# Blackburn with Darwen Asylum Seekers and Refugees Health Needs Assessment 2018

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# ACKNOWLEDGEMENTS

Thank you to all the asylum seekers and refugees who shared their experiences. Particular thanks to all the members of the Blackburn with Darwen Asylum Support Multi-agency Forum (ASMAF), associated project workers, and volunteers who contributed time, knowledge, and expertise to this project.

# EXECUTIVE SUMMARY

## INTRODUCTION

Blackburn with Darwen (BwD) has recently been recognised as a City of Sanctuary for Asylum Seekers and Refugees (ASRs). There are up to 350 asylum seekers in the borough at any one time, and an unknown number of refugees who have chosen Blackburn as their home after being given Leave to Remain.

Globally, the number of ASRs and displaced people is rising each year due changing geo-political and environmental factors. There has been a slight downward trend of asylum applications across the EU and in the UK since 2015.

There has been no Health Needs Assessment (HNA) carried out previously for this group of individuals in BwD. This document seeks to identity the health needs of this unique group, map existing service provision, and make recommendations for local action to address the findings of this research.

## METHODS

A qualitative approach was employed to identify the health needs of ASRs in BwD. The author spent time speaking to ASRs directly at local drop-in centres. Local staff and volunteers working with ASRs were interviewed to develop understanding and local context from information obtained from ASRs directly and via literature reviews. Ethnography was also employed where appropriate to do so. Data was gathered from February – May 2018 in Blackburn with Darwen.

## FINDINGS

The health needs were identified during this research were:

- Mental health and wellbeing provision appropriate to the unique needs of ASRs requires development
- Dietary factors including malnutrition and dietary-associated conditions (physical and mental) due to limited cooking skills, local availability of familiar food, and financial pressures
- Infectious disease risk from conditions during migration and differing vaccination schedules in home countries
- Dentistry issues due to local access, language barriers, and lack of knowledge of dental hygiene
- Exacerbation of chronic conditions during migration
- Knowledge of women's health issues including FGM and rape
- Primary care awareness of the rights of ASRs in terms of access
- General awareness of ASR status in healthcare provision resulting in barriers to access
- Family members and community members being asked to provide translation services for healthcare resulting in confidentiality and disclosure concerns
- Impact of childcare, housing, and employment on health

## RECOMMENDATIONS

The report recommends that local service providers should consider:

- Physical health:
    - Explore possibilities of creation of specialist services for ASRs; staffed by GP and healthcare professionals with an interest in, and knowledge of, ASR-specific conditions and needs.
    - Ensure PHE Migrant Health checklist (available on PHE website) utilised in all first GP appointments with ASRs
- Mental health:
    - Development of self-help materials in community languages
    - ASR-specific support groups facilitated by trained professionals
    - Specialist mental health services with staff skilled in the mental health needs of ASRs
- General recommendations:
    - Training and support for all health providers in the rights of, and health needs of, ASRs. This should particularly focus on front-line administrative staff (ie, receptionists) and clinical areas of high footfall (ie, maternity, A&E, GPs, practice nurses);
    - All services should ensure that only appropriate translation services are used – children and families should not be used for this purpose. There should be active monitoring and response to issues regarding translation services by all healthcare providers;
    - Access to official translation services to be made available to non-NHS healthcare providers;
    - Written communication from service to be offered in community languages (or provided automatically if noted in patient demographic information);
    - Review of referral pathways into areas of high use by ASRs to ensure that potential barriers to access are reduced/removed;
    - Promote healthy lifestyles to ASRs via targeted interventions using existing agencies (ie, Re:Fresh) and community projects.
    - Education – specifically around English language and life skills
    - Information for ASRs about local services and their individual rights
    - Transition support once given Leave to Remain
    - Improved information sharing between partner organisations
    - Development of volunteering schemes for ASRs
    - Support for ASR project volunteers and workers

Given the transient nature of ASRs, it is suggested that this document is reviewed at regular intervals to ensure that the health needs outlined above are still relevant to the local ASR population.

## LIST OF FIGURES



## LIST OF ABBREVIATIONS AND ACRONYMS

| | |
|---|---|
| ARC | Asylum & Refugee Community [BwD-based Project] |
| AS | Asylum Seeker |
| ASMAF | Asylum Support Multi-agency Forum |
| ASR | Asylum Seekers & Refugees |
| BBV | Blood-borne Virus |
| BwD | Blackburn with Darwen |
| BwDBC | Blackburn with Darwen Borough Council |
| CCG | Clinical Commissioning Group |
| CGL | Change Grow Live |
| DARE | Darwen Asylum & Refugee Enterprise |
| DWP | Department of Work & Pensions |
| EIA | Equality Impact Assessment |
| ESOL | English for Speakers of Other Languages |

| | |
|---|---|
| FGM | Female Genital Mutilation |
| HMO | Hous(e/ing) of Multiple Occupation |
| HO | Home Office |
| IAC | Initial Accommodation Centre |
| IDP | Internally Displaced Person/People |
| IRC | International Red Cross |
| LGBTQ+ | Lesbian, Gay, Bisexual, Transgendered & Questioning |
| MLCSU | Midlands and Lancashire Commissioning Support Unit |
| MSF | Medicins Sans Frontiers (Doctors without Borders) |
| NCD | Non-communicable Disease |
| NGO | Non-Governmental Organisation |
| PSED | Public Sector Equality Duty |
| PTSD | Post-traumatic Stress Disorder |
| UC24 | Urgent Care 24 |
| UNHCR | United Nations High Commission for Refugees |
| WIT | Wellbeing Inclusion Team |

# CONTENTS

# INTRODUCTION

Asylum seekers and refugees (ASRs) are a varied and diverse group of people who come from a wide range of backgrounds. While there have always been ASRs, recent global conditions have significantly increased numbers due to conflict (such as Syria, Democratic Republic of Congo, and South Sudan); systematic persecution (Rohingya Muslims in Myanmar); poor humanitarian conditions (Yemen); and human rights violations (globally). The UN estimates that there are currently in excess of 65.6million people around the world who were forcibly displaced in 2016 (United Nations, 2017) – roughly the same as the total population of the whole of the UK.

There has been no previous Health Needs Assessments (HNA) for this unique group of people carried out locally. In 2018, BwD was recognised as a "City of Sanctuary"[1] for ASRs – it is timely therefore to provide information on the health needs of the local ASRs in 2018 and document the local service provision to support these needs in BwD.

[1] City of Sanctuary is a national initiative to create towns and cities that welcome people in need of safety.

Further details can be found at www.cityofsanctuary.org.

# AIMS & OBJECTIVES

The aims and objectives of this health needs assessment are:

## AIMS

The aim of this report is to provide information to relevant stakeholders around the health needs of asylum seekers living in BwD. This information will assist in formulating a set of recommendations to inform future work to improve the health and wellbeing of ASRs within the Borough by outlining potential interventions that may help to improve outcomes for individuals.

**NB: This Health Needs Assessment does not directly relate to economic migrants. However, some of the issues discussed may apply.**

## OBJECTIVES

1. Conduct a literature review to identify the health and wellbeing needs of ASRs and to identify evidence-based interventions targeted to meet such needs;
2. Report on the regional (North West) and local services available to ASRs;
3. Identify and analyse the met and unmet needs of ASRs within BwD;
4. Formulate recommendations to meet the needs of ASRs based on information obtained.

# BACKGROUND INFORMATION

When considering the health needs of ASRs, it is important to be aware of several key over-arching themes that are likely to affect all ASRs - regardless of country of origin or the reason for their asylum claim.

Firstly, ASRs are a vulnerable group. They have all had (diverse) experiences that have led them to seek asylum away from their home. Many have left their families and friends and may be bereaved. Many have relied on people smugglers and extreme transport conditions to escape to safety. Arriving in an unfamiliar country, where they perhaps find it difficult to communicate and navigate the complex legal processes, can be disorientating and disheartening.

Secondly, by virtue of being in a new country, ASRs are isolated from their culture, language, and support networks. Being classed as an asylum seeker – and hence not being able to work – may further increase isolation at the individual level.

Finally, while these individuals share the experience of being an asylum seeker, they are not a homogenous group. Different individuals will have different needs based on existing health conditions, country of origin, age, gender, sexual orientation, religion, social norms, and other factors. Any HNA for this group needs to consider these unique needs at the individual level, alongside any shared needs of ASRs. A "one size fits all" approach to provision of health and social care services for people seeking asylum and refugees is likely to be insufficient.

## ASYLUM PROCESS IN UK

The asylum process in the UK is complex and lengthy with several opportunities for appeal by rejected asylum seekers. In the UK, the process of asylum is regulated by international, European and UK laws. It aims to last up to six months. However, the process is frequently lengthier at present. A flowchart detailing the current asylum process is provided in Appendix 2.

## KEY DEFINITIONS

It is important to clarify terminology around ASRs to avoid potential confusion. While the terms "asylum seeker" and "refugee" are sometimes used interchangeably in popular media and daily discourse, there are clear distinctions between the groups – both in terms of their legal status and public services entitlements – which impact on their needs.

For the purposes of this document, the following definitions will be used throughout:

- An **asylum seeker** is a person who has asked the UK Government for refugee status and is awaiting a decision on their application (original application or appeal decision).
- A **refugee** is a person who 'owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of his nationality, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country' (United Nations, 2010). In UK terms, this is an asylum seeker who has been awarded refugee status by the UK Government. Refugees can also be fleeing poverty, famine, war, or natural disaster.

Therefore, all asylum seekers are refugees, but not all refugees are asylum seekers. If an asylum claim is rejected, then the asylum seeker is known as a **failed asylum seeker**. It is important to note that most asylum claims are rejected with only 27% of applications being given leave to remain after all appeals options are exhausted:

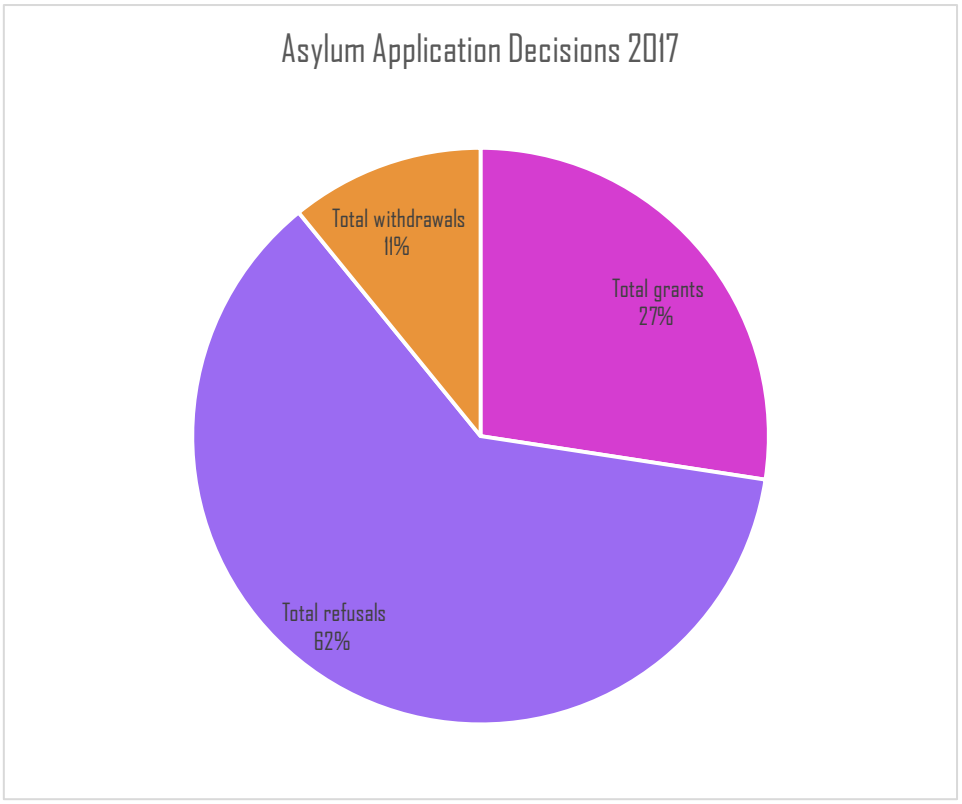


**Figure 1 - Asylum Application Decisions, 2017** ***(UK Home Office, 2018)***

Rather than risk formal deportation, many who are not given leave to remain may become undocumented residents – a hidden number whose health needs also need consideration.

In addition to the above, there is a third category of ASRs in the UK – **resettled refugees**. Resettled refugees are admitted to the country via dedicated resettlement programmes such as the Gateway Programme or Syrian Vulnerable Persons scheme with their legal status of refugee being secured before their arrival in the country. BwD does not host any resettled refugees at this time but we have agreed to host unaccompanied asylum seeker children.

## ENTITLEMENTS OF ASYLUM SEEKERS & REFUGEES

As soon as someone is given "Leave to Remain" status by the UK Government, they are entitled to the same state support and public service access as any other UK national. This includes education, health care, social care, housing, and full welfare support.

While someone is an asylum seeker, they are entitled to free healthcare (primary, secondary, acute and mental health). Dispersal housing is supported by the Home Office (HO) and a small welfare payment is available. This is currently £37.75 per week per individual (£35.59 per week if awaiting appeal decision). There is also access to some education (primary and secondary, children only) and some additional maternity support (UK Goverment, 2018).

If an asylum application is refused and there are no further appeal options, or the individual does not wish to appeal, then they are able to access primary and emergency care for free while they remain in the country. Secondary (ie, hospital or specialist) treatment is only available at a charge to the individual. No charges are payable if secondary treatment commenced before the outcome of their asylum application was given. There is no recourse to any additional public support. Failed asylum seekers are offered two options: either to voluntarily return to their home country (a resettlement grant is available to assist with this); or to be forcibly removed from the UK.

# ASYLUM & MIGRATION STATISTICS

The information below provides details of the global, national, regional (North West England), and local (BwD) context with regards to ASR numbers and trends.

## GLOBAL CONTEXT

The number of ASRs has risen by approximately 10 million to 27 million global ASRs in 2016 (from 18 million in 1997). This represents only part of the scale of displacement as the total displaced people over the same period has risen from 32 million to 66 million with the majority of the rise being in people who are "internally displaced persons" (IDPs) – in other words, still resident in their home

country but having to live away from their usual place of residence. 0.9% of the global population is believed to be internally displaced or an ASR (2016 figures, United Nations, 2017).

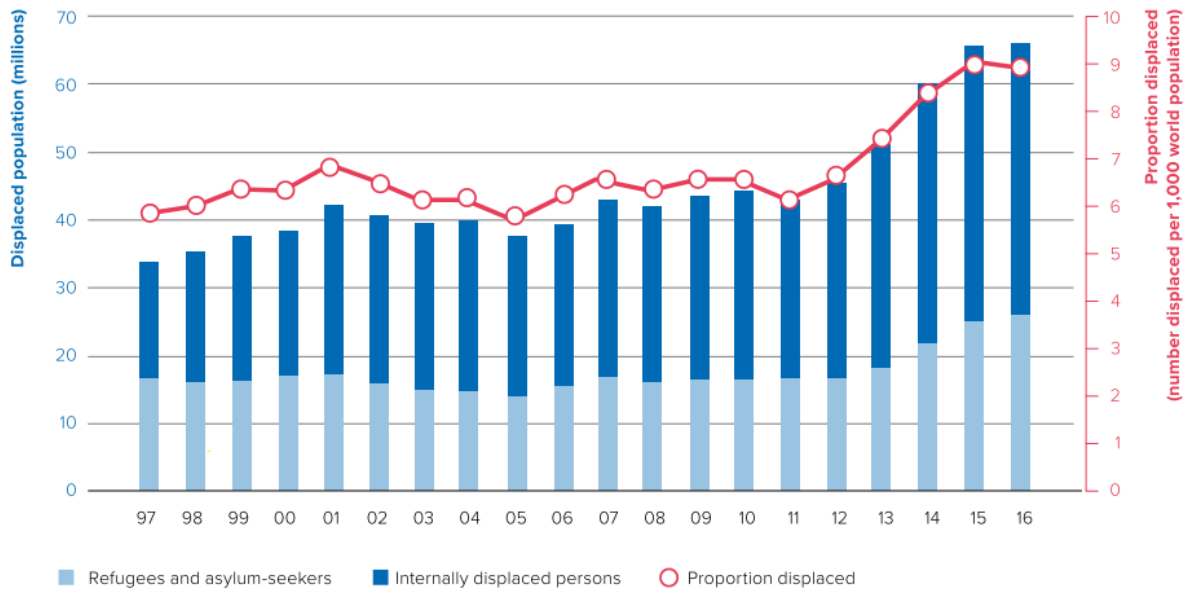


**Figure 2- Trend of Global Displacement 1997 – 2016** ***(United Nations, 2017)***

The latest figures from the EU Asylum Office show a downward trend of asylum claims across the EU in 2017 and the first 4 months of 2018. 728,470 applications were logged across the EU in 2017 (a 44% reduction on the previous year) with the majority of applications being for Germany, Italy and France (European Asylum Support Office, 2018). Turkey, Uganda, and Pakistan are the top 3 ASR host countries globally with over 5million ASRs in 2017 (UNHCR, 2018).

Global co-ordination efforts to support ASRs (and IDPs) are championed by several key global NGOs such as UNCHR, MSF, and IRC. These agencies provide front-line medical and support services in conflict areas, establish refugee camps, lobby for the rights of ASRs, and work supranationally to co-ordinate support efforts.

## NATIONAL CONTEXT

Monitoring of the numbers of ASRs nationally is carried out by the Home Office (HO). Information on total numbers of ASRs nationally are not known as people are only counted when they make an official application to Leave to Remain. Information on the total number of successful applications gives a proxy for the number of refugees but, like other UK citizens, once they have leave to remain, their movements are not routinely monitored and any emigration, or death, is counted as general UK

population movement so this figure is not robust. The graph below shows the total number of asylum applications in the UK per year since 2013.

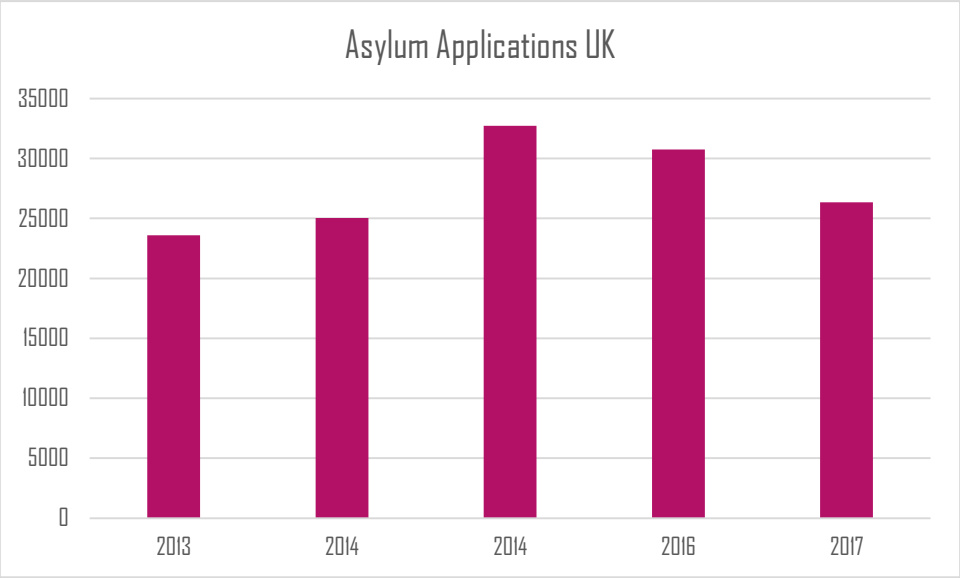


**Figure 3- Asylum Applications to UK (2013 – 2017)** ***(British Refugee Council, 2017)***

The UK has less asylum applications per 10,000 resident population than the EU average with 6 per 10,000 in UK compared to 25 per 10,000 across EU based on 2017 figures (House of Commons Library, 2018).

Initial asylum applications are screened (usually at airports or the Asylum Intake Unit in Croydon) to take preliminary information, assess need, and transfer the individual to a regional Initial Accommodation Centre (IAC). If, under international convention, the UK is not the appropriate country for a claim for asylum to be processed, individuals may be removed from the country at this point.

## REGIONAL CONTEXT

Once an individual has lodged an asylum claim, they are sent to a regional IAC. In the North West, this is in Liverpool. At the IAC, ASs are provided with accommodation in a housing block (with their own kitchens), and receive nurse-led medical triage (provided by Urgent Care 24 - UC24[2]) with GP support available "out of centre" if it is required. There is not a full health screen at the IAC or at any

[2] UC24 is a social enterprise healthcare provider who provide services across Merseyside. Further details can be found at www.urgentcare24.com.

other point in the asylum seeker process (bar GP registration). An ASs will stay at the IAC until dispersal accommodation can be found.

The asylum seeker trends in the North West are shown below:

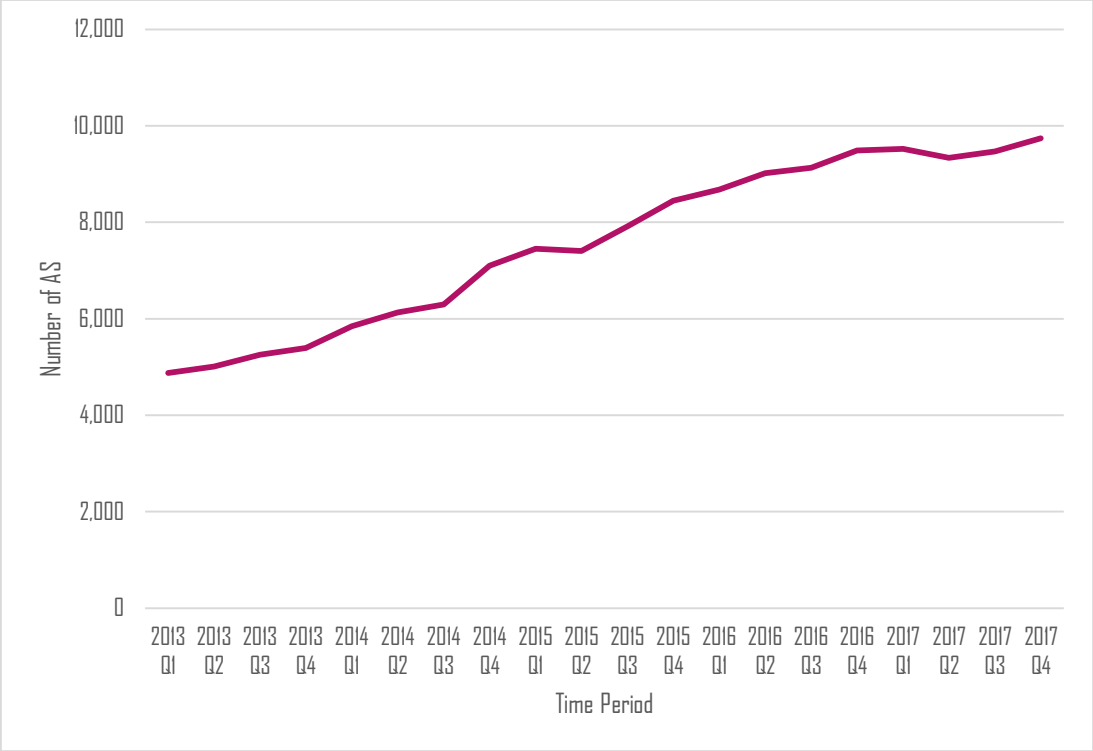


**Figure 4 - NW England Total Claims for Section 95 2013 – 2017** ***(Office of National Statistics, 2018)***

The North West has traditionally hosted significantly more asylum seekers than other regions. In Q4 2017, the North West hosted 9,739 ASs in receipt of Section 95 support[3], while the South East (excluding London) hosted 598.

## LOCAL CONTEXT

The issues around knowledge of the local ASR population mirrors those outlined at the regional and national level. As core asylum seeker provision (housing, introduction to area etc) is provided by SERCO under contract from the HO (COMPASS contract), no local statutory provider receives official

[3] Section 95 refers to Government support provided to asylum seekers who are awaiting the outcome of their claim for asylum. It is referred to in this manner as it is legally provided for under Section 95 of the Immigration and Asylum Act 1999.

information about ASs in the area at any one time, their personal demographics (age, gender, health status etc), or where they are living. Support agencies are aware of who is accessing their services but not every ASR will engage with services. BwD workers believe that the majority of current (June 2018) ASRs in BwD are from Pakistan, Nigeria, and Iraq with lower numbers of Afghani, Syrian, Palestinian, and Sudensese. The country of origin of ASRs frequently changes based on geopolitical circumstances.

Officially, BwD has a cap on the number of AS that will be placed in the borough at any one time (currently limited to 350). This equates to approx. 1:400 AS:BwD population which is approximately half the national average for a local authority area (1:200). Exact numbers of ASs in the area are provided monthly to BwDBC by the Home Office via the Regional Strategic Migration Partnership (RSMP).

Local agencies only become officially notified of the identity of ASs when they are given Leave to Remain (and, therefore, notice to quit their SERCO accommodation). At this point, they are only entitled to SERCO housing for a further 4 weeks and then the local authority has a statutory duty to provide housing options advice.

The trend analysis of BwD ASs receiving Section 95 support (ie, who have claimed asylum but not received a decision) is below:

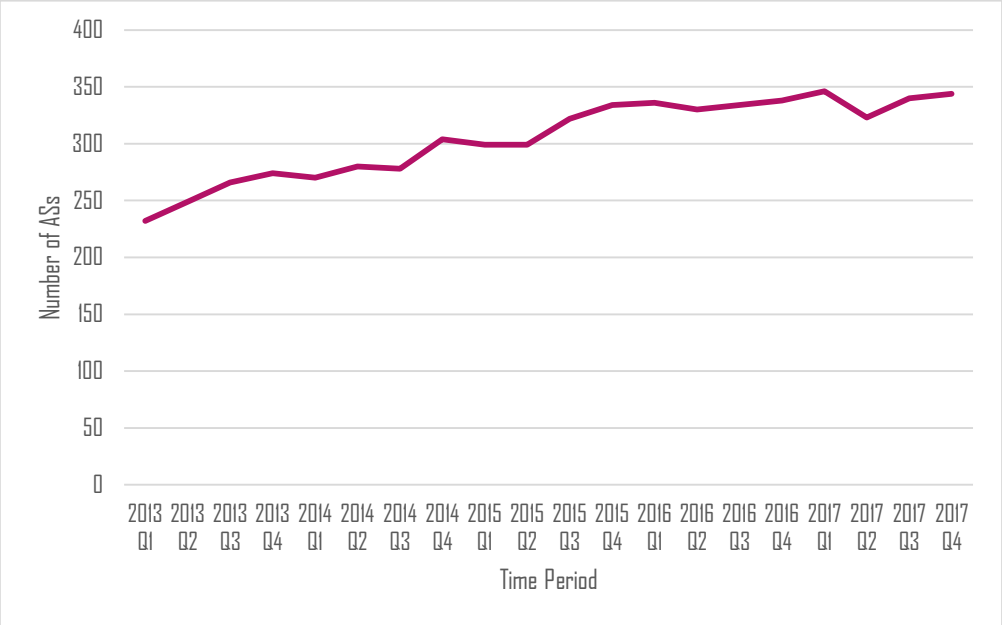


**Figure 5- BwD: Total Individuals Supported Under Section 95 2013 - 2017*(Office of National Statistics, 2018)***

The experience of local agencies within BwD highlights that the majority of people who receive Leave to Remain status often stay and settle in Blackburn but when and if they decide to move away,

Department of Work and Pensions (DWP) are the only agency who would be aware of their immigration status.

# METHODS

To ensure as much relevant information was captured as possible, this Health Needs Assessment used a range of different methods:

1. Data from various sources was analysed to draw a national and local picture of the asylum seeker and refugee situation;
2. A detailed literature search of the evidence was carried out to review the existing knowledge around the needs of asylum seekers as well as evidence-based interventions designed to meet such needs;
3. Evidence from interviews with key stakeholders and local ASRs was gathered to gain information on the current services available and the experiences and the challenges faced by both providers and asylum seekers within the BwD area. A list of stakeholders consulted can be found in Appendix 3;
4. Insights gained from ethnography and author observations during the production of this document have also been included where appropriate.

All data was gathered between February and May 2018.

# CURRENT SERVICE PROVISION

As detailed in the Background Information, ASRs (until status changes to "failed asylum seeker"), are eligible to access NHS provision including GPs, hospital services (inpatient and outpatient), maternity services, and mental health services. ASRs are assisted with local GP registration by SERCO as part of their introduction to the area support. ASRs are signposted to the nearest GP to their accommodation.

Co-ordination, referral, and signposting between agencies (bar the NHS and statutory providers) is generally on an informal basis. The ASMAF supports networking between local ASR staff and organisations. A working group between BwDBC and the CCG has been established to drive improvement in statutory support for ASRs.

To understand the wider support available to ASRs outside of NHS provision, a service mapping exercise was carried out with members of ASMAF in May 2018. The purpose of the service mapping was to document all voluntary and statutory provision (outside of core NHS) that exists locally to support ASRs. Services encompass housing support, health, drop-in, and advisory/advocacy.

## HOUSING SUPPORT

For ASs, housing support (on arrival into area from the IAC) is provided by **SERCO**. SERCO manage and maintain 93 properties ranging from single-person provision to family accommodation across the borough. Once a positive decision has been made, then the person has 28 days to vacate their SERCO housing. At this point, responsibility for housing transfers to the local authority **(BwDBC Housing Dept)** who have a small selection of properties available to support ASRs on a short-term basis. There is a duty for the local authority to find housing for vulnerable households (disabilities, children etc).

Alternative housing support providers for ASRs (for those who do not receive Leave to Remain or for whom there is no vulnerability) include **Salvation Army**, **NightSafe**, and **Foyer** plus other houses of multiple occupation (HMOs) in the borough. Most ASRs accessing this accommodation are single males.

## HEALTH

Additional support for health needs (outside of NHS) is provided by the voluntary sector - mostly under public health commissioned services.

The **CGL Wellbeing Inclusion Team** (WIT) are available at drop-in centres and through appointments. Health Care Assistants offer screening for infectious diseases, basic health checks, complementary healthcare (auricular acupuncture) and referral to other services.

Further screening is provided at the drop-in centres for latent **TB Screening** (NHS commissioned service), and **HIV Advice & Support Service** (provided by Renaissance). Both services provide initial screening plus on-going clinical support and/or supported referral to secondary care services as needed.

In addition to the drop-in services below, voluntary sector wellbeing support is provided by **Action Factory** who run an arts programmes for ASRs in the borough. **Lancashire Mind** are also able to provide support and signpost as needed.

## DROP-IN/SUPPORT CENTRES

There are three main drop-in services for ASRs located in BwD – two located in Blackburn, and one in Darwen. All of these services are provided by the voluntary sector.

Both the **Darwen Asylum & Refugee Enterprise (DARE)** and Blackburn **Asylum & Refugee Community (ARC)** provide a range of services including weekly drop-in, English language classes, and advocacy/advice. ARC has also commenced a Job Club (with volunteer opportunity service being developed) for ASRs with Leave to Remain. Service users self-refer into both ARC and DARE. Both centres run from church premises and act as a "hub" for other services who make use of the facilities to support ASRs – effectively acting as a "one-stop shop" on drop-in days.

The **YMCA New Beginnings/Champion Group** is a Big Lottery-funded initiative that promotes peer-support within ASR communities across the borough. The primary focus of the group is the development of Community Champions who identify and support ASRs within their local communities. They also provide a monthly drop-in session where they host guest speakers on a range of ASR issues.

## EDUCATION

Statutory education is provided for ASRs of school-age (5 to 16 years). Access and support into schools locally is currently facilitated by the **New Arrivals Team** (local authority funded) but this service will be ending in July 2018 and there are no plans to replace this support. There is no recourse to financial support for formal education – including English language classes – for new ASRs over school-age. ASRs over 16 who have been awaiting an asylum decision from the HO for longer than 6

months are eligible to access education provision (including higher and further education) on the same terms as "home" students (Asylum Information Database, 2018).

**Princes Trust** offer short-courses and mentoring for all young people which are open to ASRs aged 16-25years with appropriate language skills.

## ADVISORY/ADVOCACY

There are a wide range of general and special interest organisations that offer advice and advocacy to ASRs. For individuals, these include:

- **City Heart (Liverpool)** – trafficking support (based in Liverpool but provides support in BwD if needed)
- **Red Cross –** international family tracing and reunion service (FRTA) and travel assistance for official asylum related appointments
- **Lancashire LGBT** – although their experience is that ASRs prefer to access LGBT+ support out of area (mainly Manchester) due to fear of persecution within the community
- Legal aid solicitors

More generally, and not usually providing advice/advocacy to individuals but acting on a collective basis, there is:

- **North West Strategic Migration Partnership**
- **Migrant Help**
- **Asylum Matters** (hosted by City of Sanctuary UK)
- **Refugee Action**
- **Healthwatch BwD**
- **Children's Society**
- **Lancashire Constabulary** (Prevent Team and Early Intervention Teams)

## CONTROLLING MIGRATION FUND

BwDBC has been successful in securing funding from the Department for Housing, Communities and Local Government for a discreet project – **Integrating Refugees and Migrants in BwD**. This funding (from 2017 – 2019) allows the provision of temporary housing for ASRs who have been given Leave to Remain to enable them to apply for, and access, benefits and longer-term housing. The funding also provides resources to ARC and DARE to deliver Job Club and English language classes for local ASRs.

# FINDINGS

The findings discussed here have been developed following interviews with ASR workers, and ASRs attending drop-in projects in the borough. The findings below represent key themes that emerged from these interviews and observations, supported (where possible) with other sources of evidence.

## COMMON HEALTH NEEDS OF ASRS

### MENTAL HEALTH & WELLBEING

Mental health emerged as one of the key themes throughout the consultation exercise with both workers and ASRs raising it as a health need. This is to be expected given that there is a higher prevalence of mental health conditions within the ASR population compared to the general population (Fazel, Wheeler and Danesh, 2005). Post-traumatic stress disorder (PTSD) is most commonly diagnosed within the first year of arrival with anxiety and depression prevalence increasing 5 years post-resettlement (Giacco, Laxhman and Priebe, 2018).

Pre-UK experiences play an important role in the mental health and wellbeing of ASRs in BwD. Bereavement, traumatic experiences that caused the need to seek asylum (such as conflict, torture, and threats), and experiences *en route* to safety lay the foundations for PTSD with suggestions that over 30% of ASRs suffer with PTSD as a result of these factors (Chey *et al.*, 2009). Isolation from usual support networks, delayed culture shock, boredom (as unable to work or study until given Leave to Remain), financial pressures, and feeling of lack of control over their personal situation as an ASR appear to both compound PTSD as well as lead to later on-set anxiety and/or depression. Estimations of the prevalence of suicide and self-harm in ASRs suggest that this is over twice the rate seen in the general population (Cohen, 2008). Anxiety in ASRs arising from communication with the HO was a recurring theme in discussions with

Daniel* approached a local drop-in service following a call from the Home Office about his application. As the case workers at the drop-in were all with other clients, he was asked to wait to be seen. In his heightened anxiety, he thought the delay meant that the drop-in service was working with the Home Office.

Rather than wait to see a case worker, Daniel went back home and took an overdose of medication which resulted in seizures, respiratory arrest and hospital admission.

(*All case studies in this document are real examples but names and other identifiable details have been changed to protect the individuals concerned)

BwD workers.

A recent survey by Healthwatch Blackburn with Darwen (2018) suggests that 18% of local ASRs have accessed mental health provision but this is not a representative sample and literature, with local anecdotal evidence, suggests demand is likely to be significantly higher than this. Several local ASRs reported being wary about mental health services due to fear and/or stigma of mental health issues. There may also be issues about the appropriateness of talking therapies as treatment for those who are not confident English speakers and the need for service providers to truly understand the unique issues affecting ASRs.

## FOOD, POVERTY, & MALNUTRITION

There are a range of issues around food for ASRs in BwD – some of which are unique to the area, and some that are reflective of the experiences of ASRs across the country. Broad key themes for all ASRs are:

- **Malnutrition** from an inadequate diet (through not eating enough and/or eating poor quality food);
- Development of **dietary-associated conditions** (diabetes, rickets, scurvy etc.); and
- **Mental health conditions** arising from inadequate nutrition, and stress and anxiety of experiencing food poverty.

Locally, cooking skills of ASRs appear poor (especially single men as, culturally, they may not have undertaken cooking in their home country). One worker reported that she had had to show a young male ASR how to make a bowl of cereal. Compounding this is limited cooking facilities being provided in AS accommodation (no SERCO property has a microwave as standard) which reduces the food that can be prepared if ASs do not have cooking skills; together with individuals having to adjust to different types of food, ingredients, and cooking techniques than they may have grown up with.

The limited financial resource that individuals are provided with by the HO restricts their dietary options due to their proximity to food sources (especially cheap, healthy and, in some cases, halal) and limitations on opportunities to travel to seek better quality/value. Economies of scale mean that those in families or other extended networks who pool resources may be able to experience a better quality diet than those who are alone. Additionally, many families are not aware that they are eligible for free school meals as an AS until supported to apply for this by workers.

## INFECTIOUS DISEASES

ASRs are at a higher risk of infectious diseases than the general population – partially due to living conditions before/during migration (Eiset and Wejse, 2017). Other contributing factors are ASRs coming from areas with different endemic disease and differing vaccination schedules globally. Children may also become ASRs during a vaccination programme and so may not have received their full doses of common vaccines.

There is no routine screening for blood-borne viruses (BBV) or TB as part of the asylum application process but all attendees of local drop-in centres are encouraged to attend for testing with both ARC and DARE hosting TB, HIV, and BBV screening services on a regular basis. Public Health England (PHE) recommend that infectious diseases are considered by medical practitioners when patients present with ill health.

Sexually Transmitted Infections (STIs) were not raised as a specific issue by local ASRs or workers but PHE suggests that STI screening should be an essential part of the management of migrant health, appropriate to individual circumstances (Public Health England, 2018).

## NON-COMMUNICABLE DISEASES

Non-communicable diseases (NCDs) are a major contributor to the health needs of ASRs. There are 2 main NCD fields that are particularly pertinent to ASRs:

- **Dental health** – there is significant dental decay and lack of awareness of dental hygiene amongst the local ASR community. ASRs are entitled to the same dentistry access as the general population – free of charge - but a lack of translation services available in local dentistry practices often prevents attendance. There are reports of ASRs being turned away from dentists where they are not able to provide their own interpreter as dentists do not routinely use Language Line.
- **Chronic conditions** may not have been treated, monitored, or managed during the migration process due to access to healthcare facilities and medication, and a lack of perception of urgency of care by the individual themselves. This can lead to a deterioration of an existing condition which may have long-term health consequences. NCDs account for 80% of the global burden of disease with the prevalence of NCDs in ASRs from some areas being very high (30% - 50%) (Amara and Aljunid, 2014).

## WOMEN'S HEALTH

Women's Health was raised by both workers and ASRs themselves. This is not surprising given that in the UK "asylum-seeking women are three times more likely to die in childbirth and up to four times more likely to experience postnatal depression than the general population because of a complex combination of physical, psychological, educational, monetary and language problems" (Asif, Baugh and Jones, 2015). The issues raised below in the "Access to Health Services" section apply equally to obstetrics and gynaecology services. Specific issues to women's health include:

**Female genital mutilation** (FGM) – while illegal in the UK and condoned internationally, women from some areas are likely to have undergone this either in their home country, or, for younger women/girls, illegally while in the UK. This process risks psychological trauma and a range of long-term physical health effects – for example, urinary and vaginal functioning, and infection (World Health Organization, 2018). Awareness of FGM has increased in recent years but this should form a key part of health professional's knowledge around ASR health.

While acknowledged that this is not exclusively a female issue, it is possible ASRs have experienced **rape and sexual violence**. Research by the Refugee Council suggests that approximately 44% of ASRs are directly affected by this – either in their home country, or en route to safety (Refugee Council, 2012). This can lead to psychological and physical trauma, both short- and long-term.

Women's Health providers need to be sensitive to the **translational needs** that ASRs may have. ASRs locally reported very young (<10 years) children acting as translators during complex gynaecology and obstetrics appointments – a practice that can affect the patient through removal of their dignity and confidentiality, as well as affecting the child psychologically too who may be exposed to information about their mother's health that they, nor the mother, would want them to know. Similar reports in maternity settings – ante-natal, post-natal, and during labour - were received from ASRs and workers.

## ACCESS TO HEALTH SERVICES

Access to healthcare was a clear issue for both ASRs and workers. Workers were keen to praise SERCO for the additional work that they had undertaken in ensuring that GP registrations were happening for all ASRs with a recent survey by Healthwatch suggesting that 94% of local ASRs are registered with a GP (Healthwatch Blackburn with Darwen, 2018). This was a change in practice by SERCO following concerns raised by members of ASMAF that ASRs were not supported in the GP registration process. Workers remain concerned that, should there be a change of HO contract, this support may stop as it is not a service that SERCO are currently contracted to provide. There are also concerns that ASRs are

Ibrahim had a history of epilepsy and was running low on his medication (an urgent medical issue). He attended his GPs with his children where he had completed his registration paperwork the week before. He was told by the receptionist that, as he had not completed the GP registration process, he was not able to see a doctor. This distressed Ibrahim who believed that this would mean he would have potentially life-threatening seizures. The receptionist informed him that he would need to attend A&E to get his medication (lack of medication being neither an accident, nor an emergency – GPs, nurse prescribers, and pharmacists are both able to assist with this issue).

Ibrahim did not understand the system, nor spoke good enough English, to be able to debate this point with the receptionist. Coincidentally, a local ASR worker happened to be in the waiting area who was able to advocate for Ibrahim which resulted in his being able to get his medication that day from that practice.

not being made aware of the need to attend GP registration appointments (usually with a practice nurse) and so there is an assumption that they are registered when, in practice, they have only completed half the process.

Lack of awareness – by ASRs of the NHS system, and by healthcare providers of the needs of ASRs – was at the crux of many issues around access. Workers reported that, particularly in referrals to secondary care, providers were not aware of ASR status and so had made no provision for extended appointments (due to complex issues), or translation services (via Language Line). In many instances, these were not resolved at appointment either with family members acting as translators in direct contradiction with patient confidentiality rights. Additionally, there is currently no provision for health records from UC24 assessments at the IAC to be made available to local GPs which results in GPs having to duplicate medical histories, tests, and screenings that may have been already undertaken.

Awareness (or lack of) of NHS services available, particularly at anything other than primary care level, results in ASRs being disempowered to request access to services. This lack of knowledge appears to be an ongoing issue as it was documented locally in 2016 (Bairstow and Altham, 2016).

Length of appointments to deal with complex issues in primary care were also raised as an issue with ASRs feeling that appointments were rushed. This may be due to cultural differences about

the role of primary care physicians and the nature of appointments, but also due to additional pressures put on short appointment times by need for external translation services (Language Line).

Confusion arising from recent changes to policy around charging overseas visitors for NHS treatment (from which ASRs are exempt) compounded barriers to access at all levels – usually at the reception/booking-in area of NHS services. ASRs reported receiving letters from the NHS demanding payment for services to which they were legally entitled. This caused anxiety as the ASRs thought that they had accessed services correctly and were in possession of the correct paperwork detailing their exemption status. Fear of these charges has deterred use of NHS provision by local ASRs.

Other barriers to healthcare are the cost of transport for appointments – particularly those that take place outside of the borough (East Lancashire Hospital Trust provides some services in Burnley and other East Lancashire locations). A hospital shuttle bus is available between hospital sites but this was not well-known in the local community. In some instances, local drop-in centres support ASRs to attend hospital appointments but this is not always possible due to limited resources.

## OTHER FACTORS FOR CONSIDERATION

### RISK-TAKING BEHAVIOURS

Anecdotal information from workers suggests that ASRs are more likely to engage in risk-taking behaviours (such as smoking and drug-use) than the general population. The reasons for this are likely to be acculturation and as a coping mechanism for underlying mental health issues (as detailed above). Workers also reported that there was a lack of knowledge about the dangers of these risky-behaviours amongst ASRs.

### LANGUAGE

Language remains a key issue for ASRs in navigating the NHS system, and other support services. Locally, providers are commissioned to use Language Line in all NHS appointments (bar dentistry) with non-English speakers. In practice, this is not always happening leading to potential privacy and dignity concerns (see "Women's Health"). Many ASRs spoke about this which suggests that the issue is quite widespread. This may be due to a pre-appointment lack of communication between providers of the translation needs of the individual. There were also reports that official translation services themselves may not recognise the variety of dialects within a language and therefore be inaccurately translating if the ASR and translator are speaking different dialects.

In non-NHS settings, confidentiality and consent is potentially an even bigger issue with commissioned services operating at a grassroots level in open community buildings and with no access to Language Line. This results in other service users being used to provide unofficial translation with an additional lack of privacy from the physical setting in which services are operating. This risks ASRs not fully disclosing information to workers because of the setting. Additionally, although unlikely, there is a risk that translators may be withholding information between service users and workers, or imprecisely translating which could impact on clinical treatment/advice given.

Health-related letters and forms are often only available in English which requires support from workers or the wider community to understand. This raises the same issues as above. It should be noted that literacy levels are also not as high as in the UK in many parts of the world (particularly for females) so even if someone speaks English, it should not be assumed that they are able to read the language.

English language learning opportunities for AS compound these language issues. At present, there is no access to Government-supported formal English for Speakers of Other Languages (ESOL) for ASs until they have been awaiting an asylum decision for 6-months (see "Education" above). There are informal English classes available through the drop-in centres. If an AS wishes to undertake formal ESOL learning, they will be required to pay tuition fees until they are granted Leave to Remain (at which point courses are free). There is also very limited provision of ESOL classes in the borough.

Mohammad developed a growth on the back of his head. He presented to the GP who referred him to secondary care where he received an operation to remove the growth. Two weeks after this operation, he received a copy of a letter that the consultant had written to his GP informing him of the benign pathology result.

Mohammad did not have the English language skills to understand the letter. He came to ARC in visible distress thinking that the letter meant that he had been given a terminal diagnosis. Workers were able to explain to him that the letter was good news.

## HOUSING

Housing plays a large role in the health of ASRs. In their country of origin, and particularly en route to the UK, ASRs are likely to experience over-crowding and lack of sanitation, making them more susceptible to the health issues outlined above.

The transition from AS to refugee also causes issues around housing. Single men may find that they are housed in HMOs or with voluntary providers. There is also the risk of exposure to risk-taking behaviours such as drugs/alcohol with anecdotal reports that some single male refugees choose to be homeless or sofa-surf as alternatives.

Refugees are able to choose where they live in the borough by registering with the Choice Based Lettings Scheme (known as Be-with-Us) and bid for properties. However, there is limited housing stock and high demand. This may mean a move away from their existing support networks, schools, etc and lead to social isolation and associated mental health and wellbeing effects.

Private rental accommodation also causes issues for refugees when they move away from local authority housing provision. This is primarily due to the financial burden of landlords requiring hefty deposits, application fees, and upfront rent – problems that are not unique to the refugee community. More worryingly was reports from refugees that they had had applications for housing with private landlords declined as they were not viewed as having appropriate "Right to Rent" status due to their Leave to Remain not being permanent. The HO guidance is clear that refugees with Leave to Remain do have a right to rent (Home Office, 2016) but tenants may not know about their legal rights. There may be a lack of knowledge by letting agents and landlords too.

## CHILDCARE

Childcare in relation to health-needs is frequently overlooked by providers. For ASRs, particularly recent arrivals, are less likely than the general population to have support networks that are able to provide childcare support. This can create additional worry for patients and may result in patients not attending for treatment if childcare is unavailable.

## EMPLOYMENT & FINANCE

Employment is an issue for ASRs. As previously detailed, ASs are unable to work until they are granted Leave to Remain, a process that can take years from arrival to the UK. During this time the lack of employment places families under financial hardship and risks deskilling individuals. Once Leave to Remain is granted, there can be complications regarding transfer of overseas qualifications (paperwork for which may have been lost en route to the UK or remain in the country of origin). There

can also be significant costs for recognition of overseas training by professional bodies, or exam fees to prove English language competence.

Often refugees experience poor terms and conditions when they seek work with national reports of pay below the minimum wage, lack of sick pay and holiday pay, zero-hours contracts with no job certainty etc. It is likely this is due to both exploitative employers and a lack of awareness of UK employment law and individual rights by refugees.

There is an additional risk of ASRs being victims of modern slavery and trafficking – frequently under the auspices of repaying a "debt" accrued from travel arrangements from their country of origin. The UN believes that approximately 77% of ASRs travelling via boat across the Mediterranean are victims of trafficking and/or slavery (International Organisation for Migration (IOM), 2017). Slavery and trafficking can result in significant psychological distress and physical trauma. The same survey (International Organisation for Migration (IOM), 2017) suggests that 2.1% of the same group of ASRs have experienced organ trafficking and the medical needs arising from these practices are likely to be great so it is important that workers are aware that it is a possibility that ASRs have experienced this.

Debt was a concern for ASRs in BwD – partly due to low funds received until they are given Leave to Remain, but also due to increased expenditure on leaving SERCO properties and inability to work (see above).

Haya, a single mother from Syria, needed to attend hospital for a day case procedure and arranged childcare support for the day via a local neighbour. A DARE volunteer went to collect Haya from the hospital that evening where she was informed that Haya was not medically well enough to return home. The DARE volunteer explained that Haya had a daughter she needed to look after but the ward staff were unable to offer any support or suggestions on how the issue could be resolved. The ward staff informed the DARE worker that Haya should have been told that she may need to stay overnight and should have made appropriate arrangements. It is not known if this information was provided to Haya who, lacking in English skills, did not understand or if this information was not given.

The DARE volunteer was able to liaise with social services and the neighbour on behalf of Haya to arrange extended childcare provision for the duration of Haya's hospital stay.

## PUBLIC SECTOR EQUALITY DUTY (PSED)

All publicly funded organisations are required to meet certain mandated legal

duties in accordance with the PSED outlined in the Equality Act 2010 when making decisions that affect patients and/or employees. Support for the local Clinical Commissioning Group (CCG) in ensuring it fulfils its responsibilities is provided by the Equality & Inclusion Team at Midlands and Lancashire Commissioning Support Unit (MLCSU). MLCSU recently updated its training packages for both GPs and CCGs around ASRs. An Equality Impact Risk Assessment toolkit (which includes ASRs) and guidance has also recently been updated.

BwDBC and BwDCCG currently comply with PSED via Equality Impact Assessments (EIAs) for all decision-making processes to identify potential impacts, especially for groups with protected characteristics and other vulnerable groups.

## LIMITATIONS OF HNA

There are significant limitations to this HNA which require discussion.

- First and foremost, only ASRs who are accessing services were contacted. This means that the results are not truly reflective of the BwD ASR population as we are unable to comment on the health needs of those who are not as engaged with provision. Their needs may be very similar to those discussed above, or they may be very different.
- Children were not directly contacted about their experiences as part of this study. The drop-in centres operate during school-hours and therefore, 5-16 year olds were not around to participate.

It is suggested that efforts be made to understand the health needs of these two groups specifically.

Sufficient English language was required by ASRs to participate in sharing their experiences – this is likely to indicate either high educational level and/or being in the UK for a significant amount of time.

There are at least 350 ASRs in BwD. This research was only able to consult with a small proportion of these. Workers gave a broader view of issues affecting the wider community but this health needs assessment should not be taken to be statistically representative of the whole ASR population.

As discussed in the "Background Information", the countries of origin – and demographics - of ASRs changes frequently dependent on geopolitical and global environmental factors. The majority of the issues outlined in this document will be applicable regardless of country of origin or reason for seeking asylum. Due diligence should be applied if this document is used to inform service delivery to ensure that the needs of current ASRs remain the same as detailed above.

# RECOMMENDATIONS

The information in this document provides a snapshot of the health needs of ASRs in BwD during early 2018. Recommendations below serve to provide suggestions of potential solutions to tackle these current problems for the benefit of existing, and future, ASRs in BwD. Fundamentally, actions should be targeted on ensuring the reduction of health inequalities experienced by ASRs.

It is crucial that addressing the health needs of ASRs encompasses a whole-systems approach. This required active engagement with, and ownership of, actions by all ASR stakeholders across the statutory and voluntary sectors including ASMAF members, social services, NHS providers, and health service commissioners. Robertshaw, Dhesi and Jones (2017) advocate the following areas as essential features of a health-system that is ASR-centered but this could be applied to any ASR-centered service:


**Figure 6 - Features of ASR-centered Healthcare*(Robertshaw, Dhesi and Jones, 2017)***

## PRIMARY CARE RECOMMENDATIONS

As primary care is often the first, and main, contact that ASRs have with healthcare, the following recommendations may help to address some of the issues outlined above:

- Explore possibilities of creation of specialist services for ASRs; staffed by GP and healthcare professionals with an interest in, and knowledge of, ASR-specific conditions and needs.
- Ensure PHE Migrant Health checklist (available on PHE website) utilised in all first GP appointments with ASRs

## MENTAL HEALTH RECOMMENDATIONS

Given the issues around language barriers and the prevalence of mental health conditions in ASRs, this is an area that needs clear focus. Options to consider include:

- Development of self-help materials in community languages
- ASR-specific support groups facilitated by trained professionals
- Specialist mental health services with staff skilled in the mental health needs of ASRs

## GENERAL HEALTH RECOMMENDATIONS

The recommendations here transgress individual healthcare services:

- Training and support for all health providers in the rights of, and health needs of, ASRs. This should particularly focus on front-line administrative staff (ie, receptionists) and clinical areas of high footfall (ie, maternity, A&E, GPs, practice nurses);
- All services should ensure that only appropriate translation services are used – children and families should not be used for this purpose. There should be active monitoring and response to issues regarding translation services by all healthcare providers;
- Access to official translation services to be made available to non-NHS healthcare providers;
- Written communication from service to be offered in community languages (or provided automatically if noted in patient demographic information);
- Review of referral pathways into areas of high use by ASRs to ensure that potential barriers to access are reduced/removed;
- Promote healthy lifestyles to ASRs via targeted interventions using existing agencies (ie, Re:Fresh) and community projects.

## OTHER FACTORS

## EDUCATION

Free English language education would significantly reduce some of the issues around access to health services, isolation, and anxiety experienced by local ASRs. This would also assist with wider community integration and ensure that they are have the skills required for employment once a decision is made on their asylum applications.

Life skills education would also assist in increasing individual confidence as well as helping to address some of the issues outlined in this HNA such as risk-taking behaviours and cookery skills. This may also help foster increase social links within the community and reduce social isolation.

## INFORMATION FOR ASRS

ASRs were not aware of a lot of services available to them, nor their legal rights in key areas. A web-portal for BwD ASRs containing this information, in a variety of community languages (via online web-page translation tools), could be developed and easily updated by ASMAF members. Printed copies could given to ASs by SERCO as part of their induction to the area.

Formal transition support for refugees leaving SERCO housing who have been given Leave to Remain would be beneficial. This could include basic information on how to pay bills, how to change utility suppliers, access to schools, registration at a new GPs etc as the UK systems are likely to be significantly different from those experienced to date.

## OTHER RECOMMENDATIONS

Information sharing between organisations needs to be addressed in order that all agencies are able to proactively provide assistance to ASRs. This is a national issue but BwD should continue efforts to find local solutions and lobby for national change.

Volunteering opportunities for ASRs is already being explored by ARC and DARE as part of the Controlling Migration funding. This could be further developed, in conjunction with the local Council for Voluntary Services (Community CVS) to ensure that opportunities exist for ASRs to volunteer in the wider community. There are well-documented benefits of volunteering to the individual in terms of physical health and mental wellbeing; as well as benefits to organisations that provide volunteer opportunities. Additionally, experience of work environments within the BwD area may improve employment prospects for ASRs once they have Leave to Remain. Volunteering is also being explored as part of the new Integrated Neighbourhood Teams across the Pennine Lancashire area – it would be timely to ensure that ASRs are considered as part of this development from the outset.

This report only provides information about those individuals who are accessing some ASR services. ASMAF and partners need to consider mechanisms by which they can offer support to ASRs who are disengaged from services at present.

Support for ASRs in BwD would not be possible without the relentless hard work and dedication of an army of workers and volunteers. Literature suggests that these workers and volunteers are frequently exposed to distressing situations that can impact on mental wellbeing (Griffiths *et al.*, 2003). Ensuring that these individuals receive adequate professional support is vital to maintaining ASR care and support.

Finally, given the transient nature of ASRs, it is suggested that this document is reviewed at regular intervals to ensure that the health needs outlined above are still relevant to the local ASR population.

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# APPENDICES

## APPENDIX 1 – LITERATURE SEARCH CRITERIA

A literature review was undertaken using SCOPUS to support the development of this HNA. SCOPUS was selected to reflect that health needs of ASRs are broader than the focus of more clinically orientated databases such as MEDLINE. The search criteria are detailed below:

1. 2007 to present = **35,867 document results**

   "Asylum seeker*" OR "refugee*" OR "migrant*"

   AND

   "health need" OR "health" OR "medicine" OR "medical"

   OR

   "mental health" OR "stress" OR "depression" OR "post traumatic stress" OR "PTSD" OR "anxiety" OR "isolation"

   OR

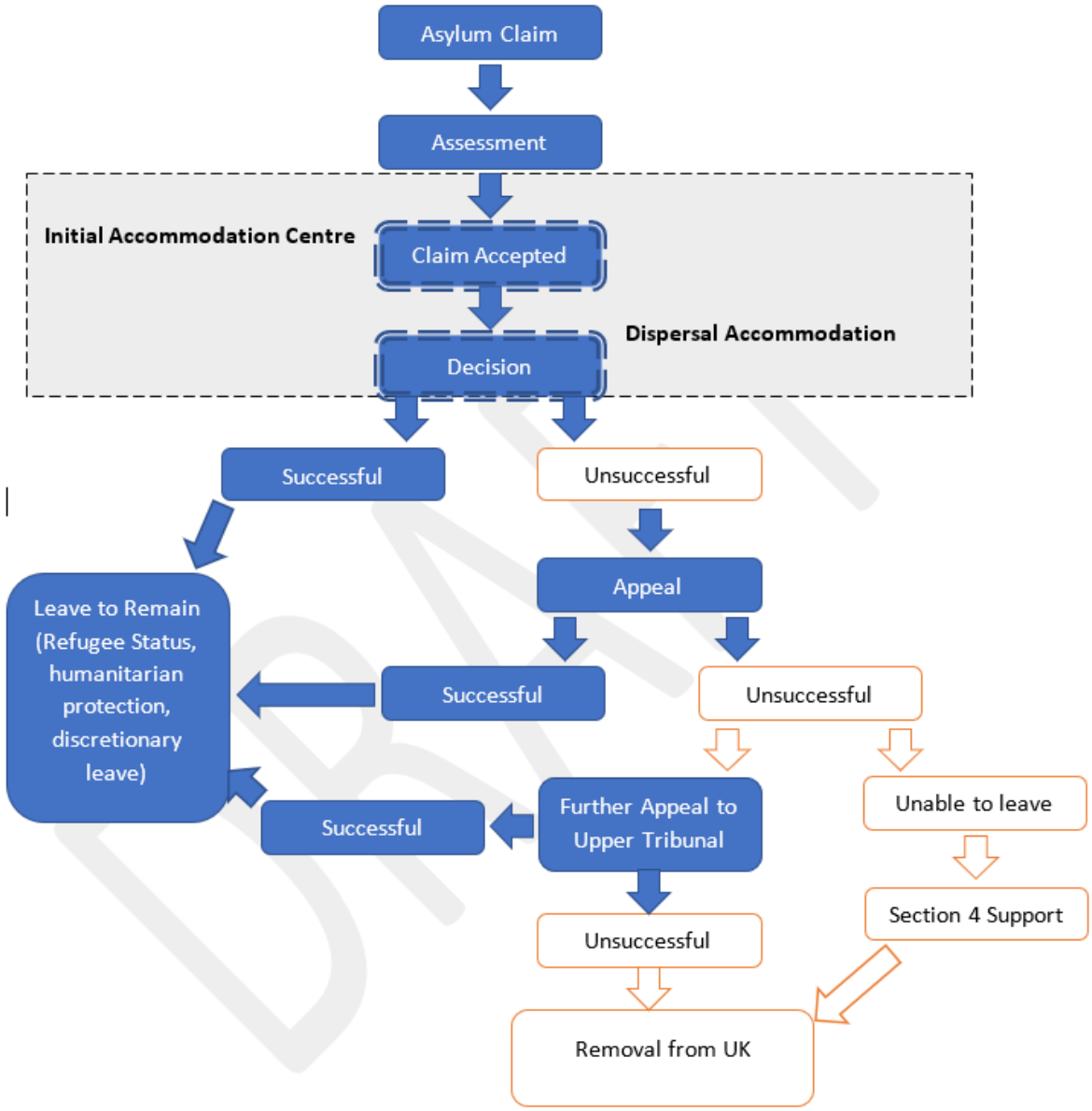
   "physical health" OR "communicable disease" OR "infection*" OR "chronic disease"

   OR

   "social" OR "access" OR "integration" OR "culture" OR "housing*" OR "education*" OR "care"

2. Only UK and English language articles = **4718 document results**
3. Restrict to social sciences, medicine, nursing, immunology, health professions, multidisciplinary, and dentistry = **4136 document results**
4. Restrict to articles, book chapters and conference notes **= 3406 document results**
5. Limit to 2010 onwards (change in govt and national policy) = **2555 document results**
6. Sort on relevance. Review abstract and title of **top 250 results = 115 results**
7. Review of full text of documents = **85 results**

## APPENDIX 2 – FLOW CHART OF THE PROCESS OF CLAIMING ASYLUM IN THE UK (2018)



## APPENDIX 3 – LIST OF STAKEHOLDERS CONSULTED

The following stakeholder organisations were consulted with directly to inform this health needs assessment:

- Action Factory
- Asylum Matters
- Blackburn Asylum & Refugee Community (ARC)
- Blackburn with Darwen Borough Council (Public Health & Housing Teams)
- Blackburn with Darwen Clinical Commissioning Group
- Blackburn YMCA New Beginnings Project
- British Red Cross Refugee Services (Lancashire)
- Change, Grow, Live (CGL) Wellbeing Inclusion Team
- City of Sanctuary
- Darwen Asylum and Refugee Enterprise (DARE)
- Darwen United Reformed Churches
- Lancashire LGBT
- Midlands and Lancashire Commissioning Support Unit
- North West Regional Strategic Migration Partnership
- Princes Trust
- Renaissance HIV Rapid Testing Service

In addition, the Blackburn ASMAF distribution list have received regular updates about this piece of work via email and at meetings. All members have been invited to comment on the development of the project and the final piece of work.

Asylum seekers and refugees were approached directly at both ARC and DARE. The purpose of the project and confidentiality was explained to them prior to soliciting their views about their health and experiences of healthcare.