Occasional Paper No. 05 - June 2002

# Improving the Health of Asylum Seekers: An Overview

N&YPHO

public health Observatories

tandem: communications research

ISBN: 1-903945-14-8

## Background

> *"Would immigration matters be any harder to sort out if asylum seekers were treated with respect, given decent accommodation and not suddenly dispersed and separated from family and friends, irrespective of pending hospital appointments, late pregnancy etc?"* ***PMS pilot, health professional***

This research was commissioned in response to concerns expressed by health service providers and was carried out between October 2001 and January 2002. This paper provides an overview of the detailed report *Improving the Health of Asylum Seekers in Northern and Yorkshire: a Report on Service Provision and Needs* (Wilson, 2002) available on the Northern & Yorkshire PHO website: www.nypho.org.uk.

## Summary of main findings:

- In September 2001, there were more than 11,700 asylum seekers in West Yorkshire, Humberside and the North East;
- Asylum seekers are socially excluded and vulnerable to poor health;
- Many agencies are committed to providing services but co-ordination is variable;
- There is a need for better data gathering and dissemination;
- Mental health is a major concern;
- Language and communication issues are also key.

## Action is required to develop:

- National policy on health issues led by the Department of Health;
- Improved information systems, including clarification of the role of the National Asylum Support Service;
- Translated health care information at national level;
- Commitment at regional level across agencies to respond to asylum seeker needs;
- Local support for community sector development;
- Mechanisms for regional dissemination of good practice, promoting sustainability and mainstreaming services.

## Introduction

The Immigration and Asylum Act, 1999[1] initiated a system for dispersing newly arrived asylum seekers to areas other than London and the South East of England. This dispersal system is managed by the National Asylum Support Service (NASS), part of the Immigration and Casework Directorate based within the Home Office.

Under the scheme, vouchers and accommodation are given to those asylum seekers deemed by NASS to need support. A number of private housing providers and some local authorities have entered into contracts with NASS to provide accommodation and varying levels of support. The local authorities are grouped into regional consortia. Consortia and regionally based NASS managers are responsible for bringing together and co-ordinating key services.

Across the UK, agencies working with asylum seekers have strongly criticised the complexity and shortcomings of the dispersal system. Their concerns have been backed up by a number of reports. Housing has often proved to be unsuitable and inadequate, in particular in the private sector[2]. Asylum seekers often do not get the advice and support they need to access services[3]. The voucher system has caused stigmatisation and hardship[4]. NASS has proved to be too bureaucratic and remote, working from Croydon and with only one manager in each region[4].

The voluntary and community sectors, and many public services, have not been given additional resources to enable them to work effectively with this new and vulnerable client group[5]. Agreed language clusters have often been ignored, placing severe strain on interpreting services[5]. Racist attacks against asylum seekers have taken place in many areas[6,7].

With regard to health, it is only in recent months that national policy has started to be developed in relation to health services for asylum seekers.

The exact numbers of asylum seekers in the regions are not known. In addition to those dispersed by NASS, there are asylum seekers who arrived before NASS was set up or who have been housed in the North by local authorities in the South. There are also refugees who have lived here for many years. The statistics given in this report, therefore, do not represent the total number of asylum seekers and refugees in the region.

The recently published White Paper, *Secure Borders, Safe Haven: Integration with Diversity in Modern Britain*[8], outlines major changes to the asylum system over the next few years. This includes:

- Induction Centres for all new arrivals with initial health screening;
- Accommodation Centres for some during the period of claim; and
- Removal Centres for those with failed claims.

There is no detail at this stage as to how health care services will be provided. The voucher system will be abolished before the end of 2002 and a new 'smart' Application Registration Card introduced. More effort will be put into the integration of accepted refugees. There are clearly many lessons from the current system to be applied in developing the new one.

## Rationale

The health of refugee communities in the United Kingdom is poor[9]. Many are living below the poverty threshold, which poses a threat to their health[10]. Many factors have been identified as contributing to the vulnerability of asylum seekers[11, 12, 13]:

- The relatively poor health care systems in some countries of origin;
- The turmoil caused by war or oppression;
- Experiences of torture and persecution;
- The difficulties of travelling and claiming asylum;
- Cultural bereavement and alienation;
- Accommodation in low-grade housing;
- Isolation and lack of community;
- Difficulties of communication;
- Lack of choice, influence and status;
- Hostility and racism in the media and surrounding communities.

Services and communities in the regions have struggled to meet the needs of newly dispersed asylum seekers. Gradually, expertise and services have developed, though often without the benefit of additional resources[5]. The Northern & Yorkshire Public Health Observatory commissioned this research in September 2001 in order to assist with the sharing of expertise and information, and the strengthening of networks and good practice in the region.

## Aims

The research area was the Northern & Yorkshire NHS region, excluding North Cumbria and with a focus on those areas that were actively receiving asylum seekers in October 2001. North Yorkshire, Northumberland and County Durham were not taking part in dispersal at the time, and were therefore not included in the research.

The research set out to achieve the following in relation to the health of asylum seekers:

- To present a "picture" of the population of asylum seekers at a particular point in time, including basic demographic data;
- To explore what data is collected, by whom, and how it is used, identifying shortcomings in its collection and use;
- To provide a brief overview of current health service provision, identifying gaps, needs and examples of good practice.

The research objectives are set out in more detail in the full report.

## Process of investigation

The process of investigation included attendance at meeting and conferences, use of questionnaires and interviews with asylum seekers and refugee community representatives.

### *Meetings and conferences*

The researcher met with a number of key workers, in order to develop and pilot the questionnaires, the contents of which were agreed by the steering group.

### *Questionnaire*

Questionnaires were sent to:

- NASS manager in Head Office, Croydon (100% response rate);
- The two regional consortia (50% response rate);
- The ten Health Authorities in areas receiving dispersed asylum seekers (70%);
- All 24 Primary Care Groups and Trusts (PCG/Ts) in areas receiving dispersed asylum seekers (75%);
- One GP in each of the above PCG/T areas (42%);
- The ten NHS Personal Medical Services (PMS) pilots working with asylum seekers (90%);
- 29 voluntary and community organisations (41%);
- 23 health practitioners and some other professionals (65%);
- 8 private housing providers (37.5% plus 1 extra local authority response).

In total, 131 questionnaires were sent, with 76 (58%) replies covering 79 (60%) organisations.

### *Interviews with asylum seekers and refugee community representatives*

**Interviews were conducted with 17 asylum seekers in Hull**. They were contacted through a local support group and the local authority Asylum Team. More information is available in Appendices 3 and 8 of the full report.

**The Regional Refugee Forum North East** took part in a focus group discussion. This Forum brings together representatives of a number of refugee community organisations based in the North East. More information on this is available in Appendices 2 and 10 of the full report.

In addition, a brief review was conducted of recent reports produced within West Yorkshire, Humberside and the North East that include the views of asylum seekers.

## Asylum statistics: Northern & Yorkshire region

All housing providers and both consortia were also asked for statistical data. Only one Consortium and three housing providers sent this in. Because their data are not comprehensive, this section therefore relies on data from NASS to give an overview of the population of asylum seekers in West Yorkshire, Humberside and the North East.

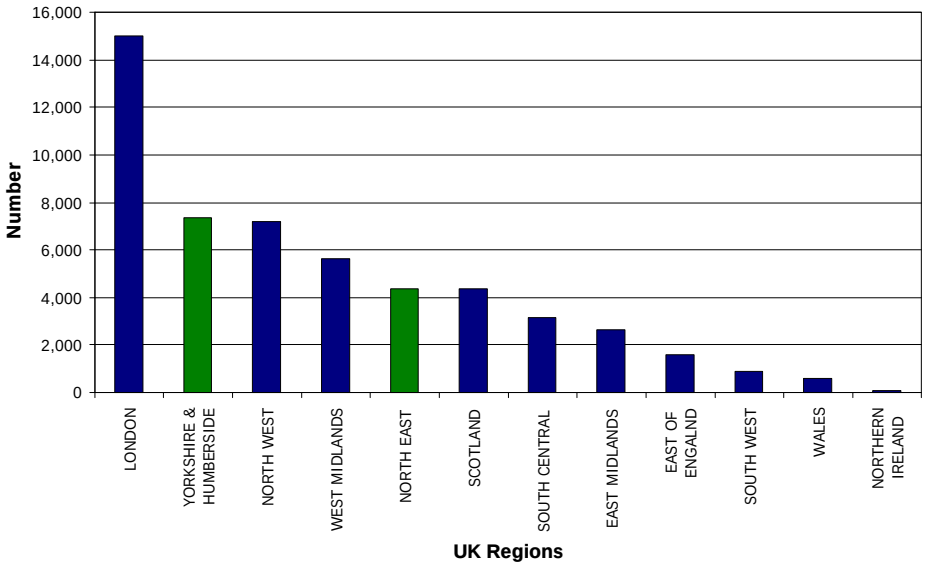
The NASS figures refer to 30 September 2001. They have been rounded by NASS to the nearest ten, and figures therefore may not sum. Figures exclude cases where the asylum seeker's support has been ceased. Families are defined by NASS as any group of two or more people.

The figures apply only to principal applicants, unless otherwise stated, as little information is currently available on dependants. NASS was unable to provide information about the number of asylum seekers residing in hostels, the number of asylum seekers who had moved out of the region, or the number of asylum seekers supported in the region broken down by language. This information cannot currently be accessed from the NASS database.

The figures do not include people with refugee status or leave to remain, unaccompanied minors, and asylum seekers who arrived in the region before dispersal was introduced. These "missing" numbers are likely to be significant.

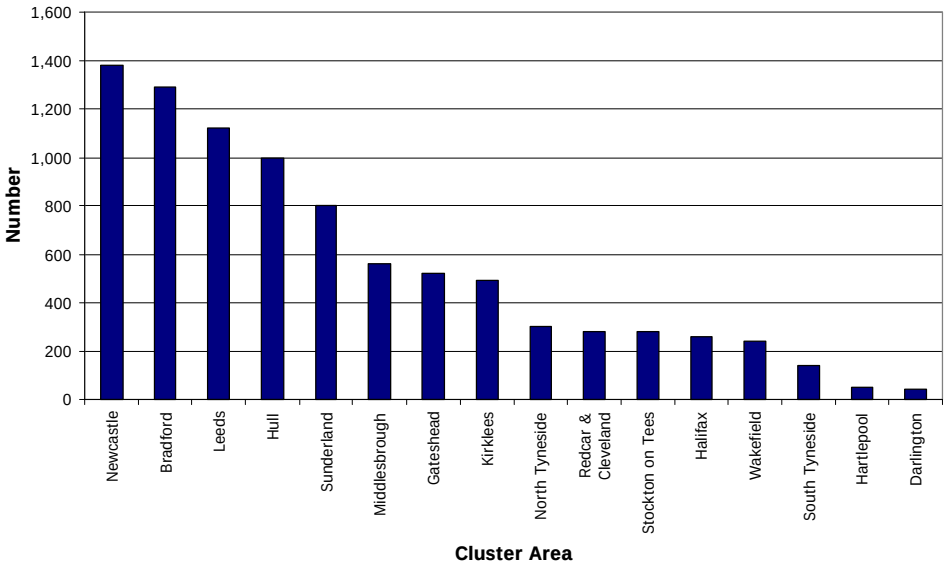
At the end of September 2001, London had the highest number of dispersed asylum seekers at 15,000. Yorkshire and Humberside ranked second with 7,330. The North East had 4,380 asylum seekers (these figures include dependants).

Figure 1: The national picture - NASS supported asylum seekers by region, September 2001



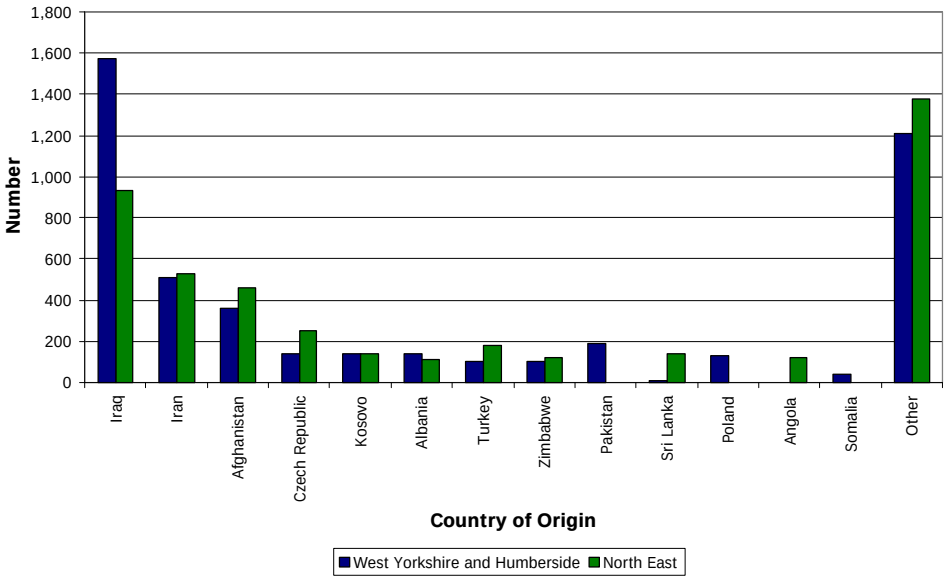

Figures 2 and 3 describe numbers and nationalities of asylum seekers and dependants in Northern and Yorkshire, known to NASS on 30 September 2001.

Figure 2: The regional picture - NASS supported asylum seekers by cluster area, September 2001



The significant number of people of 'other' nationalities shown in Figure 3 reflects the fact that there are small numbers of people from more than 30 different nationalities dispersed to the region. This can result in increased isolation for the asylum seekers involved, and to particular challenges and costs for services needing to reach these individuals.

Figure 3: Nationality of Asylum Seekers in West Yorkshire and Humberside and the North East (including dependents), 30 September 2001




The total number of principal applicants (i.e. not including dependants) in West Yorkshire and Humberside (excluding North and South Yorkshire) is 3,430. The total in the North East is 2,870. Table 1 gives further information on principal applicants.

### Table 1: Information on principal applicants

| Principal Applicant | | North East | West Yorkshire and Humberside |
|---|---|---|---|
| **Level of NASS support** | In NASS accommodation | 2830 | 3270 |
| | Vouchers only | 40 | 170 |
| **Sex** | Male | 2460 | 3030 |
| | Female | 410 | 410 |
| **Age*** | 18-35 | 2270 | 2970 |
| | 36-60 | 590 | 440 |
| | 61+ | 10 | 10 |
| **Family status** | Single | 2180 | 2900 |
| | Families | 690 | 540 |

*: Under 18's are classified as unaccompanied minors and are not eligible for NASS support.

## Data collection issues

NASS, the Consortia, health authorities, PCG/Ts and housing providers were asked about data collection issues, in order to identify the amount of information available or being gathered, and related issues.

### *Data available to services as asylum seekers arrive*

Health authorities received information from NASS relating to the name, nationality, sex, language, age and address of asylum seekers being sent to their area. The type of housing provision (whether public or private) and previous medical history were not supplied by NASS.

PCG/Ts were asked if they received any information from their health authority, with regard to asylum seekers being dispersed to their area – little information was being passed on. One PCG said that they got minimal forms that were "*often wrong, and don't reflect a true picture*".

Consortia and housing providers said they sometimes got information (one said "never"). Most were not satisfied with the level of information they received.

### *Ways of improving the data*

The majority of health authorities, PCG/Ts, and housing providers said the data they got from NASS could be improved, as did the Consortium. The following were suggested:

- Increased completeness of data and accuracy of detail (6);
- Medical problems or history (4);
- Name of housing provider (2);
- Notification of decisions (2);
- A database for all asylum seekers who are residing in area (2);
- A form for all asylum seekers, with date of birth, language and medical history (2);
- Data to arrive at appropriate time (2);
- Anticipated date of arrival (1).

A PCT representative said:

> *"The reason for not doing this [setting up a database] is said to be that asylum seekers often do not arrive. At least this could be documented and there would be a baseline from which to start."*

Housing providers wanted in particular to know about special requirements:

> *"More detail – for instance, how a problem affects somebody, or whether the accommodation allocated will be suitable. We may be told that someone is a diagnosed schizophrenic but not what arrangements exist with regard to medication."*

### *Making more use of the data*

Most health authorities and PCG/Ts identified ways they could make more use of the data. However, five said that this was difficult because they didn't receive accurate or sufficient data from NASS. Others obstacles identified were lack of resources, time constraints, and lack of clerical support and personnel.

### *Data gathered on asylum seekers after they have arrived*

Most of the health authorities said they were routinely collecting data on asylum seekers once they arrived in their area. Often this was the health profile filled in by a health visitor, or records kept by a screening service. None of the PCG/Ts was gathering data.

### *Provision of demographic data*

Consortia, housing providers and NASS were asked to provide a range of demographic information, for 30 September 2001 or a later date. Only two questions - the total numbers of NASS-dispersed asylum seekers in their accommodation, and numbers by nationality - could be answered by all respondents. The housing providers and NASS were able to report on family composition.

### *Reasons for difficulty in providing demographic data*

The Consortia, housing providers and NASS were asked to summarise the reasons why some or all of the data was difficult to provide. A Consortium and a housing provider commented:

> *"We have to use a variety of sources and gather information from a number of different agencies and local authorities. Our database as a Consortium covers all authorities but we do not have access to all their information."*

> *"With regard to data on asylum seekers moving out of our accommodation, the figure we give will not be accurate. It relates to the number we know left as they had a decision. In reality it will be much greater. We think that when a lot of people receive a decision, especially a negative one, they leave our accommodation very quickly to go to parts of the country where they have family or friends. As clients receive notification of their decision weeks before we do, the vast majority of people leaving our accommodation are classified as 'absconders' as we do not know why or where they have gone."*

### *Data on registration, screening, immunisation, and interpreting services*

Health authorities were asked to provide statistical data relating to registration, screening, immunisation, and provision of interpreting services. Only four health authorities were able to answer some or all of these questions. They were then asked what data they considered would help ensure effective uptake and delivery of health services to this client group. Three health authorities responded:

- A central multi-agency database including TB screening, GP registration;
- More detailed health needs assessment and analysis of data;
- Age, sex, location, language, registration.

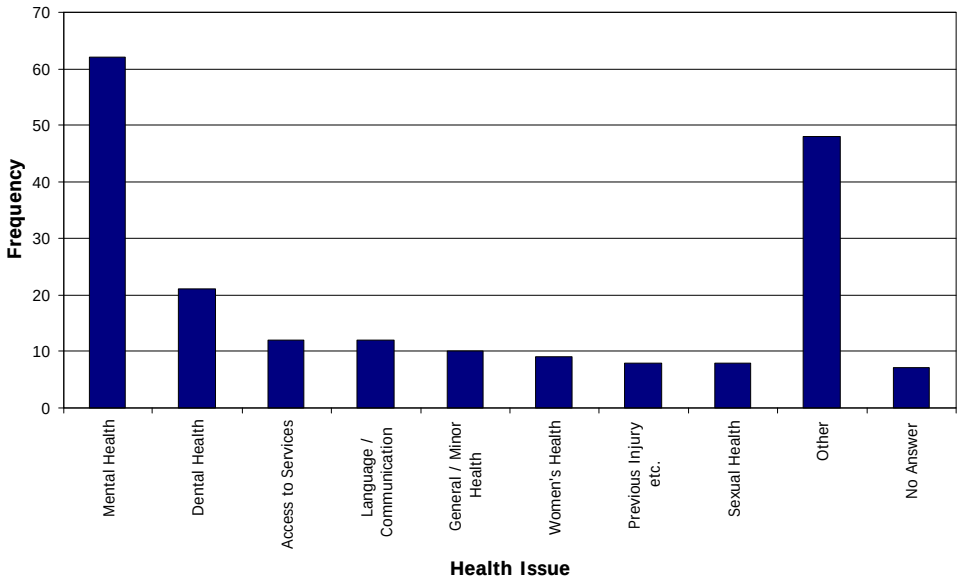
## Health issues

### *The most frequent health issues*

*Questionnaire Respondents*

Figure 4 shows that respondents to the postal questionnaires identified mental health as the most frequently encountered health issue (62 respondents), followed by dental health.

Figure 4: Health issues most frequently encountered among asylum seekers




One member of staff at a PMS pilot wrote:

> *"Many asylum seekers have emotional problems and require a great deal of encouragement and support visits – marked improvements in their well being are noted once they begin to mix at college for social events. Some asylum seekers need extra support from GPs or mental health services. There is a broad spectrum of mental health issues, though few need specialist input from a psychiatrist."*

Respondents were also asked which health issues caused their organisation most difficulty. Seventy out of 76 responded. Again, mental health was named most often (20 respondents), with regard to issues and resources. This was followed by language and communication (7 respondents).

*Asylum seekers and the Regional Refugee Forum North East*

The asylum seekers interviewed in Hull (17) were asked what they thought were the main health problems for asylum seekers. They answered as follows:

- Mental health (12);
- Poverty/environment/system (10);
- General health care issues (10);
- Specific health issues (8);
- GP services (5).

> *"There are a lot of sexual health problems, no sex is a big problem. There needs to be a way to meet women. When people have no English they can't communicate."*

> *"There are problems with addiction. They give you drugs for anti-depression, and so there is addiction to prescribed drugs. Maybe some asylum seekers arrive addicted. People are living in mixed households. They are vulnerable to drug addiction. No-one gives a damn."*

The Regional Refugee Forum North East emphasised the prevalence and urgency of mental health difficulties. These were seen as arising both pre-arrival, and as a result of the experience of being an asylum seeker in the UK. They also raised issues related to sexual health and drug and alcohol addiction.

### *Satisfaction with health care services*

*Asylum seekers*

Asylum seekers in Hull were asked how satisfied they were with their health care. A number of problems were raised including waiting times, living conditions and poverty, being given painkillers, the appointments system, and the attitude of some staff. The area of difficulty most frequently raised was language and communication.

> *"Doctors avoid using an interpreter."*

Asylum seekers were also asked if there was anything that they were pleased with in relation to the health care they had received. Six people said they were pleased with their GP, and some other forms of support were also named.

> *"Getting to be part of a network has helped a lot."*

Several had been helped to access health services on arrival by a range of agencies and support groups, and valued this. Language support was seen as very important. Often, asylum seekers had needed help with a wide range of issues affecting their health and well-being.

> *"The health visitor came to my house. She was very nice. She brought an interpreter. My child was not well – she saw to this. A radiator wasn't working. She sorted it out."*

All the asylum seekers interviewed were registered with a GP, and most were registered with a dentist. Communication, difficulties with registration, and other access problems were raised.

> *"I didn't see anyone at first. After three or four months I got a card saying 'Doctor X is your GP'. I left it for another six months. I was tortured and in a very bad condition."*

> *"The dentist was no good. He wanted me to sign but I said I can't sign because I don't know what is written. He said sign or find another dentist. He didn't explain what it said. Since that day I don't go to the dentist."*

*Refugee Forum North East*

The Refugee Forum raised the following service issues:

- **Language -** The group underlined the importance of good language services, as a basic entitlement for asylum seekers. They said some health services were reluctant to make use of interpreters, and they noted a number of booking and administrative issues that hindered good practice.

- **Primary care -** The group commented on difficulties in registering with GPs. In addition they felt that asylum seekers are unfamiliar with the system in the UK, and this lack of understanding can lead to them feeling discriminated against. Some health workers, including GPs, were seen as having negative attitudes towards asylum seekers, who they see as transient, costly (because of interpreting requirements) and unreliable (because some people miss appointments). There was a perceived lack of thorough investigation and explanation during GP consultations.

- **Information and health promotion -** This was seen as very important, and a number of gaps were identified, in particular in connection with sexual health and drug and alcohol abuse.

- **Other -** The Forum also discussed difficulties of language and access with regard to dental care, screening and secondary care. They said inappropriate accommodation was undermining health. They also criticised the voucher system, and the social and economic conditions that asylum seekers have to cope with.

### *Other issues*

*Questionnaire respondents*

Seventy-five out of 76 respondents identified other difficulties that staff experience with regard to planning and delivering services for asylum seekers. The following were each cited by 20 or more respondents:

- Asylum seekers' lack of understanding of health services e.g., who does what, entitlements etc. (60);
- Lack of translated materials (57);
- Asylum seekers unrealistic expectations of health services e.g., appointments system, waiting times etc. (49);
- Cost of interpretation service (43);
- Lack of funding (40);
- Lack of interpretation service (37);
- Reluctance of health workers to use language services (32);
- Lack of central government policy (31);
- Quality of interpretation service (25);
- Difficulties with HC2 form (22);
- Hostility among health staff (22).

## Suggested ways of resolving problems

### *Suggestions made by questionnaire respondents*

All 76 questionnaire respondents were asked if they could identify ways of resolving the gaps and problems. Sixty-six responded with at least one suggestion:

- Translated health information (20);
- Interpreting services (17);
- Additional funding/resources (16);
- Training & information for service providers (15);

- Specialist services (13);
- Mental health services (12);
- NASS/government role (10);
- GP services (7);
- Training/information for asylum seekers (7);
- Multi agency/joined up working (6);
- Other (5).

This included calls for more translated information, and a centralised database of translated health information:

> *"All health promotion material - particularly the Department of Health material – should be translated into different languages. There is a desperate need for this."* ***PMS pilot***

Respondents wanted better access to interpreters and improved funding for the use of language services. Additional training was called for, and better availability and dissemination of information. With regard to specialist services, the most frequently made suggestion was for the setting up of a dedicated medical team to provide short or medium term primary care:

> *"Provision of a dedicated team developing expertise but also building capacity and understanding in mainstream services to enable integration into local communities." PCG*

A number of respondents also recommended the provision of specialist mental health services and workers, and specialist counselling sessions. Some called for the introduction of patient held records. Others wanted more time and resources.

Six suggestions were directed at NASS, with three agencies recommending better planning and co-ordination of dispersal. Six proposals concerned the Department of Health - three of these related to the HC2 form, and three agencies called for "more leadership/guidance from the centre" and "more clarity in government policy".

> *"We need better government planning. Would immigration matters be any harder to sort out if asylum seekers were treated with respect, given decent accommodation and not suddenly dispersed and separated from family and friends, irrespective of pending hospital appointments, late pregnancy etc?" PMS pilot*

Some respondents recommended education provision for asylum seekers, to help them to understand services and the NHS system. Most other suggestions were about underlying values and approaches, such as respect for individuals, involving asylum seekers and seeking out their views, using community development as a way of working, and having good support systems for staff.

### *Suggestions made by asylum seekers*

Eleven of the 17 interviewees in Hull came up with a range of recommendations. These included:

- Providing more money or allowances to asylum seekers (so families could cope better, and so people could get to appointments and buy essential goods);
- More activities;
- Better communication;
- Child care;
- Access to computers and language classes;
- Better housing; and
- Improvements in GP and hospital services.

### *Suggestions made by the Regional Refugee Forum North East*

The Regional Refugee Forum North East made many suggestions for improvement, including:

- More specialist mental health and counselling services;
- More sensitivity in services towards asylum seekers;
- More health promotion work and information, in partnership with community organisations;
- Better access to and uptake of services, including primary care, dental services and screening services;
- An end to the use of hostels to house asylum seekers;
- Making use of medically-trained refugees and asylum seekers;
- Training and developing bi-lingual workers within the community;
- Providing adequate resources to community organisations.

Above all, the Forum called for the prompt and on-going involvement of refugee community organisations and the Forum in policy, planning and service delivery.

## Other findings from the postal questionnaire

**Staff training needs** - A number of respondents wanted training on asylum issues and cultural awareness (17); mental health issues and torture (15); use of interpreters (9).

**GP registration** - Health Visitors played an important role in ensuring the registration of asylum seekers with GP practices in four health authorities. Some health authorities said they had experienced difficulties, others reported high levels of registration.

**Screening** - Most health authorities responding to the question had a programme of TB screening, though the procedures and mechanisms for delivery varied. A Health Visitor or Specialist Nurse usually had a key role. Little statistical information was available – the health authorities providing information reported that 50% or more of their asylum seeker population had been screened for TB.

**Language services** - The amount and type of information available varied. One health authority spent £200,000 in one financial year, for around 2,000 asylum seekers (some had more than one session with an interpreter present). This covered face to face and telephone interpreting in primary and secondary care, but did not include translation costs. Another health authority reported that, in the last financial year, the cost per asylum seeker was approximately £120 for interpreting services in primary and secondary care.

**Co-ordinating bodies** - Most respondents attended at least one co-ordinating body at which asylum seeker and health issues were discussed.

**Policy documents and guidelines** - Few respondents had developed these.

**Consultation with asylum seekers** - There were very few instances of asylum seekers being consulted about service development and delivery.

**Research** - A few agencies were involved in research into asylum seekers and health issues in the region.

**Receipt or administration of new or additional funding** - Of the 76 respondents, 31 reported receiving or administering new or additional funding in order to focus on health issues. The majority identified PMS and LDS as the funding source.

**Involvement of other agencies** - Some other health initiatives were identified, in particular involving Health Action Zones (3), health promotion services (6), local hospitals (2), mental health services (4), and voluntary sector or other bodies.

## Examples of Service Models identified by respondents

Everyone sent the postal questionnaire was asked if they were aware of any examples of good practice in their own or other organisations that they had found helpful with regard to asylum seeker health and health services. More than forty agencies and initiatives were named. The following is a small sample.

### *PMS pilots*

Personal Medical Services (PMS) schemes enable enhanced or separate primary care services to be developed for asylum seekers and other vulnerable sectors of the population. In the Northern and Yorkshire region there are ten PMS pilot schemes working with asylum seekers. Nine took part in this research: four work with asylum seekers only, and five work with other client groups as well.

Most work to provide a culturally sensitive, holistic service to meet the healthcare needs of asylum seekers. They provide some or all of the following: screening; immunisation; initial health assessment; primary health care; help accessing to other services; counselling; advocacy; health promotion; information; social events. Staff also network widely, training other workers in asylum issues, and working to influence policy and practice and to promote multi-agency working.

### *Voluntary and community sector involvement*

Many new groups have developed in the region to meet the needs of dispersed asylum seekers, and already established agencies have also worked to provide services. In Hull, for instance, a number of groups and networks now exist offering advice and support.

### *Mental health*

Leeds Crisis Centre has worked closely with the Medical Foundation for the Care of Victims of Torture: one staff member is in training with the Foundation, and shares their expertise with the rest of the team. The Whole System Mental Health Project in North Tyneside is working with other local agencies to simplify referrals so people are not 'bounced around the system'.

### *Data management*

Leeds Health Authority has teamed up with Leeds City Council to employ a clerk to gather data from all available sources. The resulting database allows better targeting of services.

### *Training*

Bradford Health Authority convened a half-day seminar in November 2001 bringing together health and other services working with asylum seekers, to promote awareness, share information, discuss issues and strengthen joint working. Universities and other agencies in the North East have formed a consortium to enable asylum seeker and refugee health professionals to work in the NHS in the UK. Newcastle Interpreting Service for Health and Social Services has teamed up with Gateshead Health and Council Services to run Refugee Awareness Training Days.

### *Co-ordination*

There are many examples of strong co-ordinating bodies. The Refugee and Asylum Seekers Health Action Group was set up in Newcastle in 1999, and brings together local health workers, and others from the public and voluntary sectors. The group is campaigning to get milk tokens for asylum seeker families, and has developed welcome packs for asylum seekers which are available in six languages.

### *Funding*

East Riding & Hull Health Authority has secured three year Joint Strategy Funding to provide interpretation services for Primary Care (£50,000, p/a for 3 years) and £30,000 p/a for 18 months to provide a language co-ordinator for all agencies.

The Retreat (a private mental health service based in York) is obtaining funding from the Save the Children Fund for work in Hull with young asylum seekers. Gateshead Asylum Seeker Support Team has gained Health Improvement Plan funding for a heath visitor, a nursery nurse and clerical support.

## Recommendations

The following section outlines recommendation for action at national, regional and local level which are based on the findings of this research.

> *"If we get health services right for asylum seekers, it will help us to provide good services for all."* ***Health Authority representative***

### *National*

1. The Department of Health needs to be closely involved in policy, providing leadership, guidance and support.
2. National policy should be developed with regard to the transfer of information between agencies. In particular, the role of NASS should be clarified, to ensure that timely, accurate and relevant information is disseminated to appropriate agencies.
3. NASS and the Department of Health should explore the use of individual patient-held records for asylum seekers, with one nationally agreed template for use across all regions.

4. The new induction process should include individual health assessment to a nationally agreed pro forma, and health information arising from this should be taken into account in decisions about dispersal and accommodation.
5. Translated health care information and health promotion materials should be prepared nationally, and disseminated in hard copy and electronically.
6. Language clusters facilitate the efficient delivery of health services: agreements on clustering should therefore be strictly observed.

### *Regional*

7. The incoming Regional Directors of Public Health, with their remit to tackle inequalities in health, will be uniquely well placed to forge links between services and to ensure that the health needs of vulnerable groups are high on the agenda of policy makers and commissioners of services.
8. At strategic health authority level, steps should be taken to ensure that appropriate mental health services are available to asylum seekers who require them.

### *Local*

9. PCTs need to recognise the health needs of asylum seekers within their populations, and ensure that local services are available to them. In particular, mental health needs and issues relating to dental health, screening and immunisation should be addressed. This will require investment in interagency data collection, monitoring, and a commitment to the involvement of refugee community organisations and consultation with asylum seekers. Identified health needs should be addressed promptly.
10. Multi-agency working needs to be strengthened, both at operational and strategic level. The asylum issue needs to be on the agenda of Local Strategic Partnerships. Related initiatives, such as sexual health strategies and Drug Action Teams, should routinely consider the needs of asylum seekers.
11. Multi-agency working should also include the sharing of lessons learned from good practice across the region. Steps should be taken to ensure the sustainability and mainstreaming of successful models of working with asylum seekers.
12. Social inclusion is key to promoting the health of this vulnerable group. Refugees and asylum seekers need to be taken into account in developmental initiatives such as Sure Start and ConneXions.
13. Community organisations play a vital role in promoting the health of asylum seekers. Their skills and expertise should be acknowledged and tapped. Long-term support needs to be in place for the development of refugee community organisations and other support groups.

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## Summary of other regional reports based on/including asylum seekers' views

This following is a summary of the findings of seven reports focussing on different parts of the study area that include the views of asylum seekers. In most studies, some interviewees commented positively on aspects of their health care. This summary focuses on the areas of difficulty identified.

| Report | Issues raised |
|---|---|
| Planning primary care services for asylum seekers: an interim report of health needs assessment in Sunderland and North Tyneside[11] | Vaccination rates; screening for TB and cervical cancer; mental health; access to dental treatment. |
| Young separated refugees in Yorkshire and Humberside[14] | For some, lack of support from housing provider; fear of complaining; not being registered with a GP and not knowing how to register; lacking appropriate forms; difficulties getting an interpreter; feelings of isolation and loneliness. |
| An overview of the health service in Sunderland from the perspective of service users who are asylum seekers in Sunderland[13] | Prior existing health needs on arrival; prior expectations of health care and services; communication; environment (e.g., climate, common illnesses, food); poor quality of accommodation; vouchers; poor mental well being; problems in accessing health services and treatment. |
| Interim evaluation report and recommendations relating to the pilot asylum seekers health service in Middlesbrough and Eston[6] | Mental health problems such as insomnia and depression; sexual health (contraception/safe sex advice); dentistry problems. Many people had not had a chest X-ray. |
| Young male asylum seekers sexual health: summary (Gateshead)[15] | Mixed knowledge of existing services, and of sexual health. Sexual health placed within a wider context of communication, integration and generic support. Need for sexual health information and provision identified. |
| Dispersed: a study of services for asylum seekers in West Yorkshire, December 1999 – March 2001[5] | Lack of guidance on where to go or what to do; mental health; dental health; sexual health and injuries caused by persecution or torture. |
| Issues affecting the primary health care of asylum seekers in Leeds: opinions of users and service providers[16] | Difficulties with registering with a GP and the appointment system; the need for vaccination cards; the importance of language services/support; mixed experience of dental treatment. |

## Useful Websites

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| **British Medical Association**<br><br>www.bma.org.uk | The BMA has published a report, "Access to health care for asylum seekers", and other relevant guidance. Available in 'Ethics' section. |
| **Department of Health**<br><br>www.doh.gov.uk | Use search mechanism (keying in 'refugees' or 'asylum seekers') to find recent output on refugee issues. |
| **MEDACT**<br><br>www.medact.org.uk | Has pages on refugee health issues in the UK, including reports on conferences and links to translated information. |
| **Medical Foundation for the Care of Victims of Torture**<br><br>www.torturecare.org.uk | Includes briefings on a number of countries, and links to medical/therapeutic related websites. |
| **NASS**<br><br>www.ind.homeoffice.gov.uk | Information from and about NASS can be reached through the asylum section of Immigration and Nationality Directorate's website. |
| **Northern & Yorkshire Public Health Observatory**<br><br>www.nypho.org.uk | The full text of this report is available. |
| **Refugee Council**<br><br>www.refugeecouncil.org.uk | This site has a lot of information about asylum and asylum seekers: health pages explain basic entitlements to care. |
| www.asylumsupport.info | An excellent resource of asylum support information, with links, news, a free email newsletter, and an extensive list of publications, including many on health. |

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Visit the Bibliography section of the full report on the Northern & Yorkshire PHO website (www.nypho.org.uk) for details of how to obtain many of the above reports.


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