Health needs of refugees and people seeking asylum

Background

People seeking asylum are forced to flee countries such as Syria, Iran, the Democratic Republic of Congo, Somalia and Eritrea due to conflict and persecution, many having been threatened, detained, beaten or tortured. The UK is signatory to the 1951 Refugee Convention and people who claim asylum are exercising a legal right to seek protection. The process can take years during which asylum seekers (AS) are entitled to health care under the Geneva Convention and UK law.

CCGs have an obligation under the Health and Social Care Act 2012 to tackle health inequalities. Asylum seekers are at the margins of society, and getting services right for this excluded group will generate learning for the care and inclusion of other marginalised groups. An appropriate service will offer care according to need, a founding principle of the NHS, and central to patient safety, health and quality improvements, and social cohesion.

Asylum seekers and the NHS

The pre and post-exile experiences of asylum seekers are different from those of the rest of the UK population, including the settled BME population. Health professionals often feel overwhelmed by the enormity of trying to meet their complex and diverse health needs.

In order to have meaningful and therapeutic contact with AS health professionals must understand:

- the complex psychosocial and medico-legal context of seeking sanctuary
- building trusting relationships with patients in unfamiliar circumstances and health systems
- the complexity and chronicity of AS problems contributing to morbidity and health risks
- the asylum system with its frequent re-organisations and limited social care resources
- the impact of poverty, destitution, hate crime and social exclusion on health
- intersectionality, cultural awareness, competence and sensibility issues
- the psychological and physical effects of torture and the effects of war
- the communication of distress and care options across language and cultural barriers.
- geography, history, geo-politics, UK politics, religion, UK law and international law
- the effects of cultural bereavement and social loss
- help seeking behaviour of people with complex psychological trauma
- their own risk of vicarious traumatisation as professionals in this field
- the benefits and limitations of voluntary sector involvement

Possible Health Issues

Mental health

Migration-specific psychiatric disorders include mood disorders, anxiety disorders, somatoform disorders, and posttraumatic stress disorders (PTSD)(1). They are often co-morbid with each other. Health professionals often misinterpret anxiety, compounded by a heightened by fear of disclosure and confidentiality breaches, as a lack of engagement. This leads to inappropriate discharge from services and consequent frustration.

Somatisation or Medically Unexplained Symptoms are common and often lead to expensive over investigation and medicalisation of misery. Pain syndromes are frequently treated with long-term expensive potentially harmful medication without full exploration or understanding of their psychosocial context. Headache consistent with chronic migraine was present in 57% of patients with PTSD at The Horizon Centre. (specialist GP practice in Salford, Greater Manchester) This improved with PTSD treatment.

Suicide risk management is a particular challenge in AS with depression. People are far from their families and usual sources of psychological and social support. They often feel hopeless about their future. Many are young adult men with previous exposure to violence, leading to self-neglect and impulsive risk-taking behaviour around health and personal safety. They require frequent assessment in safe and accessible surroundings. (The Horizon Centre had no patients from this high-risk group who committed suicide during 7 years using a primary care case management approach).

PTSD caused by a single incident in the context of reliable social support is more often seen in the indigenous or settled population and is catered for by NICE guidelines. In AS chronic and complex PTSD as a result of multiple and varied traumatic incidents is more common. Management is difficult with stressors on-going and circumstances unstable. Many AS are initially unsuitable for psychological therapies, do not understand the western model of psychological health, or drop out of therapy due to lack of physical, social and psychological resources.

The Royal College of Psychiatrists states “the psychological health of refugees and asylum seekers currently worsens on contact with the UK asylum system” (2).

Conditions of exile in the UK may be more likely to cause depression and anxiety than events in the country of origin.

Maternal and Child Health

Pregnancies are high risk and are sometimes the consequence of sexual assault or precarious relationships. Women do not have reliable access to antenatal care. The Royal College of Obstetricians and Gynaecologists reported that AS women are three times more likely to die in childbirth and seven times more likely to experience complications than the general population (3).

Unaccompanied and age disputed children are at particular risk of exploitation and need rapid identification and safeguarding. More than 50% of refugee children experience some psychiatric symptoms(1). It is important to get them back into education and learn to play again. Catch up

immunisation schedules protect the community as a whole. Addressing the needs of the whole family is paramount. To be ‘joined up’ these all require a co-ordinated primary care approach.

References

1. European Psychiatric Association. EPA Position Paper on Psychiatric Care of Refugees in Europe [Internet]. 2015. Available from: http://www.europsy.net/wp-content/uploads/2015/11/EPA-statement-on-Refugees-20151102_FINAL.pdf

2. The Royal College of Psychiatrists. Improving services for refugees and asylum seekers: position statement.

3. Royal College of Obstetricians and Gynaecologists. Confidential Enquiry in Maternal and Child Health. Why mothers die 2000–2002. The sixth report of the confidential enquiry into maternal deaths in the UK. 2004.

Barriers to accessing care for people seeking asylum

Understanding the requirement to register with a GP and practice boundaries

a. Many people come from countries where healthcare is not accessed through registration and are not aware of the UK GP gatekeeper role.

b. Some new arrivals do not understand that healthcare will be provided free and are deterred from registering due to poverty. Rumours of future charging for migrants is also putting people off registering or attending for tests.

c. The housing providers no longer provide routine information and help to register with GPs.

d. GP receptionists often ask for a passport and utilities bill despite repeated information from the PCT, BMA and RCGP to the contrary in the past 5 years

e. Practice boundaries are difficult to manage when people are being moved frequently.

The role of the GP

f. Some people are coming from healthcare systems with direct access to specialist care. Their expectations of the GP can include automatic referral on demand. Others have poor expectations of health and care and are not able to prioritise it. A mismatch between expectations and reality can create conflict or disappointment for both patient and practitioner when sufficient time is not devoted to explain the NHS processes.

g. Some people coming from areas where medications such as antibiotics and anti-malarials are used frequently without prescription feel ‘fobbed off’ with advice to manage conditions with simple analgesia and antipyretics.

h. Preventative care and management of long-term conditions are often not high priority for people experiencing insecurity and extreme poverty. They lack the means and motivation to follow healthy lifestyle advice.

Understanding the right to have an appropriate independent interpreter

i. Many people are regularly asked to bring a friend or family member to interpret for them despite this being recognised as risky practice in the NHS.

j. Gender, dialect and patient choice requirements are often ignored

k. Telephone interpretation is of poor quality and patients struggle to disclose emotional issues using these means.

l. Confidentiality and trust are barriers to using an interpreter but practitioners rarely make it explicit that these are recognised in law.

Longer consultation times

m. It is rare for a person seeking asylum to present with a single problem. Their needs are multifactorial and complex. Longer appointment times are often necessary but rarely given.

Telephone triage

n. People seeking asylum often lack credit on their phones for outgoing calls. Being kept on hold for periods of time can substantially eat into their very limited finances.

o. Language barriers for those who can manage some English face-to-face are magnified on the telephone.

p. Waiting for call back causes great anxiety and disruption

q. Requests to disclose the nature of the problem to an unseen individual are problematic. People often struggle to be able to articulate the nature of their problems easily e.g. presenting with physical pain of a psychological origin.

Disclosure

r. Lack of trust of people in authority causes reticence in disclosing traumatic incidents.

s. People seeking asylum are not sufficiently aware of confidentiality between the Home Office and the NHS.

t. Lack of continuity of care often requires an asylum seeker to repeat their traumatic history to many different practitioners leading to re-traumatisation

u. Patients often report being disbelieved by medical practitioners

Medicines management

v. Drug labels and instructions printed in English can be incomprehensible

w. There is a lack of understanding on lengths of treatment courses

x. Repeat medication ordering systems re hard to navigate

y. Follow-up appointments to check compliance are rare despite the chaotic nature of the patient group

z. It is not uncommon for people to take unsupervised medicines sent from home or those belonging to friends and family

aa. There is a lack of awareness about the indications for medication – e.g. patients talking about sleeping tablets when they mean antidepressants

Letters

bb. Lack of awareness of the importance of certain letters to the welfare of people seeking asylum and new refugees

cc. Charging for letters making them out of the reach of people who need them

dd. Lack of skill in undertaking medico-legal reporting leading to poor credibility in court

Referrals

ee. Referrals are often made to secondary care sites unknown to the patient and without geographical information to get there. Navigating the hospital building can be difficult

ff. Referral letters are sometimes not making the requirement for an interpreter clear.

gg. Although bus fares can be reclaimed people must have the cash to get there in the first place. Asylum seekers on section 4 support do not receive any cash benefits. Location of the offices to reclaim fares and language barriers prevent them from claiming

hh. Test results ordered by clinicians in hospital are not always available to GPs. Patients find this difficult to manage.

DNAs

ii. Competing priorities with greater immediate importance such as signing at the immigration reporting centre or appointments with their solicitor can mean last minute changes to schedules and DNA medical appointments.

jj. Opt-in services with welcome letters in English cause problems for patients who are unaware they need to respond in order to receive an appointment

kk. Many healthcare systems around the world do not operate a strict appointments system and this has to be clearly explained the patients

Reluctance to complain

ll. Lack of understanding of what to expect from a GP

mm. Lack of awareness of the processes through which to complain

nn. Fear of being treated differently after a complaint

oo. Fear of being removed form a GP list and being unable to access any care in future.