

Somali Disability and Elderly Association  
**Disabled and Elderly Somalis in Bristol**



67 Kington St Michael Chippenham SN14 6JE  
T 01249 758 350 F 01279 750 027  
E [enquiries@transparencyresearch.co.uk](mailto:enquiries@transparencyresearch.co.uk)  
W [www.transparencyresearch.co.uk](http://www.transparencyresearch.co.uk)

**Bethan Prosser, Latif Ismail and Alex Hall**

**SOMALI DISABILITY AND ELDERLY ASSOCIATION**  
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**DISABLED AND ELDERLY SOMALIS IN BRISTOL**

<b>1. Executive Summary .....</b>	<b>3</b>
1.1 Introduction .....	3
1.2 Methodology.....	3
1.3 Research Findings.....	3
1.4 Conclusions and Recommendations .....	4
<b>2. Introduction .....</b>	<b>5</b>
2.1 Somali Disability and Elderly Association .....	5
2.2 Transparency Research Partners Ltd .....	5
2.3 The Need for the Research.....	5
2.4 Methodology and Outcomes .....	6
2.4.1 Objectives.....	6
2.4.2 Methodology.....	6
2.4.3 What it was possible to do.....	7
2.4.4 What it was not possible to do.....	8
<b>3. Research Findings .....</b>	<b>9</b>
3.1 Number of Disabled and Elderly Somalis in Bristol.....	9
3.1.1 Census 2001 .....	9
3.1.2 Other Data Sources.....	10
3.1.3 Elderly People.....	11
3.1.4 Disabled People .....	12
3.2 Service Provision for Elderly and Disabled Somalis .....	14
3.2.1 Potential Future Provision .....	15
3.3 Service Gaps for Elderly and Disabled Somalis .....	16
3.3.1 Lack of knowledge of the services/system .....	16
3.3.2 Housing.....	16
3.3.3 Benefits .....	17
3.3.4 Health Services .....	17
3.3.5 Somali Community in Bristol.....	18
3.3.6 Language and cultural barriers to services .....	18
3.3.7 Reliance on the community and key individuals.....	19
3.3.8 Isolation.....	20
3.3.9 The need for Somali advocacy.....	20
<b>4. Conclusions and Recommendations .....</b>	<b>21</b>
4.1 Conclusions.....	21
4.2 Recommendations.....	21
<b>5. Appendices .....</b>	<b>23</b>
5.1 Appendix: Additional Related Research.....	23
5.1.1 Audit into Social Care Needs of Refugee Communities in Bristol .....	23
5.1.2 Servicelinks and the Housing Dept. of BCC Consultation with the elderly....	23
5.1.3 West of England Coalition of Disabled People, Ashley, Easton, Lawrence Hill, Knowle West and Barton Hill.....	23
5.1.4 Martha Debbage, Social Work masters dissertation .....	24
5.1.5 Bristol MIND– Assertive Outreach Research.....	24
5.1.6 Somali Mental Health Research Group .....	24
5.1.7 Waiting for the Sun to Rise – Khat Research Project, Latif Ismail, commissioned by Community at Heart .....	25
5.2 Appendix: Service Provider Profiles .....	26
5.2.1 Age Concern Bristol.....	26

5.2.2	Black Carers Project .....	26
5.2.3	Black Orchid .....	26
5.2.4	Easton Jubilee Trust.....	26
5.2.5	FabuUK.....	26
5.2.6	Bristol Mind.....	26
5.2.7	RNIB .....	26
5.2.8	St Monicas Trust.....	26
5.2.9	Somali Voice .....	27
5.2.10	ServiceLinks.....	27
5.2.11	St Paul's Advice Centre.....	27
5.2.12	WECIL .....	27
5.2.13	Welcome Project.....	27
5.2.14	Health Links .....	27
5.2.15	Bristol Older People's Forum .....	27
5.2.16	Bristol Disability Equality Forum .....	27
5.3	Appendix: Interview Schedules .....	28
5.3.1	For Service Providers.....	28
5.3.2	For Service Users .....	28

# **1. Executive Summary**

## **1.1 Introduction**

This research was conducted by *Transparency Research Partners Ltd* (TRPL) for the *Somali Disability and Elderly Association* (SDEA). The research brief was to explore the number of elderly and disabled Somalis in Bristol, current service provision for elderly and disabled Somalis and their current needs. The research was to highlight any gaps between service provision and needs.

## **1.2 Methodology**

Statistical information on this community is hard to find, therefore the methodology was largely qualitative. A TRPL researcher conducted 11 interviews with elderly and disabled Somalis in the city, 15 interviews with voluntary and statutory organisations, six interview with health professionals and two interviews with representatives from the local council. Most of these interviews were conducted over the phone, as the resources for the research were limited. Future research should include resourcing for face-to-face interviews and include more key agencies as well as a higher sample of service user respondents.

## **1.3 Research Findings**

Overall our findings were that elderly and disabled Somalis within the city were not served well by current service provision and there was a need for a community organisation to advocate on their behalf and provide direct services. Estimates of the number of Somalis in the city ranged from 15,000 to 17,000 with approximately 5% classed as 'elderly' and approximately 10% 'disabled'. This means that there are about 750 – 850 elderly Somalis and 1,500 – 1,700 disabled Somalis.

We also noted that there are differing definitions of elderly and disabled between standard English meanings and those definitions within the Somali community. In particular, the average life-expectancy of a Somali male in Somalia is 47 years (meaning elderly is more of a relative term), and Somali definitions of disability tended to refer to complete incapacity rather than a particular impairment.

There is some consensus of the location of the Somali community within Bristol which would appear to be concentrated in the wards of Ashley, Lawrence Hill and Easton.

Particular problems that faced elderly and disabled Somalis included a lack of knowledge of the system, housing, health services, a lack of community provision, language and cultural barriers, an over-reliance on community and key individuals, and isolation. These are discussed in detail in Section 3.3.

## **1.4 Conclusions and Recommendations**

The research suggests that this subsection of the Somali community is currently not served well by current levels of statutory and community sector service provision, and there is a highlighted need to fill this gap.

Overall we recommend a joined-up partnership approach to fill this gap, and further research on the needs of elderly and disabled Somalis in Bristol.

## **2. Introduction**

### **2.1 Somali Disability and Elderly Association**

The *Somali Disability and Elderly Association* (SDEA) of Bristol is a recently established community organisation that aims to provide culturally appropriate services to members of the Somali community within Bristol.

Set up by Ahmed Awale, SDEA aims to work with Somalis who are currently isolated and directly and indirectly excluded from mainstream service provision and also to work with mainstream service providers for elderly and disabled people, so as to improve their accessibility to members of the Somali community. The group intends to achieve this through delivering advice and information on Somali culture, the particular needs of elderly and disabled Somali people and the barriers they are facing to service providers. Alongside this, advice and information will be provided to clients on accessing benefits, housing, health and social services in order for them to take an active role in society and improve community cohesion.

### **2.2 Transparency Research Partners Ltd**

*Transparency Research Partners Ltd* (TRPL) has worked in the voluntary and statutory sector since 2001, and has produced high quality research for a number of organisations. As such we have experience in working with diverse groups in society including refugees, asylum seekers, people living with HIV/AIDS, minority groups and young people. Our work is often used to improve management performance or to provide direction in policy.

TRPL were commissioned by SDEA to execute this piece of research.

### **2.3 The Need for the Research**

Similarly to other refugee and newly-arrived communities the Somali community in Bristol is generally young compared to the majority community. However, many of these younger Somalis are beginning to bring other members of their family over to the UK, which may include those from older generations and still adversely affected by the war in Somalia. As services have so far been tailored to a young Somali community, it is likely that the needs of older Somali people may not have been addressed.

The traumatic conditions under which the Somali community have come to Bristol may also suggest that disability is a pertinent issue. The continual state of instability in Somalia means that the significant majority have been involved in violent and distressing situations and will have come to Bristol carrying the scars of war. This has important implications for the mental and physical well-being of the community.

Disability is a major concern within the Somali community and there are significant unmet needs among those elderly Somalis in Bristol. SDEA

estimate that the Somali population in total is approximately 15,000 individuals in Bristol, with an estimated 15% disabled, 5% elderly male and 5% elderly female. A major problem facing this group is a lack of knowledge about entitlements. Further, most Somali elderly or disabled are looked after by family members, which may have many benefits but may also result in problems of isolation.

There is a different understanding of the meaning of *disability* within the Somali community compared to contemporary English society. There is no direct translation between the Somali words for disability and those in use in modern English. Indeed, there is no word in Somali that unified all types of disabilities and thus Somali interpretations tend to mean an inability to do anything, whereas English meanings more often describe impairment amongst other abilities, rather than total incapacitation. Therefore many Somalis may not class or recognise themselves as disabled in their own language and culture, and yet may be recognised and entitled as such under English language and law.

As yet, there has been no significant research into the elderly and disabled Somali community in Bristol. This research is intended to begin to fill this gap and provide a necessary next step in understanding the needs of this community.

## **2.4 Methodology and Outcomes**

### **2.4.1 Objectives**

The research had three main objectives:

- To identify the number of Somali people in Bristol who are affected by disabilities and long-term illness and also to identify the number of elderly Somali people residing in the area.
- To identify the current service provision for the above client group, e.g. advice centres with Somali speakers to assist in completion of DLA forms; organisations offering support to Somali carers; day centres for Somali elders etc.
- To identify the gap in service provision based on the needs of the community and to guide the future work of SDEA in filling this gap.

### **2.4.2 Methodology**

Due to the poor statistical information available for the Somali population in Bristol, our methodology was largely qualitative. We undertook 11 face-to-face semi-structured interviews with Somali elderly and disabled individuals. (We originally proposed to interview 10). These consisted of two parents of disabled children, four disabled, four elderly and one disabled *and* elderly, of which, four were women and seven were men. We contacted these individuals through the help of SDEA, Fabu UK, the Welcome Project and our contacts in the community. These interviews were conducted in English and Somali.

We also conducted interviews with representatives from statutory, voluntary and community organisations. We spoke to representatives from 15 different organisations from the voluntary and community sector. These were:

- Age Concern Bristol
- Black Carers Project
- Black Orchid
- Easton Jubilee Trust
- Fabu UK
- Bristol Mind
- RNIB
- St Monica's Trust
- Somali Voice
- Service Links
- St Paul's Advice Centre
- WECIL
- The Welcome Project
- Bristol Older Peoples Forum
- Bristol Disability Equalities Forum

We also interviewed six health professionals within local health services. These were:

- Manager and Coordinator for Health Links
- Somali Linkworker
- Health Visitors and Community Nurses for the elderly at Montpelier H/C, Charlotte Keel H/C and Lawrence Hill H/C
- The Haven – health assessment team for asylum seekers

We also interviewed representatives within the council and social services:

- Equalities Officer
- Social Worker at the Adult Care Team, Welsman Social Services

Due to time and resource constraints the majority of interviews were conducted over the phone. Those interviews conducted face-to-face were with the Somali Linkworker, the Haven project, the Health Visitor for the Elderly at Montpelier H/C, the Welcome Project, Servicelinks and the Easton Jubilee Trust.

#### **2.4.3 What it was possible to do**

Considering the small resources and time period allowed for this research, it was still possible to speak to the majority of relevant agencies in Bristol. This included a significant amount of organisations working with the disabled and elderly population in Bristol, in particular those within the health profession. Where possible, Somali professionals working in this sector were contacted which enhanced interviews with detailed understanding of the Somali community.

#### **2.4.4 What it was not possible to do**

More detailed research would be enhanced by interviews with Somali Advice Project, Community @ Heart and other organisations working with the community as well as more input from social services and adult care teams working in different areas of Bristol. This research did also not have time to talk to other important Somali health professionals, such as other Somali linkworkers and the new health trainers based in Barton Hill. Future research should also look at areas outside of St Paul's and Easton and investigate where small isolated clusters of Somali are residing.

Overall, it was not possible to research in detail into the key issues raised. The specifics of problems faced by Somali disabled and elderly, such as benefits and housing were not looked into. Interviews with agencies were made difficult by conducting them on the phone as a good rapport was harder to develop. Time and resources permitting face to face interviews are recommended.

Additional relevant research is noted in Appendix 5.1.

### 3. Research Findings

#### 3.1 Number of Disabled and Elderly Somalis in Bristol

It is a recognised problem that statistical data on the Somali community is very poor. Not only are there issues with undercounting in the 2001 Census, but also the question of how Somalis categorise themselves within statutory ethnic groups. (Black African? Black British? Black Other?). Most recent estimates put the population at 15,000-17,000 within Bristol which our research indicates is widely accepted amongst the sector and within the Somali population.

##### 3.1.1 Census 2001

While detailed statistical information on Somalis is difficult to quantify, the Somali community is recognised by statisticians to be a subset of the Black African ethnic group. Thus an analysis of this group may yield information on the Somali group as proxy statistics.

Census 2001 data indicates that in total there were 2,318 Black Africans living in Bristol in 2001. This is significantly and surprisingly lower than the estimates given in Section 3.1 above, which indicates either massive under-enumeration in the 2001 census and/or sizeable migration to the area.

However, overall 7.9% of this population were aged over 50 years and 7.8% considered themselves to have a limiting long term illness. The prevalence of this varied considerably by ward. For example, while Redland had only 40 Black Africans in the Census, fully 25% of them were aged over 50; and of the 12 recorded in Bedminster, half had a limiting long term illness. Altogether, though, those areas with the largest Black African population in 2001 were Lawrence Hill, Ashley and Cabot.

Ward	Black Africans in Bristol (2001 Census)				
	Total Population	Aged Over 50		With a limiting long term illness	
		Number	Percent	Number	Percent
Ashley	309	29	9.4%	27	8.7%
Avonmouth	30	3	10.0%	0	0.0%
Bedminster	12	0	0.0%	6	50.0%
Bishopston	86	16	18.6%	3	3.5%
Bishopsworth	18	0	0.0%	0	0.0%
Brislington East	21	0	0.0%	0	0.0%
Brislington West	32	6	18.8%	3	9.4%
Cabot	199	9	4.5%	12	6.0%
Clifton	57	3	5.3%	3	5.3%
Clifton East	55	3	5.5%	7	12.7%
Cotham	45	3	6.7%	0	0.0%
Easton	101	6	5.9%	5	5.0%
Eastville	100	3	3.0%	12	12.0%
Filwood	15	3	20.0%	0	0.0%
Frome Vale	75	6	8.0%	6	8.0%

Hartcliffe	15	0	0.0%	0	0.0%
Henbury	14	3	21.4%	0	0.0%
Hengrove	22	0	0.0%	0	0.0%
Henleaze	25	3	12.0%	6	24.0%
Hillfields	53	6	11.3%	3	5.7%
Horfield	60	0	0.0%	3	5.0%
Kingsweston	38	3	7.9%	0	0.0%
Knowle	24	3	12.5%	0	0.0%
Lawrence Hill	461	42	9.1%	51	11.1%
Lockleaze	126	3	2.4%	6	4.8%
Redland	40	10	25.0%	3	7.5%
Southmead	53	3	5.7%	6	11.3%
Southville	30	3	10.0%	0	0.0%
St George East	29	6	20.7%	3	10.3%
St George West	31	3	9.7%	0	0.0%
Stockwood	3	0	0.0%	0	0.0%
Stoke Bishop	46	3	6.5%	3	6.5%
Westbury-on-Trym	9	0	0.0%	0	0.0%
Whitchurch Park	6	0	0.0%	0	0.0%
Windmill Hill	78	3	3.8%	12	15.4%
<b>ALL WARDS</b>	<b>2318</b>	<b>184</b>	<b>7.9%</b>	<b>180</b>	<b>7.8%</b>

### 3.1.2 Other Data Sources

Data from the local health authorities would appear to have most current detail, but this is hard to gain access to. Ethnic groups are recorded by GP surgeries but this falls prey to the same problems of under-enumeration and poor record-keeping. More in-depth information about each patient is recorded within their patient notes but surgeries may be either unable or unwilling to run searches. Our prior experience of working with health bodies suggest that this sort of potentially sensitive data is rarely accessed by outside agencies unless the research is commissioned by the health body itself.

More reliable data may be recorded through instances of when interpretation is used by public services, either the National Interpreting Service or via Somali link workers. This, of course, misses out any Somalis with good English or not accessing health services.

Interpretation for Bristol North PCT is provided by Health Links, who also serve most hospitals. In particular they work with Charlotte Keel Health Centre and Montpelier Health Centre, where the majority of Somalis are likely to be registered. This leaves out significant areas of Bristol. They employ two permanent female and two permanent male Somali link workers, and also employ further two male and four female interpreters who are constantly in demand. The manager for health links estimated 50-60% of work is Somali interpreting. Again, they record patient information for every instance, most useful for age ranges but disability is only recorded within medical detail of consultation, which is less easy to audit.

Anecdotal data was gained from interviews with service providers. Certain key workers could estimate the number of Somali disabled or elderly people they

worked with and their normal case load. This gives some indication of the levels of prevalence.

### **3.1.3 Elderly People**

'Elderly' itself is also a term of contention. Health Visitors define it as over 65, and Age Concern work with people over 50 on certain projects and over 55 on most others.

In Bristol overall there are almost 30,000 people over the age of 75. 30% of these people live in council, social or rent-free accommodation.<sup>1</sup>

There was a general consensus that there are not very many Somali elderly people in Bristol, especially compared to other ethnic groups such as the Caribbean community. Most people felt this was due to the way the Somali population has come to England and believe the majority are young 20-30 year old men.

Within the Somali population there were mixed feelings about how many people are elderly, and it was generally felt to be higher than service provider estimates. However most people felt there were larger amounts of over 50s, who for all intents and purposes, face issues of being elderly in the community. The average life expectancy at birth in Somalia is 47 years for a man, and 50 years for a woman, considerably lower than the UK's averages of 76 and 81 years respectively.<sup>2</sup> So there may be a considerably different perception of what is classed as elderly within the Somali population.

Our interviews suggested a modest prevalence of elderly Somalis in Bristol.

- The Health Visitor (HV) for the elderly at Charlotte Keel said two females out of ten people she works with are Somali – there are two Health Visitors for the elderly at this health centre.
- The Health Visitor at Montpelier Health Centre worked with a total three Somali elderly people. The normal total number of cases on their books is 109, known of one other.
- The Community Nurse for the elderly at Lawrence Hill health centre knew of one elderly Somali out of the whole practice.
- The Somali Link worker said three or four of 17-20 people she works with each week are elderly, majority female, at two different health centres.
- Age Concern reported one referral to Supporting People Services, which they couldn't deal with and referred to Refugee Action. There had been no other contact, though they wouldn't necessarily know about their help line.

Other agencies interviewed that work specifically with the elderly were St Monica's Trust and Bristol Older People's Forum. The latter has had no contact at all with the Somali population, though felt there must be elderly hidden in the community. St Monica's Trust thought they had a few applicants

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<sup>1</sup> Age Concern. [http://www.ageconcernbristol.org.uk/about\\_us/setting\\_the\\_scene.asp](http://www.ageconcernbristol.org.uk/about_us/setting_the_scene.asp)

<sup>2</sup> CIA World Fact book. <http://www.cia.gov/cia/publications/factbook/geos/so.html>, Age Concern. [http://www.ageconcernbristol.org.uk/about\\_us/setting\\_the\\_scene.asp](http://www.ageconcernbristol.org.uk/about_us/setting_the_scene.asp)

for help, though they would only know this through any translation requests - they have 100-150 applications a month.

Other agencies that have had contact with the elderly are St Paul's Advice Centre and Welcome Project. St Paul's Advice centre said that overall two-thirds of their clients in 2005/6 were Somali (although their figures indicate a total of 53% Black African) and in total 28% aged over 50 in the same year. The Welcome Project has seen a few elderly, but was not able to say how many out of 280 people seen 2005/6 year.

Interviewees were mostly unwilling to provide an estimate of numbers as they felt they were not able. Those who were able estimated about 5% of the Somali community are elderly. However most are unsure how big the population is and some interviewees would claim there are 500-600 elderly. This information is consistent with the census figures above (7.9%) and the fact of the remarkably lower life expectancy within Somalia.

### **3.1.4 Disabled People**

'Disability' itself has a number of differing definitions. The standard English definition is based on the notion of impairment. For example, Bristol Disability Equality Forum define a disabled person as

anybody with a physical or sensory impairment, learning difficulty or who experience mental/emotional distress. Anybody can define themselves as disabled if they feel they have been treated unfairly because of any one of these.<sup>3</sup>

The Disability Discrimination Act (DDA) sets out the circumstances in which a person is legally "disabled". It says you are disabled if you have: a mental or physical impairment, that this has an adverse effect on your ability to carry out normal day-to-day activities and that the adverse effect is substantial and is long-term (meaning it has lasted for 12 months, or is likely to last for more than 12 months or for the rest of your life).<sup>4</sup>

We have noted above that Somali definitions of disability tend to refer to complete incapacity.

Within the Somali community (individual interviews and Somali workers or Somali-led organisations), there was a general feeling that there are more disabled people than elderly. This was attributed to the war in Somalia. Ahmed Wale (SDEA) believes that every Somali has been affected by the traumas of the war rendering them disabled physically or mentally to some degree.

The Somali Mental Health Research Group concur with this and stated: "No one is left untouched by such events [civil war and factional fighting] and

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<sup>3</sup> <http://www.bccforums.org.uk/disabled/page10.html>

<sup>4</sup> <http://www.drc.org.uk/>

children either as victims, or passive observers of violence are often neglected as a necessary focus of therapeutic attention”.<sup>5</sup>

The issue of the Somali understanding of/approach to disability was raised by Somali interviewees and some service providers, however feelings around this were mixed. As it was raised by a considerable amount of people, this is a significant issue that will need to be considered in any future work.

One service user in particular knew of many who would not accept that they or their children had a disability and were refusing help from health professionals

Another service user had experienced problems as a translator explaining and understanding mental health and how professionals in UK approach it

Service providers (three voluntary and one statutory) believed disabled people are often hidden in the community, and one especially felt there is a lot of shame surrounding disability. However one Somali service provider felt the attitude is not negative and in line with an Islamic understanding

Specific organisations working with disabled people that we interviewed include Black Orchid, Bristol Mind, RNIB, WECIL, Bristol Disability Equality Forum (BDEF) and indirectly, Black Carers Project, Welcome Project and St Paul’s Advice Centre. The St Paul’s Advice Centre had 13% disabled clients in 2005-6. However these organisations have little contact with the Somali community generally.

Our interviewees suggested the following levels of prevalence of disability within the Somali community:

- The Somali Link worker knew of one disabled person out of 17-20 but of six or seven disabled children. Disabled children were also flagged up by two service users (parents of disabled children) as a significant amount of people in Bristol.
- WECIL was working with three families out of 38 on Direct Payments project, but had no information about the help line.
- Welcome Project suggested four or five out of 280 clients in 2005/6.
- The Black Orchid mental health project suggested 15 people in two months (since their Somali worker has been employed) seen in either mental hospitals or secure units.
- RNIB had four to five out of seven since January 2006.
- Black Carers Project had five carers out of over 30 on the Somali workers caseload when previously employed.
- Mind has had no contact that they’re aware of.
- BDEF has no contact that they’re aware of.

Most service users estimated the percentage of disabled people in the Somali community as double that of the elderly, making it around 10% although there

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<sup>5</sup> Somali Mental Health Research Group – Greenwich MIND and other health professionals

would need to be consensus on what is classed as a disability. The highest estimate was from FabuUK who claimed about 20% of Somalis are disabled. However, they also mentioned figures of 600 physically disabled and 1500 mentally. The Somali link worker estimated at the lower end of the scale at 5% of total Somali population, and Service links estimated the lowest at 250-300.

Most agencies interviewed are based in the inner city area, in particular in St Paul's (Ashley ward) or Easton. The exceptions are St Monica's Trust, based in Westbury-on-Trym, WECIL in Knowle West and BCC and Age Concern who are both based in the city centre. All agencies believed their Somali clients live in the Easton and Ashley wards (St Paul's, Montpelier). One person mentioned Fishponds and Redfield, whilst two spoke of neglected clusters e.g. Southmead, Hengrove and Bedminster.

Service User Interviewees lived in the following areas:

<b>Location</b>	<b>Number</b>
St Paul's (Ashley)	3
Montpelier (Ashley)	1
Easton (Easton)	4
Barton Hill (Lawrence Hill)	1
St Jude's (Lawrence Hill)	1
Redfield (St George West)	1

Areas where the elderly are living was brought up at the consultation carried out by Servicelinks in partnership with the BCC housing dept. There is real concern over isolated groups that remain hidden and cannot access services and their own community.

### **3.2 Service Provision for Elderly and Disabled Somalis**

Through talking to representatives from voluntary and community organisations (VCOs) and statutory agencies, it was clear that current service provision for elderly and disabled Somalis was very limited.

All agencies explained there is no specific service in place for Somali elderly and disabled. This poor provision was attributed to lack of funds, previous experiences with Somali-led agencies, as well as the rapid growth of the community.

However, three statutory bodies and one VCO did not see this as a particular problem at the moment and felt that a specific organisation is not currently necessary at the moment, though in the coming years there will be more elderly and disabled Somalis: "...one should plan for these things; we shouldn't wait until the situation blows up. In about 10-15 years it will definitely grow. And the political situation, you don't know how this will happen, whether there will be more people coming across." However, one service provider stated that a number of individuals from Somali community had approached them wanting to access funding but felt they were not necessarily interested in building a working relationship with them.

Most mainstream elderly and disabled services have limited contact with elderly and disabled Somalis, which is evident in the anecdotal data discussed under Section 3.1.3 and 3.1.4. The two forums have no contact with any Somali individuals. There was limited contact found with Age Concern, MIND, RNIB, BCP, WECIL and Black Orchid. Agencies with most contact with elderly and disabled Somalis are advice agencies or Somali-led.

However, good practice was found at St Paul's Advice Centre. Service User interviews indicated that this project was popular and the amount of elderly and disabled Somalis accessing their service was high. The respondent from the advice centre was also well informed and aware of issues facing Somali community.

The Welcome project was approved by several service users as very cooperative and a good source of information and understanding of issues. There was a good relationship with the community, which was mainly attributed to having male and female Somali workers and a welcoming, friendly environment that provided a flexible drop-in facility covering most issues that refugees face.

### **3.2.1 Potential Future Provision**

Some projects had a number of plans for future work with elderly and disabled Somalis. Servicelinks was working from need identified by the Refugee Support Project and trying to establish a luncheon club and to address housing issues for the elderly. However, nothing has yet transpired. FabuUK/Café Midnimo had got funding from Age Concern for chairs and tables, and was trying to set up a luncheon club as they recognised there was a lack of places to go. This was also in the planning stage. The Welcome Project was interested in helping Somali carers into employment and setting up a Somali elderly/care home. This was also in the planning stage.

BCP was struggling after funding cuts and RNIB have employed a Somali development worker to target BME community. Black Orchid have recently done the same.

There was a willingness present within most agencies to work with an elderly and disabled agency for Somalis although they did also express the possibility of developing their own services appropriately.

Four VCOs and three statutory bodies felt they did not know enough about the Somali situation in Bristol and did not understand what different community organisations existed and what they did. This was a big concern for three of the VCOs who would like one organisation they could go through. There was a general feeling that the situation is very chaotic and confusing, which made workers reluctant to try to contact agencies.

### **3.3 Service Gaps for Elderly and Disabled Somalis**

Throughout the interviews with elderly and/or disabled Somalis and the VCOs and statutory bodies, there were certain key themes emerging. It is notable that these themes converged between the service users and the service providers.

#### **3.3.1 Lack of knowledge of the services/system**

None of the service users knew of any specialist service they could go to as Somali elderly/disabled. Ten felt they had no idea what different organisations do and were confused and most felt frustrated by this but were unsure how to change their situation. Only one had been in Bristol for long time and involved in the sector, so felt they knew how to navigate the system.

Nine VCOs and statutory bodies also identified lack of information amongst elderly and disabled Somalis as the main problem for accessing services and that needs to be addressed. In particular, it was felt that many did not have sufficient knowledge of the system in the UK whether this be disability, benefits, housing, health or education. Those that identified this as a problem have been working with some Somali clients. Others with no contact with SEDs felt they could not comment.

#### **3.3.2 Housing**

Housing problems were a significant theme in all the interviews. Ten had experienced problems with housing of which seven had not had their problems resolved. These problems mainly involved repairs, problems with lifts and stairs, problems with having a bath instead of a shower or inadequate space for their family. Most housing problems were directly linked to their disability or health issues.

In one case, a disabled young man had been living in a hostel for the last 18 months in an upstairs bedroom. He had been constantly trying to move to a downstairs bedroom but was told he was not a priority. Because of his disability he could not get to the social areas very easily and often spent days at a time in his room upstairs, he therefore felt very isolated and relied heavily on a brother who sometimes visited.

Another respondent had not thought to actively complain before about their situation until questioned about it.

Seven VCOs and two statutory bodies identified housing as a serious and common problems facing elderly and disabled Somalis. In particular Servicelinks has been liaising with Easton housing BCC to try and address some of these problems through a consultation day with the elderly. They discovered distrust and misperceptions from Somalis towards sheltered accommodation due to cultural differences, language, restrictiveness and a lack of space for family/friends to stay when they visit. A Health Visitor also noted how alien blocks of flats are for elderly and disabled Somalis who are not used to stairs, lift and the social norms and therefore feel more isolated, disorientated and lonely.

### **3.3.3 Benefits**

Benefits were also raised as a key issue. Eight had ongoing problems with benefits and five had particular problems with DLA or incapacity benefit. One respondent was battling to claim benefits for the last few months and another had decided not to apply due to stories in the community. There is evidence of a perception in community that it is unlikely to get support.

Two had particular problems with the assessment for incapacity benefit, both felt very unhappy by the way they had been treated, one had been refused twice and only received on the third appeal. Difficulties with DLA and Incapacity Benefit had generated a feeling of distrust amongst most interviewees alongside economic hardships.

Five identified a need to know more about their entitlements. Two had had good experiences of St Paul's Advice Centre, one with St Monica's Community Trust and three with the Welcome Project.

Three had come as Dutch citizens and so were having to actively look for work on jobseekers allowance despite having mobility problems and only being offered unsuitable work.

Eight VCOs and one statutory body also identified benefits as another aspect elderly and disabled Somalis are struggling with. This was linked to knowing their entitlements and way around the system, as well as practical issues such as filling in forms and conducting appeals. Seven agencies thought form filling is a real issue for elderly and disabled Somalis and that there needs to be some help provided. An advice worker told us that the forms are a nightmare and the Department for Work and Pensions does not fully understand the Somali population so that applications for DLA and incapacity benefit are often refused because of a lack of awareness about war-related disabilities. This concern was raised in relation to women who have experienced sexual abuse, which is difficult to explain through the current systems in place.

### **3.3.4 Health Services**

Only two respondents felt confident about the way the NHS works. Most felt happy about their treatment by their GP/health professionals, and one had been helped immensely by her health visitor and therefore recommended this to everyone she knew.

One respondent was unhappy with the amount of information they had been given whilst waiting for a kidney transplant, and another was unhappy with the lack of support their GP had shown in a housing issue.

Three respondents wanted to be treated abroad rather than in UK, and one was unhappy with decisions made by his consultant about removing a bullet from beneath his heart and felt this was due to money rather than any concern about his well-being.

### **3.3.5 Somali Community in Bristol**

Another common theme in the interviews was the concern about the situation of the Somali community in Bristol. There was a feeling that not enough support is being given to help. Six respondents felt the Somali community was not getting enough support from statutory organisations, that there was no democratic representation of the Somali community and what positive actions existed were largely lip service.

Concerns were raised over how previous Somali-led groups have ended, including recognised previous organisational failures. To overcome this it was suggested that firstly as many different elements of the community are involved (clan and gender) and that responsible individuals who have relevant experience and genuine desire to help the community. Expressions included:

We need to come together as a community and choose responsible people to take us forwards.

We need help. But we do not need people using our name and getting money.

The Somali community is not working properly, why don't we help each other?

Three were concerned about Somali young people, mentioning behaviour and drugs.

One raised specific problems for women and literacy and also raised a concern about the changing roles of Somali women. This was echoed by one advice worker who felt family breakdown was of particular concern, especially as women appear to take on the role as carer in the home.

Some agencies recognised problems that Somali community organisations have had in the past including “funders getting their fingers burnt”. There was a deep concern that this should be avoided in the future, some believed better structuring and organisation would help. One VC in particular expressed a concern for any work to be duplicated. Servicelinks and Easton Jubilee Trust have been trying to establish a service for the elderly for some time and would not want their efforts to be wasted.

### **3.3.6 Language and cultural barriers to services**

Language was the main access problem raised by the service users. All would go to a Somali-led organisation before any other agency because of the language. All cited language as a key problem, if not for self then for others around them, and this was linked with a distrust of services.

Few cited cultural differences as a specific reason they had not accessed particular mainstream services. Only two felt they could not access services or had not in the past because of cultural differences. Three believed cultural problems more apparent for elderly than young, linking this to dress, climate and language.

Two raised the issue of Somali understanding of disability as different from way services here approach. One believed there were many Somalis who would not accept they were disabled and were actively ignoring the advice of

health professionals. This particular respondent had come to trust health professionals after their predictions about her disabled child had come to fruition. However, both felt that there needed to be more awareness about disability in the community.

All agencies noted language as a key barrier to services. Agencies felt they needed a Somali speaker in order to provide for Somali users. One in particular had not been able to carry on working with the Somali community because of lack of funds and losing a Somali worker. It was felt that this problem was overcome sufficiently in the health services through the use of health links and Somali linkworkers.

Ten VCOs noted the importance of outreach work as a way of helping elderly and disabled Somalis access services, however some felt that because of resources and funding constraints they could not go out into the community to elderly and disabled Somalis.

Fourteen agencies mentioned culture as a barrier to services for elderly and disabled Somalis. Generally this would be worse for the elderly compared to the younger generation who can adapt to life here quicker. This was linked into language barriers and types of dress as well as conservatism from the older generations. One Health Visitor felt this might be most pertinent to older men who do not have the congregational forums they may have had in Somali village life, which makes them feel less visible and isolated.

Mostly it was felt that this could mainly be overcome by having a Somali worker or working in conjunction with a Somali-led organisation. One advice worker pointed out work of BRIGHT/Somali Advice Project, referring to general consensus that the capacity within Somali population needs to be built up. Another felt Somali workers could more naturally advocate within their role, which is preferable to simply acting as translator. There was some hope that this is a development that will naturally happen as more educated Somalis move into this sector.

### **3.3.7 Reliance on the community and key individuals**

Amongst all, there was a heavy reliance on the community for information and support. Six elderly and disabled respondents were completely reliant on a key relative for all their support and access to services. Without this support they could not get help and would be in a crisis situation.

All the service users would turn first to the community for information; when asked where to send a friend in a similar situation, all suggested the community, although six did not know where to point a friend. Three suggested the Welcome Project, one their health visitor and one the CAB.

Some had received help from key individuals in an organisation. Four had got lots of help from individuals in agencies who had given particular effort and time, without which they couldn't have accessed services, and one had not accessed suitable benefits because of stories from community.

### **3.3.8 Isolation**

Alongside language and culture, isolation was noted as a key problem in the service users lives. Mostly this isolation came from being physically removed from the community. Seven respondents felt trapped at home because of their health or disability. One lady could not move from her bedroom and rarely had visitors, so experienced boredom and loneliness. One man was deaf and could only lip-read Somali, he felt particularly isolated due to his unusual circumstances. He could not access English signing groups and found it difficult communicating with the people around him.

In this respect, all expressed an interest in having a place to socialise. Many did not have the resources to go to the cafes/restaurants, and five wanted to be able to meet people of their own generation or who were in a similar situation. One felt his only social escape was to chew khat but recognised this was bad for his health. Three believed majority of Somali suffer some disability but either it has not been recognised or they are not seeking help/support

In addition, eight agencies identified isolation as a big problem for elderly or disabled Somalis, in particular this was felt most prominent for the elderly. Agencies believed many elderly and disabled would be stuck at home and physically unable to access services and socialise. There was a lack of a Somali day centre comparable to other minority group resources such as the Malcolm X Caribbean older peoples group.

### **3.3.9 The need for Somali advocacy**

All want to see a Somali-led organisation established to help with advice and information. Respondents felt such an organisation would be more accessible because of language and culture, and there was a general feeling that they would trust the advice of Somali professionals.

Six VCOs and one statutory body felt most elderly and disabled Somalis would want a one stop shop that could direct them onto other services. Several felt this could be combined with a social centre whereby other services could come into and do activities, drop in and talks on relevant topics, especially health.

One VCO said their Somali disabled clients continually became frustrated by the need to go to different organisations for every aspect of being disabled, for example benefits, getting a disabled car sticker, home help, housing and so on.

## **4. Conclusions and Recommendations**

### **4.1 Conclusions**

- Very little service provision exists for the Somali elderly and disabled. No specialist organisation caters for and few mainstream services have appropriate resources/facilities to do so.
- There is a growing need as the community expands and it is beginning to be recognised by service providers.
- There are common concerns raised by service users and providers about how any Somali elderly and disabled service is developed. These are mainly linked to previous difficulties that Somali-led/specific organisations have had in the past.

There appears to be three key needs that need to be addressed:

- A social centre (day centre, luncheon club etc) for elderly and disabled Somalis.
- The need for Somali professionals (to provide language assistance, advocacy and expand the knowledge of agencies).
- Work to address the lack of info/awareness/advice/knowledge of where to go for help.

### **4.2 Recommendations**

A considerable amount of Somali-led agencies have been set up in Bristol to set up to serve the needs of the Somali community, however this is first time that agency targeting disabled and elderly has been attempted. Our research shows that this is a notable gap in current service provision and the needs of Somali elderly and disabled people appear to be acute and require active intervention.

- Service provision needs to develop in particular looking at advice and information and a social club for Somali elderly and disabled.
- SDEA or any other organisation filling this need should work in strong partnership with existing work already being done i.e., Servicelinks/Eastern Jubilee Trust, Fabu UK and the Welcome Project.
- All agencies that have expressed an interest and willingness to work in this area should be actively linked into any work – especially BCP, Age Concern and the above.
- Any advice work that is developed needs an outreach element, moving within the community and with days in different projects and based in/supported by existing agencies.
- Any luncheon club needs to consider who is involved from the start and actively include all elements of the Somali community (clans, male/female) – possibly revising elderly and disabled combined idea.
- Any new project needs to be bench marked against other successful similar projects nationally e.g. Red Sea House, Cardiff.

- The development of an awareness-raising programme for Somalis around disability issues in the UK.
- Considering the poor statistical data available about the Somali community, we recommend a mapping exercise to determine the number of Somalis resident in Bristol including the number of elderly and disabled.

## **5. Appendices**

### **5.1 Appendix: Additional Related Research**

Although there has not been any specific research into the Somali elderly and disabled community in Bristol before, the following related research has been identified.

#### **5.1.1 Audit into Social Care Needs of Refugee Communities in Bristol**

Commissioned by the Refugee Support Project, Jan 2003. This research carried out the most in detail look at Somali social care needs so far in Bristol. It mainly found that there are significant gaps in advice and information services for this group; in particular there is a need for advocacy. It was also noted that more counselling services need to be developed, alongside support for carers, translated information and relevant training for service providers and refugee community organisations around social care support. From its findings, the refugee support project developed a business plan to establish an elderly luncheon club. Unfortunately, this project has experienced funding problems so far but has now been taken over by Servicelinks.

#### **5.1.2 Servicelinks and the Housing Dept. of BCC Consultation with the elderly**

Meeting with Somali Elders held at Field View Sheltered Home On 6 April 2006. This was a follow up to the above research and focused on the housing issues faced by Somali elderly. Further work into this area has been recommended as well as developing sheltered housing specifically aimed at Somali elderly.

#### **5.1.3 West of England Coalition of Disabled People, Ashley, Easton, Lawrence Hill, Knowle West and Barton Hill**

Bristol City Council, March to September of 2004<sup>6</sup> Although this research did not specifically look into the Somali community, it did make some conclusions in relation to the BME community in this area, which will have included a significant Somali population.

In particular:

In relation to housing it was found the members of the B&OME communities find it double hard to access appropriate housing that meets their needs. The importance of belonging to a community and feeling safe was an important issue for this section of respondents. It was also highlighted that in regards to Education Disabled members of the B&OME communities can also face disadvantage. It was claimed that being Black and Disabled doubly impaired people and language issues also came through strongly.

Issues around health also focused on language issues and appropriate service provision. Interestingly the issue of the perceptions of Disability from family and the wider community came through clearly as a barrier to accessing local health care services. Although this was raised again primarily from members of the B&OME communities these opinions echoed those of non B&OME communities. However

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<sup>6</sup> [http://www.bristol-city.gov.uk/ccm/cms-service/stream/asset/?asset\\_id=5500030](http://www.bristol-city.gov.uk/ccm/cms-service/stream/asset/?asset_id=5500030)

these sentiments and opinions were more of an undercurrent during research and it would be interesting to explore this further in the next round of consultation.

It was also recommended that “education around Disability should be offered to sections of the B&OME communities”, “culturally pertinent medical services should be provided for Disabled people” and “health prevention schemes should make stronger links with the B&OME communities.”

#### **5.1.4 Martha Debbage, Social Work masters dissertation**

Most recently, Martha Debbage, a social worker, has undertaken research into Somali older people and direct payments through her masters dissertation. So far certain themes have been developing within this research: the social isolation that the Somali elderly are experiencing and the lack of knowledge surrounding entitlements. Debbage has also begun to highlight that although direct payments are a way of ensuring choice and flexibility that may be suitable for Somali elders, it is the only way to obtain Somali carers and culturally appropriate services. In this respect direct payments become a necessity for this client group as mainstream services are not able to provide suitable support. Further, direct payments can be extremely complicated and so far Debbage has not found any Somali elders who are able to administer this themselves, taking away some of the independence intended within direct payments.

#### **5.1.5 Bristol MIND– Assertive Outreach Research<sup>7</sup>**

Bristol Mind is currently leading a three-year research project into assertive outreach:

Many people with mental health problems face social exclusion and a poor quality of life in the community. These problems are often at their most extreme in those who regularly lose contact with services. Assertive Outreach\* services have been identified as a way of achieving better contact and support for people with severe mental health problems.

The project aims to explore in depth how voluntary and statutory services can best work to promote effective access to services. The primary focus will be on the perceptions and needs of service users.

The study includes focus on the specific needs of people from black and minority ethnic groups and Gypsy and Traveller communities.

#### **5.1.6 Somali Mental Health Research Group**

Researchers within MIND have collaborated with other professionals to ascertain the mental health problems faced by the Somali people in the London Borough of Greenwich. In particular this work has been looking at prevalent health and mental health beliefs, attitudes to medication, types of mental health and experiences of services.

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<sup>7</sup> <http://www.bristolmind.org.uk/>

**5.1.7 Waiting for the Sun to Rise – Khat Research Project, Latif Ismail, commissioned by Community at Heart**

This research examined the health and social implications of khat use among the Somali community in Bristol. The report will be launched in Sept 2006.

## **5.2 Appendix: Service Provider Profiles**

### **5.2.1 Age Concern Bristol**

ACB is a local independent charity, helping hundreds of older people who live within Bristol and offer a range of services from information and advice to help with gardening.

### **5.2.2 Black Carers Project**

The Black Carers Project offers support to black and other ethnic minority carers in Bristol through providing information, practical support (via a Care Attendant Scheme for African/African Caribbean carers) outreach, advocacy and development support as well as running a young carers and a volunteer project.

### **5.2.3 Black Orchid**

Black Orchid is a black mental health advocacy project that aims to provide culturally sensitive and appropriate services to people of African Caribbean and Asian descent and other ethnic minority groups, between 16-65.

### **5.2.4 Easton Jubilee Trust**

The Easton Jubilee Trust was established in 2002 to provide educational and support services to new arrivals in the Easton area of Bristol. Projects include homework clubs, English languages classes and an older peoples luncheon club.

### **5.2.5 FabuUK**

Fabu UK is a local initiative working with the Somali community. Based at Café Midnimo, it provides a social and educational space for young Somalis and is currently trying to set up a luncheon club for the Somali elderly.

### **5.2.6 Bristol Mind**

Bristol Mind promotes a positive view of mental health and aims to provide services that are user-focused, supportive and empowering. It offers Mindline (a helpline), a Drop In, an Advocacy Information Project, and is currently undertaking a Assertive Outreach Research Project.

### **5.2.7 RNIB**

The Royal Institute for the Blind offers a range of services and support to people with sight and hearing loss. This includes Rehabilitation Services, Information, Advice and Advocacy Services, Education and Employment, Dual Sensory Service, Leisure Services and Emotional Support.

### **5.2.8 St Monicas Trust**

The St. Monica Trust provides accommodation, care and support for older and disabled people. The St Monica Trust Community Fund aims to ease financial pressure and help improve the daily lives of these individuals and families by helping them to buy the essential things they need or supporting them through a crisis. The Community Fund also gives grants to organisations with similar aims.

### **5.2.9 Somali Voice**

Somali Voice is a bilingual community based newspaper providing local news of interest to our communities and was first published in 2003 by a group of volunteers. It recognises the necessity for media representation inspired by the current information-vacuum among Somali communities.

### **5.2.10 Servicelinks**

Servicelinks is a social enterprise formed in 2005 and aims to respond to the unmet needs of specific social/cultural groups and contribute to the overall development and social cohesion of Bristol society through training, consultancy, advice and support services and a community café.

### **5.2.11 St Paul's Advice Centre**

ST Paul's Advice Centre is an independent charity and a company limited by guarantee, funded by the council and the legal services commission to serve the inner city area. It provides free welfare rights advice and some general advice, which covers benefits and appeal representation.

### **5.2.12 WECIL**

The West of England Centre for Inclusive Living (WECIL) was set up in 1995 and provides a range of services to over 4000 people a year, with the aim of promoting inclusive opportunities and enabling choice and control over their lives.<sup>8</sup>

### **5.2.13 Welcome Project**

The Welcome Project is funded by Job Centre Plus and the European Social Fund to help refugees who are on benefits into employment. Bilingual workers are employed to give practical support, information and advocacy.

### **5.2.14 Health Links**

Health Links works within BNPCT as an interpreting and advocacy service, providing 19 different languages to local health services.

### **5.2.15 Bristol Older People's Forum**

The Older People's Forum is independent of the Council and grew directly from the European Year of Older People in 1993. It aim to raise the political profile of older people, locally, nationally and internationally, and to achieve for Bristol pensioners the same rights, influence, security and income enjoyed by older people in other European countries.

### **5.2.16 Bristol Disability Equality Forum**

The Forum was set up in 1995 so that disabled people in the city could have access to the City Council in order to make their views heard and to help the City Council to understand the experience and requirements of disabled people.

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<sup>8</sup> <http://www.wecil.co.uk/index.htm>

### **5.3 Appendix: Interview Schedules**

#### **5.3.1 For Service Providers**

##### **WITH REFERENCE TO SOMALI COMMUNITY**

Describe your service users and their needs. Services provided? DLA?

Which part of Bristol do they come from?

Are there any access problems for this group in accessing your or other services?

Do they have problems accessing hospitals or other mainstream services? What sort of problems.

Are there language problems? What sort of problems do language or cultural differences create? How are they best overcome?

Do you have any relationship with any part of the elderly or disability sector in Bristol? Do you refer clients to advice services? If not why not?

Do you undertake joint projects (detail)? Are you members of the same partnerships – if so which?

Can you comment on the current provision of Somali elderly or disability services in Bristol?

In what ways does it meet needs of residents? What do you feel the people you come into contact with need in terms of advice? Are there any gaps (either geographical areas or groups of service users) – if so what are they and how can these needs be met more effectively?

What are the main barriers in communities accessing elderly or disability services currently? What is your general impression of the quality of elderly or disability services in Bristol? Have you or your service users encountered any problems with them in the past? If you could make recommendations as to how they could improve their services what would they be?

How could elderly or disability services (both council and voluntary sector) work with your organization to the benefit of Somali Bristol residents?

#### **5.3.2 For Service Users**

Age, Gender

How long have been in Bristol?

Are you: a refugee, an asylum seeker, British Citizen or an EU National (state country)?

Ethnic background.

Which part of Bristol do you live in? Do you like it? Any particular problems relating to where you live?

Do you have any health problems?

Do you have any disability?

Do you have a GP?

How do they treat you?

Do you know what the National Health Service is?

Do you know the difference between primary and secondary health care?

Do you know any mental health services available in Bristol?

Do you chew khat? How often?

Is there a Somali Elderly Club in Bristol?

Where do you meet or socialise?

It is appropriate?

What kind of accommodation do you live in?

Are there any problems you have using your current accommodation?

Do you understand your rights and responsibilities under your tenancy agreement?

What would be your ideal accommodation?

Can you tell us what sort of problems you have had *that relate to your health, age, disability*.

Where any of these problems urgent?

Where did you go for help with the problem. How was it resolved? What worked well? What could be improved?

Or did they resolve the problem themselves?

Once there, did they get referred to another agency?

How did they know where to go?

Information from :

- Friends/family

- Word of mouth
- Social services
- Library
- Police
- Community/vol orgs
- GP/health workers
- did not know where to go

Impressions of the elderly and disability services.

For those that sought help, how satisfied were they with the service?

Did they feel they got help to resolve their problem?

Did they feel their situation and needs were understood?

Were they kept informed of the work done on their problem?

Did they get the chance to discuss and agree any action taken on their behalf?

Were they happy with the outcome?

For those that did not seek help

Why did you not seek advice?

Did not think had a problem

Could not find help/advice

How did you resolve your problem(s)

Did they have problems getting to the advice service?

*Making contact/appointment*

*Opening times*

*Locating services*

*Language*

*Transport*

*Physical access*

*Confidentiality*

How did they resolve these problems?

Did they feel confident about the ability of staff at projects?

Did they experience any discrimination in accessing advice services?

How would they like advice services improved

Access

Opening times  
Means of contact  
Better facilities  
Better information e.g written, tape, braille, translators  
More contact points to eg. advice  
Better use of IT/computers  
Translated material

If you had a friend with a similar problem, where would you tell them to go and why.