"They just left me." Asylum seekers, health, and access to healthcare in initial and contingency accommodation

Jones, Lucy; Phillimore, Jenny; Fu, Lin; Hourani, Jeanine; Lessard-Phillips, Laurence; Tatem, Briony

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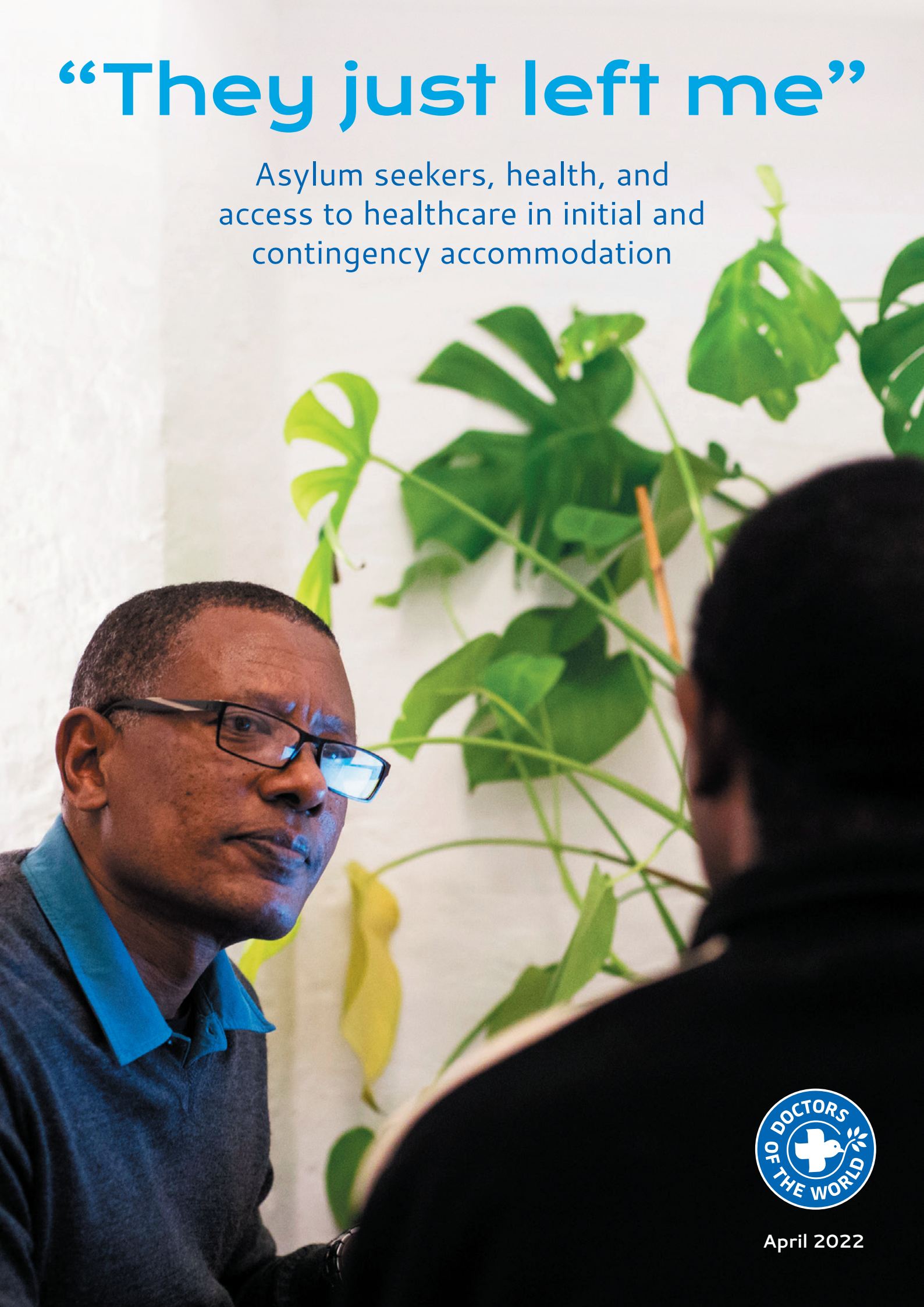

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Doctors of the World National Health Advisors Anne, Pat, Ruqoyyah and Shams provided specialist advice and testimony on their own experiences to the authors of this report. National Health Advisors are experts by experience of the UK immigration system or health exclusion. They work with DOTW using coproduction principles to promote access to healthcare for all.

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Executive summary

Since 2019 there has been a vast increase in the number of asylum seekers living in Home Office initial/contingency accommodation including hotels and repurposed Ministry of Defence (MoD) barracks with current estimates reaching over 37,000 people. Whilst originally intended for stays under 35 days the majority of people have been in the accommodation for longer periods. The government is progressing plans to develop further large scale initial/contingency accommodation as part of their immigration reforms with expectations asylum seekers may have stays for over six months.

In order to understand the impact of this accommodation on health and access to healthcare for asylum seekers The University of Birmingham collaborated with Doctors of the World UK (DOTW UK) to conduct a mixed methods study which analysed quantitative and qualitative data collected through DOTW UK's provision of health support to 313 people housed in hotels and barracks in 2020 and 2021, who we refer to in this report as service users.

The report finds that:

- **Accommodation conditions were not meeting basic human standards, which contributed to poor health. This included poor food, access to basic sanitary products, inability to store medication or have professionals visit to provide care.**
- **People reported a significant mental health impact of the loneliness, isolation and feelings of being imprisoned engendered by the conditions.**
- **Service users presented with a broad range of health needs, many people required intensive support to access and navigate the system which often took weeks or months of delays in access to care.**
- **People were unable to get prescriptions, medical care for pregnancy and children, referrals to specialists and ongoing support for medical conditions both chronic and acute. People did not know how to get and pay for medication they were prescribed and some could not access medication needed to control serious conditions.**
- **Most people had no access to information on how to meet their basic health needs and no formal sources of support from the healthcare system.**
- **Service users were forced to rely on hotel staff to answer their medical questions and access support, the staff were often unhelpful and reluctant to offer help around medical needs. Staff were also poorly informed about residents' entitlements to healthcare.**
- **People struggled to get access to dentists and opticians and again didn't have support to pay for these fees.**
- **Lack of access to timely and continuous care meant people were left without treatment and were left to suffer on their own.**
- **The evidence in this report shows that initial/contingency accommodation is unsafe for asylum seekers due to the lack of access to adequate and appropriate healthcare services and the nature and conditions, which risk directly harming service users' health.**

Recommendations

In order to not cause harm to people's health and meet their essential health needs:

- **Asylum seekers should be accommodated in a humane way that enables meaningful access to full NHS care to meet health needs and provide continuity of care. Conditions should not risk harm to physical and mental health.**
- **The Home Office should introduce a centrally funded system that houses asylum seekers in safe and sanitary housing in communities across the country where they can access decent food and toiletries and that enables access to local GP and specialist health services.**
- **Home Office contracts with accommodation providers should be amended to include provision of direct support for GP registration for everyone in Home Office accommodation and to access all NHS services and provision of health information and support to complete HC1 forms as key performance indicators.**
- **All asylum seekers receiving Home Office support should automatically receive a HC2 certificate for 12 months.**

Introduction

The Home Office has a statutory obligation to provide support including accommodation to destitute asylum seekers whilst their claims are being considered. Initial accommodation centres (IACs) are usually the first accommodation for any asylum seeker who asks for support. IACs are meant to offer temporary accommodation while asylum seekers are allocated community housing to which they are dispersed on a no choice basis. Capacity issues in IACs has led Home Office accommodation providers to use additional accommodation including repurposed Ministry of Defence barracks and hotels to house asylum seekers. Throughout this report this form of housing will be referred to initial/contingency accommodation.

Prior to 2019, when the IAC estate did not have sufficient capacity to accommodate asylum support applicants, hotels were used to accommodate asylum seekers.[1] The numbers of people in need of asylum accommodation began to rise prior to the coronavirus pandemic in 2019, and by March 2020 there were 1,200 asylum seekers accommodated in hotels. The numbers have continued to rise to 37,000 people in February 2022, which includes 12,000 resettled from Afghanistan.[2,3] The reason given for this increase has been reported to include a rise in asylum applications in 2019, compared with the previous year, delays in agreeing a new accommodation contract in some areas of the country, and the pandemic causing a delay in processing claims and a need to relocate some asylum seekers to meet social distancing guidelines.[4]

In September 2020, the government commissioned previously disused MoD sites Coltishall in Norfolk, Penally in Pembrokeshire and Napier in Kent as accommodation for people who are seeking asylum in the UK. Penally has a maximum capacity of 234 places, and Napier around 400 places (under COVID-19 conditions). Although people are theoretically free to leave the site, they are expected to be there overnight and are isolated with a heavily secured external appearance.[5] Despite the sites being defined as contingency (temporary) accommodation the contract for Napier barracks has been extended to 2025 and the Home Office has indicated that use of the site may continue beyond that date.[6]

Concerns have been expressed about the health consequences of housing asylum seekers in initial/contingency accommodation. These focus on the effect of living for long periods in accommodation designed to be temporary and the extent to which residents can access the healthcare they need, especially with regard to the complex mix of physical and psychological conditions sometimes experienced by asylum seekers. The University of Birmingham and DOTW UK have collaborated to use qualitative and quantitative data collected by DOTW UK volunteers working with service users in initial/contingency accommodation to examine the health of asylum seekers in initial/contingency accommodation, the self-reported impact of conditions on health and asylum seekers' access to the healthcare needed. The report begins with a brief description of healthcare provision in initial/contingency accommodation before moving on to outline the state of knowledge about the association between such housing and asylum seeker health. We then describe DOTW UK's services in such accommodation and the methods used to collect and analyse data. Our results are reported in several sections beginning with a description of service user profile, followed by health status and access to healthcare. The report ends with a discussion and conclusions and recommendations for the changes that need to be made to ensure access to healthcare for all asylum seekers.

Healthcare provision in initial accommodation

Everyone in the UK is entitled to register with a GP and asylum seekers can access all healthcare without charge.[7] GP Registration creates an NHS number and primary care is the main point of access to NHS services, through referral from a GP.

Asylum seekers supported by the Home Office are entitled to access the NHS low-income scheme for help with health costs including prescription, dental and optometry charges.[8] This scheme is accessed via a HC1 form to apply for a HC2 certificate, which is valid for 6 months for asylum seekers versus 12 months for most other applicants.[9]

In England, NHS Clinical Commissioning Groups are responsible for commissioning healthcare for asylum seekers accommodated within their area including those in initial and initial/contingency accommodation.

There is a requirement for asylum seekers to be offered initial health screening and Napier Barracks had a private nurse.[10] Accommodation providers are not required to provide direct support to access healthcare or register with a GP unless the person is in "obvious and urgent" need of medical care. For example, in the event of heavy blood loss, severe chest pain, pregnancy complications or a suicide attempt.[11]

In 2021, the UK Government published the New Plan for Immigration which set out plans to make changes to the asylum and migration system which included a new reception centre model.[12] This model was also referred to in the Nationality and Borders Bill to enable the Home Office "to use certain types of accommodation to house certain cohorts of asylum seekers and failed asylum seekers in order to increase efficiencies within the system and increase compliance".[13] The Home Office is seeking contractors to build a 'national portfolio' of reception centres to provide accommodation and other services for up to 8,000 people for periods of up to six months.[14] Whilst the proposed reception centres would provide basic accommodation and services including healthcare services,[15] the purpose of the centres are to facilitate the monitoring of residents and removal of people with unsuccessful claims. However, the proposals do not include details of how the aforementioned meaningful access to appropriate healthcare services will be provided for residents in accommodation centres of this size. It is likely the new reception centres will operate in a similar way to the current initial/contingency accommodation model of initial accommodation in hotels and barracks, but on a larger scale. The Home Office has described the accommodation of over 400 asylums seekers at Napier barracks as a 'prototype' for the proposed reception centres.[16]

"I've got medical needs, I suffer from some particular illness where it needs to be monitored. I was kind of broken at the time, I had depression, anxiety, I had migraine. I just had a baby as well. And I was asking if they can please register me but they said no. All those things including registering with GP are meant to be done by them but they didn't do anything. They even they just said, you need to just Google it. Excuse me but I didn't have internet. That was what I was told. And that's still what people have been told. I had to miss medication for myself and my child because of this issue with GP registration."

Ruqoyyah
Doctors of the World National Health Advisor

Background

Housing, health and forced migration

There is a clear and well-evidenced link between the nature of asylum seeker housing and their health. Housing influences individuals' well-being, identity and mental health in two key ways: the physical housing environment facilitates possible behaviours, daily activities, and social interactions; while the location of the housing within a neighbourhood enables access to facilities including healthcare resources.[17] Research with asylum seekers finds that while simply having a home can offer a sense of wellbeing, there are additional housing-related impacts on health according to both physical and social aspects, such as the condition and layout of housing and feelings of safety and belonging respectively.[18] Multiple studies reported relationships between asylum seekers housing and physical health.[19,20,21,22,23,24,25] These include relations between physical health and housing quality, instability, and overcrowding.[26] However the majority of findings have focused on mental health evidencing how factors such as housing condition, insecure tenure, discrimination, overcrowding, feeling unsafe and poor social connections could undermine mental health. [27]

Initial/contingency accommodation and asylum seeker health

The vast majority of evidence around the link between housing and asylum seeker health has focused on standard or conventional housing. Policymakers are said to believe that the punitive use of institutional forms accommodation will deter forced migrants from exercising their right to seek asylum.[28] Such accommodation can have significant negative impacts on their mental and physical health.

Whilst people are not detained in initial/contingency accommodation, there are similarities with detention accommodation. There is a growing body of evidence highlighting the negative impacts of mandatory detention on the mental health of refugees and people seeking asylum.[29,30,31,32] The literature also reveals that, for those in detention or detention-like accommodation, the uncertainty of temporary protection exacerbates the risks of ongoing depression, PTSD, and mental health-related disability for refugees and people seeking asylum.[33,34,35,36]

Doctors and medical organisations visiting barracks in the UK reported witnessing the ways in which asylum seeker's mental and physical health deteriorated over time in residence. The Chief Inspector of Borders and Immigration found that most residents at Napier Barracks had experienced depression and a third had felt suicidal, with people at risk of self-harm placed in decrepit isolation blocks.[37] Such findings reflect those from Australia where 60% of refugees and asylum seekers that Médecins sans Frontiers treated on Nauru had suicidal thoughts and one-third had attempted suicide. Two thirds were diagnosed with moderate or severe depression, 25% with anxiety disorder, and 18% with post-traumatic stress disorder.[38]

There is also a large and growing body of evidence revealing the negative impacts of non-standard accommodation on the health of refugee children.[39,40,41] Researchers have noted the development of symptoms in children such as mutism and refusal to eat or drink;[42] post-traumatic stress disorder and major depression;[43,44] suicidal ideation and self-harm;[45] development delays;[46] and emotional and behavioural problems.[47]

Living conditions and asylum seeker health

Consultations undertaken with residents of barracks found that the wellbeing of residents was harmed by their experience in barracks with 43% interviewed reporting that they had lost appetite and weight because they were unable to eat the food provided, which was not properly cooked or fresh.[48] Interviewing asylum seekers in Penally Barracks the British Red Cross found asylum seekers' isolation from the wider world, lack of distraction, and poor facilities reinforced former trauma and generated mental health problems. Between January 2020 and February 2021, British Red Cross teams referenced suicidal ideation or suicide attempts in their case notes for over 400 individuals living in asylum accommodation: an average of almost one person per day.[49] They found that asylum seekers living in hotels had to approach reception staff to request to see a GP and were asked to disclose their reason for needing medical attention, compromising their privacy and confidentiality.[50] Elsewhere a coalition of refugee and asylum seeker rights organisations found that the most pernicious effect of living in initial/contingency accommodation was the loss of autonomy and ability to exercise agency.[51] in terms of choosing where to live, who to live with, what and when to eat. Individuals described a lack of nutritious or culturally appropriate food.

Researchers in Scotland[52] found that individuals, and particularly women, felt unsafe in initial/contingency accommodation with increased anxiety levels reported. The lack of social spaces, repeated lockdowns in individual hotels and no opportunities to take part in meaningful activities left many individuals in initial/contingency accommodation feeling desperate. Some said that confinement "feels like prison", and they felt abandoned and forgotten. For many, this undermined mental health. Refugee Council staff witnessed people self-harming, in crisis and contemplating suicide. The pressure on mental health services generally meant it was extremely difficult to access support and while stuck in institutional housing asylum seekers' distress continued to deteriorate.[53]

The advent of the COVID-19 pandemic brought a renewed need to think about hygiene and overcrowding in the general population. During the early stages of the pandemic 33% of Napier barracks residents interviewed reported that they had COVID-19 symptoms, 57% received a COVID-19 test, of which 59% produced a positive result. Half of residents reported that there was no meaningful way to self-isolate or practice physical distancing given the accommodation conditions which comprised rooms of up to 30 people living together and sharing a single toilet and shower.[54] Elsewhere in the UK forced migrant survivors of sexual and gender-based violence reported no additional hygiene measures and the inability to self-isolate in shared asylum housing.[55] A number of failings were identified in initial/contingency accommodation during the pandemic. Asylum seekers were not given access to COVID-19 guidance in their own language, were given different advice to the general messaging in the UK and were supported by caseworkers who lacked knowledge about how to get tests for those with symptoms or how to manage outbreaks of the virus.[56]

Access to healthcare

Given the increased propensity to mental and physical health problems in initial/contingency accommodation it is particularly important to ensure that asylum seekers can access healthcare. Both Doctors of the World UK and the British Red Cross report that asylum seekers struggled to access healthcare in initial/contingency accommodation. In Penally Barracks, the British Red Cross reported that asylum seekers had no health screening before or after arriving. Residents reported facing long delays to access medical treatment, including those who described being in pain for prolonged periods.[57] Elsewhere women were found to have very limited access to maternity care.[58] Working in Australia, MSF found that when health services for those in temporary housing were contracted by the government, asylum seekers, and especially those with mental health problems, struggled to build trust with providers.

It is evident that living in non-standard or initial/contingency accommodation is associated with poor health and poor access to healthcare. As yet, there is little quantitative data around these associations. With this report, our aim is to provide evidence linked to this, stemming from data arising out of the work DOTW has been undertaking in initial/contingency accommodation.

DOTW UK's work

DOTW UK is part of the Médecins du Monde international network, an independent humanitarian movement. DOTW UK has been a registered charity in England and Wales since 1998 and runs clinics and advocacy programmes providing medical care, information, and practical support to people unable to access NHS services. Patients include refugees, asylum seekers, survivors of human trafficking, people experiencing homelessness, sex workers, migrants with insecure immigration status and Gypsy, Roma, and Traveller communities.

DOTW UK tackles health inequalities by helping some of the most marginalised with vulnerabilities in health to access healthcare and wider support services. Access is facilitated via a clinic, helpline and outreach programme. Holistic health assessments are provided for service users to identify risks, stressors and protective factors that might impact on health. Primary care health checks, healthcare advocacy, and help with referrals are offered, informing on what to expect and advising on rights and charging within the NHS. Whether on the telephone or face to face, service users have a social assessment and then go on to see a doctor or nurse for a medical assessment when needed.

Doctors of the World has provided advocacy and healthcare to service users in initial/contingency accommodation face to face and remotely. Support included calls to their national helpline, remote consultations with people living in Napier barracks and weekly face to face clinics at two hotels where asylum seekers were living. This report focuses on the data collected from these interactions. The next section explores the methods employed.

Methodology

Data sources

Between July 2020 and January 2022, DOTW UK provided services and in some cases medical assessments to asylum seekers accommodated in initial/contingency accommodation through 56 people calling the advice line from multiple locations, remote consultations with people in barracks, and face to face consultations at two hotels.

Social and health information were collected for 380 individual cases, using the DOTW UK standard social and medical questionnaire, with some qualitative information written by the supporting DOTW UK volunteer in the form of free notes of one and sometimes in excess of 30 pages collected about each case. Every person residing in one of the hotels also had an additional questionnaire completed which detailed health conditions, access to medication and a GP, whether emergency or antenatal care was needed and whether service users had access information about their rights and COVID-19 measures.

The questionnaire data analysed in the report comprises information for a maximum of 313 individual cases where consent was given to use their data for research. This includes 257 responses to questionnaires completed with individuals residing in hotels, 255 responses to the social information questionnaire, and 85 responses to the medical information questionnaire. The qualitative data refers to a 33% sample of the 313 service users where consent was given for use for research purposes. These included 82 residents of hotels, 10 in barracks and a further 14 using the advice line.

"I was not supported to get this certificate for the medication I need. When I was in Home Office accommodation, it was the same, I didn't receive any information and was not sure what my rights are. I think they should give more information. We were left in the unknown and left to pay for medicines. There should be clear leaflets in different languages explaining to people more with pictures and clearly showing phone numbers to get help."

Anne
Doctors of the World National Health Advisor

Data analysis

Data from the various questionnaires was analysed using descriptive univariate and bivariate statistics in Stata (usually percentage distributions across categories), sometimes comparing the results to prior years or population-level data when comparable data exists. No cell count under 5 are shown in the analyses, but any relevant information based on unreleased results are discussed qualitatively. Qualitative data from the case worker notes was analysed using a systematic thematic analysis approach. We initially sampled 10% of the qualitative data and used this to create an analysis framework. Once the framework was constructed and piloted we randomly selected a further 23% of the free notes and analysed these.

Results

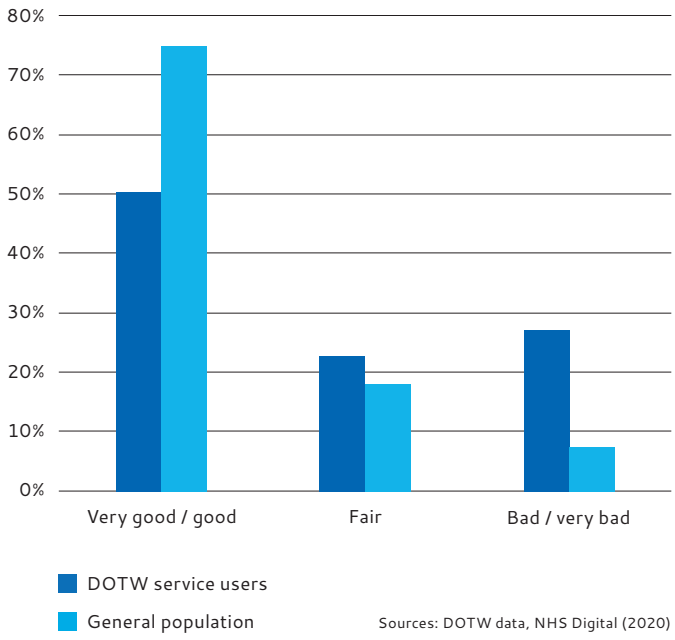
Demographics

Among the service users within our dataset, just under 95% of all individual cases are non-EU asylum seekers. With regard to location, 82.1% of the people had a face-to-face consultation whilst residing in hotels, 9.6% accessed support from hotel accommodation through the advice line, and 8.3% were residing in barracks. Just under 75% of people were men and just over 56% of the people were under the age of 30. The data included 7 pregnant women and 25 children under the age of 18. About a third of people had been in the UK for under 2 months, with some people using the service having been in the UK for over 6 months (and sometimes years).

Health status

During the consultation people were asked about their health status whilst living in hotel or barrack accommodation. Within the data 50.2% of people reported having good or very good health, 22.7% reported having fair health, and 27.1% reported having bad or very bad health. The evaluation of general health is lower than that of the general population: 74.6% good or very good; 18% fair, and 7.4% bad or very bad health according to latest estimates (see Figure 1).[59]

Figure 1: Reported health status among service users, compared to general population



Sources: DOTW data, NHS Digital (2020)

Within people residing in hotels, close to 32% reported having a mental health issue that needed to be addressed. This seems to be slightly higher than the rates reported in the general population.[60] Just over a third (34.4%) were registered with a GP and 16.3% were also taking medication.

There are various reasons why people needed to consult with DOTW UK. In fact, over 87% of people recorded at least one reason for having a consultation. Over 80% of people needed help with GP registration, over 60% needing help with a HC1 certificate, other support needed included 8.3% accessing the dentist (8.3%), counselling (3.5%) and the optometrist (2.4%).

With regard to medical needs, 85 people needed to see a doctor (number of medical consultations). Of those, 22 people were diagnosed with at least one chronic condition and 23 with an urgent condition. Just over 71.4% of people with diagnoses were regarding mental health conditions and the remainder were across a very broad range of diagnoses with numbers too low to report individually.

We identified from the sample of case worker notes more in-depth information on the reasons why service users had contacted DOTW UK, the most common reason being wanting to register with a GP. Several service users wanted help to access prescription medicine or sanitary products. Other reasons included needing medical letters confirming that hotel accommodation was unsuitable for them, help to access a dentist or with eye problems, being pregnant and needed to access antenatal care, experiencing domestic violence, needing help to get an interpreter for medical care and needing medical care for their baby, child or other relative. Some contact was related to needing a COVID-19 test or wanting a COVID-19 vaccination and not being able to arrange this directly with the hotel.

The majority contacted DOTW UK with requests for help with medical conditions or symptoms. Again mental health problems were very evident with some 56 entries referring to mental health conditions such as anxiety, PTSD, depression, and sleep disruption also commonplace. Six service users reported feeling suicidal with some having attempted suicide while in current accommodation, others self-harming or feeling so depressed they were unable to eat. In many instances the mental health conditions reported were said to have either arisen or been exacerbated by living in the accommodation. Problems associated with the nature of the food provided which was said to be of very low quality and very different to that which many service users were used to eating, were also common. Some service users reported experiencing weight loss, stomach pain or rectal bleeding which they attributed to the food. Hotels and barracks were said to be unable to vary the diet offered to asylum seekers without getting permission for a "special diet" from the Home Office. In one case the hotel would not provide medically required liquid food until they received permission which took over a week, whilst the notes described the person becoming very weak and underweight.

As noted above, service users sometimes referred to the ways that living conditions undermined their mental and physical health. Several people reported being frightened of living in the accommodation, experiencing retraumatisation feeling they were being imprisoned again, all of whose mental health rapidly deteriorated. In several instances asylum seekers said staff were very unhelpful and treated them as if they had manufactured medical conditions. The DOTW UK volunteers also often found staff unhelpful and reluctant to offer help around medical needs even in emergency situations. Some service users struggled without any access to cash, finding they had could not purchase basic clothing or toiletries or buy any food despite finding the food provided inedible. Others talked of rashes that appeared after moving to the accommodation. Individuals in hotels discussed being lonely and isolated which exacerbated mental health conditions. Service users expressed concerns about COVID-19 risks as self-isolation was difficult in crowded housing conditions.

Eight service users reported respiratory problems sometimes associated or exacerbated by living conditions. Several wanted help with skin conditions. Others mentioned conditions such as hypertension, diabetes, Hepatitis B, headaches, migraines, epilepsy and appendicitis. Additionally asylum seekers sought help with accessing care for symptoms including dizziness, lumps, allergic reactions and congestion.

Of the 104 sample case worker notes analysed, 38 showed that service users had got in touch regarding one of the above reasons. The majority, 55, contacted with 2-5 reasons and 8 people had between 6 and 10 reasons for making contact. Thus contacts with DOTW UK could involve a simple request or could be extremely complex with individuals having multiple conditions, symptoms and needs which demanded a complex range of interventions. One service user had many underlying conditions requiring access to care and a large number of prescription medications. When they contacted DOTW UK they had no access to medication. While DOTW UK was able to arrange for prescriptions the hotel would not accept controlled or refrigerated medication meaning they were unable to take essential medicine.

Access to healthcare

When asked what barriers to healthcare service users had experienced, the most frequently mentioned barriers were lack of knowledge about the healthcare system, language barriers, and administrative barriers.

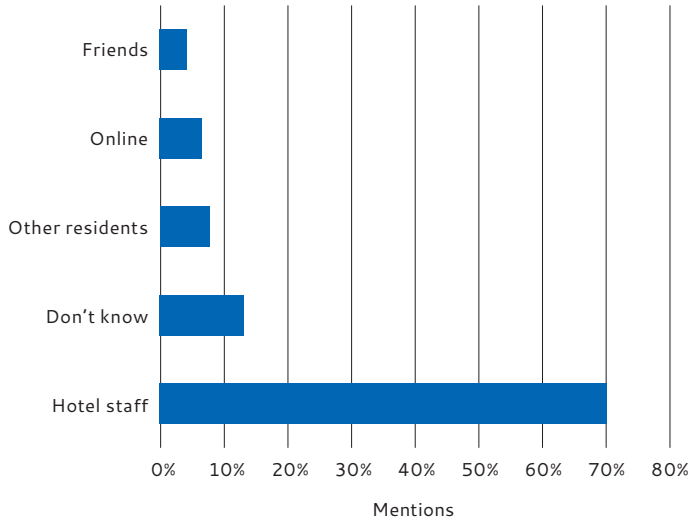
People residing in hotels were asked who they would go to for healthcare advice. Among the answers provided, 70% mentioned the hotel staff as a source of advice, 13.2% mentioned they did not know, 7.8% mentioned they would ask other residents, 6.6% mentioned they would look online, and 4.3% mentioned they would ask friends (see Figure 2).

Language was often mentioned as limiting access by service users. In the data, 52.5% of people did not have access to information about COVID-19 in their own language.

"In my experience and experience of many other people I supported, home office accommodation is so poor, it is not up to standard. You can't call this place home, it is appalling, it is something I don't know how to put, and how to describe. It just need to change, people should be treated like they are human."

Pat
Doctors of the World National Health Advisor

Figure 2: Mentions of who to go for advice



Source: DOTW data

Case worker notes showed that service users who were registered with GPs, and even receiving hospital care, still struggled with access to healthcare. Reasons included lack of information about services or not knowing how systems worked. In many cases communication from services assumed not only knowledge of the English language, but also of how organisations functioned, and who to ask for help. Some service users could not use online appointment forms. Sometimes service users attended appointments but did not understand the outcome of the consultation. Often service users tried to get help from hotel staff without success. In one instance DOTW UK determined that a service user needed access to emergency care and the hotel refused to transport the service user or to call for an ambulance. In some instances professionals such as health visitors were reluctant to visit patients at the hotels, despite requests from DOTW UK. Access to dentists was particularly difficult when there was no NHS dentist in proximity to the accommodation.

83.1% of people did not know where to get a prescription for their medication and only 26.7% of people had a HC2 certificate to help with health costs. It is important to note that prevalence of having a HC2 certificate increased with time spent in the UK. This was reflected in the case worker notes with examples of service users who were given prescriptions but could not afford to pay for them and were not aware of the HC2 certificate.

DOTW UK undertook a wide range of actions to try to address asylum seekers' needs. These varied from action focused on resolving a health problem through securing access to services or medication, to actions trying to resolve the underlying structural factors which generated health problems. In addition to registering service users with GPs, they made appointments and follow up appointments with primary or secondary care. They booked COVID-19 tests and vaccines, helped to access medication, offered STI/HIV testing and arranged interpreters. They also tried to arrange safeguarding for vulnerable service users, wrote letters on behalf of service users, helped with online referrals, and tried to help asylum seeking children access schooling or appropriate accommodation.

Of the 104 cases reviewed in detail; on 20 occasions DOTW UK took just one action on the part of a service user but more often complex problems demanded several actions. In 62 cases 2-5 actions were needed and in 21, 6-10. Each action might comprise multiple telephone calls, referral letters and e-mails and thus engagement would continue over several months. Resolution was achieved with one interaction for 55 service users, for 18 it was achieved over a month and for 28 service users it took between 1 and 6 months. One very complex case took over 6 months to resolve. Ninety out of 104 cases were resolved, 5 were not and in 7 instances DOTW UK lost contact with the service user.

On 36 occasions the work involved referral to other organisations with the DOTW UK volunteer using a combination of telephone and e-mail in order to secure referrals. DOTW UK worked extensively with Migrant Help, Care 4 Calais and CRISIS mental health services. These services often did not respond to a simple referral because they were operating over capacity. DOTW UK also connected with schools, health visitors, Refugees at Home, Single Point of Access teams, MASH teams, Community Mental Health, the Home Office, solicitors, SOLACE, the Refugee Therapy Centre, Médecins sans Frontiers, sexual health clinics, 999, Migrants Organise, consultants, psychiatrists and the migrant health EFLT team. They referred to Modern Slavery services and received several referrals from the Human Rights Network.

Discussion

Our analysis of data shows people in initial/contingency accommodation had a broad range of unmet health needs. Despite the intention of a maximum stay in accommodation for 35 days it was clear that the majority of service users had been in the UK and the accommodation for more than this time, often many months.

There were many examples of how the accommodation conditions did not meet basic human standards, which add to the existing evidence base that such conditions contributed to, and may have caused, poor health. Conditions included poor food, poor access to basic sanitary products, inability to store medication or have professionals visit to provide care.

People reported a significant mental health impact of the loneliness, isolation and feelings of being imprisoned engendered by the conditions. The treatment of people by some hotel staff also reflected this feeling of inhumanity with people not able to get help when they needed it, including in emergencies.

Service users came to DOTW UK with a variety of health needs, many people required intensive support to access and navigate the system which often took weeks/months delaying access to care.

Without access to a GP service users were unable to get prescriptions, medical care for pregnancy and children, referrals to specialists and ongoing support for medical conditions both chronic and acute. People did not know how to get and pay for medication they were prescribed.

Most service users had no access to information on how to meet their basic health needs and no formal sources of support from the healthcare system. They were forced to rely on hotel staff to answer their medical questions and access support, the staff were often unhelpful and reluctant to offer help around medical needs. Service users struggled to get access to dentists and opticians and again didn't have support to pay for these fees.

Lack of access to timely and continuous care meant people were left without treatment and were left to suffer on their own.

Conclusions

There has been a significant increase in people being accommodated in initial/contingency accommodation including barracks and hotels for indeterminate amounts of time. Whilst coinciding with the COVID-19 pandemic it appears the use of this initial/contingency accommodation will continue with the contract for Napier barracks extended until 2025 and cited as a future model for accommodation in the development of the Nationality and Borders Bill.

The evidence shows that initial/contingency accommodation is unsafe for asylum seekers due to the lack of access to adequate and appropriate healthcare services and that poor living conditions exacerbate or generate mental and potentially physical health problems.

Limitations

This report is based on data collected from service users accessing DOTW UK services and was therefore limited to three settings where in depth support was provided and some additional settings where people made contact on the open access helpline. The name of these settings was not recorded, meaning that we don't have access to a full list of hotels used during this period are unable to quantify what proportion of settings are represented. By the nature of the service, people made contact when they require additional support thus we're unable to report on the proportion of people that were successfully able to access healthcare without our support.

Recommendations

In order to not cause harm to people's health and meet their essential health needs:

Asylum seekers should be accommodated in a humane way that enables meaningful access to full NHS care to meet health needs and provide continuity of care. Conditions should not risk harm to physical and mental health.

The Home Office should introduce a centrally funded system that houses asylum seekers in safe and sanitary housing in communities across the country where they can access decent food and toiletries and that enables access to local GP and specialist health services.

Home Office contracts with accommodation providers should be amended to include provision of direct support for GP registration for everyone in Home Office accommodation and to access all NHS services and provision of health information and support to complete HC1 forms as key performance indicators.

All asylum seekers receiving Home Office support should automatically receive a HC2 certificate for 12 months.

Endnotes

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