



Migrants & public services in the UK: a review of the recent literature

Lisa Arai

The views expressed in this document are those of its author and should not be regarded as representing the views of COMPAS.

Abstract

This review is a survey of recent research on migrants' use of public services (health and social care, education, social housing and selected services provided within the criminal justice system). It offers a broad overview of existing research evidence in this field and an extensive annotated bibliography of key sources.

There is substantial work on this theme, in particular, on the health of asylum seekers and refugees, though this work rarely *specifically* examines service use, and much of it is very general in nature. Fewer research projects focus on migrants' use of education, social housing and criminal justice services. Where access to services is examined, it is usually the experience of, and barriers to, service use that is the focus, rather than other aspects of service use. Analysis of newspaper coverage showed that use of public services by asylum seekers is a prominent theme in the media, and the cause of hostility in some localities. In sum, this review finds a lack of methodologically robust research on migrants' use of public services. In general, much of the research in this area is generalised, local and small-scale in nature. There is a need for further research if the service needs of migrants are to be met in the future.

Author:

Lisa Arai works in the Child Health Research and Policy Unit at City University. Her research interests are in the areas of: child and adolescent health and well-being; access to health and other services; the health and well-being of minority ethnic populations; and methodological innovation. Email: l.arai@city.ac.uk.

Acknowledgements:

Thanks to those individuals who responded generously to requests for help with this project.

Contents

Glossary

PART ONE: Reviewing the background and literature on migrants and public services in the UK

- Introduction
- Why a review?
- Volume and Diversity of Migration
- Public Concern
- A synthesis of the research literature
- General observations
- Key factors affecting service use in the UK
 - Health and Social Care
 - Education
 - Housing
 - Criminal Justice System
- Concluding remarks

PART TWO: Appendices of Key Literature and Resources

- Introduction to Appendices
- Appendix A: Various
- Appendix B: Health & social care
- Appendix C: Education
- Appendix D: Social housing
- Appendix E: Criminal justice
- Appendix F: Databases, resource websites & other resources
- Appendix G: Key research organisations concerned with migrants & migration
- Appendix H: Key journals concerned with migrants, migration & minority ethnic groups
- Appendix I: Key organisations concerned with the welfare of migrants, refugees & asylum seekers
- Appendix J: Newspaper review

Glossary

BMA	British Medical Association
CI	Confidence intervals
DfES	Department for Education and Skills
DoH	Department of Health
ELE	Exceptional Leave to Enter
ELR	Exceptional Leave to Remain
ESOL	English for Speakers of Other Languages
U/GUM	Genito-urinary/genito-urinary medicine
GLA	Greater London Authority
HIV/AIDS	Human Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome
HO	Home Office
HLR	Humanitarian Leave to Remain
HRA	Human Rights Act
ILR	Indefinite Leave to Remain
ISC	Indian Sub-continent
LA(s)	Local Authority (s)
LEA(s)	Local Education Authority(s)
NASS	National Asylum Support Services
NGO	Non-governmental organisation
NHS	National Health Service
OR	Odds ratio
PCT(s)	Primary Care Trust(s)
PTSD	Post-Traumatic Stress Disorder
RSI(s)	Refugee specific initiative(s)
STI	Sexually transmitted infection
TB	Tuberculosis

PART ONE: Reviewing the background and literature on migrants and public services in the UK
--

Introduction

The management of migration related issues is a persistent theme in contemporary political and public debates, and part of a wider debate on the status of public services. Despite substantial amounts of research being carried out in both these areas, in particular, on the health of asylum seekers and refugees, work rarely examines service use specifically and much of it is very general in nature. There is also a disproportionate focus on asylum seekers and refugees as opposed to other categories of migrant. Fewer research projects focus on migrants' use of education, social housing and criminal justice services. Where access to services is examined, it is usually the experience of, and barriers to, service use that is the focus of research, rather than other aspects of service use.

This review aims to be a useful reference to researchers interested in migrants' use of public services. The main substance is contained within Part Two which includes: modified abstracts on selected themes (grouped by type of service); lists of useful resources, research organisations and key journals; and details of a press survey. Part One begins with a brief discussion of recent trends in migration and the rights and entitlements of migrants. Public concern over these factors is explored using a survey of recent press reports. This is followed by a synthesis of current research material, including observations on the literature and key factors affecting service use. A short conclusion draws together the main strands of this study and suggests some areas for future research.

Why a review?

There are two main reasons why it is important to increase our knowledge of migrants' use of public services. The first reason relates to the volume and

diversity of migration, both in actual and perceived terms and demands that this may place on public services. The second reason relates to public concern, as portrayed in the media, for overburdened and stretched public services. This is perceived as being made worse by 'floods' of migrants requiring support and services.

In relation to service use, key questions that might be asked include:

- Do migrants access public services?
- What services do they access, and in what numbers?
- Is service provision appropriate? If not, what are the factors affecting use of services by migrants?
- Does migrants' use of services have implications for the host population?
- What are the implications for service providers and future service provision?

It is important to understand migrants' access to services so that the services, help and other support underpinning the process of integration are appropriate, efficient and cost-effective. Migration, in some form, is inevitable, and shows no signs of slowing down in the future. There is therefore a clear need to understand the patterns of migrants' access to services. The move towards managed migration,¹ and service provision, access and use is central to this.

Volume and Diversity of Migration

Net migration in the UK has risen substantially in the past decade or so. In 2003, 151,000 more people migrated to the UK than left to live abroad. The number of people arriving to live in the UK (for at least a year) remained at 513,000, the same as the figure for the year 2002. The number of in-

¹ Spencer, S. (Ed) (2003). *The politics of migration: managing opportunity, conflict and change*. London: Blackwell Publishing Ltd.

migrants citing 'formal study' as their main reason for migration increased from 86,000 in 2001 to 135,000 in 2003; a 58 per cent rise. The proportion of in-migrants who were British citizens increased from 18 per cent in 2002 to 21 per cent in 2003.

Between 1994 and 2003, net in-migration of Old Commonwealth citizens nearly trebled. Over the same time period, net in-migration of New Commonwealth citizens doubled, and net in-migration of 'other foreign' (any country outside the EU and the Commonwealth) citizens more than trebled. Over the same period, about 1.5 million people born in the UK migrated to other countries, and more than 800,000 UK-born migrants returned to the UK.²

In the last decade, the number of people who sought asylum in the UK was around 655,000. Of these, around a third was given refugee status and about one in five appeals resulted in the granting of refugee status.³ Those who are given no rights to remain do not necessarily leave the UK; it is estimated that only about one in five asylum seekers who have been refused permission to stay actually leave the country.⁴ The ten main countries-of-origin of asylum seekers to the UK in 2003 were: Iraq, Somalia, Zimbabwe, Afghanistan, China, Iran, Turkey, Pakistan, India and the Democratic Republic of the Congo (DRC—previously Zaire). Together, these accounted for 58% of all applications from asylum seekers.

However, migration data are notoriously flawed. Not only is it difficult to get accurate figures on those entering the UK, exit controls are virtually non-existent. This makes it exceedingly difficult to get total numbers of migrants. Moreover, people move both between legal categories and change between illegal and legal statuses. For example, not all migrants are asylum seekers, and the status of migrants can change over time. An individual might enter the country on a student visa, for example, but marry a UK citizen and

² <http://www.statistics.gov.uk/cci/nugget.asp?id=260>.

³ IPPR (2003). *Asylum in the UK: an IPPR Fact File*. London: IPPR.

⁴ Home Office (2003). *Quarterly Asylum Stats*. London: Crown Copyright.

remain in the country indefinitely, or make a claim for asylum if the situation in their home country becomes unstable while they are living in the UK.⁵ Examples of the main datasets that can be used to study the behaviour of migrants in the UK are given in Part Two.

Not only is there a sense that the volume of migration is on the increase, but the complexity of migration categories also appears to be increasing. Within legal categories there is a complex range of different entitlements (Table 1). Even within one migrant status category different people may be given different entitlements. For example, international students requiring a loan or other form of support will only be entitled to apply after they have been in the UK for more than 3 years.

A lack of coherence or transparent rationale exists within the system. This may be due to the fact that it has had an ad hoc development over many years. But it also reflects competing pressures, such as whether to provide access to a service because the individual needs it, or because it is good for society (e.g. public health). A service may well be denied in order to protect public funds, ensure that access does not prove an attraction for unwanted migrants or to appease public opinion. This means that neither service providers, advice-givers nor migrants themselves are clear as to what services they might be entitled.

A series of measures introduced over the past decade have affected the rights and entitlements of migrants in the UK. In the 1990s, there were three pieces of legislation to restrict or curtail migrants' access to services and welfare benefits: the 1993 Asylum and Immigration Appeals Act; the 1996 Asylum and Immigration Act; and the 1999 Immigration and Asylum Act. In the first decade of the new century, there have been two major pieces of legislation: the Nationality, Immigration and Asylum Act 2002 and the

⁵For a comprehensive overview of the validity of British data on asylum and migration, see Audit Office (2004). *Asylum and migration: a review of Home Office statistics*. London: Crown Copyright.

Table 1: The rights & entitlements of migrants

Type of right or entitlement	Organisation providing it	General restrictions or allowances for all migrants	Rules for specific migrant groups
Various social security benefits & credits	Department for Work & Pensions; Inland Revenue; NASS	<p>Receipt depends on type of migrant & type of benefit. Those who have paid NI contributions in other countries may receive some NI—based benefits.</p> <p>Council Tax, Housing Benefit, Income Support & Income-based Jobseeker's Allowance payable if individual has right to reside & is habitually resident in the UK.¹</p>	<p>Asylum seekers must apply to NASS for help. NASS provides support that is 70% of Income Support levels.²</p> <p>Asylum seekers who are granted refugee status or ELR can claim full Income Support from date of new status.¹</p> <p>Refugees have same rights as resident UK citizens.</p>
Maternity payments	Department for Work & Pensions; NASS	Receipt depends on type of migrant & type of benefit. Those who have paid NI contributions in other countries may receive some NI—based benefits.	£300 (in the form of vouchers) may be paid to asylum seekers supported by NASS. ²
Health services	NHS Trusts	The NHS trust should establish if a person is entitled to free treatment. All patients are subject to the same registration process regardless of legal status or nationality. Hospital staff may ask questions about the patient's residence in the UK. ³	Asylum seekers have right to use all primary & secondary healthcare services. From 1st April 2004, unsuccessful asylum seekers have to pay for non-urgent in-patient hospital care. ^{3,4} Refugees have same rights as resident UK citizens.
Student loans & other forms of support for students	Student Loans Company; colleges & universities	Residence requirements must be met for student loans. Student must have been living in the UK the three years immediately before the start of the academic year in which the course begins. ⁵	Asylum seekers are not eligible for student support, Access Funds or Hardship Loans & usually have to pay overseas students fees. Exceptions can be made when the student has been living in the UK for three years (or

			the college may make a concession). ⁶
Schooling for children	Local Education Authorities	Immigration status makes no difference to educational entitlements up to age 16. ⁷	Refugee & asylum-seeking children can use pre-school facilities. Children aged 5-15 are required to attend school. ⁷
Housing	Local Authorities	Residence & other requirements must be met to be eligible for social housing. ⁸	NASS provide accommodation for asylum seekers who cannot stay with friends or relatives ² People with refugee status or ELR can join the waiting list for public housing.

Notes for Table 1:

1. http://www.dwp.gov.uk/lifeevent/benefits/extra_rules_abroad.asp
2. http://www.refugeecouncil.org.uk/infocentre/entit/sentit001.htm#nass_package
3. <http://www.refugeecouncil.org.uk/infocentre/entit/sentit004.htm>
4. See: http://www.refugeecouncil.org.uk/downloads/briefings/health_mar04.pdf for details of these changes.
5. https://www.studentsupportdirect.co.uk/protocol/view_answers_public.do?moreIndex=3&catId=10168
6. <http://www.refugeecouncil.org.uk/infocentre/entit/sentit006.htm>
7. <http://www.refugeecouncil.org.uk/infocentre/entit/sentit005.htm>
8. http://www.odpm.gov.uk/stellent/groups/odpm_housing/documents/page/odpm_house_609062-06.hcsp#P128_21145

Asylum Act 2002 and the Asylum and Immigration (Treatment of Claimants, etc) Bill (November 2003). Though these legal developments were meant to restrict numbers, there were actually increases in those seeking asylum in 1994 and 1997, so the new legislation did not appear to have an immediate deterrent effect.⁶ There is not the space here to consider fully the nature, scope and impact of these acts (these are discussed extensively in a recent publication by the Welsh Assembly Government⁷), but it should be noted that legislation relating to asylum seeking and other forms of in-migration

⁶ Audit Office (2004). *Asylum and migration: a review of Home Office statistics*. London: Crown Copyright.

⁷ Welsh Assembly Government (2004). *Asylum seekers and refugees: guidance for housing and related service providers in Wales. A consultation paper*. Cardiff: Welsh Assembly Government.

(such as entrance to the UK as a worker or student) is fast-changing, and the rules governing immigration, the use of the welfare system, rights to housing and the right to work can change quickly. An important implication of this is that the literature on migration rapidly becomes out-of-date. For this reason, the review covers research dating from 1997 to the present, with greater weight given to work published since 2003.

Public Concern

There appears to be widespread public unease about the 'swamping' of services by migrants, certainly if judged by press reporting. Where public services are under-resourced, over-burdened and poorly managed, or a combination of all three, may be debated but what is certain is that they are subject to increased scrutiny.

Analysis of newspaper coverage, undertaken to gain a sense of public concern, was based on the InfoTrac Custom Newspaper database. The analysis focused on four national newspapers: The Times, Independent, Mail and Mirror, all published daily. The search terms 'refugee' or 'asylum' or 'migrant' and 'service' were used to find relevant articles published during a one year period – from May 2003 to May 2004. Further details on the review and newspaper abstracts can be found in Part Two.

Overall, use of services by asylum seekers appeared as a prominent theme in the media, and the cause of hostility in some localities.

In particular the use of health and social care services by migrants was a frequently-cited concern. The specific issues covered fall broadly into three areas: the cost of medical services (including payments for services, or 'health tourism'); the danger from infectious diseases; and issues around testing/screening for HIV and/or tuberculosis (TB). In many reports, medical personnel expressed reservations about proposed government 'crackdowns' on health tourism, thus revealing important tensions between government priorities and doctors' perception of their responsibilities.

The perceived danger to the general public from infectious diseases brought into the country by migrants was also a major concern. There were a small number of newspaper reports on HIV positive migrants (usually asylum seekers) 'deliberately' or 'recklessly' infecting resident women. In these cases, it was the threat from infection *and* abuse of services (HIV services, housing etc) that were reported. The wisdom or otherwise of testing/screening for HIV and TB was also a feature of a number of reports and this was often linked to the both of the themes described above.

Fewer newspaper articles reported on the education of migrants. Those that did tended to centre on the difficulties of teaching children who do not speak English and/or who have suffered trauma. There were also stories expressing a general strain on services including the costs and impact on the local population.

Articles related to social housing highlighted access and the abuse of the social housing systems and/or the housing benefit system. Far more articles were on the accommodation of migrants more generally. Stories of abuse of various systems were nearly always accompanied by reports of the costs to taxpayers.

There were a limited number of articles on the use of criminal justice services by migrants, though there were several reports on the extensive use of legal aid by the foreign-born (especially during application for asylum), the abuse of the system by solicitors and, to a lesser extent, the 'criminality' of some migrants (i.e. their engagement in criminal acts). There were a small number of reports on the abuse of the criminal justice system or human rights legislation.

Overall, the coverage was negative, revolved largely around asylum seekers (rather than migrants more generally, or even established refugee populations), and did not deal specifically with issues around ethnicity other than to refer to the national origins of asylum seekers. Particular indignation

was reserved for illegal migrants, either those who had entered the country illegally or those who had failed to leave the country after an application for asylum had been refused. Had different newspapers been chosen over a different time period then, of course different results might have been found. Nonetheless, the trends are indicative of a level of public concern and suggest the kinds of issues that preoccupy people. Despite the fact that it was not the remit of this study to analyse public attitudes, the press survey does contextualise the research studies discussed below. It also provides an interesting comparison in terms of the issues that tend to be picked up by media and research.

A synthesis of the research material

The main review is based on the collation of academic and other governmental, NGO and grey literature research, produced in the UK between 1997 and 2005, with an emphasis placed on material published over the past two years.

Much like the newspaper survey, databases and catalogues were used to obtain research coverage (see Part Two for full details of resources used). The primary search terms used (which were adapted to suit the database or other resource being interrogated) were: (migrant* OR asylum OR foreign* OR overseas born OR refugee*) AND (UK OR Brit* OR Engl* OR United Kingdom OR London) AND service*.

Where possible, material referring to recent arrivals to the UK was prioritised. In some cases data relate only to foreign-born, and thus include those who have been in the UK for many years. In other cases, the data cover only migrants, or asylum seekers and refugees. The services included:

- health and social services

- education

- social housing

- the criminal justice system (police assistance to a migrant as a victim, or arrest as a suspect; prosecutions and convictions; incarceration in

prison; as clients of the probation service)

Modified abstracts of all studies (based on the abstract or executive summary, with additional commentary where necessary) appear in Appendices A-E. As noted previously, the intention here is to provide the reader with an *overview* of the literature and not a systematic or exhaustive review. For this reason, judiciousness has been exercised in the selection of texts. The details of the most relevant publications appear in the tables in the appendices, and those papers that are considered most relevant have been discussed more extensively than items of lesser relevance.

This part of the review consists of a synthesis of the material located in the annotated bibliography (Part Two). Some general observations on the literature are followed by short summaries of the material found within each key sector.

Six issues can be identified about the literature

First, the use of services by migrants is seldom the *primary* focus of much of the research though it may be an ancillary or secondary focus. The literature on the health status of migrants, for example, often mentions issues around service provision and use, but usually only briefly and as an adjunct to the main text.

Second, the research focuses on factors affecting service provision, access and use—such as language or cultural barriers—rather than on other issues relating to service use. These might include the proportion of the migrant population using services or the effects of migrants' service use on the host population's access to services. For example, do GP surgeries serving high numbers of migrants become less attractive to the host population? Or does a concentration of migrants in specific areas affect access to housing for members of the host population?

Third, work on migrants' use of services is methodologically limited, in

general. More specifically, it is often:

- General in nature;
- Small-scale (i.e. small sample sizes are used);
- Local (i.e. focuses on one geographic area);
- Tends to use the term 'asylum seekers' interchangeably with the term 'refugees', or does not properly distinguish between the two kinds of migrant.

Fourth, there is a large and growing body of research on the health, well-being, housing tenure and educational attainment of second-generation minority ethnic groups—as opposed to first-generation migrants.⁸ Alongside this body of work, or sometimes overlapping with it, is a smaller amount of research on asylum seekers and refugees. There is almost nothing on other types of migrant such as labour migrants, those who come for family reunion or union, overseas students, or the plethora of small categories like the seasonal agricultural workers or working holiday-makers.

Many of the conclusions made about service provision and use relating to minority ethnic groups can also be made about service provision by migrants. Both groups have greater problems accessing and using services than the native, white population. This may be because these populations can sometimes be poorer than the host population and have more restricted job and educational opportunities than the native population.⁹ However, recent migrants, especially those escaping war or other civil upheaval, are considered to have greater needs than the established minority ethnic population in the UK. In the case of asylum seekers specifically, there may be additional health or other problems and this may affect service uptake.

⁸ Of course, many minority ethnic individuals are migrants (or the children and grandchildren of migrants), but their place of birth is seldom the focus of much of this work.

⁹ Arai, L. & Harding, S. (2002). *Health and social care services for minority ethnic communities in the United Kingdom: a review of the literature on access and use*. MRC Social & Public Health Sciences Unit Occasional Paper No. 9. Glasgow: Medical Research Council.

So, while these two bodies of work overlap and have similarities, there are important distinctions that should be borne in mind.

Fifth, research findings about migrants' service provision, access and use are also relevant to understanding the poorer sections of the indigenous population. The latter are also likely to have problems accessing services especially social housing, healthcare and legal aid. A number of authors report local resentment towards migrants can affect their use of services; this resentment probably originates in the belief that migrants are given preferential treatment in some localities. As the British Medical Association (BMA)¹⁰ observe, it is important that migrants are not seen to have better services than the host population since this can cause tension and hostility between the two groups.

Finally, there was substantially more research on use of health and associated care services by migrants than on their use of education, housing or services in the criminal justice system.

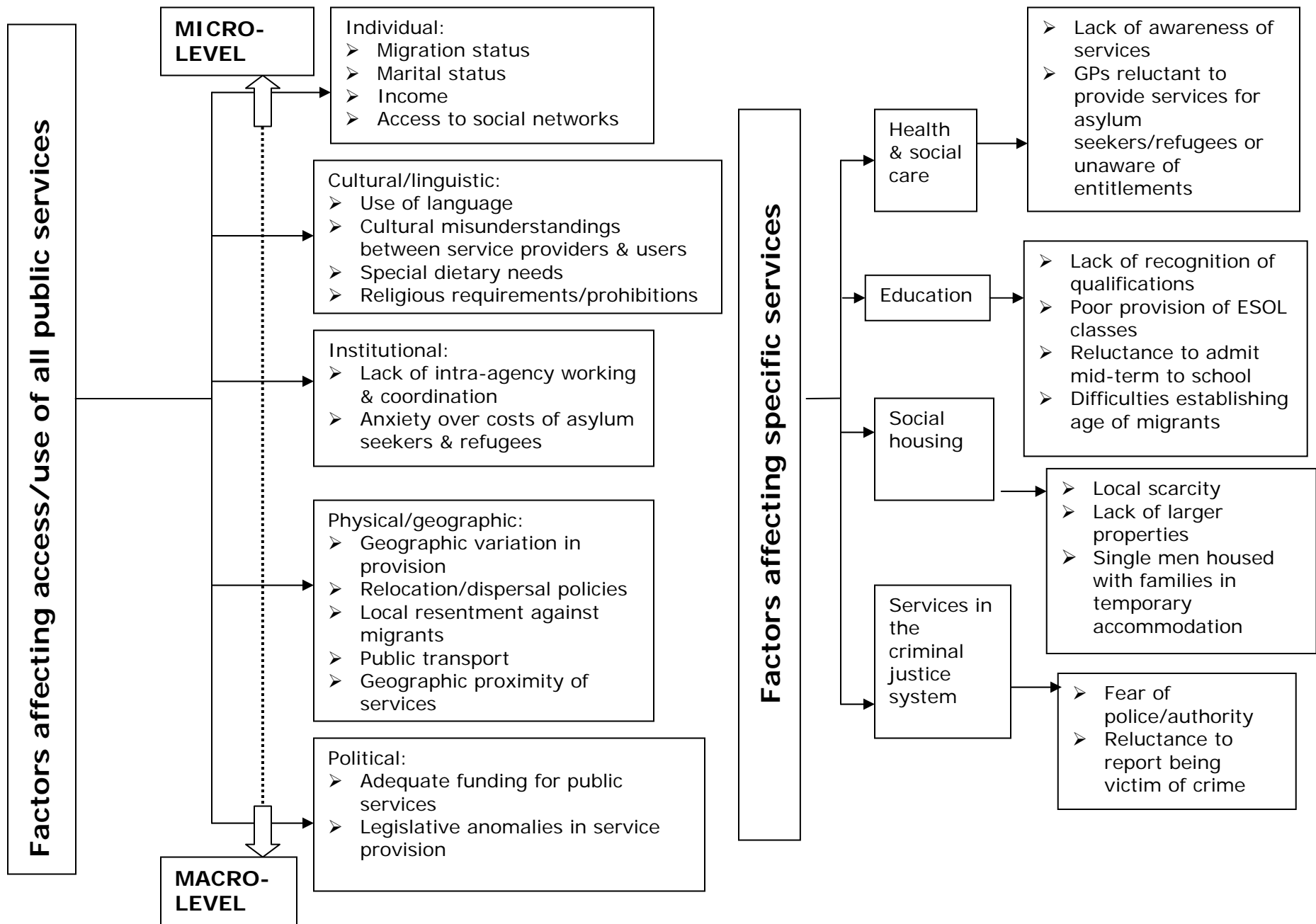
Key factors affecting access & use to public services

For a breakdown of all items retrieved and details of relevance and author please refer to Table 2 in Appendix A. Appendices B-E give the modified abstracts sorted by public service type.

Figure 1 summarises factors affecting access to, and use of, all public services. These range from the micro level, such as an individual's marital status or income, to macro level, such as political reasons underlying service funding. Likewise, factors affecting access or use of specific services are also listed. These factors as specific type and the following discussion will therefore be grouped as such.

¹⁰ British Medical Association (2002). *Asylum seekers: meeting their healthcare needs*. London: BMA.

Figure 1: Factors affecting service access/use



Health & social care

The health and social care texts identified for the survey were mainly on service access and use around issues such as: mental health; HIV/AIDS and TB; and primary healthcare needs or the health and well-being of children, either in asylum-seeking families or as unaccompanied minors. There are also a number of overviews and 'best practice' texts that offer guidance to healthcare workers. These texts were published by government departments (Department of Health), interest or pressure groups (British Medical Association, Centre for Policy Studies), research organisations (King's Fund, Joseph Rowntree Foundation) or academic journals. Most research was concerned with refugees and asylum seekers, rather than other migrant groups.

Aldous et al.¹¹ and Woodhead¹² provide good overviews of the health needs of migrants (in this case, refugees) which also explore service use. In both of these, the authors describe general barriers to service use, such as language or communication problems between patient and healthworker, and fragmented systems for providing health and other information to refugees. A similar guide to the healthcare needs of asylum seekers is provided by the BMA.¹⁰ This underlines the more specific problems that can hinder use of services, for example, that medical records do not always follow patients when they move (or are moved) elsewhere and recommends that asylum seekers be given a hand-held copy or duplicate medical records.

A consistent finding reported in these overview documents, and one also made in texts on primary care use,¹³ is that health workers often do not

¹¹ Aldous, J., Bardsley, M., Daniell, R., Gair, R., Jacobson, B., Lowdell, C., Morgan, D., Storkey, M. & Taylor, G. (1999). *Refugee health in London: key issue for public health*. The Health of Londoners Project. London: Directorate of Public Health East London & The City Health Authority.

¹² Woodhead, D. (2000). *The health and well-being of asylum seekers and refugees*. London: The Kings Fund.

¹³ Hargreaves, S. & Holmes, A. (2000). Refugees, asylum seekers and general practice: room for improvement? *British Journal of General Practice*, 50 (456), 531-

know how to deal with migrant groups and, very importantly, do not know what their entitlements are. Authors observe that few GPs routinely refer refugees for tuberculosis (TB) screening, for example. Refugees are entitled to the full range of free NHS treatment, yet there is evidence that GPs are confused about this. One study of GPs in Scotland found that nearly one fifth of their sample was unsure or incorrect about refugees' entitlements.¹⁴

'Health' or 'treatment tourism' was an issue mentioned in a number of publications. Government plans¹⁵ to tighten the rules governing access to healthcare mean the closure of loopholes previously allowing overseas visitors, with limited connections to the UK, unlimited access to receive free treatment. Health tourism (or high costs to the NHS of treating migrants) was widely reported in the press, but there were no reliable data or evidence on the extent, or even the existence, of this phenomenon in the research field (see appendix J).

Doctors' organisations have pointed to the absence of evidence of health tourism and reiterate healthcare workers' concerns that they will be forced to 'police' access to the NHS.^{16, 17} Conversely, Sergeant¹⁸ argues that NHS tourism is Britain's 'new growth industry', and there is an urgent need for the government to ensure that the costs of treating health tourists are recovered.

532. Hargreaves, S., Holmes, A. & Friedland, J. (1999). Healthcare provision for asylum seekers and refugees in the UK. *The Lancet*, 353, 1497-1498. Jones, D. & Gill, P.S. (1998). Refugees and primary care: tackling the inequalities. *British Medical Journal* 317, 1444-1446.

¹⁴ Katikireddi, S.V., Bhopal, R. & Quickfall, J.A. (2004). GPs need training and funding in caring for refugees and asylum seekers (letter). *British Medical Journal* 328,770.

¹⁵ Department of Health (2004). *Proposals to exclude overseas visitors from eligibility to free NHS primary medical services: a consultation*. London: DoH.

¹⁶ <http://www.bjhc.co.uk/news/1/2004/n40904.htm>;

<http://www.bma.org.uk/ap.nsf/Content/pr301203response>

¹⁷ Williams, P. D. (2004). Why failed asylum seekers must not be denied access to the NHS. *British Medical Journal* 329, 298.

¹⁸ Sergeant, H. (2003). *No system to abuse: immigration and healthcare in the UK*. London: Centre for Policy Studies.

Another issue identified both by the literature and media coverage concerns the management of HIV/AIDS and TB. In relation to the latter, the research is concerned primarily with prevalence¹⁹ and screening. Coker²⁰ provides a comprehensive overview of plans for screening (of both conditions) arguing that 'inclusive' policies work and coercive policies should be rejected. In relation to HIV/AIDS, papers focussed on screening,²¹ service provision,²² treatment²³ and testing.^{24, 25}

Two important publications have been produced by The Terence Higgins Trust directly addressing migrants' use of services for treatment of HIV/AIDS and issues around health (or treatment) tourism. One states that there is a considerable waiting time between migration to the UK and seeking testing for HIV, suggesting that migrants do not come to the UK specifically for treatment for HIV.²⁶ The other briefing paper discusses issues surrounding health tourism and the public health implications of the changes introduced in relation to payment for treatment of HIV.²⁷

In terms of numbers of publications on a specific issue, mental health is the

¹⁹ Callister, M.E.J., Barringer, J., Thanabalasingam, S.T., Gair, R. & Davidson, R.N. (2002). Pulmonary tuberculosis among political asylum seekers screened at Heathrow Airport, London, 1995–9. *Thorax* 57, 152-156.

²⁰ Coker, R. (2003). *Migration, public health and compulsory screening for TB and HIV*. London: IPPR.

²¹ Fortier, E. / All party parliamentary group on AIDS (APPGA) (2003). *Migration and HIV: improving lives in Britain: impact of the UK nationality and immigration system on people living with HIV*. London: All party parliamentary group on AIDS.

²² Chinouya, M. (2001). *HIV prevention and African communities living in England: a study of challenges in service provision*. London: National AIDS Trust.

²³ Weatherburn, P., Ssanyu-Sseruma, W., Hickson, F., McLean, S. & Reid, D. (2003). *Project Nasah: an investigation into the HIV treatment information and other needs of African people with HIV resident in England*.

²⁴ Fenton, K. A., Chinouya, M., Davidson, O. & Copas, A. (2002). HIV testing and high-risk sexual behaviour among London's migrant African communities: a participatory research study. *Sexually Transmitted Infections* 78, 241-245.

²⁵ Erwin, J., Morgan, M., Britten, N., Gray, K. & Peters, B. (2002). Pathways to HIV testing and care by Black African and White patients in London. *Sexually Transmitted Infections* 78, 37-39.

²⁶ Terence Higgins Trust (THT) (2003). *Recent Migrants Using HIV Services in England*. London: Terence Higgins Trust.

²⁷ Terence Higgins Trust (THT) (2004). *Background briefing: access to HIV services for all migrants to the UK*. London: Terence Higgins Trust.

most significant of the themes raised here. Numerous authors recognise that some migrant groups (notably refugees and asylum seekers) suffer trauma induced by war, conflict or torture,²⁸ and will therefore be particularly vulnerable to the effects of social isolation.²⁹ For Hodes and Goldberg,²⁸ the policy response to the mental health needs of refugees and asylum seekers has been ambivalent, in that services can be 'inadvertently stigmatising and culturally inappropriate'. They also point out that dispersal policy has probably reduced asylum seekers and refugees' access to mental health services. Refugees are unable to take advantage of their own personal contacts or important voluntary services that have been established in main cities.

Fewer texts have been written on use of services by disabled migrants³⁰ and maternity services. These again tend to focus on refugees and asylum seekers. Maternity Alliance,³¹ for example draws on in-depth, unstructured interviews with four women and the findings suggest that detention centres simply did not provide the type of care that women wanted. A larger sample used in a second paper on the same issue³² found that most of the women were satisfied with their antenatal care. However half the women experienced rudeness and racism from health professionals.

Education

Two general points can be made about the literature on access to educational services by migrants. First, much of the research looks not just at the type of education, but also explains that related factors will impact on the services

²⁸ Hodes, M. & Goldberg, D. (2002). The treatment of refugees: service provision reflects Britain's ambivalence. *Psychiatric Bulletin* 26 (1), 1-2.

²⁹ Ferguson, I. & Barclay, A. (2002). *Seeking peace of mind. The mental health needs of asylum seekers in Glasgow*. Stirling: University of Stirling.

³⁰ Harris, J. (2003). 'All doors are closed to us': a social model analysis of the experiences of disabled refugees and asylum seekers in Britain. *Disability and Society* 18 (4), 395 – 410.

³¹ Maternity Alliance (2002). *Crying shame: pregnant asylum seekers and their babies in detention*. London: Maternity Alliance and others.

³² McLeish, J. (2002). *Mothers in exile: maternity experiences of asylum seekers in England*. London: Maternity Alliance.

that are required, such as training and employment. Reports explain the intrinsic links between diverse issues of health service use, housing *and* education needs. Second, teaching students who have English as a second language was an important theme, particularly education and language needs of asylum seeking and refugee children.

Literature is produced by government departments and agencies (Audit Commission, OFSTED, Learning and Skills Councils), in journal papers and in publications from refugees' rights organisations (Refugee Council). A recent and comprehensive overview of the main issues is provided by the Audit Commission,³³ who recommend that local, regional and national agencies work together to improve the quality of services for this group.

Two prominent and recurring issues are that lack of English language skills severely hampers educational attainment (and, therefore, training and job prospects), and English for Speakers of Other Languages (ESOL) provision is not uniform and varies geographically in quality. Additionally, qualifications gained in the migrant's country-of-origin are often not recognised or educational and professional achievement is difficult to prove. In one study of 73 asylum seekers, only 7 per cent of interviewees had been able to bring certificates with them to the UK.³⁴

It should be noted that a number of authors commented that many of their respondents were highly qualified or skilled, and their inability to engage with the worlds of work and education is highly wasteful. For instance, a Scottish study found that refugees and asylum seekers were generally well qualified and possessed skills which could be easily utilised by the Scottish labour market. Some of these skills were particularly specialised and in demand, for example, surgical skills and skills in midwifery, obstetrics and gynaecology. However, the lengthy decision making process for all asylum claims often

³³ Audit Commission (2000). *A new city: supporting asylum seekers and refugees in London*. London: Crown Copyright.

³⁴ Aldridge, F. & Waddington, S. (2002). *Asylum seekers' skills and qualifications audit pilot project*. Leicester: National Institute of Adult Continuing Education.

means that refugees' and asylum seekers' motivations may lessen and their skills will become outdated.³⁵

Many of the reasons cited by migrants for their non-use of educational services are similar to those cited by sectors of the indigenous population and include such factors as the costs associated with attending classes, lack of childcare facilities and domestic responsibilities taking priority.^{36, 37} Poor use of services may be also attributable to the fact that migrants may attach different meanings to education and learning English. In one study of refugees' experiences as English language students, respondents had different perceptions about the value of the English language. Some saw it as an investment leading to an education and career, while others saw it as an opportunity provided by the host country to rebuild their lives.³⁸

However, it is clear from the research that despite education being considered important by migrants, it may be of lesser priority in the context of uncertainty about immigration status, fears about removal from the UK and mental health issues arising from trauma. This is particularly true of migrant children. Migrant children (especially those who have experienced separation from their parents) will obviously have quite different schooling needs than their non-migrant peers.³⁹ A report published by OFSTED⁴⁰ acknowledges that many schools have not been trained to identify pupils suffering psychological distress or trauma. Yet the quality of teaching and support for most asylum seeker pupils was regarded as either satisfactory or

³⁵ Charlaff, L., Ibrani, K., Lowe, M., Marsden, R. & Turney, L. (2004). *Refugees and asylum seekers in Scotland: a skills and aspirations audit*. Scottish Executive Social Research. Edinburgh: Crown Copyright.

³⁶ Griffiths, D. (2003). *English language training for refugees in London and the regions*. London: Crown Copyright.

³⁷ Bloch, A. (2002). *Refugees' opportunities and barriers in employment and training*. Leeds: Department for Work and Pensions Research Report 179.

³⁸ Dimitriadou, A. (2004). *An exploration of refugees' experiences as English language students in Further Education colleges*. Paper presented at the 2nd Annual Student Conference on Forced Migration, CRER - University of Warwick, 15th March 2004.

³⁹ Stead, J., Closs, A. & Arshad, R. (1999). *Refugee pupils in Scottish schools*. Edinburgh: The Scottish Council for Research in Education.

⁴⁰ OFSTED (2003). *The education of asylum seeker pupils*. London: Crown Copyright.

good and in general asylum seeker pupils made good progress in relatively short periods of time.

Housing

Compared to work on the health and healthcare of migrants, fewer research projects focus *specifically* on access to housing. Anderson ⁴¹ provides a useful appraisal of the literature:

Housing outcomes for new migrants to the UK are strongly mediated by the process by which they enter the country...a high proportion of migrants enter through the work permit scheme and are expected to house themselves in the owning or renting markets. There is virtually no research literature on housing outcomes for this group of migrants in the UK...Rather, research attention has focused on two aspects of housing disadvantage and homelessness in relation to migration: the housing experience of black and minority ethnic groups...and the housing experience of asylum seekers and refugees (p.16).

A small number of key documents were identified (see Appendix D). Two of these are by the Chartered Institute of Housing (CIH). ^{42, 43} In the most recent of these, it is suggested the British government should adopt community cohesion as a key aim of its policy on asylum, and encourage housing associations to provide accommodation for asylum seekers in appropriate areas, and not only where properties would otherwise be difficult

⁴¹ Anderson, I. (2002). *Migration and homelessness in the UK. Final Report to European Observatory on homelessness*. Brussels: Fédération Européenne d'Associations Nationales Travaillant avec les Sans-Abri (FEANTSA).

⁴² Chartered Institute of Housing (CIH) (1999). *Chartered Institute of Housing Evidence to the Immigration and Asylum Bill Special Standing Committee*, March 1999. London: Chartered Institute of Housing.

⁴³ Chartered Institute of Housing (2003). *Providing a safe haven—housing asylum seekers and refugees*. London: Chartered Institute of Housing.

to let. The CIH also propose that advice be given to housing agencies on how to prepare host communities. Phillips also provides a useful review of the literature and analysis of key issues in this area.⁴⁴

Temporary accommodation for asylum seekers is discussed in a report written by the Greater London Authority.⁴⁵ This highlighted a number of health and safety issues affecting asylum seekers in temporary housing. At least one in every five respondents regarded their accommodation as presenting serious problems (damp, disrepair, infestation, security, safety) and overcrowding was widespread. Over 60 per cent were not told what to do in the case of fire or emergency, and about a third said that they did not think their accommodation had smoke detectors. Almost a third felt unsafe in their own homes, five times higher than the London average of 6 per cent. Fifteen per cent had suffered some form of harassment in the last year. These problems are not, of course, specific to asylum seekers or any other type of migrant; poor conditions in temporary accommodation have been recognised as a problem for many years.⁴⁶

A qualitative research study undertaken in Leeds⁴⁷ focuses on the welfare of forced migrants, but also their experiences of housing. The sample is small and local, but the findings are useful. For those denied access to public welfare, basic accommodation and other needs are increasingly being met by other migrants, charities and refugee community organisations. Migrants' are also reported as experiencing hostility from locals who feel that their neighbourhood is adversely changed and house prices are affected.

⁴⁴ Phillips, D. (2005, forthcoming). Housing and the integration of new migrants and refugees. In S. Spencer et al. (Ed.) *The integration of new migrants and refugees: a review of the evidence and what works*. London: Home Office.

⁴⁵ Greater London Authority (GLA) (2004). *Safe and sound: asylum seekers and temporary accommodation*. London: GLA.

⁴⁶ Conway, J. (1988). *Prescription for Poor Health: The crisis for homeless families*. London: SHAC, Shelter.

⁴⁷ Dwyer, P. & Brown, D. (2004). *Meeting basic needs: exploring the welfare strategies of forced migrants*. Leeds: The School of Sociology and Social Policy, the University of Leeds.

An Institute for Public Policy Research report argues that the belief that migrants crowd the housing market at both ends is wrong.⁴⁸ Here it is important to note that asylum claimants housed by National Asylum Support Services do not take away social housing that would otherwise be available to UK nationals, or slow down their access. They are instead housed under quite separate arrangements, funded by the Home Office. This evidence suggests that, while migrants may increase demand for housing, their impact on housing shortages and rising prices should not be exaggerated.

Casey et al. looked at the extent to which asylum seekers affect local housing markets in some communities.⁴⁹ The findings suggest that the inward movement of asylum seekers impacts both positively and negatively on local housing markets: local residents welcomed a reduction in empty properties, but were also resentful of the increased competition for scarce housing resources. This type of research is relatively unique in its exploration of the impact of migration on housing markets, and more large-scale research is therefore warranted.

Criminal justice services

This review is far less comprehensive in relation to services in the criminal justice system, though research undertaken by police and probation authorities (ACPO, Hampshire Probation Service) and some journals articles have been identified.

There is literature on the policing needs of minority ethnic groups,⁵⁰ including

⁴⁸ Sriskandarajah, D. (2004). Stock taking: the real impacts of migrants on housing. *Roof Magazine*.

⁴⁹ Casey, R., Coward, S., Fordham, T., Hickman, P. Reeve, K. & Whittle, S. (2004). *The housing market impact of the presence of asylum seekers in NDC areas*. Research Report 24. Sheffield Hallam University: Centre for Regional Economic and Social Research. See also: CRESR, CUPS & EIUA (2003). *Seeking asylum in NDC areas: a report on experiences, policies & practices*. Research Report 18. Sheffield Hallam University: Centre for Regional Economic and Social Research.

⁵⁰ People from Black and minority ethnic backgrounds were at greater risk of experiencing crime than the White majority in the 2002/03 British Crime Survey (though the difference disappeared after allowing for the younger age profile of the

on how cases of racist attack are handled by the police, but this does not focus on migrants *per se*. For example the Crown Prosecution Service (CPS)⁵¹ defines race/religious crime as including crimes against asylum seekers and refugees and advises that cultural differences or sensitivities be taken into account when prosecuting racist crime. This might include, for example, being aware that a witness's availability for court hearings might be on a holy day or festival, and being sensitive to gender-related issues when meeting witnesses.

A key document provided by the Association of Chief Police Officers (ACPO) - 'Guide to Meeting the Policing Needs of Asylum Seekers and Refugees' (2001)⁵² wrote:

...the Police Service has been presented with a major task of ensuring that, while their applications are being processed, asylum seekers are afforded the same rights and protections as any other member of our society (p.12).

The report looks at police interaction with asylum seekers and refugees as victims of crime, offenders or witnesses and recognises that asylum seekers, in particular, are among the most vulnerable members of society. Crimes especially affecting asylum seekers include racism and violence, trafficking and exploitation in the sex trade. Key recommendations made in the Guide include being mindful of cultural sensitivities and making greater use of interpreters. Moreover, some migrants will be reluctant to report being the victims of crime, which may be related to their immigration status or fears of those in authority.

Black and minority ethnic group). People from Black and minority ethnic backgrounds were more likely to have high levels of worry about burglary, car crime and violence than White people. This was generally the case even when the type of area lived in and their experience of crime was allowed for.

⁵¹ Crown Prosecution Service (2003). *Guidance on prosecuting cases of racist and religious crime*. London: Crown Prosecution Service.

⁵² Association of Chief Police Officers (ACPO) (2001). *Guide to meeting the policing needs of asylum seekers and refugees*. London: Association of Chief Police Officers.

The Hampshire Probation Service reiterate this issue of cultural sensitivities, and explain the importance of fully describing asylum seekers' circumstances in probation reports.⁵³ The authors maintain that Probation Officers need to be sensitive to the potential for causing trauma or upset when asking asylum seekers why they left their own country. They should also be aware that asylum seekers are not likely to understand the criminal justice system.

There was little research, or other material, on use of legal aid services, despite this being the focus of some very indignant media coverage. The Guardian newspaper, for example, recently reported that:

More than 120 solicitors firms have been overcharging millions of pounds from the legal aid budget for handling asylum cases...The scale of the abuse is so serious that the government will this week announce plans for a pilot of its own public immigration and asylum legal service. The move follows investigations by the Legal Services Commission that led to £8m of legal aid being recouped from law firms allegedly involved in overclaiming....Between October 2001 and December 2003 in London, where the bulk of immigration work is concentrated, over £8m was recovered from a total of 124 immigration suppliers following audits, due to overclaiming or insufficient evidence to justify claims. In November 2003 in London, there were 69 immigration suppliers with the lowest possible category in the LSC's audit rating...meaning they were poor quality and overclaiming (The Guardian, 16/06/2004).⁵⁴

In addition, there is literature on the numbers of foreign nationals in the English prison system. Around 12 per cent of the English and Welsh prison population do not hold a UK passport⁵⁵ and face particular difficulties in

⁵³ Hampshire Probation Service (2004). *Practice manual for working with asylum seekers and refugees*. Hampshire: Hampshire Probation Area.

⁵⁴ http://www.guardian.co.uk/uk_news/story/0,,1239754,00.html

⁵⁵ Prison Reform Trust (2004). *Forgotten prisoners—the plight of foreign national prisoners in England and Wales*. London: Prison Reform Trust.

prison, chief among which are language problems, racism from prison staff and maintaining contact with loved ones. The situation is worse for foreign-born female prisoners who have dependent children, although there have been some developments in the treatment of foreign-born prisoners. Singh Bhui describes initiatives in Wandsworth Prison, which included setting up groups for foreign nationals, particular care given to vulnerable prisoners and the establishment of foreign national liaison officers.⁵⁶

Concluding Remarks

As outlined in this section, it is apparent that migrants do access public services, but rights and entitlements will very much depend on immigration status. Media coverage will lead us to believe that migrants present one of the key causes of strain on public services, although on the whole actual evidence for this is limited. Research does not usually focus on service use and it has tended to be small-scale and limited. There appear to be more data available on health care needs and the health care service, but even this could be improved.

What is interesting is the mismatch between concerns in the media and research. For example, there is no evidence to suggest that 'health tourism' is a major reason for migration, and yet this was an issue that often arose in the papers, especially the tabloids. In the same way there was a preoccupation in the press for use and abuse of legal services, and yet there are no reliable data to suggest that this is happening, or if it is, on what scale.

Although there is an established body of research on British minority ethnic groups and an increasing amount on asylum seekers and refugees there is little to nothing on other types of migrant – especially those here temporarily. Whilst some services are beginning to recognise the specific

⁵⁶ Singh Bhui, H. (2002). Wandsworth's work with foreign prisoners should go nationwide. *Guardian*, July 25th.

needs of different groups it varies a great deal depending on the public service sector and locality. Research is now required that will investigate the differing services used and link factors affecting use of services by all users, including migrants.

Migrants, just like poorer sections of the indigenous population, have problems accessing services (especially social housing, but also healthcare and legal aid). The press review showed local hostility towards migrants, owing to perceived preferential treatment towards them. This fact was backed up in the research evidence and proved to affect their use of services. However, this issue has not been systematically investigated on a wide scale and the implications for service providers and future service provision remain unclear.

PART TWO: Appendices of Key Literature and Resources

Introduction to Appendices

All the documents included in the review are listed in Table 2, and the following appendices are organised under the same headings as the table. In order to guide the reader, the modified abstracts included in each of these appendices have been rated according to relevance. Relevance here relates primarily to year of publication (items dating from 2003 on are more important than earlier items) and focus (items with a clear focus on service access or use are very relevant). The symbols used are:

Symbol	Meaning
*	Of little relevance
**	Medium relevance
***	Highly relevant

Please note that a number of items are labelled 'Document not available'. In these instance no assessment could be made, but the references have been kept in the review should the document become available.

'No abstract generally available' is used where the abstract for the item is not accessible freely over the internet (i.e. a database subscription is needed).

Table 2: Documents included in the review

Area	No. of documents	Key documents
Various		
	20	12: Ayotte & Williamson (2001); Bakhsh (2001); Barnardos (2000); Dennis (2002); Dunstan (2002); GLA (2004; 2004a); John et al. (2002); Marriott (2001); Refugee Council (2004); Save the Children (2002); Wilson (2001).
Health & social care		
General	35	16: Aldous et al. (1999); Blackwell et al. (2002); BMA (2002); BME Health Forum (2003); DoH(2003;2004;2005); Fountain (2003); Harris (2003); Hinton (2001);

		Papadopoulos et al. (2004); Roberts & Harris (2002); Sergeant (2003); Williams (2004); Wilson (2002); Woodhead (2000).
The health & well-being of children & young people	10	2: Gosling (2000); Macaskill & Petrie (2001).
Primary & secondary healthcare	9	5: Hargreaves & Holmes (2000); Hargreaves et al. (1999); Hounslow PCT(2004); Jones & Gill (1998); Katikireddi et al. (2004).
HIV/AIDS	18	11: BMA (2005); Chinouya (2001); Erwin et al. (2002); Fenton et al. (2002); Fortier (2003); HOC (2005); McMunn et al. (1998); THT (2004;2003) Weatherburn (2003); Weston (2003).
Mental health	22	9: Ager et al. (2002); Coid et al. (2000); Crowley (2003); DoH (2002); Ferguson & Barclay (2002); Hodes & Goldberg (2002); Mitter et al. (2004); Murphy et al. (2002); Summerfield (2001).
TB	7	2: Callister et al. (2002); Coker (2003).
Women's health	2	2: Maternity Alliance (2002); McLeish (2002).
Education		
Adult	16	10: AET (2002); Aldridge & Waddington (2002); Audit Commission (2000); Bloch (2002); Charlaff et al. (2004); Dimitriadou (2004); Griffiths (2003); Phillimore et al. (2003); Schellekens (2001); Southampton Refugee & Asylum Seeker E&TG (2003).
Children's education	15	3: Dobson et al. (200); Ofsted (2003); Stead et al. (1999).
Social housing		
	21	12: Anderson (2002); Casey et al. (2004); CIH (2003; 1999); Cole & Robinson (2003); CRESR, CUPS & EIUA (2003); Dwyer & Brown (2004); GLA (2004); Phillips (2005); RACoT (2002); Sriskandarajah (2004); Zetter & Pearl (1999).
Criminal justice system		
	12	5: ACPO (2001); CPS (2003); Hampshire PS (2004); Mortimer (2003); Prison Reform Trust (2004).

Appendix A: Various

These documents cut across the categories used in this review. Items dealing with children and young people are also here if they are general (i.e. not specifically on health, education etc.) in nature. Examples of datasets that can be used to explore migrants' use of general services are shown below.

Name of dataset	Brief description & measure of migration status	Further details
British Household Panel Survey	The main objective of the survey is to further understanding of social and economic change at the individual and household level in Britain. Nationality/country of birth.	http://www.data-archive.ac.uk/findingData/snDescription.asp?sn=5151
General Household Survey	The main aim of the survey is to collect data on a range of core topics, covering household, family and individual information. Place of birth.	http://www.data-archive.ac.uk/findingData/snDescription.asp?sn=5150

Modified abstracts

Ayotte, W. & Williamson, L. (2001). *Separated children in the UK*. London: Refugee Council. Document available at:
http://www.refugeecouncil.org.uk/downloads/rc_reports/sep_children.pdf**

An overview of UK policy and practice of caring for unaccompanied minors seeking asylum that touches on service provision and use. Below are summarised the obstacles to realising the rights of separated children.

In relation to the care system and education, there is a lack of direction and coordination from central government. The care system is under strain due to cut backs over an extended period of time and a significant increase in the numbers of separated children coming to the UK.

There is a lack of suitable accommodation for separated children; the treatment of 16 and 17 year olds as adults has become institutionalised in many local authorities (LAs). Many separated children are being excluded from education due to dispersal, difficulties with accommodation and out-of-borough placements. In addition, a culture of disbelief in respect to the age of those claiming to be under-18 has developed grown in some LAs and among some immigration and asylum officials. The Human Rights Act presents opportunities to strengthen entitlements for separated children in the following areas:

The development of a more acceptable grant formula from central government should free up LAs to develop better policies and practice. The government approach to dealing with social exclusion and to foster joined-up working between government departments ought to enable a more positive approach to ensuring that the rights of separated children can be met more appropriately.

Bakhsh, Q. (2001). ***Near the airport: refugees and asylum seeking children and families in Hounslow. Removing barriers to accessing services and resources.*** London: Eagles Consultancy for The Asian Health Agency. Document available at: <http://www.taha.org.uk/airport.pdf> **

This is a general, and wide-ranging, exploration of the use of services by asylum seekers and refugees in the London Borough of Hounslow. Six methods of data collection were used including: interviews with housing, education and other officers (n=25); meetings with voluntary sector agencies; focus groups, and questionnaires completed by 15 Council officers and officials within the voluntary sectors. Families (from 18 different countries; n=54) participated in the 'clients' perception' survey and around 20 attended focus groups meeting. Various issues were covered including racial harassment, benefits and allowances, education, access to social services etc. The results were grouped in the following categories.

Communication/languages barriers: more interpreting and translation

facilities were frequently mentioned as needed by key agencies such as housing, social services and hospitals.

Conditions and facilities: respondents said that would like better housing conditions, for the 'benefit regime' to be more sympathetic and generous and better communication facilities.

Self help and voluntary sector development: there is a need for development in this area so that people are able to use their own skills.

Barnardo's (2000). ***Children first and foremost: meeting the needs of unaccompanied asylum seeking children***. Survey findings from local authorities presented at a Barnardo's seminar 4 July 2000. Document available at:

<http://www.barnardos.org.uk/newsandevents/media/press/release.jsp?id=20>

1 **

Barnardo's undertook a survey of local authorities (LAs) in England and Wales (n=54) who receive Home Office support for providing services to unaccompanied asylum seeking children. The results showed that the majority (72%) of authorities have no specific policies to work with these children. More than a third of authorities place unaccompanied children outside the responsible borough with varied levels of support available. The survey showed that the major problems identified by LAs in dealing with unaccompanied young asylum seekers were: a shortage of appropriate accommodation; and a lack of interpreters.

Carey-Wood, J. (1997). ***Meeting refugees' needs in Britain: the role of refugee-specific initiatives***. London: HMSO. Document available at:

<http://www.homeoffice.gov.uk/rds/pdfs/occ-refugee.pdf> *

This research focused on community development, employment and training, health and housing. Three methods were used: analysis of published/unpublished information on a range of refugee agencies; interviews with key

individuals in statutory, voluntary and community agencies; case studies of selected Refugee specific Initiatives (RSIs). The following issues emerged as important to the success of RSIs.

- Clear information on the aims, objectives, priorities and limitations of the RSI should be provided to funders, users, management, staff and complementary agencies.
- RSI staff should have specialist knowledge of the mainstream services they are working with and refugees' needs. For example, refugees with nursing or medical qualifications not recognised in Britain could staff an RSI for health.
- Funding is short-term and insecure for virtually all RSIs; many staff hours are wasted in fundraising. Support and supervision could be offered to funded community groups to maximise the benefits from the resources available.

Dennis, J. (2002). ***A case for change: how refugee children are missing out. First findings from the Monitoring Project of the Refugee Children's Consortium.*** London: Refugee Council. Document available at: http://www.refugeecouncil.org.uk/downloads/rc_reports/case_for_change.pdf. **

The aim of this project was to find out where children and young people (n=118) live, what type of accommodation they live in and to record the difficulties they have in accessing education and social services. Sixty two of the children and young people were accessing some form of education, and 56 were not in education. A central problem was the length of time refugee children and young people had to wait for a place in school or college; 25 had experienced delays of more than 20 days. Among those waiting, there were reports of children waiting six months or more.

The following is recommended to enhance the education of refugee children:

- All refugee and asylum seeking children should be provided with a

- place in mainstream school within 20 days of them requesting one.
- The Department for Education and Skills (DfES) should give clear information to all stakeholders to ensure that everyone is aware of the rights and entitlements of young asylum seekers and refugees.
 - Each school with responsibility for the education of refugee and asylum seeking children should have a policy relating to their support.
 - School policies on admissions, induction and bullying should address issues relating to pupils who are refugees or asylum seekers.
 - Local Education Authorities with significant numbers of refugee and asylum seeking children should appoint a coordinator to support their education.
 - Of 118 children, 36 of them were not registered with a GP. There were some difficulties once people had registered with a GP; sometimes, children had to travel a long way to reach the only GP whose practice will allow them to register.

Dunstan, R. (2002). ***Distant voices: CAB clients' experience of continuing problems with National Asylum Support Service.***

London: Citizens Advice Bureau. Document available at:

<http://www.asylumsupport.info/publications/nacab/distantvoices.htm> **

This study used case reports (400) collected from Bureaux in England and Wales. The results suggest that there are deep-rooted problems with the standard of service provided by NASS. NACAB (National Association of Citizens' Advice Bureaux) recommends that the government accept that NASS will only be able to provide a satisfactory service if it is decentralised, so as to offer a better quality, be a responsive and accessible service at local level, with 'drop-in' services that are staffed by people with appropriate language skills. There should also be a joint 'value-for-money' audit of NASS and the NASS by the National Audit Office and the Audit Commission.

Gilroy, P. (2001). Away from home, alone. ***Community Care***, 2 Aug 26-7.

Document available at:

<http://www.communitycare.co.uk/AccessSite/articles/article.asp?liSectionID=22&liarticleID=32619> *

A brief article in which the author explains the implications of events in Kent, where social services were required to deal with 1,200 lone or separated children aged 17 years or younger who arrived at Dover in 1999 without a parent or guardian. He maintains that it is vital that all agencies work closely together, and authorities in the south east have a strategic partnership with a number of Local Authorities nationally who are willing to assist in looking after children.

Greater London Authority (GLA) (2004). ***Refugees and asylum seekers in London: a GLA perspective. Draft report for consultation.*** London: GLA Policy Support Unit. Document available at:

http://www.london.gov.uk/mayor/refugees/docs/refugees_summ.pdf ***

This recent report offers a factual basis to help the Mayor and GLA judge what policies and practical measures should be taken to deal with refugees and asylum seekers. Refugees and asylum seekers in London are estimated to number now between 350,000 and 420,000, or about one in 20 of the city's population (around 30 times greater than the UK average). Barriers and threats facing refugees and asylum seekers stem in part from racism, and are similar to those faced by Black and ethnic minority Londoners. Yet, they are also distinct and present the GLA with challenges in fulfilling many of its statutory tasks. Among the many recommendations made are that:

- Government should note that experience of the asylum process 1996-2000 suggests asylum seeking behaviour is not influenced by cutting off social security benefits.
- Government should be urged to abandon the voucher system which is likely to exacerbate poverty, social exclusion and community tensions.

- The present dispersal regime should be replaced with a national reception and settlement system.
- The government should extend eligibility for educational grants and loans to asylum seekers who have permission to work.
- London boroughs should be encouraged to build the policing and protection needs of refugee and asylum seeker communities into their local crime and disorder plans.
- The GLA should explore with its London NHS partners what measures within the NHS could improve access to health services for refugees and asylum seekers.
- The GLA should explore with partner agencies how they can help disseminate information about the NHS to refugee communities.
- The GLA and London Development Agency should establish a programme to provide training or re-training for refugees and asylum seekers with previous healthcare experience, so that they can work within the NHS as medical staff or in other roles.

Greater London Authority (GLA) (2004a). ***Offering more than they borrow: refugee children in London.*** London: GLA. Document available at:
http://www.london.gov.uk/mayor/refugees/docs/refugee_children_report.pdf
 * * *

This is a recent report from the GLA that summarises the main issues in relation to refugee children in London. It deals with service provision, access and use throughout. The main points are that:

- Unaccompanied asylum seeking children aged 16 and 17 have not been receiving adequate levels of accommodation and support.
- Social services departments are often unclear where refugee children fit within their services.
- Child protection concerns include: the lack of monitoring of children who are accompanied by an adult who is not their parent or usual

- carer; the vulnerability of children inappropriately placed in accommodation with adults not known to them; girls being taken out of the country for female genital mutilation. In addition, refugee children's mental health needs are not being adequately catered for.
- The government can help meet the educational and pastoral needs of unaccompanied refugee and asylum seeking children by minimising the impact of pupil mobility through support for planning and liaison between local services, and the provision of a travel grant where appropriate to enable refugee children to continue at the same school if re-housed. Schools also need to deal effectively with mid-term admissions, and build home-school links.
 - The London Development Agency (LDA) should be asked to consider extending its work on the educational attainment of African and African Caribbean pupils to look at the educational attainment of refugee children. The LDA should also be asked to explore how best to: disseminate information about pre-school services to refugee communities; and enable refugee communities to highlight their needs with regard to pre-school provision to service providers.
 - Through the London Health Commission, the GLA will seek to promote improvements in mental health services for refugee children in London, including training teachers and other key workers to recognise signs of distress and trauma, and projects for refugee children who are isolated.

Haringey Council (1997). ***Refugees and asylum seekers in Haringey: research project report***. London: Haringey Council.

No document available.

John, A., Lindstrom, C., Olszewska, Z., Williamson, K. & Zongolowicz, K. (2002). ***Experiences of integration: accessing resources in a new society - the case of unaccompanied minor asylum seekers in Milton Keynes***. RSC Working Paper No. 10. University Of Oxford: Refugee Studies

Centre. Document available at:

<http://www.rsc.ox.ac.uk/PDFs/workingpaper10.pdf> **

This paper describes a project which explored the integration of unaccompanied minor asylum seekers and refugees (UMAs) in Milton Keynes. Multiple research methods were used to analyse UMAs' integration, and their access to and support from social and other services. Its relatively small and local sample limits its generalisability. Research participants were 17 UMAs (6 girls, 11 boys) from Somalia, Afghanistan, Albania and Kosovo aged 14-17. The majority had been in the UK for less than 12 months.

Interviews conducted with UMAs revealed themes integral to their own experience and integration. These themes were further explored during a one-day workshop. This showed that policy and practice concerning UMAs are ill-defined and inconsistent. Institutional resources already in place are not being fully utilised as UMAs and are often an after-thought in the service provision for citizen children. UMAs encounter difficulties in accessing education facilities, and living arrangements do not consistently meet protection requirements.

The research data demonstrate that UMAs see education as a priority for personal development and for finding a place in British society. However, most UMAs receive little education, reflecting the lack of facilities to meet their needs and the failure to translate legislation into reality. It is vital that arriving UMAs receive English lessons as soon as possible.

Marriott, K. (2001). *Living in limbo. Young separated refugees in the West Midlands*. London: Save the Children. Document available at:

<http://www.rightsbase.org.uk/refugees/ysr/report.pdf> **

Researchers talked to young people (n=125) in six areas of the UK about all aspects of their lives (including service use). This report focuses on the experiences of young people in the West Midlands, which limits its generalisability. Also interviewed were professionals and other adults

(n=125) who work with young, separated asylum seekers and refugees, in order to understand what services are being provided for this group. The main findings are:

- Anxiety over the asylum process: the lack of guidance through the asylum application procedure is a source of anxiety for many young asylum seekers, particularly as many have little contact with their legal representatives.
- Inappropriate placement: almost all young separated asylum seekers are placed in temporary bed-and-breakfast accommodation, or in houses of multiple occupation with older asylum seekers or other minors.
- Support from social services: young people reported that social services were often unable to help them with their problems. Fifty-eight per cent of the young people had no named social worker.
- Need to improve educational access and support: young people prioritised the need for better access to appropriate education courses, and to English language courses.

Mynott, E & Humphries, B. (2001). *Living your life across boundaries: young separated refugees in Greater Manchester*. London: Save the Children. Details available at:

<http://www.ncadc.org.uk/archives/iled%20newszines/news25/kids.html>*

The project is a national study with the objective of giving a voice to young people who have come to the UK, without parents or carers, to seek asylum. The main findings of the Young Separated Refugees Project research are: young separated refugees want their asylum claims to be settled as quickly as possible; there is a need for well resourced accommodation; refugee children have a strong desire to access education, especially English language learning; education provision is often good but needs to be built on; support from Local Authorities and the independent sector is often poorly co-ordinated. No information is provided on data collection or analysis in the

document accessed (see weblink above).

Mynott, E. (1999). *Immigration, asylum and the provision of services in Manchester: a preliminary report*. Department of Applied Community Studies, Manchester Metropolitan University.

No document available.

Refugee Council (2004). *The Refugee Council's response to the government's Green Paper 'Every Child Matters'*. London: Refugee Council. Document available at:
www.refugeecouncil.org.uk/downloads/policy_briefings/every_child_nov03.pdf **

A response to the government's Green Paper. Though recent and with a focus on service provision and use, it is mostly a series of recommendations. Many of these are general and include:

- The government must endeavour to ensure that all refugee children are allocated school places, that Local Education Authorities and schools are aware of their statutory duties and that schools have the resources to support such children in the classroom.
- Tailored educational packages should be designed to meet the needs of youngsters who may be forced to leave the UK upon turning 18.
- All 16 and 17 year old unaccompanied children should be deemed to be in priority need for housing.

Refugee Council (2003). *Support arrangements for 16 to 17 year old unaccompanied asylum seeking children*. London: Refugee Council. Document available at:
http://www.refugeecouncil.org.uk/downloads/briefings/supp_16&17_sept03.pdf *

A short but recent briefing that focuses on the statutory aspects of service

provision. The Refugee Council point out that it has many concerns about unaccompanied children. Many of them still live in inappropriate placements with no adult to care for them. There is evidence that many are not receiving a level of support appropriate to their needs.

Robertson, D., Sathyamoorthy, G. & Ford, R. (1999). Hounslow blues. *Open Mind 95*, 8-9. No abstract generally available.*

Brief and dated discussion. The author describes the problems experienced by Somalis in the UK, which is compounded by the unfriendliness of British people and professionals and a lack of interagency communication. There needs to be a broad strategy involving the whole spectrum of service provision, primary care, community care and acute services, including specific cultural awareness training for all service providers.

Save the Children & Glasgow City Council (2002). *Starting again*. London: Save the Children. Document available from:
http://www.savethechildren.org.uk/temp/scuk/cache/cmsattach/958_Startin_gAgain.pdf **

A relatively recent study that deals with children's experiences of life in Glasgow more generally, but also deals with aspects of service provision and use. A representative sample of young asylum seekers was selected from the 1231 enrolled in Glasgow schools (n=738). There were also 35 focus groups held in 27 schools in which 525 pupils took part. Group interviews with parents of asylum seekers and mainstream pupils were also conducted. A range of individual interviews was held with public agencies involved in the dispersal programme to Glasgow. Sixty seven per cent of participants had been to school before arriving in Glasgow; 21 per cent had been in Glasgow for less than six months.

Young asylum seekers described the best things about life in Glasgow as school and teachers, doing sport and being with friends and family and the

worst things are violence, lack of safety, racism, bullying and drugs and alcohol abuse. A small sample of local mainstream pupils was also consulted. When questioned they felt that 'enough' was being done for asylum seekers. Recommendations for schools, local government, the Scottish Executive and the government that could improve children's and young asylum seekers' experiences of dispersal include the following: providing help with homework; providing opportunities for first language development; more finance for integration activities; more anti-racist training for local residents.

Wilson, R. (2001) *Dispersed : a study of services for asylum seekers in West Yorkshire December 1999 - March 2001*. York, Joseph Rowntree Charitable Trust. Document available at:
<http://www.jrct.org.uk/core/wyas.pdf> **

This research was undertaken in order to provide an overview of how services have responded in West Yorkshire to the government's policy of dispersal of asylum seekers. The sample size is fairly large (67 professionals and community representatives and 27 asylum seekers were interviewed), and it is specifically on services, but it focuses on one geographic area only (this obviously limits its generalisability). The main results include the observations that:

- The level of resourcing for many services is inadequate.
- The quality of housing is varied.
- There is sometimes only minimal help for asylum seekers with accessing services.
- Some GPs and dentists are reluctant to take on asylum seekers.
- Mental health needs are often unmet.
- There are not enough English language classes.
- The main recommendations include:

The Department of Health should provide funding and training to promote the provision of appropriate and accessible mental health services. Health promotion initiatives, including sexual health promotion, should also

be supported.

There should be more English language classes in colleges and community centres, and more initiatives to help asylum seekers into employment.

Wren, K. (2004). ***Building bridges: local responses to the resettlement of asylum seekers in Glasgow***. SCRSJ Report No. 1. Glasgow: Scottish Centre for Research on Social Justice. Document available at: <http://www.scrsj.ac.uk/Publications/BuildingBridges.pdf> *

This document is not specifically on service use, but on the asylum resettlement process more generally and local responses to it (and does include some brief description of local residents' views). The author observes that the engagement of the wider community in the process of resettlement was not successful, and suggests a number of reasons for this. These include: negative perceptions of asylum seekers circulating among some sections of the host communities; competing interests and factional politics made it difficult to engage local community activists.

Appendix B: Health & social care

This section contains details of items concerned wholly or primarily with use of health and social care services by adult and child migrant populations. Examples of key datasets concerned with health and social care are shown below.

Name of dataset	Brief description & measure of migration status	Further details
Ethnic Minority Psychiatric Illness Rates in the Community (EMPIRIC), 2000	The aim of the EMPIRIC survey was to estimate the prevalence of psychiatric morbidity among minority ethnic populations resident in England, and to compare prevalence rates between groups. Place of birth.	http://www.data-archive.ac.uk/findin-gData/snDescription.asp?sn=4685
Health Survey of England 1999: the Health of Ethnic Minorities	The aims of the Health Survey series include: providing annual data about the nation's health; estimating the proportion with specified health conditions; estimating the prevalence of risk factors associated with these conditions. Place of birth.	http://www.data-archive.ac.uk/findin-gData/snDescription.asp?sn=4365
Measurement of Psychological Disturbance in Asian Immigrants, 1975-1976	The purpose of this study was to collect data for a pilot study to investigate the psychological and social adjustment of Asian immigrants to Britain. Place of birth.	http://www.data-archive.ac.uk/findin-gData/snDescription.asp?sn=965

Modified abstracts

B1) General

Acimovic, S. & Fenney, A. (2002). ***Guidance for the NHS and personal Social Services on addressing the health and social care needs of asylum seekers dispersed through the National Asylum Support Services***. London: The Refugee Council.

No document available.

Aldous, J., Bardsley, M., Daniell, R., Gair, R., Jacobson, B., Lowdell, C., Morgan, D., Storkey, M. & Taylor, G. (1999). ***Refugee health in London: key issue for public health***. The Health of Londoners Project. London: Directorate of Public Health East London & The City Health Authority. Document available at:
http://www.lho.org.uk/Publications/Attachments/PDF_Files/refugees.pdf. **

An overview of the health needs of refugees in London that contains some discussion of service access issues (though somewhat dated now). The authors point out that many of the health problems of refugees overlap with health problems of deprived and minority ethnic groups. Previous analyses suggest that the physical health status of refugees on arrival is not poor—most refugees are young and physically fit. Specific service issues relevant to refugees include:

- Access to good quality primary care: there are doubts about whether relatively high registration rates observed in some studies are widely applicable. Registration is often temporary, and refugees tend to cluster on the lists of certain practices.
- Adequate response to mental health problems: this may range from appropriate treatment in primary care for conditions such as depression, to specialist services for individuals with major mental health problems following trauma. There is evidence of low uptake of counselling services among refugees.

- Services for communicable diseases: there is little evidence on the effectiveness of current systems for managing new entrants.
- Initial health assessment: some form of initial health assessment of new entrants offers an opportunity to act as an introduction to health services for new migrants.
- A number of general themes impacting on service use can be seen in the literature. These include issues around:
 - Language/communication problems.
 - Fragmented systems for providing health information to refugees.
 - Confusion among health professionals over refugees' and asylum seekers' rights to healthcare.
- Improving the knowledge base: there is an absence of systematic quantitative information on refugees within London, and the evidence base for evaluating specific initiatives is limited.

Ashmore, J. (2003). Just vulnerable people: working with asylum seekers and refugees. *Human Givens* 10 (2), 34-37. No abstract generally available.*

A brief and local description by a specialist health visitor about her team's approach to care for asylum seekers dispersed to Doncaster. The team became one of the pilot Personal Medical Services, a Government initiative for a new way to deliver healthcare.

Bariso, E.U. (1997). *The Horn of Africa Health research project: an assessment of the accessibility and appropriateness of healthcare services to Horn of Africa (Eritrean, Ethiopian, Oromo & Somali) communities in Camden & Islington*. London: Healthy Islington and Camden & Islington Health Authority.

No document available.

Blackwell, D., Holden, K. & Tregoning, D. (2002) An interim report of health

needs assessment of asylum seekers in Sunderland and North Tyneside
Public Health 116 (4), 221-226. No abstract generally available. **

A health needs assessment questionnaire was administered to 397 asylum seekers (291 males, 106 females) in Sunderland and North Tyneside. There was heterogeneity in country-of-origin, culture, religion and previous employment and language backgrounds. A range of health needs was identified which has implications for healthcare provision. Vaccination rates were low as was screening for tuberculosis and cervical cancer. Many asylum seekers identified symptoms related to mental health and requested help in this area. A relatively recent document but with a large (albeit local) sample that focuses on healthcare needs.

British Medical Association (BMA) (2002). ***Asylum seekers: meeting their healthcare needs***. London: BMA. Document available at:
[http://www.bma.org.uk/ap.nsf/Content/Asylumseekers/\\$file/Asylumseekers.pdf](http://www.bma.org.uk/ap.nsf/Content/Asylumseekers/$file/Asylumseekers.pdf) ***

A comprehensive and general guide to the healthcare needs of asylum seekers. There is also a section on service use.

The BMA maintains that there are some barriers to healthcare that need to be overcome in order to adequately meet the healthcare needs of asylum seekers. The most important relate to language and cultural differences. There are insufficient translation services in the UK and, as some asylum seekers are illiterate, they will not be able to read written health advice. The use of family, friends and other asylum seekers as interpreters should be discouraged as it compromises patient confidentiality. Some asylum seekers may receive a number of treatments for a single condition. This may be because there is a lack of continuity of care, or because healthcare professionals have been unable to take a proper medical history.

Asylum seekers often stay in removal centres for many months. Problems include: asylum seekers are not always taken to hospital for their

appointments; medical records do not always follow the applicant if they move to another centre; long waiting times are experienced for some services; there is a lack of uniformity in services provided to asylum seekers who stay in centres; there is a lack of clarity among medical practitioners as to their duty to notify an immigration officer if an asylum seeker claims torture.

It should be noted that barriers to healthcare are not just experienced by asylum seekers but by other UK residents too. It is important that all people have the same provision. It can cause tension where asylum seekers appear to have more provision than other members of the community. The BMA recommends that:

- The dispersal of asylum seekers should be properly resourced and managed.
- The physical and mental health of all asylum seekers should be assessed and appropriate treatment should be given.
- Asylum seekers should be informed that all health information is confidential.
- Healthcare professionals must appreciate that some asylum seekers have a fear of those in authority.
- Healthcare workers should assess the asylum seeker's current health status and address any immediate concerns. This might include: testing for Tuberculosis, Hepatitis and HIV/AIDS.
- To facilitate continuity of care, asylum seekers should be given a hand-held copy/duplicate medical records.

BME Health Forum & the Migrant & Refugee Communities Forum (2003). ***'Asylum pulse: are we feeling it right?' Final report from the Task Group: Health Needs of Asylum Seekers & Refugees in Kensington & Chelsea and Westminster.*** London: BME Health Forum and MRCF.

Document available at: http://www.westminster-pct.nhs.uk/pdfs/bme_refugees_taskgroup_finalreport.pdf **

This report provides findings and recommendations from a task group looking at the health needs (and service use) of refugees and asylum seekers in the London Boroughs of Kensington & Chelsea and Westminster (KCW). The aim of the project was to undertake consultation to hear from their users' experiences of using NHS services in KCW. A total of 20 community consultations were undertaken (n=300). Of these approximately 80 per cent were refugees, 15 per cent were asylum seekers and 5 per cent were settled migrants.

Many of the recommendations do not have cost implications, but relate to issues of attitude and culture change. The issue of interpreting, for example, arises frequently. People felt it was at the level of primary care services that action was most needed; long waiting times for GP appointments was a key issue. One way of addressing this problem is by giving more support to refugee doctors, who remain an untapped resource. Local hospitals should review their policies and practices with regard to provision of interpreting services, including access to telephone interpreting, to facilitate completion of forms, etc. Consent forms before operations should only be signed in the presence of an interpreter, or after making sure that the patient understands fully what the operation involves.

Most women felt that mixed wards were not appropriate; and the majority of women remained enclosed in their cubicles for the whole period of their hospitalisation. Training on issues in relation to Post-Traumatic Stress Disorder should be provided to frontline staff in the NHS. Mental health advocates need to be given more support to be able to assist refugees and asylum seekers.

Burnett, A. & Peel, M. (2001). Health of survivors of torture and organised violence. *British Medical Journal* 322, 606-609. Document available at: <http://bmj.bmjournals.com/cgi/content/full/322/7286/606>. *

A brief item that examines the health of the survivors of torture, but touches on issues of service provision. The authors point out that victims of torture

present with many non-specific health problems. These problems can be dealt with in the same way as any other patient with the same condition, although cultural and language difficulties may interfere. The authors maintain that: 'When working with a survivor of torture, the essentials are time, a sympathetic approach, and, if language is not shared, a trained interpreter who is not a family member or friend.'

Cambridge, P. & Williams, L. (2004). Approaches to advocacy for refugees and asylum seekers: a development case study for a local support and advice Service. *Journal of Refugee Studies* 17 (1), 97-113. Abstract available at: <http://www.ingentaconnect.com/content/oup/refuge/2004/00000017/00000001/art00097> *

A recent paper which examines the potential for advocacy in social care services supporting refugees and asylum seekers, drawing on evidence from a service development intervention for staff working in a local refugee support and advice services in the UK. Different approaches to advocacy are discussed in relation to the needs and experiences of refugees and the aims of the service.

Crouch, D. (2003). 'I've learnt so much about people and cultures.'
Nursing Times 99 (10), 38-9. No abstract generally available*

A brief report on how one health visitor's approach to her work with asylum seekers is raising awareness of their plight and ensuring their access to health services. The author describes the work of the Asylum Seekers and Refugee Project in North Staffordshire which manages allocations to GPs for those in greatest need of healthcare.

Department of Health, Social Services and Public Safety (2004). *Policy guidance on access to health and social care services*. Belfast: DHSSPSNI. Document available at:

<http://www.dhsspsni.gov.uk/publications/2004/ASGUIDANCEPRINT.pdf> *

Policy guidance for staff working within the Health and Personal Social Services sector in Northern Ireland which provides advice and information on the provision of health and social care services to asylum seekers and refugees. It covers the use of primary care services, mental health services, children's services, hospital care and maternity services. Much of the advice is very general (i.e. to be aware that many refugees have special dietary needs; to provide interpreting services to foster communication).

Department of Health (DoH) (2005). ***What are the rules on eligibility to access free NHS hospital treatment? Who is entitled to free NHS treatment?***. Advice from DoH. Available at:

http://www.dh.gov.uk/PolicyAndGuidance/International/OverseasVisitors/OverseasVisitorsGeneralArticle/fs/en?CONTENT_ID=4080704&chk=mRntQ9 ***

http://www.dh.gov.uk/PolicyAndGuidance/International/OverseasVisitors/OverseasVisitorsGeneralArticle/fs/en?CONTENT_ID=4080704&chk=mRntQ9 ***

DoH advice outlining eligibility for NHS treatment. Anyone who is deemed to be ordinarily resident in the UK is entitled to free NHS hospital treatment in England. Those not ordinarily resident are subject to the National Health Service (Charges to Overseas Visitors) Regulations 1989, as amended. These regulations place a responsibility on NHS hospitals to establish whether a person is exempt from charges or liable for charges. Nationality or past or present payments of UK taxes and National Insurance contributions are not taken into consideration when establishing residence: The only relevant issue is residence in the UK. The hospital can ask for evidence to support any claim to free treatment. All treatment given by staff at a hospital or by staff employed by a hospital may be subject to a charge with the following exceptions:

- Treatment given in an accident and emergency department (excludes emergency treatment given elsewhere in the hospital);
- Treatment given in a walk in centre providing similar services to those of an accident and emergency department of a hospital;

- Treatment for certain communicable diseases (excluding HIV/AIDS where it is only the first diagnosis and connected counselling sessions that are charge free);
- Compulsory psychiatric treatment.

Department of Health (DoH) (2004). ***Proposals to exclude overseas visitors from eligibility to free NHS primary medical services: a consultation.*** London: Crown Copyright. Document available at: http://www.dh.gov.uk/Consultations/ClosedConsultations/ClosedConsultationsArticle/fs/en?CONTENT_ID=4087618&chk=YG1MPH ***

This is a key (consultation) document focusing specifically on NHS use by non-residents. The authors maintain that the government believes the time is right to look at the usage of NHS primary medical services by overseas visitors. The rule changes close existing loopholes that have allowed overseas visitors with little or no connection to the UK to receive free NHS hospital treatment. The purpose of this document is to invite consultees to comment on proposals on the following issues:

- Changes to, and clarifying of, the rules on the eligibility of overseas visitors to receive free NHS primary medical services;
- The charging of those who would not be eligible under the new rules.
- Under these proposals, a person would be entitled to free NHS primary medical services if he or she requires treatment, which in the professional opinion of the health care clinician is immediately necessary; or is ordinarily resident in the UK; or falls within the scope of overseas visitors eligible to receive free NHS primary medical services.

Department of Health (DoH) (2003). ***Hutton proposes tighter NHS rules for treating overseas visitors. Press release.*** Document available at: http://www.dh.gov.uk/PublicationsAndStatistics/PressReleases/PressReleasesNotices/fs/en?CONTENT_ID=4047476&chk=AbL%2BD9 ***

New proposals to tighten the rules for charging overseas visitors for NHS treatment were published today by Health Minister John Hutton. The proposals outlined in a consultation document include changes to the regulations that allow the NHS to charge patients who are not resident in this country and therefore not eligible for free treatment. The proposed changes were developed following a Department of Health review of how NHS Trusts are applying the regulations. This review process found loopholes in the regulations that the new proposals seek to close. John Hutton said:

The NHS is there to provide a free at the point of use service to people who live here, not those who don't. We fully share the public's concern over any suggestion or evidence of abuse. That is why we will tighten the current rules for deciding who qualifies for free treatment under the NHS. But in proposing these changes we'll make sure that we continue to meet our international obligations in full. These rules have been in place for 14 years now without ever being properly reviewed. Times have changed, patterns of employment and migration are different, and arrangements which might have been right in 1989, are no longer effective now. They need to be fairer and clearer, and there shouldn't be any doubt as to who is eligible for free NHS services and who is not. Visitors to this country need to be in no doubt about their position should they need health care.

Some of the abuses that these proposed rule changes are aimed at stopping include:

- o Failed asylum seekers and others with no legal right to be in the country from receiving treatment free of charge.
- o Dependants of someone who is exempt from charges visiting the country briefly just to obtain free treatment.
- o Business travellers to the UK and their dependants receiving free treatment if they fall ill or are injured on a trip to the UK.

Other proposals include changes to the rules on charging for treatment of UK citizens who have been working abroad for more than five years. There are also new charge exemptions for pensioners who share their time between this country and another country, and foreign students resident in this

country. Pauline Lewis joint chair of the Overseas Visitors' Action Support Group said:

We welcome the proposals set out in today's consultation document. We have been aware of a number of abuses under the current system. For example, we see many cases of women who arrive in the UK more than 34 weeks pregnant, on a six-month holiday visa, visiting a spouse who is resident in the country. They then use their spouse's status to give birth in this country and then return home afterwards. It is this type of abuse we would like to be able to stop.

It is important to note that treatment a health professional considers to be immediately necessary to save life or avoid a pre-existing condition from worsening should not be delayed just because there are doubts about whether the patient may be chargeable. However, where a patient who is liable for charges is given emergency treatment (other than in an Accident and Emergency department) they should still be charged for that treatment once their liability has been confirmed.

Fountain, J., Bashford, J., Winters, M. & Patel, K. (2003). ***Black and minority ethnic communities in England: a review of the literature on drug use and related service provision***. London & Preston: National Treatment Agency / Centre for Ethnicity and Health, University of Central Lancashire. Document available at:
http://www.nta.nhs.uk/publications/bme_contents.htm **

A literature review that focuses on minority ethnic groups but also makes some reference to drug use by people born outside the UK. Barriers to service access are identified by the literature as the lack of acknowledgement of drug use by Black and minority ethnic communities themselves, ethnicity of staff, a lack of understanding of Black and minority ethnic cultures, language, lack of awareness of services and their functions, and fears about breaches of confidentiality. The key methods by which drug services can be made more accessible to Black and minority ethnic communities are identified by the literature as multi-agency working, outreach work and

community engagement initiatives.

Ghebrehewet, S., Regan, M., Benons, L. & Knowles, J. (2002). Provision of services to asylum seekers. Are there lessons from the experience with Kosovan refugees? *Journal of Epidemiology and Community Health* 56, 223-226. Document available at:

<http://jech.bmjournals.com/cgi/content/full/56/3/223> *

The authors report on the healthcare (and more general) needs of refugees in Liverpool (which limits the findings of the work here). They make a number of recommendations for improving arrangements for asylum seekers.

- There needs to be a strong commitment from the government to providing services based on respect for human rights.
- The current system of dispersing asylum seekers through different routes should be discontinued.
- Efforts need to be made to place asylum seekers in areas where there are existing minority communities.
- There is a need for a secured national database of asylum seekers.

Gillen, S. (2004). Asylum seeker dispersal highlights need for greater cultural awareness. *Community Care* (1505) 18-19. Document available at:

<http://www.communitycare.co.uk/AccessSite/articles/article.asp?liSectionID=22&liarticleID=43414> *

A brief item where the author reports how a lack of training is hampering social workers ability to deliver culturally sensitive services. In the North East of England, there is little understanding of the trauma and mental health problems experienced by asylum seekers. Poor knowledge of immigration law and an inability to understand other cultures were among the main problems reported.

Harris, J. (2003). 'All doors are closed to us': a social model analysis of the

experiences of disabled refugees and asylum seekers in Britain. *Disability and Society* 18 (4), 395 – 410. Abstract available at:
<http://www.ingentaconnect.com/content/carfax/cdso/2003/00000018/00000004/art00001>. **

Qualitative interviews were undertaken with disabled refugees and asylum seekers (n=38) in England to investigate access to social and welfare services.

Overall, the respondents reported that barriers to social services, benefits and social contact prove insurmountable. There are three main types of barrier: information requirements, linguistic requirements and forced moves. In relation to the first two, the respondents reported that they did not have access to information concerning what services and benefits might be available. A strong feature of the findings concerned inattention to linguistic requirements on the part of service providers. In relation to the issue of 'forced moves' that applies to asylum seekers under the NASS operated dispersal scheme, this causes disabled applicants considerable problems, particularly in relation to necessary adaptations to property, due to the temporary nature of stays.

Health Education Authority's Expert Working Group (1998). *Promoting the health of refugees*. London: Immigration Law Practitioners Association. Document available at: http://www.hda-online.org.uk/documents/promo_health_refugees.pdf *

A dated, and quite general document, specifically on refugees with some discussion of service use. Many of the recommendations are very general and concerned with improving communication, addressing language and cultural barriers and training health personnel.

Hendessi, M. & Bank-Anthony, B. (1997). *Health needs and experiences of refugees in Croydon. Report of a research project*. Croydon: Linx

Social Policy Consultancy.

No document available.

Hinton, T. (2001). *Working with refugees and asylum seekers in Lambeth, Southwark and Lewisham: a review of the work of the Refugee Health Team*. London: Crisis. Document available at: <http://www.asylumsupport.info/publications/crisis/working.pdf> **

This report presents the results of a review of the access that refugees and asylum seekers have to healthcare. The review involved collating the views of staff and of other agencies about their work. The main findings from the review are:

- o Refugees and asylum seekers face a number of difficulties in gaining access to quality healthcare.
- o These include difficulties in accessing language support, cultural barriers and a lack of accessible and appropriate information about NHS services and patients' rights.
- o Health practitioners can lack awareness about the refugee experience and may be reluctant to take on the additional workload associated with providing services for a population who may have complex needs.
- o These barriers exist in an environment where there is an absence of national strategies to provide solutions to these difficulties.

Kenny, C. (2000). Asylum seekers are 'new underclass.' *Nursing Times* 96 (44), 12-13. No abstract generally available.*

A brief item in which the author argues that the government's new policy of dispersing refugees around the country is obstructing their access to health services. Most existing access projects are based in London and the South East, but the majority of asylum seekers are now only in the area for a week or so before dispersal. No health screening is carried out by NASS, and there

is a danger that refugees could develop malnutrition if there is no system to provide cheap baby milk and vitamins.

Liratsopoulos, G., Bailey, K., Gill, J., O'Donnell, M. & Aston, R. (2000). Acceptability of health status questionnaire screening and vaccination among Kosovar refugees. *Communicable Disease and Public Health* 3(3), 198-200. Abstract available at: http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list_uids=11014035&dopt=Abstract *

The authors surveyed a group of Kosovar refugees in Bolton to assess the acceptability of vaccination and health status questionnaire screening. They examined the refugees' opinions about the confidentiality of their medical history and their willingness to take part in research. Fifteen out of 29 people responded. Most respondents were happy with the interventions.

Papadopoulos, I., Lay, M., Lees, S., Lees, S. & Gebrehiwot, A. (2003). The impact of migration on health beliefs and behaviours: the case of Ethiopian refugees in the UK. *Contemporary Nurse* 15 (3), 210-21. Abstract available at: <http://www.contemporarynurse.com/15-3p210.htm> *

This study explored the migration experiences of Ethiopian refugees in the UK and the impact of this on health beliefs and behaviours. Issue of service provision are briefly touched on. Data were collected via: semi-structured interviews with Ethiopians refugees and asylum seekers and Ethiopian professionals providing services; and a semi-structured questionnaire. The findings revealed that Ethiopian refugees place a stronger emphasis on externalised factors influencing health (such as happiness and good social relations) than they did in Ethiopia. In the UK, Ethiopian refugees are more likely to seek Western medicine than they did in Ethiopia. Nurses should understand that many refugees have had traumatic experiences and continue to live in desperate circumstances.

Papadopoulos, I., Lees, S., Lay, M. & Gebrehiwot, A. (2004). Ethiopian refugees in the UK: migration, adaptation and settlement experiences and their relevance to health. *Ethnicity and Health* 9 (1), 55-73. Document available at:

http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=15203465 **

This study explores Ethiopian refugees' and asylum seekers' experiences of settlement in the UK and their health beliefs and practices. It briefly discusses implications for service provision. Data were collected using semi-structured depth interviews and a semi-structured questionnaire. The sample consisted of Ethiopians resident in the UK (n=106). Most of the participants had sought the help of their GP in the first instance of illness, although some had experienced difficulties accessing health services due to language problems and poor understanding of the primary healthcare system.

Parker, J. (2000). Social work with refugees and asylum seekers: a rationale for developing practice. *Practice* 12 (3), 61-76. No abstract generally available*

The author considers how the increasing demand for Local Authority services, including social services, housing and other welfare agencies to support those seeking asylum in the UK, has created a need for social workers to be appropriately educated and prepared to work with asylum seekers and refugees.

Roberts, K. & Harris, J. (2002). *Disabled people in refugee and asylum seeking communities*. Social Care: Race and ethnicity series, Joseph Rowntree Foundation. York: Joseph Rowntree Foundation. Document available at: <http://www.jrf.org.uk/knowledge/findings/socialcare/962.asp> **

The 'Disabled Refugees in Britain' research project reviewed the social and welfare entitlements of disabled refugees and asylum seekers and also investigated service providers' experiences of supporting disabled people from these communities. There is no official source of data on the prevalence of impairment among refugees and asylum seekers living in Britain. Estimates range from 3 to 10 per cent of the total population of refugees and asylum seekers. Interviewers talked to 38 disabled people from six countries. Participants' age ranged from 19 to over 70, and they had a variety of impairments including physical, hearing, visual, mental health and multiple impairments.

Unmet personal care and domestic assistance needs (e.g. washing, dressing, making meals) were common, and few people were aware that social services might be able to assist with such tasks. These needs were often exacerbated by problems with inadequate housing and a lack of aids and adaptations. Also, communication difficulties were common. Accessing language classes frequently proved difficult, not only for financial reasons but also due to a lack of impairment-related access. None of the deaf participants knew British Sign Language prior to their arrival and there are very few training courses.

Most service providers were unfamiliar with the range of entitlements of disabled people within refugee and asylum seeking communities. Reception assistant organisations and Local Authority (LA) social services departments frequently encountered difficulties working with each other and with NASS. The question of financial responsibility for meeting the needs of this group of clients was a major source of contention, resulting in strained relations between agencies. Based on these findings, the researchers recommend:

Impairment-related data should be collected and incorporated into official demographic data sources relating to refugees and asylum seekers.

All NASS staff dealing with applications for support should receive full disability and race equality training.

There should be clarification of NASS responsibilities and procedures,

and of LA responsibilities, for the specific needs of disabled asylum seekers that arise from impairment or chronic illness.

The issue of responsibility for meeting the financial costs of providing community care services to disabled asylum seekers requires consideration and clarification.

Salinsky, M. (1997). Detaining asylum seekers. *British Medical Journal* 314, 356. Document available at:
<http://bmj.bmjournals.com/cgi/content/full/314/7079/456> *

A brief item which touches on service provision. The author points out that many studies report on the serious emotional effects that detention has had on asylum seekers' health. The government's detention policy should be seen in the context of increasingly restrictive asylum legislation; new legislation deprives many asylum seekers, some of whom are later recognised as genuine refugees, of the right to welfare benefits while they pursue their asylum claims.

Scott, C. & Vallely, A. (1999). *The health needs of refugees in Croydon: a rapid appraisal*. Croydon: Croydon Health Authority.

No document available.

Sergeant, H. (2003). *No system to abuse: immigration and healthcare in the UK*. London: Centre for Policy Studies. Document available at:
<http://www.cps.org.uk/harriethealth.pdf> ***

A report based on literature and interviews with selected informants (no information is provided about how these data were collected).

The author maintains that NHS tourism is Britain's 'new growth industry'. In 1992 the Accident and Emergency Department of St Mary's Hospital (in London) calculated that non-eligible patients cost them a 'substantial' 4.7 per cent of the total. The evidence is that things have got a lot worse since then.

Some consultant psychiatrists and managers claim that a 'significant' proportion—as high as 40 per cent of London acute psychiatric beds—is taken up by foreigners, including refugees and asylum seekers.

The Department of Health (DoH) warns GPs that asylum seekers arrive with, 'multiple health problems including tuberculosis, mental issues, physical and mental effects of torture and flight, language and cultural issues, also a lack of understanding of the NHS system.' It then insists there will be 'no central pot' and no money for interpreters. The DoH is unfair on NHS staff, on genuine asylum seekers and on the ordinary citizen. It is most unfair on those who live in the inner cities, many of whom are former immigrants themselves.

The author argues that the government should collect data on how much asylum seekers are costing the NHS and made suitable provision.

Other issues that should be addressed include:

- The introduction of health checks like other countries.
- The fact that the onus is on the doctor to tackle the patient to establish eligibility for treatment, and most are unhappy with this role.
- The government should consider steps such as:
 - Collecting data on the cost to the NHS of asylum seekers, health tourists and other immigrants.
 - An appraisal of the implications of the Human Rights Act on automatic entitlement to asylum for all people who have a health condition that cannot be treated in their own country.
 - Ensuring that the costs of treating health tourists are actively recovered.
 - Ensuring that health tests are carried out before immigration from countries with a high rate of contagious disease.
 - Considering the merits of introducing entitlement cards.
 - Ensuring that the Private Patient Managers in hospitals have the authority and power to perform a gateway function effectively before the patient is seen by medical staff.

Social Services Inspectorate (DoH) (1998). *They look after their own don't they: Inspection of community care services for Black and minority ethnic older people*. London: DoH. Document available at: <http://www.dh.gov.uk/assetRoot/04/08/42/86/04084286.pdf> *

Though not specifically on migrants, this report focuses on ethnic elders, most of whom migrated to the UK as adults in the 1950s and 1960s. The report focuses on social care services. Eight authorities with substantial minority populations were inspected to evaluate the extent to which arrangements for planning and delivering community care services addressed the needs of ethnic elders.

The report concludes that overall the inspected authorities were making genuine attempts to ensure that their services were relevant and accessible. However, there was a distinct lack of choice and many of the services were inappropriate to the needs of Black and ethnic minority older people. Social Services Departments varied in progress made to ensure that services to ethnic elders were relevant and accessible. Most recognised that Black elders were not a homogenous group, and were planning and designing appropriate services. For example, choice was limited in the majority of areas, and in some instances, basic services like meals on wheels were provided in an inappropriate manner. The services available tended to be those that were less intensive with few developments for high dependency needs of black elders. The ethnocentric nature of service provision also meant that some Black elders had difficulty in having their needs met.

Webb, E. (2000). Healthcare for ethnic minorities. *Current Paediatrics* 10 (3), 184-190. No abstract generally available. **

The author discusses provision of healthcare to British minority populations generally, and children specifically. The issues covered are: racism in service delivery; the specific health needs of minority populations; the needs of

disabled minority ethnic children; and the use of services by refugees and asylum seekers. Case studies are provided throughout the paper.

In sum, there are deficiencies in the screening techniques and communication of results to affected individuals. The needs of minority ethnic children affected by learning and other disabilities are not sufficiently addressed. There is some evidence that minority children may be disproportionately affected by disability. Hearing impairment may also be common in such communities; intervention for the hearing impaired must be culturally sensitive. Refugees and asylum seekers are often children, and they may have witnessed traumatic incidents and experienced famine or war. Many will require basic healthcare, such as immunisation and vision and hearing tests. They will also need appropriate therapy.

Wellard, S. (1999). Leeds delivers services to refugees. *Community Care* 13 May, 8-9. Document available at:
<http://www.communitycare.co.uk/articles/article.asp?liarticleid=27184&liSectionID=22&sKeys=refugees+leeds&liParentID=26> *

The author briefly examines how social services and the wider community are responding to refugees. He describes how Leeds' plans for responding to the arrival of 161 refugees drew on the city's peacetime emergency planning procedures and on the pre-planning for the reception of asylum seekers.

Whittington, D. & Abdi, S. (2001). *Somali substance misuse, causes and impacts*. London: OREXIS. Document available at:
<http://www.orexis.org.uk/Research.htm> *

This document is not specifically about service access/use, but does address some service provision and use issues. The aims of the work were to discover what drug problems were affecting the Somali community, and what the most effective ways of supporting people are? The researchers spoke to community groups in Lewisham, Tower Hamlets, Greenwich and Haringey

and Somali women and young men.

Khat (a widely used, plant-based drug) use was a major concern. GPs seemed unaware of issues affecting the community, and the issue of the mental health of the Somali population consistently arose in interviews. One of the main concerns was how issues affecting Somalis were being forced into a Western-based concept of the body and psychological health. This raises problems for the support of people with mental health issues. There are issues in trying to persuade people to engage with their GP, especially people who have difficulties in speaking English and who are unaware of the support systems. In conclusion, the development of specific services located within substance misuse agencies support to people with Khat and Crack problems in the Somali community is needed. Counselling support would be beneficial for those with a Crack Cocaine problem.

Williams, P. D. (2004). Why failed asylum seekers must not be denied access to the NHS. *British Medical Journal* 329, 298. Document available at: <http://bmj.bmjournals.com/cgi/content/full/329/7460/298> **

A personal view that raises concerns about restrictions on access to the NHS by failed asylum seekers. The author maintains that proposals for excluding visitors from free NHS services list some exempt infectious diseases for which no charge can be made. They also state that a person is entitled to free care if they require treatment which is an emergency or is immediately necessary. If a failed asylum seeker is being treated at intervals of seven days or less then they can 'continue to receive the treatment free of charge until such time as that person no longer needs such treatment.' This allows a GP to treat for conjunctivitis, but not to provide care for pregnancy or incontinence. Somebody with diabetes would need to have a complication before being entitled to treatment and somebody with rheumatoid arthritis would be denied treatment. Although most health professionals will be appalled at the new regulations, others will use them to justify denying care to people refused asylum and will be confused about the entitlements of people seeking

asylum. There is no hard evidence that health tourism exists.

Wilson, R. (2002). *Improving the health of asylum seekers in Northern & Yorkshire: a report on service provision and needs*. Yorkshire: Northern & Yorkshire Public Health Observatory. Document available at: http://www.nepho.org.uk/files/reference/projects/Asylum_Seekers.PDF **

A comprehensive document (with a large number of appendices) that specifically addresses service provision as well as the general health status of asylum seekers. It was relatively recently published but focuses only on one geographic area. The aims of the research were: to present a picture of the population of asylum seekers/refugees; to explore how data is collected on health needs; to provide a brief overview of current health service provision. Questionnaires were sent to various organisations including: NASS; two regional consortia; all Health Authorities in areas receiving dispersed asylum seekers (10); all Primary Care Groups and Trusts (PCG/T) in areas receiving dispersed asylum seekers (24); one GP in each of the above PCG/T areas (24). Interviews were conducted with asylum seekers in Hull (n=17). The total number of questionnaires returned was 76 (58%).

Thirty-one respondents (out of 46 asked this question in the postal questionnaire) said there were gaps in health services for asylum seekers. Appropriate mental health provision was the most frequently cited area. Refugee community representatives took part in a focus group discussion. The group raised a number of issues:

- Language: the group underlined the importance of good language services. They said some health services were reluctant to make use of interpreters.
- Mental health: difficulties were seen as arising both pre-arrival, and as a result of the experience of being an asylum seeker. A lack of counselling and specialist services was identified.
- Primary care: the group commented on difficulties in registering with GPs. Some health workers, including GPs, were seen as having negative attitudes towards asylum seekers, who they see

as transient, costly and unreliable.

- Information and health promotion: this was seen as very important, and a number of gaps were identified, particular in connection with sexual health and drug and alcohol abuse.
- Dental care: there are difficulties with registration and use of interpreters.
- Screening and secondary care: it was felt this should be easier to access, and that staff should have training in cultural issues. Asylum seekers need to be encouraged to take up screening.

Woodhead, D. (2000). *The health and well-being of asylum seekers and refugees*. London: The Kings Fund. Document available at: <http://www.kingsfund.org.uk/pdf/asar.PDF> **

This document addresses various aspects of the health and well-being of asylum seekers and refugees. One section is devoted to health service use. Data were collected from contacts in NGOs (n=7) and statutory sector organisations (n=2) who provide services for asylum seekers/refugees in London. The interviews were informal and respondents were asked questions about the new system. Most of the interviews were undertaken on the telephone (n=7). A small number were undertaken face to face (n=2).

The key points made by respondents include the observations that: health services are not oriented to the needs of asylum seekers and refugees; healthcare practitioners are not used to the surge of people with limited ability to communicate in English, presenting them with various and uncommon complaints; and asylum seekers and refugees experience problems in registering with a GP.

GP surgeries that offer good services to asylum seekers and refugees become well known and quickly develop a strong reputation with the communities with which they work. This leads to a disproportionate number of asylum seekers and refugees using those services and puts pressures on them. In addition, translation of leaflets remains poor and communication

between health professionals and asylum seekers and refugees who do not speak English is often difficult, and respondents suggested that misdiagnosis is common.

B2) The health & well-being of children & young people

Cemlyn, S. & Briskman, L. (2003). Asylum, children's rights and social work. ***Child and Family Social Work*** 8 (3), 163-178. Abstract available at: <http://www.blackwellpublishing.com/abstract.asp?ref=1356-7500&vid=8&iid=3&aid=2&s=&site=1> *

This article focuses on the situation facing children seeking asylum with/without their families in Britain and Australia, and the implications for children's rights and social work. Legislative changes and policy complexity point to increasingly punitive attitudes towards asylum seekers. The situation of children and families is discussed in terms of the exclusion of asylum seekers from basic rights and specific issues for separated children. In both countries there is widespread flouting of children's rights. The role of social workers in the statutory and voluntary sectors is considered.

Davies, M. & Webb, E. (2000). Promoting the psychological well-being of refugee children. ***Psychology and Psychiatry*** 5 (4), 541-54. Abstract available at: <http://www.ingenta.com/isis/searching/ExpandTOC/ingenta;jsessionid=3o4mr6tpmqhib.crescent?issue=pubinfobike://sage/ccp/2000/00000005/00000004&index=9> *

The authors describe the mental health needs of Somali refugee children in Wales and their use of services using case examples. Also considered are issues relating to child development of the child, their mental health problems, the war/refugee context, the Somali culture and the host culture. The authors identify developmental factors relating to the vulnerability of refugee boys in the host culture and recommend a coordinated and culturally

sensitive approach to the care of refugee children and their families.

Gosling, R. (2000). *The needs of young refugees in Lambeth, Southwark & Lewisham*. London: Lambeth, Southwark & Lewisham Health Authority. Document available at:
http://www.lho.org.uk/Publications/Attachments/PDF_Files/HAZ/Gosling2000LSL.pdf **

A number of people were recruited for this study: 34 refugee children aged 12-16 years old; 211 service providers and policy officers from health, education and social services; and 20 community and youth workers.

Nearly all the young people interviewed were registered with a GP and most had been to a dentist. More than half were critical of the service they had received from GPs; the main criticism being that they didn't feel listened to. The young people who had not experienced problems with accessing services had family members who spoke English and had a good knowledge of the system. Young people wanted more information about services and liked the idea of having an advice worker, a telephone hotline and a website.

Professionals felt that accessing services was still one of the greatest problems facing young refugees. Problems with registering with GPs and dentists and getting school places for refugee children were reported as the main problems. It was reported that some newly arrived refugee children can wait eight months for a school place to be found. Reasons for these problems were attributed to language barriers, lack of interpreting services and a lack of information and/or knowledge about services. Less than a quarter of respondents had received training on refugee issues, more than half felt that training would be useful, and over half wanted training on linking with organisations that work with refugees.

Lynch, M.A. (2001). *Providing healthcare for refugee children and unaccompanied minors*. London: MEDACT. Document available at:
http://medact.org/article_refugee.php?articleID=187 *

An overview of the healthcare needs of refugee children. The author maintains that the health of refugee children must be considered beyond ensuring access to healthcare and should include issues such as housing and education. It is important to arrange access to appropriate care for unfamiliar diseases and to recognize emotional health problems, particularly when they are related to past experiences of violence.

Lynch, M.A. & Cuninghame, C. (2000). Understanding the needs of young asylum seekers. *Archives of Disease in Childhood* (83), 384-387.

Document available at: <http://adc.bmjournals.com/cgi/reprint/83/5/384> *

A background document intended to inform those who provide care to refugee children and their families. Lack of English can become a major obstacle for refugees in accessing services, leading to under use, and the inappropriate use of children as interpreters. Those seeing asylum seeking and refugee children need access to good local interpreting services and ideally need to link workers familiar with the family's culture and able to advocate on their behalf. Experience has shown that it is unreasonable to expect refugees to slot neatly into existing styles of healthcare; they require support in accessing services, and health professionals require guidance on how to respond effectively. Paediatricians have an important role to play in advocating for local services that meet the needs of asylum seeking children in ways that are culturally acceptable and non-stigmatising.

Macaskill, S. & Petrie, M. (2001). *I Didn't Come Here For Fun...Listening to the Views of Children and Young People who are Refugees or Asylum-Seekers in Scotland*. London: Save the Children. Document

available at:

<http://www.asylumsupport.info/publications/savethechildren/viewsofchildren.pdf> **

This report highlights the difficulties faced by children and young people who are refugees and asylum seekers. Thirty-three children and young people were interviewed in small groups. Their views have been categorised into key themes. These include:

- Arrival in Scotland: the children and young people arrived often having left their home countries in circumstances which were terrifying and traumatic. They are relieved at being somewhere safe, but grieve the loss of their friends, family and life in their country of origin.
- A new home, a new environment: children and young people dispersed to Scotland are being located in socially disadvantaged areas in which they experience problems associated with property maintenance, vandalism, lack of places to play, harassment, etc.
- Going to school and learning English: the young people's education was interrupted as a result of becoming refugees and asylum seekers. Attending school and receiving an education was perceived as valuable and hugely significant. However, children and young people clearly do not always feel welcomed by other pupils.
- Keeping healthy: the children and young people are in a situation in which they experience stress related to missing parents, trauma associated with leaving their own country, worries about whether they would be allowed to stay in the UK, being located in a strange environment and experiences of harassment. While most described their experiences of using health services as positive, some had difficulties related to a lack of interpreting services, and not being able to understand what they were being told by medical professionals.
- Community and leisure: all children and young people described how they valued any opportunity to play, socialise, build and maintain friendships. Poor accommodation and lack of cash available to families as a result of the voucher system impedes normal socialising.

Mather, M. & Kerac, M. (2002). Caring for the health of children brought into the UK from abroad. *Adoption and Fostering* 26 (4), 44-54. Abstract available at:

<http://www.ingenta.com/isis/searching/Expand/ingenta?pub=infobike://baaf/afj/2002/00000026/00000004/art00007> *

The authors focus on the health needs of inter-country adoptees and unaccompanied refugee and asylum seeking children. They discuss the limitations of Department of Health guidance and identify the range of health problems that frequently go unrecognised in inter-country adopted children. Although the same problems apply to refugee and asylum seeking children, these already traumatised young people carry the double burden of the problems they arrive with, and the problems that arise once they are in the UK.

Mitchell, F. (2003). The social services response to unaccompanied children in England. *Child and Family Social Work* 8 (3), 179-189. Abstract available at: <http://www.blackwellpublishing.com/abstract.asp?ref=1356-7500&vid=8&iid=3&aid=3&s=&site=1> *

The author explores research concerns associated with: the referral and assessment process; the use of the child welfare legislative framework; and a number of issues arising from the provision of placements and other support offered to unaccompanied children. The findings of the research reviewed suggest that there are grounds for concern. However, it is argued that the evidence base is relatively weak and that very little is known about the nature and context of the social work response to this group of children and young people.

Okitikpi, T. & Aymer, C. (2003). Social work with African refugee children and their families. *Child and Family Social Work* 8 (3), 213-222. Abstract

available at: <http://www.blackwellpublishing.com/abstract.asp?ref=1356-7500&vid=8&iid=3&aid=6&s=&site=1> *

This article explores the issues and dilemmas that arise when social workers attempt to work with African refugee and asylum seeking children and their families. There is a complex interplay between social workers' skills and knowledge in this area and the prevailing social attitudes towards these groups of service users. Drawing on a small-scale research study with social workers and discussions with immigration officers and workers in voluntary agencies working with refugees and asylum seekers, the article draws some conclusions about the lessons that can be learnt in order to improve practice.

Sellen, D.W., Tedstone, A.E. & Frize, J. (2002). Food insecurity among refugee families in East London: results of a pilot assessment. *Public Health Nutrition* 5 (5), 637-44. Abstract not generally available.*

The objective of this study was to identify child hunger and examine its association with family factors, receipt of benefits, housing conditions and social support among recently arrived refugee families with young children. The design used structured and semi-structured questionnaire which were administered to a service-based, purposive sample of caregivers in East London. Respondents were 30 households with children under 5 years old.

The results suggest that all households were food-insecure, and 60 per cent of children were experiencing hunger. Child hunger was significantly associated with recent arrival, marginally significantly associated with receipt of fewer benefits and younger parenthood, and was not associated with maternal education or self-efficacy score, household size or composition or measures of social support. In conclusion, a community-based, participatory approach for rapid assessment of the prevalence, extent and causes of child hunger among newly arrived asylum seekers in Britain is feasible.

B3) Primary & secondary healthcare

Free, C., White, P., Shipman, C. & Dale, J. (1999). Access to and use of out-of-hours services by members of Vietnamese community groups in South London: a focus group study. *Family Practice* 16 (4), 369-374. Document available at: <http://fampra.oupjournals.org/cgi/content/full/16/4/369> *

Data were collected from 51 individuals participating in focus groups in the London Boroughs of Southwark and Lewisham. All respondents were Vietnamese (and most were foreign-born) There were six focus groups. Group discussions were audio taped, transcribed and coded.

The results suggest that most respondents did not know about GP's out-of-hours services, though most respondents were aware of emergency services and were impressed by the speed of response. In all the groups, language problems were cited as a deterrent to use of services and a barrier to the communication of their health problems. Children often acted as interpreters and respondents with poor English often used gestures to communicate with health professionals. The authors emphasise the commonality of themes across the focus groups, and mention the limitations of the study.

Hargreaves, S. & Holmes, A. (2000). Refugees, asylum seekers and general practice: room for improvement? *British Journal of General Practice* 50 (456), 531-532. No abstract generally available. **

Refugees present to GPs with a large number of health concerns, which places considerable strain on doctors. Immigration regulations emphasise screening for tuberculosis (TB) to detect active disease and to identify those requiring chemoprophylaxis and vaccination. However, a large, unquantified number of asylum seekers are not included in this programme.

The fact that most GPs are unaware that there is TB screening reflects the ineffectiveness of the programme. Few GPs routinely refer refugees for TB screening, and most appear to do little or no screening for common health conditions, infectious diseases, vaccination status, or inquire about the

refugees' mental health. One reason for this is that refugees are often registered by GPs as temporary rather than permanent patients. As a result of temporary registration the refugee may be denied the basic health check, and will not have a complete set of medical records. Although it can be difficult for a GP to tell a legitimate refugee or asylum seeker from an illegal immigrant, this should not influence immediate care. Attitudes to asylum seekers clearly vary between GP practices; some are open to refugees while others are not so welcoming. The present situation results in refugees inappropriately using casualty departments and often allowing their health to deteriorate to the point where they need hospital admission.

Hargreaves, S., Holmes, A. & Friedland, J. (1999). Healthcare provision for asylum seekers and refugees in the UK. *The Lancet* 353, 1497-1498. No abstract generally available**

A relatively outdated, but useful, item on the healthcare needs of asylum seekers and refugees. The authors contacted 78 London GP surgeries. Fifty eight GPs from 56 practices responded (72% of surgeries contacted) and they completed a telephone questionnaire. Forty eight of these 58 (83%) reported that they treated patients who were refugees or asylum seekers, of whom 17 were caring for over ten such patients. Forty six (79%) were unaware of the health screening that should take place at points of entry, seven believed that individuals had a chest radiograph, three thought they also had a physical examination and two were uncertain about procedures.

Fifty five GPs were aware that asylum seekers were entitled to free NHS treatment. However, at a first consultation, only 27 GPs enquired about vaccination status, usually as part of a new patient's health check. Four GPs screened for tuberculosis (TB), two for malaria, and one for parasitic infection. Three GPs checked for mental health problems. Twenty eight per cent of GPs did not offer health screening to asylum seekers. These findings suggest that health provision for asylum seekers in London is inadequate and that this may be inadvertently exposing the population to infections such as

TB. Development of specialised centres in areas with many asylum seekers should be given urgent consideration.

Hounslow PCT (2004). ***Primary care services for refugees and asylum seekers: a review***. London: Hounslow PCT. Document available at: http://www.hounslowpct.nhs.uk/publications/documents/refugees_asylum_seekers_2911.pdf ***

A recent and comprehensive document on the use of primary care services by refugees and asylum seekers. Data were collected from three main sources: published reports and articles on the health of refugees and asylum seekers; grey literature on health needs and services for refugees and asylum seekers; and face-to-face and telephone discussions with primary care providers. The results suggest that:

- Practitioners are often wary of registering patients because of fears that they will make excessive demands, and because of confusion about entitlements.
- Ancillary services can be crucial in supporting mainstream practices and in enabling them to provide appropriate care.
- All types of service identified depend on good multidisciplinary working between nurses, doctors and interpreters, and are most effective where there are good links with refugee community organisations.
- Refugees and asylum seekers present with a wide range of needs, many of which overlap with those faced by any foreign-born people, or with other marginalised groups.
- In dispersal areas, when records are properly kept, it can be easier to offer dedicated services to new arrivals than in London, where a large proportion of asylum seekers and refugees are 'hidden' among a wider population.
- Combined services for refugees and asylum seekers and other vulnerable groups, especially homeless people, may not always be appropriate because of their distinctive needs.

- Shortage of appropriate mental health services to meet the problems of mental illness has led to inter-agency partnerships in some areas to provide services for this group. Many reports also advocate a holistic approach to mental health problems.

Jones, D. & Gill, P.S. (1998). Refugees and primary care: tackling the inequalities. *British Medical Journal* 317, 1444-1446. Document available at: <http://bmj.bmjournals.com/cgi/content/full/317/7170/1444> **

The authors explore the challenges that refugees pose for primary care, and suggest alternative strategies to address inequalities in the care of refugees. Although all refugees are entitled to the full range of NHS treatment free of charge, there is evidence that GPs are confused about this. Some practices are open for refugees whereas others are effectively closed, creating neighbouring practices with very different demographic profiles and unequal needs. Information on GPs' perceptions of refugees' health needs is limited. When refugees join a GP's list they are often registered on a temporary rather than a permanent basis. This prevents access to past records, if there are any, and removes financial incentives to undertake immunisation and cervical smear tests.

The care of refugees generates an additional workload for GPs and there is evidence that current deprivation payments are not adequate. The refugee population is likely to remain large. High needs, especially psychological distress, combined with language barriers require a great deal of additional time in consultations. GPs in inner cities need adequate resources, especially interpreting services, and should be rewarded.

Jones, D. & Gill, P. (1998). Breaking down language barriers. *British Medical Journal* 316, 1476-1480. Document available at: <http://bmj.bmjournals.com/cgi/content/full/316/7143/1476> *

The NHS has not changed rapidly enough to meet the challenge posed by

patients who do not have English as a first language. Commercial telephone translation services are available, but are expensive and employ interpreters who may not have experience in medical interpreting; some districts run local telephone interpreting services, but provision is patchy. Little is known about the effects of different translation provision on the quality or costs of healthcare, but evidence from the US suggests that it can allow high quality consultations and is valued by patients.

Katikireddi, S.V., Bhopal, R. & Quickfall, J.A. (2004). GPs need training and funding in caring for refugees and asylum seekers (letter). *British Medical Journal* 328, 770. Document available at:

<http://bmj.bmjournals.com/cgi/content/full/328/7442/770> * * *

A postal questionnaire was sent to all GPs in Lothian, Scotland (n=129). It focused on the need for extra funding for GPs with refugees, the best place for providing primary care services, and the need for training.

Ninety five responses were received (response rate=73.6%). About one third of GPs had treated refugees, but few staff had undergone training. Of 82 GPs (86%) who had not received training, 17 (21%) wanted training. Nearly one fifth were unsure or incorrect about refugees' entitlement to free NHS treatment. Respondents were divided on whether refugees should be treated at normal practices or by specialist services. GPs supported extra funding and many favoured treating refugees in normal practices, but many had no relevant training. Some were unaware of refugees' NHS entitlements.

Le Feuvre, P. (2001). How primary care services can incorporate refugee healthcare. *Medicine, Conflict and Survival* 17 (2), 131-136. No abstract generally available*

Two principles should underpin the provision of primary healthcare to refugees: that refugees should have the same access to quality primary care services as the local population; and any specialist service should have the

goal of full integration of the refugee into normal general practice. The various ways in which medical care can be provided to refugees and the knowledge, skills and attitudes important to such provision are described, and one way in which such a service was provided in East Kent is reported.

Trafford, P. & Winkler F. (2000). ***Refugees and primary care***. London: The Royal College of General Practitioners.

No document available.

B4) HIV/AIDS

Bhatt, C., Phellas, C. & Pozniak, A. (2000). ***National African HIV prevention projects: evaluation report***. London: Department of Health & Enfield and Haringey Health Authority. Document available at: http://www.beh.nhs.uk/publications/general/hiv_sexual_health/hiv_evaluation_report.pdf *

An evaluation report for the first year of HIV prevention projects in African communities in England and Wales. A number of recommendations were made. These include:

- A targeted media campaign for future years that is linked to African populations for which there is strong epidemiological and clinical evidence of HIV prevention need.
- The provision of specific resources on breastfeeding and commercial baby milk products.
- Resources related to the impact of changes in antenatal testing policy on African women, their partners and their families.
- A review of dissemination sites for resources and health education materials.

British Medical Association (BMA) (2005). ***British Medical Association's written submission to the Health Select Committee inquiry - new developments in HIV/AIDS and sexual health policy***. London: BMA.

<http://www.bma.org.uk/ap.nsf/Content/BMAsexhealth> ***
 (also see House of Commons Select Committee on Health, below).

The BMA report on the likely consequences of the new and proposed changes in the charges for overseas patients with regard to HIV/AIDS services. The authors argue that, in theory, there is an obvious argument for excluding from treatment people who have not obtained proper permission to be in the UK. In practice, however, this might mean that people are abandoned when treatments are available to help them. It is also in society's interests to ensure that treatable diseases, especially those that are transmissible, are not ignored since this could be a problem for the wider society.

Late HIV infection especially is likely to be associated with other serious conditions, such as tuberculosis. High viral loads in patients with untreated HIV allow more ready sexual transmission, possibly into the resident population. From a public health perspective, the majority of serious HIV-related morbidity and mortality in the UK is associated with missed or late diagnosis, which suggests that accusations of 'health tourism' in this context are misplaced. If people arriving from Africa with HIV were treatment tourists, they would access treatment earlier rather than turning up as emergencies with undiagnosed infection.

A very important part of HIV prevention, especially for those who were infected with HIV overseas, is the prevention of transmission from mother to child. Appropriate interventions before, during and after birth can reduce the risk of HIV transmission from mother to child from 25-35 per cent to under 2 per cent, but in order to achieve this, ongoing medical care and social support is crucial. Aside from the moral and public health arguments, there is also an economic argument for preventing mother-to-child transmission.

Camden & Islington Health Authority, the African Communities Team (2000).
African Men's seminar: how can men make a difference in HIV prevention? Seminar report and key recommendations. London:
 Camden and Islington Community NHS Trust.

No document available.

Chinouya, M. (2001). ***HIV prevention and African communities living in England: a study of challenges in service provision***. London: National AIDS Trust. Document available at:
<http://www.nat.org.uk/documents/MAPPINGFINAL.doc> **

This report is an overview of HIV prevention services targeting African communities in England. The evidence was collected through telephone interviews and focus group discussions with a sample of HIV prevention service providers (n=31). From these interviews and focus group discussions it emerged that a range of HIV prevention services available to African communities exist across England, with a majority of these services concentrated in London. The study identified the following as limitations of HIV health promotion services:

- Limited funding and capacity building.
- Limited evidence-based interventions.
- Limited use of traditional modes of communication on intimate issues.
- Limited inter-agency and inter-regional collaboration.
- The recommendations made include:
 - To increase sustainable funding and capacity building.
 - To encourage inter-agency collaboration.
 - To improve the marketing of HIV prevention services.

Chinouya, M. (2001). Life in Luton. ***Mapping the sexual health prevention needs of African communities in Luton***. Unpublished document.

No document available.

Erwin, J., Morgan, M., Britten, N., Gray, K. & Peters, B. (2002). Pathways to HIV testing and care by Black African and White patients in London. ***Sexually Transmitted Infections* 78**, 37-39. Document available at:

<http://sti.bmjournals.com/cgi/content/full/78/1/37> **

The authors examine factors associated with uptake of HIV clinic services by Black African HIV positive people living in London using a questionnaire survey of patients attending an outpatient clinic in South London. All patients attending the clinic between July 1999 and March 2000 were approached. Outcome measures included: use of health services; delay in seeking HIV test; delay in uptake of HIV care; barriers to clinic use; and sources of support.

The analysis from 392 questionnaires showed that respondents were: White=64 per cent; Black African=26 per cent; other=10 per cent. Black African respondents were from Uganda (36%), Zimbabwe (14%), Zambia (12%), and 14 other African countries. Twenty one per cent had been in the UK less than 5 years, and 59 per cent less than 10 years. Twenty eight per cent of Black Africans suspected they were HIV positive before diagnosis (White patients 45%; $p < 0.01$). Before testing, 11 per cent of Black Africans had previously attended a GUM clinic and 80 per cent had consulted a GP. Twenty per cent of Black Africans expressed concern over entitlement to care and where to get an HIV test. The majority of Black Africans (66%) received HIV care within one month of diagnosis.

This study suggests that, although Black Africans are a high-risk group for HIV infection, they generally do not suspect their HIV status. While they may delay testing, their uptake of HIV clinic care and use of statutory and voluntary support services after diagnosis is similar to their White counterparts.

Erwin, J. & Peters, B. (1999). Treatment issues for HIV positive Africans in London. *Social Science and Medicine* 49, 1519-1528. No abstract generally available. *

This study explores treatment issues concerning Black Africans which may affect their uptake of therapies. Issues raised included questions about when

to start treatment, fears of side-effects, awareness of the current uncertainties surrounding combination therapies and concerns about how to achieve compliance. The social circumstances of HIV positive Black Africans together with differences in cultural beliefs and experience of healthcare in the UK give rise to particular treatment concerns. These concerns include the fear of being experimented upon, lack of confidence in drugs tested only on Whites, distrust of the medical profession and fears of discrimination.

Fenton, K. A., Chinouya, M., Davidson, O. & Copas A. (2002). HIV testing and high-risk sexual behaviour among London's migrant African communities: a participatory research study. *Sexually Transmitted Infections* 78, 241-245. Document available at: <http://sti.bmjournals.com/cgi/content/full/78/4/241> **

The authors describe the demographic and behavioural factors associated with HIV testing among migrant Africans in London using a cross-sectional survey of migrants from five sub-Saharan African communities. A questionnaire collected data on demographic characteristics, utilisation of sexual health services, HIV testing history, sexual behaviour and attitudes. Questionnaires were obtained from 748 respondents (396 men and 352 women). Median length of UK residence was six years and 34 per cent of men and 30 per cent of women reported ever having had an HIV test.

HIV testing was significantly associated with age and previous sexually transmitted infection (STI) diagnosis among women; and additionally, nationality, education, employment, and self perceived risk of acquiring HIV among men. After controlling for significant demographic variables, previous diagnosis of an STI (adjusted odds ratio, 95% confidence intervals for men: 2.96, 1.63 to 5.38, and women 2.03, 1.06 to 3.88) and perceived risk of acquiring HIV for men (adjusted odds ratio 2.28, 95% confidence intervals 1.34 to 3.90) remained independently associated. These data suggest that HIV testing remains largely associated with an individual's STI history or self perceived risk.

Focus Consultancy (2000). ***Social mapping and needs assessment of HIV prevention among West African communities in inner London (South) region.*** London: Focus Consultancy.

No document available.

Fortier, E. / All party parliamentary group on AIDS (APPGA) (2003).

Migration and HIV: improving lives in Britain: impact of the UK nationality and immigration system on people living with HIV.

London: All party parliamentary group on AIDS Document available at:

<http://www.appg-aids.org.uk/Publications/Migration%20and%20HIV%20Improving%20Lives.pdf> ***

The questions that guided this research were: how significant an impact are migrants with HIV having on UK health and social care services; what reception and treatment do they receive once they are here; how has government policy responded to the challenges; and what can be done to improve the situation for everyone infected and affected by HIV in the UK? A series of four hearings took evidence from individuals including HIV specialist clinicians, GPs, solicitors, national AIDS organisations and migrants currently living with HIV.

The main findings are that NHS services are overstretched due to prolonged under-investment. In addition, HIV prevention funding is no longer centrally ring-fenced leaving HIV services subject to the pressures that exist across the NHS. The Inquiry noted the concern of clinicians, many of whom are being increasingly asked to serve multiple roles in the clinical setting: as immigration officers, social welfare officers, support liaisons and care workers. In most cases, there was a lack of communication between the Home Office, NASS and social services, which may be putting asylum seekers in situations where they can become more ill. In particular, the practice of detaining people known to be living with HIV when they require access to

specialist care, or dispersing them to areas where no care is available, damages individual and public health. It was felt that the UK government should be addressing factors which push people to migrate in developing countries. The main conclusions include:

That the government should support policies which encourage HIV testing and it should not adopt a policy of mandatory testing upon entry. The UK government should not detain, solely for immigration purposes, individuals with serious communicable diseases if it cannot provide for their care inside removal centres.

The government should develop and implement national best practice guidance on asylum seekers living with HIV that involves both NASS and social services responsibilities, including training for senior personnel in both agencies on how to monitor and maintain good practice.

House of Commons Select Committee on Health (2005). ***New developments in sexual health and HIV/AIDS policy: third report of session 2004–05***. London: TSO. Document available at: <http://www.parliament.the-stationery-office.co.uk/pa/cm200405/cmselect/cmhealth/252/252.pdf> ***

The Committee notes that the government has introduced changes to the regulations relating to charges for NHS treatment for overseas visitors in an attempt to combat 'health tourism'. Treatment for certain communicable diseases, including tuberculosis (TB) and sexually transmitted infections (STI) is exempt on public health grounds. However, treatment for HIV is not exempt. Given the high prevalence of HIV in people born in Africa living in the UK, there is concern that this legislation will have a disproportionate impact on African communities in the UK. In principle, the Committee supports the government's attempts to tackle this problem. However, the Committee is not convinced that the government has fully understood the complexity and breadth of the issues involved in charging for HIV treatment, and the potential consequences of getting it wrong.

Although the Committee has received assurances from the government that abuse of the NHS by 'health tourists' does take place, it is difficult to place much weight on these assurances since the government was unable to provide any data on the numbers of people allegedly 'abusing' the NHS, nor the costs associated with this. The most serious adverse consequence of these changes is their potentially disastrous impact on public health.

First, if free treatment is not available, people may be deterred from taking an HIV test, and will remain in the community undiagnosed and infectious.

Second, research evidence suggests that HIV treatment can lower an individual's infectivity significantly, reducing the potential for onward transmission. It is a nonsense that the Government is prepared to fund a person's TB treatment on public health grounds but not treatment of his HIV infection.

The UK must not become a magnet for HIV positive individuals seeking to emigrate to this country simply to access free healthcare. However, some European countries have far less stringent requirements for access to HIV treatment than the UK. Furthermore, people either entering and/or remaining in this country without proper authority are a matter for the Home Office and the Immigration Services, and it is up to these services to enforce immigration regulations robustly and swiftly.

McMunn, A.M., Mwanje, R., Paine, K. & Pozniak, A.L. (1998). Health service utilization in London's African migrant communities: implications for HIV prevention. *AIDS Care* 10 (4), 453-462. Abstract not generally available. **

Ugandans are the second largest group to be affected by HIV in the UK and it is important that healthcare information and treatment is culturally appropriate. Here, the authors report the results of a study of health service use by Black Africans from Uganda residing in South East London. Respondents' details were taken from community organisation lists and additional respondents were recruited via 'snowballing' techniques. Data were

collected using a mostly closed questionnaire designed to measure knowledge and use of health services. Most respondents were female and all had been born and raised in Uganda (n=118).

Respondents were asked about their knowledge of health services. Most (74%) named a specific GP, and most (71%) were aware of an African voluntary organisation. The data on the use of health services shows that most (97%) respondents were registered with a GP and 98 per cent of these had seen a GP in the last year. At least one attendance at a genito-urinary medicine clinic was reported by 15 per cent of the sample (compared with 7 per cent for the British population generally). Most (87%) of those who had used services expressed satisfaction, though communication problems were noted and 40 per cent of the sample said that health services should work more closely with African community organisations.

Of the 17 topics itemised (ranging from healthy eating to HIV/AIDS) a third of respondents had received information on 14 of the 17 topics. Information on HIV/AIDS had been received by 76 per cent of the sample. Men, older respondents and post-'A' level educated respondents were significantly more likely to have received HIV/AIDS information. The results cannot be generalised to all African populations in the UK (Uganda was one of the first African nations to deal with HIV/AIDS and English is the official language of the country, both of which affect the use of health services by London-based Ugandans).

Terence Higgins Trust (THT) (2004). ***Background briefing: access to HIV services for all migrants to the UK***. London: Terence Higgins Trust.

Document available at:

http://www.tht.org.uk/policy/policy_pdfs/accesstohivservices.pdf ***

This briefing explains the recent changes in entitlement to NHS services for migrants to the UK, the impact these changes are already having on public and individual health and the concerns expressed by many clinicians and other HIV experts.

In response to media and political agitation about 'treatment tourism' new restrictions were imposed on all hospital services from April 2004. This meant that treatment for HIV would never be provided without charge for certain categories of people. This was despite the lack of any research showing the existence or extent of 'treatment tourism' in HIV.

It is clear (as of November 2004) that these changes to the regulations are already causing hardship. It is also beginning to be clear in the case of HIV that, while they may result in a small short term cost reduction to local NHS budgets, in the longer term they are highly likely to have a negative effect in all three major areas: the public purse; the public health; and individual health. From cases already referred to THT, the following concerns arise:

- Individuals co-infected with tuberculosis (TB) and HIV have been told that, while their TB treatment is free, the HIV treatment necessary to ensure that their TB treatment is effective will be charged for.
- At least two pregnant women have been told they will be charged (and thus effectively refused) for temporary HIV treatment to prevent transmission of HIV to their unborn child.
- Patients taken to hospital as emergencies have not been informed of possible subsequent charges, usually several thousand pounds, until their discharge from hospital. In at least one case, they have subsequently been refused access to their medical records (needed to apply for leave to remain) unless they paid a large bill first.
- People within communities of high prevalence for HIV have begun to ask why they should bother to test for HIV if they cannot obtain treatment for it.
- There have already been several cases of misinterpretation of the regulations by refusal of treatment to those entitled, and other cases where manner of questioning has discouraged people entitled to services from re-attending for them.

Although some NHS staff have said to us that 'people may be charged but if they can't pay, we won't stop treating them', there have already been

examples of debts being handed over to collection companies for pursuance. Health inequalities are already emerging between people accessing different clinics with differing interpretations of the new regulations. In the longer term, THT have the following concerns:

- It is unlikely that charging for treatment will encourage people refused asylum to return to countries they have been determined to leave.
- People with HIV unable to access antiretroviral treatment and associated services will remain in the community and be more infectious than if in treatment.
- People with progressive immune deterioration resulting from HIV will need to access emergency services multiple times, with increasing frequency and severity, resulting in many cases in far higher incident costs than a simple ongoing prescription for antiretrovirals. Annual cost of combination therapy is now under £10,000; one week's stay in intensive care can cost almost as much, and this could be repeated many times, given the high standard of emergency medical care in the UK.

Terence Higgins Trust (THT) (2003). ***Recent Migrants Using HIV Services in England***. London: Terence Higgins Trust. Document available at: http://www.tht.org.uk/policy/policy_pdfs/recent_migrant.pdf ***

This survey used basic, anonymised information from recent users of THT and other services who are also adult migrants to the UK. It aimed to map when respondents arrived, how they entered, when they were diagnosed with HIV and under what circumstances diagnosis was made. The records of 60 recent users of services were examined.

Seventeen countries were represented, 15 of them African. Of the 60 people whose case notes were revisited, just over 50 per cent (31) were of Zimbabwean origin and one in twelve (5) was from Uganda. Just over 18 per cent (11) had arrived in the UK before 2000. Ten entered in 2000, nine

entered in 2001 and 20 (33%) entered in 2002. Only five had arrived in the first nine months of the current year, 2003. Five people did not have dates of entry in their case notes. Only 13 (22%) in all were recorded as having entered the UK to seek asylum. Another 12 (20%) had entered to study. A similar number, 13 (22%) had entered as visitors for unspecified reasons, with a further seven (12%) coming to join family already here. These findings indicate that there is no identifiable single way in which people subsequently diagnosed with HIV are entering the UK; rather, the picture is a complex and diverse one.

Five people were diagnosed with HIV before 2001, with a further four diagnosed in 2001. Ten people were diagnosed in 2002, with the vast majority, 41 (68%) diagnosed only recently, in 2003. In order to examine the contention that people are entering the UK with the specific intention of obtaining treatment, two other pieces of data were examined; length of time between arrival in the UK and diagnosis, and circumstances of diagnosis. Only five people (8%) were diagnosed within three months of entry to the UK. The most common time span between entry and diagnosis was ten to twelve months, with 14 people (23%) diagnosed at this time. In all, at least 45 (75%) waited more than nine months to test after their entry. One third of people in the cases examined (20) had tested more than eighteen months after entry.

These data militates against the argument that people are coming to the UK in order to obtain treatment. Were this the case, one would expect to see a far swifter progression in the overall data from arrival to testing. The most common reason given for testing was the onset of symptomatic HIV, with 35 people (58%) testing when they became actively unwell. Almost half of these people (27% in all) fell severely ill before diagnosis. Ten women were diagnosed antenatally (17%) through routine offers of testing to all pregnant women. Another nine (15%) tested only after the death or diagnosis of a partner. Only two people reported being diagnosed prior to entering the UK, and only one person (less than 2 per cent of the sample) was diagnosed as the result of an unprompted visit to a GUM clinic.

This is a relatively small sample and there is a need for further investigation of a wider cohort.

Traore, C. (2000). ***African men and access to treatment. Report of an expert seminar.*** London: Terrance Higgins Trust.

No document available.

University of Reading (Department of Community Studies) (1998). ***A study of HIV prevention needs of Sub-Saharan people living in Berkshire.***

Berkshire: Berkshire Social Services/Health Promotion West Berkshire Priority Care Services NHS Trust.

No document available.

Weatherburn, P., Ssanyu-Sseruma, W., Hickson, F., McLean, S. & Reid, D. (2003). ***Project Nasah: an investigation into the HIV treatment information and other needs of African people with HIV resident in England.*** Document available at:

<http://www.sigmaresearch.org.uk/downloads/report03a.pdf> ***

This research attempts to describe and understand the reality of everyday life for African people with HIV in England. The sample was two thirds female (65%, n=278) and one third male (35%, n=154), and lived principally in London. The majority of all current treatment takers either usually (56%) or always (41%) understood the information given to them by HIV clinic staff. The majority (96%) of respondents currently taking treatments were somewhat (51%) or very satisfied (45%) with the way decisions about anti-HIV treatment were made between themselves and HIV clinical staff. Talking with medical staff like doctors and nurses was the most commonly used of all treatment information interventions in the last 12 months (96% had done this).

Most respondents collected written materials from their HIV (GUM) clinic (83%) and / or from support groups and HIV organisations (80%). A

quarter (27%) subscribed directly to written resources on treatments, received them from friends (26%) or accessed them via the internet (25%). Overall, 86% had taken home some reading matter concerned with treatments. Most (96%) were broadly satisfied with the information they read about treatments. Levels of need are much greater for African than for White British people with HIV in many areas.

The British government should create a supportive legal and policy environment for better HIV prevention, treatment and care and re-focus the national HIV social research agenda to answer some of the many questions raised by this survey of need specifically targeting African people with HIV.

Weston, H. (2003). Safe haven? Immigration, asylum and HIV in the UK. In Bröring, G., Canter, C., Schinaia, N. & Teixeira, B. (Eds.) ***Access to care: Privilege or right? Migration and HIV vulnerability in Europe.*** Amsterdam, The Netherlands: NIGZ. Document available at: http://212.206.44.60/systeem3/pdf/Country_report_oct031.pdf **

This report focuses mainly on issues of access to clinical health care for asylum seekers and refugees living with HIV in the UK. Asylum seekers, individuals given refugee status and those granted indefinite leave to remain in the UK are all entitled to receive free medical treatment. Many asylum seekers and refugees, however, are unaware of their entitlement to treatments in the UK. Health and social care workers are often ignorant of the rights and entitlements of these groups. As a result, the care provided to asylum seekers and refugees is extremely inconsistent and varied. Many individuals find it impossible to register with a GP or are given only temporary registration which disqualifies them from health checks, screening and immunisations. Differing interpretations of whether antiretroviral therapy constitutes emergency treatment currently lead to inconsistencies in their provision to this group.

Clinical healthcare workers report that they have not been called to justify their provision of health care to asylum seekers and refugees in any

systematic way. Regardless of theoretical entitlements, clinicians have been able to provide care on the basis of clinical need rather than residency status. Given the expense of antiretroviral therapies, this situation may change in the future if rates of HIV acquisition in the UK continue to rise and resources remain limited. Some clinicians have reported increasingly rigorous hospital trust policies on the treatment of overseas visitors.

Economic factors, racism, language difficulties, physical access issues, illness, lack of childcare, and time constraints may all limit the ability of migrants to access health care. Denial is one of the most significant factors deterring individuals in all cultures from testing for HIV. The children and grandchildren of immigrants who have no direct experience of the impact of HIV in their countries of origin are particularly unlikely to perceive themselves as being at risk of contracting HIV. There is a need for more information to be provided to refugees who may not have received effective education about HIV/AIDS in their countries of origin.

B5) Mental health

Ager, A., Malcolm, M., Sadollah, S. & 'O' May, F. (2002). Community contact and mental health amongst socially isolated refugees in Edinburgh. *Journal of Refugee Studies* 15 (1), 71-80. Abstract available at: http://www3.oup.co.uk/refuge/hdb/Volume_15/Issue_01/150071.sgm.abs.html **

This small-scale local study considered the adjustment of 26 refugees and asylum seekers resettling in Edinburgh, and touches on service use. While 92 per cent of refugees reported having social contact outside the home, only 19 per cent had established contacts outside refugee networks and language classes. Fifty four per cent scored at levels on a depression scale indicative of a diagnosis of an anxiety disorder, with 42 per cent scoring at levels indicative of depression. Social contacts outside the home were generally infrequent and, while their frequency was not associated with lower levels of mental health symptoms, refugees prioritised increased social contact above

help with practical issues and the provision of counselling.

Bracken, P. Giller, J. E. & Summerfield, D. (1997). Rethinking mental health work with survivors of wartime violence and refugees. *Journal of Refugee Studies* 10 (4), 431-42. Abstract available at:
http://www3.oup.co.uk/refuge/hdb/Volume_10/Issue_04/100431.sgm.abs.html *

An increasing number of projects have been delivered to third world war zones in the name of the treatment of 'war trauma'. Western psychology and psychiatry provide the theoretical and therapeutic tools which are used by most projects. The authors argue that because these tools are not value neutral and there are ethical problems associated with this work.

Bunce, C. (1997). Psychiatrists plan network to help asylum seekers. *British Medical Journal* 314, 535. Document available at:
<http://bmj.bmjournals.com/cgi/content/full/314/7080/535> *

Psychiatrists have become increasingly concerned about the mental healthcare of asylum seekers detained by the government and are appealing for help to establish a nationwide network of specialists trained to deal with detainees' problems. The current provision of psychiatric care to asylum seekers held in prisons or detention centres is inadequate, and specialist knowledge is needed to deal with the psychiatric needs of detainees, many of whom already suffer from the effects of torture when they come to Britain.

Coid, J.W., Khatan, N., Gault, S. & Jarman, B. (2000). Ethnic differences in admissions to secure forensic psychiatry services. *British Journal of Psychiatry* 177 (9), 241-247. Document available at:
<http://bjp.rcpsych.org/cgi/content/full/177/3/241> **

Not specifically on refugees or asylum seekers, but this study uses data on

the foreign-born. Admissions to secure forensic psychiatry services among ethnic groups were explored using data from seven Regional Health Authority areas over a seven year period. Data on socio-demographic characteristics, criminal and non-criminal behaviour leading to admission, diagnosis and source of referral were used in the analysis. Area poverty was measured using the Jarman Underprivileged Area Score (UPA).

The analysis indicates that, in the period 1988-1994, there were a total of 3155 first admissions to maximum and medium secure forensic psychiatry services in England from the seven regions (Whites=2358, 74%; Blacks=656, 21%; Asians=81, 3%; and Others=57, 2%). Logistic regression analysis suggests that, compared with White patients, Black patients were more likely to be: male; single; foreign-born; living in the 20 per cent most socio-economically deprived wards of England and Wales; and less likely to have been admitted following non-criminal behaviour. Black patients also were more likely to receive diagnoses such as schizophrenia, brief psychotic episodes, drug abuse or dependence, and less likely to receive diagnoses of depression, alcoholism and borderline personality disorder than Whites.

Crowley, P. (2003). ***An exploration of the mental health needs of asylum seekers in Newcastle***. Newcastle: the Black Mental Health Forum. Document available at: <http://www.nnt.nhs.uk/asylum/newsletter/haz.pdf> **

A mixed method approach was taken in determining the health needs of asylum seekers in Newcastle. This involved collating routine data; developing data on service use; the use of focus groups and interviews; and a review of the literature. The key findings are that experiences of using primary care services in Newcastle are mixed, and some GPs and mental health service managers expressed distrust of the asylum seekers' claims of torture.

A number of recommendations are made. In relation to the Mental Health Trust, these include:

- The Mental Health Trust must improve ethnic monitoring.
- Specialist mental health support is required for those who have

- experienced torture.
- o Access to psychological therapies (including Cognitive Behavioural Therapy) should be equitable for asylum seekers.

Davies, M. & Webb, E. (2000). Promoting the psychological well-being of refugee children. *Clinical Child Psychology and Psychiatry* 5 (4), 541-554. Abstract available at:
<http://www.ingenta.com/isis/searching/ExpandTOC/ingenta.jsessionid=4mbedqgdmb6l.circus?issue=pubinfobike://sage/ccp/2000/00000005/00000004&index=9> *

The authors describe the mental health needs of Somali refugee children in Wales and their service use. Main issues relate to the development of the child, their problems, the war/refugee context, the Somali culture and the host culture. The authors identify developmental factors relating to the vulnerability of refugee boys in the host culture and recommend a coordinated and culturally sensitive approach to the care of refugee children and their families.

Department of Health (DoH) (2002). *Ethnic minority psychiatric illness rates in the community (EMPIRIC)*. A survey carried out on behalf of the Department of Health by: National Centre for Social Research; Department of Epidemiology and Public Health at the Royal Free and University College Medical School. London: TSO. Document available at: <http://www.official-documents.co.uk/document/deps/doh/empiric/cover.htm> **

A large document on mental health that focuses on minority ethnic groups, but gives some consideration to the migration status. There is one section on service use. The data used is from the nationally representative Health Survey for England. The study asked informants when they had last seen a doctor on their own account, and subsequent questions referred to the six months preceding interview. Higher consultation levels were associated with:

female gender; increasing age; Asian ethnicity; being economically inactive (though not retired) and a CIS-R score of 12 or more (indicating the presence of a common mental disorder). For the Asian group, but not for Irish and Black Caribbean groups, those who had migrated to the UK after the age of 11 had higher consultation rates.

Ferguson, I. & Barclay, A. (2002). ***Seeking peace of mind. The mental health needs of asylum seekers in Glasgow.*** Stirling: University of Stirling. Document available at:

<http://www.dass.stir.ac.uk/staff/SeekingPeaceofMind.htm> **

In this study of asylum seekers living in Glasgow, social isolation was a major problem for many respondents. Waiting times for medical treatment was also identified as an important issue, both for GP appointments and also for appointments with consultants. Several female respondents expressed the view that they did not feel able to discuss their health problems with a male doctor. The lack of adequate interpreting services within medical facilities was experienced as a problem by these respondents. The practice of providing male interpreters to accompany female asylum seekers to medical appointments was considered distressing. The most common response to mental health problems was medication. While some respondents valued these treatments, several respondents expressed frustration that this did not address what they saw as their real problems. In sum:

There is a need to reduce waiting times for both GP and consultant services for asylum seekers and other health service users.

There is a need to improve interpreting services within health service facilities.

Female asylum seekers should be offered the option of meeting a female medical professional.

There is a need to develop responses to the mental health problems of asylum seekers which do not rely solely on the use of medication but respond in a more holistic way to the problems they face.

Garety, P. A. & Rigg, A. (2001). Early psychosis in the inner city: a survey to inform service planning. *Social Psychiatry and Psychiatric Epidemiology* 36 (11), 537-544. Abstract available at: http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=11824848 *

The study identified all presentations of people aged 16 or over with first and second episodes of psychosis in a six month period in a South London catchment. A follow-up was carried out at one year. The findings confirmed existing knowledge about the social and service needs of this population (their poor engagement with services and frequent involuntary pathways to mental healthcare). Subgroups were also identified with specific needs, such as groups of asylum seekers.

Harris, K. & Maxwell, C. (2000). A needs assessment in a refugee mental health project in North East London: extending the counselling model to community support. *Medicine, Conflict and Survival* 16(2), 201-215. Abstract available at: <http://www.tandf.co.uk/journals/archive/fmcs-abs.asp> *

This paper outlines the model used to set up a project focusing on refugee mental health needs in Waltham Forest, London. Funding was available for one mental health worker. A thorough needs assessment of refugees living in Waltham Forest determined that the provision of therapy or counselling alone would not be the most appropriate means of addressing refugees' needs. The intervention model developed therefore included awareness raising and community mobilisation, in addition to one-to-one clinical sessions.

Hodes, M. (2002). Implications for psychiatric services of chronic civilian strife: young refugees in the UK. *Advances in Psychiatric Treatment* 8, 366-376. Document available at: <http://apt.rcpsych.org/cgi/reprint/8/5/366>

*

Many refugees have experienced adversities which are risk factors for psychiatric disorders and symptoms in children and parents. Helping refugees to settle requires community and multi-agency planning of services. Young refugees may benefit from targeted community-based mental health services, which may be in the statutory or voluntary sector. The optimal service configuration and the possibility of more integrated child and adult refugee mental health services should be further investigated.

Hodes, M. (1998). Refugee children may need a lot of psychiatric help.

British Medical Journal 316, 793-794. Document available at:

<http://bmj.bmjournals.com/cgi/content/full/316/7134/793> *

A brief overview of the mental health of refugee children. Refugee children have the full range of psychopathology, and reducing children's distress should be seen in the context of the needs of the community and family. Many refugees can access primary care services and some are referred to mental health services, though these are underused by this group. Parents and guardians may be unaware of or unable to consider the children's psychological distress. The various services established for children's needs may be bewildering, and practicalities of getting to services and fears about confidentiality, especially if the parents have not been granted formal asylum, may further reduce access.

Several initiatives have been developed to tackle these problems. First, counselling services have been developed by refugees themselves, with refugee doctors becoming counsellors to their own communities. Second, a specialist service was established in London to provide care for the victims of torture. Third, refugee children and adolescents have recently been targeted through special school based mental health projects.

Hodes, M. & Goldberg, D. (2002). The treatment of refugees: service

provision reflects Britain's ambivalence. *Psychiatric Bulletin* 26 (1), 1-2.
Document available at: <http://pb.rcpsych.org/cgi/content/full/26/1/1> **

A brief discussion of Britain's ambivalence towards refugees. From a health perspective, concern has been expressed that this population has high levels of health needs, yet mobility and language barriers might make accessing health services difficult. The response of some in the field has been ambivalent towards the need for mental health service provision, arguing that, while refugees have been exposed to great adversity, services might inadvertently be stigmatising and culturally inappropriate. Specialist mental health services are warranted in view of the refugees' mobility, problems in accessing mainstream services and cultural/linguistic needs. Furthermore, as a group they have high levels of psychosocial disorders, especially Post-traumatic Stress Disorder. Many mental health professionals in community services and sector teams lack skills and resources for dealing with these problems. The dispersal policy has probably reduced the accessibility of primary care and mental health services for many asylum seekers and refugees. However, in London, where more than 90 per cent of refugees live, there are many voluntary sector services that often involve refugees as trained counsellors.

Howard, M. & Hodes, M. (2000). Psychopathology, adversity, and service utilization of young refugees. *Journal of the American Academy of Child and Adolescent Psychiatry* 39 (3), 368-377. Abstract available at: <http://www.jaacap.com/pt/re/jaacap/abstract.00004583-200003000-00020.htm;jsessionid=BLCR3NpZ6rYR52qzgsd3rvOl4j3514ne1LnJZsD75jI7JV D5O2kB!1766587852!-949856032!9001!-1> *

The aims of this study were to investigate the psychopathology, social impairment, experience of adversity and service utilisation of refugee families and their children seeking help at a child and adolescent psychiatry clinic in London. The methods used were a retrospective case-control study of

refugee children and families (n=30) individually matched with non-refugee immigrant families and White British families. Case note review was carried out to obtain data on diagnosis, social adjustment, past adversity etc. The results suggest that refugee children tended to have disorders with a psychosocial aetiology rather than neurobiological disorders. Refugees had similar levels of social impairment compared with the other groups. Refugees were much more isolated and disadvantaged, and had different referral pathways but were not more likely to drop out of treatment prematurely.

Marwaha, S. & Livingston, G. (2002). Stigma, racism or choice. Why do depressed ethnic elders avoid psychiatrists? *Journal of Affective Disorders* 72 (3), 257-65. Abstract available at: http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list_uids=12450643&dopt=Abstract *

This study was not specifically on migrants, but on ethnic elders who are foreign-born. The authors compared the views of White British and Black African Caribbean older people on depression as an illness, avenues of help and the place of mental health services. A qualitative analysis of semi-structured interviews using vignettes was undertaken. The purposive sample consisted of 40 White and Black older people, half of who had been depressed. Only one Black participant had been living in the UK for less than 30 years.

The results show that, of 21 White (10 depressed and 11 not depressed) and 19 Black (10 depressed and 9 not depressed), most people (irrespective of ethnicity or depression) recognised that there was something wrong with the man with depression. Most did not consider it an illness. Ethnicity, but not depression, affected the interpretation of the aetiology of the symptoms. A minority thought that consulting the GP would help, but some Black respondents thought it would be inappropriate. Both ethnic groups suggested that mental health services were for care, incarceration or dealing with violence. Most older people do not view depression as a mental

illness. Older people, particularly Black elders often do not see psychiatric services as appropriate and believe they are primarily for psychosis and violence.

Mitter, P.R., Krishnan, S., Bell, P., Stewart, R. & Howard, R.J. (2004). The effect of ethnicity and gender on first-contact rates for schizophrenia-like psychosis in Bangladeshi, Black and White elders in Tower Hamlets, London. *International Journal of Geriatric Psychiatry* 19 (3), 286-290. Abstract available at:

http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list_uids=15027045&dopt=Abstract **

This study investigates incident first contact rates in an area of East London with a high Bangladeshi population, to investigate if Bangladeshi-born elders have an increased referral rate for schizophrenia-like psychosis (SLP). A retrospective case note review of first contacts to the old age psychiatry service from 1997 to 2002 identifying cases of SLP was undertaken. In addition, a one-year review of first contacts for all diagnostic categories was completed.

Among the African- and Caribbean-born, but not the Bangladeshi-born, the odds ratio (OR) of being referred with SLP was significantly higher than for the British-born population. For Whites the OR for female gender and psychosis was 2.5 (1.0-6.1) and for non-Whites 0.8 (0.3-2.7). In the one year review there was a higher rate of referrals for organic disease in Bangladeshi men compared to Bangladeshi women and British-born men and women. In conclusion, Bangladeshi elderly migrants do not have an increased rate of SLP compared to indigenous elders, and old age psychiatry services in the UK should take into account the increasing needs of Bangladeshi elders with dementia.

Murphy, D., Ndegwa, D. Kanani, A., Rojas-Jaimes, C. & Webster, A. (2002). Mental health of refugees in inner-London. *Psychiatric Bulletin* 26 (6), 222-

224. Document available at: <http://pb.rcpsych.org/cgi/reprint/26/6/222> **

The authors describe the provision of mental healthcare for refugees (including asylum seekers) using data collected from refugees in inner London and in consultation with service providers. Some refugees find it hard to register with a GP, and practice lists rarely distinguish between refugee and non-refugee populations. The greatest barriers to use of services are related to language problems; three quarters of 257 GPs who responded to a survey said that they were dissatisfied with interpreting services. Clinicians need to understand the refugee's conceptualisation of mental health and there should be greater inter-agency cooperation.

O'Shea, B., Hodes, M., Down, G. & Bramley, J. (2000). A school-based mental health service for refugee children. *Clinical Child Psychology and Psychiatry* 5 (2), 189-201. Abstract available at: <http://www.ingenta.com/isis/searching/ExpandTOC/ingenta;jsessionid=2mbkdoc1aj2gu.crescent?issue=pubinfobike://sage/ccp/2000/00000005/00000002&index=4> *

The authors describe a school-based mental health service established to help psychologically distressed refugee pupils. The primary school was in an inner London borough and had a high proportion of refugee and immigrant children. Teachers identified refugee pupils with psychological difficulties and referred them to an outreach mental health worker. In addition to clinical interview, the strengths and difficulties questionnaire was used as an assessment and outcome measure.

In total 14 children (12 boys) were referred to the project. The children had been exposed to high levels of past violence and losses, and experienced ongoing socio-economic adversity. A range of psychological and family interventions were offered, which included seeing the teachers initially, the children alone and relatives. Overall children were helped by the intervention with a reduction in SDQ (a brief behavioural screening

questionnaire) scores and some children showed dramatic benefit. This model seemed acceptable to the children, families and school.

Summerfield, D. (2003). War, exile, moral knowledge and the limits of psychiatric understanding: a clinical case study of a Bosnian refugee in London. *International Journal of Social Psychiatry* 49 (4), 264-268.

Abstract available at:

http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=14727693 *

This paper describes a Bosnian refugee during a three year follow-up in a psychiatry clinic. The diagnoses of depressive disorder or Post-traumatic Stress Disorder turned out to lack validity and explanatory power. The author maintains that claims that victims of war and atrocity typically have an unmet need for mental health services are overstated.

Summerfield, D. (2001). Asylum seekers, refugees and mental health services in the UK. *Psychiatric Bulletin* 25 (5), 161-163. Document available at: <http://pb.rcpsych.org/cgi/content/full/25/5/161> **

An editorial. The author maintains that there is a paucity of data on patterns of utilisation of health services by asylum seekers and refugees, including mental health. Asylum seeker admission rates to in-patient psychiatric facilities by comparison to the general population are not known. Some GPs see asylum seekers as frequent attenders, and some asylum seekers present in psychological mode because they believe that a medical report may influence access to scarce social resources like housing.

The general lack of provision of interpreters for GP surgeries is a significant impediment to primary healthcare. A properly resourced, supervised and utilised interpreter service is the most quickly achievable means of raising the standard of mental health services. Ignorance of cross-cultural factors means that some patients receive inappropriate diagnoses.

There is still little known about the degree of 'fit' between mainstream mental health services and presentations by asylum seekers from cultures where Western psychiatry is not influential.

Trauma counselling has become a familiar provision in Britain, but recent studies have cast doubt on its efficacy. There is a trend towards the conflation of diverse populations of war victims and refugees into a unitary category of the 'traumatised'. Undue pathologisation may promote abnormal illness behaviour and increase people's sense of themselves as passive victims rather than active survivors.

Watters, C. (2002). Migration and mental healthcare in Europe: report of a preliminary mapping exercise. *Journal of Ethnic and Migration Studies* 28 (1), 153-172. Document available at: [http://www.cemes.org/JEMS/contents/28\(1\).htm#Charles%20Watters](http://www.cemes.org/JEMS/contents/28(1).htm#Charles%20Watters) *

The author offers an examination of mental health services for migrant groups in a number of European countries drawing on a range of recent studies to highlight some of the key and emerging issues in relation to the provision of mental health services within an increasingly multi ethnic and multicultural Europe. The results of a preliminary mapping exercise of mental health services for migrant groups are presented and their broader implications are considered.

Wheeler, E.L. (1998). Mental illness and social stigma: experiences in a Pakistani community in the UK. *Gender and Development* 6 (1), 37-43. Abstract available at: http://www.siyanda.org/static/wheeler_pakistanuk.htm *

The author draws on material collected from a sample of women (two thirds of whom were Pakistani migrants) released from psychiatric care in West Yorkshire. The identity of the women (which is primarily that of wife and mother) was compromised by their illness and they were stigmatised within

the community, marginalised within the family and derided for their mental illness. This was compounded by the effects of medication, which often made the women drowsy and unable to perform their duties. From the point of view of developing services to Asian women, more attention needs to be given to the development of services in a non-hospital setting. Some of the women had used group therapy techniques, but they had to have been hospitalised first, and some were receiving counselling. The author highlights some issues that should inform provision of services, but the study described here is largely exploratory; no demographic or other details of the respondents are provided, nor is sample size. No information is provided about how the material was collected or analysed.

B6) Tuberculosis

Callister, M.E.J., Barringer, J., Thanabalasingam, S.T., Gair, R. & Davidson, R.N. (2002). Pulmonary tuberculosis among political asylum seekers screened at Heathrow Airport, London, 1995–9. *Thorax* 57, 152-156.
Document available at:

www.thorax.bmjournals.com/cgi/content/full/57/2/152 **

A study was undertaken to determine the prevalence and disease characteristics of pulmonary tuberculosis (TB) in new entrants to the UK seeking political asylum. A retrospective analysis of the results of screening 53, 911 political asylum seekers arriving at Heathrow Airport between 1995 and 1999 was performed.

The overall prevalence of active TB in political asylum seekers was 241 per 100,000. There were large variations in prevalence of TB between asylum seekers from different regions, with low rates from the Middle East and high rates from the Indian Sub-continent and sub-Saharan Africa. The frequency of drug resistance was high; 22.6 per cent of culture positive cases were isoniazid resistant, 7.5 per cent were multi-drug resistant, and 4 per cent of cases diagnosed with active disease had multidrug resistant TB. It is estimated that 101 political asylum seekers with active pulmonary TB enter

the UK every year, of whom about 25 would have smear positive disease.

Coker, R. (2003). *Migration, public health and compulsory screening for TB and HIV*. London: IPPR. Document available at: <http://www.ippr.org/research/files/team19/project183/ipprWPHealth.pdf> * * *

The author observes that, in practice, screening immigrants to the UK is erratic. Screening tests for tuberculosis (TB) lack reliability, and substantial numbers of false positives result (particularly in populations with low prevalence). 'One-off' screening exercises may not detect disease in those who travel frequently back to their country of origin. There is little evidence that immigrants delay seeking care for TB, and there is little evidence that the host population is at substantial risk from immigrant associated TB. Screening programmes may result in some populations (undocumented immigrants, transient workers) being neglected in terms of detection of health problems, and may result in a false sense of security. Screening may create perverse incentives to avoid legal routes of entry, and evidence is lacking regarding the benefits and drawbacks of introducing pre-screening for TB and HIV. It is important that policy makers considering pre-entry health screening recognise that the data on the links between pre-entry screening and transmission and infection rates in countries of migration is scarce. For compulsory health screening to be fully effective in diagnosing infection, the government would need to introduce compulsory health screening for all tourists, visitors and students coming to the UK and for all returning British citizens travelling outside of the country.

Evidence suggests that inclusive policies work best and that exclusionary policies that risk alienating and stigmatising those who have tested positive may be counterproductive. Coercive policies should therefore be rejected. The public health challenge of immigrant-associated TB should be met through provision of primary care services integrated with broader social support. Immigrants and asylum seekers suffer from a range of health problems, only some of which are communicable diseases.

Gushulak, B.D. (1998). Tuberculosis control in refugees—policy and practices. *International Journal of Tuberculosis and Lung Disease* 2, (9 Suppl 1), S87-93.

No document available

Hill, A. Burge, A. & Skinner, C. (1997). Tuberculosis in National Health Service hospital staff in the West Midlands region of England, 1992-5.

Thorax 52, 994-997. Document available at:

<http://thorax.bmjournals.com/cgi/reprint/52/11/994> *

This (now dated) study was designed to assess the current incidence of tuberculosis (TB) in NHS hospital staff in the West Midlands region of England. There were 26 cases of active TB, of which 24 presented with symptoms and 12 had no pre-employment screening. All except one doctor were foreign born—mainly from the Indian Sub-continent—and of recent UK entry, while all except one nurse were White females.

Ormerod, P. (2000). Issues facing TB control (1.1). Tuberculosis in United Kingdom immigrants/organisation of tuberculosis control services. *Scottish Medical Journal* 45 (5 Suppl), 22-23; discussion 24.

No document available.

Ormerod, L. P. (1998). Is new immigrant screening for tuberculosis still worthwhile? *Journal of Infection* 37 (1), 39-40. Abstract available at: http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=9733376 *

Prospective data on new immigrant screening for 1990-1994 inclusive in the Blackburn, Hyndburn and Ribble Valley local government areas were analysed and compared with 1983-1988 data. Of the 2242 new immigrants screened, 1333 were from Pakistan, 604 from India and 305 from the rest of

the world. A total of 898 (40%) were found via the POA (Port of Arrival) system, but 1344 (60%) were only identified by local links with the Family Health Services Authority. Ten cases of active TB were found (0.45%), chemoprophylaxis was given to 19/465 (4.1%) of children aged 0-15 years, and BCG vaccination to 530/1705 (31%) of those aged under 30 years. In conclusion, between 1990-1994 the official POA system continued to perform poorly. The yield of new TB cases detected was lower than in the 1980s. Chemoprophylaxis at 4 per cent and BCG vaccination at 31 per cent showed that preventive health measures were appropriate for over one-third of new immigrants aged under 30.

Van den Bosch, C. & Roberts, J. A. (2000). Tuberculosis screening of new entrants; how can it be made more effective? *Public Health Medicine* 22 (2), 220-223. Abstract available at:
http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=10912563 *

This paper examines possible reasons for a low uptake of screening by immigrants in the UK. Screening at the new patient check-up by GPs has been shown to be practicable and effective in an East London pilot. This screening method could be expanded throughout East London and is applicable to other areas. Other ways of improving access to screening through other agencies have also been found to be acceptable. No one screening system is likely to be effective and pilots of methods of extending the access to new entrants need to be carried out and evaluated urgently.

B7) Maternity services

Maternity Alliance (2002). *Crying shame: pregnant asylum seekers and their babies in detention*. London: Maternity Alliance and others.
 Document available at:
http://www.maternityalliance.org.uk/documents/crying_shame.pdf ***

The authors drew on in-depth, unstructured interviews with four women who were detained while pregnant or with a young baby. The interviewees were recruited by convenience sampling. At the time of interview, two women had been detained for more than four months, one woman for three months and one woman for two weeks.

Generally, the healthcare centres within the detention centres did not provide the type of care that women wanted. The women remained dependent on the detention centres to escort them to hospital appointments, and in one instance the detention centre failed to take a pregnant detainee to an appointment for an ultrasound scan. The Expert Maternity Group also noted that 'continuity of carer is seen as being one of the fundamental principles underpinning woman-centred care.' The experience of being detained and moved between detention centres fractured this continuity and in one case the detention centre had failed to forward the results of blood tests to a pregnant woman who had been released.

Three of the women spoke English (as a second language) but one woman did not. She had no access to an interpreter while in detention, including during her appointment with the midwife. She had only understood part of what the midwife said to her and as far as she could tell had not been offered the standard blood tests. The authors observe that it is not possible to generalise from such a small sample of interviewees, yet similar themes emerged from the experiences of each the women who participated in this study. Key recommendations include:

The use of prolonged detention for pregnant women and mothers with young children inflicts harm disproportionate to the policy aim of immigration control.

Pregnant women and young children should not be placed in accommodation centres.

The Home Office should give proper guidance on what precisely the exceptional circumstances are which justify detention of pregnant women.

seekers in England. London: Maternity Alliance. Document available at:
http://www.maternityalliance.org.uk/documents/mothers_exile.pdf ***

A qualitative study of women's maternity experiences during the asylum process. The study involved semi-structured interviews with 33 women who were either pregnant or had recently given birth. The key findings were that:

- Half of the women experienced neglect, disrespect and racism from the maternity services.
- There was no formula milk provided at the hotels, even for the baby of an HIV positive mother who could not breastfeed. There was also no baby food available for the older babies who needed solid food.
- Women in hotels dominated by single men felt intimidated and experienced sexual harassment.
- Most of the women were satisfied with their antenatal care and half also had positive experiences during labour and the postnatal stay in hospital.
- Interpreters were generally provided when necessary, except for antenatal classes, which prevented many non-English speaking women from attending.
- Many women had not been given any information about what services and support were available to them.
- Key recommendations include:
 - Single women and families should always be accommodated separately from single men.
 - Pregnant women and new mothers should be placed in self-catering accommodation.
 - In full board accommodation there should be explicit responsibility for providing necessities for mother and baby.
 - Asylum seekers under the age of 18 should be placed with a foster family/ supported accommodation.
 - Pregnant and breastfeeding asylum seekers and their babies should have full access to the Welfare Foods Scheme.

- In relation to healthcare and maternity services, anti-racism training for NHS staff should be strengthened.
- In relation to social and practical support. Refugee community groups, befriending organisations and networks providing practical help to asylum seekers should be funded in all dispersal areas. Specialist health visitor posts should be funded to meet the needs of asylum seekers. In recognition of the emotional burden which may be carried by professionals in supporting asylum seekers who have had traumatic experiences, they should have access to effective mechanisms of peer support, debriefing and, where appropriate, counselling.

Appendix C: Education

This section is on the use of educational services (school, colleges, universities), and also some training services, by adult and child migrants in the UK. Key datasets that contain variables measuring access to educational services by migrants are shown below.

Name of dataset	Brief description & measure of migration status	Further details
1970 British Cohort Study: Sixteen-year Follow-up, 1986	The scope of the BCS70 has broadened from a medical focus at birth, to encompass physical, educational and social development at the ages of 10 and 16. Place of birth.	http://www.data-archive.ac.uk/findingData/snDescription.asp?sn=3535
Labour Force Survey	The LFS is a source of information about the ways that households and families behave in relation to the labour market. Place of birth.	http://www.data-archive.ac.uk/findingData/snDescription.asp?sn=5000
Returned Skilled Labour Migrants: from the United Kingdom to Slovakia, 2003	To explore the scale, motivations, skills and lifetime mobility of different types of skilled labour mobility to the UK from Slovakia. Questions asked of migrants.	http://www.data-archive.ac.uk/findingData/snDescription.asp?sn=5062

Modified abstracts

C1) Adult education

Africa Educational Trust (AET) (2002). *Refugees and asylum seekers in the Learning and Skills Council London North Area*. London: Africa Educational Trust, Learning and Skills Council London North. Document available at:

http://www.londonnorth.org.uk/content/documents/Refugees%20and%20Asylum%20Seekers%20in%20the%20LSC%20London%20North%20Area_.pdf

The purpose of this study was to: map the numbers of refugees and asylum seekers living in the Learning and Skills Council London North (LSCN) area; explore the issues they face; and identify areas for service improvement. The researchers conducted interviews with 356 refugees and asylum seekers. Focus group meetings were held with 138 refugees and asylum seekers living in the area. Discussions were conducted with service providers from four of the boroughs.

Eighty two per cent of the refugees and asylum seekers had completed secondary school education or above, 12 per cent had completed university and 2 per cent were at university when they fled their home country. About three quarters of those interviewed had undertaken education/training in the UK. Accessing education and training differed significantly between communities: Somalis were more likely to have undertaken education/ training than those from the Zairean Congolese or Turkish communities.

Time spent in the UK influenced the likelihood of working; the numbers accessing skilled employment increased after five years in the UK. Language skills also affected the chances of employment: 83 per cent of those who had worked in the UK had English skills at intermediate level or above. Level of education also affected the likelihood of finding employment: 88 per cent of those who had worked in the UK had completed secondary school or above. Many refugees and asylum seekers were unaware of the services available to them. The vast majority of refugees and asylum seekers relied on refugee organisations for information and advice. Many were unaware of other

service providers and lacked the confidence to access their services.

Aldridge, F. & Waddington, S. (2002). ***Asylum seekers' skills and qualifications audit pilot project***. Leicester, National Institute of Adult Continuing Education. Document available at:

<http://www.asylumsupport.info/publications/niace/skillsaudit.pdf> **

The aims of this project were to ascertain the skills and qualifications of asylum seekers in Leicester, and to provide referrals for advice and opportunities. Respondents were recruited from a pool of 440 NASS-registered asylum seekers in Leicester. They came from a variety of countries, including Iran, Iraq and Zimbabwe. A questionnaire was administered to establish the education, training, qualifications and previous employment of asylum seekers. There was also a briefing and consultation seminar with key partners and in-depth interviews with a sample of approximately 70 asylum seekers who completed the initial questionnaire. One hundred and twenty one responses (27.5%) were received in the initial survey. The average age of respondents was 28. Over 80 per cent (n=103) respondents said that they had some education/training qualifications, these ranged from school certificates to higher/professional qualifications.

Seventy three asylum seekers were interviewed. The interviewees, all of whom were waiting an initial decision or in the process of making an appeal at the time of interview, had been in Britain on average between six and seven months. Interviewees were aged between 18 and 60, with an average age of 29. Interviewees had left full-time education between the ages of eight and 34 (the average leaving age was 20). Some of the respondents' qualifications were recognised within the UK, others were not. Very few asylum seekers arrive in the UK with certificates to prove their qualifications to employers and education providers—only seven per cent of interviewees had their certificates with them, although a few more were in the process of sending for them. Although some interviewees felt that there would be no barriers to achieving their aspirations, the following barriers were identified:

- Poor English language skills.
- Places not available on courses.
- Financial need to work as well as study.
- Potential employers are not keen to employ asylum seekers.
- Uncertain future, depends on how long they are allowed to stay in the UK.
- Psychological problems.

Audit Commission (2000). ***A new city: supporting asylum seekers and refugees in London.*** London: Crown Copyright. Document available at: <http://www.asylumsupport.info/publications/auditcommission/new.pdf> **

A report from the Audit Commission which looks (generally) at service use and provision (education and other services) and accepts that rising numbers of arrivals have increased pressures on services in the capital.

The authors observe that some local agencies have developed support services for asylum seekers and refugees in London, and some schools offer language support to asylum seeking children. However, good practice is not universal and a number of challenges must be met. Variations in the costs of housing and support suggest that some boroughs make better use of resources than others, and many unaccompanied young people do not receive the same care offered to other children in need. The focus on providing food and shelter has made it difficult for authorities to develop comprehensive responses to asylum seekers' needs.

The authors recommend that local, regional and national agencies should work together to improve the quality of services for this group. London boroughs need to jointly commission services, where appropriate the Greater London Authority could assist in developing more employment and training opportunities for those who settle in the capital.

Bloch, A. (2002). ***Refugees' opportunities and barriers in employment and training.*** Leeds: Department for Work and Pensions Research Report

179. Document available at:

<http://www.dwp.gov.uk/asd/asd5/rrep179.asp>**

A report based on a study of refugees and asylum seekers from Somalia, Iraq, Kosova, Sri Lanka and Turkey. The research aim was to determine whether the training and employment support for migrants who are eligible to work is sufficient and appropriate. Six focus groups with a range of organisations were carried out. A survey was carried out with 400 refugees and asylum seekers in five regions in England and interviews were carried out in various locations.

The sample of 400 refugees and asylum seekers comprised equal numbers of men and women, and 61 per cent of the sample had been in Britain for less than five years, 39 per cent for five years or more. The majority of respondents were literate. Nearly everyone (96%) had participated in formal education before coming to Britain. Fifty-six per cent of those who arrived in Britain aged 18 or over had a qualification on arrival of which 23 per cent had a degree or higher.

Nearly two-thirds (65%) of respondents had studied one or more English language courses. Thirty-one per cent of those who had studied in the past had not completed their course. Childcare and family commitments were mentioned most often as the reason for not completing (14 respondents), followed by getting a job (10 respondents) and health (eight respondents). At the time of the survey, 15 per cent of respondents were studying. Participation in training was very low. At the time of the survey, 4 per cent of respondents were involved in training. A further 8 per cent had trained in Britain in the past. Refugees were interested in training: 60 per cent wanted to participate in training. There was a demand for training but a lack of the necessary English language proficiency, a lack of childcare and lack of information about entitlement were limiting take-up. There was a low level of labour market participation. Only 29 per cent of refugees were working at the time of the survey. English language proficiency was the factor that most determined both labour market participation and the type of

employment people had.

Brophy, M., Maxey, K., Abraham, T., Aybek, T., Bird, P. & Stanikzai, F. (1998). ***Refugee education, training and employment in Inner London***. London: FOCUS TEC.

No document available.

Charlaff, L., Ibrani, K., Lowe, M., Marsden, R. & Turney, L. (2004). ***Refugees and asylum seekers in Scotland: a skills and aspirations audit***.

Scottish Executive Social Research. Edinburgh: Crown Copyright. Document available at:

<http://www.scottishrefugeecouncil.org.uk/Documents/skillsaudit.pdf> ***

The aim of the research was to audit the skills, qualifications and aspirations of refugees and asylum seekers living in Scotland. A semi-structured questionnaire was completed by 523 refugees and asylum seekers in Glasgow and Edinburgh.

The findings indicate that refugees and asylum seekers living in Scotland are, for the most part, well qualified and possess a broad range of skills which could be utilised by the Scottish labour market. The skills and experience respondents had gained and developed in employment before coming to the UK included highly specialised skills in areas of medicine (for example, surgical skills and skills in midwifery, obstetrics and gynaecology), law and engineering.

Just over 95 per cent of respondents indicated that they had experienced some kind of formal education. Approximately 21 per cent of respondents indicated that they had completed university level education where they had studied subjects such as Business, Medicine, Education and Law. The majority of respondents (72%) indicated a desire to improve their English language skills and two-thirds indicated that they would like to access further training.

Lack of proficiency in English language and literacy was perceived by refugees and asylum seekers as a key barrier to obtaining employment in the

UK. The majority of refugees and asylum seekers had been able to access English language training in Scotland. Childcare issues may be a further barrier, particularly for single parents. Given that large numbers of respondents had been waiting some time for a decision on their asylum claim, there may be a risk that refugees' and asylum seekers' motivations may lessen over time and their skills may become outdated.

Cooke, M. & Peckham, J. (2001). Towards equal educational opportunities for asylum seekers. *Multicultural Teaching* 19 (2), 6-12. No abstract generally available.*

The authors interviewed and surveyed staff, asylum seekers, refugees and English for Speakers of Other Languages (ESOL) students at one British college, examining why the college's ESOL provision featured separate programs for the two groups. They discuss the consequences of this divide, the labelling of students and multicultural education.

Dimitriadou, A. (2004). *An exploration of refugees' experiences as English language students in Further Education colleges*. Paper presented at the 2nd Annual Student Conference on Forced Migration, CRER - University of Warwick, 15th March 2004. Document available at: <http://www2.warwick.ac.uk/fac/soc/crer/fmsc04/abstracts04/dimitriadou/> **

The study used a case study approach in two further education (FE) colleges in the London area. Data collection was based on triangulation. First, data on interaction between students were collected through 22 hours of participant observation in five classrooms. Second, a survey was carried out towards the end of each classroom observation. Questionnaires collected information on students' educational and professional backgrounds and their views towards English for Speakers of Other Languages (ESOL) and English. Third, in-depth interviews were carried out. Students came from 28 different countries; 41 students (52.6%) sought asylum on entry to Britain, 26.8 per

cent out of those were still waiting for a decision on their application, 36.6 per cent were granted ELR, 22 per cent were holding refugee status and 9.8 per cent were British citizens. However, 54.1 per cent of migrant students were British passport holders.

Three quarters of students believed that their English improved since they started ESOL courses. However, 26.8 per cent of those who sought asylum on entry to the UK believed it did not improve, compared to only 10.8 per cent of migrants. Generally ESOL provision did not vary to a large extent among the colleges, except that College A had a slightly higher number of students per class on the days observed. It seems that ESOL provision permitted the colleges to attract higher funding. Students seemed to have different perceptions about the value of the English language. Migrant students saw it as an investment in their future education and career, while refugee students saw it as an opportunity provided by the host country to rebuild their lives.

Fraser, L. (1998). *Research into the employment, training and educational needs of refugees from Vietnam in Leeds and Bradford*.

London: Refugee Action.

No document available.

Griffiths, D. (2003). *English language training for refugees in London and the regions*. London: Crown Copyright. Document available at:

<http://www.homeoffice.gov.uk/rds/pdfs2/rdsolr1403.pdf> ***

The author reports the main findings of a preliminary study investigating the provision of English for Speakers of Other Languages (ESOL) in London and other locations. The methodology comprised a literature review and fieldwork in four London boroughs, the East Midlands and the North East. Interviews were carried out with ESOL providers (n=100) and voluntary and community groups. Others interviewed included members of regional consortia and representatives from refugee community organisations.

The main findings are that ESOL providers need to take age, gender and class into account. For example, women could be offered classes at more 'child friendly' times plus free or low-cost crèche facilities. The differences between case study areas seemed to be rooted in specific settlement and immigration histories, which suggests that local strategies rather than general models may be more appropriate in meeting the new demands for ESOL. It is crucial therefore for the integration of refugees into local labour markets and communities in the UK that the provision of ESOL is adequate and appropriate.

Peabody Trust & London Research Centre (LRC) (1999). ***Refugee Skills-Net: The employment and training of skilled and qualified refugees.*** London: Peabody Trust and LRC.

No document available.

Phillimore, J., Goodson, L., Oosthuizen, R., Ferrari, E., Fathi, J., Penjwini, S. & Joseph, R. (2003). ***Asylum seekers and refugees: education, training, employment, skills and services in Coventry and Warwickshire.*** School of Public Policy, University of Birmingham, NIACE, Bostock Marketing Group: Centre for Urban and regional Studies. Document available at: <http://www.niace.org.uk/Research/ASR/Coventry-final-report.pdf> **

This research project explored the issues surrounding training and education of asylum seekers and refugees. A range of methods was used to collect data including: secondary data analysis; face to face survey; in-depth interviews with 26 asylum seekers and refugees and 30 stakeholder organisations; focus groups with four key groups; postal questionnaire and face-to-face interviews to identify provision and examine ways in which provision can be matched to needs.

The findings show that 85 per cent of respondents had been in full time education and 66 per cent (245) had obtained qualifications before living in the UK. A comparison made between the qualifications held by

asylum seekers and refugees and the local population suggests that the former held a slightly lower level of qualifications. Since leaving full time education, 59 per cent (221) of asylum seekers and refugees had undertaken some form of learning or training and 77 per cent (171) of these had done so since arriving in the UK. In the past 12 months 56 per cent (210) people had taken part in ESOL courses. The key messages to come out of this research are:

- Asylum seekers and refugees bring with them a huge amount of diversity and social and economic potential.
- The vast majority are motivated to work and learn. Many aspire to return to their former careers, most are prepared to take any type of work.
- The majority of asylum seekers and refugees saw learning as the best route to employment in the UK. Their first priority was to become proficient in English.

Refugee Council (2001). ***Conference report: refugee employment and education/training advice***. 2nd and 3rd November, 2001, held in Stockholm, Sweden.

No document available.

Schellekens, P. (2001). ***English language as a barrier to employment, education and training***. London: Department of Education and

Employment. Document available at:

<http://www.icar.org.uk/res/drp/drps/drp013.html> **

The aim of this research was to understand the barriers which second language speakers (including migrants) face when they enter the labour market. Five areas in England and Wales were covered. Across these areas a representative sample of organisations was selected, including: further education (FE) and adult educational colleges, training providers, the Careers Service, the FE Funding Council and the Refugee Council. In all, 139

members of staff were interviewed and 178 language learners. A sample of employers also gave views on language skills at work. The author states that the limited size and range of the research means that the results cannot claim to be representative. The key findings are that:

- Many second language learners have experience and skills and a high motivation to succeed. However, language is a crucial barrier to obtaining a job.
- Employers expected good English and identified unfamiliarity with UK work culture as a problem for those seeking jobs.
- Those taking ESOL were well below the achievement targets set by government, with few obtaining qualifications above NVQ level 2 (only 16 per cent, in contrast to the government target of 60 per cent of 21 year olds).
- Second language speakers wanted more language provision with a broader curriculum that included language necessary for the workplace. It is estimated that 1765 hours of learning are required to attain an adequate level of English
- Key recommendations and conclusions are that:
- There is a need for a routine collection of data that will enable language training to be developed according to the requirements of second language speakers.
- Those who provide services for second language speakers need to be aware of their long-term needs in order to progress into work or further study.

Southampton Refugee & Asylum Seeker Employment and Training Group (2003). *Refugee and asylum seeker skills audit*. Southampton: Southampton Refugee and Asylum Seeker Employment and Training Group. Document available at: <http://www.p4l.org/pdfs/whatsnew/101003.pdf> **

The aim of this research was to identify the skills, qualifications and experiences of asylum seekers and refugees in the Southampton area.

Asylum seekers and refugees (n=93) were interviewed to establish their education, qualifications and previous employment. The employment rate of those interviewed in Southampton was approximately 35 per cent. The key findings and recommendations are that:

- There is a lack of information and advice services for this group. More than half had not received any advice on training or work.
- Language is perceived by refugees to be a major barrier to accessing work and training. There is insufficient supply of ESOL courses and this holds people back from integrating with the local community and engaging with work.
- Access to higher and further education should be facilitated as much as possible to enable refugees to obtain qualifications to prevent them becoming stuck in low skill-low pay jobs.
- There are advice and guidance agencies working with refugees in Southampton, but referrals can be *ad hoc* and there is no coordinated pathway for refugees to follow in obtaining specialist advice and information.
- More work needs to be undertaken with local and national agencies to overcome the barrier of non-recognition of overseas qualifications.

Working Group on English for Speakers of Other Languages, Department of Education & Employment (2000). ***Breaking the language barriers: The report of the working group on English for speakers of other languages (ESOL)***. London: Department of Education and Employment.

Document available at:

<http://www.asylumsupport.info/publications/lifelonglearning/languagebarriers.pdf> *

Not specifically on asylum seekers or other migrants, but clearly oriented, and highly relevant to, such groups. The report addresses the needs of adults who, because it is not their first language, need to develop skills in listening, speaking, reading and writing in English. Current provision for this group of

learners has many of the same limitations as provision for basic skills. It is of mixed quality and often not easily accessible. Provision and assessment must also take account of: the personal circumstances, educational backgrounds and specific needs of minority ethnic groups and refugees. The authors make the following recommendations:

- The DfEE/LSC (Department for Education & Employment/Learning & Skills Council) should look to an expansion of provision through colleges, Local Education Authorities and the voluntary and community sector.
- The DfEE should commission the production and distribution of an information and support materials pack for the tutors and support workers of organisations providing ESOL to refugees.

C2) Children's education

Beard, J. & Bradley, N. (no year given). ***Raising the barriers: meeting the needs of refugee pupils and families in a North London borough.***
Abstract not generally available.*

The authors describe the work undertaken in one British school district to support refugee and asylum seeking students and their parents. They focus on refugees in the Haringey district, student mobility, providing a structured induction process for refugee children and families and developing parent involvement initiatives. They discuss the district's efforts to introduce the refugee experience into the curriculum, train teachers, and disseminate information on refugee issues.

Brewin, M. & Demetriades, A. (1998). ***Raising the profile of invisible students: practical and peer-led approaches to enhancing educational and emotional support for refugee and asylum seeking children in schools.*** London: Children of the Storm. Document available at:
<http://www.refugeenet.org/documents/volg.php3?ID=162> *

A document written for teachers and refugee support workers who recognise the importance catering for the needs of refugee and asylum seeking children. The authors aim to give the reader a basic background knowledge of the reasons why young people seek asylum and of the issues facing young refugees in the UK. They also describe practical, and innovative ways of establishing peer-based education and support schemes for integrating young refugees into the school environment.

Candappa, M. (2001). The right to education and an adequate standard of living: refugee children in the UK. *International Journal of Children's Rights* 8, 261-270.

No document available.

Clarke, L. (2003). Supporting asylum seekers in schools. *Support for Learning* 18 (4), 177-183. Abstract available at:

<http://www.blackwellpublishing.com/abstract.asp?ref=0268-2141&vid=18&iid=4&aid=304&s=&site=1> *

In this article, the author provides a 'hands-on' view of her work with the East Oxford Schools Inclusion Project. The needs of young asylum seekers are diverse, but the following points about asylum seekers should be noted:

- A young person can arrive anytime in the school year.
- Their use of English may be very limited.
- Children coming from contexts where they have been persecuted may have poor attention spans and study skills.

Young asylum seekers may have poor mental health.

Currie, H. & Danaher, P. A. (2001). Government funding for English Traveller education support services. *Multicultural Teaching* 19 (2), 33-36. No abstract generally available.

The authors argue that the British government's school improvement

agenda, manifested through changes to funding of migrant education, contradicts and hinders its social inclusion policy. After describing migrant education funding and discussing migrant student access and achievement, they conclude that until the education system responds to the needs of all students, migrant children will have limited or no access to education.

Dobson, J.M., Henthorne, K. & Lynas, Z. (2000). *Pupil mobility in schools*. UCL, London: Migration Research Unit. Document available at: http://www.geog.ucl.ac.uk/mru/docs/pupil_mobility.pdf **

The authors report the findings of a study to identify the nature and causes of pupil mobility in schools and the implications of high mobility for strategies to raise achievement. Mobility is defined as internal and international. The six areas selected for the study were in a variety of locations and were all associated with high rates of pupil mobility. Data were collected from: existing statistical sources relating to education, housing, planning, population and migration; interviews with Local Education Authority (LEA) staff who had information on pupil mobility through their work; and a postal survey of schools at the highest and lowest ends of the mobility range in each authority.

The results show that the highest mobility rates in schools are associated with international migration (the arrival and movement of refugees/asylum seekers and other overseas migrants), residential migration of low income families and armed forces movements. High mobility schools are more likely than lower mobility ones to take in newcomers to an area from outside the LEA, particularly those from overseas. And high mobility schools tend to have higher proportions of disadvantaged children and those with learning difficulties than lower mobility schools in their LEAs.

The authors present data on how teaching staff deal with the problems associated with high mobility among pupils. These strategies include: securing more classroom help; targeting of resources; and ensuring that staff have good knowledge of the needs of new arrivals. The authors suggest that

strategies to raise achievement in high mobility schools should include: providing resources; reducing mobility levels; and recognising a shared responsibility.

Hek, R. (work in progress, expected completion date: 31/03/06). The ***Experiences and Needs of Refugee and Asylum Seeking Children in the UK: A Literature Review***. London: Department for Education & Skills.

Some information at:

<http://www.dfes.gov.uk/rsgateway/DB/RRP/u014530/index.shtml>

Horn of Africa Youth Scheme (1998). ***Let's spell it out: peer research on the educational support needs of young refugees and asylum seekers living in Kensington and Chelsea***. London: Save the Children, 1998.

No document available.

Mott, G. (2000). ***Refugees and asylum seekers: the role of LEAs***. EMIE Report no. 59. Slough, Berkshire: EMIE.⁵⁷ Document available at: <http://www.nfer.ac.uk/emie/documents/R59.pdf> *

The author examines the role of Local Education Authorities (LEAs) in meeting the educational, and other needs, of young asylum seekers, and draws on data provided by LEAs and other statistical data. He describes background issues (the emotional upheaval linked to migration; poor or interrupted schooling before migration) and the LEA response to refugees and asylum seekers. Waiting time to admission and early years provision are also discussed. Recommendations are made for councils, LEAs and schools. These revolve around issues relating to: meeting language and communication needs; proper resourcing of work with asylum seekers and refugees; liaising with key agencies and personnel.

⁵⁷ This document provides details (in the bibliography) of a number of LEA's responses to the needs of asylum seekers and refugees, including: Lancashire LEA; Brent LEA; Bexley LEA; Harrow LEA.

OFSTED (2003). *The education of asylum seeker pupils*. London: Crown Copyright. Document available at:
<http://www.ofsted.gov.uk/publications/index.cfm?fuseaction=pubs.displayfile&id=3418&type=pdf> * * *

An OFSTED overview of the needs of asylum seeker pupils. The authors note that the schools they surveyed, committed time, effort and resources to integrating asylum seeker pupils in a positive and supportive manner. Several schools had well-established and effective arrangements for the admission and induction of the newly arrived pupils and provided good teaching support. Others were less well informed about basic procedures and guidance on the education of asylum seeker pupils.

Some schools in the dispersal authorities struggled initially to meet the learning needs of the pupils; class teachers, in particular, lacked expertise with pupils new to English. Many schools had not had any training to enable them to identify pupils with severe psychological distress and trauma. Some teachers also lacked basic background knowledge about the linguistic, cultural and educational experiences of the pupils. School staff funded by the ethnic minority achievement grant (EMAG) generally made a vital contribution in supporting the asylum seeker pupils and their families. However, there were several examples where existing school resources and staffing were diverted to meet the more immediate needs of the newly arrived pupils. The quality of teaching and of support for the great majority of the asylum seeker pupils was at least satisfactory, and often good.

Many asylum seeker pupils made good progress in relatively short periods of time and almost all made at least satisfactory progress. The Local Education Authorities (LEAs) provided at least satisfactory and, in some cases, very good support for schools receiving the pupils. Some LEAs had limited central capacity to support schools, particularly those which had no devolved EMAG funding. The most effective LEAs played a key role in the provision of advice and guidance, and in brokering the admission of pupils. Not all LEAs had effective mechanisms in place for coordinating the

admissions into schools and the contributions of different agencies supporting the asylum seeker families. Schools in less effective LEAs did not always have sufficient understanding and information about this work.

Remsbery, N., (2003). ***The education of refugee children: policy and practice in the education of refugee and asylum seekers children in England.*** London: National Children's Bureau.

No document available.

Richman, N. (1998). ***'They don't recognise our dignity': a study of the psycho-social needs of refugee families and children in Hackney.***

London: City and Hackney Community Services NHS Trust Child and Adolescent Services.

No document available.

Ritter, I. & Jones, C. (1998). ***Refugee education: mapping the field.***

London: Institute of Education, University of London. No document available.*

This book (intended for teachers, academics, and policymakers) examines the psychological adaptation of refugee children and young people. It discusses current issues in refugee education and the plight of refugees throughout the world. The author examines strategies for supporting refugee children in the early years and what specific programs have been enacted in east London primary schools. Various chapters focus on working with refugee children, the experiences of these students in the UK's education system, and the educational needs of these children.

Rutter, J. (2001). ***Supporting refugee children in 21st century Britain: a compendium of essential information.*** Trentham Books Limited. Details at: <http://www.icar.org.uk/res/drp/drps/drp025.html> *

This book brings together many different types of information: history; statistics; legal data; social research; and first-person accounts of refugee life. The book is divided into three sections. The first, 'Being a Refugee in the UK', gives an overview of the subject, defining terms and briefly describing the current refugee situation globally and in the UK in more detail. The historical background is discussed; the rights and entitlements of refugees and asylum seekers are outlined; current systems for the reception, settlement and integration are summarised. Part two, provides an overview of the subject, with recommendations for a more integrated approach, and more specific guidance in particular areas. Subjects addressed include: admission and induction; home language maintenance and development; psychological and emotional needs; racism; community links; unaccompanied refugee children; the needs of 14 – 19 year-olds; early years provision. Part three deals with refugee groups in the UK.

Rutter, J. & Hyder, T. (1998). *Refugee children in the early years: issues for policy makers and providers*. London: Save the Children. Details available at:

<http://www.crin.org/resources/infoDetail.asp?ID=1283&flag=report>

No document available.

Stead, J., Closs, A. & Arshad, R. (1999). *Refugee pupils in Scottish schools*. Edinburgh: The Scottish Council for Research in Education.

Document available at: <http://www.scre.ac.uk/pdf/spotlight/spotlight74.pdf>

**

This study had three aims: to explore policies and practices in education authorities regarding refugee pupils; to highlight refugee parents' and pupils' experiences of school; and to raise issues about how school staff understand the needs of refugee pupils. The first stage was a survey of all Scotland's Education Authorities, followed up by interviews with 'named persons' with responsibility for refugee issues in five authorities. The next stage was

interviews with refugees: 14 interviews with 23 refugee parents, and 11 interviews with twelve refugee children. Finally, interviews were held with 34 teaching staff. The findings suggest that the main factors affecting the refugee's experience of education are that:

- The experience of trauma accompanying departure from the home country and arriving in the UK may last for some time and restrict the ability of parents to engage in the education of their children. They may also be preoccupied with 'survival' issues.
- Not knowing whether they would be allowed to stay and the tension of 'living in two countries simultaneously.'
- The possible disruption of education before leaving the home country and on arrival in the UK.
- The experience of loss of material possessions, as well as emotional losses, may generate a high degree of commitment to the education of children (as a means to securing their future and 'insuring' them against such experiences in the future).
- The authors maintain that schools need to be aware of the high value most refugee families place on education. Schools should also be supported by the Scottish Executive and Education Authorities in meeting the needs of refugee parents and pupils by:
 - The production of a succinct and accessible briefing sheet to provide information on the way the Scottish education system is organised;
 - Reviewing the current level of funding and resourcing of English as an Additional Language services throughout Scotland;
 - Reviewing how the maintenance and development of home languages can be better resourced and supported in Scottish educational provision.

Appendix D: Social housing

Details of items where migrants access to, and use of, social housing has been explored are described in this section. Brief details of studies that have explored the impact of migrants on local housing markets are also given. Examples of key datasets that contain data on housing use by migrants are shown below.

Name of dataset	Brief description & measure of migration status	Further details
British Household Panel Survey	The objective of the survey is to further understanding of social and economic change at the individual and household level in Britain. Nationality/country of birth.	http://www.data-archive.ac.uk/findingData/snDescription.asp?sn=5151 .
Meeting Basic Needs? Exploring the Survival Strategies of Forced Migrants, 2004	The aims of the project were: to consider how far the housing and financial needs of refugees and asylum seekers are being met; to explore strategies used in order to meet needs; to explore the role of welfare agencies; to engage in scoping of the appropriateness of a policy allowing asylum seekers to engage in paid work. Arrival and length of stay in UK.	http://www.data-archive.ac.uk/findingData/snDescription.asp?sn=5159 .
Homelessness in London : A Psychological Profile, 1989-1990	To describe the homeless population in London, demonstrate their variety in terms of background, health, self-esteem, view of other residents, view of staff and their evaluation of their current place of stay. Place of birth.	http://www.data-archive.ac.uk/findingData/snDescription.asp?sn=2913 .

Modified abstracts

Anderson, I (2002). ***Migration and homelessness in the UK. Final Report to European Observatory on Homelessness.*** Brussels: Fédération Européenne d'Associations Nationales Travaillant avec les Sans-Abri (FEANTSA). Document available at:
http://jbas1243.kpn.be/obs/national_reports/uk/uk_migration_2002.pdf. **

This report presents a review of research on migration and homelessness in the UK. The review draws on published research and commentaries, with a focus on items published in the period 1996-2002. The author notes that there is a fairly large body of research on the use of housing by minority ethnic groups, but much less on use by migrants. She considers the historical and legal context of migration, and the housing situation of the more established migrant groups. Particular consideration is given to the interaction between poverty and homelessness or housing insecurity. There is a section on the housing situation of recent migrants. Much of this is a detailed discussion of the context (legal, social, political) of recent migration.

Bloch, A. (2002). ***The migration and settlement of refugees in Britain.*** Basingstoke: Palgrave.
 No document available.

Buck, B. (2001). ***Dispersed? Housing and supporting asylum seekers in Scotland.*** Edinburgh: Shelter.
 No document available.

Casey, R., Coward, S., Fordham, T., Hickman, P. Reeve, K. & Whittle, S. (2004). ***The housing market impact of the presence of asylum seekers in NDC areas.*** Research Report 24. Sheffield Hallam University: Centre for Regional Economic and Social Research. Document available at:
<http://ndcevaluation.adc.shu.ac.uk/ndcevaluation/Documents/Research%20>

This report assesses the extent to which asylum seekers affect local housing markets in New Deal for Communities (NDC) areas. A telephone survey of representatives from 19 NDCs was conducted in 2004, followed by in-depth case study work in three NDC areas: Newcastle, Doncaster and Coventry. Interviews with a wide range of local stakeholders were conducted, and focus groups with local residents and asylum seekers were held in two case study areas.

The evidence from the study suggests that the inward movement of asylum seekers does impact, both positively and negatively, on local housing markets. The perceived positive impacts of the presence of asylum seekers in NDC areas on the housing market include:

- Increased demand (in low demand neighbourhoods, for low demand property types).
- Repopulation of low demand areas.
- Reduced numbers of empty properties.
- Enhanced neighbourhood image and improved environmental conditions due to reduced number of empty properties.
- The perceived negative impacts of the presence of asylum seekers on the housing market in NDC areas include:
 - Increased demand (in high demand areas), thereby increasing competition for scarce housing.
 - Resentment from local populations as competition for scarce housing resources increased.
 - External perception of the area as a 'dumping ground', thus reducing popularity.
 - The study found a number of barriers impacting on the work of Partnerships in the areas. These included:
 - A lack of information about asylum seekers in the area.
 - A lack of clarity or guidance about the role of Partnerships in the asylum process, and in meeting the needs of asylum seekers.

- o A lack of awareness and understanding of immigration issues among Partnerships.

Chahal, K. (1999). ***Minority ethnic homelessness in London: findings from a rapid review***. London: NHS Executive. Document available at: <http://www.londonhealth.gov.uk/pdf/lhs/homeless2.pdf> *

This is not specifically about asylum seekers, refugees or migrants, but these groups are mentioned in the report. The method used for the report was an extensive literature search (minority ethnic housing associations were contacted, but very little relevant information was returned).

The review found that there are no accurate figures for the numbers of minority ethnic homeless people across London. Data collected using homelessness acceptance figures suggest that minority ethnic people are disproportionately homeless compared to the rest of the population. Homeless refugees, asylum seekers and homeless people from minority ethnic groups tend to stay with friends or relatives, in overcrowded households or are in other temporary arrangement like bed and breakfast or hostels. The limited data suggests differences between minority ethnic groups in terms of the extent of homelessness and its nature. This is particularly so between recently arrived minority groups and long-term resident groups or those born in the UK.

Chartered Institute of Housing (CIH) (2003). ***Providing a safe haven—housing asylum seekers and refugees***. London: CHI. Document available at: <http://www.cih.org/policy/asylumbriefing.pdf> ***

The authors propose that the British government should adopt community cohesion as a key aim of its policy on asylum. The CIH propose that the government should:

- o Develop a housing-based dispersal system which provides good; quality accommodation and support services in appropriate areas.

- Give advice to housing agencies on how to prepare host communities.
- Clarify its strategy for the use of private sector accommodation.
- Make available basic housing advice in appropriate languages for asylum seekers.
- Clarify the responsibilities of housing and advice agencies for providing services to those moving on from NASS accommodation.
- Ensure that the Immigration Service has a defined role in dealing with asylum cases which are refused, so that the responsibility does not rest mainly with accommodation providers and that they are recompensed while refused applicants continue to occupy accommodation.
- Encourage housing associations to provide accommodation for asylum seekers in appropriate areas, and not only where properties would otherwise be difficult to let.

Chartered Institute of Housing (CIH) (1999). ***Chartered Institute of Housing Evidence to the Immigration and Asylum Bill Special Standing Committee, March 1999***. London: CIH. Document available at: <http://www.parliament.the-stationery-office.co.uk/pa/cm199899/cmstand/special/st990326/90325s10.htm> **

A representation by CIH to the Committee. The evidence submitted by CIH is based on a survey carried out in two parts: the first sought the views of authorities and housing associations which have had experience of housing asylum seekers and refugees; the second sought the views of Authorities which have significant numbers of properties which are either difficult to let or surplus to demand. Thirteen housing organisations responded to the survey.

Housing providers were asked: 'Have you housed asylum seekers on low demand estates? If not, where have you housed them?' The Local Authorities (LAs) housed asylum seekers in a range of temporary accommodation until applications for asylum had been dealt with. Providers

were also asked: 'What have been the long term implications if applications for asylum seekers are accepted, and the asylum seekers decide to stay in your area?' The central problem identified by respondents is the lack of support facilities. Glasgow City Council highlighted the poor education, health and employment opportunities faced by asylum seekers. For example there are only two GPs in Scotland who speak Albanian, so Kosovan refugees faced particular problems in accessing health care.

There were a number of cost implications to services. Many of the respondents stated that there were significant cost implications to social services departments. The City and County of Cardiff pointed to the impact on communities where a significant proportion of asylum seekers and re-housed. Other costs specifically mentioned were social services, legal costs, translation, basic information about services, and funding for voluntary and community groups who work with asylum seekers.

Some LAs had housing stock which is surplus to requirements. However, what is questionable is the suitability of this housing for asylum seekers. The City and County of Swansea felt that it may not appropriate to house asylum seekers in difficult to let properties. The areas where vacant housing is situated are already plagued by problems of social exclusion. The arrival of significant numbers of asylum seekers would simply make the situation worse.

Cole, I. & Robinson, D. (2003). ***Somali housing experiences in England***. Sheffield Hallam University: Centre for Regional Economic and Social Research. Document available at:
<http://www.shu.ac.uk/cresr/pub/SOMALI%20Housing.pdf> **

The research focused on the situations and experiences of Somali households in Sheffield, Liverpool, Bristol, Ealing and Tower Hamlets. The research process involved an exploration of key data, literature and research evidence, discussions with Local Authority officers in the five areas, group discussions with community group leaders, and focus group sessions with the Somali

population.

Respondents referred to the sense of safety and security from living within a population of Somali households, as well as informal advice and support and local services provided by and for the Somali community. However, racial harassment was reported to be a widespread experience among the Somali population, especially in the current context of increasing suspicion of asylum seekers.

Somali households were reported to experience various problems accessing and utilising services provided by mainstream agencies, which often failed to understand the requirements and aspirations of Somali households. Respondents suggested that minority ethnic-led agencies were rarely aware or sensitive to Somali concerns and priorities. An array of Somali-led agencies was active in the case study districts. Few of these agencies, however, had successfully tapped into major funding streams. This outcome was linked to limited relevant expertise within the local population, divisions in the community and problems convincing funders about the extent of need among Somalis.

The majority of Somali households appear to be living in the social housing sector. This concentration is less the consequence of choice and more the result of a series of constraining forces. Homelessness is a common experience among the Somali population, although the incidence and extent of the problem is difficult to establish. Living with families and friends was reported to be the most common situation. Many Somali households were living in severely overcrowded circumstances.

Many social landlords showed a general lack of understanding about the experiences, requirements and preferences of Somali households. It is hardly surprising, given the lack of understanding of Somali housing needs, that certain aspects of provision are not sensitive to their preferences. The key issue was the language barrier between Somali households and their current or prospective landlord; and relevant translation and interpretation services either did not exist or were of limited use.

The experiences and observations of Somali households suggest that

few of the benefits associated with the development of the Black and Minority Ethnic housing movement have accrued to the Somali community. The report recommends the need to:

- Build a better understanding of Somali housing needs and preferences;
- Capture the diversity of experiences of Somali households in different local housing markets;

- Provide better support for Somali-led services and other community-led initiatives.

CRESR, CUPS & EIUA (2003). ***Seeking asylum in NDC areas: a report on experiences, policies & practices***. Research Report 18. Sheffield Hallam University: Centre for Regional Economic and Social Research. Document available at: <http://ndcevaluation.adc.shu.ac.uk/ndcevaluation/Reports.asp>

* *

The principal objectives of this study were to: identify the issues associated with the location of asylum seekers in New Deal for Communities (NDC) areas; identify the policy and practice implications for NDC Partnerships; highlight some of the approaches made to address barriers to policy and practice; and highlight key messages for policy makers. Some information is provided on housing service use and views of locals towards migrants' use of services. Interviews with local, regional and national organisations and agencies were carried out in 2003, in addition to work in five case studies NDC areas: Liverpool, Salford, Manchester, Sheffield and Haringey. At a workshop held in 2003, 70 or so representatives were invited to comment on the main findings of the research. The evidence from this work points to some major implications arising from an increase in asylum seekers. These include respondents' beliefs that:

- The presence of more asylum seekers had enhanced cultural diversity. Many asylum seekers have found the local population to be friendly, though to varying degrees, many had encountered a degree of hostility, partly driven by the view that asylum seekers are receiving preferential treatment.

In the short run, asylum seekers can reduce the numbers of vacant housing in areas of low demand, but in the longer run there are concerns about the potentially adverse impact on community cohesion.

An influx of asylum seekers can place very heavy demands on health and education services.

Many local residents are welcoming and supportive of people seeking asylum. However, some are suspicious of their motives for being in an area with high multiple deprivations and poor services. Further, some feel it is difficult to discuss matters of service capacity and priorities for resource allocation without racist accusations being made.

This study found a number of barriers impacting on the work of Partnerships, including: the inadequacy of local support structures and the paucity of local resources; a lack of partnership working in a high politicised and media aware context; and the range of anxieties of members of local communities.

Department of Transport, Local Government & the Regions (DTLR) (2001). ***Addressing the needs of Black and minority ethnic people***. London: Crown Copyright. Document available at: <http://www.asylumsupport.info/publications/detr/bmehousingneeds.pdf> *

An Action Plan from the DTLR that focuses on the housing needs of minority ethnic groups, but gives some brief consideration to the needs of asylum seekers and refugees. The authors point out that refugees are from minority ethnic backgrounds. The DTLR is looking at how refugees can be assisted to access housing, the prevention of homelessness, and how tenancies can be made more sustainable.

Dwyer, P. & Brown, D. (2004). ***Meeting basic needs: exploring the welfare strategies of forced migrants***. Leeds: The School of Sociology and Social Policy, the University of Leeds. Document available at: http://www.leeds.ac.uk/sociology/people/pddocs/ESRC_8pp.pdf **

This qualitative study focused on the welfare of migrants resident in Leeds, but also looked in detail at their experience of housing. Data were collected by in-depth interviews with migrants (n=23) and key respondents (n=11).

The main results suggest that:

- The basic housing and social security needs of many forced migrants are not being adequately met.
- The basic accommodation and day-to-day needs of those forced migrants who are denied access to public welfare are increasingly being met by other forced migrants, charities and refugee community organisations.
- Homelessness is a problem for many migrants. For those who receive a positive asylum decision, this is due to the short transition period from NASS accommodation into available social housing.
- It was reported that on occasion when forced migrants face hostility and abuse from neighbours they can find it difficult to secure moves to other locations.

Garvie, D. (2000). *Far from home: the housing of asylum seekers in private rented accommodation*. London: Shelter.

No document available.

Greater London Authority (GLA) (2004). *Safe and sound: asylum seekers and temporary accommodation*. London: GLA. Document available at: http://www.london.gov.uk/mayor/housing/docs/safe_and_sound.pdf ***

GLA undertook research to explore the experiences of asylum seekers in temporary accommodation in London. A central aim of the research was to look at the impact of poor housing conditions on health and well-being. Data were collected from three main sources: two seminars; interviews with key agencies; interviews with asylum seekers living in temporary accommodation across London (n=92). The data were not collected randomly, so may not

represent the views and experiences of all asylum seekers in London.

It is clear that many of the organisations responsible for providing accommodation are committed to a high quality, focused service for asylum seekers. Many examples of good practice were found, these include:

- Monitoring arrangements for accommodation and support.
- Performance standards and targets.
- Support arrangements for asylum seekers, including access to primary care services.
- The interviews with asylum seekers were spread across London.
- Around half were in shared and multi-occupied accommodation, the type of accommodation in which problems are likely to be most prevalent. Some asylum seekers are living in some of the poorest quality housing in the capital and, in many cases, are not receiving the support they need.
- A significant proportion of asylum seekers have health concerns, which are in many cases linked to their accommodation. A minority reported positive experiences regarding their health; 17 per cent of respondents said that their health had improved since they moved into their current accommodation.
- Many respondents had experienced significant problems with their accommodation and had encountered a lack of support. At least one in every five respondents regarded their accommodation as presenting them with serious problems with regard to damp, disrepair, infestation, security, safety and/or size. Overcrowding was widespread, with 41 per cent of households having at least one bedroom less than their household size warranted.
- Many did not receive appropriate information when they moved into their accommodation. Over 60 per cent were not told what to do in the case of fire or emergency and over half were given no information about any of the facilities in their accommodation, about how to make a complaint, about how to register with a doctor or about how to get their child into a school. About a third said that they did not think their

- accommodation had smoke detectors. Concerns about fire safety were raised, including gas leaks, electrical faults, faulty fire extinguishers and inadequate means of escape.
- Almost a third of asylum seekers in the survey felt unsafe in their own homes, five times higher than the London average of six per cent (British Crime Survey 2001/2), and 15 per cent of asylum seekers in the survey had suffered some form of harassment in the last year. There are significantly higher levels of special needs among asylum seekers compared with the general population. For example, asylum seekers are more likely to suffer from depression or anxiety (34%) and chronic long-term illness (22 per cent compared with seven per cent).
 - Almost a third of respondents believed that their health had deteriorated since they moved into their existing accommodation. Some asylum seekers faced some significant obstacles in accessing primary care services, including lack of information and language barriers.
 - Recommendations include:
 - The same minimum standards should be applied to publicly funded temporary accommodation used for asylum seekers as are applied to temporary accommodation used for households accommodated under homelessness legislation.
 - Training programmes on statutory fitness standards should be developed for professionals who are in regular contact with asylum seekers, for example community nurses and health outreach workers.
 - Procurers of accommodation should develop a protocol for sharing information about landlords who do not meet minimum standards or who are known to treat asylum seekers unfavourably. Monitoring information on complaints and the standard of service provided by landlords and agents should be used to identify poor providers.

landlords in housing both asylum seekers and refugees.

Edinburgh: Shelter Scotland. Document available at:

[www.paih.org/archives/publications/ we_can_house_you_too.htm](http://www.paih.org/archives/publications/we_can_house_you_too.htm) *

This report, based on a survey of registered social landlord (RSLs), shows that most could offer the kind of accommodation needed by asylum seekers or refugees but most have had little involvement with the present scheme or the refugees who remain in Scotland. Most RSLs would like to become more involved in housing asylum seekers and refugees. Some RSLs feel they were more limited in their ability to house asylum seekers or refugees by their low turnover of stock, and the pressures of competing demands from other groups of people recognised as being in 'housing need'. RSLs feel that they need training, practice guidance and better dissemination of information to prepare for asylum seekers and refugees. RSLs need better information on how to get involved (or more involved) in housing asylum seekers or refugees.

Office of the Deputy Prime Minister & Centre for Urban and Regional Studies, University of Birmingham (2004). ***Empowering communities, improving housing: Involving black and minority ethnic tenants and communities.*** London: Crown Copyright. Document available at: http://www.odpm.gov.uk/stellent/groups/odpm_housing/documents/page/odpm_house_029234-01.hcsp#P23_722 *

Not specifically on asylum seekers or refugees, but (in brief) sections of the report do deal with issues specific to them. In particular, the housing of asylum seekers has implications for community cohesion, and asylum seekers and recent migrants experience language and communication barriers.

Phillips, D. (2005, forthcoming). Housing and the integration of new migrants and refugees. In S. Spencer et al. (Ed.) ***The integration of new migrants***

and refugees: a review of the evidence and what works. London: Home Office. No document available. **

A comprehensive review of the literature on migrants' use of housing, but also the services that underpin the integration of migrants more generally. The author presents an overview of the housing situation of migrants, pointing out that the paucity of research in this area, and discusses the contributory factors to housing outcomes. These include: lack of resources; national policies towards the housing of migrants; and the policies of housing providers. Interventions to promote good integration are discussed. The key factors that facilitate a successful transition to good, secure accommodation include:

- Orienting newcomers and preparing existing residents.
- Providing on-going support for migrants.
- Providing 'move-on' support for new refugees
- And preventing homelessness.

Quilgars, D., Burrows, R. & Wright, K. (2003). ***Refugee housing and neighbourhood issues: a scoping review.*** University of York: Centre for Housing Policy. Details available at:
<http://www.york.ac.uk/inst/chp/publications/refugee-neighbourhood.htm> *

This publication presents the results of a scoping review of current research on housing and neighbourhood issues in relation to refugees and people seeking asylum. Issues covered by the review include: the role of the private rented sector and social landlords in first housing provision; post-acceptance/move-on housing; dispersal policy in relation to demand for social housing; neighbourhood integration; housing and community management issues; housing and community care issues.

Refugee Advisory Committee on Tyneside (2002). ***Refugee housing project North-East: refugee aspirations on move-on/second***

stage/future housing needs in the North East of England. Sunderland: Bow Community Projects Ltd. Document available at: <http://www.icar.org.uk/res/drp/drps/drp072.html> **

The purpose of this research was to identify the needs and aspirations of refugees in the region regarding 'move-on' accommodation, in and to identify the requirements for success of any future second stage housing provision. The research involved detailed interviews with people from 42 asylum seeker households (n=101) obtained through snowball sampling. A number of key findings emerge as a result of the research, including:

- If individuals could choose where they lived, 48 per cent of participants would choose to live in London.
- Participants' preferred type of 'move-on' housing was self contained, not shared homes, in secure neighbourhoods.
- Approximately 43 per cent of respondents stated that they would definitely, and a further 38 per cent would possibly, like to remain living in the North East region when considering their 'move-on' from NASS contracted dispersal accommodation.
- Access to training and employment, housing and support services and opportunities for social inclusion and community support were the 'top three' critical factors in influencing whether respondents decided to remain in the region.
- To assist in enabling effective move-on housing by refugees in the North East the following key elements are needed:
 - An anti-racist multi-cultural framework for action is needed. This must be supported, enabled and where necessary led, by policy makers and professionals.
 - The provision of refugee centred services to refugees in terms of support, information and in the provision of accessible move on housing, is a key prerequisite of a successful 'move-on' housing and integration strategy region wide.

Shelter (2000). *Consultation response: Greater London Authority: Public Services Committee scrutiny of asylum seekers and refugees*.

London: Shelter. Document available at:

<http://england.shelter.org.uk/files/docs/2076/Asylum%20Seekers%20&%20Refugees%20in%20London.pdf> *

A submission by the campaigning group to the Greater London Authority (GLA). The authors recommend that the GLA has a role in developing a London-wide strategy for responding to the housing needs of asylum seekers and refugees. The strategy should seek to identify and address the difficulties faced by asylum seekers and refugees. These include:

- Lack of awareness of and information about their housing rights.
- Lack of awareness among agencies delivering public housing services of the reasons people might have fled their countries of origin, and the implications this might have for their needs.
- Poor standards of private rented accommodation provided by either NASS contractors or social services.
- Difficulties in accessing social rented housing because of the need to prove a local connection or vulnerability.
- Difficulties in accessing private rented housing because of housing benefit restrictions and the need to pay a deposit.
- The GLA could also have a role in gathering and disseminating information and good practice on asylum seeker and refugee housing issues. This would be helpful to London boroughs when planning their strategies for accommodating and supporting asylum seekers and refugees.

Sriskandarajah, D. (2004). Stock taking: the real impacts of migrants on housing. *Roof Magazine*. Document available at:

<http://www.ippr.org.uk/articles/index.php?article=166> ***

A recent discussion piece. The author maintains that there is a belief that

migrants crowd the housing market at both ends: at one end, asylum claimants are accused of 'jumping the queue' to get scarce social housing; at the other end, highly-paid economic migrants are thought to be pushing up rents and house prices. The author maintains that it is important to recognise the relatively small numbers involved: the number of claimants and their dependents accommodated by NASS at the end March 2004 was 48,610. There were only 2,985 claimants and dependents housed by NASS within Greater London. Even when that group is added to those housed in the South East and South West the figure rises to only 5515, just over 10 per cent of the national total.

It is also important to note is that asylum claimants housed by NASS do not take away social housing that would otherwise be available to UK nationals or slow down their access. They are instead housed under separate arrangements, funded and administered centrally by the Home Office. It is argued, however, that since most international migrants settle in London, migration is responsible for high prices and rents in the capital. This argument overlooks the steady movement of people out of London and into other parts of the UK (internal migration). Taken together, the flows almost cancel out. In fact, in the decade to 2001, London actually gained only around 75,000 people from migration—accounting for less than a quarter of the capital's population increase. Even with recent population growth and migration, fewer people live in London now than did thirty years ago. This evidence suggests that, while migrants may well increase overall demand for housing slightly, their impact on housing shortages and rising prices should not be exaggerated.

Zetter, R. & Pearl, M. (1999). *Managing To survive. Asylum seekers, refugees and access to social housing*. Bristol: The Policy Press. Details at: <http://www.bris.ac.uk/Publications/TPP/pages/rp020.html> **

The authors assess the impact of major government policy changes introduced between 1993 and 1996, on housing supply processes for

refugees and/or asylum seekers. The quality of housing association service provision in London, Manchester and Birmingham and the range of management practices and support are assessed from the points of view of providers and the refugees/asylum seekers.

Between 1996 and 1999 housing services to refugees and asylum seekers have been increasingly provided by the housing association/voluntary sectors as a result of statutory and policy changes. Some housing associations have provided services for asylum seekers and refugees in ways that have been sensitive to their needs and aspirations; they provide models for others to follow. Good practice is based on culturally sensitive service delivery. Aspects valued most are privacy, cultural and social activities, own language documents, and supportive staff.

The failure to provide accommodation and services responsive to the diverse needs of refugees and asylum seekers has increased their sense of vulnerability, social exclusion and isolation. The skills and expertise of refugee community organisations are substantially under-utilised which means that consumers do not receive the best services. Wider structural and resource constraints, especially government policy, are the fundamental barriers to strategic responses and the adoption of good practice in housing provision. Recommendations include:

- A strategic approach to housing and other services is required with housing associations and refugee community organisations as the primary providers of services.
- A range of housing and support services is required, recognising changing housing needs at different phases of the reception and resettlement process.
- Housing associations and the Housing Corporation need to develop greater awareness of the issues and diverse needs relating to refugees and asylum seekers.

Appendix E: Criminal justice

This section contains details of some items exploring use of services in the criminal justice system by migrants. Examples of key datasets are shown below.

Name of dataset	Brief description & measure of migration status	Further details
Ethnic Minorities and the Police Survey, Leeds, 1987	The project's starting point was to examine whether different ethnic groups are subjected overall to different treatment within the criminal justice system. Place of birth	http://www.data-archive.ac.uk/findingData/snDescription.asp?sn=2740
Greater London Authority (GLA) Household Survey, 2002	The survey covered a wide range of policy areas in moderate detail: household and personal characteristics (including income and savings), employment, transport, crime, health, disability and housing needs. Place of birth.	http://www.data-archive.ac.uk/findingData/snDescription.asp?sn=5149&key=crime

Modified abstracts

Abernethy, R. & Hammond, N. (1999). *Working with offenders from abroad: probation practice issues*. London: Middlesex Probation Service. Document available at: <http://www.london-probation.org.uk/media/adobe/Fnu.PDF> *

The authors briefly describe the work of the Foreign Nationals Unit, their

work with offenders and prison care issues. In summary, the authors maintain that foreign-born prisoners are among the most vulnerable. Services are not always appropriate for them, and training is needed for professionals engaged in looking after foreign nationals.

ACPO (2001). ***Guide to meeting the policing needs of asylum seekers and refugees***. London: Association of Chief Police Officers. Document available at: <http://www.asylumsupport.info/publications/acpo/policing.pdf>

* * *

The Guide was drafted to identify the key features which affect the Police Service (PS), and recommend good practice which will enable Forces to deal with the challenges presented by the asylum situation. The authors identify the need for a range of options which reflect the numbers of asylum seekers being identified as illegal entrants in different Force areas, and the capability of the Immigration Service to provide an appropriate response to their detention.

Forces must recognise that there is a need for long term planning and a commitment to manage the integration of asylum seekers and refugees with local resident communities. It is reasonable to expect that, even where asylum seekers' applications are unsuccessful, they will be replaced by newly arrived asylum seekers. From the perspective of local communities the presence of asylum seekers will appear constant. Without planned action to manage the tensions which may exist between the indigenous population and asylum seekers, significant public disorder may result.

The PS must be aware of the antecedents of asylum seekers arriving in the UK. Many might have a victim history having fled from areas of conflict, others may have military antecedents, having been involved as soldiers in conflict. Others may arrive with established criminal backgrounds and a propensity to offend. It is extremely likely that Forces will experience crimes where asylum seekers are victims, witnesses or offenders. This guide identifies a number of key recommendations.

Key recommendations in relation to the immigration and asylum processes:

- Forces should appoint a liaison officer for their Regional Consortia.
- Forces should appoint liaison officers to the National Asylum Support Service.
- In relation to the processing of illegal entrants:
 - Forces should review their policy towards the arrest and processing of suspected illegal entrants (including the issue of reclaiming costs)
- In relation to arrivals and reception of asylum seekers:
 - Develop a local directory of interpreters within asylum groups to assist with communication between police and asylum communities and to assist in the initial reporting of crime
- Other recommendations made include:
 - A clear public communications strategy should be agreed by Forces with other statutory agencies.
 - Forces should appoint a liaison person/coordinator to lead on behalf of the Force on issues surrounding policing an asylum community and to facilitate partnership working.
 - The Force Coordinator should make early contact with NASS and regional consortia to establish mechanisms for information exchange
 - Forces should review their race and community awareness training to include issues particular to asylum seekers.
 - Forces should consider reviewing their media policy with other agencies.
 - Force Liaison officers should establish early contact with NASS representatives and agree protocols for accessing information to assist investigations of missing persons.
 - Where Forces receive unaccompanied minors, Police and/or social services departments should establish age verification systems to assist in processing asylum seekers believed to be adult but claiming to be juveniles.
- Forces are encouraged to review their policy for conducting police

checks for other agencies in light of the increase in the number of local authority care homes and family hostels used by asylum seekers.

Caddle, D. & Crisp, D. (1997). ***Mothers in prison***. Research Findings No. 38. London: Home Office Research and Statistics Directorate. Document available at: <http://www.homeoffice.gov.uk/rds/pdfs/r38.pdf> *

This document is not specifically about foreign-born prisoners. However, a high proportion of the female prison population are foreign nationals and many have dependent children (here, 61 per cent of the 1766 prisoners were mothers of children aged under 18). Key findings in relation to the foreign-born are that: it is difficult for women to maintain contact with their children; and some (57 per cent) foreign-born prisoners had made a limited number of phone calls home at the public expense.

Crown Prosecution Service (2003). ***Guidance on prosecuting cases of racist and religious crime***. London: Crown Prosecution Service. Document available at: <http://www.cps.gov.uk/publications/docs/rrpbcrpol.pdf> **

A policy document that does not deal with migrants *per se*, but the CPS' definition of race/religious crime includes crimes against asylum seekers and refugees. The authors cover: definitions of race/religious crime; how to prosecute race/religious crime; sentencing; and community engagement. The CPS advise that cultural differences or sensitivities be taken into account when prosecuting racist crime. This might include: being aware that a witness's availability for court hearings might be on a holy day or festival; and being sensitive to gender-related issues when meeting witnesses.

Hampshire Probation Service (2004). ***Practice manual for working with asylum seekers and refugees***. Hampshire: Hampshire Probation Area. Document available at: <http://probation.hants.gov.uk/> ***

Primarily a manual for practitioners, but contains some useful information on: statistics; legislation; the experiences of asylum seekers; probation practice guidance. Under the last section, issues such as the use of interpreters and the writing of reports are covered.

The authors maintain that it is important that asylum seekers' circumstances are fully described in probation reports. Probation officers need to be sensitive to the potential for causing trauma or upset when asking asylum seekers why they left their own country. They should also be aware that asylum seekers are not likely to understand the criminal justice system. In addition, asylum seekers are likely to be cautious about questions around their immigration status.

Harper, R. & Murphy, R. (1999). *Drug smuggling: an analysis of the traffickers 1991-1997*. London: Middlesex Probation Service. Document available at: <http://www.london-probation.org.uk/media/adobe/Fnulros.PDF>

*

Analysis of the database on Foreign Nationals at Middlesex Probation Service (n=1715) shows that 32 per cent of foreign national traffickers (in drugs) were women (compared with 22 per cent of UK traffickers) and foreign nationals were more likely to have children than the UK-born. Foreign nationals were also less likely to make a bail application than UK residents (this was not statistically significant).

Home Office (2004). *Statistics on race and the criminal justice system – 2003*. London: Crown Copyright. Document available at: <http://www.homeoffice.gov.uk/rds/pdfs04/s95race2003.pdf> *

An official, statistical overview of the ethnicity of individuals in the criminal justice system. Migrant status of individuals is not the focus of the document, but some brief data are available on this. For example, a third of prisoners belonging to a Black and minority ethnic group are foreign nationals. In

2002, 10 per cent of all male prison population and 20 per cent of all female population were foreign nationals. Foreign nationals made up 4 per cent of the White male prison population, 32 per cent of Black prisoners, 25 per cent of Asian prisoners and 44 per cent of Chinese and 'Other' prisoners. Among female prisoners, foreign nationals accounted for 5 per cent of the White population, 60 per cent of Black inmates, 42 per cent of Asian prisoners and 42 per cent of Chinese and 'Other' prisoners.

Legal Services Commission (2004). *Consultation paper on the use of interpreters in publicly funded immigration and asylum cases*. Legal Services Commission: London. Document available at: http://www.legalservices.gov.uk/devel/consultation_paper_v20.pdf *

Although very recent, this is only a consultation document and is primarily about the cost and effectiveness of interpreters in publicly-funded immigration and asylum cases. Key problems are identified. These include: high costs, variable quality and uncertainty about correct procedure. In light of these problems it is recommended that guidance be introduced that will initially meet the following three key aims:

- o To guarantee that only qualified interpreters are instructed and to improve the quality of interpreters that may be instructed in publicly funded cases.
- o To facilitate greater control over the fees paid to interpreters.
- o To introduce standard terms of appointment to clarify and simplify the procedures relating to the instruction of and payment for interpreters.

Mortimer, C. (2003). Working with Turkish speaking refugee and asylum seeking offenders. *Probation Journal* 50 (3), 289-293. Abstract available at: <http://prb.sagepub.com/cgi/content/abstract/50/3/289> **

This article highlights some of the particular challenges faced by the large

and growing population of Turkish speaking offenders in the London borough of Haringey. It draws on a small-scale study, which sought to inform the author's practice with this group of offenders.

Power, C. (2003). Irish Travellers: ethnicity, racism and pre-sentence reports. *Probation Journal* 50 (3), 252-266. Abstract available at: <http://prb.sagepub.com/cgi/content/abstract/50/3/252?> *

The author examines the treatment of Irish Travellers (many of whom are migrants) in the criminal justice system. It provides a brief background to Irish Traveller ethnicity and then outlines the causes, extent and consequences of social marginalisation and criminalisation in Britain's Irish Traveller population. This leads to a discussion of criminal justice concerns through the examination of existing research on pre-sentence reports (PSRs) concerning Irish Travellers, and interviews with probation officers and others which helped to explore prejudice and racism in the language and construction of PSRs. The article finishes by assessing possible ways to address these injustices in the sentencing process.

Prison Reform Trust (2004). *Forgotten prisoners—The plight of foreign national prisoners in England and Wales*. London: Prison Reform Trust. <http://www.prisonreformtrust.org.uk/pdf%20files/Foreign%20National%20Prisoners%20LO%20RES.pdf> ***

A briefing paper from the Prison Reform Trust that looks at the plight of foreign-born prisoners in English and Welsh prisons. About 12 per cent of the prison population are foreign nationals and one in five women in prison is foreign-born. There has been a threefold increase in their numbers over the past decade, and nearly half of foreign-born prison population are incarcerated for drugs-related offences. There are now two prisons where foreign national prisoners make up half or more of the population. In sixteen prisons they make up a quarter or more. The report concludes that despite

good practice in a few jails, prison staff are often unaware of the needs of foreign national prisoners, and services are sub-standard. The report concludes that there a number of areas where foreign nationals needs are being neglected. These include the following areas:

- Language barriers: there has been a failure to provide adequate translation and interpretation facilities which means prisoners miss out on basic provisions, such as showers, because they have not understood staff instructions. A recent Prison Service survey found that nearly 90% of prisons holding foreign national prisoners are not making regular use of the translation service.
- Isolation and mental health concerns: foreign national prisoners experience difficulties trying to maintain family contact, especially fulfilling their roles as parents. Separation from family in an alien environment can mean that their mental health needs are often greater than for other prisoners.
- Legal and immigration issues: many foreign nationals remain in jail having completed their sentence because of failure to monitor and make arrangements for those who have been recommended for deportation. Foreign national prisoners struggle to access legal and immigration advice during their sentence.
- Racism: foreign national prisoners say that racism and a lack of respect and understanding from prison staff is not uncommon.
- Preparation for release: there is a lack of proper procedures in place to prepare foreign nationals for their release and there are insufficient resettlement programmes specifically for foreign national prisoners.
- The authors make a number of recommendations. These include: the introduction of a 'foreign national prisoner strategy' in each prison; a resource pack for the foreign-born; and greater sharing of information between the Home Office and the Prison Service.

asylum seekers arriving at UK ports. *The Howard Journal of Criminal Justice* 42(3), 248-262. Abstract available at:

http://papers.ssrn.com/sol3/papers.cfm?abstract_id=416364 *

Although decisions made by immigration officers can lead to long periods in prison (or in prison-like conditions), these actions are considered to be administrative and are, therefore, not subject to the legal constraints that apply to criminal justice agencies. The author traces the many sources of discretion in the use of Immigration Act detention, using an existing analytical framework. Discretion is found to originate from the vague and permissive nature of detention guidelines, the priority given to operational considerations at ports and the failure to resolve conflicts between policy objectives.

Appendix F: Databases, resource websites & other resources

Type of service	Name of resource	Type of resource, availability & location
Health & social care	Medline	Database, free. Available at: www.ncbi.nlm.nih.gov/entrez/query.fcgi .
	Cinahl	Database, subscription.
	Psychinfo	Database, subscription.
	Cochrane databases	Database, subscription.
	ASSIA	Database, subscription.
	British Nursing Index	Database, subscription.
	BMJ (multiple journal search)	Journal and resource website, free. Available at: www.bmj.com .
	Department of Health	Resource website, free. Available at: http://www.dh.gov.uk/Home/fs/en
	Health Development Agency	Database, resource website, free. Available at: http://www.hda-online.org.uk/
	CareData	Database, free. Available at: http://www.elsc.org.uk/caredata/caredata.htm .
Education	ERIC	Database, subscription.
	British Education Index	Database, subscription.
	ERA Online	Database, subscription.
	Department for Education & Skills	Resource website, free. Available at: http://www.dfes.gov.uk/ .
Social housing	The Centre for Comparative Housing Research	Resource site, free. Available at: http://www.cchr.net/cchr.php?b=1
	The Housing Corporation	Database, free. Available at: http://cig.bre.co.uk/igp/new/main.jsp .
	Housing Policy: Policy Library	Resource website. Subscription required for most items. Available at: http://www.policylibrary.com/housing/ .
	Homeless pages	Resource website. Free to search for items. Available at: http://www.homelesspages.org.uk/
	Housing Today	Resource website, free. Available at: http://www.housing-today.co.uk/

	Office of the Deputy Prime Minister	Resource website, free. Available at: http://www.local.odpm.gov.uk/
	National Housing Federation	Resource website, free. Available at: http://www.housing.org.uk/
Criminal justice	Justis	Database, subscription.
	Lexis-Nexis	Database, subscription.
	Westlaw	Database, subscription.
	The Home Office	Resource website, free. Available at: http://www.homeoffice.gov.uk/
Other	Warwick University The Centre for Research in Ethnic Relations	Database, free. Available at: http://www.warwick.ac.uk/fac/soc/CRER_RC/
	Custom Newspaper Database	Database, subscription.
	REGARD (ESRC database)	Database, free. Available at: http://www.regard.ac.uk/ESRCInfoCentre/index.aspx .
	Asylum Policy Info	Resource website. Subscription required for many items. Available at: http://www.asylumpolicy.info/
	Official documents	Resource website, free. Available at: http://www.official-documents.co.uk/index.html .

Appendix G: Key research organisations concerned with migrants & migration

Name	Website	Purpose of organisation
COMPAS (Centre on Migration Policy & Society)	http://www.compas.ox.ac.uk/	To provide a strategic, integrated approach to understanding contemporary & future migration dynamics across sending areas & receiving contexts in the UK and EU.
ESRC Centre for Evidence in Ethnicity, Health & Diversity	http://users.wbs.ac.uk/group/ceehd/home/ceehd_home	To identify, assess & disseminate research evidence in the multidisciplinary field of ethnicity & health.
Health for asylum seekers & refugees portal	http://www.harpweb.org.uk/	HARPWEB consists of three websites developed in collaboration with health professionals working with asylum seekers & refugees in the UK.
IPPR (migration & inequalities)	http://www.ippr.org/research/index.php?current=19&detail=intro	IPPR's Migration, Equalities & Citizenship programme examines immigration & asylum policy in the UK & Europe, equalities & human rights.
Mary Seacole Research Centre (De Monfort University)	http://www.dmu.ac.uk/faculties/hls/research/msrc/index.jsp?ComponentID=13190&SourcePageID=12497#1	The Centre works with those who have an interest in issues of race & ethnicity in health.
Migration Research Unit	http://www.geog.ucl.ac.uk/mru/	To carry out research designed to increase knowledge & understanding of international population migration issues.
Refugee Dispersal & Concentration	http://ralph.swan.ac.uk/refugeedisp/home.htm	The project brings together three national authorities on issues of refugee resettlement with the aim of: identifying knowledge about refugee dispersal policies; making international comparisons of how dispersal policies have been implemented; critically appraising their impacts & identifying models of good & bad practice in dispersal.
Refugee Studies Centre	http://www.rsc.ox.ac.uk/	The leading multidisciplinary centre for research & teaching on the causes & consequences of forced migration.
Refugee Education Initiative	http://www.ioe.ac.uk/rei/	To coordinate existing Institute activities in the area of refugee education as well as initiating new activities.
Research Centre for Transcultural Studies in Health, Middlesex University	http://www.mdx.ac.uk/www/rctsh/homepage.htm	To enable the development of health professionals & health services which deliver culturally competent care, that ultimately ensures high quality care for all.

Appendix H: Key journals concerned with migrants, migration & minority ethnic groups

Name of journal	Website
General	
Citizenship Studies	http://www.tandf.co.uk/journals/titles/13621025.asp
Ethnic & Racial Studies	http://www.tandf.co.uk/journals/titles/01419870.asp
Ethnicities	http://www.sagepub.com/journal.aspx?pid=33
International Journal of Urban & Regional Research	http://www.blackwellpublishing.com/journal.asp?ref=0309-1317
Journal of Ethnic & Migration Studies	http://www.cemes.org/
Journal Of International Migration & Integration	http://jimi.metropolis.net/
Journal of Refugee Studies	http://www3.oup.co.uk/refuge/
Refugee Survey Quarterly	http://www3.oup.co.uk/refqtl/
Health & social care	
Cultural Diversity & Ethnic Minority Psychology	http://www.apa.org/journals/cdp.html
Ethnicity & Health	http://www.tandf.co.uk/journals/titles/13557858.asp
Journal of Immigrant Health	http://www.kluweronline.com/issn/1096-4045/contents
Education	
Intercultural education	http://www.tandf.co.uk/journals/titles/14675986.asp
Criminal justice system	
International Journal of Refugee Law	http://ijrl.oupjournals.org/
Journal Of Refugee Studies	http://jrs.oupjournals.org/

Appendix I: Key organisations concerned with the welfare of migrants, refugees & asylum seekers⁵⁸

Name	Website	Type of organisation	Purpose
General			
European Council on Refugees & Exiles (ECRE)	http://www.ecre.org/	International umbrella organization	ECRE is an umbrella organisation of 78 refugee-assisting agencies in 30 countries working towards fair & humane policies for the treatment of asylum seekers & refugees.
Jesuit Refugee Service	http://www.jesref.org/home.php?lang=en	NGO	The Jesuit Refugee Service is an international Catholic organisation with a mission is to accompany, serve & defend the rights of refugees & displaced people.
Joint Council for the Welfare of Immigrants	http://www.jcwi.org.uk	NGO	JCWI is an independent national voluntary organisation, campaigning for justice & combating racism in immigration and asylum law and policy.
Immigrant Council of Ireland	http://www.immigrantcouncil.ie/	NGO	The Immigrant Council of Ireland responds to the needs of immigrants in Ireland.
Immigration & Nationality Directorate (IND)	http://www.ind.homeoffice.gov.uk/default.asp	British government agency	IND is responsible for immigration control at air & sea ports throughout the UK.
Migrant Helpline	http://www.migranthelpline.org.uk/	NGO	Committed to providing a comprehensive & wide-ranging reception & advice service to asylum seekers & refugees.
National Asylum Support Service (NASS)	http://www.ind.homeoffice.gov.uk/default.asp?PageId=89	British government agency	From April 2000, NASS became responsible for the provision of support to asylum seekers.
Refugee Action	http://www.refugee-	NGO	Provides practical advice & assistance for newly arrived

⁵⁸ These are mostly British organisations, though details are provided of some important international organisations that have representation in the UK (such as a UK office), or other British interests.

	action.org.uk/		asylum seekers.
Refugee Arrivals Project	http://www.refugee-arrivals.org.uk	NGO	Refugee Arrivals Project (RAP) is an independent charity set up to assist newly arrived asylum seekers & refugees.
Reception & integration Agency	http://www.ria.gov.ie/	Irish government agency	The RIA is responsible for coordinating the provision of services to both asylum seekers & refugees.
Refugee Council	http://www.refugeecouncil.org.uk/index.htm	NGO	The Refugee Council is the largest organisation in the UK working with asylum seekers & refugees.
Refugee Week	http://www.refugeeweek.org.uk/	NGO	Refugee Week aims to celebrate the contribution of refugees to the UK & promote understanding about the reasons why people seek sanctuary.
Scottish Refugee Council	http://www.scottishrefugeecouncil.org.uk/	NGO	The Scottish Refugee Council was founded to provide advice & assistance to individuals who are forced to leave their own country.
United Nations High Commission for Refugees (UNHCR)	http://www.unhcr.ch/cgi-bin/texis/vtx/home	International agency	The protection of some 20 million uprooted people is the core mandate of UNHCR. Using the 1951 Geneva Refugee Convention as its major tool, it ensures the basic human rights of vulnerable persons & refugees.
Young Separated Refugees Project	http://www.rightsbase.org.uk/refugees/ysr/ysr.htm	Charity	The YSR Project is a national three year programme to address the needs of separated young refugees & asylum seekers.
Health & social care			
The Centre for the Care of Survivors of Torture	http://www.ccs.t.ie/	NGO	Provides trauma healthcare to survivors of torture.
Medical Foundation for the Care of Victims of Torture	http://www.torturecare.org.uk/	NGO	Founded in 1985, the Medical Foundation for the Care of Victims of Torture provides care to survivors of torture & other forms of organised violence.
Education			

Education Action International	http://www.education-action.org/home.asp.htm	NGO	Education Action International works with people who are affected by conflict in their home countries & countries of refuge.
National Association for Language Development in the Curriculum	http://www.naldic.org.uk/	Professional body	NALDIC seeks to build on proven, sound professional policies & practices & uphold bilingual pupils' entitlement to full curriculum access, appropriate EAL provision & first/home language development.
Social housing			
Accomodate	http://www.hact.org.uk/downloads.asp?PageId=89	Charity	Accomodate develops & supports local partnerships, mostly in areas of dispersal, which focus on improving the housing situations of refugees.
Asra Greater London Housing Association	http://www.asra.org.uk/	NGO	ASRA Greater London Housing Association is the leading Asian provider of rented homes.
Criminal justice			
Asylum Aid	http://www.asylumaid.org.uk/	NGO	An independent, national charity assisting refugees in the UK.
Asylum Support Info	http://www.asylumsupport.info/	NGO	AsylumSupport.info focuses on all matters that concern people seeking asylum, together with a directory of hundreds of online resources.
Bail for Immigration Detainees	http://www.biduk.org/index.htm	NGO	BID provides a free dedicated bail service for asylum seekers & migrants detained under immigration legislation, in immigration removal centres.
Children's Legal Centre	http://clc.live.poptech.coop/Homepage.asp?NodeID=89614	NGO	The Children's Legal Centre is an independent national charity concerned with law and policy affecting children & young people.
Committee to Defend Asylum Seekers	http://www.defend-asylum.org/	NGO	CDAS demands: the right to work for asylum seekers; abolition of detention centres; no forced dispersal; full legal rights; no deportation.
Criminal Justice	http://www.cjs	Government	The Criminal Justice System in

System website for England & Wales	online.org/home.html	body	England and Wales is responsible for various aspects of the work of maintaining law & order & the administration of justice.
HM Prison Service	http://www.hmprisonservice.gov.uk/	Government body	Her Majesty's Prison Service serves the public by keeping in custody those committed by the courts.
Hibiscus	No website Some details are: http://news.bbc.co.uk/2/hi/uk_news/magazine/3526891.stm	NGO	Hibiscus works with foreign nationals in British prisons.
Immigration Advisory Service	http://www.iasuk.org/	NGO	The Immigration Advisory Service is a charity participating in the Community Legal Service scheme with quality assurance.
Law Society	http://www.lawsociety.org.uk/home.law	NGO	The Law Society is the regulatory & representative body for solicitors in England & Wales.
Legal Aid Practitioners' Group	http://www.lapgroup.co.uk/index.cfm	NGO	The Legal Aid Practitioners Group is the foremost independent authority on publicly funded legal services in England & Wales.
Legal Services Commission	http://www.legal-services.gov.uk/	Government body	The Legal Services Commission is an executive non-departmental public body created under the Access to Justice Act 1999 to replace the Legal Aid Board.
London Asylum Seekers Consortium	http://www.westminster.gov.uk/socialservices/lasc/about/index.cfm	Local government body	The London Asylum Seekers Consortium (LASC), led by the Association of London Government (ALG) & Westminster City Council, provides a variety of related services for London's LAs.
National Probation Service	http://www.probatation.homeoffice.gov.uk/output/Page1.asp	Government body	The aims of the Service are to: protect the public; reduce re-offending; punish offenders in the community; ensure that offenders are aware of the effects of crime on the victims of crime; rehabilitate offenders.

The Refugee Women's Legal Group (RWLG)	http://www.crawley30.freeseerve.co.uk/	NGO	The Refugee Women's Legal Group (RWLG) was established by individuals concerned about the impact of changes in immigration law on women seeking asylum.
Refugee Legal Centre	http://www.refugee-legal-centre.org.uk/	NGO	Provides legal advice & representation.

Appendix J: Newspaper review

The InfoTrac Custom Newspapers database was used for the review of newspaper coverage. This database searches: the Times; the Sunday Times; the Independent; the Independent on Sunday; the Daily Mail; the Mail on Sunday; the Mirror; and the Sunday Mirror. During the period May 2003 to May 2004.

Search terms: refugee* OR asylum OR migrant* AND service.* The search was of news items only, where these words appeared in either the title, citation or abstract.

Main Themes Identified

Using the methods described above, the search produced approximately 1426 hits across the newspapers. Based on a reading of the title only, approximately 100 to 150 of these were more specifically on service use relevant to this review. It is important to point out that the theme of service use and access runs throughout many newspaper reports. Here, only where service use was prominent was the item included. In addition, many newspaper reports cut across themes, so that, for example, an item might cover use of social housing *and* access to healthcare services. The themes observed in newspaper reports are shown below.

Themes in newspaper reports

Area	Specific themes
Health & social care services	1. Costs of/payments for medical treatment (& health tourism)
	2. Threats from infectious diseases
	3. Voluntary/mandatory testing for HIV &/or TB)
Education	4. Needs of migrant children (especially language needs).
	5. Impact on idigeneous population & financial costs.
Social housing	6. Access to housing (including dispersal & detention centres)
	7. Abuse of housing benefit & social housing systems
Criminal justice	8. Abuse of legal aid system by migrants & solicitors

services	9. Criminality of migrants & their incarceration
Related/ancillary themes	10. General/pervasive abuse of welfare systems
	11. Government indecision/vacillation over migrants' access to services
	12. Contribution to the economy (paying for services)
	13. Destitution of asylum seekers
	14. Effects on national or local population's access to services (including local hostility)

In relation to health tourism, there were a number of newspaper reports on the apparent abuse of the NHS. The following extract is typical, and was a response to a government announcement about this issue (though the media had been reporting on health tourism for some time⁵⁹):

Failed asylum seekers and overseas visitors will be forced to pay in advance for NHS care under a crackdown on 'health tourism'. Patients seeking hospital treatment will be asked to prove that they qualify for free care. Anyone who fails to satisfy the criteria will be asked to pay upfront—or be refused treatment. Failed asylum seekers and illegal immigrants with infectious diseases including TB, rabies, measles or smallpox will be given free treatment (The Daily Mail, 27/04/04).

In many reports, medical personnel expressed reservations about proposed government 'crackdowns' on health tourism, thus revealing important tensions between government's priorities and doctors' perception of their responsibilities:

Family doctors are to be offered cash incentives to 'shop' failed asylum seekers in the latest crackdown on health tourism. Thousands of patients currently treated free of charge will face fees each time they see a GP under proposals to be unveiled this week.

⁵⁹ The BBC carried a news item about nine months earlier reporting on Department of Health 'crackdowns' on health tourism. See: <http://news.bbc.co.uk/1/hi/health/3105931.stm>.

And doctors will be told they can keep the money to encourage them to root out those not entitled to free care. GPs' leaders, however, have warned that the new initiative is likely to be met with fierce resistance, because doctors would be unwilling to turn away the sick (The Independent on Sunday, 09/05/04).

There were a number of news items on health tourism that mentioned leaked reports and anecdotal evidence. On 14/05/05, the BBC reported that: 'The government has announced plans to clamp down on so-called 'health tourists'... But is it really a big problem? Health Minister John Hutton has conceded that the government does not know how many people come to the UK to get free treatment on the NHS... There have been no substantive studies into this issue. Figures from CCI legal services, a debt collection service, put the cost at anything between £50m and £200m each year. A leaked report from Newham General Hospital in East London suggested health tourists cost the trust £1m a year. However, a subsequent study has found that the true figure may be much lower.

"Over the last three months, the number of patients identified as ineligible is 17," says Ian O'Connor, its director of finance. "The cost of this treatment over that period is £32,000." With an annual budget of £100m, this figure is practically negligible. However, Mr Hutton insists that health tourism is a problem and that action is needed...Pauline Lewis, a manager at a major hospital in South London, backs up those claims. 'It's a big problem...If you speak to the overseas managers throughout this country everyone will give you horror stories...Everyone will say they are seeing numerous patients every week. In the trust I work for, we saw 1,400 patients last year.' Gill Morgan of the NHS Confederation, which represents NHS management, shares that view. 'There are pockets of places where the extra burden on the services has been quite significant' she says.

An investigation by the BBC's Real Story team also uncovered anecdotal evidence of abuse. It included secret filming of people in Nigeria who have British GPs and travel to the UK to use the NHS. However, many experts question whether the problem is as big as the government claims. Details available at: <http://news.bbc.co.uk/1/hi/health/3356255.stm>.

Another major theme in newspaper coverage was the perceived danger (to the general public) from infectious diseases brought into the country by migrants. There were a small number of newspaper reports on HIV positive migrants (usually asylum seekers) 'deliberately' or 'recklessly' infecting resident women. In these cases, it was the threat from infection *and* abuse of services (HIV services, housing etc) that was the focus of the report.

The wisdom (or otherwise) of testing/screening for HIV (and TB) was a feature of a number of reports (this was often linked to the both of the themes described above):

The government is being accused of secretly planning to screen all immigrants for infectious diseases...The probe has been commissioned by the HO and the DoH in response to concerns over rising rates of infectious diseases such as TB, hepatitis and AIDS, and fears that they are being brought to this country by immigrants. The results of the inquiry are expected this summer, but the Government has refused to consult any outside experts, including refugee groups or health experts... (The Independent, 25/05/03).

A massive influx of asylum seekers infected with HIV is overwhelming hospitals in parts of the country, according to doctors. They say the situation is at 'crisis point' and have warned that routine operations for British patients could be cancelled as a result of the drain on resources. The cost of treating foreigners carrying the virus is forcing many NHS trusts to run up huge debts.

Last week, the Commons Health Select Committee revealed that HIV cases had risen by 26% annually, with 6,600 new cases reported in 12 months. Treatment for each patient costs 11,000 pounds a year. Dr Anne Edwards, a consultant at Oxford Radcliffe NHS Trust, said the number of cases she was treating had more than trebled in two years - and more than 80 % were foreigners.... 'If you look at all the people coming here for NHS treatment who are not eligible there are likely to be important repercussions, like the fact that your granny does not get her hip replacement.' Dr Edwards said the NHS does not have enough money to treat British HIV sufferers let alone those coming in from abroad. 'The pot of money is finite. The UK is known to be soft. It is known that if you get to the UK you can present yourself for check-up and testing.'... Britain does not force immigrants to take HIV tests, unlike many other countries including the U.S. and Australia. But this could be about to change, the DoH confirmed yesterday. A spokesman said a review is under way—with a view to bringing in compulsory screening for those from 'high risk' countries (The Daily Mail, 16/06/03).

There were fewer newspaper reports on the education of migrants. Broadly, two main themes can be seen in those few articles that explored education: the difficulties of teaching children who do not speak English and/or who have suffered trauma; and a general strain on services (including costs and impact on the local population). The following reports are typical:

If you believe the government's league tables, he runs the worst school in England. But yesterday, headmaster David Gould pointed out the facts behind the figures. St Alban's Church of England School in Sparkbrook, Birmingham, has 420 pupils aged 11 to 16. A high proportion are asylum seekers and refugees. And between them they speak an astonishing 37 different languages. Only half of those at Key Stage 3...speak English as their first language,

while many arrive with no English at all. Mr Gould criticised the Key Stage 3 performance tables for failing to reflect the true nature of the school... 'We are the only school in the inner ring road of Birmingham and we are based in a multi-ethnic area,' he said. 'We have refugees, asylum seekers and economic migrants. 'The reason the school performed badly is because in that particular age of children, they have arrived from abroad speaking no English. Some have to learn English before they can be taught other lessons, which can be quite a challenge. 'Some have no education and if someone has come from abroad then they will sometimes have other problems too...' With 37 first languages, clearly we can't have a teacher for every language. The work we do at our school is very rewarding but when these league tables come out branding us the worst in the country then that is when the problems start.' (The Daily Mail, 19/12/2003).

Children of asylum seekers are placing an 'intolerable' financial burden on schools, education watchdog OFSTED said yesterday. Inspectors said schools are having to use their own budgets to support the youngsters. This means money which would be spent on books and other equipment is being diverted to ensure that children who do not speak English can cope with lessons (The Daily Mail, 22/10/2003).

There were a small number of reports on access to social housing by migrants (and many more on the accommodation of migrants more generally). Broadly, two main issues could be discerned: issues of access to social housing; and the abuse of the social housing systems and/or the housing benefit system. The latter was nearly always accompanied by reports of the costs to taxpayers:

The vast amount being made by some landlords out of Britain's asylum crisis was laid bare yesterday. One is raking in more than

two million pounds a year of taxpayers' money by providing basic rooms for immigrants. Cyprus-born Savas Stavrou, 69, has built up an empire of more than 20 guesthouses and hotels, helping cater for some of the 100,000 immigrants who entered the country last year. Under HO rules, local councils can pay him up to 350 pounds a-week for a room, whatever its condition, as long as it houses an asylum seeker (Daily Mail, 9/05/03).

Greedy asylum seekers are raking in a fortune by illegally letting out homes the government gives them for free. Not content with receiving a range of benefit handouts, they line their pockets with cash by sub-letting to other foreign workers and students. The scam makes millions of pounds a year - and costs the treasury hundreds of thousands in unpaid tax (Sunday Mirror, 17/08/03).

There were fewer articles on the use of criminal justice services by migrants, though there were several reports on the extensive use of legal aid by the foreign-born (especially during application for asylum), the abuse of the system by solicitors and, to a lesser extent, the 'criminality' of some migrants (i.e. their engagement in criminal acts). There were a small number of reports on the abuse of the criminal justice system or human rights legislation. The following story is particularly interesting in this respect:

The Lord Chief Justice yesterday criticised the 'unconscionably high' £112,000 cost to the public of a failed case brought by asylum seekers demanding better housing. Lord Woolf, the most senior judge in England and Wales, dismissed an appeal brought by Lithuanian asylum seekers which he said 'had no prospect of success'. Lord Woolf also delivered a warning to the Legal Services Commission, saying it was important that it gave 'close scrutiny' to ensure that only appropriate cases were given legal aid.

Lord Woolf, sitting with the Master of the Rolls and Lord Justice

Auld, dismissed a case brought by the Anufrijeva family, who sued the London Borough of Southwark alleging that they had been provided with inadequate housing. The family said the council's failure breached their right to a respect for private and family life under the Human Rights Act. Vladimiras and Ala Anufrijeva came to Britain with their three children and an elderly mother in 1998....The family said that they had left behind a comfortable home in Vilnius...with a garden and orchard. The family complained when Southwark council gave them a two-storey maisonette because a steep flight of stairs made it difficult for the grandmother to 'participate' in family life... Yesterday, Lord Woolf rejected the appeal...Lord Woolf added: 'The costs of both sides were unconscionably high and out of all proportion to the issues at stake...The situation is made even more worrying by the fact that all the parties are funded out of public funds.' (The Times, 17/10/2003).

There were a number of ancillary and related themes running throughout many newspaper reports in this period. One of the most frequently occurring was of a general and pervasive abuse of welfare systems. In a small number of newspaper reports (nearly always in the Daily Mail), there were quite lengthy reports of a general abuse of services (housing, health, legal aid etc.) by asylum seekers. A prominent story in the Daily Mail was of a Slovak Gypsy family who claimed asylum in the late 1990s:

While Whitehall may be abuzz with talk of 'managed migration' and 'willing workers', in the village of Zavadka, 20 miles from the Slovak border with the Ukraine, other subjects are more pressing.' When I come, how do I get free accommodation?' 47-year-old Viera asks...Like many Slovak Gypsy families, the Krajcars developed a taste for British handouts in 1998, soon after New Labour came to power. Though they are now back in Slovakia, they were among the Slovak Roma who suddenly chose to head for

Britain that year. Government immigration policy was in chaos, and it didn't take long for word to spread that Britain was an easy touch. By the summer of 1998, more than 1,000 were coming every month. 'We were influenced to go there by my aunt who was in London,' admits Viera's son, Peter, 25, who with his wife, Lenka, borrowed the money for the flight to Heathrow. 'We were told that no other country was as good with the benefits.' Those benefits began as soon as they arrived. Having told immigration officials they were claiming asylum, they were asked to take a number of routine health tests. These revealed Lenka was pregnant and Peter had a chest infection. Although he now claims not to know what his problem was, he was hospitalised for a month courtesy of the NHS. Peter and his wife were then joined by his mother and sister, and the whole family was given a rent-free council house in Tottenham...There were other benefits, too, as Lenka explains: '...I also liked that you didn't have to wait to see a doctor or a dentist, and when I had my son over there I was looked after by a woman and had a translator with me...We also used to be able to get free breakfast ...and free nappies.' The couple's son...was born in March 1999—he has a British birth certificate—but shortly after his birth the family reluctantly decided to go back to Slovakia...So the Krajcars started to make their way home. En route, they played the asylum card in Denmark...and Germany (they stayed four months...They finally arrived home early in 2000 and ever since have been waiting for the moment to slip back into the UK (The Daily Mail, 28/04/04).

Another theme linked to service use by migrants was hostility from local populations. Sometimes this was linked explicitly to local people's perceptions of preferential treatment of foreigners over the native population. In a series of reports of rioting on a Wrexham council estate, this was also linked to racism in a context of socio-economic deprivation:

Iraqi Kurd refugees have fled a council estate in Wrexham where a mob fought running battles with police in riot gear and children as young as ten threw petrol bombs...A football gang known as the Wrexham Frontline, was blamed for orchestrating Britain's worst racially motivated riots since unrest swept former mill towns in northern England two years ago...Unrest has been brewing for six months as small groups of young, single Iraqi Kurdish men have been moved into empty, hard-to-let properties Even as the bricks and bottles were being cleared away, young men spoke of how the violence was ready to 'kick off again'. Mark Stokes, 21, who claimed not to have taken part in the riots, said that the trouble would continue until the refugees had been moved off the estate. 'There is not much sympathy for them here,' he said. 'They are not wanted.' For their part, the Iraqi Kurds say that they face racial taunts and threats of violence on a daily basis. (The Times, 25/06/03).

Police appealed for calm last night after the worst racially-motivated riots in Britain in two years. Petrol bombs and bricks rained down on officers in a night of terrifying violence on a housing estate in Wrexham...Sooner or later, the tinder looked certain to be lit. Everything had been in place for months - the racial hatred and intolerance, the rumours, the resentment over so-called preferential treatment for refugees and asylum seekers. All it needed was a spark...on this gloomy estate on the outskirts of town, tension had been simmering since the end of last year after a group of Iraqi Kurds were placed there when their asylum claims were granted... perhaps the most significant victim of this latest outbreak of racially-inspired rioting was the government's widely-practised 'dispersal programme' for farming out refugees and asylum seekers to communities around the country. Or, in this case, putting groups of refugees on a close-knit council estate of

12,500 people and assuming they would be allowed to integrate. According to the local council, every one of the 30 or 40 Iraqi Kurds who were found homes on the estate had legally been granted asylum-in this country after their claims were checked and processed. And it said all of them had found jobs and were not claiming state benefits... Caia Park estate is a short drive from the centre of Wrexham and in sight of the town's police headquarters. It is a huge sprawl of mostly barrack-like council houses, stretched along streets whose proud names may no longer reflect the spirit in which they were chosen...Caia Park..has two of the most deprived wards in the country and 16% of its residents are out of work...Caia Park once boasted good community spirit and no serious racial clashes. But yesterday the largest council estate in Wales woke to the aftermath of its second night of violence and to preparations to safeguard against a third...Council officials offered alternative accommodation yesterday to those who did not wish to spend the night on the estate...James Aylwyd, chairman of a local asylum seekers and refugee support group, said: 'There's a cultural gulf which has led to fear and misunderstanding. 'It was a mistake by Wrexham Borough Council putting refugees in "hard-to-let" properties. In such deprived areas they will deal with their difficulties in certain ways which can lead to violence. 'Clearly the housing situation is not working and an improved policy needs to be brought in quickly' (The Daily Mail, 25/06/03).

The Tory Party was at the centre of a race controversy yesterday after a senior aide urged immigrants to lead a campaign to curb asylum seekers. Conservative adviser Laurence Wedderburn said Blacks and Asians had most to lose from the rising number of refugees because many would live on their doorstep, putting pressure on local schools and hospitals. They had a duty to speak out because they could not be accused of racism...'School and

hospital provision in some poor, ethnic areas in London is already substandard,' said Mr Wedderburn...'If more asylum seekers are allowed in, it will get worse' (The Mail on Sunday, 17/08/04).

It should also be noted that, while many newspaper reports focused on the abuse of welfare systems, some newspapers did attempt to tackle the growing problem of the destitution of migrants caused by their inability to work and their dependency on meagre welfare benefits:

A judge threw David Blunkett's asylum policies into disarray yesterday by ruling that it is illegal to leave claimants to beg on the streets. The Home Secretary has been trying to strip benefits from asylum seekers who fail to apply to stay in the UK as soon as they arrive here. Mr Justice Kay said the policy was legal but only if the people denied support were not left on the streets - as some had been. (The Daily Mail, 1/08/03).