Health inequalities and diversity in Suffolk

The majority of sex workers (or prostitutes) are vulnerable individuals particularly those working on the streets. There is debate as to whether adult sex workers have choice and are consenting adult. However, the murder of a young woman in a park in 2007 might suggest that this might not be the case.

A family carer can be defined as a person who provides unpaid care whether for an elderly relative, a spouse, a child with special educational needs or a parent. The term ‘unpaid care’ covers any unpaid help, looking after or supporting family members, friends, neighbours, or others because of long-term physical, psychological or social needs.

The prison population includes some of the most vulnerable members of our society. Although prisoners have a similar range of health needs to those found in the general population, they have a higher burden of disease and often have poorer access to healthcare and social care services when they are released.

A person’s ethnicity is a complex mix of their country of origin, race, culture, language and religion. The most widely used ethnic groupings are those used in the 2001 Census. In the census individuals are asked to choose which group best describes how they see themselves.
Introduction

Some groups in our Suffolk communities suffer relatively poor health - a fact that has been shown in several previous public health reports - with a growing lifespan difference between wards of about 12 years. These inequalities are largely the result of differences in income, gender, geography, ethnicity and life circumstances.

In this year’s annual public health report, we have looked at the needs of some often overlooked communities where poorer health is more likely. Covered in the report are the needs of prisoners, sex workers, carers, black and ethnic minority communities, including gypsies and travellers, migrant workers, asylum seekers and refugees.

None of these groups share any obvious common characteristics. However, relatively little is known about their health needs. This report is not comprehensive, but it will help to inform future plans for these groups. There are several other groups which merit attention but are not included. We hope to consider these in future years.

I hope you find the report informative and that it complements the main profile of Suffolk - the Joint Strategic Needs Assessment available on www.nhs suffolk.nhs.uk.

If you have any feedback or comments, please send them to: peter.bradley@suffolkpct.nhs.uk

Progress on recommendations from last year

In last year’s report we considered the health of children and young people in Suffolk. The major issues raised were the importance of making progress to:
• Improve vaccination rates for measles, mumps and rubella.
• Prevent unhealthy lifestyles in childhood, particularly childhood obesity, risky sexual behaviour and inappropriate alcohol consumption.
• Promote healthy lifestyles in school.
• Prevent accidents.
• Improve the health, educational and social status of homeless children and children who are carers.

We have made progress on plans for future services, but we want to do even more to tackle some of the issues raised e.g. tackling childhood obesity or child homelessness. Nonetheless, there is now a greater awareness of the importance of these topics, and it is anticipated that there will be major investment for these areas in 2009/10 through the commissioning cycles of the primary care trusts in Suffolk, Suffolk County Council and the Children’s Trust.

The other recommendations from last year’s report concerned the quality of data. Major progress was made with the publication of the Joint Strategic Needs Assessment for Suffolk in 2007. It offers core data for service commissioners and brings together data from several sectors for the first time for many years. Building on this development, both NHS Suffolk and Suffolk County Council have appointed officers with a specific remit for promoting data quality in commissioning decisions.

Dr. Peter Bradley,
Director of Public Health
Suffolk County Council and NHS Suffolk.
The main issues all groups had in common were:

• Users sometimes had limited knowledge of their rights to services or how to access them appropriately.

• For some, language and communication poses difficulties when English is not spoken as a first language. Absent or inadequate interpreting services can compound the problem.

• Incomplete data collection by the health sector e.g. for ethnicity, means that the specific health needs of each community group cannot easily be assessed.

• Limited joint working between the health sector and community or advocacy groups means there are fewer chances to reach out to specific communities.

• The perception of some communities is that staff have a limited awareness of important cultural issues.

• Specific health issues are seen within some groups, which significantly contribute to health inequalities in Suffolk.
Health of prisoners in Suffolk

The prison population includes some of the most vulnerable members of our society. Prisoners experience worse physical and mental health than the general population and often have poorer access to health and social care services when back in the community.

They also have high levels of health risk behaviours such as drug abuse, alcohol abuse and smoking, which increases their chances of poor health in the future.

There are five prisons in Suffolk with 2,280 prisoners at any one time, and the turnover of prisoners during the year means that, in a 12 month period, nearer 5,000 individuals come into contact with prison health services. The health needs in the five prisons vary; the average age of prisoners is younger than the general population and there are higher proportions of prisoners from black and ethnic minority groups. Warren Hill prison holds 222 juveniles aged 15-17 and their needs are very different from the older men in the other prisons.

Up to four in five prisoners smoke and over half have had a hazardous drink problem during the year prior to prison. Mental health problems are common and estimates suggest that around 10% of teenage prisoners are likely to attempt suicide. In Warren Hill, 7% of inmates have been known to harm themselves over the past three years. Although less common in adult male prisoners, suicide attempts are still 10-20 times higher than in the community.

NHS Suffolk is responsible for ensuring prisoners receive the same standards of health care as those in the general population. Prisoners in Suffolk can access a wide range of services either in the prisons or, when necessary, at local hospitals where they are escorted by prison guards.

What should be done to improve the health of prisoners in Suffolk?

NHS Suffolk and the Prisons should:
1. Continue working together to improve the health of prisoners and take account of the findings of the recent external health needs assessment.
2. Take the opportunity of recent changes in the partnership structure to set service objectives for health care, including core objectives, pathways of care and routine data collection.
3. Increase the focus on health improvement and health protection work, and ensure a health improvement facilitator is appointed to work across the five Suffolk prisons.
4. Review and monitor mental health services and sexual health services in all prisons.
5. Ensure that prisoners have the opportunity to improve their health and understanding of health issues. This should maximise their opportunity, once released, to improve their health and access appropriate health services.
Street sex workers

The majority of sex workers (or prostitutes) are vulnerable individuals, particularly those working on the streets. Studies have shown that they are unable to access mainstream health care including primary care, despite having multiple health needs. Health problems relating to drug and alcohol abuse, untreated mental health problems, sexually transmitted infections, physical injury from violence (including domestic violence) and dental neglect have all been specifically identified as risks.

The tragic murders of five street sex workers late in 2006 prompted a commitment to joint work across agencies in Suffolk and the production of the Ipswich Prostitution Strategy 2007-12. It presented an opportunity to improve access to health care for sex workers, improve their chance of completing successful treatment for drug abuse and enable them to pursue a healthier lifestyle. The potential risks of displacement and greater vulnerability for the workers was recognised and monitored.

A multi-agency team was funded to work with the street sex workers. Currently they are in contact with 31 women, three of whom have been referred to the project as a preventative measure to ensure they do not begin working on the streets. The support of the team has meant the women have accessed services. Health issues are resolved as they occur; 15 women are actively engaged with drug and alcohol services, one being in residential rehabilitation, and dental services are responding appropriately to the women’s needs. Currently 14 children who are considered at risk are being supported through the preventative work. In addition to improved access to health care, and a healthier lifestyle due to improved housing, benefits and other support, there has also been a dramatic decrease in the number of street workers. In 2006 there were regularly 30 sex workers on the streets of Ipswich and currently there are only one or two.

The strategy has shown how committed multi agency work can really benefit vulnerable groups in our society.

What should be done to improve the health of street sex workers in Suffolk?

6. Agencies should continue to contribute and carefully evaluate the impact of the Prostitution Strategy on the health of street sex workers and see if this model can be used to improve the health of other groups.
A family carer can be defined as a person who provides unpaid care, whether for an elderly relative, a spouse, a child with additional needs or a parent. In 2000, one in six people over 16 was a family carer and one in five households contained a family carer. If carers were to be publicly funded in Suffolk, the potential cost to the authorities would be about £39m per year.

Over a third of family carers reported that caring made them worried, depressed or tired. The majority of family carers were not taking medication or receiving any therapy for mental health problems and those that were, were more likely to be those with the worst mental health problems. Only 13% of family carers had consulted a GP about mental health problems in the last year, but nearly three quarters had consulted a GP about their physical health.

Young carers are defined as carers under the age of 18. The average age of a young carer is about 12. Some 27% of young carers at secondary school and 13% of those at primary school are experiencing educational problems. Of those who care for someone who misuses drugs or alcohol, 40% have educational difficulties. Only 18% of young family carers have been formally assessed and 20% receive no other support except for their contact with a specialist young family carers project. It is likely that young family carers, as with older family carers, are at risk of physical and mental health problems.

What should be done to improve the health of carers in Suffolk?

NHS Suffolk and Suffolk County Council should:

7. Work together with the voluntary sector to create a multi-agency response for family carers in Suffolk, with lead officers in each statutory agency. Carers should be integral to service planning and development.

8. Encourage primary care services to identify carers and offer them referral to social services for assessment.

9. Develop specific policies to maintain the employment and training rights for their own workforce who have caring responsibilities.

10. Agree a common policy which offers quality respite care to family carers in Suffolk. There should be on-going commitment to assessing the needs of carers, especially around mental health issues and young family carers.
Suffolk has diverse and growing minority ethnic communities. There is no useful routinely collected data that can be used to describe the health experience of people from different ethnic groups in Suffolk. However the national picture indicates that some specific ethnic groups are at increased risk of particular health problems.

Ethnicity and health

Language problems were cited as a major barrier in accessing services for some communities. Reports were given of use of family members and even children as interpreters. In addition, it was difficult for anyone without good English skills to make a complaint.

Some representatives of minority ethnic communities perceive NHS Suffolk as being uninterested in the problems they may face, and that some staff are unaware of important cultural issues.

What should be done to improve the health of minority ethnic communities in Suffolk?

NHS Suffolk and Suffolk County Council should:
11. Ensure that contracts with service providers guarantee that data on ethnicity is systematically recorded so that health needs are known for each ethnic group. This recommendation also applies to other groups such as gypsies and travellers.
12. Draw up best practice guidelines for interpreting services with community representatives and clinicians. This recommendation also applies to other groups such as gypsies and travellers.
13. Ensure there are adequate mechanisms for those with limited English language skills to make their grievances known or to complain about services. Consideration should be given to those with limited literacy in their first language. This recommendation also applies to other groups such as migrant workers and asylum seekers.
14. Specifically train staff in awareness of important cultural issues for the diverse communities of Suffolk. This recommendation also applies to other groups such as gypsies and travellers, migrant workers, and asylum seekers.
15. NHS Suffolk should build on its membership of the Race for Health programme to explore the best ways to inform diverse groups about health messages and services. One element of this will be building on existing relationships with local and national community groups. Another would be to develop specific posts for health trainers to work with each community. This recommendation also applies to other groups such as migrant workers and asylum seekers.
Asylum seekers and refugees flee from terrible situations in their home country, leaving behind everything they own, including their family and their identity. They seek sanctuary in Suffolk and are well served by voluntary and statutory agencies. The main health issues are: being able to address specialist mental health needs that GPs do not have the time and resources to manage; and the severe risks to mental and physical health caused by destitution.

Migrant workers choose to come to the UK to find work and are employed in a wide variety of sectors beyond the traditional seasonal agricultural work, though often in low paid work. Employment issues that impact upon health are a major concern.

Migrant workers are very mobile, moving to take up employment as and where it arises, and this makes it difficult to assess numbers and needs, and to provide continuity of care.

Some 20% of asylum seekers have health problems that make daily life difficult. Between 5% and 30% of asylum seekers and refugees have been tortured, sometimes including rape and sexual violence. The rate of sexually transmitted infection, including HIV, is high in some groups. A quarter of refugee children in one study were identified as having significant psychological disturbances.

Barriers to accessing specialist support include interpreting needs, service providers’ lack of cultural awareness and knowledge of asylum issues, lack of family/community networks and support, and destitution.

However, migrant workers generally are young and healthy, but whether registered with a GP or not, they tend to access health services which respond quickly to their needs e.g. walk in centres, A&E, sexual health and maternity services, rather than accessing primary care services. This is a relatively costly way for the health service to provide care.

What should be done to improve the health of asylum seekers, refugees and migrant workers in Suffolk?

NHS Suffolk should:

16. Further develop services to meet primary care mental health needs. This should include access to psychological therapies.

17. Work in partnership across the region with the Medical Foundation for Care of Victims of Torture, to help local services respond to specialist mental health needs (e.g. Post Traumatic Stress Disorder, effects of war and torture). The role of link workers should be developed.

18. Ensure appropriate access to sexual health services. Outreach sexual health services are probably necessary. The prevalence of HIV, particularly amongst some asylum seekers from West Africa, is a particular issue.

19. Work, along with the County Council, to provide occupational health services with training and information to help them address employment and health issues, and disseminate health information e.g. rights to healthcare and GP registration.
Gypsies’ & travellers’ health

Gypsies and travellers are one of the largest ethnic groups in the East of England. They are a diverse group, some with their own language and culture. Many still travel as an inherited way of life, while some live in permanent accommodation. Gypsies and travellers experience some of the worst health in the population. The main health problems relate to poor access to healthcare and difficult conditions encountered whilst travelling.

On average, gypsy and traveller infants are 2-3 times more likely to die than infants in the general population. Twice as many gypsies and travellers report anxiety or depression compared to the general population. Up to 16% are not registered with a GP, and immunisation rates are low. Barriers to healthcare access include low levels of literacy and fear of racism.

More information is needed on the health and healthcare needs of gypsies and travellers in Suffolk and their perception of the healthcare they receive.

What should be done to improve the health of gypsies and travellers in Suffolk?

NHS Suffolk and Suffolk County Council should:
20. Ensure that gypsy and traveller ethnicity is recorded as part of routine data monitoring.
21. Support the work of the Gypsy and Traveller Steering Group for Suffolk, the countywide strategy and action plan. Specific health outcomes for this group should be developed, and consideration should be given to employing more specific link workers to work with this community.
22. NHS Suffolk should carry out a health needs assessment for the gypsy and traveller population, covering areas such as barriers to accessing care, infant mortality, immunisation and smoking.
<table>
<thead>
<tr>
<th>Community/group</th>
<th>Major health concern(s)</th>
<th>Specific issues in service planning</th>
<th>Areas for specific action</th>
<th>Areas where more information is needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prisoners</td>
<td>Sexual health, mental health, substance misuse, smoking, access to hospital services.</td>
<td>Needs vary between types of prisons and between juvenile and adult offenders.</td>
<td>Implement recommendations from recent external needs assessment. Commissioned should set objectives for health care and monitor these. Increase focus on health improvement and health protection work.</td>
<td>Mental health needs and the form services should take to meet those needs.</td>
</tr>
<tr>
<td>Sex workers</td>
<td>Sexual health, substance misuse, access to services.</td>
<td>Multi-agency response needed so that sex workers engage with appropriate services.</td>
<td>Continue to support the multi-agency strategy and recognise that the problem requires long-term action.</td>
<td>Continued monitoring of the strategy and the work of the multi-agency team.</td>
</tr>
<tr>
<td>Carers</td>
<td>Mental health, emotional and behaviour problems in young carers.</td>
<td>Needs vary greatly according to the burden of responsibility. The needs of young carers differ to those of older carers.</td>
<td>Support local multi-agency strategy as needs of carers are currently being overlooked, especially mental health issues.</td>
<td>The needs of young carers.</td>
</tr>
<tr>
<td>Afro-Caribbean</td>
<td>Stroke, HIV, mental health.</td>
<td>Very little local data about this community.</td>
<td>Partners to improve communication by liaising with community groups and focusing on prevention of common conditions through health trainers.</td>
<td>Methods to engage with the community so that they can access services, especially to prevent ill health.</td>
</tr>
<tr>
<td>South Asian</td>
<td>Coronary heart disease, diabetes, access to services.</td>
<td>Translation/interpreting services are viewed as essential for some groups.</td>
<td>Partners to improve communication by liaising with community groups and implementing new policy for interpreting. Need to focus on prevention of common conditions through health trainers.</td>
<td>Methods to engage with the community so that they can access services, especially to prevent ill health.</td>
</tr>
<tr>
<td>Migrant workers</td>
<td>Sexual health, use of services, difficulty registering with a GP.</td>
<td>Poor knowledge of rights to primary care services leads to inappropriate and costly use of emergency services.</td>
<td>Health sector to co-ordinate with occupational health departments, so rights to health services explained to migrant workers.</td>
<td>Mapping of constantly changing health needs in the community.</td>
</tr>
<tr>
<td>Asylum seekers and refugees</td>
<td>Mental health, sexual health (including HIV) and maternity services, smoking and health needs of children.</td>
<td>Health needs are considerable. Community is diverse and translation/interpreting services are essential.</td>
<td>Develop the role of link workers in both adult and children's services. Improve access to psychological therapies. Provide outreach sexual health services.</td>
<td>Health needs of those securing refugee status and of children (whether unaccompanied or with families).</td>
</tr>
<tr>
<td>Gypsies and travellers</td>
<td>Notably poor health outcomes. Infant mortality, smoking, immunisation rates, and difficulty registering with a GP.</td>
<td>Community is diverse and constantly changing. Action on accommodation is a key to better health.</td>
<td>Partners to improve communication by liaising with community groups and develop the role of link workers.</td>
<td>Reasons for poor health outcomes require a full health needs assessment.</td>
</tr>
</tbody>
</table>
Although most of the prisoners in Suffolk’s five prisons do not originate from Suffolk, while they live in Suffolk prisons their health care needs are the responsibility of the primary care trusts. NHS Suffolk has responsibility for prisoners in HMP Highpoint and HMP Edmunds Hill (situated approximately 13 miles from Bury St Edmunds) together with HMP Hollesley Bay and Warren Hill Young Offenders Institute (situated two miles from the East coast near Woodbridge); NHS Great Yarmouth and Waveney has responsibility for the health needs of prisoners in HMP Blundeston near Lowestoft.

Prison health care services should provide prisoners with access to the same quality and range of services as the general population. The primary purposes of putting someone in prison - custody and rehabilitation - place constraints on those providing health care. These are further complicated by rapid turnover in the prison population. However prison placement also represents an opportunity for those with high levels of health need to access health care, especially disease prevention and health promotion programmes, so that they can improve their health and wellbeing.

What type of prisons are in Suffolk?

The five prisons in Suffolk are different in nature and size, and have seen major changes over the past decade.

Highpoint is the largest prison, and has capacity for 816 male adult prisoners which will increase to 936 in September 2008. This compares with a capacity of 592 in 2000. It is a category C training prison which accepts men with sentences up to and including life.

Edmunds Hill is a category C resettlement prison with capacity for 371 men and usually accepts prisoners who have one year or less of their sentence to serve. This prison was a female prison with 218 places in 2000.

Hollesley Bay is a category D open prison for 345 adult males and provides resettlement and work for prisoners reaching the end of their sentences. In 2000 the open facilities were for 190 men and young offenders and were linked with a closed unit for 190 juveniles (aged 15 to 17). The juvenile establishment, whilst still on the same site, is now a separate prison called Warren Hill with capacity for 222 juveniles. The juvenile prisoners at Warren Hill are called trainees.

Blundeston prison is a category C training prison with capacity for 526 men. In 2000 it had capacity for 424 men.

Who are the prisoners?

There are up to 2,280 prisoners in Suffolk at any one time, but turnover of prisoners during the year means that, in a 12 month period, nearer 5,000 individuals pass through the prisons.
Between 20-30% of the offender population have some learning difficulties or disabilities and research into the background of adult prisoners has found a substantial proportion have experienced disadvantage and traumatic events in childhood, with 28% having experienced local authority care, 35% spending time in an institution, 25% experiencing violence at home and 47% experiencing death of a close friend or relative. Similarly two thirds of young offenders come from backgrounds where family structures have broken down, a third have significant problems with education or work, and three quarters have a history of temporary or permanent school exclusions.

What are their health problems?

Smoking, drugs and alcohol

Levels of substance misuse and smoking are higher in prisoners than the general population. Studies show that three quarters of prisoners had a hazardous or severe alcohol problem during the year prior to going to prison and up to half had some sort of drug dependence. Recent data for smoking is not available, but in 2000 the number of smokers ranged from 56% to 88% of the prison population as shown in Table 1, compared to 20% of males smoking in the community at the time. Warren Hill has been smoke free since April 2007 and trainees are given smoking cessation support on entry and have to stop smoking whilst there.

Physical health

Physical illness, particularly long term conditions, are less common in a younger population such as that found in Suffolk prisons. However, when compared to those of similar age in the community, research suggests that the level of illness is often higher in prisoners. The recent needs assessment in Suffolk prisons found that the level of many physical illnesses recorded in the medical records was lower than that expected using estimates based on research. For instance the percentage of prisoners with asthma would be expected to be around 12% for adults and 19% for the younger trainees. Although 17% of medical or drug records in Warren Hill indicated asthma, which is as expected, in the other prisons the recorded rates were much lower, between 4% and 7%.

Table 1: Percentage of prisoners in Suffolk with smoking, drug or alcohol problems

<table>
<thead>
<tr>
<th></th>
<th>Highpoint</th>
<th>Edmunds Hill*</th>
<th>Hollesley Bay</th>
<th>Warren Hill</th>
<th>Blundeston</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current smokers in 2000</td>
<td>81%</td>
<td>81%</td>
<td>56%</td>
<td>88%</td>
<td>74%</td>
</tr>
<tr>
<td>Hazardous alcohol problem in year prior to prison (est.)</td>
<td>62%</td>
<td>62%</td>
<td>68%</td>
<td>72%</td>
<td>62%</td>
</tr>
<tr>
<td>Severe alcohol problem in year prior to prison (est.)</td>
<td>4%</td>
<td>4%</td>
<td>2%</td>
<td>5%</td>
<td>4%</td>
</tr>
<tr>
<td>Any drug dependency in year prior to prison (est.)</td>
<td>43%</td>
<td>43%</td>
<td>26%*</td>
<td>53%</td>
<td>43%</td>
</tr>
</tbody>
</table>

* Female prison in 2000  ^ Lower due to open nature of prison and selection of prisoners for this environment.

(Data: Suffolk Observatory, Emma Raworth (NHS Gt. Yarmouth & Waveney) and ref 3)

Fig 1: Breakdown of the prison populations by age compared to Suffolk

Fig 2: Breakdown of the prison populations by broad ethnic group compared to Suffolk
Quite apart from this, national research indicates that dental health is a particular issue in prisoners where 87% of male prisoners expected to have some decayed teeth, with an average of 15.4 decayed or missing teeth each. The need for dental services would therefore be higher than in the general population.

The risk of blood borne virus infection, such as Hepatitis A & B and HIV, is higher in prisoners than the general population, with studies suggesting that around one in 10 have been exposed to infection, mainly due to intravenous drug use. In our local health needs assessment, the recorded levels of Hepatitis B & C in the medical notes were much lower than expected based on national estimates. In addition, the laboratory tests recorded at the West Suffolk and Ipswich hospitals suggested lower positive rates than expected in Edmunds Hill and Hollesley Bay, but reached expected positive levels when testing prisoners at Highpoint and Blundeston. Warren Hill also had a low level of positive tests which might be expected in this younger age group.

Mental health problems

Mental health problems are more common in prisoners. Some problems are risk factors for, or associated with criminal behaviour - such as personality disorders, psychosis and substance misuse, while others, such as neurotic disorders and self harm, are associated with increased likelihood of imprisonment. Although this is generally acknowledged, many prisoners in the UK still have unrecognised mental health problems and therefore do not access the treatment they need.

National estimates suggest about three quarters of prisoners in Edmunds Hill, Highpoint, Blundeston and Warren Hill would be expected to have some sort of personality disorder, although in open prisons such as Hollesley Bay, this would be nearer half. Around 40% of prisoners are likely to have experienced symptoms of a neurotic disorder (including depression) in the past week. Within Warren Hill, 10% of the teenage boys are likely to self harm and 10% are likely to have attempted suicide during the past year. Prisoners record self-harm incidents when they are aware of them, and over the past three years 7% of Warren Hill trainees have been known to harm themselves. Self harm and suicide attempts are less common in adult male prisons - involving 3% and 5% of the prison population, but is still around 10-20 times higher than the general population.

What services are provided to Suffolk prisoners?

All Suffolk prisons have a health care facility which includes a small core team, complemented by a number of visiting specialist providers offering services within the prison. When necessary, prisoners can access acute medical and surgical care in local hospitals, with appropriate prison officer escort.

Prisoners are first seen at reception (when entering the prison) and their health status and needs are assessed.

Primary care

The health care centres are nurse led with doctors visiting regularly on weekdays. Highpoint, and to a lesser extent, Edmunds Hill have had long-standing problems recruiting and retaining staff. A new contract for primary care medical services has recently been awarded and that will hopefully improve the consistency of medical cover. Recruitment of nursing staff in these two prisons has also improved recently, but there are still vacancies that are being covered by locum staff. The recent health needs assessment commented upon the high level of enthusiasm and commitment shown by many of the health care staff working in the prisons.

Prisoners have high doctor consultation rates compared to the general population, and Table 2 below shows that these differ between prisons in Suffolk (information is not available for Warren Hill or Blundeston prisons). It is not possible to say whether this is due to differences in health needs or other factors. Staffing levels are different between prisons but are unlikely to account for the differences in attendance, as services often respond to the treatment of medical problems as they occur, rather than appointments aimed to proactively promote healthy
Currently the prisons have an open access period for prisoners to access a nurse for provision of paracetamol and other over the counter medications that those in the community can buy e.g. at a supermarket or newsagent.

The health care needs assessment found that access to primary care medical and nursing services was good and was backed up by a mix of specialist clinics. However, the level of information recorded was poor and not comparable to that in general practice in the community. Facilities at Warren Hill were noted to be poor and care was poorer than in other prisons. One area of good practice was ‘discharge clinics’ in Hollesley Bay which aimed to help prisoners engage with health services in the community. However, it is not known how many discharged prisoners are now registered with a GP in the community.

In terms of broader health improvement, the picture is variable. The health care needs assessment found that services to treat those with blood borne viruses were good, but that the recording of clinical information was not. Smoking cessation services are available to support prisoners in all five Suffolk prisons but other than in Warren Hill, makes it difficult to assess the progress of these plans.

There are no specific services for those with learning disabilities. Despite a higher prevalence of those with learning disabilities in the prison population, there is limited recognition of the specific problems these people have and there is little joint work with health care around this issue.

Mental health and substance misuse services

All five Suffolk prisons have specific mental health services with a combination of primary mental health care services and in-reach specialist services. The needs are different for the prisons - for instance Warren Hill requires Child and Adolescent Mental Health services and Hollesley Bay prisoners have a relatively low use of services, which would be expected as those with mental health problems are less likely to be transferred to an open prison.

It is not clear whether the different levels and configurations of services within the adult prisons are totally appropriate, as they are partly the result of historical decisions rather than a response to health need. Detailed information about workload is not currently available from all the prisons, which makes it difficult to plan services for the future. Each prison has a mental health improvement plan, i.e. preventing mental health problems amongst prisoners before they occur, by meeting nationally agreed standards, but lack of routinely recorded information

made with fresh ingredients, sandwiches and salad available at lunch time with a better quality evening meal; however it is still not possible for trainees to eat five portions of fruit and vegetables a day unless they buy them.

Work done by the Public Health department and a dietician in Warren Hill during 2006 found that the boys’ diet was poor and they have very limited access to fresh fruit and vegetables. Joint work with the prison led to substantial improvements in diet within the budget, providing soup

<p>| Table 2: Primary care attendances per person 2007 |</p>
<table>
<thead>
<tr>
<th>Prison</th>
<th>General Practitioner</th>
<th>Nurse</th>
<th>Dental service</th>
<th>Optician</th>
</tr>
</thead>
<tbody>
<tr>
<td>Edmunds Hill</td>
<td>6.7</td>
<td>7.4</td>
<td>1.7</td>
<td>0.5</td>
</tr>
<tr>
<td>Highpoint</td>
<td>6.4</td>
<td>6.6</td>
<td>0.8</td>
<td>0.4</td>
</tr>
<tr>
<td>Hollesley Bay</td>
<td>3.9</td>
<td>20.0</td>
<td>5.2</td>
<td>0.4</td>
</tr>
</tbody>
</table>

<p>| Table 3: Primary care attendances per new reception 2007 |</p>
<table>
<thead>
<tr>
<th>Prison</th>
<th>General Practitioner</th>
<th>Nurse</th>
<th>Dental service</th>
<th>Optician</th>
</tr>
</thead>
<tbody>
<tr>
<td>Edmunds Hill</td>
<td>1.8</td>
<td>2.0</td>
<td>0.5</td>
<td>0.1</td>
</tr>
<tr>
<td>Highpoint</td>
<td>4.0</td>
<td>4.1</td>
<td>0.5</td>
<td>0.2</td>
</tr>
<tr>
<td>Hollesley Bay</td>
<td>1.3</td>
<td>6.6</td>
<td>1.7</td>
<td>0.1</td>
</tr>
</tbody>
</table>
Sexual health services

Prisoners tend to have more sexual partners and are therefore at greater risk of sexually transmitted infection. Improving sexual health in prisoners is consequently a key priority. Chlamydia screening in Warren Hill and Hollesley Bay have shown 12% of those tested aged between 16 and 24 have the infection, which is higher than the Suffolk average of 9.2%.

Specialist sexual health services are available within the prison in Hollesley Bay, Warren Hill and Blundeston, but currently there are none provided in Highpoint or Edmunds Hill, where prisoners have to travel to the West Suffolk Hospital. NHS Suffolk has recently tendered for sexual health services, and a service should be available to all prisons in the near future.

The provision of free condoms to prisoners, which they can obtain without asking, has been advocated by the Prison Reform Trust for some years in order to reduce HIV and other sexually transmitted infections. The prisons in Suffolk do not have condom policies and do not offer condoms to prisoners except on leaving or, in the case of Hollesley Bay, on weekend leave.

Hospital care

Although some prisons have in-patient facilities within the prison, this is not the case in Suffolk prisons. Prisoners requiring 24 hour health care and monitoring need to be transferred to one of the prisons within the region that have health care beds, although this is rare - in 2007, 13 prisoners were transferred from Highpoint and there has only been one transfer for this reason from Hollesley Bay in two years.

If a prisoner needs NHS hospital care he is escorted by prison officers and, if admitted, is kept under bed watch arrangements by officers. As an open prison, these arrangements do not apply to Hollesley Bay. In an emergency, prisons call 999 for an ambulance.

The information in the table shows that Warren Hill trainees have lower levels of contact with acute hospitals which would be expected with their younger age group. Highpoint prisoners have higher rates of admission and A&E attendance, and information over the past five years shows that these have been consistently higher than the general population.

Nonetheless, the rates have gradually decreased from over 120 admissions per 1000 prison population to the current 71.2 admissions per 1000 population. The most likely explanations are that the current admission policy excludes some prisoners with specific health problems because of lack of facilities. Consistency of medical and nursing care may also differ between the prisons, especially where there are staff vacancies and temporary staff are used.

What do prisoners think of the care they are offered?

In 2000, focus groups and questionnaires were used in all prisons to gain an understanding of prisoner views about health and health care. The information available is limited. However, findings were similar across all prisons and recurrent themes were; concern about unhealthy diets, lack of exercise, long waiting times for specialist services and...
lack of over the counter medication. Although the recent needs assessment in 2008 did not include prisoner views, it did highlight poor prisoner diet and the lack of access to over the counter medication, indicating that most issues are still current. There has, however, been increased funding for health care services, both for services in the prisons and hospitals, which hopefully has improved waiting times. A further recent improvement has been that prisoners now have access to the Patient Advice and Liaison Service (PALS) and complaints service should they have concerns related to their healthcare. NHS Suffolk will be specifically monitoring problems raised by prisoners through the Prison Health Partnership Group.

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Lyndon House, Ipswich

Lyndon House is a resettlement centre for homeless men in the Ipswich area run by the Salvation Army. It is open to all men aged 18 years and over of any background, race or faith. It is open to homeless men 24 hours a day, seven days a week.

Peter Green, Manager of Lyndon House said: “Lyndon House’s main objective is to help residents get from Lyndon House to their own accommodation.”

It houses up to 39 men at any one time, providing single rooms, along with breakfast, lunch and supper.

The residents’ needs are assessed on arrival and appropriate help is offered. This may include teaching life skills, such as budgeting, help with reading and writing or tenancy agreements. Lyndon House works closely with the drug and alcohol services in the area to help any resident who might need such support. It also works closely with other agencies including the local council, probation service and mental health charities.

When residents do reach the goal of having their own accommodation, Lyndon House continues to provide support through its project workers. Ex-residents are always welcome to come back and visit.

Lyndon House wants to provide other services for its residents. This includes getting the Credit Union involved to help residents with rent deposits and bank accounts in preparation for independent living.
Information was gathered from a sample of 44 prostitutes working the Ipswich streets at the time of the murders. All admitted to using Class A drugs with 52% using heroin, 39% crack or cocaine and 23% were multi users. Some 93% were of white European origin with a wide age range, although under age sex workers and human trafficking was not identified as a problem locally. The age profile and length of time working on the streets is shown below.

Studies have shown serious concerns about sex workers being unable to access mainstream health care despite having multiple health needs. Health problems related to drug and alcohol abuse, untreated mental health problems, sexually transmitted infections, physical injury from violence, including domestic violence, and dental neglect have all been specifically identified as risks, but sex workers are much less likely to access health services including primary care services.

Although prostitution is legal, many of the activities associated with it are not. Communities are likely to view the police as primarily responsible for addressing prostitution issues.

As part of the response to the Ipswich murders, a multi-agency strategy was agreed which focused on five key areas. These were: identifying the problem; developing routes out; tackling demand; prevention; and ensuring the community was kept informed. It presented an opportunity to improve access to healthcare for sex workers and improve their chances of successful drug treatment and a healthier lifestyle.

The potential risks of displacement and greater vulnerability for the workers was recognised. Therefore it was agreed to monitor closely the effects of the strategy and also have an external assessment by the University of East Anglia.

A multi-agency team was funded to work with the street sex workers and currently they are in contact with 31 women, three of whom have been referred to the project as a preventative measure, to ensure they do not begin working on the streets. The support of the team has meant the women have been able to access health and housing services. Health issues are resolved as they occur. At the time of writing, 15 women are actively engaged with drug and alcohol services, one of whom is in residential rehabilitation. The women have also been treated for dental problems. Housing problems are however still a major issue. Although the team have found housing for some, they still struggle to find it for others.

As well as this, the police have discouraged kerb crawlers, and by June 2008, 137 kerb crawlers had been arrested, six of whom went to court and only two of whom returned to the area.
There were 40 fixed penalty notices for contravention of traffic regulations issued.

A new protocol entitled “Children abused through sexual exploitation” has been agreed and training has started across the county. Currently 14 children who are considered at risk are being supported through the preventative work.

The strategy has shown how multi-agency work can really benefit vulnerable groups in our society. In 2006 there were regularly 30 sex workers on the streets of Ipswich and currently there are only one or two. Street prostitution had a significant impact on residents and businesses within the area, decreasing their perception of their own safety. The community response to the strategy has been supportive. However sex workers continue to need support from the multi-agency team and the prevention work will be required long term. The evaluation of the first year of the strategy by the University of East Anglia will be a valuable opportunity to review the strategy and focus work for the next few years.

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What do family carers need and want?

Family carers cannot be forced to care, but it is often assumed that they will. The impact of becoming a family carer on an individual can be rewarding, but often consists of demanding multiple roles, which may lead to psychological stress, isolation, physical fatigue, and limited employment and training opportunities.

It is certain that the needs of family carers will increase in the next few years. This is partly because of the increasing number of family carers, and the increased complexity of care for individuals being managed at home. However there is also an increasing recognition that family carers have a right to pursue their own careers and lifestyle choices. Some family carers may also now be caring for more than one generation. These issues conflict with their ability to provide care and support to other family members.

Carers UK estimate that family carers save the UK Government £87 billion per year based on the average number of hours spent caring and how much this would cost to replace (at £14.50 per hour). Using the same calculation for Suffolk would give us a potential cost of £306,000 was allocated to Suffolk in October 2007 for emergency respite care) and creating an Expert Carers Programme. Family carers have also been explicitly included in national health and social plans.

Who are family carers?

A family carer can be defined as a person who provides unpaid care whether for an elderly relative, a spouse, a child with additional needs or a parent. The term 'unpaid care' covers any unpaid help, looking after or supporting family members, friends, neighbours, or others because of long-term physical or mental ill-health, disability or problems related to old age. A family carer may be an adult or a child and the term is used to distinguish those who provide care for others on an unpaid basis, as opposed to those who are paid (care workers, home helps and people employed by someone with a disability).

This picture is not static - many people move in and out of caring roles.

Family carers

What support is currently available for family carers?

There are a lot of national and local initiatives which should improve services for family carers. National legislation now demands that:

- All family carers have a basic right to have their views taken into account by a local authority when it considers the support needs of a disabled person. Family carers who are providing, or intend to provide, a substantial amount of care on a regular basis to a disabled person, are given additional rights. This is the entitlement to a Carer’s Assessment. The local authority has a duty to inform eligible family carers of their right to an assessment, and to carry out an assessment if requested to do so.
- The Work and Families Act 2006 has been extended to include the right to request flexible working for employees who care, or expect to care, for adults. Family carers are consulted if there is a need to assess the mental capacity of the person for whom they are caring.

What is being promised for the future?

The 2006 Department of Health White Paper “Our health, our care, our say” proposed a new deal for family carers, by committing to updating the 1999 Carers’ Strategy, providing an information service/helpline (to start in 2008), ensuring adequate respite services (an additional £306,000 was allocated to Suffolk in October 2007 for emergency respite care) and creating an Expert Carers Programme. Family carers have also been explicitly included in national health and social plans.

The national vision is that by 2018 “carers will be universally recognised and valued as being fundamental to strong families and stable communities. Support will be tailored to meet individuals’ needs, enabling carers to maintain a balance between their caring responsibilities and a life outside caring, whilst enabling the person they support to be a full and equal citizen”.

The key outcomes the Government is seeking are:

- Carers will be respected as expert care partners and will have access to

2008 Annual Public Health Report Health inequalities and diversity in Suffolk
the integrated and personalised services they need to support them in their caring role.

- Carers will be able to have a life of their own alongside their caring role.
- Carers will be supported so that they are not forced into financial hardship by their caring role.
- Carers will be supported to stay mentally and physically well and be treated with dignity.
- Children and young people will be protected from inappropriate caring and have the support they need to learn, develop and thrive, to enjoy positive childhoods and to achieve against all the Every Child Matters’ outcomes.

One of the developments is that the NHS will also be required to look after carers better. There is an expectation that there will be new money for training in carer awareness, leading to improved engagement from health professionals, working with local government and health checks for carers. NHS Suffolk already works with Jobcentre Plus in addressing carers’ employment issues, and this will be improved upon.

Another of the Government’s objectives is to encourage councils to continue developing personalised, innovative and high quality services for family carers. They will be planned with family carers and relevant voluntary and statutory organisations, including the local NHS. Plans for local funding should support breaks for adult and young family carers in all situations, based upon their needs.

The East of England Strategic Health Authority has pledged to make healthcare in the region as available to marginalised groups as it is to the rest of the population. A family carers’ lead has been nominated. A regional strategic forum has been developed with the intention of bringing together the lead officers from the local authorities, health and the voluntary sector.

Suffolk’s current Local Area Agreement includes a target to monitor support to family carers. The aim is that at least 40% of family carers should have their needs assessed or reviewed, and as a result, receive access to specific family carers’ services, advice or information. This target will also be monitored by the Family Carers’ Partnership Board (FCPB).

**How are family carers funded?**

Direct funding to meet family carers’ own needs currently comes from the Carers’ Grant. This is in addition to the basic services to support the person cared for e.g. various forms of respite care such as residential respite and activity/day centres.

**What do we know about family carers nationally?**

Nationally, the General Household Survey (GHS) Great Britain gives the best information about family carers. Within the GHS respondents are asked about care giving.

**Key facts from the General Household Survey:**

- In 2000, one in six people over 18 was a family carer and one in five households contained a family carer.
- One in 20 family carers spend 20 or more hours per week on caring tasks.
- Women are more likely to be family carers than men and to have heavier caring loads.
- Prevalence of caring increases with age, peaking in the 45-64 year old age group as people tend to care for spouses or partners with age related health problems.
- The type of care provided most frequently involves practical support such as meals, shopping and laundry, but also commonly includes keeping an eye on someone and providing company. A quarter of family carers provide personal care such as washing.
- In five family carers had been caring for at least 10 years, and 45% for five years or more.
- Amongst those who provide 20 or more hours of care per week, about half were caring for someone who could not be left, and 8% had no-one to take over from them even briefly.
- Only 40% of family carers received visits from health, social or voluntary services.
- 39% of family carers reported that their health had been affected as a result of caring.

**Family carers identified in the 2000 GHS were then followed up by a further survey of mental health issues.**

**Key facts from the Mental Health of Family Carers Survey:**

- Female family carers were more likely than other women to have symptoms of anxiety or depression.
- Over a third of family carers reported that caring made them worried, depressed or tired.
- The prevalence of mental health problems was highest in family carers looking after a spouse or partner, and in those looking after someone with both physical and mental health problems.
- The level of mental health problems increased with the number of hours spent caring and with the provision of personal or physical support.
- Most family carers of people who received external support had not been consulted about care provision.
- Family carers with a smaller support group around them had more mental health problems, as did those who felt caring had affected their social life.
- The majority of family carers were not taking medication or receiving any therapy for mental health problems.
- Only 13% of family carers had consulted a GP about mental health problems in the last year, but nearly three quarters had consulted a GP about their physical health.
Young family carers

The third national survey of a non-random sample of young family carers (aged 18 and under) supported by services was carried out in 2004.

Key facts about young family carers:

- Around half the sample were girls, half live in lone parent families and the average age was 12.
- Young family carers care for long periods, some over 10 years, and for a range of hours per week (including some who care for over 50 hours).
- 84% of the sample is white; the largest minority group being Afro-Caribbean.
- They care for people (mainly mothers and siblings) with physical health problems, mental health problems, learning difficulties and sensory impairments.
- They provide domestic help, general and nursing-type care, emotional support and supervision, intimate personal care, and child care.
- 27% of those at secondary school and 13% of those at primary school are experiencing educational problems.
- 40% of those who care for someone who misuses drugs or alcohol have educational difficulties.
- Only 18% of young family carers have been formally assessed, and 20% receive no other support except for their contact with a specialist young family carers project.
- It is likely that young family carers, as with older family carers, are at risk of physical and mental health problems. Their problems include a wider range of behavioural and emotional difficulties.

What do we know about family carers in Suffolk?

According to the 2001 census, there were 66,486 unpaid family carers in Suffolk, but more recent estimates suggest this number is now nearer to 98,000. The census indicated that 18,918 family carers provided over 20 hours of care a week, including 64 who were over 90 years old. 12,580 family carers provided in excess of 50 hours care a week.

The health of family carers is measured in the census as good, fairly good or not good, and we can see from Tables 5 and 6 the patterns of health related to the number of hours caring and the age of family carer in Suffolk, and also the patterns of economic activity related to caring.

From census information we can see for Suffolk:

- More women than men are in caring roles.
- The prevalence of caring increases with age.
- The prevalence of health reported as ‘not good’ increases with age and, generally, with the number of hours spent caring.
- The proportion of people who are economically inactive increases as the number of hours spent caring increases.

Adult and Community Services

Information from Suffolk Family Carers (SFC) from December 2007 shows that:

- There were 3,053 family carers registered with SFC.
- Around 75% of these were female.
- Two thirds care for over 100 hours per week.
- 39% are full time family carers.

Young carers: Jake 13 and brother aged eight, mum is a single parent with epilepsy.

“When Mum fits I have to make sure she is safe and calm, my little brother down so that he can keep an eye on her whilst I call for the ambulance. …… I get a pillow and check nothing is in the way of her. I don’t go out much, I worry that she’ll have a fit and something bad will happen, and my brother gets upset easily so I have to keep him calm. I do go with mum to the doctors but it’s like I’m invisible or something, nobody tells you anything if you are young.”

### Table 5: 2001 Census standard table relating to health & unpaid care by sex and age, Suffolk

<table>
<thead>
<tr>
<th>Age Group</th>
<th>% People Provides no care in good health</th>
<th>% People Provides care 1-19 hours in good health</th>
<th>% People Provides care 20-49 hours in good health</th>
<th>% People Provides care 50(+) hours in good health</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALL PEOPLE</td>
<td>1.01%</td>
<td>2.40%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>0-15 years</td>
<td>0.23%</td>
<td>3.51%</td>
<td>3.54%</td>
<td>12.30%</td>
</tr>
<tr>
<td>16-24 years</td>
<td>5.80%</td>
<td>6.25%</td>
<td>8.54%</td>
<td>13.70%</td>
</tr>
<tr>
<td>25-54 years</td>
<td>13.40%</td>
<td>8.45%</td>
<td>13.92%</td>
<td>19.09%</td>
</tr>
<tr>
<td>55-74 years</td>
<td>23.08%</td>
<td>15.16%</td>
<td>25.46%</td>
<td>24.91%</td>
</tr>
<tr>
<td>75-89 years</td>
<td>30.43%</td>
<td>18.92%</td>
<td>0%</td>
<td>31.25%</td>
</tr>
</tbody>
</table>
The most common concern (over 50%)

- What would happen if they died.
- Paying for care.
- What would happen if they became ill.
- Being able to get enough breaks.

Concerns were:

- Family carers may not have access to the help they need.
- Family carers may not have enough breaks.
- Family carers may not have enough information and support.

In 2005, family carers in Suffolk were surveyed and said that their major concerns were:

- What would happen if they died.
- Paying for care.
- What would happen if they became ill.

The causes of family carers’ poor physical and mental health may be linked to many factors, but effective help is likely to consist of access to better information and support.

Recent research highlights the importance of employment to family carers and the need to support family carers in their career intentions. Carers UK in 2007, based on interviews with 3,000 family carers, recommended that all health and social care bodies throughout the UK review their policies and procedures, to make sure that family carers are better able to combine paid work and care, for example recognising that the timing of hospital appointments and social care services impact on family carers’ ability to work. Enabling flexible working may also provide business benefits such as savings on recruitment and retention and increased employee morale.

The following issues:

- General practice consultation rates were higher for family carers than the general practice population, with 42% for those of working age.
- Depression was recorded for 14% of those recently bereaved.
- Permanently sick or disabled.
- 6% are too young to work.
- 27% are of retirement age.
- 8% are too young to work.

Table 6: 2001 Census standard table relating to health and unpaid care by economic activity, Suffolk County

<table>
<thead>
<tr>
<th>ALL PEOPLE</th>
<th>% of population Provides care 1 to 19 hours</th>
<th>% of population Provides care 20 to 49 hours</th>
<th>% of population Provides care 50(+) hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Economically Inactive</td>
<td>9.39%</td>
<td>1.86%</td>
<td>4.78%</td>
</tr>
<tr>
<td>Economically Active</td>
<td>9.37%</td>
<td>0.92%</td>
<td>1.10%</td>
</tr>
<tr>
<td>Employee - Part Time</td>
<td>12.90%</td>
<td>1.32%</td>
<td>1.84%</td>
</tr>
<tr>
<td>Employee - Full Time</td>
<td>8.10%</td>
<td>0.78%</td>
<td>0.78%</td>
</tr>
<tr>
<td>Self-employed - Part Time</td>
<td>15.52%</td>
<td>1.32%</td>
<td>1.81%</td>
</tr>
<tr>
<td>Self Employed - Full Time</td>
<td>10.23%</td>
<td>0.90%</td>
<td>0.99%</td>
</tr>
<tr>
<td>Unemployed</td>
<td>7.16%</td>
<td>1.34%</td>
<td>1.61%</td>
</tr>
<tr>
<td>Full-time student</td>
<td>3.88%</td>
<td>0.27%</td>
<td>-</td>
</tr>
<tr>
<td>Retired</td>
<td>11.07%</td>
<td>1.57%</td>
<td>4.00%</td>
</tr>
<tr>
<td>Student</td>
<td>3.68%</td>
<td>0.40%</td>
<td>0.48%</td>
</tr>
<tr>
<td>Looking after home/family</td>
<td>10.02%</td>
<td>3.11%</td>
<td>8.60%</td>
</tr>
<tr>
<td>Permanently sick or disabled</td>
<td>6.87%</td>
<td>2.00%</td>
<td>5.28%</td>
</tr>
<tr>
<td>Other</td>
<td>6.55%</td>
<td>1.45%</td>
<td>2.48%</td>
</tr>
</tbody>
</table>

In November 2007, one Suffolk general practice carried out an audit of family carers which highlighted the following issues:

- General practice definitions of a family carer were not always clear and might include those paid to provide care.
- Records did not always recognise those recently bereaved.
- 43% of family carers were over 64 and 27% are over 75 years of age.
- 61% of family carers had at least one long term illness, with 68% on repeat medication.
- Depression was recorded for 14% of all family carers, with a higher rate (21%) for those of working age.
- General practice consultation rates were higher for family carers than the general practice population, with 88% having been seen face to face in the preceding year.

How can family carers be helped?

The causes of family carers’ poor physical and mental ill health may be linked to many factors, but effective help is likely to consist of access to better information and support.

- Group support programmes (family carers of stroke patients) and generic groups facilitated outside of statutory organisations.
- Support programmes focusing on self-efficacy, social support and coping strategy for family carers at risk of burn-out.
- Cognitive behavioural family intervention for family carers of patients suffering from schizophrenia.
- Supported physical activity programmes for older family carers.
- Family support (family carers of stroke patients).
- Family carers’ needs assessments.
- Identifying and supporting hidden family carers.

- Identifying and supporting hidden family carers20.
Support and information at the right time, as well as opportunities to meet other family carers in a social context.

Regular breaks from caring which may include time out sessions aimed at increasing wellbeing (Suffolk Family Carers Outreach Project), therapies and educational opportunities.

Family carers may not be able to access health services adequately to meet their own needs and this may be for a variety of reasons. A 2003 literature review and consultation exercise identified the barriers and effective measures to address them. These measures included:

- Training for all health professionals and front-line staff to ensure they identify family carers.
- Incentives for primary care professionals to focus on family carers’ health and proactively offer health checks.
- Identification of a point of contact or family carer support worker in each practice or service.
- Increase in the local availability of flexible and appropriate respite services.
- Education for family carers and proactive provision of information by health professionals and/or family carer support workers.
- Promotion of positive images of family carers and disability, in schools and the wider media.
- Reduction in cancelled or postponed appointments for family carers where respite care has been arranged.
- A more joined up approach with the voluntary and community sector who are able to work in a flexible manner to meet a variety of needs.
- A ‘one-stop shop’ for family carers of all ages to avoid missing out on services available.

The Suffolk Family Carers’ Partnership Board is leading on a multi-agency strategy for family carers in Suffolk, which is currently being consulted on. The strategy is aiming to ensure that all family carers, irrespective of their age, social circumstances or eligibility for statutory services:

- Are treated with dignity and respect.
- Are recognised as equal partners in planning their support.
- Receive a cohesive and integrated response.
- Are aware of their rights and opportunities.
- Are supported to make choices.
- Have the opportunity to take breaks.
- Have access to support in an emergency or crisis.
- Have access to advice and information.
- Have access to information and support to maximise their income.
- Young carers: their caring roles are minimised and do not adversely affect their opportunities.

Caroline cares for her 19 year old daughter Emma who has a learning disability and epilepsy. Since recently leaving school, Emma has been attending a course at West Suffolk College.

“...I have found this last few weeks really stressful. When Emma was at school I could concentrate at work and enjoyed my career. Now she catches a bus to college after I have left home and gets back about 3pm, I am always worrying whether she has missed the bus and if she is safe.

When I eventually discussed the situation with my manager, we agreed that a temporary three-month reduction in my hours would be long enough for me to be at home at the important times until both Emma and I are confident that she has the skills and knows what to do if something unexpected happens.

I had no idea that this would be possible and it has made all the difference.”
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What is ethnicity?

In this report the term ethnic minority group is used to indicate all groups that define themselves in a category other than white British.

Why are we talking about it?

A person’s ethnicity affects their chances of developing health problems. This may be for many reasons. Firstly, biological or genetic make-up can increase the risk of some diseases, for example diabetes is more prevalent in people of South Asian origin. Health problems may occur through direct discrimination, for example, by people in health services exhibiting stereotypes, prejudices and at times, racism, or indirectly through reduced access to good education, housing and employment - factors which are known to be associated with poorer health. Health problems may also be caused by behavioural factors, such as the chewing of betel quid/paan among Asian men which is linked to mouth cancer. Another cause of the relationship between ethnicity and ill health can be closer links to countries where particular health problems occur more frequently. Examples of this include tuberculosis and the Indian subcontinent, or HIV/AIDS and sub-Saharan Africa.

Looking at ethnicity and health helps to ensure that all groups are accessing the services they need and that the services they receive are appropriate for them.

What is the size of minority ethnic communities in Suffolk and where do they live?

In the 2001 Census, about 18,000 people in Suffolk said they were from non-white ethnic communities and 23,000 said they had a white non-British background (together 6.2 % of the population). Of the 145 wards in Suffolk, only 11 had a population that matches or exceeds the national average of residents in ethnic groups other than white British. The ethnic minority communities in Suffolk are small in absolute terms and in comparison with England as a whole.

In the years since the 2001 Census, and with the addition of economic migrants, Suffolk’s minority ethnic population has increased. For example since 2002 new national insurance numbers were given to 18,000 foreign nationals arriving in Suffolk, who were nearly all young adults.

The distribution of ethnic minority groups across Suffolk is given in fig 5 below.

Table 7: Ethnicity & Health.

<table>
<thead>
<tr>
<th>Ethnic group</th>
<th>Ethnic subgroup</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>British</td>
</tr>
<tr>
<td></td>
<td>Irish</td>
</tr>
<tr>
<td></td>
<td>Other white</td>
</tr>
<tr>
<td>Mixed</td>
<td>White and Black Caribbean</td>
</tr>
<tr>
<td></td>
<td>White and Black African</td>
</tr>
<tr>
<td></td>
<td>White and Asian</td>
</tr>
<tr>
<td></td>
<td>Other mixed</td>
</tr>
<tr>
<td>Asian or Asian British</td>
<td>Indian</td>
</tr>
<tr>
<td></td>
<td>Pakistani</td>
</tr>
<tr>
<td></td>
<td>Bangladeshi</td>
</tr>
<tr>
<td></td>
<td>Other Asian</td>
</tr>
<tr>
<td>Black or black British</td>
<td>Black Caribbean</td>
</tr>
<tr>
<td></td>
<td>Black African</td>
</tr>
<tr>
<td></td>
<td>Other black</td>
</tr>
<tr>
<td>Chinese or other ethnic</td>
<td>Chinese</td>
</tr>
<tr>
<td></td>
<td>Other ethnic group</td>
</tr>
</tbody>
</table>

Fig 5: Ethnicity & Health. Distribution of ethnic minority groups in Suffolk, (2001 Census)
Taken as a whole, the average age of ethnic minority groups is younger than that of the white British population. The Children and Young People’s Service office of Suffolk County Council in their 2006 assessment calculate that approximately 8% of children aged 16 and under were from black and minority ethnic backgrounds, an increase from 5% in 2001.

Ethnicity and occupation in Suffolk

The life chances open to people affect the occupations they are likely to take up. Those in higher status occupations are more likely to enjoy good health. Of all ethnic groups in the 2001 Census in Suffolk, the one with the lowest percentage of 16-74 year olds in higher managerial and professional occupations was white British (as shown in Fig 6 below).

This is in contrast to the national picture, where minority ethnic communities tend to be under represented in the higher managerial and professional groups.

In contrast, there are markers of disadvantage among ethnic minority communities. In 2007 children of black ethnicity were twice as likely as ethnic whites to be eligible for free school meals (approximately 20% compared with 10%). Eligibility for free school meals is a marker of deprivation and hence poorer health.

Health and wellbeing

The 2001 census also showed that the white British ethnic group in Suffolk was most likely to have a limiting long-term illness, and most likely to report their health as not good (Fig 7).

Again this is different from the national picture, in which people describing themselves as Asian (especially Pakistani or Bengali) are most likely to describe themselves as “not in good health”.

The generally younger age profile in Suffolk might, in part, explain this.

In Suffolk it would seem that the minority ethnic communities, on the whole, are not disadvantaged in their occupational opportunities or the levels of health they enjoy. Nonetheless, this may hide considerable variation in the rate of health problems in these communities.

Key health areas

Four health topics have been chosen for comment, as they show some of the largest differences between ethnic groups in England. These topics are diabetes, diseases of the heart and circulation, mental health and the death of children in their first week of life.

NHS Suffolk is hindered by currently not having good quality data on ethnicity and key health indicators. Therefore, the information given below reflects the picture in England as a whole.

Nationally the relationship between health and ethnicity is complex. People defining themselves as Asian or black are between two and five times as likely to develop diabetes. Coronary heart disease is more common amongst those defining themselves as Asian. For example, among males aged between 35 and 54, coronary heart disease is four times as common in the Pakistani community compared to the general population. In contrast coronary heart disease is less common within the black community, although strokes are more common. Stroke is twice as likely in black males aged 55 and over, compared with males of that age in the general population. The reasons for these differences in coronary heart disease and stroke are not fully known.

In mental health research, a lot of emphasis has been placed on psychosis in the Black Caribbean community. Men from the Black Caribbean community were found to be three to six times more likely to be admitted to hospital against their will with a psychotic disorder than the general population. This increased risk was not found in women from the Black Caribbean community.

Recent research into psychotic disorders in the different minority ethnic communities did not find a statistically significant increase in psychotic disorders in the Black Caribbean community. The reasons for the increased compulsory admission rate in Black Caribbean men have not been fully explained. It could be that males in this community suffer more severe forms of psychotic disorders, or that they are treated differently as a result of their ethnicity.

Fig 6: Ethnicity and Health: Percentage of those aged 16-75 years in higher managerial and professional occupations by ethnic group (Census 2001)

Fig 7: Ethnicity and Health: Percentage with a limiting long-term illness and the percentage declaring themselves not in good health in Suffolk (Census 2001)
Some have suggested that institutional racism within the psychiatric services may be a factor, but this is unlikely to be the full explanation. One study found that Black Caribbean families were more likely to access help through the criminal justice system, than the medical system, when behaviour problems were identified. In other words, differences are apparent in the care of people with psychotic disorders even before they meet the health service.

In cases of perinatal death (child stillborn or dying in the first week of life), the mother's country of origin is recorded on the death certificate. A baby born in the UK is almost twice as likely to die perinatally if their mother was born in Africa. In contrast, if the baby's mother was born in the Far East, the chance of dying perinatally is half that of the general population.

**What do ethnic minority groups in Suffolk say?**

NHS Suffolk recently held a Single Equality Day, inviting members of the minority ethnic communities in Suffolk, so that their experiences in accessing health services might be better understood. Furthermore meetings were held with mental health advocacy groups, the Bangladeshi Support Service, and the Ipswich and Suffolk Indian Association. A consultation exercise around one general practice in Suffolk with a high ethnic minority population was also conducted, and the Ipswich and Suffolk Council for Racial Equality submitted a report on ethnicity and health services. The views expressed may or may not be representative, but offer an insight into the views of these communities. The main issues identified are discussed below.

**Language and communication**

The most significant problem identified was the language barrier. Those responding stated that little is offered to people who have difficulty communicating in English to help them access services.

For convenience, family members or friends are often used as interpreters. This is a major source of anxiety among the ethnic minority group representatives. It can put family members under pressure to attend appointments in spite of other commitments that they might have. In addition, there are concerns over the quality of translation. Interpreting is a skilled task and needs, not only fluency in two languages but, the ability to convey complex messages that may have a profound impact on a person’s life. There are particular problems if confidential information needs to be conveyed.

The use of children (under 18 years old) as interpreters has additional problems. They may not have sufficient familiarity with both languages to convey the information. On occasion children miss school to act as interpreters. It is also a major burden for children to convey adverse, sensitive or confidential information to a relative or other adult.

Those responding stated that current translation services were not adequate. One service that is available in Suffolk is Language Line. This is an instantaneous interpreting service which uses interpreters over a telephone link. The patient and clinician take turns listening and speaking to the interpreter. This service is funded by NHS Suffolk for patients in Suffolk. Those responding stated that, in spite of being readily available, this service is often not used. One reason suggested for the reluctance to use Language Line was a lack of familiarity among clinicians and staff about how to use it. Some even suggested that practices were reluctant to register a patient with limited English because it is perceived to be ‘too much trouble’.

Language Line has its problems, such as the interpreter not being able to pick up or use non-verbal communication. Face-to-face translation services with a qualified interpreter is seen by some as the best solution, but it takes time to set up and is costly. It can also be intrusive to have another person in the consultation, especially if the sex of the interpreter is different from that of the patient.
Although Language Line may be underused, NHS Suffolk spent just under £35,000 on it in 2007. The service was used to help communication in 40 different languages. The most commonly used languages in 2007 were Kurdish, Portuguese, and Polish (respectively accounting for 17%, 16% and 13% of the total number of calls).

<table>
<thead>
<tr>
<th>Region</th>
<th>Number of occasions</th>
<th>Total cost of Language Line per region</th>
<th>% by Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Africa</td>
<td>37</td>
<td>£385.50</td>
<td>3%</td>
</tr>
<tr>
<td>Asian Pacific</td>
<td>257</td>
<td>£5,637.00</td>
<td>16%</td>
</tr>
<tr>
<td>Europe</td>
<td>681</td>
<td>£8,547.00</td>
<td>27%</td>
</tr>
<tr>
<td>Middle East</td>
<td>782</td>
<td>£15,600.00</td>
<td>45%</td>
</tr>
<tr>
<td>South East Asia</td>
<td>210</td>
<td>£3,196.50</td>
<td>9%</td>
</tr>
<tr>
<td>Total</td>
<td>1,967</td>
<td>£34,966.00</td>
<td>100%</td>
</tr>
</tbody>
</table>

Those responding gave three examples of how communication causes difficulties in accessing health care:

**Complaints:**
Making a complaint about services is particularly difficult where there is a language barrier. The leaflets available for supporting people wishing to complain are generally only available in English.

**Written information:**
There is inadequate health information available in languages other than English. There would be difficulties in having printed leaflets available in every language likely to be requested, but much of the information could be prepared and available electronically from NHS Suffolk and Suffolk County Council websites so that any health professional or member of the public could print them as needed.

However, in some ethnic communities the literacy rate, even in their first language, can be low. This means that simply making written material available will not be enough.

**Dementia:**
It is very difficult for someone with limited English and dementia to understand their professional carers. The number of people from the ethnic minority communities receiving professional care for dementia is likely to increase with the increasing age of the minority ethnic communities and the increasing pressures on younger family members to obtain paid work rather than look after relatives.

**Engagement**
Another major theme expressed by the respondents was that they are being labelled as “hard to reach” whereas they felt that NHS Suffolk had not made enough effort to reach their communities. Occasions were cited when NHS Suffolk was invited to send a representative to ethnic minority meetings but failed to do so. The more NHS Suffolk and the County Council are able to engage with the communities within Suffolk and recognise diversity, the more likely the health of the whole population will be improved.
Twenty interviews were initially carried out with key informants, followed by a survey and a further set of interviews to explore the issues for Landseer Road surgery.

The main findings, as expressed by those interviewed, were that there was a lack of contact with, and involvement from, NHS Suffolk to reach people from black and minority ethnic groups (BME) with health related-messages, or to organise specific health-related activities.

A secondary concern was that NHS Suffolk does not have working systems to gather data on the health needs of primary care users by ethnicity. The view was that, without this, there could be little effective planning to meet the needs of BME and other minority groups in Suffolk. Thirdly, experiences were generally very positive at Landseer Road surgery and many examples were given of good practice. More information is available in the full report.

The full, unedited summary of views from the first set of interviews is given below. It has to be emphasised that the summary expresses the views of those interviewed, based on their personal perceptions. Nonetheless, they offer insight into the community’s attitudes to health, their experiences of using healthcare services in Ipswich as well as professionals’ perceptions of the community, and the appropriateness of the services they access.

What are the perceived health needs?

Key informants made particular reference to diabetes and associated health issues, heart conditions, high blood pressure, asthma and obesity in BME populations, especially among those of South Asian origin. Diet and healthy eating, the need for more exercise, particularly among women, and a high level of smoking among men in the Bangladeshi community were also cited. So too was a growing incidence of cancer among Bangladeshis. Among older people, one person who works with older South Asians reported podiatry as an important need.

Others highlighted the need for more preventative health advice on healthy living, since many of the Bangladeshi community do not understand their bodies or understand how different health conditions are manifest. Many Bangladeshis consult their GPs about very minor health conditions but not about more serious symptoms. As a result more serious health conditions can remain hidden until a late stage. It was noted that the people from this community need simple explanations, and many health professionals are not good at providing these.

Family planning services and sexual health were mentioned as particular needs in the Landseer Road area, where the previous family planning service on the Gainsborough Estate had recently closed. This includes the need for advice to young people.

Because of their low level of health awareness, many in the Bangladeshi community need access to information to help them develop a better understanding of health related issues in general.

Screening, including for tuberculosis, was identified as an important preventive measure that many in the Bangladeshi community do not access. There is evidence of reticence about owning up to such problems as hearing difficulties among young women, because this can damage their marriage prospects. Some pregnant women may be unwilling to have HIV/AIDS tests for fear that this may affect their relationship with their husbands.

It was noted by one informant that health inequalities are stark in certain parts of Ipswich, with nearby streets contrasting high levels of prosperity and high levels of deprivation. Mortality rates in the latter were said to be much higher.

The profiling work that is being done by the Local Strategic Partnership (LSP), to be published shortly, may throw light on this.

Around the Landseer Road practice and the nearby Gainsborough Estate the population is both deprived and diverse. There are high levels of unemployment, many who smoke and a lot of low-level crime. It was suggested that these would have implications for quality of life and health.
Which GP services work well and why? Which do not work well?

GP surgeries work well for BME groups where the family doctor is prepared to be open and to give time for people to understand what is happening to them. According to several key informants, the open surgery sessions offered by Landseer Road practice are valued and effective. They offer a flexible means to see a doctor or nurse to people whose lives are not well organised and who do not use diaries. The languages spoken by the doctors at this practice were mentioned as a particular plus for South Asian patients and users.

Particular GP based services that were cited as working well included: family planning, smear tests, immunisation, blood tests, asthma clinics, prescription services, access to a community psychiatric nurse, to a counsellor, and to a midwife, though none of these was mentioned with particular reference to Bangladeshis patients. The possibility of phoning in to a practice for advice and knowing the doctor would call you back was seen as a positive service available at the Landseer Road practice; ‘people really like that’. So too was having a team of very patient receptionists.

Less satisfactory were experiences such as not being able to get through on the phone, having to wait for up to three weeks for an appointment, and being blocked by receptionists.

On a different note it was reported that it has proved very difficult to get GPs to attend regular forums held in Ipswich under the Local Strategic Partnership. Although invited, few if any attend, yet this is where some of the health issues of local BME populations are discussed.

Are health needs changing?

The people interviewed reflected concerns in the longer standing ethnic minority communities in Ipswich that the needs of new and emerging communities, such as migrant workers and Eastern Europeans, are taking precedence in the NHS agenda in the area. They are seen to be demanding new services. ‘People are very anxious about changes in the pecking order’, said one key informant. This is a hot topic in the voluntary and community sector that supports or represents BME groups.

On changing health needs, one key informant pointed out that these will vary according to the group under consideration. Others said they did not think there would be any changes.

Among specific changes and issues that were cited by some key informants were the following:

- One respondent said he thought the aging community would remain steady in BME groups, particularly amongst Bangladeshis who are unlikely to take on western ways.
- Others noted that many young people from this community are drifting away from Suffolk and Ipswich and are beginning to adopt a British way of life, suggesting that this may have an impact on the care of elders in the longer term.
- In line with this, another respondent said she thought there would be increased demands on health services from an aging Bangladesh population.
- A number of key informants noted that there were huge changes in the second and third generations of Bangladeshis in particular, and that they access services better. However another said that even second generation Bangladeshis still consult GPs for very minor matters. Some bring non-English speaking partners over for marriage, who then have the same problems as those who arrived earlier.
- This influences child rearing practices and diet. One person said of Bangladeshis ‘Diet is too ingrained to change’, and child rearing is closely related to diet. On a more hopeful note, someone said that the younger generation might be more likely to take exercise and to be concerned about his or her weight in future.
- Another key informant said that some of the younger Bangladeshis wives are starting to learn English, unlike their parents’ generation, when husbands did not want women to speak for themselves. She observed that if more young women learn English, there would be less need for interpreting services in future.

From these individual comments it seems that the picture of changing health needs is not clear, and will vary both between and within communities. This supports the literature review findings and suggests it is important not to draw stereotypical conclusions and to ensure a sound evidence base for future planning to meet the needs of BME communities.

What was said about accessing primary care and GP practices?

Language

Almost all the key informants said that language was a major issue affecting access of Bangladeshis and other South Asian groups to GP practices. Some members of the community may have been here for over 40 years, but still do not speak English. The new and emergent migrant groups, such as Poles and Portuguese, also meet barriers because of a lack of English when accessing health care.

Some evidence was reported of GPs not using interpreting facilities available to them in their dealings with non-English speakers. In some cases, children and young people are brought in to translate for their parents but do not translate accurately. It was felt inappropriate for children and young people to be involved in this way.
Knowledge of services
On top of their lack of English, it was also suggested that Bangladeshis often do not know where to go for help with health issues, or what help and services are available. For instance, they often do not know about flu jabs, or about free eye tests for the over 60s. Nor do they know about how to access other health services that are available. They need information in their own language, yet the efficacy of written information, particularly leaflets, is doubted. Many of the members of this community have come from village areas and some are not literate in their own language. This poses a double problem. On the one hand, they are ill informed about health issues and how their bodies work, and on the other they are from a largely oral and visual tradition. They need time to talk, take in and understand what they are told in health-related consultations with doctors and nurses. This led to a suggestion that GPs and other health professionals need to be culturally aware and confident with dealing with BME patients, and the observation that some are better than others in dealing with social and cultural issues.

Receptionists
Some key informants noted that the attitudes of reception staff also impact on BME users’ experience of accessing GP practices. Some receptionists do not treat them with respect and they are not always treated well. One asked rhetorically, “How well equipped were reception staff to deal with BME patients?”

Women
Women in the Bangladeshi community in particular are affected by cultural issues. Often they don’t have social networks, don’t speak English and are not encouraged by their husbands to learn. There are taboos around talking about sexual matters and most are unwilling to attend groups, or other forms of support networks, such as those set up for smoking cessation or weight loss. One key informant said that in her experience one to one support worked best. It was suggested that lack of English and unhelpful cultural beliefs is less true of second-generation Bangladeshi women. However health care providers also reported that they have found it particularly difficult to reach Bangladeshi women with small children, who are not used to using community clinics or to dropping in to pick up supplies needed for their baby’s care. Bangladeshi women often prefer to see women doctors.

Traditions
Traditional attitudes to older people can be a problem and their needs can get squeezed out because of the widely held belief that as South Asians ‘we look after our own’. A recent study on Alzheimer’s disease for instance, had indicated that it can make great demands on traditional Bangladeshi families, yet they have access to little or no support either in understanding or in dealing with it. Attitudes towards mental health are also a problem, as such conditions very often are either not understood or cause shame and are hidden. In dealing with conditions such as these, GPs and other health care professionals need empathy and particular understanding of BME cultures, if BME groups are to use services for mental health or older people successfully. These are however in short supply and hard to access across the whole community.

Deprivation
Because of the high level of deprivation experienced by some members of BME groups, one key informant noted that health needs tend to defer to economic needs, and that this can affect BME users’ readiness to access health care. Some are not willing to travel far to get to health care facilities because of the costs involved. Others over-use practices for minor things but don’t seek help with serious medical conditions, and many do not ask questions about their diagnosis or medication.

Why do people choose a particular GP practice and what factors influence this?

Culture
The general view of key informants was that when BME people arrive in Ipswich, they talk either to family members or to others in their community of origin, which is often a close-knit community. This is particularly true in the case of the South Asian communities. They find out which GPs are considered good and able to understand their needs, and generally prefer a doctor who speaks their
language and is from their own culture or a similar one. This makes them feel comfortable because they understand cultural behaviours such as fasting and vegetarianism. Once they have registered they tend to stick loyally to that GP. Language is particularly important.

Open surgeries
The availability of open surgery hours can also have an influence, particularly for users who come from small villages. It was suggested by one key informant that the availability of open surgery also gives users a sense that the GP is accessible. For other users the location of a practice is important, and for others having a female doctor is important.

Receptionist
Several key informants reiterated the importance of the way reception staff treat patients from other cultures. It was suggested that patience is a virtue in a receptionist. One said that some users preferred a small practice and the receptionist.  One said that some users had experience of holding one to one sessions with BME parents at Children’s Centres to find out about their experiences as users.

How do different ethnic groups communicate?

Meeting places
According to key informants, most ethnic groups have their own meeting places in Ipswich. Examples were:
- The Hindu Saraj.
- The Sikh temple.
- The Indian Association.
- The Bangladesh Support Centre.
- The Caribbean Centre.
- The Polish Club.
- The two mosques in Ipswich, one of which is a smaller breakaway from the larger one.
- Churches.

Several of these produce newsletters and hold events such as the Indian Mela. ‘Dr Ashok’s Health Days’ (a local community leader), were also mentioned. There is also a BME Forum, and the Council for Voluntary Services has a database, a website and a newsletter covering most voluntary and community groups in Ipswich.

Language issues
One key informant from NHS Suffolk said that NHS Suffolk does circulate documents and press releases and also puts advertisements into the press. However key informants from the voluntary and community sector said that in their experience NHS Suffolk had been approached to contribute to health advice sessions and had almost universally been told that there were no resources available for this. However someone interviewed from NHS Suffolk reported that she was attending a meeting of 30 BME groups that very evening.

What influences how people move around in Ipswich?

It was noted by several key informants that most BME people stay within their own communities, particularly the traditional immigrant groups such as Indians, Pakistanis and Bangladeshis. If they do move, they tend to stay on at the Landseer Road practice. It was reported too, that although some users did move to the new Ravenswood facility, some have now returned to Landseer Road.

South Asians tend to live towards the centre of Ipswich in small pockets like Nacton, Gainsborough, Geneva Road and Cecil Street, Oxford Street and the town centre. The biggest concentration is not around Landseer Road. One key informant said that around 60% of Bangladeshis in Ipswich work in the restaurant trade, adding that this group tended to earn low wages and live in council housing. Many of them live in the same part of Ipswich as others from their place of origin. Initially they may live with relatives, but then move to somewhere nearby. While the number of South Asians in Ipswich is quite low, it is a diverse group.

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Further information from the key informant interviews reported that:
- There are no local papers in anything but English in Ipswich, although some papers in other languages are sent up from London.
- There is also a Bengali TV channel from London.
- The general view was that word of mouth is the most common form of communication. ‘Gossiping’ is an important part of the Bengali community.
- Where a community activist or champion emerges, word about that spreads around the relevant community very fast. Trust is an important factor in this.
- Someone suggested that shop notice boards can be an effective way of reaching people in some BME communities.
- Practices themselves do, or could do, a lot of educating of their patients, as do health visitors and midwives.
- Pharmacists have a panel which publicises health messages from NHS Suffolk and also signposts people to various other health related services, including the services that pharmacies provide. It was suggested the same could be done through GP practices.

Several key informants said that communication with non-English speaking BME groups needed to recognise their cultural origins, and associated traditions for communications, which are largely face to face and use
oral and visual methods for putting the message across. (Author’s note: In Indian villages puppet shows are used to convey health messages, and there is a lot of experience of reaching illiterate communities with health information. It might be worth investigating this experience).

There was a widely held view from key informants from the voluntary and community sector that NHS Suffolk does not successfully access the BME communities in Ipswich.

What about the relationship between NHS Suffolk and different ethnic groups?

Interviewees from outside of NHS Suffolk also felt that NHS Suffolk did not have adequate data on ethnic minorities or their needs. It was suggested that what is needed at the level of NHS Suffolk is ‘real in-depth awareness of cultural issues and their implications’. In developing this it would be essential to recognise that the needs of each ethnic minority group will be different. There was a feeling that currently the Local Strategic Partnership is not picking up on the implications of ethnicity.

It was suggested by one key informant that NHS Suffolk should find a way to go forward together in meeting the health needs of BME communities. NHS Suffolk should not be left to work on such an important matter alone. It was also suggested that NHS Suffolk should appoint a BME link person to liaise with BME groups and provide them with signposts for getting assistance in delivering health messages when needed.

Are there any examples of good practice?

It was suggested that having an innovative practice manager made a big difference to how GP practices treated and reached BME groups. Some examples of good practice included:

- Offering telephone consultations.
- Offering a personalised service to users.
- A health day for women organised by the Town and Bridge project.
- Chair based exercise groups for older people or those who exercise very little. An example is a chair based exercise group held in one of the mosques.
- Chasing up people who are known to have particular health conditions that need regular checking.
- Befriending scheme offered under other services that could be applied in health.
- Networking lunches in regular meeting places.
- Appointment of a community psychiatric nurse who works with certain practices in Ipswich to help patients access community care.

One key informant noted that the new self-booking systems introduced in parts of the NHS would not work with the Landseer Road practice or with many South Asian users because they would not have sufficiently good English or technology skills.

NHS Suffolk was formally accepted as a member of the national Race for Health programme in December 2007. Race for Health (RfH) is a Department of Health initiative which was set up in 2002 to support primary care trusts to deliver measurable improvements in the health outcomes of people from BME communities.
As part of this initiative, NHS Suffolk will actively involve and consult with BME communities in order to understand the challenges which they face and their needs and aspirations in relation to improving their health and wellbeing. This is a crucial part of planning and delivering appropriate high quality services. NHS Suffolk recognises however, that in a county such as Suffolk, where there is a wide range of diverse communities, it is all too easy to overlook specific communities’ needs.

NHS Suffolk will also need to respond to the Race for Health scheme by showing itself to be a culturally sensitive employer. As NHS Suffolk is a major employer in Suffolk, this has wide reaching implications for the whole community.

Membership of the Race for Health programme will enable NHS Suffolk to work together with other primary care trusts to share experiences, test out new ideas and learn from best practice.

References

1. Article 13. (May 2008) Insights into meeting the primary health care needs of the black and ethnic minority communities of Ipswich - a report prepared for Suffolk PCT.

NHS Suffolk has worked with local groups and communities to develop a Single Equality Scheme (SES) for 2008-2011 which will help us to commission and provide, where appropriate, services that tackle health inequalities caused by differences in gender, race, religion/belief, age, sexuality or disability.

The scheme will also support us in developing a diverse and inclusive workforce which respects, values and reflects the wider community it serves, and in meeting our statutory duties in relation to equality legislation, in respect of the areas above, often expressed as Human Rights.
chapter five

Asylum seekers, refugees and migrant workers

Who are asylum seekers, refugees and migrant workers?

Asylum seekers and migrant workers are fundamentally different, and for that reason are treated very differently under UK law. Migrants, especially economic migrants, choose to move in order to improve the future prospects of themselves and their families. Asylum seekers have to move if they are to save their lives or preserve their freedom.

Asylum seeker:
a person who enters the country to claim refugee status and is waiting for the Home Office to assess their claim and decide whether or not to grant refugee status. Refused (failed) Asylum Seeker: a person whose claim for asylum has been rejected by the Home Office and who has exhausted all rights of appeal.

Refugee:
Many states which have agreed to the 1951 UN Convention also have refugee status determination procedures, to determine the person’s status according to the domestic legal system. The 1951 UN Convention and 1967 Protocol defines a refugee as a person who “owing to a well founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable, or owing to such fear, is unwilling to avail himself of the protection of that country”.

In the UK, a refugee is someone whose application for asylum has been accepted by the Home Office.

Economic migrant or migrant worker:
someone who leaves their country of origin to live and work. Many migrant workers stay for only a short time before returning to their home countries and often send money home to support their families.

A local tailored health needs assessment was carried out for both groups using several information sources, including published and unpublished reports, methods to ascertain the views of service providers and users through attendance at stakeholder meetings (Forum for Refugees, Asylum Seekers and Migrant Workers), interviews with agencies providing services (Refugee Council, Suffolk Refugee Support Forum, Suffolk Community Refugee Teams including local GPs) and representatives of voluntary and faith groups.

Asylum seekers & refugees

How many asylum seekers and refugees are there in Suffolk?

Suffolk hosts people seeking asylum particularly from Iraq, Afghanistan, Iran, Zimbabwe, China, Eritrea and Sri Lanka. All these countries are either war torn or stand accused of human rights violations. United Kingdom Border Agency (UKBA) figures show asylum applications to be at their lowest level for 14 years with only 23,430 principle applicants in 2007 (compared to 84,130 in 2002 when numbers were at their highest). The UK gives sanctuary to less than 3% of all the 8.4 million asylum seekers and refugees worldwide; most escape to countries on their home country border.

In May 2007 there were only 98 asylum seekers in Suffolk (excluding unaccompanied asylum seeking children and unrecorded refused asylum seekers), living in 47 households, which is less than 0.01% of the 314,597 dwellings in Suffolk overall.

It is difficult to estimate the numbers of refugees in Suffolk as once they are given refugee status they have rights to move house, to work or gain an education just as anyone else in the UK. There is a growing Kurdish community in Ipswich made of up asylum seekers and refugees who are able to stay and have opened shops and restaurants. Some anecdotal reports estimate the size of the population to be around 200 people.

Leaving home - Fareed’s story

I was born and raised in Afghanistan, speak Pashto and I am a Muslim. I was very happy at home helping my mother and father on our small farm and selling produce at the local market. My father was a member of a group in opposition to the Taliban and in 1998 the Taliban police came to our house and arrested him. I ran to try to help and the Taliban assaulted us both. They continued to beat me until my father admitted to having a gun. At this the Taliban shot and killed him and dragged me off to the police unit. There I was interrogated and assaulted so many times, that I begged to be killed as well. I escaped the police unit through the toilet window and found my way to my uncles. There I stayed for a week whilst they tended my wounds but it was not safe. My uncle helped me to get to Kabul and then over the border into Iran. Then I made the long and scary journey to Europe and the UK alone.

Fareed was twelve years old at the time.
**What are the health needs of asylum seekers and refugees?**

The majority of asylum seekers and refugees who arrive in the UK are fit and healthy. This could be because they are predominantly young and male. 82% of principal applicants in 2006 were under 35 years old. This is consistent with the mix of patients seen by the local specialist health service (Suffolk Community Refugee Team), between April 2003 and March 2006 as shown in the population pyramid in Fig. 9.

The majority of GP consultations at Suffolk Community Refugee Team (SCRT) between April 2003 and March 2006 reflect the young and healthy status of the client group - with skin and related disorders, respiratory system problems and general infections predominating as shown in Fig 10. Nonetheless on average, national data shows about 20% of asylum seekers and refugees have health problems that make daily life difficult.

**What issues need to be considered in developing services?**

National and international data show that specific issues related to poorer health include:

- **Pre-travel** - the situation of the country from which people come - including poorer health systems, sanctions, higher incidence of disease, lack of immunisation and health education programmes.
- **The journey** - the manner of their flight being sudden and unplanned, having to sell all they own to escape, the trauma of the journey, with possible bereavement, long distances walked, dangerous sea crossings, travelling in a container, no food, water or warm clothing, exposure to violence and abuse.
- **Living in the UK** (as an exile) - cultural bereavement, adjustment to huge life changes, isolation, lack of family and community networks, difficulties in communication, lack of control over own life decisions, lack of knowledge of services, not being allowed to work and use their skills, destitution, detention, hostility and racism.

**Sexual health and maternity care**

- 5-30% of asylum seekers and refugees have been tortured, including rape and sexual violence.
- 80,000 women in the UK have undergone female genital mutilation including some asylum seekers and refugees.
- In some countries, women and young girls are raped with the deliberate intention of infecting them with HIV.
- During pregnancy, asylum seeking women are seven times more likely to develop complications and three times more likely to die.

**Disability**

- Between 3-10% of asylum seekers and refugees are disabled.

**Mental health**

- Despite traumas experienced in the home country, research suggests that becoming an exile in the UK

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**Fig 9: Suffolk Community Refugee Team patient profile, April 2003 to March 2006**

![Population Pyramid](image1)

**Fig 10: Recorded diagnosis at consultations at SCRT April 2003 to March 2006**

![Diagnosis Chart](image2)
Life in the UK - Faith's story

After my asylum case failed, I had a week to immediately leave the hostel where I had been housed. I went from one disused building to another in Bedford to find somewhere to sleep. I found one place where a group of other men and women from Zimbabwe were living. It was so cold and I was so hungry. It was winter and I didn’t have any blankets to keep warm or any food to eat. Sometimes we had sandwiches from a supermarket that gives away food past its sell-by date. None of us were allowed to work or to claim any benefits so some people would try to find money by begging.

I was held in a detention centre for a few weeks and I was almost sent back to Zimbabwe where I faced certain death. Thankfully, the courts barred deportations to Zimbabwe so they did not send me back. Eventually I found a friend in Ipswich who took me into her house and introduced me to the refugee services here. They gave me clothing and food vouchers. I am so grateful to them for what they have done for me, but I still don’t lead a normal life as I cannot work or have my own home, let alone bring my children to the UK.

Fig 11: Entitlements for asylum seekers and refugees

<table>
<thead>
<tr>
<th>Financial support</th>
<th>Asylum seeker - claim in progress</th>
<th>Asylum seeker - claim refused</th>
<th>Refugee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supported at 70% of income support for adults; 100% for under 16s</td>
<td>Supported only if agrees to return home (&quot;Section 4 support&quot;) - hostel / shared accommodation, vouchers for specific supermarkets and limited to certain goods at £35 per week - destitute</td>
<td>As per local population</td>
<td></td>
</tr>
<tr>
<td>Housing</td>
<td>Housed in shared accommodation contracted by Home Office with National Accommodation providers (Not council housing)</td>
<td>Housed in shared accommodation contracted by Home Office with National Accommodation providers (Not council housing)</td>
<td></td>
</tr>
<tr>
<td>NHS care including GP and hospital</td>
<td>Can use NHS free. Entitled to free prescriptions</td>
<td>Previously emergency care only but now free (see note*)</td>
<td></td>
</tr>
<tr>
<td>Right to work</td>
<td>Not permitted to work</td>
<td>Not permitted to work</td>
<td></td>
</tr>
</tbody>
</table>

NOTE:
* In April 2008 Mr Justice Mitting ruled that asylum seekers whose claims had failed should, in general, be classed as ‘ordinarily resident’ in the UK and thus entitled to free NHS treatment. At the time of going to press, no decision had yet been reached by Government on whether or not to appeal this ruling. Guidance issued by the Department of Health (England) has advised that, until a final decision is reached (pending any appeal) Justice Mitting’s ruling must be followed by all NHS Trusts, primary care trusts etc.

For the latest situation or further advice please contact the Department of Health. http://www.dh.gov.uk
What are the needs of Unaccompanied Asylum Seeking Children?

The United Kingdom currently receives an average of 345 asylum applications per month from Unaccompanied Asylum Seeking Children (UASC) who are separated from their families and have no identified guardian in this country.

Separated children and teenagers come from a wide variety of backgrounds: from educated or wealthy families where they have attended school, to rural families where they may have worked as a goatherd or on a market stall. They may have come from areas where there are few health services and may not have received childhood vaccinations or dental care. Asylum seeking children are children first and asylum seekers second and so, meet criteria for support as a child in need or a looked after child, within the framework of Every Child Matters and are cared for by local Social Care Services.

In Suffolk there are currently 60 unaccompanied children and young people supported by various teams within Social Care Services. Some of the children have spent much of their childhood in Suffolk. All have had full assessments of health and social care needs. Care involves everything including finding foster care or supported accommodation, ensuring they receive vaccinations and health care, attending parent’s evening and even the simple pleasures of playing football in the park. They have the same basic needs as any other children in the community.

Service provision in Suffolk (examples of best practice)

Primary care is provided mainly through local General Practitioners and dentists with whom asylum seekers and refugees are registered. Pharmacies are also a key resource for advice on minor ailments, and most asylum seekers and refugees are aware of this facility. Many models of good practice rely on the commitment of a few dedicated health and social care professionals working alongside voluntary and unpaid workers. Often projects have short-term funding and managers spend precious time chasing further resources. The key to supporting primary care and addressing a wealth of issues is the close interagency working between the five refugee agencies in Suffolk:

- Suffolk Community Refugee Team (SCRT) - ancillary health care service provided by NHS Suffolk.
- Social Care Services Asylum Team (SCSAT) - primarily working with Unaccompanied Asylum Seeking Children.
- Refugee Council (RC) - national charitable organisation primarily supporting newly arrived and refused asylum seekers.
- Suffolk Refugee Support Forum (SRSF) - local charitable agency primarily working with refugees.
- Refugee Legal Centre (RLC) - national legal service.

- Supports registration and access to GPs, dentists, opticians and a wide range of other services as needed, thus reducing pressure on primary care and A&E services.
- Access to interpreters.
- Initial health assessment and screening for new arrivals - vaccination needs, TB initial screening and referral, Blood Borne Virus clinic.
- Specialist services - health visiting, smoking cessation, Well Women’s Clinic, Chlamydia screening.
- Adult mental health pathway - assessments, ‘space to talk,’ counselling, support work, support from the Medical Foundation for the Care of Victims of Torture, liaison with mental health services.
- Advice work - support with complex health issues, supporting appointments in primary and secondary health services; completion of forms - including prescription exemption charges.
- Befriending and mentoring by multi lingual support worker.
- Co-ordinating care for victims of domestic abuse and honour killings.
- Support for refugee health professionals through tutorials and physician’s assistant posts.
- Managing concerns patients may have with health services in conjunction with monthly Patient Advice and Liaison Service (PALS) consultations on site.
- Publicise and refer on to a wide range of services.
- Referral to groups provided in partnership with other agencies - care of unaccompanied children (SCSAT); anxiety management (Suffolk MIND); Men’s Group (RC) and Women’s Group (RC & SRSF); English classes (SRSF & RC); support, information and lifestyle skills for young people (4YP); Community Forum (SRSF).
- Multi-agency working through the Multi Agency Forum for new and emerging communities.
Suffolk is well served with statutory and voluntary sector agencies working closely in partnership to support primary care and social care services to meet the needs of this diverse group. Suffolk should be proud of the examples of best practice developed. Although access to individuals living outside Ipswich may be a concern, this was not considered to be a deterrent to a satisfying experience once they have managed to reach these services.

“I am registered with a GP and so is my family. My GP is very good.”

service user 1

“Everybody is helpful. They are very good people, in Refugee Council and SCRT.”

service user 2

“We are particularly fortunate in Ipswich to have the Suffolk Community Refugee Team...”

a service provider.

“...The problems nowadays are less to do with accessing health and more to do with destitution and impact it has on health and wellbeing. Nowadays, mental health issues are more of a concern.”

Migrant workers in the East of England range from the highly educated and skilled, to those who are highly motivated but have no formal education; migrants who come as seasonal workers, those recruited by overseas companies to work in international businesses, others who came with their families, because there were no employment opportunities in their countries of origin.12 Patterns of migration and subsequent health needs associated with the newer migrant populations change frequently, which means that the health needs of these population groups should be reassessed regularly.

How many migrant workers are there in Suffolk?

There are several sources of migration statistics. However, migrants are defined in different ways, so data sources give different numbers of migrants for the same time period.

Table 9: Foreign nationals registering for National Insurance and living in Suffolk

<table>
<thead>
<tr>
<th>Year (tax years)</th>
<th>Total NINo registrations</th>
<th>Largest national group</th>
<th>Registrations made by people from A8*</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004-05</td>
<td>3,240</td>
<td>14% from Poland (450)</td>
<td>23% from A8 (750)</td>
</tr>
<tr>
<td>2005-06</td>
<td>5,300</td>
<td>33% from Poland (1,740)</td>
<td>49% from A8 (2,590)</td>
</tr>
<tr>
<td>2006-07</td>
<td>4,860</td>
<td>37% from Poland (1,850)</td>
<td>51% from A8 (2,520)</td>
</tr>
</tbody>
</table>

* A8 former Eastern bloc countries that joined the EU in 2004

Local data for Suffolk (Table 9) is available from National Insurance Number (NINo) registrations. However, NINo registers are imprecise as they do not account for movements in and out of the county, those who have worked for one year without a break (registration is no longer required); or those who have left the UK (there is no need to “de-register”).

In which sectors do migrant workers work?

There are few reliable figures at county level. Anecdotal evidence suggests the majority of migrants appear to have moved into Ipswich, with a significant...
proportion also going to Forest Heath, St Edmundsbury and Suffolk Coastal districts. Information gathered through the Workers Registration Scheme (which requires registration of all A8 former Eastern bloc countries that joined the EU in 2004) questions the assumption that migration is for seasonal agricultural work. The Office for National Statistics publication Population Trends shows for example that:

- Waveney has the 4th highest percentage in the UK of people from the A8 countries working in the health and medical sector (40%).
- Ipswich has the 6th highest percentage of people in the UK from A8 countries working in administration, management and business services (81%).
- Mid Suffolk has the 9th highest percentage in the UK of people from the A8 countries working in food processing (36%).

Anecdotal evidence also suggests that migrants from eastern and central Europe are engaged in low-wage occupations such as agriculture, construction, hospitality and au-pair work. Many migrants accept low-skilled work and poor living conditions, for better pay than in their home countries or for other benefits, such as learning English, often because they view their job as temporary. All these factors make them more susceptible to poor health.

Like asylum seekers and refugees, the migrant worker population is made up of young healthy people. Of the 4,980 NINo applicants in 2006/07, 57% were male and 74% were aged between 18 and 34 years.

**What are the health needs of migrant workers?**

As described on page 34 health needs assessment was carried out to elicit key messages from service users and services providers. The main issues are described in the box below.

One key finding is that some migrant workers are not registered with a GP, in spite of having lived and worked in the UK for several years. This fits with anecdotal evidence from health professionals who suggest that some migrant workers use A&E services as their main means to access primary care.

Nonetheless, migrant workers who did receive primary care or hospital treatment broadly felt services were of a high quality. They particularly mentioned their satisfaction with immunisation and screening programmes and the receipt of invitation letters reminding them of forthcoming appointments.

**Are there any specific services for migrant workers?**

There are no specific health services provided for migrant workers as they are eligible to access mainstream NHS services. Work-based occupational health services, where they exist, are an important resource.

### Healthcare issues for migrant workers as stated by service users and providers:

- Lack of knowledge and service use.
- Difficulties registering with a GP because of a lack of understanding of the UK health system.
- High A&E attendance, possibly because of unfamiliarity with the UK system which separates primary and acute care.
- Preference to go to A&E even if registered with a GP, because of the ease in accessing care at A&E.
- A local increase in maternity cases, with many booking late appointments and not accessing available ante-natal care.
- Higher rates of late presentation because of problems in accessing care.
- Communication difficulties.
- Most referred to friends or family members for health information. Others accessed information through community networks and/or through established organisations within Suffolk.
- Lack of appropriate information acts as a barrier to accessing available health care.
- Most referred to friends or family members for health information. Others accessed information through community networks and/or through established organisations within Suffolk.
- Lack of available interpreting services impact on satisfaction with services received. Most migrant workers and their families who arrive in Suffolk only speak English as their second language (or do not speak the language at all).
- Difficulties in completing forms e.g. to register with a GP or provide information about medical history.
Sources of information on health needs of refugees, asylum seekers and migrant workers:

- The UN Refugee Agency
  [http://www.unhcr.org/cgi-bin/texis/vtx/home](http://www.unhcr.org/cgi-bin/texis/vtx/home)
- UK Border Agency
  [http://www.bia.homeoffice.gov.uk](http://www.bia.homeoffice.gov.uk)
- BMA
- Refugee Council
  [http://www.refugeecouncil.org.uk/content/home](http://www.refugeecouncil.org.uk/content/home)
- EEDA
  [http://www.eeda.org.uk](http://www.eeda.org.uk)
- DH website
- Kings Fund
  [http://www.kingsfund.org.uk](http://www.kingsfund.org.uk)
- Faculty of Public Health
  [http://www.fphm.org.uk](http://www.fphm.org.uk)

- Information Centre about Asylum and Refugees
  [http://www.icar.org.uk](http://www.icar.org.uk)
- ONS - for Migration stats
References

3. Suffolk County Council (March 2008) Do you know about refugees and asylum seekers?
7. ibid
8. ibid
11. ibid
There are approximately 300,000 gypsies and travellers in the UK. Systematic information is not available for this group as the census and health service use monitoring forms do not have a separate category for gypsies and travellers. Population estimates are based on methods such as caravan counting, which may miss out those in transit, on unauthorised sites and in settled accommodation. At the last count by Suffolk County Council there were approximately 534-604 gypsies on sites in Suffolk. Up to three times as many travellers live in settled accommodation. In the whole of the Eastern region, the number of gypsies and travellers is estimated to be the higher end of 17,000-50,000, making them one of the largest ethnic minority groups in this area.

The nomadic lifestyle of some gypsies and travellers makes interaction with services and institutions difficult. It can for example, be hard for gypsies and travellers to register with a GP, or to find jobs when they do not have a permanent address. The lack of information has led to a historical neglect of this community by policy makers. There are few studies about the health of gypsies and travellers. Most current research literature looks at traditional gypsies and travellers who have a nomadic heritage and excludes new travellers. These studies suggest that gypsies and travellers have some of the greatest health needs in the population.

This chapter provides a brief overview of gypsies and travellers’ health and what we are doing in Suffolk to address their needs.

What are the health issues for gypsies and traveller communities?

Children and maternal health

Immunisation against potentially life-threatening infectious diseases is offered to all children. Traditionally, this includes protection against diphtheria, tetanus, polio, pertussis (whooping cough), measles, mumps and rubella (the last three in the triple “MMR” vaccine). More recent additions are meningitis C, Haemophilus influenza (HIB) and a vaccine against invasive pneumococcal infection. There are low levels of immunisation uptake amongst gypsies and travellers as shown in Table 10.

In Suffolk, there were two measles outbreaks in 2007, one of which was in the gypsy and traveller community.

There were seven confirmed cases of measles in three different gypsy and traveller sites over a five week period. The majority of the children on the Kessingland site were immunised; this reflects good links with the local primary healthcare professionals.

Gypsies and travellers experience higher mortality rates for newborns and more stillbirths than the general population. The perinatal mortality rate is the number of stillbirths combined with the number of babies who died at less than seven days of age, per 1000 births. In gypsy and traveller communities, the rate ranges from 16-28.3 per 1000 births compared...
to 8.2-9.8 per 1000 births nationally during comparable years (Pahl et al.).

A confidential enquiry into maternal deaths in the UK from the Royal College of Obstetricians and Gynaecologists reported that travellers have “possibly the highest maternal death rate among all ethnic groups.” These alarming figures can be due to reduced and late contact with ante-natal services, which have been reported in a few studies (Pahl et al.).

Dental health is also an area of concern. As many as 71% of children between the ages of 3-15 had dental caries compared to 38.5% of five year olds in the rest of the population (Edwards et al.).

Adult health

The main source of information on adult travellers’ health comes from an extensive research report from Sheffield published in 2004 by Professor Glenys Parry and colleagues, supported by the Department of Health (Parry et al.). Other information is available from the “East Cambridgeshire and Fenlands Travellers’ Health Needs Assessment” from NHS Cambridgeshire, which covered the Forest Heath and St. Edmundsbury districts of Suffolk.

Gypsies and travellers from Sheffield, Leicester, Norfolk, London and Bristol were interviewed about their general health in the study by Professor Parry. Their responses were compared to those from permanent residents of similar age in deprived areas. Everyone was questioned about five general dimensions of health: problems with mobility, ability to self-care, impact of health on usual activity, experience of pain or discomfort, and whether they felt anxious or depressed.

Table 11 shows the proportion of gypsies and travellers who report problems in each of the health dimensions compared to the settled population in the research study. This shows that gypsies and travellers experience significantly higher levels of health problems, with the greatest difference reported for anxiety and depression.

Table 10: Immunisation uptake in gypsy and traveller communities compared to national data (Pahl et al)

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Travellers</th>
<th>National</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diptheria</td>
<td>31-33%</td>
<td>94%</td>
</tr>
<tr>
<td>Polio/Tetanus</td>
<td>15%</td>
<td>93%</td>
</tr>
<tr>
<td>Pertussis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measles/MMR</td>
<td>20%</td>
<td>81%</td>
</tr>
</tbody>
</table>

Table 11: Problems with health and daily living experienced by gypsies and travellers compared to settled population.

<table>
<thead>
<tr>
<th>Health Dimension</th>
<th>Travellers (95%CI)</th>
<th>Comparators (95%CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mobility</td>
<td>25% (19.7-30.2%)</td>
<td>15% (10.6-19.3%)</td>
</tr>
<tr>
<td>Self-care</td>
<td>11% (7.2-14.8%)</td>
<td>4% (1.6-6.4%)</td>
</tr>
<tr>
<td>Usual Activities</td>
<td>22% (17.0-27.0%)</td>
<td>13% (8.9-17.1%)</td>
</tr>
<tr>
<td>Pain</td>
<td>33% (27.5-38.5%)</td>
<td>28% (22.5-33.5%)</td>
</tr>
<tr>
<td>Anxiety/depression</td>
<td>28% (22.5-33.5%)</td>
<td>14% (9.8-18.2%)</td>
</tr>
</tbody>
</table>

CI = confidence interval

There are low rates of registration with GPs amongst gypsies and travellers, with those who travel the most having the lowest registration rates. 11% of those surveyed in the Cambridgeshire health needs assessment (HNA) and 16% of those from the Sheffield research study were not registered with a GP. Gypsies and travellers are also less

What is the link between travelling and health?

There is a clear link between health and travelling. Gypsies and travellers identify the benefits of travelling, as greater choice, freedom and more time living together as a family. On the other hand, they also encounter problems with travelling, such as lack of possibilities to secure their choices for accommodation, the lack of control if they are continually moved on from unofficial sites and the unhealthy locations of some sites which have poor facilities.

Poor health is only one factor that compels travellers to take up permanent accommodation. Comparing those gypsies and travellers in settled and non-settled accommodation, those living in settled housing have poorer health. Gypsies and travellers report that the psychological impact and “culture shock” of not travelling has a detrimental effect on their health. It is possible that poor health causes, and is caused by, gypsies’ and travellers’ relinquishing their nomadic tradition. One possibility to improve the health of members of the gypsy and traveller communities is to improve their accommodation choices and make it easier for those who wish, to continue travelling.

What do we know about the use of health services by gypsies and travellers?

There are low rates of registration with GPs amongst gypsies and travellers, with those who travel the most having the lowest registration rates. 11% of those surveyed in the Cambridgeshire health needs assessment (HNA) and 16% of those from the Sheffield research study were not registered with a GP.
likely to consult GPs and conversely more likely to use Accident and Emergency services compared to the settled population. This stems partly from their experience of discrimination from some primary care staff. Nonetheless, there are many examples where professionals, such as health visitors, have gained the trust of the community and the community is much more comfortable consulting them.

Specialised health visitors dedicated to gypsies and travellers can have an important role in improving continuity of care. They will also have a deeper insight into the specific health needs and concerns of this community, which can lead to greater satisfaction with healthcare services through better communication. Use of personally held medical records may also improve care for the gypsies and travellers.

On the other hand, poor communication and a lack of understanding of the gypsy and traveller culture by healthcare staff have been shown to reduce acceptance of healthcare especially prescribed medicines. These problems are compounded by lower levels of literacy than in the general population. The average age of leaving school for gypsies and travellers in the research study was 12.6 years. These issues were raised in the report from the Kesingland site visit. Poor communication can lead to difficulties with reading leaflets, instructions on medications and letters for appointments.

What are the issues for Suffolk concerning living conditions for gypsies and travellers?

A Suffolk cross-boundary Gypsy and Traveller Accommodation Assessment (GTAA) was conducted in 2005. The survey covered the districts of Mid-Suffolk, Babergh, Suffolk Coastal, Waveney and Ipswich. The Cambridgeshire sub-regional traveller needs assessment looked at the districts of St Edmundsbury and Forest Heath as part of their GTAA.

In the Suffolk GTAA, a majority of travellers were satisfied with the facilities available at the Suffolk sites. Gypsies and travellers living on private authorised sites had the highest level of satisfaction, whereas those living on unauthorised encampments were least satisfied. All authorised sites provide access to water and electricity, and over 90% have toilets and waste disposal collection. However, gypsy travellers have a stoical attitude, and their satisfaction may have reflected a comparison with staying on the roadside, usually on unauthorised encampments with no basic facilities. In addition, the GTAA showed that there were insufficient authorised sites and pitches to accommodate all present and future gypsies and travellers in Suffolk.

Nearly a third of those living on unauthorised encampments reported health and safety concerns such as vermin, damp, safety and access for emergency services.

Gypsy and traveller households in permanent accommodation considered their housing to be of sufficient standard. However, approximately a third of this group were expecting to leave their house, a third were unsure if they were to leave and a third intended to stay for a long period of time. The main reasons travellers choose to travel again were difficulties in living with the non-traveller community, financial pressures and feelings of isolation and ‘claustrophobia’. Gypsies and travellers were more likely to settle in permanent accommodation when they experienced long term illness. 27% of households contained someone with either a disability or long-term illness.

What are we doing in Suffolk to reduce inequalities for gypsies and travellers?

Suffolk County Council has issued its strategy to promote the wellbeing of gypsies’ and travellers’ communities for 2007-2009. The strategy aims to develop
In their own words: from gypsies and travellers in Suffolk.

“The travelling community - we worry about our children’s health.”

“Health problems don’t get picked up quickly enough because of the travelling.”

(Tracey)

“We have let down generations of children because of a shortage of stopping places. You can’t access healthcare when you are forced to be on the road all the time. Shelter and food is not living.

We need choices and opportunities, then there will be less sickness, we will be healthier. We need less dependency, more education, more empowerment.”

(Gloria)

In their own words: from gypsies and travellers in Suffolk.

a cohesive approach with partner agencies to support the needs of gypsies and travellers in Suffolk.

In response to the GTAA, the Council is planning new authorised and new transit sites, with a total of 151 additional pitches spread in different boroughs of Suffolk depending on need, (see Table 12.) These will provide more options for gypsies and travellers, allowing them to maintain their chosen lifestyle in a safer and healthier environment.

NHS Suffolk is working in collaboration with the Council and partner agencies such as education and community services, to tackle issues of health and wellbeing as part of the Council’s strategy. The activities are supported by the Gypsy and Traveller Steering Group with membership from key agencies and the community.

The main aims of this work include:

• To improve public health education amongst gypsies and travellers - including information on immunisations, teenage pregnancy, physical and mental health issues, heart disease and diabetes.

• To enable gypsies and travellers to access children’s health services.

• To improve the health of transient gypsies and travellers.

• To enable adult gypsies and travellers to access vocational courses to encourage lifelong learning, and enhance life chances and wellbeing.

• To ensure all gypsies and travellers in Suffolk are registered at a GP surgery.

• To improve gypsies’ and travellers’ knowledge of their rights with regard to benefit entitlements such as incapacity and disability benefits.

• To explore the care needs of older people within the gypsy and traveller community.

**References**


Griffiths S, Public Involvement Manager, Waveney PCT (2005) Health care for members of the travelling community


http://www.shef.ac.uk/content/1/c6/02/55/71/GT%20report%20summary.pdf (accessed 12/05/08)


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<th>Local Authority owned sites</th>
<th>Total number of pitches</th>
<th>Additional pitches planned</th>
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Table 12: Numbers and distribution of gypsy and traveller sites in Suffolk
1999 Carers’ strategy
‘Caring about Carers’ - A National Strategy for Carers published Feb 1999. (The first national strategy)

Age-disputed child
An age-disputed child is an asylum applicant whose claimed date of birth is not accepted by the Border and Immigration Agency and/or by the local authority who have been approached to provide support. This term is usually used to refer to people who claim to be children, but who are treated as adults by the Home Office and/or the local authority. Whether an individual is treated as an adult or as a child has serious implications for the way in which the person’s claim for asylum is treated, and the support received.

Application registration card (ARC)
ARC is a credit card sized document issued to asylum applicants after screening to show that they have applied for asylum. It is also used as evidence of identity, immigration status and entitlements in the UK. It holds identifying information including fingerprints and reporting arrangements in a microchip within the card.

Asylum seeker
An asylum seeker is someone who has lodged an application for protection on the basis of the Refugee Convention or Article 3 of the European Court of Human Rights.

Asylum support
Asylum seekers who are destitute may be able to receive accommodation and/or subsistence support from the Border and Immigration Agency (BIA). This form of support is also referred to as ‘BIA support’. If they have additional care needs, due to chronic illness or disability they may also be eligible to support from their local authority.

Benzodiazepines
A type of drug that can sedate people in the day and help people sleep at night. However they often cause dependence (both physical and mental) when taken for more than a few weeks.

Blood Borne Viruses
Viruses carried in people’s blood stream. The most common serious Blood Borne Viruses are hepatitis A, hepatitis B and HIV.

Border and Immigration Agency (BIA)
The Border and Immigration Agency is an executive agency of the Home Office. The Agency manages and enforces immigration control in the UK, including applications for permission to stay, citizenship and asylum. It is responsible for policy development in these areas of law. In 2008, the BIA will become part of the UK Border Agency, integrating the work of BIA, Customs and UK Visas.

Carer’s Assessment
The law says a carer has a right to an assessment if they care for someone for ‘a substantial amount of time on a regular basis’. The relevant legislation is the Carers (Recognition & Services) Act 1995 and the Carers & Disabled Children Act 2000. The purpose of a carer’s assessment is to discuss with social services the help the family carer needs with caring, plus help to maintain their own health and to balance caring with their life, work and family commitments. Adult and Community Services use the assessment to decide what help to provide.

Carers Grant Allocation
The carers grant is paid as part of the new Area Based Grant from April 2008. It is intended to enable local authorities to continue to develop innovative, personalised improvements reflecting the needs of their local carer population.

Carers UK
Was set up by carers themselves and to this day is still a member led organisation. The members appoint the Trustees who must always be a majority of carers. Members set the priorities and define campaigns.

Category C resettlement prison
A closed, secure prison which normally accepts prisoners who have a year or so of their sentence to serve. The focus tends to be on work and training as a means to help prisoners resettle into the community.

Category C training prison
A closed, secure prison accepting prisoners who may have long sentences to serve and offering extensive work and training facilities within the prison for internal and external contracts.

Category D prison
An open prison usually focusing on resettlement and working for those at the end of their sentences. Subject to a risk assessment and close monitoring, prisoners are able to work outside the prison on a voluntary or paid basis.

Census
A collection of data from the whole population. Last done in the UK in 2001.

Children in need
Those who are disabled or whose vulnerability is such that they are unlikely to reach or maintain a satisfactory level of health and development, or their health and development will be significantly impaired without the provision of services.
Community Service Volunteers (CVS)
The UK’s largest volunteering and training charity.

Coronary heart disease (CHD)
Coronary heart disease (CHD) is a narrowing of the small blood vessels that supply blood and oxygen to the heart.

Diabetes
A disease associated with high levels of sugar in the blood. A person with diabetes is at higher risk of other diseases such as heart attacks.

Dispersal
Dispersal is the process by which BIA moves an asylum seeker to accommodation outside London and the South East. They are first moved to initial accommodation while their application for asylum support is processed. Once the application has been processed and approved they are moved to dispersal accommodation elsewhere in the UK.

Ethnicity
A person’s ethnicity is a complex mix of their country of origin, race, culture, language and religion.

Every Child Matters
2004 government strategy for children focusing on all aspects of health, growth and development.

Expert Carers Programme
Part of a package of measures to support carers (the New Deal for Carers). It will build on the training already available to carers to ensure that all carers over the age of 18 can access good quality training, to enable them to safeguard their own health and wellbeing, and that of the person they care for.

In-reach
A service that is provided to prisoners within the prison and can be designed to specifically meet their needs.

Looked after Children
Children who, for a variety of reasons, are placed in the care of local authorities.

Methadone maintenance
Methadone can be substituted for opiates in the management of opioid dependence. It would be part of a treatment programme including medical, social and psychological treatment.

Neurotic disorder
Often enduring or recurrent without treatment. Symptoms are distressing to the individual and recognised by him or her as being unacceptable. They can be wide ranging and include anxiety, depression, sleep disturbance, panic etc. Social relationships may be greatly affected.

Opioids
Medication used to relieve severe pain. They are also used illegally. An example is heroin which is used by drug addicts but is also highly valuable (as diacorphine) for people who have pain from terminal cancer. They are highly addictive, both physically and mentally and as tolerance develops the same effect a higher dose is needed to achieve the same effect.

PALS
All NHS Trusts in England have a Patient Advice and Liaison Service (PALS) which aims to provide information about the NHS and help with other health-related enquiries, including how a complaint can be made or concern resolved.

Perinatal death
A perinatal death is defined as a child stillborn or dying in the first week of life.

Personality disorder
Personality disorders involve deeply ingrained maladaptive patterns of behaviour, which cause harm to the person and/or to other people. These disorders are generally recognizable by the time of adolescence, and continue through most or all of adult life.

Principle Applicant
The person under whose name the application for asylum has been submitted to the Home Office. A principle applicant can apply on behalf of other accompanying family members together and this asylum claim will be counted as one application.

Psychosis
A group of serious mental illnesses in which the sufferer has difficulty telling what is real from what is not real.

Refugee
A refugee is a person who ‘owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of his nationality, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country...’ (Definition quoted from the 1981 Refugee Convention)

Refugee Convention

Refugee status
Refugee status is awarded to someone the BIA recognises as a refugee as described in the Refugee Convention.

Section 4 support
Section 4 of the Immigration and Asylum Act 1999 gives the BIA power to grant support to some destitute asylum seekers whose asylum application and appeals have been rejected. Support granted under Section 4 is also known as ‘hard case’ support.

Self harm
Where a person harms themselves, this might included cutting or other types of physical harm.

Stroke
The sudden death of some brain cells due to a lack of oxygen when the blood flow to the brain is impaired by blockage or rupture of an artery to the brain.

Suffolk Family Carers
A charitable trust set up with the aim ‘to improve the lives of Family Carers and to provide information, advocacy and support to Family Carers of all ages, and also to raise awareness and inform service purchasers and providers about the needs of Family Carers, to enable the development of good practice throughout all organisations.’ They are a member of the Princess Royal Trust for Carers.

Unaccompanied children seeking asylum
Unaccompanied children seeking asylum are children who have applied for asylum in their own right, who are outside their country of origin and separated from both parents, or previous/legal customary primary care giver.
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