

The Review

A specialist clinic for destitute asylum seekers and refugees in London

INTRODUCTION

We present a descriptive analysis of the last 112 patients seen at our refugee health clinic, for whom we have collected complete or close to complete sociodemographic and medical data.

Sociodemographic data showed the patients to be an isolated and highly vulnerable group, with a high prevalence of untreated physical illness, in particular infectious disease, together with a high rate of mental illness.

The majority of patients were survivors of torture or rape that had occurred in countries from which they had escaped. We initiated a study to examine the challenges faced by our patients. We looked in particular at the ease with which they could access health care, and at their physical and mental health.

BACKGROUND

The terms refugee and asylum seeker are legal terms describing the stage in the process of asylum that a person has reached. Previous research has shown them to be an often immensely resilient, but disadvantaged and vulnerable group, who suffer with an increased incidence of physical and mental illness.^{1,2}

Less is known about those who regularly sleep rough or 'sofa surf,' as they are a difficult group to reach, not least because of their fears of detention and deportation. In many countries, from which they originate, the medical profession is complicit in their mistreatment and torture.³

The GP clinic has been running since 2007, as part of the 'Three Boroughs Team', (Guy's and St Thomas' Community Services), in South Lambeth. The clinic is held within a mainstream general practice building in Brixton, close to the Refugee Council. It is run on 2 days a week, by four part-time GPs and two case workers, and more recently a nurse, all with a specialist interest in refugee health care.

METHOD

Patients were referred in a number of ways: by advocates at the Refugee Council or day centres for asylum seekers, generally when they had been unable to register them with a mainstream GP; by other avenues such as the charity 'Project London'; by solicitors; or by word of mouth.

Patients were offered 30-minute

appointments, with access to a telephone interpreter in their native language. Most health conditions were dealt with in the surgery, with referrals where necessary; for example, to the START homeless mental health team, the Refugee Therapy Centre, the local TB clinic, in addition to those with expertise within the Health Inclusion Team such as the Health Improvement Specialist. Acutely ill patients requiring admission were referred to Kings' College or St Thomas' A&E departments.

A standard, structured questionnaire was designed, and completed over several appointments as information and test results became available. All patients gave expressed consent and were assured of confidentiality. The accuracy of much of the historical data could not be independently verified at the time of consultation, although evidence of torture was, in the majority of cases, upheld by the courts further down the legal line.

Data were collected by clinical staff, who knew the patients. Shanks has shown that the consistency of data obtained by someone with a rapport is much greater than with a more impersonal research worker.⁴

RESULTS

Formal collection of data started in the autumn of 2010, and were analysed for the first 112 patients with complete or near complete data.

Access to health care

Fifty-four per cent of patients had been turned away, often more than once, by mainstream general practice surgeries in the UK. This figure is clearly of particular significance to the existence of this clinic. A variety of reasons were given, as discussed below.

Sociodemographic data

A total of 112 patients, 61 male and 51 female, consulted and had questionnaires filled in and analysed during this study period. Six

minors <16 years were seen, including an 18 month old and a 1 year old. Ten women were pregnant, four of whom were in the late second or third trimesters and had had no formal antenatal care. Two of these women, one of whom was sleeping rough, had been turned away for care by London hospitals in the late stages of pregnancy. Sixty-six patients, (59%), required telephone interpreters due to difficulty in consulting in English. Ninety-one patients, (81%), were either street homeless, living in churches, mosques, or graveyards, or sofa surfing and moving regularly from one accommodation to another. Sixty-five patients (58%) had no financial support. Over half had had no food at all on the day of consultation.

Psychological data

Seventy-two per cent of patients had a history of rape and/or torture, that had taken place in the country from which they were fleeing. Half exhibited significant symptoms of depression, with just under 25% displaying symptoms consistent with post-traumatic stress disorder (PTSD), resulting from their experience of torture and war. Many, but not all, had this diagnosis confirmed by a member of the START mental health, joint homeless team, or other community mental health team. In 35% of cases seen, suicide was assessed to be a significant risk, with patients presenting multiple risk factors for suicide and few, if any, protective factors.

Only eight of the patients had a history or ongoing problem with drug and/or alcohol abuse, a figure significantly lower than that often quoted for other similarly destitute groups.⁵

Medical data

Patients presented with a wide range of common illnesses, ranging from chest infections to musculoskeletal disorders and scabies. Two people presented in the advanced stages of cancer. Six patients had diabetes, two using insulin, both of whom had no fixed abode.

"Seventy-two per cent of patients had a history of rape and/or torture, that had taken place in the country from which they were fleeing."

Testing (with informed consent) showed that 18% had at least one serious communicable disease. Five were HIV positive, six (one of whom was also infected with HIV) had acute hepatitis B or were infectious carriers of hepatitis B (with a similar number with prior resolved infection), two were infectious for hepatitis C, and one had untreated syphilis. Three patients had active TB; one Congolese man with AIDS presented with miliary TB. Many had a past history of treated or partially treated TB. Ninety-six per cent of those tested had Vitamin D deficiency.

We devised a vulnerability scale, comprising pertinent internal as well as external contributing factors, ranging from 0 to a maximum of 6, with 1 point awarded for each of the following indicators:

- minor <18 years;
- pregnancy;
- significant mental health issue;
- homelessness;
- victim of torture and or rape; or
- non-English speaker.

We found that 73% of patients had three or more vulnerability factors, while 18% had five or more.

By the end of the study period, just over half (53%) of the original patients had been mainstreamed into general practice, a key aim of the clinic.

DISCUSSION

This study was consistent with other studies of asylum seekers and refugees in finding high rates of physical and psychological illness.^{6,7}

The clinic was involved in the diagnosis and management of serious, previously undetected illness. That 54% of patients had been turned away, often more than once, by mainstream general practice surgeries in the UK was a cause for concern, because of the significant physical and mental health morbidity that would potentially have gone undetected and untreated. The public health, human, and financial cost of untreated communicable disease and missed opportunities to intervene early is a real concern. It is also arguable that systemic failure to provide primary care to this group could be considered a breach of the UK's international human rights obligations.

Many patients had encountered bureaucratic and practical barriers to registering with general practices. Some had not tried and had attended A&E instead.

Although asylum seekers and refugees are entitled to primary care, this is not always understood by providers, and our patients were frequently being asked to provide passports, (often retained by the Home Office), utility bills, and proof of address, and were repeatedly turned away if these were not produced. GPs often admit to finding consultations with this group of patients challenging within regular practice sessions, due to many factors including requests for help with complex physical, psychological, and social problems, lengthy consultations, and lack of a common language.⁸ Many practices do not now use professional interpreters.⁹ Our patients had previously either ended up inappropriately — and at significantly increased cost — in A&E departments, or simply didn't seek out a health professional when sick.

Mainstreaming, which was our goal, often required multiple interventions by our team. This involved writing medical letters, often doctor to doctor, telephone calls to GPs, practice managers, and receptionists, involvement of PALS, and on occasion, escorting the patient to the GP surgery to aid registration. The refugee healthcare team often experienced bureaucratic difficulty, due to asylum status and geographical 'area of homelessness' when persuading mental health teams to assess our patients or persuading antenatal clinics to accept pregnant women for care. Presentation in the late stages of unbooked pregnancy, a known risk factor for maternal death,¹⁰ was a significant finding, consistent with research carried out previously by Project London.

With the benefits of a medical team working closely with case workers in the same clinic, being able to address health and social problems with a holistic approach, and with significantly longer appointments, we were, over time, able to integrate more clients into mainstream practices, as other parts of their lives, legal status, employment, and language, gradually came good for many. For some, detention and deportation interceded, others disappeared during the study period and we have been unable to trace them.

We have shown that our GP clinic can make an important difference to patients as they negotiate the void between their escape from crimes of humanity inflicted upon them in other parts of the world, and the difficult process of rebuilding fragile lives in a country of asylum. Without support, many become destitute and suffer further harm, humiliation, and illness on our streets. This is a time when a specialist clinic can help, by

ADDRESS FOR CORRESPONDENCE

Polly Nyiri

Gracefield Gardens Health and Social Care Centre 3rd Floor, 2-8 Gracefield Gardens, London, SW16 2ST, UK.

E-mail: pollynyiri@nhs.net

treating urgent physical and psychological illness, facilitating access to NHS services, preventing further health deterioration and inappropriate use of acute and secondary services, and integrating patients into mainstream general practice.

Polly Nyiri,

GP working with the Refugee Service, Health Inclusion Team, Three Boroughs Primary Healthcare Team.

Judith Eling,

GP working with the Refugee Service, Health Inclusion Team, Three Boroughs Primary Healthcare Team.

Provenance

Freely submitted; not peer reviewed.

DOI: 10.3399/bjgp12X658386

REFERENCES

1. Carey Wood J, Duke K, Karn V, Marshall T. *The settlement of refugees in Britain*. London: HMSO, 1995.
2. Victorian Foundation for Survivors of Torture. *Refugee health and general practice*. Melbourne: Melbourne Printing Professionals, 1998.
3. Hoffman SJ. Ending medical complicity in state sponsored torture. *Lancet* 2011; **378**(9802): 1535–1537.
4. Shanks N. Consistency of data collected from inmates of a common lodging house. *J Epidemiol Community Health* 1981; **35**(2): 133–135.
5. Homeless Link. *Drugs and alcohol*. Policy briefing. London: Homeless Link, 2009.
6. Favaro A, Maiorani M, Colombo G, Santonastaso P. Traumatic experiences, posttraumatic stress disorder and disassociative symptoms in a group of refugees from former Yugoslavia. *J Nerv Ment Dis* 1999; **187**(5): 306–308.
7. Mollica RF, Sarajlic N, Chernoff M, et al. Longitudinal study of psychiatric symptoms, disability, mortality and emigration among Bosnian refugees. *JAMA* 2001; **286**(5): 546–554.
8. Fisher T. *Meeting the healthcare needs of refugees and asylum seekers — a survey of general practitioners*. London: BMA, Health Policy and Economic Research Unit, 2004.
9. Gill PS, Beavan J, Calvert M, Freemantle N. The unmet need for interpreting provision in UK primary care. *PLoS One* 2011; **6**(6): e20837.
10. Confidential Enquiry into Maternal and Child Health (CEMACH). *Saving mothers' lives: reviewing maternal deaths to make motherhood safer — 2003–2005*. London: CEMACH, 2007.