Executive Summary

“When a person is vulnerable or has mental health problems the situation is more serious. It affects the work you do in therapy and it is a never ending problem….Mental health gets worse because of destitution and destitution causes mental health problems”. [quote from a client at the Glasgow Psychological Trauma Service].

When clients are destitute, or at risk of destitution, the impact on mental health is significant. Clinicians and service users described worsening mental health problems related to destitution. Destitution also increased clients vulnerability to further trauma and re-victimisation and interfered with clients getting the health treatment they needed. Overall the Glasgow Psychological Trauma Service staff do not believe destitution should form part of the asylum process.

Whilst destitution continues to be a feature of the asylum process recommendations are made in relation to providing co-ordinated trauma informed practical and psychological supports for destitute asylum seekers. Suggestions are made for increasing the rights of asylum seekers with the aim of reducing disempowerment and discrimination, and promoting mental health.

1. Introduction

The NHS Greater Glasgow & Clyde Psychological Trauma Service (GPTS) welcomed the opportunity to contribute to this report for the Equalities and Human Rights Committee (EHRC) of the Scottish Parliament. This report aims to describe the impact of periods of destitution on asylum seekers and refugees accessing our service. We have collated evidence directly from clients and contributions from our multidisciplinary team.

Clinicians at the GPTS were asked to reflect on the impact of destitution on clients and specifically consider:

- the mental health impact
- implications for therapeutic engagement
- recommendations aimed at addressing these issues

It is important to note the information below was gathered from a small sample of clinicians and service users within the GPTS and is therefore not necessarily
representative of all clients we work with. Responses were collated and summarised below.

2. Glasgow Psychological Trauma Service (GPTS)

The GPTS is a tertiary level mental health service, which offers multi disciplinary psychologically informed interventions to clients who present with Complex Post Traumatic Stress Disorder (CPTSD) following experiences of complex trauma. As a service, we work with some of the most vulnerable and marginalised individuals in society, including individuals seeking asylum and those granted leave to remain. We frequently work with clients experiencing prolonged periods of destitution. We offer both individual and group interventions in line with a phased based model for Complex PTSD (see Matrix, 2015).

Complex psychological trauma represents extreme forms of traumatic stressors, which are often life threatening and or physically violating, overwhelming, terrifying, and typically chronic rather than one time-limited (Courtois and Ford, 2009). The repetitive and prolonged nature of such events and often lack of opportunity to escape can have a significant impact on the individual’s sense of self; ability to relate or trust others; perception of the world; sense of safety and ability to manage day to day life. Furthermore, individuals often present with chronic hopelessness and helplessness and feelings of disempowerment. Post Traumatic Stress Disorder symptoms are also typically apparent and are characterised by involuntarily remembering of the traumatic event(s) (e.g. intrusions, nightmares, flashbacks etc), hyperarousal (e.g. sleeping disorders, problems concentration, anxiety symptoms etc); avoidance of trauma associated thoughts, situations and actions; and negative cognitions and mood (DSM-5, APA, 2013).

Examples of complex traumatic events/stressors include childhood sexual and physical abuse, recruitment into armed conflict as a child, being a victim of war, domestic violence, sex trafficking or slave trade, female genital mutilation, experiencing torture and exposure to genocide campaigns or other forms of organised violence.

Individuals reporting symptoms of CPTSD often describe a range of other co-morbid mental health difficulties including: depression; anxiety and acute stress disorders; psychotic illnesses; dissociative disorders; and self-harm/suicidal behaviours.

Clients seen at the GPTS who are destitute, or at risk of destitution, have experienced very severe traumas and are typically experiencing CPTSD and often comorbid physical and mental health difficulties. Coping with destitution represents a significant challenge to already depleted emotional and physical resources.

3. Destitution

Destitution is legally defined within Immigration Law as circumstances wherein a person does not have adequate accommodation or means of obtaining it, whether or not living needs are met. Destitution also includes circumstances where a person does have adequate accommodation or means of obtaining it, but can’t meet other essential living needs (Immigration and Asylum Act, 1999).
Evidence has shown that for asylum seekers and refugees’ destitution can occur at various stages of the asylum process (Crawley, Hemmings & Price, 2011). This includes:

- at the beginning of the asylum process before the initial claim is made. Delays in making the claim can be related to a lack of money to travel to Home Office facilities to make the initial claim.

- during the process due to interim periods before asylum support is instated and errors relating to an individual’s entitlement. Destitution may also occur during periods when a new claim is being submitted on different grounds for asylum seekers whose original claim has been denied.

- at the end of the asylum claim when appeal rights have been exhausted or prior to lawyers applying for judicial review against asylum refusal.

- refugees that have received leave to remain but not yet received benefits due to organisational delays, may also experience destitution. Refugees in this stage may also be without accommodation after having to leave their National Asylum Support Service accommodation.

Immigration law currently restricts asylum seekers from working in the UK. Consequently during times of destitution asylum seekers are dependent on charitable organisations for support or friends, are forced to work illegally or are vulnerable to being exploited in exchange for food or accommodation. Research has shown that the experience of destitution, particularly in the later stages of the asylum process, is linked to fear of deportation to the country of origin where there is a high risk of further trauma and violence (Crawley, Hemmings & Price, 2011).

4. The mental health of asylum seekers

4.1. Pre-migration and Migration Factors

Many asylum seekers have been forced to leave their home countries because of multiple experiences of trauma (e.g. war, torture, violence) and human rights violations (e.g. persecution on the grounds of race, religion, nationality, membership of a particular social group or political opinion; Silove, Sinnerbrink, Field, Steel & Manicavasagar, 1997; Hargreaves, 2002; Hollifield et al., 2002) and report trauma related mental health problems. PTSD has been shown to be prevalent in this population (Johnson & Thomson, 2007; Fazel, Wheeler, & Danesh, 2005).

The process of migration is typically fraught with uncertainty and fear and can involve exposure to further trauma, significant loss and potentially life threatening events. For example: exposure to physical and sexual violence (Nakash et al., 2014); trafficking (Zimmerman, Hossain & Watts, 2011); loss of family and friends; and coercive control. As such, individuals arriving to the host country are vulnerable to psychological distress and mental health difficulties.

4.2. Post Migration Factors

Though it is well established that asylum seekers and refugees within the UK are at a high risk of experiencing mental health problems (Carswell, Blackburn & Baker, 2011; Momartin et al. 2006, Steel et al. 2009), there is limited information around the
specific impact of destitution. There is however a growing acknowledgement in the literature that post migration stresses contribute to the high rates of mental health difficulties for asylum seekers (Schweitzer, Brough, Vromans & Asic-Kobe, 2011; Porter & Haslam, 2005; Li, Liddell & Nickerson, 2016; Refugee Action 2006) and that asylum seeker experiences relate to cumulative traumas and losses pre-, during and post- migration. Within clinical settings, such as GPTS, models of complex-PTSD helpfully inform treatment. However, it is also essential to consider not only a patient’s psychological response to trauma experiences in their country of origin or on their journey to the UK, but also the unique current stressors affecting them post-migration. This is essential for developing a shared formulation of current difficulties, understanding how current stresses exacerbate trauma or depression symptoms and establishing a realistic treatment plan that considers ongoing stressors related to the asylum process.

4.2.1. The Asylum Process

A number of studies have shown that poor quality of life within asylum seeker and refugee groups are associated with higher levels of post-migration stress and poor mental health (Teodorescu, et al. 2012; Carlsson, Olsen, Mortensen & Kastrup, 2006; Ghazinour, Richter & Eiseman, 2004). Evidence suggests that increased psychopathology is related to delays in the application process (Laban, Gemaat, Komproe, Schreuders, & De Jong, 2004; Silove et al., 1997). In Australia, a group of asylum-seekers where found to be experiencing significantly higher levels of post-migration stress relative to their refugee counterparts (Silove et al., 1998). The study showed how differences between the asylum seeker and refugee groups appeared to be underpinned by residency security (Silove et al., 1998). Phillimore’s (2011) UK based qualitative study has shown that longer waits in the asylum process are connected to experiences of uncertainty and hopelessness (Phillimore, 2011). Further research from the UK highlights that periods of destitution can extend for some for years and have a significant impact on mental health during this time (Crawley, Hemmings & Price, 2011).

Further evidence suggests that the rejection of asylum claims (often a preceding factor to destitution) can precipitate a number of interacting emotional responses including feelings of devastation, anger and a sense of injustice (Crawley, Hemmings & Price, 2011). This often replicates and compounds the emotional responses to pre-migration trauma and human rights violations. When asylum status remains unclear a sense of sustained threat and anxiety is frequently reported (Stewart, 2005) and can interact with a complex traumatic response that ultimately exacerbates symptoms.

The compounding impact of previous trauma and post-migration stressors can have significant impact on self-concept. Research in Glasgow and London has highlighted the sense of ‘suspended identity’ associated with insecurity in entitlement to remain in the UK (Stewart, 2005). Indeed clinically, clients often discuss the sense of distress associated with a lack of certainty about their future, restricted rights and associated ‘stuckness’ which often perpetuates feelings of depression and anxiety. Evidence also suggests that uncertainty around future circumstances within asylum seeker groups can lead to a sense of hopelessness and ‘letting go’
which in turn has implications for developing a coherent and healthy self-concept (Brekke, 2010). There are implications for clients' levels of social support and sense of belonging which are again important components for recovery from experiences of complex trauma (Teodorescu, et al., 2012).

4.2.2. Fear of Return to Countries of Origin

The Home Office may argue that asylum seekers do not need to stay in the UK in destitute circumstances as they could return to their country of origin (Gillespie, 2012). There are a number of reasons why this may be inappropriate and impossible for asylum seekers. Firstly, many destitute asylum seekers are often in the process of launching an appeal or gathering information to make a new claim (Gillespie, 2012). Extreme fear for personal or family safety dominates the narratives of many asylum seekers at risk of being returned to their country of origin (Crawley, Hemmings & Price, 2011). As one Tamil asylum seeker explained, should he be returned to Sri Lanka, “I think I could be killed, army or police could kill me.” (p. 45, Gillespie, 2012). It is often due to intense fear regarding the consequences of returning to the country of origin that asylum seekers choose to remain destitute for lengthy periods of time in the UK to avoid immigration authorities who they believe will likely deport them (Crawley, Hemmings & Price, 2011).

Section 4 support can be applied for by asylum seekers facing destitution if they meet one of a number of eligibility criteria. Taking reasonable steps to leave the UK is one such criteria. For many asylum seekers extreme fear of deportation and consequent risk of further trauma has meant they have ruled out any application for Section 4 support even when they meet one of the other criteria for eligibility.

4.2.3. Unemployment and Poverty

The issue of unemployment and poverty is particularly pertinent in groups of asylum seekers that are destitute as finding a means to support survival becomes paramount (Crawley, Hemmings & Price, 2011). In general populations unemployment and hopelessness have been shown to be significant risk factor for suicide (Brown, Beck, Steer, & Grisham, 2000). Evidence from a global meta-analysis highlights that poor mental health status of displaced populations are significantly associated with restricted economic opportunities including rights and access to employment and changes to socio-economic status.

It is widely evidenced that poverty and negative mental health outcomes are significantly associated (see Murali & Oyebode, 2004). Though the causal direction between poverty and poor mental health is complex, evidence suggests that there are a number of interacting components underpinning this association. Within refugee and asylum seeker groups there is evidence showing how not being permitted to work and poverty can interact, and ultimately exacerbate symptoms of PTSD and depression (Carswell, Blackburn, & Barker, 2011).

Qualitative studies in the UK have highlighted the compounding impact of post-migration difficulties associated with employment restrictions (Burchett & Matheson, 2011), poverty, related unfavourable social representations (Stewart, 2005) and destitution specifically (Crawley, Hemmings & Price, 2011). Findings show a number of factors impacting mental health including isolation (Stewart, 2005), shame, powerlessness, hopelessness, reduced confidence as well as a lost sense of
positive identity (Crawley, Hemmings & Price, 2011). Additional qualitative evidence highlights how restrictions in occupational rights lead to increased feelings of not being in control and consequent changes to identity and a loss of previously valued roles (Burchett & Matheson, 2011).

4.2.4. Vulnerability to Re-victimisation and Exploitation

It is important to acknowledge that asylum seekers coping with destitution are among the most vulnerable groups living in the UK. Evidence suggests that with no means of financial support destitute asylum seekers are at an increased risk of exploitative relationships owing to a dependence on others for survival (Refugee Action, 2006; Crawley, Hemmings & Price, 2011). Isolation and restricted entitlement to social and health care provisions are important factors increasing vulnerability (Refugee Action, 2006; Crawley, Hemmings & Price, 2011). Evidence suggests that due to feelings of fear and disempowerment destitute asylum seekers are reluctant to approach police services (Refugee Action, 2006).

Other risk factors include homelessness and lack of food (Refugee Action, 2006; Allen, 2012). Research suggests that alongside these issues physical safety is often at risk as people are forced to sleep rough at times (Allen, 2012). These factors were shown to increase levels of distress and can naturally cause a frantic preoccupation with trying to establish how to get basic needs of shelter and sustenance in place on a daily basis (Allen, 2012).

A growing body of research suggests that women asylum seekers, often sole carers for children, are especially vulnerable when destitute (Chantler, 2012; Crawley, Hemmings & Price, 2011). These include increased likelihood of gender based/sexual violence and exploitation post-migration (Refugee Counsel [RC], 2009), human trafficking (RC, 2009), initial claim for asylum being rejected (Muggeridge & Maman, 2011), isolation (Phillimore, 2011), and intimate partner violence (Miller, Kulkarni, & Kushner, 2006).

5. Evidence from GPTS Clinicians.

The following themes are based on the responses received from clinicians working within the GPTS who were asked to consider the impact of destitution on mental health and treatment.

5.1. The Mental Health Impact of Destitution

Clinicians commented on exacerbations of mental health problems related to destitution, fear provoked by destitution, and the often lengthy periods of time within the asylum process with prologue periods of destitution.

5.1.1. Increase in acute symptoms of distress

All clinicians reported significant exacerbation of clients’ mental health difficulties during, often lengthy, periods of destitution or when there is an imminent risk of becoming destitute. For many clients destitute after a refused asylum claim clinicians witness the sense of panic and distress connected to the withdrawal of financial and accommodation support whilst clients also experience the sense of loss and despair connected to the rejected claim that represented safety and security. For some clients destitution represents a lack of safety and powerlessness which can replicate the experience of previous trauma and in turn triggers acute traumatic
responses, for example dissociation. Clients often present with an increased sense of threat, pervasive sense of anxiety and mistrust, and difficulties regulating emotions when destitute. Clinicians reported witnessing increased emotional distress and a deterioration of CPTSD symptoms.

It is clear from clinical practice, clients become despairing, hopeless and their mental state worsens as expectations of safety fail and the impact of trauma is aggravated due to the prolonged periods of destitution. The pervasive sense of anxiety associated with coping in destitute circumstances can systematically erode resilience.

5.1.2. Fears related to deportation
Alongside fears of basic survival in the UK, destitution is closely linked to fears of being returned to the county of origin. This in turn causes significant distress and deterioration in pre-existing mental health difficulties. For those experiencing traumatic reactions to pre-migration traumas the fear of returning to their country, where there is often a high risk of further trauma, is unbearable. Some clients reported choosing to remain destitute in the UK to avoid deportation. Within this context there is considerable fear that agencies will discover them and deport them back to the country of origin where clients have reported fears of torture, female genital mutilation, rape and death. In an effort to remain undiscovered by authorities some clients report avoiding services including police. This can leave clients vulnerable.

5.1.3. Risk of Self Harm and Suicide
Clinicians reported that destitute clients are at their most vulnerable and are often left feeling hopeless and helpless within their circumstances which have led to increased suicidal ideation and risk. Consequently destitute clients are more likely to be in mental health crisis and several have been offered brief admissions to psychiatric hospitals as a result. Many have required intervention from Crisis Mental Health services. One client described “being destitute makes you panic, that fear pushes you to make decisions which are dangerous…you think about suicide”. One clinician reported a recent incident in which a client had attempted suicide directly related to distress associated with recently being made destitute.

5.1.4. Vulnerability Linked to Insecure Accommodation and No Access to Money
Clinicians reported accommodation difficulties having a significant impact on client’s mental health. Issues included feeling increasing uncertain (e.g. how long can I live in this person’s house, when will they say I have to leave?), feeling a sense of shame at accepting shelter and not having any means to provide compensation to their hosts. Clients have described having to do tasks for their hosts in exchange for accommodation.

Lack of finances is a concern for all destitute clients. There were many instances of trying to source food to eat, sanitary products and suitable clothes to wear. At times clients reported being refused food bank vouchers and being made to ‘prove’ they were destitute. Often clients reported going hungry. These factors contribute to mental and physical fatigue as well as clients reporting feelings of worthlessness and being degraded.
Many destitute clients were unaware of the amenities and activities they could access through charitable organisations and destitution networks. Clinicians reported clients reported spending lengthy periods of time roaming the street due to boredom or to ‘stay out of the way’ of friends temporarily hosting them in their homes. Clients also frequently reported issues related to lack of privacy and security; on occasions clients have had belongings stolen, damaged or lost in temporary residence. These factors further compound feelings of persecution and lack of safety ultimately impacting on mental health.

5.1.5 Discrimination
A number of clinicians commented on the sense of discrimination that clients described related to rejected asylum claims, destitution and their restricted rights in the UK.

When clients reported feeling a sense of discrimination related to destitution this was often linked with feelings of anger, frustration, hopelessness and uncertainty about what the future holds. Clients are noted as reflecting on the similarities of current difficulties and past experiences of discrimination and persecution in their country of origin e.g. not having access to equal opportunities of health, education, work. Clients repeatedly express disappointment that they expected their human rights to be respected in the UK but they do not feel they have been.

Racism and discrimination issues were also cited as clients reported actual discrimination and perceived discrimination. For example being denied access to amenities was perceived as being treated “worse than an animal” by one client. The withdrawal of financial support and accommodation, alongside restricted rights preventing paid employment, is perceived by some clients as persecutory. Feelings of persecution by government may replicate previous traumas in countries of origin. For some clients the sense of persecution was experienced as though the government and society as a whole was persecuting them and as such no one could be trusted. One client refuses to go to a food bank believing she will be poisoned because she is a black asylum seeker.

5.1.6. Disempowerment and Impact on Self-worth and Identity
Clients have highlighted the implications of being labelled a ‘failed’ asylum seeker and ‘destitute’. Some interpreted these labels as; “I am not believed…I am not protected…I am accused as a liar”. This perception appears to leave clients feeling disempowered and feeling increasingly worthless and hopeless.

The impact on a person’s dignity and self worth was often reported as the worst aspect of destitution, worse than having no shelter, money or food. Beliefs such as; ‘I am worthless’ were common due to clients having to ‘beg’ for all basic needs. This view had been reported as intolerable and ‘painful’ for almost all destitute clients. Clients state they want to help themselves but have to “beg” in order to survive day to day. One client described walking the streets searching for pennies and coins. “My aim is to find 50p today…I don’t need therapy, I need 50p”. She explained to the clinician the sense of humiliation associated with this act, though preferable to begging. Many destitute asylum seekers describe the frustration of not being able to work to provide for their own basic needs. Some describe a feeling of being trapped...
or tortured by their circumstances; not being provided any means of support and being restricted from providing this for their self or family.

Two destitute female clients spoke of considering prostitution due to extreme and ongoing financial hardship, though they did not act on this. Others female clients spoke of being propositioned by the offer of money for sex when they had asked for charity from a religious organisation. Frequently cultural identity and religious faith was reported as eroded due to the persistent adversity and powerlessness of the situation.

One man however spoke of feeling ‘cared for’ by his community and church because of the ongoing emotional and practical support given to him as a destitute man in Glasgow. Other clients commented on their gratitude to those who have helped them.

5.2. Compromised Access to Treatment and Support

5.2.1. Difficulties Accessing Health Services

All clinicians reported that destitution causes a number of practical difficulties accessing health services. These include:-

- Difficulty in being able to send appointment letters due to clients having no fixed abode and consequently moving accommodation frequently.

- Telephone contact is also limited as clients are not able to put credit in mobile phones or have the means to charge a phone. If mobile phones are lost there is often no financial means of replacing them. Consequently it is more difficult for clients to arrange appointments or advise of changes to contact information.

- Financial difficulties (not being able to afford the bus fare or the fare of dependents, prior to a free bus pass being issued by the service). Moving frequently, particularly to locations less familiar to clients also impacts attendance as new travel routes have to be established.

Provision of primary and secondary mental health services is on a postcode /address basis. When clients are frequently moving between service catchment areas, providing consistent and trauma informed treatment can be an increasing challenge. (Though GPTS is city wide service we work closely with other (mental) health teams, particularly when patients are at a high risk of self harm or suicide.)

Destitute clients will encounter limited access to some strands of health care. Without the appropriate documentation, dental and eye care are not permitted. Clients have been reported as suffering long term tooth pain and bleeding gums. Some clients have reported headaches and sight problems due to a need for glasses. Naturally coping with ongoing and untreated physical health problems can elevate clients’ distress as well as limit their capacity to engage in treatments to improve mental health.

5.2.2. Impact on On Psychological Therapy

Clinicians reported difficulties in clients being able to fully engage in planned therapeutic work due to:-

- worries related to their basic survival
- clients presenting emotionally and environmentally unstable
- an absence of their basic needs being met and consequent need to problem solve and identify resources for clients
- a need to address acute symptoms of distress e.g. suicidal ideation and intent
- hunger

When basic human needs are not met the foundations for psychological therapy are also absent. All clinicians reported that treatment progress was impaired for clients experiencing destitution.

Clinicians described a shift in their therapeutic role when patients are experiencing destitution to advocating for their rights and supporting them to identify/source ways and means of meeting their basic needs. This included making applications for emergency grants, identifying food banks etc. Statutory services have a minimal duty of care for those who are destitute unless there are children involved. The majority of support is coming from voluntary sectors such as the Red Cross, Scottish Refugee Council or from charities, churches and peer or local community groups.

Clinicians are aware of the increasing demands on charities, community groups and voluntary services which have led at times to restrictions in the amount of support they can consistently provide to destitute clients.

Clinicians reported an increase in requests to support applications for Section 4 under the criteria of exceptional circumstances related to significant mental health problems and the increased vulnerability to re-victimisation and self-harm if made destitute. Typically clinicians report these applications have been refused.

5.2.3. Lack of Support Provisions for People with Serious Mental Health Difficulties

Temporary ‘host’ supports arranged through charitable organisations and night shelters are not always able to support the most vulnerable individuals including those at risk of suicide or self harm. We have learned that these individuals are excluded from basic homeless shelters due to the high risk of mental health crisis.

Clients with complex trauma often present with difficulties trusting others. Individuals have been known to refuse to go to shelters or share rooms with strangers because they will experience a worsening of their mental health symptoms.

6 Evidence from Service Users

Service users were invited to contribute responses to this report at the regular service user meeting. A number of the service users within the meeting had direct experience of being destitute for a prolonged period of time.

6.1. Experience of Destitution

“I had my first interview it was refused. Then I went to court and I was refused. I was threaten with deportation so I ranaway. That is the route of it all you are on the run, you are on the outside. ”.

“It is a difficulty journey, you have to go through concrete walls….“

“Destitution is not something anyone should experience. It’s like being tied in a black tunnel. It affects so many people.”
“Destitution leads to lots of things, it needs to be addressed. It leads to extortion, you give money because you do not want to outside, maybe it is cold or rainy. You are all packed together, no space at all. You pay a small amount to the owner, then you are accused of a crime. At the moment I cannot wash my clothes, I do not have the facilities to cook. I am given £25 a week, it does not provide for a week. I have to pay transport, they place you far from your child’s school. I don’t know it is a real problem. It leads to crime, doing things that you wouldn’t normally do to be safe. Even then you are not safe, you do not know who you are living with.”

“When I was homeless with my daughter I just cried and cried. Girls are raped or sleep with men because they need a place to live.”

“It leads to many bad things in this country that are against the law. Destitution might lead youths to drugs or stealing, women to prostitution which is not allowed in this country. It brings lots of bad things forbidden by law”.

“At the moment I cannot wash my clothes, I do not have the facilities to cook”.

“This causes people to disappear; they are scared to return to their country because they will be killed”.

6.2. Impact on Mental Health

“When a person is vulnerable or has mental health problems the situation is more serious. It affects the work you do in therapy and it is a never ending problem…. Mental health gets worse because of destitution and destitution causes mental health problems”.

“I knew a woman with a failed case, she was asked to leave so ran away from her flat. Next time I saw her she was a different person. I was scared to go near her. I don’t know I can’t explain it”.

6.3. Asylum process

“It is very good that the government are listening to the people. It is a good beginning.”

“Asylum seekers in this country should receive better care so the Scottish Government does not need to resort to justice in response to destitution. This has always been a very important part for me, destitution and the treatment of asylum seekers”.

“The Home Office should follow the law. If someone has a report from a doctor the Home Office is not taking this into account. Under article 3 they are breaking the law. This causes people to disappear; they are scared to return to their country because they will be killed.”

“I want to talk about the Home Office. They need to respect the rights of asylum seekers and the law. I am here almost three years, I have not had my interview yet. Waiting is very difficult. It would be good to have a response in a good time. If I can stay, if not tell me to go back.”
7. Conclusion

The overall pressure of the asylum system and often prolonged periods of destitution, in our experience results in an adverse mental health outcomes for clients. Clients are forced to live with uncertainty over extended periods of time, ongoing fear and anxiety associated with deportation, disempowerment and experiences of discrimination. Destitution can replicate circumstances of previous trauma and leads to further vulnerability. These cumulating factors often compound complex traumatic responses to pre-migration trauma and for some can cause significant risk of suicide. Accessing support during times of destitution is essential for maintaining mental and physical health and to protect vulnerable people being victimised.

8. Recommendations

8.1. Destitution is an unacceptable, inhumane and ultimately ineffective government strategy to encourage asylum seekers to return to countries of origin. Destitution has a significant negative impact on mental health and the effectiveness of psychological treatment. Evidence from research and the experiences of clients within the GPTS shows that people will choose prolonged periods of destitution in the UK regardless of the negative mental and physical health consequences over return to their countries of origin where they will likely face further trauma.

8.2. The asylum process has to take account of the fear of further trauma and violence for refused asylum seekers when threatened with return to the country of origin. A more humane and compassionate response to those experiencing mental health difficulties linked to experiences of trauma is needed.

8.3. Destitution should not form part of the asylum process. It is also important that asylum seekers and refugees do not experience destitution due to organisational failings and difficulties related to different organisations working together e.g. when destitution occurs for refugees with recent successful asylum claims.

8.4. We recommend that the Scottish Government consider the significant mental health impact of destitution as a matter of urgency. Destitution can also cause practical and psychological barriers to clients accessing essential mental and physical health treatments.

8.5. We recommend additional funding for health, charitable and third sector organisation to provide a co-ordinated trauma informed response to destitution that provides appropriate directed support for destitute clients. There is a need for additional resources for dedicated staff that can co-ordinate and respond to the needs of destitute and vulnerable asylum seekers and support linked up working between agencies.

The support needs of vulnerable client groups, including women at risk of prostitution and those caring for children, should be addressed urgently. Trauma informed care is underpinned by a number of important factors including physical and emotional safety, trust, choice, collaboration and empowerment (Fallot & Harris, 2009). We advocate for services to develop supportive provisions with these trauma informed principles at their core.
8.6. We advocate for the right for asylum seekers to be permitted to work, if they are able, whilst their asylum claim is processed. Many asylum seekers are willing and wish to contribute to their communities whilst living in the UK through employed activity. The right to work and access to opportunities that reduce the likelihood of severe poverty is an important factor in supporting the mental and physical health needs of asylum seekers.

We are grateful for the opportunity to be able to contribute some comments and reflections from clinicians and clients attending our service user group. We hope that the evidence provided and recommendations may help to inform developments and rights for asylum seekers and refugees within Scotland.

Acknowledgement
We would like to thank clients attending the GPTS service user group and clinicians working at the GPTS for their helpful contributions and feedback.

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References


