Evidence for the House of Commons Inquiry into Asylum Support for Children and Young People

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Introduction

I have spent the past 12 years researching new migration in the UK and throughout that time have maintained a focus on refugees and asylum seekers and their access to social welfare. I have led 20 research projects that have focused on asylum seekers and refugees (sometimes including other new migrants) access to social welfare, sat on the steering committees and advisory boards of projects looking at these issues from around the UK, and acted as an advisor to Government at local, regional, national and European levels. My evidence is mainly taken from two reports Phillimore & Thornhill (2011) and Phillimore *et al.* (2008) (see references) which look specifically at migrant maternity and refugee and asylum seeker mental health. Where appropriate I refer to other empirical data from my own projects and to data from empirical research collected by other researchers.

There is growing evidence of high maternal and infant mortality rates amongst asylum seekers and in asylum seeker dispersal areas with an upwards trend being observed (Francis et al 2009). Refugee and asylum seeking women make up 12% of all maternal deaths, and 0.3% of the population in the UK (Lewis 2007). The perinatal mortality rates in the City Hospital Trust area of Birmingham which at the time of data collection contained the highest concentration of asylum seeker housing in the city, is 12 per 1000 and rising compared with a national average of 7.6 (Perinatal Institute for Maternal and Child Health 2010). There is further evidence of the asylum support system; a combination of dispersal and levels of support; impacting upon the development, well-being and life chances of children with dispersal and detention associated with high levels of isolation, mental health problems and disruption of schooling. The remainder of this paper focuses upon the specific questions being considered by the Inquiry Panel.

The impact of income poverty and living on asylum support on children's development, well-being and life chances

Income poverty affects the health of mothers and their unborn babies. Perinatal mortality is influenced by maternal malnutrition which results when women are unable to afford healthy food (Kanneh 2009; Redshaw et al 2006). Such malnourishment was reported to be an issue facing asylum seeking women in our DoH funded Migrant Maternity research. Inter-uterine growth restriction causes of 45.6% of stillbirths and is also associated with low birth weights (Taylor & Newall 2008). Low levels of income also mean that women are unable to purchase the items they need for their babies. The lack of essential items such as pushchairs and car seats impact upon child safety and women's ability to access important maternal monitoring appointments. Inability to purchase items such as child safety locks and sterilisers can also impact upon health and safety.

While low levels of asylum support prevent women being able to access the foods they need, those on Section 4 support and using the Azure Card are in a particularly difficult position. Lack of cash prevents women from travelling to appointments for ante-natal checks and means that new mothers are unable to take their babies to health visitor clinics for check-ups. Our research identified situations where sick mothers or mothers with sick babies were unable to seek medical assistance because of the lack of travel or telephone money.

We found that pregnant women struggled to access information about the maternity grant, some not knowing of its existence. Our research showed that asylum seekers were least likely to have knowledge about financial entitlements. We were told by professionals that the window for application for funds was too short and that contractors often delivered equipment too late: after the baby was born. Money was also sometimes credited to the Azure card after the birth. Inability to purchase baby equipment with cash meant the grant was inadequate as women could not make savings by making second hand purchases. The most fortunate asylum seekers accessed help from civil society organisations such as the Red Cross and Voluntary Doula services but not all knew about these.

Destitution was also picked up as an issue in a number of our research projects and was of particular concern in relation to pregnant women and mothers with small children. Many destitute asylum seekers relied heavily on friends and family for a roof. We heard that midwives sometimes had to discharge new mothers knowing that they were homeless or did not have transport. Women relied heavily on the assistance of friends and neighbours and were extremely vulnerable to abuse. Professionals reported seeing women who had lost their babies following domestic violence. Some women were totally alone and lacked peer support. These women were more likely to become ill through exhaustion, or depressed.

A combination of low incomes, poor quality accommodation and insecurity about the future often led to mothers feeling stressed or depressed. Our mental health research suggested that "*When Mum is stressed, they (children) are stressed too*" *(*Kenyan asylum seeker, 35*)*

Particular issues have been identified around asylum accommodation, safety and welfare. Studies we undertook with children for the now defunct Learning and Skills Councils in the West Midlands (see Phillimore et al 2003) showed that asylum seeking children were unable to do their homework in noisy, overcrowded housing. In our maternity study we were told that living in dirty overcrowded housing impacted on mother and baby's health. The facilities in houses were often poor and made care of small children particularly problematic. One woman argued that the poor conditions made her unwell "*I was so ill and I wanted to go and live with my friend but they wouldn't move me. The house was so cold.....there was no washing machine*" (African Section 4). Many women were unable to get advice or support from their accommodation providers however where asylum support workers were able to provide information i.e. about how to register with schools, find a GP and access maternity services, such information was found to be very useful and could speed access to services.

The asylum support process: delays, dispersal and the Azure payment

Dispersal appears to have a marked negative impact upon pregnant women and their unborn child impacting in infant development and educational outcomes of older children. Dispersal impacts upon women's ability to register with maternity services and upon continuity of care. We identified asylum seekers who booked after 31 weeks of pregnancy (the guidelines are before 12 weeks) and one who was dispersed at such a late stage that they went labour shortly

after arrival with no local connections or knowledge of hospital locations. Asylum seekers were less likely than other groups to attend follow-up appointments.

There is a clear relationship between poor antenatal monitoring and maternal and infant mortality (Hayes et al 2011). Late access to services and inadequate or poor advice about how to access support services enhanced infant mortality risks (Kanneh 2009; Redshaw et al 2006). As noted above Section 4 women cannot attend ante-natal monitoring appointments because they have no cash to pay for transport. Dispersal on a no choice basis meant pregnant women were moved away from friends and family and were not able to access the advice and support they needed during pregnancy and were prone to post-natal depression. Some professionals described problems experienced by those who had been dispersed frequently and kept losing connections with maternity services. Housing providers did not have the specialist knowledge needed to signpost pregnant women to services. This is a particular problem for women from the Horn of Africa who have experienced FGM. Knowledge about a woman's FGM condition is critical to maternal and infant safety. Specialist services are hard to find and dispersal exacerbates this while lack of access to cash means even where women know about a service they cannot or travel call to make an appointment.

Dispersal also impacted upon children's access to education. Schooling was disrupted, children spent time out of school when they were dispersed and we heard how high concentrations of children in dispersal areas lead to schools being over-subscribed and parents having to travel some distance each day to get their children to school. Many parenst did not know that they could apply to other schools to access a place if their local school was full. They were unaware of the function of LEAs. This could result in schildren being outside of education for weeks or months. The price of bus fares was problematic. Children who had spent some time out of school gradually got behind with their work and were more likely to truant (Phillimore et al. 2008). Parents spoke of the mental health problems experienced by their children who were perpetually anxious because they could not settle or had moved frequently. Often mental health problems emanated themselves in uncharacteristic behaviour. This behaviour was sometimes interpreted as bad behaviour at school and could result in a child being suspended or excluded. Children who found themselves outside of school then became depressed and isolated because they had no other children to socialise with.

Detention of pregnant women can restrict access to maternal health services. One HIV positive respondent was unable to access any maternity services during the two months of her detention putting her baby at risk of infection with clear developmental outcome implications.

Changes needed

When dispersing pregnant women or women with small children try to place them near friends or family

Minimise the number of dispersals for pregnant women and children

Allow pregnant women to remain on (or transfer to) Section 95 support.

Pay pregnant women support in cash

Provide additional financial support for pregnant women and women with children less than a year old

Provide self-contained housing for families

End detention of pregnant women

Make linking a pregnant women with maternity services within 7 days of arrival the responsibility of UK BA housing providers

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