Asylum seekers in dispersal - healthcare issues

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This is a summary of a study which examined the provision of healthcare services for asylum seekers in areas to which they are dispersed by the National Asylum Support Service (NASS). The study investigated the accessibility and quality of healthcare provision for asylum seekers in dispersal areas; examined the impact of dispersal on the health of asylum seekers and identified existing and emerging good practice.

It was one of a series of scoping studies commissioned by the Home Office to gain a rapid understanding of what was happening 'on the ground' in support of refugees and their integration. The aim of these studies was to inform future research and development in this area rather than to be comprehensive evaluations of policy or practice. They were conducted in spring 2001, just six months after the launch of the Home Office 'Refugee Integration Strategy' and only a year after Home Office dispersal policy came into operation. As a result, dispersal policies and practices had not had time to bed down fully and some of the issues highlighted in this study have since been addressed. For example, the Department of Health has since put in place a team to co-ordinate asylum seekers' health and social care issues.

Key points

- Although most asylum seekers were relatively healthy on arrival, there were sometimes health problems associated with travelling long distances during dispersal. This was particularly the case for certain groups of asylum seekers, such as the elderly and pregnant women. Initial health screening would help to identify those at risk.

- Healthcare professionals and welfare workers were concerned that asylum seekers were being 'moved from place to place' by NASS and its accommodation providers, making it difficult to obtain registration with medical practitioners and healthcare programmes.

- High mobility also meant that healthcare providers often had to treat asylum seekers before their medical notes arrived. Some practitioners were starting to issue hand-held patient records for asylum seekers. Practitioners also noted that the inclusion of some medical information on NASS documentation would be useful (taking medical confidentiality into account).

- Most healthcare providers said that their principal problems arose from the number, diversity and irregular flow of asylum seekers.

- Good practice guidelines for asylum seeker health should be developed and promoted.

- Those interviewed expressed the need for appropriate training and more support to help staff deal with the needs of asylum seekers and refugees sensitively; to work more effectively with interpreters and help staff to deal with the emotional impacts of traumatic cases.

Aims and methods

The research methods used for this study included:

- a review of published and 'grey' (unpublished) literature

- an examination of evidence available through electronic networks

- interviews with healthcare providers and others.

Fieldwork was conducted in four main locations: Bedford, Coventry, Birmingham and Leicester. Coventry, Birmingham and Leicester are all dispersal areas with asylum seekers arriving through the National Asylum Support Service (NASS). Bedford was not a formal dispersal area but had received 'informal' dispersals from London boroughs.

Literature review

The primary focus of published reports in the health literature is on the experience and needs of recognised refugees, rather than those seeking asylum.

Increasing interest in the health of refugees and asylum seekers in the UK in the literature has led to a growth of policy-oriented discussion papers or reviews. One contribution to the UK literature, although focusing on the key issues for public health in London, brought together and reviewed much of the recent research on refugees and asylum seekers. It surveyed related developments across London health authorities (Aldous et al.,1999). Many of its findings and recommendations are echoed in this study.

Interviews

It is apparent both from recent literature and the response from healthcare providers and others that a 'learning curve' has begun, with a growing level of interest, awareness and expertise relating to refugee (and asylum seekers) health. The main priority, across the four areas studied, was some means of welcoming asylum seekers when they are sent to their dispersal area.

Questions used as the basis for interviews covered:

- the problems/needs of asylum seekers
- the impact of asylum seeker dispersal on local provision of healthcare services
- the main barriers to asylum seekers when accessing suitable healthcare support
- local innovative approaches to deal with problems
- what were the research and development needs to ensure better services in the future.

Interviews with key players in healthcare, asylum seeker support groups and NASS were conducted mostly face-to-face but some were carried out by telephone and email. Key players interviewed included:

- Local Director of Public Health (or representative)
- Members of asylum seeker/refugee support teams in the community health agency (e.g., Coventry City Council Asylum Seeker Support Team)
- Staff from Primary Care Trusts/Groups/Organisations (e.g., local GPs and other members of healthcare teams)
- Members of the voluntary and minority ethnic community sector (e.g., Migrant Helpline)
- Birmingham's Refugee Council One Stop Service
- All regional managers of the NASS system.

Health needs of asylum seekers

Although most asylum seekers were relatively healthy on arrival, they may experience health problems associated with travelling long distances during dispersal, particularly for certain groups of asylum seekers such as the elderly and pregnant women. Initial health screening would help to identify those at risk. If healthcare professionals in the regions were notified they could follow-up with appropriate health checks.

Many healthcare professionals were concerned to ensure that the health of asylum seekers remained stable. Health promotion work was seen as an important way of maintaining health, particularly of children. This should include education about the new risks they may face in Britain in respect of accident prevention and child

protection. Targeted health promotion for asylum seekers would help to address this problem, and ultimately safeguard the health of asylum seekers.

Asylum seekers experience 'enforced leisure' (or idleness), as a result of employment restrictions whilst their claim is being determined. This can lead to associated health problems and low self-esteem. Some areas were starting to issue 'passport to leisure' cards (additional support with sportswear and equipment was said to be available from faith groups). However, more formal support and funding structures would enable other agencies to provide similar services to asylum seekers.

Mobility upon receipt of a decision (and for those leaving NASS accommodation) interrupts care and may have an adverse impact on dependants. This suggests a need for some sort of an 'exit strategy' to ensure a seamless transition and continuing care for asylum seekers when they receive a decision on their claim. This should apply equally to those granted refugee status, those given leave to remain, and those who receive a negative decision.

Impacts of dispersal on healthcare services and implications for providers

Healthcare providers were concerned that decisions about where to disperse asylum seekers are based purely on the availability of accommodation, and the capacity of healthcare services is not taken into account. Nevertheless, providers are aware that the presence of asylum seekers highlights existing weaknesses in healthcare provision, rather than creates new problems.

The legal status of asylum seekers is variable, complex and confusing. Healthcare providers are often unsure how asylum status relates to healthcare entitlements. Asylum seekers may be the subject of:

- organised dispersals to the regions
- the continuing 'interim arrangements' arising from in-country applications before NASS came into operation.

Interviews with a range of healthcare professionals and support teams across the four case study areas revealed that in nearly all cases they felt that poor co-ordination by NASS was the main barrier to effective and efficient delivery of healthcare services to asylum seekers. The main issues reported by them include the:

- range of, and lack of prior information about, the demographic characteristics of incoming dispersed asylum seekers
- departure from the agreed 'language clusters'
- inconsistent standards of NASS accommodation providers
- high mobility of asylum seekers within the dispersal system
- problematic bureaucracy intended to support asylum seekers.

Most healthcare providers said that their principal problems arose from the number, diversity and irregular flow of asylum seekers. Coventry is an example of what happens in practice.

Coventry City Council

A team was set up specifically to be responsible for 30 asylum seekers under NASS dispersal arrangements. In practice, these staff also received:

- requests for help from 800 asylum seekers being accommodated by a private provider who was under contract to NASS
- about 2,000 'informal dispersal' asylum seekers who were placed locally by London/South Eastern housing authorities and social service departments

- a number of 'continuing interim arrangements' arising from in-county applications made before NASS arrangements.

Healthcare professionals are concerned that asylum seekers are being 'moved from place to place' by NASS and its accommodation providers. Welfare workers noted that their clients had reported being moved into and out of emergency accommodation with little warning, and had even been required to move from town to town on some occasions. This high mobility makes it difficult for asylum seekers to obtain registration with medical practitioners and healthcare programmes.

Hand-held patient records for asylum seekers

High mobility also means that healthcare providers are often required to treat asylum seekers in the absence of medical notes, which do not follow in time. Practitioners were beginning to address this issue by developing hand-held patient records for asylum seekers. Practitioners noted that the inclusion of some medical information on NASS documentation might also help to address this lack of information. Whilst practitioners are aware that the people who help asylum seekers to complete the NASS form are unlikely to be trained to record key health data, an initial screening of some sort would be extremely beneficial if combined with hand-held patient records. A housing-oriented translation agency (Health and Housing Resources Ltd) has devised a bilingual health screening questionnaire, which is used by some health service reception teams to acquire medical histories on registration.

Interpretation and translation

'We were advised to expect eight languages – we have only had two of those – but we have had 32 different languages spoken by the people dispersed here...'

Reception worker, Midlands

The cost and availability of interpretation, translation and advocacy (language support) were issues frequently raised by practitioners. There seems to be a lack of interpreters, and particularly medically trained interpreters. These problems are exacerbated by NASS's departure from the agreed language clusterings – it was intended that the range of languages spoken by asylum seekers would be fairly small in each group sent to a particular area.

It has been impossible for healthcare providers to plan language support needs in advance, when nationalities outside the local authority's agreement arrive without any notice. A return to dispersal by language would enable service providers to plan and cost appropriate language and cultural support.

Nearly every general medical practice appeared to have a different approach to dealing with interpretation and translation, and overall there was a great deal of worry and confusion. Some practices gained access to language support via the Language Line telephone interpreting service, although there were concerns about the quality. Other practices seemed to know little about the service or had been advised against excessive use because of restricted budgets. Some practices were in dispute about who was responsible for the cost of language support, and others were actively encouraging patients to seek referral through other agencies (e.g. the city council asylum support team) so that costs would be met by another budget holder. It was reported that some medical staff were simply refusing to seek language support, saying that they were 'too busy' or did not have the knowledge to set up bookings. Dentists were said to be refusing to treat without an interpreter but refusing to meet the cost of that service.

The research found that medical agencies were starting to work together to:

- facilitate discussion about translation and interpretation

- share the cost of issuing health information and documents in a variety of languages.

Another solution to the language support issues would be to train and employ more multilingual or otherwise language-competent staff. The success of this strategy would depend to some extent on the collation of

information concerning the skills of health staff, and better 'matching' of dispersed asylum seekers to areas through the language clustering arrangements.

Accessibility of healthcare services

Various factors influence how accessible healthcare services are for asylum seekers, such as whether information is made available, how costs are met, lack of specialist services and delays in issuing healthcare certificates.

Availability of information

There were reports that some NASS accommodation providers, and private providers in particular, were not meeting their responsibilities in helping asylum seekers to gain access to healthcare services. NASS needs to carry out regular monitoring of its accommodation providers to ensure that asylum support is being provided as contracted. Healthcare providers themselves were trying to reach out to asylum seekers by visiting NASS accommodation and providing welcome information packs to asylum seekers, making them aware of local services and how to access them.

Costs

In addition to the costs associated with language support, healthcare providers report other direct and indirect costs relating to the treatment of asylum seekers. For example, GPs report that asylum seekers affect target payments where those registered on patient lists refuse or do not turn up for vaccinations and cervical screening. Asylum seekers are likely to miss out on such routine health surveillance if they are being moved from place to place by NASS and accommodation providers.

As a result of these real or perceived costs, some healthcare providers are reluctant to register asylum seekers. Health authorities and primary care trusts have recognised this is a problem and are starting to offer raised payments for the registration of asylum seekers. Others are funding additional support staff for practices. Alternatively the relaxation of target payments for GPs or excluding asylum seekers in these target calculations could help.

Specialist healthcare

There is a lack of specialist healthcare services for asylum seekers in some regions, including HIV services and counselling support for victims of torture. In addition, the expense of travelling to health centres can make it difficult for asylum seekers to access healthcare services, basic and specialist – a problem also affecting other low-income groups in the UK.

Delay in issuing healthcare certificates

Asylum seekers who are supported by NASS will be issued with an HC2 certificate, which provides full exemption from standard medical and dental charges. This should be issued by NASS on behalf of the Department of Health with the first vouchers they receive. However, healthcare professionals, amongst others, report that issue of an HC2 certificate can take a long time, making it difficult for asylum seekers to access prescriptions meanwhile.

Training needs of medical staff

It is clear from the research that many of those working with asylum seekers have undergone a fairly steep learning curve. Some have previous experience of multi-cultural working, but nearly all require more information on the cultural and clinical backgrounds of asylum seekers. Good practice guidelines for asylum seekers' health should be developed and promoted.

Practitioners raised concerns about the impact of traumatic cases on frontline medical staff. The research suggests that appropriate training and more staff support would enable frontline staff to deliver healthcare services for asylum seekers more effectively over the longer-term, and prevent 'burn-out'. Training and support would enable staff to:

- address the needs of asylum seekers and refugees sensitively
- work more effectively with interpreters
- help them to deal with the emotional impacts of traumatic cases.

A joined-up approach

Many of the agencies (including primary care trusts) had no consistent central point of contact with overall responsibility for asylum seeker health. Hence, staff did not know where to go with specific asylum issues. A central point of reference would be beneficial, particularly in the absence of tailored training or national guidelines.

A strategic multi-agency approach to training, employing and meeting the costs of specialist heath interpreters and/or language competent clinical staff would also be beneficial. It would provide healthcare professionals with a wider support network and would prevent agencies 're-inventing the wheel' and duplicating costs. However, it should be noted that under single agency budget arrangements, multi-agency working might cause problems. For example, it was noted that in some instances where multi-agency working was being developed, the costs of partner agencies were frequently not being met (e.g. in using other team's interpreters).

Conclusions

This study was conducted only a year after the Home Office had begun to disperse asylum seekers, and some of the issues discussed may relate to 'teething' troubles, which have since been addressed. However, further research or health screening to determine the specific health needs of asylum seekers, including oral/dental health, would be of value in dispelling myths and enabling healthcare providers to plan resources. It would provide an evidence base to inform national and local health and social care policy.

It is unclear how many cases of mental illness are being missed. A number of current research studies are studying this area but mental health issues remain pertinent for asylum seekers, and further research in this area would be beneficial.

Reference

Aldous, J., Bardsley, M., Daniell, R., Gair, R., Jacobson, B., Lowdell, C., Morgan, D., Storkey, M. and Taylor, G. (1999). Refugee health in London. London: Health of Londoners' project, East London and City Health Authority.

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