.

- Lack of awareness and knowledge makes it harder to recognise symptoms. Some participants stated that the word “depression” was not known before they arrived in the UK.

- We slowly learned about health services. In Bangladesh, you have to pay for Health services, here we receive a lot more help and services.

- We are not aware of all of the health entitlements in this country. As no information about health services is available in Farsi.

- Friends have told us about the different NHS services we can use. We have used various services, including; GP services, Opticians, Dentists and Hospitals.

Q.2: Health seeking behaviours: How do you currently access health services?

- Gender behaviour; stigma; cultural taboos/behaviour
- Use of A&E – reasons?

- When confronted with health issues, “We just get on with it; “soldier on.

- Stigma and cultural taboos have a significant impact on families. Witchcraft is seen as a possible cause for serious health problems.
• Calling ‘999’ in a crisis was seen by some as the most preferred option, or going to the GP – depending on the nature of the crisis.

• Nobody here has used the A&E services (Comment from one Focus Group).

• Our understanding is that GP’s work Monday –Friday from 9.00-5.30. We are not aware of an out of hours GP Service.

• Friends have told us about the different NHS services we can use. We have used various services, including; GP services, Opticians, Dentists and Hospitals. We have not heard of the “Out of Hours” GP services.

• A few of us have used the A&E services when the GP could not offer us an appointment for two days. I did not have a positive experience with the A&E services. I waited with my daughter in the hospital for a few hours and was given no medication and then sent home.

• I had to wait for two hours before my daughter was taken for an X-ray at A&E.

• When we have women’s issues, then I would prefer a female doctor. I have previously asked for a female doctor but was given a male doctor.

• We’ve not heard about the Out of Hours GP service. We don’t know what we will need to do to use this service.

Q.3: What difficulties have you experienced accessing services and support in Rochdale?

Are the pathways obvious; clear to navigate?

• Some awareness about the type and range of NHS services available, and the navigation pathways. However, some people were less clear about how to access services in an urgency, or where these services are based.

• We have used the A&E many times because I have a few children and when they are ill if the Ambulance does not come and then we will take them to A&E.

• We have used various health services including; Dentists, Health Visitors and Midwives.

• One participant said: The experience of accessing services was much better previously, but the process is more complicated now. Some services have changed, and there is a tendency to cancel you appointment, if you are running late.

• Difficulty getting an appointment when you want it; very little space or flexibility for emergency appointment.

• Different experiences with different surgeries.

• My first GP was no good, he ripped up my prescription and he wouldn't provide me with an interpreter. I then received support from the Children’s Centre and they helped me register with a new GP.

• We have had some major difficulties in getting an interpreter at the GP. When we’ve asked for an appointment for the same day the GP has told me that an interpreter wouldn’t be available. I was told to come with my mother and to act as an interpreter for her.
• We are offered interpreters at the GP sometimes. Some GP’s are very good and always provide access to interpreters.

• Some of us have had very poor experiences with interpreters. My English has been better than the interpreter’s English!

• The interpreter will speak for only a minute and translate what the doctors has been explaining to me for over 4 minutes. We then don’t have a lot of faith in some of these interpreters.

• I have been told by my GP’s receptionist to “bring my own interpreter”. One doctor is very good, he always provides an interpreter for me. I am a Portuguese speaker, and I have had real problems in being provided with an interpreter.

• Getting an interpreter who speaks Urdu or Punjabi is not a problem. We have always been provided with an interpreter in Urdu or Punjabi when we have go to the A&E at the hospital.

• My six year old son who speaks English and Portuguese has acted as my interpreter when I’ve gone to the doctors as they have been unable to provide an interpreter. When I go to a Manchester Hospital they always provide an interpreter.

• We have had is difficulties in getting same day appointments. We ring at 8.30 and then we have to hold on for 15 minutes or more and nobody answers. We are then told that we should continue to hold on... but how long can we hold on to the phone?

• When I go to the GP he always says ‘take paracetamol’. I had a severe recurring pain in the neck and the GP wouldn’t refer me for an X-ray and told me again to ‘take paracetamol’.

• This focus group was held on 11 February 2017, one participant stated that when they called to make an appointment at the beginning of February, she was told that the "GP is booked up to April"(if you want to see your own GP).

• We attend A&E when the doctor is unable to provide us with an appointment.

Q.4: What barriers have you encountered registering with GPs and dentists?

• “System is too rigid, I was struck off for missing one (dental) appointment.”

• Main barrier is language; makes it harder to get an appointment

• I attended A&E because my 22 month old daughter went blue and was not breathing. I called the ambulance but I didn’t have good English and I couldn’t explain that my daughter wasn’t breathing. Because the ambulance took some time to arrive, I panicked and went to A&E with my daughter. I have never received information in Albanian about what to do when your child is ill.

• There has always been an interpreter in the hospital.

• Some of us learned about registering with the GP from the Asylum Team at Serco. Serco gave us the information about the GP. But those of us who came before Serco did not receive any information from any organisation. We learned through friends.

• Reluctance to use children to support
Q.5: Communication: How would you like to receive information?

- "I don’t speak good English but I should receive some care and respect."
- We don’t know how to complain if we have had poor experiences health services. For example there is a receptionist at the GP service that is racist towards me. I don’t know what I can do with this.
- Information must be relevant; any leaflets must be on specific issues.
- GP surgeries
- Internet – though not everyone is IT literate
- Training / events
- Word of mouth

Q.6: Resilience and default mechanism

What keeps you well, and what do you do when you are unable to access local health services?

a. Things that help wellbeing:

- Work
- Faith
- Shared experiences
- Family – extended family especially, which gives a notion of community and a sense of belonging.
- Employing the five pillars of "Five Ways to Wellbeing."

3. Connect: family and community; faith
4. Keep Learning: shared experiences
5. Give: charitable/voluntary work
6. Be Active: work
7. Take Notice: appreciating what others have done.

b. Default practices / alternative approaches:

When a health crisis arises, the tendency is to try and access emergency support from a GP or even A&E. When this is not available, or difficult to access the alternative is generally a resignation to the problem and just "Get on with it," as one participant puts it.

Q.7: Suggestions based on experience

- Expectations / ideal service model:
  - Warm reception
  - Meeting needs
  - Good communication process / non-judgemental
  - One that does not discriminate
  - Appreciate diagnosis / signposting
3.11  Case Studies

Case Study 1: Male, age 22, Asylum seeker

1. What is your knowledge and understanding of health and wellbeing?
   When I arrived to Rochdale I didn’t know anything about the healthcare services. I was only told how to register with the GP that’s why I struggled a lot with booking an appointment; after that things became easier with time. I suffered many times with depression during the three years I’ve been here and I didn’t know what to do until things got serious and I tried to end my life. My mother told me about Mind Wellbeing Centre.

2. Health seeking behaviours / How do you access health services in Rochdale?
   Through GP, Dentist, Accident Emergency and Raid Team – mental health services

3. What difficulties (If any) have you experienced in accessing services and support in Rochdale, are pathways obvious and clear to navigate?
   I had some difficulties in booking appointments with the first GP because the line is always busy. But when I changed, the other GP sorted this problem. Also as a foreigner, I think lots of people are facing problems with the language as they aren’t English speakers. My mother suffered from this.

4. Communication: How would you like to receive information about health services?
   By Post

5. Have you resulted in using: Cultural practices in meeting your health needs?
   Yes, a little herbs for the stomach.

6. If you had an ideal pathway or way of delivering health services what would this look like?
   They should hire volunteers from the local community who could share the same language with the refugees or asylum seekers, and help them register with any of the health services they need.

Case Study 2: Male, age 28, Asylum seeker

1. What is your knowledge and understanding of health and wellbeing
   The health services I had back home is different than here in the UK. For example, back home we did not call to book an appointment. We had two separate papers to submit to the office at the health centre. After that we could see a doctor straight away. There is more to say about the different between our health centre at home and now.

2. Health seeking behaviours / How do you access health services in Rochdale?
   Access health services in Rochdale by GP

3. What difficulties (If any) have you experienced in accessing services and support in Rochdale, are pathways obvious and clear to navigate?
   I had difficulties the first time I came to Rochdale to find a GP, but at last I found one through my house officer at SERCO. She gave me the address of the GP as well as the registration form.
4. Communication: How would you like to receive information about health services?
I would like to receive information about health services by letters, if it is possible.

5. Have you resulted in using: Cultural practices in meeting your health needs?
Yes a little herbs for the stomach.

6. If you had an ideal pathway or way of delivering health services what would this look like?
The health service I am getting now is much better.

Case Study 3: Female, age 42, Asylum seeker

1. What is your knowledge and understanding of health and wellbeing
I didn’t know about the services when I arrived in the UK. My manager told me about the GP, and before eight months booked appointment with Mind when she saw my situation. I was depressed and wasn’t feeling well.

2. Health seeking behaviours / How do you access health services in Rochdale?
GP Service, urgent care, hospital and Psychiatrist

3. What difficulties (If any) have you experienced in accessing services and support in Rochdale, are pathways obvious and clear to navigate?
It is not easy to see the GP when you need it; I mean my GP, you need to book appointment on the same day, but not every time I asked I got it.

4. Communication: How would you like to receive information about health services?
By post or SMS

5. Have you resulted in using: Cultural practices in meeting your health needs?
Yes a lot because even when I go the urgent care they give me paracetamol for everything and it’s not all the time so I prefer to use some herbs at home for stomach or cold and flu.

6. If you had an ideal pathway or way of delivering health services what would this look like?
More stuff to covering all patients, more GP appointments

Case Study 4: Ralph (Not his real name) - Age 37; from Sudan (refugee seeker)

I came to England two years ago. The health service here is strange. I was told I can go to the doctor whenever I need to. Though I have only been to the doctor once since I came. That was the first time I went to register. They asked me questions, took my temperature and other measurements. Then they said everything was ok. They also took some bloods and said if there was anything problem they will call me. Since then I have not heard from them. I have not gone back to see them because I have not been sick or anything.
The hospitals here and the doctors are good. I don’t’ have to pay to see a doctor, as I was told. Back home? There are no hospitals. In Juba there is maybe one hospital. Many doctors and workers from United Nations but mainly in refugee camps. So healthcare here is definitely better than back home. I have a doctor but no dentists.

My health is ok. Things have not been easy. I have not been sick but sometimes I get headaches. But I think it is after the drinking. I drink every evening. And I smoke too. Well, I don’t work and don’t go to college, so me and my friends we come to NESTAC when they’re open, use computers and then go back home. We play cards and buy drinks and cigarettes. We talk about home and the war and family. You know, sometimes we try not to sleep at night because of the dreams. The bodies of people, especially the women and children and all the animals. Sometimes when I talk about it I can smell everything. It is not good. Makes me sad.

I have not seen a doctor or anyone to talk about these dreams. For now I don’t think I want to talk to anyone because some people will start thinking I am crazy. British people don’t like crazy people. They will be scared that because I am asylum seeker and from Sudan I could be Janjaweed and Al-Shabaab. No! I don’t think I am mental. It is just that I don’t work, and I don’t go to school. I will be happy when I start work or go to college. I am not happy for now because of that. I don’t need medicine but if I do I will go to the hospital. That’s no problem.

I have no problems using services in Rochdale. NESTAC provides information and support. I know where GP surgery is and I have their number. I don’t have a dentist because I don’t need one. Maybe when I have tooth problem then I will register with a dentist.

I think I am a strong person. My family is Christian so I think that helps me. I believe that things will get better. Yes, very hopeful. Suicide? No! Never. I survived war in Sudan I can survive UK. I go to Manchester and Liverpool to meet other people from Sudan. Sundays I play football in Falinge field with some friends and we keep each other company.

No suggestions. I don’t know because I have not used many service. But I think if people talk to you, you know, listen and not judge you. People understand you then that’s all.

Case Study 5: Tim (Not his real name); Age 28; from Eritrea

I came to England last year. I spent three months in London and then was sent to Liverpool before being sent to Rochdale. I have lived in Rochdale about 6 months now. I share a house with three other people. One from Afghanistan and two from Somalia. Yes, I get on ok with the people from Somalia but the man from Afghanistan I hardly see him. There is no television in the house so we spend most of our time out of the house. We come here to NESTAC to use the computer and meet other people. When NESTAC is not open I go to the library. The people from Somalia all go to college so I go to learn English at Castlemere Community Centre.

When I came to Rochdale I registered with a GP, which was strange to me that everybody has a doctor. It was a good thing because back home to see a doctor was very difficult. Though consultation was free, paying for medicine was expensive. Here consultation and medication is free, which is a good thing for me.

I was diagnosed with post trauma [Post Traumatic Stress Disorder] by doctors in London. So I have medication from my doctor to help me sleep and also medication that I take when I go out, especially during the day time when I have to meet new people. I have panic attacks
especially when I hear loud sudden noises. I also panic when I see police cars or people in uniform. Last week I saw those people who put tickets on cars in town. I almost fainted.

Back home I was locked up the soldiers in a hole for many months. They took us out and beat us (showing scars on legs and back). It was difficult.

I don’t have any health problems, except when I have panic attacks I have headaches. Or when I have nightmares too, I wake up sweating. The medication is helping.

I go to see my doctor every month but also go to Fairfield hospital to see psychologist. I just started seeing the psychologist. My doctor referred me. I will see how that goes.

Yes, I get money from home office. For now I can’t work but my lawyer said I should be able to once my papers come through. Hopefully when I started working I should be able to pay back all the support I have received. The doctor and the NHs have helped me. So if I pay taxes and stay healthy they can be able help somebody else who needs help. Good things should go around, that’s what I think. That when you get help, you try and help another person.

I don’t have any problems going to hospitals. I know accident and emergency is for people who have accidents or people who a seriously sick. Me, I don’t go to accident and emergency. If I need help I go the doctor or sometimes I go to pharmacy and ask the pharmacy man what medication I can buy, if it is not expensive.

I don’t drink and I try to cook my own food, which means I manage my money better. I went to university Eritrea but I didn’t finish so I understand how important it is the save and manage things. Back home we didn’t have much so I can survive on very little.

I am alive for a reason. There is a purpose to my life that’s why I survive the prison and the torture. My friends died in Eritrea, some others in Ethiopia and Libya and in the sea crossing to Europe. I am here, therefore, there is a reason. When I have achieved that purpose then maybe I will die. Then I will it is God’s will. For Now, I am going to stay strong and positive.

No, I have never thought about suicide or harming my self

The service I have used are good. There’s nothing I want to change.
Life Story:

“If you are perceived to be mentally unwell, you are labelled crazy and no value of society, therefore ostracized usually both by family and community”, this was stated by a Somali mother with 4 children. This mother has lived in Harrow for 15 years, she became unwell in 2010. She describes feeling unwell, extremely stressed, unhappy and she did not understood what was wrong with her. She was hearing voices and had hallucinations. She could not take care of her children and she could not cope with her daily tasks and totally shut down. She was moved to one of her sister’s home within Harrow for support of herself and children because of fear that social services will take her children to foster care.

After a month long struggle of her family in which she refused to go to A&E or GP the situation has exacerbated very bad with long nights without sleep and not knowing what to do. None of her sisters and their mother speak English.

The family started asking help other community members and they were suggested to contact our HAYAAN PROJECT. One of her sisters came to us and hearing the sad story of this mother I decided to visit her at home where she was staying. Soon after I enter the home she welcome me with a smile because I knew her before she became unwell. At that time I realized that she trusted me and after short conversation she accepted my offer to support her and take her to A&E for a mental health assessment. I accompanied her to Northwick Park Hospital and she was diagnosed with cute depression and hallucinations. She was admitted in the hospital, where she was medicated and she stayed for 3 weeks. During that time, I used to visit her every week once to give her assurances and explaining her that it is her best interest to be under the care of Medical team. In the course of her treatment she had a full night sleep and relaxation for the first time and got back rationale thoughts which was amazing recovery. She was discharged from hospital and went back her home with her children. In terms of her mental health, HAYAAN WORKSHOP sessions and Independent Clinical consultation with Dr. Fido (Somali consultant psychiatrist) as well as CMHT in Bentley House in Harrow has helped a lot which gives her ongoing support and follow-ups and signposting such as benefits, housing etc.

After getting back her life she decided to volunteer our HAYAAN project and she is our “Champion Volunteer” for women and she talks openly her experience with Mental illness with other Somali Women in the community which and a result of her campaigning with us more women has joined the project and asking for help which was not possible before because of the stigma on Mental health issues.

One of her narratives of this Mother while campaigning was that two Somali women were sharing her medication for 3 months because they didn’t want to be known that they suffer Mental illness because of the stigma in the community. But after they came out, they got the support they needed and they live now happily.
4. The Conference

4.1 The conference was attended by 80 delegates from Rochdale and partner organisations across Greater Manchester. Delegates were presented with a range of topical issues affecting people from new and emerging communities. About five partner organisations attended on the day, hosting information stalls.

<table>
<thead>
<tr>
<th>Programme: Morning Session</th>
<th>Programme: Afternoon Session</th>
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<tbody>
<tr>
<td>9.30 Registration, Coffee and Networking</td>
<td>Chair (Afternoon Session)</td>
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</tbody>
</table>
| 10.00 Welcome and Introduction Herbert McKeachie, Rochdale & District Mind | 13.45 Intervention models for providing healthcare to new and emerging communities
Ian Runciman Co-Chair of NHS England National Asylum Health Plan |
| 10.05 Chair’s Opening Address Sally McLean, Integrated Commissioning Director, H&M CC6 | Laura Breese: Deputy Director of Commissioning, Primary Care, Greater Manchester Health & Social Care Partnership, NHS England |
| 10.15 Health needs of refugees & asylum seekers, and implications for healthcare providers. Abdi Gari, Somali Advocacy Worker, Mind in Harrow | 14.10 Workshops: |
| 11.05 Break | Workshop B: Barriers to accessing healthcare: Overcoming the language barrier, stigma and taboo, and impact on mental health. Facilitator: Emily Darby, Mind in Harrow |
| 11.20 Barriers to Healthcare Estelle Worthington, Regional Action Co-ordinator North West | 15.00 Feedback from Workshops & Open Question Session |
| 11.40 Lived Experience | 15.15 Closing Remarks |
| 12.00 Table Top Discussion: Breaking Barriers and improving access to healthcare for new & emerging communities. | 15.30 Close of Conference |
| 12.00 Lunch & Networking | |

4.2 Conference: Profile of participants

4.2.1 Gender of Participants

Of the 80 people who attended the conference, only 40 (50%) completed the participant profile. Of these 67% were female; see below:

**Fig. 1: Gender**

- Male (25% N=10)
- Female (68% N=27)
- Transgender...
4.2.2 Age of Participants

The majority of attendees fall within the age cohort 35–54, representing 57%, with those between 25-34 years old accounting for 18%.

4.2.3 Ethnicity of participants

Of those completing the profile questionnaire, the largest group that took part in the conference were those describing themselves as White UK and any other White background, accounting for 75%. The other 25% were those from Black, Asian and minority ethnic (BAME) backgrounds.

It is possible that a higher percentage for BAME attendees would be seen if there was a higher completion rate.

4.3.4 Sexual orientation of participants

Ninety percent of participants described their sexual orientation as heterosexual, and 7.5% not answering this question or ‘Prefer not to say.’

4.3.5 Health condition or disability of participants

Participants were asked whether they had any long-term health condition or disability, 75% said ‘none or prefer not to say;’ 15% said they were experiencing a mental health condition (including long-term depression or stress), and 10% were experiencing a physical disability or other experience of disability.

4.3.6 Religion or belief of participants

Participants were also asked about their religion or belief; 42.5% said they were ‘Christians’, with 45% saying they had no religion or belief, or preferring not to say.
4.3.7 Language of participants

Participants were asked to state their first and second language, and their preferred language for receiving information. English was the first, second and preferred spoken language of the majority of conference participants, and may have to do with the high percentage of those describing themselves as White UK/any other White background.

Table 1a: First language

<table>
<thead>
<tr>
<th>Language</th>
<th>First</th>
<th>Second</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>English</td>
<td>97.5%</td>
</tr>
<tr>
<td>2</td>
<td>Urdu</td>
<td>0%</td>
</tr>
<tr>
<td>3</td>
<td>French</td>
<td>0%</td>
</tr>
</tbody>
</table>

Table 1b: Preferred language

<table>
<thead>
<tr>
<th>Language</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>English</td>
</tr>
</tbody>
</table>

4.4 Conference Evaluation and Feedback

4.4.3 The feedback was overwhelmingly positive and encouraging (see feedback evaluation below; p.27). Some key discussion points from delegates and keynote speakers:

- In regard to mental health, people are being sectioned much earlier than they need to, and not getting the care that they need.
- "The need for better information in understanding how the NHS will support people to register with a GP (Comment from delegate)."
- Gatekeeping in general practice remains a major issue regarding poor registration.
- Lack of awareness as well as social and cultural factors tend to reduce help seeking behaviours. Precipitating factors include:
  - Experience of trauma, war, dislocation
  - Cultural beliefs about mental health
  - Lack of fluency in English
  - Lack of understanding of Western model of mental illness and of treatment, and Lack of awareness about how the NHS works.
  - The need for a bilingual health advocate (cultural broker), or bridge between the two value systems;
  - A Supporting user within their family system, according to their wishes, to state their needs which are heard and acted upon.
  - The need to empower patients to help them understand where they are in the system and what their rights are, which would help with registration.
Frontline staff questioning their entitlement, and the need to educate patients on how to interact with medical staff during a medical appointment / assessment, and who’s who in the room.

Responding to their needs as a refugee such as benefits, choice of dispersals, less frequent moves and immigration issues - fear of breaches of patient confidentiality to the Home Office.

4.4.4 Language barriers faced by new arrival and refugee communities when accessing public services:

c. The following statement from one of the presentations highlight the serious language barriers people often face in accessing services:

"I asked if I could be referred to a Dari speaker so they could understand my issues better, but they referred me to an English speaker.

I went to the counselling sessions but it didn't make much difference because I couldn't explain everything. There was no interpreter... It was a waste of time because we couldn't understand each other. This went on for a year."

d. The impact of mental health stigma and cultural taboo

The need to improve access to mental health services through community-led approach; encourage peer support and tackle stigma, and increase mental health / mainstream service providers awareness of different cultural needs.

Factors contributing to mental health stigma within refugee and migrant communities also featured throughout the focus groups sessions, and include comments such as:
Beliefs about what causes a mental health issue include Jinn possession, Saya and curses. These beliefs and myths about mental health often go unchallenged within a community.

There is therefore a feeling of being judged or labelled in the community if it was known that one was accessing mental health services. Such perceived negative attitudes act as another barrier and prevent or delay early and appropriate help seeking responses from a GP or other healthcare professionals. The default response is quite often treatment from spiritual healers, either locally or abroad, which is seen as a more effective solution. When a crisis occurs, presentation of the problem is often to A&E; at times to a GP.

4.5 ‘Feedback from Table top Discussions:

4.5.1 A number of table-top discussions were held during the conference on a range of issues relating to healthcare pathways for refugees and asylum seekers. See below:

**g. Developing local services & responses:**

“How can local agencies/organisations create a healthcare pathway for new & emerging communities that is culturally sensitive and responsive?”

- Know your demographic
- Co-production model – listening to issues
- Drawing Up
- Going back and re-evaluating
- Training
- Constantly updating
- Knowing/finding out about what barriers people face
- Developing and maintaining relationships with service users
  - Places of worship
  - Educational institutions
  - Primary/secondary care
- Key Action – Mutual Engagement

**h. Developing local services & responses**

*How do we help frontline services to better understand the range of issues asylum seekers and refugees may present with and provide better care?*

- Training for organisations
- Finding out what services need to deliver to new and emerging communities
- Ensure providers are up to date with legislation
- Champions for the community to ensure their voice is heard
- Breaking barriers – Education and belief
- More funding – to support all the action needed
- Transport issues – Getting to the service you need
i. **Breaking Barriers, Improving Access (1)**

*What do you think are the barriers currently faced by people from new & emerging communities in accessing healthcare services; and what are some of the ways in which services can become better at responding to their needs?*

- Recommendations – take opportunities to inform men/women about GP, Walk-in and A&E. How to access them and enabling action by keeping them informed.
- Understanding of local area
- Complex, medical jargon, language barrier
- Lack of confidence and knowledge of service
- What is the outcome – prescriptions
- Transport, Money, Stigma, fear
- Negative experience, Time scale
- Follow up, Access, Interpret

j. **Breaking Barriers, Improving Access (2)**

*If language is one of the barriers that prevent people from new & emerging communities accessing healthcare services (and services generally), what are some of the ways in which services can become better at responding to their needs?*

- Pictorial representation
- Simple pictures to make text more accessible
- Chunk of language – short paragraph saying ‘hand this in to the Doctor or Dentist’
- Animated/filled version of the leaflet – speaks over recording in relevant language

k. **Breaking Barriers, Improving Access (3)**

*In the Focus Group Sessions with Refugees & Asylum Seekers, men were less likely to visit their GP. Some also raised concerns about the lack of clarity regarding access to interpreting and translation services when they visited their GPs, or getting services elsewhere in the community.*

What can service providers do to encourage more men to access healthcare / general services in the community?

- Male role model
- Stereotyping
- Going to person or them coming to you/ language barriers
- Accessing GP services
- Gardening – Mind – for men
- Homes/family – build relationship even to extend family before men/trust
- Listening and talking
- Computer literacy
- Adapting/young men
I. Breaking Barriers, Stigma and Cultural Taboos

People experiencing certain health conditions such as mental health and dementia sometimes lead to stigma, embarrassment and social isolation, and a reluctance to seek help; adopting instead the default position of 'tried and tested' cultural practices.

How might service providers tackle the issue of stigma and cultural taboos, and promote wider access to healthcare services?
- Reframing the language of mental health
- Present mental health in a more positive way
- Education
- Community engagement and relations
- More visible and accessible services
- Building capacity within communities (champions)

i. A Responsive Service (1)

What would be an ideal healthcare service for new and emerging communities, including refugees & asylum seekers?
- For various groups to be involved
- To educate service providers and communities about good practice and entitlement until there is no inequality or stigma in healthcare

j. A Responsive Service (2)

In the Focus Group Sessions with Refugees & Asylum Seekers, some participants believed faith played a major role in their recovery and wellbeing, and social networks also helped keep them well.

How can service providers tap into this resource to improve access to and take up of healthcare / general services in the community?
- Well publicised
- Accessible
- Translators, interpreters
- Health screening
- Friendly GP's and receptionists
- Simple language – visual aids, less lingo, user led diagrams
- Support groups
- Sensitivity to culture
- Information on specialised needs of the patients
- Tropical medicine
- Mediation, liaison services, advocacy
- Crèche facilities, support for young families
- Alcohol and drug support
- Health education
- Local information on health care etc.
- Awareness of Asylum procedures – the stress of this procedure
- Reliable and factual information on charges
- Adequately funded and staffed
- GP Practices – Quality assurance training – one point of contact
- Champion for Rochdale
- Better publicity – community centres, services that are accessible
- More bilingual peer mentors or befrienders – connectors
- Access to leisure facilities – costs
- Who/what – make up of local Rochdale Borough, needs and health needs

4.5.2 Summary of key discussion points:

**Developing Local Services:**
- Know your demographics
- Co-production model – listening to issues / break barriers
- Champions for the community to ensure their voice is heard
- Training for organisations

**Breaking barriers, improving access:**
- Plain English
- Understanding local area and service access points
- Male focus campaign to engage them
- Address language barriers

**Breaking barriers, stigma and cultural taboos:**
- Reframing the language of mental health
- Building capacity within communities (Champions)

**Responsive services:**
- Training on good practice & entitlement
- Addressing cultural sensitivity
- Community health champions
5. Conclusion

7.1 Both the focus group sessions and conference have been very successful in capturing a good amount of data to make an informed judgement on the experiences of people from refugees and asylum seekers background, accessing health care. Of the 60 people who participated in the Focus Groups, the largest groups were Black Africans, followed by those who described themselves as Arabs. Nearly two thirds of participants were women, reflecting the low engagement with men, in regard to health care services – health and wellbeing, generally.

7.2 Although most people stated their first language as Arabic, the majority stated English as a second language, as well as their preferred language for receiving information.

7.3 The majority of respondents (78%) stated that they had no long-term health condition or disability (including mental health). It is not clear whether this is a reflection of stigma and fear – where people don’t want to say, as seen in the narratives when this question was raised in open discussion.

7.4 On the surface, most people have a fairly good knowledge of the health service, but not a good experience of it. Some viewed going to the GPs or hospital with some trepidation, because of the unfriendly reception and lack of cultural sensitivity. One participant mentioned an experience of being racially abused by a GP receptionist, and that they were unsure how to make a complaint. In a crisis, calling ‘999’ was seen as the most preferred option for some. Interestingly, several participants have not heard of the ‘Out of Hours GP Service.’

7.5 There is a strong desire to maintain health and wellbeing, but discussions about mental health were often view with stigma and cultural taboos. One of the key issues here is the lack of awareness regarding mental health, symptoms and available support.

7.6 Access was the most used word in the Focus Group discussions. It surrounds the difficulty people experienced getting to their GP, Dentist, or some other health service provision. For some, the pathway was unclear in a crisis, and the frequent changes made it even more difficult to know what is available or what your entitlement were. Where language is a barrier, it was even harder to get the right support when needed.

7.7 To maintain their wellbeing, in the face of poor experiences with health care services, people did not so much default to cultural practices, but indulged in a wide range of other activities. These include work, faith-based practices such as going to church or the mosque, talking to others about your experiences, maintaining a sense of community and belonging with family, and employing the five pillars of “Five Ways to Wellbeing.”

7.8 There are several examples of people getting a good service from their GP or hospital, or another health professional. Yet, equally, there are also several examples where the same experience has not been positive for others. And this will need to be address.

7.9 Some key discussion points from delegates and keynote speakers are cited above in section 4.3 (p.17), but additionally, and more specifically:

1. “I asked if I could be referred to a Dari speaker so they could understand my issues better, but they referred me to an English speaker

2. The lack of understanding and the stigma attached to mental illness may prevent people from seeking help.
3. Language barriers, including the lack of professional interpreting services, may prevent people from receiving information about what is available and how to access help.

4. The need for better information in understanding how the NHS will support people to register with a GP (Comment from delegate).”

5. The need “COMMUNITY CHAMPIONS,” to help improve access.

6. "I asked if I could be referred to a Dari speaker so they could understand my issues better, but they referred me to an English speaker.

7. Health professionals must have an awareness of and sensitivity to the different cultural practices and spiritual beliefs that shape a person’s health and wellbeing.

7.10 This is a small population with very high needs, and it is important to recognize this as a key inequality issue that requires specific support and resources.

8. **Recommendations: Next Step Forward**

8.1 There seem to be a general need to work with other frontline services to help improve the experience of people from new and emerging communities, especially refugees and asylum seekers accessing health care services. A next step forward would be to set up a Task and Finish Group to lead this.

8.2 Community health champions were frequently cited as a way forward. This should be encouraged, with people within the refugees and asylum communities recruited to help raise awareness and improve access.

8.3 Training for frontline health professionals, including GPs and surgery staff would help to improve cultural understanding and sensitivity.

8.4 A programme of ongoing access to health care awareness is critically needed to ensure everyone can access services when needed, especially in times of crisis.

8.5 A programme of mental health awareness training, targeted at refugees and asylum seekers, is necessary to help tackle the evident stigma and taboo that prevent many seeking help before a crisis occurs.

8.6 Refugees, asylum seekers and vulnerable migrants tend to present with complex issues – medical, psychological and social – as a result of experiences in their home country, and the process of adapting to life in the UK. Where language is also a barrier, it will require longer appointment times.

8.7 Patients from refugees, asylum seekers and vulnerable migrant communities be made more aware of their right to request a phone interpreter for appointments with healthcare professionals: this should always be offered at the time of making an appointment when it is clearly needed, including offering a choice of gender of the interpreter.

8.8 Similarly, patients should be informed of their right to make a complaint, if they are unhappy with any aspect of the service, and the procedure for doing so

8.9 These recommendations will require resourcing of some sort, and HMR CCG must recognize the level of commitment and investment needed in order to meet the specific health outcomes identified in this report.
9. Conference Feedback Analysis

9.1 Appendix 1: Feedback Analysis

1. How did you hear about the event?
   - Email from Rochdale & District Mind 47%
   - Email from Friend / colleague 15%
   - Website 0%
   - Leaflet/poster 15%
   - Other 2%

2. Main reason/s for attending the conference

![Figure 2: Reason for attending conference](image)

3. How satisfied were you:

<table>
<thead>
<tr>
<th></th>
<th>Very satisfied</th>
<th>Very dissatisfied</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>With the booking process and pre-event organisation?</td>
<td>78%</td>
<td>12%</td>
</tr>
<tr>
<td>With the organisation of the day?</td>
<td>59%</td>
<td>15%</td>
</tr>
<tr>
<td>With the venue and facilities?</td>
<td>66%</td>
<td>12%</td>
</tr>
<tr>
<td>With the arrangements and quality of the catering?</td>
<td>80%</td>
<td>7%</td>
</tr>
<tr>
<td>With the relevance of the topic areas</td>
<td>56%</td>
<td>24%</td>
</tr>
<tr>
<td>With the quality of presentation and content of the conference?</td>
<td>29%</td>
<td>49%</td>
</tr>
</tbody>
</table>

Booking process & pre-event
- 90% satisfied – very satisfied

Organisation of day:
- 74% satisfied – very satisfied

Venue & facilities:
- 78% satisfied – very satisfied

Catering
- 87% satisfied – very satisfied

Relevance of topics:
- 80% satisfied – very satisfied

Quality of Presentation
- 78% satisfied – very satisfied
4. Did you feel the length of the event was:

- Just about right: 90%.
- Too Long: 5%
- Too Short: 0%

5. Which speaker(s) were you mostly interested in listening to?

<table>
<thead>
<tr>
<th></th>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Needs of Refugees and Asylum Seekers, and implications for healthcare providers</td>
<td>56%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supporting People from New &amp; Emerging Communities (Nestac)</td>
<td>71%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intervention Model for Providing Health Care to new and emerging communities</td>
<td>41%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Barriers to Health Care</td>
<td>59%</td>
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</table>

5a. Speakers

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall, were the speakers informative, prepared, and understandable?</td>
<td>46%</td>
<td>41%</td>
</tr>
<tr>
<td>Was the material presented understandable?</td>
<td>32%</td>
<td>32%</td>
</tr>
<tr>
<td>Were the questions and discussion handled to your satisfaction?</td>
<td>41%</td>
<td>46%</td>
</tr>
</tbody>
</table>
Additional Comments Q. 5a:

- Couldn’t see the projector; not able to see slides; also open window - couldn’t hear some of the speakers.
- Unfortunately one of the videos wasn’t very easy to view on screen. Info was given on to access the video at a later date.
- A good conference, thank you!
- Hard to hear and see powerpoint. Too much of being talked at and not enough time for discussion. More focus on positive outcomes and what we should do.
- Information on the screen was unreadable. The speakers were too long.

6. Which workshop did you attend?

**Workshop A:** 32%  
*Local Services Response*

**Workshop B:** 51%  
*Breaking Barriers: Overcoming the language barrier, stigma and taboo, impact on mental health*

7. How would you grade the Workshop you attended?

<table>
<thead>
<tr>
<th>Very satisfied</th>
<th>very dissatisfied</th>
</tr>
</thead>
<tbody>
<tr>
<td>😊</td>
<td>😞</td>
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<tr>
<td>5</td>
<td>4</td>
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<td>3</td>
<td>2</td>
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<td></td>
</tr>
</tbody>
</table>

17% 37% 15%

Additional Comments Q. 7a:

- Need more time.
- Very well - delivered, good balance of participation, some repetition from speakers on the day.
- Not enough discussion time
- Ran out of time
- Good information just wish there was more time.

8. What did you enjoy most from the Conference?

**Comments:**

- Networking
- Estelle presentation
- Meeting people and learning from their knowledge / organisation
- Learning about the different barriers to healthcare for asylum seekers, and meeting professionals from different backgrounds.
- New information
- Lunch
• Listening to personal experiences
• Range of knowledgeable speakers
• Listening to knowledgeable speakers
• Diversity
• Workshops were very good
• Table conversations
• Information on services available in Rochdale
• Awareness of mental health stigma and understanding of different cultures.
• Exercises
• Signposting service users to other organisations

9. Is there anything we could do to improve the conference for next time?

Comments:
• To be able to see the powerpoint
• Better project of slides
• Visual aids and sound need improving
• Improve the visual prompts
• Have a Twitter presence #engageconference pre-event and after to show sense of purpose and good practice.
• Handouts from speakers to take away and digest, maybe contact information so further detail can be sought
• I tried to book onto the conference but got no response to my email. So I was not on the participant list. Maybe a separate email address for conference organisation.
• Do not allow people in who have no interest in the conference.
• More service users
• It was impossible to see anything at the screen because of too much light, need curtains.
• Clearer slides and videos downloading
• Check room and lighting before conference – couldn’t see or read PowerPoints

10. What will you take away with you as a result of today’s conference?

Comments:
• Key contacts
• Reasons to signpost to online information
• What is available; barriers
• Understanding the barriers to healthcare and the different attitudes will help me approach individuals in the correct manner and help / advise them correctly
• Looking at progressing forward
• Clear information, advice on different health matters
• Urgency for change to happen now
• New information on access to primary care
• The importance of support and advocacy for new and emerging communities.
• How asylum and refugees struggle to access healthcare. Cuts e.g. funding across services is not helping people in need.
• More knowledge about the situations faced by asylum seekers and emerging communities.
• Awareness of mental health needs and facilities available
• Increased knowledge of provisions and good networking opportunity
• BME Carers – a lot of needs and unique cultures the best way to support an individual is by understanding their unique individual circumstances. From that a support plan can be created which will hopefully better meet their needs.
• More understanding about the feeling of asylum seekers and what they can access.

11. Additional comments and recommendations for future events:

Comments:
• Break up speakers with activities to complete in between to remain active and involved.
• Choose a venue with blinds, PowerPoint was hard to read
• The catering service was excellent, so was the opportunity for a massage. A nice touch.
• Service user forums
• Email about future events

What will you take away with you?

1. “Understanding the barriers to healthcare and the different attitudes will help me approach individuals in the correct manner and help / advise them correctly.”
2. “How asylum and refugees struggle to access healthcare.”
3. “More understanding about the feeling of asylum seekers and what they can access.”

“I was glad to meet you last week at the engage conformance in Rochdale. It was amazing event and gain so many information from different community and seekers.” Iman Rafatmah, NHS England

“I just wanted to say what a great conference it was yesterday. Thank you.” Erica, RMBC

“I just thought I would email you – even though I completed an evaluation form last week at the Engage Event. I thought the event was fantastic... very powerful and enlightening. I loved every minute of it. Thanks very much.” June, GM Carers Trust.

“Thanks again for a great conference last week- I hope you got the outcomes you were looking for.” Emily, Mind in Harrow
Engage Conference:
Engage : Challenge : Support

How to Engage with new and emerging communities (including Refugees and Asylum Seekers)

Challenge the barriers and stigma often associated with poor access and take up of healthcare services

How to Support people with knowledge and understanding of available services and how to access them.

Breaking barriers and improving access to healthcare services for new & emerging communities.

Wednesday, 17 May 2017
9.30am – 3.30pm
Castlemere Community Centre
Tweeddale Street
Rochdale
OL11 1HH

Speakers on:
➢ Health needs of refugees & asylum seekers, and implications for healthcare providers.
➢ Supporting people from new & emerging communities: Model of good practice from Nestac.
➢ Intervention models for providing healthcare to new & emerging communities
➢ Lived experiences

For registration please contact:
Rekana Ghose & Bertha McKenzie
Tel: 01706 752339, Email: berthomckenzie@rochdalemind.org.uk or rekanganese@rochdalemed.org.uk

Workshops:
A. Local services response: Working together to identify strategies to improve pathways for healthcare.
B. Barriers to accessing healthcare: Overcoming the language barrier, stigma and taboo, and impact on mental health.

SAVE THE DATE
Appendix 2: Speakers Presentation Slide

Abdi Gure, Somali Advocacy Worker, Mind in Harrow

Summary - This presentation

- About Mind in Harrow
- Somali Advocacy Project (with King’s Fund)
- Evaluation & learning
- Creation of Hayaan Project
- Expansion and launch in Brent

About Mind

- Mind in Harrow is one of approx 160 local Mind Associations and shares mission, values and quality standards.
- Mind in Harrow is an independently constituted charity.
- Service user empowerment and diversity core Mind values

Mind in Harrow: Where is our expertise?
We are a community-based organisation.

- Vocational services
  - Head for Work
  - Employment Support Coordinator
  - Performing Arts
  - Stepping Stones courses
- Preventative services
  - ‘Befriending
  - IAPT Step 2 Service
  - Information Helpline
  - ‘On-line directory
  - Stepping Stones for Carers
- User empowerment
  - User Involvement
  - HUG
- DME specific services
  - Hayaan Somali Project
  - EKTA South Asian Project
  - Migrant & Faith Mental Health Access Project

Mind in Harrow: Achievements WINNER 2010!

The Evaluation Proposal – King’s Fund

- The King’s Fund is an independent body which
  ‘seeks to understand how the health system in
  England can be improved.’
- The Partners for Health in London assisted 20
  health providers to evaluate their effectiveness
- Mental health advocacy, one of three themes
- Awarded Mind in Harrow three-year grant ending
  Jan 2011 to develop and evaluate a new Somali
  Advocacy Project

The Evaluation Proposal – King’s Fund

Context: The need for the Somali Advocacy

- Somali refugees and asylum seekers (Approx.
  10,000 in Harrow)
- Experience of trauma, war, dislocation
- Somali beliefs about mental health
- Lack of fluency in English
- Lack of understanding of Western model of
  mental illness and of treatment
- Misperceptions or misunderstanding by NHS
- Presence of extended family
The Evaluation Proposal – King’s Fund Interventions ‘Mechanism’

Bilingual Somali advocate:
- Acting as cultural broker, or bridge between the two value systems, explaining each to user and family, and to mental health professional
- Supporting user within their family system, according to their wishes, to state their needs which are heard and acted upon

The Somali Advocacy Project – Key facts
- Grant ended Jan 2011 as three year project started Nov 2007.
- Somali bi-lingual Advocate 24 hours pwk
- Researcher 7 hours pwk
- 32 individuals and families in 2.5 years, Advocate has worked intensively with them
- 7-8 of these individuals and families Advocate continues to work intensively with them.

Somali Advocacy Mental Health Project
- Supporting people with clear cultural values to express themselves in their own way
- Working with the community to understand how their values can fit with mental health services
- Building trust and relationships between services and the community
- Converting mental health services to work with Somali community
- Sticking to community values and ensuring services are culturally appropriate
- Adapting current mental health services
- Decentralized and it’s cross-cultural system
- Exploring the community about mental issues and not just state
- Developing relationships between region and health and mental health services
- Raising awareness of mental health issues

The Evaluation Project – King’s Fund 2 years into project running (2009-10)
Evaluation methods:
1) Trained Somali bi-lingual researchers conducted structured interviews to fill in a questionnaire completed through an interview with a total of 48 respondents – Patients, NHS staff & family
2) Transcribed 6 in depth case studies with Advocate to conduct a thematic analysis

Summary of Initial learning – Structured interviews: Combined

- Q7. Did any positive change occur as a result of Somali advocacy?
  - Yes 88%
  - No 12%

Summary of Initial learning – Structured interviews: Service providers

- Q25(a). Do you understand more about Somali cultural values and mental health, as a result of advocate’s intervention?
  - Yes 62%
  - No 38%

Summary of Evaluation Findings

Interventions:
- Alliances & conflicts with NHS and Social Care staff
- More than 17 different types of intervention, offering an holistic service
- Concerns Advocate overstretched as a result

Outcomes:
- 88% believed Somali Advocate created a positive change
- Different views between service providers, users and carers about degree of positive change
- Challenges to find opportunities to explain family confidentiality model and Somali cultural norms
- 62% service providers understood more about Somali cultural values as a result of Advocate’s intervention

Hayaan Project – ‘Moving to better place’
Purpose from Somali Advocacy Pro
- Improve local Somalis access to mental health services through community-led approach
- Encourage peer support and tackle stigma
- Increase mental health/mainstream service providers awareness of Somali community’s cultural needs

Funding:
- Government’s Volunteer Fund 18 months
- Trust for London 2 years
- 50% match funding secured for 2013
Hayaan Project – ‘Moving to better place’

Activities
- Trained 20 Somali community ‘Peer Educators’
- Run fortnightly information & support workshops in a non-clinical setting
- Invite professionals as speakers and participants. Chair and Director of Operations CNWL, NHS Foundation Trust attended.

Outcomes Year 1
- Pre and post workshop surveys every session – 93 people
- 86% of participants self-report feeling better able to manage their mental health
- 91% of participants self-report more able to support other people in their community.

Peggy Molongo, Cross-Cultural Mental Health Practitioner, Nestac.

Hayaan Project – in Brent

Background
- Identified lack of culturally sensitive mental health support services for Somali community in Brent; same NHS Trust.
- Brent residents already visiting Hayaan Project in Harrow
- Additional grant 2012-13 via Mind Social Action Fund

Plans
- Monthly information & support sessions in Brent and Harrow
- Led by Somali community
- 6-7 Somali Community Volunteer ‘Peer Educators’ trained in June/July 2012
- Partner with NHS, social care and charity sector services
- Aim to raise grants and continue through 2013

Estelle Worthington, Regional Activism Co-ordinator North West.

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Somali Advocacy Worker

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asylum matters

Barriers to Healthcare in the Shadow of the New Charging Regime

Estelle Worthington,
Campaigns Project Manager, North West

What we’ll cover

- Common barriers to accessing healthcare for refugees and people seeking asylum
- New charging regime and data-sharing agreement, and effect on health inequalities
- How can barriers be overcome? Recommendations for commissioners and health service providers. Examples of good practice.
Key principles underpinning healthcare in the UK

Hippocratic Oath, 5th Century BC, and updated by BMA

"I promise that my medical knowledge will be used to benefit people’s health. They are my first concern.

"My professional judgement will be exercised as independently as possible and not be influenced by political pressures or by factors such as the social standing of the patient."

Founding of NHS, 1948

Three core principles governing the NHS since its launch on 5th July 1948 at Park Hospital in Manchester (today known as Trafford General Hospital):

- It meets the needs of everyone
- It is free at the point of delivery
- It is based on clinical need, not ability to pay

Equality Act 2010

- Provides a legal framework to protect the rights of individuals and achieve equality of opportunity for all.
- Protects you from discrimination by a range of bodies, including health and care providers.
- There are nine protected characteristics in the Equality Act. Discrimination which happens because of one or more of these characteristics is unlawful under the Act.

Health needs of refugees & people seeking asylum

Physical health needs: include diabetes, hypertension, dental disorders and conditions that are consequences of injury and torture.

Mental health needs: Depression, anxiety and post-traumatic stress disorder are common amongst asylum seekers in the UK. Exacerbated by lack of control over their circumstances (having no choice ever where to live, no right to work, and risk of destitution), and separation from culture, language, family and friends.

Maternal health needs: asylum seeking women are three times more likely to die in childbirth than the general population. Frequent moves disrupt maternity care. Low support rates lead to lower birth weight and higher infant mortality rates.

Consequences of barriers to accessing healthcare

- Rise in health inequalities.
- Failure to identify mental health issues and introduce support.
- Interrupted treatment = lack of access to essential medication for ongoing conditions.
- Delayed treatment = higher cost of care and more pressure on emergency services. Conditions become more complicated and expensive to treat.
- Longer stays in hospital.
- Delayed access to ante-natal care = complications and higher death rates.
- Absence of early diagnosis of communicable diseases, leading to possible public health risks.

Who is entitled to what?

Refugees — free care

People seeking asylum — free care

Refused asylum seekers — now chargeable for many services

BUT, regardless of the patient’s chargeable status, all immediately necessary and urgent treatment must be provided, though the patient may later be charged.

Who is entitled to what?

Refused asylum seekers: have different entitlements...

- Currently entitled to free primary care, but primary care providers must identify the chargeable status of patients and there will be a phased approach to the introduction of charging.
- Currently entitled to free emergency care, though charging may be introduced at a later date.

If a refused asylum seeker or not in receipt of statutory support (and do not qualify for patient or treatment-based exemption), charges apply for:

- All secondary healthcare, even if it is provided outside of a hospital setting or by a third party.
- Acute, Mental and Community Health Services (except primary care at the moment).
- Maternity care. Some services may even be charged up-front (e.g. antenatal classes).

Barriers in Accessing Healthcare

- Difficulties with registration
- Frontline staff questioning their entitlement
- Language barriers and communication issues
- No-choice dispersal and frequent moves
- Fear of charging
- Fear of breaches of patient confidentiality re Home Office
- Lack of awareness about how NHS works

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Case-studies
How are barriers to accessing healthcare affecting refugees and people seeking asylum?

Data-Sharing

Since 1st January 2017, a Memorandum of Understanding has been in place between the Home Office and NHS Digital. Preceded by a secret data-exchange agreement.

Allows the Home Office to access patient registration data. Enforcement officers can ask NHS Digital to share the full name, date of birth, gender, last known address and date of NHS registration of patients.

8,127 requests for data in the first 11 months of 2016, leading to 5,854 people being traced by immigration enforcement teams.

So how can we overcome these barriers?

- Use NHS England Patient Registration Guidance
- Longer appointment times
- Face to face interpreting
- "Champion" within each practice
- Get it on the GIN Devolved Health and Social Care agenda
- Follow examples of Gwyn and Oldham H&W boards
- Training for all practice staff
- Advocates for patients exercise discretion
- Follow guidance on dispersing pregnant women
- Commission specialist services for refugees and people seeking asylum
- Defy data-sharing using Safe Surgeries Toolkit
- Invest in educating patients about how to navigate birth and stay healthy
- Focus on mental health

Useful resources

- Patient Registration Standard Operating Principles for Primary Medical Care (General Practice)
- Healthcare Needs and Pregnancy Dispersal Guidance v3.0
- #StopSharing Campaign and Safe Surgeries Toolkit

Stay in touch with Asylum Matters!

Estelle Worthington: North West Campaigns Project Manager
estelle@asylummatters.org 07557 983 264

New Website Coming Soon!
http://asylummatters.org/

Iman Rafatmah, Co-Chair of NHS England National Asylum Health Pilot, and Rob Bellingham, Managing Director, Association of CCGs, GM

Inclusion Health

Rob Bellingham
- Managing Director, Association of CCGs for Greater Manchester
- Co-Chair National Asylum Health Pilot NHS England

Iman Rafatmah
- Co-Chair National Asylum Health Pilot NHS England,
- Equality Diversity Council Lived Experience Member,
- Mind Equality Improvement Board Member,
- Member/ Secretariat, Greater Manchester NHS Values Group,
Barriers to General Practice for 'Inclusion Health' groups

Asylum seekers & refugees
What do we need?
- GP’s to allow us to register and without breaching our confidentiality at reception desks (e.g., calling out ‘she/he is an asylum seeker’ in front of all the patients)
- Interpreters and volunteer support
- Culturally sensitive services
- Support with post traumatic stress and mental wellbeing
- Less confusion in the system about registration (former NHS Protect Guidance and confusion about the proposed charging policy)
- LESS HOSTILITY AND RESENTMENT
WE ARE HUMANS TOO!

National Asylum Health Pilot
Tackling Asylum Seeker Health Inequalities
- Asylum seekers experience poorer health outcomes and worse health care than the general population.
- These poorer health outcomes can contribute to reduced life expectancy and reduced healthy life expectancy for asylum seekers, which directly translates to increased costs for the health and social care sector and the wider public sector and impacts on the contribution that asylum seekers can make to UK society.
- DENIAL OF ACCESS TO PRIMARY CARE:
  - 39% of asylum seekers refused when Doctors of the World tried to register patients with a GP practice between March and October 2015.
  - 39% of registration rejections were because of lack of ID, 36% because of lack of proof of address; and 13% because of immigration status.
- Gatekeeping by GP reception staff identified as a major issue.

Key Aims of the NHS England National Asylum Health Pilot in Greater Manchester
- Asylum seeker led – enabling positive change
- High quality, appropriate healthcare for asylum seekers
- Clear, accessible information about asylum health
- Implementation of the new registration guidelines - Help to register
- Good access to appropriate services - wrap around support – health buddies, mentors, people to help us navigate the system, write letters
- Co-designing the service model and co-designing training for staff including GPs and receptionists.
- Building and sharing learning - bringing the lived experience of asylum seekers together with the expertise of the healthcare professionals to enhance healthcare and tackle inequalities in asylum health

Expo 2015
Quotations about Exclusion
It happens to us:
Invisibility, marginalisation, denial of access to care.
People with LIVED EXPERIENCE of social exclusion in healthcare,

“Nothing about us without us!”
- You can’t design services for groups of people whose lives, needs, assets and health issues are an ‘unknown’
- You can’t speak in your own language and assume it’s universal – whether that be the language of professionals, the language of acronyms, or the English language...

Expo 2015 Pledge
We will co-produce leaflets to tackle denial of access to healthcare for inclusion Health groups, commencing with a bespoke leaflet with and for asylum seekers and refugees.

CONSULTATION SESSION

ASYLUM SEEKERS HEALTH OPEN EVENT

52
Further leaflets developed by and for asylum seekers

How to use NHS services, Night and Day

Emily Danby, Bridging Cultures Coordinator, Mind in Harrow

Breaking the barriers to accessing health services
Overcoming the language barrier, stigma and taboo

Language barriers faced by new arrival and refugee communities when accessing public services

Impact of mental health stigma and cultural taboo surrounding mental health within new arrival and refugee communities

Working with communities to change attitudes towards mental health and improve access to effective mental health services

Nedaye Zan campaign
Experiences of Afghan women accessing local services
“I asked if I could be referred to a Dari speaker so they could understand my issues better, but they referred me to an English speaker.

I went to the counselling sessions but it didn’t make much difference because I couldn’t explain everything. There was no interpreter... It was a waste of time because we couldn’t understand each other. This went on for a year.”

**Tackling Mental Health Stigma Through Community Engagement**

**Start with the end in mind**

“Improve mental health awareness and access to effective mental health services among all Muslim communities in Harrow and new migrant and refugee communities in particular”

**The RIGAAR model**

- Rapport
- Information gathering
- Goal setting
- Auditing resources
- Agreeing a strategy
- Rehearsal and review

**FACTORS CONTRIBUTING TO MENTAL HEALTH STIGMA**

- Language or Arabic framework for recognizing a mental health issue or taking about mental health in a neutral way
- Role of Arabic language in framing the topic of mental health
- Stigma associated with mental health issues
- Social and cultural factors influencing mental health stigma

**IMPLICATIONS FOR NHS MENTAL HEALTH SERVICE PROVIDERS**

- Late diagnosis of mental health issues
- Difficulty accessing services
- Low access to mental health services
- Mental health stigma

**Tackling Mental Health Stigma**

- Awareness and education about mental health
- Support systems for mental health
-政策 and resources for mental health

**FACTORS CONTRIBUTING TO MENTAL HEALTH STIGMA WITHIN REFUGEE AND MIGRANT COMMUNITIES**

- Language barriers
- Cultural differences
- lack of understanding and awareness about mental health issues

**Language & Communication**

- Lack of written information in Dari & Pashto
- No third party interpreter available
- Difficulty accessing ESOL classes
- Difficulties communicating
- Self-confidence & autonomy
- Communication breakdown
- Late diagnosis of mental health issues

**Factors Contributing to Mental Health Stigma**

- Language barriers
- Cultural differences
- Lack of understanding and awareness about mental health issues

**Impact of Mental Health Stigma**

- Stigma and discrimination
- Lack of access to mental health services
- Difficulty engaging with mental health services

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Rapport
Information gathering
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Agreeing a strategy
Rehearsal and review

Benefits of a community based approach
RESPONDS TO
THE NEED
Takes root
Community ownership
Positive reputation

EXERCISE
What is the end result I want to achieve?
Rapport building
Which organisations and individuals can I make links with? What opportunities exist to get to know the community? Is there anything I can offer at this stage?
Information gathering
What key questions do I need to answer?