

Care Services Improvement Partnership **CSIP**

NIMHE (National Institute of Mental Health in England)

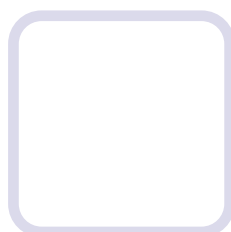


South of England
Refugee & Asylum
Seeker Consortium

Mental Health, Destitution & Asylum-Seekers

**A study of destitute asylum-seekers
in the dispersal areas of the
South East of England**

**By Hildegard Dumper,
Richard Malfait,
Nick Scott-Flynn**



Acknowledgements

This Research has been commissioned and funded by the Care Services Improvement Partnership (CSIP) & South of England Refugee & Asylum-seeker Consortium (SERASC). The recognition by both these bodies of the importance of the issues covered and the need to address them needs to be acknowledged. In particular we would like to express our appreciation to members of the Steering Group for the Research, Poppy Jaman, Race Equality Lead for Care Services Improvement Partnership (CSIP), Rob Guile, Regional Manager, and Duncan Hunt, Policy Development Manager of the South of England Refugee & Asylum-seeker Consortium (SERASC), who have guided the Research through its course with dedication and humour. The views expressed in this report are those of the authors and not necessarily of these organisations.

The Research would not have been possible without the valuable time given by all those stakeholders who contributed, many of who were instrumental in setting up interviews with individual destitute asylum-seekers. These have been identified in Appendix D. We would also like to thank those who have taken the time to read and comment on drafts of the report. These are Michael Clarke, Beverley Meesom, Manawar Jan-Khan, Mary Carter and Amanda Webb-Johnson. Thanks also to Tina McHugh for proof reading the final document.

Finally, special thanks and recognition should be given to those destitute asylum-seekers who were willing to share their experiences and thoughts for the Research. We hope that we have reflected accurately the stories and experiences that they shared with us. The Research has sought to allow their voice to be heard by a wider audience and highlight the plight of this group of people. We were struck by the dignity, magnanimity and resilience many people possessed despite the dire circumstances that they have found themselves in. We hope that their individual situations will improve.

Researchers

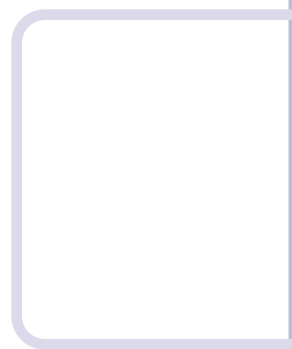
A team of independent researchers carried out the Research. Each member of the research team has extensive experience in working with refugees and asylum-seekers, in a number of different capacities and has carried out several significant pieces of research. Most recently, Richard Malfait and Nick Scott-Flynn carried out research on destitute asylum-seekers in Birmingham commissioned by RESTORE. Hildegard Dumper has carried out a number of pieces of research on different issues, particularly related to gender and health. All three are currently involved in a major piece of research on destitution commissioned by Refugee Action. This report was compiled by Hildegard Dumper.

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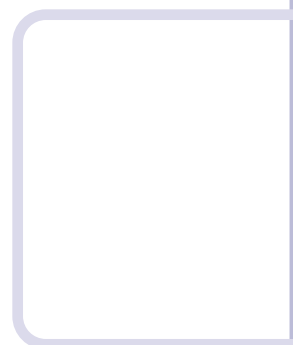
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Definitions & Abbreviations

A. Working definitions of the main terms used in this report

Asylum-Seeker

An asylum-seeker is anyone who has an application for asylum in the United Kingdom still pending. Most of the people interviewed for the Research are no longer asylum-seekers in the legal sense but have come to a point where their asylum rights are exhausted (see below). These are sometimes referred to as failed asylum-seekers. Some of those interviewed had made fresh asylum applications, usually accompanied by fresh evidence. All the individuals interviewed for the Research still saw themselves as being asylum-seekers.

Destitute asylum-seeker

The Oxford English Dictionary defines destitution as; 'Abandoned; forsaken, forlorn'. For this study we have applied the term to those who have claimed asylum in this country, who are unable to access support for their basic needs (subsistence and accommodation) from the State or from their own resources. This definition applies whether the destitution is brought about by accident, through the administrative inefficiency of the asylum and welfare systems, because of deliberate policy or the individual's lack of knowledge about entitlement due to poor access to legal advice.

Failed asylum-seeker, end of process or asylum rights exhausted (ARE)

These are different terms to describe someone whose application for asylum has been turned down and who has exhausted all their appeal rights. Technically they are liable to be removed from the country at any time.

Refugee

Someone who has been recognised as a refugee under the terms of the 1951 Convention relating to the Status of Refugees and are given indefinite leave to remain in the UK. The term 'refugee' is sometimes used to describe those who have been granted Humanitarian Protection or Discretionary Leave and are allowed to remain in the U.K for a limited period.

Dispersal

The process by which NASS moves asylum-seekers to 'dispersal' areas in different parts of the country and provides dispersal accommodation in those areas. This system was devised in 2000 as a way of relieving perceived pressure on Local Authorities in London and the South East of England by asylum-seekers requiring support in these areas. There are currently 11 regions in the UK to which asylum-seekers are dispersed, one of which is the South East.

Hard Case or Section 4 Support

The term for the support that can be offered by the Home Office (through NASS) to asylum-seekers whose asylum rights have been exhausted (ARE). The power to grant such support was established by the Immigration and Asylum Act 1999 and amended by Section 10 of the Asylum and Immigration Treatment of Claimants Act 2004. There are several conditions attached to qualify for receiving such support.



Mental Health

The term 'mental health' has been interpreted in its broadest sense as that of general well-being.

B. List of Acronyms and Abbreviations

ARE	Asylum Rights Exhausted (see list of definitions)
BME	Black and Minority Ethnic
CAB	Citizen's Advice Bureau
CSIP	Care Services Improvement Partnership
DH	Department of Health
DRC	Democratic Republic of Congo
DRE	Delivering Race Equality in Mental Health Care
EA	Emergency Accommodation - this is accommodation provided to asylum-seekers who have completed a NASS 1 form pending provision of dispersal accommodation.
ECHR	European Convention on Human Rights
HVA	Hastings Voluntary Action
LSC	Legal Services Commission
MHL	Migrant Helpline
NAM	New Asylum Model
NASS	National Asylum Support Service established in 2000 to provide support to asylum-seekers who have made their claim for asylum.
NIMHE	National Institute for Mental Health in England
PARS	Portsmouth Area Refugee Support
PASG	Portsmouth Asylum Support Group
PCT	Primary Care Trust
RCOs	Refugee Community Organisations
SERASC	South East Refugee and Asylum-Seeker Consortium
WRVS	Women's Royal Voluntary Service
WVG	Winchester Visitors Group

Foreword

Asylum seekers are amongst the most marginalised and maligned members of our society, and none more so than those who, for whatever reason, have found themselves destitute and homeless. This report provides a welcome insight into their situation and, in particular, into their mental health needs.

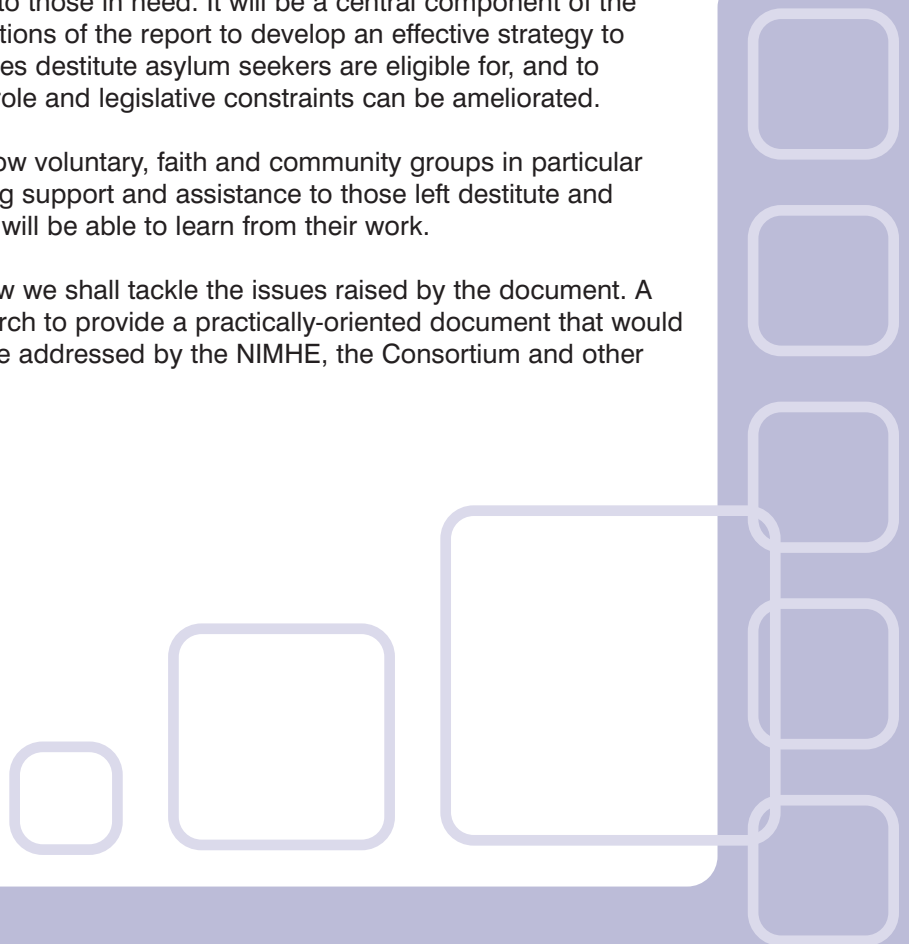
The report was jointly commissioned by the South of England Refugee & Asylum Seeker Consortium and the National Institute of Mental Health in England (NIMHE, a programme of the Care Services Improvement Partnership). Over the last eighteen months the South of England Refugee & Asylum Seeker Consortium has become increasingly aware of anecdotal evidence suggesting that destitution amongst failed asylum seekers has been increasing across the region. The Executive Steering Group of the Consortium decided that work was needed in order to identify the extent to which this perception could be grounded evidence. At the same time NIMHE wished to develop research evidence into the mental health needs of the same group in pursuit of implementing the “National Delivering Race Equality in Mental Health Care” framework (DRE). The South East region hosts two of 17 Focus Implementation Sites, which are systematically implementing DRE. This reform of services centres on the commitment to provide appropriate and responsive services, engage communities and provide better information.

Not least amongst the report's valuable contributions is to rescue from silence the voices of destitute asylum seekers themselves. The case studies and comments taken from the interviews provide a necessary and welcome corrective to what is too often a simplistic and one-dimensional presentation of asylum seekers in the media. In contrast, what emerges clearly in this report is the complexity and distinctiveness of each individual's circumstances. It also demonstrates the amount of human suffering resulting from current policies towards failed asylum seekers. We hope that this report will contribute to a more fine-grained and sympathetic understanding of the situations and motivations of those caught in the bind of destitution.

The report also makes clear the difficult position in which statutory services can find themselves in relation to destitute asylum seekers. The constraints placed on social care and health services by legislation aimed at encouraging compliance from failed asylum seekers leaves both a degree of confusion amongst providers and, at times, forms a conflict with their core mission of providing effective support to those in need. It will be a central component of the regional response to the recommendations of the report to develop an effective strategy to ensure a clear understanding of services destitute asylum seekers are eligible for, and to address how these conflicts between role and legislative constraints can be ameliorated.

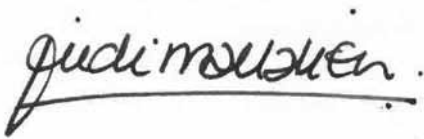
Finally, it is also encouraging to see how voluntary, faith and community groups in particular have risen to the challenge of providing support and assistance to those left destitute and homeless. It is hoped that other areas will be able to learn from their work.

This report is only the beginning in how we shall tackle the issues raised by the document. A core part of the brief was for the research to provide a practically-oriented document that would clearly indicate how this issue could be addressed by the NIMHE, the Consortium and other stakeholders in the region.



NIMHE will be taking the recommendations forward through the development of partnerships, recruitment of community development workers and funding of community engagement projects. We have already taken a first step into addressing the inequalities through our Regional Health and social Care in Criminal Justice Programme, which has been commissioned by Health Offender Partnerships at the DH to undertake a national project over the next year regarding the development of Health care Assessments in Asylum Seeker Induction Centres across the Country and rationalising the location of induction centres in the light of the development of the Home Office's new Asylum model.

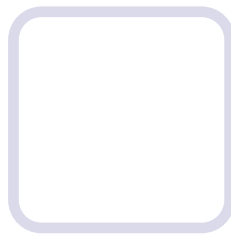
In the weeks and months ahead the Consortium will be working through its existing networks and through a series of events around the region to ensure that the recommendations are taken forward and the needs of this extremely vulnerable group of people are effectively addressed.



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Executive summary with key conclusions and recommendations

Introduction

The mental health of refugees and asylum-seekers has been well studied, in a body of literature that spans the experiences of refugees and displaced people of World War 2, through to the recent experiences of those in refugee camps and those applying for asylum in the West. In the UK, a small number of projects have emerged which attempt to assist individuals to recover from the physical and psychological effects of torture that led them to flee their country, as well as the feelings of loss and grieving that they were dealing with in their country of exile. One of the most influential of these is the Medical Foundation for the Care of Victims of Torture.

Over the last ten years, several major pieces of legislation have been introduced which has created an ever-changing climate of policy on refugees and asylum-seekers. Both statutory and voluntary sector services are faced with providing services for refugees and asylum-seekers under extremely challenging circumstances. One result of the legislation of the last decade is that significant numbers of rejected asylum seekers have had all means of support withdrawn from them and are now destitute in the UK. The previous decades of research into mental health of asylum seekers has necessarily not addressed this new phenomenon.

Within this new context in which statutory and voluntary organisations are stretched to provide for the most basic financial and housing needs of asylum-seekers, it is not surprising that the mental health needs of destitute asylum-seekers have been neglected. However, following the Race Relations Amendment Act (2000), all public authorities have an explicit duty to actively promote race equality. This new duty is not optional. Statutory health and social care organisations have to meet it, irrespective of the size of the ethnic minority population they serve. This general duty is supported by a series of specific duties applicable to both employment and service delivery.

This Research is intended to contribute to our understanding of a group of people about whom little has been recorded: destitute asylum-seekers. These are asylum-seekers who have no recourse to public funds and yet are denied the opportunity to support themselves. It provides a profile of destitute asylum-seekers in the South East region; their situation, experiences and mental health needs, based on interviews with 49 destitute asylum-seekers and a range of service providers who have a role in developing or providing services to refugees and asylum-seekers in the region (see Appendix A for more on methodology and Appendix D for Individuals and organisations consulted with).

It will provide a guide for:

- a) Health professionals and others to develop practices, which will ensure the service requirements of all asylum-seekers, but especially failed asylum-seekers, are addressed.
- b) Regional and local policy makers to understand the routes of asylum-seekers to destitution and address their needs, so that approaches can be made to promote or lobby for changes in national policy. This would be to improve the situations of those found destitute and the communities within which they find themselves.

- c) Local groups in the areas focussed on to be able to further develop work with this client group.

What the Research aims to do is to:

- Provide an insight into the lived experience of destitute asylum-seekers in the South East England region, by drawing on as far as possible the voices of refugees themselves.
- Give some guidance as to the size of the population of destitute asylum-seekers.
- Provide examples of some practical ways to address the mental health service requirements of this group of people.
- Raise awareness amongst mental health service providers of the service needs of this group.
- Identify areas needing further research or discussion.

Summary of findings

The experiences of a total of 49 destitute asylum-seekers have been included in the Research. Forty took part in one-to-one interviews whilst nine participated in a group discussion. Individuals to be interviewed were contacted through the Winchester Visitor's Group (WVG) in Southampton, Portsmouth Area Refugee Support (PARS), Refugee Action and the Kurdish Community Association in Portsmouth, Chapel Royal in Brighton, and LINKS in Hastings. This is a small sample but provides a useful window into the experiences of a little known group of people and provides a benchmark for further studies to take place and build upon.

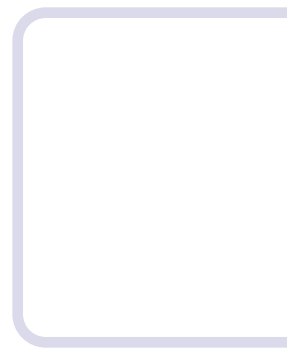
In addition, a range of individuals from health, care and voluntary sector services (see Appendix D) contributed their thoughts and experiences, which have informed our findings.

Numbers seeking asylum in the South East:

- On the first of January 2006, 1,330 asylum-seekers had been dispersed to the South East and accommodated in Portsmouth, Brighton, Hastings & St. Leonard's.
- The majority of them are from Iran, Sudan, Eritrea, Iraq and the DRC.
- Home Office statistics show that approximately 4% of asylum seekers have been dispersed to the South East.
- Calculations based on national figures suggest that there are likely to be around 1,780 destitute asylum seekers at any given time in the South East region

Interviews with destitute asylum-seekers suggest that:

- There are high levels of mental health needs amongst destitute asylum-seekers.
- Whilst some of this was precipitated by their experiences before coming to the UK, much of it has been exacerbated by destitution.
- More than 90% feared returning to their country of origin.
- Most are being accommodated by friends or acquaintances (64%) or charitable organisations (8%).



- ❑ Nearly two thirds (65%) felt their problems were caused by their inability to support themselves and wanted to be able to work.
- ❑ More than half (55%) said that they were receiving medication for depression, indicating that a significant number were able to access health care.
- ❑ However, a significant number also talked about the difficulties in finding a GP who would accept them.
- ❑ Many of them talked about the heavy burden of fear that they were living under. This was caused by the fear of being sent back, of being challenged by their GP to show proof of eligibility to health care and of sleeping rough.

Interviews with service providers suggest that

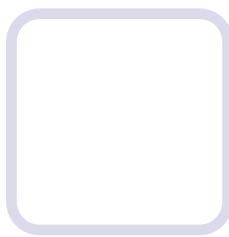
- ❑ Many feel that the scope for providing support is limited.
- ❑ An overall strategy or responsibility towards destitute asylum-seekers, in the areas covered by this Research, was lacking.
- ❑ Local Authorities are only allowed to do what the law allows them to do. How they interpret this seems to vary from authority to authority.
- ❑ Many health authorities are interpreting the DH guidance on providing health care to failed asylum-seekers in a restrictive way and failing to draw on other policy, such as the DH's Delivering Race Equality in Mental Health Care, to support the provision of health care to this group of people.
- ❑ There is concern about the inefficiency posed by the 'revolving door' syndrome. This where a destitute asylum-seeker may be hospitalised following a breakdown, cared for, discharged and hospitalised again because their destitution is aggravating their condition.

Conclusions and Recommendations

As a result of the findings from this Research, five key areas have been identified as needing urgent attention. A more detailed list of recommendations can be found in Section 8 of this report.

1. Eligibility to health services

The regulations governing eligibility of rejected asylum-seekers to both primary and secondary health care is confusing and open to an interpretation that contradicts the first core principle of the NHS. This states that 'The NHS will provide a universal service for all, based on clinical need, not the ability to pay.' The Research has shown that this confusion is contributing towards a culture of working within the health services that can require refugees and asylum-seeking communities to justify their access to health services in a way other communities are not. Such a development poses a considerable challenge to the ability of health services to meet their obligations under the Race Relations Amendment Act (2002) and implement the building blocks of the DH's Delivering Race Equality In Mental Health Care. Rejected asylum-seekers are in the main, unable to return to their country of origin for reasons described in the body of this report, are not allowed to work and being destitute, are unable to pay for their health care.



2. Regularising the status of rejected asylum-seekers.

The position of rejected asylum-seekers is inhumane. Many are unable to return to their country of origin for a variety of reasons beyond their control, yet they are not allowed to work and support themselves. A clear message from this Research has been that asylum-seekers do not want to receive welfare benefits, but want to work and support themselves. In addition, many service providers voiced concern about the economic wastage created by the 'revolving door syndrome' i.e. making someone better, discharging them, only to have them back in again because of the conditions they were having to survive in.

3. Coordination of providing services to asylum-seekers

Whilst there were some examples of good practice (see Section 7) there is a need for a more strategic approach to offering services for asylum-seekers. This would ensure the maximisation of resources and ensure the experiences of destitute asylum-seekers are not exacerbated by inefficiency and poor communication between services. There are a number of asylum-seekers made destitute because of inefficiencies.

4. Local Authority support for failed asylum-seekers

The Research found some discrepancy and ambiguity in the way Local Authorities were interpreting their responsibilities of social care for failed asylum-seekers. We suggest that greater liaison and sharing of ideas is needed between departments. This should include social services and housing as well as other relevant departments. This would be to develop more creative ways of interpreting the responsibilities of social care services towards failed asylum-seekers who are vulnerable, and maximising existing resources.

5. Essential good practice measures

Guidelines on the care of refugees and asylum-seekers have been shown to be very effective in providing a benchmark against which organisations can measure their own practice and improve the skills and competencies within the workforce (see Appendix G). Some health care professionals are genuinely anxious about their skills in meeting what they see as the specialised needs of this client group, particularly in the area of mental health needs. At the same time health authorities should resist a culture of work in which front line staff take on the role of immigration officers and ask individuals for proof of residence before allowing them to access their services. Some of those interviewed complained that some front line staff can appear to be either very ignorant of the needs of asylum-seekers or wilfully obstructive in allowing them access to services. In addition, there was a distinct lack of data available on the use of services by asylum-seekers, as there was about failed asylum-seekers as a whole in the region. The need for such data is a vital part of both adapting service provision and advocating on the issue.



Recommendations

Strategic Area	Recommendation	Who?
1. Eligibility to health services	<ul style="list-style-type: none"> <input type="checkbox"/> That the DH amend the NHS Charges to Overseas Visitors Regulations 1989 and the NHS (Charges to Overseas Visitors) (Amendment) Regulation 2004 to specifically exclude rejected asylum-seekers from liability to pay. <input type="checkbox"/> We call upon PCTs to recognise that rejected asylum-seekers are not overseas visitors and to interpret the DH guidance on the eligibility of asylum-seekers to primary and secondary health care, in line with the NHS principle of a service based on need and not the ability to pay. 	<p>Department of Health</p> <p>Primary Care Trusts</p>
2. Regularising the status of rejected asylum-seekers	<ul style="list-style-type: none"> <input type="checkbox"/> Where a rejected asylum-seeker is unable to leave the UK, they should be granted some form of leave to remain in the UK and be eligible to work and support themselves. 	Home Office
3. Coordination of services provision to all asylum-seekers	<ul style="list-style-type: none"> <input type="checkbox"/> There needs to be more liaison over the termination of NASS accommodation for all asylum-seekers. This would give all support agencies the opportunity to help failed asylum-seekers explore the options available to them. These should include NASS, voluntary sector agencies, appropriate health services and accommodation providers. <input type="checkbox"/> Each area (as already happens in some regions) should have a forum bringing together appropriate services to maximise resources and improve communication and efficiency. These forums should be fully integrated with the Regional Strategic Co-ordinating Groups. <input type="checkbox"/> NASS and NHS staff in induction centres should review how they liaise with health services in the dispersal areas. 	<p>NASS</p> <p>SERASC</p> <p>Induction centres</p>
4. Local authority support for rejected asylum-seekers	<ul style="list-style-type: none"> <input type="checkbox"/> Local Authorities should devise a overall care package for destitute asylum-seekers who are deemed vulnerable under Community care legislation <input type="checkbox"/> That there should be effective liaison between the Local Authority care services, the health authority and voluntary sector about providing joined-up care and advocacy for this client group. 	<p>Local authority care services.</p> <p>NHS Community Development Workers</p>
5. Putting in place baseline good practice measures for interpreting, training and data collection	<ul style="list-style-type: none"> <input type="checkbox"/> All services (including GP surgeries, NHS departments) should draw up and adopt Guidelines on the care of refugees and asylum-seekers. This should include a named person to monitor standards of service for refugees and asylum-seekers and develop expertise in this area, put in place systems for staff support and training, establish procedures for the treatment of failed asylum-seekers, ensure use of interpreters, amongst other measures. <input type="checkbox"/> Ways should be sought to ensure GPs and all front-line health care staff (including security guard and receptionist) attend training on the health of refugees and asylum-seekers. This would include awareness of working transculturally, working with interpreters, the physical manifestation of psychological stress, trauma and health problems such as HIV and TB. <input type="checkbox"/> That the language barriers to accessing services should be minimised by ensuring service level agreements are drawn up by PCTs with language services <input type="checkbox"/> All services, but particularly statutory services, should develop ways to record this client group as services users in the spirit of equal opportunities monitoring, whilst at the same time ensuring that asylum-seekers are not identified in a way that may lead to a denial of services or the break down of confidentiality. 	<p>All health services</p> <p>Primary Care Trusts</p> <p>Primary Care Trusts</p> <p>Primary Care Trusts, NHS Trusts, Foundation Trusts</p>



Section 1:

Introduction and Aims of the Research

The mental health of refugees and asylum-seekers has been well studied, in a body of literature that spans the experiences of refugees and displaced people of World War 2, through to the recent experiences of those in refugee camps and those applying for asylum in the West. In the UK, a small number of projects have emerged which attempt to assist individuals to recover from the physical and psychological effects of torture that led them to flee their country, as well as the feelings of loss and grieving that they were dealing with in their country of exile. One of the most influential of these is the Medical Foundation for the Care of Victims of Torture.

Over the last ten years, several major pieces of legislation have been introduced which has created an ever-changing climate of policy on refugees and asylum-seekers. Both statutory and voluntary sector services are faced with providing services for refugees and asylum-seekers under extremely challenging circumstances. One result of the legislation of the last decade is that significant numbers of rejected asylum seekers have all means of support withdrawn and are now destitute in the UK. The previous decades of research into mental health of asylum seekers has necessarily not addressed this new phenomenon.

Within this new context in which statutory and voluntary organisations are stretched to provide for the most basic financial and housing needs of asylum-seekers, it is not surprising that the mental health needs of destitute asylum-seekers have been neglected. However, following the Race Relations Amendment Act (2000), all public authorities have an explicit duty to actively promote race equality. This new duty is not optional. Statutory health and social care organisations have to meet it, irrespective of the size of the ethnic minority population they serve. This general duty is supported by a series of specific duties applicable to both employment and service delivery.

This Research is intended to contribute to our understanding of a group of people about whom little has been recorded: destitute asylum-seekers. These are asylum-seekers who have no recourse to public funds and yet are denied the opportunity to support themselves. It provides a profile of destitute asylum-seekers in the South East region; their situation, experiences and mental health needs, based on interviews with 49 destitute asylum-seekers and a range of service providers who have a role in developing or providing services to refugees and asylum-seekers in the region (see Appendix A for more on methodology and Appendix D for Individuals and organisations consulted with).

It will provide a guide for:

- a) Health professionals and others to develop practices, which will ensure the service requirements of all asylum-seekers, but especially failed asylum-seekers, are addressed.
- b) Regional and local policy makers to understand the routes of asylum-seekers to destitution and address their needs, so that approaches can be made to promote or lobby for changes in national policy. This would be to improve the situations of those found destitute and the communities within which they find themselves.
- c) Local groups in the areas focussed on to be able to further develop work with this client group.

There is a danger, a view promoted by some in the psychiatric profession, that refugees are in danger of being pathologised by too much of an emphasis on their psychological needs . It has been said that the high incidence of depression and other psychiatric disorders to be found amongst the refugee population is a 'normal reaction to an abnormal experience' . One GP taking part in the Research estimated that 95% of the refugees he saw had suffered from traumatic experiences and that it was not surprising that this group of people frequently presented for a range of both physical and psychological problems.

This Research has been sensitive to the debates around this. Care has been taken to interpret the concept of mental health in its broadest sense, that of a feeling of general well being. We were aware also of the contradictions in investigating the mental health needs of a group of people for whom current legislation on asylum has withdrawn the means of their basic survival; the ability to work, to live in secure accommodation and develop social ties and networks. We hope this report draws attention to the challenges this poses the health and other services.

A deliberate attempt has been made to make the report accessible to both the specialist and non-specialist. As far as possible we have avoided the use of jargon and the specialist vocabulary of psychiatry. The report has been designed to be read by those working to provide mental health services as well as users of the service, community workers, social workers and all those concerned with the well being of refugees and asylum-seekers.

What the Research aims to do is to:

- Provide an insight into the lived experience of destitute asylum-seekers in the South East England region, by drawing on as far as possible the voices of refugees themselves.
- Give some guidance as to the size of the population of destitute asylum-seekers.
- Provide examples of some practical ways to address the mental health service requirements of this group of people.
- Raise awareness amongst mental health service providers of the service needs of this group.
- Identify areas needing further research or discussion.

³ Summerfield D. (2001) Asylum-seekers, refugees and mental health services in the UK. *Psychiatric Bulletin* (2001) 25, 161-163

⁴ Quoted during discussion from *Medical Foundations for the Victims of Torture*

Section 2: Context of the Research

2.1. Existing Research on destitution

There is growing concern at the emergence in the UK of a group of people who, as a result of current asylum legislation, are suffering the type of poverty which the post war introduction of the national welfare system was intended to eradicate. In 2002 Oxfam and the Refugee Council produced a report linking poverty and asylum policy in the UK. Since then there have been a number of reports charting the impact of asylum policy on asylum-seekers in a several different areas, including Birmingham, Newcastle, Leicester and Scotland (see Appendix F). Refugee Action, in close collaboration with Amnesty International and others, is currently conducting research on the contribution the legal system is having on destitute asylum-seekers. To date this is the only research looking at destitution and mental health.

2.2. UK Asylum Policy⁵

Services offered to refugees and asylum-seekers in the United Kingdom are largely determined by national legislation that in turn informs policy and practice. The introduction of the National Asylum Support Service (NASS) at the end of the 1990s was accompanied by several Acts of Parliament that have been added to by further legislation, the most recent being the Asylum and Immigration Act 2004 (the most relevant Acts are listed at the end of this section). The area of asylum law and policy is a complex one and there are several key themes that are worth noting:

Changing the behaviour of asylum-seekers

The Government have sought to affect the behaviour of asylum-seekers through legislation intended to discourage asylum-seekers from coming to the UK. For example the support withdrawn from asylum-seekers who have exhausted their claim is designed ultimately to either persuade people to return to their country or make it easier for the Home Office to remove them. Similarly, provision of support to asylum-seekers is often conditional on their agreeing to be dispersed to different parts of the country. This was seen as a way to take perceived pressure off London where, prior to dispersal, over 80% of asylum-seekers were located. It is arguable though that such conditionality does not have the intended effect in that it does not change the behaviour of individuals in the way the Government intends but simply drives people underground in a way that is neither good for them or the wider community. The fact that vulnerable asylum-seekers, who cannot return or be returned to their country of origin, are ending up destitute, is evidence that the current policy and practice does not work.

Interpretation of asylum legislation

Increasingly, current legislation (or the interpretation of it) has been challenged in the courts. Often a case is brought on behalf of an individual client and used to test out the interpretation of existing legislation and set a new legal precedent which will then be used by other solicitors and asylum-seekers. Characteristically cases progress through various levels of the legal system and either side appeals against a ruling asking for the issues to be tested in a higher court. One effect of this 'see-sawing' is that it is often not possible to say at any one time that the current situation will remain the same. To add to this uncertainty there are various schemes and provisions that NASS and the Home Office are either piloting⁶ or developing their practice on. This creates an ever-changing situation in which there is often room for interpretation and misinterpretation. What is certain, however, is that the issue will continue to change and evolve and that advocacy in this area should take this into account.

⁵ <http://www.ind.homeoffice.gov.uk/lawandpolicy/legislation/>

⁶ The Home Office do not themselves use the word pilot. However in practical terms the gradual rolling-out of schemes is a pilot whatever the terminology and does present an opportunity to modify the practice.

A state of denial

It would be fair to say that the issue of destitution and to some extent mental health amongst this client group has been avoided by many bodies that should have been taking an interest. Advocacy on the issue in the last two years has secured acknowledgement from the government that there are destitute asylum-seekers. However, they have deflected any responsibility by insisting that individual's have brought this upon themselves by refusing to agree to the conditions of support (i.e. agree to return to their country of origin).

Below are some summaries of the specific legislation or developments relevant to these issues.

Section 55 (Nationality, Immigration and Asylum Act 2002)

First introduced as part of the 2002 Act it was designed to deny support to asylum-seekers deemed to have made a late claim for asylum. Over 2003-2004 a series of legal challenges were mounted that questioned both the administration of the policy and the fundamental justice of it. For example it was questioned whether denial of any support was a breach of a persons human rights. At the height of Section 55 implementation almost 50% of asylum-seekers were being denied support. A successful legal challenge in 2004 effectively meant that Section 55 has been made more or less unworkable and therefore destitution as a result of Section 55 is on the decline.

Section 4 (Immigration and Asylum Act 1999) -amended by Section 10 (Asylum and Immigration Treatment of Claimants Act 2004)

Sometimes known as hard case support, this is the provision for end of process asylum-seekers whose cases have been turned down. To be eligible for Section 4 support the failed asylum-seeker must agree to return voluntarily to their country of origin. There are some exceptions: Section 4 (hard cases) support is available for asylum-seekers who are unable to leave the UK, due to physical impediment (for example having a severe medical condition or being in the late stages of pregnancy) or other exceptional circumstances (see definition elsewhere in this report).

Section 4 support comprises basic accommodation that is offered on a no choice basis and is usually outside of London. Some people do not apply for Section 4 support because it will mean moving away from an area where they have been living for some years and have developed contacts and friendships.

In addition to accommodation, Section 4 support provides £35 per week in the form of vouchers rather than cash. All those in receipt of Section 4 support receive an HC2 form that entitles the holder to free prescriptions and some other medical treatments. To receive this support, a person must be able to show that they are complying with efforts to remove them.⁷

Even when destitute asylum-seekers fulfil the above criteria and apply for Section 4 money it is not always granted. The administration of it is often slow. NASS do very little to publicise it's existence and several of the individual asylum-seekers interviewed for the Research did not know about the possibility of Section 4. Furthermore, NASS refused Section 4 money to several people who had claimed it on the grounds that they are not really destitute. For instance, if someone had been surviving with no resources for some time, NASS have taken this to mean that they are not destitute. Recent reports by both the Citizens Advice Bureau⁸ and the Inter-Agency Partnership⁹ have criticised both the administration and limitations of Section 4 provision and have made several recommendations on changes that should be made.

⁷ Refugee Council

⁸ Shaming Destitution - CAB Evidence Briefing on Section 4 June 2006

⁹ IAP Report on the Impact of Section 4 July 2006

Section 9 (Asylum and Immigration Treatment of Claimants Act 2004)

Section 9 covers support to families who are end of process. As with Section 4 it requires families to undertake that they are willing to return to their country as a requirement of obtaining support. Furthermore it makes provision for children to be taken into care by the Local Authority (and separated from their parents) if the parents refuse the support under these terms. Section 9 was 'piloted' over the last year in four areas in the UK. These pilots have been evaluated. The voluntary sector and Local Authority representatives have put forward several objections to Section 9, ranging from it not achieving the desired effect (persuading people to return to their country), to not being cost-effective, to it severely damaging a child's development to be separated from its parents. It was found that almost half of the families affected opted out of the support system and went underground. All of these points are currently being considered by the Home Office who have, for the moment, held back from a full implementation of Section 9. However in the current political climate it is feared that they will take the scheme forward. They may for example extend it to other areas, thus increasing the likelihood of destitution as families go underground.

Section 10 (Asylum and Immigration Treatment of Claimants Act 2004)

This provision sought to require end of process asylum-seekers receiving support to do work in the community as a requirement for receiving the support. The Home Office sought to 'pilot' Section 10 and were seeking a voluntary sector partner to do this with. Although the YMCA in Glasgow was originally to have been involved they have now withdrawn and there is no pilot at this present. It is not clear what the Home Office intend to do about piloting or implementing Section 10.

New Asylum Model (NAM)

This is the name for the new system that the Home Office are devising to process all asylum claims. It is already being piloted on a small scale in a few areas in the country. It seeks, as past initiatives have sought, to make the asylum process better managed, more efficient and quicker. They hope it will improve the quality of decision-making on asylum claims and eliminate procedural problems around support by assigning specific Home Office caseworkers to each claim. They hope that this new process will greatly reduce the incidence of destitution amongst new asylum-seekers. The NAM is currently being rolled out and the Home Office have a target of it applying to every asylum-seeker by 2007. Refugee agencies are preparing to monitor how it works in practice.¹⁰ A more detailed description of the NAM can be obtained from the Home Office. In the context of this Research however the NAM does not and will not cover those asylum-seekers who are currently in the country and who are destitute.

Procedural routes to destitution

The Inter-Agency Partnership Agencies¹¹ are currently in discussion with the Home Office about the procedural or bureaucratic routes to destitution, affecting a significant proportion of their clients. This is where asylum-seekers have become destitute not as a result of being deliberately excluded from support but because of bureaucratic and procedural problems within NASS. NASS have made a commitment to work out how to eliminate these problems as they agree it is not acceptable that any asylum-seeker should be made destitute accidentally.

¹⁰ The Inter Agency Partnership will be monitoring the rollout on behalf of its member agencies.

¹¹ Welsh Refugee Council, MHL, RAP, Refugee Council, Scottish Refugee Council, Refugee Action

Human Rights Legislation

This country is party to the European Convention on Human Rights (ECHR) and as such has a duty to uphold these rights for individuals. This is not the same as the Refugee Convention that guides applications for asylum. However some asylum-seekers have made successful claims for support under this legislation. Good legal advice and advocacy is often required for such claims and this can be difficult to obtain due to a shortage of suitable or affordable solicitors. The exact meaning of this legislation is constantly being challenged and redefined through case law. At the time of conducting this Research it has not yet been established that causing someone to be destitute is on its own a breach of his or her human rights.

Legal Services Commission Review

For several years there have been arguments that asylum-seekers are not getting adequate access to good legal advice regarding their asylum claim. This is bound up with increasing restrictions on the use of legal aid for asylum cases. The Legal Services Commission (LSC) is undertaking a review of Legal Aid, and inviting contributions from the voluntary sector.¹² Several reports have been undertaken that show the current lack of access to legal support. The research currently being undertaken by Refugee Action is looking at whether there is a causal link between a lack of legal support to asylum-seekers pursuing their claim and their becoming destitute.

2.3. Other relevant policy.

Race Equality

Following the Race Relations Amendment Act (2000)¹³, all public authorities have an explicit duty to actively promote race equality. They have a general duty to:

- Eliminate unlawful racial discrimination
- Promote equality of opportunity
- Promote good race relations between people of different racial groups.

This new duty is not optional. Statutory health and social care organisations have to meet it, irrespective of the size of the ethnic minority population they serve. This general duty is supported by a series of specific duties applicable to both employment and service delivery.¹⁴

In line with this, the Department of Health (DH) has produced a number of strategy reports such as the Delivering Race Equality in Mental Health Care (DRE) strategy, amongst others (see Appendix F). DRE is an action plan for achieving equality and tackling discrimination in mental health services. It is designed to facilitate the elimination of the inequality faced by all black and minority ethnic (BME) groups in accessing mental health services. Refugees and asylum-seekers, many of whom will be destitute, are a particular category of people within the BME population. This Research is an important contribution towards helping Local Authorities fulfil their statutory obligations. It details where the gaps are for this client group and makes recommendations for how these gaps can be filled.

¹² <http://www.legalservices.gov.uk/docs/consultations/Carter-consultation-270706.pdf>

¹³ <http://www.opsi.gov.uk/acts/acts2000/20000034.htm>

¹⁴ NIMHE (2004) 'Inside Outside - Improving Mental Health Services for Black and Minority Ethnic Communities in England' DH Publications, London.

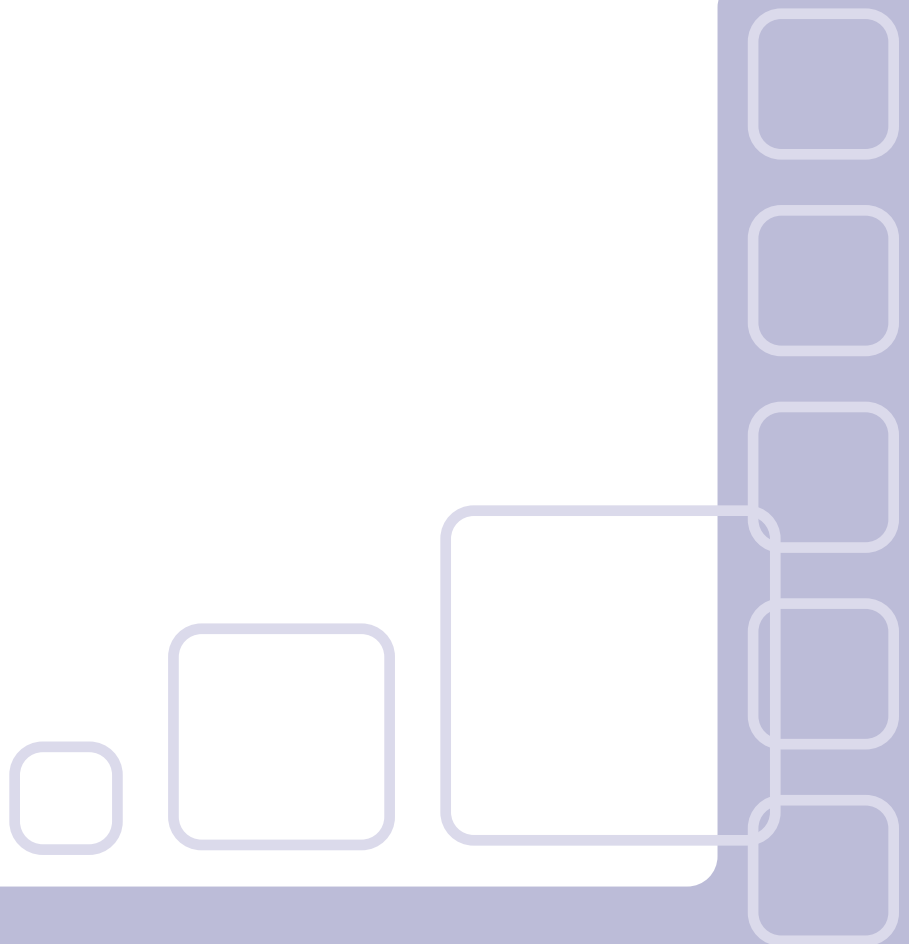
Local Authority obligations

A significant number of destitute asylum-seekers may be eligible for help from the Local Authority under their obligations to address the needs of certain vulnerable groups. The authority for this is derived under a number of pieces of legislation such as the 1948 National Assistance Act, the NHS and Community Care Act 1990 and the Children's Act 1989, to name but a few. In a general sense Community Care provision is there for those who are deemed particularly vulnerable individuals, made vulnerable for example by their poor physical or mental health. It is complicated legislation and that is reflected in the wide variation amongst Local Authorities of how to interpret their obligations under this. There are a matrix of conditions that determine eligibility, including several immigration status factors that may be taken into account. How the Community Care provision is applicable is constantly being redefined through court cases brought by both Local Authorities and individual claimants. Many of these challenges are not related to asylum-seekers specifically. Ultimately an asylum-seeker with a particular vulnerability could find themselves supported by one Local Authority under this provision but refused by another if they lived in a different area, even though their needs would be identical.

There has been significant policy and practice development regarding the responsibilities towards and rights of all children, including asylum-seekers and refugees. As with Community Care provision there are complicated legal provisions and duties that determine how the Local Authority and others exercise a duty of care to this client group. While asylum-seeking children were not the focus of this Research it should be borne in mind that several destitute asylum-seekers began their asylum claim here as children even though they are now adults. Furthermore there will be cases of destitute asylum-seekers having children while here that will affect how they are provided for. The key message is that refugee or asylum-seeking children are children first and that any care or support should be guided by this principle.

Mental health

The government is currently working on a new Mental Health Bill of 2004, designed to up-date the Mental Health Act of 1983. Part of the process includes a Race Equality Impact Assessment.



Section 3: Asylum-seekers in the South East

One of the Research aims was to quantify the numbers of destitute asylum-seekers in the South East. Due to the transient nature of the refugee and asylum-seeking population, it is difficult to quantify the number of destitute asylum-seekers in the UK. The government itself has found it difficult to do this. In this chapter, we will attempt to provide an overview of the distribution of destitute asylum-seekers and offer some guidance on estimated numbers.

3.1. Collection of data.

An area in which this Research has had marginal success is in the collection of useful data. Obtaining even minimal data, profiling its users from publicly funded bodies such as Local Authority services, has met with little success. There seems to be little clarity over where this information can be obtained and in the experience of this Research, the information is either not available or has proved to be impossible to access.

The data that has been obtained has been derived mainly from local charitable and voluntary sector organisations. In addition we have drawn on national data and, wherever appropriate, national figures for asylum applications have been used as a benchmark for analysing the local data in this Research. This provides a useful check for any anomalies that may arise during the course of the Research.

3.2. Dispersal areas

There are currently two areas in the South East in which NASS provides asylum-seekers with accommodation, Portsmouth and Hastings/St. Leonard's. Brighton & Hove was until recently a dispersal area, but dispersal there has been suspended for a year due to the city's participation in the Gateway Protection Programme. For those asylum-seekers who have made their own accommodation arrangements, NASS pays a subsistence allowance; these people are termed 'voucher-only asylum-seekers'. As Figure 1, below, shows on 1st January, 1,330 asylum-seekers had been dispersed to the South East and distributed in the areas listed.

Location	Dispersal (1.1.06)	Voucher Only (2.1.06)	Disbenefitted (1.1.06)
Dispersal areas			
Portsmouth	349	20	-
Brighton & Hove	37	30	3
Hastings & St Leonards	108	30	-
Other Areas			
Crawley	-	37	-
Milton Keynes	-	68	-
Oxford	7	74	3
Reading	-	64	-
Slough	-	140	-
Southampton	3	49	-
Berkshire (excl. Reading & Slough)	-	26	-
Buckinghamshire (exc. Milton Keynes)	31	-	-
East Sussex (excl. Brighton & Hastings)	23	-	-
Hampshire (excl. Portsmouth & Southampton)	-	31	-
Kent	-	178	5
Oxfordshire (excl. Oxford)	-	4	-
West Sussex (excl. Crawley)	-	10	-
Total	504	815	11
Regional Total	1330		

Figure 1.15

Figure 2 shows the distribution of nationalities dispersed to the three regions, which provides a possible clue to the main languages spoken by asylum-seekers in these areas. Whilst asylum-seekers may move town to find support from family or friends, information obtained through the Research indicates that when support is removed from them, most asylum-seekers prefer to stay in the town where they were initially dispersed, which they feel familiar with and possibly have friends and contacts to whom they can look for support.

Portsmouth	Nos.	Brighton & Hove	Nos.	Hastings & St. Leonards	Nos.
Sudan	17	Iran	8	Iran	23
Iran	14	Sudan	7	Eritrea	17
DRC	13	Algeria	4	Iraq	15
Afghanistan	12	Zimbabwe	3	Sudan	10
Eritrea	11	DRC	2	DRC	6
Iraq	10	Armenia	1	Afghanistan	5
Angola	6	Chad	1	Ivory Coast	4
Cameroon	6	Guinea	1	Cameroon	3
Ivory Coast	6	Iraq	1	Zimbabwe	3
Turkey	6	Somalia, Ivory Coast	1	Nigeria	3

Figure 2.¹⁶

3.3. Estimated numbers of destitute asylum-seekers in the South East

One of the objectives of the Research was to try and quantify the numbers of destitute asylum-seekers in the South East. This is impossible to do as there are no centrally collated statistics on destitution¹⁷. Once an asylum-seeker has had support withdrawn from them, they may move from the area to seek support from friends or family in another region of the UK. Even though many failed asylum-seekers faithfully sign up at the police station each month, as they are required to do, the system is not geared to providing a conclusive estimate of the numbers that may be destitute. One of the frustrations expressed by some of those we interviewed was the absence of information on those asylum-seekers who had accommodation withdrawn by NASS.

¹⁶ Figures taken from SERASC briefing January 2006.

¹⁷ ICAR Briefing May 2006 'Destitution amongst refugees and asylum-seekers in the UK'

However, drawing on methods used by the Greater London Authority (GLA)¹⁸ and others, it is possible to provide some estimate and indicate some of the trends in the asylum-seeking population of the South East.

Based on the Home Office statistics for 2004, approximately 4% of asylum-seekers were distributed to the South East. By using 4% as a benchmark figure, it is possible to arrive at a rough estimate of destitute asylum seekers in the South East. A crude method to estimate this is to subtract the figure of those who were removed (in 2004 this was 14,905) from the number of failed asylum-seekers (59,400). This will give the number of those who will have had NASS support withdrawn (44,495). By using the 4% benchmark, it is possible to estimate that in any given year, there are likely to be approximately 1,780 destitute asylum-seekers in the South East.

This estimate is supported by the local data that is available. In Southampton, the Winchester Visitor's Group supported 75 destitute asylum-seekers during the period Aug 2004 - Aug 2005. Portsmouth Area Refugee Support gives out on average 75 food parcels a week. The Kurdish Community Association in Portsmouth estimates there are 800 Kurds living in Portsmouth, a sizeable proportion of which will have had their asylum claim turned down and therefore be receiving no support. The police calculated that 50 Iraqi Kurds were asked by NASS to leave their accommodation. In Oxford, Asylum Welcome estimates that they see an average of 30 people a month whose claims have failed. In Brighton the Chapel Royal project sees about 50 people a week and estimates there are 100-200 destitute asylum-seekers in the Brighton and Hove area. The Links project in Hastings sees up to 50 a week and estimates there to be up to 100 destitute asylum-seekers in the area.

¹⁸ Mayor of London (2004) *Destitution by design: withdrawal of support from in-country asylum applicants*. Greater London Authority
http://www.london.gov.uk/mayor/refugees/docs/destitution_by_design

Section 4:

Overview of those who were interviewed

This section concentrates on summarising the findings obtained from interviews with a total of 49 destitute asylum-seekers. Forty took part in one-to-one interviews whilst nine participated in a group discussion. Individuals to be interviewed were contacted through the Winchester Visitor's Group (WVG) in Southampton, Portsmouth Area Refugee Support (PARS), Refugee Action and the Kurdish Community Association in Portsmouth, Chapel Royal in Brighton, and St. Vincent de Paul in Hastings (see Appendix A for more on methodology). This is a small sample but provides a useful window into the experiences of a little known group of people and provides a benchmark for further studies to take place and build upon.

Four of those interviewed were receiving Section 4 support. They were included either because they demonstrated how receipt of Section 4 is not a guarantee against destitution (see Section 2), or because they had been destitute and had useful experiences of mental health services.

It could be argued that the sample is biased in that it represents the experiences of those who are in touch with the support services listed, and may therefore not represent the experiences of those who are completely isolated. Efforts were made to ensure that a representative sample was obtained, by contacting mosques and community organisations. This Research and other existing research (see Appendix D for References) indicates that those asylum-seekers who are not using the various drop-in services that are available for food parcels and legal advice are either surviving illegally, receiving support from their own communities, or living in appalling circumstances.

The 2004 Home Office statistics on the main asylum applicants to the UK¹⁹ have been used as a benchmark throughout this Research, unless indicated. These are the most accessible and comprehensive data available.

The findings from this are as followed:

4.1. Gender

Nine of the 40 (29%) were women. This figure is proportionately in line with national statistics indicating that women make up 30% of all asylum applications.²⁰ Although too low a figure to identify significant gender differentiations within all the findings, these have been highlighted throughout the text whenever this occurs.

4.2. Country of Origin

Those that were interviewed came from a total of 17 different countries of origin. The sample below, when compared with national data on those seeking asylum (see Figure 4) can be regarded as fairly representative. The most glaring contradiction is the absence from the Research of interviewees from Iran, the country with the highest number of asylum applications in 2005, most of who will be Iranian Kurds. This can be accounted for by a certain amount of anecdotal evidence that the Kurdish community is a very tight knit one and look after and support each other. In a separate piece of research being carried out by the researchers²¹, a destitute Iranian Kurd described surviving on an allowance being sent by his mother who was still living in Iranian Kurdistan.



The largest nationality groups were those from Sudan and the Democratic Republic of Congo (DRC) at 15% each. This was followed by Zimbabwe. It is clear from the list below that these are all countries experiencing civil war, severe unrest and conflict. The list of those interviewed also reflects those who are particularly vulnerable. The absence of individuals from countries such as Vietnam and Jamaica (who feature in the list of national statistics) could indicate that asylum-seekers from these countries are receiving support from communities that are already well established in the UK.

Nationalities of those taking part in the Research

Country of Origin	Numbers
DRC	6
Sudan	6
Zimbabwe	4
Afghanistan	3
Algeria	3
Ethiopia	3
Ivory Coast	3
Guinea	2
Iran	2
Angola	1
Azerbaijan	1
Cameroon	1
Eritrea	1
India	1
Libya	1
Niger	1
Sierra Leone	1

Figure 3.

Top asylum applications by nationality²³

Country of Origin	Numbers
Iran	3,140
Somalia	1,770
Eritrea	1,760
China	1,735
Afghanistan	1,585
Iraq	1,435
Pakistan	1,145
Zimbabwe	1,070
DRC	1,060
Nigeria	1,010
India	970
Sudan	895
Turkey	755
Sri Lanka	405
Ethiopia	395
Vietnam	380
Jamaica	295

Figure 4.

4.3. Age Grouping

The largest number (78%) of those interviewed were from the 21 - 40 age group. This compares with the national figure of 63% applicants for asylum for that age group.

Age Grouping	CountOfAge Grouping	Percentage ²³
16-20	3	8
21-30	16	40
31-40	15	38
41-50	4	10
51-60	1	3
61-70	1	3

²² Home Office provisional figures for 2005.

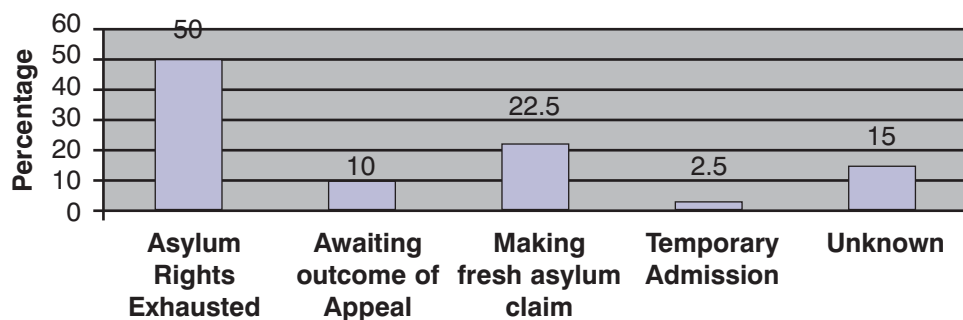
²³ Rounded to the nearest percentage

More than three quarters were single (76%). Nearly a sixth (14%) were single parents with children, 7% were married or described themselves having a partner but no children, whilst 3% were part of a couple with children.

4.5. Immigration status

Half of those interviewed were destitute because they had exhausted all other avenues for claiming asylum. Nearly a third (23%) had made a fresh application, and a few (10%) were awaiting the outcome of their appeal. For a sixth (15%) of those that were interviewed, it was unclear what their status was and they themselves seemed confused.

Current immigration status



Section 5: Surviving destitution

CASE STUDY

Paul (not real name) from Sudan

Paul is 34 years old and from the Dafur region of Sudan. He fled to the UK in 2004 after his life was threatened as part of the persecution that his ethnic group was experiencing in his country.

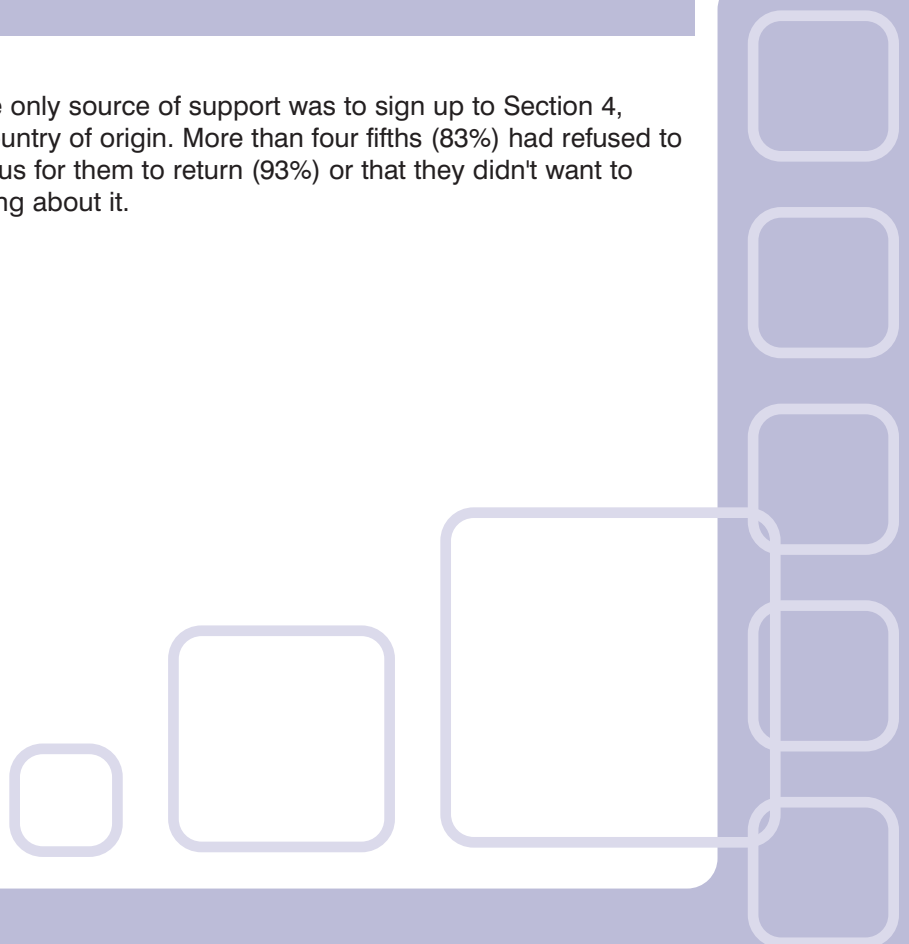
He feels that his original solicitor messed up his asylum claim by not submitting key papers at the correct time. A new solicitor managed to make a new claim for him, which was initially successful, and he was granted leave to remain. However the Home Office sought to reverse this decision as they claimed the situation in Sudan had improved. Consequently his asylum claim was refused again. He has made a fresh claim and his solicitor is confident that this will be successful as he says the evidence supporting his claim is very strong. However while awaiting this decision his NASS support has ended and he has become destitute.

Paul is a very skilled person who worked as an interpreter in the Sudan. He speaks perfect English and several other languages and is a very active member of his community giving advice and help where he can. He helps others to learn and to be able do things for themselves. He is an enormous help to many of the voluntary and statutory sector agencies in his area as he helps interpret voluntarily. However he cannot be paid for this and is dependent on support from friends and destitution projects.

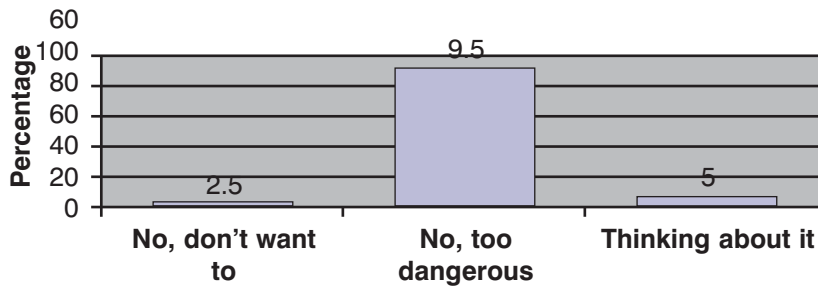
He struggles sometimes with the problem of not knowing where his next meal will come from, or having any control over the type of food he can get to eat. As he says: "It would be better surely to allow me to work so that I could pay tax and support myself. It is not right that I am dependent in this way. Would it not be better for this country to let me work until you finally decide whether I can stay?" He describes his situation as being "lost". Despite what he has had to go through he remains very active, motivated and positive. It is perhaps this that has helped him maintain both his physical and mental health. As he puts is: "We suffered in our home country, we did not think we would suffer here. That is why we are here, because of what happened back home. I left a good life apart from the trouble. I feel like I am waiting for the unknown, that is what is killing us, waiting for the unknown."

5.1. Reasons for being destitute

For almost all of those interviewed, the only source of support was to sign up to Section 4, agreeing to return voluntary to their country of origin. More than four fifths (83%) had refused to sign. They claimed it was too dangerous for them to return (93%) or that they didn't want to (3%). A few (5%) said they were thinking about it.



Can you return to your country of origin?



'I cannot go back - my mother is half Armenian. My husband was killed. I may not have family there. If your family is mixed you can't go to either country. You're rejected by Armenia and by Azerbaijan.'

'There is no freedom in Iran. I am part of a group that has been persecuted and killed. I am gay. There are no gay rights in Iran. My country is corrupt.'

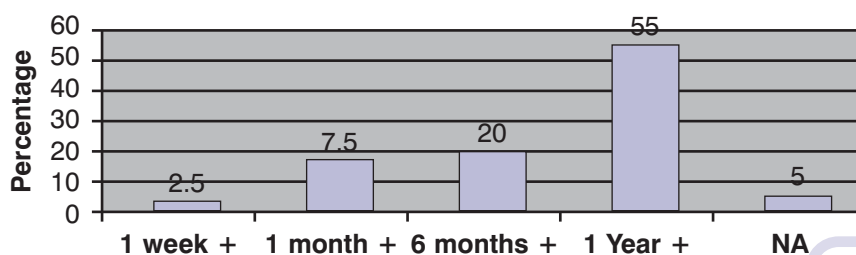
Even when destitute asylum-seekers fulfil the above criteria and apply for Section 4 money it is not always granted. The administration of it is often slow. NASS do very little to publicise its existence and several of the individual asylum-seekers interviewed for the Research did not know about the possibility of Section 4. Furthermore NASS refused Section 4 money to several who claimed it on the grounds that they are not really destitute. Ironically if someone had been surviving with no resources for some time, NASS have taken this to mean that they are not destitute.

Four (10%) of those interviewed had signed up for Section 4, of which two (50%) were unable to be returned because of the situation there and the other two had had their application turned down for legal reasons.

5.2. Experience of being destitute

Most of the people interviewed had been destitute for a considerable time. Just over half (55%), had been destitute for more than a year. One person had been destitute for two and a half years and several for nearly two years. One fifth (20%) had been destitute for more than six months with nearly a fifth (17%) destitute for more than a month.

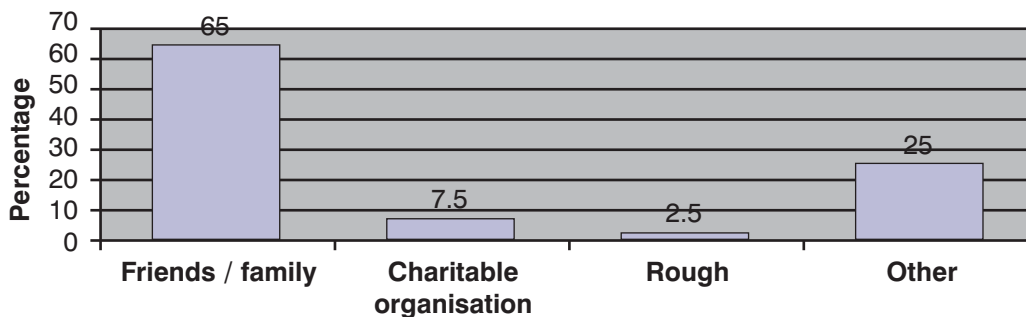
How long have you been destitute?



5.3. Accommodation

The contribution by friends, faith organisations and the generosity of individuals was central to the survival of the group of individuals interviewed in the course of this Research. The people they identified as friends were either other asylum-seekers whom they had met through their NASS accommodation, or compatriots. The heavy reliance on people where the bond was mostly circumstantial or based on nationality clearly puts a heavy strain on all concerned. Many talked about sleeping during the day whilst their host was out, or sleeping rough in order to give them some privacy. More than two thirds (64%) were being accommodated by friends, moving from person to person in order not to overstay their welcome. Many talked of sleeping in the park, one in the garden of their previous NASS accommodation, another used to sleep in the cupboard of her old NASS room. 25% were being accommodated by charitable organisations such as Winchester Visitors Group.

Current sleeping arrangements



CASE STUDY

Winchester Visitors Group

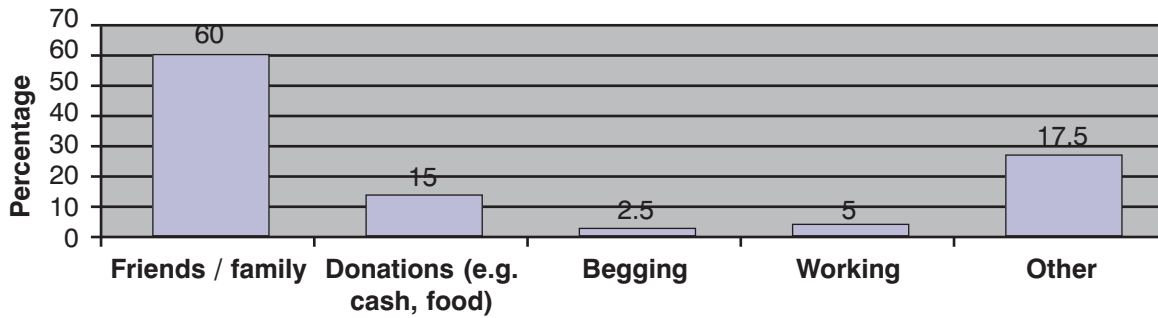
Winchester Visitor's Group (WVG) is a group of volunteers who believe that every asylum-seeker deserves respect and compassion and that applications for asylum should get a fair and proper hearing. They offer friendship, a sympathetic ear and practical support to those in the Southampton area who are experiencing difficulties. Sometimes they may help in contacting a solicitor, finding accommodation or getting access to medical treatment.

Through their ASSIST scheme, they link up with churches and other charitable organisations to raise funds for asylum-seekers who are destitute, providing them with short term accommodation and subsistence. At present this is only available for six weeks at a time.

5.4. Subsistence

In nearly two thirds of cases (60%), friends were a source of food, accommodation or money. Charitable donations were relied on by a sixth (15%) of those interviewed. A small number (5%) admitted they worked illegally to survive, doing casual work such as washing up for restaurants. One admitted that he sometimes resorted to begging on the streets. Two of the men interviewed admitted that they turned to prostitution to survive.

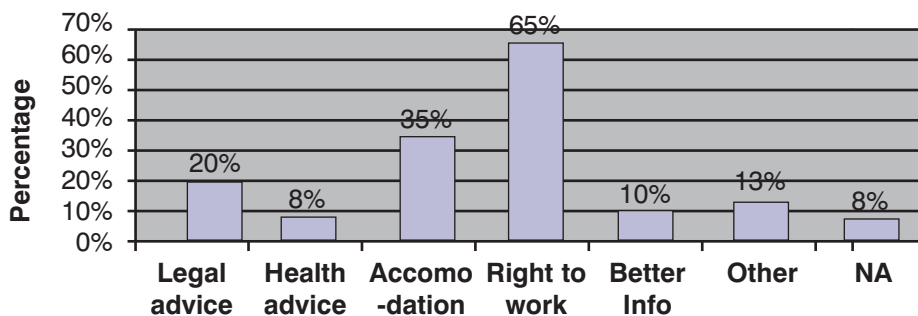
How do you survive?



5.5. What additional support would you like to receive?

The question asking what additional support would they like to see in place elicited a confused response from many of those being interviewed. It was clear that the concept of being supported through statutory provision was not something they understood. More than two thirds (65%) insisted that the right to work would alleviate their problems. This fits in with the findings that there is a strong correlation between positive mental health and economic opportunities (the right to work, access to employment and maintenance of socio-economic status).²⁴ A further third (35%) said that accommodation would help. The other answers that were given included 'more money', 'access to NASS support' and other similar requests for financial assistance. There was very little interest in their health needs (8%). There are a number of studies confirming that refugees in permanent, private accommodation have significantly better mental health than those in institutional and temporary private accommodation.²⁵

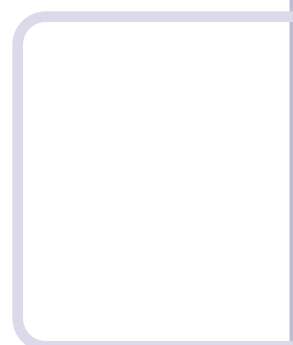
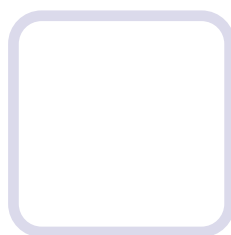
What additional support would help?



²⁴ Porter & Haslam (2005) Predisplacement and Postdisplacement Factors Associated With Mental Health of Refugees and Internally Displaced Persons. A Meta-analysis. JAMA, August 3, 2005 - Vol 294, No 5 www.jama.com

²⁵ Ibid

'Really, the problems started when they removed the right to work from asylum-seekers. During the previous system, individuals would arrive looking confused and in a distressed state. It was lovely then to see them blossom and look happy when they got work and could support themselves and maybe send money home to their families.' Health worker in an induction centre.



Section 6: Mental Health Issues

For the purposes of this Research, the term mental health was interpreted in the sense of general well-being. Those that were interviewed were invited to make their own assessment of their mental state, based on generally accepted measures for mental health such as feelings of depression, sleeplessness, thoughts of self harm, stress, loneliness.²⁶ These questions about feelings were at times met with some resistance and confusion as to what was being asked. The researchers were fully conscious of their responsibility not to enter a terrain that was sensitive and may open up deep wounds. Also, many asylum-seekers come from cultures in which talking to a stranger about their problems was not something they were comfortable with.²⁷ On some occasions, we were presented with the difficulty of interviewing an individual who was clearly confused and unable to reflect on their situation and describe it clearly within the framework of an interview. In spite of these difficulties, it was possible to come up with some useful findings.

In this section, we have tried to show the traumatic experiences many refugees have been through before they have arrived in the UK, the kinds of illnesses some of them have as a result of these experiences and the enduring stress they are experiencing as a result of their entry into the asylum system.

CASE STUDY

George (not real name) from Sierra Leone

George is 34 years old. A rebel army attacked his village killing six people in front of him and dragooned him and others from the village to join them. For the next five years he was involved with these rebels and was forced to go on raids to other areas. Eventually he managed to escape from the rebel army and return to his village. Once there, he realised that the villagers regarded him as a traitor. In his absence his father had been killed and their land stolen. He does not know what happened to his two brothers or mother. George was severely beaten by the villagers and forced to drink acid. This did terrible damage to his body. He finally fled to the UK in 2001 by bribing various people in order to get out.

He got some initial legal advice but his claim for asylum was turned down by the Home Office. The original solicitors said that they would help him appeal if he paid them money (£800). He was not able to do that. He went to another solicitor who he thought made an appeal for him but the Home Office claimed that they never received it and thus closed his case. For the last year he has been without any financial support and therefore destitute. He has received support and advice from destitution projects that have also tried to find him a new solicitor who may help him make a fresh asylum claim. In the meantime he has been staying in very cramped conditions at friends' accommodation.

Most nights he sleeps in a chair, as this is the only comfortable position he can find. He continues to receive medical care for the horrendous injuries incurred by being forced to drink acid and is on several medications. He goes to outpatients departments at the local hospital where practitioners have responded very professionally to his needs. While still in much pain and discomfort, for example he has difficulty swallowing, going to the toilet is painful, as is talking, his physical health is improving. Conversely his mental health has deteriorated and at times in the past year he has been suicidal and attended hospital after incidents of self-harm.

²⁶British Medical Association (2002) *Asylum-seekers: meeting their health care needs*. Pg. 7 BMA Publications.

²⁷Summerfield D. (2001) *Asylum-seekers, refugees and mental health services in the UK*. *Psychiatric Bulletin* (2001) 25, 161-163

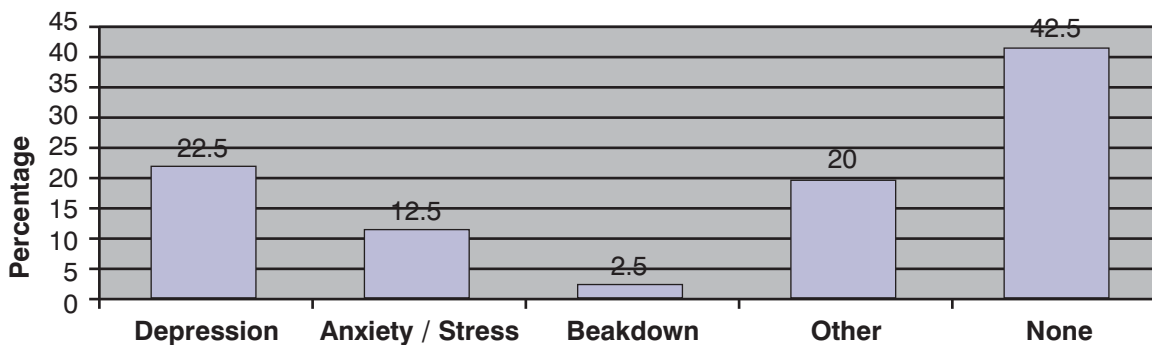
responded very professionally to his needs. While still in much pain and discomfort, for example he has difficulty swallowing, going to the toilet is painful, as is talking, his physical health is improving. Conversely his mental health has deteriorated and at times in the past year he has been suicidal and attended hospital after incidents of self-harm.

He often feels despair about his situation and trapped in the limbo of being unable to work or receive NASS support. "I find myself thinking too much about everything and get very down. I feel I am stuck." He fears being arrested by the police and deported and has no doubt that his life would be in danger if he were to return to his country. He feels frightened to talk to people, as he fears that they will be aggressive towards him because he is an asylum-seeker. In addition he does not believe he would get any medical help if he was returned to Sierra Leone and his physical condition would deteriorate. He is currently receiving psychiatric support and believes that this, along with the other health treatments he has received, has saved his life. While he has received an enormous amount of support for which he is grateful, he feels shame for the position he has found himself in. He feels that he would be able to look after and support himself if he was allowed to work. He finds it hard to understand how he can get support for his health needs but nothing for his daily living. He says his situation is precarious: "I pray for help. I pray that the Government won't forget me."

6.1. Mental and physical health before coming to the UK

When asked about their mental wellbeing before coming to the UK, nearly half (43%) said that they had no mental health problems. Of the remainder, just under half (23%) admitted that they used to feel depressed. One had suffered a breakdown and under a sixth (13%) suffered from anxiety. Just over a fifth (20%) said that they had other health problems which included physical beatings and torture at the hands of military.

Mental wellbeing before coming to UK



Some of the experiences included:

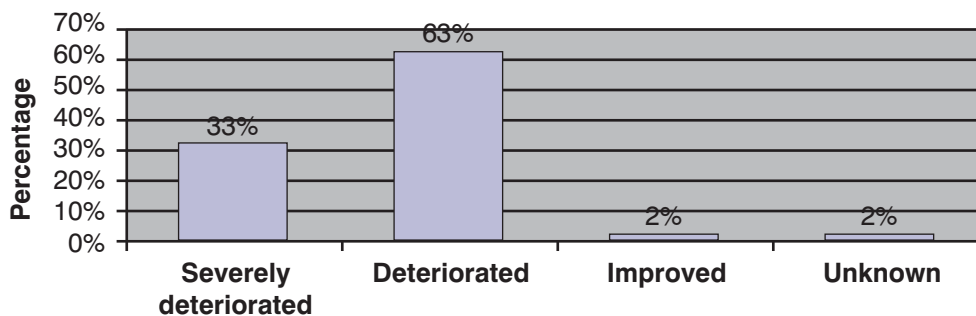
- It started when I was tortured in the Congo before coming here.
- I had a breakdown - my mother was killed and I lost a baby. My father, brother also killed. I have had suicidal feelings.
- I was badly burnt in my country.
- I don't know what I am talking about. I get sick a lot.

- I was abused as a child.
- I get headaches.
- I was tortured by the Taliban. Amongst other things this has made me short tempered. The Taliban killed my parents. I have no one to turn to.
- I have a physical problem - I was beaten up in Africa.
- I was hurt in prison and have physical problems.
- No not a mental problem - but I was poisoned.
- I had physical problems in prison in my country.
- I had some problems with nerves and distress. I worked in a political group and it became dangerous. But at home it's different - you have family and friends to support you.
- I was very stressed because of the impact of what was going on in Sudan. We lived in peace with our land and homes. Suddenly everything is gone and destroyed and we were living in fear of our lives.
- I am from a very poor family. Just as I started helping them the problems started in Sudan when we were all separated by guns and destruction. I want to help them but now I can't.
- I have Schizophrenia here and before I left Algeria. But here it is worse.
- I have Epilepsy and my brother is Schizophrenic. Here we are both worse. Especially since losing NASS support.
- Some people tried to kill me in Afghanistan. I have cuts, they banged my head and I was beaten up badly. I was in hospital.

6.2. Mental and physical health since coming to the UK

A question was also asked about their physical and mental health since coming to the UK. Nearly all (96%) felt that their health had deteriorated since coming to the UK. A third (33%) described their health as severely deteriorated. One person described their health as having improved. Without exception, respondents felt that the uncertainty about their future and the difficulties they faced to survive each day, placed an unbearable burden on them.

Mental wellbeing before coming to UK



- I suffer high stress in the UK. It is very bad. I am waiting for an operation for fibroids. I had TB and am scared it will come back. My heart is jumping, jumping. I have a back problem and headaches. When I have a headache I want to kill myself.
- I am drinking more and smoking.
- There is a lot on my mind. I think a lot. I don't get enough sleep. Sometimes I am afraid but not sure of what. If I have a GP I would go to him, but I don't have one.
- I have started having chest pains, especially when I worry.
- I have a pain in the head and get coughing fits. I have had TB.
- I hate crowds. It is rough on the street. I have lost a lot of friends who saw me as scrounging off them.

- My headaches have increased.
- My teeth are rotting. I have broken my leg. My skin is deteriorating. My mental health is suffering.
- I was diagnosed while here as being HIV positive. I became depressed at that news.
- I get a lot of headaches.
- My mental health got worse but my physical health got better.
- My mental health has deteriorated but my physical health has improved.
- My physical health has suffered.
- It was worse in prison in Sudan.
- For me and my wife - but my wife especially. She had a breakdown and is in a mental hospital now.
- Since coming to the UK, I've been refused asylum and found out I am HIV+.
- I'm ill at the moment - I go to mobile NHS vans and am given examinations but they can't find anything wrong with me - they say come back in 2 weeks. I've had a pain in my chest since last year - blood tests and X-ray say there's no problem. But my heart is beating very fast. It's affected my mental health too - I get headaches all the time.
- I'm getting bad headaches and stomach pains when I think a lot.
- Much worse now - I can't sleep or concentrate on anything. It's so stressful.
- At first when we arrived we feared the authorities - police and officials. But we later realised it wasn't like Sudan - we had support. But when you go to bed you still have bad memories.
- I am always thinking about my family back home. Now I have no home and I can't get a meal every day. I hear bad news on the television from Sudan. The government is too strong for me to go back and help.
- My health has been affected really badly. It's hard to think straight - I'm often tired and stressed. You wake up weak - you walk down the road and don't notice the cars.
- Sometimes I can't sleep. I have a lot of stress.
- I have been in a mental hospital twice since coming to the UK. My condition has got worse.
- My brother was in a mental hospital twice since being in the UK.
- I got tablets in Afghanistan but here there is no help. I think I'm going crazy.
- Since I came here I've had problems with my stomach because of the long journey to escape Sudan. I had no proper food. I saw a GP.

6.3. General feelings of wellbeing

Participants were asked a set of general questions relating to how they felt. This was to ascertain how they perceived their mental and emotional state. They were asked if they ever experienced the following:

Depression: Nearly all (83%) stated that they suffered from depression 'often' or 'usually'.

Sleeplessness: Nearly two thirds (63%) often or usually experienced loss of sleep. Women seemed to experience greater sleeplessness, with over three quarters (78%) describing having difficulties sleeping.

Stress: More than a quarter (79%) felt they suffered often or usually from stress.

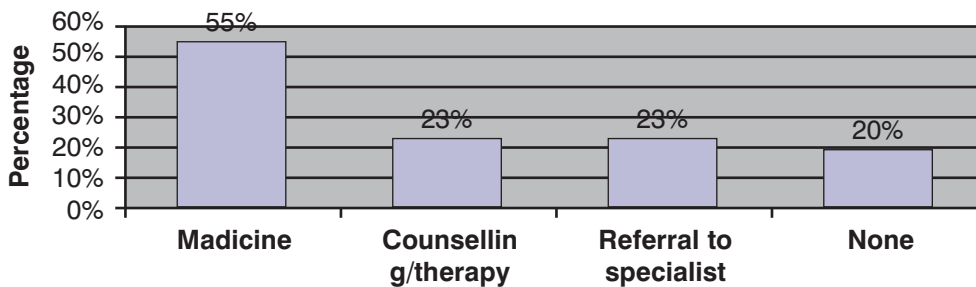
Loneliness: Similarly nearly two thirds (57%) frequently experience loneliness. More women (67%) than men described themselves as always experiencing loneliness. Of the males a fifth of the men (21%) described themselves in this way.

Self harm: Interestingly there seemed to be a strong aversion to self harm with nearly half (49%) claiming they never thought about it, a third (30%) saying they sometimes thought about it, and less than a fifth (14%) saying that this was something they thought about often or usually. Slightly more women (33%) than men (26%) sometimes thought of self harm.

6.4. Types of mental health support being received

More than half (55%) of those interviewed said that they were receiving medication for depression, sleeplessness or anxiety. A fifth (23%) had received some form of counselling or therapy. A further fifth (23%) were receiving various specialist help such as a neurologist, specialist doctor of victims of torture and treatment for burns.

Are you receiving any help?

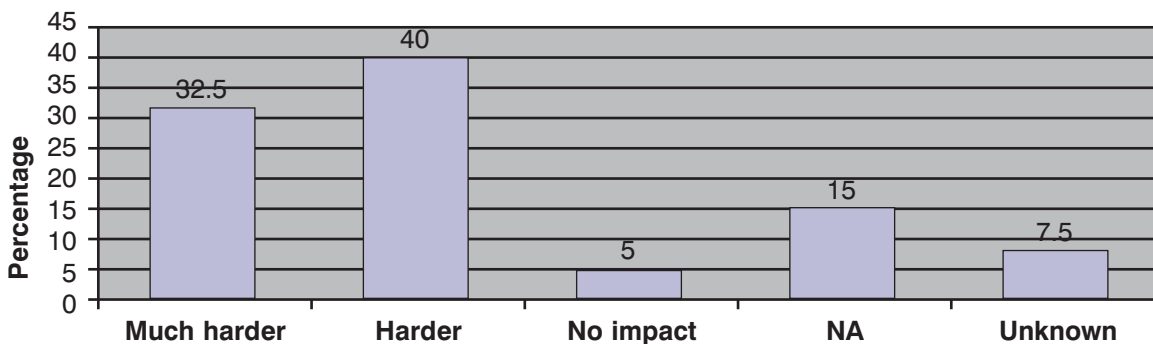


It is interesting to note that of the nine that had received counselling or therapy, only one had accessed this through their GP. Of the others, two received counselling whilst in detention, two asked the charity they were linked with to help them, two accessed counselling through their solicitor, one was referred by the police and one by a specialist agency.

6.5. Affects of destitution on accessing services

Nearly three quarters (73%) said that being destitute made it difficult to access the help they needed. There was a high awareness that they were no longer eligible for NHS primary care services. Many were too scared to visit their doctors in case they were challenged. For those who were being seen by sympathetic GPs, they had the additional worry of being challenged when they presented their prescriptions, and of not being able to afford the cost of their medication.

How did destitution affect access to getting help?



- I had a HC2 Form for six months, when I was in NASS support. Now I have to pay for myself. I need an X-ray at the moment but cannot afford it.
- I need to pay for my medication.

- It's difficult to get medicine. Until now the pharmacist hasn't asked for proof of identity - I am scared they will ask for an NHS certificate. The dentist asked for an NHS certificate and I couldn't get treatment.
- I have stomach upsets, ear problems, problems with my teeth, joint problems. I go to the general hospital.
- In January 2005, I went to the Rape Crisis Centre. I stopped going to the dentist, until I got money from the church group. I went to the GP who explained that it was normal to feel this way and that it was better not to take medication. S/he gave me medicine to help me sleep.
- I don't tell my GP the situation - he gives me a prescription but I often can't buy it.
- I fear going for treatment in case my status and eligibility to treatment gets challenged.
- I got a NASS letter saying that I was no longer eligible for a GP so I don't go. I use the Accident & Emergency hospital.
- I have to buy my paracetamol.
- I no longer have a GP.
- I don't have a GP.
- I still get help from my GP and the hospital.
- It's harder to get medicine and I feel ill a lot of the time with HIV. I have enough to worry about without destitution. My mental health is affected. I am seeing a psychiatrist.
- It's very hard to get medicine and help. Every time I go for medical help (NHS trailer) it is someone different.
- It's much harder now to get medicine.
- If you lose NASS support, you lose everything eventually.
- I had to move from Lewisham to North Kensington, Wood Green, then Southampton then to Portsmouth. It is very stressful and hard to stay with GPs /counsellors etc.
- I'm still getting medicine for my nerves but for how long? Will it be stopped now NASS support is gone?
- It is impossible to continue getting help.
- I have not got a GP since losing my NASS support. If I get ill I have no help.
- I lost my GP - so now I can't get help or medicine.
- They made an assessment of our situation to see if my brother could get money for being my carer. They said no to any financial support.
- I can't see a GP easily anymore.
- Haven't got a GP.

6.6. Cultural issues

There is increasing concern that the ways that different cultures express and deal with trauma and distress is being ignored and misinterpreted by western models of medical care.²⁸ A central strand of the DH's DRE strategy is the importance of providing a health service that is sensitive to the cultural needs of service users and their carers. In this context therefore, the Research attempted to get a sense of the different cultural attitudes to mental health. Two thirds (60%) of those interviewed came from West Africa and the thrust of the responses probably reflects the attitudes from the countries of that region. Nearly three quarters (70%)

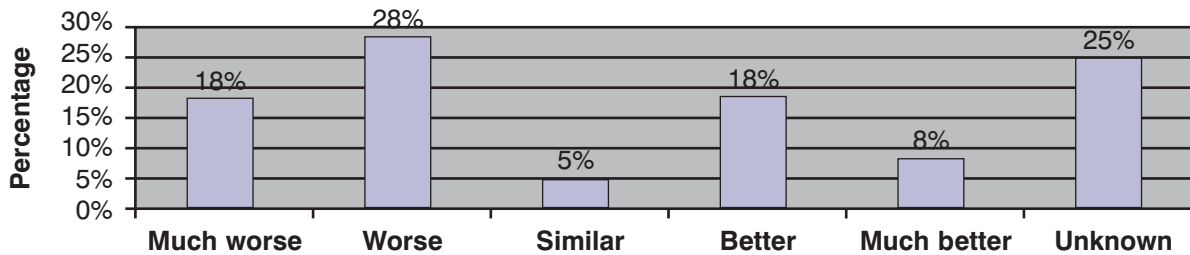
described the attitudes as being different or very different in the UK. In many of the interviews the researchers had difficulty in conveying the meaning of some of the questions related to mental health during the interviews, especially those related to 'feeling' questions.

- In Azerbaijan they would think you were crazy if you went to counselling. I took an overdose and was found by a friend.
- The lifestyle is different. We still believe in witch doctors. The DRC is a poor country, you wouldn't waste time getting counselling.
- In Sudan it is the law of nature - the strong eats the weak. There is justice and fairness here especially for those who are British. I suffered from mental illness in Sudan. There they said I was going to be crazy. Here they wouldn't describe me as crazy.
- In Cameroon you don't talk about it. Even someone who was depressed wouldn't know they were depressed. You don't talk about it like here.

6.7. Satisfaction with treatment here.

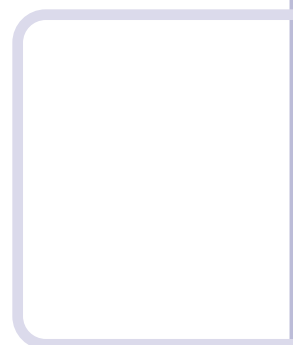
When asked if they would have received better or worse help for their mental health problems in their country of origin, just under half (45%) said that it would have been worse or much worse. A quarter (25%) said they would have received better help with another quarter (25%) being unable to comment.

Would you have been given better help in your own country of origin?



- In Congo I would go to the doctor for tablets otherwise I would go mad.
- Once I thought I was going crazy. Someone helped me with hypnosis. I found it helpful though not sure what it was.
- There would be aunties, family friends to talk to.
- It is better here. The situation in the Congo is helpless. You are powerless.
- When NASS referred me to the GP, I told him about my mental health problems. I can't remember what happened. It affected my heart. I was sweating.
- I would talk to the family.
- In Iran I would have talked to family and friends.
- I wouldn't be depressed because I would be allowed to work.
- Family would help if they were alive.
- I would get support from my family.
- If I were in Libya I would get help from my family.
- Just different.

- I would talk to friends. It would be different.
- There is no mental health support in Algiers.
- It is more specialist here and more professional. Attitudes are better.
- Where I come from it is not a sympathetic culture. Expectations are low.
- Destitution in the UK makes mental health much worse. Counselling and specialist help is meaningless if you haven't got a roof and some money.
- Family and friends would help. Specialists don't understand. You have to talk to them, but you don't to your family - they just know.
- Now I'm here - at first I thought I was safe. But now my future is empty. It is dark. Very dark.
- Your family help you back home- counselling is with your friends.
- Your family and friends help you.
- People in the UK have respect for each other. In Africa a lot of people don't go to school and there is a different mentality about mental health.



Section 7: Ability of services to respond (analysis of interviews with service providers and focus groups)

'The difference we are facing as service providers is that under previous asylum policy, there was a sense of hope. Now we are seeing more people we cannot do anything to help. There is a polarisation between those [asylum-seekers] who are successful and those who have failed. The counselling service is seeing more people in a hopeless situation.' Director of a voluntary sector organisation.

This section concentrates on analysing the ability of services to respond to this particular group of people. It brings together a number of views, derived from face-to-face interviews, telephone interviews and group discussions. In addition, we have tried to draw out examples of good practice as well as describe the principled and innovative ways that some services have managed to honour their commitment to those requiring welfare relief.

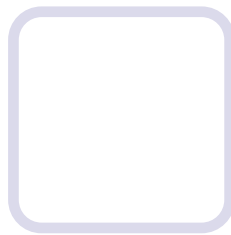
7.1 General Findings.

'We feel that we have been relatively successful to date in trying to meet the needs of this group of people. We put this down to the fact that we are very much practitioner led. However this model can't go on indefinitely without some buy-in from the people above us who ultimately control policy and resources.' Health Worker

What was striking about the response from many in both the voluntary and statutory sectors was the frustration that they felt in trying to meet the needs of destitute asylum-seekers. When presented with a destitute asylum-seeker, some feel that the scope for providing support is limited. Ambiguity about provision is often at odds with the philosophy of care they have committed themselves to, and this puts them in a very stressful position. Ever-restrictive and frequently changing asylum policies that have been implemented in recent years have contributed to confusion amongst providers and users alike. Consequently the services being provided to destitute asylum-seekers can vary from region to region.

Added to this ambiguity there is a feeling that there is no overall strategy or responsibility towards this client group. In other words no one body or sector takes full responsibility towards meeting the needs of asylum-seekers who are destitute and/or have mental health problems. This is particularly apparent in the parameters imposed on the statutory sector. For example, NASS see their role as ending once a person's asylum claim has failed and support ended (unless they sign-up for Section 4 money - see elsewhere in this report for the definition of this). On the other hand, the Home Office take the view that destitute asylum-seekers have made a choice to be destitute. Therefore currently the Home Office says that there is nothing more that they should be providing.

Local Authorities are only able to do what the law allows them to do. On the whole the Local Authorities have three main roles in this context: application of Community Care Legislation (provided through Social Services), provision of housing as appropriate and an overview of asylum and integration work in their area. However



they also have limited resources as well as having to cope with the political consequences of providing certain services.

Social Services, while part of the Local Authority, have a key role in assessing vulnerable clients who may then be eligible for support under Community Care legislation. One characteristic of this aspect of provision is that it can be interpreted very differently between different Social Services.

Health Authorities (Primary Care Trusts) also have obligations towards clients. Overall though there is again unevenness in provision depending on the models or priorities within different areas, even though the needs of the client group may be the same.

The Voluntary Sector has sought to meet some needs of this group. However there are several challenges associated with this, not least the fact that considerable resources are required. Many voluntary sector agencies are not specifically funded for work with this group.

Faith groups (that can also be seen as part of the voluntary sector) are often able to fill a gap because they have a greater flexibility. In other words they are not so bound by regulations and statutory obligations. However while providing a focal point for services in some of the cities covered in the Research their resources are stretched.

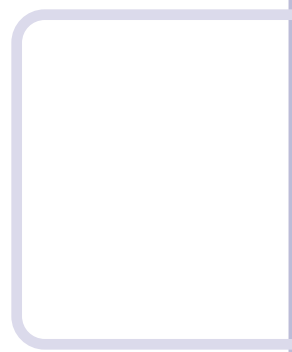
What must be stressed is that within all of the sectors concerned there are an enormous number of very dedicated individuals who have developed their skills to work with this client group. However given the above there is a need for an overall strategy for working with destitute asylum-seekers to be devised at a local and national level.

7.2. Entitlement to health support - primary and secondary care.

The interviews demonstrated that a significant number were still accessing their GPs and that there were clearly a number of GPs exercising their discretionary right to provide health care to failed asylum-seekers. The ruling on this is arguably unclear. However in the following extract from the Department of Health 'Table of Entitlement to NHS Treatment' (Correct as of March 2006), it is clear that health services have considerable freedom in how they interpret this.

For failed asylum-seekers - including those getting NASS Section 4 (formerly 'hard case') support while awaiting departure from the UK, their entitlement to primary care is as follows: *'Emergencies or treatment which is immediately necessary should continue to be provided free of charge within primary care to anyone, where in the clinical opinion of a health professional this is required.'*

For **secondary care** the table states that 'immediately necessary treatment to save life or prevent a condition from becoming life-threatening should always be given to failed asylum-seekers without delay, irrespective of their eligibility for free treatment or ability to pay.' If they are found to be chargeable, the charge should be recovered as far as is considered reasonable. Hospital treatment started during the course of an asylum-seekers claim (including any appeals) should remain free of charge until completion, it being a matter for



clinical judgement as to when a course of treatment has been completed. Any new course of treatment is chargeable, unless the treatment is for a disease that is a threat to society, such as TB.

The Research identified a number of destitute asylum-seekers who were not making use of their prescriptions, fearful at being asked to pay. The DH guidance states that health practitioners who come into contact with asylum-seekers (including failed asylum-seekers) should encourage them to apply for help with health costs through the NHS Low Income Scheme.

What was also apparent from the Research was how the complexities surrounding the entitlements of failed asylum-seekers to health care, can be mishandled by GP receptionists, with their key role as gatekeepers to both primary and secondary care services.

7.3. Access to mental health care.

'When an asylum-seeker comes to us we have no problem with care planning, referring to psychological services and so on. The problem is accommodation. For the mainstream population the cost of accommodation is covered through housing benefit. Failed asylum-seekers are not eligible for this and so the health authority has to cover this.' Psychiatric Nurse.

Primary care mental health services are mainly accessed through the GP (see Appendix B). For many BME communities, this poses a considerable barrier, as communicating sensitive information can be problematic unless properly trained interpreters are used. One refugee community estimates that 70% of visits to the GP by individuals from that community uses a family member to interpret. Whilst it was not possible to obtain figures for the numbers of failed asylum-seekers that require residential psychiatric services, discussions with the police, social workers and health care professionals, indicate that each unit may find themselves providing care to around half a dozen such patients in any given year. Often the police may come across an individual behaving in a socially inappropriate way and bring them to the unit. Providing for those failed asylum-seekers who had acute mental health needs was a cause for concern to many of those interviewed. There is a need for greater discussion to be had by all those involved in the care and rehabilitation of acute psychiatric patients as to how to address their care needs within the current system.

CASE STUDY

The Orchard

This is a residential service for patients with acute mental health issues. It has 36 beds on two wards. It operates on a recovery model, that is, it deals with the crisis facing a patient at that time and prepares for discharge by linking up with other services. From September 2005 - February 2006, it cared for 8 asylum-seekers. The routes that these patients took to the Orchard included referral by a friend, picked up by the police, transferred from A & E, and referred by the adjoining outpatients department.

The Orchard is unusual as it was the only example that we came across, in the region covered, of a statutory service having a clear policy towards the care of asylum-seekers. They have a number of approaches that may be usefully applied by others. Firstly they have a designated post to deal specifically with asylum-seekers, deal with any issue linked to their immigration status and provide specialist back up to the rest of the staff team. They have produced guidelines for their staff (see Appendix) and have a clear policy of not discharging any patient until accommodation is in place. This involves working closely with the bed managers, who attend ward meetings, to find creative ways of finding extra bed space as needed.

7.4. General responses to the mental health needs of destitute asylum-seekers

Regardless of eligibility for mental health services, there are issues about the appropriateness and effectiveness of some services. Obviously where it is a question of someone being sufficiently mentally ill that they have to be sectioned or hospitalised then there is little choice. However such cases represent a tiny minority of asylum-seekers in the area:

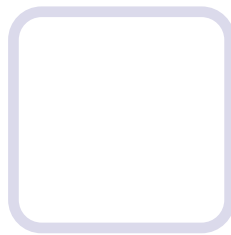
"We have had over 50,000 asylum-seekers pass through the South East in the last five years prior to dispersal. We have [health] screened all of these people and I can say that less than ten have needed to be hospitalized for mental health reasons." Health Care worker at Induction Centre

However, many stakeholders felt that there were a large variety of less acute mental health needs amongst this client group. Such needs had arisen due to a mixture of reasons:

- The experiences of being persecuted (for example, some asylum-seekers interviewed had been tortured)
- The experiences of fleeing (often a long, dangerous and uncertain journey).
- The insecurity that they experienced here in the UK.
- The culture of disbelief that they are faced with (the asylum system itself is perceived as being based on a presumption that an asylum-seeker is lying).
- The length of time someone is caught in a limbo of uncertainty.
- The loss of more usual support mechanisms such as family and friends.
- The experience of being destitute, including deterioration of physical health.
- A lack of a sense of purpose from being denied the opportunity to work legally.
- Overcrowding and lack of privacy.
- Physical threats and actual physical harm caused by others.
- Lack of access to same language health support workers or counsellors.
- Fear of and actual incidents of being arrested and detained.

In Section 6 (Mental health Issues) we give more detail of how the interviewees manifested or understood some of these needs. At this point we would like to highlight some perspectives on this issue from service providers.

Some felt strongly that it is both irresponsible and unprofessional to embark on any sort of counselling or in-depth therapy to a client who has no security in this country and who may be deported tomorrow. Others wondered whether such counselling was culturally appropriate. However, the Research showed that of those asylum-seekers who were interviewed and who had received counselling, all felt that they had benefited from one-to-one sessions.



An area in which there was still much disagreement was whether in-depth counselling should be provided in the first language of the client or whether it could be effectively done through an interpreter. This is clearly a difficult area as in many parts of the country there are not enough bi-lingual counsellors available. Furthermore some counsellors and other professionals felt ill-equipped or not skilled enough to support what they see as a client group with very specific needs.

The experiences of the Woodpath project, a counselling and therapeutic service set up in 2001, based at Refugee Resource in Oxford, seem to indicate that these difficulties can be overcome through the establishments of principles for good practice²⁹. These would include thorough training and support mechanisms for both counsellors and their interpreters.

Group work with people in a similar situation was seen as something that might provide support and be appropriate. For example providing a space for African refugee women to just talk and share experiences would be a valuable thing to do, regardless of whether it was labelled as mental health support.

Some stakeholders currently involved in counselling or working with those with a mental health need in this group wanted to stress that as with other patients with mental health needs sometimes the primary focus for support is on very practical things. For example helping the client to resolve an issue with their housing or their ability to make their own culturally appropriate food. It is suggested that such an integrated approach be followed with this client group, although the irony being that many of these very practical things are exactly what has been 'taken away' by the person becoming destitute.

Perhaps what was most striking with regard to mental health provision was that which was provided informally. Stakeholders and individual clients both spoke of the value of having or providing a welcoming space where clients were treated with dignity and respect. Often such spaces are provided seemingly informally (although a lot of work goes on in the background to provide them) and they provide significant mental health support, as well as access to practical needs and information. One such example is the LINKS Project in Hastings.

CASE STUDY

The LINKS Project Hastings

The LINKS Project is a good example of a successful and creative collaboration between the Health Authorities and others who are trying to meet the needs of this client group. Arising from work on issues such as sexual health promotion with asylum-seekers and others within the BME Community in Hastings, workers on the project became increasingly concerned about destitute asylum-seekers and their mental health. They wanted to find a way to provide support that would be effective, accessible and friendly. In 2005 a drop-in was established based in the WRVS building in St. Leonards (Hastings). The overall aim of the LINKS Project is encapsulated in the mission statement:

'The Project aims to provide a welcoming and comfortable environment in which members of Hastings' diverse refugee, asylum-seeker and black and minority ethnic (BME) communities can access a range of advice and support services under one roof. The project will be responsive to, and respectful of the needs and interests of its users and place these at the heart of its activities and future developments.'

Under this umbrella the drop-in has become a focal point that has enabled other service providers to access asylum-seekers (and others within the BME community). The Project currently provides advice and support in the following areas:

- ❑ *Employment*
- ❑ *Health*
- ❑ *Family support*
- ❑ *Debt advice*
- ❑ *Support and opportunities for young people*
- ❑ *Clothing and practical items*
- ❑ *Educational signposting*

Organisations participating in the Project include: Tomorrows People, Pulse, Working Neighbourhoods, Hastings and St Leonards Primary Care Trust, Women in Action, Citizens Advice Bureau, WRVS and the St Vincent de Paul Society, Migrant Helpline and NASS. Individuals from the local community have also volunteered their services. A Community Development Worker employed by the Hastings & St Leonards PCT facilitates the Project. This role and the Project as a whole is overseen by a Steering Group that currently consists of people from the following organisations: Hastings & St Leonards PCT, Hastings Voluntary Action (HVA), Women's Royal Voluntary Service (WRVS), Migrant Helpline and Tomorrow's People.

The strengths and main achievements of the Project include:

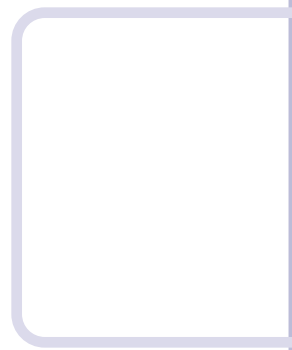
- ❑ *The establishment of an effective partnership between key organisations who come together to look at the needs and provision for this client group.*
- ❑ *Consistently high usage by members of the refugee, asylum-seeker and the BME community.*
- ❑ *The establishment and expansion of a 'One-Stop Shop' service for clients (this grew from two-hour sessions to a whole day a week).*
- ❑ *The provision of good quality advice and support to a significant number of clients.*
- ❑ *Enormous emotional and mental health support to these clients.*

It is hoped that that Project will grow and adapt as long as the needs continue.

What these experiences and views led towards was a conclusion that delivering any mental health provision needs to be approached in a both flexible and appropriate way.

7.5. Voluntary sector responses

There are a wide-range of voluntary sector agencies involved with this client group in the area. They include Refugee Specific Agencies such as Migrant Helpline, Refugee Action, Refugee Council and Winchester Visitors Group alongside organisations with a wider scope, such as the Red Cross and Citizens Advice Bureau. There are also a significant number of smaller projects or organisations and Refugee Community Organisations (RCOs) as well as faith groups. There was a lot of concern amongst all of these voluntary sector groups about this client group and a willingness to find further ways to address their needs. Organisations wanted to improve services while at the same time highlight that this group existed. There was a sense that Government and others are in a sense of denial about what is happening and need to be challenged about this. This is reflected in some of the recommendations at the end of this section.



It would be fair to say that there is no single agency with a specific mandate to support this client group. Linked with this lack of mandate is the challenge to secure funding for any specific work. Many organisations that are funded for specific activities with refugees and asylum-seekers have found that this work is being encroached upon by the needs of this group, an activity for which they are not funded. Despite this there are some excellent responses by the voluntary sector towards this client group. In both Portsmouth and Brighton & Hove for example there are projects led by the voluntary sector that provide a focal point for provision and manage to do so with remarkably few resources.

CASE STUDY

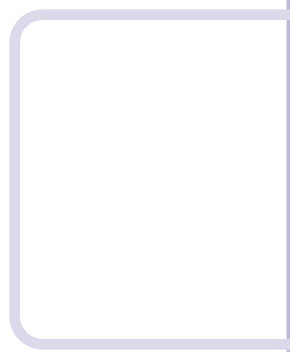
A Tale of Two Cities - Case studies from Brighton & Hove and Portsmouth

The Brighton Voices in Exile

Brighton Voices in Exile is a faith-based project that welcomes all people of different nationalities and backgrounds. Based in the Church built for Brighton's Royal Pavilion a project has evolved that is catering solely to the needs of asylum-seekers who are destitute (including some with mental health needs). Like many similar projects, its origins came from concerned individuals who were coming across an increasing number of such destitute in the City in the last two years. Some initial provision was established using volunteers. At the same time a more in-depth needs analysis secured more funding to enable the Project to employ a full-time worker. At a weekly drop-in there is both a welcoming environment where clients can mingle as well as get access to the following: one-to-one support on advocating access to mainstream services, signposting to legal services and agencies, practical support to non-perishable food, clothes and toiletries, financial support to those who are destitute or seeking asylum as well as public awareness raising. The project utilises significant numbers of volunteers and the employed worker is very active throughout the week with follow-up support to clients. It actively raises money for its work and the client group. While there are still limitations on what the project can provide and it is still evolving, it does provide an essential focal point for work in the City with this group. It is not the only place where clients can get support but for many is the first port of call and provides a central point where donations can be channelled. The value of the welcoming aspect of the drop-in cannot be overstated. Clients feel accepted and safe. It is an environment where people feel secure enough to both laugh together and cry. As this Project develops it can build upon an enormous amount of skill and dedication. It can also provide a useful bridge between those faith communities concerned with the issue and the non-faith sector.

PARS

As in Brighton and Hove PARS is a project for destitute asylum-seekers based in a Church. It operates a drop-in on two days of the week and gives clients access to a range of services including: food, clothing, advice and signposting. It does this in a very welcoming and informal environment where clients are able to talk and eat. The emotional benefits of this cannot be understated. It provides a focal point within Portsmouth for provision for this client group, although compared to some cities there seem to be a smaller range of organisations that can compliment this work. It is based in a centre where other projects exist. The advantages of this are not only that it is a well-utilised and accessible environment but that some infrastructure support can be spread across these different projects. As with many similar projects, resources are limited and insecure but it achieves an enormous amount despite this.



There are several organisations in the area that are running supportive schemes for people with mental health problems or other health needs, such as being HIV positive. Furthermore a range of voluntary sector players provide for other excluded groups, such as the homeless. However it is not always easy for asylum-seekers to get access to these schemes or support for a variety of reasons:

- Some schemes are residential and unfortunately exclude people who have no access to Housing Benefit.
- Some 'mainstream' voluntary sector partners are not aware of the needs of this client group or feel that they don't have the skills or expertise appropriate to support this group.
- Some indigenous users of other voluntary sector providers resent asylum-seekers accessing those services.
- Many voluntary sector providers have limited and precarious resources and what are often excellent projects fold because there is not continuation of funding.

The involvement of the wider voluntary sector in meeting the needs of asylum-seekers facing problems due to mental health needs and destitution should be encouraged. The traditional or mainstream voluntary sector has a huge amount of experience in catering to excluded groups and can be an enormously useful ally in advocating for this group.

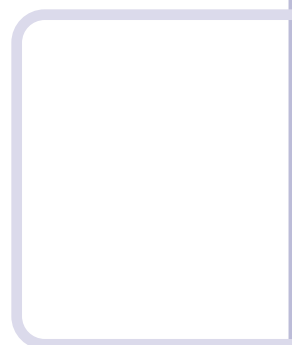
7.6. Local Authority support for 'vulnerable' asylum-seekers

'Destitution as a policy doesn't work. There is a lot out there [in the Local Authority area] but much is hidden. For example there are many people living in very overcrowded and potentially dangerous conditions. This is a concern to Local Authorities and I am sure that the costs [of destitution] will be greater in the long run if we don't find a sensible and humane way of ending the exclusion of this group.' Local Authority Worker

As with the Health and Voluntary Sectors there are many people working within Local Authorities who are concerned about this client group and have striven to find ways to meet their needs. However this is often done in the absence of an overarching strategy or an explicit policy endorsement within the Authority. In the study we have come across some examples of excellent support that individuals working for Local Authorities have managed to devise for this client group. This good practice can be built upon and we have made some suggestions as to how below. However given the political sensitivity of the issue within Local Authorities we have kept the references to the practices described below anonymous.

It could be said that there is an ongoing discussion between local and central Government as to roles and responsibilities, and importantly who is funding these roles.

'Local Authorities are running a parallel budget system. The government is out-sourcing their responsibilities to Local Authorities.' Discussion group member.



Such a discussion covers destitute asylum-seekers for whom no one seems to take overall responsibility (for their material needs or mental health). Anything that a Local Authority does provide must be done within the law and the key statutes applicable here are the Community Care Legislation and National Assistance Act. For a fuller description of these see Section 2 (Background to the Research). Providing support under these measures becomes an option when all other sources of funds have been exhausted - Section 4, family and friends for example. The crux of any such provision is based around the assessment of the vulnerability of the asylum-seeker. If someone is deemed vulnerable enough for support then a major constraint was the issue of funding. One authority described the cost of residential care for one coming to £1000 per week.

The Research showed that the interpretation of their duty to care in this context was quite varied between the Local Authorities covered by this study. For example, one authority has a policy of not removing children from mothers who are able to function appropriately as mothers. They are supporting several women who have lost their right to appeal and as a result currently have a £12,000 overspend. Another supports over 50 destitute asylum-seekers on the grounds that destitution is making the individuals concerned extremely vulnerable and that their mental health is deteriorating to the extent that their life is threatened. It is clear that someone with a particular need arising out of their destitution would be treated differently depending on which Local Authority they were based in. It is also clear that vulnerability is not an automatic pathway to support from the Local Authority. Furthermore it can be very difficult to access such support without the help of an advocate, such as a solicitor or advice worker. By definition many destitute asylum-seekers have exhausted all of their legal aid provision and no longer have access to a solicitor. Also some Social Services were not seen as approachable or sympathetic:

"To get any assistance here under this (legislation) you would have to convince them (Social Services) that you are about to jump into the sea." Local Health Worker

Where support is given it often does not seem joined-up. For example if a destitute asylum-seeker is given support under Community Care legislation because they are destitute and have mental health needs, this support should be more than just bed and breakfast. One destitute asylum-seeker thus supported who was interviewed for the study talked of his frustration at being in accommodation where he could not cook and had to leave the accommodation throughout the day, only being allowed to return in the evening. Many mental health professionals would say the key aspect of much mental health support is focussing on practical issues like suitable accommodation and allowing clients to have more control over their lives.

The Research also identified destitute asylum-seekers supported by Community Care being referred to solicitors to get advice on using their health status to support their claim for asylum.

Given the absence of overall policy it is amazing that some Local Authorities provide what they manage to. There are many individuals in Local Authorities leading the way in finding a better way to support this client group.

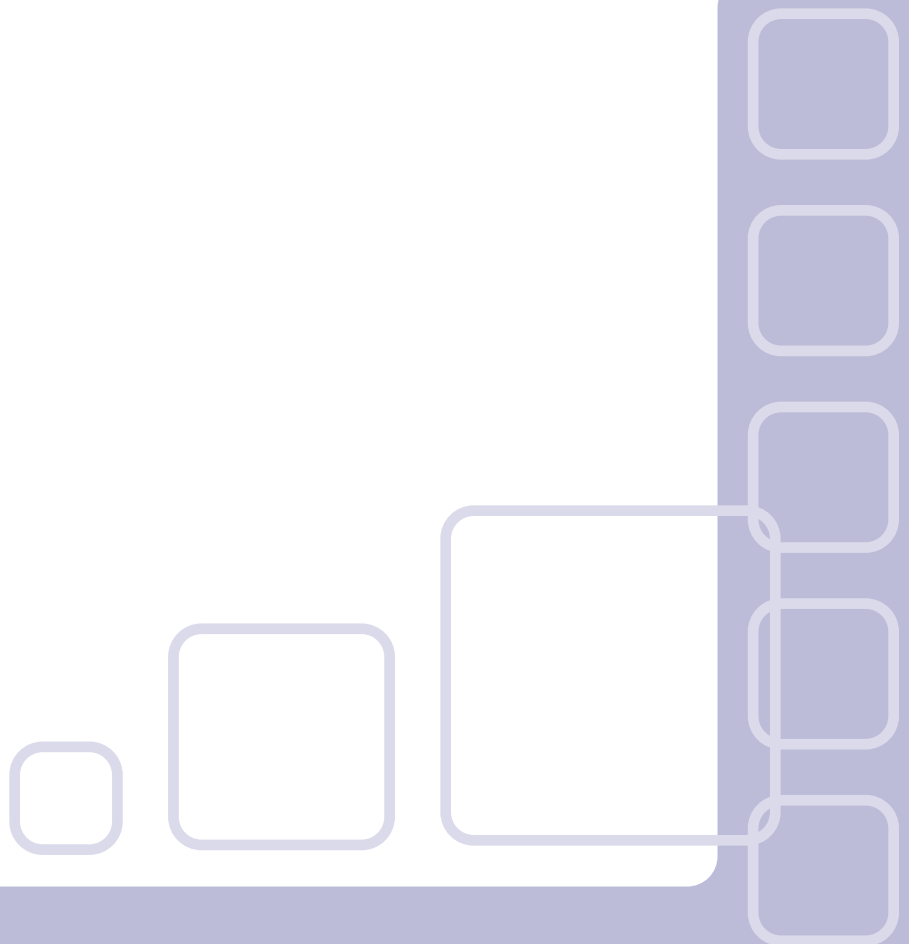


7.7. Co-ordination of services

In all the areas looked at in the study there are examples of co-ordination amongst voluntary and statutory service providers who are working with refugees and asylum-seekers, the Brighton and Hove Refugee Forum and the Portsmouth Asylum Support Group facilitated by Refugee Action, to name two. These groupings came together to share information and to promote more effective ways of working with the broader refugee and asylum-seeker client group. The specific issue of destitution and mental health amongst asylum-seekers has been discussed at all of the forums as part of this study. In all forums concern has been expressed about the needs of this group. However the forums are not necessarily decision making bodies and the step beyond information sharing requires perhaps more specific sub-groups from these forums to take forward how services are co-ordinated specifically for this client group.

7.8. The needs of staff and volunteers

Across all of the sectors there was recognition of the challenges faced by staff and volunteers working with this client group. This was not to minimize the greater difficulties experienced by the clients themselves but is a professional perspective on good working practice for staff. Many staff felt that they are not able to do very much for the clients in question (although in fact they do an enormous amount) and this is obviously a very stressful and potentially demoralizing position to be in. Many organisations had specific policies and practices of support for staff where these issues can be managed. This is not only helpful for the staff person concerned but also improves the service and provides another mechanism for monitoring the overall situation.



Section 8:

Key Conclusions and Recommendations

The following are some key recommendations that the researchers have identified as issues that need to be addressed in order to meet the mental health needs of destitute asylum-seekers more adequately.

1. Recommendations specific to Health Services

1.1. Eligibility to primary and secondary health care.

The route to mental health services is mainly through the GP. There is evidence that failed asylum-seekers are in many cases accessing primary care and receiving medication from sympathetic GPs, who are implementing their right to exercise discretion in providing primary health care to failed asylum-seekers (see Section 7.1. for information on entitlements to primary and secondary health care for failed asylum-seekers). At the same time however, there is evidence that some GPs are refusing to take on failed asylum-seekers. We recommend that:

- PCTs and GPs in all areas should take a moral stand and support the entitlement of failed asylum-seekers to both free primary and secondary health care.

1.2. Guidelines for staff on working with refugees and asylum-seekers.

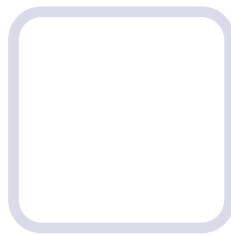
Guidelines on the care of refugees and asylum-seekers have been shown to be very effective in providing staff with a benchmark against which to measure their own practice and improving skills and competencies within the workforce (see Appendix G). Such guidelines can include procedural information, a named person to monitor standards of service for refugees and asylum-seekers, establish clear lines of communication and put in place systems for staff support. We recommend that:

- All services (including GP surgeries, NHS departments) should draw up and adopt Guidelines on the care of refugees and asylum-seekers. This would include guidance on the treatment of failed asylum-seekers, use of interpreters, staff training, and identifying a link person amongst others.

1.3. Training of staff.

Some health care professionals are genuinely anxious about their skills in meeting what they see as the specialised needs of this client group, particularly in the area of mental health needs. Staff who control access to services were felt to be either very ignorant of the needs of asylum-seekers or wilfully obstructive. All health authorities should resist a culture of work in which front line staff take on the role of immigration officers and ask individuals for proof of residence before allowing them to access their services. Training would mitigate this happening. We recommend that:

- There should be clear training and guidance provided to GPs and all health care staff on the health of refugees and asylum-seekers. This would include awareness of working transculturally, working with interpreters, the physical manifestation of psychological stress, trauma and health problems such as HIV and TB.



1.4. Outreach

Some of the best practice observed in the Research occurred where service providers had sought imaginative ways in which to provide their services. A successful model that we came across is 'The Links' in Hastings and St. Leonard's. This is a drop-in centre where a range of welfare advice, health, counselling, legal and other services are offered in partnership with a range of service providers, both voluntary and statutory. The services are aimed at the wider BME community and include failed asylum-seekers. We would recommend that

- This model (see Section 7) be replicated in all of the major towns where there are destitute asylum-seekers.

1.5. Counselling Services

The routes to counselling taken by those interviewed as part of this Research were mainly through coming into contact with another service, such as a solicitor, rape crisis centre or the police. Those that received counselling found it very helpful. However, it is a complex area (see Section 7). We recommend that:

- PCTs support the development of counselling services and that these should include failed asylum-seekers as part of their client base. The form these services take may differ from region to region. However, the use of properly trained and qualified interpreters to work alongside a counsellor is central to the success of any service.

2. Recommendations specific to Local Authority services

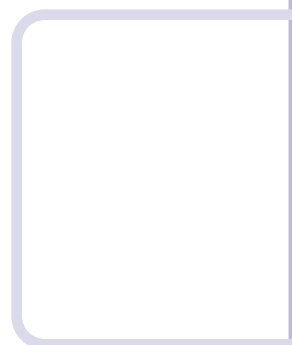
2.1. Supporting failed asylum-seekers

The Research found some discrepancy and ambiguity in the way Local Authorities were interpreting their responsibilities of social care for failed asylum-seekers. We suggest that greater liaison and sharing of ideas is needed between departments. This should include social services and housing as well as other relevant departments. This would be to develop more creative ways of interpreting the responsibilities of social care services towards failed asylum-seekers who are vulnerable, and maximising existing resources. Specifically we recommend Local Authorities:

- Devise a overall care package for destitute asylum-seekers who are deemed vulnerable under Community Care legislation.
- Liaise effectively within both the Local Authority itself and with the Health Authority and voluntary sector about providing joined-up care.
- Develop or build upon mechanisms for joint advocacy with the voluntary sector on the needs of this client group.
- Adopt training for staff about the needs of this client group.

3. Recommendations applicable to coordination and maximising resources

Whilst there were some examples of good practice (see Section 7), there is a need for a more strategic approach, bringing together housing, health, social services and NASS to provide an integrated package of support for failed asylum-seekers. The appropriate lead for the recommendations listed below will vary from area to area. However, we suggest SERASC should take a lead in ensuring the effective mechanisms are established.



3.1. Responding to immediate threat of destitution

Although the majority of destitute asylum-seekers are at the end of the asylum process, there are a significant number who are made destitute because of poor procedural difficulties. For example, people granted refugee status lose their NASS support after only 28 days. Often they cannot access mainstream support within this time frame and end up destitute.

- There needs to be more liaison over the termination of NASS accommodation for all asylum-seekers. This would be to eliminate procedural destitution as well as give all support agencies the opportunity to help failed asylum-seekers explore the options available to them. Those involved should include NASS, voluntary sector agencies, an appropriate health service, social services and accommodation providers.

3.2. Responding to more long-term needs.

- The good practice of having forums for co-ordination should be continued.
- Ways should be found to make other mainstream (non-refugee) provision accessible to failed asylum-seekers, such as homeless hostels, women's refuges or specialist health projects such as those catering for people who are HIV positive. This should bring together refugee agencies, health providers, social services and others as appropriate.
- These forums should be fully integrated with the Regional Strategic Co-ordinating Groups as the work with this client group has a relationship to dispersal and integration.

4. Recommendations for good practice

4.1. Data

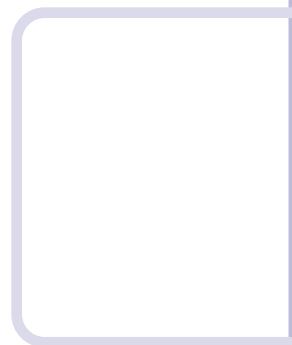
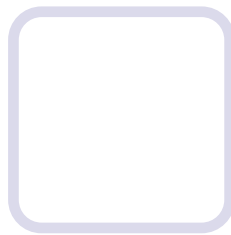
There was a distinct lack of data available on the use of services by asylum-seekers, as there was about failed asylum-seekers as a whole in the region. The need for such data is a vital part of both adapting service provision and advocating on the issue.

- Statutory services should develop ways to record numbers in the spirit of equal opportunities monitoring, whilst at the same time ensuring that asylum-seekers are not identified in a negative way that may lead to a denial of services or the break down of confidentiality.
- Voluntary sector agencies involved with destitute asylum-seekers should adopt some baseline recording mechanisms for recording both the numbers involved and the reasons for destitution.

4.2. Communication.

Key for many asylum-seekers is the ability to have both their needs understood and to be able to understand their rights and responsibilities. Many had found that their initial asylum claims had faltered because of poor or non-existent interpreting provision. In the same vein, many health practitioners expressed a frustration at the difficulty of providing a service in the first language of the client. While interpreting services do exist in the region, there seemed to be evidence that many services were not using these services systematically. Within the region covered, there were variations on the availability of interpreting services. We recommend that;

- Access to properly trained and qualified interpreters should continue to be a priority for health and social care services. Resources should be found to develop community interpreting services such as Sussex Interpreting Services.
- That the language barriers to accessing services should be minimised by ensuring service level agreements are drawn up by PCTs with language services



5. Recommendations for addressing national policy

5.1. National Conference

There is much work with this client group all over the country (and in Europe) and there would be a benefit from bringing together practitioners to share good practice and experience. We recommend that SERASC hold such a meeting across the national Consortia.

5.2. Regularising status of failed asylum-seekers who cannot return.

The position of asylum-seekers who cannot return to their country of origin is inhumane. Many who should be receiving Section 4 support are not. We recommend that:

- NIMHE and SERASC press for the Immigration & Nationality Directorate to take responsibility (or under the New Asylum Model, the case owner) for identifying who should qualify for Section 4 support.
- When it is impossible for a failed asylum-seeker to leave the UK, they should be granted some form of leave to remain in the UK, and be eligible to work and support themselves.

5.3. Legal advice and support

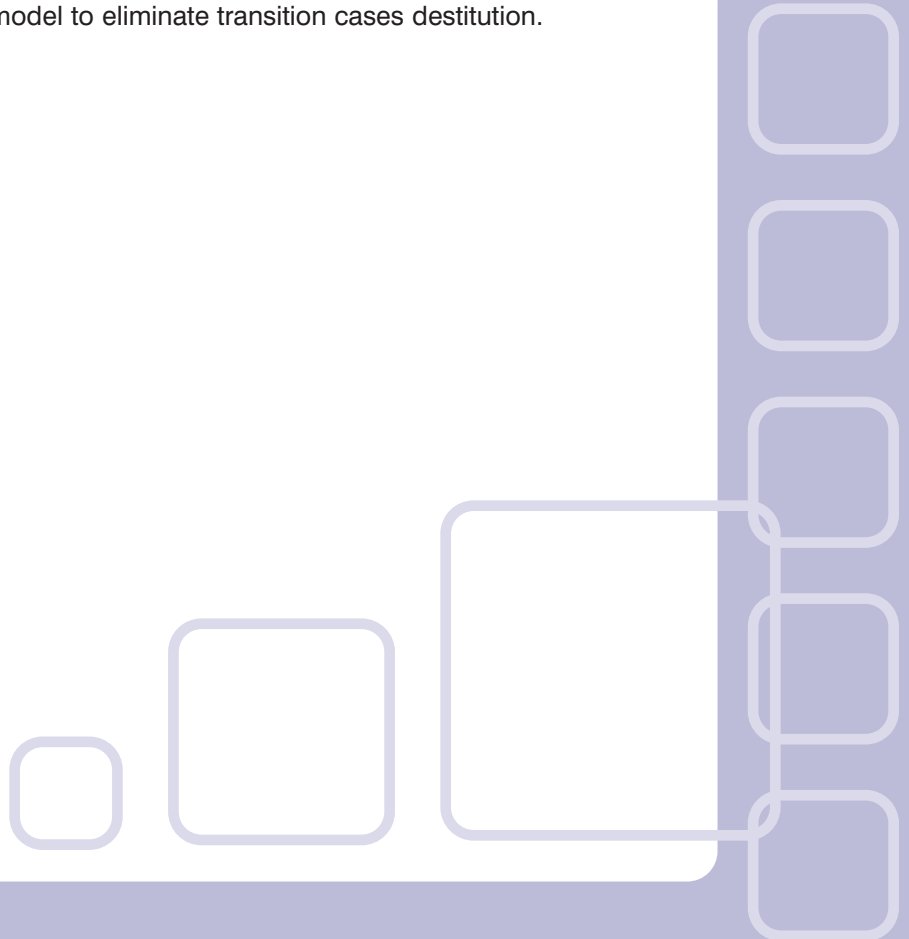
When working with this group of people, all services need to appreciate how the insecurity of their immigration status is of dominant concern. At the core of so many of their problems was the lack of access to good legal advice. Actions that will change the current policy limiting legal aid and hence access to good quality legal advice are needed.

- All stakeholders should continue to press the government to implement a system which makes access to legal advice and representation possible for asylum-seekers at all stages of the asylum process.

6. Recommendations for improving communication between NASS and other services

There are many individuals working within NASS to ensure the provision of an efficient and sympathetic service. However, the Research uncovered a continuing need for greater liaison between NASS and other services, at all stages of the process. We recommend that:

- NASS staff and NHS staff in induction centres review how they liaise with health services in dispersal areas.
- Close liaison between NASS and all relevant services (see Recommendation 3) to eliminate all forms of procedural destitution.
- The adoption of the Sunrise (<http://press.homeoffice.gov.uk/press-releases/233351?version=1>) model to eliminate transition cases destitution.



APPENDIX A - METHODOLOGY

A. Objectives of the Research

In conjunction with the steering group, specific aims and objectives were drawn up for the Research. These were identified as:

- 1) To draw up a picture of the current use of mental health services amongst asylum-seekers and refugees in the South of England.
- 2) To explore cultural attitudes prevalent among the client group towards mental health care and identify the extent of refugees in need of but not benefiting from formal mental health care.
- 3) To explore and analyse the scale of destitution amongst refugees and asylum-seekers in the South of England.
- 4) To provide a realistic assessment of the capacity to respond fully to these issues in the region, in both the statutory and voluntary sector.
- 5) To give a voice to the perspective and views of refugees and asylum-seekers, providing a platform that can both validate and respect their experiences.
- 6) To make recommendations for service delivery to refugees and asylum-seekers which are fully owned by providers and service users alike.
- 7) To produce reports with recommendations alongside other material that can be used to train and inform staff and service users.
- 8) To launch the Report and its findings at a series of meetings in the region, to which would be invited not only stakeholders involved in the Research itself but also other bodies such as the Home Office and Regional Funding representatives.

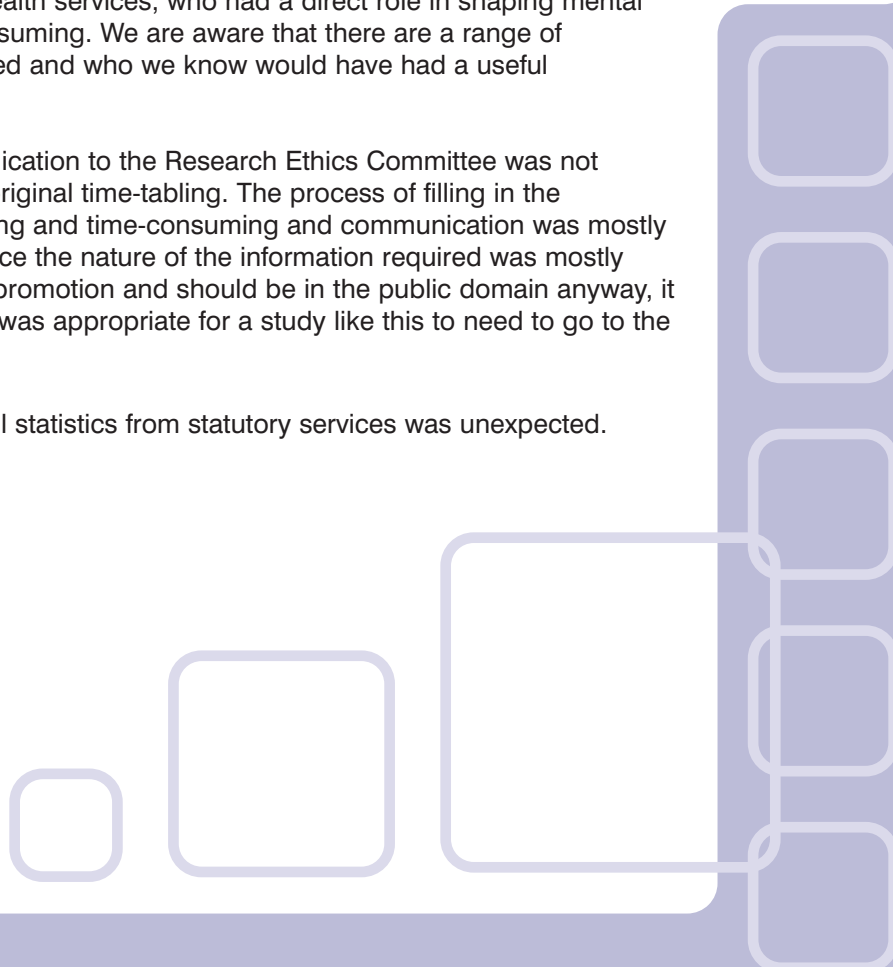
These have mostly been met, within the limitations placed on the Research, detailed below.

B. Limitations placed on the Research

Firstly, the scope of the Research was large and clear parameters had to be in place in order to be able to complete the study on time and within the resources available. This meant focusing the study on the dispersal areas to the exclusion of a number of areas such as Reading and Slough, which it would have been useful to have included. In addition, identifying individuals within key strategic posts within the health services, who had a direct role in shaping mental health service provision, was time-consuming. We are aware that there are a range of individuals who we have not interviewed and who we know would have had a useful contribution to make.

Secondly the time required for an application to the Research Ethics Committee was not something that was factored into the original time-tabling. The process of filling in the application form was extremely daunting and time-consuming and communication was mostly only possible through the website. Since the nature of the information required was mostly information that was related to health promotion and should be in the public domain anyway, it does raise a question as to whether it was appropriate for a study like this to need to go to the Ethics Committee.

Thirdly, the difficulty of obtaining useful statistics from statutory services was unexpected.



C. Overall impact of the Research

The overall impact of the Research was anticipated to be three-fold:

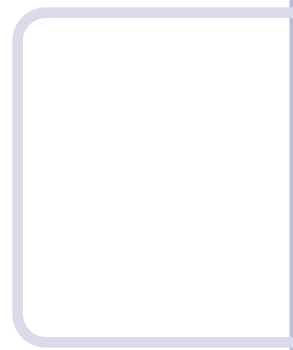
- Service providers will be better able to tailor their services to both the mental health and physical needs of refugees and asylum-seekers.
- Those service users will be more aware of what is on offer from the statutory and voluntary sector.
- Services will be provided in a cost effective manner. For example early identification of and appropriate responses to mental health needs alongside those of the destitute are more likely to avoid costly interventions at a later crisis stage after a persons condition has deteriorated.

D. Methodology

The Research criteria identified Portsmouth, Brighton & Hove, Hastings & St. Leonard's, Oxford and Kent as priority areas. Through further discussion and consultation, it was agreed that the Research would concentrate on Portsmouth, Brighton & Hove and Hastings & St. Leonard's.

A number of methods and approaches were used:

- Desk research to identify existing information on the mental health needs of refugees and asylum-seekers and identify good practice models. This also contributed towards the drawing up of a benchmark against which existing services in the area could be measured.
- An initial list of over 75 stakeholders was drawn up, identifying key stakeholders amongst health services and refugee organisations and services. A fairly representative total of 31 stakeholders contributed to the analysis developed through the Research of the ability of services to respond to the needs of this client group. Interviews were conducted with a range of representative service providers including statutory, voluntary and community sector services, NHS staff, refugee organisations, police, homeless hostels and other staff in organisations working with refugees and asylum-seekers in the region. (see Appendix). This contributed to the mapping exercise, identified gaps and provided anecdotal evidence of the experience of staff in dealing with destitute asylum-seekers.
- In-depth interviews with refugees and asylum-seekers to collect evidence on what works within current services and what doesn't. This also provided an opportunity for refugees to share their stories and perspectives. 40 asylum-seekers and refugees were interviewed one-to-one, representing a range of nationalities and a representative mix of gender. Individuals to be interviewed were identified through the support services for destitute asylum-seekers. On the whole, this proved to be quite successful.
- A number of regular forums included a special item for the Research (listed in the Appendix) in which participants were given the chance to contribute their views and experiences of the research questions. Special discussion groups were also set up specifically to address the research questions.
- Existing data held by service providers such as drop-in centres, NHS mental health services and other primary care services, refugee organisations, accommodation providers and others was sought and analysed.
- Understanding regional initiatives and policies that may apply to this client group, such as the SERASC Strategy for 2006-2008.



APPENDIX B

INDIVIDUALS AND ORGANISATIONS CONTRIBUTING TO THE RESEARCH

Many people shared their thoughts with us during the course of the research for which we are enormously grateful. The list below indicates the range of people that we approached and who contributed towards the shape of this research. For some, their contribution may have been a brief telephone call, pointing us in the direction of other contacts, others participated in one of the discussion groups we held and others we met up with individually for more in-depth discussion. There were many others who contributed through wider meetings, who we have not necessarily listed. We apologise for any omissions.

Brighton

Lucy Bryson, Refugee Policy Co-ordinator, Brighton & Hove City Council
Mary-Jane Burkett, Interfaith asylum support worker, Chapel Royal Brighton
Richard Cartwright, Mental Health Worker Brighton & Hove PCT
Ann Fordham, Project Worker, Migrant Helpline, Brighton
John Holstrom, Assistant Chief Executive, Brighton Housing Trust
Paul WhiteHead, Senior Project Worker, Migrant Helpline Brighton
Stephen Silverwood, Manager, Refugee Advice Project, Money Advice, Community Support (MACS)
Sue Earlham, Refugee Advice Project, Money Advice Community Support (MACS)

Hampshire

Mo Francis, City College, Southampton
Christine Knight, Winchester Visitor's Group
Beverley Meeson, Focussed implementation site coordinator of mental health in Hampshire

Hastings

Mark Horan, Community Partnerships Officer, Hastings Borough Council
Lorraine Dickins, Community Development Worker, Hastings and St. Leonards Primary Care Trust
Kevin Dillistone, Health Promotion Advisor, Hastings and St. Leonards Primary Care Trust
Yasser Dirki, Co-ordinator, Hastings Kurdish Welfare Association
Christopher Maxwell-Stewart, Volunteer Society of St Vincent de Paul, Hastings
Marc Turczanski, Senior Project Worker, Migrant Helpline, Hastings

Kent

Mary Blanche, Head of Service Refugees and Asylum-Seekers, Kent County Council
Charles Bourner, Kent Refugee Support Group
Susan Fawcus, Operations Manager, Migrant Helpline
Annie Ledger, Chief Executive Migrant Helpline
Dr. Le Feuvre and colleagues of the Health Team for Kent Induction Centres
Pam Paine, Special Needs Coordinator, Migrant Helpline

Oxford

Jeremy Burrows, UASC Service Manager, Oxford
Penny Browne, Child Assessment service Acting service manager, Oxford
Funmi Durodola, Oxford Mental Healthcare Trust.
Hana Graham, The Bridging Project, Oxford
Dai Warburton, Asylum Welcome, Oxford
Amanda Webb-Johnson, Refugee Resource, Oxford

Portsmouth

Jan Blackman, Service Development Manager, Portsmouth Counselling Service
Tunde Bright-Davies Manager, PRENO
Angela Dryer, Portsmouth County Council Social Care
Lyn Gadnidzee, Coordinator, Ma Afrique Unity
Lucy Haworth, Clearsprings
Julia Hender, Portsmouth PCT
Mai Hoang, Portsmouth Vietnamese Community Association
Yan Chen Ishi, Red Cross
Dana Ibrahim, Kurdish Community
Shirley Jackson, SE Manager, Refugee Action Asylum advice
Maggie Knox, Manager, PARS (Portsmouth Area Refugee Support)
Carol Lambert, Clinical Nurse, Somers Town Health Centre.
Anna Mlynik, Consultant
Tony McCarthy, Community Development Worker,
Refugee Action Development & Integration Team
Kevin Oster, Consultant
Angela Park, Head of Child Psychology
John Parke, Consultant Clinical Psychologist
Frances Pilling, PMSG (Portsmouth Minority Support Group)
Barbara Probst, Cross Cultural Community Worker, Portsmouth Counselling Service
Susanna Rosenberg, Joint Commissioning Manager for Mental Health
Mandy Sellars, Head of Community Services, Adult Mental Health

APPENDIX C

LIST OF ORGANISATIONS CONSULTED WITH

Brighton Housing Trust
Kent County Council
Kent Refugee Support Group
Migrant Helpline
Refugee Resource (Oxford)
PARS
Portsmouth Counselling Service
Portsmouth County Council Care Services
Refugee Action
Sussex Interpreting Service
Winchester Visitor's Group

LIST OF MEETINGS HELD

20.02.06	Regional Police Forum
20.03.06	Portsmouth Asylum Support Group
13.04.06	Focus Group organised by Oxfordshire County Council, Asylum-seeker Service
20.04.06	Meeting organised by Consultant Clinical Psychologist, Portsmouth PCT.
21.03.06	Kent Wide Strategic Reference Group on Asylum-Seekers and Refugees
05.04.06	Hastings Multi-Agency Refugee and Asylum-Seeker Group
28.04.06	Chapel Royal Brighton Group session with asylum-seekers and volunteers
31.01.06	Kent Refugee Support Group Planning Meeting (Margate)
19.06.06	Migrant Helpline and Induction Centre, Dover.

REFERENCES AND SOME USEFUL RESOURCES

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Destitution

- Mayor of London (Feb 2004) Destitution by Design. Greater London Authority www.london.gov.uk/mayor/refugees/labyrinth_report.pdf
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