Providing care for refugees and people seeking asylum

"It was the doctor, not my lawyer, who saved my life. He knew what to look for and he asked me about it and wrote a letter." (Patient who was given permission to stay in the UK)

Working with people seeking asylum and refugees can be extremely rewarding, despite the challenges.

We acknowledge that, for most practices, capacity is a huge issue right now; if this is new work for your practice, it is likely to feel overwhelming. The purpose of this article is to help to make these consultations as effective as possible and increase confidence for those of us who have less experience in these situations.

This article shares some approaches and experiences which might help you if faced with scenarios like the ones below. It has been written by GPs involved in TortureID, co-produced with two people with lived experience, and is based on references which include:

- Seeking Asylum and Mental Health: A Practical Guide for Professionals, Eds Maloney, Nelki & Summers (Cambridge University Press, 2022).
- gov.uk – language interpreting and translation: migrant health guide.
- NICE guidance on PTSD (NG116, 2018).

In this article, we offer an overview of our responsibilities to this vulnerable group and some simple tools that may help us meet their needs.

Context

The war in Ukraine has drawn fresh attention to people experiencing horrendous events and embarking on journeys to safer places. By April 2022, 200 000 British people had offered their homes to refugees from war-torn Ukraine, and hosts will have had to help register them with the local GP practice. However, the UK has always had refugees and asylum seekers, and, increasingly, their medical care is delivered in 'standard' general practice.

Wars in other parts of the world are perhaps less well covered in the media, and we may feel less of an immediate connection to those affected. But in many other countries (including Afghanistan, Syria, Sudan, Eritrea, Iran and Iraq), human rights abuses are commonplace and political persecution may occur, which can cause people to flee. People can seek asylum for a variety of reasons and from a variety of countries.

Some common issues affect everyone escaping adversity and arriving in a new country, yet there are significant differences in how refugees from different countries are treated when they arrive in the UK. But, armed with a little bit of relevant knowledge, we could make a huge difference, lifesaving on occasions, to some of the most vulnerable people in Britain today.

The challenge we face…

Although a well-designed and coordinated refugee programme should take the lead in helping people re-establish themselves, there is usually nothing in place!

GP practices are one of the only services left to do what they can without additional resources. Any funding that has been available has only ever been provided inconsistently.

There are only a handful of GP practices in the UK with a ***specific*** remit to look after people seeking asylum, and many inner-city practices in deprived areas have simply quietly absorbed large refugee populations without much guidance. There is, however, a growing experience and knowledge base within the GP community.

There are no easy answers, and no protocols or flowcharts to follow. In primary care, we are familiar with tackling crisis presentations and people with a history of trauma, but refugees and people seeking asylum may come with added layers of complexity that require additional specific knowledge, and we tackle the basics below.

How might refugees and people seeking asylum present in primary care?

Let's consider some cases:

Iryna and Sofia (Ukraine)	*Mrs Atkins, on your list for many years, is participating in Homes for Ukraine and hosting Iryna and her five-year-old daughter, Sofia. She has asked for an urgent appointment. Expressing nothing but gratitude, Iryna has been weeping most of the time, responding poorly to Sofia, and coming out of her room less and less.*
Anh (Vietnam)	*A social worker brings in Anh, who is Vietnamese, and says he is aged 16. He arrived alone in the UK 2 months ago. He was put into a hotel for adults on arrival as the authorities decided he was 18 years old. He is frightened of going to sleep and wakes with nightmares. He is not managing to engage with the college place offered to him.*
Ghasem (Iran)	*Ghasem is staying on an Iranian friend's sofa. He is in reception asking to register. He is complaining of a lot of pain and is raising his voice. He has a letter from orthopaedics which states that he was listed for a hip replacement but this was cancelled when he became ineligible for free secondary care. You agree to see him as an emergency and notice scars on both outer buttocks when you examine his hip.*

The GP team faces several dilemmas with these scenarios, which may initially seem daunting:

- How to respond effectively and efficiently to the high levels of distress?
- What to prioritise?
- What are the risks?
- How much should Iryna, Anh and Ghasem be encouraged to disclose their experiences – or would this 're-traumatise' them?
- How much is it your role to help with the very difficult situations these patients are in, given all the other pressures faced by general practice?

So, what can we do to deliver effective care…?

Making our practices welcoming and accessible

Any member of the practice team responding to such scenarios as a human being, with warmth, kindness and patience, is therapeutic, even when we don't immediately know what to do! Here are some tips.

Make registration easy	*Patients like Ghasem commonly experience being wrongly refused registration (Doctors of the World, Research Briefing 2019).* Being able to register may be the first step in regaining trust and stepping towards recovery. This cannot be over-emphasised. • **Anyone in the UK can register with a GP practice (even if they have been refused asylum).** • People can only be prevented from registering if your list is closed. • We can ask for documents if this is a practice-wide policy we apply to **all** patients, but the absence of ID documents must never be used as a reason not to register a patient/provide urgent care (though, undoubtedly, these documents help to create accurate medical records). *Are your whole team aware of this?* *You will find a link to the NHS guidance in the useful resources box, below.*
Create a welcoming environment	A growing understanding of trauma-informed care tells us that building an environment where people feel safe enables them to build trust and is therapeutic. This begins as soon as the person walks through the door. • Talk to your team about the atmosphere in the waiting room – consider how you greet people. • Even a simple poster saying 'Welcome' in multiple languages can make a difference. *You may also find the article on 'Adverse childhood experiences and trauma-informed care' helpful.*
Use interpreters consistently	• People using NHS care have a right to language support if they need it (gov.uk – language interpreting and translation: migrant health guide). Often, they do not receive it. • The whole GP team (clinical and administrative) should offer and use interpreters (BMA 2022). While this does increase consultation lengths, not doing this leads to mistakes, complaints and misunderstanding, and does not save time in the long run. • GMC guidance reminds us that we have a responsibility to make sure that we have tried our best to be understood. • While it may be logistically tricky, it is not good practice to use family members and friends as interpreters. If you do find yourself having to use them, be mindful of accuracy, consent and confidentiality, and that there may be limits to what can be discussed. Strongly discourage children being offered to interpret as this is rarely appropriate. • Telephone interpreting is widely available and has the advantages of flexibility and convenience. The choice between face-to-face and telephone interpreting is usually made at commissioning level so your options depend on local provision.

	• If you do not have access to professional interpreting at no cost to your practice, this should be taken up with local commissioners. • Match the interpreter to the consultation, where possible. For example, be aware that if female patients are consulting about contraception, sexual health or gynaecological problems, they may find it difficult to answer questions about these issues via a male interpreter. *Do you have commissioned telephone interpreting?* *Are all team members aware how to access interpreting services?* *Can the note be flagged so that an interpreter is pre-arranged and you are given the time you need for these longer consultations (at least a double appointment)?* *Is there an easy-access phone number in each consulting room?*
Aim to provide continuity of care	• Forming a safe and responsive attachment, and enabling continuity of care with the GP team, is important for everyone. • It is especially important when people have faced major life difficulties, are far from home, find it difficult to trust and need to tell their story. *This takes time and can be difficult with current pressures on primary care. Is it possible to offer double appointments to make this consultation more effective and potentially reduce reconsulting rates?* • This does not need to be time-consuming or unboundaried, but should be as consistent as possible. • Simple contact with the team can be all that is needed in a personal crisis. *If you have a large community of refugees or people seeking asylum at your practice, you may want to have a named GP who takes a lead on this work.*
Use the whole primary care team to support people navigating a new and complex system	Struggling to navigate complex systems may lead to people giving up and not receiving the care and support they need. Examples may include: • Complex and bureaucratic appointment systems. • Organising and paying for transport. Your team will need to arrange support and safety-net outcomes of referrals until you can be sure the patient knows how to manage. Adding a flag to the front page of the patient notes can be a helpful way of highlighting this need for additional support. If you have access, care navigators will usually be aware of local resources for support. It's more work sorting it out after it has gone wrong. All asylum seekers are entitled to HC2 certificates to provide full health costs if they are receiving Asylum Support from UK Visa and Immigration Services. Help may be needed with accessing these HC2 forms, and remember that there is help for transport to hospital appointments. You will find a link in the useful resources box below.
Find out about third-sector agencies working in your area	It is worth exploring which third-sector agencies in your area are working with people seeking asylum and refugees. They generally know more than we do about asylum and can be a considerable help to the patient and the practice. If your team wants to do more, Doctors of the World offers a training package to enable GP practices to sign up as a 'safe surgery', taking steps to tackle the barriers faced by many migrants in accessing healthcare, on the basis that small changes in practice can make a difference (Doctors of the World – safe surgeries).

Hear the person's story: enabling disclosure of trauma

"Some people will not tell you unless you ask. It can give bad memories, but asylum seekers need you to ask, so that you can help." (Advice from a refugee patient)

For each person in the case studies at the beginning of this article, we cannot assume we know what their 'trauma' is, or indeed the risks the person still faces.

You probably don't need to know ***exactly*** what happened in order to offer care, but you do need to know and acknowledge that something ***did*** happen, even if you then 'park' it. Without doing this, our relationship with the patient is not rooted in their reality, and we are likely to end up with multiple misunderstood physical symptoms, frustrations and potentially disengagement.

Simple message: we need to show we are interested, ask, and create a space where people feel safe to talk!

Let's consider Iryna…

A lot has happened to Iryna. Don't assume you know what her 'trauma' is.

Some things can't be easily disclosed – such as loss, witnessed violence, sexual trauma, betrayals or feeling guilty or ashamed.

What if I make things worse?

Many clinicians fear they are opening a 'can of worms' by asking what has happened, and may be afraid of causing distress. But Iryna is likely to be thinking about it all the time anyway.

It is important to show that you're interested and aware, and to get some context.

We can use communication skills that we already have:

- Ask open questions and listen for longer without interruption. A useful question might be, "Some people from your country have had very bad experiences. Has anything like that happened to you?".
- Short sentences are helpful to ensure as much meaning as possible is retained in translation.
- It is important to remember that this is high-quality healthcare in itself, even if no ailments are 'treated' or boxes ticked.
- NICE guidance recommends that all refugees and people seeking asylum are screened for PTSD; effectively, this means asking them if something bad has happened to them (NICE 2018, NG116), though there is a specific tool called the PC-PTSD (see link at the end of the article). You can read more about this in our article on *Post-traumatic stress disorder*.

Understand the very basics of asylum and the interface with healthcare

A person's immigration status has a huge bearing on their health and wellbeing so it is worth knowing the bare essentials about asylum.

Let's use our cases to consider this further:

Iryna has been given 'leave to remain' in the UK for 3 years. This is a special arrangement for people from Ukraine during the current conflict. She therefore has no reason to fear being removed and can seek work. She has full access to all benefits and services.

Anh was trafficked and he must apply for asylum and wait for his claim to be decided. This is a complicated process and can take months to many years! Decisions about asylum are made by the Home Office and Immigration Tribunals/Courts. Unfortunately, initial decisions can be wrong as evidenced by the success of later appeals and fresh claims: in 2019–20, 41% of appeals were allowed (Refugee Council, 2020). If Anh is successful, he will be given leave to remain for up to 5 years. When this leave to remain expires, there is usually an opportunity to extend the period but this can be a stressful process. Anh has some rights but is not allowed to work.

Ghasem has applied for asylum but the Home Office and Courts did not accept his claim for protection. He has been told to return to Iran and all his rights in the UK have been removed. There is no arrangement for claimants to routinely have any form of medical assessment so many decisions are made without important medical evidence being necessarily known about and considered.

The table below explains their differences in entitlements to benefits, work, education and healthcare (Refugee Council – the truth about asylum; gov.uk – NHS entitlements: migrant health guide).

	Immigration status	Access to benefits	Permission to work	Permission to study	Access to NHS
Iryna	'Leave to remain'. Refugee status.	• Full entitlement to universal benefits.	Yes.	Yes.	Full entitlement to all NHS services.
Anh	'Asylum seeker'. Has made application to be recognised as a refugee and is awaiting a decision.	• No entitlement to universal benefits. • Accommodation provided by Home Office.	No (with a few exceptions).	Limited.	Full entitlement to all NHS services.

		• £40.85 per week for food, travel and toiletries.			
Ghasem	'Refused asylum' and no further appeals. 'Refused asylum seeker'. 'Failed asylum seeker'. NOTE: *He may yet make a 'fresh claim' if new evidence (such as overlooked medical evidence) comes to light, when the whole process restarts.*	• No access to universal benefits. • No accommodation or money from the Home Office. • In a few cases, medical need can permit a 'section 4' application for accommodation and some limited financial support.	No.	No.	Can access primary care. No rights to secondary care except: • Emergency care. • Certain communicable diseases. • Conditions caused by torture, female genital mutilation, domestic violence or sexual violence.

In addition to these complex legal and bureaucratic processes, many refugees in the UK are also dealing with isolation, poverty, racism and hostility. Those seeking asylum face insecurity about their future. Those who have been refused asylum deal with all this, plus the removal of help to meet even their basic needs.

Remember safeguarding

We think about safeguarding in every consultation and as a whole team, but it is particularly important to be aware of safeguarding issues in this group. We need to think about who is especially vulnerable and how we might help protect them from further harm.

Here are some examples to consider:

- People may be terrified of returning to their home country for whatever reason, and become highly distressed by negative developments in their asylum claim.
- People who become desperate and lose hope can become suicidal.
- People may be at risk of immigration detention. Adults can be detained indefinitely at any point during their asylum claim. People who are survivors of torture or who have severe mental health problems should not be detained but sometimes are.
- People may face destitution because of refused asylum claims.
- People who have been trafficked to the UK may still be under the control of or sought after by their traffickers *(Anh is Vietnamese and at high risk of this).* There is a link to a useful leaflet on this below.
- Separated young people, like Anh, have often had traumatic experiences as children in their country and on the journey. They are highly likely to avoid discussing what has happened and often seem to be coping well. They have protected status as children but, once they reach 18y, they become subject to the asylum process, and this can be highly distressing and difficult for them to understand. There have been recent concerns about suicides in young people seeking asylum (reported in the Guardian, June 2022).
- Children within families need to be considered too or their needs may be overlooked. Psychologists at Manchester University have produced a leaflet to support adults supporting children in displaced Ukrainian families.

Ghasem has many of these additional vulnerabilities. He is already destitute and without hope. He fears detention and deportation. On top of this, he is in chronic pain. It may seem like an unsolvable situation, but a GP team can help turn this around.

If, for example, when asked, he attributes his scars to an attempted sexual assault in an Iranian jail, you can have a high index of suspicion of torture. This information will reduce the risk of immigration detention and re-open doors that have closed to him; he may be able to make a 'fresh claim' for asylum and get his housing and food reinstated. His operation for hip arthritis could be back on the cards if he becomes either fully entitled as a person seeking asylum again, or he fulfils the exemption for charging as a 'survivor of torture'. You may be able to make a significant difference by writing a short letter or even simply providing a copy of your consultation notes.

We know that capacity is tight at the moment but even a printout of your documentation may be sufficient to make a life-changing difference. While it may not be our job (and many of us may lack confidence) to decide if injuries are consistent with torture, we can document what we see and what is said and, if necessary, signpost on to organisations such as TortureID or Freedom from Torture which can provide more detailed documentation.

Ensure good documentation

Careful recording of interactions with these patients is essential and protective.

A good record is a healthcare intervention in itself! It can reduce the need for re-asking about difficult histories and keep the clinician appraised of the context.

A comprehensive, careful and impartially-written record may also help solicitors and decision-makers identify and understand people who have been harmed, and assist the progress of their asylum claim if it has not been resolved.

- Code problems like ‘victim of torture’ or ‘modern slavery’ if you suspect them (with consent). Create problem or summary headers so these issues can be easily seen. They are just as serious as a medical condition.
- Appropriate tagging of a record may alert reception and admin staff to particular needs for continuity of care and follow-up.
- Record symptoms of psychological distress and observations such as patients getting upset when certain issues are raised. Record any mental health diagnoses you make or suspect. Think about PTSD.
- Record any injuries you are told about or discover, as above.

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- We can make a really big difference by doing small things well.
- Anyone in the UK can register with a GP practice (even if they have been refused asylum).
- Work as a primary care team to make your practice welcoming – *could you sign up as a 'safe surgery'?*
- Ask, have a long listen, document well. Make links with third-sector organisations. *Could a care navigator or social prescriber support this work? Or a champion in your admin team?*
- Ensure you know what your local translation services and provision are and how to access them.
- Use the right translator for the job.
- Remember PTSD.
- Remember safeguarding of the person and any children.

How can I get more involved in this type of work?

If you want to get more involved in humanitarian work, here are some suggestions:

- **Train as a medico-legal report writer.** There is a large unmet need. GPs make some of the best report writers because they can cover both physical and psychological aspects of abuse. There are several organisations offering opportunities to volunteer, including:
  - TortureID.
  - Freedom from Torture (for those who have been tortured).
  - The Helen Bamber Foundation (for people who have been tortured and/or trafficked).
  - Medical Justice (focuses on people detained in immigration removal centres).
- **Network**. There is a great need for more GPs and nurses to develop an interest in humanitarian work inside the UK. It can be extremely rewarding. If you are interested in informally networking and sharing ideas, contact admin@tortureid.org.
- TortureID is able to support capacity-building within general practice and share practical tips and materials which can help with identifying and recording human rights abuses.
- There may also be other practices in your area that provide inclusion healthcare for other groups, including homeless and other marginalised people. They are likely to have similar processes in place and are usually happy to help and offer advice.
- If you can influence **commissioning**, keep asking what is being done for these groups.

Useful resources:

Websites (all resources are hyperlinked for ease of use in GPCPD)

- Torture ID
- Freedom from torture
- Seeking Asylum and Mental Health (a website to support health professionals, updated regularly)
- Doctors of the World – safe surgeries
- gov.uk - identifying and supporting victims of modern slavery
- Accessing HC2 forms from NHS BSA
- PC-PTSD screening tool
- Manchester – psychologists use Syrian experience to help Ukrainian families (leaflet for adults supporting children in displaced Ukrainian families)