A health needs assessment for asylum seekers and other vulnerable migrants in Southampton and Portsmouth

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CONTENTS

1 INTRODUCTION

Asylum Seekers (AS) are forced migrants. They have escaped persecution or conflict in their home countries and are seeking protection in another country. Their experiences before leaving their country of origin, on their journey and during the process of seeking asylum, have particular implications for their health and wellbeing. This assessment looks specifically at AS, and other vulnerable migrants such as failed AS, because their health needs tend to be greater and more complex than other categories of migrant[1]. (See Appendix for definitions of different types of migrant).

The aim of this assessment is to gather information on the health needs of AS (both adults and children) living in the cities of Southampton and Portsmouth and to describe the relevant services, and any gaps in those services, in order to make recommendations to better meet their needs.
This aim is supported by the following objectives:-

- Collate relevant national and local epidemiological data
- Review the relevant literature and consult with local stakeholders (including AS themselves) on the health needs of AS and other vulnerable migrants
- Gather information on the key services that are currently available to support the health and wellbeing of AS in Southampton and Portsmouth
- Explore best practice service provision in comparator areas

This assessment has been guided by a steering group made up of a subgroup of the Wessex Global Health Network. Rather than covering the whole of Wessex, the scope has been limited to Southampton and Portsmouth as these local authorities are the only ones in Wessex to accept AS[i]. With rising pressure on the UK Government to achieve a more equitable distribution of AS across the country[2], it seems likely that other local authorities will be accepting AS in the future and, therefore,

the findings of this assessment may become increasingly relevant to other areas in Wessex.

This report begins with a description of the methodologies used followed by epidemiological data describing the numbers of AS living locally. The health needs of AS in Southampton and Portsmouth, identified from relevant literature and local stakeholder consultation, are then discussed. Next is a summary of key local services followed by a description of 'what works' which is informed by looking at best practice locally and elsewhere. Finally, the information from the assessment is used to analyse where the gaps in service are and to make recommendations for better meeting the health needs of AS.

A health needs assessment should be a tool for change so it is intended that the recommendations in this document are converted into an action plan to be adopted by the relevant organisations in Southampton and Portsmouth.

2 METHODOLOGY

Health needs assessment is a 'systematic public health process for identifying the unmet health and care needs of a population, making changes to meet those unmet needs and creating health gain' [3]. In public health 'need' is defined as the 'ability to benefit'[4]. There were four main approaches used in this needs assessment:

2.1 Literature review

A review of relevant literature was undertaken by searching both published and grey literature. Whilst there is a wealth of literature on migrant health, it is often difficult to disaggregate findings to AS specifically[5]. The findings from the literature are incorporated alongside the findings of the stakeholder consultation throughout this document.

2.2 Epidemiological data analysis

Epidemiological data was obtained from Home Office statistics[6]. Although further data was available from the accommodation provider, Ready Homes (via the SE Migration Partnership), and from local services and voluntary agencies, this was considered sensitive as could potentially disclose information about individuals so was not included in this publicly available report.

2.3 Comparative needs assessment

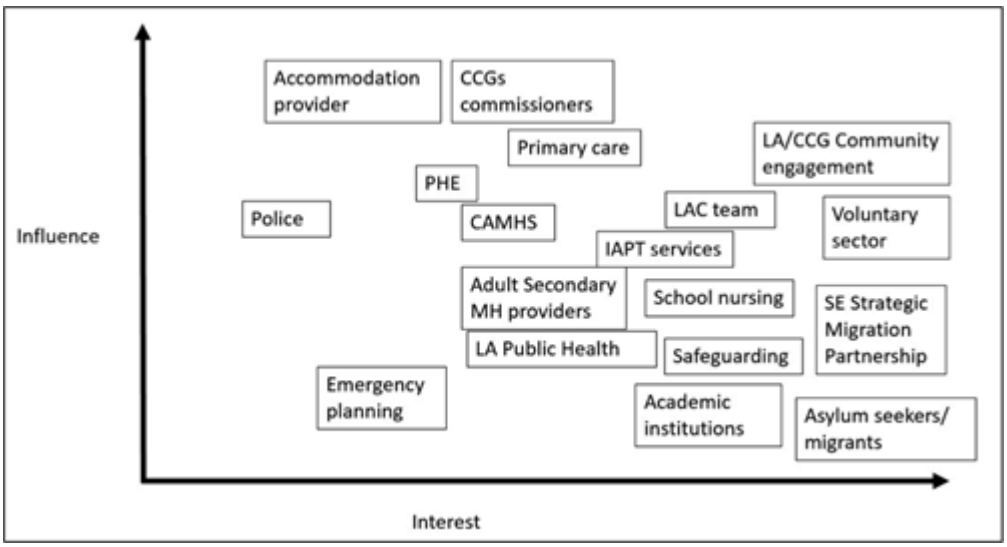
A comparative needs assessment approach has also been used to establish models of good practice from elsewhere that could be applied in Southampton and Portsmouth. The "comparative approach" contrasts the services received by the population in one area with those received in other areas[7]. In order to make the most appropriate comparisons, there has been an attempt to focus primarily on areas considered 'most similar' to Southampton and Portsmouth (such as Bristol, Norwich and Plymouth)[8].

2.4 Corporate needs assessment

This assessment of needs has largely been done through a 'corporate' approach which involves collecting the views of stakeholders, including professionals and AS themselves, on what the needs are, what services are available and whether there are any gaps in services[4]

In order to ascertain which stakeholders to consult, a stakeholder analysis was carried out. This involved drawing up a list of all the people and groups involved with the health and wellbeing of AS and other vulnerable migrants in Southampton and/or Portsmouth. The level of interest and influence of each of the stakeholders was then assessed and mapped onto a chart (see Figure 1).

Figure 1: Stakeholder map



Over 35 face-to-face or telephone meetings were conducted with

stakeholders. The conversations were not audio-recorded but substantial notes taken plus written reflections were made immediately after each conversation to assist with the identification of themes. The consultations were an iterative process involving continuous review of notes in order to identify themes as well as to identify additional stakeholders to consult. This report includes the predominant themes identified which were based on majority views.

Stakeholders were asked about the health needs of AS and other vulnerable migrants. They were also asked about the services provided to this population group, about any gaps in services and for their views on potential improvements.

Additionally, four focus groups were conducted with AS. Two were conducted at the Avenue Multi-Cultural Centre in Southampton and two at the All Saints drop-in in Portsmouth. There were separate focus groups for men and women. All focus groups were conducted in English so participants were selected on the basis of being able to understand and speak a reasonably good level of English. The limitation of this in terms of gathering the views of non-English speakers is acknowledged and the findings from the focus groups are considered with this bias in mind.
The focus groups were held in private rooms at each venue and were audio-recorded. Key themes were identified from the discussions but the whole conversation was not transcribed verbatim. Quotes were transcribed from the recordings to illustrate the themes. The audio-recordings were then deleted. Names and other key details of the participants were not recorded so there is no risk of disclosure of participants' identity. Two facilitators were present at all focus groups and the themes were identified by one of the facilitators and then verified by the other facilitator.

3 EPIDEMIOLOGICAL DATA

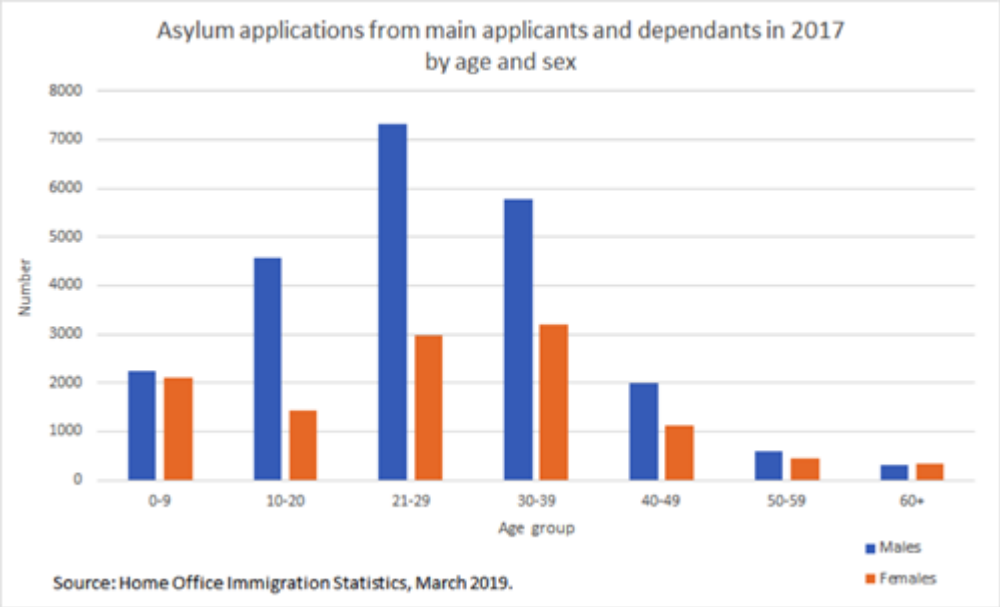
3.1 National Data

There were 32,693 asylum applications in the UK (main applicants only) in the year ending June 2019. At that time, there were 45,203 people receiving Section 95 support, 1,583 receiving Section 98 support and 3,893 receiving Section 4 support (see Appendix for explanations of these different types of support).[6]

The chart below shows the age and sex breakdown of UK asylum

applicants and their dependents in 2017. The higher proportion of males and young adults has been seen for many years[6].

Figure 2: UK Asylum applications by age and sex, 2017[6]



In the year ending June 2019, there were 3,496 applications from Unaccompanied Asylum-Seeking Children (UASC). More detailed data is available for 2018, when there were 2,872 UASC of whom 89% were male and three-quarters were aged 16-17 years. The table below shows that Eritrea, Sudan, Vietnam and Iraq were the most common countries of origin for these children.

Table 1: **Most common countries of origin for UASC arriving in the UK in 2018**

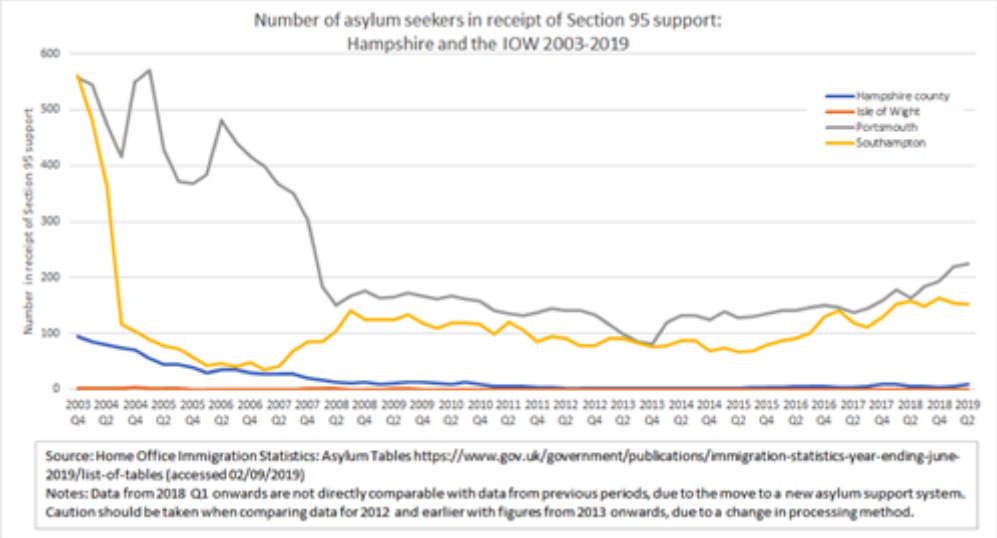
Country of Origin	Number of UASC
Eritrea	620
Sudan	462
Vietnam	312
Iraq	308
Albania	286
Iran	251
Afghanistan	210
Ethiopia	117
Other	306
TOTAL	2,872

Source: Home Office Immigration Statistics[6]

3.2 Local Data

As at June 2019 there were 224 AS being supported in Portsmouth under Section 95 and 153 in Southampton. There is no data on the numbers of failed AS living locally. The chart below shows how the number of AS being supported in the cities, and elsewhere in Hampshire, has changed since 2003.

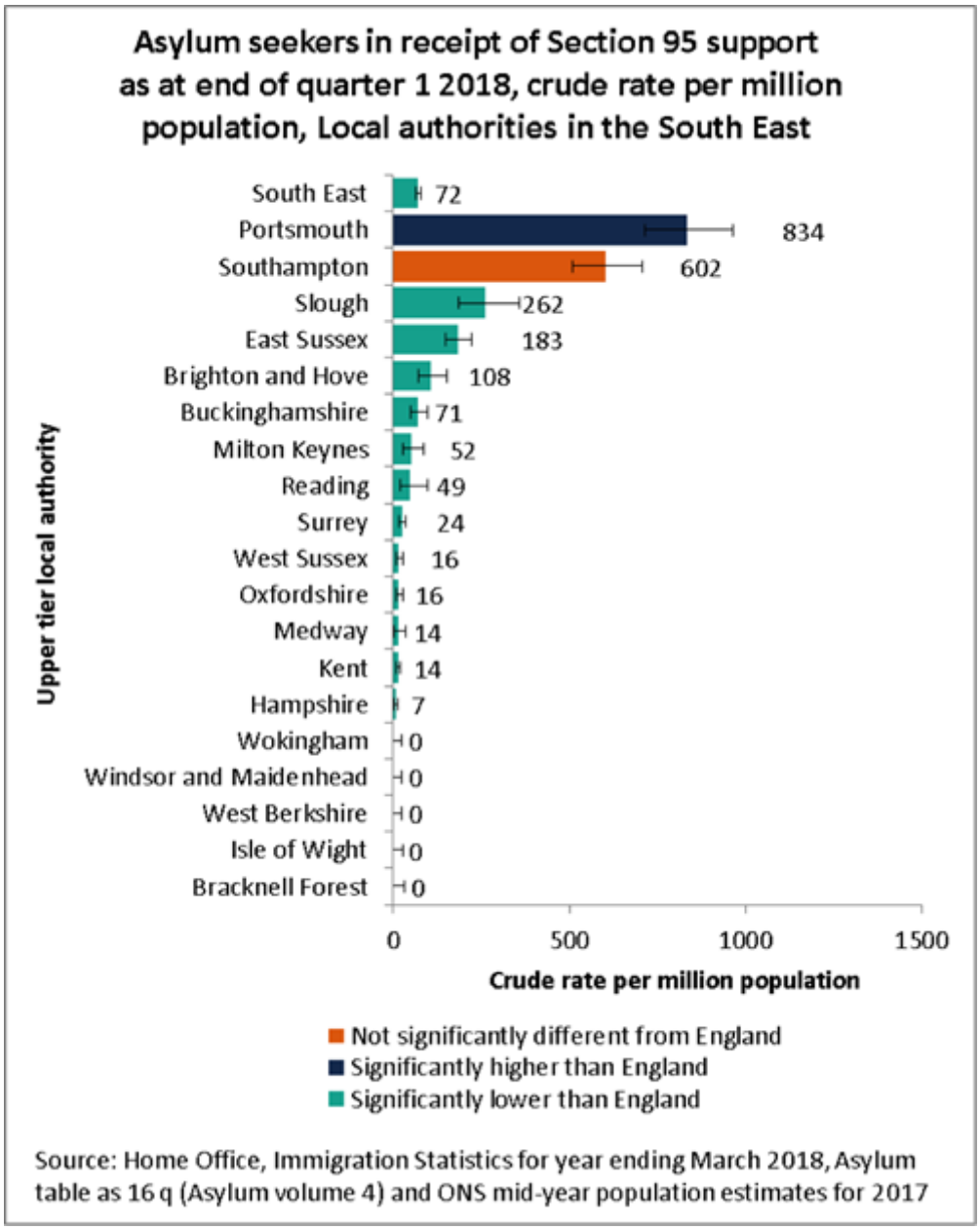
Figure 3: Asylum seekers in receipt of Section 95 support, Hampshire and Isle of Wight 2003-2018[6]



Of the AS receiving Section 95 support, the vast majority (208 in Portsmouth and 148 in Southampton) were living in dispersal accommodation.

The following chart shows the rate of AS per million population in each local authority in the South East at the end of Q1 2018. There were 834 AS per million population in Portsmouth which was higher than any other local authority in the South East and significantly higher than the England average.

Figure 4: AS in receipt of Section 95 support per million population, 2018



In 2018 there were 72 UASC in local authority care in Portsmouth and 14 in Southampton[9]. However, unpublished data from local services suggests the numbers are now much higher in Portsmouth. These children are cared for in children's homes, foster care or other special residential settings. The table below shows how the numbers have changed over the past few years; the increase in Portsmouth has been particularly significant

Table 2: Unaccompanied asylum-seeking children

Year	England	South East region	Hampshire	Isle of Wight	Portsmouth	Southampton
2008	3890	700	35	0	20	20
2009	3480	620	30	0	20	20
2010	2730	530	30	0	20	15
2011	2200	430	25	0	20	10
2012	1860	410	25	0	15	0
2013				0	0	0
2014	1970	450	25	0	5	0
2015	2030	440	20	0	9	0
2016	4210	1350	30	0	30	0
2017	4560	1070	80	0	45	10
2018	4480	850	112	7	72	14

Source: Children looked after in England including adoption - Local Authority Table LAA4[9]

In 2018 UASC in Portsmouth made up 0.16% of the child population which is higher than the national ceiling of 0.07% beyond which local authorities can apply for a National Transfer of children to another local authority[10]. In 2018 UASC in Southampton made up 0.03% of the child population.

4 IDENTIFICATION OF NEEDS

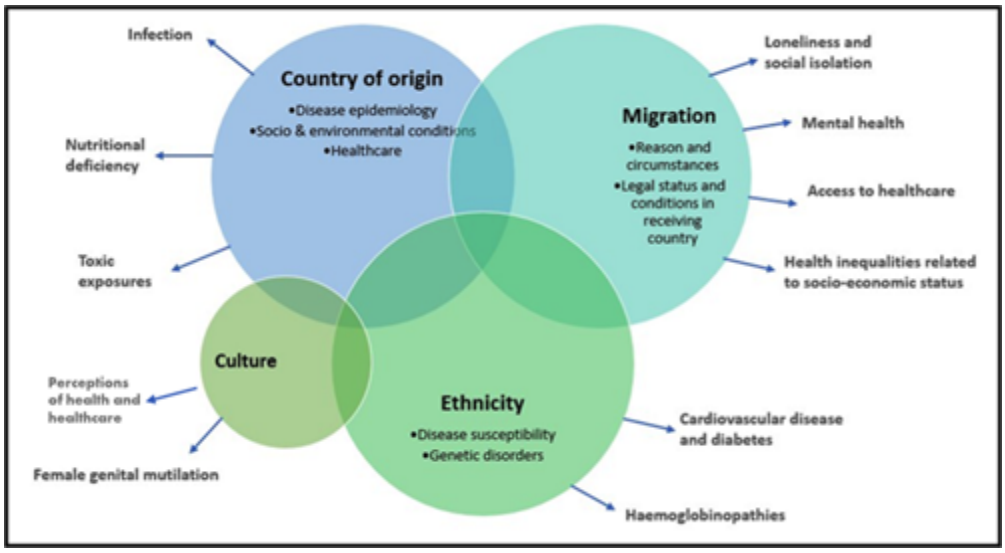
4.1 Overview

The majority of AS come from countries that are experiencing war, conflict or other abuse of human rights. Additionally, these countries of origin are less likely to have good access to health care, safe drinking water, accommodation, food supply and education. Such countries have a limited capacity to treat those with acute health concerns and chronic diseases or to provide immunisation. Additionally, AS may spend many weeks or months travelling to try and reach a safe place. During their journey they are likely to have stayed in overcrowded camps with very poor hygiene, lack of sanitation and exposure to disease.[11] AS will probably have found it very difficult to meet their basic needs during

times of persecution in their home country and during their journey to the UK.

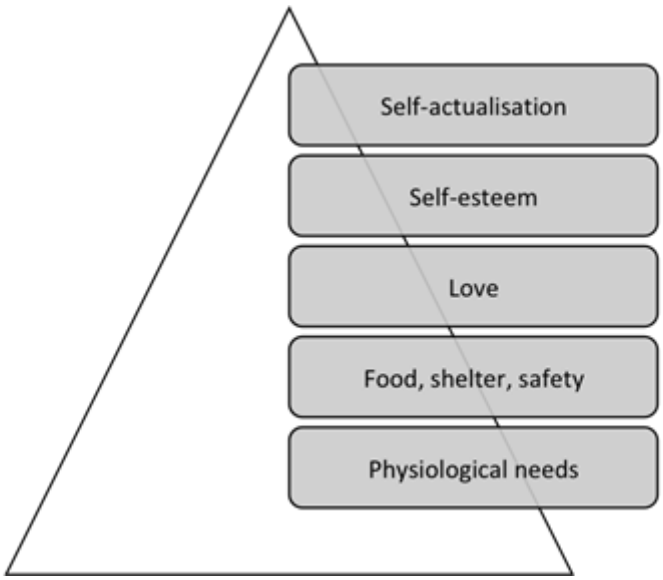
The diagram below summarises the factors influencing the health of migrants[12]; many stakeholders also emphasised the significant impact of the asylum process itself.

Figure 5: Factors influencing the health of migrants (adapted from PHE 2018)[12]



In Southampton and Portsmouth most AS receive accommodation and basic living support[13]. However, meeting basic needs remains very difficult even for supported AS and it is virtually impossible for other vulnerable migrants (such as failed AS who are no longer in receipt of Home Office support). Many stakeholders in this assessment mentioned Maslow's hierarchy of need (see Figure 6) where the needs at the bottom of the pyramid (i.e. physiological needs such as water and food) must be satisfied before other needs (such as self-esteem) are met[14]. For instance, several healthcare professionals spoke about the difficulties in meeting the healthcare needs of vulnerable migrants when they cannot offer them accommodation through Section 117 (see Appendix for further information). This hierarchy of need may explain the tendency of some AS to drop in and out of treatment or therapy, which is an issue mentioned by several different healthcare professionals during this assessment.

Figure 6: Maslow's Hierarchy of Needs[14]



The following themes emerged from the stakeholder consultation and from the relevant literature; they are divided broadly into physical health, mental health and access to services. It is, however, important to note that AS are not a homogenous group (they encompass significant diversity of ethnicity, faith, language, culture, politics, education and socio-economic backgrounds) and, therefore, their needs will be individual just like the rest of the population.

4.2 Physical Health

Some stakeholders referred to the 'healthy migrant effect' meaning that it is often the younger and healthier people who attempt and succeed to move to a new country[15]. This is often the case for economic migrants whereas AS, although often young men, are particularly vulnerable to certain health conditions because of their experiences either before, during or after migration[1 16].

The following physical health issues were identified in this assessment.

4.2.1 Maternal health

Concerns over poorer maternal outcomes for AS and vulnerable migrants were mentioned by several of the healthcare professionals consulted in this assessment. There is evidence from across Europe that immigrant

women have a higher risk of low birth weight, preterm delivery, perinatal mortality, and congenital malformations, even after adjustment for age at delivery and parity[5]. A systematic review found that pregnant AS in the UK have considerable unmet needs[17]. In 2007 12% of all maternal deaths in the UK were refugees and AS, despite these groups making up just 0.3% of the population in the United Kingdom at that time[18].

4.2.2 Sexual health

Studies have highlighted the sexual and reproductive health needs of AS and vulnerable migrants, with high levels of sexual gender-based violence being reported along with limited access to contraception[19].
Several stakeholders mentioned the cultural sensitivities of sexual health needs and services for AS; particularly in relation to accessing contraception and uptake of cervical screening.

Female Genital Mutilation (FGM)[20] was also mentioned as a significant issue by several stakeholders. For some AS, the threat of FGM to their daughters is the very reason for their asylum claim. Health and care professionals consulted in this assessment appeared to be well aware of their safeguarding responsibilities regarding FGM but did mention the challenge of raising this sensitive issue with patients.

4.2.3 Chronic disease

Although AS are often younger than the general population, ethnic differences in disease susceptibility can mean that some are more at risk of certain long term conditions[21]. Several AS who took part in the focus groups described positive experiences of managing their conditions, such as diabetes, in primary care since arriving in Southampton or Portsmouth.

Stakeholders described how chronic disease in AS can also stem from their traumatic experiences; for instance, stress responses during the journey can increase the risk of heart disease and diabetes. Additionally, exposure to noxious chemicals and shrapnel can lead to long-term co-morbidities such as chronic mobility problems.

4.2.4 Communicable disease

Most AS originate from low- and middle-income countries, where there is a generally higher prevalence of infectious diseases such as Hepatitis B, Tuberculosis and HIV than in the UK.[22] Additionally, the risk of

contracting infectious diseases may be increased by poor living conditions before and after migration[23]. Vaccinations are often incomplete and AS are unlikely to have records to demonstrate their vaccination status[24]. Infectious diseases and issues around vaccination were a particular concern raised by the stakeholders involved in caring for UASC.

4.2.5 Other physical ill health and injuries

Stakeholders mentioned physical health issues caused by experiences of conflict or torture, such as amputations or shrapnel being embedded inside the body. Impacts of the journey itself were also mentioned, including hypothermia from travelling in refrigerated lorries and malnutrition.

4.3 Mental Health

Throughout the stakeholder consultation, mental health was consistently mentioned by professionals as a key area of need for AS in Southampton and Portsmouth. Mental health was also talked about by AS themselves but they tended not to describe it in these terms instead talking about their symptoms. The mental health issues most frequently mentioned were anxiety, depression and Post Traumatic Stress Disorder (PTSD); comorbidity with physical health problems was also common.

PTSD is the most common mental health diagnosis in refugees who seek treatment (K.Young, personal communication, 13/09/2019). AS have often experienced multiple traumatic events involving repeated, and prolonged exposures to threat and violence which puts them at much greater risk of 'complex PTSD'[25]. This is characterised by high levels of dissociation, nightmares and flashbacks plus some complex PTSD sufferers experience 'psychotic-like' symptoms (e.g. hearing the voice of a torturer commenting on events in the here and now.)

One AS in the focus groups hinted at the trauma he had been through and the impact of this on his mental health:-

> *"Many bad things happened to me...I'm 30 years old so I need to do something for my life and for my future....the problem in my head...think, think too much".*

Studies have shown that prevalence of clinically significant symptoms of depression, anxiety and risk for post-traumatic stress disorder are significantly higher among AS compared to the general population of the

host country[26]. Fazel et alestimated that 9% of adult refugees may suffer with post-traumatic stress disorder, which is approximately 10 times that of an age-matched American population[27], whilst other studies indicate rates of PTSD and depression are 14-15 times higher in refugees then the host population (K.Young, personal communication, 13/09/2019).

Difficulties with anxiety, loneliness, grief, anger, self-harm and insomnia are also widely documented in refugee populations and suicide rates have been found to be higher than in host populations[28] [29]. In addition, there is an acknowledged interaction between the psychological well-being of refugees and the physical disabilities/chronic health conditions that they may experience as a consequence of war and torture (K.Young, personal communication, 13/09/2019).

One GP practice in Southampton has analysed the results of a special health check done on 55 of their patients who are refugees; they found that 25% of these refugee patients had evidence of PTSD and 25% had depression[30]. This compares with a prevalence of 4.4% in the general population of the UK[31]. Belz et al (2017) report high levels of comorbidity of PTSD and depression among distressed refugees at a reception centre in Germany; 94% of patients who had PTSD also had depression[32].

Stress continues for AS even after arrival in a host country through loss of social networks, shifting societal roles and integration issues[19]. Additionally, local stakeholders reported the impact on mental health of the asylum process itself; one voluntary sector employee described 'points of crisis' happening all the way through the process. Although the evidence is limited, an extended asylum procedure appears to be associated with increased psychiatric disorder[5].

In the focus groups, AS spoke about the impact of the asylum process on mental wellbeing, particularly because of the uncertainties and the lack of purpose each day from not being able to work:-

> *"I try to find things to keep my head running....if you allow the process to get to you then every one of us is going to be mentally cracked down at the end of the day....the process is very hostile, it's very mean, so if you can't find things to do to keep you running and then get tired at the end of the day so you fall asleep...everyone is going to have mental issues if we just sit down like this"*

Sleep disturbances are common amongst AS. In a study of a clinical sample of refugees attending a specialized centre in the Denmark, almost all reported sleep disturbances and recurrent nightmares[33]. One focus

group participant in Southampton explained that:-

> *"sometimes the stress makes you forget everything....and you can't sleep....you may even forget your phone....you just forget everything....sometimes this comes for 4-5 days and I just lay on my bed and can't sleep and just thinking like this and I don't know where it has come from..."*

It is clear from the available literature and from the stakeholder consultation that distinguishing between mental and physical problems is particularly complex amongst the AS population. Some literature describes this as 'somatisation' (i.e. presentation of mental health problems in the form of physical symptoms) which is reportedly higher in refugees from non-Western countries than the general Western population[34]. However, other sources and some local stakeholders describe physical pain as a result of mental health issues, particularly from experience of trauma[35]. This complex presentation of symptoms makes investigation difficult and costly. Inaccurate diagnoses may occur and AS may feel that they are not being listened to or believed.

Generally, people with poorer mental health experience higher rates of adverse outcomes such as poverty and social exclusion which can lead to substance misuse and incarceration[36]. Several stakeholders mentioned a concern that AS in Southampton and Portsmouth were more likely to become involved in criminal activity if their mental health issues were not addressed.

4.4 Children's Health

With unprecedented numbers of UASC in Portsmouth, identifying the health needs of young AS is particularly important.Often the issues for UASC are the same as for adults, with stakeholders specifically mentioning communicable disease, sexual health and mental wellbeing.

Figure 7: Risk factors for mental illness in UASC[37]

Local professionals working with AS children were concerned about communicable diseases; in particular, the uncertainty around vaccination status as well as cultural reasons for parents not consenting to immunisations such as HPV. However, as with adults, the over-whelming concern was for the mental health of these young people; the diagram in Figure 7 shows the risk factors for mental illness in UASC. The Kent UASC HNA provides a comprehensive review of the literature on the health needs of these young people[37].

4.5 Accessing Health Services

The evidence from this assessment suggests that, generally, AS in Southampton and Portsmouth are able to register with a GP and navigate the healthcare system reasonably well. Participants in the focus groups mentioned that information is provided when they initially arrive at their accommodation to direct them to local services including primary care.

However, in the focus groups, several AS mentioned that negative experiences of accessing healthcare have driven them to avoid seeking professional support and instead accessing care through other means. For instance, one participant said:-

> *"personally for me I do not enjoy going to the GP or the hospital....I don't go any more...I just go to Savers to buy painkillers or whatever..."*

And another commented how one person's bad experience could dissuade other AS from accessing healthcare:-

> *"most people in the migrant community they talk to each other...so they would be like 'oh my god...don't go to hospital'..."*

Below is a summary of the barriers to accessing healthcare that were identified in the stakeholder consultation and from the published literature.

4.5.1 Waiting for appointments

Several participants in the focus groups mentioned the time taken for getting an appointment. Some stakeholders have suggested that dissatisfaction around this is shared by the UK population generally whilst others said that it may reflect differences in accessing healthcare in countries of origin (for instance, AS may be used to waiting in a queue to see a doctor that day rather than having to make an appointment for several days' time).
One consequence of this was that some AS said that they felt they had to over-emphasise the significance of their health issue in order to get a quicker appointment:-

> *"sometimes we have to show, for example, that our pain is really killing us, for example, and then we get a short appointment"*

This clearly can result in a difficult dynamic between clinician and AS as well as exacerbating any issue of AS feeling they are not being believed.

4.5.2 Language

Language, as a barrier to meeting AS health needs, was raised repeatedly across all types of stakeholders and in the published literature[19,38]. For instance, several stakeholders mentioned that healthcare services, such as primary care and IAPT, often have telephone triage as the standard pathway which is a significant barrier for a non-English speaker.

In accordance with national guidance[39], the use of family or friends as interpreters was not favoured by stakeholders because of issues of confidentiality and safeguarding.

While various interpreter services are available to healthcare professionals in Southampton and Portsmouth, several issues were

identified with these. For instance, less common languages or dialects can be difficult to source an interpreter for and sometimes interpreters do not turn up on time.

A recent survey of GP trainees in neighbouring Dorset revealed that they lacked knowledge regarding migrant health needs and rights to care. They also lacked experience and confidence in caring for this patient group with language mentioned as the biggest perceived challenge.[38]

4.5.3 Cultural differences

In addition to language, other cultural differences were mentioned by many stakeholders as barriers to accessing healthcare. A recent systematic review into the challenges in providing healthcare services to AS and refugees, identified cultural understanding as an issue. Studies in the review identified issues such as using different terms to refer to health conditions, unfamiliar concepts (such as preventive care) and unreasonably high expectations of health services amongst AS. Additionally, differences in cultural values such as gender roles, decision-making, social taboos and time-orientation were mentioned as challenges.[19]

Some healthcare professionals consulted in this assessment described different perceptions of risk between AS and the general UK population; for instance, a minor respiratory illness may be perceived as likely to be life threatening by someone from a country where childhood mortality from pneumonia is common.

4.5.4 Dignity and respect

Several participants in the focus groups mentioned that they had at times felt they were treated without dignity or respect when accessing healthcare services in Southampton and Portsmouth. In relation to her experience of maternity care, one AS stated:-

> *"sometimes they fail to recognise that you are a member of the human species"*

Many participants mentioned that they felt messages about their health could have been communicated to them in a better way.

4.5.5 Ease of access and cost of healthcare

Many of the stakeholders mentioned uncertainty about AS eligibility for

healthcare. During the stakeholder consultation, healthcare professionals frequently sought clarification about charging for services, particularly for failed AS. The AS themselves talked about the stress that results from being presented with a bill for healthcare.

"I don't know if I have to pay for it or if it is free for us...I don't have any other problems apart from that"

AS also described the confusion and stress of paying for non-prescription drugs and several questioned why their GP told them to buy drugs, such as painkillers, rather than giving them a prescription which would have been free.

The 'hostile environment' policy[40], which has resulted in AS being asked to prove their entitlement to healthcare before receiving treatment, was mentioned by several stakeholders and the AS themselves. This was felt to be hugely inappropriate, to cause considerable stress, and sometimes to exacerbate ill health.

The distance to hospital and the associated cost of getting there was a significant barrier for many AS.

> *"I got referred to one of them and I didn't know where it was....I went to St Marys and I was told I was not on the system....eventually when I found out where it was...it was like an hours walk".*

5 OVERVIEW OF AVAILABLE SERVICES

Below is an overview of some of the key services in Southampton and Portsmouth that provide support and health care to AS and other vulnerable migrants; there are similarities but also differences in the services offered in the two cities.

5.1 Voluntary and community services

The Avenue Multicultural Centre (AMC) is a partnership venture (Avenue St Andrew's Church, British Red Cross, CLEAR and Southampton & Winchester Visitors Group [S&WVG]) offering help and support to AS and refugees every Friday at The Avenue St Andrew's Church. AMC has been running for the past 11 years. Every week clients can seek advice, enrol in English language classes, take part in activities and obtain food. Data

on number of AS accessing these services is difficult to obtain but SWVG estimate that they see about a third of all those AS in Southampton as clients, particularly the longer term and complex cases. Visitor attendance at the AMC is normally between 60-70 per week, excluding children, with the main countries of origin being Iran, Zimbabwe, Nigeria, Iraq, Pakistan, Eritrea and Somalia. Clients also come from Sierra Leone, Albania, Sudan, Syria, China, Mauritania, Saudi Arabia and other countries.

The agencies involved in the AMC also offer further support in addition to the drop-ins, such as befriending, financial support and assistance in getting legal advice[41]. The Red Cross also offers practical support and a service to try and reunite family members[42].

In Portsmouth there is a drop-in at All Saints church on Mondays and Thursdays which is run collaboratively by Red Cross and Friends Without Borders[43]. The drop-in offers a chance for social interaction as well as professional advice and advocacy. Food parcels are provided at the Thursday sessions. Friends Without Borders also offers access to legal advice.

As a snapshot, on one Thursday in August 2019, about 60 visitors were recorded as coming to the Portsmouth drop-in (80 including children). The countries they came from included Afghanistan, Iran, Zimbabwe, Cameroon, Iraq, China, Ethiopia, Eritrea, Portugal, Albania, Bangladesh, Turkey, Pakistan and Ghana.

At the focus groups, AS gave a clear message of the tremendous benefits they get from the drop-ins and the voluntary services in both Southampton and Portsmouth.

There are also various multi-cultural groups that meet in both cities run through a mixture of voluntary, religious and local authority partnerships. For instance, Portsmouth has a Cross-Cultural Women's Group[44] which meets weekly and in Southampton there is a regular group to support mental wellbeing at the New Testament Church of God in St Denys.

Both Southampton and Portsmouth have declared themselves Cities of Sanctuary[45]. This is a fairly recent initiative for Portsmouth (launched June 2019) but the Southampton group is more established and has set up different 'streams' of sanctuary such as the welcome stream which puts together packs for AS newly arriving in the city, libraries of sanctuary and the school stream which engages local children.

5.2 Public services

5.2.1 Primary Care

In both Southampton and Portsmouth, Home Office dispersal accommodation is distributed in various locations across the cities so AS may register with several different GP practices. However, in Southampton there are two practices which see the majority of AS and other vulnerable migrants; Homeless Healthcare and St Marys. These practices are both experienced in providing services to this population group. For instance, at St Marys a refugee-appropriate health check has been developed, within the SystemOne clinical system, and staff are regularly reminded to use it. The Homeless Healthcare Service is the practice that is most likely to serve failed asylum seekers who are not in official accommodation.

5.2.2 Mental Health Services

Solent Mind provides some peer support programmes in Southampton[46], where people, who have themselves had mental ill health, offer support and sign-posting to others, but there is no service specifically for AS and vulnerable migrants currently commissioned in the city.

Portsmouth is launching a new service in Autumn 2019, called 'Positive Minds'[47], which will be fronted by peer supporters but also have clinical support available. This service will be available to AS in the city if they chose to access it.

Across the UK, short-term psychological therapy is now provided by Improving Access to Psychological Therapies (IAPT) services. In Portsmouth the IAPT service is 'Talking Change', provided by NHS Solent[48], and in Southampton it is 'Steps 2 Wellbeing'[49], provided by Dorset Healthcare University NHS Trust.

Secondary mental health services are available through Solent NHS Trust in Portsmouth and Southern Health in Southampton. Southampton Homeless Healthcare hosts mental health nurses on site and a new initiative in Portsmouth will provide mental health workers within the city's homeless services[50].

Services for PTSD are largely offered through IAPT unless the patient has reached crisis point, or poses a significant risk to either themselves or others, when they may be referred to secondary mental health. Neither

city has a dedicated trauma service.

Several stakeholders mentioned that offering therapy to AS can be difficult for mental health services because there is often a policy of not starting therapy with people who are transient and, therefore unlikely to be able to finish treatment, because of the harm this can do. How this policy is defined and enacted differs between services.

5.2.3 Services for UASC

When UASC arrive in Portsmouth there is no initial health screen at the port. Instead they will receive the same medical assessment as any other Looked-After Child (LAC) which is done by the community paediatrician within 20 days of a complete referral. The referral documentation needs to include name, date of birth, GP details and NHS number, all of which can be challenging to obtain accurately for a variety of reasons. Delays in providing the complete referral have often occurred in the past (for instance, if the age assessment proves difficult or registration with a GP is delayed) although stakeholders felt that this process is improving.

The LAC assessment covers physical and mental health and results in a report which is sent to all professionals involved in the care of the UASC, including the GP, social worker and the UASC themselves. This report includes details of the UASC's history which, on being shared with relevant agencies, should mean that the young person does not have to keep re-telling their story.

The community paediatric team sends out, to the key workers of new UASC arriving in the city, a checklist of health issues to be aware of.
In October 2018 Portsmouth City Council commissioned a two-year project to develop a trauma-informed model of care for UASC in the city. This has been developed from the work of Dr Ana Draper from the Tavistock Clinic and involves four key elements[51] [52]:-

1 Nutrition
2 Sleep
3 Continuing bonds – hopeful relationships back in the child's home country
4 Fast feet forward – a sports group using adapted Eye Movement Desensitization and Reprocessing (EMDR) therapy

A psychologist is in post to deliver this model through training of those professionals who come into contact with UASC, such as social workers and Looked-After Children nurses.

Both Portsmouth[53] and Southampton[54] are working towards becoming 'restorative' cities. 'Restorative working' focuses on building relationships that create positive change to improve outcomes.

For instance, in Southampton the restorative, child-friendly initiatives include the Cultural Education Partnership[55] and the Schools of Sanctuary Network[56]. Through this work there have been regular sessions[57] to raise awareness of adverse childhood experiences and the impact of trauma but these do not specifically cover AS.

5.2.4 Safeguarding

CCG Commissioners in both Southampton and Portsmouth have ensured that providers of healthcare services have a 'Safeguarding Adult Policy' which reflects the Care Act 2014, is compliant with the Hampshire 4LSAB Multi-Agency Safeguarding Adults Policy & Guidance and includes specific information on Female Genital Mutilation, Modern Day Slavery and Radicalisation. Although this policy is in place, dynamic changes of movement such as removal of AS to other cities and into immigration detention centres raises several implications of safeguarding in practice[58].

5.2.5 Other services

Several years ago the PEPSI (Patient Experience and Public and Service Involvement) group existed in Portsmouth to provide a place for the local community to voice their needs and concerns to healthcare providers.

The group met monthly and was well attended by people from a range of different communities. However, due to service reconfiguration the group no longer exists. (S. Ahmed Khan, personal communication, 10/10/2019)
The Independence and Wellbeing Team at Portsmouth City Council offers cultural awareness training for NHS staff[59].

6 EVIDENCE OF WHAT WORKS

6.1 Language and communication

Finding an effective way to communicate between healthcare professionals and AS is absolutely vital but stakeholders, and the published literature, gave mixed views on whether interpretation is best

provided by telephone or face-to-face.

Telephone interpretation is more flexible so is more appropriate for services where AS have difficulty sticking to appointment times. A telephone service can also be viewed as more confidential and so may feel more acceptable for the AS. (A. Gachango, personal communication, 16/08/2019)

Face-to-face interpretation may be considered more appropriate for mental health therapy, especially where an AS is being asked to talk about the trauma they have experienced. (K.Young, personal communication, 13/09/2019).

The comparative analysis in this assessment revealed the value that other areas have found in using the same interpreters regularly and engaging them in the process. For instance, in the Bristol Traumatic Stress Service, clients speaking several different languages may be present in a 'Moving On After Trauma' (MOAT) group so three or four interpreters are sometimes required at the same time. However, because the service has used the same interpreters for quite a while, these individuals have a good understanding of the sessions and are very experienced so have almost become co-facilitators. (M. Griggs, personal communication, 23/07/2019)

Other ways of improving the interpretation include booking the same interpreter in advance for all future appointments and asking the interpreter to arrive early so they can briefly meet with the AS before the appointment.[60] Additionally, training healthcare professionals in working through interpreters can be useful; for instance, Lancashire Care NHS Trust have made the RCPsych e-learning module on working through interpreters[61] freely available to all staff (A. Summers, personal communication, 02/09/2019).

6.2 Improving Cultural Awareness

'Cultural competence' is a term used to describe having an awareness of, and responding appropriately to, a person's cultural background. Betancourt et al defined cultural competence in healthcare as 'the ability of systems to provide care to patients with diverse values, beliefs and behaviours, including tailoring delivery to meet patients' social, cultural and linguistic needs'.[62]

A recent systematic review confirmed that gaining cultural awareness and understanding is an important facilitator of AS care. This included

understanding differences in values, body language, health practices and health presentations. Cultural understanding allowed health professionals to adjust their healthcare practice accordingly. Personal qualities in health professionals that were deemed to enhance cross-cultural interactions were sensitivity, empathy and cultural humility.[19]

At its most basic, cultural awareness requires knowledge of the political system, religious beliefs and infectious diseases in the AS country of origin. It is clearly not reasonable to expect health professionals to know about all possible countries of origin so it is important to provide them with resources to access this information.[5] Locally, factsheets about different countries of origin of UASC in Portsmouth have been supplied to key workers (D. Dunne, personal communication, 09/07/2019) so that they can understand more about the background of the young people they are working with. There are also various websites available providing this type of information[63 64].

However, healthcare professionals need much more support than this to become culturally competent. There needs to be awareness and understanding of the context in which AS are seeking health; for instance, the fact that clinical environments can mimic interrogation rooms and, therefore, re-traumatize the individual. Also, therapists need to understand how alien it can be to ask an AS to describe their historical experiences, their traumas, their journeys and their losses; AS may have no experience of describing or expressing their emotional and psychological experiences through one-to-one formal conversation, instead being more used to the concept of healing through methods such as meditation, herbal medicine and dance. (A. Stoddard-Ajayi, personal communication, 03/04/2019). There are some sources of help for both clinicians and patients to better communicate about symptoms and needs[65].

Dorset has adapted it's GP training curriculum to include refugee health[38]. In Southampton, GP trainees cover these issues within a diversity module whilst in Portsmouth cultural awareness is on the curriculum, but this does not currently include migrant health.

Providing a flexible approach to care, acknowledging the difficulty many AS have in consistent engagement, is one way of making culturally competent services. This has been shown to work in Manchester using Methods of Levels theory with a patient group affected by psychosis who, similar to AS, are not stable enough to commit to regular, routine treatment. Providing a flexible service, that allowed them to drop in and out, gave positive outcomes as well as being cost-effective through

reducing missed appointments.[66]

Much of the published evidence suggests the importance of involving refugees in policy, planning, design and delivery of their own care in order to provide culturally competent services [25]. There are examples this type of 'cultural advisory group' working elsewhere in the UK[67 68 69]. In the men's focus group in Portsmouth, providing advice to the NHS was felt like a positive experience that they could engage with; one participant commented:-

"good idea that every 3 months you have a group like this....and bring someone from the NHS..."

6.3 Initial health assessments

There are examples from elsewhere in the UK of providing comprehensive initial health assessments for AS when they first arrive in the Home Office dispersal accommodation.

In Bristol, 'The Haven' is a specialist primary healthcare service for AS and refugees[70]. The service sees between 300-400 people per year. A member of the Haven team visits each new AS in their accommodation and offers them a health assessment at the clinic. This is a comprehensive assessment carried out in a 90-minute appointment slot.

The AS may then see one of the doctors at the clinic for a 60-minute appointment and/or an in-house psychologist. Although registered with a GP elsewhere, the AS will have follow-on appointments at The Haven. A telephone interpretation service is used if necessary and clients are sent text message reminders to help avoid late or missed appointments. (A. Gachango, personal communication, 16/08/2019)

NICE Guidance states that services should consider the routine use of a validated, brief screening instrument for PTSD as part of any comprehensive physical and mental health screen[71]. As previously mentioned, St Marys surgery in Southampton, has developed a refugee health check which does include an informal assessment of mental health. This has not been rolled out to other Southampton practices and there is nothing similar currently available in Portsmouth.

6.4 Reducing social isolation

"For many seeking asylum, it is all too easy to remain isolated in their room which may feel safe, however, it is well recognised that social

isolation makes people vulnerable to depression and to deteriorating health…..Those who do well form new connections."[72]

When AS in the focus groups were asked what would help to reduce their stress several mentioned the benefit of social interaction, for instance:-
"people need somewhere to get together and have a chat....groups of people talking, laughing makes you forget the stress"

Peer support is an effective way of reducing social isolation and is included in NICE recommendations for the treatment of PTSD[71].
Evidence from a local peer support project 'Gateway Portsmouth – co-producing community integration'[73] found even under the least favourable assumptions the project provided a very good social return on investment. The following recommendations came out of the project:-

- Early interventions to support integration for new migrants, perhaps as a welcome pack offering both training and participation opportunities, is life changing for participants and communities.
- Support for new women migrants is particularly valuable in community building, as they often face cultural, practical and emotional barriers.

Guidance from Wales suggests peer support for refugees and AS as a way of reducing social isolation and engaging with service providers. It also offers a chance to get involved in social activities, education and training which can improve physical and mental wellbeing as well as aiding integration.[74]

In Southampton, the women in the focus group particularly mentioned the benefit of being involved in their local church and that this could offer a suitable route for mental health support:-

"it would be divine....if the health service was more joined up with the church. There is more acceptance in the church. The church is where we run to, that's where we feel comfortable".

6.5 Mental Health Services

Trauma-focused therapy should start as soon as possible because then AS will find it easier to move on with other aspects of their life and to interact socially. The fact that AS can be transient is not a reason to delay therapy; evidence from refugee camps shows that trauma therapy can have positive outcomes even whilst a person is still in a traumatic and transient situation. (K. Young, personal communication, 13/09/2019)

Helping AS to address basic needs can result in better engagement with mental health services. At the Woodfield Trauma Service in London, the first stage of treatment for complex PTSD is stabilisation which includes both psychological and practical support. The practical aspects are done by a support worker who sign-posts to other services, writes letters and acts as a mediator. This means that the therapy time is not taken up with dealing with these practical issues. (K. Young, personal communication, 13/09/2019)

AS who are experiencing mental health difficulties could benefit from **psycho-education** which aims to help people understand what is happening to them and how to manage these difficulties. Grounding exercises and breathing techniques, along with a whole range of anxiety management techniques, such as progressive muscle relaxation, can be easily taught and help AS to feel more present and in control of their own functioning.[72]

Currently, **Narrative Exposure Therapy (NET)** is accepted as the treatment with the most evidence for effectiveness in treating PTSD in refugees and AS who have experienced multiple traumatic events[75] [76] [77].

NET is a short-term therapy for multiple trauma. It involves mapping out life experiences to work out which are the traumatic events that need processing. The idea being to contextualise each traumatic event and thus allow painful emotions to be linked to these past episodes rather than the her and now.

In the Bristol Traumatic Stress Service, AS are assessed within IAPT by specialist assessors. If they are considered appropriate for trauma work within IAPT then they follow a 3-phase trauma model. Most of the AS assessed at the Bristol Service would not meet the criteria for secondary MH service. Phase 1 is stabilisation which is done through 'Moving on after trauma' (MOAT) groups where the purpose is to normalise reactions to trauma. There are separate male and female groups plus a young persons' group (16-21 year olds). Some groups have crèche facilities and the service pays bus fares and provides some food. The aim is to have 8-10 people in a group (although it can be up to 13) and there may be 3 or 4 interpreters. The groups meet for 2 hour sessions once a week for 7-8 weeks. Phase 2 is therapy such as NET and phase 3 is re-integration. (M. Griggs, personal communication, 23/07/2019)

In Norwich forced migrants with mental health needs were mainly seen in primary care or in the local IAPT service. Most of those forced migrants

referred to the secondary mental health services were either unable to engage (due to communication difficulties, transportation problems etc) or were discharged shortly after the initial assessments. The reason for discharge was mainly because their mental health problems were often seen as "situational" (i.e. due to desperation to stay in the UK if they were AS, or due to the adjustment reaction to resettlement and cultural bereavement process for refugees). A clinic was set up to bridge this gap in the service. The clinic is run by a consultant psychiatrist and is held in the community at premises familiar to the forced migrants. The clinics are not intended to replace care through the mental health services but aim to assess, advice and signpost patients for further treatment. (Y. Hameed, personal communication, 05/08/2019)

6.6 Trauma-informed cities

There is a growing movement of trauma-informed communities, particularly around adverse childhood experiences. A trauma-informed community is an area where knowledge of how trauma can affect people – and how best to respond to this impact – is commonplace so that all key local services can integrate this knowledge into the way they interact with people every day.

NHS Education for Scotland has a project to develop trauma-informed organisations so has developed a range of resources including training materials and competency frameworks[78].

Plymouth has a Trauma-Informed Network which is derived from a ground-up coalition of professionals from across services, with professional experience of how trauma can affect people. The Network currently includes 70 individuals, representing approximately 30 agencies ranging from Police, schools, Barnardo's, NSPCC, Devon CCG as well as Plymouth City Council.

"Plymouth as a trauma aware city recognises the evidence base that is emerging day by day, across both national and international communities, which identifies that the impact of trauma and the consequences of exposure to harmful experiences of adversity, as a profound health, wellbeing and social care issue of our time. This understanding creates an exciting and definitive opportunity to fundamentally shift the agenda, by bringing people, communities, city services and systems together to address the causes of adversity at the earliest opportunity, thereby becoming more boldly prevention focused."[79]

7 GAP ANALYSIS AND RECOMMENDATIONS

SUMMARY OF RECOMMENDATIONS

Mental Health Services

SOUTHAMPTON AND PORTSMOUTH:

- Consider inclusion of a validated, brief screening instrument for PTSD at initial GP registration
- Develop peer support services for AS
- Adapt IAPT services to better meet the needs of AS (e.g. outreach, more flexibility)
- Ensure availability of appropriate interpreter services
- Fund NET training for IAPT therapists

Children

PORTSMOUTH:

- Review and adapt the UASC pathway to health assessment to expedite appropriate treatment and prevention referrals
- Evaluate and, if found to be effective, ensure sustainability of the trauma-informed model of care for UASC

SOUTHAMPTON:

- Enhance the emerging child-friendly initiative by including AS in all activities

Awareness

SOUTHAMPTON AND PORTSMOUTH:

- Training for healthcare professionals in the health needs of AS and their eligibility for care
- Additional training for GPs in the impacts of trauma that AS may have experienced
- Improve cultural competence through the establishment of cultural advisory groups
- Use this assessment to support initiatives to develop trauma-informed communities in both Southampton and Portsmouth

7.1 Mental health services

This assessment has identified that mental wellbeing of AS and other vulnerable migrants, in both Southampton and Portsmouth, is a key unmet need.

As a first step, peer support services should be developed for the AS population in both Southampton and Portsmouth. These should ideally be in an easily accessible location and somewhere that AS feel comfortable visiting, such as the regular drop-ins run by the voluntary sector. In Portsmouth an outreach service for AS from the new 'Positive Minds' service could be considered.

Peer supporters should be trained to deliver basic psycho-education which would help AS understand that physical symptoms they may experience could be due to emotional distress.

Many AS have experienced multiple trauma, but appropriate support often falls in the gap between IAPT and secondary MH services. Use of a validated, brief screening instrument for PTSD when AS first register with a GP would speed up the referral to the most appropriate source of support. IAPT services in Southampton and Portsmouth are already aware of, and attempting to meet, the need for complex PTSD therapy but should be further supported to improve access to their services and to provide appropriate therapies for AS.

In particular, considering the provision of appropriately trained IAPT practitioners as an out-reach service would increase accessibility of the service for AS. Also, services could be designed to be flexible so that AS who find it difficult to engage are able to drop in and out of therapy. IAPT services could also work more in partnership with local voluntary agencies who could offer the practical support that is needed as part of the initial stabilisation phase of treatment.

Appropriate interpreter services must be available for IAPT, and other mental health services, providing care to AS. Telephone interpretation may be considered as this can offer a wide diversity of languages/dialects and facilitate a more flexible approach to appointments.

Mental health services need funding to ensure that their staff have the skills required to meet the needs of AS. For instance, training in complex, comorbid physical and mental health problems. It is vital that IAPT services are able to train some of their therapists in NET as this has the

best evidence base for multiple trauma in vulnerable migrants.

7.2 Children

Stakeholder consultation has identified concerns from local practitioners that the health needs of UASC arriving in Portsmouth are not being assessed quickly enough due to delays in getting the complete referral information. This process is improving but each step towards assessment needs to be timely and efficient so that the pathway is robust enough to cope with potentially large numbers of UASC arriving in Portsmouth at the same time (as has happened in the past).

A review and adaption of the UASC pathway to health assessment is recommended to expediate appropriate referrals for treatment and prevention, including initiation of immunisations.

The trauma-informed model of care adopted in Portsmouth seems to be an appropriate response to the unprecedented numbers of UASC arriving in the city in recent years. This initiative should be properly evaluated and, if found to be effective, sustained beyond the initial two years.
In Southampton, the emerging child-friendly initiative should be enhanced by including awareness of AS in all activities such as training.

7.3 Awareness

Awareness training for healthcare professionals and CCG staff, covering the findings of this needs assessment, clarity about AS eligibility for care and the impact of 'hostile environment' policies, is necessary to better meet the health needs of AS in Southampton and Portsmouth.
Additionally, trauma-focused training should be provided for healthcare professionals, particularly GPs, who are likely to see AS and other vulnerable migrants. Use of an initial assessment in primary care which includes mental health would aid early identification of health issues.
GP training curriculums in Southampton and Portsmouth should be further adapted to cover cultural awareness, the context in which AS seek healthcare and the complexity of physical and mental health symptoms.

There is often a disconnect between AS and healthcare professionals due to a combination of language, cultural barriers and a power imbalance. This should be tackled by developing the 'cultural competence' of healthcare professionals. As a minimum requirement, country-specific information could be made available to professionals involved in the care of AS. Most important though is an understanding of AS cultural needs so

that the delivery of services can be tailored appropriately to meet these needs. This will help AS feel that they are being treated with respect and dignity and that they are being listened to and believed. 'Cultural advisory groups', made up of interested staff and the local community (including AS), should be established within local healthcare systems; this will help develop culturally appropriate services and embed cultural competence within the organisations.

There is also a need to increase awareness more widely across Southampton and Portsmouth of the trauma that AS are likely to have suffered, the impact this may have on their health and appropriate responses. Both cities are already making some progress towards being trauma-informed communities. The results of this needs assessment should be used to support work on these initiatives so that all people who are in contact with AS become more mindful of the impact of trauma and feel more equipped to offer support.

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9 APPENDIX: DEFINITIONS

ASYLUM SEEKERS (AS): defined according to the UN Declaration of Human Rights as a person who enters a country in order to claim asylum and who has the claim assessed through an asylum process[80]. AS are entitled to receive all NHS services[60].

EYE MOVEMENT DESENSITIZATION AND REPROCESSING (EMDR) THERAPY: EMDR therapy involves the identification of unprocessed traumatic experiences. The worst aspect of the memory is recalled whilst the client is simultaneously directed to move their eyes from side to side (or employ some other form of bilateral stimulation). The effect is to desensitise the client to the distressing memory and reprocess the memory so that the associated cognitions become more adaptive.

FAILED ASYLUM SEEKER: an informal term for those asylum seekers whose claims and appeals have been rejected. Failed asylum seekers are made up of two groups with varying levels of entitlement to care as detailed below[60]:-

1 Those who become section 4 supported: These are asylum seekers who continue to engage with the Home Office and who, for health or safety reasons, are unable to return to their country of origin immediately. Section 4-supported failed asylum seekers are exempt from all charges and entitled to all NHS services

2 Those who become undocumented because they are no longer engaging with the Home Office. There are no Department of Health regulations concerning their entitlement to primary care. GPs have the discretion to register any patient, irrespective of residency status, unless the person resides outside the practice boundary. Undocumented asylum seekers are not generally eligible for hospital treatment unless to save life or to prevent a condition from becoming life-threatening. They are eligible for:

- Treatment in A&E and walk-in centres
- Family planning services
- Sexual health clinic treatment (excluding HIV treatment)
- HIV diagnostic services
- Compulsory mental health treatment
- Treatment of some communicable diseases

MIGRANT: Someone that lives in a different country to the one they were born in

NARRATIVE EXPOSURE THERAPY (NET): NET was developed by the

Schauer, Neuner and Elbert, members of NGO Vivo International, originally as a treatment to be used in refugee camps in low income countries[81] [82]. NET is 10-session intervention which enables the client to talk through in detail all the pertinent traumatic events in his or her life. It starts with the construction of a 'lifeline', which gives the therapist and client an overview of the client's life, including traumatic and less traumatic events. Then, they agree on which traumatic events to focus in therapy and the rest of the treatment involves the detailed exposition of the traumatic events. The therapist transcribes this exposition in summary between sessions (this is known as 'the narrative'.)

REFUGEE: The United Nations High Commissioner for Refugees (UNHCR) defines a refugee as someone who 'owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of his nationality, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country' [83]

REFUGEE STATUS/LEAVE TO REMAIN: In the UK, an asylum seeker is granted "refugee status" or "leave to remain" if their asylum claim is successful or if they are granted the status for humanitarian reasons. The refugee status gives the individual the same rights of a UK citizen, being allowed to live and work in the country for a period of five years, after which the refugee would have to apply for indefinite leave to remain.

RESETTLED REFUGEES: Refugees that have been resettled in the UK under one of the various resettlement programmes, e.g. the Syrian Resettlement programme.

SECTION 4 SUPPORT: Some asylum seekers who have had their claims refused can apply for somewhere to live and £35.39 per person on a payment card which can be used at certain shops. The payment card will not be given if the offer of a place to live is not taken up and no cash will be given to a refused asylum seeker. This can only be given if the person is homeless, does not have any money to buy food and you can show that there's a reason why they are unable leave the UK straight away

SECTION 95 SUPPORT: Weekly support of £37.75 per person and per family member, which is intended to cover essential living needs. It includes a calculation of £0.92 per week per person for Healthcare. Pregnant women and mothers of new babies and children up to 3 may receive between £3 and £5 extra per week and a one-off maternity payment of £300. The allowance is loaded onto an ASPEN (debit) card each week, which can be converted to cash.

SECTION 98 SUPPORT: is the temporary provision of accommodation for asylum seekers who would otherwise be destitute and who are either awaiting a verdict on their section 95 support application, or receiving section 95 support but are waiting to be allocated their dispersal accommodation.

SECTION 117 SUPPORT: When a person who has been detained under the Mental Health Act ceases to be detained, the former patient must be provided with aftercare services under section 117 of the Act. These aftercare services can include accommodation.

UNACCOMPANIED ASYLUM SEEKING CHILD (UASC): a person who, at the time of making their asylum application, is under 18 years of age or who, in the absence of documentary evidence, appears to be under that age and who is applying for asylum in his/her own right and is without adult family member(s) or guardian(s) to turn to in this country.

[i] Local authorities choose whether they will allow asylum seekers to be housed in accommodation in their area; Southampton and Portsmouth are two of just 150 (out of 453) local authorities who have agreed to accept AS84.