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Supporting people with immigration issues in the context of the Mental Health Act 1983 and Mental Capacity Act 2005

Dikoff, B

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Providing mental health support to migrants and asylum seekers with uncertain or unresolved immigration status and/or with 'No Recourse to Public Funds' (NRPF) can pose a distinct challenge for mental health practitioners within both hospital and community settings. As an outcome of the UK's Hostile Environment policy,[1] some migrants and asylum seekers are precluded from accessing statutory welfare support and services, such as when a person has been refused permission to stay in the UK but has not yet been able to lodge an appeal against this decision or to submit a fresh claim. Yet such support is integral to ensure holistic and effective care planning, particularly for people with serious mental illness. This includes people who are detained under the Mental Health Act 1983 (MHA), or treated under the Mental Capacity Act 2005 (MCA), who may lack capacity to conduct their immigration case, or challenge their proposed removal or deportation from the UK.[2,3]

When planning and conducting an assessment of migrants and asylum seekers under the MHA, difficulties may arise, including mistrust of professionals due to limited or adverse past experience with authorities, unstable accommodation, lack of knowledge of services, concerns about data sharing, lack of reliable collateral history and lack of access to reliable and consistent interpreters. During the period of detention under the MHA, these same issues are likely to persist, with additional concerns including access to legal advice on immigration and ability to maintain links with government agencies on immigration status. These are important additional factors that are likely to influence the detained individual's care pathway and influence assessments of their prognosis and risk, which are key tasks for treating mental health professionals. In turn, this influences planning beyond the period of detention under MHA, because instability of post-discharge accommodation, uncertainty around supervising team and concerns around removal may combine to inhibit recovery, increase the likelihood of relapse and contribute to associated risk behaviours.

These challenges persist even post-discharge, in the community. Migrants and asylum seekers with NRPF are unable to access welfare benefits, housing assistance and, often, support from social services.[4] Further, those with uncertain immigration status are at risk of enforcement actions such as bail reporting conditions, electronic tagging[5,6] and indefinite detention[7] as well as forced removal and deportations, all of which are known to have a detrimental impact on mental health and wellbeing.[8,9]

Not all migrants are entitled to Home Office accommodation—this depends mainly on the nature of their immigration case, and on whether and if they are destitute. When they are, accommodation is offered on a no-choice basis across the country. This is known as the UK's 'dispersal' policy. This policy has been in place since 2000 and refers to the practice of spreading asylum applicants throughout the country to ensure equitable distribution of resources among local authorities. The accommodation provided may be unsuitable, for example, people with PTSD and associated nightmares being allocated shared rooms. Dispersal may also result in discontinuity of care since the mental health team that has worked with and built relationships with the person can no longer work with them.

In addition, issues with the accommodation provided by the Home Office can aggravate pre-existing mental health problems. These include de facto 'curfews', monitoring, barriers to accessing healthcare and schools, re-traumatisation due to the sites being ex-army barracks, as well as threats and harassment from far-right extremists.[10]

The lack of availability of legal aid representations for migrants and asylum seekers means it is often very difficult for individuals to get the help and legal advice or input that they require to resolve their immigration issues and gain full access to statutory welfare support and services.[11] Furthermore, the new immigration legislation contained in the UK's Nationality and Borders Act 2022 introduces a further series of policies designed to augment the 'hostile environment' approach, including contested proposals to send asylum seekers to Rwanda.[12]

It is clearly challenging to provide adequate and appropriate support to this vulnerable group in such circumstances. Considering the high likelihood of problems following discharge, it is, therefore, crucial that the Responsible Clinician (RC) under whose care the person is detained, starts planning for after-care as early as possible in the process.[13] Referrals should be made as early as possible to organisations and registered professionals who are able to provide immigration support and advice. This may

involve referrals to safeguarding teams as well as supporting the patient to seek legal advice and charity support. Individuals might also require ongoing support and advocacy to maximise their capacity to engage with complex immigration processes, and to ensure continuity of care when there are fluctuations in mental disorder. Further challenges for destitute asylum seekers may include inability to pay prescription charges which may be interpreted as 'non-compliance,' not having sufficiently stable housing that would make follow-up difficult, as well as worries about less restrictive community options in cases of deteriorating mental states.

There might be instances where the person might be too unwell and/or lack the requisite mental capacity to make decisions in relation to their immigration matter.[14] Following the principles of the Mental Capacity Act 2005, reasonable adjustments and assistance should be provided to the individual to maximise their capacity. This could include waiting for the individual's condition to stabilise first before addressing the immigration issue in a trauma-informed way.[15] In cases where there is a condition in which capacity cannot be regained or it is not possible to wait, an independent advocate or a litigation friend could potentially be identified and appointed to make immigration decisions on behalf of someone who lacks capacity to do so, following the Best Interest process.[16]

It is important to note that, unlike support under the Care Act,[17] access to Section 117 aftercare support is not dependent on immigration status in any way. Recipients of such aftercare support under Section 117 are also not liable to any charge. Support, which can include subsistence and accommodation, should be provided under Section 117 to address any needs arising from or related to the person's mental disorder and, significantly, to "reduce the risk of deterioration of the person's mental condition".[18]

Practitioners should consider what support a migrant patient can access upon discharge from hospital, and how, practically speaking, the patient would be able to access such support. For example, while a patient might be able to live independently in Home Office accommodation, it is important to consider what impact the dispersal policy might have and whether the person will be able to rebuild their support network in an entirely new area of the country. The impact of delays in getting this support in place should be considered, such as delays in General Practice registration[19] and in referrals to the local mental health team. In addition, of great importance to this group is the availability of local charitable organisations and groups in the area where the person is discharged; this should be reviewed by the discharging mental health team.[20]

While lack of immigration status and/or access to public funds need to be addressed, practitioners should continue to adopt a person-centred approach to ensure that any support sought or offered is appropriate and acceptable to the individual patient and takes into account their individual needs. There can be many other risk factors affecting migrants and asylum seekers, including personal or family relationships, social isolation, lack of understanding of their condition, trauma, social stigma, or physical health issues. Despite the inherent uncertainty, many can also be addressed whilst immigration issues are being resolved.[21] For example, while migrants without status do not have the right to work, many would still benefit from assistance to access education, training and/or volunteering opportunities to help reduce isolation and encourage positive activities. Migrants and asylum seekers without clear identity documents often face difficulties registering for such opportunities and would require support.

The hostile environment presents a significant challenge to the provision of adequate support for migrants and asylum seekers with mental health issues. It is often inappropriate for practitioners to seek assistance directly from the Home Office. The immigration system is highly adversarial and sharing information with the Home Office can carry a significant risk of negative unintended consequences for the patient. There is also an additional issue around public safety and the responsibility of the professional in cases of individuals detained under the MHA, where disclosure may be unethical for mentally unwell patients who lack mental capacity to make disclosure decisions. At the same time, psychosocial stressors arising from immigration issues are likely to influence recovery or relapse for the individual.

Therefore, in our view, support to access independent qualified immigration advice should be considered to be an essential part of the clinical care of the person. It addresses an important psychosocial stressor for this patient group, whilst at the same time protecting their best interest.

Immigration law is complex and rapidly evolving. We, therefore, recommend that there should be an immigration lead or an immigration hub in each mental health service, which can be accessed for advice on immigration-related advocacy and support to patients, such as assistance in finding qualified legal advice and immigration representation and providing information about local charities and advice organisations. We recommend that training and support are made available to mental health staff to ensure a better understanding of the hostile environment, its impact, and how to best advocate on behalf of this patient group. There are many free resources available on this issue and leading groups, charities, and organisations who can provide necessary training.[22] Such training should ideally be mandatory and its uptake audited.

Case study:
XA is an asylum seeker from the DRC. He suffers from paranoid schizophrenia and presents with delusional beliefs about being a messenger of God and states that an Illuminati group is trying to kill him. Despite this, XA at times would say that he wants to go back to the DRC as God would protect him. He does not seem to have anyone back in the DRC but has a sister who lives in the UK. He was detained under Section 3 of the MHA after being found shouting on the street naked in the middle of winter. After a few months, XA stabilised but his delusions persisted. He was referred to a local charity who were able to help obtain his Home Office file, provide initial immigration advice, secure legal aid and help find him legally aided representation as XA is destitute and does not have access to financial support.

His legal aid solicitor raised a concern around his mental capacity to make decisions around his immigration matter. A formal assessment was carried out, and when he was found to lack the requisite mental capacity, an application to the Court of Protection was made to appoint his sister to make immigration decisions on his behalf.

Eventually, XA was ready for discharge to the community. It was considered that asylum support accommodation would not be suitable for XA given the risk of dispersal and the importance of his relationship with his sister as a protective factor, particularly considering that she is making immigration decisions on his behalf. He was thus provided with supported accommodation through Section 117 support in his local area, while at the same time assisted to apply for subsistence only support from the Home Office. While his immigration case continues, his mental health coordinator helps XA access local classes and activities, namely ESOL class and a football group.

This case, fictitious but combining elements from real cases seen by the authors, helps to demonstrate how immigration factors were addressed as a key part of in-patient treatment under the MHA from the very beginning, by referring him to a local charity to get him access to legal aid for immigration advice, leading to concerns about his capacity and the involvement of the Court of Protection and finally, considering the risks of dispersal when planning Section 117 support for the person.

We believe that immigration issues need to be seen as a key part of appropriate mental health management, particularly in case of in-patients detained under the MHA or MCA, where the treating team has some statutory responsibilities. Consideration of immigration issues should not be seen as an optional extra, but a key part of holistic and person-centred care.[23]

List of declarations

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Brian Dikoff[1], Rukyya Hassan[2], Rohit Shankar[3], Cornelius Katona[4], Lucia Chaplin[5], Andrew Forrester[6] and Piyal Sen[7]

[1]*Migrants Organise, UK*
[2]*Greater Manchester Mental Health NHS Trust, Manchester, UK*
[3]*University of Plymouth Peninsula School of Medicine, Truro UK, Cornwall Partnership NHS Foundation Trust Truro UK*
[4]*Helen Bamber Foundation London UK and Division of Psychiatry, University College London UK*
[5]*Cambridgeshire and Peterborough NHS Foundation Trust*
[6]*Cardiff University, UK*
[7]*Brunel University and Elysium Healthcare, UK*

Corresponding author:
Professor Piyal Sen, Chadwick Lodge and Eaglestone View, Chadwick Drive, Eaglestone, Milton Keynes MK6 5LS, Emails: piyal.sen2@brunel.ac.uk; piyal.sen@elysiumhealthcare.co.uk