NHS Hull

After Wilberforce:
an independent enquiry into the health and social needs of asylum seekers and refugees in Hull.

Peter Campion, Sally Brown, Helen Thornton-Jones

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Contents

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Peter Campion, Helen Thornton-Jones, Sally Brown.
January 2009.

After Wilberforce

After Wilberforce, slavery was abolished – not.
True, laws were passed to outlaw the practice,
and slaves were freed and even recompensed
with tiny sums to compensate for their loss
of dignity, freedom, and their relatives' lives.

After Wilberforce, nothing changed. Men still
exploited the vulnerable, taking people from their homes
and forcing them to act against their wills.
to fight as child soldiers, to work as bonded workers,
to prostitute their bodies for the gratification of men.

After Wilberforce, people still fled persecution,
not as slaves, but as refugees, seeking sanctuary,
a defended refuge in a warring world. But in many
places asylum seekers are called scroungers,
not believed when they describe the indescribable
atrocities that they witnessed in their homelands.

After Wilberforce, some cities welcomed these seekers
of sanctuary, by opening their doors, giving kindness,
making communication possible through interpreters,
meeting health needs with sensitivity and skill,
providing whatever was necessary to bring comfort.

After Wilberforce, the city of Kingston upon Hull still cares.
"Humane Hull", where those who seek asylum find
a welcome, like a safe haven for a ship in a storm.
Thank God for Wilberforce, thank God for Hull,
where people offer sanctuary, after Wilberforce.

Peter Campion, 9th January 2009

Executive Summary:

Commissioned by NHS Hull, this project has four aims:

a. to gather the views of asylum seekers and refugees in Hull about their lives, and health;
b. to consult with all relevant agencies in the city concerned with the health and social care of asylum seekers and refugees;
c. to identify best practice in asylum seeker and refugee care in other parts of the country;
d. to propose a strategy for the health and social care of asylum seekers and refugees in Hull.

We carried out extensive interviews with asylum seekers and refugees, and with service providers, and present the findings in chapters 2-4. While much good work is being done in Hull, we found evidence of many shortcomings, with asylum seekers finding it difficult to access primary care, and widespread examples of poor housing affecting health. Professional interpreters are not used as much as they could be, and felt the need for more training and support.

Other cities which we visited had elements of exemplary approaches to asylum seeker care, notably Sheffield but also Bradford, Leeds and Birmingham (chapter 5) and we recommend the adoption of many of these methods.

We draw attention to several important and authoritative reports, especially the three reports of the Independent Asylum Commission (6.4), and the two on destitution from the Joseph Rowntree Charitable Trust (3.1).

Our recommendations (chapter 7) fall into two groups: strategic and operational. Strategically we recommend:

1. that NHS Hull and the Local Strategic Partnership create a Sanctuary Board (SB) under the main LSP Board, to oversee the proposed strategy for the health and social care of asylum seekers and refugees, with a small staff to support the work for change.
2. the wider use of the term “Sanctuary” instead of “asylum” (because of the latter’s negative associations in the public mind) and the promotion of Hull as a “City of Sanctuary”.
3. a city-wide educational programme for all NHS personnel, which the SB and its staff would action,

4. better communication between agencies, both statutory and voluntary, leading to more “joined up working” across the sectors. This again would be a function of the new board.

Operationally we propose:

5. minor changes to enhance existing TB screening,
6. the adoption of a local patient-held Personal Health Record,
7. changes to clinical recording to facilitate audit in Primary Care,
8. training and support for interpreters,
9. commissioning of specific mental health treatment for post-traumatic stress disorder (PTSD),
10. a new multi-media multi-language DVD welcome programme for all new arrivals,
11. greater involvement by the PCT in ensuring adequate standards of housing,
12. a greater focus on the needs of destitute people,
13. a review of family and child counselling services, and specific support for the Haven Project,
14. training of health staff in awareness of trafficking of adults and children,
15. an enhanced capitation fee for general practice care of asylum seekers for the first 18 months.

The cost of implementing these recommendations is about £140,000, of which £70,000 is for the Haven Project, £35,000 for the PTSD service, and £22,000 for staff to support the proposed new Sanctuary Board. Some of this, such as the commissioning of additional mental health care, and the support for the interpreter service, may be recouped from the new Transitional Impacts of Migration Fund from the Department of Communities and Local Government.

The educational recommendations should be implemented through the existing training structures, such as the “protected time for learning” for all primary care staff, but also by encouraging practice-based learning.

After Wilberforce, who spent his life working towards the abolition of slavery, the city has an opportunity to address another humane goal, to welcome those seeking sanctuary from persecution around the world. “Humane Hull” would be a welcome label for this city, after Wilberforce.

Peter Campion, Sally Brown, Helen Thornton-Jones. March 2009.

Chapter 1. Introduction

1.1. The project

NHS Hull commissioned the authors after a competitive tendering process to carry out an investigation into the health and social care needs of asylum seekers and refugees in Hull, the services currently provided, and "best practice" in other cities.

This report represents the findings of this study, with the recommendations which have been produced in consultation with the project's steering group (see acknowledgements) and with stakeholders who attended an open meeting in January 2009.

1.2. Background

A Refugee is defined by the 1951 United Nations Convention Relating to the Status of Refugees, and its 1967 Protocol amendment. It provides a general legal framework on which states can build their refugee policy, and is the basis for UK legislation[1].

Asylum seekers are people who, not having a right to stay in the UK, have claimed refugee status on arrival in the UK. The UK Borders Agency (UKBA, the body within the Home Office responsible for immigration matters) applies various procedures designed to establish whether this claimed refugee status is recognised by the UK. Refugee status is not conferred by the asylum process, rather existing refugee status is recognised (or not recognised). In the latter case, the person is termed, rather inaccurately, a "failed asylum seeker", a better term being "refused asylum seeker". A second category of person, who is not recognised as a refugee in the terms of the "Convention", may still be granted leave to remain in the UK for "Humanitarian Protection" if "substantial grounds have been shown for believing that the person concerned, if he returned to the country of return, would face a real risk of suffering serious harm and is unable, or, owing to such risk, unwilling to avail himself of the protection of that country"[2].

Thus the terms "refugee" and "asylum seeker" are ambiguous, and open to misunderstanding, and misuse, especially by the media. For the purposes of this report, and to clarify common usage, a "refugee" is a person whose claim to be allowed to stay in this country has been accepted by the UKBA, while an "asylum seeker" is someone whose claim has not been accepted, whether because it is still being considered, or has been turned

[1] http://www.unhcr.org/protect/PROTECTION/3b66c2aa10.pdf
[2] http://www.ukba.homeoffice.gov.uk/policyandlaw/immigrationlaw/immigrationrules/part11/

down, and may or may not be being further pursued through legal channels. Some of these may have exhausted all avenues of legal appeal[3], but nevertheless their status may still be subject to further review under the "legacy cases" procedures[4] (now called "case resolution").

The practical implications of these labels are important[5]: while asylum seekers are obliged to report to the UKBA, usually at a specified police station and at specified intervals, refugees whose status has been accepted become as "free" as the general population, entitled to receive state benefits, and free to live and work where they choose. Thus they cease to exist as a special category, and effectively may become invisible to policy makers. This has major implications for health policy, since any special health or social needs identified as applying to asylum seekers (such as mental health needs, social isolation, language needs) clearly still apply to them after their refugee status has been acknowledged. But as a group they are no longer easily identified.

Asylum seekers may be receiving support from the UKBA either in the form of accommodation and a weekly cash allowance (known as "Section 95 support"), or by accommodation and vouchers for food, under "Section 4" (which caters for "hard cases", people whose claim has failed, but are unable to return to their own country due to illness, late stages of pregnancy, or because it is too dangerous to return). The third group of asylum seekers are those who receive nothing, and are so by definition "destitute". They sleep in friends' houses, "sofa surfing", sometimes accommodated by charities[6], or sleep rough. They may also obtain food and money from charities[7]. The scale of destitution is explored later in this report [8].

Refugees, those asylum seekers who have been granted leave to remain, either for "Convention" reasons or for "Humanitarian protection", experience a dramatic change in personal circumstances, suddenly becoming "legal", no longer required to report to a police station, but also no longer eligible for their support under Section 95 or Section 4. Their

[3] These are termed by the Home Office and UKBA "Appeal Rights Exhaused" or ARE cases.
[4] http://www.ukba.homeoffice.gov.uk/asylum/process/oldercases/
[5] Dave Brown, the Refugee Integration Manager for the Yorkshire & Humber Regional Migration Partnership, has created a comprehensive guide to the terminology, reproduced in Appendix 1.
[6] Of which the Boaz Trust is the exemplar - http://boaztrust.org.uk/
[7] In Hull these include the Methodist Church on Princes Avenue, and the 167 Centre on Spring Bank.
[8] The Joseph Rowntree Charitable Trust's Reports "Destitution in Leeds" (2007) and "More Destitution in Leeds" (2008) address this question for the city of Leeds.

accommodation provider gives them notice to quit (up to 6 weeks), and they have to fend for themselves, and their family.

The Government has set up a new Refugee Employment and Integration Service (REIS)[9], but this will only be available to asylum seekers granted refugee status or Humanitarian Protection from 1 October 2008. People gaining status from the case resolution process (see sections 1.3 and 1.5 below) will not be able to access this service. Referrals can only be made by the New Asylum Model caseworker. In Hull the REIS is being administered by the Northern Refugee Centre.

Thus the health and social needs of asylum seekers are more easily defined than those of refugees, and most of the empirical data in this report relates to the former. However, most of the conclusions relating to asylum seekers also apply to refugees, and this report certainly applies to both categories.

1.3. How many asylum seekers and refugees are there in the UK, and in Hull?

The recent Shelter report[10] covers all aspects of housing for immigrants, and includes the following summary of the numbers of asylum seekers:

> "At its peak in 2002/03, approximately 100,830 people sought asylum (including dependants) in the UK. By 2007/08, this figure came down to 28,860. These numbers are small in comparison with the total volume of people arriving in search of work, or the number of UK nationals emigrating abroad." (p.9)

This puts into perspective the relative numbers of asylum seekers compared to other migrants. In 2007 the total international inwards migration was 605,000[11], while in the 12 months to the end of June 2008 there were 25,070 applications for asylum (excluding dependants)[12]. *Thus asylum seekers accounted for only 4% of all known immigration into the UK last year.*

The same Home Office Quarterly Statistical Summary reports:

- The total number of asylum seekers (including dependents) in receipt of asylum support was 27 per cent lower in Q4 2008 (32,580) than at the end of Q4 2007 (44,495).

[9] http://www.ukba.homeoffice.gov.uk/aboutus/workingwithus/workingwithasylum/integration/ries/
[10] http://england.shelter.org.uk/professional_resources/policy_library/policy_library_folder/no_place_like_home_policy_discussion_paper (accessed 30/12/08)
[11] http://www.statistics.gov.uk/pdfdir/popest0808.pdf (accessed 30/12/08)
[12] http://www.homeoffice.gov.uk/rds/pdfs09/immiq408.pdf (accessed 24/3/09)

- 6,195 asylum seekers were receiving subsistence only support.
- 25,145 asylum seekers were supported in dispersal accommodation.
- 1,240 asylum seekers were supported in initial accommodation.
- 10,295 asylum seekers were receiving Section 4 support; 63% higher than in Q4 2007 (9,140)

The numbers in supported accommodation in Hull at the end of December 2008 were 322 in Section 95 (formerly NASS) accommodation and 178 in Section 4 accommodation, a total of 500 individuals[13].

There remain many individuals whose application for asylum predated the current system (i.e. before March 2007), and which are now termed "older cases"[14]. The numbers are unknown – earlier estimates of 400,000 are now regarded as excessive, but the true number is unclear. How many of these are in Hull is a matter of speculation: some will be receiving Section 4 support, but we have attempted to measure the scale of destitution in Hull, and report this later (chapter 3).

The Yorkshire & Humber Regional Migration Partnership recently (December 2008) published its Draft Integration Strategy for Refugees and Asylum Seekers in Yorkshire & Humber (2009 – 2011)[15], produced by Dave Brown, its Refugee Integration Manager. We reproduce in Appendix 2 its summary of numbers in the Region. This paper estimates the number of refugees in the Region as 15-20,000, or about the same number as the total of asylum seekers including those refused. Translating this to Hull, where there are about 600 asylum seekers, but unknown numbers of refused asylum seekers; and there could be of the order of 1,000 refugees settled in the city.

Many of these, who were dispersed to Hull between 1999 and the present time will have put down roots, taken jobs, and some married local people. Their health needs will have become more aligned to those of the general population, but some will continue to need help with integration, through language classes, other education, and because of long-term physical or mental illness or disability.

We have not commented, nor were we asked to, on the numbers of migrants from the EU, including the so-called A8 accession states, but we

[13] Personal communication S. Ibbetson, 8/1/09
[14] http://www.ukba.homeoffice.gov.uk/asylum/process/oldercases/whatareoldercases/
[15] http://www.refugeeaccess.info/uploads/y&h/RIM_draft_int_stratYH_Dec08.pdf

know from the recent work by Professor Gary Craig and colleagues that the figures are orders of magnitude greater than these[16,17].

1.4. The Human Rights context – "health" as a human right.

The International Convention on Economic, Social and Cultural Rights (of which Article 12 is the "Right to Health")[18,19] is one of a group of international instruments to emerge after the Second World War, along with the United Nations Convention on the Status of Refugees[20], and the UN Convention on the Rights of the Child[21]. Although the UK has ratified the ICESCR, and so would appear to be committed to the "right to health", the integrity of this right to health, which seems implicit in the existence of the NHS, is actually threatened when certain groups of asylum seekers, those termed "appeal rights exhausted", or "no recourse to public funds", are denied access to health care.

1.5. UK Legislative and policy context.

This is a fast-changing area of UK law and administrative practice, made more difficult because the names of the agencies involved have frequently changed, as have the technical terms employed. The responsible arm of government within the Home Office is the UK Border Agency (UKBA), while the process formerly known as the New Asylum Model (NAM) is now known as the "Asylum Determination Procedure" (ADP). People who had claimed asylum prior to the start of the NAM on 7th March 2007, or had not been allocated a "Case Owner" before that date, are now known as "Case Resolution Cases" (CRC). Most of these have reached the "appeals rights exhausted" (ARE) stage, and so are in theory susceptible to "administrative removal". Such removals are handled by UKBA Enforcement teams, which deal with both current (ADP) cases and CRC's. Most of these people are said to have "no recourse to public funds" (NRPF).

Under the Asylum Determination Procedure, since March 2007, all cases are now allocated a Case Owner, with whom the asylum seeker has direct contact via a telephone number, and which works to a far swifter timetable.

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[16] Adamson S, Craig G, Wilkinson M. "Migrant workers in the Humber Sub-Region: A report for the Humber Improvement Partnership". Centre for Research in Social Inclusion and Social Justice, University of Hull 2008

[17] Lewis H, Craig G, Adamson S, Wilkinson M. "Refugees, asylum seekers and migrants in Yorkshire and Humber, 1999-2008, Leeds, Yorkshire Futures, 2008.

[18] http://www2.essex.ac.uk/human_rights_centre/rth/ and The Lancet, Volume 372, Issue 9655, Pages 2047 - 2085, 13 December 2008

[19] Appendix 4 contains the recent expansion on Article 12 by the UN Committee on Economic, Social, and Cultural Rights, setting out the practical implications of this instrument.

[20] http://www.unhcr.org/protect/PROTECTION/3b66c2aa10.pdf

[21] UN Convention on the Rights of the Child (CRC). New York: United Nations, 1989.

However, both the Leeds destitution surveys and ours suggest that destitution remains a significant outcome of the new procedures (see Chapter 3).

1.6. "Managing the impacts of migration" [22]

This Government paper outlines how the Department for Communities and Local Government plans to support integration, and in particular refers to a new "Transitional Impacts of Migration Fund"[23], designed to build capacity in local service providers and support innovative projects from 2009-10. Money for the fund will be raised through increases to certain fees for immigration applications (p.36). This fund is expected to become available in 2009, and could be used locally to improve advice services, information systems, language learning provision, community development with refugee organizations, and other innovative ways of assisting integration. We shall refer to it later when discussing how our recommendations could be funded.

1.7. Existing resource materials

The Faculty of Public Health has prepared a concise guide for medical practitioners[24], summarizing the specific health needs of asylum seekers and refugees in the UK.

The briefing paper by Dr Angela Burnett, a senior medical examiner at the Medical Foundation for the victims of torture, gives and excellent summary of the specific health needs of asylum seekers and refugees[25].

The Department of Health's resource pack[26], written in collaboration with the Refugee Council, although somewhat dated (2003, but due to be re-issued) covers most of the issues addressed by this report, and offers extremely valuable advice for Primary Care commissioners and providers.

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[22] http://www.communities.gov.uk/documents/communities/pdf/838935.pdf (accessed 30/12/08)

[23] http://www.ukba.homeoffice.gov.uk/sitecontent/documents/aboutus/consultations/closedconsultations/pathtocitizenship/pathtocitizenship?view=Binary (accessed 01/01/09)

[24] http://www.fphm.org.uk/resources/AtoZ/bs_aslym_seeker_health.pdf (accessed 16/2/09)

[25] http://www.torturecare.org.uk/files/brief27.rtf (accessed 16/2/09)

[26] Caring for Dispersed Asylum Seekers. A Resource Pack. Department of Health and Refugee Council, 2003. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4010379 (accessed 16/2/09)

Chapter 2: What did asylum seekers themselves think about their situation in Hull, in relation to healthcare, interpreters, housing, education, and public attitudes? Findings of qualitative interviews including focus groups.

2.1. Methods

We have based our empirical enquiry on a range of methods, seeking to interview, in an open, semi-structured way, both asylum seekers and refugees, and also service providers and policy makers.

We used focus groups to take advantage of the interaction between group members in discussing the questions posed. We used individual interviews to obtain more confidential views from a range of respondents, to whom we guaranteed confidentiality. Most of these interviews and groups were recorded, and transcribed. A few were recorded by means of contemporaneous notes.

We recruited four focus groups with the help of the Goodwin Trust Community Wardens. Two were women's groups, one a mainly male Kurdish group, and one a mixed African group. We recruited individual interviewees at the various drop-in facilities (Open Doors, ARKH, 167 Centre, and the Goodwin Community Wardens shops).

We used interpreters in all the focus groups, and in all interviews unless the respondent had sufficient English. All the focus groups and most of the interviews were recorded and fully transcribed. If not, detailed field notes were made including verbatim quotes.

We collected documentary data from service providers, from internet searches, and from websites of relevant agencies.

Qualitative analysis followed standard methods, three researchers separately reading and identifying themes, which were then discussed and refined, iteratively.

2.2. Findings

2.2.1. Positive experiences of the NHS:

Several of our interviewees had positive perceptions of GPs, usually by comparison with their home country, but also when the doctor spoke the same language as them, such as Punjabi, or Arabic.

In two of the focus groups, asked the same question about satisfaction with the GP, participants responded through the interpreter very positively, in relation to their experience in their country of origin:

> *"The lady says our GP is good; her GP listens and she thinks he understands. He speaks Punjabi so she is quite happy." (Interpreter for Women's FG1)*
>
> and
>
> *"he goes to his GP and they give him treatment, he is very happy, it is much better than where they come from." (Interpreter for male FG 2).*

An asylum seeker from Nigeria when asked "What has been your experience of doctors and the health service?" replied:

> *"Very nice, very good. To me especially because of my home country and the way doctors treated people there: even if you were at the point of death, if you don't have any money the doctor won't treat you."*

This person who had suffered an acute medical emergency had a more general positive view:

> *"Can you summarise your experience of the NHS?*
>
> *"They didn't recognise your colour or race; they treat the whole patient."*
>
> *What did you mean by "whole patient?*
>
> *"I was in a 6-patient bay, got lots of attention, doctors visited all hours, the nurses came very quickly when I rang with pain from the catheter. In Jordan I stayed in 2 different hospitals, and there is a big gap between here and there – here is much better." (A, Iraq refugee)*

The experiences of the "Gateway"[27] refugees such as A were markedly more positive than those of asylum seekers in Hull. Because of the high level of one-to-one support provided by the Refugee Council team, they

[27] Small groups of refugees from other countries such as the Democratic Republic of the Congo, and Iraq, accepted into the UK under the Gateway Protection Programme of the UNHCR. The Refugee Council employs a dedicated support team in Hull which works with them for the first 12 months.
http://www.refugeecouncil.org.uk/Resources/Refugee%20Council/downloads/briefings/gateway_prot_oct04.pdf

had generally been taken personally to register with a GP, and given help with accessing pharmacists and hospitals. In contrast, most asylum seekers found they had to fend for themselves, many having difficulty accessing these services[28].

2.2.2. Negative perceptions of the NHS:

Many of those interviewed however had negative perceptions of their doctors. Expectations of medical care were not being met, in some cases due to inappropriate expectations, but in many, fully justified.

One consistent concern was the unwillingness of doctors to write letters in support of re-housing, when the housing was described as very unsuitable.

> *"She lives on the 6th floor. Sometime the elevator doesn't work so she has to walk up and down the stairs, and she went to the housing office to tell them that she wants a house changed. The housing office told her go to your GP, he has to confirm what you're saying before we can believe you; and the GP told her 'come back tomorrow and I will have the letter ready for you'. Next day she went and the GP told her we cannot do such things for everybody that comes here." (Interpreter for Women's FG)*

> *"she needs a medical report so she can prove to the Housing Authority that that is why she has got this condition, because of that property, but the GP says to the lady 'I cannot provide you with this'." (Interpreter for Women's FG)*

> *"The only problem is that the Housing Office wants a letter from his wife's GP, and the GP says we cannot do this sort of thing to help you with the housing, we can only give you medication to make you better. But the Housing Office is telling his wife we want a medical report from your doctor to prove what you are saying. And the GP is saying 'I'm not a housing provider'!" (Interpreter for Kurdish male FG 3)*

> *"And then when I went to the doctor to ask for a letter about my problem, they didn't help me. Then I changed my doctors, and he write a letter for me." (KH Iran)*

[28] This was also the experience of asylum seekers described in an earlier report from Wakefield and Sheffield: Craig G et al (2004) "A safe place to stay? Wakefield and Sheffield City Councils.

Expectations of medical care were sometimes unrealistic, possibly coloured by their experiences in their former countries, where access to specialists was unrestricted, where prescribing (of antibiotics) might be more liberal (less controlled), and where in a private system there were paradoxically fewer barriers and more time.

> *"every time I go for my son he says no any problem just go look after baby and no give me any medication." (Women's FG1)*

> *"And I see my doctor, I have any problem I go to see and after I go to same doctor for my children. I don't have a special doctor for children." (Women's FG)*

> *"The GP did no tests, nor any examination, just wrote a prescription, the same with my daughter, didn't examine, just write." (A, Iraq refugee)*

"Continuity of care"[29] (i.e. seeing the same doctor on successive visits) has long been recognised as desirable in general practice, although ways have also been described to mitigate breaches in continuity (better communication between staff, better records, planned hand-over of care). Some of our respondents could not understand why they could not see the same doctor at each visit.

> *"The ladies are all just mentioning names but each time they go book an appointment with a GP it's a different person. They never see the same GP twice." (Interpreter for women's FG)*

2.2.3. Problems with interpreters:

We asked in all groups and interviews for views about interpreters. We were surprised to discover that the request for an interpreter could result in delays in getting an appointment with the GP:

> *"The ladies say if you book an appointment and ask for an interpreter they usually give you from 3 days to 1 week notice because they need to book interpreter but if you don't need an interpreter, they will give you an appointment for the same day. If you call at 8am only they will give you an appointment for 12 o'clock." (Interpreter for women's FG)*

[29] Haggerty, JL, Reid, RJ, Freeman, GK, Starfield, BH, Adair, CE, McKendry, R. "Continuity of care: a multidisciplinary review." *BMJ* 2003;327;1219-1221

Many authors[30] have described the disadvantages of family or friends as interpreters, yet we found many instances of these being tolerated or even encouraged.

> *"I get from the ladies they don't trust their relatives to take care of it for them because they're not professional interpreters". (Interpreter for women's FG)*

> *"They say they don't have interpreter there." (Kurdish male FG3) (he went on to say friend interprets for him, but he is not happy about that.)*

> *"Yes he says if it was interpreter he is not allowed to tell anybody about my problems, but if it is a friend they could sometimes even use it against each other when they fall out and things like that." (Interpreter for Kurdish male FG3)*

Very specific concerns were felt by more than one respondent from Iran, about the potential for interpreters to be in league with or even in the pay of the Iran government.

> *"To have an interpreter, it has got to be objective – for example how I know this interpreter is connected with the Iranian government? Or with other organisation which goes seeking to trace the people? How I know this? Do I know the person?"(A, Iran)*

The extreme sensitivity of some of the problems experienced by these people is illustrated by this man who felt too ashamed to use an interpreter:

> *"Some doctors do not understand – I explained my problems to one doctor but he did not understand, and did not do anything. My problem is something I am ashamed of – I cannot use an interpreter because I am ashamed." (NM, Iran)*

Many asylum seekers experience shame for all kinds of reasons and those reasons may take a long time to emerge (years, not weeks) and the building of trust is central to that process.

[30] e.g. Tribe R and Raval H (Eds.) "Working with Interpreters in Mental Health". Hove, Brunner-Routledge, 2003, pp.12, 72; Burnett A. http://www.torturecare.org.uk/files/brief27.rtf (pp.5-6)

2.2.4. Problems registering with GPs:

All asylum seekers need of course to register with a GP as soon as possible after arriving in Hull. They usually need help with this, and it is part of the contractual duties of the various housing providers to signpost (but not to accompany) their tenants to an appropriate practice. It appears that different asylum seekers have different experiences of registering.

> *"Because I give lady my passport and she said I must go to city council and ask them to give me the little paper that says I live there. First I must come here to give me one paper said medical centre give you one paper that say you living the name of road and in finish you go to centre, you give lady the paper…" (Man FG 2)*

> *"The staff there doesn't know how to register the people even. They ask passport from the people. How can they have passport, or driving license? This is asylum! How will you ask this of people seeking asylum. Some of the people doesn't have ID." (A, Iran)*

> *"The receptionist at (names practice) was not helpful – they wanted a passport, or some other proof of address. So I was not able to register there." (JF Sudan)*

It was very apparent from all our focus groups and many interviews that registering with a GP was neither easy nor straightforward. Those in the Homeless Team engaged in the initial health screening of new arrivals tended to select only certain (complex) cases to The Quays, which was perceived as having special expertise, but limited capacity, and to direct others to the practice nearest to their accommodation. The experience of staff at The Quays was of asylum seekers transferring to them from other practices, due to dissatisfaction.

2.2.5. Mental health problems difficult to admit, pervasive, and poorly handled by professionals:

We asked all our respondents whether they had experienced any emotional health problems, and if so, what sort of help they had received. It was clear that "mental health" was not a concept that translated easily into the language or culture of many of our respondents.

Asked about explaining emotional problems to the GP, this asylum seeker replied (through an interpreter):

> *"He says after this incident he was having problems with temper, he used to go off and tell his friend he getting angry with them for no reason. So he went to his GP and told him he got problem with his temper, and they give him paracetamol. So he say what you do with paracetamol when you got bad temper?" (Kurdish FG3)*

An asylum seeker from Africa, whose claim had been refused, and who had experienced the "Enforcement Team" knocking at her door, when asked "How is your health now?" commented:

> *"It's improving. When someone is living a life of fear, medication doesn't take away the fear and worry. Thinking makes me not sleep." (J, interviewed at Open Doors)*

Another asylum seeker, from Sudan, who had been tortured, probably on some sort of rack, and had his head kicked, described flashbacks, bad dreams, and fear at night. When asked whether he had told his GP about these symptoms, he replied "no", and the interpreter explained that he did not feel it appropriate to discuss this with his GP.

We found evidence for a high prevalence of mental distress among our respondents, but for many this was not seen as a medical issue. When they did bring it to the attention of their doctor, they tended to receive medication, which was not perceived as helpful.

2.2.6. Dental care difficult to access:

There was general agreement that access to dental care was difficult, and many had not ever tried to get a dentist. We found a lack of awareness of those services that were available, for example, none of the focus group members was aware of the Hull Dental Access Centre.

2.2.7. Housing widely seen as unsatisfactory, contributing to ill health:

We chose to begin most of the interviews around the respondents' experiences of housing, and we were right in expecting plenty of reaction. In some of the focus groups this topic ran for some time. Our respondents had no difficulty associating housing with an adverse impact on health:

> *"No hot water whatsoever. When it rains, all the time coming through the internal walls. He said if you want I can take pictures to record it, and of course it is affecting the health. Even mentally as well because obviously he's stressed about it, and that will affect him mentally if not physically." (Interpreter for Kurdish male FG3)*

"Eight people, small room, and kitchen is dirty and everything is dirty, I was the one to establish cleanness there; I was the one to give them instruction, I was to give them education for health. Because I am a doctor, of dental medicine and doctor of public health; I know the mode of transmission of diseases. ….. communicable diseases." (A, Iran, who was a qualified dentist.)

"My house is very very unhygienic, and lot of problem in my house. The water from the toilet fall into the sink. I write a letter to my caseworker, and do not ever reply to this." (KH Iran)

"In a house in St Georges Road, there are damp black spots on the wall. When I get back from the ESOL [English for Speakers of Other Languages] class the house smells damp. I tried to change the house, and was given a form, but was told no chance because of the floods." (H, Iraqi refugee, with wife, 2 children aged 5 & 7 and mother aged 55).

We found only a few instances of satisfaction with housing, such as the following account from a Gateway refugee, who had been housed in an outer estate in East Hull, who despite hearing adverse comments about Bransholme, was himself pleasantly surprised, and quite content to live there with his family.

"Bransholme, house good, quiet and beautiful location. I heard some rumours about bad events in the past 3-5 years. Such things happen everywhere. I met a Kurdish man in the market, who reacted with surprise when I told him that I lived in Bransholme." (A, Iraq refugee).

Another Gateway refugee whose house developed a water leak and who initially phoned "999" found his neighbour to be a great help in contacting a plumber. (M, Iraq male)

2.2.8. College (education) not as available as the need suggests:

Asylum seekers and refugees were unhappy when they had been unable to get into an ESOL class (English for Speakers of Other Languages)[31]. We found many who had either been delayed in getting into ESOL classes or who were still waiting.

[31] Current policy is to allow asylum seekers free ESOL classes after 6 months in the UK, see: http://www.hullcc.gov.uk/portal/page?_pageid=221,585393&_dad=portal&_schema=PORTAL (accessed 10/3/09)

> *"He has registered with Hull College about 8 months ago asking to be put on the register and since then he hasn't heard anything from them so the waiting list eight months and he still hasn't heard anything so it could take longer as well." (Interpreter for Kurdish male FG3)*

Asked about English classes, she said she had enrolled at a college, but was told that they would be writing to her – nothing received yet. (Iranian woman, from fieldnotes)

> *"When I went to Hull College, I was told, I have to pay for my course, so things are not getting much, so I was told by somebody else to go to somewhere like "centre" at Park Avenue, yes, that's where I am doing a course." (M, Sierra Leone)*

> *Wife attends Eastfield Adult Education Centre, Anlaby Road, arranged by the Refugee Council. 2 days/week, 2 hours/day, and he goes as well, also 2 days/week. (A, Iraq refugee, from fieldnotes).*

We also found evidence of asylum seekers being unable to find the money required to pay for ESOL classes or the tests leading to certificates.

2.2.9. Public Attitudes:

We asked our respondents how they perceived public attitudes towards asylum seekers in Hull, both in the NHS and the wider community. Those who had been here for several years generally reflected that things had improved, compared to their experiences in Hull five years ago.

> *"He says in my opinion ninety-five percent of the people at the reception are good, so that in his opinion it is a high percentage and he is happy with that percentage. The majority is good." (Interpreter for Kurdish FG3)*

This man appeared phlegmatic about racist abuse:

> *"Have you had any problems with people from Hull?*
> *"Sometimes you get problem, outdoors, but that's normal, because not from here."*
> *"What do they actually say?"*
> *"They say 'go back to your country'. I don't mind about it, I understand it." (A, Iraq)*

Another response, from a longstanding resident of the city, involved in community work for refugees, and who himself originally came from Africa, was far more pessimistic when asked about attitudes:

> *"They are getting worse; the police are not supportive; even PCSO's [Police Community Support Officers][32] don't attend when invited, such as when we invited them to our after school club – they just didn't turn up."*

> *"Refugees and asylum seekers when they go into pubs and social clubs are not welcome. They are actively abused. People say 'Black bastard' and 'It's become dark in here'."*

> *"Treatment at A&E for asylum seekers and refugees is not good – the way they talk to you is so patronising. Staff need training in how to work with BME people."*

Part of his response refers to "white East Europeans", presumably meaning the recent migrants from the new accession states, and describes overt racism:

> *"I am perturbed – white East Europeans call us niggers, spit and hold their noses in the street."*

[32] "Police Community Support Officers are members of support staff employed, directed and managed by their Police Force. They will work to complement and support regular police officers, providing a visible and accessible uniformed presence to improve the quality of life in the community and offer greater public reassurance."
http://www.policecommunitysupportofficer.com/welcome.html (accessed 2/10/08)

3. The survey of destitute asylum seekers in Hull

3.1. Background

"Destitution" has already been defined (1.2) as people who are receiving neither housing nor cash/vouchers, and so are dependent on goodwill and charity, and may be sleeping rough. Curiously in the course of our enquiries we found widespread confusion among service providers about the nature and definition of destitution.

3.2. Method.

We conducted a two-week survey across four agencies mimicking the Rowntree Trust's two surveys in Leeds, using identical data collection forms and methods. In 2007 the Joseph Rowntree Charitable Trust[33] published the findings of its "Enquiry into destitution among refused asylum seekers", which had identified 118 destitute individuals in a 4-week survey of five agencies in 2006. In 2008 a follow-up survey "More destitution in Leeds" found 331 destitute people in Leeds over a similar 4-week period.

Each of the four centres (Princes Avenue Methodist Church Open Doors drop-in, the 167 Centre, Springbank, the Goodwin Trust's Community shop in Walker Street, and the ARKH centre on Albion Street) undertook to record all cases of destitution among their clients over a two week period starting 24th November 2008. ARKH were unable to collect data during the second week and so extended their collection time for a third week.

3.3. Survey results.

A total of 43 destitute asylum seekers was recorded by the four agencies, but while the Open Doors drop in accounted for 35, the others each recorded between 2 and 3 individuals. This reflects the nature of their activities – only the Open Doors actually gave out bags of food and small sums of money. The main work of the other three is to provide advice and support.

Taking the total (and we took steps to avoid double counting) only 3 of the 43 were women. The countries of origin are set out in table 1, and the proportions compared with the 2008 Leeds survey.

[33] Both reports available at:
http://www.jrct.org.uk/documents.asp?section=00010006&lib=00030002

Table 1. Countries of origin of destitute asylum seekers in Hull (and Leeds)

Country of origin	Number (%)	% in Leeds 2008 survey
Iraq	13 (30%)	7%
Iran	10 (23%)	16%
Sudan	8 (19%)	6%
Zimbabwe	3 (7%)	22%
South Africa	2 (4.6%)	0.5%
Afghanistan	2 (4.6%)	4%
Somalia	2 (4.6%)	2%
Syria	1 (2.3)	0.2%
Algeria	1 (2.3)	0.2%
Palestine	1 (2.3)	0%
Others	0	43%
Totals	43 (100%)	100%

This illustrates the differences between cities in the ethnic mix of asylum seekers and hence of destitute people. Leeds had a big influx of Zimbabweans, who formed their largest group, while for Hull the Iraqis (i.e. Kurdish people) were the largest, with Iranians close behind.

Each respondent was asked about the reason for their being destitute. Their responses are set out in table 2, and again the percentages from the Leeds 2008 survey are added for comparison**.**

Table 2. Reasons for destitution in Hull (and Leeds)

Reason for destitution	Number (%)	Leeds 2008
End of process (S4 not applied for)	11 (26%)	26%
End of process (S4 refused)	11 (26%)	15%
End of process (S4 awaited)	8 (19%)	27%
End of process (no further details)	5 (12%)	5%
Positive decision but no housing	3 (7%)	4%
Denied support under S55	2 (4.6%)	
New arrival	1 (2.3%)	
Not known	2 (4.6%)	

Thus most (35/43) had reached the end of the asylum application and appeals process, and were for various reasons not in receipt of Section 4 (hard case) support. Section 55 refers to the rejection of asylum applications due to delay in seeking asylum, applying “in country” rather than applying in the port of arrival (“in port”). Only two of our sample had experienced this.

We asked how long they had been destitute (Table 3).

Table 3: duration of destitution in Hull (and Leeds)

Duration of destitution	Number (%)	Leeds 2008*
More than 2 years	19 (44%)	27% (47%)
1-2 years	7 (16%)	10% (17%)
6-12 months	5 (12%)	11% (18%)
3-6 months	6 (14%)	8% (14%)
Less than 3 months	5 (12%)	42%

(*percentages in brackets are excluding those under three months)

The Leeds survey picked up many short-term destitute which did not appear in our numbers. If these are excluded, there are very similar proportions of long-term destitute in Hull and Leeds, 44-47%

We established whether the respondents had been subject to the "New asylum model" (NAM), which came into force in March 2007. 15 of the 43 (35%) in our survey were under the NAM, which clearly refutes any claim that the NAM would prevent destitution (by immediate removal of failed cases). This is considerably higher than in Leeds where 17% were under the NAM.

We asked each person where they had spent the previous night:

Table 4: where destitute asylum seekers spent the previous night.

Where spent previous night	Number (%)	Leeds 2008
With friends or relatives	32 (74%)	58%
In NASS accommodation	5 (12%)	11%
Homeless shelter	2 (4.6%)	1%
Outdoors (street, park, doorway)	2 (4.6%)	12%
Unknown	1	1%

The two who stayed in a "homeless shelter" were fortunate, since most hostels do not accept "failed" asylum seekers, as they cannot recoup their costs from the benefits system. We were not surprised to count two sleeping rough: this is a regular occurrence, as "staying with friends" is highly unreliable and individuals may be evicted a short notice. We expect that this, as with the whole sample, is a considerable under-estimate of the total picture in Hull (see 3.4 below).

We asked the agencies to make a judgement about level of risk to health in each case: low risk was those who were receiving some support, and had somewhere to stay; moderate risk were those whose wellbeing was judged to be affected to some extent, despite getting some support; while

high risk cases had no support, poor health, and were possibly sleeping rough. 30 of our 43 were judged at low risk, 11 at moderate risk, and 2 were felt to be at high risk as defined above.

3.4. Interpretation of the survey findings.

The 2008 Leeds survey identified 331 destitute cases. The numbers of supported (i.e. not destitute) asylum seekers in Leeds and Hull are 2160 and 506 respectively (May 2008 Home Office data[34]). Using this ratio (4.3), the expected number of destitute asylum seekers in Hull would be 77. We actually identified 43, over a two week period. It is reasonable to suppose that the actual number could be two or more times the number we identified, that is around 100.

[34] http://www.refugeeaccess.info/uploads/news/Asylum40.pdf

4. What services are provided for asylum seekers and refugees in Hull? Findings from interviews and other data from service providers.

4.1. English for speakers of other languages (ESOL)

Several authors cited in the recent literature review by Craig and colleagues[35] identify the ability to understand and speak English as crucial to effective integration. These authors note that prior to cuts in the provision of ESOL courses in 2007,

> "Attending college for ESOL and other training in other basic skills such as computing was a key feature of life for asylum seekers while their claim was being processed."

However, they found evidence in the literature that:

> "Cutting ESOL provision has clear consequences for the capacity of asylum seekers to learn English, understand British institutions, mix with other people, and remain active and occupied while they await the outcome of their claim. Frontloading ESOL provision is an efficient use of resources as over the long term individuals may accumulate barriers to their learning". (p.44)

This section is based on information provided by staff of Hull College[36], one of the major providers of ESOL courses in Hull, with 500 places. Other providers are the Adult Education Service of the City Council[37] (The Avenues and Eastfield Adult Education Centres), the Hull Ethnic Minorities Community Centre[38], East Riding College, Beverley FE College, the Park Street Afro-Caribbean Centre, Wyke and Wilberforce 6th Form Colleges, the Workers Educational Association (Mitchell Community Centre) the North Hull Women's Willow Centre[39], the 167 Centre[40], and the Goodwin Trust[41], and "Skills4Communities" at 265 Anlaby Road.

Funding restrictions apply to Hull College (and probably to the other statutory providers, but not to the voluntary sector) which prevent asylum seekers accessing ESOL until they have been here for 6 months[42], (16-18

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[35] Lewis H, Craig G, Adamson S, Wilkinson M "Refugees, asylum seekers and migrants in Yorkshire and Humber, 1999-2008" Yorkshire Futures, Leeds 2008.
[36] http://www.hull-college.ac.uk/learning/schoolInfo.asp?schoolID=22
[37] http://www.hullcc.gov.uk/portal/page?_pageid=221,521071&_dad=portal&_schema=PORTAL
[38] http://www.hemccfl.org.uk/
[39] http://beehive.thisishull.co.uk/default.asp?WCI=SiteHome&ID=2883&PageID=13358
[40] http://www.hanaonline.org.uk/index.php/hana-members/37-hana-members/48-167-centre
[41] http://www.training.goodwintrust.org/
[42] http://www.hullcc.gov.uk/portal/page?_pageid=221,585393&_dad=portal&_schema=PORTAL

year olds are exempt from this restriction) and also if they have been refused. Refugees on the other hand have the same access as other citizens, and can get student loans, and other grants. Current funding does not cover the fees for exams (£50), which are needed when applying for UK citizenship.

It is the case that some asylum seekers access more than one ESOL course at a time, so may be attending Hull College once a week and the Avenues Adult Education Centre another day each week. The ESOL providers' network is aware of this phenomenon, but unable to prevent it, and so release places for others who cannot access any course. There may be as many as 60 waiting for a course.

So while there appeared to be extensive provision of ESOL courses in Hull, there was a discrepancy between this and the findings of our interviews and focus groups. According to our respondents, it is not easy to access ESOL classes, and there are significant barriers.

4.2. Reception and screening

All asylum seekers are offered screening at the Westbourne Centre, where they are seen by the TB nurse and one of the Health Visitors from the Homeless Team (half of whose work is with asylum seekers). Families receive home visits for this. When the HV identifies a child or family with significant health problems (not uncommon), they follow them up with further home visits, liaise with their GP, and make appropriate referrals.

In the course of this initial assessment the asylum seekers are routinely asked about sexual health, sexual history including abuse and rape, and exploitation (as in trafficking). But not all asylum seekers attend these assessments, and only the families are followed up. So there is a serious risk of major public health risks (TB, STD) being overlooked, unless similar screening checks are carried out by the General Practice where the asylum seeker registers. (See section 5.1 for an example of best practice for this problem.)

4.3. General Practice (Primary Care)

Several GPs involved in asylum seeker care were formally interviewed in early 2009, to explore their perceptions of the problems associated with asylum seekers as patients, and their suggestions for change.

Problems identified were:

a. asylum seekers require more time than other patients, because they require longer consultations if interpretation is used, and they tend to consult more frequently;
b. obtaining interpreters can be difficult for emergency or acute consultations;
c. asylum seekers often do not understand the NHS, and the role of GPs, and tend to expect referral to specialists;
d. appointments to secondary care are difficult to arrange through Choose and Book, and are sometimes missed due to an incorrect address being used;
e. cultural differences, such as are reflected in gender roles, can create problems for GPs unfamiliar with the particular culture in question;
f. interpreters vary in their level of skill and their styles of working.

Considering ways the PCT could help these issues, GPs felt that there should be:

a. a “dedicated” primary care service for asylum seekers, for the initial period of residence in Hull, which would enable a group of GPs to develop expertise, and would protect vulnerable families from the sort of aggression sometimes seen among addiction patients, violent patients, and prejudiced patients. (This is the pattern developed in Sheffield, where it works very well.)
b. additional training for interpreters;
c. training for GPs (and other primary care staff) in diversity and equality, in working with interpreters, and in common health problems among asylum seekers;
d. better availability of information literature (about the NHS, and specific health matters) in a range of languages, and suitable for printing out in the consultation;

One GP identified the recent arrival of a legal service (the CLAC) (see 4.6 below) as a positive measure, so that she was able to confer by telephone with the solicitor who had requested a report. Another, while willing to write letters when requested, felt some requests for housing letters were unrealistic in the circumstances.

4.4. Support for children and families

Asylum seekers identified by the Health Visitors in the Homeless Team as in need of psychological support are generally referred into the mental health services, via the new single point of access (see 4.5), where they are triaged to either primary care counselling, primary care psychology, or the community mental health team. However, children and adolescents

needing mental health care are referred to the Inter-Agency Link Team which links into the Child and Adolescent Mental Health Service (CAMHS). When children and adolescents are referred into the CAMHS, these families are frequently referred on to the Haven Project (see below), where they receive social and counselling support, in close collaboration with the CAMHS team.

The Haven Project is a specialist counselling service in Hull, within the voluntary sector, which has provided long-term counselling for asylum seeker and refugee families and individuals exposed to significant trauma, and also a cultural integration project. However, its limited funding from the Hull Children's Services is currently (2009) coming to an end, and its future is uncertain.

Since Haven and CAMHS began to work together, referrals of Black and ethnic minority (BME) families into the CAMH service numbered 12 from the Haven project, nine from GPs (3 of which were co-worked with Haven), four from hospital accident and emergency departments, all co-worked with Haven, and one from the Homeless team. The model is that if a parent does not understand the function of CAMHS, or does not share the same view of the child's needs, the family will be referred back to Haven to work with them in the community to see if those barriers can be overcome. The concept of a third sector organisation acting as a 'bridge' to more specialised statutory services is central to this model.

The Haven Project Final Report[43] describes its origins as one of nine set up through the charity Action for Children in Conflict. It notes that:

> "a major strength of the project has been the close working relationship we have developed with the Clinical Psychology team in CAMHS. We have developed a fast track referral route and now on occasion do joint assessments and share aspects of the work with a family, so that CAMHS may do the specific clinical work while Haven meet with a family in the community."

Haven contains a significant body of expertise (its two therapists are highly experienced and qualified), well-developed networks (with CAMHS, the voluntary sector, and primary care), and the intangible goodwill that derives from 6 years of effective working.

[43] Martin G. The Haven Project, Hull 2002-7, Final Report.

There have been two trafficked young people referred to Haven. Haven's specialist understanding of the asylum process was helpful in gaining "Section 4" support for one of these.

There are currently 24 "unaccompanied minors" in Hull, whose care is the responsibility of the Social Services. It is a great concern to the Child and Adolescent Mental Health team that these young people are not getting prompt resolution of their asylum status at age 17.5, which should happen, and so are reaching age 18 and entering a state of "limbo", with consequent greatly increased anxiety.

Solace[44] is a specialist regional refugee mental health service, based in Leeds but working in Bradford through a contract with Bradford PCT and also in Wakefield in an induction centre in partnership with the Refugee Council. Solace has built up a great deal of experience of a specialist nature and has run training courses in Bradford, York and Leeds on general refugee mental health, on child refugees, and on working with interpreters, Solace also trains the interpreters it uses and has a training and support programme for them which could be delivered in Hull. Solace has the potential to absorb and support the work of Haven, should continuing funding become available.

4.5. Specialist adult mental health services

The pathways into mental health services in the NHS in Hull have recently (October 2008) changed with the introduction of a "single point of access" (SPA). This is a triage process, whereby all referral into mental health care (apart from children and adolescents, see above 4.4) are screened by a member of the intake team based at Miranda House, and allocated to the range of services (Primary Care Mental Health Workers, Primary Care Counselling, Primary Care Psychology, the Community Mental Health Teams, and Older Adult Care). Referral is by letter, referral form, or phone. The form specifies the completion of the PHQ-9 and/or the GAD-7. It also includes a "language" box, to indicate the need for an interpreter[45]. The triage process uses a frequent triage meeting attended by representatives from all the services, and is based on risk assessment.

Mental health problems affect a large proportion of asylum seekers, ranging from mild adjustment reactions and anxiety to major depression and post-traumatic stress disorder[46]. A survey of agencies in Leeds suggested that 83% of destitute asylum seekers suffered emotional

[44] http://www.solace-uk.org.uk/
[45] If an interpreter is needed, the Hull City Council Interpreter Service is used.
[46] http://www.fphm.org.uk/resources/AtoZ/bs_aslym_seeker_health.pdf

distress of some sort[47], 51% had a diagnosed mental illness and 26% had actually discussed suicide in the previous month.

There is a simple 4-item screen[48] based on the 17-item PTDS checklist, which could easily be used in primary care:

> Screen for PTSD *(Prins, et al., 2004, Primary Care Psychiatry)*
> "In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month, you:
>
> 1. Have had nightmares about it or thought about it when you did not want to?
>
> 2. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?
>
> 3. Were constantly on guard, watchful, or easily startled?
>
> 4. Felt numb or detached from others, activities, or your surroundings?"
>
> If two or more are answered with "yes", a diagnosis of PTSD is probable. When PTSD is diagnosed, the current response is likely to be Primary Care Counselling, which is being augmented by the deployment of three new "high intensity IAPTs workers.

There is in the Humber Mental Health NHS Trust a specialised Trauma Service, which is currently not funded for clients other than ex-service personnel. We were advised that the service could readily expand to work with asylum seekers and refugees with PTSD needing more specialised treatment than could be provided within the framework described earlier. The NICE guideline on PTSD recommends specific therapies – trauma-focussed CBT, or eye movement desensitisation and reprocessing (EMDR). Both are available in the Trauma Service. The leader of this team, Dr Jenny Ormerod, has prepared a costed proposal to expand to meet the needs of refugees and asylum seekers with more complex psychological trauma, and this is found in Appendix 7.

[47] http://www.pafras.org.uk/documents/PAFRAS_Briefing_Paper_5_-_Mental_health,_destitution_and_asylum.pdf
[48] http://www.racgp.org.au/Content/NavigationMenu/ClinicalResources/RACGPGuidelines/PTSDclinicaltreatmentalgorithm/200810PTSDAlgorithm.pdf

All the mental health specialists agreed that further training in the specific mental health needs of asylum seekers and refugees would be helpful for practitioners, and that interpreters definitely needed a support system to enable de-briefing after traumatic therapy sessions, or for general support.

4.6. Interpreter services

The main source of interpreters in Primary Care is the Interpretation and Translation Service (ITS), a joint agency of Hull City Council and Hull PCT, which acts as an agency for freelance interpreters who are self-employed.

The service provides a "Welcome pack" for new recruits, which sets out its terms and conditions, and also, and more salient to this report, its "Good practice guide for sessional interpreters/translators". This sets out for interpreters three pages of clearly stated good practice, which corresponds closely to best practice as found in standard texts and articles.[49, 50].

Another major supplier of interpretation services in hull is Global Accent Ltd. They currently work with the hospitals, and also provide an out-of-hours service for primary care. Their interpreters also work for the courts, the probation service, and other agencies.

We were told that all Global Accent interpreters are CRB checked (Enhanced Disclosure) every 2 years and adhere to a Code of Conduct in line with the Institute of Linguists, while many are DPSI (Diploma in Public Services Interpreting) [51] qualified.

A small group of registered ITS interpreters acted as a focus group to consider ways in which the service could be improved.

The ITS does not organise any training or support activities for its registered interpreters. However, the manager indicated that they recognised the need, and would be interested in both training and support if funding were available. The interpreter group felt this would be widely acceptable to their colleagues. The need for interpretation and translation

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[49] Tribe R and Raval H (Eds.) "Working with Interpreters in Mental Health". Hove, Brunner-Routledge, 2003

[50] Tribe R "Working with Interpreters". *The Psychologist,* Vol 20; 159-161, March 2007; http://www.thepsychologist.org.uk/archive/archive_home.cfm/volumeID_20-editionID_145-ArticleID_1158-getfile_getPDF/thepsychologist%5C0307asy4.pdf

[51] http://www.iol.org.uk/qualifications/DPSI/DPSIHandbook.pdf (accessed 8/1/09) http://www.iol.org.uk/qualifications/exams_dpsi.asp (accessed 8/1/09)

to be recognised as specialist skills is highlighted in the clinical and social policy literature[52].

Unlike those working in the courts and police settings, interpreters working through ITS are not required to demonstrate competence by formal qualifications, but they do have to have CRB clearance.

Despite the clear "Good Practice Guide" issued by the ITS, it does appear that not all interpreters working under its auspices in Hull are following the guidelines. The interpreters and their clients were in agreement that some interpreters fell short of best practice.

One problem is the interpreter not having sufficient fluency in the language in question. Asylum seekers or refugees with limited English proficiency can sometimes tell that their interpreter is not translating what they have said. Some interpreters may claim fluency in a language in order to attract more work, when their familiarity with the language is insufficient. On other occasions, the Asylum Support Team may be unable to find a suitable qualified interpreter at short notice, and may ask a less suitable colleague to take the job. This may suffice in some situations, but is clearly unacceptable for complex consultations.

Another reported problem was interpreters going beyond the boundaries of their role (clearly set out in the Guide). This had led to other interpreters being criticised by patients for not doing whatever the first interpreter had done (such as giving practical help, or giving advice outside the consultation). The group discussed the "Link Worker" role, found in other cities including London, where the Link Worker acts as both interpreter and family aid, doing practical help. In Sheffield there are two "Family Support Workers" who have a similar role, and both helper and interpreter. This is not the role of interpreters in Hull.

The interpreter focus group suggested routine feedback from the health professional to the ITS office, using a simple form that could be faxed.

The interpreters spoke of attitudes in NHS staff towards themselves and their clients, of disrespect, verging on racist. This clearly needs attention, in the first instance through simple diversity training, but also focussed training in working with interpreters.

Some situations in which interpreters find themselves working lead to considerable stress. These could be counselling, psychotherapy, child

[52] Tribe R *ibid.*

protection meetings, or other disclosures of traumatic experiences. At present there are no opportunities for interpreters to receive any support or de-briefing, but this would be particularly welcome by the interpreters.

Alongside the Institute of Linguists, mentioned earlier, there is now a Government sponsored body, CILT, the National Centre for Languages[53], which has produced a set of standards for public interpreting services[54], and which represents the Government's strategy for languages.

Tribe & Ravel (2003) describe how a PCT might set up and run a generic course for users and practitioners of interpreting[55], based on the authors' experience and the wider literature.

4.7. Sexual health services

We interviewed Tish Lamb, operations manager of the Cornerhouse (Yorkshire), a voluntary sector agency based in Hull dealing with all aspects of sexual health, including HIV/AIDS, family planning and prevention of Sexually Transmitted Infections (STIs). The purpose was to cross-check our findings of a lack of evidence for significant numbers of trafficked women in the context of immigration. She confirmed this, noting only very limited anecdotal evidence of trafficked women in the commercial sex industry in Hull (unlike other cities where it is more prevalent).

She believed that the care available to HIV positive asylum seekers from the NHS was excellent, but that this group sometimes suffered from relative isolation and lack of social support, especially when re-located from larger cities such as London.

Refugees and asylum seekers who are HIV positive receive care from either of the two specialist services in Hull, based at Conifer House and Castle Hill hospital. Information from both clients and service providers suggest that the care is of a very high standard.

4.8. Legal advice

Until October 2008, immigration advice was available free from the Leo Schultz Project, a specifically funded programme within Hull Citizens' Advice Bureau, which provided consultations both at the CAB offices in Hull and at outreach points in the city.

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[53] http://www.cilt.org.uk/about/index.htm (accessed 24/3/09)
[54] http://www.cilt.org.uk/standards/NOSIrev2006.pdf (accessed 24/3/09)
[55] Tribe R and Raval H (Eds.) "Working with Interpreters in Mental Health". Hove, Brunner-Routledge, 2003, pp. 54-68.

Despite the loss of the Leo Schultz Project, and the transfer of many staff to the new Community Legal Advice Centre (see below), Hull CAB still provides open access advice to many asylum seekers and refugees at its Hull offices, and through one seconded staff member at the Princes Avenue Methodist Church drop-in (see 4.9 below).

The situation in Hull changed in October 2008, when the Community Legal Advice Centre (CLAC) opened in Essex House, in the centre of Hull. This is a commercial organisation, a partnership between a private company (A4e) and a firm of solicitors in Sheffield.

The CLAC offers open access legal advice to those unable to afford solicitors, and to those seeking advice on immigration matters it has two members of staff qualified to give advice at OISC level 3. For more complex legal advice the office is visited once weekly by a solicitor from Sheffield (the head office of the solicitor firm involved), and can draw on other solicitors if needed.

The ability of the CLAC to deliver high quality legal representation for asylum seekers has yet to be demonstrated, as at the time of the enquiry they had not taken any cases through the courts.

4.9. Other voluntary and charitable organisations

The Princes Avenue Methodist Church runs a “drop-in” every Thursday where asylum seekers and refugees including families are offered friendship, hot food, and access to immigration advice from a specialist seconded from the Citizens’ Advice Bureau (see 4.8 above).

The Princes Avenue Methodist Church Hardship Fund supports about 4 refused asylum seekers in hostel accommodation, and gives food bags and small cash sums to about 40 destitute, and also food bags to those in need who receive NASS or Section 4 support. Each week about 100 food bags are issued.

The 167 Centre on Springbank is a voluntary sector agency run by Gary Pounder, and funded by the EMIF (Ethnic Minority Innovation Fund) from the Office of the Deputy Prime Minister, Hull City Council, Hull Community Investment Fund and from the Big Lottery Fund. The centre is open daily Mondays to Fridays, and attracts around 500-100 people each month with problems ranging from immigration, health, employment, benefit problems, training, education, finding solicitors and homelessness,

drawing clients from as far afield as Doncaster or Bradford. The centre gives a limited number of donated food bags to destitute people.

It has a special interest and expertise in "Lesbian Gay Bisexual and Transsexual" people and provides an advice service and support groups. The centre's volunteer staff includes two with several languages, and so they do not find the need for outside interpreters.

Skills 4 Communities[56] is a voluntary organisation with premises in Anlaby Road which serves the BME community including asylum seekers, offering immigration advice at OISC Level 1, support, internet access, classes in ESOL, and life skills.

ARKH[57] (Asylum Seekers Kingston upon Hull) offers a drop-in at its Albion Street basement premises, a venue for Refugee Council service for the Gateway programme, and a befriending service, English classes, and a football team.

4.10. The Expert Patients Programme (EPP)

We considered whether the needs of refugees and asylum seekers might to any extent be met by the EPP. There is some research from the Borough of Islington[58] where the authors propose a "refugee expert patient programme" for those refugees with multiple and/or complex needs. While there is a theoretical place for refugees in the EPP, in practice it does not seem to have happened yet, in Hull or elsewhere.

A possible place for the EPP could be in using refugees as advisers to those who have recently gained refugee status or Humanitarian Protection, and who urgently need help and advice in integrating into society.

[56] http://www.skills4communities.co.uk/
[57] http://www.arkh.org.uk/
[58] http://www.islington.gov.uk/DownloadableDocuments/HealthandSocialCare/Pdf/mapping.pdf

5. What is "Best practice"? Examples from other cities.

5.1. Sheffield

In 2002 the South Sheffield PCT (now Sheffield PCT) set up a service dedicated to asylum seekers, led by a nurse consultant, and based in a PCT Managed Service model. The service continues to be managed by the nurse consultant, with one full time equivalent general practitioner (actually 3 part-time GPs), two nurse practitioners, one health visitor, two family support workers, and a linked counselling and mental health team, all based in the Central Health Centre in the centre of Sheffield (shared with the sexual health clinic).

Among the many examples of best practice found in this service is their patient-held "Personal Health Record". This is simply a modified version of the patient held record given to all asylum seekers when they first arrive at the induction centres. Hull asylum seekers do hold these, but they are seldom used. There is a version available on the Department of Health web-site[59].

Another exemplary practice is the provision of funded training and support sessions for the interpreters (hosted by the PCT, but otherwise similar to the Hull Interpreter Service).

While Hull has a problem with attendance at the arrivals health screening, especially among single men (see 4.2), Sheffield has solved this by running a minibus service to physically take newly arrived asylum seekers to their first appointments, and to the follow up appointment two weeks later. This relies on the close cooperation of housing providers, who provide lists of new arrivals each week.

Because registration with a GP is so important, and because the housing providers are not contractually obliged to ensure that that happens, the Sheffield service has developed an effective liaison with housing providers to ensure that every new arrival does register with a suitable practice, not necessarily the Central Health Clinic practice.

The nurse consultant explained the enormous value of the two Family Support Workers (who were recruited from the refugee population, and so are bi-lingual and community based). They are supervised by the

59 http://www.dh.gov.uk/en/Healthcare/International/AsylumseekersAndrefugees/DH_4080751?IdcService=GET_FILE&dID=4484&Rendition=Web (accessed 16/2/09)

dedicated Health Visitor, who is known by the more relevant name of "Families Nurse".

TB screening for asylum seekers in Sheffield is now done using the "Quantiferon Gold" test, a blood test which is cost-effective[60] and hence much better than the traditional Mantoux test, which depends on a repeat attendance to be read. In the Sheffield experience the prevalence of latent TB is 14%.

The Sheffield service has a clear policy for writing medical reports: it requires written requests from the legal adviser, it has a price tariff, but it defers to the Medical Foundation[61] for all requests for medico-legal reports when there is a history of torture. However, the three GPs who work at the Sheffield centre have had basic training from the Medical Foundation, to enable them to recognise cases needing this further assessment.

Sheffield has become the first "City of Sanctuary", an ideal that "fosters a culture of hospitality" towards those seeking asylum or sanctuary. There are 80 organisations involved, all of which display a prominent sign that they welcome asylum seekers. This is further discussed below (sections 6.5, 7.1, and Appendices 3 and 4).

5.2. Birmingham

At a meeting of the RCGP primary care refugee and asylum network in Birmingham on 14th October 2008, we gathered information about best practice in Sandwell PCT, where the Cape Hill Medical Centre has an APMS contract to provide care for about one thousand two hundred asylum seekers and refugees in the Sandwell PCT. The contract between Pathfinder Healthcare Developments (PHD) Limited and the PCT is designed to provide optimum care for this group, with 20 minute appointments built in to the contract. It is based on an "enhanced capitation fee" of £120 paid for asylum seekers and refugees within 18 months of arrival.

[60] see Adams K, Cartlich K, Thaker H, Anderson G, Newton A. "The use of Quantiferon gold as a screening tool in a prison TB outbreak: some advantages over traditional screening methods". Journal of Infection, Volume 55, Issue 3, Pages e54, September 2007 for a recent local report on this test.

[61] http://www.torturecare.org.uk/ The Medical Foundation for Victims of Torture is the most respected source of medical reports in asylum cases. They only accept requests for reports from legal advisers, but accept referrals for treatment from survivors themselves, friends and family, GPs, solicitors, refugee community organisations or any other voluntary or statutory sector body. All services are free to the client.

The practice has designed a series of templates (for EMIS[62]), and an evaluation tool which corresponds to a special QOF[63]. Their nursing team[64] carry out extended "new patient checks" on this group, using an adapted template which obviously applies Read codes to all relevant aspects.

Accurate coding of asylum status is clearly a first step in the PCT knowing the scale of need. There is an urgent need for practices to apply standard codes for asylum seekers, refugees and destitute asylum seekers.

Medical students at Birmingham were leading an initiative to bring asylum health into the UK undergraduate curriculum, "Crossing Borders"[65], which has already been adopted by HYMS.

5.3. Liverpool.

There is a Merseyside Asylum Seeker Health group which hold monthly meetings to both develop services and to provide education for all types of staff working in this area.

The Merseyside Fire Brigade carries out routine inspections of properties used by asylum seekers, because of the recognised increased risk of fire in such premises. In the course of these inspections they uncover other breaches of Health and Safety regulations and are able to advise landlords, to the benefit of the asylum seekers.

5.4. Manchester/Salford

Dr Pip Fisher, a GP in Kirklees, has produced a DVD in several languages designed for newly arrived asylum seekers, introducing the NHS. This could be simply adopted for Hull, or (at a cost) a local one produced. It is available from the Black Health Agency[66] as a download or a DVD.

Dr Fisher also runs a training programme in Salford for refugee doctors, to which those in Hull are usually redirected by the Deanery in Leeds which is responsible for their integration.

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[62] EMIS is one of the main GP computer systems in Hull, alongside SystemOne and a few others. Tempates should be transferable across systems.
[63] The Quality and Outcomes Framework, a system for rewarding GPs for certain activities.
[64] The health care assistant does the first part, and a nurse practitioner or practice nurse the second part, the whole process taking about 1 hour.
[65] http://crossingborders.org.uk/index.php?option=com_content&task=section&id=12&Itemid=44 (accessed 5/1/09)
[66] http://www.blackhealthagency.org.uk/

5.5. Bradford

In 2003 the Bradford and Airedale Teaching PCT established a PMS practice Bevan House, dedicated to homeless people and asylum seekers. It was a firm policy that substance misuse services were to be kept separate from this.

The PCT team comprises six GPs (all part-time, and all but one also working in other practices), two nurses, (one being the clinical lead), two health visitors, a midwife, a podiatrist, a counsellor, and a clinical psychologist (with a special interest in PTSD). The service is housed in a building shared with the PCT outreach team (TB screening etc.), the asylum support team, and a food store stocked by voluntary contributions.

The Bevan House Homeless & Asylum Support Team is a partnership between Bradford City Teaching Primary Care Trust and Horton Housing Association (HHA). It is a joint approach to working with homeless people in response to their housing needs, health and social well-being. HHA's specific role is to provide housing related support for people living in temporary accommodation, throughout the Bradford District[67].

The PCT recently set up an interpreting service, through which all interpreters are now booked[68].

Bevan House has no "catchment area", so draws from across the city and beyond. Newly arrived asylum seekers are not necessarily registered there, but many do register, by recommendations by word of mouth. The list is approximately 50% asylum seekers and 50% homeless families. They are developing a policy for "moving on" asylum seekers who gain status and settle, and need to be integrated into their local NHS.

Bevan House has a "special QOF" for homeless and asylum seekers, with associated computer templates. As a way of improving continuity and helping sessional staff to access information, they have recently set up a practice intranet, containing relevant material.

5.6. Huddersfield

The Whitehouse Centre in Huddersfield is a PMS practice which deals with all asylum seekers as they arrive in the city, some for many years if they have particular needs.(although it does include drug addicts and the

[67] http://www.hortonhousing.co.uk/servicessup_details_blank.asp?location=bradford&ID=35
[68] http://www.bradfordairedale-pct.nhs.uk/Equality+and+Diversity/Interpreting+Services/

homeless also). Dr Pip Fisher is the specialist GP, supported by a team including a specialist counsellor.

6. Discussion of findings in the context of existing research, and current policy

6.1. Literature Review for Yorkshire Futures[69]

This extensive review of research into asylum seekers, refugees and migrants in the Yorkshire and Humber Region was carried out concurrently with the present project, and published in January 2009. It sets in perspective the numbers of asylum seekers, refugees, and other types of migrants into the region.

It highlights many of the issues of health, housing, interpreters, English language classes, and the roles of the voluntary sector that are addressed in this report. It adds important new information about the European Union migrant population, and other migrant types.

It recommends action by health and local authorities to address poor housing, and to improve ESOL provision. It highlights the role of Local Strategic Partnerships, and urges continuing efforts to "bust myths" about asylum and migration.

6.2. Qualitative study from Glasgow

O'Donnell and colleagues from Glasgow recently carried out two qualitative studies of asylum seekers' views of health and the health system[70]. Their findings were quite consistent with ours, in particular that respondents were generally pleased with the health service they had experienced in the UK, but those who came from countries where the health system was markedly different from the NHS were confused and disoriented by features such as appointments, waiting lists, and apparent denial of treatments such as antibiotics.

6.3. The POPPY Project and the Refugee Women's Resource Project at Asylum Aid.

This group reported a review of the New Asylum Model and its impact on trafficked women claiming asylum[71] in which they highlight specific legal issues relating to this group, for which good legal support is essential, and

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[69] Lewis H, Craig G, Adamson S, Wilkinson M. "Refugees, asylum seekers and migrants in Yorkshire and Humber, 1999-2008, Leeds, Yorkshire Futures, 2008.

[70] O'Donnell CA, Higgins M, Chauhan R, Mullen K. *"They think we're OK and we know we're not"*. A qualitative study of asylum seeker' access, knowledge and views to healthcare in the UK. BMC Health Services Research 2007.

[71] Stephen-Smith et al 2008. "Good Intentions: A review of the New Asylum Model and its impact on trafficked women claiming asylum." http://www.eaves4women.co.uk/POPPY_Project/Documents/Recent_Reports/Good_intentions.pdf

the special psychological traumas experienced. These observations would be well noted by all GPs working with asylum seekers, and by those nurses responsible for new patient health screenings.

The Home Office Asylum Policy Instruction on Gender Issues in the Asylum Claim states that: "Women who have been sexually assaulted may suffer trauma. The symptoms of this include persistent fear, a loss of self-confidence and self-esteem, difficulty in concentration, an attitude of self-blame, shame, a pervasive loss of control and memory loss or distortion. Decision-makers should be aware of this and how such factors may affect how a woman responds during interview".[72]

6.4. Legal advice – timing and quality

Since an asylum seeker is characterised by their having applied for, but not yet been granted, leave to remain in the UK on the grounds of their claimed refugee status, or other humanitarian grounds, the outcome of the legal process (of initial application, initial hearing, and subsequent appeals) is critical to their aspirations of successful settlement in the UK.

A Home Office report "The role of early legal advice in asylum applications"[73] (Immigration Research and Statistics Service, RDS, Home Office Online Report 06/05) concluded:

> "Overall, the findings suggest that competent legal representatives can contribute to a good quality decision by helping the applicant to present the details of his or her case in an SEF or witness statement." (p.vi)

In other words, even the government accepts that legal advice is a necessary part of the humane processing of asylum seekers' claims[74]. Research in many areas of quasi-judicial activity confirms that good legal or para-legal advice substantially enhances the chance of asylum claims being accepted or appeals being upheld[75].

This study included a questionnaire survey of BIA caseworkers, which found that they had concerns about reports submitted from GPs. This

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[72] Asylum Policy Instruction (API)/October 2006 "Gender Issues in the Asylum Claim". http://www.ukba.homeoffice.gov.uk/sitecontent/documents/policyandlaw/asylumpolicyinstructions/apis/genderissueintheasylum.pdf?view=Binary (accessed 13/2/09)

[73] http://www.homeoffice.gov.uk/rds/pdfs05/rdsolr0605.pdf (accessed 30/12/08)

[74] A recent UKBA consultation on the 2009 Immigration and Citizenship Bill (12 Sept 2008) includes the statement: "Ensure all have good access to quality legal representation; ensure fairness of asylum decision and appeal outcome" as an aspiration.

[75] Professor Gary Craig: personal communication.

showed that UKBA staff treated reports from GPs as less reliable than medical reports from specialists, in particular from the Medical Foundation and Helen Bamber Foundation doctors. The implication of this finding would seem to be that GPs should seek help from these organisations if a medical report is likely to be material in an asylum seeker's claim.

One of the issues about mental health care is the need for advocacy to work alongside the clinicians. Effective healthcare must include an involvement in the legal process, by understanding the issues, and knowing how to work with the legal profession.

6.5. The Independent Asylum Commission (IAC)

The IAC arose out of a group in London that in 2004 investigated the quality of care at Lunar House, the Croydon headquarters of the Immigration and Nationality Directorate (now UKBA). The commission set out to investigate the whole of the UK asylum system. In their interim findings the IAC expressed concern at the poor quality of initial decision-making by the Home Office, and noted that:

> "Representation by an accredited and high quality legal representative is likely to play a significant part in the number of cases won on appeal. This highlights the harmful consequences of the absence for many asylum seekers of any legal support or representation at the initial stage." (p.25)

This corroborates the previous recommendations that asylum seekers should have ready and prompt access to good legal support.

"Saving Sanctuary" [76] the Commission's first report, summarised its position on the term "sanctuary" as follows:

a. People share a common understanding of the term 'sanctuary' as a safe, secure place in which someone can take refuge;
b. People view sanctuary as an overwhelmingly positive word and can relate the concept to their own lives positively, many even citing their home, bedroom, the countryside, or a spiritual retreat as examples of their own personal sanctuary;

[76] http://www.citizensforsanctuary.org.uk/pages/reports/SavingSanctuary.pdf the Commission's first report, outlining public attitudes towards asylum and proposing a new term "Sanctuary" to replace asylum, and commending the "City of Sanctuary" movement (www.cityofsanctuary.com) as one way of promoting a better public understanding of sanctuary.

c. People also understand and accept that sanctuary can refer to a place of safety for those from abroad who are fleeing persecution;
d. People believe strongly that it is a good thing that the UK provides sanctuary to those fleeing persecution.

The Commission's second report, "Safe Return"[77], addresses the needs of those whose claims are refused. It vigorously promotes the option of allowing refused asylum seekers the right to work, on a temporary basis, and re-asserts the harmful impact of destitution in this group.

The third report of the IAC, "Deserving Dignity"[78] includes a set of recommendations concerning healthcare which are reproduced in full below. The enquiry had noted that "the Commissioners are concerned at the difficulties asylum seekers experience in signing on with a GP and the pressures this is likely to generate on Accident and Emergency Departments of Hospitals". This clearly resonates with our findings, reported above.

Independent Asylum Commission recommendations on healthcare stated that:

a. "there should be pre-screening health assessments for asylum seekers to identify health needs, including mental health needs, at the earliest possible stage.
b. "that asylum seekers with chronic physical or mental health needs should be supported by special teams tasked with planning for their needs and ensuring continuity of care after dispersal, on the model of NHS complex discharge planning.
c. "that healthcare should be provided on the basis of need, and that asylum seekers should be eligible for primary and secondary health care until their case is successful, or they leave the UK; in particular and specifically that all peri-natal healthcare should be free.
d. "that asylum seekers' health entitlements should be more clearly communicated to asylum seekers, support organisations and health professionals.
e. "that any measures to curb 'health tourism' that affect asylum seekers be evidence based and take into consideration the risk of abuse, public health impact and the long-term health and financial

[77] http://www.citizensforsanctuary.org.uk/pages/reports/SafeReturn.pdf
[78] http://www.citizensforsanctuary.org.uk/pages/reports/DeservingDignity.pdf

costs of not providing early treatment, specifically for asylum seekers.

f. "that disabled asylum seekers should be able to access suitable accommodation and support, and be properly protected in detention.
g. "that, where asylum seekers have GPs or other healthcare providers, healthcare workers in Immigration Removal Centres should be proactive in contacting them to ensure continuity of care."

We strongly commend to the PCT these three IAC reports, and suggest that their recommendations carry weight and should be taken seriously.

6.6. The City of Sanctuary movement[79]

City of Sanctuary is a grass-roots movement to build a culture of hospitality for those seeking sanctuary in the UK. Their goal is to create towns and cities throughout the UK which are proud to be places of safety, and which include refugees and people seeking sanctuary fully in the life of their communities. Sheffield was the first City of Sanctuary, where there is a gradually increasing awareness of and support for refugees and asylum seekers[80].

The list of cities that already have C of S groups, the first step to becoming a City of Sanctuary (Bradford, Bristol, Coventry, Leicester, Liverpool, London, Norwich, Nottingham, Oxford, and Sheffield) is impressive. At least one Hull third sector organisation, Open Doors at Princes Avenue Methodist Church, has met with Craig Barnett, leader of the Sheffield group. Appendix 2 sets out the steps to be taken to constitute a City of Sanctuary. This report will recommend that NHS Hull and its partner Hull City Council should encourage the various third sector bodies in the field to consider forming a City of Sanctuary group.

6.7. Entitlement to NHS health care

Until recently, NHS organisations have been in an invidious position towards "failed asylum seekers" as a result of the "health tourism" policies which require non-citizens to be charged for all but emergency care. The Department's web-site clarified the situation as follows:

> "A judicial review took place on 10/11 April 2008 regarding a failed asylum seeker receiving free hospital treatment. The resultant ruling in the High Court makes it possible for failed asylum seekers to be

[79] http://www.cityofsanctuary.com/
[80] "A city built on sanctuary" The Guardian, Wed June 4th 2008. http://www.guardian.co.uk/society/2008/jun/04/asylum.support.sheffield

> considered 'ordinarily resident' in the UK, and, consequently, entitled to free NHS hospital treatment. The Department is considering options on a potential appeal, but unless and until the decision is overturned the Judge's decision is effectively the law. Guidance has now been issued by DH to the NHS."[81]

The resulting table of entitlement[82] (Appendix 6) dated November 2008, and still current at March 2009, shows how the "ordinary residence letter"[83] of May 2008 should be used to determine whether a particular "failed" asylum seeker is to be treated as "ordinarily resident" for the purposes of these rules. In practice now asylum seekers of whatever sort should experience no more difficulty in accessing NHS care than anybody else. The Department of Health however continues to pursue this matter in the courts, and readers should seek up to date information from the DoH website.

[81] http://www.dh.gov.uk/en/Healthcare/International/asylumseekersandrefugees/index.htm
[82] http://www.dh.gov.uk/en/Healthcare/International/asylumseekersandrefugees/index.htm?IdcService=GET_FILE&dID=176615&Rendition=Web
[83] http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_084479

7. Conclusions and recommendations*.*

7.1. Introduction

This report has described a wide range of evidence concerning the health, health needs, and health care of asylum seekers and to a lesser extent of refugees. It has presented findings from its own enquiries from asylum seekers and refugees in Hull, (chapters 2 & 3) and from those who seek to meet their health and social needs (chapters 4 & 5). It has summarised the current Government policy and statistics (chapter 1), and some relevant research (chapter 6). It has drawn attention to several important and authoritative reports, especially the three reports of the Independent Asylum Commission (section 6.5), and the two from the Joseph Rowntree Trust (section 3.2), and a number of relevant recent research reports.

The big question is, “what should we in Hull be doing about the refugees and asylum seekers in our city?” This report suggests we need to consider (1) our duty of care for the most vulnerable in society*;* (2) the scale of the need*;* and (3) the quality of our services

7.2. The duty of care[84]

In our investigation we found many instances in Hull of excellence in caring for vulnerable and sick people who were fleeing from persecution in their own countries. We commend the dedication of many staff in statutory agencies (the NHS, and the City Council’s Asylum Support Team, Housing, and Education and Learning) and the many volunteers in third sector organisations.

We were disappointed to hear from our respondents of occasions when care was less than good; when there appeared to be discrimination, and lack of understanding.

We believe there is room for change in all involved in asylum seekers’ care, to raise knowledge of health needs, and to shift attitudes from suspicion and hostility to welcoming and caring, and to challenge racist attitudes wherever they exist.

[84] "The best test of a civilised society is the way in which it treats its most vulnerable and weakest members." attributed to Mahatma Gandhi

7.3. The scale of the need

In this report we have demonstrated that the number of supported asylum seekers in Hull is only 500. The number of destitute, "refused" asylum seekers is unknown: our estimate, based on our survey, is around 100.

The number of refugees, those granted leave to remain in the UK, on whatever grounds, is also unknown, but we suggest a figure of 1,000 as a crude estimate. Many others having been granted leave to remain, have left the city. Other immigrants, mainly from A8 countries, and especially Polish nationals, also show exceptional health and social needs, which should also be addressed. The recent report by Professor Gary Craig's team[85] explores these issues.

7.4. The quality of services

We identified aspects of good practice in other places, notably Sheffield, Birmingham, Bradford, which could inform the design and implementation of better practice in Hull. We have some specific suggestions, in the following sections, based on these examples, and on the evidence we have gathered.

7.5. Terminology – "Sanctuary" rather than "Asylum"?

Following the recommendation of the Independent Asylum Commission, we favour the term "sanctuary" over "asylum", since the latter appears to have negative connotations for many people. Our proposed "Sanctuary Welfare Board" follows this.

For Hull to join the City of Sanctuary movement (6.6 and Appendices 3 and 4), and become a "City of Sanctuary" would reinforce this change in terminology, and contribute towards the desired shift in public attitudes.

7.6. A Sanctuary Board

There needs to be a "critical mass" of committed senior managers and professionals in the NHS and City Council whose commitment to the health and social care of asylum seekers will result in action.

We recommend that NHS Hull and the City Council set up a Board under the Local Strategic Partnership[86], provisionally called the Sanctuary Board

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[85] Adamson S, Craig G, Wilkinson M. "Migrant workers in the Humber Sub-Region: A report for the Humber Improvement Partnership". Centre for Research in Social Inclusion and Social Justice, University of Hull 2008

[86] Local Strategic Partnerships (LSPs) are non-statutory, multi-agency partnerships which match local authority boundaries. They bring together at a local level the different parts of the public, private, community and voluntary sectors. See: http://www.neighbourhood.gov.uk/page.asp?id=531

(SB), whose task will be to implement and monitor the Strategy for Asylum Seeker Health and Social Care, encompassing all initiatives, statutory and voluntary, to provide health and social care for asylum seekers in Hull.

This "Sanctuary Board" would include representatives from the NHS (PCT, Humber Mental Health Trust, Hull Hospitals Trust), the City Council (Asylum support, Education, Social Services), refugee community organisations (RCO's), and the voluntary agencies, and might also include representation from the police, the Fire and Rescue Service, and from business.

This Board will have leadership at Director level, and an Executive Group of 3 or 4 key staff meeting regularly to manage the work. There should be a staff appointment at manager level with secretarial support, drawn from both host organisations (PCT and HCC).

COST: estimated staff costs for the two support appointments are £22,000 (see appendix 8)

The possibility of collaboration with other members of the Humber sub-Region should be explored, in the context of an expanded remit to include other migrants and excluded groups such as Travellers.

7.7. Better communication between agencies and across sectors.

We found that many of the agencies currently providing health and social care for asylum seekers appeared to be working in relative isolation, especially across sectors (statutory and voluntary), despite an effective bi-monthly Multi-Agency Meeting. In particular there is less effective use made of the voluntary sector by statutory agencies.

The Refugee Community Organisations (RCO's) have recently been brought together by the Northern Refugee Network to meet in a new RCO Forum. This is probably not the appropriate vehicle for achieving better co-ordination, as it is primarily about supporting RCO's.

Services should be more co-ordinated, both by better communication between agencies, and by achieving more willingness to work across sectors. Front-line health services such as GPs and hospitals, schools, and colleges need to be better aware of resources for asylum seekers and refugees.

COST: a budget of £900 is suggested for this function (Appendix 8)

Such cost of enhancing such joined-up working might be a reasonable use for the proposed new "Transitional Impacts of Migration Fund" (see section 1.6).

7.8. Housing as a determinant of health

This enquiry has again revealed the adverse impact of poor quality housing on the health of asylum seekers. We obtained abundant evidence of unhealthy housing from the private sector (but not the Local Authority provided housing). This housing is provided through contracts between the housing providers and the UK Borders Agency.

We recommend that the SB initially request the UKBA Contract Compliance Unit to audit the private sector housing provision in Hull, and take appropriate action. We recommend that the PCT though its Environmental Health section take an active part in ensuring adequate housing quality.

7.9. Better information for new arrivals

Most if not all asylum seekers come from places where the health system is very different from ours. Better information needs to be provided to new arrivals about the NHS, and specifically about the way General Practice operates. They need information in a form that they can assimilate, in their own language, possibly in the form of a video/DVD[87], (see 5.4).

COST: for 100 DVD's £500 (less if channelled through the voluntary sector)

Front-line health workers should not assume that asylum seekers have understood the complexities of the NHS after a single introductory session.

Housing providers should be offered help in their role in guiding new arrivals through the process of registering with a GP, dentist, and other parts of the NHS.

7.10. Destitution – a health risk

Our survey of destitute asylum seekers suggests that there are of the order of 100 destitute individuals in Hull (but this could still be an under-

[87] The Black Health Agency in Manchester has one, developed by Dr Pip Fisher: http://www.blackhealthagency.org.uk/index.php/Section85.html

estimate). Compared to other cities (such as Sheffield, Leeds, Liverpool) Hull makes very little provision for these.

The Princes Avenue Methodist Church Hardship Fund supports about 4 in hostel accommodation, and gives food bags and small cash sums to destitute, and food bags to those in need who receive NASS or Section 4 support. The 167 Centre also gives food bags.

More co-ordination between the various charities could increase the availability of emergency and short term housing for destitute asylum seekers.

We therefore recommend that through its links with the voluntary sector the LSP encourage liaison between agencies to maximise support for destitute asylum seekers.

7.11. English for Speakers of Other Languages (ESOL)

We concluded that improvement in English proficiency was a key factor in the health of asylum seekers and refugees. Despite extensive provision of ESOL classes, there appear to be numbers waiting to start classes.

ESOL providers should seek to ensure a fair allocation of resources, if possible preventing multiple enrolments by some at the expense of others.

7.12. Resources for General practice

One of the reasons General Practitioners appeared reluctant to engage in this enquiry is thought to be the perception that good quality care for asylum seekers is costly, and so unprofitable. The PCT should consider developing a special enhanced capitation fee for asylum seeker patients by analogy with the enhanced capitation for the elderly, on the grounds that these patients will require substantially more time for longer and more frequent consultations. £120 has been agreed in Sandwell (sect 5.2). The current average rate is £54.

Such payments would then also cover the costs of the additional letters referred to in the report, for which asylum seekers are clearly unable to pay themselves.

COST: £66 extra global sum per asylum seeker for first 18 mths = £6,600 p.a. (assuming 100 recent asylum seekers)

7.13. Crucial role of interpreters – need for training and support

Interpreters are crucial to the delivery of effective care to this group, most of whom on arrival in the UK have Limited English Proficiency. All interpreters should be properly trained and supported: there are now good guides to best practice for interpreters and health professionals.

NHS Hull and the City Council should commission further training and continuing support for all interpreters registered with the Interpreter and Translation Service. As part of the proposed education plan there should be specific training of clinicians in how to work with interpreters.

COST: quarterly educational meetings for interpreters £1,840 p.a.

7.14. Education of professionals in the specific health needs

Hull's health strategy for asylum seekers and refugees should take account of the known health needs of this group, in particular the high incidence of mental health problems, specific infectious diseases (TB, HIV), vitamin D deficiency, especially in women and young people, and the late physical and emotional effects of trauma and torture. Symptoms must not be attributed to "stress" without careful investigation by a proper history using a trained interpreter if necessary, and full physical examination and investigations. Mental illnesses must be diagnosed with the same thoroughness, and the role of interpreters is even more important here.

We found wide acceptance by frontline clinical staff of the need for further education around the health needs of and care for asylum seekers. This includes receptionists, nurses and general practitioners. Training should be proportionate to their level of involvement and appropriate to their role. There will be a cost in mounting educational programmes for the various professional groups, but it should be possible for this to be incorporated into ongoing educational activities**.**

Continuing clinical education in refugee and asylum seeker health should be offered across disciplines to all clinicians in Hull.

Resources for providing training include existing Hull services (The Quays, the Trauma Service, Haven) and wider afield (the Medical Foundation in Manchester, Solace in Leeds).

7.15. Mental health needs

Asylum seekers and refugees are at high risk of PTSD, and other significant mental illness. There appears to be insufficient access to specialist mental health care, although referral pathways into mental health in Hull have recently changed, and the impact of the new single point of access system is unclear.

NHS Hull should clarify and disseminate the referral pathways for asylum seekers and refugees into mental health services including the commissioning of specialist PTSD care.

COST: the cost of a proposed PTSD service for asylum seekers and refugees would be £35,000 (see Appendix 7 for full costings).

7.16. Vulnerable families and children

Asylum seekers who are under 18, both unaccompanied children and children in families, have special needs, and are provided for in special ways. Health care for this group must be closely monitored and if necessary training provided for front line professionals.

Haven and CAMHS are an integral part of the service available to this group, providing specialised counselling and therapy for the most traumatised and vulnerable children and young persons.

We recommend that the funding for the Haven project, previously from the Children's Services of Hull City Council, be taken over by the PCT (see Appendix 7 and 8 for more details).

COST: the annual cost of the Haven Project is approximately £70,000.

7.17. Tuberculosis screening

Best practice, especially the Sheffield centre (5.1.7) would point to the routine use of the Quantiferon Gold test for TB screening, as this does not depend on return visits for reading the results, and has been shown to be cost-effective.

We suggest that NHS Hull consult with the Consultants in Communicable Diseases in the Acute Trust about the feasibility of extending the use of the Quantiferon Gold test for routine TB screening of asylum seekers.

7.18. Health records

Best practice points to the adoption of a local Personal Health Record (PHR), similar to that used in Sheffield, with local information set out in all the main languages (5.1.2). NHS Hull should adopt the Sheffield model of the Personal Health Record.

COST: preparation and printing of local information for insertion into the supplied (blue book) loose-leaf record estimate £2,500 (or less)

7.19. Coding of Primary Care records

NHS Hull should ensure that all primary care providers use standard Read codes for asylum seekers and refugees in order to enable proper auditing of services. This could be encouraged by providing one or more computer templates for the systems in use in practices.

7.20. Trafficking

We found, in our limited enquiry, little evidence of trafficking of women and children for sexual or other exploitation in Hull, but are aware that it does happen, and small numbers are known to the Health services. All health professionals need to be aware and able to ask appropriate questions to detect such trafficking in vulnerable people.

Recognising that this is one of the roles of Hull's Wilberforce Institute for the study of Slavery and Emancipation[88], we recommend that steps be taken to raise awareness among health professionals of the possibility of women and children having been "trafficked" for exploitative purposes.

[88] www.hull.ac.uk/wise or contact Professor Gary Craig: g.craig@hull.ac.uk

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Appendix 1 (from the Yorkshire & Humber Regional Migration Partnership's document[89] "Who are migrants?")

Definitions of 'types' of migrants

Below are definitions of the terms for different types of migrants included in the diagram on p.1 of the paper "Who are migrants?".

- **A2 Migrant** – A person from the A2 countries that joined the EU (European Union) in January 2007. The A2 members are: Bulgaria and Romania.
- **A8 Migrant –** A migrant from the A8 countries that joined the EU (European Union) in May 2004. These countries are: Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Slovakia and Slovenia. The A8 are all members of the A10.
- **A10 Migrant** – A person from the A10 countries that joined the EU (European Union) in May 2004, including the A8 Cyprus and Malta. The A10 includes: Cyprus, Czech Republic, Estonia, Hungary, Latvia, Lithuania, Malta, Poland, Slovakia and Slovenia.
- **Asylum Seeker** – A person who has applied for protection under the UN Convention and is awaiting a decision on this application (including those who are at different appeal stages).
- **Cyprus & Malta** – A person from Cyprus and Malta that joined the EU (European Union) in May 2004. Cyprus and Malta are members of the A10.
- **Destitute Refused Asylum Seeker** – A refused asylum seeker who is destitute, and does not receive Section 4 Support.
- **Detained Asylum Seeker** – A person who is detained during the asylum process. This usually occurs as part of the 'fast-track' process.
- **Detained Refused Asylum Seeker** – A refused asylum seeker who is detained. This is usually prior to deportation.
- **Discretionary Leave** – A person who receives leave to remain in the UK as a refugee, granted if a person does not meet the strict criteria of the UN Convention, but for reasons including family reasons and medical cases.
- **Dispersed Asylum Seeker** – An asylum seeker receiving housing n dispersal accommodation and subsistence (financial) support. This is officially called Section 95 Support.
- **EEA Migrant –** A person from countries that are members of the EEA (European Economic Area) which includes the EU plus Iceland, Liechtenstein and Norway. The members of the EEA are: Austria, Belgium, Bulgaria, Cyprus, Czech Republic, Denmark, Estonia,

[89] http://www.refugeeaccess.info/uploads/y&h/RIM_who_are_migrantsNov08v2.pdf (accessed 3/1/09)

Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Italy, Latvia, Liechtenstein, Lithuania, Luxembourg, Malta, Netherlands, Norway, Poland, Portugal, Romania, Slovakia, Slovenia, Spain, Sweden, United Kingdom. Switzerland, although not actually a member of the EEA is often also included in policies applying to EEA members.

- **EU 15 Migrant –** A person from the 15 countries that were EU (European Union) members before the EU Accession countries joined in 2004 and 2007. The EU 15 includes: Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, Netherlands, Portugal, Spain, Sweden, United Kingdom.
- **EU Accession Migrant** – A person from one of the countries that joined the EU (European Union) in 2004 (A10) and 2007 (A2). The accession countries are: Bulgaria, Cyprus, Czech Republic, Estonia, Hungary, Latvia, Lithuania, Malta, Poland, Romania, Slovakia and Slovenia.
- **EU Migrant** – A person from an EU (European Union) member state, including the EU 15 and the EU Accession countries. The 27 EU states are: Austria, Belgium, Bulgaria, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Ireland, Italy, Latvia, Lithuania, Luxembourg, Malta, Netherlands, Poland, Portugal, Romania, Slovakia, Slovenia, Spain, Sweden, United Kingdom.
- **EU Student** – A student from the EU (European Union). This often also refers to people from the EEA (and Switzerland) who have similar rights as members of the EU to financial support.
- **Exceptional Leave to Remain** – A person receiving leave to remain as a refugee, granted if the person does not meet the strict criteria of the UN Convention. It was replaced in 2003 by Humanitarian Protection and Discretionary Leave.
- **Family Migrant** – A person who has come to the UK to join a member of their family, and given a right to live in the UK. This term does not normally apply to EU migrants as they are able to enter the UK in their own right, nor does it normally apply to the family of refugees who are given the same status as the person they are joining, and therefore also classed as refugees.
- **Highly Skilled Migrant Worker** – A person who has entered and can work in the UK under ‘Tier 1’ of the ‘points-based system’ (introduced earlier in 2008). This applies to a person who is seeking highly skilled employment in the UK or are self-employed or setting up a business.
- **Humanitarian Protection** – A person who receives leave to remain in the UK as a refugee, granted if a person does not meet the strict criteria of the UN Convention but faces a real risk of serious harm.
- **Iceland, Liechtenstein, Norway (& Switzerland)** – EEA migrants who are from countries that are not members of the EU. This applies to the

following EEA members: Iceland, Liechtenstein and Norway. Switzerland is often also included in policies applying to EEA members.

- **Indefinite Leave to Remain** – A person who receives leave to remain in the UK as a refugee, granted for a number of reasons including programmes to clear backlogs in the asylum system (e.g. 'Family ILR Exercise' and 'Case Resolution').
- **Induction Asylum Seeker** – An asylum seeker receiving who is in Initial Accommodation (Induction Centre), before being dispersed. This is officially called Section 98 Support.
- **International Student** – A person from outside the UK, who is a student in the UK.
- **Low Skilled Migrant –** A person who has entered and can work in the UK under 'Tier 3' of the 'points-based system'. This applies to low skilled workers to fill specific labour shortages. At the time of writing this was 'suspended for the foreseeable future'.
- **Migrant** – A person who leaves one country and resides in another. In the UK this refers to all people who have entered and live in the UK (i.e. immigrants). In Y&H, the working definition of 'migrant' includes all groups in the diagram (p.1).
- **Migrant Worker** – A person who has left their country of origin to work in another. In the UK, this includes people entering as EEA migrants and those part of the new points-based system.
- **Migration** – The movement of people between different countries. In the UK this is often used in the context of all migrants coming to live in the UK (i.e. immigrants).
- **Non-EEA Migrant Worker** – A migrant worker from outside of the EEA. Non-EEA migrant workers will enter the UK under the points-based system.
- **Non-EU Student** – A student from outside the EU. This may also be used to apply to students from outside of the EEA (and Switzerland). Non-EU students enter and can study in the UK under 'Tier 4' of the 'points-based system' (to be introduced in March 2009).
- **Points-Based System –** New system for migrants from outside of the EEA, to work train or study in the UK. The points-based system contains five tiers which have different conditions, entitlements and entry-clearance checks. There is a points-based assessment to decide if a person qualifies. The five Tiers are: (1) highly skilled migrants, (2) skilled migrants, (3) low skilled migrants, (4) students and youth mobility and (5) temporary workers. The points-based system will be introduced in phases beginning in 2008.
- **Refugee** – A person given leave to remain in the UK as a result of a process which began with a claim and/or assessment for protection under the UN Convention. In Y&H this includes people receiving the

following statuses: Refugee Status, Humanitarian Protection, Discretionary Leave, Exceptional Leave to Remain and Indefinite Leave to Remain.

- **Refugee Status** – A person who has been given leave to remain in the UK as a refugee due to meeting the criteria in the UN Convention.
- **Refused Asylum Seeker** – A person who was previously an asylum seeker, whose claim for protection and subsequent claims and appeals have been refused, with all appeal rights exhausted (ARE). They are also sometimes referred to as failed asylum seekers. This includes people who are on Section 4 Support' and people who are 'destitute'.
- **Section 4 Refused Asylum Seeker**– A refused asylum seeker who accesses Section 4 Support. This consists of housing and (subsistence) vouchers.
- **Skilled Migrant Worker** – A person who has entered and can work in the UK under 'Tier 2' of the 'points-based system' (from 27th November 2008). This applies to 'skilled people' with a job offer who are looking for employment in the UK, or are self-employed or setting up a business.
- **Sub's Only Asylum Seeker –** An asylum seeker who accesses 'Subsistence Only Support'. This is subsistence (financial) support without housing.
- **Trafficked Person** – A person who is a victim of Human Trafficking, and in this context moved from another country to the UK. The UN defines trafficking in persons as "the recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation".
- **Undocumented Migrant** – A person who does not have a valid immigration status either through entering the UK without permission, or because they entered under another status and have stayed beyond the period of time allowed.
- **Unsupported Asylum Seeker** – An asylum seeker who does not access any housing or subsistence (financial) support.
- **Youth Mobility and Temporary Worker** – A person allowed to work in the UK for a limited period of time to satisfy primarily non-economic objectives under 'Tier 5' of the 'points-based system' (from 27th November 2008) .

Appendix 2 – Numbers in Yorkshire & Humber Region[90]

5.3.1 Estimate of Total Number of Refugees and Asylum Seekers in Y&H

The estimated total number of refugees and asylum seekers in the Yorkshire & Humber region is 28,000 – 39,000. This represents 0.5% – 0.75% of the total population of the Yorkshire & Humber region.

5.3.2 Refugees

There are 15,000 – 20,000 refugees estimated to be living in Y&H. Roughly 50% of asylum seekers in Y&H become refugees. Estimating the number of refugees is difficult because there is not accurate data available for every type of refugee that receives status[10], and little information on the number of refugees entering or leaving the region after receiving their status.

5.3.3 Asylum Seekers

There are 5,500 asylum seekers estimated to be living in Y&H at the time of writing:

- 300 – 350 asylum seekers estimated to be in Initial Accommodation (Induction centres)
- 4,400 in dispersal housing and receiving Subsistence Support
- 240 asylum seekers receiving Subsistence Only Support
- 400 Unaccompanied Asylum Seeker Children (UASCs)
- There are also a few unsupported asylum seekers, but there is no estimate of the number

5.3.4 Refused Asylum Seekers

There are 7,500 – 13,500 refused asylum seekers estimated to be living in Y&H.

- 3,500 refused asylum seekers receiving Section 4 Support
- 4,000 – 10,000 destitute refused asylum seekers estimated to be living in Y&H. Estimating the number of destitute refused asylum seekers there are in the region is difficult because there is no clear data on the number of people who return to their country of origin, or those who enter or leave the region.

[90] http://www.refugeeaccess.info/uploads/y&h/RIM_draft_int_stratYH_Dec08.pdf

Appendix 3
The Sheffield City of Sanctuary Manifesto[91]

A City of Sanctuary will be one in which:

Community
- Asylum-seekers and refugees are fully included in the activities and membership of local community groups.
- Host communities receive support to enable them to integrate asylum-seekers and refugees.
- Conflict resolution and mediation services are available to communities experiencing tension over asylum-seekers and refugees.
- The contribution of asylum-seekers and refugees to the city is fully recognised in local media and cultural events.
- Asylum-seekers and refugees have a voice in the media and in local decision-making.
- People in all communities feel safe from harassment, racism and persecution.

Health
- The physical and mental health needs of asylum-seekers and refugees are recognised and supported by health and other services.

Employment
- All asylum-seekers and refugees have the opportunity to engage in constructive activity which is appropriate to their skills and experience, whether through volunteering or paid work (for those with work permission).

Access to Services
- Asylum-seekers and refugees are enabled to access local services, including essential transport.
- Asylum-seekers and refugees have access to adequate legal representation and advice services.

Education
- Asylum-seekers and refugees have access to free English language tuition.
- Skills training and further educational opportunities are available to all.

Children
- The needs of asylum-seeker and refugee children are recognised and supported by schools, public services and local communities.

Housing & Destitution
- Safe and healthy accommodation is available to all people who are in housing need.
- Subsistence support is available from a variety of sources to anyone who is threatened with destitution.

Solidarity
- Local organisations and communities support efforts to inform public debate and policy on asylum and immigration, in order to realise a fairer and more humane asylum system.

[91] http://www.cityofsanctuary.com/sheffield-manifesto

Appendix 4

Process for recognition of a City of Sanctuary[92]

1. The local working group develops its own goals and strategy for meeting the criteria outlined above, in a way that is relevant to their situation. The group maintains regular contact with the national network in order to share reports on progress, ideas and resources.
2. When the local group has achieved its initial goals, it reports to the national network group (composed of all City of Sanctuary working groups) and proposes holding an official launch.
3. The national group may ask questions, make suggestions, or recommend further work that may need to be done.
4. When there is agreement by the national network group that the criteria have been met, the local group holds an official launch, which will be recognised and publicised by the national movement.
5. Following recognition as an official City of Sanctuary, the local group will continue to support the development of a culture of hospitality and to monitor continued progress. Recognition as a City of Sanctuary is not the end of the process, since there will always be further work to do towards the aspiration of being a fully inclusive town or city.

June 2008

[92] http://www.cityofsanctuary.com/resources/criteria

Appendix 5
General comment 14 on Article 12 of the International Covenant on Economic, Social, and Cultural Rights

Article 12 of the International Covenant on Economic, Social, and Cultural Rights very briefly sets out the right to the highest attainable standard of health. General comment 14 provides the UN Committee on Economic, Social, and Cultural Rights' interpretation of article 12. Although not legally binding, the comment is highly authoritative.

• Encompassing physical and mental health, the right to health places obligations on governments in relation to health care and the underlying determinants of health—these obligations include provision of clean water, adequate sanitation, nutritious food, adequate shelter, education, a safe environment, health-related information, and freedom from discrimination.

• Governments have, for example, obligations regarding maternal, child, and reproductive health; healthy natural and workplace environments; the prevention, treatment, and control of diseases; health facilities, services, and goods.

• Governments have an obligation to give particular attention to marginal individuals, communities, and populations, creating a need for as much disaggregation of data as possible.

• Within a country, health facilities, services, and goods must be available in sufficient quantity, accessible (including affordable) to everyone without discrimination, culturally acceptable (eg, respectful of medical ethics and sensitive to gender and culture), and of good quality.

• The right to health is subject to progressive realisation and resource availability.

• Nonetheless, governments must take deliberate, concrete, and targeted steps to ensure the progressive realisation of the right as expeditiously and effectively as possible.

• However, core obligations are subject to neither progressive realisation nor resource availability. Expressly taking into account the Declaration of Alma-Ata, they include obligations to ensure access to health facilities, goods, and services to everyone, including marginal groups, without discrimination; to ensure everyone is free from hunger; to ensure access to basic shelter,

housing and sanitation, and an adequate supply of safe and potable water; to provide essential drugs, as defined under the WHO action programme on essential drugs; to ensure equitable distribution of all health facilities, goods, and services; and to adopt and implement a national public-health strategy and plan of action, by way of a participatory and transparent process.

• The right to health requires opportunities for as much participation as possible by individuals and communities in health-related decision making.

• Governments have an obligation to ensure that non-state stakeholders are respectful of the right to health (eg, do not discriminate).

• Developed states, and others in a position to assist, should provide international assistance and cooperation in health to developing countries (eg, economic and technical assistance to help developing countries fulfil their core obligations). All states “have an obligation to ensure that their actions as members of international organizations take due account of the right to health”.

• Monitoring, accountability and redress are essential. Given progressive realisation, indicators and benchmarks are indispensable if governments are to be held to account.

• The right to health is closely related to, and dependent upon, numerous other human rights, such as the rights to life, education, and access to information.

• In narrowly defined circumstances and as a last resort, the enjoyment of some human rights may be interfered with to achieve a public health goal. For example, quarantine for a serious communicable disease, such as ebola fever, may, under certain circumstances, be necessary for the public good, and lawful under human rights, even though it limits an individual’s freedom of movement.

Appendix 6[93]

TABLE OF ENTITLEMENT TO NHS TREATMENT (Correct as of November 2008) **A judicial review took place on 10/11 April 2008 regarding a failed asylum seeker receiving free hospital treatment. The resultant ruling in the High Court makes it possible for failed asylum seekers to be considered 'ordinarily resident' in the UK, and consequently, entitled to free NHS hospital treatment. Each case must be considered on an individual basis. Unless and until the decision is overturned at the appeal, scheduled during November 2008, the Judge's decision is effectively the law. Guidance has been issued by DH to the NHS which explains the effects of the ruling on trusts and failed asylum seekers. A copy of the full guidance can be linked to from the Asylum Seeker Coordination Team home page.**		
Status	Primary Care	Secondary Care
Asylum Seeker	A person who has formally applied for asylum is entitled to NHS treatment without charge for as long as their application (including appeals) is under consideration. They will have to pay certain statutory NHS charges (e.g. prescription charges) unless they also qualify for exemption from these (see notes section), and will go on waiting lists. Since asylum seekers are entitled to free NHS treatment, they can apply to a general practitioner to register as a patient. Asylum seekers are exempt from charges for NHS hospital treatment.	A person who has formally applied for asylum is entitled to NHS treatment without charge for as long as their application (including appeals) is under consideration. They will have to pay certain statutory NHS charges (e.g. prescription charges) unless they also qualify for exemption from these (see notes section), and will go on waiting lists. Since asylum seekers are entitled to free NHS treatment, they can apply to a general practitioner to register as a patient. Asylum seekers are exempt from charges for NHS hospital treatment.
Asylum Seeker refused but appealing decision.	Access to primary care without charge. As for Asylum Seeker	Access to secondary care without charge As for Asylum Seeker.
Asylum Seeker denied support under Section 55 of the 2002 Act, but still claiming asylum.	Access to primary care without charge. As for Asylum Seeker	Access to secondary care without charge As for Asylum Seeker.
Failed asylum seekers – including those getting Border & Immigration Agency (BIA) Section 4 support while awaiting departure from the UK	GP practices have the discretion to accept such people as registered NHS patients. In cooperation with the Home Office, DH will review access to NHS healthcare by foreign nationals this year. The review will include access to both primary and secondary care and will look at a range of issues relating to immigration and asylum arrangements, particularly the eligibility of failed asylum seekers and the status of children, whether accompanied or unaccompanied, as well as public health issues. Emergencies or treatment which is immediately necessary should continue to be provided free of charge within primary care to anyone, where in the clinical opinion of a health care	For secondary care, failed asylum seekers who are not considered ordinarily resident in the UK are not generally eligible for free hospital treatment. However, immediately necessary treatment to save life or prevent a condition from becoming life-threatening should always be given to failed asylum seekers without delay, irrespective of their eligibility for free treatment or ability to pay. However if they are found to be chargeable, the charge will still apply, and recovery should be pursued as far as the trust considers reasonable. Any course of hospital treatment already underway at the time when the asylum seeker's claim, including any appeals, is finally rejected should remain free of charge until completion. It will be a matter for clinical

93

http://www.dh.gov.uk/en/Healthcare/International/asylumseekersandrefugees/index.htm?IdcService=GET_FILE&dID=176615&Rendition=Web

	professional this is required. N.B. The judicial review ruling has had no effect on Primary Care.	judgement as to when a particular course of treatment has been completed. Treatment which is not immediately necessary, but which is urgent and a clinician considers cannot wait until the person returns home must also be given, even if deposits cannot be secured. Any new course of treatment, begun after the asylum claim is finally rejected, will be chargeable (unless the treatment itself is exempt under the provisions of the NHS (Charges to Overseas Visitors) Regulations 1989, as amended, e.g. TB) – or unless the failed asylum seeker is considered to be ordinarily resident. Trusts should refer to the document "Implementing the Overseas Visitors Hospital Charging Regulations - Guidance for NHS Trust Hospitals in England" for advice on how and when to make the charge in these cases. They should also refer to the guidance on failed asylum seekers and Ordinarily Residents. In cooperation with the Home Office, DH is currently reviewing access to NHS healthcare by foreign nationals. The review includes access to both primary and secondary care and looks at a range of issues relating to immigration and asylum arrangements, particularly the eligibility of failed asylum seekers and the status of children, whether accompanied or unaccompanied, as well as public health issues.
Given Refugee Status (successful asylum seeker or, arriving in the country through a Government initiative, i.e. Refugee Gateway Scheme)	Access to primary care without charge. As for Asylum Seeker.	Access to secondary care without charge As for Asylum Seeker.
Given Discretionary Leave to Remain	Access to primary care without charge As for Asylum Seeker.	Access to secondary care without charge As for Asylum Seeker
Given Humanitarian Protection	Access to primary care without charge As for Asylum Seeker.	Access to secondary care without charge As for Asylum Seeker.

Appendix 7

Asylum Seekers and Refugee Health Strategy Hull
Expansion of Trauma Service

Dr Jennie Ormerod, Consultant Clinical Psychologist, Humber Traumatic Stress Service

Asylum seekers and refugees are a high risk group for post traumatic stress symptoms due to increased likelihood of having experienced traumatic experiences in their own country and also due to the potential of exposure to trauma on resettling in the UK. For asylum seekers this is complicated by the threat of deportation.

This group is a specialist group due to the fact that they will often have been exposed to multiple and prolonged trauma, the complexity of adjusting to a new country and the need to work with interpreters and have an understanding of different cultural backgrounds. For these reasons asylum seekers and refugees would not fall under the usual remit of the trauma service but would be seen as a specialist group.

Proposal

1. Clinical Work

In order for the trauma service to work with asylum seekers and refugees that present with post-traumatic stress symptoms or as is more likely in many cases complex trauma we would need a designated worker. This worker would be part of the trauma service but would work alongside existing services working with asylum seekers and refugees.

a. Currently there is a project in the third sector called the Haven project that works with families seeking asylum. They have a good awareness of psychological issues and currently have an established pathway into child services via Patricia Ross, Consultant Child Psychologist for children. We would propose a triangular referral system in which the Haven project could refer parents to the trauma service and this service and Patricia's service

could link for family work. This would improve communication between organisations that work well together for the family. However this set up would depend on the funding for the Haven project being continued. Currently it is due to run out in March of this year.

b. Secondly the primary care mental health team based at the Octagon work with asylum seekers and refugees referred through GPs in the area. Their remit is 6 – 20 sessions of intervention. We would suggest a stepped care approach through which asylum seekers or refugees suffering from complex trauma could be referred on by this team to the trauma service.

Clinical space would be required to see clients in ideally linked to the Octagon or other services for asylum seekers possibly on Spring Bank.

2. Supervision and Training

There would be a role to offer supervision to the primary care mental health team and to IAPT workers that become involved in working with asylum seekers and refugees. There would capacity to set up and offer training to other practitioners in awareness of issues that asylum seekers and refugees present with.

3. Interpreters

Currently there are no formal support mechanisms for interpreters. This proposal would include setting up and establishing training and support mechanisms for interpreters. There would also need to be a referral pathway established into the trauma service for those interpreters affected by the work in that it triggers off reminders of their own trauma.

4. Costings

For a worker to fulfil these requirements we would need someone with sufficient experience in the area of both trauma and asylum seekers, who is also capable of service development work. This would need to be an 8B Psychologist that has been qualified at least two years ideally with experience in these areas. However we would suggest that would not need to be a full

time post and the roles set out above could be achieved in 3 days a week post. Costings for this post are below: (please note this does not currently include non-pay costs).

	Full-time Cost	**WTE**	**Annual Cost**
Pay Band 8b	53,162	0.60	31,897
Total Pay Costs			**31,897**
Non Pay Costs			Not included
Support Costs @ 10%			**3,190**
Total cost per annum			**35,087**

Appendix 8 – Summary of costs

		Staff	Non-pay	Total
Sanctuary Board support staff	0.5 wte band 5	13,357	2,671	16,028
	0.25 band 3	4,895	979	5,874
Educational programme for interpreters	Assuming ten interpreters, 3 mthly for 2 hours		1,840	1,840
Sector liaison meetings	Six meetings at £150		900	900
MH PTSD service	0.6	35,000		35.000
Patient held record	(generous estimate)		2,500	2,500
Multi language DVD	Based on unit price of £5		500	500
Enhanced global sum capitation	Based on 100 recent asylum seekers @ £120 (currently £54)	6,600		6,600
Total				**69,232**

Budget (approximate) for continuing the Haven Project from April 2009:

Haven project	Manager (p/t) and 2 p/t therapists	70,000		70,000