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Welsh Government
Policy Implementation Guidance

Health and wellbeing provision for refugees and asylum seekers

December 2018

Mae'r ddogfen yma hefyd ar gael yn Gymraeg.
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Table of Contents

Purpose		1
Key actions		1
Definitions		2
Introduction		3
Section 1	WHY THIS GUIDANCE IS NEEDED	4
Section 2	WHAT WE KNOW ABOUT THE RAS POPULATION	10
Section 3	IMPLEMENTATION, GOVERNANCE AND ACCOUNTABILITY	15
Section 4	PROVIDING FOR THE HEALTHCARE NEEDS OF RAS	20
Section 5	GOOD PRACTICE	29
Section 6	MANAGING RISK	35
Annex 1	Pathway on the provision of healthcare to RAS	40

POLICY IMPLEMENTATION GUIDANCE ON HEALTH AND WELLBEING PROVISION FOR REFUGEES AND ASYLUM SEEKERS

Purpose

This guidance aims to address issues and concerns raised in relation to the provision of primary and secondary services to refugees and asylum seekers (RAS). It provides direction and a template for health boards to develop consistent local protocols, policy and practice; underpinned by robust processes, procedures, administrative and governance arrangements to which health boards are expected to adhere to ensure continuity of healthcare and equity of access.

Key actions

- Health boards working with other stakeholders should periodically review activity against this guidance, working towards agreed national standards, to ensure consistency and high quality delivery of healthcare services.
- Locally, health boards should seek to engage all partners involved in the delivery of services within the health board footprint to support implementation of this guidance. Regional partnership arrangements already exist across Wales which bring health, local authority and other providers of services together. Wherever possible these existing mechanisms should be used to fulfil this requirement, including linking in with the requirements of the Homeless and Vulnerable Groups Health Action Plan (HaVGHAPS).
- Each health board should appoint a named person who leads and acts as co-ordinator for the RAS agenda providing a source of advice to practitioners and managers, and as an advocate for RAS.
- Health boards, assisted by WLGA and PHW Health intelligence, should agree a standard dataset for implementation across Wales, incorporating, but not limited to, the data detailed in section 3, enabling service provision and performance to be monitored. This should be informed by and encompass evidence of best practice across Wales.
- In relation to the delivery of services, health boards should adhere to this guidance to ensure consistency of provision and common care standards.
- Current health and immunisation assessments of need (formally known as the 'Blue Book') should be reviewed within a reasonable timescale, informed by the national needs assessment and other research currently underway, to reflect the issues and needs affecting the RAS population arriving in Wales, with due regard to safeguarding concerns such as potential trafficking, sexual exploitation, Female Genital Mutilation (FGM).
- Public Health Wales should work with health boards to develop a standard approach to health screening, building on good practice already occurring in Cardiff and Vale and elsewhere.
- Health boards, supported by the WLGA and Public Health Wales, should collaborate to undertake a comprehensive health needs assessment of the needs of RAS to inform future priorities, strategies and health board Integrated Medium Term Plans; identify gaps in provision; ensure resources are targeted to improve health; inform commissioning arrangements; and help reduce inequalities.

- Health boards should consider the training needs of staff at all tiers of provision and encompassing all those who will come into contact with RAS, including administration and other staff and not just limited to clinical staff.
- Welsh Government will formally review implementation and application of this guidance by December 2021. Health boards will feed updates into their half yearly HaVGHAP reporting.

Definitions

In order to be recognised as a refugee, an asylum seeker must fulfil the terms of the 1951 Geneva Convention and demonstrate that: “...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, or owing to such fear, is unwilling to avail himself of the protection of that country...”

In order to be formally recognised as a refugee an asylum seeker must demonstrate that (s)he is personally at risk of persecution were (s)he to be returned to his/her country of origin. This is not always easy to determine and it is not for health boards to decide or be influenced by the individual’s status as all receive free health service access.

In addition the United Nations Convention on the Rights of the Child (UNCRC)¹ is the most complete statement of children’s rights ever produced and is the most widely-ratified international human rights treaty in history. In 2011 Wales became the first country in the UK to make the UNCRC part of its domestic law. Under the UNCRC ‘a child means every human being below the age of 18 years unless under the law applicable to the child, majority is attained earlier.’ Children must be treated as such if they claim to be below 18 years of age and as such no x-rays or medical age determination should be asked for.

Throughout this guidance the term RAS will be used to refer to individuals who fall within one of five categories, unless otherwise stated:

- an asylum seeker is recognised in the UK as someone who has applied for refugee status in the UK and is still waiting for a decision on that application;
- a refugee who has already received a positive decision from the authorities on his or her asylum claim;
- those refused asylum and who are awaiting removal from the country;
- Refugees resettled in the UK under any of the UK Government’s Resettlement Programmes (such as the Syrian Resettlement Programme or Vulnerable Children’s Resettlement Scheme); and
- Unaccompanied asylum seeking children who are outside their country of origin and seek asylum in the UK. They are separated from parents and relatives, and are not in the care of a responsible adult.

¹ <http://gov.wales/topics/people-and-communities/people/children-and-young-people/rights/uncrc/?lang=en>

Introduction

This policy implementation guidance builds on and replaces earlier 2009 guidance on healthcare issues for asylum seekers in Wales².

Unlike health care, the asylum and immigration agenda is not a devolved issue within Wales and is the responsibility of the UK Government.

The most beneficial supportive RAS experience comes in the form of a welcoming and supportive community. This indicates a need to ensure that there is a co-ordinated response to the provision of support and community resources.

When the asylum dispersal process was established, there was an initial intention of dispersing people to areas where there were already established communities of that particular nationality. In reality, this had not always been achievable due to a variety of factors, including: the sheer numbers of particular nationalities; local capacity; and the fact that some dispersal areas had little prior immigration.

The asylum seeker population may share some similarities to other minority groups, although they have more specific needs which are often related to the reason for their asylum claim or arise after the application, such as exposure to trauma.

² <http://www.wales.nhs.uk/sitesplus/888/news/14727>

SECTION 1 WHY THIS GUIDANCE IS NEEDED

The strategic and legislative framework

- 1.1 There are multiple strategic and legislative documents which support the integration of the RAS population in Wales and the rest of the UK. These include:
- 1.2 The **Equality Act 2010**³ places a due regard duty on public authorities, including local health boards, to:
 - Eliminate discrimination, harassment and victimisation;
 - Advance equality of opportunity; and
 - Foster good relations between those who share a protected characteristic and those who do not.
- 1.3 This may include:
 - Removing or minimising disadvantages experienced by RAS due to their protected characteristics;
 - Taking steps to meet the needs of people from protected groups where these are different to other people; or
 - Implementing the Good Practice outlined in Section 5 of this document.
- 1.4 The Welsh Government's **Strategic Equality Plan**⁴, reiterates the objective to put the needs, rights and contributions of people with protected characteristics at the heart of the design and delivery of public services, including health.
- 1.5 The Well-being of Future Generations (Wales) Act (2015)⁵ came into force in April 2016 and seeks to improve the social, economic, environmental and cultural well-being of Wales. It makes public bodies think more about the long-term; work better with people and communities and each other; look to prevent problems and take a more joined-up approach. The Act has 7 well-being goals, shown in figure 1, creating a vision to, amongst other things; make Wales healthier, more equal, globally responsible and more resilient.

³ <https://www.gov.uk/guidance/equality-act-2010-guidance>

⁴ <http://gov.wales/docs/ds/jlg/publications/equality/161214-strategic-equality-plan-en.pdf>

⁵ <http://gov.wales/topics/people-and-communities/people/future-generations-act/?lang=en>

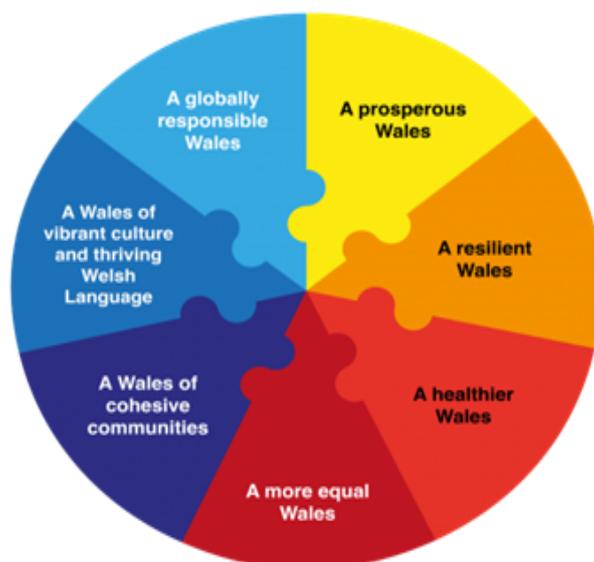


Figure 1: 7 well-being goals of the Act

- 1.6 Building on the UNCRC, the **'Rights of Children and Young Persons (Wales) Measure' 2011**⁶, was passed at the National Assembly for Wales in January 2011. The Measure strengthened and built on the rights based approach of the Welsh Government to making policy for children and young people in Wales. It placed a duty on all Welsh Ministers to have due regard to the substantive rights and obligations within the UNCRC and its optional protocols.
- 1.7 **Prosperity for all** – the national strategy⁷ was published on 19 September 2017. It contains the Welsh Government's twelve strategic objectives for 2017-2021 and the steps it proposes to take to meet them.. The well-being objectives include:
- Deliver quality health and care services fit for the future.
 - Promote good health and wellbeing for everyone.
 - Build healthier communities and better environments.
- 1.8 **Taking Wales Forward (2016-2021)**⁸ is the Welsh Government's five year plan to drive improvement in the Welsh economy and public services, delivering a Wales which is prosperous and secure, healthy and active, ambitious and learning, united and connected. It prioritises health treatment, support, prevention and de-escalation.
- 1.9 RAS in Wales are entitled to receive NHS treatment free of charge. Since July 2009, under the **National Health Service (Charges to Overseas Visitors) (Amendment) (Wales) Regulations**⁹, refused asylum seekers have also been able to access free healthcare in Wales. RAS are entitled to the same equity of access to health services as the resident population. There are statutory NHS charges for some services (where qualification for exemption does not apply), and in common with the resident population RAS will use routine NHS waiting lists.

⁶ <http://gov.wales/topics/people-and-communities/people/children-and-young-people/rights/uncrc/?lang=en>

⁷ <http://gov.wales/docs/strategies/170919-prosperity-for-all-en.pdf>

⁸ <http://gov.wales/docs/strategies/160920-taking-wales-forward-en.pdf>

⁹ <http://www.legislation.gov.uk/wsi/2014/1622/contents/made>

- 1.10 The Welsh Government's **Refugee and Asylum Seeker Delivery Plan**¹⁰¹¹ is currently being reviewed, in collaboration with key stakeholders. The aim of the plan is to set out how the Welsh Government will support RAS in non-devolved areas of policy and how other public bodies and Third Sector organisations will contribute to supporting RAS. Asylum and Immigration policy itself is not devolved to Wales. In 2015 the Welsh Government produced a '**Welcome to Wales**' pack¹² for Syrian refugees to provide them with up to date (at the time of publication) information on settling and living in Wales, including healthcare services. 'Welcome to Wales' is currently being updated to make it fit-for-purpose for all RAS in Wales.
- 1.11 In April 2017 the National Assembly for Wales Equality, Local Government and Communities Committee, published "**I used to be someone**"¹³ - the results of its inquiry into the needs of RAS in Wales. Among other things the report made recommendations that the Welsh Government should ensure sufficient provision for health screening and mental health support, underpinned by a robust monitoring and evaluation. This guidance seeks to support health services to address these recommendations, in conjunction with the updated Refugee and Asylum Seeker Delivery Plan.
- 1.12 From April 2017 until March 2020, the Welsh Government will fund the '**Asylum Rights Programme**' (**ARP**) to provide advice and advocacy to RAS across Wales. The ARP is a collaboration of 7 organisations supporting these communities. The programme offers general advice and advocacy, as well as specialist legal advice, and advocacy for children and young people. It also supports 'advocacy forums' and 'Sanctuary Speakers' to self-advocate for changes, seeks to challenge negative media perceptions and trains organisations on safeguarding vulnerabilities experienced by these communities. More information is available¹⁴:

Safeguarding

- 1.13 Safeguarding is about protecting children and adults from abuse or neglect and educating those around them to recognise the signs and dangers. The Social Services and Well-being (Wales) Act 2014 introduces a strengthened, robust and effective partnership approach to safeguarding. Professionals need to be aware of the safeguarding needs of RAS, in particular adults with needs for care and support and unaccompanied asylum seeking children and follow recognised procedures when they suspect a safeguarding issue has arisen.
- 1.14 The National Independent Safeguarding Board provides support and advice to safeguarding adults boards and safeguarding children boards across Wales to ensure that they are effective and report on the adequacy and effectiveness of arrangements to safeguard children and adults and make recommendations to the Welsh Ministers as to how those arrangements could be improved.
- 1.15 The All Wales Children Protection Procedures, currently being reviewed following the introduction of the Social Services and Well-being (Wales) Act 2014 inform

¹⁰ When published to be referred to as the *Nation of Sanctuary Delivery Plan*

¹¹ <http://gov.wales/docs/dsjlg/publications/equality/160316-refugee-asylum-seeker-delivery-plan-en.pdf>

¹² <http://gov.wales/docs/dsjlg/publications/equality/151209-welcome-to-wales-en.pdf>

¹³ <https://www.assembly.wales/laid%20documents/cr-ld11012/cr-ld11012-e.pdf>

¹⁴ <http://welshrefugeecouncil.org.uk/what-we-do/deliver-support-services/asylum-rights-programme-arp>

safeguarding process and practice across Wales. New National Protection Procedures for children and adults will be published on behalf of ADSS Cymru next year. This work will include specific practice guidance on safeguarding unaccompanied asylum seeker children.

- 1.16 A national action plan¹⁵ to prevent and protect children and young people from sexual exploitation sets out a framework and minimum standards that Safeguarding Children Boards and partner agencies should work collectively and individually towards and build on to:
- prevent and protect children and young people from sexual exploitation
 - provide responsive, appropriate and consistent support to those identified as being subject to or at risk of sexual exploitation; and
 - contribute to the identification, disruption and prosecution of perpetrators
- 1.17 Statutory guidance¹⁶ on child sexual exploitation was issued in 2011 and is currently being reviewed. All health board frontline staff should receive mandatory training in relation to the guidance.

Vulnerable Groups Standards

- 1.18 It is widely recognised that vulnerable populations and homeless people experience significant ill-health, often have complex needs, and have worse health outcomes than the general population. In 2013 Welsh Government published **Standards for Improving the Health and Well-being of Homeless People and Specific Vulnerable Groups**¹⁷, developed in partnership with Public Health Wales as an update of the original *Improving the Health and Well-being of Homeless and Specific Vulnerable Groups Standards*¹⁸, first issued in 2009. The standards set out a framework for joint-working at local level. They are designed to ensure the NHS, local authorities and other agencies with an interest work together in assessing and meeting the needs of people who are homeless and other vulnerable groups.
- 1.19 The standards requires each local area to produce a Homeless People and Vulnerable Groups' Health Action Plan (HaVGHAPs), showing how it would ensure the health needs of all ages of homeless people and specific vulnerable groups are addressed.
- 1.20 In this context, the specific vulnerable groups included RAS (for the first two years following granting of refugee status). We expect health boards to submit to Welsh Government six monthly updates under the HaVGHAPS regarding the healthcare provision for RAS.

¹⁵ <http://gov.wales/docs/dhss/publications/160225childseapen.pdf>

¹⁶ <http://gov.wales/docs/dhss/publications/policy/110107guidanceen.pdf>

¹⁷ <http://gov.wales/docs/dhss/publications/130429homelessnessen.pdf>

¹⁸ <http://gov.wales/topics/health/nhswales/healthservice/homeless/?lang=en>

Prudent healthcare

- 1.21 Prudent Healthcare¹⁹ puts NHS Wales at the front of a growing international effort to get greater value from healthcare systems for patients. It aims to create a patient-centred system. An NHS based on Prudent Healthcare principles ensures patients receive the most appropriate agreed treatments.
- 1.22 In delivering services to RAS, health boards should have regard to the principles of Prudent Healthcare by:
- achieving health and wellbeing with the public, patients and professionals as equal partners through co-production;
 - caring for those with the greatest health needs first, making the most effective use of all skills and resources;
 - doing only what is needed, no more, no less; and do no harm; and;
 - reducing inappropriate variation using evidence based practices consistently and transparently

Funding services

- 1.23 Health boards are responsible for making reasonable provision for their resident population, including the needs of specific groups or individuals such as RAS, who may settle within their area. However, recognising the additional needs and implications for local services some specific support has been made available.

Syrian Resettlement Programme: Healthcare Funding Framework for Wales

- 1.24 In March 2016, the Welsh Government published the ‘Syrian Resettlement Programme: Healthcare Funding Framework for Wales’. The Framework provides health boards with clarity on the processes by which refugees’ healthcare needs will be identified, the funding arrangements in place to support them in meeting those costs, and the mechanism by which they will agree and claim those costs from the UK Government.
- 1.25 Under the Framework, health boards receive reimbursement from the UK Government for each refugee resettled in their area under the programme for the first 12 months following the individual’s arrival in the local area. Funding has two elements:
- i. An initial payment of £2,600 to support healthcare costs for each individual resettled. Of this £600 is provided to cover initial registration with primary care providers and £2,000 for any secondary care required.
 - ii. Where an individual requires secondary medical care during the first 12 months the cost of which exceeds the baseline level of £2,000, the UK Government will reimburse those costs on a case-by-case basis.
- 1.26 There is no additional funding available for health costs for individual refugees beyond the first 12 months of their resettlement date. Any medical treatment

¹⁹ <http://gov.wales/topics/health/nhswales/prudent-healthcare/?lang=en>

required beyond the first 12 months will need to be met from normal health board allocations.

SECTION 2 WHAT WE KNOW ABOUT THE RAS POPULATION

- 2.1 **Asylum seeking adults and unaccompanied children** may make their own way to the UK to make a claim for international protection and if successful, become a recognised **refugee**). Other ways in which asylum-seeking children may arrive are as follows;

National Transfer Scheme for Unaccompanied Asylum Seeking Children²⁰ – launched by the UK Government in July 2016 as a voluntary transfer scheme between local authorities for the care of unaccompanied asylum seeking children who arrive in the UK and claim asylum. The scheme was launched to encourage local authorities to volunteer to support unaccompanied asylum-seeking children so there is a more even distribution of caring responsibilities across the country. Under the scheme, a child arriving in one local authority area already under strain caring for unaccompanied asylum seeking children may be transferred to another council with capacity. The Transfer of Responsibility for Relevant Children (Extension to Wales, Scotland and Northern Ireland) Regulations 2018²¹ extends this scheme to cover the whole of the United Kingdom.

Dubs Scheme²² – The Dubs Amendment is an amendment to the UK Immigration Act 2016, subsequently incorporated into law, as Section 67 of the Immigration Act 2016. The Amendment opened up a safe and legal route to the UK for unaccompanied children living in Europe – provided it is in their best interests.

The Dublin Regulation²³ - an EU law that sets out member states' responsibilities around asylum seeker applications. It states that asylum seekers with family members already under international protection, or in the process of seeking asylum, have the right to claim asylum in the same country. Under this regulation, family unity takes precedence over other criteria, such as the first country reached in the EU by a refugee. The rules are supposed to allow family members to apply in one state and transfer responsibility to another state where their family are located.

- 2.2 **Refugees:** Asylum seekers may be granted refugee status in the UK, and other refugees may arrive in the UK from other countries to reunite with families in the UK, or they may arrive under a planned resettlement scheme, as follows;

Vulnerable Children's Resettlement Scheme²⁴ –announced on 21 April 2016 has, as its aim, the resettlement of 3,000 vulnerable and refugee children and their families from the MENA (Middle East and North Africa) Region. *The criteria are: those with medical needs or disabilities; survivors of or those at risk of violence, abuse or exploitation including sexual and gender based violence; children at risk of harmful practices such as FGM, forced marriage; children without legal documentation; children in detention; children at risk of losing their refugee status; children at risk of not attending school; children associated with armed forces or groups; facing the risk of child labour; and child carers.*

²⁰ <https://www.gov.uk/government/news/government-launches-national-transfer-scheme-for-migrant-children>

²¹ https://www.legislation.gov.uk/uksi/2018/153/pdfs/ukxi_20180153_en.pdf

²² <https://www.gov.uk/government/news/unaccompanied-asylum-seeking-children-to-be-resettled-from-europe>

²³ <https://www.gov.uk/government/collections/asylum-claims-and-the-dublin-regulations>

²⁴ <https://www.gov.uk/government/news/new-scheme-launched-to-resettle-children-at-risk>

Syrian Vulnerable Persons Resettlement Scheme²⁵ (VPRS)– originally launched in January 2014 provides sanctuary to several hundred vulnerable Syrians over three years. In view of the worsening situation in Syria, the scheme was extended in September 2015, with the intention of resettling 20,000 refugees from the conflict by 2020.

RAS population in Wales

- 2.3 Until 2001, relatively low numbers of RAS decided to settle in Wales compared to other parts of the UK. This changed when dispersal areas were established in Wales, although the overall numbers still remain low in comparison to some other parts of the UK. RAS are dispersed to Home Office procured accommodation in Cardiff, Newport, Swansea and Wrexham.
- 2.4 At the end of June 2018, Wales was home to 3148 asylum seekers dispersed among the four Welsh dispersal areas of Cardiff (1,458), Newport (571), Swansea (957) and Wrexham (162). Since the inception of the **Syrian Vulnerable Persons Resettlement Scheme** in late 2015, Wales had also become home to 854 Syrian refugees, dispersed among every local authority. This number is broadly similar to historic levels of asylum seekers in Wales, following a period of lower numbers between 2008 and 2014.
- 2.5 According to data provided by the Wales Strategic Migration Partnership, the top five countries of origin of asylum seekers living in Wales at the end of June 2018 were Pakistan, Iraq, Congo, Somalia and Syria. The most common age group of asylum seekers is 25-34 years. Just under half of all asylum seekers living in Wales are female. It is likely that the place of origin of the bulk of RAS is likely to be Asia, the Middle East and the African sub-continent, with Home Office data for the period 2016 showing 89% of asylum applicants were from these areas.
- 2.6 Whilst dated, the International Health Coordination Centre, Public Health Wales, produced a briefing on '**Refugees and Asylum Seekers: Public Health implications for Wales**'²⁶ in November 2015, which provides a focus on the impact of the population movement in the UK and Wales.
- 2.7 More recently Public Health Wales have commissioned Swansea University and Displaced People in Action (DPIA) to find out how asylum seekers and refugees access health care from the National Health Service in Wales. During the HEAR study, Swansea University will work in partnership with DPIA and Welsh charities to find out how people access NHS services, what problems they may have, and what has worked well for people. The findings are due to be published by the end of 2018.

²⁵ <https://www.gov.uk/government/publications/syrian-vulnerable-person-resettlement-programme-fact-sheet>

²⁶ http://www.gpone.wales.nhs.uk/sitesplus/documents/1000/IHD_IHCC_Refugees%20Asylum%20Seekers%20briefing_141215_external_final%20%282%29.pdf

RAS healthcare needs

- 2.8 Like any population group, RAS are not homogeneous - they are individuals with differing health statuses and needs. Some studies suggest the average physical health status of RAS on arrival is not particularly poor in comparison with the general UK population.
- 2.9 Different cultures will have and hold different perspectives on health and illness. They have different experiences and perspectives which impacts on this. Health problems they may experience are not necessarily different from that of the indigenous population but their problems may be expressed in ways that reflect their cultural background which may be different. For instance, mental health issues may be considered taboo, the concept is little understood or the language they speak may not include words for conditions such as depression or post traumatic stress disorder (PTSD). However, there are some particular issues, such as the impact of torture and violence experienced or witnessed, which may be new to services.
- 2.10 There is limited information on the background, circumstances and needs of refugees in Wales, particularly in relation to healthcare. Asylum seekers who are granted refugee status are not required to live in a particular area of the UK and may move elsewhere. Much of what is known has been deduced from information which is dated; has been produced elsewhere in the UK or internationally; or from research with small groups of refugees in Wales, such as the focus groups funded by Welsh Government to specifically consider healthcare in early 2017.
- 2.11 In general RAS are very happy and grateful for the NHS service and the NHS staff providing those services. Services such as maternity were particularly well received. Though concerns were raised in relation to:
- access to appropriate mental health services, particularly in relation to anxiety and depression. RAS wanted help and support but did not want to be medicalised. There is therefore a need for more talking therapies, with interpretation where necessary, particularly in relation to PTSD. There was also a level of social stigma from RAS around mental health issues. However, this in itself should not be a reason for not ensuring the availability of professional, high-quality and culturally-appropriate treatment.
 - access to dentistry.
 - barriers around integration and English language skills.
 - a need for more knowledge and understanding among healthcare workers on transition from asylum seeker to refugee status.
- 2.12 Evidence from the Swedish Support Platform for Migration and Health²⁷ (MILSA) knowledge about the services available and language barriers, poverty and anxiety associated with experiences in the country of origin and during the asylum process, and separation from home and family. In common with the indigenous population evidence suggests that demonstrates that when a migrant is newly arrived, there are many risk factors which influence health, causing the health of

²⁷ <http://www.lansstyrelsen.se/skane/SiteCollectionDocuments/Sv/manniska-och-samhalle/integration/partnerskap-skane/MILSA/Anthology%20MILSA%20%E2%80%93%20Support%20Platform%20for%20Migration%20and%20health%20-%20Laying%20the%20foundation.pdf>

the migrant to worsen to below the arrival levels before it begins to increase over a period of approximately 7-10 years. These findings are supported by evidence showing that whilst RAS often arrive in the UK in good health, this can quickly decline due to issues, such as lack of mental health problems are made worse by poor housing and a lack of employment and social stimulus, a key theme in the Welsh Government's Together for Mental Health Strategy²⁸ (2012).

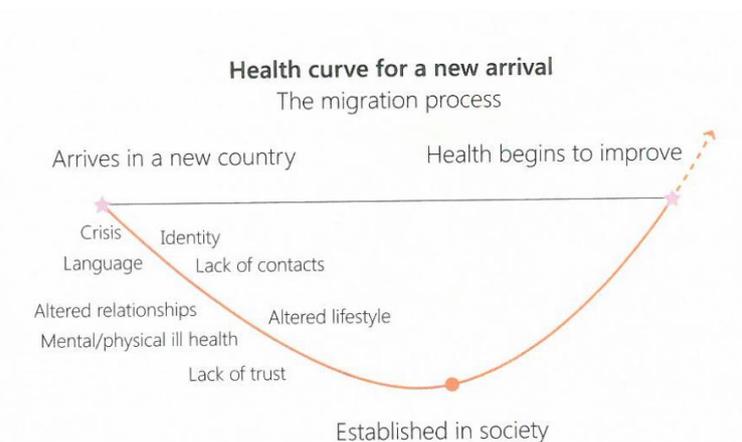


Figure 2: Health curve for a new arrival

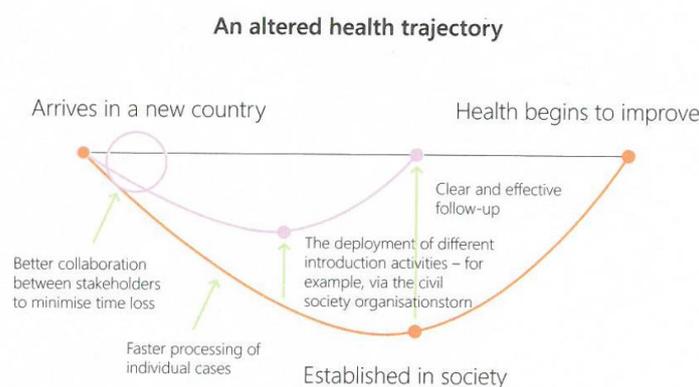


Figure 3: An altered health trajectory

2.13 This issue is not unique to Wales, as most health systems did not consider a mass migration on the unprecedented scale seen over recent years. Health 2020, the World Health Organization's policy framework for health, acknowledges migrants as a vulnerable group where the burden of ill health is felt, with 75 million migrants living in the WHO European Region.

2.14 Although RAS are legally entitled to access primary and secondary healthcare in Wales, equity of access needs to be assured. This will require proper consideration of social, cultural and structural barriers, such as ensuring those refused refugee status are aware of their entitlement to free healthcare, as they may be anxious about contact with the authorities and therefore not seek out assistance when required.

²⁸ <http://gov.wales/docs/dhss/publications/121031tmhfinalen.pdf>

Common health problems

- 2.15 Information from the World Health Organisation indicates that the health problems of refugees are similar to those of the rest of the population, although some groups may have a higher prevalence. The most frequent health problems of newly arrived RAS include accidental injuries, hypothermia, burns, gastrointestinal illnesses, cardiovascular events, pregnancy and delivery-related complications, diabetes and hypertension, all of which can lead to more chronic conditions requiring long-term treatment. Female RAS frequently face specific challenges, particularly in maternal, newborn and child health, sexual and reproductive health, and violence. Children can also face similar issues together with issues such as vaccinations having been missed.
- 2.16 The exposure of refugees and migrants to the risks associated with population movements – psychosocial disorders, reproductive health problems, higher newborn mortality, drug abuse, nutrition disorders, alcoholism and exposure to violence – increase their vulnerability to communicable and non-communicable diseases (NCDs). The key issue with regard to NCDs is the interruption of care, due either to lack of access or to the decimation of health care systems and providers; displacement results in interruption of the continuous treatment that is crucial for chronic conditions.
- 2.17 Vulnerable individuals, especially children, are prone to respiratory infections and gastrointestinal illnesses because of poor living conditions, suboptimal hygiene and deprivation during migration. Poor hygienic conditions can also lead to skin infections. Furthermore, the number of casualties and deaths among refugees and migrants crossing the Mediterranean Sea has increased rapidly, with over 5,000 people estimated to have died or gone missing at sea in 2016 and more than 2,000 by June 2017. This increases emotional and mental stresses on family and friends who survived the journey.

SECTION 3 IMPLEMENTATION, GOVERNANCE AND ACCOUNTABILITY

Guiding principles and implementation

- 3.1 This guidance aims to address the issues and concerns raised in relation to the provision of healthcare (primary and secondary services) to RAS. Health boards are expected to keep provision under review to ensure it remains fit for purpose. Following adoption, Welsh Government, working with health boards will review provision by no later than December 2021 to ensure consistency of application across Wales and that arrangements are meeting the needs of service users.
- 3.2 In developing local services health boards should have regard to the following principles, which build on the five ways of working contained in the Well-being of Future Generations Act 2015:
- be safe and respectful in order to meet the needs of the RAS, with processes which are fit for purpose.
 - be person centred, putting the individual at the heart of service delivery by promoting early and easy access to provide support, particularly for those requiring ongoing care for chronic or other long term conditions.
 - engage service users and their representatives in planning and service delivery.
 - work in partnership with other healthcare services and other agencies and disciplines across health, local authority and third sector services to meet the holistic needs of the service user.
 - have strong clinical and wider governance structures with robust planning, review and reporting arrangements.
 - have adequate interpretation services for all aspects of healthcare.

The principles in practice

- 3.3 Delivering good healthcare should be a shared process, centred around the wishes and needs of the service user, involving health professionals, the individual and their representatives.
- 3.4 The service user should not feel they are being pushed into services which are unfamiliar with no support. There needs to be continuity in relation to the professionals they deal with and who provide their care. This will often be their primary care provider in their local GP practice. Information should be readily available to the service user in a language they will understand, explaining how healthcare is structured, the processes followed and what they can expect from services. It should explain their rights and what they can expect in relation to their ongoing care. The service user should know how they can raise concerns if they feel the process is not being adhered to, or their needs are not being met. The NHS Wales Putting Things Right²⁹ process should be accessible to RAS with no, or limited English language skills.

²⁹ <http://www.wales.nhs.uk/ourservices/publicaccountability/puttingthingsright>

- 3.5 Community Health Council's (CHC's) also provide the independent voice representing the public's interest in the NHS. They monitor the quality of the NHS services provided and assist and advise people who wish to make complaints about NHS services; offering information and advice about health and related services. CHC's should ensure that local NHS provision meets the needs of RAS and act in their best interests when an individual RAS raises a concern with them.
- 3.6 It is the responsibility of health boards to arrange free interpretation during consultations and interpreter services are integral to providing effective and sensitive health care. RAS could be encouraged to bring support with them to appointments, if they feel that is helpful to them. However, use of family and friends to provide interpretation should be avoided as this brings unnecessary risks to the patient and potentially exposes the family member/friend to sensitive personal information.
- 3.7 Healthcare professionals should be made aware of the cultural, gender and other needs of service users. This will likely require additional training for some staff.
- 3.8 Through existing governance and performance monitoring arrangements health boards should review the provision of RAS services and report periodically on the effectiveness of arrangements.

Outcomes expected from guidance

- 3.9 RAS in Wales will have equitable access to appropriate services, advice, advocacy and support which will have a positive effect on their health and wellbeing. Implementation of this guidance will:
- Reduce health inequalities, with better access to services and information and advice on healthcare in Wales.
 - Reduce escalation of treatable health conditions, and the avoidable spreading of communicable disease due to the availability of information and increased awareness raising.
 - Reduce inappropriate and costly misuse of health services such as presentations at emergency departments as a result of RAS expectations being managed appropriately.
 - Improve awareness of and access to public health information on preventative care.
 - Improve access to advocacy, peer support and other social networks to improve integration and engage with the wider community; improve physical and mental wellbeing; reduce social isolation and increase local participation and interaction; and raise awareness of safeguarding such as Female Genital Mutilation, age of consent, child sexual exploitation.
 - Reduce pressure on health teams and other agencies by working together.

Governance and joint working

- 3.10 The health needs of RAS are wide and varied. They cannot be met solely by one organisation. There is a need for joint working across the Welsh and UK Governments, health boards, the third sector and local authorities in order to improve and sustain health and wellbeing.

- 3.11 Meeting the health and care needs of RAS requires a culture of collaboration and strong relationships across organisational boundaries. This can often be difficult given different organisational cultures but there are benefits not only for the individual RAS, who will find they have access to appropriate services in a timely fashion, but also to organisations through the cost-effective delivery of services; improved effectiveness and efficiency as appropriate interventions can prevent more serious issues developing in the longer-term; and promoting a whole systems approach and shared responsibility among service providers.
- 3.12 Health boards working with partners at a local and national level should seek to periodically review progress against implementation of this guidance on at least an annual basis. This will help support and inform a more strategic review of the effectiveness of arrangements and a more formal review of implementation of the guidance which Welsh Government will undertake by December 2021.
- 3.13 In implementing and keeping this guidance under review locally, health boards and partners should use existing local partnership and engagement arrangements which already exist to promote collaboration rather than creating new, bespoke structures.
- 3.14 The key aims of keeping this guidance under review will include:
- overseeing implementation of this guidance and the ability to compare provision across health boards to ensure consistency and equity of access;
 - the ability to promote the sharing of good practice;
 - facilitation of positive joint working;
 - implementation of standard health needs assessments for asylum seekers.
- 3.15 To support activity within individual health boards and ensure services are fit for purpose, fully meeting the needs of RAS, each health board should have a named person who leads and acts as co-ordinator, a source of advice to practitioners and managers, and as an advocate for RAS. This already exists in some areas and should be promoted across all health boards as good practice, with health boards ensuring consistency in resourcing and training for the role.

Data collection and secondary use

- 3.16 High quality information systems are also required to plan and monitor services. The population of RAS is fluid, as new conflicts promote the movement of individuals from new areas of the world and as existing individuals move both within Wales and the wider UK.
- 3.17 All health boards should use appropriate read codes to register RAS onto information systems (13ZN – asylum seeker and 13ZB – refugee) and have in place robust data collection arrangements to be able to track and report the numbers and the delivery of services to RAS. This will:
- inform the work of the monitoring and evaluation performance against this guidance;
 - enable service commissioners and deliverers to plan effectively;

- facilitate the comparison of the delivery of consistent services across health boards; and
- enable staff to periodically review service provision arrangements on a case by case basis to learn lessons and to share best practice.

3.18 Health boards should work with partners in WLGA and Public Health Wales to agree a standard dataset for implementation across Wales, which should include as a minimum:

- Date of arrival/presentation to NHS Wales (usually Cardiff initial access centre and dispersal area)
- Date of Birth as reported by the client, rather than as a result of any pseudo estimate
- Country of origin and countries of transit
- Primary spoken language, second languages and level of English
- Date of initial assessment
- Date of registration with primary care services in dispersal area
- Referral to secondary services:
 - speciality
 - Primary Diagnosis
 - Secondary Diagnosis
- Referral to mental health services:
 - secondary care adult services
 - secondary care CAMHS
 - LPMHSS
 - other e.g. lower level needs met by third sector referral via key worker
- Immunisations status and immunisations due
- Female Genital Mutilation.

3.19 Local authorities in particular are important partners in the delivery of services and the sharing of relevant data will enable services to develop a comprehensive picture of what provision is being delivered and compare the uptake of health and non-health services.

Information sharing across agencies

3.20 As RAS move around Wales and the UK there will clearly be a need for organisations to share personal information to ensure services can be delivered in an appropriate way to them. The **Wales Accord on the Sharing of Personal Information**³⁰ (WASPI) provides a framework for service-providing organisations directly concerned with the health, education, safety, and social well being of people in Wales. In particular, it concerns those organisations that hold information about individuals and who need to share that information to deliver effective services.

3.21 Within WASPI the Welsh Government led **Sharing Personal Information Project** aims to make sure public services, as well as appropriate third and private sector service providers, share personal information about individuals

³⁰ <http://www.waspi.org/>

legally, safely and with confidence. This is facilitated by establishing agreed requirements and mechanisms for the exchange of personal information between service providers.

- 3.22 All Welsh Local Authorities, Health Boards/Trusts, Police Forces, Fire Services, a large number of charities and voluntary sector organisations have signed up to the Accord. Other organisations, such as schools, GP practices, Housing Associations and some private sector organisations have also signed the Accord.
- 3.23 RAS personal information will need to be shared across health boards as appropriate, but also with other organisations tasked with delivering services to children, young people and families; care and support services; community safety, such as domestic abuse and safeguarding providers; and education. As a minimum sharing should involve the outcomes of initial assessment and any identified medical problems and their management. Despite the importance of this fact, there can still be relatively long delays in information passing from one service to another; this should be avoided. Any care arrangements across health and social care services will also require the sharing of information in a timely manner as required by the Social Services and Wellbeing (Wales) Act 2014.
- 3.24 Health boards should have regard to WASPI and develop appropriate information sharing protocols (ISPs) and Data Disclosure Agreements (DDAs) in order to effectively meet the needs of RAS. ISPs and DDAs identify the operational requirements when sharing specific sets of personal information between multiple organisations on a reciprocal basis.

SECTION 4 PROVIDING FOR THE HEALTHCARE NEEDS OF RAS

4.1 Healthcare services to RAS will be delivered in line with the care pathway at annex 1. The following should also be considered when delivering services to RAS.

Arrival

4.2 In Wales, **Cardiff Health Access Practice (CHAP)** provides health screening and signposting assessments for newly arrived asylum seekers when they are in temporary initial accommodation in Cardiff, prior to being relocated to the four main dispersal areas in Wales (Cardiff, Newport, Swansea & Wrexham). CHAP specifically provides:

- health screening and signposting
- access to a nurse-led immediate and necessary healthcare service
- maternity and child health services

4.3 CHAP also provides a very limited general medical service for those asylum seekers dispersed and/or granted leave to remain in Cardiff, until they are assigned a primary care provider. However, CHAP is just the start of the process in Wales for those formally dispersed to initial accommodation in Cardiff. Many will then be onwardly dispersed to other areas where the bulk of their care will be provided locally. RAS can also arrive in Wales without ever setting foot in Cardiff, as they may have arrived from other Initial Accommodation centres in England

RAS population health needs assessment

4.4 The socio-geographical differences of Wales means a 'one size fits all' approach to service delivery is inappropriate and health boards need the freedom to organise service delivery which recognises the distinct needs of their local communities. In this respect, and in relation to the delivery of services to RAS, the principal receiving health boards (Cardiff and Vale, Aneurin Bevan, Abertawe Bro Morgannwg and Betsi Cadwaladr) all have different local approaches. However, they should all agree common standards and in line with this guidance.

4.5 In this respect activity should be informed by a comprehensive needs assessment as an important step in planning and commissioning services. It helps health boards understand the needs of the population and the type and distribution of health and care services that will bring the greatest benefit. Given changes in the policy and migration patterns in recent years service, delivery needs to be underpinned by a robust health needs assessment of the current and projected issues facing the RAS population.

4.6 Health boards should collaborate in undertaking a comprehensive health needs assessment of the needs of RAS. This will inform current and future priorities, strategies and health board Integrated Medium Term Plans; identify gaps in provision; ensure resources are targeted to improve health; inform commissioning arrangements; and help reduce inequalities.

Co-production

- 4.7 Co-production is one of the main principles of the Social Services and Well-being (Wales) Act 2014. It means working with and involving individuals, their family, friends and carers to make sure care and support is the best it can be. It is a way of working that involves people who use health and care services in equal partnership; and which engages people at the earliest stages of service design, development and evaluation. Co-production acknowledges that people with 'lived experience' of a particular condition are often best placed to advise on what support and services will make a positive difference to their lives.
- 4.8 Co-production will increase the impact of prudent healthcare principles. It is an approach where people and professionals share power and work together in equal partnership. Co-production values all participants as equals and is built around people, and not around systems. Instead of fitting people into existing services, professionals work with people to find the best way to achieve the outcomes that matter to them. This is the fundamental principle of the Social Services and Well-being (Wales) Act 2014.
- 4.9 Co-produced projects and activities in Wales have had a significant impact on health, well being and community cohesion. As a principle, co-production needs to be embraced across all health and care settings and systems, to refocus the work of NHS Wales and Social Services on people. The key features of co-production are:
- Value all participants as equals and assets and everyone has a contribution to make.
 - Develop and support peer networks of friendship and support are vital to health and well-being. Peer networks help to build confidence and give people a voice.
 - Reciprocity and the impulse to give back.
 - Outcomes focus on achieving the outcomes that matter to individuals, rather than on the process of delivering services.
- 4.10 Health boards should have in place mechanisms to engage RAS in the design, delivery and on-going monitoring and evaluation of services they use. This relates to services delivered specifically for RAS, such as on arrival and initial assessment and more general services which they may require access to in primary and secondary care. Health boards should ensure they have an opportunity to give their opinion, that their voice is heard and that their views are acted on.

Standardised individual healthcare assessments

- 4.11 The Social Services and Well-being (Wales) Act 2014 requires health boards and local authorities to assess if the person 'may' have an eligible need for care and/or support. This entitlement extends to RAS. Irrespective of what, if any, healthcare assessment has occurred prior to arrival in Wales, health boards should ensure that a consistent approach is adopted to undertaking an assessment of the individual's health and wellbeing needs. In this respect, individual systems such as the current health and immunisation assessments of need (formally known as

the 'Blue Book') should be reviewed and updated to reflect the issues and needs of RAS currently arriving in Wales, such as potential trafficking, sexual exploitation and FGM. Any resulting care and support plan must be developed in partnership with the individual concerned to ensure an agreed understanding of how the needs will be met and the personal outcomes will be achieved. Local authorities should work with local health boards to agree arrangements across the health board footprint area. A local authority must keep care and support plans under review to ensure eligible needs and agreed outcomes are continuing to be met.

4.12 In November 2015, Public Health Wales produced a brief guide for service providers in Wales regarding Screening of New Entrants arriving via the Syrian Vulnerable Persons Relocation Scheme (SVPRS)³¹. This could act as a template for adoption in relation to screening all RAS (adults and children), though at the very least health boards should agree a standard approach for national adoption, which includes as a minimum:

- Past health – any surgery, illnesses and injuries requiring treatment.
- Ask routine history on consanguinity, siblings and family illnesses.
- Family members may be in detention centres or placed elsewhere and it is helpful to know their location and contact details.
- Physical health – undertake an examination including overall appearance, vision, hearing, chest, gut, skin, neurology, co-ordination, gait, cardiac, dental care, assessment of puberty (if indicated).
- Mental health screening in line with the Welsh Government's **Good Practice Guidance on the Provision of Mental Health Support for Asylum Seekers and Refugees Dispersed to Wales**³² (2017).
- Growth and nutrition – height and weight and whether malnutrition is suspected
- Look for signs of anaemia and vitamin deficiency
- Diet and constipation.
- Signs of conditions such as scabies, lice, eczema, infected acne should be sought and documented. Presence of tattoos and risk of blood-borne disease such as hepatitis B and HIV.
- Injuries should be documented carefully.
- If a sea journey was involved, ask about any near drowning/resuscitation episodes.
- Drug and alcohol consumption
- Sexual health and domestic abuse including FGM.

4.13 For RAS children the following will also need to be covered. It should not be assumed that developmental problems are solely due to the displaced and traumatic refugee experience.

- **Preschool children** – document perinatal history and any perinatal screening in the home country including hearing and new-born bloodspot.
- **For younger children** food and weaning practices may vary due to unfamiliarity with local shopping and food insecurity.

³¹ <http://www.gpone.wales.nhs.uk/sitesplus/documents/1000/PHW%20New%20entrant%20guidance%20v1%20FINAL%20-%2018nov2015.pdf>

³² <http://gov.wales/docs/dhss/publications/170223whc009en.pdf>

- **Pre school and school-aged children** - Developmental milestones, play and learning, including schooling, learning difficulties, outstanding achievements and talents.
- **Preschool children** should be referred for developmental assessment and further follow up if there are any concerns. It may also be appropriate to refer **school-aged** children for further follow-up if there are any concerns.

Vaccination for new refugees and migrants World Health Organisation (WHO) recommendations

- 4.14 Vaccine-preventable diseases are just as likely to be transmitted to host country populations by a resident of that country after a holiday in a cholera-endemic country as by RAS. However, countries of transit and conditions (e.g. camps) will need to be documented for clinicians to assess risk.
- 4.15 The WHO does not routinely collect information on transmission of vaccine-preventable diseases among refugees and migrants or on their vaccination coverage; however, well-documented outbreaks of measles have originated by transmission from migrants, mobile populations, international travellers and tourists alike. Equitable access to vaccination is of prime importance and is one of the objectives of the **European Vaccine Action Plan 2015–2020**. The plan urges all countries to ensure the eligibility and access of refugees, migrants, international travelers and marginalised communities to culturally appropriate vaccination services and information.
- 4.16 Many countries, such as those receiving large influxes of migrants, are incorporating vaccination of migrants into their routine vaccination programmes.
- 4.17 Where RAS are able to provide a good account of vaccinations received, these can be cross-checked with the WHO vaccinations schedule website and plans can be made for any further vaccinations required by taking note of when an antigen was introduced into a country's schedule. Where RAS have unknown vaccination status healthcare professionals will need to assess the likelihood that standard immunisation protocols / WHO Immunisation Schedules would have been followed in the person's country of origin. The following principles should be followed for individuals with uncertain or incomplete immunisation status:
- Unless there is a reliable documented vaccine history, individuals should be assumed to be unimmunised and a full course of immunisations planned
 - Individuals coming to UK part way through their immunisation schedule should be transferred onto the UK schedule and immunised as appropriate for age
 - If the primary course has been started but not completed, continue where left off – no need to repeat doses or restart course
 - Plan catch-up immunisation schedule with minimum number of visits and within a minimum possible timescale – aim to protect individual in shortest time possible.

4.18 The Green Book ³³ has the latest information on vaccines and vaccination procedures, for vaccine preventable infectious diseases in the UK. Health boards should agree a clear consistent protocol for ensuring a standardised approach to vaccination in line with Green Book guidance. In this respect the CHAP service is developing a screening pathway for infectious diseases. Health boards should consider the need for a consistent screening pathway across Wales and the extent to which the CHAP model could be used for this purpose.

Primary care general practitioner services

4.19 Primary care professionals serve on the front lines of healthcare. They are the first point of contact with the NHS and are the first to see the onset of chronic debilitating physical conditions, sensory loss and mental illness. They ensure patients get the right care, in the right setting, by the most appropriate provider in line with the principles of prudent healthcare.

4.20 RAS are entitled to access treatment from GPs irrespective of their asylum status and the Equality Act 2010 provides an opportunity to challenge health boards if they are denied access to services. This also applies to the range of NHS funded services delivered by community pharmacies.

4.21 In January 2016, Public Health Wales' Primary Care Quality department produced '**Access to NHS services by Asylum Seekers, Failed Asylum Seekers and Refugees**'; A brief guide for General Medical Practices (GMP's)³⁴, which provides advice about access to GMP services from potential patients wishing to register and who are also seeking asylum, or are failed asylum seekers or refugees.

4.22 GP practices should ensure that all staff, both clinical and administrative have access to training and information on their obligations. RAS may have insufficient English language skills and/or low literacy and staff should be sensitive to this. In practice this will mean ensuring information is available in an accessible format and staff are able to offer assistance in the completion of any required forms. Written communications are also unlikely to be appropriate for a significant proportion of RAS.

4.23 GP practices and other primary care services should establish ways of informing and reminding RAS of appointments by text message and telephone. Leaving an answerphone or voicemail message or recording a verbal reminder on to an individual's mobile telephone may prove helpful in some cases. However, face to face communication will generally yield the most positive responses. Local community support groups or trusted elders within the community (such as religious and spiritual leaders) can assist with communicating and engaging individuals in relation to health and social care needs. There also needs to be some flexibility in relation to the timing and duration of appointments and the potential for longer or multiple appointments if more than one patient from the same family asks to be seen.

³³

[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/554298/Green_Book_Chapter_11.p](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/554298/Green_Book_Chapter_11.pdf)

³⁴ <http://www.wales.nhs.uk/sitesplus/888/news/40204>

- 4.24 There also needs to be flexibility in relation to an individual's having access to a male or female GP, or other healthcare worker.

Health promotion and improvement

- 4.25 Health promotion messages are important to change attitudes and in tackling stigma, particularly in relation to mental health, and healthcare professionals play an essential role in providing early health promotion messages to RAS. Messages should concentrate on well-established areas such as healthy eating, smoking, alcohol and substance misuse how to stay safe and avoid danger, good sexual health (including how to access sexual health services and FGM support) and when to access GP services. Some of these concepts may be unfamiliar to RAS and sensitivity will be required in formulating health promotion messages to RAS. Health promotion messages should be continued by primary care services and should be provided in a way which is accessible to RAS.
- 4.26 Poverty and isolation may be issues for RAS and enquiries should be made about the individual's social networks. This should include questions about who they can talk to; have they started to make friends; do they want to access faith or cultural groups; do they know about educational, employment, volunteering opportunities or local sports access as a way of starting to carry out normal activities to support good mental and physical health.
- 4.27 Health promotion information and signposting to services should be available in formats which are accessible to the individual. Some health boards are already producing accessible health promotion information. Aneurin Bevan which has developed information accessible in pictorial form and Abertawe Bro Morgannwg has developed signposting information whereby clients are given maps of their allocated GP which include photographs of the GP practice to facilitate a visual aid. Health assessment appointments are sent in the client's language and have a map of the clinic, and dental practice maps have photographs of the buildings on them. This practice has been recognised by the Wales Audit Office as an area of good practice for clients with little or no English.
- 4.28 Health boards should work with partners, including the Third Sector to deliver health promotion and health improvement messages to RAS. This could be achieved through development of dedicated drop-in sessions, or liaising with partners providing existing drop-in sessions which may be preferable as they are so new to the country and may have particularly acute interpretation needs. However, refugees will need to be preparing to integrate and dedicated drop-in services could prolong that process when services should be promoting independence.

Mental health

- 4.29 In relation to the provision of mental health services to RAS the Welsh Government provided guidance and a pathway for health boards to follow in the February 2017 Welsh Health Circular (WHC) '**Good Practice Guidance on the Provision of Mental Health Support for Asylum Seekers and Refugees Dispersed to Wales**'. Health boards should have regard to this guidance in delivering mental health services to RAS. Welsh Government also provided

funding of £40,000 to ensure that mental health practitioners in both child and adolescent and adult mental health services are trained in the delivery of trauma focused care to this group. In total 29 practitioners accessed trauma training across adult and children's mental health with ongoing support and supervision sessions available from the training providers.

- 4.30 As part of the planning and assessment process for meeting the needs of RAS health boards should consider the extent to which current levels of expertise are sufficient to meet demand. Health boards should ensure services know which professionals have received trauma training within their area and ensure any RAS requiring detailed mental health assessment and interventions are able to access them via the agreed mental health care pathway.
- 4.31 Supporting this work health boards may wish to consider how initial screening for mental illness can be improved so that individuals can be identified and referred to local primary mental health support services or secondary mental health services as appropriate. Mental health screening should form part of initial screening on arrival and any RAS identified as requiring further mental health support should progress via the agreed mental health pathway. Interventions offered should be foremost person-centred and acknowledge holistic and individual experience of the person who may have encountered dehumanising violence, war, terror and traumatic journeys to the UK, which may impact on their mental health. Asylum seekers, in particular, have been identified as a high risk group who are particularly vulnerable to suicide and self harm in the Welsh Government's Talk to Me 2 strategy³⁵.
- 4.32 Many psychological difficulties may arise some time after arrival in the UK and may develop as a result of social isolation, stigmatisation, poverty, language and cultural barriers, social problems, etc. Conversely, not all RAS will have mental health needs and of those that do, not all will require access to specialist help and support. Many will have low level emotional and mental health needs which, in line with the principles of Prudent Healthcare, can and should be dealt with in other settings, such as in primary care mental health services.
- 4.33 Under the Mental Health (Wales) Measure 2010 the Welsh Government has expanded access to mental health services, particularly in primary care with the development of Local Primary Mental Health Support Services (LPMHSS). These provide speedy access to assessment and interventions in a local community setting. These services have been set challenging targets of 28 days from referral to assessment and 28 days from assessment to intervention and the needs of RAS may well be met by these services in many instances. Supporting the delivery of interventions the British Psychological Society published Guidelines for Psychologists on Working with Interpreters³⁶.
- 4.34 For RAS children they may find their low level needs are best met though local authority counselling occurring in school settings. These counselling services, which are available to all year six and above pupils, have established links with

³⁵ <https://gov.wales/docs/dhss/publications/150716strategyen.pdf>

³⁶ <https://www.bps.org.uk/sites/bps.org.uk/files/Policy%20-%20Files/Working%20with%20interpreters%20-%20guidelines%20for%20psychologists.pdf>

specialist CAMHS and are able to escalate/deescalate as the young person's needs dictate.

- 4.35 Whichever service provides for the mental health needs of RAS, they need to ensure they individuals have equitable access in line with the general population. Clinicians should be mindful that mental health difficulties may sometimes be expressed via physical symptoms. GPs referring to LPMHSS services need to follow existing referral mechanisms and health boards need to ensure sufficient capacity and expertise (i.e. communications) exist within the system to meet RAS needs.

Communicable diseases

- 4.36 The prevalence and nature of bacterial and viral infections will vary across countries. RAS are at risk of acquiring infectious diseases in their country of origin prior to migration, during migration, as well as in their destination country. RAS can therefore have different risk profiles to the indigenous population. This highlights the importance of considering, and improving the recording of country of birth as a risk factor for infection.
- 4.37 A significant number of RAS arrive from countries where infections such as Tuberculosis and blood borne viruses are highly prevalent, and/or they may have been exposed to these diseases en route to the UK.
- 4.38 The journeys to the UK often involve overcrowding and contact with unwell persons and this can increase the risk of transmission of infection to others. It is therefore important to ensure that on arrival in Wales appropriate infection control measures are implemented should an asylum seeker or refugee have or develop symptoms of a communicable disease.

Sexual and reproductive health

- 4.39 In addition to those RAS who may have been in consensual sexual relationships, some may have experienced rape and torture, or FGM in their home country; been subject to sexual abuse, trafficking, exploitation and slavery en route to the UK; and some may have worked as commercial sex workers either before, en route to, or following arrival in the UK. Healthcare professionals should carry out a full sexual health review including questions about whether the individual is sexually active and whether they are pregnant as well as discussing contraceptive options. Ideally this should be carried out in the context of a comprehensive assessment, and in association with the local Department of Sexual Health Services.
- 4.40 Exposure to violence, rape and other trauma should be explored sensitively. Not all people are able to disclose on first assessment if they have been raped and this will need careful inquiry.
- 4.41 Some may require onward referral to mental health services for trauma related counselling or to third sector counselling providers such as those providing Sexual Assault Referral Centre (SARC) services.

Dentistry, Optometry and Pharmaceutical

4.42 Prior to dispersal, RAS can access emergency eye care and dental services. Once dispersed, they can access NHS dental treatment, ophthalmic and pharmaceutical services in the same way as any other UK resident. In common with those normally resident, they will have to pay certain statutory NHS charges, unless they qualify for exemption, such as via form HC2, and will have to go on NHS waiting lists for any treatment required.

Pregnancy and maternity services

4.43 Women seeking asylum in the UK are often late in presenting to antenatal services. They may also have poor general health, anaemia, high parity, closely spaced pregnancies, HIV, hepatitis B, hepatitis C and female genital mutilation. Studies have shown poor antenatal care and pregnancy outcomes amongst RAS.

SECTION 5 GOOD PRACTICE

Barriers to accessing services

5.1 Although accessing healthcare is difficult for many vulnerable groups, RAS face a number of specific barriers including:

Personal

- lack of awareness of how to access the NHS
- Disruption in continuity of health care, often as a result on 'no choice' dispersal across the UK
- unfamiliarity with models of care provided by the NHS - depending on their country of origin RAS may have very different expectations and experiences of primary healthcare. For some, primary care may have a lack of credibility or be perceived as a second class service whilst for others it may be a completely unfamiliar concept
- lack of available information
- unrealistic expectations of the NHS
- difficulty in finding a GP with whom to register
- language and communication - language issues are a key issue with regard to access to services which includes access to healthcare. Language problems may be significant contributory factor to social isolation
- lack of documentation
- confidentiality - fear of authority and mistrust issues
- likely traumatic experiences, including potentially torture, rape or witnessing death
- stigma related to some health issues e.g. rape, sexually transmitted diseases, mental illness.

Structural

- lack of understanding of issues and rights and entitlements by health professionals
- lack of available information
- poverty
- homelessness and temporary accommodation
- discrimination and inaccessible services
- lack of social networks
- language and communication issues
- difficulty in registering with a GP
- lack of training for NHS staff
- misconceived ideas and ignorance about the needs of this population.

5.2 It is important, however, to acknowledge that although the ultimate aim of providing NHS care to RAS is through mainstream service provision, a model of care to facilitate and support integration, or to ensure public health issues are addressed may initially be appropriate. Existing experience suggests the key factors for the development and implementation of successful models of services and interventions include:

- early and systematic health needs assessment - including appropriate screening and appropriate follow up (to include screening for TB with appropriate follow up)
- vaccination and immunisation catch-up programmes
- an appropriate model of care (e.g. consideration to dedicated interim primary care service)
- good access and support to primary care services
- health promotion for both physical and mental health
- culturally sensitive services
- access to appropriate language and translation facilities/services
- multi-agency working
- available training for all relevant NHS and related services.

Health literacy

- 5.3 Health literacy is a social determinant of health and is strongly linked with other social determinants such as poverty, unemployment and membership of minority ethnic groups. Where health literacy differs from these other social factors it is, potentially, open to change through improving health systems and building patient and public awareness and skills.
- 5.4 Health literacy can be defined as 'the personal characteristics and social resources needed for individuals and communities to access, understand, appraise and use information and services to make decisions about health.' (WHO,2015)
- 5.5 Levels of functional health literacy are likely to be low for RAS, in addition to issues relating to English literacy levels, health information in current circulation is often too complex. Health literacy has real effects on health and illness. Older people with low health literacy have higher mortality and research from the US and Europe shows people with low health literacy are more likely to have long-term health conditions which in turn are more likely to limit their activities. People with low health literacy rate their health as lower than people with higher health literacy levels; people with low health literacy and lower educational levels are more likely to have unhealthy lifestyles.

Information and awareness raising

- 5.6 As with the wider population the provision of health and well being information should be an important part of services offered to RAS.
- 5.7 The availability of translated materials on health may prove useful but other methods will be necessary where literacy, or other communication needs such as hearing or sight loss, is an issue. Ultimately, the provision of information, advice and assistance is best delivered face-to-face and those receiving health services should be encouraged to bring support with them to appointments if that enables a better patient experience.
- 5.8 Health promotion information should therefore be provided through a variety of methods. This may include individual sessions, group talks and workshops as well as written information (care should be taken when translating material to ensure overall accuracy and cultural appropriateness).

- 5.9 It may be useful to include information on services, their structure and delivery, together with information on Third Sector organisations operating in the locality within any local healthcare information and literature.
- 5.10 Section 17 of the Social Services and Well-being (Wales) Act 2014 places a duty on local authorities to secure the provision of an information, advice and assistance service. The purpose is to provide people (including RAS) with information and advice relating to care and support, including support for carers, and to provide assistance to them in accessing it. Information, advice and assistance must be provided in a manner that makes it accessible to the individual for whom it is intended. Information and advice is to be made available to all people regardless of whether they have needs for care and support. Health boards are under a duty to facilitate the service by providing information about the care and support that they provide. Dewis Cymru³⁷ has been established as an online repository of information, advice and assistance to meet the requirements of the Act.
- 5.11 There is a need to provide accessible information to RAS which details:
- what they can expect from services (i.e. waiting times, access to services, dentistry, etc.)
 - ways to reduce stigma and discrimination
 - explanation of UK cultural expectations regarding child care, supervision, physical chastisement, Female Genital Mutilation, etc.

Training for healthcare staff working with RAS

- 5.12 It is important for RAS to have accessible information on services and what they can expect from the NHS in Wales. It is equally important that health boards ensure staff at all tiers of provision - from health care support workers and health visitors to GPs and other local practice staff such as receptionists; wider primary care staff; secondary care and more specialist staff - have access to training and awareness of the needs of RAS.
- 5.13 Health boards should therefore consider the need for online learning resources for staff which encompasses cultural awareness and the need to maintain minimal use of jargon. As a minimum all staff will need to have undertaken the NHS Wales **Treat Me Fairly**³⁸ e-learning course, though health boards, particularly those with large numbers of resident RAS, may wish to supplement this with more dedicated training on RAS needs.
- 5.14 There also needs to be support and advocacy for people with complex cases and at transition points such as on arrival, at dispersal and when given refugee status or refused. Whilst not specifically healthcare related the **Asylum Rights Programme**³⁹, funded by the Welsh Government, is a partnership of seven Welsh organisations which promotes and ensures the rights of people seeking asylum and living in Wales in three ways:

³⁷ <https://www.dewis.wales/>

³⁸ <http://www.equalityhumanrights.wales.nhs.uk/treat-me-fairly-e-learning-1>

³⁹ <http://welshrefugeecouncil.org.uk/news/21042017-1405/asylum-rights-programme-arp>

- Ensuring that people seeking asylum know their rights and have support, where and when needed, to claim them.
- Ensuring that professionals working with people seeking asylum understand the needs of the people they are supporting, as well as their role in contributing to a Wales where rights are enjoyed.
- Informing and influencing public understanding about the right to asylum and the benefits of welcoming people in need to Wales.

Language / interpreting including sign language

- 5.15 Language and communication are likely to be amongst the key barriers that face asylum seekers seeking to access healthcare. This is compounded by the plethora of cultures within the RAS population which can be particularly challenging to both service planners and providers.
- 5.16 Within healthcare access to language support, both orally and in writing, is essential to ensure that individuals understand the advice and programme of care offered as well as being able to give informed consent to treatments.
- 5.17 Organisations should have clear protocols and policies in place to ensure staff know how to access the available translation services, their role and responsibilities regarding the provision of interpreters, and that standards of interpretation and translation are of a good quality.
- 5.18 There are a significant number of organisations providing translated material and in order to avoid duplication organisations should consider what is already available and whether it could be adapted and utilised.
- 5.19 It is the responsibility of health boards to arrange free interpretation during consultations and interpreter services are integral to providing effective health care.
- 5.20 Interpretation can take many forms, some which may have been used in the past should now be discouraged, for instance the:
- informal use of family members. This is inappropriate for a number of reasons including that it may not be in the client's best interest, with concerns regarding confidentiality and safety if a husband or partner is used, or the use of accompanying children, which may expose the child to inappropriate knowledge
 - use of bilingual health workers, support workers and volunteers, which brings issues around misinterpretation and potential liability.
- 5.21 Health boards should only use accredited interpretation services such as:
- the Wales Interpretation and Translation service⁴⁰ (WITS), designed for use by all public services in Wales and aimed to replace the profusion of separate translation arrangements with a "one-stop-shop" that improves service quality and reliability, with all health boards signed up its use; and

⁴⁰ <https://www.wits.wales/>

- LanguageLine⁴¹, which provides interpreting services in over 240 languages 24 hours a day, 365 days a year over the telephone.

5.22 However, use of accredited services may also bring issues such as the use of professional interpreters who are generally male which may make some women reluctant to discuss issues. However, female interpreters are available and the client's wishes over interpreter gender should be respected. Health boards should consider evaluating the use of interpreters they use.

5.23 In line with the requirements of the Equality Act 2010, RAS should not be discriminated against due to a lack of knowledge of English. Health boards need to ensure that adequate interpretation resources are available and are suitable to the case under discussion, with the ability to communicate often complex issues in an empathic but accurate manner. Continuity of an interpreter may also be beneficial in relation to RAS with chronic long-term conditions, or mental illness where patients may feel more comfortable with an interpreter they have come to know and the interpreter is more familiar with the individual and their case. It may also be more appropriate to work with interpreters with specialist knowledge and training in relation to mental health issues and/or trauma and violence. This was recommended in the 2018 Auditor General for Wales' report *Speak my language: Overcoming language and communication barriers in public services*⁴².

Peer support

5.24 Peer mentoring schemes have been run successfully in Wales for a number of years focusing on specific groups of individuals, such as ex military veterans, substance misusers and those suffering from poor mental health and wellbeing.

5.25 Peers – people with lived experience of RAS or other issues for example recovery from mental health, substance misuse – are ideally placed to provide support, practical advice, and encouragement, acting to guide the individual through a system which seems completely alien to them. Peer mentoring provides RAS with a pathway out of social isolation and poverty by providing support to engage with service providers, but also in relation to wider community and social activities, education, training or employment in order to benefit their physical and mental wellbeing and integrate them into the communities in which they live.

5.26 The role of a peer mentor can be described as:

- Providing help, support and guidance designed to help maintain positive momentum towards the ultimate goal of achieving an enhanced quality of life.
- Helping individuals access services to meet their care needs, such as health, housing, etc, providing support in the interaction with those services.
- Supporting recovery from substance misuse including alcohol, and from mental health issues.
- Supporting people in engaging with the labour market, towards developing skills, access training, and obtain and retain employment.
- Providing focus for partners and wider family support networks.

⁴¹ <https://www.languageline.com/uk/wcu/customers/>

⁴² <http://www.audit.wales/system/files/publications/speak-my-language-2018-english.pdf>

- Providing enhanced skills for the mentor as an individual with unique insight into RAS circumstances, developing their own skills as practitioners and promoting opportunities to become a Peer Mentor.
- Filling gaps in current services, by providing case work support which often stops short at providing support only in relation to clinical issues.
- Helping the individual transition between services and understand how systems and processes work.

5.27 Health boards should consider working with third sector providers to support the development of voluntary peer mentor networks in their areas.

SECTION 6 MANAGING RISK

Community cohesion and radicalisation

- 6.1 We live in increasingly diverse communities which face challenges arising from migration, intergenerational differences, the impact of poverty and the growing influence of extremism. Community cohesion policies meet these challenges by encouraging integration, valuing difference, fostering equality and focusing on the shared values that join people together. The Welsh Government is working with partners in Local Authorities, police forces, and the third sector, to strengthen, mainstream and sustain both local and regional community cohesion approaches across seven outcome areas.
- 6.2 Health boards should ensure that those working closely with these communities have been PREVENT⁴³ trained to ensure they can recognise any concerning activities.

Domestic abuse, trafficking and slavery

- 6.3 RAS experiencing domestic violence are particularly vulnerable because they may lack family and community support. Their access to accommodation may be dependant on their partner, who is the 'lead applicant' for their asylum claim, and while UK Visas and Immigration and the accommodation provider do have policies to deal with domestic abuse, it may still be very difficult for victims of abuse to report the behaviour or leave the abuser. Abuse may take many forms such as controlling behaviour or financial abuse and in some cultures, domestic violence is tolerated or is kept within the family, or victims may be unaware that help is available. Their partner's violent behaviour may be tolerated because of the violence that they may have experienced themselves. Physical chastisement of children may be acceptable in some cultures whereas not in Wales.
- 6.4 Some RAS are trafficked to the UK for the purposes of working in the sex industry, forced labour or domestic servitude. They may not have made an application for asylum but may have a case to apply for asylum and as such may require legal advice. They have a wide range of physical and psychological health needs but may be hard to reach, as they may be fearful of contact with statutory services.
- 6.5 Health boards need to be aware of the signs of violence against women, gender based violence and domestic abuse or trafficking and may need to consider how best to engage potential victims on their own and away from their partner. The Welsh Government's Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act⁴⁴ 2015 aims to improve the Public Sector response to such abuse and violence. Amongst other things it will:
- Improve arrangements to promote awareness of, and prevent, protect and support victims of gender-based violence, domestic abuse and sexual violence
 - Introduce a needs-based approach to developing strategies which will ensure strong strategic direction and strengthened accountability

⁴³ <https://www.elearning.prevent.homeoffice.gov.uk/edu/screen2.html>

⁴⁴ <http://www.legislation.gov.uk/anaw/2015/3/contents/enacted>

- Ensure strategic level ownership, through the appointment of a Ministerial Adviser who will have a role in advising Welsh Ministers and improving joint working amongst agencies across this sector
- Improve consistency, quality and join-up of service provision.

- 6.6 Ask and Act is one element of the new statutory obligations under the Act, with an organisational duty to encourage relevant professionals to “Ask” potential victims in certain circumstances (targeted enquiry); and to “Act” so that harm as a result of the violence and abuse is reduced.
- 6.7 Health boards need to take account of the requirements of the Act in developing services for RAS.

Female Genital Mutilation (FGM)

6.8 Female Genital Mutilation (FGM) is a collective term for a range of procedures which involve partial or total removal of the external female genitalia for non-medical reasons. It is sometimes referred to as female circumcision, or female genital cutting. The practice is medically unnecessary, is extremely painful and has potential serious health consequences, both at the time when the mutilation is carried out, and in later life.

6.9 FGM has been classified by the World Health Organization (WHO) into four major types, all of which may be relevant to the offences arising under the Female Genital Mutilation Act⁴⁵ 2003:

Type I: Clitoridectomy: partial or total removal of the clitoris;

Type II: Excision: partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora;

Type III: Infibulation: narrowing of the vaginal opening through the creation of a covering seal:

Type IV: Other: all other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterizing the genital area.

6.10 Professionals are expected to inform the patient/client that FGM is illegal in the UK, including when a child is taken out of the country for the procedure. If they have been "cut", a referral should be made to specialist services for a follow-up assessment. Professionals should ask girls/young women if they have been subjected to FGM. Any child (under age 18) who has undergone FGM must be reported to social services and to the police.

6.11 To ensure consistency health boards should adhere to the common care pathway⁴⁶ which aims to meet the needs of young women who have been, or may be suspected of being at risk of FGM, with appropriate referral to other agencies and services as appropriate.

⁴⁵ <https://www.legislation.gov.uk/ukpga/2003/31/contents>

⁴⁶ <http://www.gpone.wales.nhs.uk/sitesplus/documents/1000/All%20Wales%20Clinical%20Pathway%20-%20FGM.pdf>

Unaccompanied Asylum Seeking Children and Refugee Children (referred to as children and young people)

- 6.12 In line with the duties contained in Part 6 of the Social Services and Well-being (Wales) Act 2014, unaccompanied asylum seeking children are treated as Looked After Children. Thus when they arrive in Wales, they are placed in the care of foster families or enter independent but supported living arrangements.
- 6.13 Children and young people arrive via a number of different routes but the most common form of arrival is 'spontaneously', that is, not through planned arrival, via clandestine means. They may be smuggled or trafficked into the UK or travelled themselves. The current Children Receiving Care and Support Census (February 2018) reports that there are 105 asylum seeking children in Wales, both accompanied and unaccompanied. Overall, the children and young people arrive here in generally good physical health although there are issues in respect of their mental health. Where there are physical health issues they generally correlate with their mode of arrival. If they have arrived via a Government scheme (such as the Vulnerable Children's Resettlement Scheme, the Syrian Resettlement Programme, the National Transfer Scheme (not currently operational in Wales) and the s67/Dubs Scheme) they should have had access to healthcare before and after arrival and records should exist of the assessments undertaken for onward sharing with primary healthcare staff.
- 6.14 If they have arrived spontaneously, they will not receive a health assessment until they are here. Arriving spontaneously means it is more likely that they will have undertaken a dangerous journey, perhaps having made a number of previous attempts, and the journey(s) will likely have caused injuries and illnesses. For example, there are reports of damaged bones, open wounds and trench foot. This said, those that arrive in a managed way, via a Government scheme, will have health needs associated with their experience of displacement and along with those that arrive spontaneously, some of the health needs are not usually presented by the general looked after child population.
- 6.15 Evidence shows that the typical physical health issues that children and young people present with are of the public health variety (i.e. blood-borne viruses and sexual health issues), gastro-intestinal problems and FGM. In respect of mental health, the children and young people present with a variety of trauma and emotional health-related problems. These problems are a result of their reasons for fleeing their homes (i.e. war, poverty, persecution, despotic regimes and climate change) and, where they have taken them, the experiences of the journeys they have taken to reach the UK. All of these issues would all fall in to the realm of Adverse Childhood Experiences (ACEs). Recent research has shown high levels of negative life experiences, such as 46% had experienced the death of a close family member and 75% were not in contact with any family. In addition to adversity prior to fleeing their homes, 51% experienced trauma en route to the UK; 32% reported detention; 27% experienced physical assault and 12% were tortured⁴⁷. It will be important for all health practitioners working with these children and young people to understand the effect of these and other ACEs on health and wellbeing. The research states that there are predictable health needs in this

⁴⁷ https://adc.bmj.com/content/103/Suppl_1/A2.1

population and should be accounted for in planning for and increasing access to mental health services.

- 6.16 For healthcare practitioners working with these children and young people, it is important that they are properly skilled and equipped to deliver the services they need. Building trust, especially where the children and young people's experience of authority figures is likely to be negative, is probably the most important action to take. A trusting relationship provides the foundation for good care and support and part of that foundation is ensuring that practitioners are culturally sensitive to the needs of the children and young people. In this respect, cultural awareness training for practitioners will likely be needed. Helping the children and young people to understand their own health needs, in the context of preventing illness and disease and taking care of oneself, is also an important function of practitioners as it educates them about the how the health system works in Wales. The importance of providing this help face-to-face cannot be underestimated but where this is not possible, easy to understand materials that are made available in a way that engages the recipients, need to be developed.
- 6.17 There are a number of resources available to help healthcare practitioners working with RAS children and young people. These include a detailed health assessment process prepared by the Royal College of Paediatrics and Child Health⁴⁸ and the UASC Health team in Kent⁴⁹ has developed an online resource for use by healthcare practitioners.
- 6.18 An issue of some significance for these children and young people is age assessment. If the Home Office/UKVI and/or the local authority looking to foster the child with a family believe that the physical appearance or demeanour of the young person 'very strongly suggests' that they are over 18, then an age assessment should be carried out. This can be a lengthy and detailed process and can be challenging for all concerned, the young people and practitioners alike. Establishing that the young person is a 'child' (under 18) is paramount to ensuring that he or she receives the correct advice and support. It is also important to ensure the safety of any other children and young people who might be in the same placement with the young person. There is an Age Assessment Toolkit⁵⁰ which describes the process of age assessment and the role of health practitioners within it. It is being updated and will be available in 2019.
- 6.19 There is much debate about the appropriateness of carrying out medical testing to determine a young person's age and there are strong views against this practice, held by many medical and public health professionals. The Toolkit is clear that medical examinations can be considered as part of the wider, holistic multi-agency age assessment; that the reports of such examinations should never be considered in isolation and that X-rays or other invasive checks, should not be requested or carried out.
- 6.20 A medical professional's opinion carries no more weight than that of a social worker. Medical examinations should only be carried out with the young person's consent and by practitioners with evidenced, track recorded expertise of assessing

⁴⁸ <https://www.rcpch.ac.uk/improving-child-health/child-protection/refugee-and-unaccompanied-asylum-seeking-cyp/paediatric-heal>

⁴⁹ <http://www.uaschealth.org/>

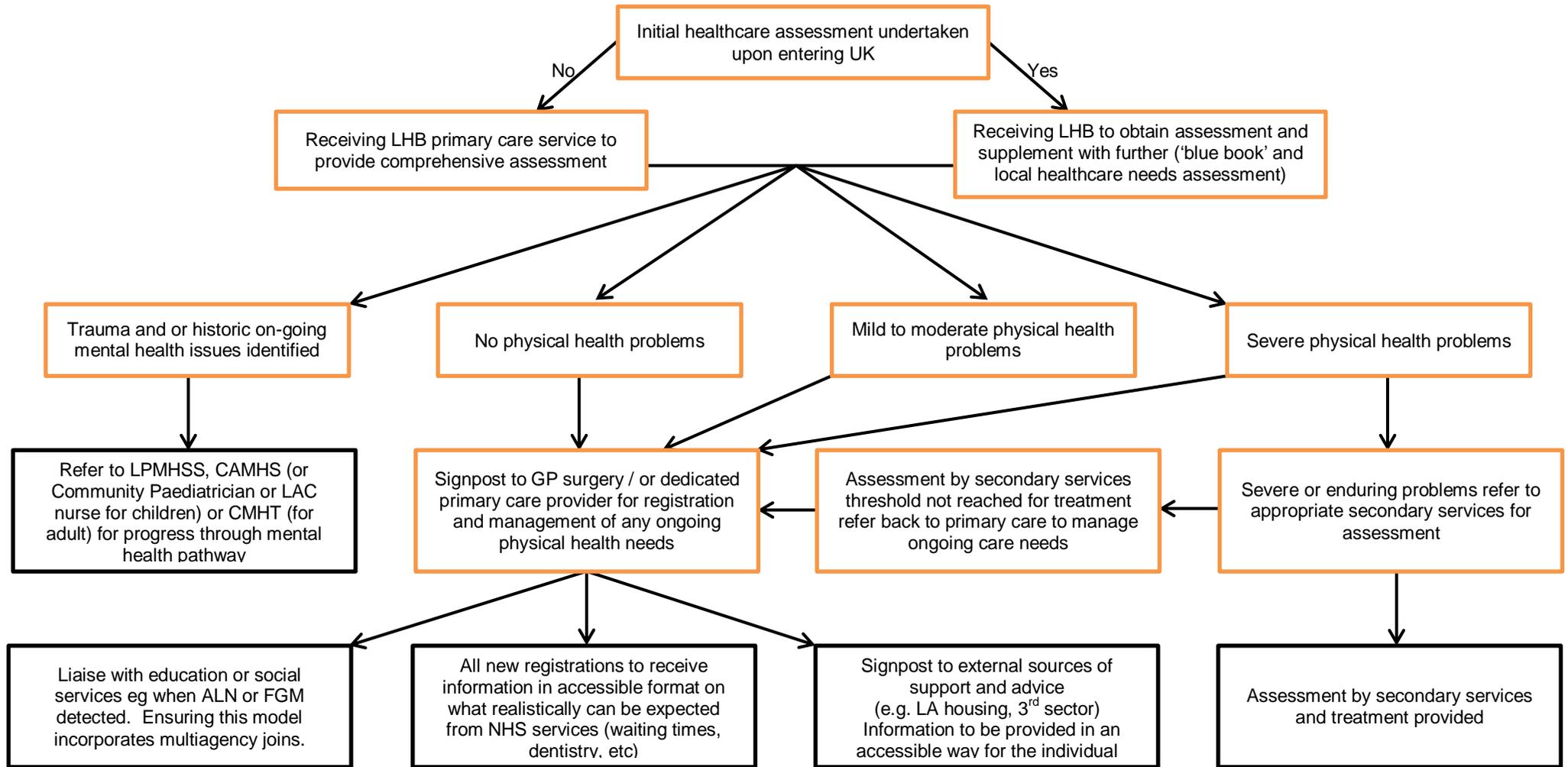
⁵⁰ <http://www.wsmp.org.uk/documents/wsmp/News%20and%20Events/150330%20Age%20Assessment%20Toolkit%20Final%20July.pdf>

asylum seeking young people from a wide range of countries and working with experienced social workers in the process.

- 6.21 It is worth noting the position of the Royal College of Paediatrics and Child Health position statement, which is that *'There is no single reliable method for making precise estimates. The most appropriate approach is to use a holistic evaluation, incorporating narrative accounts, physical assessment of puberty and growth, and cognitive, behavioural and emotional assessments.'* Also the British Dental Association's position statement which is that *'We are vigorously opposed to the use of dental X-rays to determine whether asylum seekers have reached 18. It's not only an inaccurate method for assessing age, but it is both inappropriate and unethical to take radiographs of people when there is no health benefit for them. X-rays taken for a clinically-justified reason must not be used for another purpose without the patient's informed consent, without coercion and in full knowledge of how the radiograph will be used and by whom.'*

Annex

ANNEX 1 – PATHWAY ON THE PROVISION OF HEALTHCARE TO RAS^{51/52}



⁵¹ For unaccompanied children and individuals who have not been identified prior to arrival in Wales ensure signposting to appropriate services (LA, HO, drug/alcohol, sexual exploitation, etc)

⁵² Referral for most problems is delayed until dispersal due to patients having moved by the time an appointment comes through, the NHS also has to pay for new, emergency presentations prior to dispersal. For those diagnosed with HIV should be referred into secondary care as quickly as possible. For those prescribed anti-retroviral therapy (ART) should immediate (within 24 hours) access to ART should be arranged.