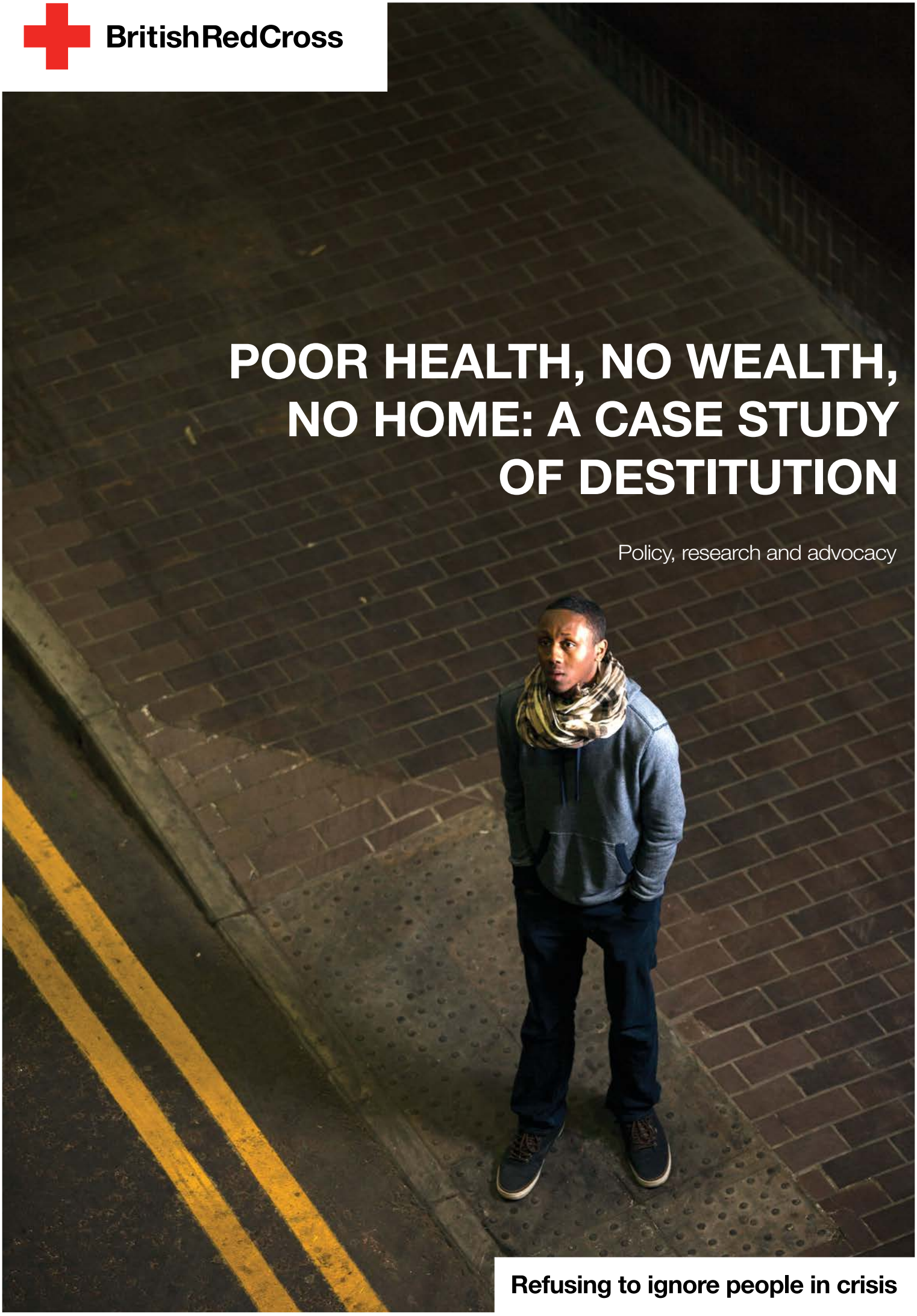
British Red Cross

POOR HEALTH, NO WEALTH, NO HOME: A CASE STUDY OF DESTITUTION

Policy, research and advocacy



Refusing to ignore people in crisis

POOR HEALTH, NO WEALTH, NO HOME: A CASE STUDY OF DESTITUTION

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Foreword

Fleeing your home and arriving in a new country is a traumatic experience. The British Red Cross supports vulnerable refugees and asylum seekers as they settle into their new home and lives.

But once here in the UK, many people who fled one extraordinary crisis now face another: destitution.

As one man said to us during the research: “You lose your whole self-worth.”

This latest report on destitution from the Red Cross uses the experiences of asylum seekers across South Yorkshire as a case study. However, the findings are likely to be echoed throughout the UK – and they paint a bleak picture:

> Two-thirds of asylum seekers report regular hunger – and **a quarter are going hungry every day.**

> **More than half have no fixed address.** In our experience, this adds to the risk of serious – including sexual – exploitation.

> **More than half said their health had worsened.**

This research is highly pertinent, since the publication of the government’s Immigration Bill in 2015 will include changes to asylum support.

We fear these legislative changes, if left unaltered, could plunge thousands more people into destitution. It will add to the struggles of those who have exhausted their appeal rights, but cannot leave the UK through no fault of their own. Families with children will be hit especially hard.

We believe these families should be helped out of destitution until they receive refugee status or can leave the country.

Although the Red Cross stands ready to help those in crisis, we also try to prevent people reaching crisis point in the first place.

That’s why this research and its recommendations are so important. I hope you agree.

Norman McKinley
Executive director of UK operations

Executive summary

> **[This is] a group characterised by vulnerability, inability to satisfy essential needs, and poor health and wellbeing.**

Destitute asylum seekers, a particularly vulnerable group, approach the British Red Cross for a variety of reasons: whether because they have nowhere else to turn, their families or friends cannot support them fully or at all, or they need help with making asylum applications or reapplications.

Destitution can occur throughout the asylum application process. For instance, it may occur because the limited statutory support received does not permit individuals to live in such a way that their essential living needs are met. In other cases, it might be because upon being refused and unable to return to their country of origin, individuals are unable to work and are ineligible for statutory support.

Research objectives

This report follows the 2013 Red Cross report on destitution in Greater Manchester.

Our principle objective was to examine the experience of destitution among asylum seekers living in South Yorkshire (Barnsley, Doncaster,

Rotherham and Sheffield) in relation to the following:

- family responsibilities
- the period of time without government support
- access and usage of non-governmental resources such as friends, family, acquaintances and charities
- health and wellbeing.

Research methodology

Surveys (using questionnaires) were implemented over a one-month period with asylum seekers who used destitution services offered by the Red Cross and partner organisations.

Key findings

The majority of the 56 participants in this research were destitute refused asylum seekers who had been destitute for more than one year. Our findings show that their experience of deprivation was characterised by vulnerability (inconsistent access to essential resources) and uncertainty (when the resources available did not meet their basic needs).

- **Food:**
  - Sixty-six per cent of participants reported experiencing hunger, without being able to satisfy it, on a weekly basis: 23 per cent experienced hunger every day of a given week.
  - Forty-three per cent of participants received food from friends, family and acquaintances (support networks) every day. Yet 15 of these 24 participants still experienced hunger without being able to satisfy it on a weekly basis. Of the 30 participants who received food from charities, 70 per cent reported experiencing hunger without being able to satisfy it on a weekly basis.

- **Shelter:**
  - Sixty-one per cent of participants reported sleeping at the homes of their support network during the previous month and 54 per cent reported sleeping at resources made available by charities.

- **Social networks:**
  - Eighteen per cent of participants did not have at least one person close enough to them that they could be counted on to help or support them with serious problems. But even of those that did, 22 per cent either had not or rarely felt close to others over the previous two weeks. The findings suggest that having someone to count on for help or support with serious personal problems does not necessarily translate to them being physically available, which would have consequences on the material support these individuals are able to provide.

Our findings also showed the experience of being destitute in relation to health and wellbeing.

- **Health and wellbeing:**
  - When comparing their health on the day of the interview with that of a year before, 55 per cent of participants said that their health was either somewhat worse or much worse. Of the 32 participants who had been destitute for more than one year, 59 per cent reported that their health had worsened.
  - Wellbeing among participants was worse than the national average as measured by

the Health Survey of England 2012 (scores: 39 vs 52, respectively, out of a potential of 70).

Conclusion

Our findings show that refused asylum seekers who have been destitute for more than one year, and who formed the majority of our research sample, are a group characterised by vulnerability, inability to satisfy essential needs, and poor health and wellbeing. The informal resources available, which include friends, family and acquaintances and charities, did not satisfy all participants' essential needs. Such resources were characterised by inconsistency and uncertainty. For example, staying in accommodation provided by informal resources did not ensure that hunger was met; and hunger was experienced on a weekly basis even where participants received food from such resources.

Our findings also help to reveal some of the potential impacts of destitution. In particular, the health and wellbeing of the destitute asylum seekers in our study were largely poor, poorer than that of the general population, and characterised by the presence of a range of physical and mental health co-morbidities.

Ultimately, the participants in this study help us to better understand the experience of destitution. Their experiences also help to confirm that informal resources are not an adequate replacement for statutory support designed to meet essential needs such as food, accommodation and healthcare provision.

The following recommendations are based on the findings from this research and are specific to the Red Cross, the Ministry of Justice, the Home Office and the Department of Health.

Recommendations

The charitable sector, including the Red Cross

> Coordinate on data capture to build a more robust evidence base to inform policymakers at local and national levels, as well as how best to use existing resources.

> Develop and practise coordinated activity to ensure that food, shelter and health support are more consistently provided.

> Engage Migration Yorkshire, the regional strategic migration partnership in which local and central governmental entities as well as charities are involved, to discuss how best to address these issues through policy development and collaboration.

Elected officials / policymakers

> Consider and address destitution's impacts on health and wellbeing in the context of the right to health.

> Ensure that the Immigration Bill (2015–2016) does not create a situation where more people experience destitution, and that support arrangements are holistic and satisfy essential needs.

Home Office

> Make statutory support available to all individuals experiencing destitution until they either return to their country of origin or receive leave to remain in the UK. This recommendation should inform development of the Immigration Bill (2015–2016) and regulations within the Immigration Act 2016.

> Grant limited leave to remain to individuals who cannot be returned. Allowing such individuals to fall into destitution is unacceptable.

> Effectively support asylum seekers who volunteer to return to their country of origin in a dignified and respectful manner. By not doing so, they are subjected to a life of dependency and deprivation.

Department of Health

> Make primary and secondary healthcare free and available to all asylum seekers no matter their status, as is the case in Scotland, Wales and Northern Ireland.

1 Introduction

1.1 Background

The vision of the British Red Cross is a world in which everyone gets the help they need in a crisis.

We have a long tradition of providing practical and emotional support to vulnerable refugees across the UK, as well as providing support to asylum seekers throughout all stages of the application process.[1]

Destitute asylum seekers, a particularly vulnerable group, approach the Red Cross for a variety of reasons: whether because they have nowhere else to turn, their families or friends cannot support them fully or at all, or they need help with making asylum applications or further submissions. The support available varies across the country and can include the provision of donated clothing, prepared meals or food, signposting to shelters or other specialist charities, practical and emotional

1 A refugee is a person who "owing to a well-founded fear of being prosecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside of his nationality, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country" (Convention Relating to the Status of Refugees 1951). An asylum seeker is "someone who has applied for asylum and is waiting for a decision as to whether or not they are a refugee" (UNHCR, n.d.).

support, as well as emergency cash support.[2] Less frequently, life skills or English as a second language courses, programmes specific to young or expecting mothers, and supermarket vouchers are available.

1.2 Defining destitution

Destitution can occur throughout the asylum application process. For instance, it may occur because the limited statutory support received does not enable individuals to live in such a way that their essential living needs are met. In other cases, it might be because upon being refused and unable to return to their country of origin, individuals are unable to work and are ineligible for statutory support. Definitions of destitution vary and many are specific to asylum seekers.

According to section 95(3) of the Immigration and Asylum Act 1999, an asylum seeker is destitute if:

> *"(a) he does not have adequate accommodation or any means of obtaining it (whether or not his other essential living needs are met); or*
>
> *(b) he has adequate accommodation or the means of obtaining it, but cannot meet his other essential living needs."*

Variations of this definition have been produced across the charitable sector. In *A Decade of Destitution*, which focused on Greater Manchester, the Red Cross defines "destitute refugees and asylum seekers as anyone who has claimed or is in the process of claiming asylum, and is without any form of statutory support" (British Red Cross, 2013: 11). Similarly, Oxfam GB defines destitution in relation to asylum seekers "for whom legitimate access to resources is prohibited through legislation and policy" and goes further by qualifying that it "describe[s] a situation of extreme poverty or economic marginalisation" (Crawley et al., 2011: 21). Like the Red Cross and Oxfam definitions, the Information Centre about Asylum and Refugees (ICAR) describes destitution as the "inability to access statutory support mechanisms", but also associates it with "reliance on friends, family and charitable groups for basic subsistence and/or accommodation. It can also be defined by its symptoms or effects, such as homelessness" (ICAR, n.d.). Finally, a recent report published by the Joseph Rowntree Foundation provides a definition of destitution that is deprivation-based and includes income-based criteria, and which does not exclusively relate to asylum seekers. Developed through expert consultation, destitution encompasses those who:

> *"suffer an enforced lack of the following minimum material necessities: shelter, food, heating, lighting, clothing and basic toiletries."*

Or

> *"Have an income level so low that they are unable to provide these minimum material necessities for themselves" (Fitzpatrick et al., 2015: 32).*

The charities' definitions frame destitution by cause (answering why someone is destitute) and effect (describing what happens when someone is destitute). Within each of the charities' definitions, destitution is viewed as a consequence of policy – exclusion from statutory support or a means of earning income. The effects of destitution raised by the definitions are more diverse; however, all are rooted thematically around deprivation. The charities' definitions diverge from the legal definition insofar as the latter defines destitution by its effects alone, without considering what has caused an individual to become destitute in the first place.

This report uses the legal definition of destitution, taking into consideration the experiences of those who are destitute. It also considers the policy context that shapes experiences with destitution, whether through limitations on statutory support or the prohibition of the right to work.

1.3 Statutory support

Statutory support during the application process: section 95 and section 98

During the asylum application process, including appeals, asylum seekers may apply for statutory support that is intended to prevent their destitution (Refugee Council, 2013). Section 95 of the Immigration and Asylum Act 1999 enables support for asylum seekers or dependants of asylum seekers "who appear to … be destitute or to be likely to become destitute within such period as may be prescribed" (Immigration and Asylum Act 1999: 67). Section 95 support can be received in the form of accommodation and subsistence, or subsistence only where the Home Office is satisfied that private residence is sufficient (ibid.). The amount of money received per week under section 95 varies according to family claimants

2 Cash support of £10 per person for a maximum of 12 weeks is available to destitute asylum seekers in emergencies, though this is not available in every part of the country.

present in the UK as well as age. From August 2015, "a new standard rate applies to all adults and children" so that "households with children will receive less cash support" than previously (Gower, 2015: 3).

If an asylum seeker or their dependants become destitute "pending the consideration of their support application under section 95", they may apply for section 98 support as a short-term interim measure (Home Office, 2014: section 1.2). Under section 98 full-board accommodation is temporarily granted in initial accommodation centres operated by charities (UKVI, 2015c). In initial accommodation asylum seekers can submit and wait for the outcome of their section 95 applications or await dispersal to section 95 accommodation (ibid.).

To be eligible for section 95 and section 98 support, an asylum seeker must satisfy the legislated definition of destitution discussed in Part 1.2. Additionally, under section 95, asylum seekers must demonstrate that they submitted their applications for status "as soon as reasonably practicable" (Gower, 2015: 3).[3] An asylum seeker may appeal against a rejected section 95 application, but legal aid is only available where the support under consideration includes accommodation (Refugee Council, 2013).

Once refugee status is obtained, the individual may, if necessary, transition to mainstream benefits such as Job Seekers Allowance or Employment and Support Allowance. This transition can incorporate complications to the detriment of new refugees, which are discussed in the Red Cross report *The Move-on Period: An Ordeal for New Refugees* (Carnet et al., 2014a) and the Refugee Council report *28 Days Later* (Doyle, 2014). Where an initial asylum claim has been refused and appeal rights have been exhausted, applicants are expected to leave the UK. Both refused and successful applicants undergo a transition period. Individuals whose claims are refused are granted 21 days to leave the UK. In exceptional circumstances, they can apply for section 4 support during this period. For successful claims, 28 days are granted to transition to mainstream benefits, including housing. During each 'grace period', section 95 support is provided and individuals are expected to prepare for life without it. Section 95 support is available to refused asylum seekers during the grace period on the condition that they file their appeal within 10 days of receiving a refusal.

Statutory support following a refused claim

When an asylum seeker's application for refugee status fails, and where they are not granted humanitarian protection status or discretionary leave to remain, they are expected to leave the UK and return to their country of origin.

However, if a refused asylum seeker remains in the UK with the intention of either making a new application or because they cannot return due to no fault of their own[4] they may be eligible for section 4 support. Crucially, according to the Refugee Council, the purpose of section 4 "is to provide temporary support to people who are destitute and who, through no fault of their own, are unable to leave the UK" (Martin, 2006: 5). Section 4 of the Immigration and Asylum Act 1999 enables the Secretary of State to provide accommodation and financial support to asylum seekers whose applications have been refused and who are destitute or in imminent danger of becoming so.[5]

Section 4 support is distributed according to strict eligibility criteria found within regulations and Home Office guidance. A refused asylum seeker is eligible on the criterion that they are destitute, defined in the same way as section 95 and section 98 support, or are likely to become destitute within a 14-day period (UKVI, 2015b: section 1.7).

In addition to the first criterion, applicants must satisfy at least one of the following five criteria found in regulation 3(2) (a)–(e) of the Immigration and Asylum Act 1999:

> *"(a) The person is taking all reasonable steps to leave the UK or place themselves in a position in which they are able to leave the UK. This could include complying with attempts to obtain a travel document to facilitate departure.*
>
> *(b) The person is unable to leave the UK by reason of physical impediment to travel or for some other medical reason.*
>
> *(c) The person is unable to leave the UK because in the opinion of the Secretary of State there is currently no viable route of return available.*

3 This policy reflects section 55 of the Borders, Citizenship and Immigration Act 2002.

4 This might include cases where, for example, an individual's country of origin forbids their return, they cannot afford the costs of returning or because they fear for their safety.

5 Section 95 support is provided to refused asylum seekers with child dependants at the time of receiving a refusal and applying for support.

(d) The person has made an application for Scotland for judicial review of a decision in relation to their asylum claim or, in England and Wales or Northern Ireland, has applied for such a judicial review and been granted permission or leave to proceed.

(e) The provision of accommodation is necessary for the purpose of avoiding a breach of a person's Convention rights, within the meaning of the Human Rights Act 1998" (UKVI, 2015b: Section 1.2).[6]

Once section 4 support is granted to individual refused asylum seekers, the Azure card system is used to provide £35.39 per week. This is significantly less than what is received under mainstream benefits. The card system ensures that cash is inaccessible and that the recipients can only shop at retailers registered with the Home Office. Pregnant women can receive an additional £3 per week, as well as a one-off maternity payment of £250 (Carnet et al., 2014a; UKVI, 2015a). Additionally, parents or guardians can request £5 per week for babies under one year and £3 for children older than one year until their third birthday (UKVI, 2015a). The card limits purchases to food, essential toiletries, clothing and credit for mobile phones, but cannot be used for travel (Carnet et al., 2014b). Our 2014 research demonstrates that the Azure card system and section 4 support "do not allow refused asylum seekers to meet their basic needs and live with dignity [thereby causing] unnecessary humanitarian suffering" (ibid.: 49).

Where no statutory support is available and refused asylum seekers become destitute, they must rely on informal resources to survive. Given the constraints imposed upon refused destitute asylum seekers and the effects of destitution more generally, we discuss health and wellbeing with reference to international and domestic policy frameworks.

The Home Office Consultation on Support Rates to Refused Asylum Seekers and the Immigration Bill 2015–2016

In August 2015, the Home Office published *Reforming Support for Failed Asylum Seekers and Other Illegal Migrants*, a consultation paper intended to inform the Immigration Bill (2015–2016) (Home Office, 2015a). The consultation paper's purpose was to ensure that public money would "not be used to support illegal migrants, including failed asylum seekers, who can leave the UK and should do so" (ibid.: 2). To this end, it proposed "to legislate to curtail the scope of such support, [consistent] with [the UK's] international human rights obligations, and to remove incentives for migrants to remain in the UK where they have no lawful basis for doing so" (ibid.: 2). Among its proposals, the Home Office consultation paper proposes to:

- Repeal section 4.
- Restrict receipt of section 95 support following a refusal for both individuals and families with dependent children to a grace period. The proposed length of this grace period was 21 days for individuals and 28 days for families.
- Abolish the right to appeal where the Home Office refuses or discontinues support for those who have been refused but face a genuine obstacle to returning home.
- Frame the UK's legal obligations to children, predicated on human rights law, in such a way that the state does not owe support to individuals and families who decide to not leave the UK or take steps to leave following their refusal. In so doing, destitution experienced was identified as an issue that the state is not obliged to address, but rather one that individuals are obliged to avoid by either leaving the UK or by providing an explanation of why and how they could not leave.
- Limit the responsibilities and duties of local authorities to destitute children.

The response of the Red Cross to the consultation paper articulates our reservations on many of the proposals raised, identifying the likely increase in experiences of destitution among individuals and families with children, as well as the increase in opportunity for being subjected to trafficking and exploitation.[7] Were these proposals to be retained within the Immigration Bill (2015–2016), this report provides a cautionary tale, illustrating the consequences and challenges of destitution.

Following the Home Office consultation, the government published the Immigration Bill (2015–2016). According to the bill's impact

6 Applicants with dependants under 18, who were eligible for section 95 support "at the time their asylum appeal rights were exhausted, continue to be eligible for that support in accordance with Section 94(5)" (UKVI, 2015b: section 1.6). However, when a child becomes a dependant or is born after the 21-day grace period following the termination of asylum support, the family will not be eligible for section 95 support, though they may be eligible for section 4 support.

7 The Red Cross submitted a detailed analysis of the consultation paper to the Home Office in September 2015 (Beswick, 2015).

assessment, the bill's purpose is to "reduce illegal immigration and to take a tougher approach to dealing with those who should no longer be [in the UK], including those who have either entered the country illegally or overstayed their visa" (Home Office, 2015b: 1). At the time of writing, following a review of the bill and its impact assessment, many of the proposals within the consultation paper will likely be developed through regulations of the Immigration Act 2016 (ibid.: 11). However, the bill, in its first iteration, incorporates proposals that may impact on experiences of destitution. These include the repeal of section 4 and the introduction of section 95A support, part 2 on 'Access to services' and schedule 6 on 'Support for certain categories of migrant.'

The bill proposes to repeal section 4 support and introduce section 95A support found in schedule 6 on 'Support for certain categories of migrant' (Immigration Bill: 93). Section 95A support is intended for individuals or families with dependent children who are refused asylum seekers and unable to leave the UK due to a "genuine obstacle" (ibid.: 94). However, the exclusion criteria, the value of support and the period of support are not clarified in the bill. It also proposes that section 95A support will be conditional on "communal activities" (ibid.: 94).

Paragraphs 33A–33C of part 2 of the bill propose that landlords will be guilty of an offence in England where two conditions are met: first, "the premises are occupied by an adult who is disqualified as a result of their immigration status from occupying the premises under a residential tenancy agreement"; and second, "the landlord knows or has reasonable cause to believe that the premises are occupied by an adult who is disqualified [from living there]" (ibid.: 8). Furthermore, the government proposes that the Secretary of State will be responsible for informing landlords when a tenant is disqualified from living in their property. Landlords are thereafter obliged, under penalty of imprisonment, a fine or both, to evict their tenants.

The bill also proposes to freeze and close bank accounts of 'disqualified' individuals. Schedule 3 of the bill on bank accounts seeks to prohibit disqualified persons from opening current accounts, as well as to oblige banks to carry out

checks on customers' immigration status. Where a customer is found to be in the UK without status, banks are then required to report this to the Secretary of State. It is then the decision of the Secretary of State to decide whether to apply a freezing order, which would prohibit "each person and body by or for whom the account is operated from making withdrawals or payments from the account" (ibid.: 68–69). While this is unlikely to impact destitute refused asylum seekers due to their limited resources, it does create opportunity for destitution by removing existing resources.

It is unclear from the bill (in its present draft) as to whether and at what stage of the asylum process proposals relating to landlords and banks will affect refused asylum seekers. It is also unclear whether a refused asylum seeker sleeping on a friend's or family member's couch, whose mail from the Home Office is forwarded to that address, would also be forcibly removed and whether their host would also incur punitive measures. Whatever the case, the proposals should be received cautiously insofar as they may create opportunities for the removal of essential resources from refused asylum seekers.

Health, wellbeing and destitution

The experience of destitution is also associated with impacts on the individual's health and wellbeing. It is therefore useful to understand existing rights to health and their relationship to destitution.

In a report by the United Nations Office of the High Commissioner for Human Rights (OHCHR) and the World Health Organization (WHO), "the right to health is [identified as] an inclusive right" that addresses access to healthcare as well as "a wide range of factors that can help us lead a healthy life" (OHCHR and WHO, 2008: 1). The right to health contains freedoms and entitlements. These freedoms include, among others, freedom from "inhuman or degrading treatment or punishment" (ibid.: 1). Entitlements, on the other hand, include: "the right to a system of health protection providing equality of opportunity for everyone to enjoy the highest attainable level of health; the right to prevention, treatment and control of diseases; access to essential medicines; maternal, child and reproductive health; [and] equal and timely access to basic health services" (ibid.: 3–4). Fundamental to the right to health is non-discrimination, "a key human right", so that health services, goods and facilities are provided without "distinction, exclusion or restriction made on the basis of various grounds which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise of human rights and fundamental freedoms" (ibid.: 7).

The UK National Health Service (NHS) constitution reflects the international right to health through an articulation of principles and rights. The guiding principles of the NHS include a "comprehensive service, available to all" and "access to NHS services … based on clinical need, not on an individual's ability to pay" (NHS, 2013: 3). Individuals' rights include the right to receive NHS services free of charge, access to NHS services without being refused on "unreasonable grounds", and the right to "not be unlawfully discriminated against in the provision of NHS services, including on grounds of gender, race, disability, age, sexual orientation, religion, belief, gender reassignment, pregnancy and maternity or marital or civil partnership status" (ibid.: 6).

When comparing English legislation on healthcare provision and health policy relating to refused asylum seekers, incongruities arise – in particular, equality of opportunity to enjoy the highest attainable level of health and, potentially, where specialist care is required to treat and control chronic or complex health needs.

According to part 3 of the Immigration Act 2014, entitlements to free healthcare for asylum seekers vary by immigration status and health needs (part 3, chapter 2, paragraphs 38 and 39). For example, an asylum seeker waiting for the outcome of their application and a refused asylum seeker receiving section 4 support will have access to free primary and secondary healthcare (UKVI, 2015a, 2015b: section 14.6).[8] In contrast, a refused asylum seeker without statutory support can access free primary healthcare, but is excluded from free secondary healthcare and is obliged to pay for it when received.[9] These entitlements are explained by the Department of Health as reflecting the government's commitment to "ensuring that any new system takes into account international law and [its] humanitarian obligations" (Department of Health, 2014a: 23). Yet despite this discrepancy

8 Primary healthcare refers to "the first point of contact for physical and mental health and wellbeing concerns, in non-urgent cases. These include general practitioners (GPs), but also dentists, opticians, and pharmacists" (Department of Health, 2013: 4). Secondary healthcare occurs "when a GP refers a patient to a particular hospital for further investigation or treatment" (ibid.: 4).

9 This may change with the Immigration Bill 2015–2016 so that refused asylum seekers no longer have access to free primary healthcare.

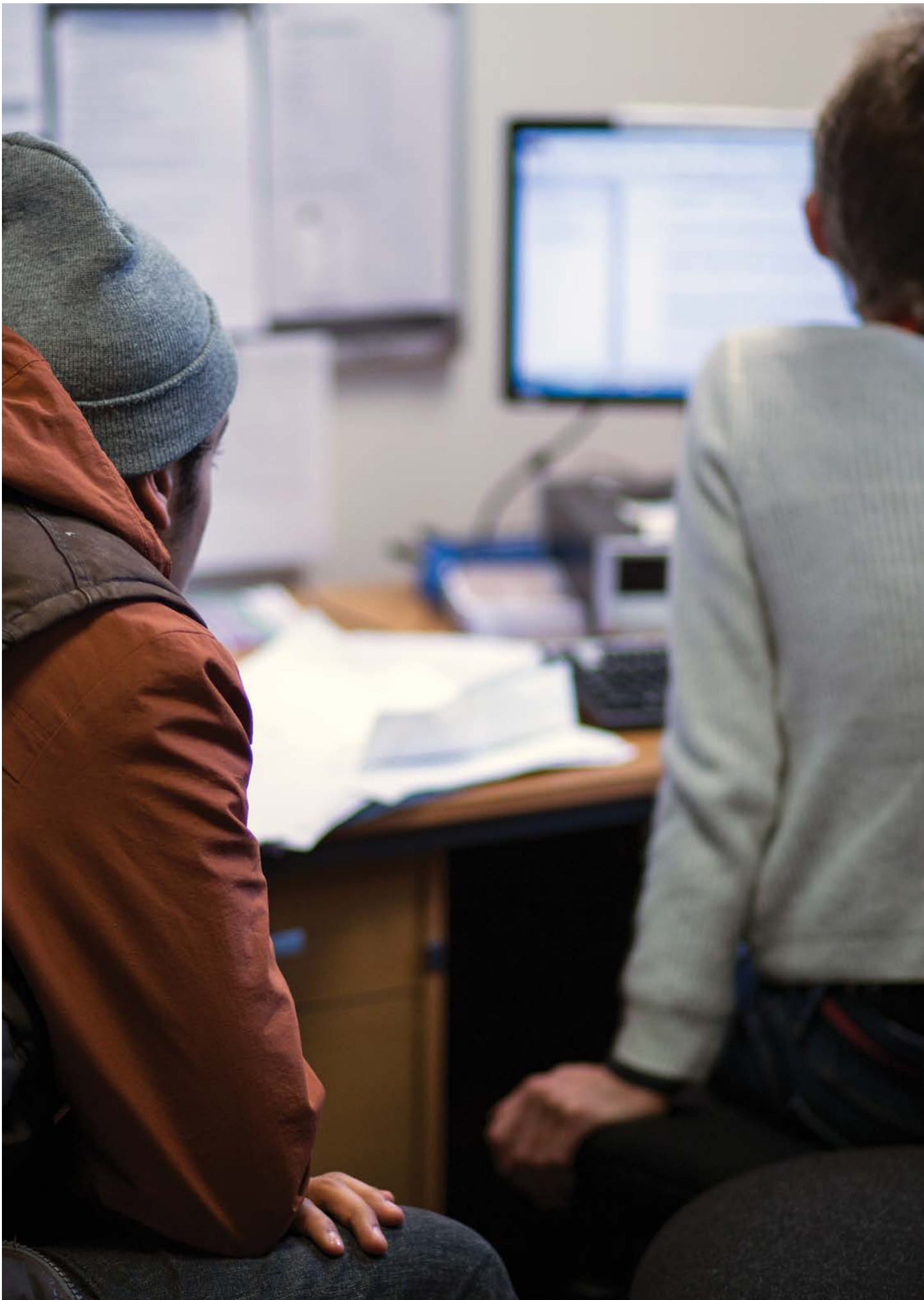
in chargeable services, the Department of Health notes that "it is unlikely that many [illegal migrants, including failed asylum seekers liable to removal] will have the resources to pay" (Department of Health, 2013: 20). Given the constraints placed on destitute refused asylum seekers without statutory support or full healthcare, it is necessary to explore what the implications of such a policy are in relation to those asylum seekers who are refused and destitute.

Determinants of health are "multiple and complex" (Hunter, 2010: 11). According to a Local Government Association report, which cites the WHO's Commission on Social Determinants of Health, "poor health is [identified as] the result of the unequal distribution of power, income, goods, and services" and that "access to healthcare, schools and education, … conditions of work and leisure, homes, communities, towns, or cities" can impact one's opportunity to lead a flourishing life (ibid.: 11).

In the context of destitution, as the British Medical Association (BMA) notes, "refused asylum seekers in particular can often find themselves destitute and living in conditions which can have a negative impact on their physical and psychological health" (BMA, 2012: 1). Furthermore, a 2012 report conducted by Glasgow Caledonian University identifies that many participants with poor health in their study were also destitute and while most participants "had a GP, [their] access to secondary healthcare was difficult, particularly when homeless" (Gillespie, 2012: 49).

Despite an association between destitution and poor health, and the likelihood that refused asylum seekers will experience destitution, healthcare provision is guided by a policy that makes access to specialist health services prohibitively expensive. This is especially the case for destitute refused asylum seekers and in particular those who are unable to return to their country of origin.

In addition to health, wellbeing should also be explored in relation to destitution. According to the NHS, wellbeing can relate to resilience in the face of challenges and a feeling that one can do and accomplish desired tasks and goals (NHS, n.d.). Having "positive mental wellbeing is predictive of quality of life, improved life expectancy and greater life satisfaction. It is also linked to people's physical health and recovery from both physical and mental ill health" (Bridges, 2013: 3). With the interrelationship between health, wellbeing and life experience so clearly defined, wellbeing deserves consideration when analysing the consequences and experiences of destitution.



2 Research objectives

The aim of this research study was to explore the humanitarian crisis experienced by destitute asylum seekers and refugees in South Yorkshire, following on from a similar research project conducted in Greater Manchester in 2013 (British Red Cross, 2013). The present research does not seek to duplicate the Greater Manchester report or to provide findings that are comparable. Instead, like the Greater Manchester report, it seeks to present analysis and findings of the experiences of destitution in a discrete area within the UK. Unlike the Greater Manchester report, this study provides a more developed analysis of the resources available to destitute asylum seekers as well as whether these resources meet essential needs. As the majority of participants within the present study were refused asylum, the report principally focuses on their experiences of destitution.

In exploring this crisis, our principle objective was to examine the experiences of destitution in relation to the following:

- family responsibilities
- the period of time without government support

- access to and use of non-governmental resources such as friends, family, acquaintances and charities
- health and wellbeing.

This holistic understanding will inform British Red Cross public advocacy on behalf of destitute asylum seekers, including our contributions to the Immigration Bill (2015–2016).

2.1 Methodology

To achieve the research objectives, a mixed methods design was adopted, using a questionnaire and in-depth interviews. The latter were used to inform case studies.

Potential participants were identified as eligible for the research if they were an asylum seeker or recent refugee and were receiving destitution support from the Red Cross, which can be provided to individuals both with and without access to statutory support.

In addition to Red Cross service users, individuals accessing destitution support through other charities (ASSIST, Northern Refugee Centre, and South Yorkshire Refugee Law and Justice) were either referred to the research team or were asked to participate in the research during scheduled drop-ins. This necessarily excluded destitute asylum seekers who did not receive support from these charities.

The methods used enable a snapshot examination of the impacts of destitution on the asylum seekers and refugees who participated in the research. Due to the way in which the sample was selected, the descriptive statistics produced in the analysis cannot be extrapolated to the whole population of destitute asylum seekers.

Despite this, the findings may be treated as an indication of what is experienced by destitute asylum seekers.

Questionnaire

The questionnaire was adapted from that used in our 2013 research on destitution in Manchester (British Red Cross, 2013). The Greater Manchester questionnaire covered the features of destitution outlined for exploration in the research objectives, with additional questions added on health, wellbeing and informal resources (the questionnaire is reproduced as Appendix A in this report). Following training, caseworkers and volunteers implemented the adapted questionnaires over the period of one month.

The wellbeing test used is the Warwick–Edinburgh Mental Wellbeing Scale (WEMWBS) as found in the Health Survey of England 2012 (HSE 2012; NatCen Social Research and University College of London, 2012). It was chosen as it allowed comparison with the general English population and because its 14 components could be used to run various analyses with other findings in the research. Minor alterations were made to the wellbeing question in the HSE 2012 to improve the flow of the questionnaire and to allow Red Cross staff to ask participants the wellbeing question directly. This is in contrast to the HSE 2012 version which participants filled out independently. The question, as posed to participants, is given in Appendix A, question 21.

Interview

At the conclusion of the survey, participants who fulfilled specific criteria (listed in Appendix B) were asked to take part in an in-depth interview. Seven interviews were conducted by a researcher during a scheduled meeting or during drop-in sessions. The majority of individuals who completed the questionnaire and interview were Red Cross service users.

3 Findings

Fifty-six participants completed a questionnaire, seven of whom were subsequently interviewed.

3.1 Profile of participants

Eighty-two per cent (n=46) of participants were men, slightly higher than the 2013 statistics on asylum seekers (73 per cent men) (Refugee Council, 2014).

All participants were adults, ranging from 19 to 55 years (mean 34, standard deviation 9 years). When grouped by age, individuals aged 25–29 and 30–34 were the most frequent at 26 per cent and 22 per cent of the sample, respectively.

The ages of female participants ranged from 23 to 52 years, with an average age of 35. Male participants' ages ranged from 19 to 55 years, with an average of 34.[10]

Participants originated from 25 countries. Iraq (16 per cent, n=9) was the country from which the most participants originated. This was followed by

10 One male participant's age is missing.

Iran and Zimbabwe (each with 11 per cent, n=6) and Syria (9 per cent, n=5). Appendix C provides a breakdown of the remaining countries.

Of the 56 participants, 18 per cent (n=10) said they were responsible for family members based in the UK. Seven of these 10 participants had been destitute for more than one year. Nine of the participants[11] reported caring for a combined total of 14 family members. Of the 14 family members, 11 were 17 years old or younger, nine of whom were participants' children. One spouse was mentioned and on two occasions the participants' mothers were mentioned.

11 One participant did not provide detailed information about his dependent family members.

4 Examining destitution

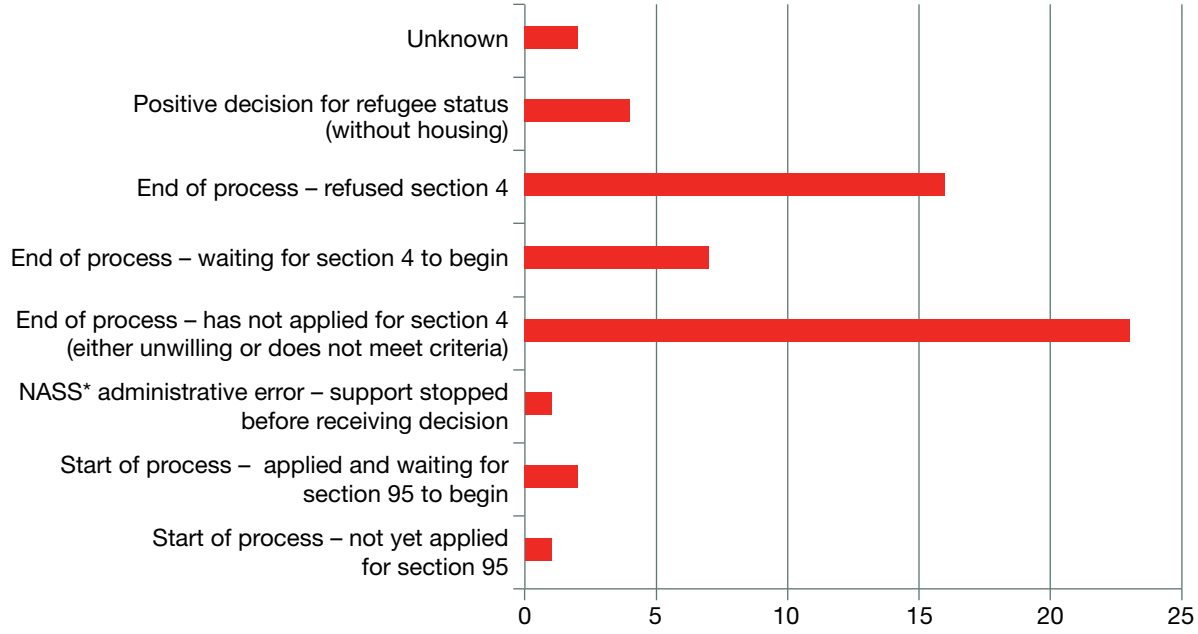
> **I've been like this for seven years – no house, nothing.**

4.1 Destitution at stages within the asylum process

The majority of participants (89 per cent, n=50) were destitute and at the end of the asylum application process, which refers to asylum seekers who have received a decision on their application (see Figure 1 for breakdown of participants by stage of process). Participants at the end of the process fell into four categories: refused section 4; waiting for section 4 to begin; had not applied for section 4; or they had received status and were destitute due to the 'move-on' period in which they were transitioning from asylum support to mainstream benefits (see Table 1 for further details).[12]

12 Although not the focus of this research due to their low representation in this study, our report *The Move-on Period: An Ordeal for New Refugees* provides insight into experiences of destitution during the move-on period.

FIGURE 1 DETAILS ON STAGE WITHIN THE APPLICATION PROCESS



* NASS, national asylum support system.

Table 1: Destitute at the end of the process

	Number of participants	Percentage of participants
End of process – refused section 4	16	29
End of process – waiting for section 4 to begin	7	13
End of process – has not applied for section 4 due to not meeting the criteria	23	41
Received asylum status – in the move-on period	4	7
Total	**50**	**89**

Of the 29 per cent (n=16) of participants who were refused section 4, some, but not all, understood why they were refused:

> *"I applied for section 4 about four or five times. They've refused every try. I applied because my health isn't OK … They asked everything about me. I gave them. I gave medical reports, everything. They said no."*
>
> 42-year-old female

Although relatively few participants were destitute with refugee status (7 per cent; n=4), in all of such cases participants explained that they became destitute while waiting to transition to mainstream benefits. Previous research has shown that status alone is not enough to avoid destitution in all cases because of the difficulty in moving to mainstream benefits within 28 days of receiving the decision (Carnet et al., 2014a).

Four participants experienced destitution early in the application process. In one case, an administrative error prevented receipt of financial support, making it impossible for the participant to buy food. Two others experienced destitution while waiting for their section 95 support to begin; however, no assessment was made as to whether they had applied for section 98 support in the interim. The fourth person had not yet applied for section 95 support as they had only recently begun the asylum application process.

4.2 Period of destitution

The period of time participants had been without statutory support provides another means by which their experience of destitution can be assessed.

Participants were asked how long they had been without government support.

As Table 2 illustrates, **the majority (57 per cent) reported being without government support for more than one year** and, although the questionnaire did not clarify the length of time without support beyond one year, discussion with participants revealed a range of one to eight years. The percentage may be an underestimation, however, given that the questionnaire did not account for multiple periods without support. For example, someone may have been destitute, then received section 4 support, only to fall destitute again once the support terminated.

Age was found to be unrelated to how long a person had been destitute.

4.3 The use of informal resources

Support networks and relationships with others

Without government support, or the option of supporting themselves through legal employment, destitute asylum seekers were found to resort to informal resources for their survival. For the purpose of this research, informal resources include friends, family and acquaintances ('support networks'), as well as charities. These two kinds of informal resources are discussed throughout the report in relation to support received and the ability to satisfy basic needs.

Participants were asked how many people were close enough to them that they could count on them for help with serious personal problems. This may have been interpreted as people participants could go to for emotional and personal support rather than financial or material support. Indeed, their closest friends may be unable to assist them materially due to their own financial constraints; alternatively, participants may not wish to ask for material support due to the nature of relationships. Answers to this, summarised in Table 3, provide some insight into participants' support networks.

Eighty-two per cent (n=46) of participants had at least one person close enough to them that could be counted on to help with serious personal problems, while **18 per cent (n=10) reported not having anyone**.

Informal support networks were characterised by uncertainty and inconsistency. When comparing responses to having someone close to count on for serious personal problems to how frequently over the previous two weeks participants felt close to others, summarised in Table 4, findings did not always correspond.

Of those who reported having one or more people close enough that they could be counted on to help with serious personal problems (n=41), 10 either did not or rarely felt close to others over the previous two weeks. This may be due to spatial constraints.

Table 2: Time without government support

Time without government support	Number of participants	Percentage of participants
Up to 1 month	11	20
5–6 months	6	11
6 months to 1 year	2	4
More than 1 year	32	57
Never received government support	3	5
Did not know	1	2
Total	**55**	**99**[13]

13 One participant did not provide information, representing 2 per cent of all participants.

Table 3: Support networks: Number of people close enough to participants that they could be counted on for help with serious personal problems

Number of people close enough they can be counted on to help with serious personal problems	Number of participants	Percentage of participants
0	10	18
1 or 2	18	32
3 or 4	14	25
5 or more	14	25
Total	**56**	**100**

Table 4: Understanding support networks

How often participants felt close to others over the previous two weeks	Number of people close enough that they could be counted on to help with serious personal problems				
	0	1 or 2	3 or 4	5 or more	Total
None of the time	3	4	1	2	10
Rarely	0	0	3	0	3
Some of the time	0	9	5	1	15
Often	3	3	3	3	12
All of the time	2	1	1	5	9
Total	**8**	**17**	**13**	**11**	**49**[14]

Where participants had close friends or family in the UK, but not nearby, feeling close to them over the previous two-week period may not have been possible from a physical viewpoint. For example, in interview 3 (see below, p. 25), the participant's closest friend moved away and so they were unable to engage one another as before.

Conversely, five participants reported feeling close to others "often" or "all the time" over the previous two weeks but did not have anyone to count on to help with personal problems. This may be due to the nature of their relationships. For example, participants highlighted that they received support from recently met acquaintances and friends of friends. Again, interview 3 highlighted that the participant sometimes received support from people he met at coffee shops, though they were not close friends.

The findings indicate that **having someone to count on for serious personal problems does not necessarily translate to them being physically available**, which would have a consequence on the material support these individuals were able to provide. Consequently, uncertainty is introduced into the nature of relationships between participants and their close friends.

When exploring the nature of support networks alongside who else was dependent upon the participant, the complexities are clear. In particular, the support participants receive and the support they also provide can affect the quality of their relationships.

Four male participants explained that they met their partners, or ex-partners, while living in the UK. These relationships were complex due to participants' financial dependence on their partners or due to sharing participants' limited income received from charitable resources. These participants explained that dependence was a strain on their relationships and, in one case, was associated with consideration of self-harm.

14 Seven participants did not provide a response as to whether they felt close to others over the previous two weeks.

"My children require fatherly and family care that I am not able to offer them. If care is not taken by government a person may end up ending his life."

38-year-old male

Furthermore, when male participants discussed family breakdown due to their inability to provide material support for their families, they raised gender-oriented commentary about their self-worth. In particular, they articulated their inability to act as a man and how this deviated from their families' respective social norms and expectations.

Interview 1 helps to contextualise the experience of fatherhood while destitute.

Interview 1: *Destitution and fatherhood*

"I wanted to be a good husband, but the relationship ended. I moved out – it was her house and I had no rights to family here. She said that if I wasn't with her that I couldn't see my baby. My daughter was four months old when it ended. The whole relationship with my wife and daughter was destroyed.

The lack of support and being destitute destroyed the relationship with the mother of my baby. I moved into her accommodation when we got married. The problem was that I was not providing. She was responsible for everything. She wasn't working and was on welfare. I could tell the money wasn't enough. We couldn't afford sugar, milk. We would quarrel over small things – as a mature person you would know it was because of support.

In African culture … as a man, I felt disrespected. No job – it fell apart."

30-year-old male

Access to food

Participants were asked how many times per week they were hungry without the ability to satisfy their hunger (see Table 5).

Although we are unable to qualify the physical consequences of the hunger experienced, how 'normal' the state of hunger had become, or the severity or length of time the hunger was experienced, our findings provide insight into the frequency of hunger as experienced by participants. These findings, in turn, provide an opportunity to assess whether essential needs are met by resources available.

Most concerning is that **66 per cent (n=37) of participants experienced hunger, without the ability to satisfy it, on a weekly basis and 23 per cent (n=13) reported experiencing hunger without the ability to satisfy it every day of a given week**. In the absence of knowing the duration of this hunger throughout the day, we would view the experience of hunger one to two times a week and three to four times a week equally.

Participants were asked how frequently they accessed food through support networks over a given week (see Table 6). Sixty-six per cent (n=37) of participants reported receiving food from support networks, with 43 per cent (n=24) receiving food through these resources every day.

For the participants who received food from support networks, our findings indicate that support networks were a consistent source of food. This is substantiated by the finding that no participants selected "one-off". Furthermore, 50 per cent of all participants, or 60 per cent of participants who admitted receiving food from support networks, reported receiving food every

Table 5: Inability to satisfy hunger over the period of a week

Times per week hungry without ability to satisfy	Number of participants	Percentage of participants
Every day	13	23
3 to 4 times	12	21
1 to 2 times	12	21
Never	18	32
Total	**55**	**97**[15]

15 One participant did not provide a response, representing 2 per cent of all participants.

Table 6: Frequency that food was accessed through acquaintances, friends or family over a week

Frequency of food accessed through support networks per week	Number of participants	Percentage of participants
Every day	24	43
Most days	4	7
Occasionally	9	16
One-off	0	0
Never	10	18
Total	**47**	**84**[16]

day or most days. However, we cannot be sure whether and to what degree participants obtained food from the same individual.

When comparing hunger without the ability to satisfy it to the frequency of accessing food through support networks, **only nine of the 24 participants who reported receiving food from support networks every day never experienced hunger without the ability to satisfy it.** The remaining 15 participants experienced hunger on a weekly basis. Of the 37 participants who accessed food through support networks, 70 per cent (n=26) reported experiencing hunger on a weekly basis without the ability to satisfy it. This indicates that **although support networks are accessed for food, it appears that this is not enough to satisfy hunger.**

Participants were also asked how frequently they obtained food through charities over a given week. Of the 56 participants, 54 per cent (n=30) reported receiving food from charities (see Table 7).

Where food was accessed on a daily basis through charities, this was often through living in the homes of charity patrons where a meal is provided. Participants also attended food banks for meals or other charity-organised drop-ins. Unlike support networks, "one-off" access was most frequently reported. In contrast to findings on accessing food through support networks, only 18 per cent (n=10) of participants reported receiving food from charities most days or every day. As such, when compared to food from support networks, this may be characterised as inconsistent and so not a stable means by which participants were fed.

Like support networks, participants who accessed food through charities continued to experience hunger on a weekly basis. **Of the 30 participants who received food from charities, 70 per cent**

Table 7: Frequency that food was accessed through charities over a week

Frequency food accessed (per week)	Number of participants	Percentage of participants
Every day	7	13
Most days	3	5
Occasionally	5	9
One-off	15	27
Never	7	13
Total	**37**	**67**[17]

16 Nine participants did not provide a response, accounting for 16 per cent of all participants.

17 Nineteen participants did not provide a response, accounting for 34 per cent of all participants.

(n=21) reported experiencing hunger without the ability to satisfy it on a weekly basis.

It is likely that participants access food from different friends, family and acquaintances, as well as different charities either simultaneously or in rotation, though the exact nature and frequency of this was not examined. Indeed, **30 per cent (n=17) of participants were found to access food through *both* support networks and charities, demonstrating diversification of informal resources.** This pattern of access may be due to food only being available at certain times or days from a given resource or from a felt need not to exploit their friends and family. This is contextualised by interview quote 2 (below). Despite this diversification of resources, **65 per cent of the 17 participants who accessed food through support networks and charities also reported experiencing hunger without the ability to satisfy it at least once a week, while 18 per cent said that they were hungry every day of a given week.**

Ultimately, destitute asylum seekers without statutory support were found to rely on informal resources to access food. As demonstrated by the data, these resources are not sufficient for the 66 per cent of participants who experience hunger on a weekly basis.

Access to shelter

Without statutory support or a means of paying for accommodation themselves, many destitute asylum seekers are left to seek out accommodation through support networks or charities. Access to a place to sleep was assessed by asking how frequently participants stayed with support networks or charities over the period of a month. We also assessed whether feeling close to others corresponded to the frequency of staying with friends, family or acquaintances. Lastly, we sought to understand whether there was consistent or varied access to these resources on a monthly basis and why.

Over the previous month, 61 per cent (n=34) of participants reported having slept at the homes of friends, family or acquaintances. Some friends, family or acquaintances lived in section 95 accommodation where there are restrictions on hosting participants. For asylum seekers, hosting others poses a high risk, which may result in losing their accommodation. As one participant explained:

> *"I made friends at English classes. After that, I'd visit them in their house. They're asylum seekers, too. I've known them for three months. I have never stayed with them. I can't. They're in [section 95] accommodation."*
>
> 52-year-old female

The reliance on support networks to provide shelter is clear. While this finding adds to the growing picture that support networks are relied upon greatly to provide support, of the 10 participants who said they felt close to others "none of the time" or "rarely", eight slept at the homes of friends, family or acquaintances anywhere from two nights to more than three weeks over the previous month (see Table 8). Given this, **one cannot assume that having informal support is either truly satisfying destitute asylum seekers' needs or that it provides or indicates a quality of deep relationship.** Indeed, it may even be a source of tension, unease or it may be indicative of an exploitative relationship.

The pattern is confirmed by external research which found that "staying with friends in the longer term is difficult. As a result, many people move from friend to friend to avoid becoming too much of a burden … [while] many people feel uncomfortable relying on others" (Crawley et al., 2011: 55–56).

In addition to support networks, 38 participants provided information on how many nights over the previous month they had slept at resources made accessible through charities (see Table 9). This includes rooms effectively donated by patrons of particular charities as well as night shelters.

As with the pattern identified in access to food, our findings suggest that people are using multiple sources of accommodation and rotating between friends, family or acquaintances and charities, and also within them.

Interview 2: *Support networks and friends of friends*

"I stay with different friends at different times. I met one friend – also a Zimbabwean. Most friends are not Zimbabwean but all are from Africa – one from Zambia, Guinea, etc.

Sometimes I feel very small. They pay for everything and you can't contribute anything. I feel terrible. That's why I go to different places. It's like parents and a child.

No, not really. I feel it's a temporary thing.

I don't feel I can stay with friends as long as I need to."

29-year-old male

In addition, the reasons for accessing multiple sources of accommodation emerged during the participants' interviews and discussion as they completed the questionnaire. Participants did not feel they could stay with friends indefinitely, as demonstrated by interview 3. In particular, and confirmed by external evidence, destitute asylum seekers reported that if the circumstances of their friends changed, then they were susceptible to being without accommodation (Crawley et al., 2011). This consistency issue was raised in relation to accommodation made available through charities as well. In particular, some participants explained that their access to places to sleep through charities was time-limited due to internal policies.

Table 8: Closeness to others, assessed by frequency of sleeping at home of friends, family or acquaintances

How often participants felt close to others over the previous two weeks	Frequency participants slept at the home of a friend, family or acquaintance over the previous month					
	Never	One-off	2 to 6 nights	1 to 2 weeks	More than 3 weeks	Total
None of the time	1	0	1	0	5	7
Rarely	1	0	0	1	1	3
Some of the time	3	1	2	0	8	14
Often	0	0	1	0	8	9
All the time	1	0	1	1	4	7
Total	**6**	**1**	**5**	**2**	**26**	**40**

Table 9: Nights stayed at a charity over the previous month

Time period	Number of participants	Percentage of total participants
Never	8	14
One-off	1	2
2 to 6 nights	1	2
1 to 2 weeks	9	16
More than 3 weeks	19	34
Total	**38**	**68**[18]

Interview 3: *Support networks and acquaintances*

"I've been like this for seven years – no house, nothing. [A local charity] helps for one year. They give £20 a week. For six months they give me accommodation, then ask me to go out. Before [the local charity] I'd sleep on floors, couches – no shower in three or four days. Now I have a shower, can change my clothes. It's like I'm homeless but I'm not homeless … [The local charity] saved my life.

My girlfriend is scared of the [local charity's] house. There's a lot of people inside.

Before [the local charity], four or five friends let me stay with them. I didn't know them well. I met them in … coffee shops. It's very difficult. Sometimes they say yes, sometimes no. I had one friend [locally] – he is a good guy, very helpful. He helped me so much. But he's moved …

Now that I have house [temporarily from the local charity] my life change so much."

26-year-old male

In addition to assessing close relationships and accommodation, the relationship between access to food and accommodation was also examined.

Seventy per cent (n=28) of participants who slept at the homes of friends, family or acquaintances still experienced hunger without the ability to satisfy it on a weekly basis; and 23 per cent (n=9) experienced hunger every day. To put this into context, 31 of the 40 participants who stayed with people in their support network also reported receiving food from them, yet among these 31 participants 22 reported experiencing hunger without the ability to satisfy it on a weekly basis. This represents 39 per cent of all participants to this research, or 71 per cent of participants who stayed with friends, family or acquaintances and received food from them. **This finding is indicative of the consistency of food received, and that there are no assurances that the food received is adequate to satisfy all needs.**

Twenty per cent (n=6) of participants who reported sleeping at charities experienced hunger on a weekly basis without the ability to satisfy it. Two participants, who reported staying with charities for more than three weeks per month, reported that they experienced hunger every day.

Our findings indicate that informal resources, accessed through support networks and charities, are characterised by inconsistency and uncertainty. This is the context of support during destitution; it is now important to examine the impacts of destitution, specifically on health and wellbeing.

18 Eighteen participants did not provide a response, representing 32 per cent of all participants.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5 Health and wellbeing while destitute

> **You feel terrible here, it is a horrible situation. The psychological toil is the worst thing.**

5.1 Physical health: today and a year ago

Participants were asked to report on their health on the day of the survey and their health today compared with a year ago. Following their self-assessment, participants were asked why they had ranked their health in a particular way.

Health today

Participants were asked to qualify their health according to five answer options ranging from very good to very bad, summarised in Table 10.

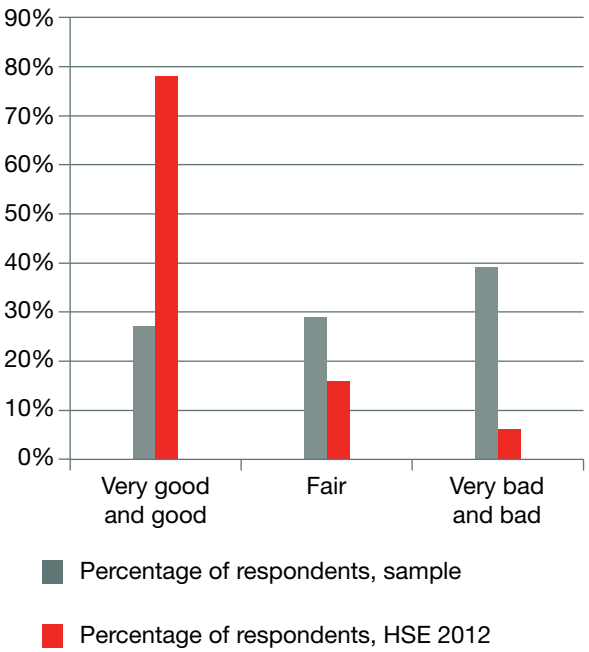
Just over a quarter (27 per cent) reported their health on the day as either good or very good, but **over a third (39 per cent) felt their health on the day was bad or very bad.**

Our findings are nearly opposite those of the latest National Health Survey for England 2012 (HSE), particularly when the very good and good, and very bad and bad scores are aggregated (see Figure 2). While this comparison is problematic due to the HSE 2012 including demographic categories not covered in this analysis, such as individuals of advanced age or

Table 10: Health today

Health today	Number of participants	Percentage of participants
Very good	7	13
Good	8	14
Fair	16	29
Bad	9	16
Very bad	13	23
Total	**53**	**95**[19]

FIGURE 2 HEALTH TODAY COMPARISON: SAMPLE AND HSE 2012, AGGREGATED



younger than 19, the comparison still offers an illustration of just how much worse our participants viewed their health compared to the wider population.

The 29 per cent of participants who reported their health as "fair" require consideration. If fair and good responses were aggregated, they would total 56 per cent of the sample compared to 39 per cent who reported bad or very bad health. However, while "fair" may be understood as neutral, it is worth considering that the standard by which a destitute asylum seeker qualifies "fair" may be different from a person who is not in their circumstances. Issues around benchmarks or baselines are, however, beyond the scope of this research.

Physical health on the day compared to a year ago

Measuring changes in health, and drawing a causal link between destitution and such changes, is complex and requires a rigorous analysis. We do not truly have a baseline for our participants' health before destitution, and so in order to ascertain a health change we asked for self-reported health today as compared to one year ago. Findings are summarised in Table 11.

Changing health in the context of destitution

> *"My situation is not good, not healthy. I have never lived like this."*
>
> 44-year-old male

Assessing whether the period of destitution and changes in health are related is detailed in Table 12.

Of the 32 participants who had been destitute for more than one year, 59 per cent (n=19) reported that their health had worsened, 25 per cent (n=8) reported that their health had stayed the same; and 16 per cent (n=5) reported that their health had improved. While it is possible that one year ago their health may have been poor and remained so – resulting in the neutral answer of 'about the same' – **our findings nonetheless show a pattern of deteriorating health in those destitute for the longest.**

When asked to give reasons for worsening health, participants discussed a range of co-morbidities affecting their mental and physical health. While none of these can be causally linked to destitution, some participants clarified that their health conditions arose, or worsened, while they were destitute. Table 13 provides insight into

19 Three participants did not provide a response, representing 5 per cent of all participants.

Table 11: Health today compared to a year ago

Health today compared to a year ago	Number of participants	Percentage of participants
Much better	3	5
Somewhat better	8	14
About the same	13	23
Somewhat worse	17	30
Much worse	14	25
Total	**55**	**97**[20]

Table 12: Period without government support and health today compared to a year ago

Health today compared to a year ago	Period without government support				
	Up to 1 month	2 to 5 months	6 months to 1 year	More than 1 year	Total
Much worse	4	1	0	6	11
Somewhat worse	3	2	0	13	18
About the same	1	2	0	8	11
Somewhat better	3	1	1	2	7
Much better	0	0	0	3	3
Total	**11**	**6**	**1**	**32**	**50**[21]

Table 13: Descriptions of worsened health for participants destitute for more than one year

Physical health	Psychological and emotional health	Both physical and psychological health
> Liver problems > Hemorrhoids, indigestion and recurring headaches that disrupt sleep > High blood pressure > Getting older	> Recurring migraines and stress > Chest and breathing problems, asthma and stress > Exhaustion due to not having a place to sleep > Stomach ulcer caused by depression medication > Sexual dysfunction, severe depression, loss of diet, lack of exercise, social isolation, nightmares	> Stress associated with not having support or accommodation > Nightmares, flashbacks and problems with sleeping > Depression > Feeling down, depressed, low self-esteem at thought of having no future

20 One participant did not provide a response, representing 2 per cent of all participants.

21 Four participants did not clarify the length of time they were without government support. Two of these participants said that their health was "much worse", one said that it was "about the same" and one said that it was "somewhat better".

co-morbidities experienced by participants who identified that their health had worsened. Each bullet point reflects a particular respondent's response so that 13 out of 32 participants destitute for more than one year are represented.

In contrast, participants experiencing improved health explained that this was due to medicine received or hospitalisation. With regard to healthcare received, the research cannot in every case elaborate whether it was received while participants were destitute or whether it was before they received an outcome on their application. One individual, who required hospitalisation for mental health issues, received this support while destitute.

The health issues raised by participants without government support for more than one year and who identified that their health improved over the past year are listed in Table 14.

Stability in health, represented by "about the same", does not necessarily represent a neutral or positive experience of health. Of the eight participants reporting stable health, more than half (n=5) reported having been in poor but stable health over the period. The remaining three participants, on the contrary, reported good and stable health. They referred to sports that kept them in shape, religion and support from friends. To put this into perspective, the three participants who reported consistently good health over the year represent 5 per cent of the sample (n=56) and 9 per cent of participants without government support for more than one year.

The health issues raised by participants without government support for more than one year and who identified that their health stayed about the same over the past year are listed in Table 15.

5.2 Wellbeing

> *"You lose your whole self-worth. If you're allowed to work, it might help. You're in limbo, you don't know what to do. What it does to me … I'm uncertain – I just go find a place to help volunteer."*
>
> 29-year-old male

Wellbeing scores of 47 out of 56 participants are analysed.[22] Among the 47 participants, 13 had missing data and omitted either one or two of the 14 fields. An average was taken of the participants' responses to allow for further analysis to take place without removing all the participants' data completely.

22 In accordance with external guidance, nine participants were excluded or dropped from the analysis (Steward-Brown and Janmohamed, 2008). Seven participants did not provide any information on the wellbeing question; and two participants partially filled out their questionnaires, but omitted more than three of the 14 fields.

Table 14: Descriptions of improved health for participants destitute for more than one year

Physical health	Psychological and emotional health
> Daily arthritis medication is helping > Stomach operation two or three years ago. Is still taking medication, which has improved his health > Stopped smoking due to being without money and health improved	> Hospitalised for mental health issues; since released feels better and gets checked on by medical staff

Table 15: Descriptions of health that stayed about the same for participants destitute for more than one year

Physical health	Psychological and emotional health	Both physical and psychological health
> No sleep, no food, no documents. Too many cigarettes in order to forget the bad situation. Nothing has changed since last year > Play football to keep fit > Eye has had lots of operations	> Nightmares, flashbacks and problems with sleeping > Depression > Feeling down, depressed, low self-esteem at thought of having no future	> Gift from God > Destitution makes you very depressed; also have lost weight and strength > Depression and epilepsy; engages in a lot of voluntary activities to keep spirits up. Acts normally even though does not feel it

"It is a hopeless situation, very depressing, an endless cycle. It is like being stuck in a cage with, there is nowhere to go, it is very bad. You feel terrible here, it is a horrible situation. The psychological toil is the worst thing."

40-year-old male

The lowest possible score for the wellbeing test is 14 and the highest level of wellbeing is 70. Wellbeing scores for participants ranged from 15 to 68, with an average score of 39 (standard deviation: 12.5). Within the HSE 2012, the average score was 52.5 with a standard deviation of 9.0. So, while our average shows much lower wellbeing, there is a wider variation in scores within our study, perhaps due to the smaller sample size.

The average score for women participants was 39.1 and for men it was 38.9. This is lower than the average score for men (52.5) and women (52.2) in the HSE 2012 sample data (Bridges, 2013: 1). Even for the most deprived areas of England, HSE data still reports scores of 51.1 for men and 50.2 for women – which might be assumed to be close to a deprivation level of our sample but with a safety net of statutory support and accommodation (ibid.).

Comparing the sample with the HSE 2012 with filters

Comparing scores by sex and age helps to reduce the effect of other external variables, such as the impact of advanced age on wellbeing scores when taken as an overall average. This provides for a more reasonable comparison with the HSE 2012 findings. This breakdown can be found in Appendix D.

When examining our data against HSE 2012 data for the different ages of participants, our sample still shows largely poorer wellbeing among participants within this study. However, it is possible that the scores of participants in this study may be scrutinised further.

Caseworkers, who conducted the survey (questionnaires) and had long-term experience with participants, explained that within some cultures there is a reluctance to show what might be perceived as weakness or vulnerability. This may inflate positive responses or those where "often" and "all of the time" were selected, especially among men.

6 Conclusion and recommendations

Our research found that the existing resources available did not satisfy all participants' essential needs, such as food and shelter.

Our findings show that refused asylum seekers who have been destitute for more than one year, and who formed the majority of our research sample, are a group characterised by vulnerability, inability to satisfy their essential needs, and poor health and wellbeing. Ultimately, the findings from this study should help us better understand the experience of destitution among refused asylum seekers, as well as provide insight into policy change to reduce destitution. This report echoes the experience detailed in the destitution research conducted in Greater Manchester (British Red Cross, 2013) and there is little reason to believe this would differ substantially in other areas.

Our research found that the existing resources available did not satisfy all participants' essential needs, such as food and shelter. These resources, which include friends, family and acquaintances, as well as charities, were sometimes characterised by inconsistency and uncertainty. This was demonstrated where participants were found to experience hunger on a weekly basis without the ability to satisfy it, and where participants slept at alternative locations over a period of a month, switching among friends, family or acquaintances

and between support networks and charities. It was further substantiated by the finding that feeling close to someone – having someone you feel you can rely on – does not ensure being able to satisfy even the most basic of needs. Ensuring that destitute asylum seekers' essential needs are met requires end-to-end statutory support and may also benefit from greater coordination among the charitable sector's services. As our findings indicate, available informal resources do not, in all cases, adequately replace such support. Furthermore, our research on the Azure card showed that section 4 support does not necessarily meet these needs either (Carnet et al., 2014b).

In addition to assessing the resources available to research participants, our findings also help to reveal some of the potential impacts of destitution. In particular, the health and wellbeing of the destitute asylum seekers in our study are largely poor – poorer than that of the general population – and characterised by the presence of a range of physical and mental health co-morbidities. This was substantiated by participants' perceptions of their health at present, as well as changes in health in the context of destitution, where more than half said that their health had worsened over the previous year. Worsening health in the context of destitution, and the asylum process in general, suggests the need for changes which would improve health early or reduce failing health during the asylum process.

Our participants' wellbeing was also poorer than that of other people, as found in the HSE 2012, whose participants, it can be assumed, would not have endured the same life experience as the asylum seekers in this study. Furthermore, HSE 2012 respondents were also likely not subject to the same levels of statutory support. With the consequences of negative wellbeing on health, it is clear that the experience of destitution is such that it may create opportunities for compounding health issues.

Studies of health that seek to establish causality between a particular experience (such as destitution) and health status or changes in health require more sophisticated methodologies than the ones used in this study. Despite this, the findings within this research should encourage further investigation into the subject and point towards the need for statutory support to remedy poor health and wellbeing deficits.

That there were people in our study who had been refused asylum and destitute for up to eight years, is indicative that destitution may be considerably prolonged or even indefinite. The reasons for this may be diverse, but were not examined in this study. However, it is known that possible reasons include: a lack of identification documents and their ostensible country of origin refuses to issue new ones, refused re-entry as a matter of policy, or because there is no viable and secure route of return. Where individuals

cannot return, they should be permitted to live and work independently, without spending their lives, or large portions of their lives, destitute and dependent on others' charity and goodwill.

The following recommendations are based on the findings of this research and are specific to the British Red Cross, the Ministry of Justice, the Home Office and the Department of Health.

6.1 The charitable sector, including the Red Cross

The findings show that, while the charitable sector plays an important role in addressing destitute asylum seekers' essential needs, it does not, even in conjunction with support networks, meet all such needs. However, the charitable sector should continue to develop capacities to more comprehensively address needs as they arise and persist.

Given this, the charitable sector should:

> Coordinate on data capture to build a more robust evidence base to inform policymakers at local and national levels, as well as how best to use existing resources.

> Develop and practise coordinated activity to ensure that food, shelter and health support are more consistently provided.

> Engage Migration Yorkshire, the regional strategic migration partnership in which local and central governmental entities as well as charities are involved, to discuss how best to address these issues through policy development and collaboration.

6.2 Elected officials

Policymakers should:

> Consider and address destitution's impacts on health and wellbeing in the context of the right to health.

> Ensure that the Immigration Bill (2015–2016) does not create opportunities for destitution to be experienced and that support arrangements are holistic and satisfy essential needs.

6.3 Home Office

The Home Office should:

> Make statutory support available to all individuals experiencing destitution until they either return to their country of origin or receive leave to remain in the UK. This recommendation should inform development of the Immigration Bill (2015–2016) and regulations within the Immigration Act 2016.

> Grant limited leave to remain to individuals who cannot be returned. Allowing such individuals to fall into destitution is unacceptable.

> Effectively support asylum seekers who volunteer to return to their country of origin in a dignified and respectful manner. By not doing so, they are subjected to a life of dependency and deprivation.

6.4 Department of Health

The Department of Health and the NHS should:

> Make primary and secondary healthcare free and available to all asylum seekers no matter their status, as is the case in Scotland, Wales and Northern Ireland.

References

Beswick, J. (2015) Submission to: 'Reforming support for failed asylum seekers and other illegal migrants', London: British Red Cross, [Online], Available: www.redcross.org.uk/~/media/BritishRedCross/Documents/About%20us/ImmigrationBill2015.pdf

Bridges, S. (2013) *Wellbeing*, London: The Health and Social Care Information Centre, [Online], Available: www.hscic.gov.uk/catalogue/PUB13218/HSE2012-Ch5-Wellbeing.pdf

British Medical Association (2012) *Access to healthcare for asylum seekers and refused asylum seekers – guidance for doctors*, London: British Medical Association, [Online], Available: bma.org.uk/-/media/files/pdfs/practical%20advice%20at%20work/ethics/asylumseekeraccessguidancenovember2012.pdf

British Red Cross (2013) *A decade of destitution: time to make a change*, Manchester: British Red Cross, [Online], Available: www.redcross.org.uk/~/media/BritishRedCross/Documents/What%20we%20do/UK%20services/Greater%20Manchester%20destitution%20report.pdf

Carnet, P., Blanchard, C. and Apollonio, F. (2014a) *The move-on period: an ordeal for new refugees*, London: British Red Cross, [Online], Available: www.redcross.org.uk/~/media/BritishRedCross/Documents/About%20us/Research%20reports%20by%20advocacy%20dept/Move%20on%20period%20report.pdf

Carnet, P., Blanchard, C. and Ellis, J. (2014b) *The Azure payment card: the humanitarian cost of a cashless system*, London: British Red Cross, [Online], from: www.redcross.org.uk/About-us/Advocacy/Refugees/Azure-payment-card

Crawley, H., Hemmings, J. and Price., N. (2011) *Coping with destitution: survival and livelihood strategies of refused asylum seekers living in the UK*, Oxford: Oxfam GB, [Online], Available: policy-practice.oxfam.org.uk/publications/coping-with-destitution-survival-and-livelihood-strategies-of-refused-asylum-se-121667

Department of Health (2012) *Guidance on providing NHS treatment for asylum seekers and refugees*, [Online], Available: www.gov.uk/government/news/guidance-on-providing-nhs-treatment-for-asylum-seekers-and-refugees

Department of Health (2013) *Guide to the healthcare system in England*, London: Department of Health, [Online], Available: www.gov.uk/government/uploads/system/uploads/attachment_data/file/194002/9421-2900878-TSO-NHS_Guide_to_Healthcare_WEB.PDF

Department of Health (2014) *Visitor & Migrant NHS Cost Recovery Programme: implementation plan 2014–2016*, London: Department of Health, [Online], Available: www.gov.uk/government/uploads/system/uploads/attachment_data/file/329789/NHS_Implentatation_Plan_Phase_3.PDF

Doyle, L. (2014) *28 days later: experiences of new refugees in the UK*, Stratford: British Refugee Council, [Online], Available: www.refugeecouncil.org.uk/assets/0003/1769/28_days_later.pdf

Eurostat (2010) *EHIS wave 1 guidelines*, European Commission, [Online], Available: ec.europa.eu/eurostat/documents/203647/203710/EHIS_wave_1_guidelines.pdf/ffbeb62c-8f64-4151-938c-9ef171d148e0

Fitzpatrick, S., Bramley, G., Blenkinsopp, S., Johnsen, S., Littlewood, M., Netto, G., Sosenko, F. and Watts., B. (2015) *Destitution in the UK: an interim report*, York: Joseph Rowntree Foundation, [Online], Available: www.jrf.org.uk/sites/files/jrf/destitution.pdf

Gillespie, M. (2012) *Trapped: destitution and asylum in Scotland*, Glasgow: Glasgow Caledonian University, [Online], Available: www.scottishrefugeecouncil.org.uk/assets/0000/5050/Trapped_destitution_and_asylum_final.pdf

Gower, M. (2015) *'Asylum support': accommodation and financial support for asylum seekers*, (HC, Standard Note: SN/HA/1909), London: House of Commons Library, [Online], Available: http://researchbriefings.parliament.uk/ResearchBriefing/Summary/SN01909#fullreport

Home Office (2014) *Assessing destitution*, London: Home Office, [Online], Available: www.gov.uk/government/uploads/system/uploads/attachment_data/file/326774/Assessing_Destitution_Instruction.pdf

Home Office (2015a) *Reforming support for failed asylum seekers and other illegal migrants*, London: Home Office, [Online], Available: www.gov.uk/government/uploads/system/uploads/attachment_data/file/451088/Reforming_support_for_failed_asylum_seekers_and_other_illegal_migrants_-_Consultation_Document.pdf

Home Office (2015b) *Impact assessment*, London: Home Office, [Online], Available: www.gov.uk/government/uploads/system/uploads/attachment_data/file/461689/Overarching_Impact_Assessment.pdf

Hunter, D. (2010) 'What makes people healthy and what makes them ill?' In: Campbell, F. *The social determinants of health and the role of local government*, London: IDeA, [Online], Available: www.local.gov.uk/c/document_library/get_file?uuid=eb92e4f1-78ad-4099-9dcf-64b534ea5f5c&groupId=10180

Information Centre about Asylum and Refugees (ICAR) (n.d.) Destitution, [Online], Available from: http://www.icar.org.uk/6575/briefings/destitution.html

Immigration Act 2014, c. 22, London: The Stationary Office, [Online], Available: www.legislation.gov.uk/ukpga/2014/22/pdfs/ukpga_20140022_en.pdf

Immigration and Asylum Act 1999, c. 33, London: The Stationary Office. [Online]. Available: www.legislation.gov.uk/ukpga/1999/33/pdfs/ukpga_19990033_en.pdf

Immigration Bill (Bill 74), London: The Stationary Office, [Online], Available: www.publications.parliament.uk/pa/bills/cbill/2015-2016/0074/15074.pdf

Martin, S. (2006) Refugee agencies policy response: the Impact of Section 4 Support, London: Refugee Council, [Online], Available: www.refugeecouncil.org.uk/assets/0001/6343/IAP_Section_4_support

NatCen Social Research and University College of London (2012) Health Survey for England 2012, UK Data Service, The Health and Social Care Information Centre, [Online], Available: discover.ukdataservice.ac.uk/series/?sn=2000021#access

NHS (2013) *The NHS Constitution*, London: Department of Health, [Online], Available: www.gov.uk/government/uploads/system/uploads/attachment_data/file/170656/NHS_Constitution.pdf

NHS (n.d.) *Five steps to mental wellbeing*, [Online], Available: www.nhs.uk/conditions/stress-anxiety-depression/pages/improve-mental-wellbeing.aspx

Office of the United Nations High Commissioner for Human Rights and World Health Organization (2008) *The right to health factsheet No. 31*, Geneva: OHCHR, [Online], Available: www.ohchr.org/Documents/Publications/Factsheet31.pdf

Refugee Council (2013) *Asylum support*, Refugee Council, [Online], Available: http://www.refugeecouncil.org.uk/assets/0003/0290/Asylum_Support.pdf

Refugee Council (2014) *Asylum statistics*, Refugee Council, [Online], Available: www.refugeecouncil.org.uk/assets/0003/1356/Asylum_Statistics_Feb_2014.pdf

Steward-Brown, S. and Janmohamed, K. (2008) *Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS)*, Warwick: Warwick Medical School, University of Warwick, [Online], Available: www.healthscotland.com/uploads/documents/7551-WEMWBS%20User%20Guide%20Version%201%20June%202008.pdf

UK Visas and Immigration (UKVI) (2015a) *Asylum support*, [Online], Available: www.gov.uk/asylum-support/what-youll-get

UK Visas and Immigration (UKVI) (2015b) *Asylum support, section 4 policy and process*, [Online], Available: www.gov.uk/government/uploads/system/uploads/attachment_data/file/414232/Asylum_Support_Section_4_Policy_and_Process_v4.pdf

UK Visas and Immigration (UKVI) (2015c) *Asylum support: policy bulletins instructions*, [Online], Available: www.gov.uk/government/uploads/system/uploads/attachment_data/file/422990/Asylum_Support_Policy_Bulletin_Instructions_Public_v6.pdf

UNHCR (n.d.) *The facts: asylum in the UK*, [Online], Available: www.unhcr.org.uk/about-us/the-uk-and-asylum.html

Appendix A
Questionnaire – Destitution in South Yorkshire

Guidance note to the caseworker:

If there are questions for which the caseworker already knows the answer, please do not ask and fill in accordingly. Questions that can be answered by the caseworker will be identified with: "*Caseworker, fill in if known."* A formulated question is also provided should the caseworker feel that it is necessary to ask.

All italicised text addresses the caseworker. It may be a note, comment or instructions on a given question.

Service users may expand on questions. Please do your best to write this content down on the questionnaire or on another piece of paper.

Read: *"This questionnaire is being used to help the British Red Cross better understand how being without government support affects people seeking asylum. It will be used to inform a research report. Your name and any names you mention will not be included in the report – everything will be anonymised.*

The ultimate goal of our work is to make compelling arguments to government that the current system in place is inadequate and that the repercussions on asylum seekers are unnecessary, harmful and need to be fixed."

Caseworker, identify location of interview:

Barnsley	Doncaster	Rotherham	Sheffield

BASIC INFORMATION ON INTERVIEWEE

1. **Ask: *"Is this the first time you have taken part in the questionnaire?"***

Yes	No	Unsure

1a. If no, ask: *"Where were you interviewed before?"* OR *"Who interviewed you before?"*

If recently interviewed by partner organisation, end interview.

2. **Caseworker, fill in sex:**

M	F	Other

3. **Caseworker, fill in date of birth, or age, if known: *"What is your date of birth?" (dd/mm/yy)***

4. **Caseworker, fill in name if known. If necessary, ask: *"Can you tell me your full name?"***

Caseworker, state: *"Your name will not be used in any public documents. It will only be used to make certain that you have not been interviewed twice by partner organisations."*

4a. If client does not wish to share name, ask: *"May I use your first name?"*

5. **Caseworker, fill in country of origin if known: *"Where are you originally from?"***

IDENTIFYING DEPENDANTS

6. Ask: *"Do you support any family members in the UK?"*

Yes	No

6a. If yes, ask: *"Can you tell me their relationship to you? For example, whether they are your son, daughter or spouse."*

Relationship	Male #	Female #	Other description
Spouse			
Child (under 18)			
Extended family			

CLIENT'S DESTITUTION BACKGROUND

7. Ask: *"Do you currently receive any support from the government – like housing or a benefits allowance?"*

Yes	No	Unsure

7a. If yes, ask: *"Can you tell me what kind of support you receive and how long you have received it?"*

Financial	Housing	Unsure

Caseworker, if known tick appropriate box below:

Section 95	
Section 98	
Section 4	
Unsure	

8. If (7) no, ask: *"Have you tried to apply for government support – in particular, section 4?"*

Yes	No

8a. If no, *"Why not?"*

CONSEQUENCES OF DESTITUTION

9. If (7) no, ask: *"How long has it been since you stopped receiving support?"*

<1 – 1 month	
2–5 months	
6 months to one year	
More than one year	

10. If known, tick the reason for destitution.

If not known, ask: *"What did you most recently do in making your application for refugee status?"* If needed, read some options as prompts.

Start of process – not yet applied for section 95 (NASS)	
Start of process – applied and waiting for section 95 to begin	
Denied support under section 55	
NASS administrative error – support stopped during asylum process	
Lost NASS support due to breach of conditions (e.g. absence, working illegally, alternative income)	
End of process – not applied for section 4 (unwilling; don't meet criteria; if age disputed please note this)	
End of process – waiting for section 4 support to begin	
End of process – refused section 4	
End of process – previously supported by Social Services as UASC	
Positive decision (without housing)	
Social services – applied and waiting for social services support	
Adult social care – social services support removed	
unknown	

11. Ask: *"Have you required legal advice throughout the asylum process?"*

Yes	No

11a. *"What was it about?"*

12. *"Were you able to access legal advice as you required it?"*

Yes	No

12a. If no, *"Why not?"*

12b. If yes, *"How did you access it?"*

13. **Ask: *"Where did you sleep last night?"***

In previous NASS accommodation	
With family or friends	
Outdoors (e.g. on street, park, in doorway)	
Bus station or other public building	
Homeless shelter	
Accommodation provided by church, mosque or other faith group	
Charity (name) accommodation	
Other (please specify)	
No response	

DEPENDENCE ON OTHERS

14. **Ask: *"How many people are so close to you that you can count on them if you have serious personal problems?"*** [23]

0	
1 or 2	
3 or 4	
5 or more	

15. **Ask: *"Have you received any support in the past month? For example from friends, family, acquaintances or charity?"***

Yes	No

15a. If yes, *"How did you access it?"*

Family	
Friends	
Charities	
People you've just met	

16. **Ask: *"How many times in the past month have you stayed with a friend, family member or person you have just met in order to get a place to sleep?"*** Fill in 'Person' column before asking 16a.

16a. *"And how many days in the past month have you slept at a charity or a shelter?"*

	Person	Charity/religious inst.
Never		
One-off		
2 to 6 nights		
1 to 2 weeks		
More than 3 weeks		

23 Eurostat (2010: 19).

17. **Ask: *"How many days in a given week do you receive food or a meal from a friend, family members or a person you have recently met?"*** Fill in "Person" column before asking 17a.

17a. *"And how many days in a given week do you receive food or a meal from charity or religious institution (food bank)?"*

	Person	Charity/religious inst.
Every day (7)		
Most days (4–6)		
Occasionally (2–3)		
Once a week		
Never (0)		

Read: *"The next question is being asked because other organisations have found it to be something that occurs with their service users. Please do not feel that I am suggesting anything by it."*

18. **Ask: *"Have you ever worked or provided some service to this person, or anyone else, in exchange for food and housing?"*** Examples include: cleaning their flat or looking after their kids.

Yes	No

HEALTH

19. **Ask: "In general, would you say that your health is:"** [24]

Very good	
Good	
Fair	
Bad	
Very bad	

19a. Ask, *"Why is that?"*

20. **Ask: "Compared to one year ago, how would you rate your health in general now?"**

Much better	
Somewhat better	
About the same	
Somewhat worse	
Much worse	

20a. Ask, *"Why is that?"*

24 HSE 2012.

Read: *"The following question has multiple parts and is focused on your emotional wellbeing. The British Red Cross did not write this question. It has been taken from the Health Survey of England, which has been used on the general population within England. We hope to use your and other interviewees' responses to compare against the answers given by the general population.*

Some of the parts of the next question may be difficult and even brutal. If you feel that you don't wish to respond, please tell me. I apologise if what follows is difficult, but know that your responses are greatly appreciated."

21. State: *"I'll now read some statements about feelings and thoughts. Please tell me which of the following answers – none of the time; rarely; some of the time; all of the time; or don't know – best describes your experience of each over the last two weeks. The statements and answers are also on this printout for you to look at as I read through them. Please let me know if you don't understand the statement and I can explain it to you. There are no right or wrong answers."* [25]

Provide interviewee with a printout of this chart so that they can read along if necessary and to show them the answer options. The printout does not have comments and is framed in the first person, e.g. "I've been feeling …"

G	Fields *Comments describing prompts are in italics*	None of the time	Rarely	Some of the time	Often	All of the time	No answer/ refused	Don't know
1	You've been feeling optimistic about the future. This refers to whether the interviewee has been hopeful or positive about the future.							
2	You've been feeling useful. This refers to whether the interviewee has felt as though they have or could have contributed or done something. E.g. by volunteering, etc.							
3	You've been feeling relaxed. This refers to whether the interviewee has felt at ease and without worry or stress.							
4	You've been feeling interested in other people. This refers to whether the interviewee has wanted to engage with/talk to, meet or learn about other people.							
5	You've had energy to spare. This addresses whether interviewees have been exhausted/talk during the time period or whether they have maintained their energy/ vitality.							

25 HSE 2012.

G	Fields *Comments describing prompts are in italics*	None of the time	Rarely	Some of the time	Often	All of the time	No answer/ refused	Don't know
6	You've been dealing with problems well. This addresses whether interviewees have been able to cope with any challenges or problems that occur.							
7	You've been thinking clearly. This refers to interviewees' ability to think with clarity or precisely or their ability to judge what is important and make decisions.							
8	You've been feeling good about yourself. This refers to interviewees' self-worth and self-esteem.							
9	You've been feeling close to other people. This refers to interviewees' experience in relating to others socially and may include close friends, romantic partners, but not acquaintances.							
10	You've been feeling confident. This refers to whether the interviewee has felt self-assured or positive.							
11	You've been able to make up your own mind about things. This refers to interviewees' ability to think critically and make decisions.							
12	You've been feeling loved.							
13	You've been interested in new things.							
14	You've been feeling cheerful.							

22. **Ask: *"How many times a week are you hungry without ability to satisfy your hunger?"***

Never	
One to two times a week	
Three to six times a week	
Every day	
Very bad	

23. **Ask: *"Is there anything else you would like to share in relation to your experience?"***

Appendix B Checklist – Identifying interview opportunities

Ideally, the following characteristics will be present for potential interviewees. This checklist will be used throughout the research. In theory, the checklist will be used by colleagues to identify interviewees based either on case notes or on recollection.

"Req'd" refers to characteristics that are essential for potential interviewees. "Desired" fields refer to characteristics that are not essential but would add value to the research. We, however, do not wish to encourage that these fields are overlooked.

Characteristic	Req'd	Desired
Refugee or asylum seeker	X	
Demonstrates willingness to speak about their experience with destitution. Shy clients are poor interviewees.	X	
Relies on others financially or for other basic necessities like food and clothing	X	
Speaks and understands English at a conversational (more than basic) level. If not, please clarify language needed for translation		X
Has been destitute for at least six months (relates to right to work argument)		X
Currently or previously stayed at someone's house due to not having a permanent home of their own		X
Has previously or currently works to earn income or has traded (transacted) work for subsistence like food, shelter or clothing		X
Has previously held a career		X
Wishes to build a career in the UK		X

Appendix C Participants' countries of origin

Country of origin	Participants per country	Percentage of total participants
Afghanistan	2	4
Algeria	2	4
Cameroon	1	2
Côte d'Ivoire	1	2
Democratic Republic of Congo	1	2
Eritrea	3	5
Ethiopia	1	2
The Gambia	2	4
Ghana	1	2
India	2	4
Iran	6	11
Iraq	9	16
Kuwait	1	2
Liberia	1	2
Nigeria	2	4
Palestine	1	2
Senegal	1	2
Somalia	2	4
South Sudan	1	2
Sri Lanka	1	2
Stateless	1	2
Sudan	1	2
Syria	5	9
Yemen	2	4
Zimbabwe	6	11
Total	**56**	**106[26]**

26 The total is greater than 100% due to rounding.

Appendix D Sample and HSE 2012 wellbeing data comparison

Where sex and age are used as filters, the comparison of average wellbeing score proves more revealing insofar as intervening variables (e.g. scores of people of advanced ages) are removed from influencing the averages taken.

Age groups were used where there was more than one sample participant per grouping. In cases where there was only one participant per grouping, scores relating exclusively to that age were considered within the HSE 2012 data.

All but one sample score per age group (48-year-old woman) achieved wellbeing scores less than those of the same age group within the HSE 2012.

In the majority of comparisons, excluding the aforementioned one, the difference in wellbeing scores exceeds the difference between the HSE 2012 average and average scores of people living in the most deprived circumstances.

This examination would benefit from a larger sample of destitute asylum seekers to better identify average scores per age group and to minimise variance around the mean. For the purpose of this report, it is only meant to demonstrate how the participants within this study scored in relation to people their same age and sex as documented within the HSE 2012.

Table D1: Wellbeing scores compared, males

Age group	Destitute asylum seekers – sample	HSE 2012	Difference in scores: HSE – Sample
19	36	52.8	16.8
20–24	31	52.9	21.9
25–29	40.2	52.2	12.0
30–34	34.8	52.6	17.8
35–39	41.2	52.9	11.7
40–44	39.2	51.7	12.5
45–49	44.5	51.6	7.1
50	51	53.4	2.4
55	43	53.5	10.5

Table D2: Wellbeing scores compared, females

Age group	Destitute asylum seekers – sample	HSE 2012	Difference in scores: HSE – Sample
20–24	33	51.7	18.7
28	27	53.1	26.1
30–34	49	52.8	3.8
40–44	33.5	51.1	17.6
48	52	51.6	–0.4
52	34	49.3	15.3

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