Refugees and asylum seekers in Primary Care: from looking after to working together

Aim
Many GPs and other members of the Primary Care team will be looking after refugees and asylum seekers in their practices. Some refugees will have arrived recently; others will have arrived long ago and be settled in this country. This chapter will describe what resources are available to refugees in primary care and review the evidence of their effectiveness where it is available. It seeks to make available information about the situation of refugees in the UK which is relevant to GPs and primary care teams. This chapter points to sources of training for the relevant skills and discusses how the attitudes of learners may be challenged. It will discuss the role of more specialist services and the role of ordinary Primary Care teams. It will try to help answer the question: “What can GPs and other members of the Primary Care team in "ordinary" practices do?” An excellent case study, detailing how a practice adapted to an influx of refugees, has previously been published by the Royal College of General Practitioners (1).

List of Key Learning Points

Knowledge
1) Asylum law and procedure; p. 4-7.
2) Access to primary care for asylum seekers; p.8.
3) Organisation of primary care services for asylum seekers; p.8-12.
4) The triple trauma of the refugee; p.5.
5) Distinguishing between physical illness and somatic symptoms as an expression of distress; p.13.
6) Vitamin D deficiency; p.13.

Skills
1) Use of interpreters; p.10-11.
2) Dr Laura Pugh’s presentation in the resource list; p.15.
Attitudes
1) Empathy; p.1.
2) Managing expectations; p.1.
3) How empathy might be taught; p.14.

The GP Curriculum and refugees
Care of refugees and asylum seekers is not mentioned specifically in the RCGP GP curriculum. Equally most curriculum statements have some relevance to the care of this group. The interpretative statement with the most direct relevance is statement 3.4; “Promoting equality and valuing diversity.”

Introduction
Primary care for refugees is, in important ways, like primary care for all patients. There are only likely to be ten minutes available for the consultation. Patients’ expectations may be unrealistic; their needs are multifarious and not all medical. Some of the services to which the practitioner might wish to refer the patient are underfunded or absent. Yet a kind smile and time spent listening will be accepted with gratitude. It is not necessary to refer every refugee who says “he has lost his heart” for a thallium scan.

It is at the core of general practice to elicit the health beliefs and expectations of the patient and, in this respect, consultations with refugees are no different. Indeed, in some ways this can be easier with refugees. This is because we know that their beliefs will be different from our own and therefore the need to explore health beliefs is clear. With UK born patients it is easy to assume that they share our own beliefs so that we fail to check that the patients share them, and end up giving advice which is based on beliefs the patients do not share or perhaps even understand. Equally expectations of health care will be different and this applies especially to the divide between primary and secondary care (2).

Methodology
Because refugees tend to lead traumatic and unstable lives in a legislative framework that is rapidly changing, there is little in the way of RCTs on their care. There is, however, a wealth of descriptive evidence about their situation. We describe our methodology in more detail on the “NHS net” website (see resources below) (3).
**Current situation**

Since 1945 war, civil unrest, human rights violations, and natural disasters have led to large numbers of people seeking refuge in other countries, or being internally displaced in their own countries. The UN High Commission for Refugees estimated that there are 11.4 million refugees and asylum seekers worldwide in 2007 (4). Two thirds of the world’s refugees live in developing countries, with only 21% in Europe, and less than 3% or about 270,000 in the UK (5). In 2007 the top four countries of origin of asylum seekers in the UK were Afghanistan, Iran, China, Iraq (6) (7). The number of applications for asylum in Britain has fallen dramatically in recent years from 84,000 in 2002 to 23,430 in 2007 (8a) (8). In general 20% to 30% of asylum seekers have been awarded refugee status or leave to stay on humanitarian grounds.

Refugees are only a small proportion of the migrants living in Britain. There are about 2.8 million legal migrants (IPPR fact file 2004) and an estimated half a million irregular (illegal) migrant workers, many in the hotel and hospitality industry in the South –East. There are also an unknown number of failed asylum seekers who have not been removed or cannot be removed from the UK. Migration and migration policy in the UK have been recently well reviewed by the USA based “Migration policy institute” (9). Recently the UK government has tried with some success to restrict the number of asylum seekers. This policy has had two arms. On the one hand border controls have been increased as symbolised by the creation of the new BIA (Borders and Immigration agency). On the other hand, to quote from the “Migration Policy Institute” report;

“Probably less effective in curtailing claims, but intensely consequential to asylum-seeking communities, have been policy moves to reduce access to benefits and the labour market, increase surveillance and detention, and force relocation outside of London in a policy known as dispersal. For example, as of 2002, asylum seekers are not permitted to work; they receive social benefits at levels below those accorded to British citizens and legal residents with entitlement. To be eligible for government-funded housing, they must accept dispersal outside of London. Over 100,000 asylum seekers have been relocated so far, typically placed in cheap housing in deprived areas. Furthermore, there has been a steady rise in asylum seekers in detention centres. Over the last five years, there have been an average number of 1,453 asylum
seekers in detention per year. The number of asylum claims has dropped, but these latter measures have come at the expense of social cost and disruption. There is widespread destitution among some asylum-seeking groups, and a range of non-governmental organizations (NGOs) are troubled by various aspects of their lives and government treatment. For example, NGOs have raised concerns over asylum seekers' employment and access to quality housing, health, and education. They have also campaigned vigorously against several aspects of asylum-seeker hardship, including detention — particularly of children and families — destitution, and access to justice.”

<table>
<thead>
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<th>Numbers (best guess)</th>
<th>Employment rights</th>
<th>Other rights</th>
</tr>
</thead>
<tbody>
<tr>
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<td>Legal</td>
<td>2.8 million</td>
<td>Yes</td>
<td>Some</td>
</tr>
<tr>
<td>Economic Migrants with “irregular” papers</td>
<td>Irregular</td>
<td>500,000</td>
<td>No</td>
<td>Few</td>
</tr>
<tr>
<td>Asylum seekers</td>
<td>Legal (under international treaty; The Geneva convention)</td>
<td>20,000</td>
<td>No</td>
<td>Substantial</td>
</tr>
<tr>
<td>Refugees</td>
<td>Legal</td>
<td></td>
<td>Yes</td>
<td>As UK citizens</td>
</tr>
<tr>
<td>“Failed asylum seekers”</td>
<td>Variable</td>
<td>Greater than 100,000</td>
<td>no</td>
<td>Few</td>
</tr>
</tbody>
</table>

Table 1; approximate numbers of various categories of migrants in the UK

**Definitions**

The 1951 UN Refugee Convention (Geneva Convention), to which the UK government is a signatory, defines a *refugee* as someone outside his or her own country and unable to return as a result of a well-founded fear of persecution on grounds of race, religion, nationality, political opinion or membership of a social group (10). Until April 2006 a person accepted as a refugee under the Geneva Convention was granted refugee status and Indefinite Leave to Remain (ILR) in the UK. Since then a refugee is given temporary status for five years with permanent status only granted if he/she is still considered to be at risk at the end of this period (10).
In the UK an *asylum seeker* is a person seeking recognition as a refugee who has submitted an application for protection under the Geneva Convention and is waiting for the claim to be decided by the Home Office. This includes people who have made an initial application, or who have had an initial application refused and are awaiting an appeal or a decision from an appeal. They may have asylum seeker status for several years as there are many stages to the appeal process, and during the last decade, many asylum decisions have taken a very long time to resolve.

Most asylum seekers are not granted refugee status but before April 2003 could be granted Exceptional Leave to Remain (ELR) for up to 4 years. Since April 2003 ELR was replaced by Humanitarian Protection (HP) and Discretionary Leave (DL). HP grants leave for 5 years to people who face breaches of human rights under Article 3 of the European Convention on Human Rights (ECHR) relating to inhuman or degrading treatment or punishment. DL grants leave for three years under Article 8 of the ECHR which covers the right to private and family life. Unaccompanied minors are granted DL until they reach age 18. After these periods their status must be reviewed and they are expected to return to their country if the situation there improves (11). This situation can give rise to further protracted appeals. Between 2001 and 2005 there was a dramatic fall in the proportion of applicants granted some kind of leave, from 28% to 17% (12).

A *failed asylum seeker* is a person whose asylum application has been refused and who is deemed to have exhausted all available channels for appeal. However, many such people are pursuing further legal challenges as Home Office decisions may be wrong, for instance where the Home Office has failed to take account of its own Gender Guidance (13) or where circumstances have been identified that were not taken into account in the initial decision or appeal. Some are simply unable to go back to their home country (14) (15).

**The triple trauma of the refugee**

Refugees go through many difficulties. Long ago Baker separated these difficulties into three phases which he called the “triple trauma of the refugee” (16). The first phase is the trauma in the country of origin, a trauma so severe that the refugee decides to leave his home. The second trauma is the trauma endured during migration where refugees may travel arduously overland or by air with false or no documentation in fear of what will happen to them on arrival. The third trauma is the trauma of resettlement in the host country.
Table 2; Baker’s triple trauma of Refugees

<table>
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<tr>
<th>Trauma</th>
<th>Responsibility of Host country authorities?</th>
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</thead>
<tbody>
<tr>
<td>In country of origin</td>
<td>No</td>
</tr>
<tr>
<td>During flight and migration</td>
<td>No</td>
</tr>
<tr>
<td>In host country</td>
<td>Yes</td>
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</table>

There have been attempts to quantify the relative importance of these factors (17). Recent studies have shown that the health of refugees can worsen after reaching the UK (18) (19). Professor Derrick Silove has devoted a good part of his career to investigating the mental health of refugees in Australia. He contrasts the good mental health of an earlier generation of Vietnamese refugees who were welcomed and integrated with the current situation in Australia where asylum seekers are detained in isolated camps (20) (21;22). Although his studies are necessarily cohort studies rather than RCTs, they are perhaps the best evidence we have that the policies of the host country affect the mental health of refugees. The evidence on the mental health of refugees has recently been reviewed by three UK based authors (23).

**The asylum process in the UK**

It is worth describing in more details what happens to an asylum seeker after arrival in the UK, because the stage they have reached in this process will affect their interaction with primary care. It should be borne in mind that successfully completing the difficult journey to the UK proves qualities of resourcefulness and resilience which bode well for eventual integration and contribution to the host society.

In 2005 the government has introduced a “New Asylum Model” (NAM) to deal with asylum applications. Under the NAM applicants have a screening interview as soon as they lodge their asylum claim. They are then allocated to one of a range of tracks through which their claim is processed. The most important difference between tracks is between applicants who are “fast-tracked” and those who are given temporary admission into the UK. Fast-tracked applicants, largely determined by nationality, are detained in immigration centres while their claim is processed within tight deadlines. Applicants who are not detained have to complete a Statement of
Evidence Form within ten working days, giving their reasons for claiming asylum. This form is then used as the basis for a full asylum interview (24). This interview is taken as the basis of the claim for asylum. Any subsequent changes are seen as evidence of unreliability.

Yet the first interview with a government official may well not reflect the full story. A refugee may have fled his or her home because of physical, including sexual, violence and torture from government agents or others and may still be traumatised from the experiences they suffered. The Home Office’s own Gender Guidance require sensitive treatment of women who may experienced sexual violence, but a recent study shows that this guidance is often not followed (25) (13). Brain injury, malnutrition, depression and post-traumatic stress disorder (PTSD) may impair accurate recall (26). Moreover, the culture at the home office has been described as a “culture of disbelief” (27). The initial interview process has been helpfully examined in detail by UNHCR and this report passed to the Home Office (28).

Following the interview the asylum seekers may be dealt with under the Fast Track procedure and detained under a tight timetable with very limited time for appeal against refusal (24a). Those not detained in this way are entitled to support by the National Asylum Support Service (NASS). From October 2009 this support will be reduced to £35.13 per week from the current £42.16 which itself is 70% of the Income Support level for adults (29). NASS also provides accommodation for asylum seekers in dispersal areas outside London and the South-East. Refugees who are receiving treatment from the Medical Foundation for the Care of Victims of Torture are not dispersed from London.

There may follow months or years of appeals. Asylum seekers currently have no right to work though they may apply after 12 months to have the conditions of their stay changed to enable them to seek employment.

During the asylum process an unpublished proportion of asylum seekers are detained in custody, some in detention centres and some in prisons, although they have been charged with no crime. This proportion has been estimated at 10% and may be higher in asylum seekers of particular ethnic origins (30). Britain is the only European country where asylum seekers can be detained indefinitely and without judicial review (30).
What primary care is available?

Entitlement to Primary care
Asylum seekers are entitled to NHS treatment without charge for as long as their applications (including appeals) are under consideration and they can thus apply to register with a general practitioner. They can also apply for free prescriptions using form HC2. Both asylum seekers and anyone given leave to remain are exempt from charges for NHS hospital treatment. Currently GP practices have the discretion to accept failed asylum seekers as registered NHS patients. This is however a situation which has been shifting recently and the Department of Health website, which covers entitlement to both primary and secondary care, should be checked (31); a textbook cannot be up to date on a matter of this nature. However, uncertainty about entitlement has resulted in confusion among both asylum seekers and GPs about their rights to treatment. A new consultation period is set to open in autumn 2009; the BMJ has summarised the current position (32).

Secondary care including treatment already underway is chargeable from the date the asylum claim is deemed to have failed (31). Maternity care, while chargeable, should not be denied due to lack of funds. Testing for HIV and treatment of TB remain free, treatment for HIV does not. Peter Hall’s editorial in the BMJ deplores the lack of access of failed asylum seekers to secondary care and points to its damaging consequences (33). He questions whether the government, and any doctor denying access to health care, is in breach of the UN international covenant on economic social and cultural rights (Geneva, UN 1976.) The government and any individual complying may also be in breach of EU directives (34).

There is currently no requirement for practices to ask to see official documentation (e.g. a passport) but the Department of Health & Refugee Council suggest that some supporting evidence of address may assist registration (35).

Primary care
Gateway services
“Gateway services” are not general practices and do not themselves offer comprehensive primary care services, but facilitate access to full registration in mainstream practices and may also provide specialist support to mainstream
practitioners. They also provide information about other health services such as dentists, pharmacists and hospitals.

Access for refugees and asylum seekers requires health professionals to identify people who are not registered and provide them with information and often assistance about what to do. Personal Medical Services (PMS) pilots have played a major role in facilitating access to health care for this group both in dispersal areas and in other places by means of dedicated practices or specialist refugee clinics in general practice (35); (36); (37); (38). Such practices, or specialist health teams or nurse-led outreach services provide one gateway to primary care registration. These services can provide treatment to refugees and asylum seekers in hostels and health centres and liaise with GPs to get patients registered in mainstream services. Some use hand-held records to facilitate continuity of care (39); (40); (41).

Where no dedicated services are yet in place, specialist staff can play a crucial coordinating role in ensuring access to services, monitoring need, and providing support to front line health workers responsible for delivering care. This may involve support for asylum seekers and GPs and developing information systems to check that people are registered. Some PCTs employ specialist Health Visitors for asylum seekers who work across the PCT as well as with dedicated practices to facilitate GP and dentist registration for refugees and asylum seekers (38).

**Core Services**

By “core” services we mean general practice. Core services are normally provided in mainstream practices with no specialist provision but can be provided in dedicated practices.

Most dedicated practices are funded as PMS with a local contract with a PCT to provide a dedicated service, or simply to give special services to refugees. Special services to refugees can now be funded under the new GMS contract (nGMS) via a “local enhanced service” in a mainstream practice.

Dedicated practices for asylum seekers, many of which are nurse-led, serve a local population of asylum seekers or particular accommodation centers or hostels and often also serve other vulnerable population groups, especially homeless people. They offer a wide range of services to their patients, beginning with full registration and comprehensive health assessments. Other services such as TB screening and vaccination depend on the staffing levels and facilities available. Dedicated practices
usually have a holistic approach to health care, providing multi-disciplinary services and offering more time to patients (35).

In dispersal areas, such practices maintain strong links with housing providers, who are their main initial contact with patients. Most have well established links with social care services and with others such as child care or baby clinics to which patients are referred when appropriate (42); (43).

While dedicated practices offer useful solutions where there are large numbers of refugees and asylum seekers, they also risk becoming redundant if asylum seekers are dispersed elsewhere or if the numbers coming into the area they serve are reduced. Thus PCTs face a choice between funding specialised services or existing mainstream services, a choice present when funding health care for all disadvantaged groups. The recent trend to put health services for other disadvantaged groups out to tender to private providers may well be applied to health services to refugees.

Support services

There are two main types of support services: those concerned with facilitating communication and information, including health promotion, and those providing specialist care, especially in mental health and for survivors of trauma. All require training and support for health professionals.

Support services facilitating communication and information

Refugee health teams and dedicated practices, particularly, see involvement with local communities as part of their remit and as essential to facilitate access for members of refugee communities. Community based organizations can contribute significantly to planning more appropriate and acceptable services and can be the source of interpreters, advocates and link workers; (44). Language is a major barrier both to accessing primary care and to reporting health problems (45) (46). A common solution is for relatives to interpret on the patient’s behalf. This has serious limitations especially regarding confidentiality and sexual health, let alone allegations of rape or torture.

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<th>Suitable for Gynaecological problems/Rape or torture</th>
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<tbody>
<tr>
<td>Family Interpreters</td>
<td>Free</td>
<td>Yes</td>
<td>No</td>
</tr>
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</table>
A good interpreter is also an advocate; explaining the patient’s world to the doctor and the doctor’s world to the patient.

Translated materials, welcome packs, appointment cards (http://www.communicate-health.org.uk/card/) and specific leaflets, are available both nationally (47) and locally (48) (49). The DoH produces a patient-held record card, which can be downloaded in a number of languages (39). It also produces a comprehensive list of translated resources (50) and points to other websites such as Harpweb (www.harpweb.org.uk) and Medact (http://medact.org). Other resources include Sounds Healthy which is the result of a Health Action Zone Pilot Project in Sheffield Leicester and Nottingham; http://www.surgerydoor.co.uk/3cities/index_audio.html. This is an extensive site with oral as well as written content. Heron is a similar site based in Norfolk; http://www.heron.nhs.uk/pidsearch.asp. MultiKulti provides written resources in many languages covering not just health but education, housing, legal advice and so on; http://www.multikulti.org.uk/zh/health/. Finally Diabetes UK publishes leaflets in many languages about diabetes http://www.diabetes.org.uk/language/index.html.

Support services for Mental Health and services for survivors of torture and organized violence

There is widespread agreement that there is a shortage of appropriate mental health services to meet their needs (51); (44); (52); (53); (54); (55). The Scrutiny Report on Access to Primary Care in London suggests that to adequately meet mental health needs PCTs would have to increase their allocation two or threefold (56).

There are a limited number of specialist services for refugees and asylum seekers run by Mental Health Trusts or by independent bodies (35); (57); (58). Some trauma services include survivors of torture or violent conflicts within their remit. The Medical Foundation for Victims of Torture offers both physical and mental health services for this group (http://www.torturecare.org.uk). However, such services may not

<table>
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<tbody>
<tr>
<td>Professional interpreters</td>
<td>High</td>
<td>Yes</td>
<td>Yes, but see text</td>
</tr>
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</table>

Table 3; Use of interpreters
be available to refugees and asylum seekers with more general mental health problems. Where there is very high demand for existing services, or where no specialist services exist partnerships have been or are being developed between a number of agencies to provide services for this group (53). Finally there is extensive experience of providing mental health services in complex emergencies, such as internally displaced refugees (59), but it is uncertain how closely this applies to the UK situation.

**Health needs and the provision of services within general practice**

Most mental health care for refugees is provided within general practice and good practice guides exist (60;61). The Royal College of Psychiatrists has recently reviewed the mental healthcare of asylum seekers and refugees (62). A small minority of refugees and asylum seekers suffer from well defined mental illnesses such as schizophrenia for which there is standard treatment but most just feel great distress and anxiety which may not require medical treatment. One study suggests that a lack of social support is a stronger predictor of distress than trauma factors (63). Many reports advocate social and practical support to address refugees’ mental health problems and several partnership initiatives have been developed with refugee community groups to support social as well as counseling services with their members (64) (65;66). This can also help to avoid the stigmatisation of mental illness which exists in many cultures.

Some professionals attribute much distress among refugees and asylum seekers to Post Traumatic Stress Disorder (PTSD) as a specific illness for which specific treatments exist (67). The National Institute of Clinical Excellence (NICE) has recently published a guideline on treating PTSD (68).

Physical illness is also common in refugees. It must be distinguished from mental distress which is often expressed in physical symptoms such as headache or whole body pain. Cultural expectations of early referral for hospital tests or treatment are likely to be more of a challenge than difficulty in diagnosis. Dr. Juliet Lawson has run a training course to help GPs look after refugees in Oxfordshire. We are indebted to her for table 4 showing common stress related symptoms and the serious diseases they may mask.
Antenatal care for refugee women poses specific problems and a useful training pack is available from Medact (see resource list.) Women refugees suffer from a range of gender-specific problems, especially the after effects of rape. Some general features of these are covered in a presentation on NHS Networks (69), as is HIV care (70).

Female genital mutilation (FGM) is common in a belt of sub-Saharan Africa running from Somalia to West Africa (71). The great majority of women in the UK with FGM will be from Somalia. Clearly a good interpreter and cultural sensitivity is required in raising these issues with women. The wishes of individual women will vary (72). The treatment, if desired, is surgical, and the key issue is to operate before the women goes into labour. Hence a reversal operation (defibulation) before pregnancy is desirable; if pregnant, the operation should be planned at twenty weeks rather than undertaken as an emergency during labour. There are clinics specialising in this area at Guy’s and Thomas’s and Northwick Park Hospitals in London.

Of recent years it has become clear that Vitamin D deficiency is common in some populations and this is exacerbated by pregnancy. At the extreme all Afghan women wearing a burka will be deficient in Vitamin D. The symptoms are principally of non-specific whole body pain, a symptom often also caused by psychological distress. The response to Vitamin D treatment can be dramatic. The BNF contains a simple guideline, a good online presentation is available (73).

In parts of the world TB is common and a low threshold for doing a chest X-ray is reasonable (25). It has however, proved difficult to measure the incidence of TB and other infectious diseases in refugee populations (74). The Department of Health identifies a twofold purpose in TB screening – to identify and promptly treat infected individuals both for their own welfare and to prevent transmission to others, and for
vaccination or preventive chemoprophylaxis of children and young adults who might be at risk. Concerning HIV opinion is moving to a quicker decision to test once a person presents for care. This is because HIV/AIDS has become a treatable infectious disease, so that early diagnosis has advantages both for the patient and the community (75).

**Different perspectives**

To understand the politics of primary health care for refugees and asylum seekers it is worth recognising the different perspectives and expectations of stakeholders. Most GPs have a humanitarian outlook and are willing to look after refugees but, according to a BMA survey, they would wish to be paid, to have the time and the training to do the job, and to have services to which they may refer (76). Refugees’ expectations of health care may reflect unfamiliarity with GP services, especially the need for booking and appointments in primary care rather than immediate hospital treatment. Mental illness and epilepsy may be more strongly stigmatised than in the host community. Existing patients’ ability to access GPs must also be considered. There is anecdotal evidence that providing dedicated services for asylum seekers risks generating resentment among the original patients in a practice or locality (28). The government’s health policy is to provide a broad spectrum of services but in practice provision reflects concerns both with cost of provision and with public health. It may also be influenced by the government’s desire not to appear “soft” on asylum seekers (77).

**Understanding how it feels to be a refugee**

Treating refugees in primary care requires not only the information of the sort provided in this chapter and skills such as the use of interpreters, but an ability to view the world from the point of view of a refugee. We believe this can be taught and in a number of ways. If the practice is one with many refugees then the doctor can learn directly from them. Clearly stories of refugees in literature or films may be helpful for some. For others this can be taught in a tutorial. The trick is to encourage the registrar to remember a suitable memory such as a memory of a migration, or a first day at boarding school. He is then lead to grasp that the feelings he had then are at least some guide to the feelings refugees are likely to be experiencing now and, with luck, experiences a moment of illumination and empathy (78).
Some learners may feel overwhelmed by the seemingly endless needs that a refugee can express in a ten minute consultation. Dr. Laura Pugh has written a useful power point presentation that covers this question (see resources.)

**Conclusion**

We have tried to describe the current situation of refugees in the UK and their journey through the health care system. There is a tension between the provision of specialised services, most appropriate at the beginning of the asylum process, and the provision of services in mainstream primary care which may facilitate integration and allow more continuity of care. Finally we have highlighted a number of resources that may be helpful to all primary care teams looking refugees.

**List of resources;**

Internet version of the review on which this chapter is based;
http://www.networks.nhs.uk/uploads/09/08/refugeesupdate4with_tables.doc (accessed 15/08/09). This review has been updated regularly and also contains extensive references.

Manuals on the internet
- Burnett, A. & Fassil, Y. 2002, Meeting the health needs of refugee and asylum seekers in the UK: an information and resource pack for health workers DoH (accessed 15/08/09), London.

- Fine, B. & Cheal, C. 2004, Resource pack to help General Practitioners and other Primary Health Care Professionals in their work with Refugees and Asylum Seekers Lambeth Primary Care Trust, London

Medact's "Maternity Access and Advocacy Pack”
http://www.medact.org/reaching_out_home.php (accessed 15/098/09)

Useful websites;
There is a useful website on NHS networks, which points to all the other resources;

- There is a tutorial on primary care for asylum seekers at doctors.net (site registration required, then search for refugee tutorial) http://www.doctors.net.uk/
- Language line offers telephone interpreting. http://www.languageline.co.uk/
Medact provides a forum for interested people; you can join the e-mail list and ask more detailed questions to a group of people who will try and help. [http://www.medact.org/](http://www.medact.org/)

Harpweb has many resources especially translated materials. [http://www.harpweb.org.uk/](http://www.harpweb.org.uk/)


Dr Laura Pugh’s PowerPoint presentation on the ten minute consultation. It was presented at the Second National Conference for Doctors Working with Asylum Seekers and Refugees and can be downloaded from the internet; [http://www.networks.nhs.uk/uploads/06/03/refugeeconf/pugh.ppt](http://www.networks.nhs.uk/uploads/06/03/refugeeconf/pugh.ppt) (accessed 15/08/09)


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Ref Type: Online Source


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Ref Type: Online Source


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(65) Ager A. Mental health issues in refugee populations. Boston: Harvard Centre for the study of culture and medicine; 1993.


Ref Type: Online Source
