

Guy's and St Thomas'



NHS Foundation Trust

Resource pack to help general practitioners and other primary health care professionals in their work with refugees and asylum seekers

Written by Dr A Carol Cheal and Dr Brian P Fine
Updated by Dr Judith Eling

Revised June 2012

First edition produced by
The Refugee Health Team LSL September 2004



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Introduction

Do you sometimes see patients who are asylum seekers or refugees?

Do you sometimes have difficulties in working with these patients?

This resource pack is designed to:

- help you overcome the difficulties;
- provide you with useful information;
- make your work more satisfying, and more helpful for your patients.

In the pack we* will detail the common areas of difficulty and suggest useful approaches to each of them.

It is our intention that this pack will be a working tool. Individual pages will be regularly updated as patient needs and available services change.

* 'We, the authors of this Resource Pack, Dr Brian Fine (formerly a GP in Lambeth), Dr Carol Cheal (formerly a GP in Lewisham), have done research and development work into the health needs of refugees, asylum seekers and survivors of torture, particularly in south-east London. We have trained and worked at Freedom from Torture, formerly the Medical Foundation for the Care of Victims of Torture. We attempt to keep up to date in this challenging and changing area of medical work.

We would like to acknowledge the help and encouragement of the following people in the production and updating of this resource pack: Dr Ann Lorek (consultant community paediatrician), Professor Janice Rymer (consultant in obstetrics and gynaecology), Dr Peter Le Feuvre (GP), Dr Paul Williams (GP), The Newham Language Shop, Carmen Rojas (service manager of Three Boroughs Primary Health Care Team) Marcia Martins da Rosa (former Refugee Health Team leader) and the following members and former members of the Refugee Health Team LSL – Azhar Hammadi, Simin Mousavi, Rookmin Singh and Cherrine Ricketts.

The resource pack was updated in 2012 by Dr Judith Eling, GP with the Refugee Service, Health Inclusion Team LSL. Dr Eling has been providing weekly GP clinics for destitute asylum seekers in Lambeth since 2006.

The Health Inclusion Team provides a GP specialist service in partnership with the Pavilion Medical Centre, Lambeth.

Common problems for GPs and primary health care professionals working with refugees and asylum seekers

Do you recognise any of the areas described in the list below?

- Language and interpretation problems
- Patients unwilling or unable to talk
- Differences in understanding of health, disease and treatment
- Lack of time for complex problems
- Lack of knowledge on medical, psychological or social problems
- Multiple physical symptoms with no clear cause
- Bizarre behaviour, extreme distress and psychiatric emergencies
- Discovering a history of rape, torture or other abuse
- Aggressive or demanding behaviour at the reception desk

- People requesting certificates, letters and reports
- Lack of information about patient or their background
- Entitlement to NHS services (primary and secondary care)
- Will asylum seekers and refugees adversely affect targets?
- Who can help me with these complex problems?
- How does the asylum system work?
- What does the legal language around asylum mean?

NB This list can never be exhaustive, but covers most of the issues identified in research work done by a number of groups.

Case Scenario

A 28 year old man comes to the reception desk of your surgery. He speaks little English and is accompanied by another man who speaks slightly more.

They say they have been told they need to see a doctor, but it is not clear why. The friend mentions a cough, and also that they need a letter from the doctor.

The receptionists are very busy, the patient is not registered with the practice and there are no appointments left for the day.

What next?

Language and interpretation problems

Common problems include:

- Patient does not speak English, or a language that you speak
- It is unclear what language the patient speaks
- Patient is unable to communicate with receptionists regarding appointments, etc
- Patient and clinician having difficulties communicating
- Patient is unable to understand the health ideas or concepts that are commonly used by us
- Patient has expectations of our service that are not appropriate
- Patient does not understand how our systems work - in the surgery or in the NHS generally
- Consultations take much longer if there is a language problem

Some suggestions for dealing with these problems:

- Use a professional interpreter
- Use a family member or friend to interpret
- Use a patient advocate
- Use an interpreter from a refugee community organisation (RCO), if available

- Use written language materials - including a language recognition card.

Use a professional interpreter

This should be a trained interpreter. All primary care staff, including GPs and all the staff in a GP surgery, family planning clinic staff, health visitors and district nurses, A&E Staff, can use the Lambeth, Southwark and Lewisham Interpreting Service. Their interpreters are trained in the language of health issues.

Interpreters can be booked in advance for face-to-face interpreting. In an emergency, when there is insufficient time to book a face-to-face interpreter, the Interpreting Service can connect you to a telephone interpreter.

The telephone interpreting service can be used by passing the handset of your phone between yourself and the patient, or by putting the whole telephone on 'hands-free speaker-mode' if possible. Some telephones have the option of an additional handset or earpiece to be plugged in.

For access to the LSL Interpreting Service, see below. For GPs and GP staff you will only need to give the address of your practice. The service is available for telephone interpreting 'out-of-hours', including use by doctors working at SELDOC.

Use a family member or friend to interpret

In an emergency, this may be the only option available to you, but there are obvious disadvantages.

- The patient may not want to disclose information to a family member or friend.
- Children acting as interpreters may be at risk of hearing things which are inappropriate for their age.
- Children may not be able to disclose information in front of another family member.
- The "interpreter" may not understand the concepts or the language of health matters.
- The "interpreter", being untrained, may give you their view rather than translating the patient's own words.

For these reasons it is always better to use a professional, trained interpreter, if at all possible.

Use a patient advocate

Advocates are usually trained interpreters who also have a role in representing the patient's interests. As well as translating the patient's words, the advocate may put forward their own views and suggestions. In a consultation this could be either helpful or confusing.

It is important to clarify the role of the person accompanying the patient at the start of the consultation. Some PCTs are now providing bilingual health advocates rather than interpreters.

Use an interpreter from a refugee community organisation (RCO), if available

Some RCOs can provide interpreters or advocates. They may make a charge for this service. The Health Inclusion Team LSL might know which local RCOs offer this service. Contact them on: **020 3049 4700.**

Use written language materials

Language recognition cards can help receptionists identify the patient's first language and hence find a suitable interpreter. The card can be accessed via the Newham Language Shop website: <http://www.languageshop.org.uk/languageidentification.htm>

Downloadable appointment cards - Newham Language Shop's website has a function which allows a range of appointment cards to be translated into different languages. This function can be accessed on <http://www.languageshop.org/translatedinformation.asp>

Multilingual health resources - The Department of Health (DH) has produced a number of translated leaflets, including a leaflet on the NHS for newly arrived asylum seekers: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/DH_4123594

An extensive list of resources is listed on the former Home Office Refugee Integration Portal Health website (now archived):
<http://webarchive.nationalarchives.gov.uk/20090805000644/http://www.nrif.org.uk/Health/Mental/contributingtothecommunity/index.asp?oi=02-02>

Tips on working with interpreters:

- Try to allow for the fact that a consultation will take at least twice as long with an interpreter present.
- If the interpreter can arrive early and meet the patient briefly before the consultation, this can enable them to establish rapport and possibly save time in the consultation. However, issues such as confidentiality and the appropriateness of this need to be considered.
- It may be worthwhile clarifying the role of the interpreter before the consultation - for example, do they see themselves as having a patient-advocacy role or are they purely there to translate what the patient says.
- It is worth asking the interpreter to tell you if there are any language or cultural problems in translating your words or the patient's words.

Interpreting services for Lambeth, Southwark and Lewisham PCTs

1 Lower Marsh, Lambeth, SE1 7NT

Tel: 020 3049 3913

For booking face-to-face interpreters office hours are from 09.00 – 17.00

When making a booking, please be prepared to give the patient's name, health professional's name, address for the consultation, language name and appointment date and time.

Minimum notice period required to make a booking depends on how common the language is.

For more common languages, most bookings can be made with only a few days' notice, however for rarer languages, at least one week's notice is required.

Language Line

<http://www.language.co.uk>

To access a telephone interpreter
24/7 Tel: 0845 3109900

Please be ready to give your organisation's name, their Language Line PIN code, language name, your name and your occupation and to state whether you require a call-out to the patient's telephone number (Language Line will arrange a three-way call so that you can contact a patient by phone using an interpreter) or whether the patient is physically present.

Usually you will be connected in less than 60 seconds to an interpreter, but for some languages there is a longer wait, so you might ask a receptionist to arrange the call for you and to put you through when the interpreter becomes available.



Language Identification Card

Point to your language and an interpreter will be called

Albanian

Tregoni me gisht gjuhën që e flitni ashtu që të thirret përkthyesi

Amharic

ወደ ቋንቋዎ ያመልክቱና አስተርጓሚ ያመራልዎታል።

Arabic

أشّر إلى لغتك
و سيتم استدعاء مترجم.

Bengali

আপনার ভাষা কোনটা দেখান এবং
একজন ইন্টারপ্রিটার বা দোভাষীকে ডাকা হবে

Chinese

請指出你的語言，我們
便會聯絡一位傳譯員。

Farsi

به زبان خود اشاره کنید تا برایتان مترجم بیاوریم.

French

Indiquez votre langue du doigt et un
interprète sera appelé.

Greek

Υποδείξτε τη γλώσσα που μιλάτε και
θα φέρουμε διερμηνέα.

Gujarati

તમારી ભાષા બતાવો અને દુભાષિયાને
બોલાવવામાં આવશે.

Hindi

अपनी भाषा की ओर संकेत करें, एक अनुवादक बुलाया
जायेगा।

Lingala

Pona monoko y* olobaka
bakobengela yo interprete.

Lithuanian

Nurodykite savo kalbą ir bus
vertejas jums tuoj iškvieštas

Luganda

Londa olulimi lwo mw'ezo era
omuvvunuzi aggya kuyitibwa.

Malayalam

നിങ്ങളുടെ ഭാഷ എന്തെന്ന് ചൂണ്ടിക്കാട്ടുക.
നിങ്ങളുടെ ഭാഷ എന്തെന്ന് ചൂണ്ടിക്കാട്ടുക.

Pashto

مړباني د كړي هغه ژبه را وښايئ چې پرې خبريږئ.
مونږ به ورته ژباړونكي (ترجمان) را وغواړو.

Polish

Wskaz jakim językiem mówisz a
tłumacz będzie wezwany.

Portuguese

Indique a sua língua e será chamado
um intérprete.

Punjabi

ਆਪਣੀ ਭਾਸ਼ਾ ਵਲ ਇਸ਼ਾਰਾ ਕਰੋ ਅਤੇ
ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਨੂੰ ਬੁਲਾਇਆ ਜਾਵੇਗਾ।

Russian

Укажите на ваш родной язык, и переводчик
будет вызван.

Serbo-Croat

Pokažite koji je vaš jezik,
pa ćemo pozvati prevodioca.

Somali

Farta saar luqadda aad ku hadashid si
qof turjubaan ah laguugu soo yeero.

Spanish

Señale su idioma con el dedo y
llamaremos a un interprete.

Swahili

Tafadhali onyesha lugha
yako na mkalimani ataitwa.

Tamil

உங்கள் மொழியை சுட்டிக் காண்பித்தால், மொழி
பெயர்ப்பாளர் ஒருவர் அழைக்கப்படுவார்.

Tigrinya

ናብ ቋንቋኻ አመልክቶ ኣተርጓሚ
ክጽወዕልካ እዩ።

Turkish

Hangi dilde konuştuğunuzu
gösteriniz, tercüman getirilecek.

Urdu

اپنی زبان کی طرف اشارہ کیجئے
اور ایک ترجمان کو بلا دیا جائے گا

Vietnamese

Chỉ vào ngôn ngữ của quý vị và một thông dịch
viên sẽ được gọi đến.

For further copies of this Language Identification Card,
please contact the Newham Language Shop on 020 3373 4000.

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Other problems in communication and establishing rapport

Many issues other than 'not speaking the same language' can result in problems with communication.

Common problems include:

- Cultural issues
- Gender issues
- A history of post-traumatic stress disorder in the patient
- Fear or lack of trust in doctors and health professionals
- Lack of knowledge or understanding of the role of the NHS
- Misunderstandings or misconceptions about the role of the GP.

Cultural issues

People from different cultures may have a different understanding of areas relating to health and disease. These areas of difference may include:

- The significance of particular symptoms
- The understanding of the human body and its systems
- The approach to disease and treatment
- Taboos about discussing certain topics.

For this reason, some patients may be very concerned about having blood tests, for example. Blood may be regarded as having a very specific significance so a patient might be reluctant to have any taken.

It is important to try and understand what the patient thinks about their symptoms and to identify differences between your perception and theirs. Only then can you begin to explain and gain the confidence of the patient.

Gender issues

It may be very important for a patient that they are seen by or examined by a clinician of a particular gender. Failure to be sensitive to this issue may offend very strongly held religious or cultural beliefs, and may disrupt an individual's social functioning within their community.

The gender of an interpreter may also be important, and although it is not always possible to accommodate specific requests, it is worth mentioning this when booking a face-to-face interpreter.

The key issue is to be aware of this possibility, and to be prepared to discuss the problem with the patient, if unable to meet their request. Sometimes the presence of a chaperone may be helpful for the patient as well as for the clinician.

Post-traumatic stress disorder

Patients who are refugees or asylum seekers may have suffered major trauma prior to their arrival in the UK. Estimates of the prevalence of torture suggest that as many as 30% of refugees may be survivors of torture^{1,2}. Many of these patients will have post-traumatic stress disorder (PTSD)³. Amongst the features of this anxiety disorder is the development of extreme anxiety when faced with triggers or stimuli bringing back memories of the original stress. Patients often go to great lengths to avoid situations likely to trigger these memories.

Please remember that triggers of PTSD symptoms may include aspects of a normal surgery situation, such as waiting in a queue, or removing clothing for a clinical examination. These circumstances may bring back unbearably painful memories associated with extreme anxiety.

Sometimes these problems can result in angry outbursts, patients feeling unable to remain in the waiting room, or patients failing to turn up for their appointments.

Fear or lack of trust of doctors and health professionals

Unfortunately, in some countries doctors have been involved in the torture of prisoners. Also, people who inflict torture sometimes claim to be doctors, when they are not. In some countries doctors and other health professionals have a role in providing information to the state about patients.

In these circumstances it is not surprising that patients are sometimes anxious about disclosing information to doctors or other staff. We should be aware of this possibility, and reassure patients of our impartiality and of our professional duty of confidentiality. Patients need to know that we always try to act in their best interests, rather than in the interests of somebody else.

Lack of knowledge or understanding of the NHS

Asylum seekers come from all parts of the globe, and from countries where the health care system may be radically different from the NHS. They may come from a country that does not have a system of primary care at all. Although most asylum seekers are provided with induction packs explaining the system, it is not surprising that many think we can help with problems that are not within our remit.

It may help if we can work out what they are looking for, and then decide who is the best person or organisation to help. This may not be within the NHS at all. We should not assume that we have a responsibility to find a solution for all problems, but we might be able to point patients in the right direction, and perhaps explain a bit more about how things work in the UK.

Misunderstandings or misconceptions about the role of the GP

This follows on from what is said above. If a person comes from a country where there is no GP service, it is not surprising if they do not really know the best way to use our service.

As we strive to make GP services more accessible, it may be that we are the one place where an asylum seeker can get access to a sympathetic ear, and a person who is perceived to have the power to help. Although it is a good idea to try and help, it is also important to ensure that the patient learns how systems work in the UK, and where to get the most appropriate help.

In Lambeth, Southwark and Lewisham, it may be a good idea to refer the patient for further assistance from the Health Inclusion Team .

Cultural differences in approaches to health and disease

- Background
- Issues for asylum seekers and refugees
- Counselling
- Impact of rape and torture

Background

Most of us are aware of cultural differences between diverse population groups in South London. Sometimes these cultural differences can be barriers to the provision of health care.

For example, having epileptic fits may have a significance determined by the culture of the patient. This may result in a reluctance to accept a diagnosis of epilepsy and to take medication. Another example may be the patient who is reluctant to remove clothing for a physical examination, because this is felt to be offensive within their culture.

Issues for asylum seekers and refugees

Among the diverse population of refugees and asylum seekers there are likely to be many cultural differences which we need to be aware of. Of course it is impossible for us to know the culturally determined health beliefs of all our patients.

It is helpful to be aware of these, avoid making assumptions, and enquire sensitively about patients' ideas.

The educational level of the patient will also effect their health beliefs and understanding.

Counselling

One concept which may be alien to some asylum seekers from some areas, is counselling. In some countries in the Horn of Africa, for example, there is a widely held belief in 'active forgetting' - in other words that healing takes place best by not thinking about painful and traumatic experiences⁴. This may work for some people, and they may not like the idea of 'talking therapies' where they are encouraged to discuss their past traumas. Even so, a patient from these cultures might benefit from counselling if it is presented in an appropriate and sensitive way.

Impact of rape and torture

We have said that among asylum seekers up to 30% may be victims of torture^{1,2}. Many female asylum seekers may have experienced rape whilst in prison, as an act of war, or during their escape to Britain.

As well as suffering the obvious physical and psychological consequences, in some cultures a woman who has been raped is regarded by her family as an object of shame and may be cast out⁶. This may complicate the presentation of rape - a woman feels not only the inevitable shame of having been violated, but fears that disclosure of her experience may result in her complete alienation from her remaining family and community.

Issues of rape and torture might emerge when offering a routine examination such as a cervical smear test. This may explain an unexpected reluctance of a patient to undergo a physical examination. The issues around rape and torture are discussed below.

Lack of time

- Lack of time is the most common difficulty raised by GPs and health professionals in working with asylum seekers.

Many of us have had the experience of spending a long time in a consultation with an asylum seeker. We may feel overwhelmed at the idea of seeing an asylum seeker, with a long list of complex problems and a high level of anxiety, in a ten minute appointment. If an interpreter is available, communication is easier, but the consultation is likely to take at least twice as long.

Some suggestions for coping with this difficulty more effectively:

- Prioritise the problems
- Assume that a series of appointments will be needed
- Deal with what is appropriate
- Arrange double appointments, especially if an interpreter is required
- Document your workload

Prioritise the problems

Prioritise - deal with the most urgent problems first. Some problems can wait - don't feel you have to deal with everything at once. Many of the patient's symptoms will be long-standing and cannot be sorted out very quickly.

Many psychosomatic symptoms will improve with time, and with a more settled situation for the patient.

Assume that a series of appointments will be needed

If you deal with the urgent problems first, other issues can be explored in subsequent consultations.

Most patients will appreciate the opportunity to return to see the same clinician over a period of time.

Deal with what is appropriate

Patients may come to you with an expectation that you can deal with all sorts of problems. Some may be outside your remit, and you need to make this clear to the patient. The distress of the patient may be relieved by talking to somebody with appropriate expertise.

This may be:

- A good solicitor
- A caseworker from the Refugee Council,
- A worker from a refugee community organisation,
- A social worker from the Social Services Asylum Team,
- A case worker from the Health Inclusion Team LSL (formerly the Refugee Health Team LSL),
- A specialist from Freedom from Torture (formerly the Medical Foundation for the Care of Victims of Torture)

Complex medical problems may well require investigations or referral to secondary care, as for any other patient. Once again, these problems are sometimes long-standing, and you may need to assess the urgency of any referral.

Arrange double appointments, especially if an interpreter is required

If it is possible to arrange a double appointment whenever an interpreter is booked, this will help.

Also, it may be useful for the interpreter to spend a little time in the waiting room talking to the patient first, and discovering what are the patient's priorities, although the interpreter may not see this as their role.

Document your workload

It is important to document when you are seeing asylum seekers and refugees with interpreters, and to be able to feed back to the PCT the effect on your workload.

Common medical problems

Patients who are asylum seekers frequently present with a variety of symptoms. The causes of these symptoms may be physical, psychological or related to their particular social circumstances, as with any other patient.

However, symptoms in asylum seekers may also be caused by:

- conditions related to their country of origin,
- conditions related to their experiences in captivity, or
- conditions related to their flight from persecution.

Conditions related to the country of origin

These will depend on the country or part of the world that the asylum seeker comes from, and conditions that are prevalent there. They may include:

- Malaria
- TB
- HIV
- Tropical diseases
- Diseases of malnutrition
- Poorly controlled chronic diseases, such as diabetes, hypertension
- Female genital mutilation (female circumcision)

Conditions related to experiences in captivity

These may include conditions resulting from war and civil strife, imprisonment in poor conditions, and torture. They include:

- Traumatic injuries, such as fractures, amputations, bullet wounds, dental trauma
- Conditions secondary to torture, such as shoulder or brachial plexus problems caused by being suspended by the arms
- Unwanted pregnancy, sexually transmitted infections, or ano-genital trauma caused by rape
- Eye and ear problems secondary to head injuries
- Post-traumatic epilepsy
- Increased risk of peptic ulcer and H. pylori infection
- Poorly controlled chronic diseases e.g. diabetes, hypertension
- Diseases of malnutrition
- Psychological problems - see section on 'Bizarre behaviour, distress and psychiatric problems'

Conditions related to flight from persecution

These will be conditions acquired during the journey to asylum, often over a prolonged period of time and in very poor conditions. These conditions include:

- Skin infections and infestations e.g. scabies
- Unwanted pregnancy, sexually transmitted infections, or ano-genital trauma caused by rape
- Gastroenteritis
- Psychological problems, including acute stress reaction and disorientation - see section on 'Bizarre behaviour, distress and psychiatric problems'.
- Establishing - this follows when the person is beginning to settle into their community in the UK, and is characterised as a stage of adjustment
- Integrating - is when the person begins to feel truly accepted, usually some time after the granting of refugee status. It is characterised as a state of acceptance
- Departing - as when an asylum claim is refused and the possibility of return or deportation may arise. It is characterised by a feeling of rejection

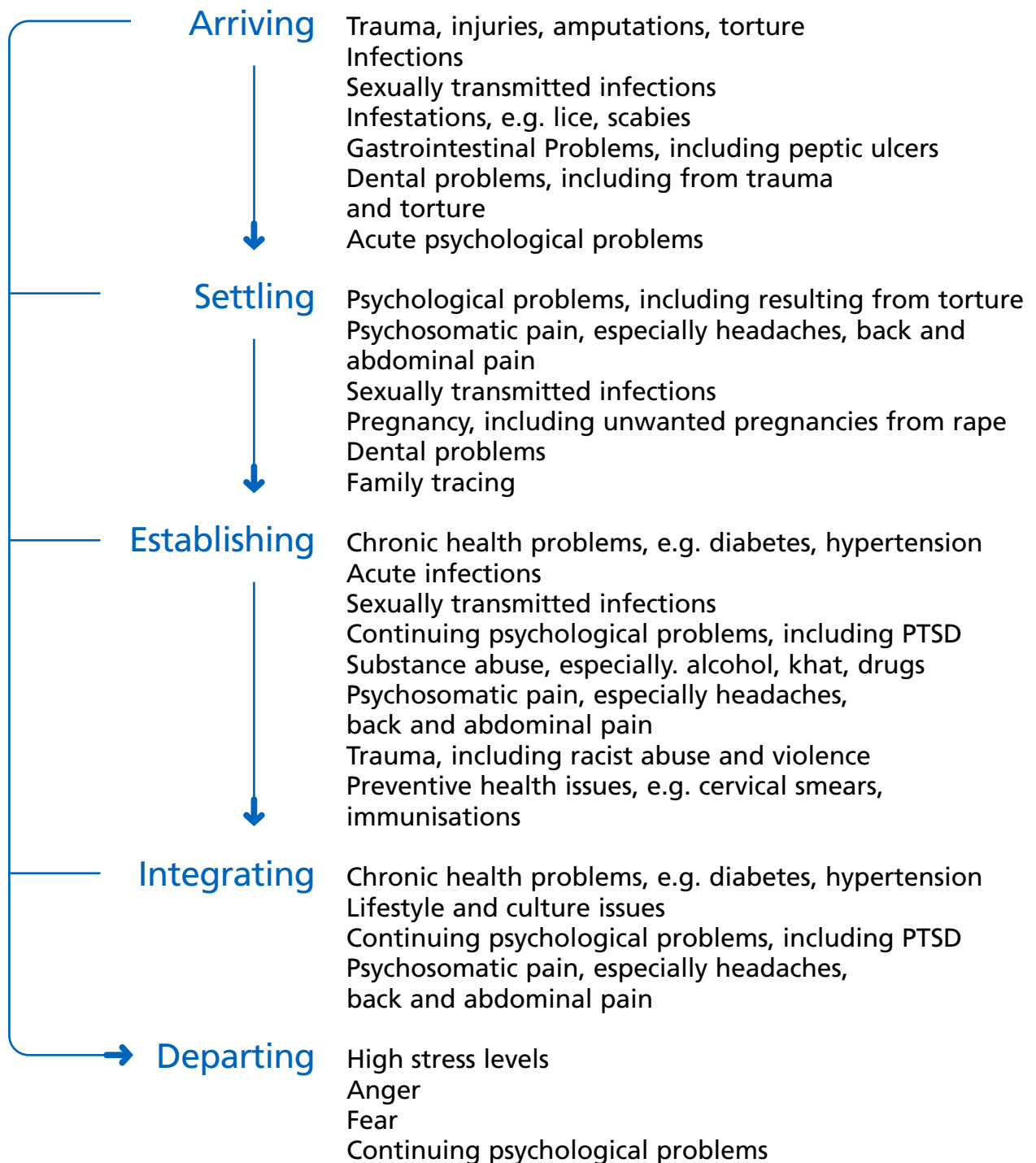
At each of these stages, particular medical and psychological conditions will be more likely to present.

When considering these conditions, one helpful concept is that of 'The Sequence of Need', as described by Dr P. Le Feuvre in 2000. This concept encompasses the idea that the physical and psychological problems of an asylum seeker are to some extent determined by how long they have been in the UK and how far they have got towards being settled here.

The Sequence of Need describes five stages in the process:

- Arriving - this is the stage reached on arrival in the place of asylum, and is characterised by a state of euphoria
- Settling - this is the next stage, when the person begins to feel very aware of what has been lost and that all is not ideal here. It is characterised by a state of disappointment and a feeling of loss

The Sequence of Need (P. Le Feuvre 2000)



What can we do? Who can help us?

How can we respond to these medical problems? A number of basic principles apply:

■ Don't panic

- Assess the situation medically, as you would do with any other patient
- Consider appropriate referrals to secondary care, as with any other patient
- Prioritise problems according to their clinical urgency
- Assume that you will need extra time and follow-up appointments

■ If stuck get advice from

- Hospital colleagues
 - Freedom from Torture:
020 7697 7777
www.freedomfromtorture.org
 - The Hospital for Tropical Diseases:
contact the University College London Hospital switchboard on **0845 155 5000** and ask to be put through to the on-call tropical medicine registrar
<http://www.thehtd.org>
 - The Three Boroughs Health Inclusion Team:
020 3049 4700
www.threeboroughs.nhs.uk
- Remember that some problems resolve over time, and some require some investigation prior to referral

Female genital mutilation

This is a problem which may affect many women from sub-Saharan Africa and the Middle East⁷. It is practised in a wide variety of cultures and is not confined to one religious group. For example, it is estimated that 98% of women in Somalia have had infibulation (see below), 89% of women in Sudan have had infibulation, and 90% of women from Ethiopia and Eritrea have had some form of FGM⁸.

The age at which it is performed varies among different groups, but is usually between two and twelve. FGM is illegal in the UK and has been condemned by the WHO.

What is female genital mutilation?

There are 3 main types of FGM:

Type 1

Clitoridectomy - this involves excision of the prepuce of the clitoris, with or without the clitoris itself.

Type 2

Excision of the clitoris with partial or total excision of the labia minora.

Type 3

Infibulation - excision of part or all of the external genitalia with stitching or narrowing of the vaginal opening.

What are the effects of FGM?

Women may present to health services at various times with problems related to FGM:

- Following menarche, girls may have problems because of insufficient opening left for the flow of menstrual blood - this can lead to haematocolpos.
- They may also suffer from urinary outflow problems leading to recurrent urinary infections.
- Women may suffer from dyspareunia or difficulty with penetration due to a pinhole introitus.
- They may suffer from lack of sexual responsiveness.
- Women may present requesting advice about what help is available to reverse the procedure.
- The most common time for problems to present is in labour - with prolonged or obstructed labour, requiring de-infibulation for delivery to occur.
- There may be a problem following delivery, when relatives or even the woman herself, may ask for her to be re-infibulated (stitched back to her previous state), when repairing an episiotomy. This practice of re-infibulation is illegal in the UK.

What can be done to help with FGM?

Surgical correction of infibulation (de-infibulation) can be carried out at any time. However, for a woman presenting in pregnancy, de-infibulation should be performed electively under anaesthesia at around 20 weeks if possible. De-infibulation can now be carried out under local anaesthetic at the Guy's and St Thomas' NHS Foundation Trust African Well Woman's Clinic (see below).

It is important to know that it is illegal for anyone to take a child out of the UK for the purposes of having FGM performed elsewhere – anyone who suspects this is planned should contact child protection services immediately. There is comprehensive guidance on managing all aspects of FGM in the "Multi-Agency Practice Guidelines: Female Genital Mutilation", published by the Foreign and Commonwealth Office in 2011. This document can be downloaded online at www.fco.gov.uk/fgm

The London Safeguarding Children Board have produced detailed guidelines on what action should be taken to protect children who may be at risk of FGM and also provides other FGM resources:
<http://www.londonscb.gov.uk/fgm/>

There is an African Well Woman's clinic at Guy's and St Thomas' NHS Foundation Trust which is run by FGM Specialist Midwife Comfort Momoh, and she is also available for advice and further information about problems relating to FGM.

Comfort Momoh can be contacted at Guy's and St Thomas' on **020 7188 6872** or by email on comfort.momoh@gstt.nhs.uk

There is a list of other hospitals and clinics in the UK offering specialist FGM services at <http://www.forwarduk.org.uk/resources/support/well-woman-clinics>

Complex or multiple symptoms

Asylum seekers often seem to present with several apparently unrelated symptoms. Consultations may also be compounded by requests for help with non-medical problems.

There may be several reasons for these complex and confusing consultations.

- Lack of understanding of the role of the GP within the NHS system
- Psychosomatic symptoms
- Multiple physical pathology
- Previous abuse, such as torture or rape

Lack of understanding of the role of the GP within the NHS system

Asylum seekers may come from countries with very different health systems from ours, and do not know how the NHS works, or what GPs or A&E departments are for. These difficulties are explained in more detail in the section on 'Other problems in communication and establishing rapport'.

Psychosomatic symptoms

Some or all the symptoms presented may be psychosomatic presentations reflecting the wider problems of this group of patients. These problems include:

- Coping with multiple losses, such as loss of family members, home, social status, language and culture
- Coping with the anxiety associated with going through the asylum process

Finding the time to go into the underlying problems may well be the key to tackling these symptoms.

Multiple physical pathology

Unlike many other young adult patients that we see, asylum seekers may have multiple physical pathology producing multiple symptoms. The pathology is usually the consequence of mistreatment, trauma and deprivation. These traumas may have occurred in prison or captivity in the home country, or during the journey to escape from persecution.

Previous abuse, such as torture or rape

Presentation with multiple symptoms may be a reflection of previous serious abuse, such as torture or rape (of both women and men). It is worth noting that amongst asylum seekers, the incidence of torture is variously estimated at between 5% and 30%^{1,2} depending on definitions used.

Amongst people who have been tortured, it seems to be quite common to suffer from headaches, epigastric pain and back pain⁹. All three of these symptoms may be psychosomatic in origin.

These symptoms may gradually resolve with time and with resolution of the patient's unsettled situation. However, some patients who have experienced rape or torture may require longer term psychological help. They may not wish to discuss their experiences, but if they do, it can go some way towards addressing their problems. Other patients may benefit from a referral for counselling, or to the specialist Traumatic Stress Service (currently via your local Community Mental Health Team), or to Freedom from Torture.

Nevertheless, it is important to bear in mind the possibility of physical causes for these symptoms. Headaches may be related to previous head injuries. If there are associated fits or funny turns, it might be wise to refer to a neurologist for investigation of possible post-traumatic epilepsy. Epigastric pain may follow changes in eating patterns and perhaps having a very inadequate diet in prison. *Helicobacter pylori* is more common in prisoners and it is worth checking for this. Stress-related peptic ulceration is also more common in this population. Back pain may be related to beatings and suspension while in captivity. Torture survivors may have been suspended for prolonged periods of time from ropes or chains attached to their wrists or ankles. They may also have been kept in uncomfortable or cramped conditions, being unable to lie down or stand up straight.

It is therefore worthwhile asking patients who present with multiple symptoms whether they have suffered mistreatment in the past.

The presentation of these patients has many parallels with that of survivors of other forms of abuse, such as child sexual abuse. As we know, it may be a long time before a patient feels able to disclose the underlying cause for a physical symptom.

Bizarre behaviour, extreme distress and psychiatric problems

Aspects to be considered in this section include:

- Acute stress reactions
- Cultural variability in reaction to distress
- Depression
- Post-traumatic stress disorder (PTSD)
- Substance abuse
- Suicide risk
- Psychotic illness
- Vulnerability and resilience

Acute stress reactions

Patients who are asylum seekers sometimes present with behaviour or symptoms suggestive of mental health problems. This behaviour can be quite bizarre or dramatic. However, before making a diagnosis of a formal mental illness, it is worth considering whether this could be a normal reaction to a highly stressful situation. Remember that many asylum seekers will have only recently experienced imprisonment, torture, escape, danger and fear.

These people may now be in a situation where they do not speak the language, they do not understand how society works in the UK, they lack family or other social support and they do not know if they will be allowed to remain in the country. In these

circumstances it is not surprising that what may seem to be a relatively minor frustration can trigger a disproportionate reaction. This does not mean that the patient is mentally ill.

Cultural variability in reaction to distress

Asylum seekers come to the UK from all parts of the world. People react very differently to stressful situations in different cultures¹⁰. It is important to consider whether the patient's presentation is a normal reaction in the context of their own culture.

This can be quite hard to assess, but another person from the same background as the patient may be able to clarify things. Contacts with refugee community organisations or discussion with a member of the Health Inclusion Team LSL might be helpful.

Depression

Asylum seekers are particularly vulnerable to depression¹¹. They have suffered many losses and are in a new and uncertain situation. Symptoms suggestive of depression should be assessed as with any other patient, and appropriate treatment and referrals considered. The risk of suicide should always be assessed (see below).

Post-traumatic stress disorder (PTSD)

PTSD is an anxiety disorder triggered or caused by one or more very severe traumatic experiences. The diagnostic criteria^{12,13} state that it occurs within six months of the trauma and that

symptoms last for at least one month.

The symptoms include:

- Re-experiencing the trauma as flashbacks, nightmares or other intrusive memories
- Avoidance behaviour - avoiding any situation which may trigger memories of the trauma.
- Emotional numbness and feeling detached.
- Hyperarousal - including irritability, angry outbursts, poor concentration and insomnia.

PTSD is relatively common amongst asylum seekers³, particularly those who have experienced torture, rape, violence or war. These experiences are very common amongst asylum seekers - it is estimated that between 5% and 30% of all asylum seekers have been tortured^{1,2}.

The symptoms of PTSD can be extremely disabling, making it even harder to cope with the difficulties experienced as an asylum seeker, such as poor housing, lack of finances and lack of activity. It may result in difficulties in dealing with authority figures, who bring back memories of the original trauma, or in dealing with frustration, and can be one of the reasons for problems occurring in GP surgery waiting rooms.

PTSD sometimes settles by itself, over a period of time¹⁴, and is particularly helped by developing a new social support network - if the patient can develop links within the local community or with a refugee community organisation, for example.

In more severe or protracted cases, treatment with an SSRI antidepressant drug can help, as can a range of behavioural treatments or counselling. There are NICE guidelines on the management of PTSD in primary and secondary care (<http://guidance.nice.org.uk/CG26>).

Treatment of PTSD can be very difficult if the patient's life is disturbed and unsettled, perhaps still waiting to hear if they will be given asylum, living in poor quality, noisy accommodation, with uncertainty over the fate of family and friends, and coping with life in a new country. Sometimes these problems have to be resolved before the patient is able to address the problems of PTSD. SSRI drugs can be helpful in alleviating some of the symptoms in the meantime¹⁵.

In more severe cases it might be worthwhile getting help from the Traumatic Stress Service, based at the Maudsley Hospital. Analysis of the evidence for various approaches to treatment of PTSD suggests that trauma-focused cognitive behavioural therapy, and eye movement desensitisation and reprocessing (EMDR) are the best forms of treatment. These forms of therapy are only likely to be available from tertiary centres such as the Traumatic Stress Service.

From 2004, referrals for treatment at the Traumatic Stress Service are only possible from secondary care, so you will need to refer the patient to your local Community Mental Health Team (CMHT) first.

Finally, it is always important to remember that PTSD is an independent risk factor for suicide (see below). If the patient is exhibiting suicidal thoughts or plans, an urgent referral to your local CMHT should be considered.

Substance abuse

Asylum seekers arriving in the UK since October 2002 have not been allowed to work, and there are severe restrictions placed on them even doing voluntary work. This may mean that many of them have very little to do, apart from worrying about their circumstances. They also are living on very small amounts of money (the amount provided by NASS is set at 70% of income support levels).

One result of this lack of activity and frustration, sometimes combined with intolerable symptoms of PTSD (see above), can be the use of alcohol or other recreational drugs as a coping mechanism¹⁶. Some of these drugs may not be illegal, such as the practice of chewing Khat leaves, which is common among people from the Horn of Africa. khat contains chemicals that have a euphoriant and stimulant effect, somewhat akin to amphetamines.

The excessive use of drugs such as alcohol and khat can lead to problems of depression, lassitude, abdominal pain or overt psychiatric problems. There is concern in some communities about the excessive use of khat amongst young Somali men, for example, and the risk that reducing the intake of khat may lead to an increase in the consumption of alcohol or other drugs.

Suicide risk

As a group, asylum seekers often have a number of known risk factors for suicide. These risk factors include relative young age, unemployment, lack of social support (e.g single, separated, loss of supportive community). There will also be significant numbers coping with continuing long-term painful symptoms as a result of torture.

In addition, as already stated above, many asylum seekers will also have psychiatric illness that increases the risk of suicide, such as PTSD or depression, or sometimes both of these together.

In these circumstances it is always important to make a clear assessment of the risk of deliberate self harm or suicide in asylum seekers with psychiatric symptoms, exactly as one would do for any other patient.

Patients with these background risk factors for suicide may be at particularly high risk of suicide at certain times. These triggers may include rejections such as Home Office refusal letters (refusing the asylum claim), or legal rulings rejecting the claim for asylum. Significant numbers of asylum claims are incorrectly rejected, being accepted at a later stage of appeal. A patient with multiple risk factors, having fled from persecution and torture to claim asylum in the UK, may attempt suicide when the legal system appears to reject his or her story.

Psychotic illness

Asylum seekers and refugees, like anybody else, may present with symptoms suggestive of psychotic illness. There is considerable debate as to whether severe and enduring mental illnesses such as schizophrenia are more common amongst refugees in the UK. However, it is always important to consider whether symptoms are a culturally appropriate response to stress, rather than a manifestation of a psychotic illness (see page 24).

Nevertheless asylum seekers and refugees may develop schizophrenia or other severe mental illnesses, and should be treated as any other person with these illnesses. It is worth trying to establish whether the patient had a history of mental illness before they left their home country, and, if so, how this was managed. If they do have a severe and enduring mental illness, it is possible that the stresses related to their persecution, and then their flight from persecution, may trigger an acute episode of mental illness.

When a patient appears to have a psychotic illness, it is very important to ensure that there is good clear communication with the patient, using an interpreter whenever possible. Getting advice on responses to stress in the background culture is always helpful in attempting to understand what is going on.

Vulnerability and resilience

When thinking about the mental health of refugees and asylum seekers, it is important to keep in mind that there are factors putting them at increased risk of mental illness. These include multiple losses, low self-esteem, lack of support, worries and guilt about family or others left behind.

Equally there may be factors that confer strength and resilience to them. In order to seek asylum, a person may have survived and then escaped from a very hostile and dangerous situation, and subsequently survived a long and dangerous flight to safety. This suggests that the asylum seeker may well have significant strengths.

In fact many asylum seekers reaching the UK are highly educated and qualified people, from a professional background, or people who had businesses in their home country, until the problems arose that led them to flee and seek asylum. The fact that they have managed to reach the UK suggests that they have personal qualities of drive, assertiveness and enterprise.

The process of seeking asylum in the UK can itself be dispiriting and demoralising, resulting in loss of self esteem and feelings of guilt and despair. In these circumstances it can be helpful to encourage the patient to focus on their strengths, skills and achievements, both in their life before they left their home country, and also in the ways in which they have managed to survive since they left.

Discovering a history of rape, torture or other abuse

According to different studies, up to 30% of asylum seekers may be survivors of torture^{1,2}, so we need to have this possibility in mind when seeing a patient who is an asylum seeker or refugee.

In considering these issues there are three main areas of difficulty:

- Establishing a diagnosis
- How to help a patient once the history emerges
- How the doctor, nurse or health professional copes with these issues emerging

Establishing a diagnosis

Possibly the biggest problem in helping these patients is the natural reluctance to disclose what has happened, or to talk about it¹⁷. Torture and rape are similar in their effects to other abusive disorders, such as child sexual abuse. Patients often feel an overwhelming sense of shame and guilt, a loss of self esteem, and often a major change in the way in which they feel about themselves. Non-sexual torture is probably more common in male asylum seekers and rape is more common in women, but both occur in men and women.

One clue may be patients presenting with unexplained symptoms, such as headaches, abdominal pain or back pain, or with multiple minor symptoms. In these circumstances, it is always worthwhile considering the possibility of torture or rape, and asking about it. The late disclosure of these experiences is well documented¹⁸, and may not emerge for many years, exactly as with child sexual abuse.

The important point is to be aware of the possibility of rape and torture amongst this group of patients.

One issue for the clinician is how to have the confidence to ask patients about these areas. We will deal with this later. What is clear is that if the patient does not spontaneously disclose their experience, it is not likely to emerge if we do not ask.

How to help a patient once the history emerges

Once a history of torture and/or rape emerges, a number of important areas relating to management follow.

- If a woman or child has been raped recently, the possibility of pregnancy must be considered.
- If a pregnancy has resulted, complex issues around the continuance of the pregnancy or termination of pregnancy must be explored.
- In either male or female rape, the possibility of a sexually transmitted infection (including HIV) must be explored and excluded.
- In either male or female rape, the possibility of ano-genital traumatic injury should be considered.

- In the case of non-sexual torture, precise details of exactly what was done should be elicited. This will help the doctor to identify possible physical consequences. Amongst the more common consequences are shoulder or brachial plexus injuries as a result of the patient being hanged by their wrists, a process called suspension¹⁹. Other common problems are ear or eye damage, and dental trauma, but the consequences of physical torture should be thought about as in any case of trauma.
- Probably the biggest areas of disability and disorder resulting from torture and rape are the psychological consequences. These include depression, PTSD, other anxiety disorders, psychosexual problems, uncertainty about sexual orientation (particularly in men), loss of a sense of self worth and self esteem. These problems need to be managed as with any other patient, using the resources available in primary care as well as specialist services, and possibly the help of specialist organisations such as the Freedom from Torture.
- As well as the effects of torture or rape on the individual, clinicians should consider possible effects on other members of the family, the partner or children. They may have witnessed aspects of the torture and rape, and certainly will be living with the consequences. Sometimes a family approach to care is appropriate.

How the doctor, nurse or health professional copes with these issues emerging

There are several issues for the clinician in dealing with a patient with a history of torture or rape. These include:

- Anxiety about how the patient will react when talking about their experiences
- Anxiety about how the clinician will cope when hearing about the brutality experienced by the patient
- Anxiety about what to do next, once the history emerges
- Linked to the above, anxiety about where to get help in dealing with the patient
- Concerns about how much time will be involved in dealing with the patient, once the history emerges

Anxiety about how the patient will react when talking about their experiences

Many clinicians express anxiety that the patient may become acutely distressed, or break down in some other way, or even become suicidal, if a history of previous torture or rape is brought out into the open.

In fact, it is likely that the patient will be very distressed when talking about aspects of their mistreatment and abuse. The aspect that is most distressing will, of course, vary from patient to patient. However, although tears may be shed and some anger expressed, it is highly unlikely that the patient will become more overtly unwell than they are already.

The patient will not talk about these matters until they feel safe enough to do so, and this depends to a large extent on the openness of the clinician to hear their story. For many patients it will be a matter of great relief that a professional they respect is prepared to hear the story and deal with their concerns about the consequences of their mistreatment.

Once a history of torture, rape or other abuse or mistreatment emerges, it is important to organise follow up for the patient. It is likely that they will have very mixed feelings afterwards, and will find it hard to sleep or function for a few days following disclosure. Follow up with the clinician will therefore be vital, to reassure the patient that they should expect to feel the way they are feeling, and that they are not going mad.

Anxiety about how the clinician will cope when hearing about the brutality experienced by the patient

Many doctors will feel and sometimes say that they do not know how they will cope if they hear stories of terrible brutality committed against the patient. Discussing torture is not a commonplace clinical experience, and usually one that we are not prepared for in our training. Nevertheless, there are parallels with hearing stories of child sexual abuse, for example, which may also remain undisclosed for many years.

In fact these concerns about our own feelings are very appropriate. As when hearing other stories about patients' abuse or traumatic experiences, the clinician ends up "holding" a lot of unpleasant feelings. Clinicians should ensure that they have a source of support in relation to these difficult consultations. This could be a colleague, a professional support group, another member of the team, or a partner or friend.

Problems will only arise if nobody is available to discuss the case, and the emotions engendered in the clinician. In these circumstances it is worthwhile trying to contact a colleague who has experience in this area. Most of them would be only too happy to discuss the case, as they will have been in the same situation themselves. Possible local contacts are listed in the section on 'Sources of help with these Complex problems' on page 50.

Anxiety about what to do next, once the history emerges

Once again, a common concern of doctors is that they will not know what to do if the patient starts to talk about being tortured or raped. This will not be a common experience for the doctor and the doctor is unlikely to feel prepared for this.

In fact, it is likely that the patient will also have these uncertainties. The whole point about the effect of torture and other abuse is that it is kept secret, protected from view by a veil of shame, guilt and fear. However, the first and most important aspect of disclosure is that it is extremely helpful for the patient simply to have a health professional to hear the story, and not to be rejected by that clinician. All that is required in the first instance is the time and the willingness to hear the story.

Once the details begin to emerge, and this in itself may take some time or several appointments, then decisions can start to be made about what the further management should be, and this will, of course, depend on the details of what actually happened.

There may well be important aspects of investigation or medical management, such as the need for screening for sexually transmitted infections, or for referral for orthopaedic investigation or for physiotherapy. With disclosure, aspects of psychological management can be considered, depending on the symptomatology and diagnosis. It may well be appropriate to consider discussing the case with a colleague with more experience in the field. Possible contacts are listed in the section on 'Sources of help with these complex problems' on page 55.

Many of the concerns about 'what to do next', are really a concern about how the clinician will feel or cope with hearing the details of the story, and this should be considered as described above.

[Linked to the above, anxiety about where to get help in dealing with the patient](#)

This theme has been touched on in several places before. There are two important aspects to this concern. The first is that although dealing with torture or rape can never be an easy or straightforward business, it is not fundamentally different from many other tricky consultations that GPs and other clinicians frequently deal with.

We see other patients with problems and anxieties that have been kept secret for a long time, such as sexual abuse, and we develop increasing confidence in dealing with these problems by realising that there is no magic solution. The patient must be given the time they require, and their symptoms, concerns and perceptions explored.

The second aspect is that there are clinicians and organisations that deal with torture much more frequently who would be available to give advice. Locally we have the Health Inclusion Team LSL and the Traumatic Stress Service. In North London there is Freedom from Torture, formerly the Medical Foundation for the Care of Victims of Torture. Contacting these organisations, as well as generic services in secondary care may be very helpful for us when dealing with patients who have experienced torture. The contact information for these organisations are given in the section on 'Sources of help with these complex problems'.

Concerns about how much time will be involved in dealing with the patient, once the history emerges

When a patient discloses a history of torture or rape, it is not possible to deal with this quickly. It will be a major decision for the patient to tell you about what happened, and they need to be listened to. This will inevitably take time, usually more than the time allotted for the consultation.

This situation is, of course, no different to that of any patient disclosing a major problem in their life, such as the fact that they are deeply depressed, possibly suicidal, or the disclosure of other significant traumas, such as sexual abuse or rape.

Following on from this first disclosure, we should expect the patient to need quite a lot of time. This is perhaps something that should be discussed from the outset, with plans made as to when we can see them again, and the amount of time we can devote to the process of exploring the story.

There are options available to the clinician. It may be decided that the story would be best explored in detail by another member of the practice team, such as the practice counsellor, or by another counselling agency. Equally, the clinician may feel that an early referral for an assessment in secondary care is best. Discussing the case with a specialist in the field, as detailed in the section on 'Sources of help with these complex problems' may be helpful in deciding whether the clinician initially hearing the story is the best person to allocate further time to the patient.

It will be important to explain your thoughts on further care with the patient, to ensure that both they and you are realistic about what can be offered, and to prevent the patient feeling rejected if you are referring them to another professional.

Children's problems

Children who are asylum seekers or refugees not infrequently present to primary care providers. They may be a member of a family, or living with a relative. Sometimes they are alone, and are officially classified as 'unaccompanied minors' (minors in this context means aged under 18).

These children may have a number of problems related to being asylum seekers or refugees. There may also be challenges or problems for practices in managing these patients. These issues include:

- Interpretation and advocacy
- Immunisation problems and possible effects on meeting targets
- Trauma and sexual violence
- Disturbed behaviour
- Medical problems
- Issues for unaccompanied asylum seeking children
- Child protection issues

Interpretation and advocacy

Children may be recruited to act as interpreters for older members of their family, if their English is better. Although this may sometimes be unavoidable, it is generally considered to be unacceptable. Children should not be put in a position of hearing things about older family members that are not appropriate for them to hear. Therefore it would be useful to have interpreters present.

Equally, many child refugees may have had experiences that they might not wish their family members to hear, and so should also be offered the opportunity to have an interpreter. It is important to remember that many child refugees will be suffering from depression or post-traumatic stress disorder as a result of their experiences, and a significant number of them, particularly the girls, may have been raped. In view of this, the gender of the interpreter should also be considered.

Further information on interpreting can be found in the section on language and interpretation problems.

Unaccompanied children may need some help in understanding and negotiating new systems, such as appointment systems. This help might be provided by a social worker, as unaccompanied asylum seeking children are the responsibility of social services.

Immunisation problems and possible effects on targets

All children should be included in the relevant immunisation schedules, as for the rest of the population. Problems arise for a number of reasons.

- The child and their parent/carer may not know or have the details of immunisations that the child has already received.
- The country of origin of the child may have a different immunisation programme to that currently in place in the UK.
- Primary care clinicians may well not know what immunisations to give, or how to implement a catch-up immunisation programme.
- Unimmunised children may prejudice immunisation targets, and adversely affect practice budgets.

Sources of advice and help are given below, and the current schedule for undocumented or incomplete immunisations is at the end of this section on children's problems. Our experience of refugee families is that they are usually very keen for their children to be protected by immunisation, and will readily comply with plans, if these are explained to them.

Trauma and sexual violence

Child refugees may be survivors of war trauma or accidents resulting from the process of escape from their home country. They may have been tortured themselves or subjected to sexual assault or rape. These children may require screening and follow up for sexually transmitted infections or pregnancy. A recent study of unaccompanied children attending a local community paediatric department revealed that one in three of the girls had been raped, as well as several boys²⁰. Some vulnerable children have been abused since arriving in the UK, and the risk of this should be remembered.

It is not uncommon for child refugees to have witnessed extreme violence before their escape. They may have seen members of their own family or others abused, assaulted, raped, injured or killed.

Less commonly, older children may have been involved in acts of violence against others. There are countries, such as Uganda, the Democratic Republic of Congo and Sierra Leone, in which children have been forcibly recruited into regular or guerrilla armies, and have taken part in or witnessed acts of atrocity²¹.

Disturbed behaviour

The experiences of children escaping from their country, as well as those more disturbing experiences described above, can result in a range of disturbed behaviour. Sometimes disturbance may result from the fact that children are supporting other family members who are grieving or

have mental health problems. The pattern will of course depend on the age of the child, but may include:

- Soiling and secondary enuresis
- Aggressive behaviour
- Behavioural problems in relation to other children, often noted at school
- School refusal
- Disturbed family relationships
- Abnormally sexualised behaviour in young children
- Inappropriate sexual activity or prostitution in older children

When approaching these presentations, clinicians need to be aware of the possibility of undisclosed trauma, as described above²². Sometimes these problems can be helped using the resources available within primary care, though specialist advice may be required.

→ See pages 36 & 37

Medical problems

Children may have any of the medical problems described in the section on 'Common medical problems'.

In addition child refugees may acquire infections such as measles, due to absent or inadequate immunisation. Children, particularly those not living in a stable family unit, may be suffering from malnutrition, and cases of rickets and scurvy are now being identified. Refugee teenage mothers appear to be particularly at risk of being malnourished.

Issues for unaccompanied minors

An unaccompanied minor is the term used by the Home Office to describe a child under 18 outside their country of origin who is not accompanied by a close relative.

UASC (Unaccompanied Asylum Seeking Children) are the responsibility of Social Services. However, it is important to be aware that these children may be placed in accommodation a long way away from their 'home' social services area. This means that they may have very little contact with a responsible social worker. GPs and other primary care clinicians should not assume that somebody is keeping a close eye on these children and their needs.

Some children are age-disputed by UKBA, which means that the Home Office does not recognise their claim to be under 18. The young person can then dispute this Home Office decision with legal help. If they are unsuccessful and are not recognised as being under 18 they will be treated in the same way as an adult asylum seeker, and will not receive any support from social services.

UASC may have many problems, physical and psychological. They are often very lonely and isolated, and may not know what has happened to their family members. Sometimes a referral to the Red Cross International Tracing and Message Service can be very valuable.

These children may well be among the most vulnerable patients in the community. They may have very little external support, and being children may have little relevant experience to draw upon. In addition, if they do not speak English, they may be unable to communicate with others.

Child protection issues

As mentioned above, children who are asylum seekers or refugees can be in an extremely vulnerable position. They may have already been abused before arriving in the UK, but can sometimes be the victims of abuse in the UK.

Tensions within families can be great, and children may receive physical punishments from their parents or carers that can amount to child abuse.

Older children, particularly if they are unaccompanied, may become drawn into prostitution, or may have even been brought into the UK by others, specifically for that purpose. Sometimes children are brought into the UK to work in households as virtual slaves. Although these children may not technically be asylum seekers or refugees, they are at huge risk, and primary care clinicians need to be aware of the possibility that they may be seeing these children.

One specific child protection issue is that of female genital mutilation (FGM). Some refugees come from communities that have a tradition of practising FGM. This is illegal in the UK, and a highly risky procedure to the girl, with possible consequences described in the section on 'Medical Problems - Female Genital Mutilation'. Instances have been reported of refugees attempting to take girls out of the UK to have FGM performed elsewhere. If this is suspected, clinicians should alert the authorities here, in line with local child protection procedures.

Sources of help for GPs and primary care clinicians dealing with children

Medical advice

The Health Protection Agency produces a schedule of "Vaccination for individuals with incomplete or uncertain immunisation status" (see page 38) which should be followed.

In Lambeth, Dr Ann Lorek at the Mary Sheridan Centre is a consultant community paediatrician with a special interest in the health of refugee children.

Tel: 020 3049 4005

Social services

In Lambeth, the Asylum Seekers Team provides specialist social work support to asylum seeking unaccompanied minors.

Tel: 020 7926 0785

The online resource 'Meeting the health needs of refugees and asylum seekers' covers the needs of children, adolescents and unaccompanied minors and is hosted on the website **www.migranthealthse.co.uk**, following the link for DH/NHS Specialist Support.

Family Tracing:

The Red Cross' London International Tracing and Message Services (ITMS) team can be contacted through local Red Cross offices. Their addresses can be found on the Red Cross website

www.redcross.org.uk

Tel: 020 7704 5686.

Internet Resources

The Race and Equality Foundation's 'Better Health website' collects guidance, research reports and weblinks relevant to the health of asylum seekers and refugees.

It can be found at

<http://www.better-health.org.uk/>

The former joint DH/Home Office Refugee Integration website which has now been archived at

<http://webarchive.nationalarchives.gov.uk/20090805000644/>

<http://www.nrif.org.uk/Health/index.asp>

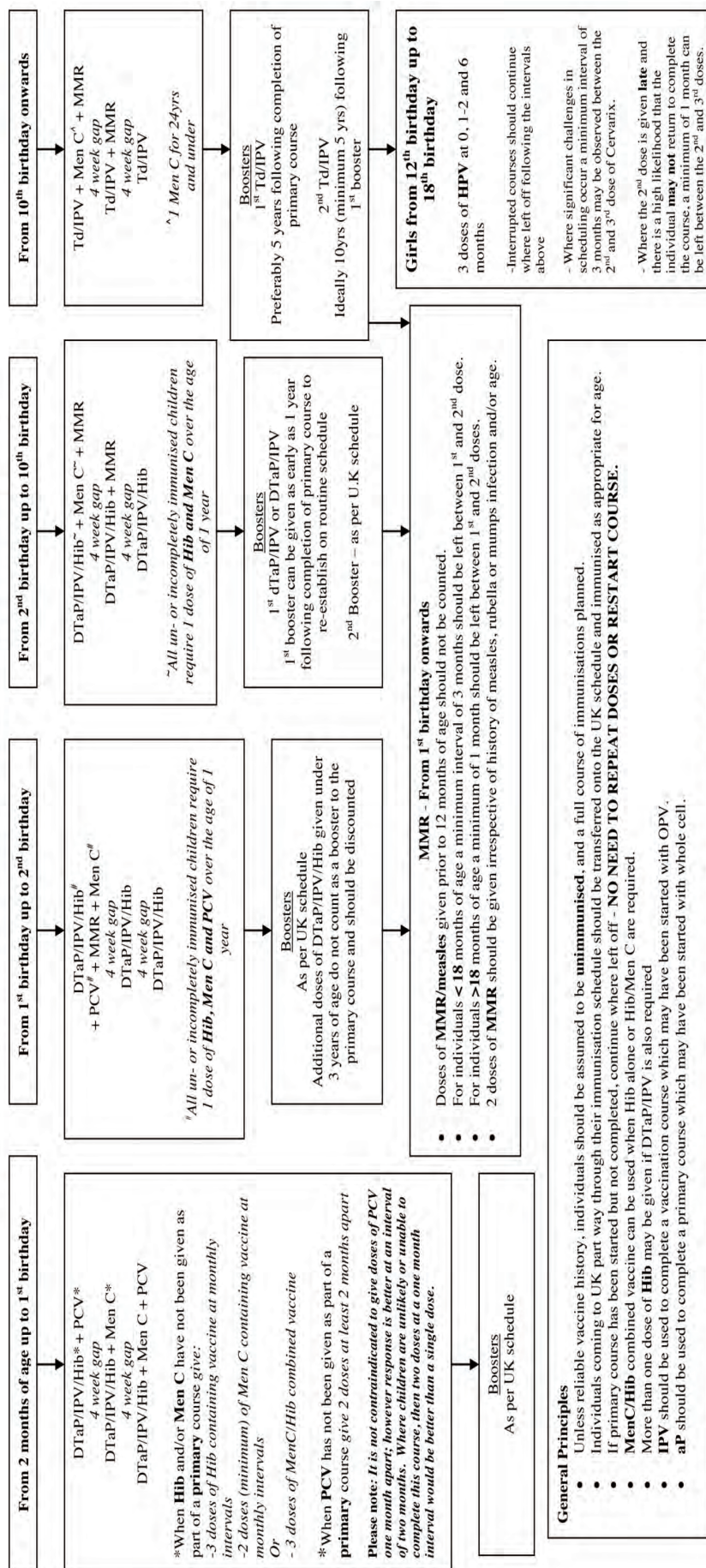
provides information, guidance and examples of good practice to support the integration of refugees and is aimed at health professionals. It has a section providing resources on the health needs of refugee children.



Centre for Infections, Immunisation Department
Last update: April 2010

For World Health Organisation country-by-country vaccination schedules and coverage information, see:
http://apps.who.int/immunization_monitoring/en/globalsummary/countryprofileselect.cfm

Vaccination of Individuals with Uncertain or Incomplete Immunisation Status



Note: BCG and Hepatitis B should be given according to local policy and has not been included in this algorithm.

Aggressive or demanding behaviour at reception desk

Dealing with refugees and asylum seekers at reception will, of course, provide the same potential problems as with other patients, but understanding some of the possible complicating issues might help.

- Language problems
- Patients with PTSD
- Racism among other patients
- Misconceptions about entitlement to health care

Language problems

Offering patients an interpreting service into their own language gives a very positive message that you are trying to be helpful. This in itself may prevent other problems arising.

If it is not immediately clear what language is required, a language identification card at the front desk can help to begin communication. If receptionists have a more private area of the reception counter where they can talk to someone, and perhaps speak via a phone interpreter, this may help to establish what is wanted, and the most appropriate appointment to make. (See also the section on language and interpretation problems and a sample language identification card)

Patients with PTSD

As mentioned in the section on PTSD, patients with this condition suffer from flashbacks and avoidance behaviour. They may become uncontrollably anxious or have aggressive outbursts in certain situations, such as feeling they are not being listened to, or having to wait in a queue. They may also find it difficult to keep appointments. This can be very difficult to deal with in a situation where the surgery is trying to run a service for all its patients and is extremely busy.

However, if staff have some understanding of the factors underlying a patient's behaviour, they are more likely to be able to accommodate the patient without causing major disruption. Receptionists are well aware that patients with other psychological or emotional problems may present in what seems at first to be a challenging manner. Of course, the same rules and policies about aggressive behaviour in the surgery and towards staff must apply to all patients, and practice policies may need to be explained to patients in their own language.

Racism among other patients

In many areas resentment has arisen among existing residents over services given to asylum seekers. This is a very difficult issue and one that certainly arises from policies and attitudes beyond the remit of health services. However, it would seem to be sensible that services for asylum seekers should be integrated as far as possible into the existing health services.

It is an important principle that overt racism will not be tolerated on NHS premises. Practices may wish to develop approaches to dealing with this, if it should arise.

Misconceptions about entitlement to health care

Awkward situations can arise at the reception desk when staff are unsure if a patient is entitled to register for NHS primary care. This can lead to conflict and problems in reception.

As a general rule, all asylum seekers and refugees are entitled to full NHS care, in general practice and in hospital. This question is fully addressed in the section on 'Entitlement to NHS services'.

Another issue that can lead to conflict at the reception desk is that some asylum seekers may have unrealistic expectations of the service. This can arise if they do not understand how the NHS and general practice in the UK works. See pages 10 and 11 for a fuller discussion of this issue.

General principle

Avoiding problems at the reception desk is an important matter for the smooth running of the service. Conflicts and aggressive behaviour can arise from patients of any and all backgrounds. Many practices ensure that training in dealing with demanding or 'difficult' patients is provided for all staff.

People requesting certificates, letters and reports

Asylum seekers and refugees often present with non-health related issues. This may be because:

- They are dealing with basic life issues, for example homelessness and housing, no money for food, or threats to personal safety
- They do not understand the role of the GP
- They do not know who else to turn to for help

Common requests from asylum seekers and refugees include:

- Letters to help appeals against dispersal to UKBA accommodation outside London
- Medical declaration to help in applying for so called Section 4 support from United Kingdom Border Agency (UKBA)
- Letters in support of application for Section 21 support under the National Assistance Act
- Letters in support of housing applications

Letters to help in appeals against dispersal to UKBA accommodation outside London

UKBA provides accommodation and support for destitute asylum seekers who are still awaiting the outcome of their initial asylum application or appeal. This is essential because asylum seekers are not entitled to work or to claim normal benefits, until their asylum claim is decided. The accommodation is allocated on a no choice basis, and virtually all accommodation allocated through UKBA's designated accommodation providers is located outside London and the South East.

Patients sometimes request letters in support of their appeal against dispersal. Some asylum seekers may have contacts and communities in London and may particularly wish to stay here. Equally, there may be established refugee communities in some of the dispersal centres around the UK, with well-established support networks. It should therefore not be assumed that asylum seekers would be in a worse situation if moved out of London.

Particular reasons for being exempt from dispersal include suffering from a condition which requires treatment at the Freedom from Torture or the Helen Bamber Foundation, or having a disability or medical condition that can only be treated in London^{24,27}.

Medical declaration to help in applying for Section 4 Support from UKBA

Section 4 support comprises accommodation and financial support (currently £35.39 in the form of an "Azure" payment card that can be used in certain shops) which is provided to asylum seekers who have been unsuccessful in their asylum claim and meet one of a number of possible criteria. One of the criteria is that the person is "unable to leave the United Kingdom because of a physical impediment to travel or for some other medical reason". The patient would ask you to complete a medical declaration form issued by UKBA in which you are asked to state details of the medical condition that might render the patient unable to travel from the UK, as well as indicating when the patient might be able to leave the UK. If you feel unable to answer all or some of these questions you could indicate to UKBA that you recommend they consult someone more expert such as a travel health professional or an aviation medicine professional. It is very important that the patient understands the implications of submitting the form to UKBA, that is they are agreeing to return to their country of origin once they become medically fit to do so. You might also be asked to provide a MatB1 certificate for a pregnant asylum seeker who is destitute, as this may enable her to apply for section 4 support; in this case you will not need to complete a medical declaration form.

Letters in support of application for Section 21 support under the National Assistance Act

Destitute asylum seekers who have exhausted their appeal rights and do not qualify for section 4 support may be able to apply for section 21 support under the National Assistance Act. This type of support is provided by local authorities, and usually the assessment would be made by their "no recourse to public funds" team. The asylum seeker will only qualify for this support if they have a need for "care and attention", which means they need "looking after" by another person. This means the threshold for obtaining this kind of support is quite high, and usually it is helpful if the patient approaches a welfare solicitor to assist them with the application. However a health professional can make the referral to social services requesting an assessment (social services then have a legal obligation to carry out an eligibility test and an assessment of need). Further information on this process can be found on Islington Council's website http://www.islington.gov.uk/advice/asylumimmigration/refugees_migrants/nrpf/Pages/default.aspx. The patient will require some medical evidence to support their application, which can be a letter from the GP outlining their condition, treatment, prognosis and explaining why the patient has a need to be looked after.

Letters in support of housing applications

If and when an asylum seeker is granted asylum, and so becomes a refugee, s/he loses entitlement to UKBA support after 28 days. Up to this point they have not been entitled to work and earn money, but they can now do so or claim Job Seekers Allowance.

It is often at this time that a refugee will suddenly become homeless and have no means of paying for rented accommodation. They will need to apply to the Homeless Persons Unit of the local authority, and a single man with no dependants is unlikely to be offered housing.

At this stage, a letter from a doctor or nurse can be helpful if the patient is vulnerable. This may be the case if they have a continuing medical or psychological condition, such as from the effects of torture.

GP surgeries should not charge asylum seekers for the provision of letters, reports or statements as the maximum weekly cash or payment card allowance an asylum seeker who is a single person will be able to claim is currently £35.39 and others may have no financial support at all. If the request for a report comes from a solicitor, it may be possible to negotiate a fee for the provision of the letter or report, however given the constraints on legal aid, this may be difficult.

In order to understand some of the possible requests asylum seekers may make, it can be helpful to know about the asylum application system and asylum support services

Getting background information about patients

Background information is sometimes very important for health professionals working with asylum seekers and refugees. This information usually falls into one of two categories:

- Information about the patient and his/her past medical history
- Information about the patient's country of origin

Information about the patient and his/her past medical history

Many asylum seekers, particularly those supported by UKBA, are given hand-held medical records when they arrive in the area. If an asylum seeker has had the opportunity to see a nurse from the Health Inclusion Team LSL, their past medical history may have been documented in the hand-held record.

It is important to ask such patients presenting to the surgery to bring their hand-held record if they have one, as it can save a lot of time in primary care consultations.

Information about the patient's country of origin

Information about a patient's country of origin may be useful in understanding the patient's presentation. It can be helpful and interesting to know about the situation in the country from which he or she has fled. It may also be useful to find out the prevalence of certain diseases, such as HIV, in his or her country of origin.

Sources of such information include:

- 1) The World Guide (2007) - book published by New Internationalist Publications Ltd. Information about every country in the world and is updated and published every two years. Can be seen on New Internationalist website:
<http://www.newint.org/>
- 2) Home Office Country of Origin Information – detailed information covering geography, economy, history, state structures, human rights, chronology and prominent people, for the most common countries of origin of asylum seekers to the UK.
<http://www.ukba.homeoffice.gov.uk/policyandlaw/guidance/coi/>
- 3) The World Health Organisation's Global Health Atlas -
<http://apps.who.int/globalatlas/> has much information, including this Global HIV/AIDS on-line database.
- 4) United Nations High Commissioner for Refugees (UNHCR)'s Refworld website has a vast collection of reports relating to situations in countries of origin.
<http://www.unhcr.org/cgi-bin/texis/vtx/refworld/rwmain>

Entitlement to NHS services – primary and secondary care

This is one of the commonest areas of concern and confusion in relation to health care of asylum seekers and refugees.

The most recent legislative changes in this area are the "Overseas Visitors Hospital Charging Regulations 2011". Guidance on the implementation of this document can be found at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_127393.

These came into force on 1 August 2011 and cover entitlement to free hospital care for different groups of overseas visitors including asylum seekers and refugees. The most important change to the previous legislation is entitlement to secondary care of some groups of refused asylum seekers, which has now been extended and is explained in more detail below.

The BMA Ethics department issued guidance in April 2012 on access to health care for asylum seekers and refused asylum seekers which can be found at

<http://bma.org.uk/practical-support-at-work/ethics/ethics-a-to-z>

The current legal situation in summary is as follows:

- All those with a positive decision on their asylum claim (refugee status, discretionary leave or humanitarian protection) and asylum seekers awaiting a decision on a claim or appeal are entitled to all NHS care without payment. They can register with a GP and receive hospital treatment free of charge.
- Unaccompanied Asylum Seeking Children (UASC) with limited leave are similarly entitled to free health care while their leave remains "current" until a decision is made on the extension application and, if refused, an appeal is finally determined.
- Anyone who has come to the UK under family reunion will not have made an asylum application but will have a passport stamp for leave to remain. They also have full entitlement to health care.
- Refused asylum seekers (those asylum seekers whose application for asylum has been rejected and who have exhausted all appeal rights) are not eligible for free secondary care treatment, except for the following groups:
 - a) refused ("failed" in DH terminology) asylum seekers who are being supported by the UKBA under section 4 or section 95 are exempt from charges.
 - b) refused asylum seekers who make a fresh application for asylum, temporary protection or humanitarian protection will become asylum seekers again and will therefore be exempt from charges until that new application is considered.

c) asylum seekers undergoing a particular course of treatment when their asylum application is rejected or when they stop receiving UKBA support. They will be entitled to free treatment until that course concludes or they leave the country.

- There are currently no DH regulations specifically concerning entitlement of refused asylum seekers to primary care. The DH 2011 overseas visitors secondary care legislation makes reference to primary care in one paragraph. It states that GP practices have the discretion to accept any person, including overseas visitors, to be either fully registered as an NHS patient, or as a temporary resident if they are to be in an area between 24 hours and three months. GPs have a duty to provide, free of charge, treatment which they consider to be immediately necessary or emergency. The DH document reiterates that registration with a GP practice is exclusively a matter for the GP.
- In primary care, entitlement to register does not depend on ordinary residence, immigration status or nationality. Practices can only refuse to register patients if their lists is closed or if the patient does not live in their catchment area or they have some other reasonable grounds. Such grounds must not be related to the patient's race, gender, social class, age, religion, sexual orientation, appearance, disability or medical condition. Therefore practices cannot refuse to register a patient on the grounds that they are a refused asylum seeker.

- Furthermore, there is no mechanism for primary care providers to check immigration status of people registering to join their lists (unlike in secondary care where such mechanisms exist), nor is there any obligation or expectation for primary care providers to do so.

The following treatments are always free of charge, regardless of a person's immigration status:

- Emergency treatment which is provided in a hospital emergency department or walk-in centre. This does not extend to services provided once the patient has been admitted as an in-patient.
- Treatments of certain communicable diseases (i.e. those listed in schedule 1 of the National Health Service (Charges to overseas visitors) Regulations 1989).
- Treatment received at a special clinic for a sexually transmitted disease. Free treatment for HIV has been restricted, but as of October 2012, anyone who has been in the UK for six months or more is entitled to free treatment for HIV. Until then only initial HIV testing and counselling were free for failed asylum seekers.
- Compulsory psychiatric treatment.
- Family planning services.

- 6) Treatment which the treating clinician considers to be 'immediately necessary' must be provided without delay regardless of a person's immigration status. It is not free of charge but must not be delayed or withheld while the person's chargeable status is determined, and must not be withheld if the person is unable to pay in advance. Maternity care, including antenatal, birth and postnatal care, is always considered 'immediately necessary'.

Documentation requested for registration with GP surgeries

The only documents that can reasonably be requested from an asylum seeker when registering are evidence of address (to ensure they live in the practice area), and evidence of identity. This evidence can only be requested if it is asked of all patients registering with the practice.

It may be difficult for some asylum seekers to produce the same type of documentation required of other patients. This applies to both proof of address as well as evidence of identity.

For example, many asylum seekers staying in the London area are lodging with friends or family. They will therefore not be able to produce utility bills or tenancy agreements as proof of address. As they are not generally permitted to work, they will also not have bank statements or other income related documentation. Those staying in UKBA accommodation will generally have an offer of accommodation letter.

It is therefore important that practices use discretion in what kind of documentation is required for registration, for example they might request a letter from a friend stating they are staying with them, or a letter to their current contact address from their solicitor, rather than a utility bill.

Asylum seekers will not be in possession of a passport and will therefore not be able to produce this as evidence of identity. The only photographic ID most asylum seekers will be in possession of is the "Application Registration Card" (ARC card) issued by UKBA as acknowledgement of an asylum application having been made. It is the size of a credit card with a photo, and is currently issued at the asylum screening interview. The interview can be several weeks after arrival in the UK, so until then, an asylum seeker may not have any ID. Some asylum seekers are issued with a "Standard Acknowledgement Letter" rather than an ARC card. For these reasons, it is again important that practices are flexible in the type of ID documentation they request from asylum seekers.

From a legal perspective, any registration policy, practice or criterion which makes it harder for asylum seekers than those with UK national origins to register is likely to be unjustifiable, and so unlawful, indirect discrimination.

Help with prescription charges and other health costs for asylum seekers

Asylum seekers and refused asylum seekers may qualify for free NHS prescriptions, free NHS dental treatment, necessary travel costs to and from hospital for NHS treatment, free NHS sight tests and the full value of and NHS optical voucher towards the costs of glasses or contact lenses.

In order to show exemption from these charges, a patient needs to be in possession of a valid HC2 certificate. This is issued to any person who has a sufficiently low income. To obtain an HC2 certificate, an HC1 form needs to be completed. This is available from many surgeries, hospitals, dentists and opticians.

It is helpful if primary care practitioners can make newly registered asylum seeker patients aware of their entitlement to apply for an HC2 certificate; many would otherwise not be able to cover prescription and other health costs.

UKBA will automatically apply for HC2 certificates for asylum seekers when they first apply for UKBA asylum support, however this does not include all asylum seekers so it is important to check whether the patient has already been issued an HC2 certificate or not.

Will asylum seekers & refugees adversely affect NHS targets?

In the current 'target-driven' climate of primary care in the NHS, some GPs and practice managers express concerns that having large numbers of asylum seekers and refugees on their lists will adversely affect their ability to achieve their targets.

This concern may apply to areas such as childhood and pre-school immunisation targets, cervical cytology targets, influenza immunisation targets, and all the areas that fall within the Quality and Outcomes Framework.

- How realistic are these concerns?
- What can be done to improve uptake?
- What other general measures may be helpful?

How realistic are these concerns about targets?

There is little available data about the uptake of preventive health messages and measures by asylum seekers or refugees, so we can only comment on this on the basis of anecdotal data.

When asylum seekers first arrive in the UK, their main concern is likely to be that of achieving asylum and safety. At this time, they are less likely to be receptive to messages about their long-term health. Also, if an asylum seeker has been subjected to torture, particularly sexual torture, s/he is likely to be somewhat anxious about intrusive or sensitive physical examinations.

It is worth bearing in mind that refugees in the UK come from many parts of the world, where health services and public health information may be completely different from ours.

On the other hand, the main reason that asylum seekers come here is to achieve safety, and so in the long term they are likely to be highly motivated to accept offers of help with their health and that of their family. For example, a number of GPs have remarked that asylum seekers are much more likely to want their children to be immunised against infectious diseases, such as measles, than the background population.

We should not assume that all patients know about preventive health measures or the reasons for them. It is therefore important to establish what patients already know, and what their views are on these health matters. Then, an explanation, using an interpreter if necessary, may be all that is needed.

What can be done to improve the uptake of target-related preventive health measures?

A number of approaches are likely to be of help. These include:

- Patient education about how the NHS works
- Health education targeted at groups who may not have previously received these messages
- Involving other appropriate members of the team, such as health visitors
- Sensitivity to the problems of asylum seekers, such as lack of trust and preoccupation with other matters
- Picking the right time to push the preventive health message - sometimes this means waiting
- Developing good and trusting relationships with these patients

General measures that may be of help

If a practice or other primary care provider has a problem with achieving targets, and this is thought to be related to the particular patient groups in the practice population, it might well be worthwhile documenting the problem, and taking this up with the relevant commissioning body. They will have the same agenda of trying to achieve better uptake rates, and better health for the whole population.

If a practice or an area has a particular need, such as a large number of asylum seekers, it might be possible to have this problem recognised and additional funding found through the system of 'Enhanced Services'.

It is possible that particular work can be done by refugee health teams in getting the message across to relevant patient groups about the benefit and importance of public health measures. Equally these organisations might have very useful suggestions about how to enhance uptake.

At all times it is important that GP practices and other primary care providers are aware of the entitlement of these groups of patients to NHS care (see the section "Entitlement to NHS services"). All patients are entitled to refuse offers of preventive health measures, and such a refusal should never be used as a way of blocking a patient from entitlement to NHS care.

Sources of help with these complex problems

Useful contacts and resources

Contacts and resources are classified into:

- Local (south east London) resources
- National resources

Useful information from these sources can often be obtained from written material, by telephone, by email, or from web-based resources.

Local Resources - South East London

- The Health Inclusion Team LSL
- Refugee community organisations (RCOs)
- Refugee Council London

1) The refugee services of the Health Inclusion Team LSL

The Health Inclusion Team (HIT) is a multi-disciplinary team working across Lambeth, Southwark and Lewisham which provides health care to specific hard-to-reach groups of refugees and asylum seekers and aims to improve access to other health services. It is part of the Three Boroughs Primary Health Care Team (hosted by Guy's and St Thomas' NHS Foundation Trust). The team is also able to organise general or specific training for practices, in areas related to refugee and asylum seeker health.

The Health Inclusion is an excellent source of up-to-date information for clinicians and primary care staff. The best way to contact the team is by phone or email (see below).

Address:
Health Inclusion Team
Gracefield Gardens Health and Social Care Centre,
3rd floor,
2-8 Gracefield Gardens,
Streatham, London SW16 2ST

Phone:
020 3049 4700

Fax:
020 3049 4701

Enquiry E-mail:
rhtisl.admin@lambethpct.nhs.uk

More information via the web-site:
www.threeboroughs.nhs.uk

2) Refugee Community Organisations (RCOs)

There are a number of RCOs based locally in south-east London. The Health Inclusion Team LSL (see 1 above for contact details) maintains a services directory of such organisations, and might be able to suggest helpful contacts for you.

3) Refugee Council

The Refugee Council at its various London bases will help asylum seekers and refugees from all London boroughs, and is also the national head office of the Refugee Council.

- The Support and Advice Section will offer support and advice to asylum seekers and refugees at all stages of the asylum seeking process. Advice covers issues such as welfare (support and entitlement), training, education and employment, the asylum process and UKBA support system. The service is no longer on a drop-in basis and people seeking advice need to contact the own-language telephone advice service (OLTAS) on 0808 808 2255, where they can speak to an advisor in a language of their choice. Clients may then be asked to attend one of their adult service units in North London, West London, or Stratford, if necessary.
- Therapeutic services for vulnerable refugees and asylum seekers with health and mental health needs are available by appointment only from the Refugee Council offices in Bethnal Green and Stratford. Appointments can be made by email at **therapeutic@refugeecouncil.org.uk**

- The Children's Panel provide guidance to unaccompanied asylum seeking children.
- Destitution services where destitute clients can receive practical advice and support, a meal, and emergency provisions at the Refugee Council's drop-in destitution services around London on Mondays, Tuesdays, Thursdays and Fridays.

Mondays and Thursdays
from 14.30-17.30

Address:

**Central London Day Centre
Hinde Street Methodist Church
19 Thayer Street
London W1U 2QJ**

Tuesdays from 11.00-16.00

Address:

**Deptford Day Centre
999 Club
Deptford
21 Deptford Broadway
London SE8 4PA**

Website:

www.refugeecouncil.org.uk

National Resources

1) Refugee Council

The Refugee Council provides practical services to refugees and asylum seekers and also has a central role in lobbying and campaigning on asylum seeker and refugee policy. The organisation also provides educational and information materials for a wide range of users (asylum seekers, schools, refugee community organisations, local authorities).

The website has useful information on the asylum process and support and welfare arrangements for asylum seekers, as well as policy briefings, research, and reports prepared by the organisation. There are multilingual (20 languages) information leaflets for asylum seekers and refugees on topics such as the asylum process, support, services and refugee integration.

<http://www.refugeecouncil.org.uk/practice/services>

2) Freedom from Torture

Freedom from Torture, a registered charity established in 1985 and originally called the Medical Foundation for the Care of Victims of Torture, is the only organisation in the UK dedicated solely to the treatment of torture survivors. The main treatment centre is in London, with branches in Manchester, Newcastle, Birmingham and Glasgow. The organisation offers medical consultation, examination and forensic documentation of injuries, psychological treatment and support, and practical help. It is also aiming to educate the public and decision makers about torture and its consequences, and engages in advocacy work to influence government policy.

The website's "Publications" section contains an expansive clinical bibliography around therapy for torture survivors, clinical examination of torture survivors, medico legal report writing and other human rights topics. There are also country reports on torture based on testimonies of FFT clients.

Address:
**111 Isledon Road,
Islington,
London N7 7JW**

Phone:
020 7697 7777

www.freedomfromtorture.org

3) MEDACT - Medical Action for Global Security

Medact is a global health charity which undertakes education, research and advocacy on the health implications of conflict, development and environmental change. Refugee and asylum health is one of the areas on which the organisation campaigns, in particular on the issue of entitlement to NHS care for refused asylum seekers. The website has a lot of useful reports, briefings and links on this issue.

Address:
**Medact,
The Grayston Centre,
28 Charles Square,
London N1 6HT**

Phone:
020 7324 4734

www.medact.org

4) The Red Cross

The Red Cross refugee services help vulnerable asylum seekers and refugees access essential services. The organisation provides emergency provisions for those facing severe hardship and also gives orientation support and advice. The organisation has also focused resources on helping destitute asylum seekers and supporting young people and refugee women.

The main Refugee Support Unit for London (providing orientation, case work, emergency provisions, a clothing project and a women in crisis service) is at:

Address:
**Aztec Row,
5 Berners Road,
London N1 0PW**

Phone:
020 7704 5670

There are also second-hand clothing projects at:

Address:
**Bethnal Green Clothing Project,
1 Pott Street,
London E2 0EF
(Mondays 10am-4pm)**

And

Address:
**Croydon Clothing Project,
47 Coombe Road,
London CR0 1BQ
(Thursdays 10am-4pm)**

Website:
**[http://www.redcross.org.uk/
What-we-do/Refugee-services](http://www.redcross.org.uk/What-we-do/Refugee-services)**

5) **"Better Health" website**

This is hosted by the Race Equality Foundation and has a wealth of relevant resources.

Website:
<http://www.better-health.org.uk/>

6) **Department of Health – archived information**

The former DH Asylum Seeker Co-ordination Team produced and commissioned information on refugee health. The documents are archived at

Website:
**[http://webarchive.nationalarchives.gov.uk/+www.dh.gov.uk/en/
Healthcare/International/
AsylumseekersAndrefugees/
index.htm](http://webarchive.nationalarchives.gov.uk/+www.dh.gov.uk/en/Healthcare/International/AsylumseekersAndrefugees/index.htm)**

7) **Home Office Country of Origin Information Service (COI service)**

This provides sourced information on asylum seekers' countries of origin, focusing mainly on human rights issues. The information is aimed at UKBA officials involved in the asylum determination process. It is compiled from information sources such as the US state department, the UNHCR, human rights organisations and news media.

Website:
**[http://www.ukba.homeoffice.gov.u
k/policyandlaw/guidance/coi/](http://www.ukba.homeoffice.gov.uk/policyandlaw/guidance/coi/)**

8) South East Migrant Health website

This hosts various relevant resources including "Meeting the health needs of asylum seekers and refugees", by Angela Burnett and Yohannes Fassil, which was originally produced in 2002. It includes practical information, details of useful contacts and examples of good practice and can be found at <http://www.migranthealthse.co.uk/>

Clinical Bibliography

Sources of more clinical information

Refugees and Asylum Seekers

- 1) Burnett A, Fassil Y. Meeting the Health Needs of Refugees and Asylum Seekers in the UK, 2002. Comprehensive information with practical advice, details of useful contacts and resources and examples of good practice. The updated version is available as an online resource.
<http://www.migranthealthse.co.uk/dhnhs-specialist-support>
- 2) Department of Health. Caring for Dispersed Asylum Seekers – A Resource Pack, June 2003. A publication from the Department of Health (jointly with the Refugee Council), covering entitlement to healthcare, support arrangements, health guidelines, social care legislation and mental health sections. Download from
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4010379
- 3) Burnett A. Guidelines for Health Workers Providing Care for Asylum Seekers and Refugees, The Medical Foundation, 2002. Available online on
<http://www.better-health.org.uk/resources/toolkits/guide-health-workers-providing-care-asylum-seekers-and-refugees>
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Torture and Human Rights

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<http://www.unhcr.org/refworld/docid/4638aca62.html>

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- 13) World Medical Association. Declaration of Tokyo. Guidelines for physicians concerning torture and other cruel, inhuman or degrading treatment or punishment in relation to detention and imprisonment. WMA, 1975.
- 14) Rape as a Method of Torture – Edited by Michael Peel. Medical Foundation for the Care of Victims of Torture 2004.

General Background Reading

- 15) Storr A (ed.). Human destructiveness. The roots of genocide and human cruelty. Routledge, 1991. An interesting small book, exploring the psychological background of human cruelty and torture.

Glossary of terms and an outline of the UK asylum system

Article 3 (of ECHR)

Article 3 of the European Convention on Human Rights (ECHR) states that 'no one shall be subjected to torture or inhuman or degrading treatment or punishment'. A person can make a claim for protection based directly on Article 3 of ECHR as states are prohibited from returning a person to a country where she/he may suffer a violation of his/her rights under Article 3.

Asylum seeker

An asylum seeker is someone who is present in the UK and has requested international protection under the terms of the 1951 United Nations Convention relating to the Status of Refugees. An asylum seeker is defined as someone who has made a claim for asylum and has either: i) yet to receive an initial decision on their claim or ii) been refused asylum by the UK authorities but still has a legal avenue to appeal against the UK's decision to refuse asylum. An asylum seeker is legitimately in the UK until such time as they have been refused asylum and have exhausted all legal rights of appeal - there is no such thing as an illegal asylum seeker.

An asylum seeker is usually not allowed to take up paid employment and is not entitled to benefits.

Asylum support

Asylum seekers who are destitute may be able to receive accommodation and/or subsistence support from the UK Border Agency (UKBA). This form of support is also referred to as 'UKBA support', see below. If they have additional care needs, due to chronic illness or disability they may also be eligible to support from their local authority.

Case owner

The UKBA uses 'case owner' to refer to an official within its New Asylum Model who is responsible for an asylum seeker's case throughout the process, from application to the granting of status or removal. Their roles include deciding whether status should be granted, dealing with asylum support, integration or removal. The UKBA also uses the term to refer to an official at Senior Executive Officer level within the Case Resolution Directorate (see below) who is responsible for several teams of case workers.

Discretionary Leave

is a form of immigration status granted to a person who the UKBA has decided does not qualify for refugee status or humanitarian protection but where there are other strong reasons why the person needs to stay in the UK temporarily.

Dispersal

Dispersal is the process by which the UKBA moves an asylum seeker to accommodation outside London and the South East. They are first moved to initial accommodation while their application for asylum support is processed. Once the application has been processed and approved they are moved to dispersal accommodation elsewhere in the UK.

ELR – Exceptional leave to remain

This was a form of immigration status in use before April 2003. It was granted to asylum seekers who the Home Office decided did not meet the definition of a refugee as defined in the Refugee Convention but it decided should be allowed to remain in the UK for other reasons.

Family reunion

Family reunion is the policy enabling people to bring their spouse and dependent children to join them in the UK. Those granted refugee status can apply for family reunion immediately.

Further submissions

Further submissions can be made by unsuccessful asylum seekers if their personal circumstances or the circumstances in their home country have changed. Further submissions can only be made in person at Liverpool Further Submissions Unit. Some asylum seekers can make further submissions at a regular reporting event and those who meet the exceptional criteria may be able to send further submissions by post rather than in person.

The Geneva Convention This is the United Nations convention adopted in 1951 which defines a refugee as: a person who:

- a) has a well-founded fear of persecution for reasons of race, religion, nationality, membership of a particular social group, or political opinion;
- b) is outside the country they belong to or normally live in; and
- c) is unable or unwilling to return home for fear of persecution.

In 1967 a supplementary UN Protocol Relating to the Status of Refugees was adopted, applying the criteria of the 1951 convention to any person, anywhere in the world, at any time. The UK and 130 other countries are signatories to the Geneva Convention and/or the supplementary protocol.

ILR – Indefinite leave to remain is a form of immigration status given by the UKBA. It is also called “permanent residence” or “settled status” as it gives permission to stay in the UK on a permanent basis. People with this status are allowed to work legally in the UK and are entitled to benefits.

Immigration removal centre

Immigration removal centres are detention centres. They are used to detain people under Immigration Act powers, including those at any stage of the asylum process, not as the title might imply, just prior to removal.

Judicial review

In the context of asylum claims, judicial review enables the applicant to challenge the way in which an asylum decision was made, usually on the grounds that the decision was illegal, procedurally improper, irrational or disproportionate. Judicial reviews cannot be used to challenge the asylum decision itself, this is the role of the Immigration and Asylum Chamber. (First Tier Tribunal or Upper Tribunal)

Legacy case denotes a person whose asylum case was not within the New Asylum Model (NAM) by the 5th March 2007. There is a backlog of legacy cases that the UKBA is currently processing.

Limited leave to remain is the immigration status conferred to those people granted refugee status since 30 August 2005. It is valid for 5 years. The person needs to apply for indefinite leave to remain prior to the 5-year period running out, otherwise they will lose all rights to benefits and their need for protection will be re-examined. A person with limited leave to remain is allowed to work in the UK and is entitled to benefits.

National Assistance Act 1948 (NAA)

The National Assistance Act 1948 gives local authorities the responsibility to provide accommodation and services to people with a disability or other care need. It also puts an obligation on local authorities to conduct an assessment of anyone who might require residential care. In practice, the UKBA is responsible for asylum seekers whose need for care and attention arises solely because they are destitute or from the effects of destitution, while local authorities are responsible for asylum seekers whose needs are additional to being destitute.

New Asylum Model (NAM)

The New Asylum Model was introduced by the UKBA for all new asylum claims in April 2007. NAM entails a 'case owner' from the UKBA who is responsible for processing the application from beginning to end, including making the initial decision whether or not to grant refugee status.

Refugee A refugee, as defined by the United Nations Geneva Convention 1951, is a person who:

- a) has a well-founded fear of persecution for reasons of race, religion, nationality, membership of a particular social group, or political opinion; and
- b) is outside the country they belong to or normally live in; and
- c) is unable or unwilling to return home for fear of persecution.

As of 30th August 2005, those granted refugee status in the UK have been given 5 years' limited leave to remain rather than indefinite leave.

Refugee Status This means that the person has been recognised by the UKBA as a refugee under the terms of the Geneva Convention.

Refused asylum seeker A person whose asylum application has been unsuccessful and who has no other claim for protection awaiting a decision. Some refused asylum seekers voluntarily return home, others are forcibly returned and for some it is not safe or practical for them to return until conditions in their country change.

Section 4 support

Section 4 of the Immigration and Asylum Act 1999 gives the UKBA power to grant support to some destitute asylum seekers whose asylum application and appeals have been rejected. Support granted under Section 4 is also known as 'hard case' support.

Regular Reporting Event

The visits an asylum seeker is required to make to a reporting centre, as set out in the IS 96 letter. These are often weekly, but may be reduced to fortnightly or monthly in certain circumstances such as poor health.

Subsistence support

Subsistence support is the cash element of UKBA support. Asylum seekers who have accommodation, for example with friends or relatives, can apply for subsistence support only. This form of support is also known as cash support.

UK Border Agency (UKBA)

The UK Border Agency (UKBA) is an executive agency of the Home Office. The agency manages and enforces immigration control in the UK, including applications for permission to stay, citizenship and asylum. It is responsible for policy development in these areas of law.

Unaccompanied asylum seeking children

Unaccompanied asylum seeking children are children (under 18 years of age) who have applied for asylum in their own right, who are outside their country of origin and separated from both parents, or previous/legal customary care giver. Upper Tribunal (UT) appeals can be made to the UT against dismissal of an appeal by the First Tier Tribunal (FTT). If the UT finds that there are errors of law in the FTT determination, they may hear the case themselves and make a new decision.

A summary of the UK asylum system (Correct at August 2012)

In March 2007 the Home Office introduced the New Asylum Model (NAM). Under this system each newly applying asylum seeker is allocated a case owner who is responsible for all aspects of their case, from beginning to end. The UKBA's stated aim is for a conclusion to be reached on new applications within six months. The case owner is the single point of contact on the progress of the application, both for the applicant and for their legal representative. The case owner is responsible for interviewing the applicant, for making the initial decision on their application, for managing the support they are entitled to receive, and for assisting either integration in the UK in the case of a positive decision or for arranging return to the country of origin, either voluntarily or by enforced removal.

1) Applying for asylum

UKBA expects persons wishing to claim asylum to make their asylum applications as soon as "reasonably practicable". This would normally be at the port of entry to the UK. There is a risk that an asylum seeker will not be entitled to UKBA support (financial and accommodation) if they have made their application at a later stage (this rule comes under the powers of section 55 of the Nationality, Immigration and Asylum Act 2002). A person already in the UK who wants to claim asylum needs to make their application at the Asylum Screening Units (ASU) in Wellesley Road, Croydon (either by making an appointment or

attending the walk-in service there) or in Liverpool.

2) Screening

The person making the application will be interviewed briefly (see below) and fingerprinted and photographed. Applicants are asked to bring passports (which will be retained by UKBA), police registration certificates, other ID and passport photos, as well as documentation of their financial and accommodation arrangements and documents supporting the basis of their asylum application. The application and screening process is similar whether the asylum application is made at the port of entry or at the Asylum Screening Units in Croydon and Liverpool.

The screening interview consists of questions on bio-data, travel history, health, a summary of the basis of the claim, security screening and family background.

Depending on the individual circumstances of the applicant, for example whether they are deemed to have committed an immigration offence (e.g. entering the UK without proper documentation or by verbal deception) they are then either detained or given temporary admission. If they are not detained then an Application Registration Card (ARC) will usually be issued along with the IS96 (a letter stating reporting requirements), and a routing letter. Some applicants are issued with a Standard Acknowledgement Letter rather than an ARC card at this point.

If the applicant has requested accommodation it will be initially provided in Initial Accommodation (hostel-type accommodation, currently in London this is in Croydon and a small number of places in Southwark).

3) First meeting with case owner

This should take place within a few days of an asylum application being made. If the applicant has applied for accommodation through UKBA, the case owner will usually be in the region where the person is dispersed to. The case owner will explain the asylum process, invite the applicant to the asylum interview, offer help in finding legal representation and confirm reporting arrangements.

4) The asylum interview

The asylum interview should take place about a week after the first meeting with the case owner. Attendance at the interview is compulsory; otherwise the claim will be automatically refused. This interview is the only chance for the individual to explain to UKBA why they fear return to their country. They need to satisfy the case owner about who they are and which country they are from, and are also expected to provide evidence of what they say in the form of documentation. The applicant is able to bring a legal representative to the interview if they wish (this is unlikely to be possible if the legal representative is funded through legal aid). Alternatively they can ask for the interview to be tape-recorded.

5) Waiting for a decision

While waiting for a decision from UKBA the applicant will be expected to report regularly to an official centre, as specified on their IS96 document. Usually reporting is requested weekly. If an applicant fails to present at the specified time each week, the support they are receiving may be stopped and they may be detained.

The case owner will decide whether the applicant is entitled to receive support. The current level of cash support for a single adult is £36.62 and for a single parent it is £43.94). There are higher rates for children and additional funds for pregnant women. Housing is allocated on a no-choice basis. Most UKBA accommodation is outside London and the South East (Midlands, North East, North West, Wales, and Scotland). Asylum seekers waiting for a decision are not normally allowed to work.

6) The asylum decision

The UKBA states that the asylum decision should be given within about 30 days from the date on which the application was made; however practical experience shows that it usually takes significantly longer. The case owner makes the decision and communicates it to the applicant. The case owner may grant refugee status or humanitarian protection status, or refuse to grant asylum. However, in certain circumstances, if asylum is refused, discretionary leave to remain may be granted.

- a) If the applicant is granted refugee status:

The applicant is recognised as a refugee and they will be given a refugee status document and a residence permit that allows them to enter and stay in the UK for an initial period of five years. Limited leave for five years was introduced in August 2005. Holders of this status whose limited leave is about to expire, need to apply to UKBA for an extension of their leave. This is called applying for permission to settle in the UK and if successful results in granting of indefinite leave to remain. This application needs to be made in the month before the limited leave expires, otherwise the individual loses their permission to stay and their right to benefits and an in-depth review of the case is carried out.

People who hold refugee status or another form of positive decision (humanitarian protection or discretionary leave) are entitled to the same benefits as other UK residents and are allowed to work.

UKBA support including accommodation will be withdrawn 28 days from the date of granting refugee status, so it is important that the person is advised to apply for benefits as soon as possible, otherwise they might find themselves destitute.

- b) If the applicant is not recognised as a refugee under the Refugee Convention:

The case owner may decide they should be able to stay for humanitarian or other reasons and grant a form of status called humanitarian protection status, usually for five years. They are issued an immigration status document along with a residence permit. Once humanitarian protection status expires, the person can apply for extended leave and/or settlement (after five years of leave to remain).

If the case owner decides there are no reasons for the applicant to stay, they will be expected to leave the UK. They will be informed about options for returning to their country of origin, including through the Voluntary Assisted Return and Reintegration Programme. If the person does not leave the UK, UKBA state that they will enforce removal, and that they are likely to detain the person until they are removed from the UK.

If an asylum application has been rejected and appeal rights exhausted, the person will lose their entitlement to any UKBA support including accommodation. However it is possible for someone in this position to apply for Section 4 support from UKBA (accommodation and financial support to the value of £35.39 per week payable through an "Azure" payment card), if they meet one of a set of requirements.

These are:

- i) Taking all reasonable steps to leave the UK
- ii) Being unable to leave the UK because of a physical impediment to travel or for some other medical reason (e.g. advanced pregnancy).
- iii) Being unable to leave the UK because there is currently no viable route of return available
- iv) Having applied for a judicial review of the asylum decision and having been given permission to proceed with it
- v) If there is otherwise a breach of the person's rights, within the meaning of the Human Rights Act 1998. This can include someone having submitted further representations which seek a fresh claim for asylum.

7. Appeal

Asylum applicants who have received a written notice of a refusal decision from UKBA can appeal against the refusal. Ideally they should have the help of a legal adviser when appealing their asylum refusal. They need to lodge their appeal by completing a form within 10 working days of the date of the refusal decision letter. The appeal will be initially decided by an independent tribunal called the First Tier Tribunal (FTT) of the Immigration and Asylum Chamber. This is heard by one or more immigration judges, sometimes accompanied by non-legal members of the Tribunal.

An asylum seeker should continue to receive support from UKBA for the duration of their appeal.

8. Fresh claims/further submissions

A "fresh claim" can be made if:

- a) there is substantive new evidence emerging after the person has exhausted all appeal rights,
- b) if there has been a significant change in the political situation in the country of origin
- c) if the applicant has developed a life-threatening medical condition
- d) if there has been substantial change to the life or circumstances of the applicant occurring in the passage of time from the initial decision.

If UKBA decide that this submission of evidence significantly differs from material previously considered, it will be accepted as a fresh claim to be heard in the Upper Tribunal. If not, the applicant can apply directly to the Upper Tribunal.

Further appeals to the Administrative Court (also called the High Court) for a judicial review, or to the Court of Appeal or the Supreme Court are also possible but generally require expert legal help.

If UKBA accepts the newly submitted materials as a fresh claim, and then refuses the new claim for asylum, the person may have access to a judicial review.

9. Detention

A person who has been asked to leave the UK may be detained without warning while their removal from the UK is being arranged. UKBA currently has 11 immigration removal centres around the UK where people awaiting removal are detained (the closest to London are Brook House and Tinsley House near Gatwick and Colnbrook and Harmondsworth near Heathrow). Asylum applicants who are detained have the right to a bail hearing, but they have to instigate the process. Asylum applicants are likely to have practical difficulties in securing bail.

Legal advisers can make representations for the release of their clients.

Further details on the asylum process can be found on the UKBA website:

<http://www.ukba.homeoffice.gov.uk/asylum>

and on the Refugee Council website:

<http://www.refugeecouncil.org.uk/practice/basics/process.htm>

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Handwriting practice area with 20 horizontal dashed lines.

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Resource Pack
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Produced by the Health Inclusion Team (HIT) LSL
1st edition September 2004
2nd edition March 2005
This edition June 2012

Address:

HIT, 3rd floor, Gracefield Gardens,
Health and Social Care Centre,
2-8 Gracefield Gardens, London SW16 2ST

Phone:

020 3049 4700

Email:

gst-tr.referralsBBVHT@nhs.net

Website:

www.threeboroughs.nhs.uk

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