REACH

COMMUNITY HEALTH PROJECT

A Qualitative Study Examining Perceived Barriers in Accessing Healthcare Services: Asylum Seekers and Refugee (ASRs) and Service Providers Perspective

A Report by REACH Community Health Project

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Glasgow Centre for Population Health

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CONTENTS

REACH Community Health Project is an innovative national voluntary organisation whose aim is to improve the health of Black and Minority Ethnic (BME) communities living in Scotland. The project is also committed to facilitate change within mainstream health services to better address the health needs of this particular community. To achieve these aims REACH has developed a triangulated formula in the form of a Services Unit, Policy and Research Unit and a Cultural Diversity Training Health Unit.

Our ***vision*** is a multi-cultural society in which all people have equal access to appropriate health services and our ***mission*** is to empower BME communities by ensuring that their health needs are fully met.

REACH Community Health Project have three key objectives as working principles which, helps us to implement our policies into practice thereby achieving our aims. The objectives are as follows;

1. To provide a range of good quality, culturally-sensitive preventative health **services**
2. To influence mainstream **policy** and undertake innovative **research** so as to identify and remove barriers to health for BME communities
3. To provide **cultural diversity training** for mainstream, voluntary and private sector organisations working with BME communities

Chief Investigator
Shabir Banday

Co-researcher
Sumera Bhatti

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FORWARD

'…[H]ealth, which is a state of complete physical, mental and social wellbeing, and not merely the absence or infirmity, is a fundamental human right…' (Alma-Ata, 1978).

Health, as defined by the Alma-Ata Declaration, is a universal right. However, securing this right for all people, regardless of territorial or, indeed, cultural boundaries, has proven to be an almost insurmountable challenge. This has been particularly evident in respect to the needs of Asylum Seekers and Refugees (ASRs).

Within our city, much has been done to try to provide for the health of ASRs. Recognition, and strong commendation, must to be given to the array of statutory and voluntary organisations (including the Glasgow Asylum Seekers Support Project, The Refugee Support Team, The Scottish Refugee council, and the British Red Cross) whose collaborative efforts have significantly benefited diverse, and venerable, ASR communities.

However, much work still needs to be done. In particular, sustained focus need s, to be brought on overcoming health services access barriers, REACH Community Health Project, in partnership with the Glasgow Centre for Population Health, has produced this research report in an effort to contribute to this. It is our hope that the finding herein will encourage further study in this area and, ultimately, contributes to ensuring that all ASR communities in Glasgow enjoy the health benefits that they, as a matter of principle, are entitled to.

Shehla Ihsan
Chairperson
REACH Community Health Project

Executive Summary

Background

Aims

This research was designed to address the question what do Asylum Seekers and Refugees (ASRs), and Service Providers (voluntary and statutory) perceive to be the attitudinal and operational barriers in accessing and providing Healthcare Services for ASRs?
More specific issues are

- What possible barriers perceived by ASR in accessing Healthcare Services within the boundary of the South East Community Health and Care Partnership (CHCP)?
- What are the barriers perceived by Service Providers within this CHCP?
- To make recommendations to those working with/for ASRs, particularly in Glasgow. More so to Greater Glasgow and Clyde Health Board & South East CHCP to develop healthcare services that are accessible and sensitive to this community.

Research Methods

Both ASRs and those providing Healthcare services to them were asked as to what they saw as the main barriers to access. A method of triangulated qualitative research was used to allow exploration of topics and space for unanticipated themes to emerge. The initial phase of research was a literature review to scope the background to issues of health access amongst the ASR community. A second phase utilised in-depth interviews with 25 ASRs resident in South East Community Health and Care Partnership. A third stage used focus groups with service providers from both the voluntary (7 individuals) and statutory (9 individuals) sectors.

Findings

From the perspective of Asylum Seekers and Refugees

Barriers that emerged for understanding access to health services from the perspective ASRs themselves centred around;

i. Knowledge and understanding of available services and how to access them,
ii. Language and interpretation
iii. How encountering service providers is shaped by the experience and expectations associated with being an asylum seeker or refugee

i. Knowledge and Understanding of Health Services

Respondents reported that the specific organisation and operation of primary care system in Scotland, with its systems of referrals from General Practice, is not obvious or easy to navigate. This would lead to new arrivals being unsure of what to expect from health services in the UK. In the Glasgow context, a written source of information (The '*Welcome to Glasgow'* Pack) introduced ASRs to the local system of health care provision and access. In many circumstances this was complimented with information given verbally. However, the information reported by ASRs was limited to identifying the appointed health care centre for the area they were to reside in. Additional information on the extent and breadth of specific services available on the NHS was not provided.

ii. Language and Interpretation

The barrier posed by language differences for new arrivals in Scotland was anticipated from previous research and knowledge of ASR experiences (Tailor and Gair, 1999; Donna and Berry, 1999; Gamell et al, 1993). This study found that language could combine with limited knowledge of available health care to further impede access despite steps made to provide written and oral interpretation services. This would be further intensified in emergency situations when even those with relative confidence in everyday communication in English could find it difficult to understand and answer questions being asked of them and to communicate effectively. There was also evidence of difficulties in accessing interpreters in emergency situations.

For routine consultations there were mixed responses as to whether requiring an interpreter hindered access. Whereas many felt it slowed the process down, others had found no problems. In some instances, both for emergency and routine consultations, ASRs relied on family members or friends for interpreting, however this was not always seen as appropriate dependent on the nature of the condition being presented.

Language and interpretation issues were also reported by health professionals that are discussed in the section on professionals' responses below.

iii. The Experience and Expectations Associated with ASR Status

A key emergent theme was the low expectation from services by ASRs, linked to ASRs having a low status and internalising their felt stigma shaped by negative media reporting and responses from some sections of their communities of residence. Against a background of ASRs being portrayed as a drain on resources there was sense from some ASRs that they were not sufficiently entitled to free health care, were reluctant to be critical of the care they did receive and did not wish to conform to a view of taking resources away from others by being heavy users of health services.

Many of the health issues related to ASR status are mental and emotional issues stemming from their experiences both in their country of origin and the uncertain experience of life in Scotland, with deportation of themselves or those close to

them an ever present possibility coupled with being unable to work or access other rights constitutive of full citizenship and inclusion. Partly on account of this tenuous situation and its emotional consequences and partly on account of language difficulties, the characteristics of compassion, understanding and patience from health professionals were valued by respondents. The quality of relationship with health care workers was highly valued yet was an aspect on which ASRs felt health provision was weak.

From the Perspective of Voluntary and Statutory Health Service Providers

The barriers that emerged thought to impede access and uptake of health service by ASRs from the providers (both statutory and voluntary) were broadly similar as identified by the ASR group themselves. However, where issues were shared slightly different aspects of these themes were raised. Additionally, themes around the experience and capacity of workers to deal with ASR issues effectively, and problems stemming from the coordination of services were highlighted.

i. Knowledge and Understanding of Health Services

Health care professionals provided further evidence that there was an absence of knowledge among ASRs on the organisational structure of the NHS. However, it was also suggested that the absence of free, public provision of medical services in countries of origin may be a contributory factor. Service providers also identified gaps in information provision on arrival as contributing to the problem. It was noted however that with frequent use and increased exposure to the system by individuals, these problems seemed to be overcome.

ii. Language and Interpretation

Both voluntary and statutory health care professionals considered language and communication barriers to be major obstacles for ASRs. Additional to the themes emergent from ASRs themselves, health professionals questioned the quality and availability of translation and interpretation services in certain languages (e.g. Kurdish). Some translated written material, it was felt, failed to inform intended target users in cases where they could speak but not read their own language. An important issue that was raised by voluntary sector providers were incidences when interpreters had omitted information in consultations, with particular reference to an occasion when medical interventions would impinge cultural or religious prohibitions. The voluntary group also raised questions about the adequacy of the process by which someone can become an interpreter and whether it was sufficient for the sensitivity required. Issues stemming from familiarity of network based interpreters were also raised and this may impinge on the perceived confidentiality offered.

iii. The Experience and Expectation Associated with ASR Status

From the voluntary healthcare providers the strength of some of the peer support networks ASRs had access to, was raised as strengths-based barrier to accessing health services. However, there was also recognition that social support was not sufficient in the face of the stresses that accompanies the ASR experience. Consequently, developing this strength of mutual assistance by better integrating it into knowledge of, and access to, available services was seen as a way of going forward. However, running contrary to this perception of strong mutual support, it was also commented on that health was not high on the agenda of many ASRs with more immediate material and economic concerns taking priority.

Health service providers also highlighted the tenuous nature of ASR experience as a potential barrier but, differing from ASR reports, highlighting how fear of deportation could lead to suspicion of services provided by the state. This perception also relates to the theme of *Knowledge and Understanding of Health Services* as it suggests that the confidentiality of medical services and the separation of the NHS from the Home Office is not understood by many in the ASR community.

iv. Job Stress, Lack of Training and Absence of Coordination Between Services

The professional group also reflected on how aspects of their roles and their organisation may create barriers to access for ASRs. Despite recognising good knowledge of the health issues that face ASRs (mental as well as physical) amongst and between professional groups, many felt improvements could be made to better assist the execution of roles.

Job stress was recognised as a factor in working with ASRs who present problems that can lead to emotional burn-out and high staff turnover, particularly for voluntary sector staff. The lack of financial incentives and prestige involved in working with ASRs was considered poorly matched to the professional challenges involved. There was recognition that personal strength and a certain set of personal qualities were essential for continued performance in this role. Amongst voluntary sector providers in particular there was knowledge of those who worked outside their contracted hours and gave money out of their own pocket to aid cases.

Lack of training was identified from the statutory group as a barrier to effective working particularly for those who came into direct contact with ASRs (GPs, nurses and receptionists). Although there was knowledge of specific training of working with the ASR community available, the cost was considered prohibitive.

The absence of coordination related directly to statutory health professions. Issues such as where the first point of call for interpretation services lay or who has primary responsibility for families that have children were raised. In communities that had a high number of ASRs, the health centre in this

community could be seen as a primary reference point for knowledge and information by other service providers, less used to working with ASRs. This could also impede the patient experience as services not used to dealing with ASRs on a daily basis could not act as efficiently as with non ASR patients. A coordinated approach across all services and geographic areas was called for to relieve the pressure felt in areas with high concentrations of ASRs.

Conclusions and recommendations

- Lack of knowledge about healthcare services by ASRs, particularly in relation to how they operate within the UK context is currently underestimated. This is related to understanding processes as much as information of where local services are. Recommendation that the use of multiple methods, written, verbal and translated in patient's language.

- Important issues were raised about the quality of interpreting services. In particular relating to conducting interpretation around culturally or gender sensitive issues. The guarantee of confidentiality could also be undermined (if not actually broken) by use of interpreters from small and localised ASR communities. Interpreting services and their organisations need to assuage such fears.

- Service users felt the interpersonal qualities (compassion and patience) of health professionals to be important. This was given additional emphasis given the emotional and mental strain of being an ASR and potential difficulties in communication. It is advised that more efforts should be into maintaining high standards in communication and sensitivity to ASR experiences.

- Mainstream and specific service providers are still learning about the issues and processes involved in providing services to the ASR community. In some instances, this leads to absence of clarity about roles and expectations between service providers; it is also the case that some geographic areas of the city have developed greater experience than others. The report authors recommend wider availability of training and the development of an integrated strategy to assist the smooth running and delivery of healthcare and related services.

1. Background

"the debate over globalisation is moving beyond simple categories of good and bad, yea or nay, integration or disintegration….political, civic and business leaders still need to decide on what aspects of globalisation are worth encouraging and which are not." Zachary (2001)

This research focuses on ascertaining the perceived health needs and barriers for asylum seekers and refugees (ASRs) in accessing healthcare services within the South East Community Health and Care Partnership (SE CHCP) in Glasgow, both from the perspective of ASRs and the service providers.

It is well known that there has been a mass movement of people from country to country and region to region for centuries. The current trend of globalisation and trade has led to mass movement of people; in addition to this the development of fast communication systems has made it easier and faster to travel around the world.

Unfortunately due to socio-economic and political uncertainty currently there are several parts of the world suffering from the effects of conflicts, wars, famine and oppression causing residing citizens to leave their countries for their own safety. This has been complemented with legislations such as The Human Rights Act (2007) which actively places a legal obligation on countries who have signed-up for this treaty to provide asylum.

The United Kingdom (UK) Government is one of the countries which are a signatory for the Human Rights Act (2007.) The number of people seeking asylum in the UK has fluctuated over recent years (Harris & Telfer 2001). In terms of asylum applications per head of population the UK ranks ninth in Europe (Home Office, 2004). Under the 1999 Immigration and Asylum Act many asylum seekers were dispersed throughout Britain, one of the cities of dispersal being Glasgow.

Over the past decade Glasgow has increasingly become a multicultural society, as 34% of Scotland's Black and Minority Ethnic (BME) population lives in Glasgow. National Asylum Seekers Support (NASS) (1999) had calculated that there were approximately 6000 asylum seekers in Glasgow. However, this figure does not include refugees—individuals that have been granted leave to remain in the country—or asylum seekers living in private accommodation. Thus, the real number of asylum seekers and refugees living in Glasgow may be far higher than the numbers reported (Scottish Refugee Council, 2003).

1.1 Demography

Asylum seekers and refugees (ASR) are not a homogenous group, as they originate from various countries, cultures, religions and bring variety of experiences. The majority of ASRs in Glasgow/Scotland are from Turkey (14%), Somalia (9%), Pakistan (9%), Iran (9%), and Afghanistan (6%) who fled from ethnic or religious violence in their home countries (CoSLA Refugee and Asylum Seekers Consortium, 2003). It has been difficult to ascertain the exact male to female ratio of ASR's however according to Heath & Jefferies (2004) the vast majority of asylum applicants were male, with one third of principal asylum applicants being female in December 2004.

1.2 Definition of Asylum Seekers and Refugees (ASRs)

According to the United Nations (UN) 1951 Refugee Convention, an asylum seeker is defined as

> "*A person having a well-founded fear of being persecuted for reasons of religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable, or owing to such fear, is unwilling to avail himself of the protection of that country*."

The right to seek asylum is embodied in the Universal Declaration of Human Rights (1948), which states '*everyone has the right to seek and to enjoy in other countries asylum from persecution'*. An asylum seeker can obtain asylum if he/she meets the United Nations (UN) Refugee Convention's definition of a refugee.

A refugee is a person who

> "*owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of his nationality, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country…*"

2. Literature Review Findings

The methodology for the literature review included reviewing published and unpublished research studies conducted both in Scotland and throughout the UK. Here are the some of the findings from the literature summarised under key themes which have been used in this research study for a consistent approach.

2.1 Health Needs

The literature shows that asylum seekers and refugees constitute a vulnerable population and the major cause for this has been attributed to the risk factors associated with pre and post migration. Some of the examples of post-migration factors which came out as prominent in the literature review included detention, length of asylum procedure, language barriers, discrimination, lack of social support, unemployment and lack of knowledge about the new health care system.

The majority of asylum seekers in the UK are supported by state with the accommodation costs paid by the Home Office while their asylum case is pending. Moreover, failed asylum seekers coming from countries facing considerable upheaval and violent conflict where the health system may have collapsed (Mares, 2000) may be presented with various physical and mental health needs and might have experienced torture and sexual violence. (Sundquist & Johansson 1996; Pernice &Brook, 1996)

2.1.1 Physical Health Needs

According to Burnett & Peel (2002) one in six asylum seekers have severe physical problems. The prominent physical health needs which emerged from the findings of the literature review included fractures, epilepsy or deafness from head injuries, or non-specific musculoskeletal pain or weakness. (Summerfield, 2001)

The literature also reports that the incidence of infectious and nutritional diseases varies between refugee groups according to their country of origin (Bardsley & Storkey, 2000). The presence of HIV, hepatitis A and B, tuberculosis or immunisable diseases is apparent amongst some (Smith, 2000). Parasitic and intestinal infections are also common in refugees from developing countries or those who have spent time in refugee camps (Ramsey & Turner, 1993). Communicable diseases found to be prevalent in asylum seekers and refugees included lice, scabies, intestinal parasites, tuberculosis, chronic hepatitis B, Human Immunodeficiency Virus (HIV)/ Aids and syphilis (Aldous et al. 1999; British Medical Association, 2002).

2.1.2 Mental Health Needs

The mental health needs among asylum seekers and refugees emerged as one of the prominent health needs. Two thirds of asylum seekers had experienced mental health problems (Burnett & Fassil 2002). Mental health problems following trauma are a significant issue for some, while emotional distress is much more widespread (Burnett & Peel 2001).

It has been shown that symptoms such as depression and anxiety, panic attacks, or agoraphobia are often reactions to refugees' past experiences and current situations. One of the studies carried out in the UK focusing on Iraqi refugees found that all had been separated involuntarily from close family members, 65% had a history of systematic torture during detention, and 29% were unable to speak any English (Laban et al., 2004) with consequences for integration into host country.

Social isolation and poverty have a compounding negative impact on mental health, as can hostility and racism towards asylum seekers and refugees. Mojee et al. (2003) identified a third of asylum seekers in their survey to attribute the process of claiming asylum to their psychological distress, with 29% finding living circumstances and feeling unsafe to cause distress.

Other studies have found that refugees are at higher risk of psychiatric disorders such as depression, suicide, psychosis, post-traumatic stress disorder and substance misuse (Gorst- Unsworth 1992; Ramsay et al. 1993; Health of Londoners Project 1999).

2.2 Access to HealthCare Services

Access to healthcare services, particularly difficulty in accessing primary care health services by asylum seekers has been a recurrent theme across numerous studies (Karmi 1992, Ramsey & Turner 1993, Refugee Health Consortium 1998, Hargreaves et al. 2000, Ghebrehewet et al. 2002).

Asylum seekers and refugees, unlike other overseas visitors, are entitled to all National Health Services (NHS) without payment. This includes the right to register with a general practitioner (GP), dentist or optician and to receive NHS prescriptions and specialist care. Despite being able to obtain prescriptions without charge, an exemption certificate (HC2) is required, which is part of the support package for asylum seekers. This can take up to three weeks to be issued. Many people arrive with no money and receive vouchers. This can often involve time delays, leaving asylum seekers in a vulnerable position.
New applicants are provided with vouchers and a small amount of cash that gives them an income 70% of that of normal income support, with a large majority living considerably below the poverty threshold (London Health Observatory 2003). This non-monetary system in circulation for asylum seekers and refugees has an impact on the health of this population including ramifications both on their mental and physical health.

2.3 Barriers to Accessing Healthcare Services

The entitlement to healthcare access for ASRs does not necessarily imply equity in access to health care services as there are additional attitudinal and operational barriers causing hindrances, which include knowledge and awareness about the health system, language & cultural barriers.

2.3.1 Lack of Awareness of Healthcare Services

Lack of awareness of availability of health services stemming from insufficient or no information to asylum seekers about the health care system in the host country is a common factor contributing to unequal access and uptake of services. (Norredam M et al 2005)

2.3.2 Language Barrier

One of the biggest barriers to asylum seekers and refugees accessing health care is language. Language barriers at frontline services such as at the reception desk and during the consultation are common. As a result these language barriers might make accessing health services difficult (Taylor & Gair, 1999).

Lack of adequate professional interpreting services present a barrier for all non-English speaking patients, but this barrier is greater for those with psychological and emotional difficulties that can only be explored verbally. Particularly when some have experiences of abuse which they have previously never described, even the process of giving testimony in itself can be therapeutic (Donna & Berry, 1999). Gamell and colleagues (1993) also pointed out women asylum seekers were less likely to speak English or be literate than their male counterparts.

In a study by Weaver (2003) it was found that patients had not received interpretation support when attending appointments, with Mojee et al. (2003) reporting further that some are unable to read appointment letters which prevent them from accessing services. Interpreting services are often not available outside working hours and for acute consultations (Hargreaves, Holmes and Friedland, 2005)

2.3.3 General Practitioners

During the period in which individuals wait for approval or rejection of their asylum application (a process that may last years), general practitioners (GPs) are called upon to provide health care.

Most GP surgeries represent a point of reference for the health of asylum seekers & refugees. Presentations are typically in somatic form, often non-specific bodily pains, headaches, dizziness and weakness, which reflect both culturally ordained modes of help-seeking and their view of what is appropriate to bring to a medical setting (Lin et al, 1985).

GP knowledge of asylum seeker and refugee rights and entitlements seems to be poor, which has led to asylum seekers and refugees receiving an inadequate service (Ramsay et al., 1993; Hargreaves et al., 1999). Although many GP practices assume that asylum seekers and refugees had knowledge of how the

health care system works, refugees themselves report difficulty in registering with GPs (Wilson, 2002). Some GPs are reported to have closed their lists to asylum seekers because of the *"overwhelming need and insurmountable language difficulties"* fearing the impact of the burden on their practices (Jones, 2000).
Apart from GPs' attitudes, other barriers to healthcare access for asylum seekers in the UK include practitioner inexperience with uncommon and complicated health problems; a lack of relevant cultural, health and health service educational material for both asylum seekers and healthcare staff; language difficulties; misunderstandings; and inadequately resourced interpreter and advocacy services.

Although there have been some studies on geographical inequalities of health provision by GPs in the UK (Jones & Gill, 1998) there is little information on the extent of health-care provision for asylum seekers and refugees in relation to different areas of the UK.

Furthermore, the findings from the literature review do not shed light on the perceptions of ASRs on barriers to accessing healthcare service in Glasgow. However one study, North of Glasgow ASR health needs study by NHS Greater Glasgow and Clyde Health Board did touch upon the perceptions of ASRs and service providers leading to identification ASR health needs in North of Glasgow.
However the present study is intended to encapsulate the perceptions of both service users (ASRs) and service providers (healthcare professionals) particularly focusing on the health care access issues for ASRs and thereby complementing the findings of the literature review and other studies.

3. Research Methodology

3.1 Design

Triangulated qualitative research was employed for this research study. Triangulation is conventionally defined as the purposive gathering of multiple sources of data and the use of these data sources in the reporting of results (Babbie, 1989; Neuman, 2003).

The triangulated approach involves the use of multiple measures – for example, focus groups, interviews and observation – to gain a more complete picture of a phenomenon, all fully reported on and compared. Triangulated qualitative research employs well-established and well defined methods of data collection such as focus groups and interviews alongside other techniques to obtain a more complete understanding of the issues (Guba and Lincoln, 2000). In essence, triangulated studies help with the confirmation and completeness of the research findings, in which different methods and approaches are used to obtain a set of results and gain a more complete picture, which may be missed through the application one single method.

3.2 Data Collection

In this research we used methodological triangulation, where, the first method of research involved conducting an extensive review of the literature available on asylum seekers and refugees' health needs and the barriers previous researches have found in accessing health care service provisions. This extensive literature review not only looked at studies carried out in Glasgow but also included studies conducted throughout the United Kingdom (UK). This was necessary to overcome the scarcity of such studies carried out in Glasgow. The findings from the first method gave an overall insight into the research subject. Furthermore the semi-structured questionnaire, themes/categories and questions for the focus groups and interviews were designed on the basis of these findings.

The second method involved conducting in-depth interviews with the help of a semi-structured questionnaire; this method was implemented with asylum seekers and refugee research participants. In-depth interviews using a semi structure questionnaire allowed a degree of flexibility for participants in relating and explaining in greater detail without being overly rigid; thus allowing them to be succinct in their responses. This allowed participants to elaborate on aspects or views which they subscribe importance to or wish to make pertinent. The use of these semi-structured interviews in the research study generated data rich in individual experiences and understanding of the perceived barriers to accessing healthcare services and their understanding of health services.

The interviews with ASR research participants were tape recorded and notes taken. An individual copy of the questionnaire was allocated for each research participant's interview. These were coded and the same code was applied for each recorded interviews (where applicable) and the consent form. However, in most cases ASRs were not happy with the tape recording the interviews; in such cases field notes were the key source of documenting the information/findings subsequently, recorded interviews and field notes for each interview were transcribed immediately to avoid losing any information. The interviews and the transcribing of the raw data were carried out by the co-researcher, under the supervision of the chief investigator, who reported to the line manager regularly.

The third method in the process involved holding focus groups using key themes and topics and was implemented with healthcare professionals from the statutory and the voluntary sector. However, considering the different working nature of professionals from the voluntary and statutory sector, separate focus groups were carried out for the participants from these two distinct groups. The use of focus groups in this research allowed generating a healthy discussion around the chosen themes/topics. Hence, allowing healthcare professionals from these two groups to present their opinions and perceptions about perceived barriers to accessing healthcare services for ASRs and their understanding of healthcare services. Each of the focus group discussions with healthcare professionals (from both statutory and voluntary sector) were tape recorded and notes were also made during the process of the discussions. The recording and notes for each of the two separate groups (statutory and voluntary healthcare professionals) were transcribed separately. The focus groups (one focus group for the statutory

sector and two focus groups for voluntary sector) were carried out by the chief investigator and the co-researcher, however transcribing of the data was carried out by the co-researcher.

Therefore this triangulated methodology helped to encapsulate the views of both the service users (ASRs) and service providers (healthcare professionals).

3.3 Research Participants

Participants were asylum seekers and refugees who resided within the boundary of South East Glasgow Community Health and Care Partnership (CHCP), and all the participants were above the age of 18 years. The sample size for the semi-structured interviews was a total of 25 participants. The other participants included healthcare professionals from the voluntary sector (7 participants) and the statutory sector (6 participants). Inclusion criteria for this group was that they should be directly working with/for asylum seekers and refugees, however in this case we did not set the geographical boundary (to specifically the South East Glasgow CHCP) because of the specialised services required for the ASRs.

3.4 Recruitment of Research Participants

The ASR participants were recruited from voluntary and community organisations from within the boundary of the South East Glasgow CHCP. Participants were provided with information on the research project and those making voluntary consent were asked to participate in the in-depth interviews.

Health professional participants from statutory service providers and voluntary service providers were recruited according to their level of work and contact with asylum seekers and refugees. Professionals from a range of services and backgrounds were invited to attend the focus groups and consent for voluntary participation was sought.

3.5 Data Analysis

Content and narrative data analysis methods were used for this research. Themes were identified through transcripts as those emergent from the focus groups and in-depth interviews. Sequences of core phrases, views, opinions and ideas were taken as indicators of themes. Content analysis on themes allowed for comparison, understanding and insight into the themes alongside comparing and linking other related themes accordingly.

First phase of data analysis was carried out by the co-researcher under the supervision of the chief investigator, which then led to the first draft report. The draft analysis was then counter checked by the chief investigator, who designed the research study/methodology and the questionnaires (for both interviews and focus groups) with advice from the line manager and a team from of the ASR advisory committee. The final report was then written up by the chief investigator with comments from the line manager, advisory committee member and the Qualitative Research Specialist from the GCPH (funding body) incorporated into the final report.

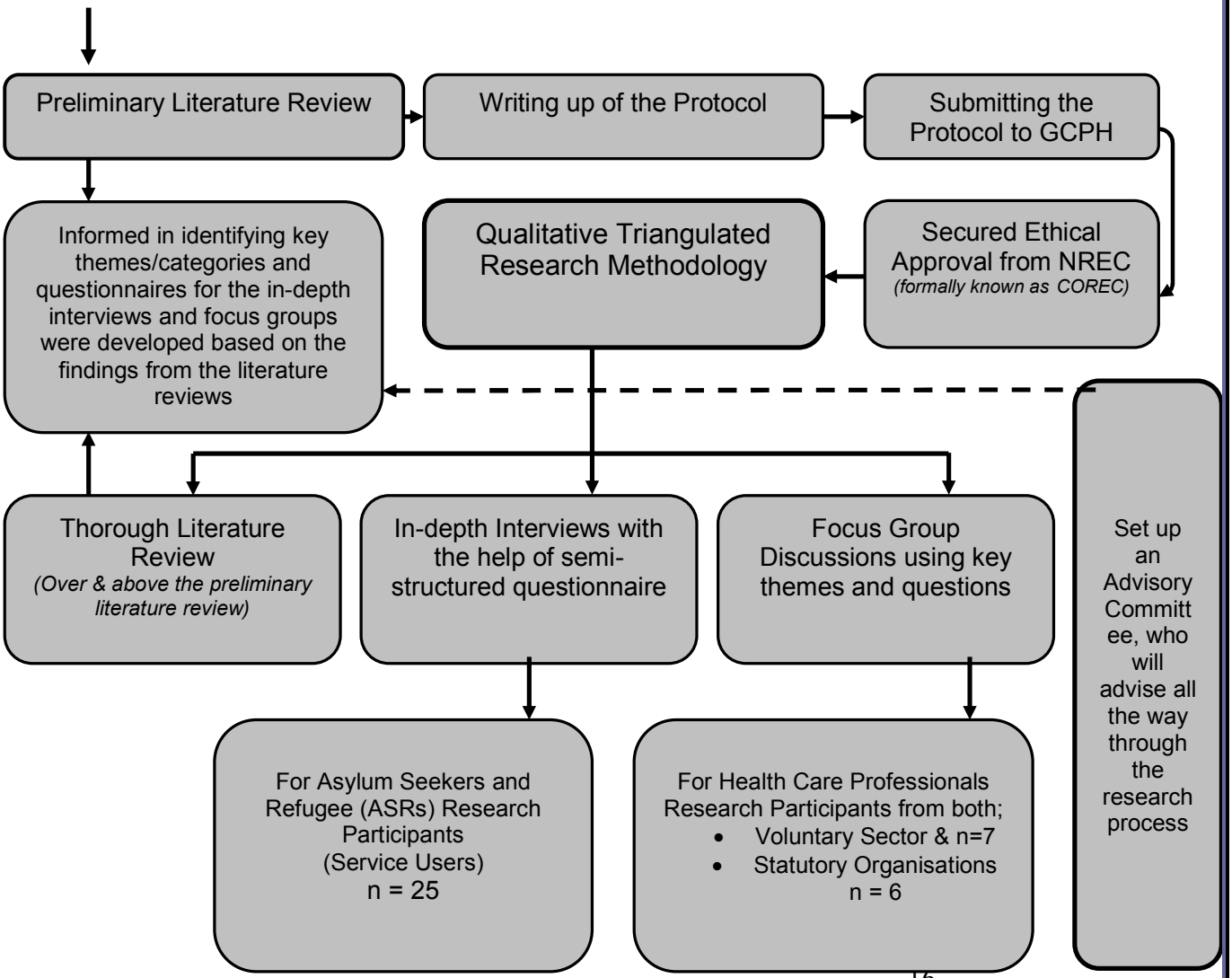
4. Ethical Approval

Ethical approval was sought from the NHS National Research Ethics Service (NRES) formerly known as the NHS Central Office for Research Ethics Committee. The ethical approval was given through the committee constituted in accordance with the Governance Arrangement for NRES in the UK at the Divisional Head Quarters and the Research and Development Directorate at Gartnavel Royal Hospital, Glasgow. Hence, all the way through this research process strict guidelines were followed as prescribed by the ethics approval committee.

4.1 Quality Assurance in Research Methodology and Design

In addition to the ethical approval of the research methodology and design, including themes, categories and questionnaire was peer reviewed by research/subject experts who were part of the ASR research advisory committee. The advisory committee worked with the research team by giving their expert opinions and advice throughout the entire process of the research.

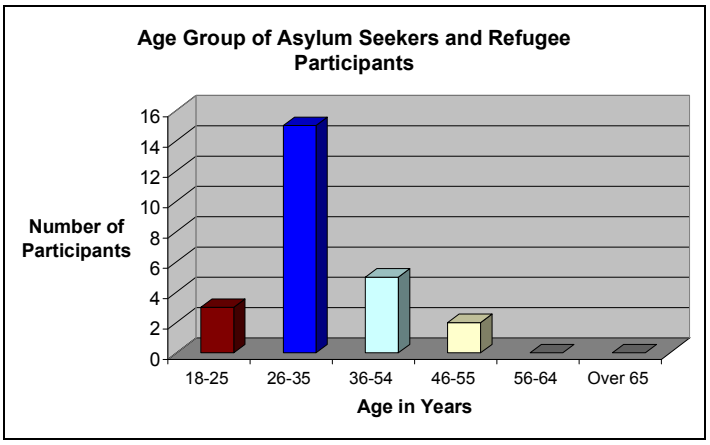
5. A Flow Diagram of the Research Process Methodology



6. Asylum Seekers and Refugee (ASR) Research Participants - An Overview

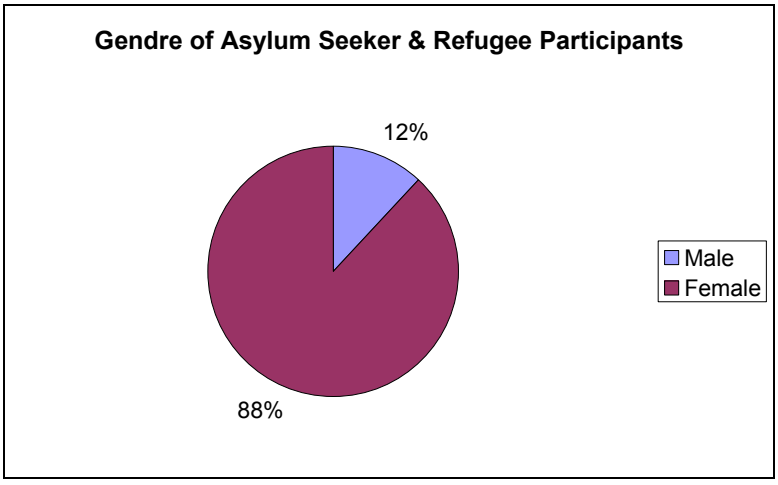
Age

As is visible from the graph, most of the research participants were within the age group of 25-35, which reflects the demography of the ASR population in Glasgow.



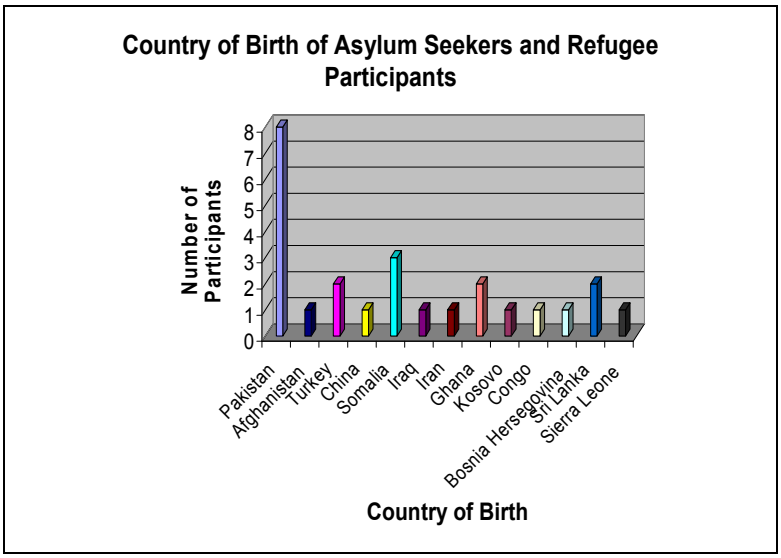
Gender

There were also more female participants in the research study compared to male, and this reflected the numbers attending the drop in's from where most recruitment was carried out. However, it is well known that men are hard to reach group in any community. In this research we had the challenge of accessing ASR men because of their status and places (Drop in Centres) where we had access to ASRs did not attract men in as greater numbers as women. Furthermore, we felt that men were reluctant to participate in the research and to be interviewed.



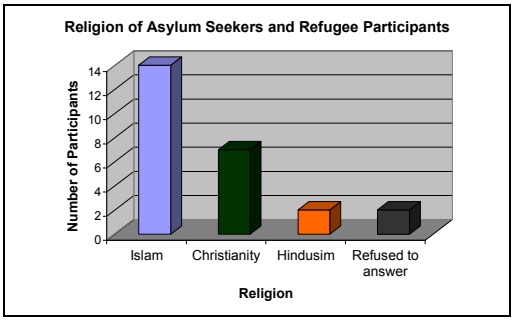
Country of Birth

There was a diverse mix of individuals from various countries, with a large majority in the study being from Pakistan. This reflects the demography of ASR population within the SE CHCP boundary; additionally Pakistani ASR population is the second highest in Glasgow (9%).



Religious Background

Religious background of participants varied, but majority of them identified themselves as being followers of Islam, followed by Christianity respectively.



Research Findings From the Asylum Seekers and Refugees Perspective

Asylum Seeker and Refugee research participants were asked about their perception of perceived barriers in accessing healthcare services and their understanding and knowledge of healthcare services. The data here comes from in-depth interviews with the help of a semi-structured questionnaire.

7. Research Findings from ASRs Perspective

As mentioned previously in the methodology section, a two pronged approach was taken in relation to recruiting participants in this study.

In this particular section we cover the findings from the perspective of ASRs, transcribed under key themes from the in-depth interviews with research participants from the ASR communities. The broader themes were identified at the time of the designing of the questionnaire, which were based on the findings of the literature reviews. However additional themes emerged during the process of the data collection carried out through interviews with the help of a semi-structured questionnaire.

7.1 Knowledge and Information on Health Services

The ASR participants were asked about the information available to them about health services after their arrival in Glasgow. Furthermore the theme also explored the participant's knowledge of health services.

The responses indicate that there seems to be differences in the method employed to relay information about health services to asylum seekers and refugees. For some of the ASR participants the information on health services was given in a verbal format and in certain cases participants were informed about resources and transport which could help them further. The ASR participants relayed their experiences to us, some of which included:

"I was given information on health services verbally" (In-depth Interview-P3)

"…Was given information [verbal] on where resources in community were" (In-depth Interview -P6)

"All the information was verbal, and also told me which transport goes to the health centre".(In-depth Interview- P10)

While some participants made reference to the information received on health services as part of the "Welcome to Glasgow" pack in written format, *"I was given* a *booklet, the Welcome to Glasgow Pack" (In-depth Interview-P7.)* Another participant indicated that their Welcome to Glasgow Pack included a "*Leaflet of nearby health centre and GPs" (In-depth Interview -P2).*

It emerged that some of the ASR participants received the information through a mixed means or various means via the project worker, the welcome pack and verbally with practical support. "*Those who found accommodation for us informed me/us where GP/Health Centre was located." (In-depth Interview -P5)*

This 'multi-method' of giving information to participants was further highlighted by other examples from participants*:*

"I was told by the project worker who was from NASS he showed me where to go and gave me the information verbally, and I was at Castlemilk at that time." (In-depth Interview -P10)

"I was given a package, given the address of my GP. And was told I would receive a letter to get an appointment to see the doctor at the Govanhill Centre. Information was clear because it was in French and easy to understand. The social worker….the project worker from GASSP gave me the information." (In-depth Interview- P8)

It seemed that most asylum seekers and refugees were content with the information provided about the health services and in certain cases the findings also indicated that language support/interpreters were available with information about the health services.
"I was informed through NASS by their Project Worker, regarding the GP, was told where and how to register. Information was given verbally. An interpreter was supplied, who explained it all in own language." *(In-depth Interview- P11)*

"*Information was related through an interpreter present and provided that spoke the language [Somalian]."(In-depth Interview- P3)*

However, it is important to note that the type of information relayed with the aid of interpreters seemed mostly to refer to the nearby or appointed health centre as the primary stop for access to other services as indicated by participants;

> *…"was told where health centre was located, GPs and hospitals". (In-depth Interview- P3)*

I received information about GP and health centre, where health centre was, and other important health information – such as contact details and phone number. (In-depth Interview- P4)

It was revealed in the primary data that General Practitioners (GPs) are the most commonly used health services by asylum seekers and refugees. As well as mentioning hospital services; there was little or no references made to specific services, apart from the accident and emergency. Hence, information about GP services was more prevalent among ASR participants who were given information via interpretation support, "*When we came they gave us the address and details of the hospital and other health services" (In-depth Interview- P9)*

7.2 Perception of Barriers to Healthcare Services

Having examined the information available about the health services to asylum seekers and refugees we wanted to explore through the interviews their perception of barriers to health services. Questions were asked about any arising issues prior to attending the services and during the services. Several useful themes emerged as barriers to accessing heath services for ASRs, which perhaps could over-shadow the positive experiences relayed about the information available on health services for ASRs, as transcribed in the above section.

7.2.1 Language Barrier

Concerns around difficulty with language were brought forward in terms of service access, "*It is easy to make appointment because health centre is near to my house; so I just visit to make an appointment. Sometimes [do it over the] phone but find it difficult due to language barrier". (In-depth Interview P15)*

It is well known that not being able to speak the language is a barrier for anyone as it has been identified by ASRs from this research. The language barrier creates a greater hindrance when making appointments over the phone, *"It is easy if you speak the language, when you speak the language you can call on the phone, sometimes you have to call on the phone, and is easy when you speak the language. But when you don't it's a real problem". (In-depth Interview - P8)* Also, during emergencies the language barrier is being reflected by the participants as a hindrance, "*There was an incident when daughter was sick and emergency services were called. They asked so many questions and not being able to understand the question – due to language problems – not being able to concentrate because of the worry, distress and anxiety of daughter being very sick and not being able to answer questions made the experience very distressing" (In-depth Interview -P11)*

7.2.2 Interpreting Services

It has emerged that interpreting services are available to overcome the hindrances created by language barriers for ASRs', hence it seems to be well utilised by this particular community. However, accessing interpreting services during emergency appointments came out to be a prominent issue, *"we always get an interpreter quickly……., unless it is an emergency, then it is not possible for them to book an interpreter at very short or no prior notice." (In-depth Interview- P15)*

Moreover, it is likely that due to the nature of urgency and the short notice period it can be difficult to arrange language interpreters, however for asylum seekers and refugees it seems to cause a lot of distress and frustration, "*for emergency appointments…you do not get an interpreter at short notice, so is difficult to communicate with the doctor". (In-depth Interview -P11)*

Some of the asylum seekers and refugees entail the help of a friend or members of the community as interpreters if the appointment is at a short notice or it is an emergency, *"One time I remember when I saw my friend, she asked me to help them when she had an appointment on the same day, so then I was to be the interpreter for them for when they went to the GP "P8* However, it seemed due to cultural/religious issues it was not always possible to entail the help of relatives

and friends, "*usually my son used to go and interpret for me, but then when it came to female problems I would ask for an interpreter" (In-depth Interview- P9)*

Overall, it has emerged that the interpreting service is well utilised, with some having ceased use due to improvements in their English.. However, having an interpreter was advised by health care providers (GPs) in order to fully address the patient's health needs fearing that some information may go amiss or be misunderstood.

"*Do not require an interpreter while accessing services. Initially for first appointment had an interpreter, but at the appointment the Dr had said English is good and so do not need to have an interpreter. Also said it would improve my English to not rely on an interpreter – so does not book or ask for interpreter anymore." (In-depth Interview- P5)*

"But they advise me to take an interpreter always so that we don't miss out any health problems due to the language barrier….. They even advise us that not to miss out on any health problem, so it is very good and beneficial for you to always have an interpreter" (In-depth Interview-P5)

One of the important points that came out of this research is a mixed message in relation to the correlation between requesting for an interpreter and prolonging appointment "*We always get an interpreter quickly, and it does not affect the timing or waiting period of our appointment, unless it is an emergency." (In-depth Interview -P15)*

"When I need the GP I prefer not to ask for an interpreter so I can get an appointment as soon as possible, because if I ask for an interpreter I have to wait for an appointment."(In-depth Interview -P9)

"One time I asked for a quick appointment because it was important and when they asked about interpreter I said no don't want one because that would mean my appointment would have been made at much later date,"(In-depth Interview -P14)

Hence, it can be said that some participants did not encounter any negative effects in terms of waiting time when requesting an interpreter, whereas others expressed concerns in relation to not getting an early appointment if an interpreter was also to be arranged. It can be assumed that the unavailability of an interpreter for emergency appointments or those made for the same day may be the cause of some individuals associating the provision of interpreters with the waiting time of an appointment. This may lead some to assume that by not requesting an interpreter the waiting period for an appointment may reduce.

7.2.3 Asylum Seeker Status (Stigma)

It has emerged from the research that there is reluctance with regards to asking for treatments or accessing services by some ASRs on account of their status as asylum seekers, an example of an attitudinal or indirect barrier to accessing health care services.

"I have a lot of health problems but present one at a time. Do not want to overburden him since he is already helping me a lot with my existing health issues that I have related to him. Feel they may think I am taking advantage of the free health system, and so do not want to give that impression" (In-depth Interview- P12)

"We think whatever we are getting it is fine, and not to demand for too much...This is my feeling about this, because of our status they might take offence or not take our demanding health care or various services too well." (*In-depth Interview -P9)*

It was also evidenced that they feel obliged to accept the services provided by the health care services and are reluctant to be critical of them, even if they had concerns.. However, the expectation that health professionals were able to meet the health needs of the patients (ASRs) was stated to be an implicit and unexpressed expectation accessing health services for treatment.

…you go to him and he says "its fine, its fine" even the dentist. I go to him and my tooth is growing out a little bit but he says "its fine" but I want him to do more… I remember with my daughter, I had to meet 3 different doctors. Before the last one gave me the right medication… They don't really examine, they just look and say "try that, try that". So it is like you are a guinea pig. And when you do not know the country you assume they know what you need or what will work. (*In-depth Interview- P8)*

7.2.4 Treatment by Healthcare Professionals

Accordingly, it appears that there can be perceptions of inappropriate or wrong treatment by health professionals, explicitly by GPs and Dentists. It is assumed that prior knowledge of which treatment or medication ASR patients' need is required to have their health needs met successfully, "*So you have to find somebody to give you the right information, you have to know what you want, and then tell them that this is what you want and not another one."* (*In-depth Interview - P8*)

In regard to the perception of inappropriate treatment, emphasis is also being given to "proper treatment" and a good relationship with the GP. "*But GP herself is nice, listens, sensitive and understanding. Important to have a good relationship with GP – since you have to go GP for problems and they should understand you – cannot understand if relationship is not good* "(*In-depth Interview - P6)* Furthermore, it seems to imply that having a good relationship with the GP leads to better understanding of ASR's health issues by the GPs and being treated for health problems better.

Having health problems treated "properly" was an important issue and predicted continued use for future or anticipated health issues

I know he will just give me paracetamol so I think it's a waste of time to go, make appointment, sit and wait and then see him if he is going to just give me Paracetamol. I can buy that from the shops. (*In-depth Interview -P25)*

Another important point which appears is the perception among ASRs that those GPs consulting materials/books during consultation/diagnosis reveals their lack of knowledge about the disease. **'***For any problem that requires medication some doctors take out a book and look through that to decide which medication to give. Makes you feel unsure uneasy about the skills of the doctor*. (*In-depth Interview - P25)*

However this may be categorised as a cultural barrier for in certain communities this action may reflect the incompetence of a healthcare professional.

7.2.5 Interpersonal skills of Healthcare Professionals

The interpersonal and people skills of health professionals were deemed to be important in making ASRs feel at ease and confident, and was seen to relate to the competency of health professionals.

Preferences were given to health professionals who were kind, understanding and patient as such characteristics made the ASRs feel more comfortable and at ease.

"Have one particular doctor – female, like her way of approach, character and method of interacting. Will always ask for that GP when making appointments, even if it means she has to wait a few days or have a late appointment." (In-depth Interview -P5)

7.2.6 Gender Preference of Healthcare Professional

Gender of health professionals is a prominent for asylum seekers and refugees when seeing a doctor/health professional. Some, however preferred a female health professional for physical health examinations and to relate health problems of a female nature "*For the gynaecological tests, I cannot speak to a male doctor but if it was a sore throat or something like this then I think it is ok".* (*In-depth Interview -P8)*

However for some, having a female health professional was a preference regardless of the type of health problem, as they felt more comfortable with a female doctor, with some stating it as a religious need. Hence, stating gender preference at the point of referral was felt to clear up problems encountered when male health professionals were involved in treatment.

"Gender of health professional is important, is important to have a female doctor. One time a referral was made to the hospital and the clinician was male, so was unable to change at such late notice and refused to sit through appointment." (In-depth Interview -P10)

8. Health Needs

In the course of in-depth interviews it has emerged that asylum seekers and refugees have both physical and mental health needs. Specific physical health needs were not the focus of in the in-depth interviews. Qualitative methodology is better suited to extracting information about access issues and mental health needs. It is well documented that one of the major heath needs for asylum seekers and refugees are mental health needs and in this research provided the scope to explore dormant health needs related to mental health and a great deal of the dormant health needs and the their grounding in the experiences of refugees and asylum seekers. This relates to particularly pending asylum cases, detachment from country and culture of origin and integration in the UK.

"Because we are very depressed, we have not had any result on our case and it has been 5 years and can't go back to our country" (*In-depth Interview- P9)*

"Mental stress and tension is very common. You are away from your children, mother passed away and I couldn't attend her funeral" (In-depth Interview P9)

One of the ASR research participants succinctly described the linkages between mental health, physical health and their status of being an asylum seeker, "*my physical health problems and mental health problems affect one another, to the point that I don't feel happy anymore. My physical health problems keep me worried and that causes stress and then the no decision on case for the past 5 years also keeps me worried." (In-depth Interview P-13)*

During the interviews most of the ASR research participants clearly mentioned some key issues i.e. i) being worried and tense with their status, ii) hopelessness, and iii) uncertainty about the future of their children. These issues are considered as some of the indicators of mental health among ASRs, and indeed the findings from the literature review identify mental health as one of the major health issues among the ASR population in general.

9. Summary

Hence the findings from the perspective of asylum seekers and refugees about their perceived barriers to accessing healthcare services and their knowledge about the healthcare system can be summarised under the following headings. The perceived barriers seem to be both attitudinal and operational, indeed from the perspective of ASRs.

Knowledge and information to health services

Method of relaying information

Overall it has emerged that there is a reasonably efficient means of relaying information about the health services available to ASRs. This can also be assumed as ASRs have a reasonably sound understanding of health services available to them. However it is to emphasise that most of the services they have described in this research were relevant to primary care services and particularly services provided by general practitioners (GPs).

It has emerged that there is one particular method frequently utilised to convey the message about healthcare services by the health authorities (healthcare service), and that is the "Welcome to Glasgow Pack".

However, it has also emerged that there are other ways through which information was relayed to ASRs, therefore the three main categories which came out to be prominent are; written (Welcome to Glasgow pack), oral and practical support.

Content of Healthcare Information

Information relayed about health services was limited to referring participants to the appointed health centre for the area which they reside in. There seems to be little or no further elaboration on health services which are a part of the health centre or provided in the health centre at the initial sign posting.

Additional information on other health services entitled to them, including what services are available, what kinds of services they provide, their intended use or how to access them does not seem to be relayed. Information on expecting future correspondence from the health centre to register and visit the doctors however was provided.

Perception of Barriers to Healthcare Services

Asylum seekers and refugees have identified several issues described as barriers to accessing healthcare services for them, these included, both attitudinal and operational barriers.

Language Barrier

Problems in accessing services or obtaining appropriate treatment were found to be compounded by language difficulties. The language difficulties affect health at all levels, from accessing services to obtaining information on service providers and service provision, and to relaying health difficulties to health professionals and receiving appropriate treatment.

Provisions to accommodate and address language difficulties have included the publishing of health material in various languages, the availability of interpreter support and help lines in various languages. Language difficulties and its effect become apparent and magnified when language support is not available such as in cases of emergency appointments or contacting emergency services.

Gender & Interpreting

Language support in terms of interpreting or arranging an interpreter is made available to all patients who require it and is offered regardless of history of utilisation of this service or apparent or obvious need. Alongside language, the gender of interpreter required is also queried and arrangements made. Obtaining an interpreter for the individual's language and gender preference for appointments at the health centre are accommodated, however gender preference of interpreter when accessing secondary or specialist services (emergency services) was found to be problematic.

Treatment and Qualities in Healthcare Professionals

Treatments given/prescribed by healthcare professionals were described positively, with compassion, understanding and patience being key traits and qualities seen as important in a health professional. Good interpersonal skills and being a competent doctor included being able to provide the correct treatment in terms of medication and make appropriate referrals to other agencies and organisations as a supplement to the treatment given by the doctor.

Gender of Healthcare Professionals

As the majority of participants were female, a preference was reported for female health practitioner for physical examinations. For some having a female health professional generally to attend to all their medical needs was the preference. The request for a female practitioner was complied with on most occasions, except in a few instances where gender of health professional was not stated in referrals to specialist services and posed a problem for the

participants. Some of the requests for a female health professional were made by the GP if he/she was aware of the patients preference, otherwise the participants would need to make the request.

Asylum Seeker Stigma

The status of being an asylum seeker seems to be considered a 'stigma' by ASRs themselves, that appears to manifest in a reluctance to fully explain all of their problems in one consultation with GP, opting for more episodic disclosure to GPs. Although to an extent ASRs are stigmatised this is not necessarily by healthcare professionals themselves however the effects of felt stigma in wider society, particularly media interpretations of migrants overburdening local services appears to be undermining ASRs' view of health care as a right and entitlement. Furthermore, a sense of obligation was conveyed by ASRs for their use of healthcare services that they felt powerless to repay.

In contrast to this, there was the unexpressed expectation form ASRs for health professionals to fully address their health needs when accessing healthcare services for treatment**.**

Health Needs

Access and use of health services was found to be mostly for physical health problems. Attending appointments with the GP were mostly for common ailments such as the cold and flu or for obtaining information on request of other services and individuals, the majority of requests relating to their case or appeal. For women with children, health visitors and post natal health services were in place. Mental health problems were loosely referred to in context of the stress and anxiety associated with waiting for a decision on their case but there was no explicit mention of mental health problems.

The Research Findings from the Healthcare Professionals Perspective

Health care professionals were asked about their perception of perceived barriers in accessing health care services for asylum seekers and refugees. However, in order to capture the views of health care providers from both the voluntary and statutory sector, separate focus groups were conducted for participants from each sector using standard questionnaire/themes for all the focus groups.

10. Research Findings from the Voluntary Sector Health Care Professional's Perspective

Although the same questions and themes were used for both (statutory and voluntary healthcare professionals) the groups there seems to be a difference in their emphasis on certain key themes.

10.1 Knowledge and Understanding of Health Needs of Asylum Seekers and Refugees

10.1.1 Mental and Physical Health Needs

It has emerged from this research that the healthcare professionals from the voluntary sector identified mental health as the major health needs for ASRs; moreover they equally address physical health needs. "*Mental health and housing is a big issue. Also physical health, But for the people who come to the drop in they are physically able to attend and do not have deteriorated physical health, but for those who attend the drop in they do have some mental health problems" (FG – Vol. Sec)*

It has been acknowledged in the research by the healthcare professionals from the voluntary sector that the figures for the physical health problems could be higher than they assume, this is due to the fact that mobility issues for those with physical health problems may hinder access to drop in centres., which means their issues of mental health may not be brought to their attention.
During the focus group discussions with the voluntary sector healthcare professionals it emerged that issues surrounding housing and asylum cases have an effect on the mental health of asylum seeker and refugees. Furthermore, the stress of pending asylum cases and deportation events of members of the community lead to indulging in behaviours detrimental to health, such as smoking,

"*Deportation as well has a bad impact on them. They always think about it "when will we be deported", all this thinking sometimes causes them health problems, and a lot of stress. And to remove the stress some of them, a lot of them say smoking is very good as a stress reliever."(FG – Vol. Sec)*

The issues of mental health needs were further emphasised by providing examples of asylum seekers and refugees receiving treatment for mental health problems, "*One of the women that I worked with was on anti-depressants, and the other women who she knew of that were waiting for their asylum cases were also on anti-depressants*." *(FG – Vol. Sec)*

Voluntary sector healthcare professionals felt that the lack of information or awareness of the services, organisations and agencies that worked for, on behalf of or advocated for asylum seekers and refugees amongst healthcare professionals, particularly for mental health problems, was viewed to contribute towards not having health needs identified.

"*Also not all GPs know about services or organisations which are out there, they are more knowledgeable and clued up about physical health problems." (FG- Vol. Sec)*

However, it was felt that health was not prioritised by asylum seekers and refugees and more attention was focused on their cases and asylum status. The effect of the wait was thought to have a bad and negative impact on their health.

"*The major issues that asylum seekers and refugees focus a lot on their status and their case, and don't really care very much about their health. Some of them have been here about 6, 7years and still haven't got their status and makes them think about the case. It does have a bad impact on their health*." *(FG – Vol. Sec)*

10.2 Perception of Barriers to Healthcare Service Provision

10.2.1 Language Barrier

Difficulties in communication, particularly those concerning language barriers was one of the obvious issues affecting the population, not only within a health context but on other areas of their life. From the voluntary sector healthcare professional's perspective for ASRs', *"Language is major issue and barrier, which means they cannot access or use services they are entitled to such as applying for a house, or a job or education or health services." (FG – Vol. Sec)*

It seems to indicate that asylum seekers and refugees coming from countries where there is a strong culture of speaking to people could face more barriers in accessing healthcare services because of their expectations. *"Especially if they come from countries where if you go somewhere you should speak to people and if they speak to you, you should have something to say to them. So the major issue is language." (FG – Vol. Sec)*

Hence, the language barrier was seen as a factor contributing in preventing access to services for asylum seekers and refugees.

"*When they cannot understand or explain their situation and they are told they are not entitled to get that right" (FG – Vol. Sec)*

However, it came out from the research findings that the resources to address the language barrier, by publications of written material in various languages was a positive step but they still think that there are a significant number of ASR community who are isolated because they can not read, and if they can, they can not understand.

"*Yes, if you go anywhere you can get a leaflet that has information and explains the services the organisation can provide, but the problem is they cannot read. Sometimes they can read, but cannot understand properly what it is saying. So they need someone to explain to them the services which they are entitled to" (FG – Vol. Sec)*

Hence, emphasis seems to be on using multiple methods to relay information about the health services.

It emerged that voluntary sector health professionals have a positive experience about the availability and quality of language support at health centres, but accessing language support for emergencies was seen to be a problem.

"*In Govanhill, most people are registered with Govanhill health centre and they are quite good in giving language support, but it is not easy to get emergency appointments due to not being able to get language support in at short notice" (FG – Vol. Sec)*

Moreover, they had incidents related to them about the quality of the language support supplied. Interpreters had been reported to be poorly skilled and were not given the correct training, "*sometimes they can get a translator, I am not sure of other languages, but for Kurdish they cannot get a good quality translator. They (ASR) are not happy with the translator. (FG – Vol. Sec)*

The key recurrent problem about the language support supplied (interpreters) came out to be issues surrounding omitting information or details as part of the interpreting "*A lot of people complain about the refusals they get from the Home Office, particularly the reasons they get a refusal. Most often say they never mentioned that in the interviews or sometimes with health services." (FG – Vol. Sec)*

Furthermore, incidences of interpreters omitting information or answering on behalf of the individual seem to have undesirable results. One particular example of such an incidence that emerged from the findings seems to very poignant, "*…..and had an interpreter. The doctors said that they may be able to do some treatment, and is possible to overcome the cancer. The doctor then said he was not able to provide treatment and when asked why, the interpreter said he told the doctor that it is not allowed in Islam, Which is not the interpreter's job to say that and told the interpreter that afterwards. But the boy did not receive treatment and died" (FG – Vol. Sec)*

In addition there seems to be issues around training for interpreters and perhaps some code of conduct for interpreting services, as it has emerged that some of the interpreters for a certain community or language were those who had initially been along to appointments and those individuals were still interpreting under professional and skilled guises on that premise without adequate training.

"*They just studied at Langside College or a college and done intermediate level courses in English. They helped asylum seekers and refugees when they first came here in the beginning, so sometimes they are still used as substitutes for interpreting. A lot of people have problems with that." (FG – Vol. Sec)*

Also barriers existed with the interpreting services for some individuals, because of the familiarity of the interpreter and being well known in the community, as a

result individuals tend to feel uncomfortable in having such interpreters. **"***The issue is that some of the communities are quite small in Glasgow, so the interpreters may be quite known. So they may not feel very comfortable in a situation where the interpreter is seen at Church or out and about." (FG – Vol. Sec)*

10.3 Factors Contributing to Low Uptake of Healthcare Services by ASRs

The barriers mentioned above certainly could lead to the low uptake of health services by asylum seekers and refugees. However, we asked voluntary sector healthcare professionals about their perception of factors within the asylum seekers and refugees that could lead to a low uptake of health services by ASRs.

10.3.1 Understanding of the Healthcare Service

Understanding the organisational structures and systems, alongside procedures was felt to be a contributing factor for the low uptake of services by asylum seekers and refugees. "*For some people it takes a while to understand the system here. Some people think you can just turn up at the health centre and be seen straight away. Don't understand the appointment system, and get really confused when told to make an appointment and come back again. So it is not really explained to people, people are just expected to find out for themselves." (FG- Vol. Sec. HP)*

Having little or no information on what to expect from health services or the range of services available to ASRs was also seen to be a problem *"They may also not know services are there, and so do not know what to expect from them*." *(FG- Vol. Sec HP)*

However, it was felt that exposure and frequent use of the health services counteracted and addressed the unfamiliarity and confusion over referral procedure and appointment system.

10.3.2 Accessing Healthcare Services

The experience of some asylum seekers and refugees of not being able to access healthcare following their asylum case failing was identified, despite having the right to seek medical attention regardless of their asylum status.

"Those who have refugee status they can access health service. But for others, asylum seekers who have refuses or appeals who have been exhausted, they cannot really access health services because probably they ask for a letter from the nurse or other professionals of support and they are not entitled any longer to using any services." (FG – Vol. Sec HP)

10.3.3 Lack of Knowledge about Organisations

The understanding of the various organisations and agencies that work with and advocate for asylum seekers and refugee's was felt to be misunderstood or confused with the agencies that this population have frequent contact with could also lead to low uptake of health services.

"*For example Refugee Council is a big organisation but a lot of people (ASRs) do not know what it is for. Sometimes they think it is a branch of the Home Office, they do not know it is a non-governmental, charity organisation who gives information to asylum seekers and refugees." (FG- Vol. Sec)*

Also there seems to be a lack of information on aspects of the health services and the various service providers involved or available to them for their health problems, both mental health and physical health. This could easily omit asylum seekers and refugees from using various health services, particularly specialised health services.

"*People I have worked with do not have knowledge of specialist services for people seeking asylum and refugee, such as the COMPASS team, who are a mental health team and part of the NHS Health board and offer services to asylum seekers and refugees*." *(FG – Vol. Sec HP)*

10.3.4 Support Networks

Having social support was not seen to be cohesive or sufficient enough to replace conventional health services or provide a long term answer to addressing health problems for ASRs.

"I think people have big support networks, like the Church or their own support networks....And with the whole stress of filling in an asylum application as well on top of the trauma they faced when they came here, even with strong support networks; you still need that extra help, that professional help. So I would not say the support networks are a substitute."(FG – Vol. Sec HP)

It seems to suggest that asylum seekers and refugees have their own social support networks, which if better supported and utilised could facilitate more effective healthcare system for this particular community. Even though it can not be a substitute for better healthcare, indeed it will certainly complement the whole process especially for the wellbeing of ASRs.

11. Research Findings from the Statutory Healthcare Professional's Perspective

Professionals from statutory organisations deemed there to be a plethora of health problems amongst asylum seekers and refugees, some of which are apparent from the beginning, others becoming more pronounced and aware following a period of time.

11.1 Knowledge and Understanding of Health Needs of Asylum Seekers and Refugees (ASRs)

During the course of the focus group discussion participants were asked about the issues that they face while working with ASRs. This helped to bring out several major issues, listed below.

11.1.1 Physical Health

It has emerged that the physical health of asylum seekers and refugees were very much apparent to the statutory health care professionals, however it was felt that much of the information received via other agencies and organisations prior to individuals (ASRs) arriving in the UK was found to be inadequate or inaccurate. **"***Sometimes we get health information but it is very sparse. It may say someone's got a limp but they are in a wheelchair, that's how bad it's been in the past (FG-St. HP)*

Therefore, it seems to suggest that due to the inconsistency in receiving information about ASR health needs from other agencies prior to registering with the healthcare system in Glasgow (UK), majority of health needs go amiss and only become apparent further on in their time in the UK. "*unmet health needs in the narrow range of health such as infectious diseases and sexually transmitted diseases and so on and so forth; a lot of these things get missed*" *(FG-St HP)*

11.1.2 Mental Health

Mental health emerged as a recurrent theme during the focus group discussion as individual participants talked in depth about this particular health need of the ASRs. It was felt that the mental health needs of asylum seekers and refugees due to ***their nature*** were not apparent from the initial stages. Some of the mental health problems were related through staff who worked closely with them (ASRs) "*But once they start to befriend the project workers, they begin to tell people why they are here, and if they have any medical problems. We don't know the medical needs of the asylum seekers in the city; probably there is a huge amount of mental health issues we have not tapped into yet because they are reluctant to tell people*. *(FG – St. HP)*

When asked, what they meant by the *nature of ASRs*, it seems to reflect on their (ASR's) uncertainty of life in the UK, relating to decisions being made on their asylum cases were thought to have a significant impact on mental health "*You can't live your life when in limbo, because you don't know what your future is going to be." (FG – St. HP)*. Living conditions of asylum seekers and being idle without work were other suggested indicators causing mental health issues

among ASRs. *"They may be in a flat, or have been for 7 years since the first dispersal and they have not had a decision. So that must play on their mind, the vast majority are also out of work. So you're sitting at home all day, you can't work and you are waiting on a decision. That must have an effect on peoples mental health I think." (FG–St. HP)*

It emerged that according to the health professionals from the statutory agencies mental health issues among asylum seeker and refuges is caused by a multitude of issues. However, there is a strong indication for mental health issues relating to experiences in their home country, particularly countries involved in civil wars, such as persecution and torture. Alongside this, it seems to suggest that not being able to work or to engage in provisions that were otherwise the norm could exacerbate or lead to a deterioration in the mental health status of ASRs.

"So the issues of asylum seekers are not simply those that happened to them in their country of origin, persecution and torture may be there and their status, their social support, lack of provision like work or something to structure their day. All of these things have a huge impact on their mental health. And particularly the uncertainty where they may become failed asylum seekers. So those kinds of pressures and being left in limbo (FG- St. HP)

Some of the research participants from the statutory healthcare professionals group thought that within the multitude of factors affecting the mental health issues of ASRs that some factors were common and shared with the general population. Here are some of the statements, which suggest this theory,

> *"but they are living in the flat and its overcrowded or damp, so just the problems that people in Glasgow have. (FG – St. HP)*
>
> *"Whatever point asylum seekers and refugees come into services you don't just the narrow range of seeing somebody who is just depressed or traumatised. You will see someone who has really difficult accommodation problems or their solicitor is not doing their job; you see the whole range, and this person is saying "I have all these needs" which is hard to pull apart." (FG – St. HP)*
>
> *"And that you cannot work, we all get some of our status in life from what we do, and you might have been a teacher, a nurse, or a medic in your country and then you're not, is very hard. I think those two things that continue to problems and the anxiety." (FG- St. HP)*

11.2 Barriers to Healthcare Service Provision

11.2.1 Language

In relation to the language barrier it is certainly evident from the research that statutory healthcare professionals do experience difficulty in communicating with ASRs despite having the facility for translation in the form of translated materials, "o*bviously the language barrier is a big barrier to access in health, even in the resources we have access to such as translated materials and translators but it is costly as well. The resources and the literature that we have access to is all very limited as well*. *"(FG – St HP)*

"….you try to give as much information as you can in their own language. But some people can't read it, they can speak the language but can't read it."*(FG- St. HP)*

Therefore, it can be assumed that even with the high cost incurred by health department on translating materials there is still a gap in conveying the message effectively through to the ASRs. It can also be assumed that along with the translation a system of relaying messages verbally in the required language may prove to be effective.

11.2.2 Lack of knowledge about the healthcare services and service providers

The statutory healthcare professionals seemed to have experiences where they felt that the asylum seekers and refugees clearly lack knowledge and understanding about the health service system in Glasgow. "*I think people have a real problem with – they think we are National Asylum Support Service (NASS) or Immigration. They don't know Glasgow City Council, the Health Board, NASS, Immigration they find that very difficult and it takes them a good few years to understand that." (FG- St. HP)*

In addition, unfamiliarity with the city and not being able to understand the services available to them can be further exacerbated by not being able to understand the composition of those services and of the system operating within the organisation providing services.

The healthcare professionals seemed to have an understating of the reasons for such lack of knowledge among ASRs, some of which is already been discussed earlier as barriers. *"It's about knowledge as well, about what services there are to access. I mean we have families who regularly take their children if they are unwell up to Yorkhill to accident and emergency which is an inappropriate thing to do if you're child has a cough or a high temperature. But if you don't speak English and can't phone NHS 24 you don't know how to access the local services, it is very difficult to know what to do." (FG – St. HP)*

Furthermore, it can be assumed that there is ambiguity and fear of the Home Office officials among ASRs, which indirectly leads to them being apprehensive about healthcare professionals creating barriers in accessing health care services. "*When I first have to make contact they are not really aware of what my role is, because they've come from a country where the health service may be very undeveloped in the first place. They are very suspicious of you initially because they think you are a government organisation, and you work alongside NASS, so you have to re-assure them that you are an advocate for them.*" (*FG – St. HP)*

The reason for ambiguity and fear amongst ASRs apparently relate to the unfamiliarity of healthcare services and the role of staff. Additionally, healthcare professionals also felt that the lack of healthcare system in the country of origin can play a role in creating suspicion and ambiguity. "*I've got full knowledge of what the range of services is, but how does an asylum seeker know if the surgery is closed they can phone NHS 24 and if it's a real emergency they should go here" (FG – St. HP).*

"When people don't have health services that are as structured as ours, they don't know what to expect. And when you don't know what to expect you don't know how to approach or which services to access". (FG – St. HP)

Moreover, health professionals seemed to think that it was the responsibly of individual health professionals working or in contact with asylum seekers and refugees to provide information on the health services.

"That is our role as individual practitioners to advise them and empower them with this information to take the service up." (FG – St. HP)

11.2.3 Information

It has been apparent from the focus group discussion with the statutory healthcare professionals that informing asylum seekers and refugees on the services or resources available to them was seen to be overwhelming. This coupled with settling in a foreign city; alongside language barriers could amplify barriers to the service provision for ASRs.

"Even if you give them leaflets, because they've just arrived here and you're bombarding them....They were saying "yes" but they don't know Glasgow, they don't know where they are and you're hitting them with all this information and are giving them too much." (FG – St. HP)

11.2.4 Healthcare Professional Issues Working with ASRs

In addition to the above barriers there seems to be issues directly related to statutory healthcare professionals that could lead to barriers in the provision of effective healthcare services to asylum seekers and refugees.

Job stress

It transpired from the focus group discussion with statutory healthcare professionals that those directly working with ASRs are stressed and overwhelmed with the problems seen in ASRs, leading to turnover of staff, "*there's been a high turnover of staff because people get very overwhelmed by the breadth of the problems these families come with and very quickly become burnt* out*." (F-G St. HP)*

Predominantly, it is the nature of healthcare professional's work, and the lack of incentives for carrying out such work has been attributed to high staff turnover.

"Also knowing that they are having serious health problems created in front of you and all you can do is direct them if they are in a crisis, but otherwise you can't do anything" (FG – St. HP)

Sometimes it is so awful and you walk away from somebody you think "I can't really help, I can tell them how to feed their child, but that's not what they need at the moment" (FG-St. HP)

Moreover, those staff who into work with ASRs are being considered as having the personal desire and sincerity to make a difference to the lives of the ASR community, "*Its down to the individual if they have a real incentive to work with that particular client group, there's no incentive to take on these extra pressures that come with these families seeking asylum, so very quickly they often move on. So it is down to whether there is an element of dedication of practitioner." (FG- St. HP)*

Therefore, it can be assumed that personal dedication, of being able to make a difference to the lives of ASRs could deduce that staff turnover. Feeling unable and helpless in addressing all the needs of service users fully contributed to job stress.

Job Role and Remit

It is apparent that there is a sincere dedication among healthcare professionals working with ASRs, which seems to motivate them to work outside their tasks and working hours. "*Most of our staff have stayed over the past 7 years, and I know there are some of our staff that give them money out of their pockets, and I say to them you can't do that. But they say "you haven't seen the flat or the state their kids are in" and they get frustrated when they phone the Home Office – they're not interested, they're just numbers to them" (FG – St. HP)*

However, these extra tasks carried out by healthcare professionals outside their roles and remit perhaps unconsciously leads to stress, "*the project workers were taking them shopping, running about. And then we had to make the decision that isn't our role, we can't be doing this. People were getting burnt out, people were getting stressed out." (F-G St HP)*

It can be assumed from the findings that either there is no absolute clarity about the roles and responsibilities for some of the healthcare professionals working with ASRs or some of the healthcare professionals are not clear about their roles and responsibilities, "they *were saying "oh it is all very expensive and we're not sure if we are allowed" and so on and so forth. If those services don't know what they can provide then what chance has an asylum seeker got? (FG- St. HP)*

Additionally, issues around lack of resources and overwhelmed work complemented with their dedication and empathy for ASRs lead to further frustration and stress amongst statutory healthcare professionals leading to barriers in the provision healthcare services for ASRs.

"It could probably be a sign of frustration as well, they have to go that extra bit further for these families, and it takes that extra bit longer but there is no resources within the practise and the phones are going while they are trying to arrange an interpreter." (FG-St. HP)

"Funding is an issue and finding extra resources in practises that are working with families seeking asylum." (FG-ST. HP)

Lack of Training

Complementing the issues described above as barriers directly related to statutory healthcare professionals is a lack of understanding among these professionals about working with ASRs. "*Again we are not given any specific training, and it's a situation where the family has arrived, we learn as we go, and constantly reflect on what's happening and improve on how we do things." (FG-St. HP)*

Hence, lack of training and need for training to work with asylum seekers and refugees came clearly apparent from this study, especially for those involved working directly with the ASRs such as, general practitioners (GPs), nurses and receptionists at GP surgeries and/or health centres.

"there is a big training need there for people who are in the front line of services. They maybe don't understand why it's so difficult to get services, why they are finding it hard to put across what the problem is" (FG-St. HP)

It seems that the statutory healthcare professionals are aware of training available but that the cost involved in training was perhaps felt to be one of the issues leading to the lack of training for staff working with asylum seekers and refugees. "*I know the Refugee council does training on awareness issues but it's expensive, and it's not something the health service particularly takes." (FG-St. HP)*

11.2.5 Lack of Coordination between Service Providers

In addition to the issues directly related to the statutory healthcare professionals, there seems to be inconsistency and lack of certainty in the roles of those working with asylum seekers as a problem leading to an ineffective working partnership within and between services.

"*There is a huge problem and you are right about other people not knowing.....I'll have social workers phoning up about the kids "asylum…can you deal with that?" and we go "no, it's a kid involved, you deal with it" or we have the police phoning saying "can you get an interpreter?" "No I don't get the interpreter, you get the interpreter". (FG-St. HP)*

Particularly, uncertainty of having access to translating services or interpreters for those working with asylum seekers and refugees was expressed to be an important issue and could led to problems in delivering effective health services.

"*All health services, whatever primary care, secondary care or whatever they have the right to interpreting, there shouldn't be any cost issues thought about. The Scottish Executive has provided this, but for example we had interactions with a patient at COMPASS who said that he phoned NHS 24, and they got all into a fluster about getting interpreting." (FG- St. HP)*

11.3 Factors Contributing to Low Uptake of Healthcare services by ASR

The above discussed perception of statutory healthcare professionals on barriers to accessing healthcare services by ASRs could evidently contribute towards the low uptake of healthcare services by ASRs. Including issues directly related to their own working conditions and environment. However, we asked statutory healthcare professionals about their perception of factors within the asylum seekers and refugees that could lead to low uptake of health services.

11.3.1 Lack of understanding of healthcare services

It emerged that not having a clear understanding of available services among ASRs and confusion surrounding it contributes to low uptake of service by ASR communities. *"I think it is difficult if people don't understand the system and it is difficult to get them into that system. So perhaps people aren't phoning or taking up what is required. I think it is about education, which is difficult to do that." (FG-St. HP)*

In relation to this, it was also being reflected that not having a clear concept or a model of health services further contributed to the process of low uptake, *"also the concept of when you are trying to encourage someone to take up a health service and they do not have a model of a health service,..... So sometimes that is magnified across everything, not just for the medication but going into the health system "what are they going to do to me? Are they going to put me in hospital? Will I be able to look after the children?" (FG-St. HP)*

It can be assumed that the apprehension about the services available, which can be attributed to a lack of information or inadequate explaining about the services perhaps account for the low utilisation of services by the asylum seeker and refugee population.

11.3.2 Low Priority to Health

Low priority towards their own health was thought to be another factor contributing towards the low uptake of health services by asylum seekers. *"Our primary remit is about education and health and preventing ill health, whereas a lot of families come from countries where there is no healthcare, so health is low on the agenda. Their priorities are having a roof over their head, having money, having food so these are the basic elements. So you're in there banging away about how important illness prevention is, it doesn't mean an awful lot to them. (FG-St. HP)*

Having a low priority towards their health is being attributed with having little understanding about the health services, which is further being linked to their knowledge and experience of health system in their native countries.

12. Positive Changes

12.1 Interdisciplinary partnership

Even though coordination between various service providers emerged to be one of barriers for delivering effective healthcare services for asylum seekers and refugee, equally *"there are [pockets of really good service, the joined up working between statutory service providers and voluntary organisations." (FG-St. HP)*

Hence the interdisciplinary partnership between health and social services was felt to be an ideal and effective model of work, but it is suggested that better communication is needed to make it work effectively.

12.2 Glasgow Model

The Glasgow system of delivering services for asylum seekers and refugees is being reflected as impressive model, *"I think the very fact that we have the Glasgow model for this, having GASSP, and the health co-ordinator in place, whereby the rest of the country don't have that." (FG-St. HP)* (s)

Furthermore, being able alter amount of work for those with high stress and high intensity cases was seen to be positive as it allowed more time to be dedicated to those who required the extra input and be less stressful for workers. *"we have separate teams set up and our caseloads numbers are smaller so we can give that extra support, whereas in the rest of the country its just a practise as anyone else, they have huge caseloads and don't have that extra time to deal with the breadth of problems." (FG-St. HP)*

12.3 Integrated Services

Statutory healthcare professionals seem to refer to some of the suggestions about integrating specialised services into generic services as not a good idea. *"It has been talked about in the past that our service should be integrated back into the generic services because it is not right to have specialist services that segregate people. But I think there is a need for a separate service, because a lot of people have complex problems and do need a separate service. They are so traumatised and need more help." (FG- St. HP)*

Hence, the existence of specialist services was thought to be necessary in addressing and treating the asylum seeker and refugee population due to the demand and the needs which this population has.

Moreover, the delivery of integrated services is being considered as a positive step, *"I think the best health promotions are those that are integrated into other services... awareness like housing and other things. Where it is integrated into other organisations were people are going anyway is where it works well." (FG- St. HP)*

Hence, it can be assumed that promoting good health and the health services and organisations developed and in existence for asylum seekers and refugees were felt to be more effective by those agencies and organisation already utilised by this sector of the population as it had presented greater opportunities for raising awareness to a larger number of people.

13. Summary

Although, the findings of the research for healthcare professionals (voluntary sector and statutory sector) have been transcribed separately in the above section, here we have amalgamated them to summarise the findings.

Knowledge and understanding of Health needs of ASRs

Service providers from statutory organisations and the voluntary sector understood asylum seekers and refugee's to have a plethora of health needs, both physical and mental. However, due to working with asylum seekers and refugees directly with their health needs, professionals from the statutory organisations were more aware of the various health problems afflicting this population and of the constraints within the health services in meeting their needs.

Mental Health

Much of the mental health needs were related to factors and events entailed to pre-migration, in their home country including being victims of torture, involved in civil wars and possibly raped or abused. Waiting for a decision on the asylum case and not being able to work was thought to cause distress, particularly with not being allowed to work and the absence of structure and role that follows/. Not being able to plan ahead and anticipating a decision on their case, in addition to hearing about families deported all was thought to substantially aggravate fears and induce stress.

Physical Health
Physical health needs of this population were linked to communicable and infectious diseases which could be treated via immunisation. Mobility difficulties amongst some were also noted, however scarcity of information upon the arrival of asylum seekers and refugees was attributed to health needs being missed or not being adequately and appropriately treated.

Perception of Barriers to Healthcare Service Provision

Language
Both voluntary and statutory healthcare professionals considered language and communication barriers to be major obstacles for asylum seekers in accessing various healthcare services. The availability of written material in different languages was known to be in existence, however how much of the material was utilised by asylum seekers and refugees or how relevant the content of the material is, and many ASRs not being able to read the available materials Were clearly issues.

Interpreter Service
Although both the participant groups (statutory and voluntary healthcare professionals) mentioned the existence of interpreters to overcome language barriers, voluntary sector healthcare professional participants seemed to question the quality of interpreters, particularly for certain languages, (Kurdish). Generally, both the participant groups concurred with the issues of interpreting services during emergency cases, however voluntary healthcare professionals highlight the issue of interpreters known within the community leading to barriers in accessing the interpreting services. Moreover the omission of certain information by interpreters was clearly a serious issue according to voluntary sector healthcare professional participants.

Lack of knowledge about the Healthcare Services and Service Provider
Unfamiliarity with the structural organisation in terms of the tiered health system and the referral procedure of the health services were seen to be a factor for asylum seekers and refugees when first accessing services. Not having information or understanding the appointment system and how to access services was problematic for and for new arrivals; however with time with increased exposure and frequent use these problems could be overcome..
Additionally, fear among ASRs of the Home Office officials leads them to be apprehensive toward healthcare professionals. Furthermore, according to voluntary sector healthcare professional participants there seems to be a lack of information about the agencies and services working for ASRs among statutory healthcare professionals, particularly General Practitioners (GPs).

Healthcare professional issues ***(Prevalent among statutory healthcare professionals' participants only*****)**

Job Stress and High Turnover

Owing to the nature of work by those in the voluntary sector, there were no reported job stresses. However for statutory healthcare workers there was frequent mention of burnt out, high staff turnover and feelings of helplessness in not being able to help their service users to the capacity that they would prefer. Often working outside of the job remit was the case, with some not working to their level of specialism as they were required to tailor their level of expertise and level of work to suit the service user, which was more apparent for those working in the field of mental health. Applying a holistic approach to working with asylum seekers and refugees was seen to be pertinent, as a variety of issues, personal, social and economic had an impact on their health.

Lack of Training

Lack of specialist training to work with ASRs was highlighted as a barrier in providing effective services. This was despite the fact that for many of the healthcare workers motivation was high to make a difference to the lives of ASRs.

Lack of Coordination

There is a lack of coordination among health and social care service providers and others working for asylum seekers and refugees leading to confusion and thereby acting as a barrier in providing effective service the ASR communities.

Factors Contributing to Low Uptake of Healthcare Services by ASRs

Regarding the specific question of low uptake of healthcare services by ASRs over and above the barriers already mentioned, both research participant groups agree that there is a;

- Lack of understanding among ASRs with regards to the healthcare services
- Lack of knowledge about the organisations within the healthcare services
- Apprehension about the healthcare service providers, which in turn stems from alack of knowledge about healthcare professionals within the ASR communities

However, the voluntary sector healthcare professionals felt that support system available was not cohesive thereby leading to low uptake of healthcare services. Likewise, both statutory and voluntary healthcare professionals felt that low priority was given by ASRs their health and this could be conferred to their past experience and culture of health and healthcare in countries of origin.

Positive Changes

It has emerged that an improved means of communication between health and social services could lead to (improved communication) an effective model of work in order to reduce barriers for delivering effective healthcare services for ASRs.

Specifically the *Glasgow model* of delivery of services for ASRs is adaptable to the situation of the case being dealt with thus staff are not over-burdened with

plethora of caseloads and as a result quality time is put into cases requiring extra support.

In relation to integrating specialised services, this was considered to be a positive notion by some statutory healthcare professionals; others did not support this notion. However they believed that the complexity of the nature of problems faced by ASRs required ASRs to have a specialised service.

The translated material was seen to be a positive step towards encouraging asylum seekers and refugees to access healthcare services, with availability of material in various formats to reach a large majority of the population. Interdisciplinary communication and work between services and organisations to address gaps between services or to pick up on the health of asylum seekers and refugees in between visits or appointments was also employed.

13.1 A summary table of the key attitudinal and operational barriers from the perspective of both, service users (ASRs) and service providers (healthcare professionals – from voluntary and statutory sector.)

	Asylum Seekers & Refugees (ASR) Perspective	**Service Provider Perspective**	
		Voluntary Sector Healthcare Professionals Perspective	**Statutory Sector Healthcare Professionals Perspective**
Attitudinal Barrier	○ Status of Being an Asylum seeker ○ Perception of wrong treatment by healthcare professionals (GPs and Dentists) ○ Doctors consulting Books in between consultations	○ Lack of information or awareness of organisations and agencies working for ASRs among statutory healthcare professionals, particularly GPs ○ Familiarity of interpreters within the ASR community ○ Failed asylum case ○ Misunderstanding about agencies and organisations - Fear of Home Office	○ Apprehensive of healthcare professionals - Fear of Home office ○ Lack of similar healthcare system in their country of origin ○ Unfamiliarity with the roles and remits healthcare professionals ○ Low priority to health by ASRs
Operational Barrier	○ Language Barrier (particularly for appointments over the phone) ○ Interpreting Service during emergency ○ Gender preference	○ Language ○ Most ASRs can not read ○ Accessing language support ○ Quality of language support (Interpreters) ○ Omitting information or answering on behalf of the individual (ASR) ○ Lack of a Code of Conduct for interpreters ○ Lack of understanding of organisational structure and systems and procedures ○ Lack of knowledge about specialist services ○ Lack of support network for ASRs	○ Language - Not being able to communicate effectively ○ Lack of knowledge and understanding about the health services ○ Unfamiliarity with the city – Glasgow (country) ○ Not being able to understand the composition and operating system of services ○ Not being able to access the local services ○ Job stress among statutory healthcare professionals working directly with ASRs ○ High turnover of healthcare staff directly working with ASRs ○ Lack of training for healthcare professionals to work with ASRs ○ Lack of coordination between service providers

14. Discussion

This qualitative research was carried out within the boundary of Glasgow South East Community Health Care Partnership (CHCP) with representative samples from asylum seekers and refugee (ASRs) participants, and healthcare professional participants representing both the voluntary and statutory sector. The research indicates a strong correlation between the perceptions of barriers to accessing healthcare services by ASRs, from both the healthcare professionals and the ASRs themselves.

Furthermore, the results from this research are supported by the findings from the literature reviews, which examined other research carried out in various regions of the UK. Moreover, there was a scarcity of published research carried out in Scotland on the subject of ASR's perception of barriers to healthcare services.

Therefore, the findings from this particular research are paramount to policy makers, healthcare service providers and indeed for those who wish to endeavour to improve the health of this vulnerable group (ASRs). Certainly, we do not suggest these findings are exhaustive, and it only covers SE CHCP. However, this particular community (ASR) being a special group there are specialist services which are applicable Glasgow wide and in some cases Scotland wide, therefore the findings will be useful for most healthcare professionals across the spectrum working with/for asylum seekers and refugees. Furthermore, this research simultaneously captures the perceptions of both the service providers (healthcare professionals) and service users (ASR), which does not seems to reflect in any of the studies undertaken on ASRs in Scotland, certainly not in studies that we have come across during the process of this research.

14.1 Conclusion and Recommendations

The following are the conclusion and recommendations from this research intending to guide those working with/for ASRs, particularly in Glasgow.

- **Lack of Knowledge about healthcare services and the system:** Despite the dissemination of information about healthcare provision given to new ASRs, the evidence here suggests there are still barriers to understanding the structures and procedures to accessing services within both voluntary and statutory. This is related to issues of understanding processes as much as information of where local services are.

- **Information on healthcare services through multiple means and methods:** It emerged that the best and effective way of relaying information to ASRs about the healthcare service is through multiple methods i.e. written, verbal and translated in their languages. It is advisable to ensure that the materials (leaflet and others) are available through multiple means i.e. healthcare workers/visitors, GP Surgeries, social work and local/community and voluntary organisations.

- **Interpreting Services:** Even though it has emerged that interpreting services are available and most ASR communities are aware of such services, some important issues were raised about the quality of interpreting services. A code of conduct for interpreters may be required, particularly in sensitive health care settings. Also it is suggested that the healthcare professionals need to be aware of the cultural and social issues in providing interpreting services, i.e.: These could encompass gender specific interpreter and checking interpreter qualifications. This research shows that ASRs are not comfortable with interpreters, who are particularly well known within their small community), hence it is advised to be cautious of interpreters known within certain ASR communities. Most importantly, the healthcare professionals need to be aware of the interpreters omitting information during the process of translation which can have major consequences on healthcare services for ASRs.
  Non-availability of Interpreter services: There seems to be difficulty for ASRs in accessing interpreter services during emergencies, both for primary (appointment with the GP) and secondary healthcare (accident and emergency). Hence, it is suggested to improve access to interpreter services at all times to avoid any delay in accessing healthcare services by ASRs.
- **Communication and attitude of healthcare professionals:** It is strongly suggested that the communication styles of healthcare professionals play an important role in accessing healthcare services by ASRs. It is advisable that more efforts should be put into improving the communication and attitudinal skills of healthcare professionals, including sensitivity to the issues and experiences of ASRs.

- **Clarity of roles and remits for statutory healthcare professionals:** There seems to be confusion about the clarity of roles for healthcare workers. Hence it is suggested to perhaps matching the broader healthcare needs of ASRs with the current job description of healthcare workers and possibly revaluating their roles and remits. It is worth considering an assessment to see if there are new challenges to address in meeting the full range of needs presented by ASRs.

- **Training for healthcare professionals:** This research certainly identifies a need for cultural competency training for healthcare professionals working with ASRs, particularly for those working directly with ASRs. Moreover, training is also being suggested on basic counselling skills for healthcare professionals visiting ASRs at their premises, moreover support is also advised for professionals who have to deal with overwhelming circumstances.

- **Coordination and better communication between service providers:** To avoid occurrence of barriers due to the lack coordination and communication between the service providers, it is recommended to further improve the communication system between all the service

providers of ASRs. This can be achieved through clarity of their roles and remits and also by ensuring that there is a better system of sharing information among service providers.

- **Integrated services:** This research highlights a mixed message about the delivery of integrated services for ASRs. It certainly approves the system of integrated services currently available; however it is suggested to further strengthen this system and improve the communication between services, particularly health and social care services.

- **Awareness of the indirect barriers:** Whether it is needs of mental health among ASRs or delivery of services by healthcare professionals and barriers to accessing services. All of these issues are largely affected by ASR's cultural, religious, social, status of being an asylum seeker and their experiences in their county of origin. Hence, it is recommended that the healthcare professionals and policy makers have in depth understanding of such indirect causes of barriers before designing and delivering services for this particular community.

- **Heterogeneity of Asylum Seekers and Refugees (ASRs):** Like any other community ASRs are not a homogeneous group. However unlike any other communities, ASRs are unsettled, unsure of how long they will be in the UK, fresh with memories of past experiences. With the additional barrier of not having the right to work and the majority are completely ignorant of the healthcare system of Glasgow or similar systems with many not being able to speak the language. Hence, it is this short period of time as ASRs with numerous complications which completely differentiates them from other disadvantaged groups, including BME groups. This makes it harder for healthcare professionals to understand their health needs and issues surrounding access to healthcare services.
  It is recommended that healthcare professionals and policy makers understand these subtleties of coming from different countries, which also means different ways to addressing the healthcare and service needs of this particular community.

- **Positive Changes**: There were several positive comments about the healthcare services and the service provision which emerged from this research. However, there is still room for improvements.
  Relaying information about health services: there seems to be a reasonably good response from the ASR participants about the availability of information on health services. However there is still much required improvement in the delivery of this service and accessibility to the wider audience including the use of multiple methods.

Glasgow Model: The system of delivering services for ASRs in Glasgow is being hailed as an impressive model allowing alterations in the level of work in relation to those health professionals with high stress and high intensity of cases.

Integrated Services: The delivery of integrated services to ASRs has emerged to be a successful method of providing effective services by healthcare professionals.

Interpreting Services: This service seems to widely available and well used in Glasgow by ASRs however it needs improvement as suggested above.

14.2 Further Recommendations

In addition to the concluded points with recommendations mentioned in section 14.1, here are some further key recommendations.

Strategic Policy is recommended for healthcare policy makers within the Greater Glasgow and Clyde Health Board and South East CHCP on relaying information to healthcare services and structures within the healthcare system with continuous monitoring and evaluation process involving, communities and voluntary organisations.

Decisional policy on the asylum status needs to be reviewed by the Home Office in order to shorten the decision period and facilitate avoiding ASRs being left in uncertain situations for a long period of time (up to 5 years). Thereby help in improving some of the key health and wellbeing issues among ASRs, such as mental health. Even though such policies are not formed by healthcare policy makers and may be politically sensitive, nevertheless, it is important from the perspective of good health and wellbeing of ASRs and therefore healthcare policy makers have a role to play in influencing such policies.

Policy on effective engagement and participation of ASRs is needed, it is understood that there are standards of community engagement (i.e.10 standards of community engagement). However it is recommended that there should be specific policy within the SE CHCP and Health Boards across Scotland for effective engagement of ASRs and encourage their involvement in positive activities to keep them occupied and avoid the feeling of being in isolation, uncertainty and worthlessness. Moreover, there are asylum seekers and refugees, who are employable and should have the opportunity to develop their skills and contribute towards the Scottish society as long as they are legally residing in the country, either voluntarily or as paid employees. Such a policy will facilitate in giving respect and worthiness to ASRs and thereby improving their health and wellbeing. One area where they might be of particular benefit to the wider community is as mentors to newly arrived ASRs to help overcome some of the problems of accessing health services documented in this report.

Staff Training and Development should be further encouraged by SE CHCP and Health Boards across Scotland, particularly those staff working directly with ASRs should be provided specialised training to deal with this particular group. Training such as cultural competency and training on working with vulnerable groups, which involves handling emotional circumstances in advisable.

Effective Data Collection and ethnic monitoring of ASRs is highly recommended for all the Health Boards across Scotland. Particularly with reference to this research study SE CHCP and Greater Glasgow and Clyde Health Board should be actively monitoring the access of healthcare services by ASRs and having a centralised data on ASRs residing in Glasgow. Such initiative will contribute to researchers, policy makers and healthcare service providers in addressing the specific health needs of this particular group.

Overlap between asylum seekers and refugees: it is highly recommended for those working to improve the health of ASRs to be precautious about ***asylum seekers*** and ***refugees*** as most of the time these two groups are considered as one group (with no distinction being made). However their needs could be completely different or similar depending on the duration of being a refugee.

Effective communication between numerous service providers: it is recommended that more efforts can be put towards improving the communication between numerous services providers, i.e. between social workers, healthcare visitors and police. Now with the integrated healthcare system in Glasgow/Scotland through the formation of CHCPs it has become more important to have an efficient communication system.

Information sharing it is highly recommended to look into the needs to improve the methods of sharing information between various health and social care providers for asylum seekers and refugees; particularly, between service providers from the voluntary and the statutory sector. Principally it is the responsibility of mainstream healthcare providers and policy makers to engage and work in equal partnership with the voluntary sector.

Further Research

Overall to address some of the challenges that have arisen in this research and to complement these findings further research is advised with a larger sample size within a larger geographical area in Glasgow/Scotland. Particularly, a larger quantitative research study addressing specific issue(s) coming out of this research.

Moreover it is anticipated that the findings of the research will help and contribute to better address the health and healthcare needs of ASRs living in Glasgow/Scotland.

14.3 Challenges during the Research Process

It is well established that carrying out an effective research with a vulnerable group like asylum seekers and refugees, within a short span of time is always challenging. Here are some of the major challenges that have arisen;

Scarcity of Research and information about ASRs in Glasgow: there are a limited number of researches available on ASRs health in Glasgow; however up to some extent we have managed to overcome this by accessing both published and unpublished researches. Moreover, this meant spending more time searching for research carried out outside of Glasgow, Scotland. Hence it took a greater amount of time in designing and developing questionnaires and themes based on the findings from the literature review (preliminary literature review). In addition to this there is not a centralised source to access data on ASRs living in Glasgow due to which more time was spent than previously assumed on collating information through numerous sources.

Accessing ASR research participants: Due to the fact that there was not enough information available about ASRs in Glasgow it was even more difficult to reach out to ASR groups within the limited study area of SE CHCP boundary in Glasgow. Furthermore, there were issues around 'dawn raids' occurring at the time of the research which meant that the ASRs were apprehensive about people approaching them. However this was overcome by contacting 'drop-in' centres and spending time with the ASRs (along with the officials) at numerous drop-in centres which helped many ASRs to participate in this research.

Language barrier: In the process of interviewing ASR participants' language was an issue however it was partly overcome by having a co-researcher who was fluent in speaking the required language. Moreover some of the research participants were dropped out to avoid the loss of data in translation.

Accessing research participants from the statutory healthcare sector: This was a hindrance in the process of the research which led to delay in holding a focus group for these particular research participants, and had to compromise with one focus group as opposed to the original proposal of two focus groups.

Overall the delay in the entire process of this research was a major hindrance due to numerous factors (some of which described above) including securing ethical approval for the research and recruiting an appropriate and efficient co-researcher.

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