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capacity, not under compulsion but deprived of their liberty, have yet to be finalised under the Mental Capacity Act 2005 and proposed Mental Health Act 1983 amendment, we trust that the flow chart will facilitate good practice, providing a guide to the process of assessing capacity in more complex cases.

Declaration of interest

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Working with asylum seekers with mental illness distressed by the Home Office dispersal programme

Successive UK governments have introduced increasingly tough asylum policies. Recent immigration legislations (for example the Asylum and Immigration Act 1999 and the Nationality, Immigration and Asylum Act 2002) have continued this tradition. The dramatic reduction in asylum applications by 54% between 2002 and 2004 (Heath & Jeffries, 2005) suggests these measures are effective and hence politically attractive.

One of the major initiatives introduced by the Asylum and Immigration Act 1999 is the dispersal of newly arrived asylum seekers from London and the South-East to other parts of the UK. Although the dispersal programme has proved controversial, it is supported by economic and political arguments. For instance, long-term accommodation is more readily available and cheaper outside London and the South-East. Also, as the major entry ports to the UK are in the south-east of England, without dispersal the region is likely to continue hosting disproportionate numbers of asylum seekers. This could lead to excessive pressures on services and resentment by local communities.

Nevertheless, post-migration adversities (like dispersal) are associated with higher rates of psychiatric disorder in refugees (Sack *et al*, 1996, Heptinstall *et al*, 2004). For vulnerable asylum seekers, dispersal could mean loss of newly established support networks. Also press reports of serious racially motivated crimes against dispersed asylum seekers (Macleod, 2002) could be unsettling.

Although many asylum seekers may cope well with dispersal, some become distressed. This paper discusses some of the issues around working with asylum seekers referred to mental health services as a result of a dispersal-related mental disorder. Supporting this client group can be challenging as it involves working with agencies and procedures which most mental health clinicians are unlikely to be familiar with.

The paper is based on the author's experience of working with this client group, discussions with other professionals with expertise, and resources from statutory and voluntary organisations working with asylum seekers. References and links to these resources are provided (see also Box 1 for a list of relevant Acts). The paper examines some general issues about dispersal and considers two scenarios to illustrate the issues highlighted. The UK immigration and asylum processes

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Box 1. Relevant legislations for asylum seekers with mental illness facing dispersal

Children Act 1989
Immigration and Asylum Act 1999
Mental Health Act 1983
National Assistance Act 1948
National Health Service and Community Care Act 1990
Nationality, Immigration and Asylum Act 2002

continue to evolve but updated information is accessible through organisations such as the Refugee Council (http://www.refugeecouncil.org.uk).

Dispersal

The dispersal programme applies only to asylum seekers requiring provision of long-term accommodation. Dispersal is managed by the Border and Immigration Agency (BIA; formerly by the National Asylum Support Service), which provides accommodation and financial subsistence for asylum seekers. Asylum seekers who do not need BIA-supported accommodation (for example those staying with friends and family) are provided financial subsistence only and are not subject to dispersal.

The BIA operational guidance encourages case workers to consider personal circumstances such as medical treatment, special needs, family ties, education, ethnic group and religion prior to decision on dispersal (Immigration and Nationality Directorate, 2004*a*). However, the guidance is also clear that most personal circumstances would not be sufficient to prevent dispersal.

The BIA may consider request for dispersal to particular locations if this can be justified. An example could be to continue a specialist treatment started in London at an equivalent specialist centre outside the south-east of England. Deferment of dispersal to allow completion of an ongoing treatment may also be considered (Immigration and Nationality Department, 2005*a*).

Asylum seekers subject to dispersal are offered accommodation outside London and the south-east on a 'no choice' basis for location. Asylum seekers who fail to travel on the day of dispersal without reasonable excuse will have their BIA support terminated (Immigration and Nationality Directorate, 2005*b*). Families supported by BIA who fail to travel are expected to leave their emergency accommodation within 5 working days. However, the offer of accommodation in the dispersal location remains open indefinitely.

Clinical scenarios

Asylum seekers referred because of dispersal-related mental disorder can be divided into two broad categories. Most affected individuals are likely to have mild to moderately severe psychiatric disorder with no major risk concerns. A smaller proportion may present with severe psychiatric disorder such as psychosis or a severe depressive episode associated with risk of harm to self or others. The differing severity, complexity and risk profile of these two groups suggest that mental health strategies for support are likely to be different.

Mild to moderate psychiatric disorder

Mental health clinicians should undertake a comprehensive assessment of the asylum seeker's needs and risk profiles. Given that most asylum seekers come from non-Western societies and that Western psychiatry is not universally valid, it is crucial for the clinician to consider cross-cultural issues (Summerfield, 2001). The use of interpreters with knowledge of mental health issues is often critical in such cases.

If the assessment finds a mild to moderately severe psychiatric disorder with no major risks, mental health support should be focused on helping the individual accept and adjust to dispersal. Reassurance and psychoeducation may be sufficient in some cases, and short-term cognitive–behavioural therapy or solution focused work may be helpful for others. The reasons for dispersal should be explained to the patient and obvious misconceptions corrected. They should be informed that free NHS and mental health services are accessible throughout the UK. It is advisable to transfer the individual to an equivalent mental health service in the dispersal location for follow-up.

In such cases, challenging dispersal should be avoided, as it may be inappropriate and unlikely to succeed. A challenge is also likely to falsely raise the individual's expectations, making eventual dispersal more traumatic. If the individual has friends or relatives they can live with, they might consider opting out of BIA-supported accommodation, which then excludes them from dispersal. They will still be eligible for financial support by the BIA.

Severe psychiatric disorder

The individual may be acutely psychotic and severely disturbed with high risk of harm to self or others. They may be too ill to travel long distances even with clinical supervision. Also, the receiving mental health service may not be sufficiently primed to support the complex needs of such a patient. Challenging dispersal under these circumstances would be appropriate. The responsible mental health clinician should contact the BIA to consider deferment of dispersal. Recent BIA guidance recognises that abrupt cessation of psychiatric treatment can result in serious deterioration of the individual's mental health and compromise long-term recovery (Immigration and Nationality Department, 2005*a*). This guidance explicitly requires that where a psychiatrist states that an individual proposed for dispersal is at high risk of suicide, serious self-harm or harm to others, they should be referred to BIA complex case work team.

If the BIA declines to defer dispersal, the clinician should review the case because the individual may have subsequently improved and safe dispersal may be feasible. Where the mental state and risk profile remain

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the same or worse, the clinician should contact the BIA again with an update. If the individual is at risk of suicide, self-harm or harm to others, the clinician should check that the BIA complex case work team has reviewed the case as required by Policy Bulletin 85 (Immigration and Nationality Department, 2005*a*).

In the unlikely event that the BIA insists on immediate dispersal despite compelling medical evidence, the individual's legal advisers could request for a judicial review. This allows an independent judge to review the decision by the BIA. If successful, the judge could quash the decision or direct the BIA to reconsider it (Immigration and Nationality Directorate, 2001). The individual might also contact their local member of parliament for support.

With treatment, some asylum seekers with severe psychiatric disorder will become well enough to travel. Their care should be transferred within a care programme approach framework.

Alternatives to BIA support

Sole BIA support may be inadequate or inappropriate for asylum seekers with severe psychiatric disorders. Support through health and or social services provision may be more appropriate. For example, such individuals may access support under section 47(1) of the NHS and Community Care Act 1990. Asylum seekers detained under section 3 of the Mental Health Act 1983 are entitled to after-care services under section 117. Local authorities are also required under section 21 of the National Assistance Act 1948 to provide accommodation and financial assistance to individuals in need of 'care and attention' (Refugee Council, 2007). Asylum seekers with mental or physical health needs could be supported under this legislation. Children seeking asylum may also access support under section 17 of the Children Act 1989. *Policy Bulletin 82* (Immigration and Nationality Department, 2004*b*) provides more information on support for asylum seekers with care needs.

Conclusions

Asylum is an emotive subject and working with asylum seekers with mental illness can be challenging. It is therefore helpful for clinicians to be consistently objective in their work with this client group. The clinician's work should be guided by ongoing judgements of the individual's clinical needs and risk assessment.

Many asylum seekers with mental illness would, with support, cope with dispersal. A minority may be too ill, making immediate dispersal unsafe. These latter people would require clinicians to liaise with BIA to defer dispersal. Mental health assessment may show that BIA support may indeed be inappropriate for such individuals. Their complex needs may be better supported within health and social services provision.

The dispersal programme is politically and economically attractive; hence it is likely to continue. Mental health clinicians need to understand the issues involved in order to best support individuals who suffer psychiatric distress as a result of the programme.

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Declaration of interest

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