Asylum Seekers and Refugees
This needs assessment was prepared in July 2015 by the Public Health Action Support Team on behalf of Suffolk County Council.
Summary

Asylum seekers and refugees introduction

- Ipswich was receiving refugees prior to its designation by the Home Office as a dispersal centre for asylum seekers and refugees. Since that time there have always been approximately 70 to 90 people in the County in this category applying for a decision, appealing a decision or being designated a refugee for five years prior to applying for indefinite leave to remain.
- Asylum seekers and refugees have very distinct needs and need appropriate services. Once leave to remain has been granted (“a positive decision”), the individual acquires the status of refugee and has the same rights as other UK residents, free to live anywhere in the UK, take a job and apply for benefits. Once a refugee has leave to remain, he has to leave the Home Office dispersal accommodation in Ipswich. At this point, a new asylum seeker will be moved into the dispersal accommodation and the refugee may choose to remain in Ipswich as well, resulting in an increase in the migrant population. The burden of care on health services is always being renewed.

Asylum seekers and refugees key points

- Asylum seekers include unaccompanied minors, usually aged between sixteen and eighteen years but sometimes younger, as well as single adults, couples and families.
- They may not all be new arrivals in the UK. People may have lived in the UK under other circumstances but find they need to apply for asylum.
- An increasing number have no recourse to public funds and may become destitute.
- Many arriving to seek asylum are strong and well but others may be emotionally and physically damaged.
- Norfolk Suffolk and Cambridgeshire is designated by the Home Office to receive a maximum of 450 asylum seekers at any one time, 150 each in Ipswich, Peterborough and Norwich.
- New arrangements are in place for tuberculosis screening which mean less treatment is required in the UK. Asylum seekers are tested pre-entry and can only apply if they are clear of the disease. This process will exclude people...
already resident in the UK and making a new claim to asylum, people who are trafficked to the UK, and illegal immigrants

- Many asylum seekers find the NHS system difficult to understand; the GP’s role as gatekeeper to other services is not usual in other countries. Even though the system is explained to them, they still worry that they will be charged for services. Their access to services may depend on them having a clearer understanding of their entitlements and the way the system works.

- The regular statutory services in primary and secondary care work well mainly because of the significant additional contribution made by the Health Outreach Project and the voluntary Suffolk Refugee Support.

- Data recording issues and the time of year requests were made to the Health Outreach Project resulted in minimal data sets being available from this service.

- Although some asylum seekers and refugees in Suffolk come from countries with a high burden of Tuberculosis (TB), there is no local data that demonstrates local services do not manage this adequately.

- Language and communication affects service access and efficient usage and is vital to integration and good health.

Asylum seeker and refugees recommendations

1. NHS England and the Clinical Commissioning Groups should collaborate to ensure continued capacity and capability in primary care is available for asylum seekers and refugees.

2. The CCGs should support the Health Outreach Project to improve their monitoring and reporting of activity and outcomes so that the full scope of their work is recognised.

3. Suffolk County Council and the NHS should explore options for improving access to services including NHS services which are particularly challenging due to language barriers.

4. The Home Office should be informed that G4S is not meeting the minimum standards set out in their accommodation contract so that accommodations for this group can be improved.

5. Asylum seekers and refugees can be at risk of Vitamin D deficiency. Young children (under 5 years) and mothers who are pregnant or breastfeeding should be informed of Healthy Start vitamins. Those who are over 65 years; have low or no exposure to the sun either for cultural reasons (covering their skin); are housebound or confined indoors for long periods; have darker skin should be
encouraged to take Vitamin D supplements.

Throughout this document the asylum seeker is described as “he” and “him”. This is for ease of language and the content applies equally to male and female asylum seekers though the majority are male.

**Who are asylum seekers and refugees and why is this important for Suffolk?**

**Introduction**
Asylum seekers are people who are making a claim to stay in Britain because of fear of persecution in their home country. Many have suffered threats, imprisonment, torture, injury or threat of death. This makes returning to that country extremely dangerous. The 1951 United Nations Convention relating to the status of refugees defines a refugee as a person:

“who is outside his or her country of nationality or habitual residence; has a well-founded fear of being persecuted because of his or her race, religion, nationality, membership of a particular social group or political opinion; and is unable or unwilling to avail him or herself of the protection of that country, or to return there, for fear of persecution” (UNHCR 2011).

Asylum applications in the UK were at a peak of over 80,000 in 2002. Since then, this has reduced and remained at approximately 25,000 per year (ONS May, 2015).

Those claiming asylum are first housed in ‘initial accommodation’ under section 98 of the Immigration and Asylum Act. It is here where health screening should take place, with the results forwarded once they are dispersed under section 95. There is no initial accommodation in the East of England.

Asylum claims are handled by a branch of the Home Office known as UK Visas and Immigration. Asylum seekers are supported with accommodation and subsistence (a room and £36.95 per week for a single person over the age of 18) if they are destitute, but they may not take a job unless it is one on the shortage occupation list and if their asylum claim has not been decided within twelve months, nor access formal ESOL¹ classes. There are

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¹ English for Speakers of Other Languages
others who are supported only with subsistence as they find accommodation with family or friends.

Once asylum seekers have received a positive decision on their application, they may be granted refugee status and given leave to remain for five years in the UK after which they can apply for indefinite leave to remain. The refugee\(^2\) may decide to settle in Ipswich, the place to which he was dispersed, or may travel to be nearer friends. He has the same rights as other residents in Britain and can look for work, claim benefits, reside in the place of his choice and apply for British citizenship. Other positive decisions for asylum seekers include discretionary leave to remain of one to three years or humanitarian protection.

Whilst not all obtain a positive decision, there are many reasons why some may not be able to return to their countries of origin, perhaps because of war or other instability, or there being no viable route of return (no flights to the country nor embassy in the UK from which to obtain a visa), or permission has been obtained to proceed with a judicial review against the decision, or he is too ill (or a woman in the late stages of pregnancy) to travel. Possibly the country that he claimed to have left does not recognise him as one of their citizens, so while he may be declined leave to remain in the UK he is also refused leave to return to the country which he claimed as his origin. Whilst awaiting deportation, which can take many months, a small support package is available through the National Asylum Support Service.

Failed asylum seekers have been unable to establish to a reasonable degree of likelihood that they would suffer persecution if they were to return to their home nation. It is estimated that there may be as many as half a million failed asylum seekers remaining in the UK.

The majority of initial applications are unsuccessful. For example, in 2006 only 10% of applicants were granted refugee status. Of those who were able to launch an appeal against this decision, 73% were dismissed (Taylor 2009).

Unaccompanied minors also arrive seeking asylum. These are generally aged between 16 and 18 years though they may be younger. They are looked after by Social Services and placed in private foster care whilst their application is decided.

\(^2\) Once an individual has received the right to remain in Britain, he is no longer an asylum seeker and is generally referred to as a refugee. (Suffolk Refugee Support)
Not all asylum seekers are new arrivals. They may have been in the UK when conditions in their country of origin changed and it became unsafe to return. One family cited as living in Ipswich with two children had been in the UK for a number of years, but had not renewed their visas so were seeking asylum. A single Libyan man had entered England to undertake a university course but during that time the Libyan civil war commenced and he could not return home so is also seeking asylum.

This needs assessment includes current and failed asylum seekers, and refugees. It does not include undocumented migrants, people who arrive on valid visas but become undocumented because they overstay, or people who have entered the country illegally and not by the asylum seeking or visa processes.

No Recourse to Public Funds (NRPF)
This is a condition imposed on someone due to their immigration status. The public funds include a large number of mainly out-of-work benefits.

People are subject to immigration control if they:

- have leave to enter or remain in the UK with the condition 'no recourse to public funds'
- have leave to enter or remain in the UK that is subject to a maintenance undertaking, for example, an adult dependant of a person with settled status (possibly a spouse of a refugee), or
- require but do not have leave to enter or remain (for example, visa overstayers, illegal entrants, or failed asylum seekers who claimed asylum after entering the UK, rather than at the port of entry).
- When subject to immigration control, a person is prohibited from accessing public funds. This contributes to the public health problem since it is possible for people affected in this way to become destitute.

There is some redress. For example if lack of recourse to public funds affects a family with children, they can be referred to social services for a human rights assessment under the duties that social services have under the Children Act. A vulnerable adult may be entitled to support under the Care Act. Those families found to have need would receive housing and support from the social services department. In Suffolk, training is being arranged for housing providers and advice agencies since they need to know who to refer to social services. People have already presented in a destitute state so action needs to be planned.
There has always been the potential for this – as with failed asylum seekers who overstayed, but they often are part of a community with friends to help.

NHS treatment is subject to overseas visitors charging regulations. All refugees and asylum seekers are exempt.

**Why this is an important public health problem**

Asylum seekers and refugees, within a wide spectrum of vulnerability, have health needs which are more complex than those of the general population. Research undertaken by City University (2014) found that most asylum seekers arrive in the UK in good health; a minority arrive in considerable distress, sometimes with a number of complex physical and mental health needs, especially if they have experienced torture and organised violence.

Some asylum seekers experience mental health problems that cannot be addressed by the GP but fail to meet the criteria for receiving psychiatric treatment, meaning that many receive no treatment. They may have been self-medicating for anxiety and depression in their country of origin and be unable to access similar medication in the UK. The impact of exile on refugees is evident in many physical illnesses such as tuberculosis (TB) as a result of poor living conditions; and HIV undisclosed because asylum seekers fear that it will jeopardise their asylum application.

They may experience difficulties in accessing GP services and an increased reliance on Accident and Emergency or other direct access services. They may not understand how to use NHS systems (Stagg et al 2012).

Unaccompanied asylum-seeking children are vulnerable; some are under 16, though most are older, and the fact that the majority have no parent or guardian in the UK. Taylor (2009) found that “in almost all indices of physical, mental, and social wellbeing, asylum seekers and refugees suffer a disproportionate burden of morbidity.”

Refused asylum seekers awaiting voluntary return or removal receive minimal support (accommodation and shopping vouchers) but this is not available to those who decide not to leave the UK and consequently have no recourse to public funds and only limited healthcare. Care from a GP or in Accident and Emergency would be available, but admission to a ward or

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visit as an outpatient would be charged. Other services which may be accessed by someone with NRPF include an NHS walk-in centre, family planning services, diagnosis and treatment of specified infectious diseases, or of sexually transmitted diseases, or treatment required for a physical or mental condition caused by torture, female genital mutilation, domestic violence or sexual violence.

Up to half in this population are suffering from depression (Aspinell 2014). In 2007, this group was estimated to number 510,000 across the UK.

Some Asylum Seekers and Refugees can be at risk of Vitamin D deficiency (NICE guidance PH56). Vitamin D is essential for skeletal growth and bone health. Severe deficiency can result in rickets (among children) and osteomalacia (among children and adults). Dietary sources are limited. The main source of Vitamin D is from sunlight on skin. However, from mid-October to the beginning of April in the UK there is no ambient ultraviolet sunlight of the appropriate wavelength. Infants and children under 5; pregnant and breastfeeding women, particularly teenagers and young women; people over 65; people who have low or no exposure to the sun, for example, those who cover their skin for cultural reasons, who are housebound or confined indoors for long periods and people with darker skin, for example, people for Africa, African-Caribbean or South Asian family origin are at risk groups. These groups should be encouraged to take Vitamin D supplements.

**Links to other PHAST needs assessments**
Although the groups are discrete, some aspects of health status and access to health services may have common features with the needs assessment on Eastern Europeans and also on Gypsy, Roma and Traveller People.

Asylum seekers and refugees are an important public health problem in Suffolk because of the numbers who are regularly dispersed to Ipswich, their needs and care while they seek asylum, and the growing numbers who may settle in Ipswich and the surrounding areas following receipt of a positive decision to remain.

**What is the local picture?**
Asylum seekers and refugees were a significant minority in Suffolk even before Ipswich was designated a dispersal centre 4 under Home Office rules. In 2000, Iraqi Kurdish men began to

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4 Dispersal is the process by which the Home Office moves an asylum seeker to accommodation outside London and the South East. They are first moved to initial accommodation while their application for asylum support is processed. Once the application has been processed and approved they are moved to dispersal accommodation elsewhere in the UK.
arrive in Ipswich seeking asylum and from 2004 Iranian Kurds joined them. There is now a population of about 1,000 Kurdish men who were given positive decisions on asylum applications with leave to remain in the UK and are now settled with their families.

Suffolk is in the East and Midlands Home Office region and is takes about 10% (450) of asylum seekers housed in this region. Other centres in Norfolk and Cambridgeshire are Norwich and Peterborough. There is an agreement by which each of these towns can take a maximum of 150 Home Office supported asylum seekers at any one time. However there are rarely more than 90 in Ipswich as there is insufficient affordable, quality accommodation for more. Management of the accommodation services contract by G4S was criticised by the National Audit Office (NAO 2014) for poor standard of quality in the housing provided for asylum seekers, and for delay in acquiring new properties. This situation still pertains, although a decent standard of accommodation for people who have fled unsafe and threatening conditions is a basic requirement for physical and mental health.

There are also small numbers of people who stay with friends or family while making their asylum claim – so called ‘subsistence only’ applicants. Their access to services will be informed by their hosts’ awareness of local provision.

Advice and support to asylum seekers in Ipswich is provided by a voluntary agency, Suffolk Refugee Support (SRS). In the year to March 2015 79 asylum seekers known to SRS were settled in Ipswich. These came from sixteen countries; the largest contingents are detailed in Table 1.

Table 1: Asylum seekers in Suffolk by country of origin, April 2014 to March 2015

<table>
<thead>
<tr>
<th>Country of origin</th>
<th>Asylum seekers</th>
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<tbody>
<tr>
<td>Iraq</td>
<td>21</td>
</tr>
<tr>
<td>Iran</td>
<td>14</td>
</tr>
<tr>
<td>Pakistan</td>
<td>8</td>
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<tr>
<td>Eritrea</td>
<td>4</td>
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<tr>
<td>Albania</td>
<td>4</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>5</td>
</tr>
</tbody>
</table>

Source: Suffolk Refugee Support

In addition there were another 23 asylum seekers from 12 other countries, a total of 79 people.
Table 2: Asylum seekers, unaccompanied minors, 1 June 2013 to 30 June 2015

<table>
<thead>
<tr>
<th>Period</th>
<th>Number</th>
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<tbody>
<tr>
<td>1/06/13 – 31/12/13</td>
<td>4</td>
</tr>
<tr>
<td>01/01/14 – 31/12/14</td>
<td>24</td>
</tr>
<tr>
<td>01/01/15 – 30/06/15</td>
<td>19</td>
</tr>
<tr>
<td>Total</td>
<td>47</td>
</tr>
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</table>

Source: SCC Fostering service

These young people arrived from Eritrea, Iran, Albania, Sudan, Vietnam and Afghanistan. Young men often enter the UK on lorries, and in that case will be registered in the County where they are found. Some of these will have arrived at Felixstowe.

There is a comprehensive service available in Ipswich. Suffolk Refugee Support provides information, help with form-filling, language skills, companionship and caring, advice and advocacy. They comment “we can easily overlook just how resilient, positive and creative” the asylum seekers can be. The Health Outreach provides health and social care support in identifying problems and signposting to solutions, in providing a good start as asylum seekers and refugees arrive in Ipswich, and making themselves known as a service to which those people can return. These additional services complement the clinical work in primary care. If they were not there, the offer that primary care alone could make would be much less effective.

What is the evidence base for interventions? What is best practice?
The key question approached by a number of studies is how access is gained by vulnerable migrants to primary care and to secondary care.

Primary care is often not available in migrants’ country of origin, and they may expect to go to hospital for initial assessment of a problem. They also lack knowledge about payment for health services, and anecdotal evidence suggests that some NHS Trusts are also unclear. Access is related to accurate understanding of points of entry to the NHS and confidence about charges which might be levied in the system.
Aspinell (2014) reviewed the payment structure for health services available to vulnerable migrants:

- There is no required minimum period of stay in the UK before a person - including asylum seekers, refugees, and failed asylum seekers - can be registered with a GP. GPs can only decline such people if their list is closed or on other non-discriminatory grounds.
- GPs have a duty to provide emergency treatment free of charge regardless of migrants' residential or registration status.
- Charging regulations in secondary care have frequently changed. Since May 2012, a person seeking asylum or granted asylum, temporary or humanitarian protection under immigration rules is exempt from NHS charges and should be recognised as a refugee.
- Failed asylum seekers are generally liable for NHS hospital treatment charges, although there are exemptions for those continuing to be supported by UK Visas and Immigration.

All primary care services are available without cost to asylum seekers and refugees. The debate continues on the best way to structure primary care services for asylum seekers and refugees (Feldman 2006). Three models are proposed:

- “Gateway services” facilitate entry into primary care by identifying unregistered patients and carrying out health assessments.
- “Core services” provide full registration and may be provided by dedicated practices or by mainstream practices.
- “Ancillary services” are those that supplement and support core services' ability to meet the additional health needs of this group. They include language and information services, close links with community-based organisations, specialist mental health services and services for survivors of torture and organised violence, as well as targeted health promotion and training of health workers.

The discussion is limited by lack of evaluation of different models, but stresses the importance of ancillary services to successful mainstream provision.
Aspinell further considers registration rates of newly arrived refugees and asylum seekers. “The most robust estimates suggest that only about a third of all generic new entrants to the UK were registered”, and only 19% of asylum seekers. This varied across the UK, with rates approaching 100% in London. Aspinell notes: “the evidence was based on those entering the UK from countries with a high risk of TB who underwent port health tuberculosis screening”; this introduces a potential bias.

The question of how primary care should meet the challenge of newly arrived asylum seekers was the subject of a national survey of primary care (Eling 2010). There was insufficient data to evaluate the different models that had been developed in response to local need around the UK. However, factors were identified which influenced the configuration for a local service:

- local health service factors – enthusiasm to prepare for sudden large influxes of new entrants and the consequent resource implications,
- demographic and geographic factors – the ratio of new entrants to the established population, and the expected disease epidemiology in the new arrival group,
- local enthusiasms and politics, how much support could be expected from commissioners to engage with the agenda of including and supporting asylum seekers and refugees, and whether there should be specialist GP surgeries.

A brief introduction to this discussion is included here as there are similar questions to be answered in Ipswich. However the model which is in place in Suffolk is The Health Outreach receiving referrals on all newly dispersed arrivals through the asylum service, then arranging certain screening and healthcare advice before facilitating registration with a GP. This fulfils the “Ancillary services” (Aspinell) requirement. Compared with the total number of asylum seekers entering the UK, East of England does not receive many. However systems have to be in place both for proper access and use of the services, and also for health risks such as TB. The level of this risk should reduce as new screening procedures are implemented in the country of origin of asylum seekers prior to application being made.

Tuberculosis (NICE, 2011), is an infectious but treatable disease. It is the second most common cause of death globally. In 2012 there were 8,751 new cases in the UK, an incidence of 13.9/100,000. Since 2004, people arriving from countries with an incidence of tuberculosis of over 40/100,000 are screened on arrival. More recently, people applying for asylum in the UK from the 22 WHO high burden countries for the disease are screened
before they leave their country. If they are infectious they can seek medication and can re-apply when they are well. This is both cheaper and more effective. (UKBA, 2012).

What is the pattern of services in Suffolk at present?
This section is arranged following the asylum seeker’s route from arrival.

Port Health
TB screening is no longer carried out at Heathrow and Gatwick airports. Those resident in one of the 22 WHO high burden countries for TB will be tested before being allowed to commence an asylum seeking journey.

On arrival in Ipswich
Outreach and preventive work is provided by the Health Outreach, which works at all stages of the prevention, treatment and care pathway, providing treatment, information and advice on health and social issues and facilitating access to GPs and other mainstream health and social services.

It is specifically commissioned to provide health and social care advice and support to refugees and asylum seekers as well as other specific groups of marginalised and vulnerable adults.

The Health Outreach also has a geographic spread across Suffolk, a main static base located in Ipswich and visiting arrangements with the mobile clinic to a number of the market towns in the County.

The Health Outreach provides initial contact treatment and advice widely in Suffolk. The Health Outreach team consists of general nurses, mental health nurses, and a blood-borne virus nurse specialist, social workers, a GP, a physician’s assistant, support workers and administrative staff encouraging links with health services. The team also liaises with and support other organisations such as the Suffolk Refugee Support.

On arrival in the UK, a new asylum seeker is placed in UK Visas & Immigration temporary initial accommodation, where there are health teams that provide health checks. Once his support application has been granted, he leaves this accommodation and is transferred into
dispersal accommodation until he receives a decision on the asylum application, or his support needs or circumstances change.

The Health Outreach in Ipswich is notified of all new arrivals directly by secure email, as a first point of contact with health services in Ipswich. Two formal systems are employed, one for unaccompanied young persons and one for adults and families.

Unaccompanied young persons are brought to The Health Outreach by social care with either their care provider or foster carer.

Adults and families are notified to The Health Outreach by the Home Office and the housing provider G4S. The Health Outreach makes direct contact with the new arrival(s) to begin the assessment as soon as possible, usually immediately after arrival.

The Health Outreach will ensure the person has a GP, dentist, optician and referral to Suffolk Refugee Support and elsewhere as appropriate.

Where there is anxiety and depression, The Health Outreach will provide counselling. The system is efficient and few if any are missed, but it depends on sufficient GP practices being able and willing to absorb the potentially heavy new additional workload.

The Health Outreach also has strong links with the other dispersal sites in the region (particularly with City Reach in Norwich) so if there are any changes of location during dispersal, a new referral can be made quickly.

Asylum seekers and refugees receive free primary and secondary care and are entitled to free prescriptions for medication, dental care, eye tests and spectacles.

**Primary care**

In Ipswich, new arrivals join one of the town centre practices. Barrack Lane Medical Centre is not a specialist practice but receives many asylum seekers and refugees. A new patient check is carried out by the practice nurse, as for any newly registering patient, and leaflets are available in a number of languages. There are probably no previous notes, except those from screening in initial accommodation and language is a problem so the process of registration may take extra time. It can be straightforward or the person may present with very distressing and complex problems.
Barrack Lane Medical Centre holds a monthly multidisciplinary team meeting attended by external professionals including adult social workers, a link worker from Norfolk and Suffolk Foundation Trust (NSFT), the community cancer care team, community matron and The Health Outreach Team. Any input from other professionals on the needs of particular patients, including new asylum seekers and refugees, are discussed at the meeting. In this context, The Health Outreach is providing most of the “ancillary services” mentioned in the last section, with specialist mental health service from NSFT and English classes and information and social support by Suffolk Refugee Support.

**Secondary care**

Despite the documented high incidence of mental health problems amongst asylum seekers and refugees, there are no dedicated services at Norfolk and Suffolk Foundation Trust Hospital though there is a plan to look at whether these are needed. Counselling is provided at The Health Outreach and in interviews with asylum seekers this service was commended.

**Service user opinion**

Two visits were made, one to a group of overseas women who were mostly interviewed separately as they did not want to break up the activity they were engaged in to form a focus group. The second was a lunch club of people from a range of nationalities who participated in a focus group.

The women had all had contact with The Health Outreach so all were registered with a GP and knew how to get appointments, and to see that their children’s health needs were met. A common problem was waiting and queuing for services, it was not in their experience. If medication was needed, they had to wait at the doctor’s surgery for a prescription whereas at home they would have gone to the pharmacy and bought it over the counter. If they wanted a doctor, they would go to the hospital.

They knew how to get access to language line, though some said they did not think it was their responsibility to ask for it; it should be automatically provided.

They had been comprehensively introduced to different health services by The Health Outreach.

Their children were up-to-date with immunisations and vaccinations, and the women had had cervical screening. One man wanted to know why he could not have screening for
diabetes as he knew it was a risk for him.

They cooked together as one of their activities, but one women expressed her frustration that when she was newly arrived, she didn’t recognise the food in the shops and for example, had no idea how to cook broccoli.

They found it difficult to keep warm in winter and the fuel bills were high; this may only have applied to those with positive decisions who were responsible for their own bills.

Although many were alone in the UK they seemed to have made relationships together and were sharing child care for example. They liked meeting together and they were pleased that halal food was easily available.

**What additional information is needed?**

- The Health Outreach was unable to provide specific quantitative analysis of its dataset. The work of The Health Outreach is commended by professionals and clients alike but in this needs assessment, only qualitative description can be offered as The Health Outreach was unable to provide statistical information relating to its service. As all budgets are under threat The Health Outreach should find a way of presenting its activity in a way that will stand scrutiny.

- A two year audit by a GP practice of registrations of new patients arriving from non EU countries cross referenced to referrals for specialist mental health services is underway but not currently available.

**What can be concluded?**

Asylum seekers are brought together by the most difficult of circumstances. In 2006, only 10% of asylum claims were successful and three-quarters of appeals were rejected.

They are effectively homeless, placed where they are told and open to being moved by the housing provider if the needs of another client would more closely fit the size of the accommodation. The interviews with asylum seekers show the level of anxiety and depression, possibly linked to the insecurity of their situation of whether a positive decision is to be obtained (the Home Office aims to complete enquiries in six months) and if so, whether after five years, indefinite leave is granted. The possibility of detention and deportation remains for a long time.
They are often alone without family or friends; some having moved to different countries before and if they have family, they may never see them again.

In interviews some negative comments were expressed. Some less common languages or dialects were not available on Language Line. Asylum seekers and refugees found it very difficult to understand queuing and waiting. Most come from different health systems and may not expect to have to get a prescription for drugs which they just used to go out and buy at home.

The pathway of services available in Ipswich, the main receiving centre for the asylum seekers and refugees arriving in Suffolk, is comprehensive. Having been received by The Health Outreach, the new arrivals are then provided with health screening and advice and enabled to register with a GP. This makes the Suffolk population of asylum seekers and refugees different from those in some other parts of the UK. The GP is then able to use Language Line for consultation with the patient. Social life, language skills and integration into British life is supported by Suffolk Refugee Service.

We conclude that supported by the additional services, and subject to an audit to clarify the capacity of GP practices to continue to accept all new comers, a satisfactory service is available to asylum seekers and refugees.

References


Vitamin D: increasing supplement use among at-risk groups NICE guidance PH56 [https://www.nice.org.uk/guidance/ph56](https://www.nice.org.uk/guidance/ph56)
Appendix A: Asylum Seekers and Refugees

Surveys of service user opinion

These views were collected at two meetings. The first was a group for international women held weekly by Suffolk Refugee Support. The women take time for coffee and to socialise and then do an activity together. It is an important meeting place for women many of whom are entirely alone, and at different stages of the asylum seeking process.

Client 1. From Nigeria, an asylum seeker awaiting a decision. She has been in the UK for four years, the only one in her family, and she has a daughter of 1.5 years.

She likes her GP surgery. She has been at another one in the town centre but she had to change accommodation and the new one is better, much quieter and not so busy. She has come from London where she was had an apartment for mother and baby.

The health system was different in Nigeria. You had to pay for everything so you would just go and buy the medicine you wanted.

She understands how to keep herself well, but she is quiet and a bit withdrawn. She has depression, which she had before the baby was born. She has medication which she has taken for a long time. For eighteen months she has received counselling at The Health Outreach Project and this really helps.

We talked about the weather and how she found England. She would not go back – she does not want her daughter to be cut. She said you cannot live in Nigeria if this is not done; she could not go to school, as the child’s mum she could not get a job. She would be outcast.
Client 2. Travelled from Eritrea to Ethiopia. Had been in Sudan previously. She was hounded out because she was a Pentecostal. She has been in the UK for four years, and she had a positive decision so now she is a refugee and can remain for five years. Now she is anxious about whether she can get independent leave to remain. She is the only one in her family in the UK and she has a three year old child. She says the women’s group and her church are her family. She also gets counselling at The Health Outreach Project.

She is registered with a GP and has a hospital appointment for a bladder infection. The child’s immunisations and vaccinations are up to date, and she attends for cervical screening.

Money is difficult for her. As a refugee she does not receive the small amount she had as an asylum seeker. She has a zero hour’s contract which does not pay much. She works night shifts when she can leave the child with friends, but she wants a job with a proper contract. It is difficult as sometimes they call her into work, and the travelling is not cheap but when she gets there they may say they don’t need her.

Clients 3, 4, 5. Three women interviewed together. All from Iraqi Kurdistan but unknown to each other prior to living in the UK.

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<th>B</th>
<th>C</th>
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<tbody>
<tr>
<td>Been in England</td>
<td>6 years</td>
<td>1 year</td>
<td>7 years</td>
</tr>
<tr>
<td>Income</td>
<td>Husband taxi driver</td>
<td>Benefits. Her husband has NRPF but wife gets support as an asylum seeker.</td>
<td>Husband works in a garage</td>
</tr>
<tr>
<td>Registered with GP</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Husband helped her at first with language. Now he wants her to manage. She will take her son to an appointment</td>
<td>Trying for a baby and depressed. Went for fertility treatment and they tried to use Language Line but it did not have her language – Bandini, a</td>
<td>Went to A &amp; E for a heart problem. Her friend interpreted. She can do English but not when it’s her and she’s worried.</td>
</tr>
</tbody>
</table>
Client 6. From Sri Lanka. Her husband was wrongly accused of being a member of the Tamil Tigers and had to flee Sri Lanka or be killed. He came to England and after 5 years, with indefinite leave to remain he was able to bring his wife and children to join him. The children are bilingual but the father will never be able to return to Sri Lanka. He had been a pharmacist in their country but now works in an off licence. The children are now 11 years and 15 years, and the mum would love to get a job but she cannot. In Sri Lanka she had a professional role but here cannot find any sort of job.

The children are up to date with immunisations and vaccinations (BCG). They do not use the health service much. She had a breathing problem in 2013 and had an emergency appointment at the GP and was sent to hospital.

She does not like the system in the NHS. In Sri Lanka everything had to be paid for but you could buy what you wanted, there was no restriction for example on antibiotics. She would like to be able to get them when she wanted them.
Focus Group report from Asylum Seekers and Refugees Ipswich 13/05/15

In total there were 16 respondents.

1. What is your country of origin?
   - Nigeria, Eritrea, Kurdish (Iraq x3), Sri Lanka (x2), Iran (x7), Congo, Ruanda.
   - There were 13 women and three men.

2. How long have you been in the UK?
   - Length of time in Britain ranged from 10 months to 13 years.

3. Do you consider yourself to be healthy?
   Most respondents considered themselves to be healthy. One older man said he had diabetes, a hernia and heart trouble. One woman mentioned infertility, another lack of treatment for painful periods and one was pregnant. As the conversation developed more conditions and visits to hospital were discussed. One woman was concerned that she had pain and had returned to the doctor 2 – 3 times but still has the pain.

Access and use of health services

4. What do you do if you feel ill?
   - Most said they would go to A and E, although they knew about calling 111. They were critical of the time to wait at the doctor’s surgery. Experience is that they pay in their own country and they get service when they ask for it. They did not like waiting and queuing.

5. GP registration, use of GP service
   - All respondents were registered with a GP. One woman had been required to move house and found her new GP surgery much less supportive than the previous one which had provided a very good service to asylum seekers. A man reported that if patients booked a double appointment with the GP, the surgery knew that translation was needed.

6. Hospital attendance
   - Antenatal care had been used by some of the women.

7. Health Outreach Project
This was a first point of call for most Asylum seekers. Here they had been introduced to a GP, provided with application forms for free prescriptions, advice on using 111 (with request for an interpreter), all of the male asylum seekers and refugees had used Health Outreach Project. Also advice had been received on accessing an optician and a dentist. Screening had been offered for HIV and TB and this was appreciated.

8. What else do you need?
   One woman would have liked information on how to cook British ingredients which they had not seen before. She described cooking broccoli until it was soft rather than to retain the vitamins. Vegetables in her country required long cooking and she had not seen broccoli before.

9. Prevention – ways you keep yourself healthy
   Participants were a bit vague here. They knew they did not like winter and cold houses and some talked about being unable to afford enough heat. They knew about healthy food and exercise. All the women participated in cervical screening.

10. Any other factors affecting health or access to care
    Halal shops centre Ipswich - good
    Unaccompanied minors – have issues with budgeting and cooking skills
    If they are under 16 they are fostered; if 16 – 17 independent living.