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Supporting Asylum Seekers: Practice and Ethical Issues for Health and Welfare Professionals

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Introduction

We have heard throughout the conference of experiences of asylum seekers and refugees, both in their attempts to enter countries of refuge, and in their treatment after entry – that is, both external and internal controls. External controls are relatively recent, having been introduced in Ireland in the 1930s and a bit earlier in the UK at the turn of the 20th century. So we must not assume that external restrictions have always existed. They have been instigated by governments partly for economic reasons, partly for nationalistic reasons. My talk today will focus primarily on *internal* controls, but at the start I must declare my position and beliefs about external controls, because all I have to say will be coloured by my wider perspective. I do not accept the commonsense position that we must have immigration controls, that otherwise our countries would be flooded with people from all over the world, especially from poor, developing countries, who would take our jobs, drain our welfare systems dry and cause massive social upheaval in the form of racial unrest. I do not believe that immigration controls are necessary or even workable, or that people would swarm to western countries from the developing world if they were removed. Immigration controls depend on a process of racialisation of peoples who are regarded as 'other', as 'not like' us and therefore a contaminating influence. Underpinning them are imaginary distinctions between 'native' and 'foreigner', 'citizen' and 'alien, 'us' and 'them', and along with these binaries are others: 'civilised/uncivilised', 'cultured/primitive', 'rational/emotional', all of which construct the 'other' as a threat and as inferior. Immigration policies hold a notion of a homogeneous community, where we are all of the same stock, the same blood, and they occlude the reality that most countries are made up of a rich mixture of peoples from very different origins. The justification for border controls depends on the persuasiveness of these inclusionary and exclusionary nationalist and racially informed arguments. In my view there can never be 'fair', non-racist immigration controls.

The apocalyptic pronouncements about 'hordes of foreigners' are not supported by the available research (see Humphries, 2004), but by fear, prejudice and political calculation. Human populations have always been on the move, and it is ethically indefensible to give complete freedom to some and seriously restrict others. In any case, in a globalised world, movement is a normal process born out of socio-economic structures and transnational lives and identities. This position on open borders is still a minority one, and until recently has been dismissed as fanciful, naïve and unworkable. However in 2003 a Global Commission on International Migration was set up with the encouragement of the UN Secretary-General, to make recommendations for the formulation of a coherent and global response to migration issues. Its report, gives serious consideration to the vision of migration without borders and the free movement of people across the globe (Pécoud and de Guchteneire, 2005). At the very same time, however, the EU has issued a Directive tightening up the criteria by which member states can grant or withhold refugee status. So, the issue will continue to be contentious for the foreseeable future.

Therefore if I were asked for recommendations to come out of this conference, the first one would be to campaign, or at least foster a political position of movement as a human right, and an end to external controls on our countries.

Internal Controls

But I have been asked to address the dilemmas and the concerns that confront social professionals – those practice and ethical issues that we all need to work through and respond to in changing patterns of health and welfare, that is the impact of *internal* controls, the other side of the coin of immigration policy. All non-citizens who are allowed to enter a country, certainly countries in Europe, are subject to restrictions on their movement, where they live, what benefits they are entitled to, whether they can work. Social professionals are charged in a range of ways with managing these controls and providing services. Although we understand professionalism as fundamentally having a commitment to relieve suffering and maximise the quality of life for service users, we need to recognise that all forms of welfare incorporate concepts of both <u>inclusion</u> and <u>exclusion</u>. Professionals act on behalf of the state to administer policies that treat people unequally. They act as gatekeepers controlling access to resources, and they make decisions about who should be helped and under what conditions. When we come to think about asylum

seekers, across Europe there are attempts to harmonize policies that will deter asylum seekers, that will make all states equally unattractive to those fleeing persecution, that will cut to the bone any help given,. In that sense, we are all involved in political activity, whether we acknowledge it or not. The emphasis is not on rights, or on compassion or on equal treatment, but on deterrence and exclusion. Exclusion has been a theme of every presentation you have heard today. It entails a number of dimensions:

- accepted levels of material well being and social benefits;
- commonly held legal and social rights;
- a positive opinion of status and identity.

(Burden and Hamm, 2000).

In the case of asylum seekers, these exclusions are reinforced by media and politicians' constant representation of asylum seekers as 'bogus', 'criminal' and 'welfare scroungers', as those of you who have been following the UK election run-up will know only too well. The competition between the main parties is who can be the toughest on these uninvited and unwelcome aliens.

In terms of material well-being, in countries of the European Union, most systems give a level of subsistence that is below the official poverty line. And in order to get this, asylum seekers must submit themselves to compulsory dispersal, imposition of residence, regular reporting, exclusion from work. They may be fingerprinted, detained without a court order, tagged electronically.

The level of support given to asylum seekers in Britain was researched by Oxfam and the Refugee Council, and their report confirmed the shocking impact on people's lives. It said, 'The results are deeply disturbing, and lead us to the conclusion that asylum seekers are forced to live at a level of poverty that is unacceptable in a civilised society' (Refugee Council and Oxfam, 2002, p.1). The researchers interviewed forty organisations working with asylum seekers and found that asylum seekers have barely enough money to buy food of a quantity and quality to maintain an adequate diet, and experience poor health and hunger. They cannot buy enough clothes or shoes to keep warm or buy school uniforms.

What this all means for you as professionals is that when you work with asylum seekers, you are working with the poorest of the poor, people who are often worse off than the most deprived of your other clients or patients. And yet, both in Ireland and in the UK, health and welfare professionals have increasingly been drawn into an explicit policing of controls (Christie, 2002; Humphries, 2004a). In Britain the Home Office has sought cooperation on the policing of provision from health, education and welfare services, checking documentation, ensuring only those who are entitled to provision actually receive it, and reporting anyone who tries to access services without entitlement. It was emphasised by the Home Office that all branches of the state should come together to prevent abuse of services (Humphries, 2002).

What then has been the response to asylum seekers from health and welfare professionals? The evidence suggests that the response is contradictory, with instances of good practice, against a background of complicity with oppressive policies. A number of studies of social work responses in Britain suggest:

- social workers are still generally ignorant of immigration law
- services are very poorly coordinated
- social workers do not accept that asylum seekers are their business
- they have actively attempted to avoid their responsibilities (see Humphries, 2002).

The most reliable support appears to come from NGOs, particularly refugee support groups, especially those who share their origins in similar communities as the asylum seekers. The risk here is that the statutory services may leave (indeed have left) them to get on with it. I have visited a number of rural areas in the North West of England where refugee groups were the only contact asylum seekers had with support services, and were entirely dependent on them for advice and help. The workers said the statutory authorities 'keep telling us it's not their business'.

I interviewed community mental health and primary care teams to find out what responses were being made to the mental health needs of asylum seekers. The UK government has made mental health one of its top three health priorities, and its national service framework identifies refugees and asylum seekers as especially vulnerable (see Humphries, 2004a). The teams I interviewed said mental health was an urgent issue for refugees, as the risk of suicide was high amongst them. I met one very concerned nurse attached to a GP surgery who was active in supporting asylum

seekers in a Lancashire town, but was desperate to find other supports. She happened to be visiting the community mental health team the day I interviewed them, and pleaded with them to take referrals from the surgery. In spite of a duty to make an assessment of social and mental health needs, the CMHT team said there was little they could do. They said there were not enough interpreters; they said that in any case, interpreters should be psychologically trained; they said they themselves had no expertise in post-traumatic stress syndrome; they said they could offer only short–term support and asylum seekers need long-term help; they said for some cultures psychiatric treatment is an alien concept anyway. There was an overall reluctance to have any dealings with asylum seekers, regardless of statutory responsibilities. And yet in interviews with asylum seekers I confronted the theme of depression over and over again, resulting not only from the trauma of the experiences from which they had fled, but from inability to access support, from joblessness, from everyday, wearying racism, from social isolation, from harassment of immigration officials, from the threat of deportation, from simply not knowing when and whether they could settle in their new country, or whether they would see their homes again. Surely these are all emotions professionals understand? Surely their toolkit of theories and methods can encompass these needs? Why the reluctance to engage?

One can appreciate that all professionals workers are overworked and unappreciated, and reluctant to take on work, especially if they can get away with it where the potential client group is undervalued and regarded as undeserving anyway. I felt too there was also a real fear of not being able to understand or communicate, of being incompetent in this field, of not having had the training or skills to work with asylum seekers. There is no obligation in most professional courses to develop practice appropriate to asylum seekers, there is indeed very little academic input on most courses. There is a desperate need for training to be dragged into the 21st century in terms of the character of multiracial societies. The topic would be a good one for inter-professional training.

Women

I want to make a plea to this audience on behalf of asylum seeking women. Women asylum seekers are often invisible, in that if they arrive with a male partner it is his application that is considered, not hers. She is an appendage, yet she may have a

claim to asylum in her own right. Yet if her claim is not considered and her marriage breaks up, she may face deportation. Her other choice is to stay in a marriage that may be unhappy and violent. I have met asylum seeking women in women's refuges who were lucky enough to get out and get support. But they are the minority. Social professionals must become sensitive to their needs as women, not only as the mothers of their children. I have become increasingly worried, since the politicisation of child abuse, that women are seen only as mothers. I have read students' essays that describe their practice – they say "there is a violent relationship between the parents and I am concerned for the effects of this on the children". Of course this is a priority, but it should not obliterate a concern for a vulnerable woman.

Women asylum seekers may have experienced gender-related or gender-specific persecution. They may suffer as a result of their relationship to a male relative being pursued by the authorities in their country of origin; they may be carriers of messages; they may hide dissenters. Or they may be persecuted specifically as women – through rape, or female genital mutilation (FGM), or through refusing to conform to moral codes thought suitable for women. When they come to this country they may not have an opportunity to share these experiences. Ferguson and Barclay (2002) carried out research in Glasgow that showed the inadequacy of women's mental services for asylum seekers. They pointed out that many of their problems result from experiences they have had after arriving in Britain – racism, poverty, destitution. I interviewed women (some of whom are professionals themselves – teachers, doctors, nurses, chemists) who fretted about joblessness, about social isolation, about poverty and not being able to pursue their profession. It is time to prioritise women's needs: to make sure they are not housed in places that make them vulnerable; to help them access services; to give them the opportunity to talk about their worries and pressures; to encourage them towards a new start.

I have a friend in Manchester who is a single parent asylum seeker with four children. She has been in England for five years and is in the final stages of appealing against refusal of asylum status. She still has fears that she will be tracked down by the people who caused her to flee Pakistan in the first instance. She has been on an emotional roller-coaster over the years, allowed to work initially and then having this withdrawn; housed in one of the poorest areas of the city; living on subsistence income; restricted in her movements; children in fear of immigration officers arriving

to take them away. In spite of this, she has not only fought on and is leading a campaign to support her application, but she is also working voluntarily for a local advice centre. She had an astonishing experience before Christmas last year. She had received a letter from the immigration authorities to attend a deportation interview, and had to attend to be told the arrangements for her removal, which was now imminent. The day after the interview she received another letter, this time from Buckingham Palace. The Queen was inviting her to a reception to acknowledge and celebrate her contribution to her local community. So she went to the palace, but she was not allowed to distribute her campaign leaflets or tell the Queen about her asylum case. The good thing was that her story hit the headlines. It was on the national and local TV and radio news; there was a big article and photograph in *The Guardian* newspaper, and she got maximum publicity for her campaign. She is still here, still without a decision, still living on the edge of apprehension and fear, but still struggling. This is an example of a response that is led by the asylum seeker herself – the campaign is entirely focused around her – her knowledge, her definitions of what is needed, her ideas about strategy. Her supporters bring skills and expertise in different areas, some of them have influence at a political level, and all are working together to the same end. I thought I would offer that inspiring story so that you do not get too despairing.

Children

Work with children is one of the key areas of practice. Health Boards in Ireland and local authorities in Britain have similar responsibilities towards unaccompanied asylum seeking children. Both are signatories of the UN Convention of the Rights of the Child. But Britain has signalled a reservation to the Convention. The UK reserves the right to apply asylum and immigration legislation...as it deems necessary. In other words, the Convention will not be allowed to impinge upon national immigration and nationality law. What are the effects of this?

Children are sometimes kept in Detention Centres, or Young Offenders Institutions or even in adult prisons; they are often treated as asylum seekers first, rather than as children first – this means that immigration legislation can take priority over children's legislation, and the 'best interests' principle can be ignored. The process as to whether a child is recognised officially as an 'unaccompanied asylum seeking child' is rather hit and miss. If a child is given this status it leads into a particular care regime,

and the child is the responsibility of the local authority, must be accommodated, supported, educated and given access to health care services, as is the case in Ireland. If it is decided the person is not a child but an adult asylum seeker, lesser rights result. In Britain, there is a great deal of concern about the means by which these decisions are made, and often it is a case of guessing whether a person is really a child. Where a person does not have age-related documentation, immigration officers and social workers have to make an assessment of a young person's age. There is evidence that there is a 'culture of disbelief', with officials more inclined to think a person is lying, rather than give them the benefit of the doubt. Yet paediatricians say that for young people aged 15-18 the margin of error in estimating their age may be as much as five years either side. In some authorities if it is assumed a young person is 18 or over, they may get placed in unsupported accommodation where they may be vulnerable to exploitation or attack. I spoke to a social worker recently who said he witnessed a situation where social workers disbelieved a young person about his age and called in the police. The child was held in a police cell for several hours before he was released. Surely the world would not crash in if professionals adopted the principle to giving a child the benefit of the doubt?

Unaccompanied children are sometimes placed in accommodation, but not followed up or offered ongoing support. The Refugee Council has expressed concern about the use of B&B or hostel accommodation – with cramped, overcrowded, inadequate conditions, lacking in basic facilities such as hot water or heating and living with adults who have not been assessed for their suitability to share accommodation with minors. Stanley (2001) described an example of good practice, which consisted of semi-independent accommodation where the young people have their own self-contained accommodation, but also have access to a social worker who is on site 24 hours a day. This of course was provided by an NGO, not by statutory authorities. More like it are urgently needed.

Children of course, are the most vulnerable of all, even those who come with their parents. In Britain their parents will get less support for them than do other parents – there is no entitlement to any of the range of benefits aimed at children. You may know that the UK parliament has recently (2004) passed its latest act that will withdraw welfare support from failed asylum seekers who do not cooperate with their

deportation. This will make them destitute and could result in their children being taken into care. This puts professional workers in the position of taking children into care solely because of poverty – a situation that the 1989 Children Act was explicitly designed to avoid. Amnesty International (2000) has commented that this is one of the rare areas of UK law concerning children where the 'best interests' principle does not play a part or where the protection of the child is not the paramount concern (p. 32).

Conclusion

Health and welfare professionals have a commitment to anti-oppressive and anti-discriminatory practice, particularly relating to class, 'race', gender, sexuality, disability and age. I want to put it to you that immigration policy discriminates on all the grounds professionals claim to oppose. Those who are rich and white are the most likely to have least problems in gaining entry to countries in Europe. Exclusion depends on a nationalist construction of certain groups as 'other', as 'not of us', as 'alien'. Immigration policies treat women as dependents of men. Gay and lesbian people are treated differently from heterosexual people. Young asylum seekers do not have access to the same treatment as young citizens. How are professionals to respond? I have given examples of evidence that suggests a disappointing and oppressive response from professions, particularly social workers in the UK.

But let me draw together some of the threads of my talk, thinking about them in relation to both professional practice and professional ethics.

I suggest an approach that

- regards immigration controls as intrinsically racist and therefore contrary to professional ideals. Adopt a position of open borders
- resists policies of exclusion and the policing role of professionals
- considers and does not ignore the ethical and moral implications of policies and legislation
- insists that health and welfare professionals have a duty to inform themselves about immigration policy, and about the needs of asylum seekers
- actively campaigns for resources (interpreters, specialist services, etc.)
- agitates for training in qualifying and post-qualifying training – towards fostering a questioning and critical stance on policy and practice

- works for all this in multi-professional ways
- brings women's needs into focus
- gets involved in campaigns led by asylum seekers themselves
- treat unaccompanied asylum seeking children as children first
- give them the benefit of the doubt on their age and their story
- seeks to work collectively and internationally

Is health and welfare always and inevitably driven by changing global and domestic economic and political contexts? Is it possible as we fondly believe that we can be steered by internal ideals about the intrinsic value of every human being, and the urgency of ensuring their basic human rights? There are examples that suggest professional groups are resisting the role that has been placed on them. Last year the AGM of the British National Association of Midwives voted for a motion that committed them to resist policies that punished those seeking asylum; the British Association of Social Workers said it would support any social worker who resisted their employers' insistence to implement policies that resulted in children of asylum seekers being taken into care as a result of destitution. A couple of weeks ago the Irish National Teachers' Organization (INTO) spoke out about deportations of school children and searches in schools for failed asylum seekers (Irish Examiner, 29 March 2005). The British National Union of Teachers has voted to campaign for the abolition of immigration controls.

So there are ways forward, individually, collectively, and I believe internationally, since all European countries with immigration controls share many of the problems we face. I leave you to consider these ways forward, and to look urgently at your practice and your ethical responsibilities, with a view to action for change.

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