Objectives for Supporting Work with Refugees and Asylum Seekers

- Provide information on asylum seekers and refugee entitlement to health care in the UK.
- Identify the major medical, psychosocial and cultural problems which affect the health of these groups.
- Provide links to sources of support including local and national organisations.

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Aim of the Occasional Paper

This occasional paper is designed for use in primary health care / general practice to improve the management of medical and mental health problems in patients who are refugees and asylum seekers.

This paper is based on a resource pack published by the Department of Health and Lambeth PCT in 2004 (see references) and a “Good Practice Guideline for Working with Refugees and Asylum Seekers” written by Dr Angela Burnett in 2001.
Why do refugees come to the UK?

The United Kingdom is a signatory to the 1951 Geneva Convention which defines a refugee and their legal, social and human rights.

The 1951 Convention was mainly devised to protect European refugees in the aftermath of World War II. The 1967 Protocol extends to refugees from anywhere in the world.

The Geneva Convention defines a refugee as:

“A person who has a well founded fear of persecution for reasons of race, religion, nationality, membership of a particular social group or political opinion. Someone who is outside the country of his/her nationality and is unable or, owing to such fear, is unwilling to avail himself/herself of the protection of that country; or who, not having a nationality and being outside the country of his/her former habitual residence is unable, or owing to such fear, is unwilling to return to it.”

According to the United Nations High Commission for Refugees (UNHCR), there were 20.8 million refugees in the world in 2006. The majority of refugees remain in countries neighbouring their own.

The number of people who registered as asylum seekers in the UK in 2006 has fallen from 82,000 in 2002 to 28,320, including dependants. (See Fig 1.)

Most applicants in 2006 came from Eritrea, Afghanistan, Iran, China and Somalia.

Over three-quarters were less than 35 years old.

Currently, the UK ranks 12th in asylum applications per head of population in the European Union.

The fall in numbers of applications followed changes in the Nationality, Immigration and Asylum Act of 2002. This Act tightened border controls, visa requirements, restricted access to work and support, and designated certain countries as generally safe.

Despite this trend, there are still significant numbers of refugees given permanent leave to remain in the UK. In 2006, 31,220 asylum-related permanent settlements, including dependents, were granted, 55 per cent fewer than in 2005 (69,535).

For a more detailed definition of Asylum Status in the UK see Appendix 1.

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For a more detailed definition of Asylum Status in the UK see Appendix 1.
Entitlement and Access to NHS Services

Primary Care

A refugee is a person who has applied for and has been granted asylum in the UK. Refugees are entitled to receive all NHS services.

An asylum seeker is a person who has applied for asylum in the UK, and is either awaiting a decision, or is in the process of appealing a negative decision. Asylum seekers are entitled to receive all NHS services.

A failed asylum seeker is a person who has applied for asylum in the UK and their application and all possible levels of appeal have been rejected. The Department of Health’s position regarding entitlement to primary care for failed asylum seekers is ambiguous.

Health Service Circular 1999/018 states that failed asylum seekers should not be registered in primary care BUT that GP practices have the discretion to accept applicants as registered NHS patients.

We consider that registration of all groups provides the best possible solution.

Timely access to primary care may prevent serious illness and expensive hospital admissions. Access to health care is a human right, and doctors denying such access may be in conflict with professional responsibilities.

Requesting documents, such as proof of address and identity, should be consistent and apply to everyone.

There is no requirement for a practice to view a passport at registration.

For information on further exemptions for health costs see Appendix 3 regarding HC1 certificates.

Secondary Care

Failed asylum seekers, overstayers of visas, and overseas visitors are not generally eligible for free hospital treatment.

However, immediately necessary treatment to save lives or prevent a condition from becoming life-threatening should always be given.

Any course of treatment already underway at the time when the asylum seeker’s claim, including any appeals, is rejected should remain free of charge until completion. Any new course of treatment, begun after the asylum claim is rejected, will be chargeable.

Certain services are exempt from charges for everyone as follows:

- Treatment provided solely in an accident and emergency department (AED).
- Treatment provided in a Walk-In Centre.
- Treatment of certain communicable diseases to protect the wider public. (Appendix 2)
- Compulsory mental health treatment.
- Family planning services.
- Treatment provided at, or resulting from a referral from a sexual health clinic, excluding HIV.
- HIV/AIDS initial tests and counselling (any post diagnostic treatment or drugs may be charged to those ineligible for hospital treatment).

Summary Table of Entitlement to NHS Services

<table>
<thead>
<tr>
<th></th>
<th>Primary Care - General Practice</th>
<th>AED’s and Walk-In Centres</th>
<th>Secondary Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asylum Seeker</td>
<td>Eligible</td>
<td>Eligible</td>
<td>Eligible</td>
</tr>
<tr>
<td>Failed Asylum Seeker</td>
<td>Discretionary</td>
<td>Eligible for urgent or immediate medical attention</td>
<td>Eligible for treatment started before final refusal. Ineligible for treatment starting after final refusal</td>
</tr>
<tr>
<td>Refugee</td>
<td>Eligible</td>
<td>Eligible</td>
<td>Eligible</td>
</tr>
</tbody>
</table>

Current Department of Health Regulations place a responsibility on NHS hospitals to establish if a person is entitled to treatment without charge.
Communication, Culture, and Expectations of Health Care

Communication

Language can be a barrier to providing appropriate primary care services and information to asylum seekers and refugees.

Advocates provide valuable cultural information to clinicians and can help patients understand how to use the NHS and related services.

Solutions to communication problems may include:

- Using a professional interpreter.
- Using a trained patient advocate.
- Using telephone interpreting services.
- Using written language materials.

Family members and friends are the commonest source of language support.

Avoid using children to interpret, this may cause embarrassment for parents and give inappropriate responsibilities for the children.

When working with an interpreter or advocate:

- Allow more time for appointments.
- Discuss how you will work together. If possible have a debriefing session.
- Maintain eye contact with the patient rather than the interpreter.
- Emphasise confidentially.
- Address the patient directly as “you” rather than as “(s)he”.
- Speak slowly and clearly, one or two sentences at a time.
- Ensure that everything you say is translated.
- Watch and listen. Important non-verbal cues may be picked up during the consultation.

Culture and Health

People from different cultures may have a different understanding of health and disease. They may also have very different expectations of health care systems and clinical staff.

- Be aware of culturally determined health beliefs.
- Try and understand what the patient thinks about their symptoms and illness.
- Do not make assumptions.
- Identify differences between your perceptions and theirs.
- Enquire about traditional healers and medicines.

Expectations of Health Care

Explanations of how the NHS functions and the role of primary and secondary care may avoid a conflict of expectations.

Examples include:

- Expectation of hospital referrals for conditions which in the UK are treated in primary care.
- Expectation for investigations, interventions, and drugs for conditions managed more conservatively in the UK.

Local Advocacy Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>City &amp; Hackney</td>
<td>020 7683 4024</td>
</tr>
<tr>
<td>Newham</td>
<td>020 7445 7743</td>
</tr>
<tr>
<td>Tower Hamlets</td>
<td>020 8223 8934</td>
</tr>
</tbody>
</table>

Telephone Interpreting

<table>
<thead>
<tr>
<th>Service</th>
<th>Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newham Language Shop</td>
<td>020 8430 3040</td>
</tr>
<tr>
<td>Language Line</td>
<td>0800 1692879 or 0800 7833503</td>
</tr>
<tr>
<td>Language is Everything</td>
<td>020 8230 0800 or 0800 7317878</td>
</tr>
</tbody>
</table>
The Asylum Experience

Patients who are asylum seekers frequently present with a variety of problems and symptoms due to their recent life experiences.

The Experience of Loss

Those leaving their country to seek asylum are vulnerable and experience many losses. As well as losing family members, through death and separation, they lose their home, friends, money, job and identity, and may lose dignity and hope.

It is the multiple losses and, most importantly, the loss of their role, status and usual support networks that may make it difficult for people to cope in a new environment.

The Sequence of Need

(P. Le Feuvre 2000)

After the initial relief of arriving, frustration and disillusionment may ensue, as the reality of a life in a new country becomes apparent.

There are many psychological and physical problems that may become apparent while refugees and asylum seekers settle in the UK.

Other factors which impact on the physical and psychological health of refugees and which can lead to diminished self-esteem and increasing dependence on others are:

- Poor access to education and housing
- Racism and discrimination leading to isolation
- Enforced idleness as they are banned from working, volunteering and higher education while they wait for asylum claims to be determined.

What can we do? Who can help us?

It is important to enable people to develop independence, acquire language, and have access to education and employment.

Integration requires support from local communities and services.

Refugee community organisations (RCOs) and volunteer sector groups provide advice and support to asylum seekers and refugees. They may provide immigration, asylum seekers and benefits advice, interpreting and translating.

RCO’s can act as advocates, reducing isolation, providing orientation, social support networks, information in people’s own language and a connection with their own culture.

The MULTIKULTI website provides an up to date list of RCO’s: www.multikulti.org.uk/agencies/
Medical Problems and Physical Health

The physical health needs of asylum seekers and refugees may depend on

- Their country of origin
- Previous access to health care and living conditions
- More recent experiences and flight from country of origin

Common medical problems may include:

- Malaria
- Tuberculosis
- HIV/AIDS and Sexually Transmitted Infections (STI’s)
- Tropical diseases
- Malnutrition
- Poorly controlled chronic diseases
- Female Genital Mutilation (FGM)

Common conditions related to captivity and flight may include:

- Traumatic injuries secondary to torture
- Rape and unwanted pregnancies
- Eye and ear problems secondary to head injury
- Post traumatic epilepsy

Tuberculosis

New entrants registering with a practice should be offered screening for TB at a new patient health check. Only a minority of new arrivals are screened at the port of entry.

NICE (2006) Guidelines advises tuberculin testing and/or BCG vaccination for new entrants to the UK if they are:

- From a high-incidence country (defined as an incidence of more than 40 per 100,000 per year) AND
- No evidence of vaccination from documentation or BCG scar AND
- Are aged younger than 16 years OR 16-35 years from a sub-Saharan African country or a country with a TB incidence of 500 per 100,000.
- For countries with high incidence rates of TB go to the Health Protection Agency website at www.hpa.org.uk and search ‘WHO country data TB’

BCG immunisation is contraindicated in the immunocompromised and / or HIV infected person.

New entrants from a country with a high incidence of TB should be offered a chest x-ray if they have not had one recently, unless younger than 11 or possibly pregnant.

Refer patients to appropriate local TB services for further clinical assessment and possible treatment if:

- Symptoms are suggestive of TB such as persistent cough, fever, night sweats, weight loss, haemoptysis
- Abnormal CXR
- Strongly positive tuberculin test

TB Services

<table>
<thead>
<tr>
<th>City &amp; Hackney Homerton Hospital</th>
<th>020 8510 7775</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newham Chest Clinic, Shrewsbury Road Health Centre</td>
<td>020 8983 2441</td>
</tr>
<tr>
<td>Tower Hamlets The London Chest Hospital</td>
<td>020 8586 5222</td>
</tr>
</tbody>
</table>

Immunisations and Screening

Conflict may have disrupted immunisation programmes and many families may have lost their records of immunisations.

For children, Department of Health advice states, “where there is no reliable history of previous immunisation, it should be assumed that children are unimmunised and the full UK recommendations should be followed.” (See www.dh.gov.uk and search "the green book")

Offer HiB and Meningitis C vaccines to those in the appropriate age groups.

The new patient check is also an opportunity to offer:

- Rubella antibody testing for women of childbearing age and immunisation to women who are not currently pregnant
- Hepatitis B and C serology to new entrants
- Testing and immunisation of family members of Hepatitis B carriers
**HIV/AIDS**

HIV/AIDS is more common amongst refugees and asylum seekers. It may be difficult to address, due to stigma and concerns about confidentiality.

Some refugees may have been placed at risk through a blood transfusion, contaminated needle, paid sex, intravenous drug use, mother to child transmission or sexual violation.

Those at risk should be offered information, confidential voluntary counselling and testing for HIV and other STI's. This may be done at a Genito-Urinary Medicine clinic (GUM).

**HIV/AIDS Support Organisations**

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Website</th>
</tr>
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<tbody>
<tr>
<td>Terrence Higgins Trust</td>
<td><a href="http://www.tht.org.uk">www.tht.org.uk</a></td>
</tr>
<tr>
<td>National African AIDS Helpline</td>
<td>Tel: 0800 0967500</td>
</tr>
<tr>
<td>Positively Women EC1V 1LR</td>
<td>Tel: 020 7713 0222</td>
</tr>
<tr>
<td>Lighthouse East London</td>
<td>Tel: 020 7812 1723</td>
</tr>
<tr>
<td>Positive East E15 1HP</td>
<td>Tel: 020 7791 2855</td>
</tr>
</tbody>
</table>

**Family Planning**

The full range of family planning information and options should be offered to all refugees and asylum seekers.

People may not use family planning due to religious or cultural reasons, but this should not be assumed.

Teenage refugees may feel caught between two cultures - that of their parents and that of their peers. Young people's sexual health services may offer an additional choice to the GP setting.

**Female Genital Mutilation (FGM)**

FGM (also known as female circumcision) is practiced in a wide variety of cultures and is not confined to one religious group.

Many women from sub-Saharan Africa, the Middle East, and South-East Asia are affected by this practice.

**FGM is illegal in the UK and has been condemned by the World Health Organisation (WHO).**

FGM might include clitoridectomy, partial or total excision of the labia and stitching and/or narrowing of the vaginal opening (infibulation).

Women may present with delayed menstruation, urinary problems, dyspareunia and sexual dysfunction. Commonly, FGM will present as problems in labour and delivery. Ideally, FGM should be identified as early as possible.

Surgical correction of infibulation is best done before a planned pregnancy. For a list of clinics offering advice and treatment go to the Foundation for Women's Health Research and Development website: (www.forwarduk.org.uk/resources/support/well-woman-clinics).

For additional resources for refugee women see Appendix 4.

It is illegal to take a child out of the UK for the purposes of having FGM. If this is suspected, child protection services should be contacted immediately.

**General Screening**

Screening, such as cervical cytology and mammography, has a low uptake amongst refugee communities.

Uptake can be increased through working with health advocates who can explain the role of health promotion and by availability of choice of gender of health workers.
Distress and Mental Health Problems

Expressions of distress and the ways in which people cope differ both between and within cultures. This makes the assessment and treatment of refugees with psychological health problems complex.

Cultural differences along with barriers of language and communication may increase the possibility of a misdiagnosis of mental illness.

Consider whether a patient’s presentation is a normal reaction in the context of their own culture.

What can be done?

For the majority, fostering confidence in their ability to renew a normal life, as far as possible, can do much to relieve the inevitable feelings of loss, sadness and anxiety.

Practical measures to reduce isolation and gain access to social support may be the most significant interventions.

Psychosomatic Symptoms

In the asylum and refugee population, physical presentations of psychological distress are common. Although people may attribute their symptoms to physical problems and expect investigations and treatment, they are often aware of the interrelations between physical and psychological symptoms.

Common symptoms of distress include:

- Distressing dreams
- Poor sleep patterns and sleep disturbance
- Recurrent vivid memories
- Headaches, palpitations, sweating, trembling, choking sensations
- Chest or abdominal discomfort
- Muscle pains and/or back pain
- Feeling weak or easily tired
- Loss of concentration
- Jumpiness or easily startled
- Low mood and frequent crying
- Irritability

Remember that many asylum seekers will have recent experience of imprisonment, torture, escape, danger and fear. These symptoms are common responses to distress and do not necessarily indicate mental illness.

What can we do?

Psychosomatic symptoms commonly last for sometime. It may be useful to chart the variability of such symptoms with mood states by, for example, using a diary.

When seeing patients with non-specific physical symptoms:

- Take complaints seriously and investigate physical causes for symptoms.
- Help to make the connections between body and mind.
- Look for cultural clues and check with an advocate if these are common or typical ways of expressing distress.
- Avoid dismissing symptoms or giving reassurances that they will go away quickly.
- If symptoms persist, consider ways of reducing distress by suggesting social engagements, exercise and counselling.

Common Mental Health Symptoms

Symptoms of anxiety, depression, guilt and shame and a poor sleep pattern are common amongst refugees.

Social isolation and poverty have a compounding effect on mental health symptoms, along with hostility, racism and fear of deportation.

Avoid over-medicalising normal expressions of grief and distress and be selective with medication, such as hypnotics.

REMEMBER: A minority of patients may develop psychiatric symptoms or frank mental illness, some of whom may have prior history of mental health problems and contact with mental health services.

Suicide Risk

As a group, asylum seekers often have a number of known risk factors for suicide which include:

- Relative young age
- Unemployment
- Lack of social support
- Psychiatric illness

In addition, feelings of hopelessness and despair, when faced with the possible rejection of asylum status and/or the inability to work or function in a new society, may lead asylum seekers to contemplate suicide.

A documented assessment of suicide risk should be made for all those with depression or other psychiatric symptoms.
**Post-traumatic Stress Disorder (PTSD)**

PTSD is an anxiety disorder triggered or caused by one or more very severe traumatic experiences. The diagnostic criteria state that it occurs within six months of the trauma and that symptoms last for at least one month.

The symptoms include:

- Re-experiencing the trauma as flashbacks, nightmares or other intrusive memories.
- Avoiding any situation which may trigger memories of the trauma.
- Emotional numbness and feelings of detachment.
- Hyperarousal - including irritability, angry outbursts, poor concentration and insomnia.

The diagnosis of PTSD should be used cautiously, as it medicalises common reactions and assumes a universally valid and applicable model.

Symptoms of PTSD do not necessarily mean the same in different cultural and social settings and many of those whose symptoms fit the checklist for PTSD continue to manage their lives effectively.

**What can be done?**

Helpful responses include:

- Supportive listening.
- Not expecting to do too much in one session.
- Having contact and getting support from other health care professionals and services.

In more severe or protracted cases, treatment with an SSRI antidepressant drug can help, as can a range of behavioural treatments and/or counselling.

Symptoms which may need specialist help include:

- Consistent failure to function properly with daily tasks.
- Frequently expressed suicidal ideas or plans.
- Social withdrawal and self-neglect.
- Behaviour or talk that is abnormal or strange within the person’s own culture.
- Psychotic features.
- Aggression towards self and/or others.

**Torture**

It is estimated that up to 30% of asylum seekers may be victims of torture.

Torture is any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person in order to obtain information, as a punishment or intimidation or through discrimination.

Its effects may be physical and psychological and may result from a person’s direct experience of torture or through being forced to watch the torture of others.

A survivor of torture may have difficulties with body image and may be preoccupied that his or her body has been irreparably damaged, leading to repeated consultations.

**Remember:**

- A story of torture or rape might emerge when doing routine examinations.
- Address physical symptoms whilst recognising that some may be physical expressions of distress.
- Listen to the patient’s testimony if they are willing or want to talk.
- Recognise that specialist skills may be needed to manage complex symptoms of distress.

Organisations offering support and treatment for victims of torture and violence:

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Tel:</th>
<th>Website</th>
</tr>
</thead>
<tbody>
<tr>
<td>Helen Bamber Foundation WC1A 1JT</td>
<td>02 07631 4492</td>
<td><a href="http://www.helenbamber.org">www.helenbamber.org</a></td>
</tr>
<tr>
<td>Medical Foundation for the Care of the Victims of Torture N7 7JW</td>
<td>020 7697 7777</td>
<td><a href="http://www.torturecare.org.uk">www.torturecare.org.uk</a></td>
</tr>
</tbody>
</table>
**Psychological Therapies and Counselling**

Counselling may be an unfamiliar concept for refugees and asylum seekers. Some may be more accustomed to discussing problems with family or members of their own communities.

Some patients might benefit from counselling presented in a culturally appropriate and sensitive way. Some members of the refugee community are trained in counselling skills.

Story-telling and sharing through narrative, art or dance may be helpful.

**Counselling Services**

<table>
<thead>
<tr>
<th>Service</th>
<th>Contact Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black Women’s Health and Family Support E2 9LU</td>
<td>Tel: 020 8980 3503 <a href="mailto:bwhafsl@btconnect.com">bwhafsl@btconnect.com</a></td>
</tr>
<tr>
<td>East London Asian Family Counselling E1 1DW</td>
<td>Tel: 020 7377 8640</td>
</tr>
<tr>
<td>DERMAN (Turkish and Kurdish Services) N1 6TG</td>
<td>Tel: 020 7613 5944 <a href="http://www.derman.org.uk">www.derman.org.uk</a></td>
</tr>
<tr>
<td>MIND City &amp; Hackney E9 7SN</td>
<td>Tel: 020 8985 4239 <a href="http://www.cityandhacknemind.org.uk">www.cityandhacknemind.org.uk</a></td>
</tr>
<tr>
<td>MIND Tower Hamlets E3 4DA</td>
<td>Tel: 020 7510 1081 <a href="http://www.mith.org.uk">www.mith.org.uk</a></td>
</tr>
<tr>
<td>Newham Psychology and Counselling E13 8HJ</td>
<td>Tel: 020 7445 7777</td>
</tr>
<tr>
<td>Salvation Army Counselling Service E15 4LU</td>
<td>Tel: 020 8536 5480</td>
</tr>
<tr>
<td>Tower Hamlets Psychology and Counselling Services E1 0LR</td>
<td>Tel: 020 7791 3667</td>
</tr>
</tbody>
</table>

When discussing substance misuse, there is a need to involve and support families and to stress confidentiality.

**Drugs and Alcohol Services**

<table>
<thead>
<tr>
<th>Service</th>
<th>Contact Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addaction: Hackney</td>
<td>Tel: 020 8442 9678</td>
</tr>
<tr>
<td>Addaction: Tower Hamlets</td>
<td>Tel: 020 8880 7780 (Bethnal Green)</td>
</tr>
<tr>
<td></td>
<td>Tel: 020 7790 1344 (Wapping)</td>
</tr>
<tr>
<td>City &amp; Hackney Alcohol Services</td>
<td>Tel: 020 7613 1313</td>
</tr>
<tr>
<td>Drinkline</td>
<td>Tel: 0800 9178282</td>
</tr>
<tr>
<td>Drug and Alcohol Services</td>
<td>Tel: 020 8257 3068 (Stratford)</td>
</tr>
<tr>
<td></td>
<td>Tel: 020 7702 0002 (Whitechapel)</td>
</tr>
<tr>
<td></td>
<td><a href="http://www.dasl.org.uk">www.dasl.org.uk</a></td>
</tr>
<tr>
<td>National Drugs Helpline</td>
<td>Tel: 0800 776600</td>
</tr>
<tr>
<td>Newham Community Drug Team E13 8E</td>
<td>Tel: 020 7474 2222 <a href="http://www.in-volve.org.uk">www.in-volve.org.uk</a></td>
</tr>
<tr>
<td>Tower Hamlets Alcohol Services E3 5ES</td>
<td>Tel: 020 8983 4861 <a href="http://www.thas.org.uk">www.thas.org.uk</a></td>
</tr>
</tbody>
</table>

**Health Care Worker’s Needs**

Working with refugees is both rewarding and challenging.

On occasions we may feel overwhelmed by the complex needs of asylum seekers and the difficulties of managing these within a brief consultation.

Suggestions include:

- Prioritise the problems and deal with the urgent problems first.
- Assume that a series of appointments will be needed.
- Arrange double appointments, especially if an interpreter is required.

General advice includes:

- Identify what patients are looking for.
- Decide who is the best person or organisation to help.
- Do not assume that you have a responsibility to find a solution to all problems.
- Encourage contact with local and national support networks.
- Ensure that patients learn how the NHS and related services work in the UK.

Health care workers may be exposed to a high degree of distress in listening to people’s accounts of their experiences and may need support themselves.
Local and National organisations can provide helpful and useful information to health care workers working with asylum seekers and refugees. The following organisations provide general information on this patient group as well as more specific educational and legal advice.

### General Information on Refugees and Asylum Seekers

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Address</th>
<th>Tel</th>
<th>Website</th>
</tr>
</thead>
<tbody>
<tr>
<td>United Nations High Commission for Refugees (UNHCR)</td>
<td>Public Info Unit, WC2R 1HH</td>
<td>020 7759 8090</td>
<td>unhcr.org.uk</td>
</tr>
<tr>
<td>The Refugee Council</td>
<td>SW9 8BB</td>
<td>020 7346 6700</td>
<td>refugee-council.org.uk</td>
</tr>
<tr>
<td>Refugee Unit</td>
<td>British Red Cross London Branch</td>
<td>020 704 5670/5692</td>
<td>redcross.org.uk</td>
</tr>
<tr>
<td>Medact</td>
<td>N1 6HT</td>
<td>020 7324 4739</td>
<td>medact.org</td>
</tr>
<tr>
<td>Refugee Action</td>
<td>SE1 8SB</td>
<td>020 7654 7700</td>
<td>refugee-action.org.uk</td>
</tr>
<tr>
<td>East of England Consortium Website: Health for Asylum Seekers and Refugee Portal</td>
<td></td>
<td></td>
<td>harpweb.org.uk</td>
</tr>
</tbody>
</table>

### General Educational and Legal Advice:

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Address</th>
<th>Tel</th>
<th>Website</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cedar Centre</td>
<td>E14 9WA</td>
<td>020 7538 4600</td>
<td>cedarcentre.co.uk</td>
</tr>
<tr>
<td>Education Action International</td>
<td>London EC14</td>
<td>020 7742 5800</td>
<td>education-action.org</td>
</tr>
<tr>
<td>Hackney Community Law Centre</td>
<td>E5 0PD</td>
<td>020 8985 8364</td>
<td>hclc.org.uk</td>
</tr>
<tr>
<td>PRAXIS</td>
<td>E2 0EF</td>
<td>020 7729 7985</td>
<td>praxis.org.uk</td>
</tr>
<tr>
<td>Refugee Legal Centre</td>
<td>E1 2DA</td>
<td>020 7780 3200</td>
<td>refugee-legal-centre.org.uk</td>
</tr>
<tr>
<td>Tower Hamlets Law Centre</td>
<td>E1 1BJ</td>
<td>020 7247 8998</td>
<td>thlc.co.uk</td>
</tr>
<tr>
<td>Newham Law Centre</td>
<td></td>
<td>020 8555 3331</td>
<td></td>
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</tbody>
</table>
Appendix 1: Definition of Refugee and Asylum Status and the New Asylum Model

The various definitions of Asylum Status are: (Home Office Asylum Policy Unit)

**Asylum Seeker:** A person who has submitted an application for protection under the Geneva Convention and is awaiting a decision from the Home Office on their asylum claim. In order to fulfill the terms of the Geneva Convention an asylum seeker must demonstrate that he or she is personally at risk of persecution if returned to the country of origin.

**Refugee Status:** A person whose asylum claim has been accepted by the Home Office and granted Leave to Enter/Remain (LTE/LTR) in the UK for 5 years, subject to review, becoming eligible to apply for Settled Status or Indefinite Leave to Remain (ILR) after that time.

**Indefinite Leave to Remain (ILR) or Settled Status:** Someone given permanent residence in the UK. Eligible for family reunion only if able to support them without recourse to state benefits or public funds.

**Humanitarian Protection (HP):** A person who the Home Office accepts has strong reasons not to return to their country of origin but is unable to demonstrate a claim for asylum. May be granted ILR after 5 years upon review. If protection is no longer needed and a person has no other basis of stay in the UK they will be expected to leave. Those granted HP on or after 30 August 2005 have immediate right to family reunion.

**Discretionary Leave (DL):** A person who may be granted leave for a limited number of specific reasons under current law, such as in the context of a marriage or civil partnership application or on very specific medical grounds. They might not be in need of international protection, or will have been excluded from such protection. A person on DL will normally become eligible to apply for ILR after 6 years.

**Asylum Seeker Refused or Denied:** A person whose asylum application and appeal has been rejected and who should make arrangements to leave the UK as soon as practicable.

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**The New Asylum Model**

Since April 2007, all new asylum applications have come under the “New Asylum Model” announced by Government in a document entitled Controlling of Borders: Making Migration work for Britain (2005). This system aims to speed up the process for determining asylum claims and to improve the quality of asylum decisions. Core to the new process is the focus on the single “case owner”: one professional responsible for managing both the case and the claimant throughout the asylum process.

The National Asylum Support System (NASS), an agency of the Home Office, was disbanded in 2006. The legislation in respect of eligibility for asylum support, and the categories of support available have not changed. Asylum support is now managed through regional structures and the provision of support is an integral part of asylum casework for new cases.

Under the provisions of section 97 of the Immigration and Asylum Act 1999, asylum seekers who arrive and are homeless are dispersed to areas where accommodation is available, often outside London and the Southeast.

Support under Section 4 of the Immigration and Asylum Act 1999, is provided in the form of accommodation and vouchers to cover the cost of food and other basic essential items.
Appendix 2: Communicable diseases exempt from treatment charges (Asylum Health Team, Department of Health):

<table>
<thead>
<tr>
<th>Communicable and Tropical Diseases:</th>
</tr>
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<tbody>
<tr>
<td>Hospital for Tropical Diseases</td>
</tr>
<tr>
<td>WC1E 6AU</td>
</tr>
<tr>
<td>Tel: 020 7383 0080</td>
</tr>
<tr>
<td><a href="http://www.thehtd.org">www.thehtd.org</a></td>
</tr>
<tr>
<td>Health Protection Agency</td>
</tr>
<tr>
<td>WC1V 7PP</td>
</tr>
<tr>
<td>Tel: 020 7759 2700/2701</td>
</tr>
<tr>
<td><a href="http://www.hpa.org.uk">www.hpa.org.uk</a></td>
</tr>
</tbody>
</table>

Appendix 3

Help with Health Costs

Asylum seekers and refugees may qualify for exemption certificates.

HC1 Certificates are claim forms for help with health costs including prescriptions through the NHS Low Income Scheme (LIS). They provide entitlement to:

- Free NHS prescriptions
- Free NHS dental treatment
- Free NHS wigs and fabric supports
- Free NHS eye sight tests
- Free NHS vouchers towards the cost of spectacles
- Refunds of necessary travel costs to and from hospital for NHS treatment

HC1 forms can be ordered through the Prescription Pricing Authority (0845 8501166) or [www.ppa.org.uk/ppa/HC1_form_intro.htm](http://www.ppa.org.uk/ppa/HC1_form_intro.htm) or in bulk from the Department of Health (08451 5554555).
Appendix 4: Community Organisations

Organisations are always changing. For an up to date list of refugee community organisations see the website: MULTIKULTI (www.multikulti.org.uk/agencies).

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Contact Details</th>
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<tbody>
<tr>
<td>Refugee Women’s Resource Project N1 1RY</td>
<td>Tel: 020 7354 9631 <a href="http://www.asylumaid.org.uk">www.asylumaid.org.uk</a></td>
</tr>
<tr>
<td>Refugee Women’s Association E8 3DL</td>
<td>Tel: 020 7923 2412 <a href="mailto:rwa@refugeewomen.org.uk">rwa@refugeewomen.org.uk</a></td>
</tr>
<tr>
<td>Women’s Health &amp; Family Services E1 5HU</td>
<td>Tel: 020 7377 8725 <a href="http://www.whfs.org.uk">www.whfs.org.uk</a></td>
</tr>
<tr>
<td>Latin American Women’s Aid E8 3DL</td>
<td>Tel: 020 7275 0321 <a href="mailto:info@lasadv.org.uk">info@lasadv.org.uk</a></td>
</tr>
</tbody>
</table>

References


Acknowledgements

This occasional paper has been written with the support of Dr. Angela Burnett as an update to her Good Practice Guideline published in November 2001. This version has been updated and revised by Dr. Flavia Franca and Dr. Sally Hull and typeset by Gladys Fordjour.
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CEG website
http://www.ihse.qmul.ac.uk/chs/nhs/ceg/index.html