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ESSAY

Why asylum seekers deserve better healthcare, and how we can give it to them

Many asylum seekers in the UK find themselves in a purgatory of paperwork that leaves a total absence of healthcare. Olivia Farrant and colleagues explain how, in the depths of the pandemic, a model response was born

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In August 2020, Kirsteen McDonagh met a young family staying at an address that seemed strange. The family had only recently migrated to the United Kingdom and had been housed in student accommodation in central London. It was, the family explained, "contingency accommodation" in which they had been placed by the Home Office while they waited for their asylum claim to be processed. This was the first case of hundreds that McDonagh, a specialist health visitor for homeless families, employed by Central and North West London NHS Foundation Trust, would encounter.[1]

The crisis in Afghanistan has again brought migration into the international spotlight. Refugee migration to the UK shows little sign of diminishing, and the problem of how to best look after asylum seekers is becoming acute. Many new arrivals have complex health needs for which current NHS healthcare systems struggle to offer appropriate care, exacerbating the trauma already experienced by many of these vulnerable people and families.

In June 2021, key recommendations were published by the Safeguarding Adults National Network in relation to the health and wellbeing of people seeking asylum.[2] The current ability of local health services to meet the complex needs of asylum seekers is variable; many pockets of good practice exist across the country, but many areas have struggled to respond to the demands of meeting these complex healthcare responsibilities. An asylum seeker is a person who seeks protection from persecution and serious human rights violations in another country, but who hasn't yet been legally recognised as a refugee and is waiting to receive a decision on their asylum claim.[3] In 2020, most asylum seekers in the UK came from Albania, Eritrea, Iran, Iraq, Sudan, and Syria.[4]

When a person claims asylum in the UK—and if they are destitute—they are provided with "initial accommodation." There are approximately 13 initial accommodation hostels around the UK; they are designed to be short term and often have commissioned health and social services allocated to them. The Home Office's target is for people to remain in initial accommodation for 35 days, before being rehoused in longer term "dispersal accommodation"—generally a house or flat in a residential area, often shared with others—to wait for their asylum claim to be processed.[5] The Home Office's target is for 98% of claims to be processed within six months.[6] After a claim is processed, the asylum seeker is either granted permission to stay under humanitarian protection, including as a refugee, or the claim is refused, and they are deported.[7] Contingency accommodation is used when all places in both initial and dispersal accommodation are filled. It comprises hotels in often non-residential areas with no allocated health, education, or schooling services. Its use has skyrocketed in the covid-19 pandemic.

At the end of March 2021, 66 185 people were waiting for an initial decision from the Home Office, the highest number in over a decade. Around 50 000 of these people had waited for over six months, and asylum claims are currently taking between one and three years to be processed.[6] Asylum seekers are not permitted to work during this processing period and are provided with a subsistence allowance of £39.63 a week.

Studies have shown that the uncertainty of this long process can have a major negative effect on asylum seekers' mental health.[6,8] But this is just one of the many health needs that can go unmet during an asylum seeker's long wait for security.

Why the system is broken

In the UK, all asylum seekers have the right to access primary and secondary NHS services without charge. But the barriers to access can be so high that these rights are very challenging to realise.[9] GP registration is often wrongly denied if someone does not have appropriate identification or proof of address, transport costs can be prohibitively expensive, negotiating complex NHS procedures can be difficult for non-English speakers, and existing complexities in the healthcare system are amplified by repeated relocation.[10]

At our clinic in central London, nurse practitioner Anna Burnley phoned a refugee patient who had missed an appointment. The patient explained that they had been moved to new accommodation. "The patient very kindly offered to come to another appointment but said she didn't know how far it was," Burnley said. It transpired that they were in Scotland. This type of occurrence is far from unusual.

The recent shift to remote consultations has presented additional challenges for people with limited access

to technology and the internet. This has led to a huge reduction in primary care interactions, even among UK permanent residents.[11] These barriers extend to secondary care, where there is often confusion among patients and NHS staff regarding the legal entitlements of this group. Asylum seekers may not know where to find a doctor or that care is free of charge. Even if they successfully navigate all these barriers, the strictly time limited structure of a typical NHS consultation can be inadequate for the complex and interconnected problems of most asylum seeking families: appointments in primary or secondary care are brief and usually have a narrow focus.

Respond

In the London borough of Camden, a team of primary and secondary healthcare providers have initiated a pragmatic, joined up approach that could be applicable around the country. It started in December 2020, as the UK entered another lockdown, and covid-19 case numbers were rising dramatically. Health and safeguarding professionals in Camden became increasingly concerned about the needs of patients seeking asylum.

McDonagh had spoken with her NHS safeguarding colleagues about the vulnerability of babies and young children placed in contingency accommodation. The safeguarding team recognised a similar profile of needs to those they had seen in unaccompanied asylum seeking children. In 2016, a specialised service had been set up for these children, and infection and paediatric consultants at University College London Hospital (UCLH) had wanted to adapt this model into a family focused migrant health screening service for some time. Here, amid a global crisis, was an opportunity—Respond was born. Respond is an integrated model of care, designed to meet the complex needs of asylum seekers in contingency accommodation. The service is hosted by UCLH but is delivered either directly in the contingency or initial accommodation or in primary care practices.

After GP registration, asylum seekers are given an appointment with an infection and inclusion health practitioner who assesses the family holistically, using a trauma informed approach. They start investigations according to a protocol and refer or signpost to relevant services such as antenatal care, opticians, and dentists (table 1). Families are screened as units, parents alongside their children, and appointments are longer to allow time for comprehensive assessment.

Table 1 | The Respond model—comprehensive screening and action in primary care

Health and wellbeing domain	Screening activity	Associated Respond actions
Physical health including infectious diseases	Physical health symptom survey. Medical, drug, and vaccination history. Screening for HIV, tuberculosis, viral hepatitis, schistosomiasis, strongyloidiasis, and other relevant gut parasites and infections	Referral for catch-up immunisations. Specialist review of positive ID screening results. Signposting to accessible vision and hearing screening. Booking of targeted GP appointments
Emotional and psychological wellbeing	Mental health symptom survey. RHS-15 screening completion[12]	Referral to local primary and secondary care mental health services. Signposting to community support groups and useful wellbeing resources
Sexual and reproductive health	Sexual health screening, STI testing and access contraception	Referral to antenatal services. Referral to sexual health services. Booking of targeted primary care input for contraception
Child development and family functioning	Key developmental domain screening and observation, exploring current access to local play and education resources	Referral to local child development services, allocation of a family support worker with local authority early help services. Engagement with specialist health visitor and school nursing teams
Trauma and safeguarding	Targeted screening questions to uncover history of trafficking, sexual exploitation, torture, FGM, modern slavery, and domestic violence. Consideration of impact of parental trauma on parenting capacity	Referral to early help and safeguarding services. Referral to third sector organisations for victims of trauma and torture
Oral and dental health	Dental pain, access to toothbrushes and toothpaste, referral to urgent and non-urgent dental services	Oral health promotion packs, facilitation of access to emergency dental care, signposting to accessible local dental services, referral for specialist

FGM=female genital mutilation; RHS=refugee health screener; STI=sexually transmitted disease.

As well as referrals within the NHS, partnerships with the local authority "early help" services and non-governmental organisations allow for additional support with housing, schooling, and welfare services. After the appointment, further decisions are made at a dedicated care planning meeting in the community, or a tertiary level multidisciplinary team meeting for complex cases. The cornerstone of these meetings—and the Respond model as a whole—is the formulation of an integrated migrant health plan, an electronic document that outlines the key issues for each family member. This document stays with the family as they move around the country thus avoiding having to start again after each short notice relocation.

To deliver an efficient, effective, and scalable service, staff must have adequate training, be empowered, feel supported, and have a safe space to debrief. Alongside the clinical work, staff who work directly with patients receive a weekly training series in collaboration with the Helen Bamber Foundation, the United Nations High Commissioner for Refugees, and Forrest Medicolegal Service. Respond has also started peer support groups with the clinical psychology service for providers to be able to reflect on this emotionally challenging work.

In August 2021, for example, Respond screened 38 patients, making up 10 families, in a Camden based general practice. Almost all these patients (91%) were found to have an acute or chronic medical issue and were appropriately triaged, often without needing a GP

appointment. Screenings have picked up advanced presentations of common conditions because of lack of access to healthcare and interruptions in medication—for example, an urgent prescription for a patient with epilepsy who had had her seizure medication thrown overboard by a people smuggler on the crossing from Calais, a same day review for a patient with an unexplained 10 kg weight loss, and an expedited speech and language therapy appointment for an 11 year old with a debilitatingly severe stammer.

Respond has encountered disease and injury related to shrapnel wounds and torture and has provided a space for the first disclosures of sexual violence. Nine of every 10 families seen needed onward referral after a careful assessment of their mental health. Respond has provided universal screening for infectious diseases and detected infections in 30% of those screened, including latent tuberculosis, strongyloidiasis, and schistosomiasis.

For the asylum seeking families that have overcome the multiple barriers preventing them from accessing healthcare, we calculate that this clinic saves approximately 10 GP appointments per family, a total of approximately 100 GP appointments a month. Issues are often interconnected within a family, so if each person had their problems looked at in isolation, they would take far longer to address. Providing information to patients about NHS services, as well as documenting important negative findings in the patient record (such as the absence of safeguarding concerns), will also save time in primary care.

Many of these patients have not been accessing healthcare, which is why their presentation is so complex. Engaging with the Respond team might initially lead to more planned encounters with healthcare professionals in this previously marginalised population with unmet health and social care needs. A key benefit of the model is its flexibility and potential to extend to general practices across the country. It will be relevant long after the contingency hotels stop being used and could be adapted for other underserved populations that are commonly unable to navigate the health system and have poorer health outcomes as a result.

This is a critical time for such an intervention, with a wealth of research showing the deepening of health inequalities caused by the covid-19 pandemic.[13] As the delivery of care using the Respond model continues to expand, we hope to objectively show its success in ensuring access to quality healthcare for an underserved population who, frankly, have been through enough.

Case study: Ayana

Ayana* arrived in Camden in the summer of 2020. The widowed pregnant mother of a five year old girl, she had fled Eritrea a year earlier after an attack on her village by government forces. Upon arriving in the UK, Ayana was growing increasingly worried about her daughter's speech delay. Ayana had also received no antenatal care for her new pregnancy, now in its second trimester. Troubled by persistent pain in her left leg after falling from a lorry in northern France and kept awake by flashbacks and nightmares, Ayana was barely sleeping.

It took six weeks for Ayana to register with a local GP surgery and make an appointment to see a doctor. Half her allocated appointment time was spent trying to find a translator who spoke her language, and she struggled to articulate the persistent concerns she has regarding her daughter's health and development. Displaced and powerless, she didn't feel able to talk about the violence and trauma leading to this pregnancy, nor how she would feel about the baby when it arrived. These thoughts were now crowded out by worries about her daughter's future and the pain from her leg injury. In Ayana's case the complexity of her family's physical, emotional, and wellbeing needs required an appointment length far longer than the allotted 10 minute slot.

Ayana and her daughter were assessed by an infection and inclusion health practitioner from Respond, alongside a family support worker who was able to distract Ayana's daughter with play so that Ayana could talk about the trauma they had both endured. Ayana was then promptly referred to antenatal care services, investigated for asymptomatic infections, scheduled for immunisations, and supported to register for a school. The family's case was discussed at the local care planning meeting, and referrals to a community paediatrician and speech therapist were made for Ayana's daughter, as well as a referral to family mental health services.

After 98 days in initial accommodation, Ayana and her daughter were moved to more permanent accommodation 200 miles away. Ayana's integrated migrant health plan assisted health professionals in the new area to plan her care and ensured that Ayana did not need to undergo the trauma of repeating her background history, including her history of sexual violence, at every new health encounter.

*Ayana is a fictional name. Her case study is an example drawn from the combined experiences of many of the asylum seekers presenting to the Respond service.

Biographies

Olivia Farrant is a research fellow at the Hospital of Tropical Diseases, UCLH. She is working on the Respond project while completing her medical training. Before this, she worked on the covid-19 response in Sierra Leone and on clinical research in tuberculosis and malaria.

Sarah Eisen is a co-lead for Respond and a consultant paediatrician at the Hospital for Tropical Diseases, UCLH, with a special interest in infectious diseases, tropical medicine, and migrant health. She has been running services for asylum seeking populations in North Central London for several years.

Chris van Tulleken is a doctor at the Hospital for Tropical Diseases, UCLH, where he works with Respond, and an associate professor at UCL. His academic work focuses on conflicts of interest and research integrity. He is also a broadcaster for children and adults on the BBC.

Allison Ward is a co-lead for Respond and a consultant community paediatrician working as a named doctor for safeguarding and looked after children in the London borough of Camden. She works across the Royal Free London, Central and North West, and UCLH NHS Foundation Trusts. She leads the North Central London Integrated Health Network for unaccompanied asylum seeking children.

Nicky Longley is one of the co-leads for Respond, a consultant in infectious diseases and travel medicine at the Hospital for Tropical Diseases, UCLH, and associate professor of travel medicine at London School of HTM. Nicky has a particular interest in refugee health and prevention of infection in the immunosuppressed traveller.

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