

Care Services Improvement Partnership **CSIP**

*NIMHE (National Institute of Mental Health in England)*

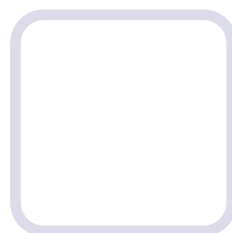


**South of England**  
Refugee & Asylum  
Seeker Consortium

# **Mental Health, Destitution & Asylum-Seekers**

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

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## Introduction

The mental health of refugees and asylum-seekers has been well documented in a body of literature that spans the experiences of refugees and displaced people of World War 2, as well as 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 the individual deal with the experiences of torture that led them to flee and 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, creating 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the legislation of the last decade is that significant numbers of rejected asylum-seekers have had all means of support withdrawn from them and are now destitute in the UK.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 context, it is not surprising that the mental health needs of destitute asylum-seekers should be neglected. There are other more pressing issues for this group of people. 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.<sup>1</sup>

This research is intended to contribute to our understanding of a group of people about which little has been recorded. These are destitute asylum-seekers who have no recourse to public funds and yet are denied the opportunity to support themselves. By concentrating on the dispersal areas of Portsmouth, Brighton, Hastings & St. Leonards, it provides a profile of destitute asylum-seekers who were dispersed to the South East region, their situation, experiences and mental health needs. It is 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.

<sup>1</sup> NIMHE (2004) 'Inside Outside - Improving Mental Health Services for Black and Minority Ethnic Communities in England' DH Publications, London.

**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 in order 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.

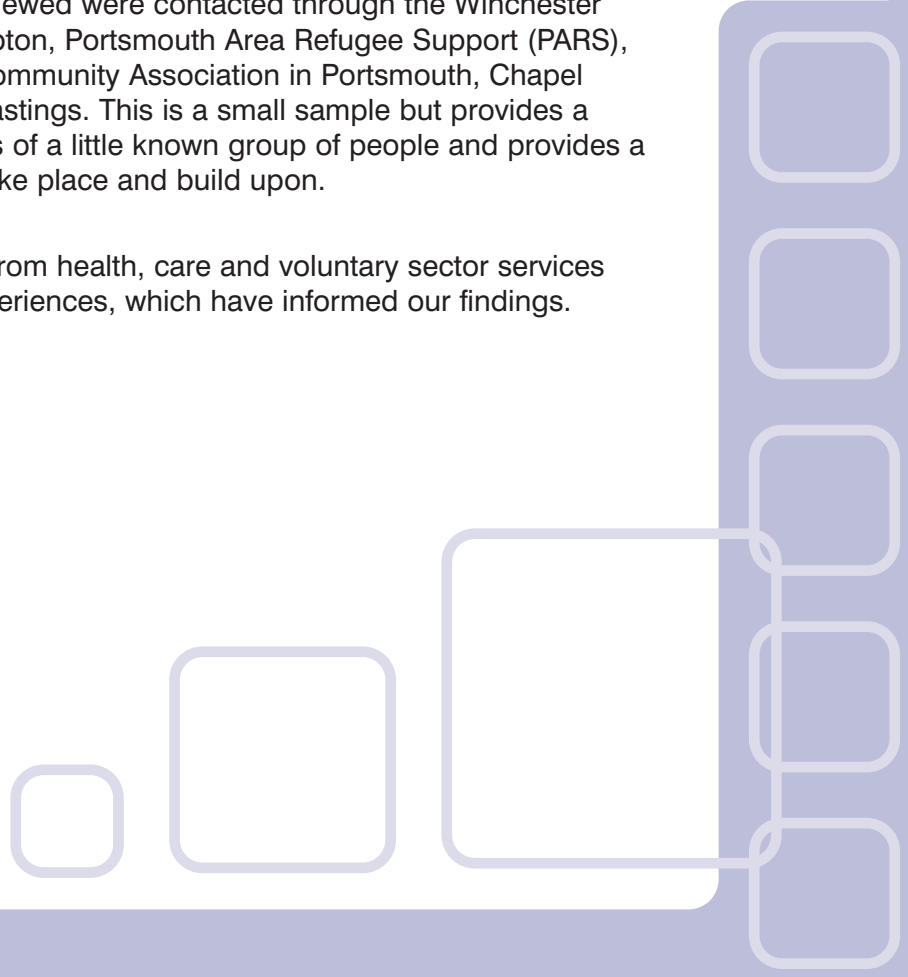
**What the research aims to do is to:**

- 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 contributed their thoughts and experiences, which have informed our findings.



### **Numbers seeking asylum in the South East:**

- By 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 were from Iran, Sudan, Eritrea, Iraq and the Democratic Republic of Congo.
- 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 is 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

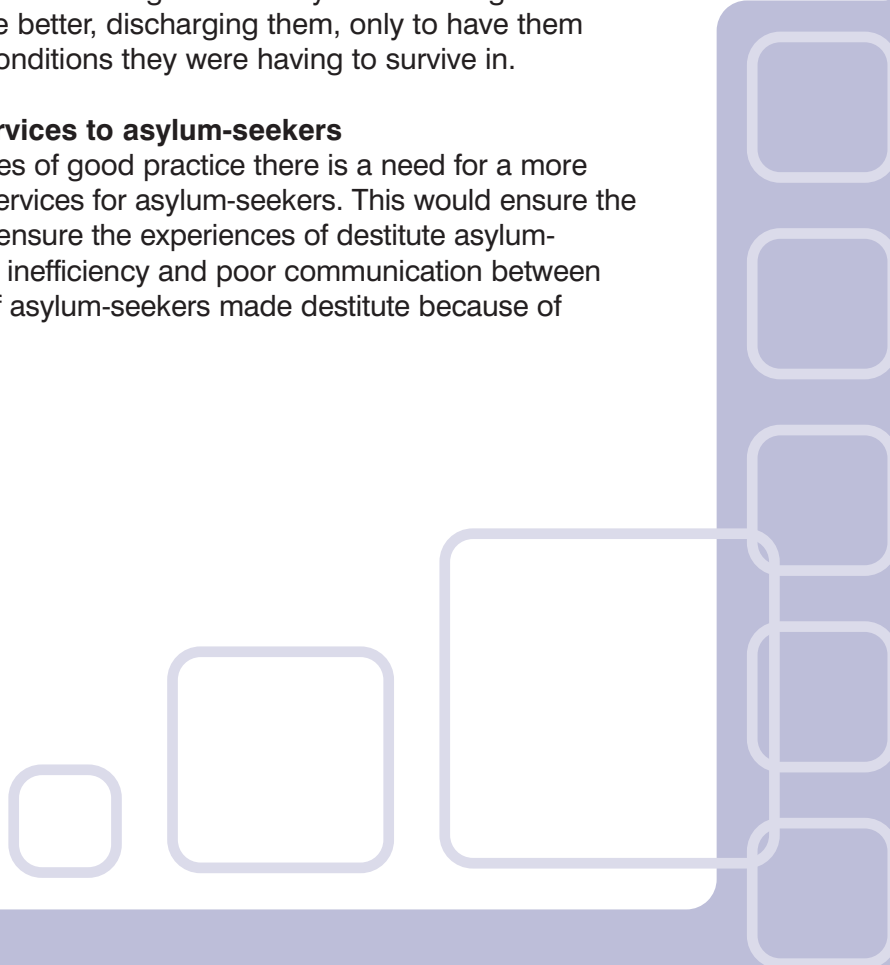
The regulations governing eligibility of rejected asylum-seekers to both primary and secondary health care is confusing and open to an interpretation that contradicts the first core principle of the NHS. This states that 'The NHS will provide a universal service for all, based on clinical need, not the 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 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 help 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. 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?
<b>1. Eligibility to health services</b>	<ul style="list-style-type: none"> <li><input type="checkbox"/> DH should 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.</li> <li><input type="checkbox"/> PCTs should 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.</li> </ul>	<p>Department of Health</p> <p>Primary Care Trusts</p>
<b>2. Regularising the status of rejected asylum-seekers</b>	<ul style="list-style-type: none"> <li><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.</li> </ul>	Home Office
<b>3. Coordination of services provision to all asylum-seekers</b>	<ul style="list-style-type: none"> <li><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.</li> <li><input type="checkbox"/> Each area should have a forum bringing together appropriate services to maximise resources and improve communication and efficiency. As already happens in some regions e.g. Portsmouth and Hastings), these forums should be fully integrated with the Regional Strategic Co-ordinating Groups.</li> <li><input type="checkbox"/> NASS and NHS staff in induction centres should review how they liaise with health services in the dispersal areas.</li> </ul>	<p>NASS</p> <p>SERASC</p> <p>Induction centres</p>
<b>4. Local authority support for rejected asylum-seekers</b>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Local authorities should devise an overall care package for destitute asylum-seekers who are deemed vulnerable under Community care legislation.</li> <li><input type="checkbox"/> 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.</li> </ul>	<p>Local authority care services.</p> <p>NHS Community Development Workers</p>
<b>5. Putting in place baseline good practice measures for interpreting, training and data collection</b>	<ul style="list-style-type: none"> <li><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.</li> <li><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.</li> <li><input type="checkbox"/> Language barriers to accessing services should be minimised by ensuring service level agreements are drawn up by PCTs with language services</li> <li><input type="checkbox"/> All services, but particularly statutory services, should develop ways to record this client group as service 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.</li> </ul>	<p>All health services</p> <p>Primary Care Trusts</p> <p>Primary Care Trusts</p> <p>Primary Care Trusts, NHS Trusts, Foundation Trusts</p>

Copies of the complete report can be obtained from:

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This 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 is one of 17 Focus Implementation Sites piloting this reform of services which centres on the commitment to provide appropriate and responsive services, engage communities and provide better information.

This report is only the beginning in how we shall tackle the issues raised by the document. In the weeks and months ahead NIMHE and the Consortium will be working to ensure that the recommendations are taken forward and the needs of this extremely vulnerable group of people are effectively addressed.

