

Community Focus Group with:

Latin American Women's Rights Service (LAWRS)

Findings & Recommendations

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Healthwatch Southwark

As part of the Health & Social Care Act 2012, Healthwatch Southwark (HWS) was established in April 2013, delivered through the contract won by Community Action Southwark (CAS). Supported by a National Healthwatch England, HWS is intended to bring the local consumer **voice and champion patient and public involvement** to influence, shape and ultimately improve health and social care services in Southwark.

HWS is currently guided by a sub-committee of CAS consisting nine organisational representatives affiliated with a range of community and user groups. For more information visit www.healthwatchsouthwark.co.uk

1. Why are we carrying out our Community Focus Groups?

For Healthwatch to be as representative of the local community's voice (and needs), we have started a programme of engagement with a wider and more diverse part of the population, in particular the *seldom heard-those not typically involved in consultations or statutory engagement structures*. Thus, we will be holding an ongoing programme of Community Focus Groups. As part of our engagement strategy we will engage and involve both community and user groups, and the wider population.

Programme aim:¹

- Increase our knowledge, and insight into a range of issues across different groups
- Build ongoing relationships with individuals, groups and organisations and fulfilling our role as the *network of networks*.
- Inform our Strategic Priorities and Activities (see Appendix)
- Influence specific services and longer term planning and delivery of local services.

Focus Group aim: To explore the key issues within these communities, specifically:

- Highlight particular health and care behaviours,
- Gain insight into the challenges they face, both specific and general faced by members of the community

What will we do with it?

- Develop ways to address them working in partnership with those bodies responsible for health and care services, including using our statutory powers

2. Profile of the Latin American Community

¹Note: Findings are not intended to be represented of a whole community, there is diversity within all communities, nor quantifiable.

Based on the recent comprehensive research project in the Latin Community (“*No longer Invisible, 2011*”), over 1000 people were surveyed through a mix of long, short questionnaires, focus groups and in-depth interviews.

- There is an estimated 113, 500 (61%) living in London (2008)²
- Could be referred to as a new migrant group, with 2/3 arriving since 2000 and more than 1/3 arriving since 2005.
- There is no official national statistics/monitoring data for the Latin American communities, with mixed identities of nationalities within the Latin American countries.
- There is national low take up of health and welfare public services. 1 in 5 are not **registered with a GP** and 4 in 10 have not seen a dentist³
- Many use **private health services**⁴, sometimes alongside a GP
- Many use **migrant organisations** for a variety of advice and support needs.
- **Limited or lack of information** due to language and awareness issues
- **Language difficulties** hindered their integration into economy and society.

Specifically in Southwark,

- Southwark Council has officially recognised the Latin American Community has a separate ethnic group (2012). More recently, Lambeth Council has also officially recognised the group (2013)
- Southwark & Lambeth hold the largest concentrations, with high numbers of Bolivians and Colombians.⁵
- The Latin American groups include: Bolivians, Peruvians, Ecuadorians, Brazilians, Columbians, although this is not exhaustive

Relating to Health...

- Feedback on the difficulties in registering with a GP practice
- **Private services** are an issue, including unofficial over-the-counter medicines. (Southwark Council’s *Healthwatch Outreach Report (Oct 2012)*)

3. What we did

The session was conducted in Spanish, led by LAWRS with staff support from CLAUK and Healthwatch. The approach was a mixed method approach, comprising a short survey with key topics explored in focus group discussions, case studies and detail into the ‘*whys and how’s*’.

Approximately 29 people were present, including those arriving late and leaving early. A total of 25 surveys were returned. The session was split into two: **Part 1: Survey**, and **Part 2: Discussion**

Accompanying documents were translated and provided at the session:

- **A signposting document** providing information on how to access health services, outside of GP Out of Hours, and social care services including how to leave feedback / complain about services was translated.
- **Survey**

²McIlwaine. C, Camilo Cock. J and Linneker. B, Supported by Queen Mary University of London, LAWRS, Trust for London, “*No Longer Invisible People*”, 2011

³ Ibid. Survey

⁴ 40% of those surveyed used private services and 1/3 access community organisations for support and advice

⁵ Survey respondents 15% Southwark and 14% from Lambeth.

4. Findings

Findings from both parts of the session will be themed into the key aims, following the topic guide.

1. Key challenges or barriers in accessing health & social care services
2. Needs specific to the community
3. Ways to offer “good quality services”
4. Best way to get and obtain information

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1. Key challenges or barriers in accessing health & social care services

A lot of discussion and experiences centred on GP access and hospital care services. What came through strongly were the **perceived** barriers regarding *non-clinical care*, *specialist services* and cases of *clinical consequences*. **Language** and **Information** on services and the health care system seemed to be the underlying issues in creating challenges to access.

Quotes from participants are included in the text below. Case studies referred to are included in the appendices.

A) Language

Most attendees could not speak or read English and this hindered their ability to both *access* services, and get a *'good quality 'experience*.

i. Access(Process)

Through the Focus Group, it came out strongly the difficulties in **registering** with a GP arising from a **language barrier** was strongly emphasised. They could not communicate and/or understand the 'dos and don'ts' and 'can and cannot'. Experiences ranged from being "*denied the right to register until they could bring someone who could speak English*" with some resulting in using the Accident & Emergency departments to *finding it difficult to know what document was needed*.

Many experiences expressed that the actual process of **entering** a Practice to register was very unwelcoming and felt "*humiliated and disrespected*" or "*way they speak to you...*"

The **availability of an interpreter** affected how long it would take to book an appointment "*the same appointment is delayed 2-3 weeks when having an interpreter*" or if the appointment took place or not. "*...got there... there wasn't an interpreter, the appointment was cancelled. I am still waiting...*".

ii. Quality (of Service)

In the discussions, **quality** highlighted two dimensions; the **availability of interpreter** to facilitate communication, and the **quality of the interpretation** in a health context.

Survey results showed 4/5 (20) people did not have an **interpreter** at GP service level, with $\frac{3}{4}$ felt that it affected the **quality** of their GP appointment "*a lot*". Some referred to the role of the receptionist facilitating interpreting services. "Receptionists are negligent to **arrange** for interpreting services"

Follow up appointment and letters received were in English and then missed or not understood which affected the follow up care. One person shared her experience relating to her child's care who had had asthma "*She couldn't argue due to the language barrier...she now takes him to the hospital with a paper that explains his condition in English*" (Case Study 7). Another lady shared her experience "*She broke down into tears as her pain was unbearable, but couldn't argue with the doctor, as her English language knowledge was very limited...*" (Case Study 5)

Children and/or relatives have also acted as an informal interpreter.

“When they don’t have the phone line we depend on our children to understand what the doctors say” ‘I usually call my friends over the phone and they translate for me with the doctors...’ (Case 8)

Booking an interpreter did not always mean the appointment would take place. Delays, cancellations and interpreter availability were common. *“The same appointment is delayed 2 or 3 weeks when having an interpreter”*.

Where an interpreter was made available, the quality of the translation was questioned with the patient not always satisfied. *“You can never know whether they are translating correctly and sometimes they seem very insecure of knowing medical language”*.

When using informal interpreters (family, friends), it is more likely for miscommunications and misunderstanding between the GP and the patient to take place, resulting in negative experiences of care. Case 8 highlighted *“I usually call my friends over the phone and they translate for me with the doctors. They have told me my baby has not developed as expected, but my friends did not understand exactly what that meant, since they do not know about medicine. I do not know exactly what or why my baby hasn’t developed. ...nobody has offered me an interpreter to explain what happens with my baby...”*

B) Information

i. No place to go to get information- Where or how to get info?

On the whole, many attendees did not know *where or how* to get information relating to NHS and social care. Survey results showed **friends and associates** through word of mouth were their main source of information and advice (Case 9) *and/or* how to access services. The same number of people also said that they did not know where to get information *“friends because I don’t know where else to go”*. 4 people cited community **groups or associations**. 2 stated **newspapers** with one referring to the Southwark primary school service and another said GP/hospital.

“It is very difficult to find information about services and treatments”

In the survey, we asked if a) they had a long term condition and what it was and b) if they felt supported to manage their long term condition. Interestingly, many respondents responded (X) to part b) they *“did not feel they could support their condition”*, even when they stated they did not have a long term condition. In response to the follow up question of *what would help them*, most said *“more information”*.

Where information was provided, it was **not given in Spanish**. This applied to both general service information (i.e. alternatives to Accident & Emergency) and specific services (i.e. specialists, sexual health clinics or other social and community services) not known to them.

“We don’t know who is entitled to what.” (In relation to Patient Transport)

ii. Pathways: Treatments, services provided/not provided, entitlement to what (PROCESS)

Through discussions there were many experiences whereby lack of information and/ awareness of services prevented or delayed their access or treatment.

- The majority **did not know** how to access the different services listed (GPs, emergency room, specialists, sexual health clinics, or other social or community services). This survey result showed that aside from a couple of responses, most did not know where to go outside of GP hours, aside from the A&E. (although this is common across the general population as well). Only 28% knew a little about the services offered at GP level, 56% did not know.
- If they could not access a service for whatever reason, they had **no way of knowing if that was accurate or not** “...if a service is denied I am unsure if that can be reported...”. Most people did not know about the complaints process, “...other women and their babies should not go through this...but I couldn't because I did know” (Case 6)but those who did “it does not have any way to support a person who does not speak English”
- This included **what other services** were available relating to their care, i.e. patient transport. “We don't know who is entitled to what.. .’
- There was a strong sense of a **barrier by GPs to access specialist** services or tests.

“started having problems walking and urine leakage. As her GP was reluctant to run any kind of colon test, she went to visit another GP and then paid £600 in x-rays. She was the referred to a neurologist, had a series of MRI tests ...” (Case study 5)

“GPs are very reluctant to refer patients to specialists; they only send you when the condition is extremely bad”

2. Needs specific to the Latin community

A lot of discussion centred around the limited understanding from health staff on Latin cultural characteristics in terms of female sexual health and health habits, and in terms of social care around family dynamics.

In order to understand, the following issues, you will need to understand the context (in italics)

In marriages and relationships, a healthy sexual life is encouraged and considered a part of Latin culture. However, as a generally considered patriarchal society, women seldom openly discuss this part publicly due to stigma issues attached. (LAWRS)

Many felt it could be **difficult to speak** about certain topics ranging from sexual health, sex life, birth control to period situations. One described themselves as a “*patriarchal society*” and it was *embarrassing* to speak to men about sexual health particularly “*lack of understanding on issues to female sexual among males*”, or a female from “*traditional cultures*” where they felt ‘under scrutiny’.

What came out through discussions was that **sensitivity and support** was needed when interacting with the migrant community, especially as many will have limited knowledge on NHS and social care services.

A lot of attendees felt their **needs were ignored** which they felt resulted from a lack of support/channels to express their need.

3. Ways to offer a good quality services.

First what is meant by a 'good quality service?' This section centred on what attendees thought a good quality service should be, some of which was drawn out from case studies...

- **Representative staff** that reflects the diversity of the population, especially related to pockets of GP practices where Latin communities are concentrated. A Latin American receptionist could expedite some of these cultural awareness and access issues.
- **Education** about the new and unknown UK system, understanding the health structures and pathways as distinct from Latin American countries. Latin staff could support the information dissemination. ([Medication, drug prescribing, access to specialists tests](#))
- A place to getting **information and signposting** service in Spanish.
- **Easier access to specialist services and tests.**
- The role of staff/receptionists to be aware and assess **if the person requires language** line or an interpreter with the willingness to facilitate this.

*"Receptionists are negligent to **arrange** for interpreting services" Receptionists should understand why people ask for interpreters and should not be reluctant to do so when needed."*

- Clinical staff and support staff, especially receptionists, should have **cultural and diversity awareness training** in terms of understanding and communicating with particular groups
- Compassion, patience and sensitivity and empathetic approach.

4. Best way to get information to the Latin American community, and obtain information from them

We asked *where* individuals currently receive their information and *how* they would like to receive it.

Currently⁶ 1/3 of attendees go to their friends or people they know for information and advice, 1/3 did not know where to get information, 1/6 people said community groups and associations, a couple referred to newspapers with individual cases relating to children services, GP/hospitals.

"friends because I don't know where else to go"

What is the best way to receive information?

- Website and by post
- Workshops for migrants
- Easier access to information, signposting or advocacy in Spanish

⁶ 2 people did not answer this question.

How can bodies/we (statutory bodies, Providers, Commissioners) obtain information from you?

- By making it easier to complain and/ or get advice
- By making it easier to leave feedback on services (*i.e. a place they could give feedback which could be at their GP or in a specific location after they have received a medical / social care service*)
- Include Latin American ethnicity into their data monitoring

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Other areas that could be explored..

Other issues that were mentioned but not explored in detail included:

Social Care

- Similar issues arose relating to little understanding of how the social care system operates, who is entitled to what, and how to get information about support and other services. This included the 'soft side of care' and patient experience, sensitivity, support and compassion. Examples included:
 - Child with disabilities. *"I feel the social worker wanted me to go back to Spain, so he did not have to deal with my case."* (Case 10) - *'Keyworker spoke English...tried best.*
 - Applying for disability allowance *hasn't been able to contact adult social care services to get information...since all info is in English....'*
 - *Case study 9 about patient transport relating to social care.*

Discharge and communication between hospital doctors and GPs

- Consequences relating to **different medication, prescription and diagnoses**, between GPs and Hospital Doctors. (Case 1, 3, 4)
- Some cases clearly referenced that not being able to communicate in English either exacerbated the situation or indirectly affected the outcome of the situation. (See case studies: Case 7)

Other primary care services

- Are similar issues arising in different primary care services, outside of GP services?

"My child had an appointment with the optometrist, I waited for 3 week for that appointment, I requested an interpreter, when I got there, there wasn't an interpreter, and the appointment was cancelled. I am still waiting for the appointment"

Complaints process

- Not understanding how and who to complain to, and sometimes not being able to complain due to language or other issues.

After this extremely traumatic experience, she wanted to make a complaint - "other women and their babies should not go through this" - but couldn't do so due to lack of knowledge of the complaint procedures. (Case Study 6)

The effect of eating habits on health

"Our eating habits are completely different than the British or Asian ones. We come here and, because the water has a lot of scale, our digestive system struggles"

GP specialism in paediatrics (child health)

- Acknowledging that LAWRS is a women's organisation and will understandably have higher proportion of mothers, it's not unexpected that **paediatric services** was highlighted. Experiences relating to the GP role not possessing the knowledge required to treat young

children with one attendee stating “*Children should not be seen by a GP who doesn’t know anything about children*”

5. Conclusions/Summary

- Some issues seem to be more prevalent in the Latin community as well as **specific issues** around language and information and cultural characteristics, however there are other issues that also **reflect broader issues from the ‘general population’**.
- Not being able to speak English, especially when the **means to support or facilitate communication is not there**, hugely affected both access to services, and the quality of care experienced. If support is not provided, it cannot be expected that people will speak up.
- Complementary to language, **useful information was not easy to find**. There is a huge knowledge gap on where to go to find information led to anecdotal and word of mouth as an unofficial source. This created uncertainty on what the experience should be or if the professional information/advice given was credible. In some cases they did not know if they were within their rights to ask questions, challenge or they were worried about repercussions.
- The Group showed minimal awareness and understanding of the different services available, if the GP practice was closed and as an alternative to A&E. Coupled with the knowledge gap, this has implications on current local and national NHS campaigns particularly around the “Choose Well”, the review into the urgent care system and the policy and cultural drive towards ‘empowering people to self-manage their conditions’.
- Communication and information were not in **accessible format**, i.e. translated documents, services, as appropriate.
- There is a strong sense of wanting and needing to be informed, with a **keenness to access this information** whether that is in workshops, or from a central source.
- A lot of unhappiness about how staff, particularly receptionists, communicated and engaged with patients, particularly those not confident in their knowledge of the system, and in their English ability.
- **By understanding the cultural context, particularly around sexual health**, could help to address their issues around the difficulties in speaking to males and females from conservative backgrounds.
- **A lot of bad experiences have led to a breakdown of trust with GPs**, and between GPs and Hospitals. Some implications included reverting to private services (accredited or not is another issue), and/or using the A&E as their ‘go-to’ place for care treatment.
- By not being able to access the complaints process, and knowing where to leave feedback, could mean that **Service Providers and Commissioners may miss the opportunity to obtain user intelligence**, which could be incorporated into service/systems improvement.

6. Recommendations / Actions / Who

For service providers to include Latin American ethnicity their data monitoring

- To help identify the population, what services and where they are accessing them. This will provide the start of dialogue towards understanding needs and supporting access.

Breaking down access barriers to local services *through support and information:*

- GP Practices to make their registration process clear

What we have done?

- *HWS has produced a statement outlining the process for registering with a GP Practice, including what is allowed and what isn't. LAWRS has translated and circulated the statement.*

Immediate work...

- *HWS to produce a log for LAWRS and other Latin groups, to record experiences at specific GP practices.*

- Clear information on how to access Interpretation at both GP's and Hospitals

Immediate work...

- *HWS will produce a summary sheet on access to interpretation services at primary care services and at hospitals (Future: NHS 111 sheet to follow)*
- *Understand the current process, and the relationship between language line and an interpreter.*

Building awareness of local health & social care services

Immediate work...

- *HWS produced a signposting document outlining how to access different health and social care services and how to complaint.*
- *LAWRS has translated and cascaded this. We will further build links with other local Latin groups to circulate this information widely.*

Receiving Information

- Understanding key patient pathways (i.e. how to access, or know where to)

- Information workshops, service updates through HW to community hotspots and networks
- Simple place to get info & signposting

Making it easier to leave feedback, and complain

- GP Practices and Hospital Wards should make clear, advertised and physical means of encouraging feedback, and those wanted to complain. (Mapping of the Latin Population within GP surgeries could inform the extent of reasonable adjustments).

- Take the complaints section from Healthwatch Signposting document, and transform into a leaflet.

This includes the organisation, Voiceability, commissioned to provide complaints support (Independent Complaints Advocacy Service) regarding NHS services. (Social Care is different)

Cultural & diversity awareness

- For frontline staff to undertake cultural and diversity training, particularly around sensitively, support, patience etc. to migrants who may not have information.

Other work...

Shorter specific pieces of work, as indicated, will be actioned. However, wider pieces of recommendations will be incorporated when formulating our action & monitoring plan for our priority: *Access to GP services*. This will also include focus group findings from our recent deaf support group. **DATE: JAN/ early FEB 2014**

Further exploration on the practicalities and approach, the role of statutory body or other body/group required and the monitoring side is needed. However Part of the Priority Action Plan will include,

- Mapping staff population
- For GP practices in particular, to understand their local patient population in terms of additional needs.
- Partnerships with LAWRS and other statutory bodies (LBS, CCG) to facilitate community feedback, & distribute information
 - Short term - be informed
 - Longer term - get involved in decision making at local level
- Support to complain and/or feedback

Strategies these findings will feed into

- Primary and Community-based Care Strategy (NHS Southwark CCG)
- NHS Southwark CCG Commissioning intentions 2014/15
- Joint Health & Well Being Strategy 2014 onwards
- Joint Strategic Needs Assessment

APPENDIX A:

Latin American Women's Right Service

LAWRS is a charity established in 1983 directly engaging with other 4,000 Latin American migrant women in the UK every year. It delivers programmes which focus on promoting economic security, tackling violence against women and girls, and on improving opportunities for successful integration. www.lawrs.org.uk

Coalition of Latin Americans in the UK (CLAUK)

CLAUK is a coalition of 11 Latin American organisations that have come together to raise awareness and understanding of the issues facing the Latin American community in the UK and to provide a collective voice for, and represent the collective interests of the Latin American community in the UK.

www.clauk.org.uk

APPENDIX B: CASE STUDIES

Note: All names have been changed.

Case 1

4-year-old girl with heart problems and diabetes had to be taken to the hospital due to a crisis. She was given a prescription. When her mother took her to the GP, the GP said that the medication was not appropriate for her case and that it would actually harm her. The girl wasn't given the prescription, had a new crisis and had to be taken to the hospital where the mother was questioned for not giving the child the medication.

Case 2

As an informal community worker, Sandra normally accompanies people to the hospital to help them with the English. She frequently finds that patients are referred from the GP to a hospital, and from one hospital to another without providing a clear treatment plan.

Case 3

An older Latin American with Diabetes type 2 (56 y.o.) was given a prescription in the hospital after an emergency episode, when she went back to her GP, he told her that prescription wasn't for her and

stopped the prescription. She had to go back to the emergency room, where she was called negligent for stopping the previous prescribed medications. She stated she does not know trust any of the doctors' opinions anymore.

Case 4

Marta (Colombian, 43) went to the GP with pains in her stomach. She was told it could be a premature sign of menopause. As the symptoms were persistent she was told that she could be pregnant. After a check-up and no responses, Marta went to the hospital where she had a meeting with a team of 10, which included nurses and doctors. Her condition was getting worse, she started bleeding a lot, but she had no diagnosis. After 6 months, she decided to go back to her home country to seek medical advice, having to face a 12-hour flight with severe blood loss. The doctors in her home country found that she had fibroids. She had to go through surgery and she was informed that her life was at risk.

Case 5

Mabel (Ecuadorian, 45) was feeling pain in her back. She went to see the GP and was given anti-inflammatory tablets. After a few months, the problem persisted and she started having problems walking and urine leakage. As her GP was reluctant to run any kind of column test, she went to visit another GP and then paid £600 in X-rays. She was then referred to a neurologist, had a series of MRI tests and was then told, "You have absolutely no problem". She broke into tears as her pain was unbearable, but couldn't argue with the doctor, as her English language knowledge was very limited. She decided to pay for private services. Her private doctor explained that she had 3 worn discs in her spine. She spent £2,800 over 8 months to receive treatment. She now feels a lot better but continues to pay for private services periodically.

Case 6

Laura (Peruvian, 35) was about to deliver her baby in St. Thomas Hospital. Her water broke, but she didn't have enough dilation. She was told that although her water broke the labour could still wait up to 72 hours and was sent home. She asked to give birth by caesarean, but the doctors did not agree to it. She had an induced dry labour, which resulted in the baby having to stay in intensive care for 5 days due to the severe wounds (burnt from lack of liquid and had to be pulled out). Her husband was present, begging for a caesarean to be performed, but the doctors did not agree. The baby was born with a very low pulse and currently has respiratory problems. After this extremely traumatic experience, she wanted to make a complaint - "other women and their babies should not go through this" - but couldn't do so due to lack of knowledge of the complaint procedures.

Case 7

Manuela (Bolivia, 32) has a 3-year-old boy with asthma. He once had a crisis and was making a whistling noise when breathing, so she took him to the GP who told her that it was "normal" and that there was nothing to worry about. He provided no treatment, but she couldn't argue due to the language barrier. She took the child to the St. Thomas Hospital, the child had an infection in his right lung, had to be intubated, was given oxygen and had a very low pulse. She went back to the GP, but she was told that they had no records of the boy having asthma as they had lost his clinical history. Since then, and as she is unable to speak English, every time the boy has an asthma problem, she takes him to the hospital with a paper that explains his condition in English.

Case 8

Violeta (Ecuador, 34). “I am pregnant; I have worked for the entire 7 months of my pregnancy. I have never given an interpreter to talk about my baby’s situation. I usually call my friends over the phone and they translate for me with the doctors. They have told me my baby has not developed as expected, but my friends did not understand exactly what that meant, since they do not have knowledge about medicine. Therefore, I do not know exactly what or why my baby hasn’t developed. I have been hospitalised twice, and no body has offered me an interpreter to explain what happens with my baby. I am also homeless and live one day in one house, and one day in another one, but I am afraid to contact social services because they might take my baby away. I know they know I speak Spanish, but they act as if I can understand everything”.

Social Services

Case 9

“We don’t know who is entitled to what. I have my mother in law and my 2-year-old daughter to take care of every day while my husband works. My mother in law uses a wheelchair and whenever I need to take her to the hospital; it is very difficult for me to get her into the car while keeping an eye on my daughter. I always end up paying for a mini cab, although we have a low income. I feel very guilty because, although we have a park across the road, my daughter is in the house all day because I have to take care of her granny. We don’t even know what kind of help we can receive in terms of transport or help in the house.”

Case 10

Luz, (Ecuador, 40), “I have 2 children with disabilities, and I had to work to feed them, for a while I left them in the place where we used to live by themselves, so I can work. Then, I had social services to visit me, they stated I had to stop doing that; otherwise they will take my children away. I stopped going to work because I did not have anyone to take care of my children. I was evicted from the place I rented, and I did not have any money. The social worker contacted the Spanish embassy to see if they can take me back to Spain, they responded that was not possible. Social services allocated one room in a hostel to me and my 2 children with special needs, without a school or any income. I have also to pay the hostel, and I did not have any income. I have a key worker for the children, but he only speaks English, however, he has tried his best and he is trying to help. However, the social worker is not very involved in the case, and despite all the complications with older child aggressive behaviour towards my younger child, I am still living in one room accommodation. The psychiatrist and doctors have written letters stating the distress that my children are living by living in one room accommodation. The social worker was worried about my children when I left them alone for work, but he is not worry about my children who have especial needs becoming emotional distress of being in one room. I feel the social worker wanted me to go back to Spain, so he did not have to deal with my case.”

Case 11

Mari (Colombia, 36). “My husband has been diagnosed with a chronic illness in his back, which will only degenerate from now on, and this does not allow him to work. We do not have any income coming into the house, since I have to take care of him and my daughter most of the time. I am applying for disability allowance; however, I haven’t been able to contact adult social services to obtain information on how I can get help, since all the information is in English.”

APPENDIX C: SURVEY RESULTS

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