King's Fund

The Health of Refugees

A guide for GPs

Ros Levenson with
Naaz Coker

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Foreword by Naaz Coker, Chair, the British Refugee Council

Managing the health of refugees and asylum seekers is a complex process requiring a sensitive approach to identifying, assessing and responding to the particular needs of specific groups of people who are frequently traumatised, depressed and extremely vulnerable.

In today's world there are nearly 15 million refugees. These are people who have fled from their countries because of war, persecution because of their religious and political beliefs or because their ethnicity puts their lives in danger. Current events in Yugoslavia have highlighted the traumas faced by persecuted families and their communities.

The movement of refugees is one of the major moral and political issues facing our world today. The UK, at this very moment, is preparing to accommodate displaced families from Kosova. This reaffirms the high priority that needs to be given to planning for and meeting the special and essential health needs of this vulnerable group of people.

For the sake of brevity, the term "refugees and asylum seekers" is employed; however, many of the issues affecting health and access to healthcare apply equally to all people who have been given Exceptional Leave to Remain (ELR) or Exceptional Leave to Enter (ELE), those whose applications have been refused and are appealing as well as those who enter the country under "family reunion" regulations.

The primary care system has to respond to the challenge of meeting the needs of these groups of people who will increasingly be dispersed through the country following the introduction of the government's new Immigration and Asylum Bill. These guidelines are specially timely and relevant for General Practitioners who will have the responsibility for managing the health of refugees.

It is critical that health and social care providers are aware of why people become refugees and the support and assistance they may need when they arrive in a new country. These guidelines will make it easier for refugees and asylum seekers to gain access to health services to meet their special needs. I commend this document to all clinicians and service providers in the primary care system.

A message from the Chair of the RCGP Health Inequalities Task Group

Many inner city GPs have patients who are refugees or asylum seekers, and have become increasingly aware of the health needs and the difficulties that may face displaced people who are newly arrived in the UK. Increasingly, GPs outside the inner cities will also have patients who are refugees or asylum seekers. All GPs will wish to ensure that primary care is at the forefront of ensuring that the NHS is responsive to the needs of these vulnerable patients. GPs and primary health care team colleagues see the effects of health inequalities every day, and they are aware that refugees and asylum seekers can be socially excluded as a result of communication barriers, prejudice, the magnitude of their own distressing experiences and, indeed, some confusion among healthcare professionals about how they can help to ensure access to health care and other services.

This publication from the King's Fund is designed to help GPs and their primary care colleagues to ensure that they can play their part in improving access to primary care for refugees and asylum seekers. The RCGP Health Inequalities Task Group warmly welcomes this publication and commends it to GPs and primary health care teams.

Introduction

This booklet is a brief guide for General Practitioners (GPs) and colleagues in the primary health care team who may have patients who are refugees or asylum seekers, and wish to ensure that they have the knowledge and skills to deliver an appropriate service to those patients. GPs, nurses, counsellors, receptionists, practice managers, therapists etc. can make a great contribution to the care of refugees and asylum seekers, but they need support in order to do so. Some of this support can take the form of information on the entitlements of refugees and asylum seekers to NHS services, backed up by an awareness of some of the main issues that affect the health of refugees and their access to health care. This document aims to provide a brief summary of some of these issues.

At the same time, many of the issues that confront refugees and asylum seekers, and those who are involved in their health care, have far-reaching policy implications, and need to be addressed by central government, within the health care professions and elsewhere. For example, resource issues, training issues, benchmarking of good practice in respect of interpreters, linkworkers and advocates, the role of the health authorities and their partners in Health Improvement Programmes, and the role of Primary Care Groups (PCGs) in developing services for refugees and asylum seekers (as well as other Black and minority ethnic people) need to be addressed throughout the country, and are beyond the scope of this document, though the importance of these issues is fully acknowledged.

This document is arranged into the following sections for ease of reference:

PART 1 - Definitions

What is a refugee?

In simple terms, a refugee is someone who is unable to return to his or her country due to fear of persecution. A more legalistic definition is found in the 1951 United Nations Convention and the 1967 Protocol Relating to the Status of Refugees (see box 1). The UK is a signatory to these documents.

BOX 1

Definition of a refugee

According to the 1951 UN Convention, a refugee is a person who:

"Owing to a well founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion is outside the country of his nationality and is unable, or owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence, as a result of such events, is unable to or, owing to such fear, is unwilling to return to it."

In order to be accepted as a refugee, it is necessary to apply for asylum. A refugee is someone who has been recognised as a refugee (i.e. whose application for asylum has been accepted).

What is an asylum seeker?

An asylum seeker is someone who is applying for refugee status - in order to be accepted as a refugee in the UK, it is necessary to first apply for asylum. Each individual application is then looked at by the Asylum Screening Unit of the Immigration and Nationality Directorate in the Home Office. It can take quite a long time (sometimes years) to reach a decision.

People who apply for asylum may do so at the port of entry (port applicants), or they may do so once they are already in the UK (in-country applicants). There is an important difference between these two types of application in terms of subsequent entitlements to welfare benefits. This is explained further in Part 3, see below.

PART 2 - What happens after applying for asylum?

When a person applies for asylum, the Home Office will decide whether to recognise the applicant as a refugee, or refuse the application completely, or they may refuse refugee status but grant Exceptional Leave to Remain/Enter (ELR/ELE).

BOX 2

Some facts and figures about asylum applications

Between January and December 1998 there were 46,010 new asylum applications. In the same period, the Home Office made 26,720 decisions on asylum applications. Of these, 20% were granted refugee status, 15% were given Exceptional Leave to Remain and 65% were refused.[1]

The process of decision making can be terribly slow. In July 1998 there were more than 52,000 asylum seekers waiting for a first decision on their case, and over 21,000 waiting for appeal decisions. About 10,000 people had been waiting since before 1993 for a decision and about 20,000 had been waiting since July 1993 and the end of 1995[2]. The Government has announced plans for speeding up the process and dealing with backlogs in considering asylum applications.

Indefinite Leave to Remain (ILR), Exceptional Leave to Remain (ELR) and Exceptional Leave to enter (ELE)

Refugee status is granted where the Home Office decides that a person meets the definition set out in the UN Convention. Before July 1998, a person who had held refugee status for four years could apply for Indefinite Leave to Remain (ILR- also known as "settlement" or "settled status") in the UK. Since 27 July 1998, anybody recognised as a refugee has also been granted ILR at the same time.

If the Home Office decides that a person does not come within the definitions of the UN Convention, but it may be dangerous for the person to return to their country of origin because of the present situation in that country, Exceptional Leave to Remain (ELR) - or Exceptional leave to Enter (ELE) if the applicant was a port applicant -

[1] Refugee Council. Statistical Analysis, January to December 1998.
[2] Briefing on the Government's Immigration and Asylum White Paper. The Refugee Council. July 1998.

may be granted. Until July 1998, ELR was likely to be granted for one year, but could be renewed twice for up to three years each time (making 7 years in all). After 27 July 1998, people granted ELR have been granted it for one year, followed by three years (making 4 years in all), after which time they can apply for ILR.

People who have been recognised as a refugee or granted ELR or ILR have the same entitlements to welfare benefits, health, housing, education and employment as British citizens (but see Part 3, below, for information on asylum seekers and financial benefits).

Appeals

Asylum seekers who are refused refugee status have the right to appeal to a Special Adjudicator of the Immigration Appeals Authority.

Refugees and their families

Once recognised as a refugee, their dependants can apply for permission to join them in the UK. The situation is different for people with ELR, as they usually have to wait until they have had ELR for four years before any such application can be successfully made and it has to be shown that the family can be maintained without recourse to public funds (though in exceptional circumstances, compassionate grounds may lead to an earlier consideration).

PART 3 - Entitlement to financial benefits for asylum seekers

The present situation (as at April 1999)

(Note - the situation described in this section will be fundamentally changed once the new Immigration and Asylum Bill is passed. See below for key implications)

Major changes in entitlement to benefits were introduced by the Asylum and Immigration Act 1996. This Act introduced different rules for asylum seekers who applied for asylum at the port of entry (port applicants), and for those who applied later (in-country applicants).

Port applicants are permitted to claim income support, (at a lower rate than normal), housing benefit and council tax benefit.

In-country applicants (other than those who claimed asylum before the benefits changes were introduced), or those appealing against a refusal to grant refugee status, are not eligible for these benefits (other than housing benefit). They have to rely on assistance from local authorities, under the National Assistance Act 1948. That Act gave local councils a responsibility to care for adult asylum seekers who were destitute, by providing them with support in kind. In other words, they had to provide food and shelter. This assistance is given through vouchers, and not in cash. Families with children and unaccompanied children are supported under the Children Act 1989, and this can include cash.

This means that those asylum seekers who are no longer entitled to claim income support and other financial benefits have to rely on assistance from local councils. Many such asylum seekers live in poor hostel-type accommodation, and they and their families live in poverty. The consequences to both physical and mental health are far-reaching, and are discussed further below.

Entitlement to financial benefits for asylum seekers – how the situation may change

In July 1998, the Government published a White Paper, *Faster, Fairer, Firmer: a modern approach to Immigration and Asylum in the UK*. This has a number of proposals, which have been the subject of consultation, and the Government subsequently introduced a new Immigration and Asylum Bill (in February 1999). It is not possible to summarise all the potential changes here, but with regard to claims by asylum seekers for income support and other financial benefits, the key proposals are as follows.

The proposed new arrangements would remove from all asylum seekers any entitlements to claim income support until they receive a positive decision (i.e. refugee status or ELR). They would also remove the responsibilities currently held by local authorities under the National Assistance Act 1948, and under current homelessness legislation. The essence of the proposals are to move to a "cashless" system, with a new national agency, operated by the Home Office, organising the system. The proposed national agency would contract with a variety of providers around the country, including local authorities, housing associations, voluntary organisations and the private sector, to provide packages of support for asylum seekers. (Unaccompanied children would not be covered by this scheme and would continue to be the responsibility of the local authority under the Children Act 1989.)

Community refugee organisations, refugee agencies and many other groups have expressed deep concerns that one inadequate system will be replaced by another that in many respects is even worse. Both the concept of "support in kind" and the likely level of funding for such a scheme seem likely to ensure that poverty will continue to be a key theme in the lives of asylum seekers, with all the predictable consequences on health. However, it is not possible, at this stage, to predict exactly what will, and what will not become law.

The Immigration and Asylum Bill - some key implications for refugees and asylum seekers

The provisions of the new Immigration and Asylum Bill are extensive and need not be summarised here. However, GPs and colleagues in primary health care teams may need to be aware of one or two specifics. For example, in addition to the implications of "cashless" support for asylum seekers, the health of asylum seekers may well be affected by the plan for the national agency, operated by the Home Office, to make only one offer of accommodation and support, somewhere in the UK. If they refuse this single offer, they will not be entitled to a second offer of accomodation. This is likely to result in isolation for asylum seekers, and a high level of consequent stress. It may also make the task of health care professionals more difficult, as local informal networks may be unavailable to support asylum seekers in the places where they are accommodated, particularly if those places are outside the major cities.

PART 4 - Entitlement to NHS services

Entitlement to free treatment

There is much misunderstanding on this issue, but the facts are simple: all refugees, those with ELR and asylum seekers are entitled to all NHS services, both in hospital and through a GP, just like other residents of the UK. ***Unlike some other overseas visitors, refugees and asylum seekers do not have to pay to see a GP or hospital doctor.*** (See box 3)

BOX 3 - entitlement to health care for refugees and asylum seekers

Excerpt from Statutory Instrument no. 306: The National Health Service (Charges to Overseas Visitors) Regulations 1989.
"Overseas visitors exempt from charges:
4. No charge shall be made in respect of any services forming part of the health service provided for an overseas visitor, being a person, or the spouse or child of a person- c) who has been accepted as refugee in the United Kingdom, or who has made a formal application for leave to stay as a refugee in the United Kingdom..."

Excerpt from Health Service Circular HSC 1999/018
Overseas visitors' eligibility to receive free primary care
"A refugee given leave to remain in the UK should be regarded as ordinarily resident. A refugee who is in the UK awaiting the result of his application to remain in this country should also be regarded as ordinarily resident because he or she is residing lawfully for a settled purpose."

In spite of this, some refugees and asylum seekers report being asked for passports and proof of identity or immigration status, and of meeting ignorance within the NHS about the rights of access of refugees and asylum seekers to free NHS treatment. GP practices should not ask for passports or other documents in relation to the status of refugees and asylum seekers, as this is not required, and may deter people from registering with a GP. If a practice particularly feels the need for some sort of proof of status, they could ask to see the person's Home Office letter as confirmation.

Refugees, asylum seekers and those with ELR are likely to be asked about their status at hospitals if they are referred for secondary care. This sometimes causes delays while documentation is verified. GPs are in a strong position to monitor whether their refugee

and asylum seeker patients are meeting unnecessary or insensitive obstacles to secondary care, and to challenge such obstacles individually and through PCGs.

There is no statutory restriction whatsoever on access to healthcare for refugees and asylum seekers, but there may be many problems for people who wish to access services. This can mean that some refugees and asylum seekers may not seek help until they have a serious health emergency, or until a condition has become chronic. It is, therefore, essential that GPs ensure that the basic facts about entitlement are understood by all members of the primary healthcare team, and in particular by those who have first contact with patients, e.g. practice managers and receptionists.

Registration with a GP

GPs should offer permanent registration to refugees and asylum seekers, rather than temporary registration, wherever possible. In offering permanent registration, they are more likely to be able to offer ongoing care, and to obtain previous records if they exist. Temporary registration also removes incentives to undertake cervical smear tests and immunisations. Moreover, refugees may not be as mobile as is sometimes thought. Jones and Gill[3] refer to a Home Office study[4] that found that 70% of refugees had been living in their current home for more than a year.

GPs and the primary health care team can improve healthcare for refugees and asylum seekers by:

- *Registering refugees and asylum seekers as patients on a permanent basis, unless there is a particular reason for opting for temporary registration*
- *Encouraging access to immunisation and screening programmes*
- *Referring refugees and asylum seekers to suitable sources of legal advice, support and assistance for social and economic problems that may affect their health.*

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[3] Refugees and primary care: tackling the inequalities. Jones D and Gill P. BMJ Vol. 317, 21 November 1998: 1444-1446.

[4] The settlement of refugees in Britain. Home Office Research Study 141. London HMSO. 1995.

- *Ensuring that all practice staff are aware of the kinds of problems faced by refugees and asylum seekers, and that they are trained to meet those needs sympathetically*
- *Alerting the PCG to the needs and experiences of refugees and asylum seekers*
- *Building links with local voluntary organisations and community groups*

Charges for NHS prescriptions, NHS sight tests and vouchers for glasses and NHS dental treatment

As explained in Part 3, some asylum seekers lost their entitlement to income support, housing benefit and council tax benefit in 1996, while the current Immigration and Asylum Bill seeks to remove all asylum seekers from entitlement to cash benefits. One of the many problems that follows from removing entitlement to income support is that asylum seekers who are not eligible for income support also lose the automatic exemption from NHS prescription, dental and optical charges that accompanies receipt of income support. However, asylum seekers without means can apply for help with NHS charges because they are on a low income (or no income).

In order to apply for help with NHS charges, asylum seekers need to complete form HC1 (formerly known as AG1) which is obtainable from many surgeries and clinics, main post offices, benefit offices etc. However, this form is quite long and complicated and is only available in English, and people may need help and advice in order to complete it. Also, it can take several weeks to process the form, so wherever possible, asylum seekers should be advised to fill in the form at the earliest possible opportunity. If they wait until they need free prescriptions, or a free sight test, or free dental treatment, they will not be able to get the help as soon as it is needed. Unfortunately, new applications have to be made every 6 months, and this is a further obstacle for asylum seekers and any other people with complex problems in their lives.

BOX 4

Help with health costs - how the primary care team can help asylum seekers who are not entitled to benefits

- Order a supply of HC1 forms from the Health Authority to keep in the surgery, and offer them to refugees and to asylum seekers who are not eligible for financial benefits.
- Find out where help is available in appropriate languages to assist patients in completing these forms.
- Remind asylum seekers to fill the forms in before they actually need help with health costs, if possible. (New patient health checks may offer an opportunity to advise patients that they can apply for help with health costs).
- Ensure that all colleagues in the primary health care team are aware of the need to inform asylum seekers that they will need to apply for exemption from charges for prescriptions, dental care, sight tests, travel to hospital etc.

PART 5 - Being a refugee/asylum seeker - how it can affect people's health

Not all refugees are the same; their experiences differ greatly depending on individual circumstances, on where they come from, on what they have experienced prior to leaving their homes, and on their personal and family circumstances. It is all too easy to simplify and stereotype the experiences of men, women and children of all ages, various ethnic groups and nationalities, different religions etc. and to see them all as "refugees". However, what all refugees and asylum seekers will have in common is the unwanted experience of upheaval and having to uproot from their country of origin, and to make their way in a different culture and political and social environment. Many refugees and asylum seekers may also have experienced great traumas in the events leading up to fleeing their country of origin. The points below should not be taken to apply to all refugees, but are intended to remind healthcare professionals of the range of factors that may influence the health of refugees and asylum seekers.

Poverty and homelessness

The experience of poverty and destitution is common among refuges and asylum seekers, particularly since the changes to entitlements to benefits. As discussed above, the "cashless" system of assistance to asylum seekers will increase the problems of poverty, even if non-cash help/help in kind becomes better co-ordinated. Poor diet, depression, and the many diseases that are exacerbated by a poor environment are all likely to factor in the experience of many people. Accommodation by local authorities is frequently in poor quality temporary accommodation, with overcrowding and poor physical conditions being common.

Racism and discrimination

Many refugees encounter racism and other forms of discrimination, and even where legal redress is possible, their vulnerability makes it difficult to challenge it effectively. The experience of encountering racism in a place that had been seen as a safe haven is

all the more devastating to those who experience it. Experiences of individual and institutional racism may lead to a breakdown in trust, with adverse consequences to people's health. The primary health care team needs to develop an understanding of why some refugees and asylum seekers may be reluctant to trust officials and professionals in any capacity; they need to allow time for trust to develop.

Loss of status

Refugees and asylum seekers may come from all strata of society in their countries of origin; while some have come from poor socio-economic backgrounds, others have held important positions in their professions and in public life. Refugees in the UK - now, as in the past - bring with them a rich diversity of experience, and many are skilled and experienced experts in their field. However, once in the UK, most will experience severe difficulties in securing suitable employment, commensurate with their former status. Professional skills and qualifications obtained overseas are often not recognised here. For example, nurses and doctors are usually unable to practice their professions here until they have taken further exams and courses of study; refugee doctors may be working as care assistants, or unable to find work at all - an appalling waste to the NHS and a loss of status and self esteem to the individuals concerned. Other skilled workers may find that they are unable to find employment that utilises their skills and experience. Whatever skills refugees bring with them, they are likely to experience low status and low self esteem once they become refugees.

BOX 5

Refugees come from all walks of life

It is incorrect to assume that all refugees are either helpless victims, or that they have all held important posts at home. The fact is that refugees come from all walks of life and have a variety of skills, trades and professions. While being aware of the vulnerability that results from upheaval, it is as well to remember that refugees and asylum seekers are actually survivors of very difficult circumstances, and although they may be adversely affected by their experiences, they may also have enormous strengths. Health care professionals need to be aware that while refugees and asylum seekers need information and support, more often than not they have the ability to be resourceful and resilient.

Bereavement and loss of loved ones

For some people, the circumstances leading up to seeking asylum include war, famine and great movements of populations. Significant numbers of refugees have lost people close to them, often in the most tragic circumstances. Children and adults may have witnessed brutality and murder and have been in grave danger themselves. Women who have lost their partners are often particularly isolated, and may be single parents as a result of their loss, with little or no access to other family support. Even where refugees have not been bereaved, the loss of their homes, their identity, their neighbours and the familiar sights and sounds of their former lives are akin to bereavement. Spouses and children and other close family members may have been left behind, resulting in fear and worry about their safety as well as possible lengthy separation.

Experience of torture and traumatic events

Some refugees have personal experience of torture, and have witnessed the torture of others. Some refugees (both men and women) have experienced sexual assaults. Some may have physical scars, and others emotional scars from their traumatic experiences. The ability to trust others, including health professionals, is certainly undermined by such experiences. Experience of torture can also have a profound impact on how people perceive and present their health problems. Some GPs report that survivors of torture tend to present their problems in physical terms, for example, an inability to sleep, bad dreams, headaches, palpitations, sweats etc. This may result in multiple prescriptions, or in being sent for a battery of tests. The need to treat the whole person in the light of their experiences is paramount. Equally, it should not be assumed that all ailments are a reflection of past traumatic experiences, and they should be investigated appropriately.

GPs may feel under-confident in treating survivors of torture, and may wish to have sources of expert advice for themselves as well as specialist services for referral where this is indicated. Some suggestions for help can be found in the section entitled *For advice and further information* at the end of this report. However, GPs and other members of the primary health care team can do a great deal to help people who have experienced torture or other traumas, and they should not assume that caring for people who have experienced traumatic events is beyond their competence.

BOX 6

Treating people who have experienced torture

- Do not underestimate the value in the primary care setting of real listening, supported by interpreters, where necessary.
- If a refugee or asylum seeker has multiple problems and the GP can only tackle some of them, it is still very beneficial to do so; the patient will feel better because some of their problems are being addressed.
- GPs are in a good position to help people who have experienced torture or other traumatic events; they can do so by enabling people to talk, by the use of medications and by a wide range of other therapies.
- Referrals to specialist trauma centres may be more effective once the asylum seeker's status has been settled; until then, the asylum seeker may feel that they remain in a traumatic situation, and may be less able to move on to more detailed psychological work on their problems

Refugee children

Refugee children are likely to be under great stress. Like adults, they have experienced great cultural upheaval and may have experienced violence and loss. Refugee children sometimes tend to appear to be mature beyond their years when they are with adults, but may nevertheless show their immaturity and the effects of their adverse experiences in other contexts, and it should not be forgotten that they are children, and have the physical and emotional needs of children.

Until now, local authorities have had a responsibility to refugee families with children as well as unaccompanied children, under the Children Act 1989. The Immigration and Asylum Bill 1999 seeks to remove from local authorities the responsibility to provide for asylum seeking families, in the absence of special needs requiring a social services response. However, unaccompanied children seeking asylum will remain the responsibility of local authorities under the Children Act 1989.

Vulnerability to particular conditions

It is impossible to generalise in a brief document about the health of refugees, since refugees come from all parts of the globe. It is also extremely important to ensure that stereotypical judgements are not made, and that it is important to check back to the

detail of the individual patient's history and experience. It should not be forgotten that refugees and asylum seekers may be vulnerable to a range of "ordinary" health-related problems, including high rates of smoking, hypertension, coronary heart disease, mental health problems, etc. However, GPs and the primary healthcare team may find it useful to have a checklist of questions to ask themselves when they see patients who are refugees or asylum seekers (many of these questions will also apply to other patients). For example:

BOX 7

Treating refugees and asylum seekers - questions for the GP to consider

- How does the patient's background affect the way in which they describe their symptoms?
- Are there particular cultural factors to take into account, e.g. attitudes to mental illness, stigma attached to certain conditions?
- Have all members of the family had a full and appropriate range of immunisations?
- For children, what effect have their experiences had on their health, development and psychological well-being?
- Does the patient come from a part of the world where a particular health condition is common or endemic?
- Could the patient's symptoms be explained by a disease that is uncommon in the UK (e.g. tropical diseases, certain parasitic infections?)
- Does the patient come from an ethnic group that experiences high levels of particular health problems (e.g. sickle cell anaemia)?
- Does the public health department of the health authority have useful information on the health problems that prevail in the countries of origin of local refugees and asylum seekers?
- Has the patient experienced trauma, torture, bereavement or other extreme circumstances that affect their health?
- Is the patient separated from other family members?

PART 6 - Promoting better access to primary health care

There are many factors that may stand in the way of good access to primary care by refugees and asylum seekers. It is important for GPs and colleagues in the primary health care team to be aware of perceived barriers to accessing primary care as they can directly address some of the perceived obstacles, while being sensitive to some of the concerns that refugees and asylum seekers may have in accessing primary care.

Different expectations of primary care

Depending on where they come from, refugees and asylum seekers may have very different experiences and expectations of primary care. Many will come from countries with quite different healthcare systems, and the concept of free primary care, offered by a general practitioner may be unfamiliar. In some countries, healthcare is associated with hospital care, and locally based primary care services may lack credibility or be seen as second class services, and it may take time to modify these ideas.

Confidentiality

Refugees and asylum seekers may fear that consultations will not be confidential. The confidential nature of the doctor-patient relationship, and the relationship with others in the primary healthcare team, should be explained, with frequent reassurance given on this, if necessary. For some people, this confidentiality will be quite different from the experiences that they have had in their countries of origin, and trust may build up quite slowly. Refugees and asylum seekers may fear that the doctor will give information about their physical or mental health to the Home Office or to other government departments, and that this will jeopardise their chances of being allowed to stay in the U.K. A study in South London in 1994[5] found that 4% of refugees believed that their GP worked for the Home Office.

[5] Stating the Obvious - factors which influence uptake and provision of primary health services for refugees. Grant C and Deane J, Lambeth, Southwark and Lewisham Health Commission, 1995.

Appointments systems

Appointments systems may be off-putting or difficult to understand for some people, and care will need to be taken to ensure that refugees and asylum seekers understand what is being offered when they are given an appointment to see the GP, and that they understand that an inability to see them at once does not mean that they are unwelcome at the practice. As refugees and asylum seekers may sometimes present with very complex problems that cannot be properly addressed in a short consultation, longer appointments may sometimes be necessary.

Priority given to other problems

For some refugees, addressing health concerns may have a less urgent priority than sorting out other problems. Pressing matters relating to benefits, housing, and their application for asylum may all take precedence over non-urgent health concerns, and may make it difficult, in practice, for some people to access services. However, this view is not universally shared by all those who work with refugees and asylum seekers, and some comment that women refugees, in particular, have deep concerns about health, particularly for their children, and they wish to access help with regard to child health and development, speech and language therapy and support for children who have experienced deeply disturbing events in their lives.

Homelessness and temporary accommodation

Homelessness and temporary accommodation can be barriers to access for refugees and asylum seekers. Refugee and asylum seekers may feel that it is not worth registering with a GP, or may think that they cannot do so if they are not in permanent accommodation. However, even temporary accommodation can continue for a considerable time, and permanent registration with a GP, wherever possible, offers the best chance for comprehensive care, supported by proper records.

Language and communication

The lack of a common language is one of the most fundamental obstacles to accessing healthcare. GPs need to ensure that they and their colleagues are fully aware of local resources to assist with translation and interpreting, although as Jones and Gill[6] point out, these local resources may be inadequate. As with any minority ethnic patients, the use of children and other family members as interpreters should be avoided, for all the usual reasons, but also because deeply distressing material may be disclosed. For example, some female refugees have experienced serious sexual assaults of which male partners may remain unaware, and the use of any relatives for interpreting may be a great obstacle to effective communication, and should always be avoided if possible.

It is important to be aware of local sources of language support. Questions to ask include:

- ***What interpreting sessions are available through the Health Authority?***
- ***Does the local health authority have a contract with Language Line (a commercial provider of telephone interpreting) or access to other telephone interpreting services?***
- ***Is there a local interpreting service in appropriate languages available to GPs?***
- ***Does the local authority offer any access to interpreting services?***

While walk-in consultations and home visits may pose particular problems, it may be possible to book interpreters for particular purposes, e.g. child health and immunisation clinics, ante-natal clinics, new patient checks etc.

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[6] Jones D and Gill P. op cit.

PART 7 - For advice and further information

Refugee Council

3 Bondway

London SW8 1SJ

Tel: 0171-820 3000 / Refugee Council Advice Line Tel: 0171-582 9929

(Monday to Friday, 10.00 am to 1.00pm).

For refugees, asylum seekers and people who work with them.

Joint Council for the Welfare of Immigrants

115 Old Street

London EC1V 9JR

Tel: 0171-251 8708 / Advice line telephone: 0171-251 8706

(Monday, Tuesday, Thursday, 10.00am to 12.30pm)

Advice, information, help and representation for people with immigration or nationality problems.

Refugee Legal Centre

Sussex House

39-45 Bermondsey Street

London SE1 3XF

Tel: 0171-827 9090

Free legal advice for asylum seekers on all aspects of the asylum procedure and conditions of stay

Immigration Advisory Service

County House

190 Great Dover Street

London SE1 4YB

Tel: 0171-357 6917 / 24-hour helpline Tel: 0181-814 1559

Immigration Law Practitioners Association

1st Floor, Lindsey House

40-41 Charterhouse Street

London EC1M 4JH

Tel: 0171-251 8383

Maintains directory of solicitors, barristers and other providers of immigration advice who are members of the Association

Medical Foundation for the Care of Victims of Torture

96-98 Grafton Road

London NW5 3EJ

Tel: 0171-813 7777

Provides services for survivors of torture and other forms of organised violence. Centre staff carry out case work, counselling, advice regarding welfare rights, medical treatment, psychiatry, psychotherapy, group therapy, complementary therapy, family therapy, and child and adolescent psychotherapy. They can also advise people on how to register with a GP. Foundation staff run training sessions and workshops for professional groups working with refugees and survivors of torture, and can discuss issues with health care workers.

The Traumatic Stress Clinic

73 Charlotte Street

London W1P 1LB

Tel: 0171-530 3666

Offers treatment to refugees experiencing serious trauma reaction; also offers advice on local services for treating traumatic stress, and advice on management

Language Line

Swallow House

11-21 Northdown Street

London N1 9BN

Tel : (enquiries) 0171-520 1400 or 0800 78 33 503

Language Line is a commercial telephone interpreting service, across a wide range of languages. A number of Health Authorities and NHS Trusts have contracts with Language Line.

Community Health Council

The local Community Health Council (CHC) may be a useful source of support and advice for patients in getting the best out of the NHS. Their address can be found in the telephone directory.

Voluntary Action Council/Council for Voluntary Service

Titles of voluntary organisations differ from place to place, but most areas have a Voluntary Action Council that will have knowledge of local community groups and organisations that can advise and assist refugees.

NHS Direct

Tel: 0845 46 47

An NHS 24-hour nurse-led telephone advice service, which has been operating in some areas since March 1998, and which will cover the whole country by autumn 2000.

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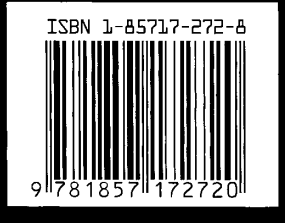

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