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Supporting Refugees and People Seeking Asylum

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This submission forms Chapt 5 of *Sites of Confinement* (ed. V, Canning, European Group for the Study of Deviance and Social Control , forthcoming Oct.2014)

It documents a serious and disturbing example of breach of Rule 35 , alarming professional failures by hospital and detention centre staff, and an inhumane detention and deportation regime detrimental to the well-being of mentally ill and highly vulnerable persons.

The case study begins on p.3

SOCIAL WORK WITH REFUGEES EXPERIENCING MENTAL HEALTH PROBLEMS WITHIN THE UK ASYLUM SYSTEM

Introduction

This chapter outlines challenges faced by people seeking asylum in the United Kingdom. It focuses specifically on the treatment of applicants living with mental health problems, and explores the problems they can face in accessing health-care, both within the community and within detention centres, as well as factors which can affect the prospects of long-term recovery in the UK.

Through the lens of a case-study, barriers to accessing health care will be addressed, specifically in relation to finding a voice with which to express individual psycho-social requirements. The efforts of social workers from refugee community organisations to advocate on their behalf will also be identified. This particular insight is facilitated through my own role as social worker with *Revive*[1], a non-governmental organisation which provides practical and social support and legal advice for asylum seekers, refugees and other vulnerable migrants in order to promote and protect their human rights.

[1] Revive is involved with the training of medical professionals around best practice in the care of asylum seekers and refugees. Revive also takes part in the training of UKBA staff to improve decision-making around asylum applications. We campaign with service users for an end to destitution of asylum seekers in the UK.

Psycho-social support for people seeking asylum

The term "asylum" literally means "place of refuge". Its legal definition is the protection granted by a state to someone who has left their home country as a refugee for reasons consistent with the Geneva Convention. [2] The majority of people who access Revive's social work service experience psychological and mental health problems caused by trauma experienced in his/her country of origin, which is often further compounded by difficulties experienced in the UK. Revive's services include one-to-one long-term support with social workers, helping with identified needs such as signposting to other specialist voluntary sector organisations, accessing statutory health and social care services and advocacy, especially with the UK Border Agency. Social workers and volunteers accompany service users to important appointments and appeal hearings and undertake home visits when necessary. Social workers also run drop-in centres. A warm welcome and opportunities to socialise are provided at the centres by a dedicated team of volunteers as well as lunch, emergency food parcels, clothing and advice from qualified workers. We receive referrals to our social work department from services such as Clinical Psychologists, statutory Mental Health services and Freedom from Torture.

Research by Grey et al (2010) indicates that asylum seekers and refugees who have been treated inhumanely in their country of origin have a higher chance of recovery when they are accepted in to community networks in the host country as well as provided with access to appropriate services and legal recognition as refugees because this provides a sense of safety and a chance to rebuild lives. As they argue, "Factors in exile such as social isolation and unemployment are stronger predictors of depressive morbidity than trauma factors. Identified risk factors for development of PTSD and depression include a loss of social network, fear of repatriation and family separation" (Grey et al., 2010:180). Survivors of torture are more likely to suffer from psychological problems associated with trauma than other refugees (Craig, 2010: 14). Long-term psychological therapies and in some cases psychiatric medication have been proven to be effective for the treatment of asylum seekers and refugees with PTSD and other mental health problems (Kinzie, 2010:131-133).

Sites of Confinement: Detention of Asylum Seekers with Mental Health Problems

This brings us to consider detention of asylum seekers in the UK. According to official United Kingdom Border Agency (UKBA) policy asylum applicants who have suffered torture should not be confined in a detention centre unless there are "exceptional circumstances" [3] due to the stresses placed upon the detained person. This includes individuals with independent evidence of torture and those with a medical condition which cannot be satisfactorily treated in detention. However, a High Court Ruling last year (17th May 2013) called UKBA to account for not following its own policies. In each of these five test cases, the detainees said they had been unlawfully detained because of a systematic failure by UKBA staff to take the medical assessment process seriously. Medical evidence of torture had been ignored. The cases centered on the use of "Rule 35"[4] reports. If a doctor has concerns about the mental or physical

[2] *'A refugee is a person who: "owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of his nationality, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country" (*Article 1, 1951 Convention Relating to the Status of Refugees) In the UK an asylum seeker is someone who has asked the Government for refugee status and is waiting to hear the outcome of their application.(www.unhcr.org.uk)

[3] Section 55.10 of the UKBA's Enforcement Instructions and Guidance lists groups of people who are considered suitable for detention only in very exceptional circumstances.

[4] Rule 35 lays out requirements for practitioners working with detained asylum seekers. Further information available here: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/257437/rule35reports.pdf

well-being of a detainee in a detention centre according to law a "Rule 35" report has to be filed. [5] The judge in these High Court cases said that the system was "not working as it should" and Rule 35 reports had not been filed. The ruling declared that each of the men seeking asylum had been unlawfully detained by UKBA and they were subsequently released. All the claimants in the High Court case had been able to establish the unlawfulness of their detention through the assistance of Medical Justice, who provided access to independent medical experts. [6]

National Health Service (NHS) staff, both within the community and within detention centres, require adequate training and support in how to assess, diagnose and care for asylum seekers and refugees who are presenting with Post Traumatic Stress Disorder (PTSD) and other mental health problems. Patients are sometimes diagnosed with conditions such as "adjustment disorder"[7] when they may be in fact presenting with symptoms which could be indicative of Post-Traumatic Stress Disorder which is a more severe psychological condition that in some cases can cause the onset of acute mental illness (Kinzie, 2010:124). It is crucial that individuals receive appropriate support and/or treatment and follow up care following such a diagnosis. The treatment of asylum seekers and refugees experiencing complex trauma is the subject of considerable debate within Western psychiatry. There may be significant cultural factors which can complicate the assessment process and the appropriate diagnosis and on-going care of refugee populations, as well as debates around the Western-centricity of PTSD and psychiatry more generally (Grey *et al,* 2010, pp.178-180). However, it is almost universally acknowledged by psychiatrists that refugee survivors of torture can experience ongoing psycho-social impacts of such abuses, which may be compounded by difficulties in accessing mental health services and long-term, multi-disciplinary therapies as needed (Cross et al, 2010, pp.100-101).

The Impacts of Detention through the Lens of a Case Study

Last year, Mohammed[8], a user of Revive's drop-in service, was forcibly removed from the UK around two weeks after he was admitted to hospital suffering what may have been an acute psychotic episode. He had been refused asylum from a Middle Eastern country and his case was that he had been ill-treated and he feared retuning there. When he had been interviewed by UKBA during his asylum claim he had found it difficult to give a clear account of what had happened to him due to his psychological difficulties and lack of trust in UKBA officials following a history of persecution. He had been street homeless for months when he came to our drop-in service with a friend and he said that he survived mostly by eating out of bins. His UKBA accommodation had been terminated following the refusal of his asylum case and he carried his legal papers in a plastic bag which he kept in a bush where he slept at night-time. When he came to the drop-in centre every week he was offered advice and access to interpreters as he spoke little English.

Mohammed seemed very distressed when he came to the centre, but over the course of a few sessions he built up a trusting relationship with workers. He showed social workers scars from where he had self-harmed previously by burning himself on his arms. He was withdrawn and workers observed that he appeared to be "hearing voices" or responding to auditory hallucinations. He was very scared to seek medical help but after a drop-in session where he appeared particularly disturbed a social worker

[5] The Detention Centre Rules 2001

[6] In 2012, Medical Justice published a detailed report "The Second Torture" which found that the safeguards to identify victims of torture were failing at every stage and that torture survivors were routinely being detained in breach of Home Office policy.

[7] An adjustment disorder (AD) "occurs when an individual is unable to adjust to or cope with a particular stressor, like a major life event or difficult situation such as homelessness or social isolation".

[8] I refer to the service user in the following case-study as "Mohammed". This is a pseudonym to protect his identity.

encouraged him to go to the Accident and Emergency Department of the local hospital because he was clearly in urgent need of medical attention. The drop-in centre was closed early that day when the social worker who had been allocated as his key worker accompanied Mohammed.

During the mental health assessment at the hospital it was apparent that Mohammed's self-care was very poor and he told staff that he thought that others were telling him to harm himself. According to medical notes [9] his initial diagnosis following this assessment was of "agitated depression" and he was admitted for one week to a psychiatric ward as a voluntary patient. He was observed on the ward to be "passive" and not to eat much. He expressed suicidal thoughts and "occasional" hallucinations. No medication was prescribed and he was assessed as suffering from a possible "adjustment disorder". He didn't have access to an interpreter throughout medical assessments at the hospital despite his obvious difficulties in expressing himself in English.

During the time that Mohammed stayed on the hospital ward, his social worker rang the hospital twice to try to discuss options for his accommodation on discharge such as applying to the local authority's No Recourse to Public Funds department for temporary housing, but she found it difficult to communicate with the hospital. Only a week later he was discharged and was picked up directly from the hospital ward by UK Border Agency staff who had been informed by hospital staff of his presence there. An out-patients appointment with a psychiatrist had been arranged by the hospital for one week later but Mohammed could not attend this because UK Border Agency took him to a detention centre two hundred miles away.

All medical services at that time within the detention centre were provided by a private company. Mohammed was seen initially there by a General Practitioner (GP) and according to medical notes he was extremely withdrawn and scared. He told the GP that he was suffering from hallucinations which he didn't feel he could discuss much, of people hitting him, telling him to stay away from people and voices telling him not to speak. The GP decided that he was suffering from a psychotic disorder and prescribed him anti-psychotic medication. However, *a Rule 35 report was not submitted* and his detention continued.

Mohammed was then seen the following day by a detention centre psychiatrist for a further assessment and was diagnosed as having a possible personality disorder with no sign of psychosis. The anti-psychotic medication was discontinued and he received no further medical care from detention centre staff. At the request of his social worker Medical Justice arranged for an independent doctor to see Mohammed at the detention centre. According to the medical report he appeared to be suffering from thought disorder and he could not explain his history and his background well. He was still responding to hallucinations and he expressed strong suicidal thoughts. He appeared to be very traumatised. The doctor concluded that he may have been suffering from schizophrenia and recommended within the report that Mohammed was acutely mentally unwell and that he was unable to care for himself but that with appropriate medication and follow up care he could recover in the long-term. The report also warned that without treatment or support Mohammed was at severe risk of coming to harm.

Under Rule 35 guide-lines as part of UKBA's duty of care for detainees who may be mentally unwell and unable to provide a coherent account of their difficulties medical staff should consult with family and friends or other professionals who may be able to provide a history and background information. Mohammed's social worker urgently faxed over a letter to the detention centre expressing concerns for

[9] Medical notes from the hospital and detention centre were passed on to Medical Justice when ' Mohammed 'was in detention. and they were subsequently passed on to Revive.

his well-being. The letter stated that he had told staff that he had been ill-treated in his country of origin and it questioned the legitimacy of his continuing detention considering how acutely mentally unwell he appeared to be. A response to this letter from UKBA has to date not been received.

The Medical Justice report written by the independent doctor was urgently faxed to UKBA by legal representatives following their assessment. It could have formed the basis for a fresh asylum claim but due to the speed of the "removal" process it did not reach UKBA in time to stop the flight. Mohammed was expelled from the UK at the end of 2012, days after he had been admitted to the detention centre and around two years after he had come to the UK. He was forcibly taken back to the country from which he had fled. We have not heard from him again and his last contact with my organisation took place when he rang his social worker and informed her that he had been detained. His future is at best uncertain because he did not have any contact with family or friends who could have cared for him and mental health services in his country of origin are very limited.

A complaint was submitted by Revive last year to the hospital which cared for Mohammed prior to his transfer to the detention centre. A response was received following a detailed investigation. It recognised that there were shortcomings in Mohammed's care. The hospital said that the purpose of contacting UK Border Agency was to "make arrangements for Mohammed's accommodation" and staff were "not aware" that UK Border Agency would detain him. The hospital staff stated that they thought they were acting according to his "best interests". However, the term "best interests" is usually used by professionals where there are questions about a patient's mental capacity to make their own decisions. Under the provisions of the Mental Capacity Act, in these particular cases any family and all professionals involved in the care of the patient should be consulted regarding the best option for discharge. [10] Although Mohammed was unwell he was well aware of where he was and where he didn't wish to be as he requested help from his social worker to get out of the detention centre as soon as he arrived there so he was capable of making his own decisions.

The hospital investigation found that there had been a breach of confidentiality because Mohammed had not consented to ward staff contacting UK Border Agency on his behalf and he was not consulted about this. The investigating officer included in her recommendations that hospital staff should receive "further training" on the care of people seeking asylum and that the member of staff who disclosed his location to UK Border Agency should have "supervision" with his line manager "to review his decision making in relation to the Code of Practice in respect of Patient Confidentiality." The investigating officer also found that the lack of access to interpreters was a concern and that communication by hospital staff with Mohammed's social worker was inadequate.

As from April 2013 responsibility for health-care in detention centres has been transferred from private companies to the NHS commissioner. This is a welcome change because standards of health-care should be raised and detention centres will be regularly inspected just as prisons are. Healthcare complaints procedures should fall into line with the rest of the NHS, although it is of course very difficult for a person to make a complaint when UKBA has returned them to their country of origin. The ultimate decision to release or to forcibly return a sick person who is in detention will still lie with the UKBA which has targets to meet (Burnett, 2000: 26). UKBA continues to allow discredited private companies such as G4S and SERCO to run detention centres.

[10] Mental Capacity Act 2005 (www.legislation.gov.uk)

It seems that the combination of factors leading to Mohammad's detention and expulsion from the UK built up to a "perfect storm". An adult with a history of ill-treatment and psychological problems became acutely mentally unwell following the refusal of his asylum case and subsequent destitution. He was let down by mental health services both within the hospital and at the detention centre prior to his forced departure from the UK. He was given several different diagnoses by medical professionals within a short space of time when he would have benefited from a long-term period of assessment, follow-up care from mental health services and psychological therapies. He made contact with mental health services at a time of crisis which was crucial for his long-term recovery and this could have led to his rehabilitation within the community and possibly a fresh claim for asylum.

Conclusion: individual, but not unique

Mohammed, like many asylum seekers living with mental health problems whilst adapting to a new system and host country, struggled to articulate and assert his needs. Due to his sense of powerlessness against the state, he trusted social workers to speak on his behalf and worked to find a community which could recognise and identify the issues he faced. He was temporarily provided with crisis support from his social worker but would have benefited from long-term social work support as planned. Mohammed fled his country with the expectation that he would be protected from further harm. This government rejected his application for refugee status and failed to recognise his right to be treated in a dignified way in the UK with due legal process.

Worryingly, Mohammed's case, although individual, is not unique but indicative of wider experiences of the asylum system. It is a cause for concern that there are recent cases highlighted within this article where medical staff worked with immigration departments with outcomes that were detrimental to the well-being of patients seeking asylum in the UK, even when staff were unaware of the potential consequences. It is a paradox that this testimony of Mohammad's experiences here in the UK as a person seeking "asylum" is only possible after the UK government rejected his own personal testimony and curtailed his stay here.

Many challenges lie ahead for NHS staff caring for vulnerable asylum seekers across statutory mental health settings so that the "best interests" of these individuals really can be protected. There is an important role for staff within refugee community organisations to work in partnership with medical professionals on behalf of service users with mental health problems to try to ensure that best possible outcomes can be achieved for the care and support of these vulnerable individuals. Oppressive immigration legislation enforcing destitution, detention and in some cases expulsion from the UK of asylum seekers who are in need of mental health care should and must be challenged.