

# refugee council conference report



## Safe from harm? Health and social care for vulnerable refugees and asylum seekers

**Refugee Council conferences**

**Supported by the King's Fund and the Social Care Institute for  
Excellence**

Regent's College, London  
1 November 2006

Royal York Hotel, York  
7 November 2006

Other Refugee Council publications are available at [www.refugeecouncil.org.uk](http://www.refugeecouncil.org.uk)

Registered charity no. 1014576 Registered company no. 2727514 Registered address: 240-250 Ferndale Road London SW9 8BB



## Aims and objectives of the conferences

Restrictions on access to health and social care can have a devastating impact on already vulnerable refugees who have come to the UK for protection. Providing a comprehensive and joined up service to this group, at the same time as meeting the demands of new policies, is a real challenge. Specific attention to the needs and experiences of refugees is essential, but not in isolation – rather, as part of mainstream provision.

Asylum seekers and refugees can have complex health needs including those that arise from trauma and deprivation in their country of origin and during flight. As many as 20 per cent have severe physical health problems that make their day-to-day life difficult. Victims of torture can have both physical and mental health concerns. The conferences in London and York aimed to provide information and to discuss good practice, highlighting the health and social care needs of vulnerable refugees and identifying key areas of development in policy and practice.

The morning plenary sessions and the afternoon workshops:

- brought together front-line staff and policy-makers from a range of NGO, business and public sector backgrounds, particularly health and social care professionals
- identified potential needs of refugees within the context of overall service provision
- clarified the legislative and policy background to health and social care for asylum seekers and refugees
- examined the current needs of health and social care professionals in this area
- related health and social care needs to roles, rights and entitlements across the sectors
- determined subjective and practical barriers to health and social care
- discussed recommendations for ensuring access to mainstream and specialist services.

The conference in **London** was chaired by **Anna Reisenberger**, Acting Chief Executive of the Refugee Council. Five speakers provided information and raised critical issues: **Sue Willman**, **Parveen Kumar**, **Pete Fleischmann**, **Karen McColl** and **Nancy Kelley**. The conference in **York** was chaired by **Alistair Griggs**, Director of Operations of the Refugee Council. The five speakers were **Sue Willman**, **Nancy Kelley**, **Karen McColl**, **Elaine McHale** and **Linda Christon**. In the afternoons, workshops on a range of topics provided an opportunity for delegates to learn more about particular issues, to share their experience, and to discuss the development of policy and practice. In total, about 280 people from a wide range of agencies attended the two conferences.

## Structure of this report

The report first gives an account of the plenary sessions at the London conference. Three of the speakers gave their presentations again at the York conference. Therefore, the second part of the report highlights the two additional contributions in York. Brief summaries of the workshop discussions follow, derived from material provided by notetakers in London and York. Finally, the conference presentations by Sue Willman and Nancy Kelley are reproduced in full as appendices to the report.

The Refugee Council arranged for both conferences to be recorded for archiving and to support the development of this report. Unfortunately, there were technical problems in both London and York. As CDs of the plenary sessions were not available, accounts of the plenary sessions rely for the most part on text and PowerPoint slides provided by speakers.

While the Refugee Council welcomes a diverse range of speakers and workshop facilitators, the views and opinions expressed by them in the conferences were not necessarily those of the Refugee Council.

The Refugee Council would like to express thanks to all speakers, workshop facilitators, delegates and notetakers, and to the Social Care Institute for Excellence and the King's Fund.

London, 1 November 2006

**Sue Willman** gave the first presentation, **Access and entitlements to health and social care**. She is a partner at Pierce Glynn, a south London solicitors' firm specialising in asylum support. Before this, she worked for 14 years at Hammersmith and Fulham Community Law Centre, and helped to establish a local Refugee Forum. She is chair of the Asylum Support Appeals Project and co-author of the Legal Action Group's handbook *Support for Asylum Seekers* (2nd edition, 2004); she has represented asylum seekers in many important welfare cases.

Sue Willman began by pointing out that it was a relatively new idea that asylum seekers and other migrants with health or social care needs should be treated very differently from other vulnerable UK residents. She then described the situation as it has developed since the 1999 Immigration and Asylum Act, drawing detailed attention to legislation, regulations, legal cases, and interpretations by local and health authorities. She highlighted the significant contribution of voluntary, refugee, health, social work and other organisations in providing evidence for test cases and lobbying for improved services for asylum-seekers. Notes of her talk are in **Appendix 1** (page 18).

Health authority interpretations are also discussed in a Refugee Council 2006 report which was included in conference delegates' packs: *First do No Harm: Denying healthcare to people whose asylum claims have failed* by Nancy Kelley and Juliette Stevenson – see [www.refugeecouncil.org.uk](http://www.refugeecouncil.org.uk).

**Professor Parveen Kumar CBE**, President of the British Medical Association, then spoke on **The future of health care in relation to asylum seekers and refugees**. Her clinical practice, research and involvement in medical education have been primarily in north and east London hospitals. She is co-author of a textbook on clinical medicine which is used worldwide, and has been a member of or chaired numerous medical committees.

Parveen Kumar started by describing aspects of health care before the introduction of the NHS in 1948. In general, treatment required payment. Poor people therefore tended to rely on home remedies and charities; the poorest workers (although not their families) had free access to GPs, but had to pay for hospital treatment. Mentally ill people were locked away in institutions, and destitute older people went to the workhouse or other public institutions. Now the NHS is a publicly funded health care system on a massive scale, employing over a million people including about 100,000 doctors. She gave some striking figures about a 'typical day' in the NHS. For example, a million people visit their GP, 33,000 visit hospital accident and emergency departments, 25,000 operations are carried out and 2,000 babies are delivered. Despite the scale of such activity, the UK lags behind many other European countries in the number of physicians per 1,000 population and health care expenditure as a percentage of Gross Domestic Product.

Many complex factors affect the health of the population, singly and in combination. These factors include age (and the increasing proportion of older people in the population), genetic profiles, and 'lifestyle choices' about smoking, exercise and alcohol use. There are environmental factors such as pollution, and socio-economic factors including poverty. Another important aspect is, of course, the effectiveness of health services.

Such complexity makes it difficult to see clearly the future of health care. The uncertainty is increased by rising public and patient expectations, changing boundaries between health professionals, costly modern technology and an expansion of the range of health care sites and sources.

Parveen Kumar pointed out that such complex factors and uncertainties provide the NHS context within which health care for asylum seekers and refugees is considered and delivered. She described some likely health problems and possible barriers to obtaining appropriate and effective services. Some of the health problems are the result of circumstances in the country of origin, where children may not have had vaccinations or immunisations, and diseases such as TB and diabetes might not have been diagnosed. There may be physical and psychological effects of torture and war, including malnutrition, injuries, depression and anxiety. Further problems may result from stresses during flight or while awaiting determination of status. She noted that a 2002 British Medical Association report on *Asylum Seekers: Meeting their healthcare needs* ([www.bma.org.uk](http://www.bma.org.uk)) had concluded that the asylum process itself could have a detrimental impact on the health of asylum seekers.

Among the barriers to obtaining health care are communication and language problems, and the complexity of documentation required to achieve exemption from payment. NASS dispersal arrangements may mean lack of continuity of care. Asylum seekers may not be able initially to reveal painful physical or mental problems to health workers, or they may only gradually become aware of illnesses. The concept of 'health tourism', with assumptions made about people's reasons for coming to the UK, has introduced further significant barriers to health care for asylum seekers.

On a more optimistic note, Parveen Kumar stressed the 'instinct' of doctors to heal, to treat the person in front of them. She said that refugees and asylum seekers can make valuable contributions to the cultural and economic life of the country. Their talents and enthusiasm should be nurtured for their own benefit, that of the community as a whole and the NHS. She outlined practical steps taken by the British Medical Association to assist refugee doctors. These include a special BMA benefits package with access to the BMA library and journals; the refugee doctor database set up in conjunction with the Refugee Council in 2001, and the Refugee Doctor Liaison Group, which is an informal group meeting three times a year. She noted that the Home Office is providing funding 2007-2009 for a project called ARRIVE (Assisting the return of refugee doctors to viable employment), which includes clinical placements or support to move into alternative careers.

During the **question period** which followed one delegate raised the issue of terminology, criticising use of the phrase 'failed asylum seeker'. Anna Reisenberger agreed and explained that Refugee Council usage is 'refused asylum seeker' or someone 'whose claim has failed'. Several issues were raised about funding of support for asylum seekers: the respective responsibilities of NASS and social services in particular situations; a refugee visitors' group being asked to provide financially for parents of children supported by social services; and whether GPs are entitled to extra funding when they take on asylum seekers as temporary patients. Concern was expressed about the concept of 'health tourism' being applied to asylum seekers, despite the lack of any relevant evidence base.

After a break for refreshments, **Pete Fleischmann**, Principal Advisor – Participation, Social Care Institute for Excellence (SCIE), spoke on **Supporting access to social care**, substituting for his colleague **Nasa Begum** who prepared the presentation but was unable to attend and present. Pete Fleischmann has been active in the mental health user movement for over 15 years, and has been a development worker and co-ordinator of Brent Mental Health User Group as well as working as an independent consultant on user involvement issues. He has a strong personal interest in health and social care needs of refugees and asylum seekers as his father was a refugee from Nazi Germany. Nasa Begum has worked at SCIE as Principal Adviser Participation since 2003 and has led their work on the social care needs of refugees and asylum seekers. She has held a range of local authority, policy and charity sector posts, been published several times and sat on the board of a number of organisations including National Centre for Independent Living. Nasa has used social care services throughout her life and been active in service user and carer participation work both in a professional and personal capacity for over 20 years.

SCIE's role is to improve the experience of people using social care services by developing and promoting knowledge about good practice. In 2005, SCIE held a series of consultation events about the future of social care in England, aiming to reach groups not often reached through consultation exercises. Among those involved were asylum seekers and refugees. Pete Fleischmann began his talk by quoting what some participants had said about their problems in attempting to access social care. Among the issues raised by these moving accounts were lack of recognition by social care agencies of the extremely difficult circumstances of some families, and unrealistic expectations of how much stress carers can continue to endure. The findings of this consultation are contained in SCIE report *I'm not asking to live like the Queen* which is available on the SCIE website, [www.scie.org.uk](http://www.scie.org.uk).

Pete Fleischmann said that the key challenges were to engage with refugees and asylum seekers with social care needs, to increase their access to appropriate support and to improve the quality of such support. He went on to outline lessons which had been learned in the process of engaging with refugees and asylum seekers with social care needs. He stressed the value of working through existing trusted networks where these exist, although it is important too to offer genuine choice over preferred methods of consultation and involvement. Ample time to reach out to and gain the confidence of refugees and asylum seekers is important, with assurances of confidentiality.

There are, however, barriers of many kind to effective consultation and engagement. An obvious one in the case of asylum seekers is dispersal to another location. Other barriers include refugees' and asylum seekers' unease about being involved because of the possible stigma surrounding physical disability and mental health problems; a belief that it is a family duty to look after family members; and fear of repercussions if known to be involved in consultation, with concern that any minimal support already being received might be terminated. Sometimes potential service users are willing to participate, but their carers discourage or refuse such involvement. Lack of childcare support can be a problem: even if costs while attending consultation events will be reimbursed, some people have no access to individuals who could look after their children. Finally, there is often confusion about what social care is, and how it differs from benefits or food voucher services.

Pete Fleischmann then turned to issues of social care access and quality. The first requisite for social care agencies is to establish information about the numbers, characteristics and social care needs of asylum seekers and refugees locally. Once there has been consultation and involvement, outcomes must be fed back if good will is to be retained. SCIE stresses the need to adopt a holistic view, taking into account practical, legal and social problems faced by the individual. At the same time, the organisation recommends the creation of specialist teams and services within social services to plan and deliver social care for refugees and asylum seekers, rather than a reliance on generic local authority teams. Where refugee and asylum seeker projects and organisations exist locally, building partnerships with these is important, as is capacity building and providing resources for community and voluntary sector provision.

Among SCIE's suggestions for improving social care for refugees and asylum seekers are assessments carried out jointly by social services and knowledgeable community members or organisations, careful work in choosing and using interpreters, reviewing social care eligibility criteria to ensure these take into account the specific experiences of refugees and asylum seekers, and investing in 'low level' services such as luncheon clubs which can act as springboards for advice, information and mutual support. It may be useful to explore the potential of new social services arrangements providing individual budgets for those with high support needs.

Pete Fleischmann concluded by drawing attention to SCIE's August 2006 discussion paper on *The Social Care Needs of Refugees and Asylum Seekers* by Bharti Patel and Nancy Kelley, in conference delegates' packs and available at [www.scie.org.uk](http://www.scie.org.uk). He noted that SCIE is collating information about working with refugees and asylum seekers in order to produce a good practice guide. He urged delegates to contribute relevant experience and ideas to SCIE through his colleague Nasa Begum ([nasa.begum@scie.org.uk](mailto:nasa.begum@scie.org.uk)).

**Karen McColl**, Director, Médecins du Monde UK, then presented **Health as a human right: responding to the health needs of refugees, asylum seekers and other vulnerable migrants in the UK**. She has worked in public health policy and international health, and joined Médecins du Monde when the UK office was established in 1998.

Médecins du Monde is an international medical humanitarian organisation. It was set up in France but is now an international network with delegations and offices in 16 countries, 297 projects in over 80 countries, and 1,200 volunteers working overseas ([www.medecinsdumonde.org.uk](http://www.medecinsdumonde.org.uk)). The organisation works both in developing and developed countries, and has 20 years' experience of providing health care to vulnerable groups in France. In January 2006, the organisation established Project: London, an advocacy and health care initiative. It aims to improve access to health care for vulnerable groups by:

- documenting the number, health situation and needs of people who have difficulty accessing health care
- using this information to advocate for better health provision for these groups
- offering advice and practical assistance to help people access NHS and other relevant services
- providing some basic medical care in the interim.

The project will reach out to migrants, homeless people and street sex workers, in partnership with and using the premises of organisations already working with these groups. The first phase has involved two afternoon clinics each week for vulnerable migrants, held at Praxis in east London. Between January and September, Project: London service users have included refugees, asylum seekers and refused asylum seekers, and 'irregular migrants'. Karen McColl said that the information collated so far can provide a small snapshot of the barriers to health care which people experience on a much wider scale.

Early findings on primary care show that most project clients experience difficulty in registering with a GP. Part of the problem is the burden of documentation, with people not always able to produce the required proof of address and ID. There are serious language barriers, with a majority of the project's clients needing language support. There is 'huge confusion' about entitlement to primary care, and very variable practice. She noted that these problems are all restricting access to primary care even before any introduction of government regulations intended to restrict access.

In relation to secondary care, Karen McColl said that the rules labelled as 'charges for overseas visitors' were having a dramatic impact on vulnerable people living in the UK. There was a lack of clarity about what is 'immediately necessary treatment'; and denial of HIV treatment is inconsistent with other areas of government policy. She outlined some case studies of Project: London service users who have had difficulty accessing secondary care.

Maternity care is another area of confusion and concern. In principle, women should not be denied maternity care because they are unable to pay, but in practice the rules are being applied very differently. Pregnant women become frightened following discussions with hospital overseas payment officers, and some women are deterred completely from further ante-natal care, with obvious dangers to mother and child.

Karen McColl pointed out that many European countries provide access to health care for all migrants regardless of their status (although in some countries the reality is sometimes rather different from the policy). In the Netherlands, irregular migrants are excluded from the national health insurance but a special fund has been established for their health care; in Italy irregular migrants have access to health care in both theory and practice. Of the 11 European countries where Médecins du Monde works, eight provide free access to HIV treatment for people without regular status residing in their country.

Restrictions on entitlement to NHS treatment prevent vulnerable people from accessing needed medical care. These restrictions endanger the core principle of the NHS and there is no safety net, as none has been needed until now. Médecins du Monde therefore strongly urges a return to a universal service, and will continue to work with organisations such as the Refugee Council for the removal of unfair restrictions.

The final speaker in the morning session was **Nancy Kelley**, Head of International & UK Policy at the Refugee Council. She spoke on **Surviving destitution: access to services at the end of the asylum process**. Before coming to the Refugee Council in 2005 she was a Principal Policy Officer for Barnardo's, focusing on education, mental health and asylum seeking children and families; she chaired the Refugee Children's Consortium. She has worked with the Children's Rights Commissioner for London and for Mind. She is an experienced trainer and has published widely.

Nancy Kelley outlined available evidence about the health and social care needs of refugees and asylum seekers. She went on to discuss the legislative arrangements affecting those at the end of the asylum process, the impact of detention, and the implications of the denial of secondary health care. In conclusion she drew attention to the Refugee Council's new campaign, Just.Fair ([www.refugeecouncil.org.uk/justfair](http://www.refugeecouncil.org.uk/justfair)). See **Appendix 2** for a full version of her presentation (page 24).

A brief **question period** concluded the morning session. Among the issues raised were the detention of children and the exemption of detention centres from the provisions of the 2004 Children Act; the negative attitude towards refugees and asylum seekers held by some health professionals; and a refugee support group's difficulties in achieving dialogue with its local social services department. One delegate drew attention to the possible implications of the European Union's Qualification Directive, which took effect in October. This sets out minimum standards for qualification for refugee status or other forms of international protection in the EU.

**Anna Reisenberger** then ended the morning session by thanking all the speakers. She stressed that there was no evidence that refugees came to the UK to take advantage of the NHS. There was evidence, though, of substantial unmet health needs, and refused asylum seekers were a particularly vulnerable group. She urged all delegates to read the material about Just.Fair in their packs, and to join the Refugee Council in pressing for a more humane approach.

York, 7 November 2006

**Sue Willman** gave the first presentation of the day, as she had at the London conference. For a note about her experience and her talk, see above (page 4). Notes of her talk **Access and entitlements to health and social care** are in **Appendix 1** (page 18).

The next speaker was **Nancy Kelley**, who also spoke at the London conference. For a note about her experience and her talk, see above (page 8). For the full presentation of **Surviving destitution: access to services at the end of the asylum process** see **Appendix 2** (page 24).

After a break for coffee, the conference resumed to hear the next speaker. **Elaine McHale**, Corporate Director, Family Services, Wakefield Council, discussed **The future of social care** and how this relates to provision for asylum seekers and refugees. She has been at Wakefield Metropolitan District Council since 2001, after working for Manchester, Wigan and Bolton local authorities and a voluntary adoption and fostering agency. Her current commitments include chairing York University's Making Research Count Steering Group, and membership of a government task force and working group.

Elaine McHale said that in trying to make sense of the future we need to understand the present shape of social care and the context within which it operates; and in considering the future we need to be aware of the opportunities and challenges it presents for social services' work with asylum seekers and refugees.

Current legislation and policy for social care have been shaped in the last 15 to 20 years. The costs associated with retirement and care for the increasing proportion of older people have caused us to see growing old as a burden rather than a cause for celebration. Not only are we successful at growing older but technological advances mean we are able to facilitate life and life chances for those who have severe disabilities. In addition, as a prosperous and educated nation we have rising expectations of services and service provision. All this is against a backdrop of limited resources and a reluctance to levy additional taxes to pay for services which offer the choice and quality we demand.

At the same time, attitudes to community and civic duty have changed, with a greater tendency to look after oneself and to blame others when things don't go the way we expect them to. And then there are incidents which punctuate and question our morals and values such as the case of Victoria Climbié, who anticipated a better future in England but instead lost her life. That death brought about the creation of Children's Services and their separation from Adult Social Services. Such redrafting of boundaries can create opportunities for individual children and adults, but also provides challenges when working with families.

There is increasing emphasis on social services commissioning services from voluntary or private sector providers. In addition, the concept of direct payments has been extended, with new opportunities for individuals to design and commission their own care through individual budgets. In the future, local authorities will not necessarily provide social care services. Rather, their role will be as strategic commissioners.

Elaine McHale pointed out that another emphasis within policy is on partnership working. A vast number of agencies impinge on the lives of those with social care needs, so there is the potential for duplication and confusion. Working in partnership to enable seamless service provision and accessibility can provide efficiencies, and can improve individuals' experience of services.

One of the greatest challenges for social care in the future will be balancing the costs of provision against demand. How we assess need, the needs we identify and accept as requiring help, will continue to challenge the sector. Some demand for care may lessen if we help people to help themselves and to remain fitter both physically and psychologically. This may also be the case if we seek community alternatives to formal care. But these require a culture shift in how we join up services and expect other services such as housing, transport and leisure to contribute to the wellbeing of individuals. Required too, is a flexible and adaptable workforce, and we have to be open to where that workforce may come from. As employers we have to be capable of identifying, facilitating and supporting future employees within their own communities.

The arrival of asylum seekers in many local authorities since the start of NASS dispersals in 2000 has created a growing challenge to social services departments to provide local services that can be resourced, understood and accessed. In Wakefield, six years of dispersal have brought about 1600 asylum seekers from over 50 nationalities, a number that represents 25 per cent of the existing black and minority ethnic population (largely of Pakistani and Indian origins).

Only about a quarter have remained after being granted refugee status, but they are of many different nationalities and some are now living in outlying areas of Wakefield district. Consequently, there has been a substantial shift in the cultural make-up of the district. There is growing evidence of a need for a significant proportion of asylum seekers and refugees to access social services as well as many other public services. The diverse needs of these new residents require specific attention, as opposed to combining them into a generalised 'black and minority ethnic' category.

The situation is complicated by rapidly changing legislation. High Court judgements and local interpretations of these, for example Section 9 of the 2004 Asylum and Immigration Act, now being piloted, clashes fundamentally with the 1989 Children Act. Resource implications are of major significance for local authorities. The approach taken in Wakefield has been to utilise the NASS dispersal contract to create a multi-agency asylum seeker team able to provide quick and preventative support, taking pressure off mainstream services. The key to the success of the approach is multi-agency practice by dedicated staff whose complementary skills are geared to pragmatic problem solving. However, Elaine McHale stressed that asylum seekers are self-determined people and emphasis must be on encouraging their initiative and promoting their independence. Despite some resource and communication difficulties, she feels that overall the Wakefield approach has worked well.

The future of social care is enshrined in two policy initiatives: *Every Child Matters* and *Our Health, Our Say, Our Care*. Both are concerned with enabling people to realise their potential, and both offer challenges and opportunities in delivering social care to refugees and asylum seekers. The government's stated aim is for every child, whatever their background or their circumstances, to have the support they need to be healthy, stay safe, enjoy and achieve, make a positive contribution to society and achieve economic wellbeing. For adults, the outcomes focus on personal dignity and respect, freedom from discrimination and harassment, improved health and emotional wellbeing, improved quality of life, choice and control as well as making a positive contribution and achieving economic wellbeing.

The two initiatives offer opportunities in helping asylum seekers and refugees who require services. For example, if we are to deliver Every Child Matters outcomes to all children there has to be a new approach. The tension between policies for safeguarding and protecting children, and those controlling immigration, is neither inevitable nor inexorable. As with all other areas of policy it is possible to reconcile seemingly conflicting areas and objectives and to carry out existing functions in a way that takes into account the need to safeguard and prioritise the welfare of children. The starting point is an acknowledgement that children subject to immigration control are children first and immigrants second.

We have to improve the communication skills of workers and facilitate access by refugees and asylum seekers to English language learning. We have to offer clearer eligibility arrangements, and equal opportunities for care based on assessed needs. Possibilities for social care employment and volunteering should be developed. There should be encouragement of networking and of involvement in the delivery or co-ordination of services.

Elaine McHale concluded by setting out six principles for social care work with asylum seekers and refugees:

- a dedicated multi-agency approach built on operational experience
- a preventative approach that enhances independence and promotes initiative
- comprehensible access based on transparent eligibility criteria
- working in partnership with the voluntary sector
- consultation with asylum seekers and refugees themselves
- a focus on empowering refugees and asylum seekers requiring social care support in order to maximise independence, choice and control.

The next speaker was **Karen McColl**, who had also spoken at the London conference. For a report of her talk on **Health as a human right: responding to the health needs of refugees, asylum seekers and other vulnerable migrants** in the UK see above (page 7).

The final presentation at York, **Supporting access to social care**, was given by **Linda Christon**, Regional Director (Yorkshire and Humberside), Inspection, Regulation and Review, Commission for Social Care Inspection (CSCI). She has worked in local government for 20 years, with extensive experience in housing and social care. She is CSCI's national lead on Equality and Diversity.

Linda Christon began by explaining the role of the Commission in assessing the performance of local councils, registering and inspecting services which provide care, publishing special studies and reporting to Parliament on the state of social care. She described what adults say they want from services: choice, flexibility, information, safety, fairness and non-discrimination. They want to be treated with respect, to be allowed to take risks, and for their voice to be heard. They are also concerned with costs and value for money. Children say that they want to be treated as individuals, asked their views and have these views taken as seriously as the views of adults.

In general there has been an improvement in the performance of local councils and the standards reached by regulated services. New services have been developed providing better models of care provision. These include more flexible intermediate care schemes, extra-care housing, assistive technology, better support for informal carers and provision of individual budgets to service users. There are, however, many areas where improvement is needed such as waiting times for assessment and the ways in which home care is provided. Mental health services are still patchy and older people are not always treated with sufficient dignity and respect. All too often people are being excluded from services because of the high eligibility thresholds being set.

Linda Christon said that the challenge social care faces is to develop a greater focus on the users of services. There needs to be strong leadership and a commitment to change, and a willingness to work with partners (particularly health) to achieve change. Other requirements are a skilled and stable workforce, good commissioning practice, together with effective performance management and quality assurance. Social care agencies have to engage with and provide services for all sectors of the community.

All these developments must take place within a context of social care values of equality, social justice and dignity, with adherence to the statutory duties to promote disability equality, race equality and human rights. Social care services have to identify and meet the needs of the most disadvantaged people, with an inclusive approach enabling service users to access all mainstream services. The appropriate model of care is one based on active rights and citizenship.

She noted that improvements are required in the ways councils exercise their roles as commissioners of services, rather than providers. People's views and aspirations are not yet at the centre of commissioning approaches, and councils do not always make the necessary connections between action plans, budgets and strategic commissioning intentions. Dynamic and long term evaluation of local current and projected needs is required, and councils should be seeking out the views of the most excluded and disadvantaged people. Linda Christon pointed out that CSCI assesses councils on how well they facilitate access to services, and their record on diversity and equality; it holds to account councils which commission poor services.

She then outlined some of the findings of *Safeguarding Children: The second joint Chief Inspectors' Report on arrangements to safeguard children* (2005) ([www.safeguardingchildren.org.uk](http://www.safeguardingchildren.org.uk)). Among the areas covered in the report were inconsistencies in services for 16-18 year old asylum seeking children, concerns about children in immigration removal centres, and the absence of arrangements for welfare assessment and care planning for children in detention. She said that the government, in its 2006 response, had accepted most of the recommendations of the report including those concerning unaccompanied asylum seeking children. However, Recommendation 10 relating to care plans, continuity of education and reviews for children in removal centres had been rejected on the grounds that adequate arrangements were already in place. (For the government's response, *Making Safeguarding Everyone's Business*, see [www.everychildmatters.gov.uk](http://www.everychildmatters.gov.uk).)

In the **question period**, concern was expressed about the quality of some local social care services. There was also discussion of asylum seekers' entitlement to after care, when they had had treatment for mental health problems.

**Alistair Griggs** thanked all the speakers. As this was the final plenary session of the conference, he expressed his thanks also to the workshop facilitators, staff and volunteers. He said that the input from high quality speakers on a range of health and social care policy areas presented an excellent basis for the afternoon workshops. He hoped all delegates would find these workshops stimulating, and useful in their subsequent work.

## Workshops

In the afternoon workshops, nine topics were addressed in London and eight in York. In most cases, each workshop was held twice during the afternoon so that delegates had the opportunity to attend two different ones. The following brief reports summarise ideas and information drawn from the sessions in both London and York.

### **Assessing need: key issues when working with survivors of torture**

London Facilitator: **Angela Burnett** and **Tina Puryear, Medical Foundation for the Care of Victims of Torture.**

York Facilitator: **Katy Woodward, Medical Foundation for the Care of Victims of Torture**

The workshop provided an opportunity for delegates to increase their understanding of the experience of torture victims, and to consider key issues in providing services to them. Among the topics covered were definitions of torture, the contexts in which it is experienced, the need for awareness of its many possible social, physical and psychological effects, and the importance of identifying survivors.

The Medical Foundation for the Care of Victims of Torture ([www.torturecare.org.uk](http://www.torturecare.org.uk)) has a holistic approach to work with victims of torture, and has developed a range of possible interventions including medical attention, physical therapies, psychological support, casework and group therapy. The organisation's principles for providing effective treatment include recognition that there is no single technique appropriate in all cases. 'Hearing testimonies and bearing witness' is key, but so is the responsibility to act. The service must be non-oppressive, non-pathologising and non-discriminatory. Working with victims of torture can be very stressful, so support and supervision are critically important.

Detailed information was provided about common physical and psychological health problems presented by survivors of torture, and about points to cover in assessments. Case studies were discussed in small groups, and referrals to appropriate agencies considered.

*(Notetakers: Ismeta Kay, Beba Parker, Zenebe Woldegebriel, Sharon Witton)*

### **Establishing new partnerships: forming links between statutory and voluntary sector service providers**

Facilitators: **Andrew Keefe, Refugee Council, and John O'Neil, START (South Thames Assessment, Research and Training)**

The focus of the workshop was on collaborative working between the Refugee Council and the START outreach team. The relationship began as an informal one, with START taking referrals from the Refugee Council and training staff in mental health issues. In 2005, the relationship was formalised in a contract, and in 2006 an in-house clinic was established, with a member of the START team attending the Refugee Council drop-in service in Brixton one day a week.

This partnership between voluntary and statutory agencies has had advantages for both – an important factor in successful partnerships. For example, better training for Refugee Council staff has led to more appropriate referrals, there are practical benefits when interpreters have been trained in mental health issues, START staff have gained better understanding of the asylum process and its effects on individuals. Early identification of problems is cost-effective, and prevents deterioration of mental state.

Delegates tackled a case study from the perspective either of a community mental health team or a voluntary sector provider, assessing the problems faced by the client and preparing a plan of action. Among issues raised by delegates during the workshop were difficulties in obtaining funding for joint voluntary-statutory work, and the challenges in working outside London: many services do not see a role for themselves in working with refugees and asylum seekers, and refugee community organisations can be difficult to find.

*(Notetakers: Roisin Cavanagh, Helen Clegg, Andy Martin, Joanna Richmond)*

### **Improving advocacy skills for non-lawyers working in the health and social care sectors** Facilitators: **Sue Willman, Pierce Glynn Solicitors, and Lisa Woodall (London workshop only), Asylum Support Appeals Project**

The workshop identified legal and policy issues affecting asylum seekers needing health and social care services, and discussed the tactics and skills which non-lawyers might use to support clients. The first step in advocating for an asylum seeker is to identify problems and possible solutions, as problems may be interlinked and they may need to be tackled in a particular order. The facilitators stressed that a non-lawyer can certainly take steps to assist people who are having difficulty in accessing services; in some cases the problem can be sorted out without any need for legal advice; if legal action is later needed the steps taken at an earlier stage can be crucial.

Information was presented about exclusions from services and possibilities of support from social services, the NHS and NASS, as well as the fresh claim option. Using a case study, delegates considered possible ways forward which they could suggest to clients, such as emergency help with immediate support needs, assistance with getting evidence to support the client's case, writing supportive letters, and referring for legal advice. In relation to a delegate's question about Section 4, 'hard case' support, Sue Willman stressed that a client does not have to indicate willingness to return home: five options are set out in NASS Policy Bulletin 71.

Workshop participants were provided with a list of useful websites and other contacts, and with information helpful for approaching NASS, using health and social services complaints procedures, and appealing to the Asylum Support Adjudicators.

*(Notetakers: Marcella Celli, Helen Clegg, Nora McKenna, Stephanie White)*

### **Improving communication, improving services** Facilitator: **Edward Maw, Refugee Council**

The workshop explored the aspects of front line work with non-English speakers, beginning with an examination of the role of interpreting and translation in improving services for asylum seekers and refugees. At the Refugee Council an in-house team of paid staff covers the main languages, but the Refugee Council also maintains a list of people offering additional languages face-to-face or over the phone. As interpreters gain experience and develop relationships with other staff they can perform a more holistic role by addressing issues relating to the cultural and power relationships between client and service provider. In the case of translation, an agency provides translations of a professional standard but documents are then, wherever possible, proofread by Refugee Council multilingual staff to ensure that the language used is appropriate for the client group. Smaller documents and signage are produced by the interpreting team.

The Council's bi-cultural team can provide services directly without using an interpreter. Where interpreters are used, much emphasis is placed on ensuring that they understand how the Refugee Council works with asylum seekers and refugees. Debriefing sessions with experienced interpreters can provide helpful feedback on cultural and other matters, and the Refugee Council has various methods of obtaining feedback from clients themselves.

Among issues raised in the workshop were the selection of interpreters, the qualifications required, possible conflicts of interest, the boundary with advocacy, and the importance of stressing to interpreters the need for confidentiality and impartiality. There were also questions about the responsibility of schools, education authorities and GPs for providing interpreting, and the possible limitations on working through a third person, for example in counselling.

*(Notetakers: Maggie Ashworth, Roisin Cavanagh, Natasha King, Joanna Richmond)*

### **Female genital mutilation: working with the law, child protection issues and the impact on health**

Facilitator: **Enshrah Ahmed, FORWARD (Foundation for Women's Health, Research and Development)**

Female genital mutilation (FGM), also called female circumcision or cutting, is practised in the UK, Europe and east and west Africa. Most information about it comes from Unicef and the World Health Organisation, and the latter estimates that over 138 million women and girls world-wide are affected by FGM. There can be severe short and longer term implications for health, and there is increasing concern about possible HIV infection because of the circumstances in which FGM is carried out. Many reasons are given for the practice, but these have neither medical nor religious foundation, and FORWARD's view is that the issue is one of human rights and child protection.

FORWARD is an international NGO working to advance the sexual and reproductive health and human rights of African girls and women, attempting to influence policy and challenge practices such as FGM and forced marriage. The organisation has an active UK programme including discussions with and training events for statutory bodies, religious centres (including London Central Mosque), and refugee or other community organisations. For details, see [www.forwarduk.org.uk](http://www.forwarduk.org.uk).

Since 2004, it has not just been illegal to perform FGM in the UK, but if a girl is taken out of the country for FGM to be performed it is still considered a crime and parents can be prosecuted. No one has yet been prosecuted under the new law, perhaps because social services departments are anxious about seeming to challenge a cultural practice. However, a significant development in October 2006 was a ruling by the Law Lords that a teenager fearing circumcision should be granted asylum. This followed initial rejection of her asylum application by an Immigration Appeal Tribunal and the Court of Appeal.

Delegates watched a FORWARD video, and discussed the issues raised. Among delegates' questions were how to reach out to communities in order to open dialogue on FGM, and whether FGM made women reluctant to visit doctors.

*(Notetakers: Beba Parker, Juliette Stevenson)*

### **Supporting women as victims of rape and sexual violence**

Facilitator: **Elena Hage, Refugee Council**

In the experience of asylum seekers and refugees, sexual violence can encompass anything from offers of food, protection or other assistance in exchange for sexual favours, to rape and other physical sexual assaults. Sexual violence can occur before flight, on the journey or in the country of asylum. According to UNHCR, the majority of reported cases of sexual violence involve female targets and male perpetrators. Female victims seen by the Refugee Council range from educated middle class women to poor illiterate women, and the countries they come from range from reserved traditional societies to those more relaxed about the role of women.

Elena Hage described the holistic approach of the bi-cultural team in working with women victims. Delegates then used three case studies to consider possible ways of supporting the women involved, drawing on their own work experience where relevant. Among the issues raised were how to elicit women's needs in a sensitive way, the clues that may be given through body language, ways of working appropriately with interpreters, presentation of options when rape has led to pregnancy, and the components of a holistic approach. Confidentiality was seen as a major concern of clients, leading sometimes to reluctance to be open with solicitors and other agencies. Other areas considered were cultural awareness when working with victims of sexual violence, working with destitute asylum seekers, access to counselling and the psychological consequences of sexual violence.

*(Notetakers: Marcella Celli, Claire Reindorp, Kate Rhine)*

## **Understanding barriers to integration for refugee children with health, education and social needs**

Facilitator: **Dr Helen Robertson, Birmingham Community Children's Centre**

Delegates at this workshop were asked to list the basic needs of children, and then some of the barriers that refugee children might face in having these needs met. The remainder of the workshop discussed barriers to health care services, and explored ideas for improved access. Lack of time meant that education and social needs could not be discussed in detail.

Some of the barriers to health care are general ones not exclusive to asylum seekers and refugees, for example shortage of GPs in inner city areas and barriers related to poverty or homelessness. Others result from attitudes of NHS staff such as intolerance of people who do not speak English, or lack of interest in learning about other cultures or practices such as FGM. Dispersal causes considerable problems, and Helen Robertson set out the steps which would be required for someone moving to another area and seeking to continue treatment. In addition to problems in accessing primary and secondary care, as outlined in the morning session, there is great uncertainty about entitlement to tertiary care (long term life enhancing treatment).

Delegates expressed concerns about recruiting and working with interpreters. Among the problems raised were the sudden need for a particular language and the difficulty of assuring quality, the continuing inappropriate use of family members to interpret, support needs of interpreters listening to distressing stories, establishing and maintaining appropriate boundaries for interpreters, and the time required for appointments where an interpreter is involved.

*(Notetakers: Judith Dennis, Sharon Witton, Zenebe Woldegebriel)*

## **Understanding the health and social care concerns of older refugees**

Facilitators: **Elaheh Rambarzini, Refugee Council, and Claire Ball, Age Concern**

Until recently, relatively little attention has been paid to older refugees and asylum seekers. They have been largely 'invisible' to policy makers and service providers, both from the perspective of those working with refugee communities, and those working with older people. A two-year partnership programme by the Refugee Council, Age Concern England, Age Concern London and the Association of Greater London Older Women (AGLOW) is attempting to fill some of the gaps in knowledge, with an emphasis on obtaining the views of older refugees themselves about their needs and concerns through interviews and regional 'listening events'.

The Older Refugees programme is currently completing the first phase of research activities, and has produced *Older Refugees in the UK: A literature review*, a 2006 working paper prepared by the Refugee Council for the Older Refugees Programme ([www.refugeecouncil.org.uk](http://www.refugeecouncil.org.uk)). Reports of the individual interviews with older refugees, and a survey of Refugee Community Organisations and other voluntary organisations' work with older refugees will be published early in 2007. The first 'listening event' for older refugees and asylum-seekers in London was held in November 2006, hosted by the Greater London Authority at City Hall. Two further regional Listening Events are being organised in the West Midlands and in Yorkshire & Humber in April and May 2007 respectively.

The background to the project includes issues of unemployment and underemployment, inadequate housing, language barriers, health and mobility problems, insufficient access to appropriate services, family relationship problems, and loneliness and isolation. Racism, sexism and ageism may affect older refugees' lives. However, it is critically important to understand that older refugees and asylum seekers are individuals, not a uniform group, and to recognise their strengths and abilities. Delegates worked on case studies in small groups to identify problems and the possible ways in which complex needs might be prioritised and met through a range of agencies. It was noted that voluntary, including community organisations working directly with refugees, have a particularly important and valuable role in helping to identify and make more visible the specific needs and concerns of older refugees. Larger voluntary organisations working with older people, such as Age Concern, and statutory service providers should also ensure that they are aware of, and developing appropriate outreach and responses to the specific needs and concerns of older refugees and asylum-seekers. *(Notetakers: Maggie Ashworth, Natasha King)*

### **Working within the community to support disabled refugees**

Facilitator: **Jane Cook, HOPE project/Hillingdon PCT**

Disability is a complex matter, and Jane Cook set out the definition used in legislation and the ways in which being disabled can impact on individuals' lives practically, emotionally, in their relationships with others and within their communities. She outlined the many physical and mental health impairments which may affect refugees. Personal barriers to dealing with these can include cultural factors, fear, lack of knowledge of how the health system works, and communication barriers. Asylum seekers' priority may be dealing with their asylum application rather than their disability.

The barriers encountered in accessing services may include agencies' resource constraints, lack of joined-up thinking or working among agencies, inflexible systems and negative attitudes on the part of service providers. There can also be barriers to engagement or support in the community. Delegates looked at case studies to consider what services might be useful to the individuals and families described, how these might be accessed and other options for support which might be available.

*(Notetakers: Helen Clegg, Nora McKenna)*

*The Refugee Council would like to extend thanks to Refugee Council volunteer, Naomi Connelly for preparing this report.*

8 January 2007

Information and Marketing team  
Refugee Council

## Appendix 1

### Access and entitlements to health and social care

Sue Willman, Partner, Pierce Glynn Solicitors

*Everyone has the right to a standard of living adequate to the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services...*,  
**Universal Declaration of Human Rights 1948, Article 25(1)**

#### Social Care – a brief overview

1. The idea that asylum-seekers and other migrants who have health or social care needs should be treated very differently from any other vulnerable UK resident is a relatively new one. Restrictions on community care services were only introduced in 2002, followed more recently by the restrictions on NHS secondary treatment in 2004.
2. When access to mainstream benefits and housing was withdrawn from in-country asylum-seekers in 1999, destitute adults were rescued with community care provision (R v Hammersmith and Fulham LBC ex parte M), and families got help under the Children Act. Many of the single adults, who were supported under Section 21 of the National Assistance Act were able-bodied, with no particular care needs.
3. That led to the Immigration and Asylum Act in 1999, excluding asylum-seekers from access to mainstream housing and benefits, including disability benefits, replacing it with the National Asylum Support Service (NASS) provision of asylum support. The new scheme worked by excluding destitute asylum-seekers from assistance under Section 21 of the National Assistance Act 1948. But the exclusion only applies to asylum-seekers if their need for care and attention has arisen *solely* because [they] are destitute, or because of the effects of destitution.
4. It was not until 2002 (Nationality, Immigration and Asylum Act 2002, Schedule 3) that certain migrants with care needs were excluded from community care, housing and Children Act services, except where provision was needed to avoid a breach of their human rights. Those exclusions are:
  - Refugees from other EEA countries
  - EEA citizens
  - Refused asylum seekers with removal directions
  - A person who is unlawfully in the UK
  - A failed asylum seeker with a child who fails to leave the UK voluntarily  
- Asylum and Immigration (Treatment of Claimants, etc Act , Section 9)
5. We are still in limbo on Section 9, awaiting a government announcement about whether it will abolish or replace the scheme. No more families have had their support withdrawn under it since the pilot ended at the start of the year. Some of the 113 families affected by the pilot remain without support.

## Social services or NASS?

1. Since 1999 there has been a struggle in the courts between central and local government about who is responsible for vulnerable asylum seekers and former asylum seekers with care needs.
2. The first round was lost by Wandsworth and Leicester councils in a Court of Appeal case called *R v Wandsworth LBC ex p O* (2000), which involved two 'overstayers' who needed accommodation under Section 21 National Assistance Act 1948. One had severe psychiatric problems, the other had recurring cancer of the duodenum which required continuous medical treatment. The court seemed to have decided that where there were 'non-destitution needs' the person fell within the community care regime even if their accommodation and support needs could be met in other ways. In the words of one of the judges, then Lord Justice Simon Brown:
  3. *'If there are to be immigrant beggars on our streets, then let them at least not be old, ill or disabled'*.
  4. Ironically, another of the judges, then Lady Justice Hale said:
    5. *'It makes no sense for the old, the sick or the disabled to be eligible for hospital and other health services but not for the community care services they need'*.
6. The second round was lost in the House of Lords in 2001 by Westminster City Council (*v NASS*). Mrs. Ahmed was an asylum-seeker with spinal myeloma. She needed wheelchair accessible self-contained accommodation near the hospital. The court had no hesitation in finding that where an asylum seeker's needs for services under Section 21 arose not solely from destitution, the responsibility to meet those needs lay with the local authority, and not with NASS.
7. Round 3 was lost by Lambeth Council in a Court of Appeal case called *Mani*. Mr. Mani had a congenital abnormality of his right leg which was about half the length of his left leg, which limited his mobility. He used crutches and a prosthetic limb which meant he had needed some help with housework, carrying heavy shopping and bathing. He also had a history of psychotic illnesses. Lord Justice Simon Brown again supported the position that social services clearly had a Section 21 duty.
8. In the meantime there had been some consolation for hard-pressed local authorities with Schedule 3 (see above on page 18). It was not until *R (AW) v Croydon LBC* [2005] that the effect of these exclusions on a former asylum seeker with mental health needs were considered. The High Court decided that a refused asylum seeker who originally applied at port and so had temporary admission was lawfully in the UK and so was not excluded from community care services. A refused asylum seeker who had applied in-country was not lawfully in the UK. But they could still access Section 21 accommodation if it was needed to avoid a breach of their human rights. This will normally be where they have made a valid fresh asylum or human rights claim (not yet recorded by the Home Office). If not, their options would probably be NASS Section 4 support or to leave the UK. Both sides are appealing.
9. Perhaps the last word on the debate will be a recent case involving a destitute asylum-seeker with HIV who needed a fridge for his medication (*R (M) v Slough LBC* [2006]). The council argued that the physical effects of homelessness arose from his destitution so NASS were responsible for accommodating him. The Court of Appeal agreed that destitution plus medical needs meant his needs for Section 21 assistance were not solely due to his destitution.

## Children

1. Where an adult with care needs has dependent children, financial responsibility is split, with NASS paying for the children and Social Services paying for the parent (see *O v Haringey LBC* [2004] and NASS Policy Bulletin 82). Carers may be the responsibility of the local authority or NASS.
2. In a case where the parents of two severely disabled teenagers had to carry them upstairs to the bedroom and downstairs to the toilet, it was NASS, not Social Services who were responsible for financing adequate accommodation and support. If NASS could not identify adequate accessible accommodation, the local authority could be asked to assist.

## Healthcare - Who is lawfully here?

3. Refugees, people with leave to remain such as discretionary leave or humanitarian protection, asylum-seekers with outstanding claims and appeals and their dependants are entitled to free NHS treatment. But regulations introduced in April 2004 limited access to secondary health care (hospital treatment) for some former asylum seekers and other migrants. Similar regulations are being considered for primary care (GP treatment).
4. The way the regulations work is that an overseas visitor is liable to be charged for NHS secondary care. But an overseas visitor is defined simply as "a person not ordinarily resident in the UK" (regulation 1 NHS (Charges to Overseas Visitors) Regulations 1989 as amended). Also all those who have resided lawfully in the UK for a period of not less than 1 year are exempted from charges (regulation 4(b)).
5. There are exceptions from charging where the patient is already receiving a course of treatment which can be completed. Emergency services provided at A and E and walk-in centres remain free of charge.
6. NHS Trusts have to identify those who are not ordinarily resident or otherwise exempt from charges for hospital treatment and to charge them for treatment. They have been following the Department of Health guidance 'Implementing the Overseas Visitors Charging Regulations – Guidance for NHS Trust hospitals in England' at [www.dh.gov.uk](http://www.dh.gov.uk). Asylum-seekers are granted free treatment because they are regarded as 'ordinarily resident' at least until their claim/appeal has been determined.

## Who is ordinarily resident?

1. Firstly, in the *AW* case referred to above it was decided that an asylum-seeker with temporary admission was lawfully in the UK. Secondly, the House of Lords has decided that an asylum-seeker with temporary admission is 'lawfully present' in the UK (*Szoma v SSWP*). In another case they decided that 'ordinary residence' depended on its context and the place where a person was actually living for example a labourer could be ordinarily resident on a farm where he was working if he had no other accommodation. It can be argued that a person who is lawfully present in the UK can expect to become 'ordinarily resident' here if he has come here voluntarily and intends to settle here for a short or long duration (*Nessa v CAO [1999]*).

2. But NHS trusts have been following the guidance and refusing treatment to failed asylum-seekers unless it is emergency or 'immediately necessary' healthcare. In the case of a Palestinian with chronic and severe liver disease, this meant he was refused surgery to relieve the pain, and simply offered painkillers. Although his asylum claim has been refused he is currently unable to return to Palestine because the Israeli authorities are not willing to issue travel documents. He has temporary admission, which is normally granted to those asylum-seekers who make their claim 'on arrival' or 'at the port' when they enter the UK, as opposed to 'in-country' applicants.
3. We recently applied to the High Court arguing that because he has temporary admission, he was lawfully resident in the UK and the Department of Health guidance was unlawful (*R (A) v West Middlesex University Hospital NHS Trust (1) and Secretary of State for Health (Secretary of State for the Home Department, interested party)* CO/8095/06). The hospital trust made more enquiries at the Home Office who confirmed that he had temporary admission. The trust accepted that he was eligible for treatment and he now has a consultant's appointment.
4. We hope to continue his case against the Department, arguing that the guidance is wrong and must be changed because of others in his situation who are being refused treatment. We have been helped with evidence from MDM, Medact, the Refugee Council and others to show that there is a steady stream of former asylum-seekers being refused treatment for cancer, antenatal and post-natal treatment and a variety of other chronic conditions, some of which are potentially life-threatening.
5. This argument may also help those with an outstanding claim under article 3 of the Human Rights Convention (as opposed to a refugee claim) if they have been here for 12 months.
6. There is also some help in the Council Directive 2003/9/EC laying down minimum standards for the reception of asylum seekers. The Reception Directive requires EU member states such as the UK to provide healthcare for asylum-seekers. They must ensure that asylum seekers 'receive the necessary health care which shall include, at least, emergency care and essential treatment of illness'. Applicants with special needs should receive medical or other assistance. The Directive applies only to asylum-seekers within the UK, but this includes 'a third country national or stateless person who has made an application for asylum in respect of which a final decision has not yet been taken'. This could include a failed asylum-seeker who has made a fresh claim which has not yet been recorded or decided.
7. For more information about the Directive see *Asylum Support: A practitioner's guide to the EU Reception Directive* published by [www.justice.org.uk](http://www.justice.org.uk)

## Other exemptions

1. Even where there is no exemption from charges, 'immediately necessary' treatment should be provided, if required, before a decision has been made about liability for charging. The guidance says:

*Trusts need to treat people in need of immediately necessary care regardless of their ability to pay. This may be because their condition is life-threatening, or because if treatment is not given immediately it will become life-threatening, or because serious damage will be caused by any delay. It is a matter of clinical judgment which should not be second-guessed by administrative staff....Where immediately necessary treatment takes place and the trust knows that payment is unlikely, treatment should be limited to that which is clinically necessary to enable the patient to return to their own country, treatment is not 'immediately necessary'.*

2. One example of immediately necessary treatment is ante and post-natal care. Research shows that asylum seeking mothers who don't access medical treatment are seven times more likely to die as a result of pregnancy/childbirth than British women. The Department of Health's guidance stresses that failed asylum seekers should receive maternity care 'because of the severe health risks associated with conditions such as eclampsia and pre-eclampsia, maternity services should not be withheld if the woman is unable to pay in advance'.
3. If the patient can lawfully carry out certain types of voluntary work s/he will be exempt from charges. The voluntary work must be providing services similar to health and social services for example for caring organisations under the Health Services and Public Health Act 1968 Section 64 and Section 65. There are numerous voluntary bodies who get these grants. The difficulty is that post asylum-seekers or former asylum-seekers do not have permission to work lawfully and voluntary work is included. For those that do, the organisations with grants under Section 64 are listed at:

[www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/FinanceAndPlanning/Section64Grants/fs/en](http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/FinanceAndPlanning/Section64Grants/fs/en)

4. Treatment is free for a list of communicable diseases such as MRSA, measles and yellow fever. It is not free for HIV treatment except for testing.

## The Human Rights Act

1. As a public body, the health trust must consider whether the refusal of medical treatment will interfere with the right to life under Article 2 of the European Convention on Human Rights (ECHR). The case law of the European Court of Human Rights confirms that a refusal of medical treatment may amount to a breach of the right to life as well as an unjustified interference in private life – see *Cyprus v Turkey* (2001) (Application No 00025781/94 ECHR 2001-IV). There may also be a breach of Article 3 (freedom from inhuman and degrading treatment).
2. The case law of the European Court of Human Rights suggest that health trusts and the UK courts should interpret the regulations so as to avoid an interference with ECHR rights - to respect for life (Article 2), to freedom from inhuman and degrading treatment (Article 3), to respect for family life (Article 8), and outlawing discrimination (Article 14).
3. It may be possible to argue that it is not reasonable or proportionate to refuse medical treatment to foreign nationals who are lawfully in the UK and that the 1989 Regulations are incompatible with Articles 8 (right to respect for family, home and private life) and 14 (anti discrimination article) of the Convention.

## Primary care (GP treatment)

1. The government is considering changes so failed asylum-seekers and others would not be able to consult a GP without payment unless the condition was 'life threatening' or the treatment was 'immediately necessary' (Proposals to Exclude Overseas Visitors from Eligibility to Free NHS Primary Medical Services, Department of Health May 2004). But at present there are no indications of a timescale for introducing them.
2. Primary care includes GP treatment, dental treatment and eye tests from an optometrist or ophthalmic optician. Many of the principles explained in relation to secondary treatment apply here, but primary care is not covered by the Overseas Visitors Regulations. Asylum seekers have a right to free primary care until their claim is decided.
3. NHS Circular 1999/018 states that failed asylum seekers should not be registered with a GP. However, a GP has discretion as to whether or not to accept anyone onto their list, including a failed asylum-seeker or anyone who is not ordinarily resident or is unlawfully in the UK. So they can decide to accept a patient and treat them.
4. A GP has three options if a failed asylum-seeker applies to join their list: accept them as a permanent patient; treat them as a temporary patient; refuse to accept them on their list and charge for treatment as a private patient. [See NHS (General Medical Services) Regulations 1992 as amended and the Circular 1999/018].
5. A GP must provide emergency treatment or immediately necessary treatment for a maximum of 14 days to a temporary patient.
6. The effect of the secondary care changes and rumoured primary care changes has been confusion for staff in GP's receptions about who can and can't receive treatment. Failed asylum seekers who have an outstanding fresh asylum or human rights claim or who can't travel home receive housing and support from NASS under Section 4 of the Immigration and Asylum Act 2004. At the same time they may be refused secondary care and have no automatic right to primary care. Many, including our client Mr. A, have then needed treatment at the Accident and Emergency Department.

## Appendix 2

### Surviving destitution: access to services at the end of the asylum process

Nancy Kelley, Head of UK and International Policy, Refugee Council

It's wonderful to have an opportunity to address today's conference. In my speech, I will focus on asylum seekers whose claims have been refused. I'd like to start with a little context about the health and care needs of refugees and asylum seekers, then consider how the ethos of health and social care fits (or doesn't fit) with the current ethos of immigration control, then finally look at some specific examples of the way in which health and care needs are ignored, exacerbated or even created by government policy at the end of the process.

#### **Health and care needs of refugees and asylum seekers**

- 20% of refugees and asylum seekers have physical health problems that make day to day life difficult.

These can be the result of conditions in their country of origin, including poverty, lack of preventative healthcare and the prevalence of particular diseases such as TB or HIV.

- 5 - 30% of refugees and asylum seekers have been tortured, including many who have been subjected to rape and sexual violence.

The physical effects of torture include head injuries, crushed bones and extensive scarring, in addition to physical symptoms caused by psychological stress. Rape carries a risk of contracting HIV or other sexually transmitted diseases. Torture and sexual violence have significant effects on the long-term mental health and well being of victims.

- Maternal deaths amongst this population are high, and over 80,000 women and girls in the UK have undergone FGM.

The high rate of maternal deaths is a result of a range of factors including lack of access to antenatal care, and poor nutrition.

Having undergone FGM leaves girls and women with significant sexual and reproductive health needs in addition to severe emotional trauma.

#### **Health and care needs of refugees and asylum seekers**

- Refugees and asylum seekers have mental health needs caused or exacerbated by the trauma of persecution and flight and the stress of life in the UK.

Asylum seekers and refugees are one of the highest risk groups for suicide in the UK

- 3 - 10% of refugees and asylum seekers are disabled.

Lack of understanding of the needs of this group, but existing evidence illustrates a high level of unmet basic care needs

- Refugee and asylum seeking elders experience profound isolation and loss.

Elders make up only a small proportion of asylum applications, and the experience of flight combined with the stress of life in the UK can cause both health and mental health problems.

- Refugee families with children need family support to enable them to begin a healing process, access education, and adjust to their life in the UK.

Traumatic experiences pre and post flight, changes to family structure and roles, interrupted education, loss of usual carers, and social isolation all have a profound impact on refugee children. The UK government describes asylum-seeking children as 'amongst the most vulnerable children in the UK' in its Every Child Matters agenda, but often fails to meet these children's needs.

The asylum process makes this already bad situation worse. Both the relative poverty in which applicants live, and the stress or uncertainty of life here contributes to a decline in their health and well-being.

Accessing services can be difficult if not impossible, as a result of language and information barriers, shortfalls in service provision, particularly culturally sensitive services provision, and the pressures of surviving and trying to deal with the asylum claim.

So if this is the picture for asylum seekers whilst their claim is being considered, what happens to asylum seekers when their claims are refused?

### **Care *versus* Immigration Control**

- *Patients must be able to trust doctors with their lives and health. To justify that trust you must show respect for human life and you must make the care of your patient your first concern*  
(Good Medical Practice, GMC)
- *Social workers attempt to relieve and prevent hardship and suffering. They have a responsibility to help individuals, families, groups and communities through the provision and operation of appropriate services and by contributing to social planning*  
(Code of Ethics for Social Workers, BASW)
- *Our priority is to toughen our borders, prevent abuse of our immigration laws and manage migration to the benefit of the UK*  
(*Fair, Effective, Transparent and Trusted*, Immigration Nationality Directorate, Home Office, Chapter 2, para 2:1)

Over recent years we have seen a radical shift in government policy away from seeing asylum seekers whose claims have been refused both through the lens of immigration control AND as individuals with support, housing, health and care needs to be met, towards seeing ALL aspects of their lives and experiences purely through the lens of immigration control.

The person-centred ethos of our health and social care systems has no place in the current government response to those people who have reached the end of the asylum process with a negative outcome.

Instead, policies are deliberately designed to create and exploit their vulnerability in the attempt to drive up returns, and drive down applications.

All of these policies are de-humanised, described as 'encouraging voluntary return', 'sending messages' or 'making it clear that people must leave if they have no legal right to be in the UK.'

I'd like to briefly consider three policy areas in more depth: the increased use of detention and its impact, poverty and destitution and denial of access to secondary care.

### **Detention as 'deterrent' or default**

The five-year strategy on immigration outlines plans to:

*'move towards the point that it becomes the norm that those who fail can be detained'*

This isn't a policy supported by evidence: a recent UNCHR report on alternatives to detention across 34 states, found little or no evidence that detention was necessary in destination states such as the UK.

Rather, it is a policy driven in part by administrative convenience, and in part by a wish to 'demonstrate' something about the way in which the UK immigration system functions.

But in addition to being a serious breach of human rights, detention can have a profound effect on the health and well being of detainees.

### **Failures to assess or meet health and care needs of detained asylum seekers**

The decision to detain a person, and all reviews of detention, require an assessment of whether that person is 'fit to be detained', with particular regard to the vulnerability of torture survivors.

The experience of agencies such as BID (Bail for Immigration Detainees) and evidence from HMIP inspections suggest that asylum seekers with health or mental health problems and torture survivors are often detained including for long periods of time.

Disrupted or inadequate treatment including not passing on health records, treatment plans or medications and not referring to appropriate specialists is commonplace.

## **Mental health / children and adults**

The experience of detention can have a profound impact on the mental health of detainees, particularly that of children and other vulnerable groups. Accessing proper mental health support services from detention is impossible.

The recent HMIP report into the health service at Yarl's Wood IRC provides a stark insight into the services provided to vulnerable detainees.

The report was triggered by the treatment of a group of women on hunger strike, and in general, the enquiry found that:

*'the healthcare service was not geared to meet the needs of those with serious health problems or the significant numbers of detainees held for longer periods for whom prolonged and uncertain detention was itself likely to be detrimental to their wellbeing'*

*'The inadequacy of healthcare systems in the IRC was compounded by the unresponsiveness of the IND to clinical concerns about an alleged history of trauma or adverse medical consequences of continued detention'*

In the report, the most powerful portrait of the human costs of detention policy comes from Yarl's Wood's Head of Religious Affairs, the Rev Larry Wright who said:

*'the centre is like a human clearing house... People have few outlets for stress. Suicide and self harm forms are going up. I keep sending concerns to the IND contract monitor or doing letters for bail applications, but there is resistance to interrupting the removals process. Then there is the culture of mistrust, with all the inherent dangers: an attitude of 'these people will do anything to stay' generates resistance to wanting to see anything more. There is no clear strategy when people start losing the will to live'*

So, in the increased use of detention we see a policy with no clear evidential basis, that at best is indifferent to the vulnerability of those it affects and at worst exploits that vulnerability to enable removals.

## **Poverty and destitution**

An increasing proportion of Refugee Council's caseload is made up of destitute asylum seekers, desperate for shelter and food. This is the direct result of a series of policy changes aimed at 'encouraging' asylum seekers to return to their countries of origin when their claims are refused by removing all access to housing or support, something that has often been described as an attempt to 'starve people out' of the country.

In practice, fearful of return, these policies simply drive people into the illegal economy or onto the streets, and radically increase the financial pressure on refugee communities, faith communities and voluntary or community sector organisations. Living with this degree of insecurity and poverty has the predictable impact on health and care needs: they get far, far worse.

### **Schedule 3, Nationality Immigration and Asylum Act 2002**

Excludes asylum seekers whose claims have been refused from community care, housing and children act services, unless failure to provide a service would lead to a breach of their human rights.

The human cost can be terrifying. Our Specialist Team, based in our London office has worked with women who, left homeless and penniless as a result of Schedule 3, have been raped whilst sleeping rough on the streets, as well as many people whose mental health has been unable to withstand the pressures of homelessness, poverty and threat of removal, and who have needed inpatient psychiatric care.

### **Section 4, 'hard case' support**

Designed as a short term safety net to provide limited support to those who either could not return, or were cooperating with the return process, Section 4 has become a long term support regime for a growing number of those whose claims are refused.

The appalling quality of the accommodation provided and the inadequate and stigmatising voucher regime both contribute to deterioration in the health and wellbeing of those 'lucky' enough to be on Section 4 support.

The inadequacy of Section 4 support is not accidental, as is clear from the following speech made by Baroness Ashton of Upholland during debates on the 2005 Bill.

*'While meeting essential needs, the support should not act as an incentive for people to remain in the UK once they've exhausted their appeal rights. We do not want to invite people to draw on the public purse if they do not need to; more importantly, nor do we want to reduce the incentive for people to take steps to leave the UK voluntarily.'*

Whilst those on Section 4 are not quite being starved out of the country, the regime is designed to make their lives here intolerable, thus 'reducing the incentive' to stay in the UK.

### **Section 9, Asylum and Immigration (Treatment of Claimants) Act 2004**

Until the introduction of Section 9, families with children remained one of the few groups whose support was protected even after their claim for asylum was refused. To date, Section 9 has only been rolled out in three pilot areas, applying to 116 families, and it remains to be seen whether in response to overwhelming pressure and clear evidence of its failure the policy will be repealed, or merely revised. Nonetheless, the implementation of the pilot phase had a devastating impact on the families and children concerned.

Refugee Council worked with 29 of the families, finding that

- Families were confused and terrified that their children would be taken into care, making it impossible for them to consider their position particularly the complex issue of return.
- In a third of the families, parents had significant health needs, ranging from heart problems to sickle cell anaemia, and late stage pregnancy.
- In 80% of the families, one or both parents had significant mental health needs, ranging from diagnosed conditions to depression and anxiety.
- Children were experiencing problems relating to trauma in their country of origin, and poverty or stress related illness related to their life in the UK.
- Many families had already fled their accommodation. We were unable to contact many families as a result.

Although not rolled out, Section 9 remains a clear illustration of just how divorced the policy regime is from its human impact, or the humane ethos of the health and social care system.

### **Denial of secondary healthcare**

This year, the Refugee Council published a report *First do no Harm: Denying healthcare to asylum seekers whose claims have failed*. The report documents our experience of working with people denied healthcare under the NHS (Charges to Overseas Visitors) (Amendment) Regulation 2004.

As Sue has noted, the impact of the regulation is to remove entitlement to secondary (hospital) health care for asylum seekers whose claims have been refused.

Justified as a measure to combat health tourism, this policy stands alongside Section 9 in its total lack of respect for the human rights or needs of the vulnerable.

### **Maternity care**

Despite exemption from up-front charging for maternity care, confusion about the policy has led to many women being denied maternity care, placing their own and their children's lives at risk.

One young woman we worked with gave birth in hospital, and her baby was immediately admitted to special care. She was invoiced for £3,024, and totally unable to pay, she was too frightened to take her baby for follow up checks in case debt collectors or IND removals staff were waiting at the hospital.

### **Cancer**

We worked with a man with bowel cancer, admitted to Accident and Emergency with uncontrolled bleeding and scheduled for an operation as soon as the bleeding stopped. When the hospital discovered his immigration status he was billed for thousands of pounds, his operation cancelled and he was discharged, told to come back 'when his condition deteriorates.'

## Chronic health needs

We worked with a diabetic man in renal failure, referred to us in desperation by his own primary care trust as they had been unable to influence the local hospital. By the time of referral he had been charged more than £70,000 for his care.

## HIV

Under the regulation, HIV testing and counselling is free, but treatment is available only to those who can pay.

We worked with a woman with cancer and possible HIV infection (her husband had died of AIDS). Her trust denied her cancer care, and offered to test, but not treat her for HIV.

## Trauma care

We worked with a man who sustained multiple leg and hip fractures in an accident. He needs pain management support, physiotherapy and possibly bone grafts. He was charged £4,572 for his emergency treatment, and told he can only have the ongoing care if he pays.

These cases illustrate the terrible consequences the policy has for individuals, but the policy and its implementation also have significant implications for the ethos underpinning the work of the NHS (much as Section 9 for social services departments)

*Patients must be able to trust doctors with their lives and health. To justify that trust you must show respect for human life and you must make the care of your patient your first concern'*  
(Good Medical Practice, GMC)

- *Social workers attempt to relieve and prevent hardship and suffering. They have a responsibility to help individuals, families, groups and communities through the provision and operation of appropriate services and by contributing to social planning*  
(Code of Ethics for Social Workers, BASW)

If the increased use of detention represents a policy that is indifferent to the health and wellbeing of asylum seekers, and withdrawal of support a policy that deliberately creates a situation that is likely to harm health and wellbeing, the charging regulations represent the naked use of health and care services as a tool for immigration control; something that is unimaginable from the perspective of ethical health and care practice.

Allowing this to continue should not be an option. Our health and welfare systems were founded on the principle of universal access, and the idea that health and wellbeing are fundamental both to the individual and to our society as a whole. It's essential that we continue to work together, and fight for a system that respects the human rights and needs of refugees and asylum seekers, including those whose claims have been refused.

## Just.Fair

With that in mind, I'm delighted to have the opportunity to launch Refugee Council's new campaign Just. Fair

The aim of the campaign is to bring together the voluntary and community, statutory sector agencies, unions and faith groups to challenge policies that deliberately create destitution and suffering for asylum seekers and refugees and to effect change at a local, regional and national level.

It's about collaboration: in the first phase of the campaign, the Refugee Council will be concentrating on working with partners to challenge the NHS charging regulations, and we'd love your support in this, but we may also be able to support you in working on your priority issues through joint projects, sharing information and campaign tools, or endorsing your work.

Please take the time to look at the information you've been given about Just.Fair. You can sign up today to become part of our mailing list and receive updates on the campaign, but please do more than this – go back to your organisations and talk about what you can do, and what we can do together to begin the long process of changing attitudes and changing policy.

The right to seek and enjoy asylum from persecution is a fundamental human right. Punishing people for exercising that right by locking them up, plunging them into destitution and leaving them to suffer is an unforgivable abuse. Together we can stand up for a system which is rights based, humane, just. Fair.