An Exploration of Health and Social Care Practitioners' Work with Mental Health Clients Who Have No Recourse to Public Funds

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Abstract

This is an exploratory study which set out to examine the practice experience of frontline mental health professionals who provide care for service users who have no recourse to public funds. Considering the multiple layers of vulnerability this client group faces, their needs are unique and more complex than most mental health patients in the general population. The frontline professional is therefore faced with a client whose condition is mediated by a complex mix of debilitating migration experience, mental health and lack of access to welfare support.

Using Free Association Narrative method, the researcher conducted in-depth interviews on a sample of 7 frontline professionals with a view to understanding what their practice experiences are while caring for someone who cannot access state welfare benefits because of their immigration status. I also wanted to interrogate the extent to which they are able to deliver high-quality care (Health & Social Care Reg.9, 2014).

Findings from this research indicate that frontline professionals face diverse anxiety provoking situations which they defend against. The study also shows that frontline professionals work in emotionally laden environment where they are daily assailed with conscious and unconscious cues projected at them. Diverse hues of emotions were identified ranging from anger to self deprecation, and moral injury. Another finding was that professionals experienced on going role conflicts emanating from different stakeholders around the work space. In spite of all of these, frontline professionals enjoyed significant amount of discretions in their work within the ambit of policies.

Another significant finding was that professionals' perspectives and practice orientations were influenced by other factors like ethnic and professional backgrounds, the work setting and the level of responsibility of the professional within the organisational structure.

Paul Hoggett's writing on Containment and Conflicts by Public Bureaucracies provided the conceptual framework to illuminate the findings.

Declaration

This thesis has not been previously submitted for any degree. This represents my own research and original work. It cannot be attributed to any other person or persons.

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Table of Content

List of Tables/Figures

ACRONYMS/ABBREVIATIONS

HSCP	Health and Social Care Professional
NHS	National Health Service
CQC	Care Quality Commission
NRPF	No Recourse To Public Funds
BAME	Black Asian And Minority Ethnic
MHF	Mental Health Foundation
MDT	Multidisciplinary Team
MHA	Mental Health Act
AMHP	Approved Mental Health Professional
MCA	Mental Capacity Act (2005)
SCIE	Social Care Institute For Excellen
CPA	Care Programme Approach
CCA	Community Care Act
ICS	Integrated Care Systems

Acknowledgement

I want to express my heartfelt thanks to the Almighty God for the grace and the privilege to complete this course of study. It has indeed been a journey in view of other competing demands for time and resources.

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Introduction

Background to the Study

This study seeks to gain a deeper understanding of the practice experience of health and social care professionals (HSCP) who provide care for mental health clients who are subject to immigration controls and therefore have no recourse to public funds (NRPF).

In this study, I intend to examine their practice to identify and unveil key issues that characterise these practitioners' engagement in the frontline. I intend to draw attention to the apparent and subtle dynamics that shape the delivery of services to patients with NRPF and the implications for practice and the experience of these service users.

In addition, I aim to interrogate how professionals can deliver 'high-quality care that ensures the service users have the best possible care experience. (Health & Social Care- Regulations 9) (2014). I also intend to examine other issues within the HSCP organisations and in the broader socio-political milieu, which impact care delivery to migrants with mental illness who have no recourse to public funds. The subject of interest is mental health patients from minority ethnic backgrounds who have established diagnosis of enduring mental health illness and were admitted under compulsory powers of the Mental Health Act section 3, 37, 45A, 47, or 48. By implication of being admitted under any of these sections, the patient is subject to section 117 aftercare of the MHA. This section provides that on discharge from the hospital, such patient is entitled to ongoing aftercare from health and social services in order to meet his needs arising because of his mental health condition(s), and to reduce the chance of his condition getting worse, so he doesn't have to be readmitted into hospital.

Considering the multiple layers of vulnerability of this client group- such as being people from ethnic minorities mental illness, irregular immigration status, poor social support among others, I wonder how effective are the interventions

provided to this client group. There seems to be a deafening silence characterising the plights of this client group. Or is this silence mirroring the voicelessness of the group? Hogget (2000) draws a corollary between voice and power arguing that voice gives meaning and expression to people's experience. Without a voice therefore people are left with experiences that they have no way of symbolising. Perhaps, the voicelessness of this client group and their caregivers is indicative of their powerlessness to bring about tangible changes in their shared experiences.

The implication is that there is an army of people at the periphery of the society living fragile, lonely, and uncertain lives with little or no social capital. As a result, they find it difficult to re-establish their place in the world' being unable to reconstruct their sense of self and social identities. Such experiences of humiliation, social defeat, and entrapment are often seen as precursors of mental distress (Selten and Greae, 2007) and perpetuate such mental distress.

The aim of the research is to invite frontline practitioners to recognise the need to develop their capacity to function effectively as a good container for the challenges in the frontline. The research will also generate interest in the plight of the vulnerable and explore how their needs can be better met in the society. The research anchors its main findings on how social policy and emotional burdens shape frontline workers' work with service users who have NRPF. Lipsky (1980) asserted in his concept of the street-level bureaucracy that policymaking does not simply end at formulation and that policies are made in the crowded offices and daily encounters of street-level workers. This concept defined frontline workers as having some responsibility for the delivery of policy and public services at the local level and engaging with the community in their day-to-day work. Lipsky averred that discretion is an important concept in understanding the policy-making role of street-level bureaucrats and is taken to mean choice or judgment within recognised boundaries. Lipsky identified a number of techniques or strategies that characterise the discretion of street-level bureaucrats. This includes routinising services, redefining or limiting the clients to be served, asserting priorities, and generally developing practices that permit them to process the work they are required to do in some way', often in the context of severe limitations on personnel and organisational resources.

Being an insider research, I draw on my personal experience to enrich the research data and also to reflect on and document my experiences first, as a frontline mental health practitioner, then as a black minority ethnic migrant, and lastly as someone who in recent past had no recourse to public funds.

The following section highlights the researcher's background and experience, which influenced the choice of this research.

The Researcher's Background and Migration Story

Before relocating to the UK in 2007, I had my education in Nigeria with a Bachelor's degree in Psychology and a Master's in International Relations. I had a stint as a federal civil servant and later joined a private sector oil-producing company. While on this job, I enrolled in and completed an MBA course. Following the return to democratic rule in Nigeria in 1999, I joined a United Nations-funded development agency that was set up to mobilise resources from the private sector and multinational corporations to execute development projects in the newly democratic country. While on this job, I began to explore the possibility of migrating abroad mainly to give my children what I believe is a better future than what was obtainable in Nigeria.

Since I was already in the development sector and with my background in Psychology, my uncle advised me, as he is a qualified Social Worker in England to explore the possibility of studying Social Work. That was the beginning of my journey into social work as I registered for a Masters in Social Work course. Upon completing the course, I applied for a highly skilled migrant visa, and having met all the criteria, I was granted a visa to the United Kingdom. My migration journey to the UK was a major lifetime project spanning about 6 years, with attendant psychological and financial costs.

I arrived in the United Kingdom in January 2007 alone while my wife and three children remained in Nigeria. On arrival, I was received and housed by my younger sister and her family, and I lived with them for the next three years. While waiting for my Social Work degree result to be released, I took up support

work through agencies in adults' and children's homes. I also volunteered for one year in an adult mental health community day centre and an older adults care home. This experience gave me an idea of what the social care sector is about in the UK, as it was a total departure from the development work I was used to in Nigeria. I also volunteered in my local church as a minister- teaching and counseling.

With personal studies, support, and guidance from my uncle and two members of my local church who are qualified social workers, I was able to complete my registration as a social worker and began to practise, initially as a locum and later as a permanent staff in an adult mental health service. I later trained and was warranted to practise as an approved mental health professional (AMHP). In these roles, I encountered quite many service users who have NRPF. Their stories and the circumstances that led some of them into NRPF resonated with me. Some developed a mental illness due to a lack of social support, while for others, their recovery is a mirage due to the precarious situation.

Working with these people was challenging as I was reminded of my own vulnerabilities- the loss, the lack of support, the unfulfilled dreams, expectations from home. The precarity of the entire situation was overwhelming and anxiety-provoking. (See Practice Reflection in Chapter 7)

During this time, in addition to separation from my family, I was also burdened and preoccupied with meeting the Home Office visa conditions, which required that I earn a certain amount of income to qualify for visa renewal. I had to do an extra job to augment my income to meet the home office threshold. At a time, I was combining three jobs! I had to take one year of intermission in my studies at Tavistock to work to raise funds to meet visa requirements. This was in addition to the child care of my 3 sons before my wife joined two years later. Of course, the financial requirement increased when my children joined me as I needed evidence that I can maintain them without recourse to public funds. Looking back at this period, I wondered how I would have coped if, for any reason, either due to illness or unemployment, I was not able to work actively. That would have jeopardised our immigration status tipping us into illegal status, or we would have aborted the entire relocation project and returned to Nigeria. In the course of my professional practice as a frontline social worker in the

mental health service, I found out that many migrants suffered emotional breakdowns and ended up in mental health service due to the pressure directly or indirectly related to their immigration situations.

My children and I were granted permanent residence permits in the fifth year while my wife got hers a year later. Until you are granted the indefinite leave to remain, as a migrant you are in a state of uncertainty and flux, where your entire thoughts and actions are mobilised towards how to regularise your immigration status. This state is characterised by a lot of anxieties, uncertainties, and not knowing. There is a thin line between having the right immigration status and becoming an illegal immigrant. You become extra cautious about what you do and where you go so as not to run foul of the law as an offence or infraction could jeopardise your status. Added to these are expectations from friends and family members who expect the migrant to send money to them at home. There is also pressure from the newly arrived children who want to fit into their new country and repudiate their former country. I recall an incident while we were preparing for the life in the UK test for our citizenship applications, my 15-year-old son stated that those who are writing the test had better prepared well so they can pass because he is not willing to return to Africa. I knew he was reminding the three of us who are taking the test that the family's destiny in the UK depends on us. This added another ounce to the pressure. I felt we are now at a point of no return, and we must give it all that is required to secure our stay.

On reflection, I now wonder, how would someone who is emotionally fragile survive the stress associated with the visa process? How would someone who could not meet the financial requirements survive? How could a migrant who did not have the kind of local support I enjoyed manage without breaking down? What are the services out there that can support migrants to meet Home office requirements and prevent them from falling into the illegal migrants' category? For migrants who are susceptible to emotional breakdown or mental illness or already have mental health diagnosis what chance if any, do they stand? How do frontline professionals manage clients whose care needs are compounded by immigration issues? How do frontline professionals navigate the conflicts between their duty of care and exclusionary policies targeted at migrants?

In another breadth, looking at some very dire cases, I wondered why people would leave their countries only to plunge themselves into subhuman conditions? Looking at the severity of some clients' conditions, I have sometimes wondered why people would move their whole family to a unknown terrain without thorough planning and resources to fund the process? Though I was aware that people migrate for different reasons and under different circumstances, the precarity and hopelessness of some of these cases can evoke a judgemental view from the most objective observer.

In the course of the fieldwork and listening to Anita, Chris, and Lorna's stories, tears welled up in my eyes by the accounts they gave of their experience with their service users. Nevertheless, equally astounding was their expression of helplessness and hopelessness as frontline professionals who work with this client group. This also resonated with me as it reminded me of how despondent I felt when I worked with BO, an NRPF service user on my caseload a while ago. I present a detailed account of my personal experience of working with BO as a frontline practitioner in Chapter 6.

The study was informed by psychoanalytic thinking. A psychoanalytic approach helps us understand the role of unconscious anxieties and how they are managed. Psychoanalytic concepts such as projection, identification, splitting, defence system, containment, grief, and loss, among others, were used to undergird the study. For instance, I am aware that the client can mobilise the professional through projection to act on his or her behalf. As a mode of communication, it can convey aspects of the client's emotional state, which the client disowned or is not in touch with. The significance of these subliminal transactions and what it portends for professional practice were explored. Practitioner/client relationship has been described as a communication bridge that provides a vital link across two worlds: that of the practitioner and that of the service user where empathy and self-knowledge act as central tools from which to read the similarities and differences that lie within and across these two worlds (Sudbery, 2002, pg 156 cited in Trevithick, 2011). I discussed psychoanalytic concepts further in Chapter 3 under Theoretical perspectives.

Research Questions:

The overarching question the research seeks to answer is:

What can we understand from the practice experience of frontline health and social care practitioners in their work with mental health service users who have no recourse to public funds?

Other sub-questions are:

i. How does HSCP negotiate the conflict between the duty of care and exclusionary policies for service users who have no recourse to public funds?

ii. What are the main challenges faced by HSCP in delivering high-quality care to clients who have NRPF?

iii. As professionals, what can we understand by the plight of patients who have NRPF?

Outline of the Thesis

Chapter 1 examines the literature that underpins the study and points out the gaps that make this research relevant and unique. The literature covers areas such as globalisation and migration; migration into the United Kingdom; migrants in the welfare state and; race, racism, and mental health; and frontline practice in health and social care.

Chapter 2 addresses the methodologies used in the research, while Chapter 3 outlines the theoretical framework which underpins the study. Chapter 4 introduces us to the participants and their backgrounds.

Chapters 5 and 6 discuss the main findings from the study. The discussion focused on similarities and differences among the cases, and how these influence the orientation and perspectives of the participants. An attempt was made to map the journey of a typical service user across different professionals' perspectives and what this might mean for the service user.

Chapter 7 discusses the main findings and conclusions, recommendations and implications for practice, policy, and organisations and researcher practice reflections

Chapter 8 concludes the project with limitations of the study and recommendations for future researches; summary of the thesis and personal reflections on the research journey

Chapter One

LITERATURE REVIEW
Overview

This section examined theories of globalisation and its pervasive influence as a ubiquitous change driver and 'victim' of other spinning factors. I also did an overview of patterns of migration in the United Kingdom. An attempt was also made to look at how race and racism affect the mental health of migrants. This is followed by an examination of how migrants are caught up in the tensions and contradictions in a welfare state. The chapter concluded with a focus on mental health services in the UK.

The frontline mental health worker is responsible for managing the mental health of those migrants whom the effects of globalisation have impacted. In addition, many of these migrants face ongoing racial discrimination in various forms.

i. Globalisation and Migration

As a concept, globalisation has been defined variously over the years, with some connotations referring to progress, development and stability, integration and cooperation, and others referring to regression, colonialism, and destabilization. The concept of globalisation can be examined from numerous perspectives, and this essay shall examine some of the concepts of globalisation that are relevant to the research topic.

Anthony Giddens (1996) described globalisation as a generalised process linked to modernity. He defines it as "the intensification of worldwide social relations which link distant localities in such a way that local happenings are shaped by events occurring many miles away and vice-versa. This partly explains why an event in a faraway country have reverberating effects in another country. Giddens argued that discontinuities of modern society have coped up with 'the pace of change', 'the scope of change' and 'the nature of change'. *The pace of change* refers to how the traditional society accelerated its motion towards modernism and, accordingly the modern era towards post-

modernism. *The scope of change* states that with the increasing use of technology, the interconnectedness, social transformation of society is speeding up. Societies are slowly moulding towards homogenization, and as a result, the earth's surface is becoming a virtual world. *The nature of change* however concerns the changing nature of institutions. For instance, with modernity, the nature of the political systems of the world regions are changing. With globalisation the nation-states are gradually converting into 'global governance'.

David Harvey (1990) coined the term 'Time-Space Compression' to describe that if there is acceleration in economic activities in the world, there follows the destruction of spatial cross-borders and distances automatically. With increasing communication and technology, the capital moves to the transnational boundaries much wider and faster. He believes that the compression of time and space is a key factor behind globalisation. Saskia Sassen's "The Global City" (1991) concentrates on the phenomenon of globalisation as territory and scale. It is based upon trans-borderless or 'deterritorialization'. This concept argues that social relations are detaching from their place of origin to place of destination, which can manifest on a multi-scalar basis i.e. from local to regional, regional to national, and national to global.

Economic globalization refers to the increasing interdependence of world economies due to the growing scale of cross-border trade of commodities and services, the flow of international capital, and the wide and rapid spread of technologies (Shangquan,G. 2000).

Globalisation also has implications for Culture and political processes across the world. Culture refers to the characterisation of a particular region, people, lifestyles, and habits. It focuses on the customs, norms, and values and other societal behaviors. While material culture visualizes the Culture i.e. physically embedded like the patterns of consumption, artifacts, and other substantial properties, non-material Culture is the expression of ideas, values, norms etc. From the prospect of globalisation, Culture is the cultivation of intricate social actions that occurs globally with focus on the integration, convergence and diffusion of the cultural traits. (Crozet, 2017)

Inherent in the above concepts of globalisation is the indispensable role of migration- the mobility of people within and across national frontiers. Globalisation process and human migration are intricately intertwined phenomena. The reach of migration is progressively global, stimulated by progressively more complex and sophisticated social, political and economic decision making.

The Global Migration: An Overview

In today's interconnected world, international migration presents a complex phenomenon that impacts virtually every aspect of human life- economic, socio-political and security. There is a plethora of perspectives across disciplines to explain the reasons and the processes of migration. Neo-classical equilibrium models push-pull models and migration systems theories, as well as dominant interpretations of migrant network theories, can all be situated within the functionalist paradigm of social theory, which sees migration as an optimisation strategy of individuals or families making cost-benefit calculations.(Massey, 1993). In the same vein, migration theories such as dual labour-market theory (Piore, 1979), world-systems theory (Wallerstein 1974, 1980), dependency theory (Frank, 1966), neo-Marxist theory, and critical globalisation theory (Sassen, 1991) are broadly similar interpretations of migration as being shaped by structural economic and power inequalities, and how migration plays a key role in sustaining such inequalities. All these theories can be categorised within the historical-structural paradigm, also known as 'conflict theory', which focuses on how powerful elites oppress and exploit poor and vulnerable people, how capital seeks to recruit and exploit labour and how ideology and religion play a key role in justifying exploitation and injustice by making them appear as the normal and natural order of things.

More recent theories that focus on migrants' everyday experiences, perceptions, and identity – such as transnational (Vertovec, 2009), diaspora (Cohen, 1997) and creolisation (Cohen, 2007) theories – can all be situated within the symbolic interactionist perspective in social theory.

Migration encompasses various movements and situations involving people of all walks of life and backgrounds. Migration is inextricably intertwined with geopolitics, trade, and cultural exchange and provides opportunities for states, businesses, and communities to benefit enormously. Migration has improved people's lives in both the origin and host countries. It has also offered opportunities for millions of people worldwide to live safe and meaningful lives abroad. On the other hand, we have seen increased migration and displacement occurring due to conflict, persecution, environmental degradation, change, lack of human security, and opportunity. While most international migration occurs legally, some of the greatest insecurities for migrants, and much of public concern about immigration, is associated with irregular migration often with severe, traumatic, and tragic eventualities.

In the last decade, migration has become a high priority policy issue by many governments, politicians, and the public worldwide. It is likely to continue to be on the front burner of socio-political discourse for the foreseeable future because of its relevance to economic prosperity, human development, safety, and security. The International Organisation for Migration estimates about 281 million migrants worldwide, representing 3.6% of the world population. (IOM Annual Report, 2021).

There have been concerns on how the receiving countries respond to immigrants through official policies, including those with human rights implications and those with racial stereotyping and discrimination undertone. Promoters of such anti-immigration legislation had argued that such policies help curb illegal immigration that has far-reaching outcomes on local economies. It has been argued that perpetrators of racially motivated violence against migrants have used the anti-immigration laws as a reason to target and attack immigrants due to the increasing collective anti-immigrant attitudes. (Miklikowska, 2017).

ii. Patterns of Migration in the United Kingdom

For decades, migration flows from outside Europe to the UK were primarily dominated by immigrants from former colonies in Asia, Africa, and the

Caribbean, which led to largely settled minorities. From the late 1990s, immigration became increasingly diverse. Migration became a highly contentious issue on the political and public agenda concerning regular and irregular immigrants. While border enforcement was traditionally tough in the UK, internal enforcement only recently shifted from a liberal to a more restrictive approach, involving increased surveillance and police cooperation. (Volmer, 2011)

The first great migrations of modern times in Europe were those associated with racial slavery and with colonial conquest and settlement in areas as diverse as America, the Indian sub-continent, and Africa. Closely tied to these was the gradual emergence of industrial capitalism, an era that saw the great transformation of many European societies from rural, agricultural to predominantly urban-industrial formations. Undoubtedly, Britain was a major player and beneficiary of the above transformation, which gave rise to new, distinct, and ultimately momentous patterns of migration (Mason, 2000). British expansion and the growth of colonial exploitation and settlement helped establish the economic foundations of this era. One critical legacy of these developments was a growing black population in Britain from the sixteenth century onwards (Fryer,1984), especially in port cities of Bristol, Liverpool, and London.

With the growth of industrialisation in the nineteenth century, a new pattern of migration emerged, which saw the immigration of people from less developed economies to fill specific niches or labour shortages. The Irish being the closest and oldest colonial depend and being such a preferred destination; this has thrown up a lot of social, political challenges in the land.

iii. Tensions and Contradictions: Migrants in a Welfare State

In this section, I examined the current tensions and contradictions that characterise the policy agenda of the United Kingdom as a welfare state. I also examined the implications of such an agenda on immigration.

Scholars have recognised a fundamental tension between immigration and access to welfare. The American Nobel laureate Milton Friedman (1978) had argued that national welfare states could not coexist with the free movement of labour. Echoing Friedman, Garry Freeman (1986) asserted that it is one thing to have free immigration to jobs, it is another thing to have free immigration to welfare, and you cannot have both. This position was further elaborated on by Rhus (2017) with reference to the European Union policies of unrestricted migration and equal access to national welfare. Rhus argued that a combination of free movement and unrestricted access to welfare could undermine the political sustainability of free movement because it does not take into cognizance the differentials in the labour markets and the welfare states across the EU. Concerns over the impact of intra-EU migration have become a major political issue fuelling Eurosceptic attitudes combined with anti-immigrant sentiments and contributed to, and culminated in Brexit (Hobolt, 2016).

The experience of the EU has shown that the tension between labour migration and inclusive welfare states is real. Free movement of persons and cross-border welfare in the EU has become increasingly salient issues in national public debates. Across the EU, immigration has assumed a place of prominence during political campaigns in most member states – with 'welfare tourism' being part of the political vocabulary (Blauberger et al. 2018). There has also been an increase in the popularity of extreme right-wing elements and sentiments across the EU.

The balance between openness to immigration and access to social rights is also reflected in public opinion toward immigration in many western countries and it has become a relatively undisputed core feature of recent proposals for immigration reforms. Research evidence on the determinants of attitudes toward immigration suggests that social and other rights for migrants can reduce public support for more open admission policies, especially among skilled (and well-paid) residents whose taxes would contribute to covering most of the costs of providing public services and benefits for low-skilled migrants (Blinder, S. and Markaki, Y. 2018). Theoretically, all rights – for migrants and non-migrants – create multidimensional costs and benefits that vary across different types of rights, between the short and long run, and – critically –

between workers with different skills and earnings. Cox and Posner (2009) averred that because rights have consequences, in the sense that they create costs and benefits, restrictions of migrant rights are, and need to be analysed as, instruments of nations states' labour immigration policies.

Whereas economic liberalisation provides more opportunities to highly skilled and highly educated individuals, it increases insecurity among citizens with low levels of human capital. Well-educated and highly-skilled citizens have the cognitive, professional, and behavioural skills to compete in changing environments successfully, and are thus more likely to embrace change and mobility (Hakhverdian *et al*. 2013). Examining the United States, Scheve and Slaughter (2001) found that low-skilled citizens are significantly more likely to oppose immigration. More broadly, globalisation and economic openness tend to increase wage volatility, resulting in workers feeling economically insecure because they tend to face higher risks of unemployment or low wages (Walter 2010).

At the individual level, how citizens interpret opportunities and threats deriving from migration may depend on their level of skills and education. On the one hand, those with high levels of human capital, who are more likely to benefit from international competition and flexible access to low-cost employment, may perceive migration as an opportunity. On the other hand, individuals with low levels of human capital may see migrants as a threat to their status because it adds an extra layer of competition with non-natives, thus opposing the opening up of borders. (Sofia Vasilopoulou et al., 2019)

There is also evidence that trade-offs between openness and migrant rights can characterise labour immigration programmes. That is, programmes that are more open to admitting migrant workers are also more restrictive concerning specific rights. It is pertinent to note that the trade-off between openness and rights affects only a few specific rights rather than all rights. They most commonly include selected social and economic rights and rights relating to residency and family reunion. Trade-offs between openness and migrant rights are evident in policies that target a range of skills but are generally not present in labour immigration programs specifically designed for admitting the most

highly skilled workers for whom there is an intense international competition. (Sofia Vasilopoulou et al, 2019).

With the economic downturn of 2008, the debates about free movement took a more frenetic turn. This development was further fueled by the end of the transitional restrictions on the employment of Romanian and Bulgarians. The latter event is particularly created fears about a mass influx of A2 workers into the EU15 member states. Various EU member states began, many for the first time, to call for urgent reform of the free movement of EU workers. While several proposals were put forward to engage with these concerns, the tension between the free movement of labour and equal access to the welfare state, was and still is, a common issue at the heart of the debate in all countries. An increasing number of countries argue that the EU has to face up to this tension but there is some disagreement about what should be done, i.e. restrict the free movement of labour, restrict access to the welfare state, or both?

Welfare state and the fiscal effects of immigration

The extent to which access to welfare benefits requires a prior contribution by the beneficiary plays a key role in shaping the fiscal effects of immigration. Welfare benefits can be broadly classified into contributory and non-contributory benefits. Contributory benefits are benefits that are only paid if the beneficiary (and their employer) has made a prior contribution. Non-contributory benefits are paid regardless of whether the beneficiary has made prior contributions or not. Within non-contributory benefits, it is common to further distinguish between means-tested benefits (which target the poor as they are paid only if the beneficiary's income is less than a certain threshold) and non-means-tested benefits that can include universal benefits for all residents and categorical benefits for specific groups of the population.

The structure of the taxation system (e.g. its progressivity), the precise mix between contributory and non-contributory benefits provided by the national benefits system affects the impacts of labour immigration on public finance and the social policies of the host country in at least three ways. First, in welfare systems characterized by a high share of non-contributory benefits, low-skilled

labour immigration will be associated with greater net fiscal costs (or smaller net fiscal benefits), at least in the short term, than in welfare systems that include more contributory benefits. This is because new migrants can access non-contributory benefits immediately and without having to make a specific social contribution toward funding that benefit. In contrast, new migrants will only become eligible to access contributory benefits after a qualifying period and make specific contributions to the social insurance system. So, everything else being equal, the difference between taxes paid and benefits received by low-skilled migrant workers will be more favourable to the state under more contributory systems.

In addition, non-contributory benefits systems can make it more difficult – or at least more costly – to target social policies at specific groups among the resident population. The UK provides means-tested (non-contributory) tax credits to low-income earners. There are two elements to tax credits – *working tax credits* plus *child tax credits* for those working tax credit claimants with children. So this is effectively a form of income support for low-wage workers in the UK. The stated purposes of this policy are to raise the incomes of those in low-wage employment and thereby make low-wage employment more attractive than being out of work and receiving out-of-work benefits and to reduce child poverty in the UK. Ref

Routes to No Recourse to Public Funds (NRPF)

According to No Recourse to Public Funds Network (NRPF) a national network safeguarding the welfare of destitute families, adults, and care leavers who are unable to access benefits due to their immigration status, a person will have no recourse to public funds when they are 'subject to immigration control', as defined in section 115 of the Immigration and Asylum Act 1999. Those who are subject to immigration controls cannot claim public funds (benefits, tax credits, allowances, and housing assistance), unless an exception applies.

The following are the categories of people who are subject to immigration control and therefore have no recourse to public funds, those who have:

a) Leave to enter as a visitor
b) Leave to remain as a spouse
c) Leave to remain as a student
d) Leave to remain granted under family or private life rules
e) Leave to enter or remain in the UK that is subject to a maintenance undertaking, such as:
i. Indefinite leave to remain as the adult-dependent relative of a person with settled status (five-year prohibition on claiming public funds)
ii. No leave to enter or remain when they are required to have this, such as:
a. An asylum seeker
b. A visa overstayer
c. An appeal rights exhausted (ARE) asylum seeker

A person with leave to enter or remain that is subject to the NRPF conditions will have the term 'no public funds' written on their residence permit, entry clearance vignette, or biometric residence permit (BRP).

Unless they have the right of abode or are exempt from immigration control, all non-UK nationals are required to obtain leave to enter or remain to live in the UK. When leave to enter or remain is granted, conditions may be imposed on the person relating to employment and access to public funds. These conditions vary depending on the type of leave that the person has been granted. Usually, those granted limited leave to visit, study, work, or join the family in the UK, will have the 'no recourse to public funds (NRPF) condition imposed. A person who does not have any leave to enter or remain when they are required to have this will also have no recourse to public funds.

For immigration purposes, the term 'public funds' only applies to certain benefits; universal credit, allowances, tax credits, and homelessness assistance under Part VII of the Housing Act 1996 and a local authority allocation of social housing under Part VI of the Housing Act 1996. Other publicly funded services are not classed as 'public funds' for immigration purposes and therefore should not be refused to a person solely because they have no recourse to public funds. However, when a service has immigration-related eligibility requirements, the person's immigration status will usually need to be established, such as

whether they have a form of immigration permission and, if so, what type of visa they hold.

There are situations when NRPF individuals can be eligible for assistance from their local authorities for a range of services including education and social care. Under the National Assistance Act 1948, the Children Act 1989, and the Human Rights Act 1998 Local authorities have duties towards all residents within their area. Therefore, boroughs are often left with the responsibility to provide for subsistence and accommodation needs that, under different circumstances, would be centrally funded. At the moment, local authorities receive no additional funding for these costs.

When an individual falls within the excluded group, social services will need to undertake a human rights assessment to establish whether the individual can return to their country of origin to avoid a situation of destitution in the UK, or whether there is a legal or practical barrier that means they cannot be expected to return. Social services' support can only be provided where this is necessary to prevent a breach of the person's human rights. The exclusion is set out in Section 54 and Schedule 3 of the Nationality, Immigration and Asylum Act 2002. When an adult cannot access benefits and housing assistance due to having no recourse to public funds, their local council may have a duty to provide accommodation and financial support if they are assessed as having care and support needs by social services.

In addition to social and economic reasons, there is a general view that all these intricate webs of policies aimed at constricting migrants and controlling immigration are a result of, and part of the institutional structure sustaining racism.

iv. Race, Racism and Mental Health Services in the UK

In this section, using relevant literature I tried to look at the concept of race and racism and also shed light on the nexus that exists between race, racism, and mental health. I attempt to explore how racism is broadly implicated both as a trigger and sustainer of mental health among the minority population in the UK.

I also draw attention to multiple barriers faced by migrants that make them more susceptible to mental and emotional stress and breakdown. I also look at the literature on the adverse health effects of structural racism and how it exacerbates the experiences of this client group who are already confronted with the burden of migration and mental illness.

The concept of race has its root in the global expansion of European societies from the late fifteenth century. This period was marked by a rapid social change in Europe, resulting in the transformation of European societies from primarily rural agricultural to urban-industrial formations. This era was also marked by a new way of thinking and the development of science. This was closely followed by a growing expedition to, and exploration of other parts of the world, which brought Europeans increasingly in contact with other human societies whom they saw as different in their physical appearances, especially in their skin colour and the pattern of social organisation. (Mason. D. 2000).

With increased development in technology, industrialisation, and increased military might of the Europeans, there were apparent power differentials between Europeans and those with whom they had contacts, which was attributed to European superiority. Deploying their scientific and economic advancement, Europe with its white superiority complex legitimised the use of physical characteristics to classify people into a racial hierarchy. This toxic concept helped justify foreign conquests, empire-building, slavery, the annihilation of indigenous peoples, forcing the entire population into servitude, and the Holocaust. (Mason. D. 2000)

Omi and Winant (1993) theorize that, although race is a social construct, it is deeply entrenched in society. They asserted that, because society is scrupulously racialized, race is a necessary aspect of social identification. The process of racialization is socially perpetuating because we reason and do things racially. Their theory of racial formation considers the historical consequences of race and how the experiences of racialized groups are articulated socio-politically. Omi and Winant also argued that racial classifications apply to contemporary socio-political relations in terms of domination and resistance.

Benjamin P. Bowser (2017) noted the dynamic interaction of racism at three different levels- cultural, institutional, and individual levels. He described racism as a stool that stands upright and serves its purpose because it has three legs. Each leg is necessary and works in conjunction with the others. All three legs together are necessary and sufficient for the stool to stay upright; no one or two of the three legs can hold the stool up by themselves. He based his theory on the premise that Cultural racism (the presumption of White supremacy and Black inferiority) precedes and preconditions institutional expressions of racism. Without racist cultural scripts, institutional expressions of racism would not occur. Also, Cultural racism provides the blueprint and architecture for the organization of institutional racism, its objectives (White dominance), and criteria for success (White privilege). Cultural racism is passed on intergenerationally and is part of the content of White racial identity. It should be noted that Institutional racism is essential for both the perpetuation of White privilege and of White dominance. Institutional racism keeps racism going within and across generations. It in turn reinforces cultural racism. Institutional racism precedes and preconditions Individual expressions of racism. Cultural racism is also a necessary precondition to Individual racism, but its impact is mediated through Institutional racism.

Suman Fernando (2017) in his contribution defined racism as a way of thinking that places a superior white people in a position of power over racially inferior peoples of various other races- non-white races being delineated into a variety of 'Others' mainly based on perceived skin colour, black, red, yellow, brown and so on. Franz Fanon (1967) talked of 'vulgar racism in its biological form' which later changed to 'cultural racism' which is a more sophisticated form of racism in which the object is no longer the physiology of the individual but the cultural style of a people. Fernando (2017) asserted that institutional racism is the idea that racism embedded deeply in the Culture of a society leads to the notion that it is incorporated in that society's structures and or its social and political institutions.

Jones, Camara (2000) developed a framework for understanding racism on three levels: institutionalized, personally mediated, and internalized. Jones

posited that 'racism is a system of structuring opportunity and assigning value based on the social interpretation of how one looks that unfairly disadvantages some individuals and communities, unfairly advantages other individuals and communities, and saps the strength of the whole society through the waste of human resources

In this framework, she defined institutionalized racism as differential access to the goods, services, and opportunities of society by race. Institutionalized racism is sometimes legalized, and often manifests as an inherited disadvantage. It is structural, having been codified in institutions of custom, practice, and law, so there need not be an identifiable perpetrator. She posits that institutionalized racism is often evident as inaction in the face of need. and manifests itself both in material conditions and in access to power. Concerning material conditions, examples include differential access to quality education, sound housing, gainful employment, appropriate medical facilities, and a clean environment. Concerning access to power, examples include differential access to information (including one's history), resources (including wealth and organizational infrastructure), and voice (including voting rights, representation in government, and control of the media). She argued that institutionalized racism is largely implicated in the positive correlation that exists between race and socioeconomic status.

Personally mediated racism is defined as prejudice and discrimination, where prejudice means differential assumptions about the abilities, motives, and intentions of others according to their race, and discrimination means differential actions toward others according to their race. Most people think of this when they hear the word "racism." Personally mediated racism can be intentional and unintentional, and it includes acts of commission and acts of omission. It manifests as lack of respect (poor or no service, failure to communicate options), suspicion (shopkeepers' vigilance; everyday avoidance, including street crossing, purse clutching, and standing when there are empty seats on public transportation), devaluation (surprise at competence, stifling of aspirations), scapegoating, and dehumanization (police brutality, hate crimes) (Jones, 2000)

Internalized racism is defined as acceptance by members of the stigmatized races of negative messages about their abilities and intrinsic worth. It is characterized by their not believing in others who look like them, and not believing in themselves. It involves accepting limitations to one's own full humanity, including one's spectrum of dreams, one's right to self-determination, and one's range of allowable self-expression. It manifests as an embracing of "whiteness" (use of hair straighteners and bleaching creams, stratification by skin tone within communities of color, and "the white man's ice is colder" syndrome); self-devaluation (racial slurs as nicknames, rejection of ancestral Culture, and fratricide); and resignation, helplessness, and hopelessness (dropping out of school, failing to vote, and engaging in risky health practices). Jones' framework captures to a great extent the essence of this study.

García & Sharif (2015) asserted that racism as a social condition is a fundamental cause of health and illness and that racism permeates individual attitudes or interpersonal exchanges and pervades structural factors such as institutional policies and societal norms. They posited that health disparities, discrimination, and residential segregation, are by-products of racism. Research findings show racism is a social determinant of health that perpetuates and exacerbates poor health outcomes for racialised populations. The institutional climate that minority ethnic people experience in predominantly white institutions is debilitating and characterised by marginalisation, isolation, objectification as the other, and biases (Fletcher *et al*, 2015).

In the UK, research findings show that minority ethnic groups face significant disparities in mental health care. Disproportionate rates of people from Black Asian Minorities Ethnic (BAME) populations have been detained under the Mental Health Act 1983. They are more likely to be readmitted once discharged, and it is more probable that they will be assessed as violent. Ethnic minority groups experience disparities in mental health in terms of access to care and treatment for mental ill-health. Families who are new migrants, asylum seekers, and refugees experience practical and cultural barriers which can lead to poor service from children services and mental health services. (Mental Health Foundation Report, 2016)

Research has also demonstrated that people from BAME backgrounds experience excessive use of seclusion in psychiatric wards and that restraint is used disproportionately on people from these backgrounds. (Secretary of State for Health and Social Care, Statement 2021, p. 13)

A 2016 UK study examining the Mental Health Act 2007 assessments found black people are four times as likely as white people to be detained under the Mental Health Act with about 321.7 detentions per 100,000 people, compared with 73.4 per 100,000 people and that Black Caribbean people had the highest rate of detention out of all ethnic groups. (Mental Health Foundation Report, 2016)

The Mental Health Foundation report which also showed the association between ethnicity, mental health problems, and socioeconomic status found that people from black ethnic minority backgrounds have a higher prevalence of psychosis compared with the white majority population. A study found that women of Pakistani and Bangladeshi origin were at an elevated risk of schizophrenia after adjustment for socioeconomic status. Studies show that PTSD is higher in women of black ethnic origin and this association is related to the higher levels of sexual assaults that they experience; however, women of black ethnic origin are less likely to report or seek help for assaults or trauma. In a report by the National Institute for Mental Health (2003), it was noted that people of black African Caribbean, and South Asian origin are less likely to have mental health problems detected by their GP, suggesting that they miss opportunities for early intervention.

Research suggests that asylum seekers and refugees are more likely to experience poor mental health than the local population, including higher depression, PTSD, and other anxiety disorders. Increased vulnerability to mental health problems is linked to pre-migration experiences, particularly exposure to war trauma, and the post-migration conditions that refugees often face, including separation from family, difficulties with asylum procedures or detention, unemployment, and inadequate housing. (Mental Health Foundation Report 2016)

The dynamics of racism and social exclusion are reflected in differential rates of mental disorders, access to care, use of coercive treatment, and outcomes (Morgan, McKenzie & Fearon, 2008). The lived experience of people from racialised groups who suffer from mental health has been challenging. They have had to navigate services that were designed and work from a dominant discourse, with little or no opportunity to challenge racism and oppression embedded in the system. This dominant discourse tends to focus more on a medical model which individualise the aetiology of mental illness and approaches to treatment thereby overlooking structural and social factors. Experiencing racism can make us more likely to develop mental health problems. It can also lead to internalised racism and internalised colourism, and racial trauma. (Mental Health Foundation, 2016)

Experiences of racism are usually personal to the victim and may intersect with other issues such as gender, religion, sexuality, and disability. Racism can make people feel unwelcome, lonely or isolated. People may experience anxiety, panic, fearful and unsafe. They may worry about how people are going to perceive and treat you. They might feel visibly different and vulnerable when they are around lots of people of a different race. Angry or frustrated. Particularly if they feel they are being treated unfairly and feel powerless to control it. People who experience racism have reported feeling stressed especially after events such as sudden, unexpected abuse from another person, or due to long-term exposure to regular microaggression, or from the ongoing effects of systemic racism. People can feel unusual and strange especially if people highlight, mock or criticise things that are' different' about you. People can be left confused or unsure about their experience especially if others ignore or deny your experiences, questioning their reality. Racism may force people to suppress their feelings to avoid more racial abuse and to keep safe. This can leave the victim numb or carry the emotion for a long time. (MIND, 2021)

Racism, COVID-19 and Mental Health

The impact of the coronavirus pandemic has again highlighted the systemic racism as reports show that Black and Asian people have been disproportionately affected by the pandemic due mainly to inequality in

employment as they work more in the frontline where they are in direct contact with the ravaging virus. They also experience income inequality being low-income earners and cannot afford to self-isolate or take time off. Minorities are also prone to live more in crowded accommodation which makes it difficult to isolate (Lancet Migration, 2020)

Miriam Orcutt et al (2021), highlighted how the pandemic had exacerbated pre-existing structural challenges facing migrants across the world. In health systems, they included a lack of capacity and inclusiveness, and obstacles to healthcare including immigration status, language barriers, and inadequate or inappropriate information. Migrants often experienced crowded and unhealthy living conditions, especially in detention and reception contexts, and precarious finances. Exacerbation of existing xenophobia and racism and tightened immigration restrictions and border controls were also widely reported.

In conclusion, the minority population and especially those with irregular immigration status are confronted with multiple barriers in accessing social and health care, including legal status; discrimination and xenophobia; lack of migrant-inclusive health systems and health policies; which result in poor outcomes due to delayed or no access to supportive treatment. Aspects such as inaccessible or inappropriate health communications/information; and fear and mistrust of healthcare authorities or government providers also exist as challenges. The disproportionate loss of BAME patients to the COVID 19 pandemic underscores the insidious impact of racism on the minority population.

v. **Frontline Health and Social Care Practice in Mental Health**:

The Health and Social Care Act 2012 requires each Clinical Commissioning Group (CCG) to in the exercise of its functions, have regard to the need to reduce inequalities between patients concerning their ability to access health services; reduce inequalities between patients pertaining to the outcomes achieved for them; promote the involvement of patients and their carers in decisions about the provision of health services to them and enable patients to make choices concerning aspects of health services provided to them.

The mental health service is structured as a multidisciplinary service with professionals of diverse backgrounds working together towards achieving a desirable outcome for the service user. A typical MDT consists of professionals such as psychiatrists, doctors, psychiatric nurses, social workers, Occupational therapists, psychologists, and support workers who work to complement one another to provide holistic care for the patient either as an inpatient or in the community setting.

Mental health services offer a wide range of interventions for service users of all ages- children and adolescents, working-age adults, and older adults. There are also specialised services for different types of mental illness such as Eating Disorder services, Early Intervention for Psychosis, Perinatal services, and people with emotional dysregulation. These specialised services are structured in line with identified local needs and protocols.

The recently published NHS Long Term Plan set out a commitment for the NHS to transform community mental health services for adult and older adults by investing almost £1 billion per year by 2023/24 to implement new and integrated models of primary and community mental health services for people with severe mental health problems across every integrated care system (ICS) in England. Starting from April 2021, all ICS systems will be implementing new models over the next three years, supported by year-on-year growth in the new NHS Long Term Plan investment. The Community Mental Health Framework will be replacing the Care Programme Approach (CPA)] for community mental health services while retaining its theoretical principles based on good care coordination and high-quality care planning.

The legal and policy context that shapes the practice of mental health professionals include the NHS and Community Care Act 1990 (CCA), the Mental Health Act 1983 (MHA), the Mental Capacity Act (MCA), and the Human Rights Act. The CCA requires health authorities to work in tandem with the local authorities to set arrangements for care and treatment in the community of people with mental health problems. It places a duty on local authorities to assess an individual's needs and circumstances and determine whether or not the person meets the eligibility criteria and threshold to receive services.

The Mental Health Act 1983 (MHA) provides the legal framework to determine admission to a psychiatric inpatient unit. Access to the inpatient unit can be voluntary or compulsory. An individual can be admitted 'detained' or 'sectioned' after all alternatives have been considered or if there is a risk to the individual or others. The MHA sets out the required number and special expertise of mental health practitioners needed to enforce the Act, the role of the approved mental health professional (AMHP), the rights of relatives to be involved in decisions, and the rights of patients to appeal.

The Human Rights Act provides that public authorities must make sure they respect and protect the human rights of service users when they provide health and care services. This may involve taking positive steps to ensure human rights are not breached. The aim of the MCA is to promote and safeguard decision-making within a legal framework. It does this by empowering people to make decisions for themselves wherever possible and by protecting people who do not have the capacity to protect themselves by setting out a flexible framework that puts individuals at the heart of the decision-making process. It is a key law for supporting people with mental health problems.

These are the key legislations that define the work environment of front line mental health professionals. There are other associated and relevant legislations, policies, guidelines, protocol that the professionals must be knowledgeable of in the performance of their duties.

Frontline professionals in mental health services use several approaches to discharge their duties according to their service protocols. One of these approaches is the recovery model, a framework or guiding principle that focuses on working with the individual service user to identify their strengths and build resilience. It also focuses on working with individuals to regain control, support recovery, and lead a meaningful life. Recovery does not always mean complete recovery from a mental health problem, but rather, it is about staying in control of their life despite their mental health problem. Another approach is personalisation; people with mental health problems can benefit from

personalised social care as it increases choice and control and identifies what works best for them. The concept includes prevention, early intervention, and self-directed support. (SCIE)

Assessment is an approach used to determine the individual's health and social care needs. The outcome of this assessment may be an intervention by the service, advice, or referral to another service. All assessments should include an assessment of risks to the individual, and the possible impact of this on them, their family, and others, including the public. The assessment of an individual's mental health must be holistic and cover psychological health, social functioning, physical wellbeing, and social circumstances, among others. The outcome of this assessment will determine the nature of the intervention

Where the MDT provides an intervention, a care plan is agreed upon in writing with the service user. A crisis and contingency plan will form part of the care plan. It identifies early warning signs for setbacks and what to do if the person is becoming unwell. Most interventions will be led and organised by a care coordinator. The care coordinator is often the key contact person. They are usually mental health professionals such as a nurse, social worker, or occupational therapist. They provide a link between the individual, their family, and other professionals and work with the service user to make sure their care plan is effective. They are responsible for ensuring regular reviews take place and coordinating work with other agencies.

The above attempts to present the structure and the modus operandi of the mental health service as currently constituted. Over the years, there have been a series of plans, reforms, and high-sounding aspirations that yielded at best very modest achievements. Without being pessimistic, we wait to see the dramatic change The New Long Term Plan will deliver. Cooper (2005) noted the considerable difficulty in accommodating thoughtfulness about the pain associated with mental distress in society. He alluded to the fact that mental illness defies common sense. It is a repudiation of what is common and what is sensible and brings with it a complexity that requires engagement and understanding, not rhetoric. He advocated for the need to have the mental well-being of the professionals in mind and not just the quality of service. He argued

that the staff's mental health is put at risk not just by the disturbance of the patient but also by the lack of attention to the physical, intellectual, and psychological environment of the professionals.

Lipsky (1980) asserted that public service professionals are drawn into public service because they want to be of help to others. There is no sector where this assertion is more exemplified as in the human services sector like the National Health Service. This view was echoed by Cooper (2018), who expressed that by and large, well-intentioned and motivated people are attracted to welfare work whether as clinicians, teachers, or members of one of the essential administrative professions that support the clinical task.

Therefore, the challenge is not the absence of commitment and dedication from staff, but a lack of thinking about the need for psychological nourishment for the frontline professionals so they can develop a robust capacity to contain and process the complexities they encounter on the frontline. Flipping and churning out policies, agendas, and plans are attempts to use policies and organising to soothe the psychic pain of society. This approach has never been effective nor sustainable. Obholzer(2003) argued for the need for an organisation to enter into a depressive state where stakeholders will agree on the primary task and also be in touch with the nature of anxieties being projected into the container rather than defensively blocking them out of awareness.

Lotta and Pires (2019) observed that many governments invest enormous political energy and resources to the formulation and implementation of services aimed at providing support for those in situation of vulnerability and exclusion without success. They went further to argue that even when they do deliver, these services might engender forms of social inequality reproduction in their day-to-day operations such that street level implementation turns into not only a locus for the visualization of existing inequalities, but also a place where social inequalities might be reproduced, contrary to original policy intentions.

Chapter Summary:

This chapter presented a review of literature on the concepts of globalisation and migration and how the two phenomena are inextricably intertwined, and the social, cultural, and political impact they have on the world. An attempt has also been made to give an account of historical and contemporary migration patterns into the United Kingdom. The above three discussion points laid the foundation for the tensions and contradictions in the welfare state about migrants. The ensuing anxieties emanating from these contradictions are responded to with a plethora of legislation aimed at constricting the rights of migrants, among whom are this population of mental health users who are excluded from accessing state benefits.

Because the exclusionary policies and their implementation are situated against the notions of 'difference' and 'differentiation,' an attempt was made to understand the insidious role that race, and racism might play. The chapter concludes with a look at the agency of government saddled with the unenviable responsibility of managing the perturbation of the complex interaction between these phenomena at the frontline. In order to be an effective container, mental health services, both as organisations and staff, need to enlarge their capacity to bear pain' as they engage with the work (Cooper, 2012).

Chapter Two

Research Methodology:

i. Introduction

This exploratory research seeks to understand and gain more insight into the experiences of frontline health and social care professionals who work directly with mental health service users who have NRPF. Researchers use exploratory research to gain familiarity with an existing phenomenon and acquire new insight into it to form a more specific problem. Exploratory research is the process of investigating a problem that has not been studied or thoroughly investigated in the past (Hammarberg, et al, 2016). Exploratory type of research is usually conducted to better understand an existing problem. Considering that the frontline professional is constantly in close proximity to people in great pain, whether physical or emotional, or both, they are prone to stressful conditions which they have to defend against. In addition, frontline professionals are also participants in their organisation's defence system.

ii. Research Design

The research was conducted using qualitative methodology as this was considered the most appropriate approach to understand and address the research questions. Qualitative method enriches our understanding of the complex and multidimensional phenomena encountered in the research. Qualitative method considers the social and cultural context of the problem being investigated and the meanings and interpretations that participants ascribe to their actions and the actions of others. It offers an in-depth and holistic understanding of phenomena and processes, the avoidance of imposing commonsensical or the researcher's categories to actors, subtlety, detail, and the avoidance of the limitation of actors' discourses to some (usually pre-selected) quantitative variables (Rubin and Rubin 2005). Qualitative methods are used to answer questions about experience, meaning and perspective, most often from the participant's standpoint.

Maxwell (2013) asserts that qualitative research works with the universe of meanings, motives, aspirations, beliefs, values, and attitudes, which corresponds to a deeper space of relationships, processes, and phenomena

that cannot be reduced to the operationalization of variables. Qualitative method offers a great deal of potential for understanding the dynamics and intersubjective unconscious processes at work in the research. The research aims to explore frontline workers' experience as health and caregivers to vulnerable mental health patients. This role carries a lot of subliminal cues, and transactions below the surface that shape and define the delivery of services to the client group. For instance, the vulnerability of service users often evokes strong emotions in the practitioners, reminding them of their vulnerability. Power dynamics between a professional and the service user demands ongoing negotiation and reflexivity. These phenomena, being not discreet or quantifiable, are better captured using a qualitative approach. Qualitative research is therefore concerned with aspects of reality that cannot be quantified, focusing on understanding and explaining the dynamics of social relations. A qualitative orientation usually emphasizes meaning as contextual or situated, reality or realities as multiple, and researcher subjectivity is not just valid but a resource (Braun and Clarke, 2013).

It has also been argued that the researcher wields much influence in qualitative research that can taint the research's credibility. However, being an ethnographic researcher, the researcher is an integral and active participant in the entire research process. His views, feelings, and interpretations of his findings are germane to the research output. Ethnography lends itself to studying small societies' beliefs, social interactions, and behaviours, involving participation and observation over a period, and the interpretation of the data collected (Denzin and Lincoln, 2011;cited in Loshini Naidoo, 2015). The goal of ethnography was to give an analytical description of other cultures (Barbour, 2007) and explore a particular phenomenon (Atkinson and Hammersley, 1994, cited in Loshini Naidoo, 2015).

iii. **Free Association Narrative Interview (FANI)**

One-to-one in-depth interviews were conducted with each participant using a free association narrative interview (FANI). FANI was developed by Hollway and Jefferson (2000, 2003). They used Melanie Klein's work to develop a theory of defended subjects where the researcher and the participants are viewed as being anxious and as defended subjects. Klein's position is that the most primitive defences against anxiety are intersubjective.

FANI assumes that unconscious connections will be revealed through the links people make if they are free to structure their narratives (Hollway & Jefferson, 2008). They argued that this approach emphasises the meaning that is created within the research pair and the context within which the account makes sense. It is believed that by eliciting a narrative structured according to the principles of free association, the researcher can have access to the interviewee's concerns which would probably not be accessible using a more traditional method. FANI assumes that people cannot necessarily tell it like it is because their own remembered actions may not be transparent to them on account of defences against anxiety (Hollway & Jefferson, 2008).

FANI emphasises the importance of homing in on the narrator's emotional sequencing of their stories and attending to the rich detail of awkwardness, contradictions, and strong or unusual patterns. It also emphasises the need to hold in mind the idea of 'multiple narrative truths' in developing interpretations of the qualitative data. The provision of the second interview with the subject allows the researcher to return to identified points of specific interest.
FANI acknowledges the position of the researcher in the analytical account. The researcher is not just a passing reference, thereby ensuring a form of reflexivity as the data analysis acknowledges the researcher/subject relationship.

According to Hollway and Jefferson (2000), FANI as an interview method was based on four principles that facilitate the interviewee's meaning frame production. The first is to use open-ended questions and avoid closed and leading question, which may have evoked either a 'yes' or 'no' answer or made

the respondent feel that he or she had to think of a particular incident. Instead, I asked: 'Using specific instances tell me what your experiences are while working with service users who have no recourse to public funds. This question was designed to encourage participants to talk about their practice experiences.

The second principle is that of eliciting a story. Story-telling shares many things in common with the psychoanalytic method of free association: the particular story told, the manner and detail of its telling, the points emphasized, the morals drawn all represent choices made by the storyteller. Such choices reveal, often more so than the teller suspects (Hollway and Jefferson 2000a p. 35). This principle also allows the researcher to look at various forms of projective communication, of transference and counter-transference, that are present in the interview relationship. Why do people tell certain parts of certain stories? Why are they telling them? What form of responses are they trying to elicit from the interviewer? For instance, while some of my participants emphasised more on the emotional pain of their experience, others dwelt more on how their messianic role as rescuers and super carers of the service users. Yet others were more political and consumed by the perceived injustices of the system.

The third principle is to try and avoid using 'why' questions to avoid participants giving sociological or clichéd responses. Hollway and Jefferson (2000a) note that this may seem counterintuitive as people's explanations of their actions are helpful in understanding them. The final principle is that of using respondents' ordering and phrasing. This involves careful listening to be able to ask follow-up questions using the respondents' own words and phrases without the researcher offering their own interpretations. Hollway and Jefferson (2000a) note that this required discipline and practice to transform the researcher from a visible asker of questions to the almost invisible, facilitating catalyst to the participant's stories' (p. 36). This does not imply the stance of an objective observer; rather it means not imposing a structure on the narrative. I find this very uncomfortable initially during the interview stage of the research. We had moments of prolonged and awkward silence when the participant was waiting for me to prod her to continue her narration.

Using FANI, I carried out two interview sessions with each of the 7 participants. At the first session, the participant was asked to narrate their personal experiences of working with service users who have no recourse to public funds. Participants were asked to use stories of their encounters in their narration. In the word of Polanyi, the narrator takes responsibility for 'making the relevance of the telling clear' (quoted in Cahse, 1995:2). Eliciting stories have the advantage of making people give an account of what actually happened. The participant was at liberty to choose what story of their experience to tell, the manner and detail of the story they narrate, how to tell it, the delivery sequence, and the points to emphasise. My role at this stage was to listen attentively, making notes of key issues and themes to consider for further exploration at the second interview. The second interview was used to clarify some of the claims and contradictions that were identified during the first interview.

iv. **Researcher's Positioning: The Insider/Outsider Paradox**

The researcher as a participant has the advantage of being immersed in the culture over an extended period, and therefore, he is in a position to discover what was hidden, such that the researcher and the participants played major roles in co-production and interpretation of the research materials. As the researcher, I share some commonalities with the direct participants of the research and the service users whose circumstances were examined in this study. I am a mental health social worker with many years of experience in frontline practice. I have served as a care coordinator to mental health service users, some who have no recourse to public funds. As a frontline practitioner, I am aware of some of the challenges frontline health and social care professionals face while working with this client group. In addition, 4 of the participants are migrants from black African backgrounds like myself. They all migrated to the United Kingdom to study and to practise as mental health professionals. I have interacted with some of the participants in the course of carrying out my frontline duties. In addition to these, I also share my experience as a migrant who had no recourse to public funds just like these 4 participants and the service users . When I arrived in the UK about 13 years ago on a highly skilled migrant program, it was stated on my visa that 'No recourse to public funds. These shared experiences as professionals and as migrants made the

research process more collaborative. There were also shared meanings and understanding of issues raised during the interviews. For instance, most of the parlances and terms commonly used in mental health were freely used without further clarifications by the researcher or the participants. This engendered mutual understanding and coherence in the interview process.

The researcher and participants had shared understanding of experiences of working with mental health service users who have NRPF. In the course of the interviews, I was often reminded of my own frontline experiences. I identify with their experiences (Bhopal 2011, pg 24). In addition, listening to participants from minority ethnic backgrounds narrating their practice and lived experiences resonated with me as some of their tortuous migration journeys, practice experience, and the structural racism they currently face reminded me of my own experiences.

Despite these commonalities and my insider status, I was still an outsider to a considerable extent. The researcher/participant dyad was apparent as the participants saw me as the driver of the interactions and ascribed more power to me. On many occasions, they waited for instructions and cues from me or sought my affirmation before continuing with their narrations. In addition, my practice setting was also different from most of the participants who were either hospital-based practitioners or in clinical roles, unlike the researcher. Another point of difference was that the professional background of most participants was not social work, unlike the researcher. In effect I was both an insider and an outsider at the same time. Lorde(1984) remarked that such paradoxes are important in research because they make visible those differences that constitute experiences of 'otherness', 'insiderness' and 'outsiderness'. It also reveals the subtle ways in which identities shift and reconfigure, making it possible to occupy insider-outsider positions simultaneously. In his influential treatise, Insiders and Outsiders, Merton(1972) asserted that individuals have not a single status but a status set: a complement of variously interrelated statuses that interact to affect their behaviour and perspectives. How the researcher is positioned as similar and different to the research participants, concerning culture, class, 'race', ethnicity, gender, age, sexual orientation and

ability, also need to be taken into account, alongside attention to context (Fine, 1994; Wilkinson and Kitzinger, 1996).

v. **Reflexivity**

The qualitative researcher has been described as a 'research instrument', and one of the ways the researcher proves his/her credibility is reflexivity (Denzin and Lincoln, 1998). Reflexivity refers to being conscious of the researcher's potential influence on the research process and how to manage it. (Sandelowski, 1986). Reflexivity is a resource for understanding data that are embodied, unspoken, or unavailable to consciousness (Clarke, Hoggett, 2009). Reflexivity provides a window into the researcher's experience of the research encounter, how they feel, listen, and what they can hear and notice (Back 2007; Hubbard et al 2001; Hunt 1989). The research encounter has been described as a co-created space such that the researcher and the research activity are seen as part of the production of knowledge (Frosh, 2010), with research subjects being "… reflexively constituted between the researcher and the researched". (Mauthner and Doucet, 2003).

Throughout the research process, I was aware of the need to be in touch with my inner feelings, thoughts, doubts, and emotions and not be carried away by the obvious. Therefore the practice of reflexivity helped me to engage with the research endeavour in order to produce rich and credible research data.

Right from the choice of the research topic and drawing up research questions, I was conscious of my identity as a migrant and a frontline practitioner researching the sensitive area of race, migration, and frontline work. Having been subject to immigration control myself, I was alive to what it meant to have NRPF, and especially if someone has a mental illness. I was also alive to the challenges mental health practitioners face in their day-to-day frontline work with migrants who have no recourse to public funds.

I made use of field notes to document the emotional dynamics of the research encounters and my personal reactions and thoughts to different situations in the course of the research.The use of reflective space helped me decipher the participants' conscious and unconscious expressions and mine as the

researcher. The regular supervision and seminar sessions helped tremendously to unearth many unknown and unseen elements in the data I brought into supervision. Such supervisions which are largely psychoanalytically informed provided 'additional pairs of eyes' to look at the materials brought for discussion. In one of such group seminars, I realised that I might be researching myself considering the many similarities I share with the participants and the service users. This realisation made me more aware of the need to be more reflexive and guide against projecting or imposing my thoughts and experiences into the research process while at the same time remaining a co-producer of the research data.

The FANI method of interviewing provided an opportunity for me to clarify and resolve any subjectivity I might have inadvertently brought into the participant-researcher encounter. The free association method gave the participants the freedom to narrate their stories as they wish without imposition thereby giving credibility and authenticity to the materials generated. Reflexivity helped me have a more holistic understanding of the data set within the research context.
In light of the above, reflexivity played a critical role in generating a credible data set. It helped to glean powerful but subtle intersubjective materials lying below the surface of the research process, including the researcher/participant dyad. Reflexivity provides a vehicle that gives the research credibility and shape.

vi. **Data Analysis:**

Qualitative data analysis has been described as a continuous exercise that evolves throughout the research project's life, starting from when the research questions are formulated to the write-up and conclusion of the research findings (Suter, W.N., 2012). It has been argued that analysing qualitative data requires being sensitive and maintaining curiosity about the data set. It requires being open minded and diligent to mine the hidden aspects of the data. Qualitative data analysis aims to uncover emerging themes, patterns, concepts, insights, and understandings (Patton, 2002).

Hollway and Jefferson (2004) identified 4 core questions associated with analysing qualitative data: What do we notice in the data? Why do we notice

what we notice? How can we interpret what we notice? How can we know that our interpretation is right? To answer these questions, the researcher must immerse himself in the data and interrogate the dataset based on the aim of the study as articulated in the research questions. Schram (2006) describes qualitative research as a 'contested work in progress' and as a task that embraces complexity, uncovering and challenging taken for granted assumptions and being 'comfortable with uncertainty. Qualitative research aims closer to problem generation (problematizing) than problem solution (Schram, 2006).

Story-based analysis is an interpretive research methodology, recognising as do Feldman *et al*. (2004, p. 147, cited in Durose, 2009, p. 41) that stories are 'a essential tool that individuals use to communicate and create understanding with other people and for themselves. Maynard-Moody and Musheno (2000) have also highlighted an important advantage of story-based research: Stories give research a pungency and vitality … because they give such prominence to individual actions and motives ... Stories illustrate the consequences of following, bending or ignoring rules and practices. They bring institutions to life; they provide a glimpse of what it is like to [work there] (Maynard-Moody and Musheno,2003, p. 30, cited in Durose, 2009, p. 41). The stories given by frontline workers were essentially a microscope for examining minute details and a telescope for scanning the intellectual horizon for themes and patterns' (Maynard-Moody and Musheno, 2006). The extensive notes and recordings taken throughout the research were also transcribed. The process of transcription made a crucial contribution to developing the narrative reflecting Harry Wolcott's (1990) comment that 'writing *is* thinking'. The iterative nature of this process was then further developed by sharing initial analyses both with research participants and with other researchers in the field (Erlandson *et al*., 1993). This process demonstrated a commitment to 'get it right' in terms of the lived experience of frontline workers (Schwartz-Shea, 2006, p. 105). Story-based research is complex, ambiguous, selective and subjective (Maynard Moody and Musheno, 2003; Stake, 2000; Yanow, 2000) but it provides an important insight not given by other research methodologies into frontline work.

At the end of the interviews, the research participants have produced over 14 hours of audio recordings, which were transcribed into over 80 pages of transcripts and several pages of handwritten field notes and supervision notes. These materials were subjected to critical examination, careful interpretation and synthesis to discover patterns,themes, categories and ideas. Materials were discussed at one to one supervision sessions with my research supervisors and also with colleagues at seminars, all of whom brought additional 'pairs of eyes' to examine and interrogate the data, bringing new perspectives to the data.

Thematic Analysis:

The research data were analysed using thematic analysis (TA) method. TA works well with many different interpretative frameworks, ranging from phenomenological ones to critical constructionist interrogations of meaning. And it, therefore, has the potential to answer different research questions. TA can address questions about, and be used to describe, the "lived experiences" of particular social groups (Mellor and Lovell 2012). TA offers flexibility around data collection including interviews; focus groups; diaries, visual methods, participatory methods, surveys, a wide range of secondary sources. TA enables the researcher to give an insightful understanding of the data set which transcend ordinary interpretation of information gathered during the research exercise. It allows for thorough and detailed scrutiny and iterative analysis of the data. TA has been described as an analytical method which is theoretically independent and characterised by open coding, and therefore adaptable to different types of qualitative enquiries. Braun & Clarke (2019). TA is a method for identifying, analyzing, and reporting patterns (themes) within data. TA resembles grounded theory analysis, in that the themes emerge from the primary data. It organizes and describes the data set in rich detail and frequently interprets various aspects of the research topic. The level of sophistication achieved by this method can vary; ranging from a simple description of all the themes identified to analyses of how the different themes relate to one another in a conceptual map (Pope et al. 2007).

The advantage of TA is that it provides a means of organizing and combining the findings from a large, diverse body of research (Pope et al. 2007). It can handle qualitative and quantitative findings, and it can be a deductive, theoretically driven approach or an inductive one, in which themes 'emerge' from the process of synthesis. However, transparency is usually criticized in thematic synthesis, since there are many different ways to approach it. It has been suggested that researchers using TA do often have some kind of social justice motivation such as giving voice to socially marginalized group, or a group rarely allowed to speak or be heard in a particular context (Braun and Clarke, 2013). This is a fitting justification for the desirability of using TA for analysing data on the experience of frontline practitioners who work with mental health service users who are victims of exclusionary policies.

Braun and Clarke (2019) recommended a 6 stage approach to TA. Stage one is familiarisation with the data, which requires the researcher to be immersed in and engaged with the data, looking out for what is interesting and about possibilities and connections between data and existing literature. It entails listening to recorded audio, reading and re-reading textual data, and taking note of interesting features in the data. The next phase, generating code, involves systematic engagement with the data with a focussed attention to make sense of the data systematically. This stage entails labelling or coding emerging patterns. The next stage is constructing themes. This is the phase where themes are built and named at the intersection of data, researcher's experience and subjectivity, and research questions. The next 2 stages are Revising and Defining themes. These stages require the researcher to be open and flexible enough to change, merge or discard any of the themes in order to have clear definition of each of the themes. The last stage is that of producing the report. The researcher is required to stay close to the data and work iteratively by revisiting the data against the research questions. They noted that this process is not linear but rather it is a reflexive and recursive process.

At the end of the fieldwork, I pulled together all the materials generated from the transcriptions, field notes, personal reflections, notes taken in supervision and group seminars sessions. I spent considerable time familiarising myself with the data- listening to audio recordings, reading and re-reading the transcripts and

reviewing the field notes. I began to identify emerging patterns and coding them and grouping them into categories along the lines of what appear to be emerging themes. The aim of coding and theme development is to provide a coherent and compelling interpretation of the data, grounded in the data. I identified themes based on conceptual patterns to develop an understanding of patterned meaning across the dataset. Through rigorous iterative process, a better conceptualisation of the data began to emerge. This process demanded deep engagement to move beyond the surface or obvious content of the data and to identify unifying patterns of meaning. With a closer and more inquisitive focus on the text of the themes, I was able to sieve and distil what each participant's data set was pointing to within the context of their responses and meaning-frame. I should also say that there were new meanings and phenomena emerging from the data. I was able to develop a concise formulation of each participant's case into a coherent whole. It should be noted that the process was not at all linear as I had to move from to and fro to look at and recheck the data again and again. It has been noted that the process is recursive and reflexive rather than linear (Braun and Clarke, 2019)

Fig. 1. **Data Analysis Process**

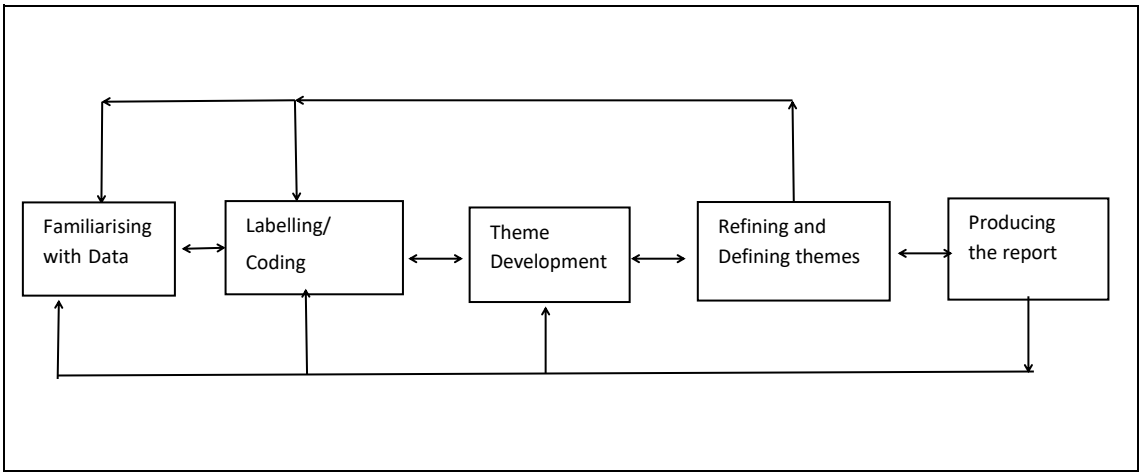


Table 1: Thematic Analysis of Data

Extracts from Transcripts Pointing to Themes	Sub Theme	Theme	Description of demeanour	Analysis
Henry: This is the difficulty and dilemma we face. While these processes are ongoing or being put in place or sorted out, the bed is being blocked. If you are symptoms free, you don't need to be on the acute ward. Such people become delayed discharge- 'detoc', which puts a lot of pressure on us. **.....**I mean it leaves us very vulnerable. It leaves us very vulnerable because you have duty of care to your patients as well. If you have a patient that has got NRPF, …… but the patient is blocking a bed, what do you do? You know, the whole Trust comes to that conclusion that they have to discharge you, unfortunately you have to find your 'square root' but it leaves you very vulnerable because they are human beings, it leaves you open. **Anita:** Am not going to judge about that, am not an immigration officer, but with my own job as care coordinator, as health practitioner, it makes my job quite difficult to work in that kind of environment. I went there the other day, the house was infested with bedbugs, it was heart breaking…… ….. As I said earlier, it makes you feel you have not actually completed your job because all these immigration issues affect their recovery…. ……. So, you as a professional, you as a nurse, as a care coordinator, as a substance misuse professional, as a team leader, you then look that there is no where to place this client. And you can't take them to your house, you just have to discharge them back to the streets	Frontline professionals feel helpless in their caring role for patients who have no recourse to public funds	**Frontline practitioners are vulnerable in providing care for patients who have NRPF**	Despondent, Helplessness Unfulfilled, Difficulties Challenges Conflicted Disempowered Frustrated Stuck Hands tied Feeling like a failure Disenchanted Despair	• Frontline practitioners may feel incapacitated in performing their caring role due to exclusionary/discriminatory policies policies targeted at patients with NRPF. • Frontline practitioners may be conflicted as they are caught between their primary task of care and having to implement the organisational/governmental discriminatory policies. • Practitioners are at risk of suffering moral injury • Practitioners may depersonalise NRPF patients

Anita.. how are they going to recover from their illness? As a person, it breaks my heart ….when a decision is made to discharge someone regardless of whatever the outcome is, is very demotivating, very demoralising, the staff becomes more and more emotional because you are dealing with another human being, who has no means of surviving the basic things… **Henry**: So, I always empathise and it does affect you as a professional and a human being, knowing that there are people out there who came to this country to make a living for themselves like we all do but different paths and unfortunate circumstances led them to be where they are…. **Chris**: As health care professional, what I found I end up doing is that at times I have to take money from my own pocket, not that I need them to pay back but when you visit someone, and they tell you that they have not eaten, they haven't got anything to eat. May be that day they went to food bank, but food bank was closed, and they have no money. I ended up taking money from my own pocket. But this is still short term, I can give five pounds or ten pounds…… …...You give more time to them. You are a human being at the end of the day, you want to know, has this person eaten, have they drank, how have they survived through the day? So you devote more time to them	Frontline practitioners commit more time and efforts on patients who have NRPF. Professionals spend personal resources-money and time on patients who have NRPF. Caring for NRPF patients places emotional toll/labour on frontline mental health professionals	**Frontline MH practitioners carry emotional burden in performance of their role**	Soliciting for food/material items from colleagues Going extra mile to meet their needs Invest more time on their cases Giving them money or buying groceries for them	• Disproportionate use of time on NRPF patients • Frontline practitioners carry significant emotional burdens related top their work with NRPF patients and may therefore not be effective care providers • Because of their impotence to rescue their patients, frontline practitioners may see themselves as victims as much as their patients

Cross Case Analysis: (CCA)

Cross-case analysis is a method that facilitates the comparison of commonalities and differences in the events, activities, and processes; the units of analyses in case studies. Cross-case analysis is a research method that can mobilize knowledge from individual case studies. Mobilization of case knowledge occurs when researchers accumulate case knowledge, compare and contrast cases, and in doing so, produce new knowledge. The term cross-case analysis is sometimes used as a general umbrella term for the analysis of two or more case studies to produce a synthesized outcome (Khan and Van Wynsberghe 2008).

Miles and Huberman (1994) described cross-case analysis as tricky and requiring a careful look at complex configurations of processes within each case. Miles and Huberman (1984, 1994) identified three concurrent flow of activities in CCA: data reduction, data display and conclusion drawing/ verification. Data reduction is the identification of items of evidence in the primary studies. It should be noted that the major data reduction is conducted in the primary studies themselves. Data is then clustered into meta-matrices and time-ordered displays, which are used to draw conclusions from the synthesized studies. The use of matrices and tables facilitates the comparison of the cases and areas of agreement or disagreement across cases and to search for patterns and themes that cut across the cases. Therefore, the researcher has the responsibility of interpreting the answers so that they can be reduced to variables.

In case-oriented approaches, commonalities across multiple instances of a phenomenon may contribute to conditional generalizations thought formation of types or families of studies. One advantage of the method is the transparency that the data matrices allow to the process of synthesis. One disadvantage is that it may lead to conclusions of the abstracts levels of the variables and cases without considering the whole context of the studies. Merriam noted that ultimately, cross-case analysis differs little from analysis of data in a single qualitative case study and suggested that the results could vary from a unified

description across cases, meaning that reinforcement was found across cases; to new categories, themes, or concepts; or substantive theory from an integrated framework. (Merrian, S.B.1998).

Engaging in cross-case analysis extends the investigator's expertise beyond the single case. It provokes the researcher's imagination, prompts new questions, reveals new dimensions, produces alternatives, generates models, and constructs ideals and utopias (Stretton, 1969). Cross-case analysis enables case study researchers to delineate the combination of factors that may have contributed to the outcomes of the case, seek or construct an explanation as to why one case is different or the same as others, make sense of puzzling or unique findings, or further articulate the concepts, hypotheses, or theories discovered or constructed from the original case. Cross-case analysis enhances researchers' capacities to understand how relationships may exist among discrete cases, accumulate knowledge from the original case, refine and develop concepts (Ragin, 1997), and build or test theory (Eckstein,2002). Furthermore, cross-case analysis allows the researcher to compare cases from one or more settings, communities, or groups. This provides opportunities to learn from different cases and gather critical evidence to modify policy. (Khan and Van Wynsberghe 2008)

Following the individual case analysis and reflective discussions of my findings in supervisions and group seminars, I embarked on some higher order of analysis to make a proper and more incisive sense of what the data has revealed. This afforded me opportunities to see different dimensions of the data set and introduced a new level of consideration and interpretation across the cases. Robert Stakes (2006) averred that with deep study differences among cases grow. I noticed new patterns emerging across cases opening up entirely new areas of inquisitional attention, one of which was pointing towards systemic issues in the organisation and policy context. Another pointer was towards patterns based on ethnic/biographical backgrounds of the participants as data on minority ethnic background behaved in a certain way from data from participants of white British background. Another line of enquiry emerging was patterns based on the practice settings of participants, that is, inpatient (clinical) and community-based. Another area was looking at the data along the

participants' professional background- medical/nursing and non-medical (social work and OT). Another area of focus was looking at the data in terms of status within the organisation- senior managers and middle level staff.

After analysing the cases along these variables, a detailed report of findings was produced detailing my observation and inferences.

vii. **Sampling Procedure:**

According to Yin (1994a), a sample is usually selected based on the relevance, feasibility, access and willingness of participants to fully participate in the study. Considering the subject under investigation, I recruited a purposive sample of 7 frontline mental health practitioners for the study. Participants were recruited and selected specifically because they can illuminate the phenomenon being investigated .The sampling design is based on the judgement of the researcher as to who will provide the best information to achieve the objectives of the study. This involves identification and selection of individuals or groups of individuals that are proficient and well-informed with the phenomenon of interest. In addition to knowledge and experience, they must be available and be willing to participate, and have the ability to communicate experiences and opinions in an articulate and expressive manner.

Purposive or judgemental sampling is a strategy in which particular settings, persons or events are selected deliberately in order to provide important information that cannot be obtained from other choices (Maxwell, 1996). It is where the researcher includes cases or participants in the sample because they believe that they warrant inclusion. (Taherdoos, H,. 2016)
Simply put, the researcher decides what needs to be known and sets out to find people who can and are willing to provide the information by virtue of knowledge or experience . (Etikan,I, et al. 2016)
The sampling strategy I used for the research was purposive or judgemental sampling. Purposive sampling relies on the judgment of the researcher in selecting the units to be studied based upon a variety of criteria which may include specialist knowledge of the research issue, or capacity, availability and willingness to participate in the research.

The main goal of purposive sampling is to focus on particular characteristics of a population that are of interest, which will best enable the researcher to answer the research questions. The samples chosen are homogeneous as they have similar characteristics because such characteristics are of particular interest to the researcher.

The focus of the research is to explore the practice experience of frontline mental health practitioners who work with mental health service users who have no recourse to public funds. From the above, a potential participant must meet the following criteria

1. Must be a mental health practitioner who is registered with a professional body

2. Must be working in the frontline in a mental health service

3. They must have experience of working with service users who have no recourse to public funds

There were no considerations for variables like practice setting, gender, professional background, and other differences. The focus of the research was participants' experience and what it was like working with service users who have NRPF.

I applied to carry out the research in an NHS Trust that provides various mental health services across four boroughs in community and hospital settings. The application was to seek permission to interview members of their staff in the research. After rigorous screening and scrutiny, my application was granted. I also applied to NHS Health Research Authority through the Integrated Research Application System (IRAS) as a mandatory requirement before any study can be carried out within the NHS. This was another rigorous and lengthy exercise. Approval was granted with an IRAS project ID assigned (see App x).

I sent out HRA and UREC approved adverts to various services and departments within the Trust to create awareness about the study and to request that interested practitioners who want to participate should contact me. I have worked in this Trust for about five years and do have personal and professional contacts across the various services and departments. I got some phone calls seeking clarifications about the research, but only one person agreed to participate. I contacted some team and ward managers to address their team members to elicit interest and participation in the research. I sent out Invitation to Participate letters to various departments, services, and wards to which I got some more responses indicating their willingness to participate. At the end a total of 18 participants expressed interest in participating; however, only 7 eventually made themselves available for the two interview sessions. Some participants attended only one interview session but did not return for the second interview giving work and family commitments as reasons for not returning. All interviews were held at mutually agreed locations and sites in the Trust premises.

The first interview meeting was preceded by sharing and discussing the participant information sheet (see Appedix 3) with the participant and getting them to read and sign off the consent form (see Appendix 4). They were advised that they are free to withdraw from the interview any time, and that even after the interview they are free to request that their data is not incorporated into the research. They were reassured of total confidentiality of any information they share in the course of the research. For most of the participants, the first interview lasted about one hour, except for the interview session with Charlene when we were engrossed in the interview. Even after the recording has stopped, we both spent some more time discussing issues relating to the subject area.

The first interview session was more of listening to the story of the participant, observing and noting their general demeanour. Using an open question, I asked the participant to tell me using specific stories and instances, what are their experiences as a frontline worker, while working with service users who have no recourse to public funds. Listening to their stories uninterrupted, I watched out for contradictions, inconsistencies, avoidances and emotional fluctuations,

noting issues they emphasised, choice of words, sequences and ordering, manner of presentation among others. For many, there were moments of long silences where the participant expected me to lead the discussion. After each interview session, I would look over the notes I have made and document my reflection of the encounter.

The second interview was used to clarify issues that came up during the first session. Based on my observation and reflections on the first interview, I sought clarification on key issues I have identified that are of interest to the research questions. It was used to seek further evidences to confirm emerging hunches and hypothesis (Hollway and Jerfferson, 2004) This was also used as an opportunity to share my initial findings in the first interview session to establish the validity of the data and ensuring that the participant meaning frame and perspectives are captured and preserved. It also helped to ensure that the researcher has not visited 'violence' on the participant's view.

viii. Ethical Considerations

Researchers in studies that involve human participants are expected to adhere to some key principles and actions for their research endeavour to be considered ethical. These principles include freedom from harm, right to self-determination, right to privacy, and right to anonymity and confidentiality. In almost all studies that involve human interaction between the subject and the researcher, there is a potential for at least temporary discomfort. Higher levels of discomfort may result from more extensive procedures involving physiological measurements or from asking subjects to recall difficult experiences. Anonymity and confidentiality are two mechanisms which help to protect subject privacy, for example when subject identity cannot be linked with her or his individual responses. Confidentiality of data must be maintained. Breaches of confidentiality can cause psychosocial harm to subjects and destroy researcher/subject trust. (Rogers, B. 1987)

In summary, the conduct of ethical research requires that the researcher be conscious of the benefits and risks of the research, protect the rights of

participants, secure informed consent and be aware of the guidelines and regulations that govern the ethical conduct of research.

In order to meet these guidelines, I applied for and obtained ethic approvals from three different organisations and institutional bodies. As stated earlier,I applied for and was granted an approval by NHS Health Research Authority,(HRA) a statutory body set up to ensure that an health and social care research is ethically reviewed and approved and to promote transparency in research. This was a mandatory approval as participants were drawn from an NHS organisation. HRA registers all researches conducted within the NHS through their Integrated Research Application System (IRAS). (See Appendix).

I also applied for and was granted approval by the University Research Ethics Committee (UREC). (see appendix). The third approval was from the local trust where the research took place. All these approvals went through rigorous and extensive scrutiny to ensure the research fulfil the requirements of freedom from harm ; right to self-determination ; right to privacy ; right to anonymity and confidentiality. All these principles were strictly and fully adhered to during the research.

ix. Research Bias

Being an exploratory research, this study involves a description of themes, related charateristics and meanings, and basic observations and interpretations. The subjective nature of qualitative research poses a challenge to the researcher to be reflexive and avoid ‘bias’ wherever possible. Bias is the “inclination or prejudice for or against one person or group, especially in a way considered to be unfair,” A bias is a strong, preconceived notion of someone or something, based on information we have, perceive to have, or lack. It is a subjective way of thinking that originates from an individual’s own perception, experiences, or points of view and can lead to the distortion of reality and thereby affect the validity and reliability of research findings. Researchers bring to each study their experiences, ideas, prejudices, and personal philosophies, which if accounted for in advance of the study, enhance the transparency of possible research bias.

As an insider researcher, some aspects of my findings particularly with regard to the positions of the participants were surprising. For instance, participants in

Quadrant 3 appeared to have spoken out strongly and directly against government policies that they believe are anti-immigrants. Based on my personal experience and the general anti-migrant mood in the society, my personal prejudice was that being white British, their response would be consistent with the view of the dominant group they belong to as far as issues relating to migration is concerned. Similarly, I would expect participants from minority background to be more strident and forceful in their opposition to anti migrant policies. However, available data showed direct opposites of these positions. This discovery led me to moments of self-reflection and to ask firstly, how genuine were the Q3 participants and what is responsible for their deviant position? I however noted that their opposition and condemnation of these exclusionary policies might have not changed anything in the immediate situation, yet having a voice and being able to express themselves in the manner they did are positive advocacy signs for NRPF clients. The confidence exuded by these participants can be attributed to the safety and security they felt and enjoyed as members of the dominant group. Participants from minority backgrounds, even though British citizens formally, could not express their views as forcefully as the Q3 participants. It should be noted that, like the service users, ethnic minority participants have also experienced racism in different forms which has vitiated their confidence and voice partly due to negative racial projections over time.

On personal introspection, I do wonder what my assessment and understanding of the participants' responses might be enacting in terms of my internalised racism. I find it troubling that I might be a purveyor of 'white man ice is colder' phenomenon. Idealisation leads to identification with the idealised object. Dalal, (2006) asserted that black and white are binary opposites, and as we embrace one, we simultaneously repudiate the other. This I would argue might be the situation with many practitioners of ethnic minority background not excluding the researcher. I therefore recognise my struggle in maintaining an objective stand on my data.

In this essay, I have set out in the Methodology how the themes were developed and I have used direct quotes from the participants to authenticate the data, I am nevertheless aware that other researchers may see and interpret the data differently.

Chapter Summary

I have presented in this chapter details of the methodology used in the research covering the research design, the data collection method, and the analytical techniques I used for making sense of the data collected. By virtue of the research topic, the most appropriate method of investigation is qualitative research, which captured the non-discreet data set generated during the research encounter. The FANI approach used for data collection was also considered suitable as it provided the necessary liberty for the participants to relay their experiences in stories unhindered. This approach is empowering as it places the participant at the centre of his story unhindered.

The two analytical approaches used to mine and distill the data in order to make a concrete sense of it were identified and discussed extensively, namely thematic analysis and cross-case analysis. The paradox I presented as a researcher within the research enterprise was also discussed. By virtue of my shared identity with the participants and the service users, I was an insider participant but with a closer look at the data, I also was an outsider in the research circle. Both positions have implications for how the research was conducted, analysed, interpreted, and presented. The ethical consideration guiding the research was also discussed.

The next chapter discusses the theoretical framework underpinning the research.

Chapter Three

Theoretical Perspective:

A. Bureaucracy: A site for contestation- Paul Hoggett

i. **Introduction**:

This research aims to explore the experience of frontline practitioners who work directly with mental health service users who have no recourse to public funds. This category of service users is subject to exclusionary policies which preclude them from accessing several social benefits which are thought to be critical to their care and recovery. There is therefore an assumption that this additional layer of deprivation would pose a significant challenge to frontline workers who are involved in their care.

In an attempt to find a theoretical framework to analyse and understand the findings of the research, attention was directed at understanding the relevance and the signification of bureaucracy in the delivery of goods and services in the modern welfare state. I was intrigued by the complexities and contradictions that emerged from the analysed data. The pertinent questions to ask among others are: what is the role of bureaucracy in the modern welfare state? What kind of bureaucracy would be most effective in delivering public services, especially for the marginalised and minoritised, un and less deserving ones? In answering these questions and clarifying others, I was attracted to the writings of Paul Hoggett on public bureaucracies and especially his thoughts on social policy and emotions.

In his treatise titled, 'The Containment of Ethical and Moral Conflicts by Public Bureaucracies', Hoggett (2005) averred that modern government and the state apparatus that supports it are characterised by two key phenomena which are unique to it. First, that modern government is the site for the continuous contestation of public purposes, and secondly, the public service provides a means of containing the moral ambivalence of its citizens.

Hoggett asserts that these characteristics are reminders that modern government and public service are more than a site for delivery of goods and

services to the public but rather, a site for particular kinds of social relations, loaded with moral and ethical meanings and potentials

ii. **Bureaucracy and Contested Purposes**

Hoggett noted that there are varieties of bureaucracy as there are different kinds of states. He asserts that thepost-war welfare state assumed distinctive forms with distinctive purposes. However, according to Claus Offe (1984), the welfare state was essentially a contradictory formation that had to meet the requirements of both capital and labour. The post-war welfare state was required to continuously work to sustain its legitimacy through its commitment to social justice and an expression of democratic accountability through the development of forms of local and regional government.

This commitment to social justice strengthened the existing constitutional liberal emphasis on impartiality, avoidance of nepotism, cronyism, and patronage, and the demand to treat citizens the same and to avoid judgment contaminated by prejudice. Hoggett noted that in reality, this commitment is in conflict with the disciplinary function of the welfare state, one of which encouraged frontline professionals to make a distinction between 'deserving' and 'undeserving' poor; even though the welfare state in Britain is considered a system which embodied universalistic principles.

In the last two decades, there have been changes in the socio-political arena and social policy is now largely subordinated to economic policy. In addition, there has been the emergence of new social identities and the development of recognition politics alongside redistributive politics. This, therefore, meant that the universalistic claim of the welfare state has become subject to critique, and more recently by advocates of particularism; particularly forms of cultural particularism built on cultural or religious identities (Spicker, 1993). The particularism perspective believes the state should be able to respond to the needs of a particular group, otherwise their social and economic rights remain unattended to. Hoggett asserts that the tension between universalism and particularism is inherent and irresolvable and that this points to the conflictual nature of public purpose.

Chatal Moufe (1993) argued that politics in a modern democracy must accept division and conflict as unavoidable, and the reconciliation of rival claims and conflicting interests can only be partial and provisional. Hoggett noted that impassioned and ongoing conflict is an essential condition for vitality in public life, and that public service is the necessary embodiment of such conflictual purposes. Hoggett referred to Lipsky (1980:41) who noted that a typical mechanism for legislative conflict resolution is to pass on intractable conflicts for resolution (or continued irresolution) to the administrative level. Hoggett remarked that as a consequence, it is often at the level of operations that unresolved value conflicts are most sharply enacted, where public officials and local representatives find themselves 'living out' rather than 'acting upon' the contradictions of the complex and diverse society in which they live.

Evans, T and Harris, J. (2004) also echoed Lipsky and stated that due to the dilemma of the public service workers, managers have limited ability to exercise control over them and those street-level workers are left to deal with policy and resource quagmire such that the worker has to work out practical versions of public policy which may look unlike official pronouncements. They noted that frontline staff work conditions are fraught with resource inadequacy, vague and ambiguous agency goals, and work with high caseloads in the context of uncertainty. They argue further that the ongoing conflict between the managers and the street-level worker is their divergent goal. While the manager focuses on pursuing the agency goals, the street-level bureaucrats are interested in processing work consistent with their preferences and only the agency policies that can attract sanctions. The participants in this research well exemplified this position. Policies that require a service user to be treated in the hospital for several weeks to stabilise his mental health but encourage the same service user to be discharged back into the streets because he has no accommodation to go to when he is well. It is as if he will be punished with homelessness for responding well to treatment! Such policies are pretty nebulous. Dame, one of the participants, called such vague and ambiguous policies 'bonkers'. In my encounter with BO, I also experienced such conflict. BO received a weekly allowance of £65 for upkeep, but he is not allowed to work even though he wanted desperately to work, even as a volunteer! Meanwhile, his care plan indicates that employment will help his mental health, and there are government

initiatives to encourage and support mental health patients to go into employment. These are examples of conflicting situations the frontline worker deals with daily at work. Furthermore, at various times I was tempted to advise BO to look for cash-in-hand work but for the risk of encouraging him to violate immigration laws.

Regarding the divergence between managers and street-level bureaucrats, another participant, Henry (bed manager), appeared to have acted consistently with this point. Henry's preoccupation was how to free up bed spaces by discharging stable patients to the street, or temporary bread and breakfast accommodation, or return them to their home country with a staff escort.

iii**. Impartiality and Responsiveness**

Weber's model of ideal bureaucracy is described as impartial, impersonate, and formal, where organisational objectives are not confused with personal motivations or other interests. For Weber, the good bureaucrat must observe strict adherence to procedure, accept hierarchical order, reject personal moral enthusiasms and commit to the purposes of the office. du Gay also argues for Weber that these ethical attributes of the good bureaucrat are products of definite ethical practices and techniques. In his response to criticisms that Weber's ideal bureaucracy was means-oriented and amoral and diminishes the role of purpose and value in bureaucracy, du Gay argued that rather than be a weakness, Weber's position is a better demonstration of democratic equalisation and therefore a more ethical approach to running an organisation than that based on personal, whimsical considerations, and that impartiality of the bureaucrat entails a capacity to treat people as individual cases.

Du Gay echoing Weber argued that bureaucracy is indispensable in modern human organisations because of the challenge of achieving inharmonious, passionately held 'ultimate ends' in a pluralistic society. The implication is that state bureaucracy cannot be an instrument for realising a prescribed set of ends. He averred that the bureaucrat must cultivate a trained indifference to the idea of ultimate ends because he recognises that the opportunity cost of pursuing one end at the expense of another may be huge. Therefore, the bureaucrat is

expected to set aside his/her own particular values because of a commitment to the higher purposes of the office.

In contrast, Hoggett, however, argued that the ideal of 'trained indifference' of the bureaucrat is not practical. He stated that based on experience, modern bureaucracies have shown to be an inherently contradictory unstable phenomenon. He asserts that inherent in the nature of modern bureaucracies are strategies such as segmentalism (division and departmentalisation) and informalisation (e.g use of discretion). Hoggett posited that these contradictions are the impetus that gives modern bureaucracy its dynamism and that 'the system can only work if actors within it use judgement and discretion. He argued that 'the real art of the bureaucrat lies in the exercise of discretion and the use of judgement in the application of policies to particular cases, or the implementation of policies where there are no precedents, or the operationalisation of rule-governed systems' in full knowledge that no system can ever provide guidance for every eventuality. He argued further that rather than slavish adherence to rule governed procedures, the objectivity of bureaucracy is based on the use of judgement in complex, ambiguous and contested environment that constitute the everyday lived reality of the civil servant, health service professional, or local government official (Vickers 1965). He asserted that in view of the radically pluralistic and agonistic nature of modern democracies, the art of government is to pass on to the 'administrative realm' the goal conflicts it cannot manage. Lipsky (1980) had recognised how street level bureaucrats were left to reconcile such social contradictions. Hoggett concluded that public bureaucracies operate in an environment that is complex, indeterminate, ambiguous, contested, shifting and uncertain.

In order to deal with these indeterminate and complex situations, my participants reported diverse ways of coping with the challenges by taking discretionary steps and initiatives. Chris, a community psychiatrist nurse reported:

You give more time to them. You are a human being at the end of the day, you want to know, has this person eaten? have they drank, how have they survived through the day? So you devote more time to them.

He went further:

May be that day they went to food bank, but food bank was closed, and they have no money. I ended up taking money from my own pocket. But this is still short term, I can give five pounds or ten pounds

As rightly argued by Hoggett, practitioners cannot be indifferent to what they experience in the frontline. Frontline practice is a value laden arena where the practitioner's values, ethics, emotions, feelings and all such subterranean attributes are called to play. Cooper (2012) underscores the importance of relationship in mental health service stating that the capacity for relationship is what informs the mental health intervention, because symptoms of mental distress manifest themselves in absent, distorted, or damaged social relationships, which are the basis of psychological nourishment and mental health. A professional who maintains a stoical distance from the service user would not bring a tangible change to the life of the service user.

In my work with BO, there were times when I was preoccupied by the thoughts of his situation for days thinking and checking with colleagues how we could get him off the immigration restrictions imposed on him. To be an effective frontline professional, one should let 'the work disturb you'.

iv**. Ethic of Care and Ethic of Justice**

Another contradiction that the bureaucrat contends with daily is the inherent tension between the ethic of care and ethic of justice (Mendus, 1993). This refers to a compassionate concern for the individual and his or her plight on the one hand, and a realisation that whatever the merits of this particular case, the public official also has a responsibility towards all those potentially equally worthy cases whose cases can be brought to mind abstractly because they are not immediately and physically present. One of the research participants, Henry (bed manager) pointed this out clearly in his narration about NPRF patients blocking beds. Hear him:

….if you have someone who has No Recourse to Public Funds blocking the bed and you feel you need to resolve that issue, it can take one year, two years, six months, does that mean that person will hinder another person from coming to hospital to have appropriate care?

This practitioner was holding in mind, in abstraction a yet to be admitted patient who he believes has a right to an admission bed space which is being blocked by an NRPF patient who cannot be discharged because he has no accommodation and not necessarily because he needs treatment in the hospital. Hear Henry again:

I mean it leaves us very vulnerable. It leaves us very vulnerable because you have duty of care to your patients as well. If you have a patient that has got NRPF, ……but the patient is blocking a bed, what do you do? You know, the whole Trust comes to that conclusion that they have to discharge you, unfortunately you have to find your 'square root' but it leaves you very vulnerable because they are human beings, it leaves you open

This practitioner is left to bear the emotional burden of his action of discharging someone to the street so as to make room for another patient who is acutely unwell and more deserving of the bed space.

Anita, a community based CPN also reported:

So, you as a professional, you as a nurse, as a care coordinator, as a substance misuse professional, as a team leader, you then look that there is no where to place this client. And you can't take them to your house, you just have to discharge them back to the streets…

On further reflection, Anita again said:

….when a decision is made to discharge someone regardless of whatever the outcome is, is very demotivating, very demoralising, the staff becomes more and more emotional because you are dealing with another human being, who has no means of surviving the basic things…

This is a picture of the emotional turmoil experienced by frontline practitioners as they perform their public service roles. As shown above, it is impossible to be indifferent or detached from these experiences. They leave a mark on your psyche.

v. **Bureaucracy and Ambivalence**

Another characteristic of modern bureaucracy addressed by Hoggett was that the state is required to 'contain' that part which the public seeks to alienate from itself. He argued that this alienation finds expression in a range of social anxieties which have both existential, historical and cultural dimensions. He posited that these anxieties are expressions of our moral ambivalence or, more accurately of our inability to come to terms with this moral ambivalence. Hoggett described ambivalence as the coexistence in the mind of opposing feelings, and that it gives expression to the fractured nature of the human subject.

Hoggett spoke about the need for a facilitating environment that can contain our fears, resentment, and hatreds and help us face them and come to terms with them. He identified parents, friends, teachers, doctors and public officials and politicians among others as those who can contribute to this 'social architecture of a more benign world' (Rustin and Rustin 1984). Hoggett referred to Bion's concept of containment which refers to how we seek to find another entity which can be a temporary repository for experiences that threaten to overwhelm us. Hoggett called this a 'place for experience' which is safe, strong, benign and thoughtful. Bion identifies two possible forms of relationship in containment- the symbiotic and the parasitic. The symbiotic refers to where each party in the relationship develops as a result of the encounter; and the parasitic, where one party feeds off the self's fear and destructiveness.

Hoggett's discussion centred on an existential condition which he described as a flight and alienation from oneself. He asserts that this is the material the society gets to work on, the reservoir from which a variety of more culturally and historically specific anxieties originate. The concept of social anxiety reminds of the anxiety about the fate of self and intimates, and partly cultural, a consequence of the intense ambivalence towards vulnerability, destructiveness and dependency.

He averred that public institutions and the apparatus of government as a whole play a vital role in containing undigested emotive conflicts within citizens' lives. The concept of social anxiety refers to a range of intimate fates which exist as tangible fears which connect to primitive anxieties, existential in form and loaded with affect which is potentially unbearable.

Drawing on the works of Lyth Menzies (1960) on institutional defence and Lipsky (1976) on street level bureaucrats, Hoggett saw similarities in the two theorists on social defence mechanisms employed by organisations and street level bureaucrats. Institutions and practitioners engage techniques such as splitting up contact with patient to avoid being too involved, depersonalisation, detachment, ritualised behaviour, purposeful obscurity, categorisation and others, all of which are meant to insulate the professionals from direct exposure to painful and uncomfortable experiences inherent in the role.

Peter Hupe and Michael Hill (2007) have argued that frontline workers face an 'action imperative' and so have to work to 'accommodate mess' in local governance (Lowndes, 1997). In dealing with the 'muddle and mess' that has emerged in the move towards local governance, frontline workers are now charged with reconciling the emergent demands of governance.

Social anxieties are complex in form and originate in our underdeveloped capacity to contain what is strange within us- the mad, destructive, perverse, vulnerable, helpless, and frightened parts of the self. We alienate ourselves from these dimensions of our subjectivity by locating them in the other, so that what is strange within us becomes the stranger outside of us. Hogget asserted that this is the root of our ambivalence towards the subject of welfare- the old, the bad, the sick, the mentally unwell etc. We both identify with them but at the same time refuse to recognise ourselves in them. As subjects of welfare ourselves we rely on others to meet our material and psychological needs as patients or welfare beneficiaries. However, when the self assumes the status of citizens and taxpayers, it sees other 'subject of welfare as the stranger, the other, somebody else's problem. Somebody towards whom the invulnerable self is capable of callous indifference. This position is illustrated in the account by Anita who said her NRPF service user was once told by a professional:

……*these are people's tax money they use to treat him, and it will not be fair to treat him with people's tax money when he has the right to go back to his country to receive adequate treatment for his heart condition..*

This ambivalence is an inherent dimension of the social relations of welfare and one of the functions of public bureaucracies is to serve as container for these disowned aspects of our subjectivity (Evans 2003). Hoggett averred that so long as the 'contract of mutual indifference' prevails, the form of containment offered by welfare bureaucracies will be predominantly parasitic- such that the social imagination of citizens and governments will remain impoverished, and unsupported street level bureaucrats will continue to face high levels of stress in the frontline.

vi. **Ethical Bureaucrat**

Hoggett submitted that the public official has to contain the unresolved (irresolvable) value conflicts and moral ambivalence of society; that the public official lives out the contradictions of the complex and diverse society in which he/she lives on a day to day basis, and as consequence is pulled this way and that in 'dilemmatic space' (Honig 1996). That human values are incommensurable, that values rub against each other, that the moral agent has to live with conflicts that cannot easily be resolved and simply have to be lived with, such that you have to end up disappointing someone. Williams argued that the best thing you can do in such situations is to 'act for the best' (Williams 1973:173).

Hoggett believes that the working lives of public officials exemplified 'act for the best' which echoes what Lipsky described as the 'assaults on the ego which the structure of street-level work normally delivers'.

On my reflection on this issue, perhaps the question to ask is whose best? This is a value laden issue as there are different versions of best. Best for who? Best can also be circumscribe with time and place. So when Henry discharged an NRPF to a B & B, it was an ‘act for the best’ for the new patient to take over the bed space, but may be not for the the NRPF. When he discharged to the street, that wont be the best for the best for the discharged patient. I think these conflicts remain irresolvable.

vii**. The Two Dilemma of Bureaucratic:**

Hoggett identified two categories of dilemma which correspond to the two characterizations of government bureaucracies- an embodiment of an inherently conflictual and morally ambivalent public.The public official seeks to act as impartially as possible (acting for the best) in the face of competing claims (care vs justice; individual case vs greater good, consistency vs responsiveness). Susam Mendus (2000) notes that we are in the terrain not just of pluralism but also of the impossibility of harmonious reconciliation, in which the moral agent is not exempt from the authority and the consequences of the claim she chooses to neglect. Mendus described such situations as characterised by pluralism, plus conflict, plus loss. It is loss which is experienced as failure. It is as if they internalise the flaws and faults of reality and make them their own, thereby taking on responsibility for what is irreconcilable in the real wider world. For instance, the demeanour of many of the research participants ranged from feelings of failure to culpability to feeling responsible for the chaos that characterise the experience of NRPF in the frontline. Chris said:

…...*As a health care professional, you feel like a failure because you can't solve the problems, there is only so much you can do. You are not really the decision maker about if they can have recourse to public funds, or they can have this or have that..*

The second category of dilemma is the consequence of moral ambivalence, that is the inability of citizens to recognise and deal with the vulnerability and destructiveness in self and others. Michael Feldman (1989) suggested that where X deals with ambivalence by projecting it to Y, the consequence is that Y is put in a quandary- a no win or damned if you do and damned if you don't situation. In order therefore for the contract of mutual indifference between government and citizens to be sustained, the nature of some public organisations demands that they be seen to fail, or indeed failure is a necessity.

viii**. Agency in Dilemmatic Space**

Jessop's (2000:7) depiction of the ironist as someone who recognised the likelihood of failure but proceeds as if success were possible. Unlike the cynic who is immobilised by despair and reduced to buck passing or going through the motions, the ironist willingly chooses her own form of failure, seeking creative solutions while acknowledging the limits to any solution. This practitioner accepts incompleteness and failure as essential features of social life but continues to act as if completeness and success were possible.

Hoggett however argued that Jessop's ironic detachment is only attainable on a fleeting basis. Hoggett believes that there is no amount of reflexive detachment that can free frontline professionals from the pain of the choices that they have to make, often on daily basis. He suggested that the fitting description of the public official is someone with *resilience in the face of frustration*.

Hoggett's advisory was that rather than pursuing fail-safe procedures and total quality, public bureaucracies should seek good enough solutions which are satisficing rather than maximizing. The effective public manager would therefore be the good enough manager working towards a good enough set of principles of public welfare (Williams 2000).

In conclusion, Hoggett enumerated the implications of his perspectives: that all levels of public sector are characterised by conflict of purposes and that value conflicts saturate all levels of the public sector. He asserts that an effective government would be the one that equates statecraft with soulcraft by seeking to engage citizens in ethical and moral dialogues at all levels. He averred that this would require a re-evaluation of the role and function of public official, and recognise them as fulcrum for the conflicts and contradictions of the wide society. This would necessitate the realization that the art of judgement is at the heart of public official task. He argued for reflexive redesign of public bureaucracies to equip them to respond to the ethical tasks that confront them. He opined that this would have implications for training and continuous professional development; for the creation of organisational cultures that recognised the emotional needs of street level bureaucrats; for rethinking the

nature and role of accountable and reflexive authority involved in the exercise of discretion.

B. Theoretical Perspective: Psychoanalytic Concepts

Every interpersonal interaction generates a complex web of personal responses and associations primarily out of the conscious awareness of the actors. Human behaviour is not always rational, but the feelings and subjective experiences of service users and professionals must be understood to make the necessary changes that professionals desire. Psychoanalysis provides a framework by which we seek to understand ourselves, others, and the world around us. Concepts such as transference, projection, and defence mechanisms, help us understand and use as information the feelings behind such defences and those evoked in them. Frontline practitioners are often at the receiving end of potent emotional forces characterised by ambivalence and conflict, which may be overwhelming, making it difficult for them to retain appropriate professional roles. Some of the psychoanalytic concepts engaged with by the participants and researcher in the study are discussed below.

The study draws from the works of Freud, Bowlby, Melanie Klein, and Bion, using psychoanalytic concepts to illuminate to make sense of the data. It has been argued that the fundamental drives within the human personality include the need for survival, protection, and belonging (Bowlby, 1979). Rather than staying with pain and tolerating unwanted feelings, we often default to self-preservation modes by either externalising or denying the feelings by scapegoating, idealising, projecting, and splitting, among others, to cope with the anxiety-provoking situations we encounter. Steiner (1993) described this as ‘turning a blind eye’, as a way of not seeing those things which are too uncomfortable for us to face.

Foster (2001) aptly described the conflicting experience of professionals as wanting to be with the clients and to avoid them: to love and hate them at the same time. She averred that this leaves the professional with emotional pain and oscillation between persecutory anxiety and depressive anxiety with its guilt and accompanying dangers of manic over-involvement and omnipotence. She posited that swinging between these opposing modes, the frontline worker

loses confidence in her professional skills and thereby experiences more anxiety as she feels she is not functioning as well as she should. Bollas (1978) described the psychic experience of the professionals as things that remain locked away in seemingly inaccessible places in our minds as ‘ unthought knowns’.

Freud (1922) described defences as a general designation for all the techniques the ego uses in conflicts that may lead to neurosis. He conceptualised the id, ego, and super ego and how defences protect the ego from threats. Anna Freud’s (1942) later contribution about defences led to a greater focus on the ego’s unconscious processes away from the biologically oriented drive theory.

Denial is a defence mechanism that disavows or denies thoughts, feelings, wishes, or needs that cause anxiety. It is used purely for unconscious operations that deny that which are rejected or blocked from awareness because they are threatening, frightening, or anxiety-provoking (Reber et al., 2009). Denial occurs when an aspect of self or external reality is denied because they are painful. Denial involves splitting, where there is cognitive acceptance of a painful event while the associated painful emotions are repudiated-(Bates et al., 2010).

Splitting involves dissociating from reality by separating the self or objects into good and bad. Splitting usually occurs in response to conflicts that lead an individual to repress or dissociate feelings that threaten their psychic equilibrium. Winnicott (1965) attributed the origin of this to early failures in the environmental provision, where the infant creates a ‘false self’ which is designed to protect the ‘true self’ but in the process ends up isolating and depriving the ‘true self’ of external reality.

Projection is a common defence mechanism that frontline professionals regularly experience in the course of their duty. It describes a situation where clients attribute an intolerable, unacceptable, or unwanted thought, feeling, or action to someone else or something else. Projection is preceded by denying unwanted aspects of self to someone else. Projection can be negative or positive. Identification is a defence mechanism where someone unconsciously

incorporates attributes or characteristics of another person into one's personality and is often described as the opposite of projection.

Repression as a defence system involves the wiping away from memory feelings, experiences, images, ideas, or events that are experienced as shameful, painful, threatening, or anxiety-provoking. Anna Freud (1942) described repression as the most efficacious and dangerous defence system as it entails the withdrawal of consciousness from the whole tracts of instinctual and affective life. However, Freud posited the indestructibility of the contents of the unconscious, arguing that repressed material not only escapes destruction but also has a permanent tendency to re-emerge into consciousness.

Bion (1967) developed the concept of containment to describe how a mother processes unpleasant feelings projected to her by her child in a mother-baby relationship. The mother returns the feelings to the child in a more tolerable and digestible form. This containment process is critical to the child's emotional development and maturation. Similarly, the healthcare system and frontline professionals contain the social anxieties of the citizens and their clients, respectively.

Other psychoanalytic concepts engaged with in the research are transference and countertransference. Transference is when the professional-client encounter triggers an echo of unresolved emotional issues from previous experiences in the client's life, such as abandonment, abuse, and rejection. On the other side, it can bolster the professional-client relationship if such relive are positive. Countertransference occurs when the professional-client interaction elicits echoes or reawakening in the professional, past feelings which have no connection with the present reality. This can also be positive or negative.

These are some of the concepts engaged with in the data analysis and interpretation to illuminate our understanding of the participants' responses.

C. Theoretical Perspective: Critical Race Theory

Critical race theory (CRT) also provides some insight into our understanding and interpretation of the data. CRT provides a framework for analysing and explaining how racial assumptions and biases embedded in legal rules, precedents, and institutions are implicated in determining the lifestyles and life

chances of ethnic minorities. CRT as a movement has its root in critical legal studies which focus on examining how the law and legal institutions serve the interests of the wealthy and powerful at the expense of the poor and marginalized. It is based on the premise that race is a socially constructed phenomenon that is used to oppress and exploit people of colour. CRT asserts that racism is inherent in the law and legal institutions in so far as they function to create and maintain social, economic, and political inequalities between the dominant group and the marginalised population.

In their contribution to racist state theory, Omi and Winnat (2004) define state as a constellation of institutions, the policies they carry, the conditions and rules which support or justify them and social relations in which they are embedded. They argued that every state institution consists of racially consequential decisions,made by racially interested actors who are constrained by race-inflected social norms. They assert that the state is shaped by racial conflict and that the state is inherently racial because every state action has racial consequences and because the state itself is structured to accomplish racial goals. They asserted that the state is thoroughly racialised in every respect-personal, networks, institutional mandates, policies, ideology and organisational structure.

There are some core tenets shared by CRT proponents (Delgado R and Stefancic J, 2017). First, that racism is normal and not an aberration. It is ordinary experience of most people of colour both in public and in private spheres as demonstrated by socio economic indicators like employment; access to credit, disproportionate access to social and health facilities, overrepresentation in contact and involvement in the criminal justice system etc. And because it is pervasive and occurs in everyday transactions and interrelationships, it is very hard to cure or address. Added to this is that because racism advances the interests of the dominant groups, there is little or no incentive to eradicate it. Another theme of CRT is that of differential racialisation, which suggests that depending on the need or interests of the dominant white group, minority groups periodically undergo differential racialisation, or the attribution to them of varying sets of negative stereotypes which are often depicted in films, television, literature and news media.

CRT proponents also subscribe to the idea that racism is a social construct. It holds that race and racism are products of social thought and relations. Not objective, inherent, or fixed, they correspond to no biological or genetic reality; rather, races are categories that society invents, manipulates, or disavows when convenient.

Another important tenet is what is described as ‘voice of colour’, which holds that people of colour are uniquely qualified to speak on behalf of other members of their group regarding forms and effects of racism. Because of their different histories and experiences with oppression and marginalisation, minorities writers and thinkers are able to communicate to their white counterparts matters that the whites are unlikely to know. Minority status, in other words, brings with it a presumed competence to speak about race and racism.

Chapter Summary:

This section provides us with three distinct perspectives with which we make sense of the data. Paul Hoggett’s model sheds light on the precarious position the frontline practitioner occupies and the challenges faced by bureaucracy as a point of contestation between the government and the people it serves in a welfare state. It also shows that public service including frontline practice provides a means of containing the moral ambivalence of the citizens. Hoggett asserts that these characteristics are reminders that modern government and public service are more than a site for delivery of goods and services to the public but rather, a site for particular kinds of social relations, loaded with moral and ethical meanings and potentials

The psychoanalytic concepts discussed above illuminate our understanding of the participants’ and researcher’s responses in the course of the study and also why people behaved in certain ways. Professionals daily experience anxieties due to the uncertainties and unpredictabilities that characterise their role. To achieve some level of psychic equilibrium individuals and groups employ defences to protect themselves against painful and threatening experiences (Hinshelwood, 1987).

Critical Race Theory helps to shed some light on how race and racism are implicated in the day to day experiences of minorities and highlights the ubiquity and insidious impact of racism on minoritised and marginalised population.

Chapter 4

Research Participants and Presentation of Cases

Introduction

This Chapter sets out to introduce the participants in the research. Relevant key information about them is presented in Table 2. There are 7 participants all made of 3 psychiatric nurses, two social workers, one psychiatric consultant, and one occupational therapist. Their work settings vary – 2 participants are ward-based practitioners and the remaining 5 are community-based.

Profiles of participants are also presented in tabular form showing their perspectives to the various domains which are considered relevant to the research. The researcher's comments and understanding of the responses are documented on each participant's profile, including his reflections.

Table 2: Information on participants:

Name	Gender	Professional Background	Practice Setting	Level in Organisational Structure	Ethnic Background
Anita	Female	Nursing	Community	Senior Nurse	Black African
Henry	Male	Nursing	Inpatient	Senior Management	Black African
Lorna	Female	Social Work	Community	Senior Practitioner	White British
Dame	Female	Occupational Therapy	Community	Mid-Management	White British
Chris	Male	Nursing	Community	Senior Nurse	Black African
John	Male	Psychiatric Consultant	Inpatient	Consultant Psychiatrist	Black African
Charlene	Female	Social Work	Community	Senior Practitioner	White British

Participants Profiles and Perspectives

Anita	
Ethnic Background/ Migration History	Anita is a black African female who migrated to the UK about 18 years ago. She has a history of irregular migration until she was able to regularise her stay after which she trained to be a nurse. She recalled the stressful experience she had as a single mother before regularising her stay especially in hands of solicitors and employers who she said exploited her immigration situation.
Gender	Female
Professional Background	Anita has over 7 years post qualification experience in frontline psychiatric practice as a nurse. She is currently a care coordinator in a Community Mental Health Team. She has worked as an outreach nurse in a substance misuse team where she also encountered service users who have NRPF
Practice Setting/ Level	Anita is a staff member of a community mental health team, a multi-disciplinary team made up of psychiatric nurses, psychiatric doctors, occupational therapists, support workers, and social workers. The team supports those with an established diagnosis of enduring mental health difficulties by providing a range of person-centered care and support to meet identified needs. The role also involved coordinating and liaising with other health and social care workers involved in the service user's care- such as GP, psychologist, social worker etc. Anita's role also involved periodic review of care and adjusting it to meet the current needs of the service user.
Experience of Working with Patients who have no recourse to public funds	Anita narrated an ongoing NRPF case she is working on which forms major part of her narration. She also reported previous experience of working with NRPF case in her previous work with substance misuse team.
Emotional Impact on Participant	Anita expressed anger and frustration at not being able to refer her service user who has NRPF to appropriate service due to her immigration status. *''…we would have referred her for medical treatment, but because she has no recourse, it is quite difficult. They are pushing the ball around, they pushed it to integrated care and they want to push it back to mental health….so it is very*

	difficult, so you can't get the proper treatment for her. And it is difficult for me, as a practitioner because I just want to achieve what I want to achieve here.'' She expressed frustration that the situation makes her job more difficult *''I want to achieve treating my clients, I want to see her getting better, I want to see her well. So, if you look at it, ……. it's like making your job more difficult because you don't know where to place her.''* Anita continued in an angry tone*: 'She needs a comprehensive package,…… where she gets care 24 hours to stop her from harming herself or trying to kill herself, but because of funding, no one wants to pick her up……I can't even complete referral…….. Her care needs are not being met..* She went further in her frustration *''…it makes your job difficult. It's like where am I going? your hands a tied. You are just going round and round without succeeding in what you want to achieve because when people…are not getting enough help, then their mental health will be unstable'.* She went further with tone of despondency '…….*as health practitioner, it makes my job quite difficult to work in that kind of environment. I went there the other day, the house was infested with bedbugs, it was heart breaking'*
Perspective on Inter-agency Working	Anita described her experience in working with other agencies as difficult. She reported that because her clients have NRPF no agency wanted to attend to her. She said she could not make referral to appropriate services. ….. *you send email to this body, they say she has no recourse to public funds and that you should refer her to the other person. So, it's like you go round and round and by the time you know it, it comes back to you. So, it's quite difficult''.* Anita's experience of working with Children Services who were also involved with the family was equally uninspiring …….*I was sending emails to the children social worker, they were just passing me around. In two weeks, nothing has been done. If they are on benefit, or if they have got immigration status right, it's like picking up the phone, calling the council to come and help them control the bed*

	bugs, but council couldn't do anything Anita narrated her experience of being stuck with a case *'…..it's like you have a client that has no recourse to public funds, you have treated that client and they are well and you need to discharge them, probably they have no fixed home address, and you think you need to discharge them to be stabilized in the community or refer them to housing. Housing will look at their records and discover they have no recourse to public funds, they will decline. And if you want to discharge them to bed and breakfast, it is still a housing issue because who will fund the B&B?"*
Perspectives on Social Political Context of NRPF	In her narration, Anita was of the view that government has limited resources and might be unable to meet everyone's health and care needs *'…you are not gonna blame the system. Things are not as rosy as it used to be, where everybody could get a place, everybody could get accommodation, everybody could get food, it's not as it used to be, so it is quite tight'.* Anita argued that clients with NRPF might not be deserving after all on the account of having not contributed to the economy in tax and NI: *……because this is a society now that if you don't contribute to the society, you can't gain anything out of it. People have contributed, they have paid their NI they have paid their taxes, if you look at it from that point of view. I know I am a professional, if you look at it from the point of view of the government, they are saying the truth. It's like you want to eat your cake and have it. It is not possible. Gone are the days when people eat their cake and have it……. It is not happening'.* She went further; '….. *but at the same time, you can't blame the government because they have not contributed anything to the country. To the welfare of the country, the taxes, they pay taxes somewhere else and they have come to live somewhere else. So, you don't have anybody to blame, it's just a sad thing.* Anita stated matter-of-factly that she has had to discharge clients NRPF to the streets after treatment. **'... a***fter detox,*

	they are supposed to discharge them to GP but because they have no recourse to public funds, some of them don't even have GP. You try to liaise with the organisation that brought them in, they said oh, they pick them from the streets because people are complaining; there is nothing you can do, you have to discharge them back to the street. She expressed the view that some NRPF clients may be dishonest in their claim of being mentally unwell… *at the same time, we should be very careful when we have people with mental illness when they don't have papers. Some will like to claim they are mentally unwell, while they are just trying to get papers out of the system. We are to be very careful to differentiate between them, hiding under being unwell, being mentally unwell to gain their papers.''*
Perspective on Advocacy	Anita stated that she is able to advocate for her clients who have NRPF. ''…*as a professional, I really feel it and I am prepared to advocate. I write letters to home office.'*
Creative Responses to Challenges posed by NRPF Patients	She reported a situation where she had to mobilise food vouchers from her colleagues in order to make sure her client had food to eat. *'…..I find myself going round my colleagues, asking them if they could give me food voucher.'*
Researcher/Participant Relationship	Anita interview sessions were quite engaging as she narrated her experiences with NRPF clients. She sounded passionate about her role and what she does for her clients. She was open and passionate in telling her stories
Researcher's Understanding of Anita's Narratives	Anita appeared conflicted in her narration. While she acknowledged the difficulties her clients face and the challenges she faces while carrying out her role as a care coordinator, she at the same time opined that NRPF clients might not be deserving as they did not contribute to the economy by way of tax and National Insurance. Anita also alleged that people might be using mental health as an excuse to get their papers.
Commentary	Anita started out identifying with the service users. Her experience laid bare the dilemma frontline professionals face when they are unable to safely discharge a treated person because they don't have recourse to public funds to qualify for government funded accommodation. I felt Anita's view justifying exclusionary policies on the ground that NRPF migrants might be undeserved because they have not been contributing to NI or to the tax made me wonder how

	effectively she would be able to advocate and defend or protect the interests of her NRPF service users when such interests conflict with exclusionary policies. I had a preconception that professionals from minority ethnic background would denounce any NRPF policies.
Researcher's Reflection	Anita spoke not only from the perspective of frontline professional but also as an ethnic minority who herself was once subject to NRPF. One of the key tenets of critical race theory was that of 'voice of colour' which suggests that minority practitioners are in a better position to speak about racism based on their individual experiences of marginalisation. There is an indication that Anita would be more inclined towards implementing organisational/government policies. **Anita's practice orientation tilts towards high service user focus. She was also high in institutional/legislative focus.**

Henry	
Ethnic Background/ Migration History	Henry is a black African male from Nigeria. He migrated to the UK about 15 years ago via the highly skilled migrant visa program. He is married and lives with his family in the UK.
Gender	Male
Professional Background	Henry trained and qualified as a mental health nurse in the United Kingdom. He has been in frontline nursing practice for about 10 years. He has worked in the community as well as on the ward and currently manages the bed management /discharge team
Practice Setting/ Level	He is a ward-based senior management level staff with responsibility for bed management and timely discharge of patients to free up space as well as prevention of hospitalisation through rigorous admission screening.
Experience of Working with Patients who have no recourse to public funds	Henry stated that he regularly comes across cases of patients who have no recourse to public funds in his role. *'I think in my line of work, I get to see that more frequently than anyone working, in the community'*.
Emotional Impact on Participant	Henry described his experience of working with this client group as a difficult one. He noted that this client group presents with additional pressure on professionals, and disruption of workflow in the admission and discharge cycle on the ward. '…*this is the difficulty and dilemma we face… while these processes are ongoing or being put in place or sorted out, the bed is being blocked'.*

	Henry acknowledged the challenges professionals face when patients with NRPF overstay on the ward. *'It makes the whole flow of inpatient and outpatient quite hard*'. The plight of NRPF patients also evokes strong emotions in practitioners…… *sometimes as practitioner you feel very sorry for certain clients because we are in deprived area itself and the population is of mixed and you get a lot of migrants that are not legal in the country'.* Henry expressed despair that the situation will get worse.*' For me as a practitioner, over the years it seems the situation is getting worse and will continue to get worse….'* He admitted that professionals feel vulnerable and helpless with emotional burden of this client group. '…*it leaves us very vulnerable because you have duty of care to your patients as well. If you have a patient that has got NRPF, …… but the patient is blocking a bed, what do you do? ……. they have to discharge him, ……. but it leaves you very vulnerable because they are human beings, it leaves you open'.*
Perspective on Inter-agency Working	Henry's response revealed different agencies/services apply strict adherence to boundaries when referrals are received for patients with NRPF to access statutory services such as housing and benefits'…. *because when you get in touch with local authority, they wash their hands because the patient has no recourse to public funds'.* In another example, referral to community mental health team was refused because the patient is NRPF thereby unable to access support for his mental illness in the community '…..s*o he was on the ward for almost a year. …..a care act assessment was carried out on him to determine who is going to be providing some sort of housing. The CRT wasn't willing to take him because they said you have to have recourse to public funds for you to receive CRT services. So, in the end, it transpired that local authority took responsibility to take him in and gave him housing and after a while, he got his papers.'* Henry's response suggests there are no clear provisions for patients in this category about what and how to access statutory services thereby subject to individual agencies' interpretations, and to the whims of the gatekeepers of that agencies. Frontline mental health professionals are therefore stuck with cases they do not know how to manage. Henry feels that there is a need for a national protocol so as to bring uniformity to how

	NRPF cases are handled rather than leaving it for individual Trust or team to grapple with the challenges.
Perspectives on Social Political Context of NRPF	Henry's believes that national government should engage all stakeholders to discuss and develop protocol on how services/trusts would respond to the needs of NRPF patients. He argued that local authorities don't have enough resources to meet the needs of 'legal' people how much more those who are illegal. *'……the conversation needs to be national and then drill down to the bottom, …..and that need to be carried to the commissioners and to the government, to say this is the problem we face, how do we deal with it? Do we put more money into it? Or do we just accept that each individual Trust or each individual CCG are going to be operating at loss since they have to cater for these people or, do they try and get these people back to their home countries?'* He made references to lack of resources and how services are overwhelmed by social care needs. He expressed hopelessness that the situation would continue to get dire. *'…..where are the funds going to come from. It is still a difficult case'.* Henry described the dilemma faced by professionals caring for NRPF patients' as the *'elephant in the room'* that no one wanted to talk about. He felt it is a critical issue that needs to be discussed in detail. He alluded to the fact that it causes conflicts and divisions among stake holders '…. *for me, it is a massive problem that has grown and grown and it is a sensitive topic in sense of when people start to talk about it, there is a fine line between people saying you are discriminating or being racist but needs to be talked about because it is draining on services so that in itself causes division within staff, within the organisation, within commissioners, health care providers'.*
Perspective on Advocacy	Henry reported that he advocates for NRPF patients by identifying appropriate services/agencies to refer them to based on their assessed needs in line with the organisational policy. '*Local Authority I think they, that is where the issue is. They are being squeezed as well, they are trying to save money, they can't provide services to people who are legal not to talk of people who are illegal'*. This statement reflects a bureaucratic approach. Henry acknowledged that some decisions about NRPF may be difficult for frontline non managerial staff to take and indicated that those tough decisions should be left for managers to address, especially when it comes to

	discharging NRPF patient '…..*whereas senior manager needs to take that responsibility because they are exposed to conversations that happened in meetings, they are exposed to protocols the CCG are taking or about to take'*
Creative Responses to Challenges posed by NRPF Patients	Henry reported that there are situations where patients have been forced out of ward to go and sort themselves out. I would believe that necessary risk assessments would have been carried out to ascertain that the level of risk is tolerable if a NPRF patient is discharged to the streets '*…the Trust has got no choice because there is no resources to fulfil that intervention of care, that follow up care that person requires, so you are having to force this patient out to go and sort themselves out'*. Henry and his team have facilitated repatriation of NRPF patients to their home countries, and in many instances escorted by health care professionals. While this practice was not captured in any national or organisational regulations or policy, it appeared to be popular especially in inpatient psychiatry. Rather than having NRPF patients block admission beds, they would rather provide funds to repatriate them to their countries when they are mentally stable '…… *I mean we've been in situation where we have had to buy tickets off our budget to support people to go back to their own country if they wanted to go'* Henry felt that over time, his team was able to explore the provisions of the Care Act 2014 and Human Rights Act to hold local authority accountable to address the needs of some NRPF patients who meet the criteria….*I think the Trust is now getting better as they regularly carry out Care Act assessment for people who have recourse to public funds and not just people who have no recourse to public funds. It is a new thing, it's been embedded into the system quite well, but that is the only way you can support people who have no recourse to public funds.*
Researcher/Participant Relationship	It was a bit of a challenge securing an appointment with Henry for the interview due to his busy schedule even though he had shown some enthusiasm about the research topic. I was very pleased when he eventually gave me a date as I felt that by virtue of his position as a senior manager, and one of the very few BAME staff at that level, he would bring a new perspective to the data. I noted also that he was very keen to participate in the research. I recognised that we share a lot in common as we are both black Africans from the same country. We both had similar migration stories as highly skilled migrant program visa beneficiaries and we both have frontline mental health experiences. The encounter was

	cordial, and we got down to business immediately. I felt he spoke from his heart with a lot of convictions on the subject matter. I initially thought his participation was like solidarity to me as a fellow BAME, however, the excitement on his face and positive comments after the interview made me feel the interview might have provided an opportunity to express himself and unburden. He immediately agreed to follow-up interview for the following day.
Researcher's Understanding of Henry's Narratives	By his narratives, it seems to me that Henry appeared to be protective of his team's handling of NRPF patients' cases. He rationalised this by referring to lack of resources and lack of cooperation from other agencies/services. There was also the point that government at the centre is not addressing the issue. While he recognised the difficulties and the plights of NRPF patients, he nevertheless expressed the view that he has a job to do and he needs to do it. By using the term, 'elephant in the room' to describe the NRPF cases he underscores how evasive the organisational culture of which he is a part is. Perhaps this evasiveness led to the deployment of various creative ways of managing the bed crisis-such as-facilitating the repatriation of patients; discharging patients into the streets or into B & B accommodation, or prolonged inpatient admission all of which do not provide aftercare support to patients with enduring mental illness. It is true that discussing NRPF issues could elicit some racial feelings which can be very uncomfortable in a work setting, as senior management, Henry is well placed to explore opportunities to advocate on behalf of his patients at senior management meetings. In summary, I wonder if Henry is not just being a 'good' worker/manager doing the 'good' work of clearing/cleaning up the mess of NRPF patients. By his admission, Henry is close enough to the commissioners, Directors, and the CCG to know their unvoiced views about NRPF patients. For instances, facilitating repatriation of patients to another country with staff escort is a sensitive assignment that top level management must be aware of and approve. Therefore, the emerging picture I can see from this narration is that of a defended participant who has enough justifications for how his organisation handles NRPF mental health patients cases.

Commentary	I got along well with Henry in both interview sessions and long after our meetings we kept in touch. He wished me well in this study and stated how interested he is in the area I am researching. He came across as confident and knowledgeable about the operations of the organisation by virtue of his position. However, the more I look at the data, the more the data reveals Henry defending his position at every turn even though this was not obvious to me during and immediately after the interviews. His narratives indicated that he identified with the service users at surface level. Working with NRPF patients can be anxiety-provoking considering risk issues associated with lack of aftercare and social support for them. Psychoanalytic thoughts believe that anxiety precipitates defences against the threats it poses to the self and that these operate largely at the unconscious level. In his narration, it appears to me that Henry deployed unconscious defences to manage the anxieties triggered by this task. A further line of thought considered was that, Henry's position in the organisational structure and his practice setting may have informed his views and behaviour. The higher you go on the organisational ladder, the more your perspectives change as you are more detached from day-to-day contact with the vulnerable people. The capacity to hold the patient in mind has probably waned. His functioning is now dyad- Henry and the commissioners/CCG. The patient's angle of the triangle is not visible- out of sight, out of mind. His preoccupation is now on making beds available for patients and not the patients themselves. Related to this also was increased depersonalisation of the patient because the primary task of his department has shifted towards making more beds available. There are indications also that free beds may now be offered for sale to other trusts who may be experiencing bed shortages. There is that element of commercial motivation. My expectation was that Henry being an ethnic minority professional would use his vantage position as a senior manager to address or at least highlight the predicament of NRPF service users to higher authorities. It appears that Henry was more a protagonist of the policies while he admitted that the policies are not favourable to migrants. CRT tenet suggests that because racism advances the interests of the dominant groups, there is little or no incentive to eradicate it. Henry spoke about the elephant in the room suggesting the indifference of relevant authorities to address the issue.

Researcher's Reflection	Having come to the above view, I wonder if I find myself in Henry's position, what would I do? What difference would I make as a frontline professional in management position too? How confident and how forcefully are frontline practitioners able to challenge the status quo when the care of their service users are involved? How concretely can I hold the patient in mind when I am expected to meet a managerial target ? There are no easy answer until you are there. I have sympathy for Henry as his role has become part of the organisational defence system against anxiety. **The practice orientation of Henry shows that he is more organisational/legislation focussed. He is however low on service user focus**.

Lorna	
Ethnic Background/ Migration History	Lorna is a white British lady. She was born and raised in the East End of London. She made copious reference to her East London identity and believes that this background shapes her practice and attitude to life *'….obviously, it's just my culture, my background coming from the East End is that we look up to the elders, and females should always be looked after by the males. That always plays a little heartstring with me, to be honest with you'*
Sex	Female
Professional Background	Lorna is a qualified social worker and has undertaken specialist training in mental health. She is also an approved mental health professional. Lorna has several years of frontline work as support worker before she trained to be a qualified social worker. She has over 15 years post qualification experience as a social worker.
Practice Setting/ Level	Lorna is a member of home treatment team, a multi-disciplinary team. Her team supports service users who are in crisis in the community in order to prevent hospital admission. The team also facilitates early discharge from the wards and follows up service users who have just been discharged from psychiatric wards. She is a senior practitioner in her team
Experience of Working with Patients who have no recourse to public funds	Lorna stated that she comes across a few service users who have no recourse to public funds. *'… yes, we work with quite a few people that come through with no recourse to public funds'.* She narrated her experiences of two recent cases she was involved in.
Emotional Impact on Participant	In her narration, Lorna reported different types of emotions she experienced while working with service users who have NRPF. She reported emotions ranging from sadness,

	frustration and anger. She felt the plight of NRPF service users make her feel sad. ‘ *….to me, I just find it personally really sad*. Narrating her experience in one of the NRPF cases she handled, she recalled: *It was the saddest case that I ever got involved with’. I felt really sad for them, because I felt like we had contributed to the government being even more wicked.* There was a guilt feeling of being complicit with how the state treats those who have NRPF. There were moments of frustration too where she described some policies as constraints that hinder her from discharging her duties as a social worker. Lorna also expressed anger at the system which she believes discriminates against certain people by denying them essentials of life. There was also anger at her colleagues who she said are suspicious of people who feel that some patients with NRPF are feigning mental illness. Lorna seems caught up in the emotions of the role. She was conscious of her professional/client relationship and how that would make the service user feel and respond to the engagement process. She said she was embarrassed to ask certain questions during an assessment because the service user would be embarrassed by the questions. ‘…. *I would feel embarrassed because he was embarrassed. I felt embarrassed that he was embarrassed. He was embarrassed that he was asking for help. I used to feel, "Oh, how can I make this man not feel embarrassed because I just want to help him. It was really hard’.* *‘I used to feel really awful. I don't know why, but because he was a man and he was a proud man, I used to feel I don't want him to feel that I'm judging him by any way, shape or form because I know he comes from-- In the back of my head, I know I'm a female, I was born and bred in this country. I don't want him to think, "Oh, you're just another government worker," or something like that*
Perspective on Inter-agency Working	Lorna’s narration did not highlight any challenges regarding interagency working. This was probably due to the nature of her team being a short-term crisis intervention team. She nevertheless noted that other government agencies such as police and immigration services were too high-handed in handling the case of one of her service users especially when they asked the husband to leave the country and leave behind his wife and their children.

Perspectives on Social Political Context of NRPF	Lorna expressed the view that the society is discriminatory against people with NRPF and mental health. Lorna believes UK does not offer better life to migrants contrary to what most people say or believe. *'That's why I'll never ever say to people, "You've come here for a better life." I always say to people, "You've come here for a purpose, what was that purpose?" because I don't want them to think, "Oh like everybody living in the UK", like, "You think because you've got a job, and you can drive a car and you've got this that everyone comes here for a better life?" because actually, 9 out of 10 people don't get a better life when they've come to the UK'.* Lorna alluded to the fact that migrants who come despite the discriminations against them are desperate because of the push factors in their home countries. *'I think they get discriminated against. Who would put themselves through that if you wasn't desperate? Some of these countries that people come from, they are war-torn countries. It's countries where there's no social system. You've got to be desperate to think, "I'm going to come to the UK and be treated badly and I'm still going to come knowing that," You've got to be desperate'*
Perspective on Advocacy	Lorna appeared confident to assist her service users to navigate the system. For instance, ''t*o be honest with you, I was sitting, and I would genuinely say, "Look, we need to write things that's going to make it sound better for your case. I'm not being rude; I just want to help you as much I can".* She also recognised that the service user needs to be on board with her in the advocacy*. "Look, do you want to stay in the UK and try and do your studying and have the life that you come here initially to have, or are you happy to go home?" The choice is your own. "I can help you and we have to write it in such a manner,"*
Creative Responses to Challenges posed by NRPF Patients	In addition to a lot of emotional investments, Lorna was able to gather information from colleagues about the home country of one of the service users in order to achieve a positive outcome for him. She recognised the benefits of positive personal relationship with a service user.
Researcher/Participant Relationship	The two sessions with Lorna were quite interesting however I felt Lorna was too emotionally entangled with the service users.
Researcher's Understanding of Lorna's Narratives	By her narratives, Lorna appeared to be enmeshed with her service users leaving her with huge emotional burden she could not easily disentangle herself from. She was either sad, angry, frustrated, feeling awful, or embarrassed in her involvement with these service users as evidence of

	strong identification with the service users. There was a huge use of self in Lorna's interaction with her service users. She was drawn heavily into the service users' world in order to feel what they feel. Even though as a white British female, she recognised her background as an East End lady influenced her practice substantially. There was also this consciousness of being different from other people, especially being a white British female social worker supporting mental health service users who are migrants and marginalised. She recognised these differences and the need to encourage and reassure her service users that she is on their side in order to gain their trust. This however leaves her in a state of psychological tension and contradictions. For instance, feeling embarrassed that her client could be embarrassed if she asked him a question about his mental health. Lorna wanted to be appropriate culturally and professionally to be accepted by her service users. In addition, it appears Lorna was trying to compensate for the alleged wrong of the system against her clients. I am also of the view that Lorna was making strenuous efforts to placate clients and exonerate herself as not being part of a system that is persecuting them.
Commentary	The two sessions with Lorna were quite illuminating and interesting. Lorna could be seen rationalising her practice by referring to her background as an East End lady where according to her, men are culturally meant to look after women which conflicts with her current role as a female frontline professional providing for, out of her benevolence, (not caring as a MH professional) this 'proud' vulnerable African man. Lorna was in touch with her background and also is aware of how typical paternalistic African male could interpret this. She was culturally sensitive. I would say Lorna was reflective and conscious of her action and involvement with this service user. My personal view was that Lorna, being a white British lady would speak in defence of exclusionary policies in line with the public opinion as expressed in Brexit and in the media, Lorna's line of thought was quite a departure from what I expected.
Researcher's Reflection	I am reminded of how a professional's background and values shape their practice. Lorna's narratives speak to the use of self by professionals, either as a container or a facilitator. I would say Lorna had true emotional contact with her clients to understand their needs. **Considering the practice orientation of Lorna, she appeared to be organisational and policy focussed. Lorna is also service user focussed.**

Dame	
Ethnic Background/ Migration History	Dame is a white British lady in her mid-thirties. According to her, both parents are British**.** She has no migration history
Gender	Female
Professional Background	Dame's professional background is occupational therapy and has been practising as an OT for over 10years in adult mental health inpatient and community settings.
Practice Setting/ Level	Dame's is a deputy manager in the local community mental health recovery team
Experience of Working with Patients who have no recourse to public funds	She has many years' experience of working directly with patients that have no recourse to public funds. She currently carries out initial ADL assessments of new referrals and supervises frontline staff who work with NRPF cases**.**
Emotional Impact on Participant	**Dame indicated that she felt frustrated due to inability to meet the needs of her clients because they don't have recourse to public funds** *''It leaves you feeling quite frustrated when you're……. I don't know, bang your head against the wall saying, "We need to provide this." It seems like if someone is mentally unwell and needing our service, then obviously, we have to provide it but we can't….. because I think officially we're not meant to provide a service to clients with no recourse to public funds. Officially, people are meant to have a status in this country to be coming to our team, which just seems a bit exhausting; we know that can't be the case.''* **Professionals carry burdens of concerns for clients** *'I feel very, very concerned for this family that their no recourse to public funds is an added dimension to the situation'* **Professionals felt unable to perform her duties satisfactorily, no job fulfilment**. *You can't really do recovery until someone has their primary basic needs met. That Maslow's hierarchy where you can't get psychological until you sort that out. As being a member*

	of the team senior, that's the point I'm involved and then when it's more recovery, that's something the staff can manage. I would say I imagine it's going to be quite difficult because even with clients who are very interested and want to attend groups, it's got to be free or minimum charges **It's hard work and takes a huge amount of the team's time and effort:** *'When people come to this team, they're always under section 117 of the MHA, or the Human Rights Act, ….. they come in after a lot of hard work and I think once they're in the team, they take up a huge amount of time and effort and thinking space and concern, much more than our other clients'* *'It feels so tenuous trying to get these things in place for them and because they can't get housing, we get they're not allowed to work, they quite often don't have support in the community. It feels like they take up a lot more time whoever's case they end up on, it's definitely like as a team we spend a lot more time on them.'* She added: *'A lot of the grant panels that I've been required to attend have been taking over by these clients because it's more complex and because it's ……*' **Professionals lack a voice, just like the clients they serve** *''The person who is in contact with them who should be their voice doesn't seem to have a voice, you understand what I'm saying. When you don't have a voice how do you…. what do you say? ….It's frustrating. If you don't have a voice and you don't feel heard it means that you hold on to those frustrations yourself…….. I guess you get used to working with lots of different people in really outrageous situations. It's not that you become numb to it but it just feels like that's part of the job. You have to get on with it and try and support them as best as you can.''* **Professionals feel helpless, frustrated and resign to fate** *''I guess I'm just thinking we work with our clients, for example, whose situations or we can't force them to be moved, who are having very unhappy lives but we can't make*

	it better or okay because of the red tape and the structures that we work with because of the lack of funding in different areas, all of these things. I guess in that sense it does feel frustrating but it's also something I think as professional we come to accept its part of the job and you do what you can do. You have to wiggle your way around the constrictions to get the best that you can, is the best way I can think about it really.
Perspective on Inter-agency Working	**Mental health services have a difficult relationship with other services** *''That's been a little bit harder only because with social services it's quite difficult for us to communicate with them unless they're already with them, unless they're already within social services bit''* **Other services are not helpful when it comes to NRPF clients. No good working relationship between mental health and other services.** *'I don't think other services are really that helpful at all. I'm trying to think what they already even be like or who that would be.'* *When we haven't had a named person it's really hard to access social services or understand what they're doing. We're too separate in our ways of working together*. **No one taking responsibility to support despite obvious needs** *Really badly. It felt like housing weren't supporting at all and it felt like both housing were batting it back and forth and leaving a family with two six year old's and an infestation of bed bugs*. **GPs and charities have been helpful** *'I found people like charities really helpful. I found NGOs really helpful. We have used a TSO who have been really helpful. There's been some small charities who have been more helpful I would say and more flexible in their working and more concerned than some of the more statutory organizations. GPs have been helpful too'*

	Services were passing the buck, abdicating their responsibilities *I've noticed there's been a lot of passing the buck, there's been a lot of saying, "We don't work with no recourse to public funds, so you have to do it." It might be better when they're not with our service, maybe other services are forced to step up and take more responsibility.* **Lack of support or collaboration with mental health services by other agencies when NRPF clients are involved** *I think when they are with us, there's a real lack of support from other people. I haven't noticed any support or people being particularly helpful when we try to organize care for people with no recourse course.* **MH practitioners feel stuck with NRPF clients due to the risk of losing their access to services if discharged** *'Yes. We're caught in a situation where I don't know how you discharge clients when it means they lose everything. If she's discharged now she probably will lose the accommodation….. She will relapse that way….she will lose all her money, but she won't lose her treatment instantly, because she has done so every time she has been in temporary accommodation or in stressful situations. She would lose all that recovering time and effort that we've put into her.'*
Perspectives on Social-Political Context of NRPF	**The participant feels there is a need to provide services to this client group irrespective of their immigration status** *'if someone is so unwell that they're needing this level of service and support then they shouldn't be no recourse to public funds. It's absolutely 'bonkers'. We have to be providing some support or service for people. We have to do that. Whatever they call them, however little they provide them with we still have to provide a service'* *'I think if someone's coming to a service like this regardless of their access to public funds or not they should be receiving treatment. I personally wouldn't want to ever deny anyone*

	service……. Like the guy they were trying to bill, I felt disgusted that because we were trying to save we wouldn't offer him a service if he wouldn't pay for the sessions?' National shame: *I think in the UK we shove a lot of those things down, and I think that's a real shame. I think we could be doing a lot more to welcome people.* Effect of Brexit *A lot of my clients are people who have immigrated here. Some of them have uncertain status, indefinite leave to remain. For them, I was really aware that actually it was a really scary time. They felt incredibly unwelcomed in this country. They felt that through the discussions around Brexit that actually they weren't wanted here, that people were against them. They actually felt quite scared to go out on the streets in this local area. It was quite horrifying to hear that people could be marginalized and so scared like that* **NRPF clients lack access to housing support** *I think housing have a blanket rule the same as we do, if someone has no recourse to public funds, they don't get housing. That is what I've been met with every time I've tried to refer someone for accommodation.* **Professionals' dilemma to discharge or not to discharge service users for fear of losing the care and support** *For these people, I don't understand how we're going to discharge them because if we discharge them, then the funding stops. They have no funding from us anymore. They would be moved into independent accommodation so we can't discharge. Ultimately recovery's going to fall down because we can only do so much and then we're stuck because if we take away those, people will become dependent on us because we're providing their housing, their funding, supporting them with their food. If we're not doing that and we discharge them, then they aren't getting any treatment anymore. I guess we're always going to be in a difficult situation if we think about fully making people independent* **Government policies prevent NRPF migrants from**

	community participation including employment thereby hindering their recovery process *In terms of no recourse, it's like this gentleman……..he came to this country he got a job, he was working. Then he was told by the immigration office that he's not allowed to work. It just seems 'bonkers'. If people come around and they're willing to work, they want to give to their society, their community. They want to be productive with their lives which is so important for recovery and even if they show that motivation, they're not allowed to. They're stopped from doing that.* *It seems to go against all kind of logic for me. Let alone the fact that it's cruel and mean to people to force them to be dependent members of society.* **The Participant addressed myths and misconceptions about migrants' access to social benefits and housing and misinformation being peddled to fuel anti-immigrant feelings.** *….there are all these myths about how easy it is to access these services and I don't think people are really aware of no recourse to public funds. I don't think people are aware that there's people living in their community and literally get nothing, who are living such tenuous lives where they have to report to the immigration office, where they might be removed or forced to leave the country. I think there's a lot less discussion around people in that situation than there should be. …. I think when you talk about individual cases people have a lot of sympathy but when you talk about it as a larger group I think some people are really anti-immigration and feel like it's draining our resources and feel the people who are here with no recourse should be forced to leave, whereas some people will obviously be more open.* **Participant noted the trauma and the potential cost of attempt to force people with MH to leave the country** *I guess a lot of people don't realize how traumatic the problem is. I think some people think that we should force them to leave and don't realize how potentially traumatic that experience can be or realize how well the people we are working with are. Also how unsuccessful this idea of forcing people to leave is.*

	I remember having someone taken off from an acute mental health ward because she had no leave to remain. Immigration officers came to the ward and carried her out of the ward basically. She was kept in the deportation center for three months and then she was back in our community. The amount of pain and suffering that woman went through and an entire ward of people went through for something that was completely pointless. She's still living in the UK, she still has no recourse but they cannot deport her so there's been no conclusion. They just have spent a lot of money, effort, and distress doing that. I don't think people realize those kinds of things they want or how unsuccessful that system is. **People lack understanding and compassion about migrants' circumstances** *……..people don't think about the reasons that people come over here. They don't understand how distressing it is. They think people come here and stay here out of arrogance or dismissive of the rules. I think the further away we get from the individuals the more mystery that we have and the less we think of people as persons who have individual needs and we just think of them in a general population. I think anytime we do that it's easier to get dismissive or unconcerned about people whereas if you're faced with individuals who are so unwell needing such levels of support or so distressed then you change your opinion, don't you?*
Perspective on Advocacy	**Participant identified the need for experts or specialist teams who are more knowledgeable on how and where to mobilise support for NRPF clients** *I guess as I said it was really helpful having a team that was more expert in just in covering the basics. Then you have to get people accommodation, have to get people some kind of funding, to help them know where to get vouchers, just basic things like that so then we are able to work with people and with charities in order to get people engaged in the activities and social inclusion. Having people who are experts, so you're not going back and having arguments again and again with the funding panel to try and figure out how we can get funding or support for people.* **There is a need to build better inter-agency relationships**

	I think as a Trust we need to build better relationships with the charities in this area to see what they can offer, because I'm sure there's groups and support and things that people can be accessing but we need to be better aware of what they are. Liaising with GPs, housing, that would be really helpful if they were *To leave someone without basic necessities of food or means to cook, means of like coping in communities. It goes against our professional conduct to know that and to leave it, and not do anything about it. I think sometimes we're a little bit forced to become more enmeshed in these people's lives than we would do normally.*
Creative Responses to Challenges posed by NRPF Patients	**Participant identified that there are situations where other legislations may be engaged to justify provision of care and support for NRPF clients** *I guess that's where you end up in these arguments where people will say 'No', so then you have to turn around and say, "Okay, I will do a human rights assessment. It feels very silly because you almost have to go around the houses finding a way around it to get some kind of funding or some kind of response because the need is there so we can't just ignore that, so that means we have to try and do all these tick boxes to make people agree to it''.* **Participant noted that professionals go above and beyond the call of duty at times when working with NRPF clients; at times getting enmeshed and contributing money to support them.** *People go above and beyond because they're feeling frustrated and they don't feel that this kind of treatment is fair. I think if a client was struggling but it was felt like they were being too demanding or they didn't really need what they were asking for, professionals might not be joining in as much. It's because it just feels ridiculous that these people don't have, like this lady, pots and pans to cook in her house. The basic necessity is just to eat and survive.* *That feels really neglecting as well. I think we are forced to go above and beyond because if we don't, then we're leaving someone who's chronically mentally unwell, incredibly vulnerable without even a means to cook.*

	With some of our clients, they're in such difficult situations. Not just this client group but this client group is a good example though, in such difficult situations that it feels inhuman not to try and offer the support. You get forced to become enmeshed if the service is not there. It becomes much harder to draw the line or to have boundaries when someone is in such need. There was even talk about trying to raise some funds for her through the staff, *We then were talking about how we as a staff team could just try and support her even as a short-term for the next couple of weeks* **Participant noted strong team solidarity when NRPF clients are involved** *In terms of the team's different ways of approaching it, I think as a team, we're all really confused about how to support people. Yesterday we had a situation trying to organize it, we had the social workers supporting, we had the nurses supporting, we had the team lead involved. We do as a team know, we recognize it's really difficult and so everyone tries to support.* *Everyone gets, not dragged in but willingly dragged in to try to figure out together. I guess sometimes social workers might feel more competent because it's an area they're more familiar with. Overall, I think it's something we all really struggle with.*
Researcher/Participant Relationship	I find Dame interview sessions quite engaging as she narrated her experiences with NRPF clients.
Researcher's Understanding of Dame's Narratives	Dame's comments and remarks challenged policies and questioned the negative narratives about immigrants. I saw in her a strong voice of advocacy beyond rhetoric.
Commentary	Dame is a white British professional and I wonder if her ethnicity is a factor in her show of confidence and position on this subject matter. She was vocal and challenged the prevailing culture and policies. She felt the general populace lack an understanding of the experiences of the migrants and that there is a need for public awareness so as to change the negative narratives being peddled about migration. Listening to Dame advocating for the rights of NRPF clients was fascinating to me as my initial expectation was that, participants of white British background would defend the exclusionary policies

Researcher's Reflection	Dame's narratives and perspectives are quite interesting and engaging. She spoke boldly about what she thinks are injustices and discriminatory practices.One of the roles of frontline professionals is to advocate for their clients, a voice for the voiceless. Dame was quite vocal in her view as she challenged the immigration policy based on the way it affected her clients who are NRPF. Dame appears to have the professional state of mind that is perceptive in her narration. **Dame has very low consideration for the NRPF legislations and organisational policy. She was however service user focussed.**

Chris	
Ethnic Background/ Migration History	Chris is a black African male who migrated to the UK about 12 years ago to join his wife. Chris described himself as a successful professional in his home country in East Africa before migrating to the UK. He sees his migration as an opportunity to better his life and to help other members of his family through remittances. On arrival in the UK, he engaged in low skilled jobs and later trained and qualified as a psychiatric nurse.
Gender	Male
Professional Background	Chris has over 6 years post qualification experience in frontline psychiatric practice. He is currently a care coordinator in a Community Mental Health Team.
Practice Setting/ Level	Chris is a member of a community mental health team, a multi-disciplinary team made up of psychiatric nurses, psychiatric doctors, occupational therapists, support workers, and social workers. The team supports those with established diagnoses of enduring mental health difficulties by providing a range of person-centered care and support to meet identified needs. The role also involved coordinating and liaising with other health and social care workers involved in the service user's care- such as GP, psychologist, social worker etc. Chris's role also involved the periodic review of care and adjusting it to meet current needs of the service user.

Experience of Working with Patients who have no recourse to public funds	Chris has been involved in two cases of those who have no recourse to public funds.
Emotional Impact on Participant	Chris's narration laid bare strong identification with the two cases he narrated. As he would disclose later in one of the cases, he compared himself with this service user, who he described as a fellow professional, fellow African and migrant, who unlike him, have different but unfortunate outcomes in their migration experiences. He concluded he was lucky and fortunate that he was not in the same situation as these service users. …….*''As a fellow professional, I feel for him and as a fellow African and migrant myself, you empathise, and you sort of understand where he is coming from. How his life is. Because I can picture, it is very similar to myself. I always consider myself lucky every time I met up with him and compare myself with him. You sort of compare and look at how lucky I am to be working and how unfortunate he was and there is nothing you can do''.* (Chris acknowledged some similarities with the service users but different outcomes, and now feels lucky. How did this affect his relationship with the clients?) Chris continued to identify with the despair and the frustration of his clients due to lack of social support for his service user…….*'I always thought for someone who has no recourse to public funds, there might be some organisations who can help but I later find out they are very limited, and it was very frustrating for him and for me too'* Chris narrated he faces barriers in accessing welfare services which he noted could have improved their wellbeing. In identification he described his own professional experience as 'hitting brick walls'. '' ...*but each time I wanted to help him, it's like I always felt I 'hit a brickwall'. And these are some of the difficulties and challenges I face working with someone with no recourse to public funds''.* Chris reported it was very difficult for his client to access services and identified that this makes his own job very difficult too. He used the word 'difficult' several times in the course of the interview. *''……. because they wanted to change GP to the local area, it was very very difficult because of the issue of no recourse to public funds. There is*

	a lot of obstacles which makes your job very difficult because you can't provide the support you want to the person Chris was deeply mobilised by the experiences of his service users that he continued to compare his personal experience with theirs**.....***'I consider myself very fortunate in terms of my past. Coming to the country and making a living here, you 've got the resources and you look at someone who is just like you, so you sort of compare and think this could have been me. I could be in this situation too. I consider myself fortunate; but my path was different from his and he cannot access any public service which are available. He cannot access benefits and he cannot fend for his family. I always consider myself lucky every time I met up with him and compare myself with him. You sort of compare and look at how lucky I am to be working and how unfortunate he was and there is nothing you can do."* In further identification with his service users, Chris described that 'not knowing' what await the NRPF clients leave both the clients and professionals in a limbo……*'It is not knowing when and what the end is going to be, not knowing, I think that is very difficult. Not knowing what is going to happen. It is very difficult for you as health care professional and also for the patient because on day to day, you spend more time with them'* Chris alluded to the emotional and physical cost of his involvement as service users with NRPF are seen as needy clients with whom he spent extra time and efforts, even at personal cost. By virtue of their vulnerabilities, Chris was willing to exceed call of duty on them. Empathy**: ''……***he was depressed, he did not see an end to his conditions. It's like he was suffering. He said to me, he was suffering. As a fellow professional, I feel for him and as a fellow African and migrant myself, you empathise and you sort of understand where he is coming from. How his life is. Because I can picture, it is very similar to myself''* In moments of identification, professionals could be lured to step out of role or tempted to assume messianic role. Chris alluded to this when he said: '*The other thing also, you are just a mental health professional, you are not a*

	qualified immigration adviser, so you don't know what to advise someone. Sometimes they ask you what should I do? But you don't know much about the issue. You advise them to talk to their solicitor and they tell you, solicitor won't talk to me because I don't have recourse to public funds. Maybe you should go to these organisations, you give a list of numbers and they tell them you are not eligible because you have no recourse to public funds'. Chris appears to be suggesting that the mental health service (including himself) might be proffering the wrong solutions because the primary concern of his service user is their immigration status and unless this is addressed, other interventions are cosmetic and ineffective. This left him feeling like a failure. *'The person tells you…; my problem is I don't have recourse to public funds. If this problem is solved, all the other problems will get better and you are there as a mental health professional talking about medication, talking about therapies, talking about healthy lifestyle…. As a health care professional, you feel like a failure because you can't solve the problems, there is only so much you can do. So sometimes, you as a professional you feel you are going around in circles, you are not actually dealing with the main problem'*
Perspective on Inter-agency Working	Chris made direct reference to his experience in interagency working. He however recognised that social services and Home office are not handling cases as effectively and quickly as they should. He reported '….*most people if they don't have recourse to public funds, they are probably dealing with the home office who we struggle to get information from or communicate with. ….you don't have a point of contact, you can't pick up the phone and call someone and say, "Can you let me know …., what is happening with this person," etc*

Perspectives on Social Political Context of NRPF	Chris appeared to have been caught up in a drama triangle when he expressed his helplessness as a rescuer of his service users. It should be noted that Chris did not make direct reference to the government or any agency at any time in the two interviews, it is obvious that the government policy on NRPF represents the perpetrator while the victims are his service users while he is the rescuer. *'…. I worked with him, for close to 8 months, I did not see any change, he was continually chronically depressed. He described that he felt that he was served a death sentence in a way. When someone tells you that, it shows how life can be so cruel in a way. So, I always empathise and it does affect you as a professional and a human being, knowing that there are people out there who came to this country to make a living for themselves like we all do but different paths and unfortunate circumstances led them to be where they are. So, the challenges are just finding out there is nothing you can do. You really cannot help them, the only help you can give, is what the mental health services provide like talking therapy and medication and that is all we can provide really''.* Chris identified that his service users had no voice as they are insignificant in number and are regarded as illegal and thereby unable to demand for services. He presents them as helpless with a sense of despondency. ''*Yes… they're insignificant. ….. the reason why nobody thought of them, nobody said anything is because they actually don't have a voice because who can they go and complain to? ….. because the people who are there to help them will say, "But you are here illegally." Or "You are not supposed to be getting these services." I think that's the difficulty in a lot of the people who don't have recourse to public funds and I have noticed from the ones I have worked with there is a sense of giving up because they know that nobody can help them''.* Chris did not see any role for himself beyond monitoring and giving medication. He did not see himself as standing up and being a voice for them or initiating a change in the system.
Perspective on Advocacy	Chris narrated the barriers his service users faced in accessing welfare services and how helpless he felt in supporting them around other social needs. He also indicated that he goes extra miles to support them '…y*ou find sometimes you always go extra miles I always*

	find myself going extra miles looking for non-profit organisations, charities who could help in any form but it was very difficult for him because there are always barriers for him
Creative Responses to Challenges posed by NRPF Patients	In addition to emotional investments, Chris reported there are occasions when he had to personally give his money to the services user when he found him in dire conditions. *''……what I found I end up doing is that at times I have to take money from my own pocket, not that I need them to pay back but when you visit someone, and they tell you that they have not eaten, they haven't got anything to eat. May be that day they went to food bank, but food bank was closed, and they have no money. I ended up taking money from my own pocket''.* There was also a greater demand on the professional's time. ''….*you give more time to them. You are a human being at the end of the day, you want to know, has this person eaten? have they drunk? how have they survived through the day? So, you devote more time to them. And you try your best, but the frustrating thing is that each time you hit a brick wall and there is no solution. And there are sometimes you think, is it better to advise this person to just go back because their life was much better than their current situation; now they are stuck, they can't work. Their life was probably better in the home country, maybe they had better quality of life than here''.*
Researcher/Participant Relationship	Chris was one of the earliest participants who indicated interest in the research. He showed keen interest in the subject and made himself available at the earliest opportunities for both interview sessions. The sessions with Chris were quite cordial and open. There were no inhibitions at all as Chris and researcher shared a lot in common as frontline practitioners, and we both are African migrants and shared similar migration experiences.
Researcher's Understanding of Chris's Narratives	Chris tried to position himself as a considerate and compassionate frontline professional who goes the extra mile to serve his service users including devoting more time to their cases despite hitting 'brick wall' in the process. Chris let us into his frustration for not being able to rescue his service users due to their exclusion from welfare services which he believed are important to their recovery. Chris conveyed a degree of impotence in delivering appropriate service to his clients. His account reflects a depressive state and limited capacity to act as a container

	for his service users.
Commentary	Listening to Chris interview and the high emotions accompanying it, I reflected on his narration after the interview evoked some conflicted ruminations in my mind as a migrant who had no recourse to public funds in the early years of my arrival in the UK. I 'felt lucky' too to have regular immigration status, while on another hand I thought; why would someone allow himself or herself to become an irregular migrant? I became judgemental and thought people should have been more meticulous and practical in planning their migration journeys to minimise the risk of becoming irregular migrants. On further reflection, I realised that people migrate under different circumstances- some have the luxury of planning it while others had to escape due to socio-political crisis or wars. Some migrated due to famine or lack of opportunities. This betrayed my bias against those who were caught in the web of NRPF.
Researcher's Reflection	I am reminded of how our practices are shaped by our background and values among other things. Chris' narratives speak to the burdens that frontline professionals are assailed with. Every encounter with service users leaves 'something' in us. We are to acknowledge this 'something', process it, and be able to provide the necessary support for our service users. Over identification can impede effective delivery of service. Chris presented as voiceless and incapacitated. He felt unfulfilled in his work with NRPF clients and seems resigned to fate. **I consider Chris as being more service user focussed with a high orientation towards organisational and policy perspective.**

John	
Ethnic Background/ Migration History	John is a black African male from Nigeria who migrated to the UK about 12 years ago. According to him he came to the country under the highly skilled migration programme as a medical doctor and later undertook required courses and examination to qualify as a psychiatrist. He said he is now settled in the United Kingdom with his family.
Gender	Male

Professional Background	John is a consultant psychiatrist. He has several years of experience as a psychiatrist in different trusts in the UK.
Practice Setting/ Level	John is a consultant psychiatrist in an inpatient acute male ward in a mental health hospital.
Experience of Working with Patients who have no recourse to public funds	John reported he often comes across patients who have no recourse to public funds from time to time. He informed that he has treated many of them both in his current post and in previous employments.
Emotional Impact on Participant	John described the experience of working with mental health patients with NRPF as daunting, challenging and difficult mainly because of need to liaise with other agencies.
Perspective on Inter-agency Working	John said his experience of liaison with other agencies is daunting and frustrating as they make it difficult to move things forward. *….these are the professionals we have to deal with. They can be a bit difficult and challenging* *Liaison with other agencies takes a lot of time….*
Perspectives on Social Political Context of NRPF	John feels that government needs to be clearer on the pathway of care for NRPF mental health patients. *On the national level, I would expect that if the government can actually come up to actually have a clear pathway for dealing with patients who are mentally unwell and who fall within this bracket.*
Perspective on Advocacy	John reported he often advocates for his patients in order to make them receive the support they need mainly by writing letters about their conditions and circumstances to social services
Creative Responses to Challenges posed by NRPF Patients	John reported he explores all available avenues to obtain the best outcomes for his NRPF patients
Researcher/ Participant Relationship	John and the researcher have known each other in the course of our professional practice. John felt relaxed and uninhibited to express his view and tell his stories. The two meetings were held in friendly atmosphere

Researcher's Understanding of John's Narratives	John expressed that working with NPRF patients presents a lot of challenges and is daunting. He reported frustration to move things forward. John's point of emphasis was around delayed discharge, bed blocking, liaison issues which he described as costly, frustrating and challenging. He presented himself as a caring professional who is willing to advocate on behalf of his patients to any level. During follow up session, he however expressed conflicting view suggesting full cooperation to implement exclusionary policies. John gave a suggestion on how to address the issue of NPRF and mental health social support by government having a clear pathway on how it is managed.
Commentary	John came across as a dedicated and knowledgeable professional who recognises the challenges presented by this client group. I observed an undertone of flip flop in his positions on NRPF patients. While he indicated that he treats all patients without reference to their immigration status, he felt post admission discharge process remains an issue. He seems to have a suggestion on how to address the problem but yet to raise it up with the trust senior hierarchy or consider doing something about it. This is consistent with the general apathy that characterises NRPF migrants, their voicelessness and invisibility. As a Consultant psychiatrist, it appears I ascribed a lot of power to John and expected him to make a difference in how NRPF patients are treated post discharge from inpatient.
Researcher's Reflection	I had a sense of more rhetoric on what should/could be done but left undone. The question that comes to my mind is, what motivates people to act or advocate for others? What motivates people to be a voice for the voiceless? What would motivate the privileged minority especially the BAME participants in this research to speak up for and raise concerns about NRPF service users with their respective departments and teams as a starting point? Maslow's hierarchy of needs? Self preservation? Structural or organisational barriers? These were the questions that agitated my mind and begging for answer.

Charlene	
Ethnic Background/ Migration History	Charlene is a white British lady. She was born and raised in England where she has always lived and worked all her life.
Gender	Female

Professional Background	Charlene is a qualified social worker and has undertaken specialist training in mental health. She is also an approved mental health professional.
Practice Setting/ Level	Charlene currently works in the community with the Perinatal mental health service, a multidisciplinary team. Her service supports those whose mental health problems occur during pregnancy or in the first year following childbirth
Experience of Working with Patients who have no recourse to public funds	Charlene informed that there are many cases within her service who have NRPF issues. She informed that because of their unique needs as pre or postnatal clients, the system is more sympathetic towards their social care needs than others. Charlene had worked for many years with a third sector organisation dealing with refugees and asylum seekers in the UK where she said she became aware of the plight of migrants and the associated barriers to their well-being .
Perspectives on Social Political Context of NRPF	From her narration, Charlene was very political and critical of the immigration policies. She remarked that the policy is discriminatory and dis-empowering to her clients. *…mm, also dis-empowering in that people don't feel listened to, ……., especially in terms of accessing services….. because I think a lot of the women I work with, find themselves in situation where they don't really know what they can access, what's available to uhm….* Service users grapple with low self worth and loss of self identity and self dignity *The idea of kind of losing the sense of who you are; before you are someone without recourse; people that have been teachers, lawyers and people that are kind of skilled professions, people with kind of identity in another country, and coming here and suddenly not being able to .. have that identity they start to lose confidence and their self identity* Charlene reported she felt a sense of injustice towards the NRPF clients and remarked that there is a problem with the immigration system *I feel definitely a sense of injustice and I think I have always felt there are people within the system who don't listen to our individual stories and just want to tick boxes and I feel sad* **Huge problem with government agency** *There is a huge problem in our immigration system.* *Home office makes everything difficult, and difficult to understand, all the letters they send are difficult to understand, none of the letters made sense to people even to native English speakers and if they do have to appeal at tribunals, they have to travel all the way to Hatton Cross and Heathrow. It costs money and no considerations for that.* **Government and not professionals is guilty for the chaos in the immigration system**

	…….but in terms of the way our government processes immigration claims, yes, because I think you could get completely lost in the system and people have to wait years and years before decisions are made or their asylum claims get failed and they kind of disappear, they are destitute, they don't have anything, *I think the government needs to address the issues of people that are here, people that have been here, some people say they have been here for years. That is just a life put on hold, they cant do anything, these people want to contribute, they want to work, they want to train themselves, they want to be good parents to their children,*
Emotional Impact on Participant	In her narration, Charlene reported that working with this client group was difficult due to the unique challenges they present with Charlene also experienced transference of the frustration of her clients *Hmm.., there is a kind of transference of their frustration unto you and because as professionals, we kind of especially as social workers, being quite practical emm, so yet it can be quite frustrating* She described her experience as challenging *It is really quite challenging, challenging for us as professionals- so I mean this takes a kind of emotional toll on us , in terms of our feelings and emmm* Charlene reported carrying around the emotional burden of her clients *The families definitely take most of my thinking time which is often times not the families that have most severe mental illness in them and I think because of the overwhelming social kind of situation, it tends to flood your head with…… thoughts of new babies, the future of the babies* *But it is hard, it is hard for practitioners as well, you have to sit with that and you have to kind of realise that that kind of boundaries of your own role in a way or the limit of it, and just thinking about the nature of everything for these people, like housing*,….. *After our last meeting, I just find myself a lot thinking about it, about the families in question. And part because I feel compassion, because their situation are so dire sometimes.*
Perspective on Inter-agency Working	Charlene narration did not highlight any challenges regarding interagency working. This perhaps was due to the special attention on the team because children are

	involved. .
Perspective on Advocacy	Charlene proposed a forum where service users can share experiences *It would be great to have a forum that people could grant interviews on their experiences and how they have been able to access or not access funds, it will be interesting to have a focus group of service users to hear from them, what their issue are with them* Linking service users with community resources that could help them *On a day to day basis, I just try to help people to make them feel a bit more.. be strong for them, or linking them with a group that is helpful because you can't change the home office, you can advocate, but on a day to day, we have to help*
Creative Responses to Challenges posed by NRPF Patients	*(As above) On a day to day basis, I just try to help people to make them feel a bit more.. be strong for them, or linking them with a group that is helpful because you can't change the home office, you can advocate, but on a day to day, we have to help.*
Researcher/Participant Relationship	Charlene and I got on well during the sessions as she demonstrated good understanding of the subject area having worked with refugees and asylum seekers. It was definitely a familiar subject area for her. At the end of the interview, Charlene offered that I could call her anytime if I need her for the research indicating cordiality and willingness to support the study
Researcher's Understanding of Charlene's Narratives	Charlene brought in a new perspective to the research when she brought in narratives of perinatal service users. Perinatal service users have added need, that of care for their born or unborn children in addition to the challenge of MH and immigration. For instance, the emotional impact of mother's depression on their children. I felt Charlene spoke with a lot of authority and conviction. She was political as she condemned the current immigration policies.
Commentary	Both sessions with Charlene were stimulating and revealing. Charlene appeared frustrated and disenchanted about the experiences of this client group against the background of their mental health. Again, I felt Charlene- a professional of white British background showed more interests in the predicaments of NRPF patients than ethnic minority professionals.
Researcher's Reflection	The predicament and need of this client group hit me as I was hearing about their precarious situation for the first time. This thought stayed with me for a few days after. There was also the feel of relief and excitement in Charlene in the

	course of the interviews. It was as if she has been waiting for an opportunity to pour out her mind about this issue. I noticed similar relief in the faces of some other participants. Could the participants have enjoyed unintended intrinsic benefits in the research?

Chapter Summary

This Chapter introduces us to the participants with description of their professional and ethnic backgrounds. This information is presented in tabular form so as to capture at a glance relevant information that will help in the course of data analysis, interpretation and presentation. Their responses were captured along identified themes and categories. The researcher's views, understanding and reflections of each participant were also documented. The researcher is of the view that professionals of black ethnic minority background were not a vocal against exclusionary policies unlike professionals of white ethnic background.

Chapter Five:

Presentation and Discussion of Findings Along Themes

Introduction

The primary aim of the study is to explore the practice experience of frontline mental health workers who work with migrants who have no recourse to public funds. The study seeks to understand the unique challenges these professionals face in their day to day engagement with this client group. It is inferred from the above that migrants with NRPF present with unique challenges because of their uncertain immigration status which bring additional layer of complexity to their already precarious circumstances in the country. In order to address the research questions, my findings attempt to answer critical questions related to the research focus. How do frontline professionals navigate the complexities associated with caring for NRPF service users? What impact does this have on them? What are the implications of this impact on their professional practice? What are the factors that impede or facilitate their effectiveness in caring for this client group? What does the experience of these professionals tell us about the plight of the NRPF service users? These and many more are questions that the research findings illuminate.

As a psychosocial research project, attempts were made to use psychoanalytic concepts and inferences to gain understanding of the emotional and psychological undercurrent of the findings.

The findings are presented here in two different parts. The first part discusses the experiences of the frontline professionals in their work with NRPF service users. These findings are presented along the lines of themes derived from the data following a detailed analysis of participants responses. The second part of the findings looks at how the positionings of the participants reflect in and or inform their experiences and practices. Professionals are known to come to practice with their values and background which inevitably interact and influence how they engage with the role. The section also presents a mapping of a typical service users' journey across different categories of these

professionals to try to under what it means to be an NRPF service user in the mental health service.

i. **Frontline practitioners are vulnerable in their work with patients who have no recourse to public funds**.

Working with service users who have NRPF presents with unique challenges to the frontline MH practitioners. Professionals are confronted with the precarious circumstances where the service users whose conditions were exacerbated by the exclusionary policies of government which make access to basic things of life difficult for the NRPF service user. As our participants reported, this client group has tenuous social support networks that makes their recovery journey difficult. Their access to basic things of life such as food, clothing, housing, employment are inadequate if at all present. This experience leaves the frontline professionals feeling vulnerable having to care for people who lack access to essential things of life. Henry, a senior management staff put this clearly:

It leaves us very vulnerable because you have duty of care to your patients as well. If you have a patient that has got NRPF, ……. but the patient is blocking a bed, what do you do? You know, the whole Trust comes to that conclusion that they have to discharge you to 'find your own square root'[1],….. but it leaves you very vulnerable because they are human beings, it leaves you open.

Here Henry spoke of how the organisation made a deliberate decision to discharge NRPF patients who are deemed to be stable mentally to the streets to fend for themselves. He argued, understandably, that they cannot be on the ward indefinitely because more acutely unwell patients are waiting to be admitted. Professionals are nevertheless aware that discharging patients with little or no support networks and basic means of livelihood would accelerate relapse in their mental health thereby worsening the chronicity of their symptoms and perpetuating the revolving door syndrome.

Henry went further:

We can't keep the patient indefinitely on the ward. ….. they might not necessarily be happy with it. It's probably detrimental to their mental state ….. It

[1] Henry explained it means the patient is to sort out his accommodation and other means of livelihood

is not an easy topic to talk about but sometimes you got to do what you need to do

Anita, a CPN on her part said:

So, you as a professional, you as a nurse, as a care coordinator, as a substance misuse professional, as a team leader, you then look that there is no where to place this client. And you can't take them to your house, you just have to discharge them back to the streets…

She went further:

when a decision is made to discharge someone regardless of whatever the outcome is, is very demotivating, very demoralising, the staff becomes more and more emotional because you are dealing with another human being, who has no means of surviving the basic things…

These professionals presented as emotionally conflicted. They are aware of the implications of discharging their patients without support, yet they have to do it as the the system does not provide a more desirable alternative for them.

Frontline practitioners feel exposed in taking decisions they know may not produce better outcomes for their NRPF patients. Anita expressed her frustration thus:

You know what to do but you cant do it because there is no recourse to public funds for them.. As a health care professional, you feel like a failure because you can't solve the problems, there is only so much you can do. You are not really the decision maker about if they can have recourse to public funds, or they can have this or have that…

The participants expressed they feel helpless and described their experiences as difficult, challenging and disempowering. They expressed feelings of being 'stuck', hitting 'brickwall' and despondence while delivering services to this client group. Henry said:

The difficulties with those group of patients is that ….to transit their recovery to the community especially when they don't have family network or social network that can support. ….. They've got no housing, no benefit which is the key to fundamental living standard.

Chris, a CPN said:

As much as you try to do your job and refer them to the right services or providers or activities to improve their life styles, you are stuck, because for them to have access to those resources, someone needs to have recourse to public funds or have some type of visas to be able to access the sort of services we want them to and this is a very difficult situation

Practice in these emotionally conflicting situations produces anxieties which have to be defended against by the practitioner. These practitioners are daily assailed with contradictions which mobilise anxieties they have to deal with. Melanine Klein (1946) averred that splitting occurs when a person can't keep two contradictory thoughts or feelings in mind at the same time, and therefore keeps the conflicting feelings apart and focuses on just one of them while projecting, suppressing, denying or avoiding the other. Splitting as a defence is a way of managing anxiety by protecting the ego from negative emotions. These frontline practitioners are left with no other option than to *'suck it up*' and as Henry said; '*you got to do what you need to do'.*

ii . Frontline Practitioners carry significant emotional burdens

Working with people involve a significant amount of emotional labour. The nature and context of mental health care make emotional labour inevitable for frontline professionals. Researchers identified various emotional states that healthcare professionals experience as perception of inappropriate care provided to patients (Piers et al., 2011), moral distress (Lamiani et al., 2017), loss of control during the process of patient care (Shapiro et al., 2011), as well as care-related regret (Courvoisier et al, 2013) among others. Participants in this research reported a pot-pourri of emotional states they experienced in their role as frontline practitioners working with NRPF patients. Henry expressed despair about the work and said:

For me as a practitioner, over the years it seems the situation is getting worse and will continue to get worse….

He said further:

I almost feel sometime, you have to be very hard, you have to block out your emotions to make certain decisions. You have to discharge regardless of where they go..

Henry indicated here that professionals are tempted to block their emotions and discharge vulnerable NRPF patients without proper arrangement as to where they go. We do know however that denying or blocking our emotions does not get rid of them. Rather they are temporarily suppressed only to resurface at the slightest opportunity and providing raw materials for emotional instability and ineffective practice. While reporting on one of his NRPF cases, Chris said:

As a fellow professional, I feel for him and as a fellow African and migrant myself, you empathise, and you sort of understand where he is coming from. How his life is. Because I can picture, it is very similar to myself…

Here Chris was caught up in the emotional pain of his client as he identified with this service user and compared himself with him. He admitted that he thinks about the service user even when he is at home after close of work.

Anita put her experience succinctly:

You know what to do but you cant do it because there is no recourse to public funds for them….

She went further:

As a health care professional, you feel like a failure because you can't solve the problems, there is only so much you can do. …….as I said earlier, it makes you feel you have not actually completed your job because of all these immigration issues.

In an opinionated assessment, Anita concluded*:*

So mental health practitioners, when they come in contact with clients with immigration issues, they are not fulfilled in delivering care to this client group

These participants by their accounts appear to be experiencing some form of moral injury. A professional can experience moral injury due to their own personal or other people's acts of omission or commission. It can also be as a result of betrayal by a trusted person in a critical situation. Moral injury threatens

one's deeply held beliefs and trust and can trigger negative emotions which may impede effective delivery of service. (Williamson, V et al 2021). Moral injury has been described as a strong cognitive and emotional response that occurs following events that violate a person's moral or ethical code. Moral injury can cause profound feelings of shame, guilt, self condemnation among others.

iii. Conflicts and Contradictions: Systemic Challenges of Frontline Work with NRPF

Frontline professionals practise their trade within the context of organisations which provide the platform and administrative guidelines which are designed to achieve the *raison d'etre* of the organisations. While professionals are accountable for their practices, the organisational setting within which they operate plays significant role in defining and shaping their practices. At the micro level, the structure and the culture of an organisation are crucial to service delivery. At the macro level, the sector within which the professionals operate equally plays significant role. For instance, the National Health Service- NHS as a dominant force in the health and social care sector has standards and culture which all Trusts and organisations within it subscribe to. At the national level, the national laws and government policies have overarching influence over all organisations and institutions within the country. Organisation's policies must reflect and align with the laws of the land.

However, professionals working in the frontline often experience conflicting demands from various authorities or roles. Their professional roles and responsibilities towards the public may come into conflict with new policies, organizational rules or administrative guidelines. Meanwhile, it is expected of them to implement and follow these policies and regulations and abide by their professional values while servicing the public and their managers - whose demands may diverge considerably (Maynard-Moody & Musheno, 2003; Hill & Hupe, 2009; Lipsky, 1980)

Cooper, T (2012) argues that public administrators mostly experience moral conflicts through role conflicts. Cooper noted that, the concept of roles is a convenient way to package expectations and obligations (Cooper, 2012) it is in these roles that we exercise responsibility and are held responsible by others.

Katz and Kahn (1978) define a role conflict as the simultaneous occurrence of two or more role expectations such that compliance with one would make compliance with the other more difficult.

Tummers *et al.* (2012) identified four essential role conflicts frontline professionals face when implementing public policies. In these conflicts, values and responsibilities from the public, the law, the public organization and the professional are at stake. The role conflicts are:

The policy – professional role conflict. Here, the policy content communicated by the government is in conflict with the professional values and attitudes of the professional (think for instance about morally loaded policies here, such as on abortion). Policy contents are often laid down in formal rules and regulations and may be implemented in a top-down way without consulting professionals in the field (Hill & Hupe, 2014).

The policy – client role conflict. Here, the policy content communicated by the government is in conflict with the needs and expectations of the citizen. For the professional, the role behaviour demanded by the policy content and the citizen are not compatible.

The organizational – professional role conflict. Here, the role behaviour demanded by the public organisation regarding policy implementation is not compatible with the professional values and attitudes of the professional. Public organisation demands are expressed through managers, or other organisational members creating the ethical environment (Menzel, 1996). Economic regulation of the organisation might conflict with the professional's values, for instance, when efficiency is preferred over the quality of service.

The professional – client role conflict. In this conflict, the values of the professional are not compatible with those of the client. In our case, a professional denying a homeless NPRF mental health patient an accommodation because of his immigration status is a typical example.

The experience of participants in navigating organisational and institutional environment they operate in are telling. Generally, it was evident that institutional boundaries which are largely driven by primitive processes like splitting, projections, denials and other defence techniques were pervasive.

Participants experienced difficult interagency working as services invoked national policies to justify discriminatory practices including non-provision of services to NRPF service users. There were reports of paucity of resources as justification for non-provision of services to this client group. Participants also reported cases of selective interpretation and application of government legislations to deny service provision to NRPF.

Anita recounted her experience of the challenges she faced in referring one of her NRPF cases to other services without success because the service user had no recourse to public funds and no agency was willing to fund her placement.

She needs a comprehensive package, …. where she gets care 24 hours to stop her from harming herself or trying to kill herself, but because of funding, no one wants to pick her up. Because if you look at it, I can't even complete referral……. her care needs are not being met

Frontline professionals felt ignored by colleagues in other departments/ services when the case has NRPF elements. Again Anita narrated her experience while handling an NRPF case:

I was sending emails to the children social worker, they were just passing me around. In two weeks, nothing has been done. If they have got their immigration status right, its like picking up the phone, calling the council to come and help them control the bed bugs,……..

These are the sort of treatments frontline practitioners experience when they are dealing with NRPF cases.

Henry on his part reported on what happens when NRPF patients are about to be discharged from the ward:

What do you do as a service? ….because when you get in touch with local authority, they wash their hands as they have no recourse to public funds. Local Authority are very quick to wash their hands-off issues like that. They feel they have no responsibility….

There is a culture of rejecting referrals of NPRF clients by other services on the ground that they have no recourse. This appears to be an extension of how the society rejects them through discriminatory legislations and anti immigrant commentaries in the public arena.

Even within the same organisation, boundaries are created to shut out colleagues who are dealing with NPRF cases. Henry reported:

The CRT wasn't willing to take him because they said you have to have recourse to public funds for you to have CRT.

In these examples, professionals were left with the emotional burden on trying to work out how best to support their service users who are being denied what they believe would meet their assessed needs and ameliorate their conditions.

iv**. Discretionary Practices in the Frontline:**

In his seminal work 'Street Level Bureaucrats', Lipsky (1976) had argued that front-line workers contribute significantly to policy making through exercising discretion in their everyday work and that this involves a responsibility for policy delivery, and also to engage with service users and the community. He argued that 'policy making does not simply end once a policy is set out' and commented that 'in important ways public policy is actually made in the crowded offices and daily encounters of frontline workers. Lipsky averred that discretion is required in order to apply rules in specific cases because situations are often too complex to be reduced to programmatic formats. Secondly, some situations require public employees to make judgements about people; and thirdly, discretion 'promotes workers' self regard and encourages clients to believe that workers hold the key to their well being' (Lipsky, 1980, p. 15). Finally, some frontline employees must operate independently of direct supervision as they carry out their tasks. Lipsky identifies a number of strategies that characterise the discretion of frontline workers- routinising, modifying goals, rationing their services, redefining or limiting the clientele to be served, asserting priorities and generally developing practices that permit them to process the work they are required to do in some way', often in the context of severe limitations on personnel and organisational resources (Lipsky, 1976, p. 207). Lipsky acknowledges that the content of policy and its impact on those affected can be substantially modified during the implementation stage through the discretion of street-level bureaucrats. As such, the distinction between policy as political input and implementation as administrative outcome becomes blurred. In line with Lipsky's postulations, the research participants employed diverse discretionary strategies in their engagement with patients with NRPF as shown in their narrations.

It has been argued that frontline decision makers do apply discretion in a flawed or discriminatory fashion to effectively undertake the role and that the ability to reshape policy intentions, deliberately or otherwise, was viewed as being further assisted by the ambiguous nature of legal directives (Lipsky, 1980). Negative discretion have been attributed to a complex mesh of individual, intersubjective and institutional factors. On the other hand, Foster (1983) had argued that far from service users benefiting from discretion, inequality of outcomes were embedded in its practice. Chris reported he spent more time attending to his NRPF service users than other service users:

Because I spent a lot of time, above and beyond what I was required to, trying to help him. If I have to put it in percentage-wise, if all my patients have a certain amount of time, I will always spend more time with him because I wanted to help him more

You give more time to them. You are a human being at the end of the day, you want to know, has this person eaten? have they drank? how have they survived through the day? So you devote more time to them

Anita also reported:

…. like signposting them to charity organisations or churches who can help. …… these are the only people who can help people with no recourse to public funds like churches, some charitable organisatons who provide food like food bank, hot meals. But these are just for those who are in crisis

Henry as bed manager said:

So, the only option left for mental health to support is to put him in a bed and breakfast. And what the Trust tends to do in that aspect is to seek alternative arrangement where maybe you might book a temporary B&B

Henry commented further on patients who are mentally stable and willing to return to their countries:

Yeah, I mean we've been in situation where we have had to buy tickets off our budget to support people to go back to their own country if they wanted to

Professionals also reported how they used advocacy to secure support and services for their service users.

These are not prescriptive responses but discretionary moves to deal with challenges these professionals face in the frontline.

As argued by Foster (1983) some discretionary action may engender inequality or discriminatory, the frontline professional would have to live with consequence of his decision should there be any fall out or backlash. While working with BO, and faced with his precarious condition, I always had the urge to advise him to consider taking up a cash- in- hand job in car wash, small scale construction or corner shop to earn money to sustain himself. Lipsky (1980) rightly observed that when such policy distortion are discovered, workers are often castigated for thwarting policy intentions.

v. **Chapter Summary*:***

This chapter has presented the first part of the research findings with copious reference to extracts from the participants transcriptions. All participants (I would say and the researcher) expressed some form of vulnerability due to the nature of the tasks they engage in. Dealing with consistent anxiety provoking situations exposes the practitioner to painful psychic experiences especially when they are directly in contact with the service users. As indicated in my practice experience (Chapter 6), working with BO also made me feel vulnerable as the complications of his visa application reminded me of possibility of being refused when mine was due for renewal just in a few months away. It also reminded me of how people's dreams can just fizzle away due to one unfortunate incident. In fact, a reminder of how precarious the life of an unsettled migrant can be

Closely related to the above is the fact that participants perform their duties in an emotion laden environment, both organisational and relational. Mental illness has a lot to do with relationships, both within self, carers, others; and the environment. All these forms of relationship have emotional dimensions to them. Many participants expressed lack of fulfilment, self blame, anger and feeling responsible for the harsh treatment.

Participants experienced conflicts and contradictions due to vague and ambiguous policies they have to implement in the frontline.They also experienced role conflicts in the frontline.They reported they having discretionary powers which they are able to exercise in their frontline work

We now turn to part two of the findings emerging from this research.

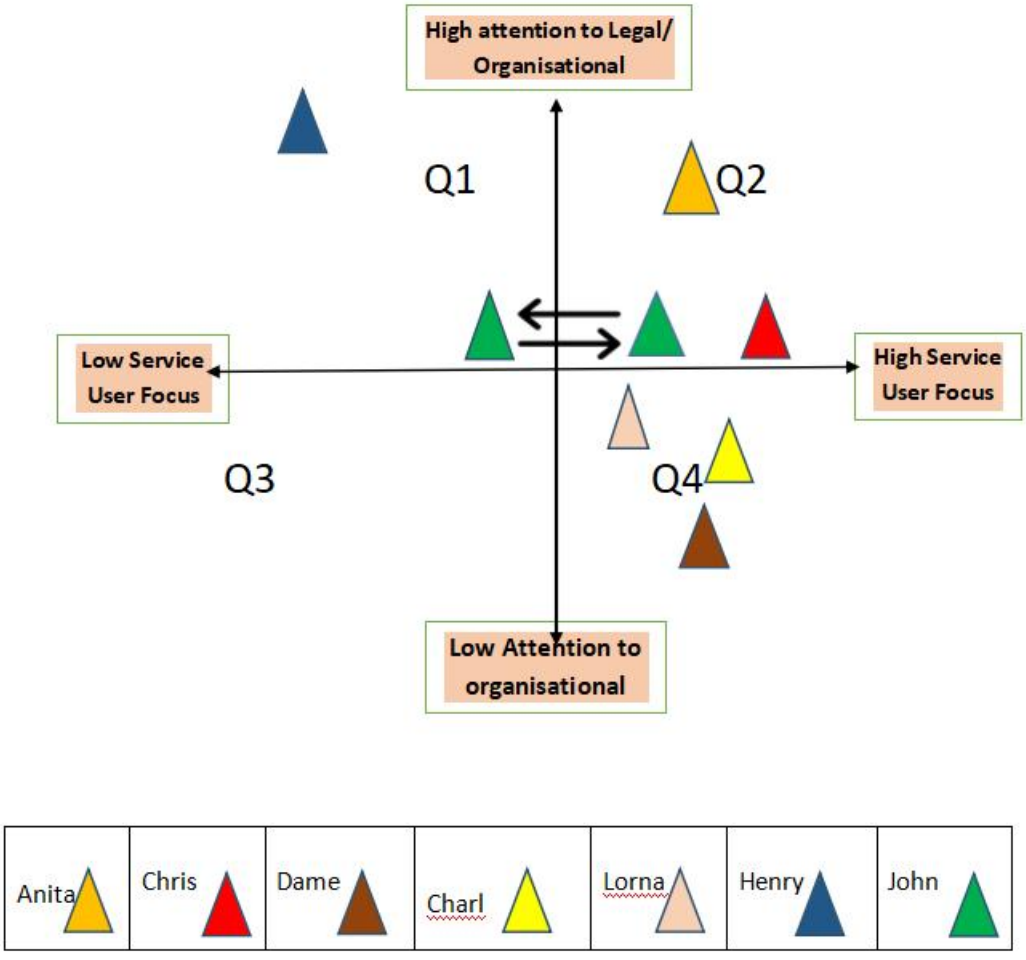
Chapter Six

Case Presentation and Findings 2:

Discussions on the Perspectives and Orientations of participants.

This section addresses further findings in the research as it relates to the positionings of the participants to enable us draw inferences on their perspectives and practice orientations. Research has shown that professionals' perspectives about their roles are influenced by multiple intricate factors. From the data, four different perspectives were identified into which the participants can be categorised. See Fig 2

Fig. 2 Diagram showing professionals Positioning and Practice Orientation



Quadrant 1.

High attention to legal/institutional perspective and Low Service user Focus:

The data showed four participants demonstrated high attention to institutional rules and regulations in their practice experience. These participants appear to be more inclined towards institutional rules and guidelines in their work with NRPF. These participants behaved in a more legalistic way and justify their practice on the organisational or government policies. These participants populate the upper sector of the diagram. The sector was again divided into two to form quadrant 1 and 2 to reflect the service user focus of the participants. Quadrant 1 represent those whose practices focus more on organisational or government policies but less focus on service users' welfare. Participants in this quadrant may attribute reasons for exclusion to policies. Practitioners here tend to adhere strictly to what the policies say irrespective of what happens to the patients. Two participants, Henry and John fall into Quadrant 1. Here is Henry's narrative:

> *And sometimes as a practitioner, where the LA says they can't provide housing, what do you do? I almost feel sometime, you have to be very hard, you have to block out your emotions to make certain decisions. You have to discharge regardless of where they go. And this is something that the organisation has to assist with. That is it.*

To strengthen his view about this, he argued:

> *Local Authority I think they, …are being squeezed as well, they are trying to save money, they can't provide services to people who are legal not to talk of people who are illegal. There is shortage of housing, education the same thing. Local Authority are very quick to wash their hands-off issues like that. They feel they have no responsibility*

From the above, Henry has unconsciously constructed a narrative of exclusion by branding these service users as 'illegal' who are less deserving as 'legal' people. By this dichotomy, Henry would probably be less concerned in allocating resources to NRPF service user when he is faced with resources scarcity.

John hinged his argument on cost and resources:

Obviously there are those cost implication which is very obvious. You mentioned about feeding, yes and apart from that even the bed space they are occupying because to the Trust, each bed space cost about £300 to £320 per day. When you're looking at such patients their discharge, being delayed by one or two weeks. When you multiply out then you can see how much money the Trust is losing in terms of that.

It should be noted that both Henry and John have a couple of things in common which may have played a role in similarities in their perspectives and orientations. They are both migrants of black ethnic background. Professionally, they are both clinically trained health care workers- Henry is a psychiatric nurse and John a consultant psychiatrist. Both of them are senior management staff and their work setting is inpatient. All these may have influenced their views

It is pertinent to note also that even though John flip flopped a couple of times it suggests that he is more service user focused than Henry.

Quadrant 2.

High attention to organisational/legal issues with more service user focussed.

Participants in Q2 like those in Q1 also showed high attention to organisational/legal issues in their practice. However, their practices are more focussed on service users than participants in Q1. Participants in this quadrant are more sympathetic and tend to identify more with service users notwithstanding the high regard they have for government and organisational policies.

In demonstration of her high regards for policies, Anita said

You are not gonna blame the system. Things are not as rosy as it used to be, …...So, it's like the funding that is meant for the citizens, that contributed to the society is being scattered all over the place. …Like the client I said I had, …. she never contributed to this country. …… if they have to look at it from human rights, they will treat her, but when they keep using human rights law to treat people that come from abroad, by the time people who have contributed to the society need treatment, there will be no funding remaining to treat the citizens. That is why I won't blame the government for putting a tight law on that

Chris on his own experience said:

For me, I remember I was having sleepless nights knowing that I have somebody out there who really, really needs the support. I can give him that support but then, I am unable to do that because of ABCD and obviously, the law doesn't allow me to do that.

Anita spoke about her practice:

You find sometimes you always go extra mile. I always find myself going extra mile looking for non-profit organisations, charities who could help in any form

These professionals' practice orientation appears to be more inclined towards strict observance of institutional/organisational policies. Data also revealed that these participants presented as conflicted as reflected in Chris' statement above. It is interesting to observe that both Anita and Chris are of black ethnic background. Professionally they are both community psychiatric nurses and their practice setting was in the community where they work as care coordinators.

The practice of these two participants are characterised by self sacrifice and going out of normal call of duty to provide hands-on practical support to their clients. They both gave examples of spending their own money for service users, spending longer hours with them and raising resources from colleagues for them.

Quadrant 3:

Low Attention to organisational policies and low service user Focus

This quadrant represents those who have low regard for organisational policies and low customer focus. In this study, none of the participants fit in to this quadrant. This is a significant finding in that, health and social care professionals are required to imbibe the six Cs of Care which are care, compassion, competence, communication, courage and commitment which are the values which should be at the core of all organisations delivering care and support. It can therefore be inferred that participants in this research subscribed to these tenets albeit to varying degrees. However, Giami (1996) has pointed out that, "don't know" and non-responses are relevant research materials since they may represent a statement of the subject in response to

the approach and the questions of the researcher and have the potential to provide crucial insights.

Quadrant 4

Low Attention to institutional policies but higher service user focus:

These are participants who demonstrated low attention to legal and institutional perspectives. Some of them actually presented as critical and queried the rationale behind exclusionary policies targeted at the NRPF patients. This category of participants considered that exclusionary polices are at variance with their professional and personal values. There are 3 participants clustered in this quadrant; Lorna, Charlene and Dame. Charlene said;

Yes. I feel a definite sense of injustice. I think I've always felt that in recent years that people are within a system that doesn't listen to their individual stories, and just want to tick boxes and fill certain quotas. Actually, people aren't seen as their individual cases. That can be very frustrating. On a much wider level, it's a huge problem with our immigration system.

She went further:

The home office makes everything difficult to understand. All the letters they send are difficult to understand. None of the processes makes sense to people even to native English speakers. If they do have to go through appeals and tribunals, they have to travel all the way down to Hatton Cross, Heathrow and it costs so much money.

While holding the government culpable for the experience of NRPF patients, Charlene remarked:

I don't feel personally or professionally responsible, but in terms of the way our government processes immigration claims, yes. People get completely lost in the system and people may claim asylum and then wait for years and years before decisions are made; or their asylum claim gets failed and they disappear and they're destitute, they don't have anything.

The home office says it wants to be strict and enforce immigration controls but actually what they're doing is just failing asylum people. …. The government needs to address this. ..some of my cases I talked about have been here for 15 years. That's just a life put on hold and they can't move forward….these are people that want to contribute. They want to work, they want to train themselves, they want to be good parents for their children.

Dame in her contribution said*:*

….. it's like this gentleman …who's volunteering five days a week, ... Then he was told by the immigration office that he's not allowed to work. It just seems 'bonkers'. If people .. they're willing to work, they want to give to their society, their community. They want to be productive with their lives which is so important for recovery and even if they show that motivation, they're not allowed to. They're stopped from doing that. It seems to go against all kinds of logic for me. Let alone the fact that it's cruel and mean to people to force them to be dependent members of society.

On her part Lorna expressed her frustration at the discriminatory treatment of her NRPF clients:

They're human beings. It doesn't matter where I come from. Where I put my hat. I'm a human being, I'm entitled to be treated like one. I just find that I get really frustrated with the constraints of, "Oh they have to be discharged" or "They can't have this or that'

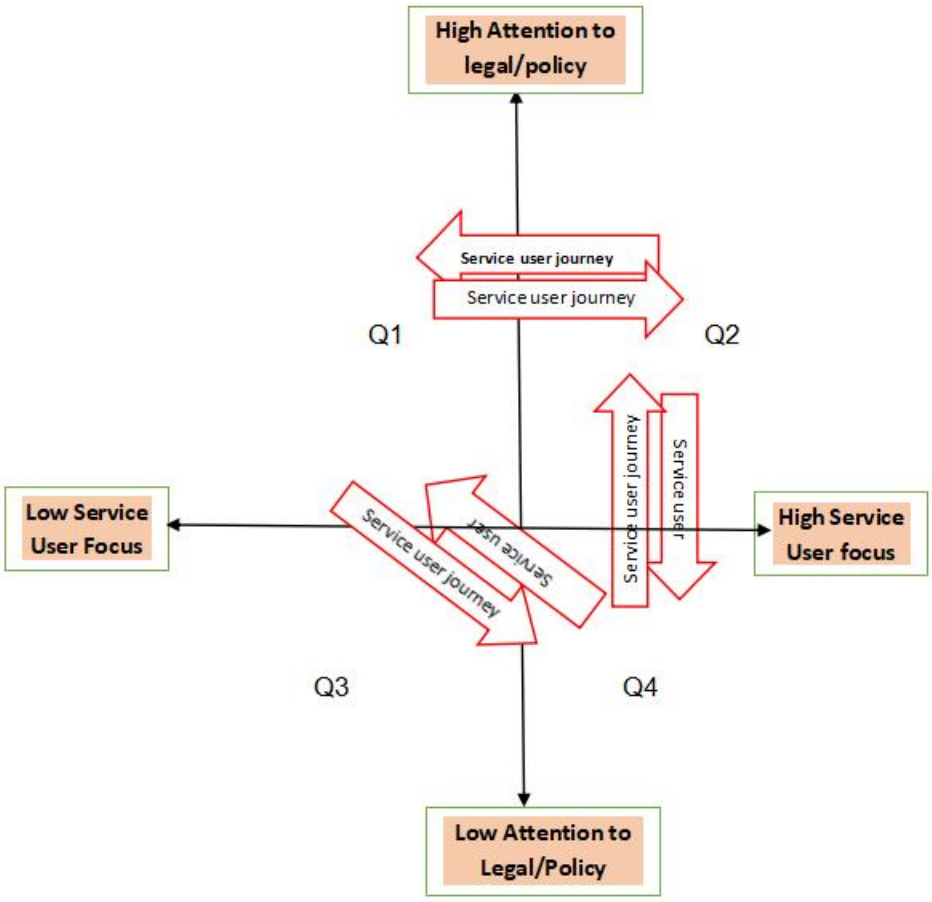
The three participants in this quadrant shared a lot of things in common. They are all white British ladies and their practice settings are in the community mental health services. They are non clinical practitioners- two of them are social workers- Lorna and Charlene; and the third person Dame is an Occupational therapist. I would argue that their ethnic background, practice setting and professional training are responsible for their perspective and orientation. They were more vocal and authoritative in expressing their views

Mapping the journey of a typical service user across the 4 Quadrants

In this section, an attempt will be made to map the journey of a typical mental health service user across the four quadrants in order to understand what sort of experience the service user would have. Perhaps the pertinent question to ask is, what is it like to be a service user in the hands of professionals across these quadrants? The experience that a person has of their care, treatment and support has been described as a cornerstone of high-quality care.There has been a drive to improve people's care experiences with emphasis on what is most important to the patient.

Figure 3

Diagram mapping Amlika's journey across Across the 4 Quadrants



The CQC's 2020 Community Mental Health Survey finds poor experiences were reported by mental health service users for support and wellbeing, crisis care and accessing care. (CQC,2021).

In mapping this, I would use Amlika, who happens to be one service user whose stories were presented by three participants- Anita, Lorna and Dame even though unknown to each other. Amlika encountered these three professionals at different stages on her care pathway. The 3 professionals have different practice perspectives and orientations. (see Fig. 2). While Anita practice orientation was located in Q2, Lorna and Dame belonged to Q4. They all belong to different community based teams. As reported by one of the participants, Amlika is a Bangladeshi lady who suffered brain injury following a fit after the birth of her child. She was discharged from the ward after treatment and would have probably have had an encounter with John and Henry whose practice orientation are located in Q1. Amlika would have met with John- a consultant psychiatrist whose practice is more inclined towards compliance with institutional policies and wavering focus on service user. John presented as conflicted and this would have affected how he attended to Amlika on the ward particularly if her discharge was delayed because of lack of accommodation due to her NRPF status.

Prior to discharge from the ward, Amlika would have probably had contact with Henry whose practice is driven by how to control organisation's costs through efficient bed management system. Henry would have facilitated prompt discharge of Amlika to a bed and breakfast if she did not have a tenancy provided by Children services (as we learnt from Dame).

Lorna (Q3) worked with Amlika and her family as a member of the home treatment/crisis team following Amlika's discharge from the ward. Lorna reported how Amlika's husband had called her at night after he was asked to leave the country by immigration officials. Immigration officials had asked him to leave his wife and children in the UK not considering he is the carer for them.

Lorna said:

He came back that night and he called me;... come, I want to talk to you," He was crying. .. I felt really sad for them, because I felt like we had contributed to the government being even more wicked.

Lorna provided listening ears to Amlika's husband in their moment of crisis and reassured him. She felt professionals have contributed to the family's predicament.

Lorna summarised her view thus*:*

But personally, I just felt really really sad for them… it really affected me. To see a family that they wanted to rip apart because of a genuine illness.

Lorna's practice orientation was more focussed on the wellbeing of service user. She was sympathetic to them and supported the family. This encounter would have been a departure from what Amlika and her family experienced during their encounter with professionals in Q1.

Amlika's next encounter with a professional was with Dame who assessed the family for support in the community setting. Here Dame in her encounter with the family said:

In terms of no recourse, it's like this gentleman, who I assessed his wife, who's volunteering five days a week,... He was working, then he was told by the immigration office that he's not allowed to work. It just seems bonkers. ..they want to be productive with their lives which is so important for recovery and even if they show that motivation, they're not allowed to.

Dame's attitude was more supportive of the man's desire (Amlika's carer/ husband) to work rather than living in destitution or on handout from people. She even described the policy as *'bonkers'.*

Next encounter was when Amlika*'*s case was allocated to Anita (Q2) as care coordinator in the community recovery team. Anita in her narration spoke extensively about Amlika*'*s case and the mixture of emotions the case evoked in her.

Anita said:

I find myself going round my colleagues, asking them if they could give me food voucher. …. I personally went to collect the food for them, those groceries they gave to me? It wont be enough for 2 weeks.

Here, Anita recounted how she provided practical support for Amlika and her family and the frustration she faced in the process. Anita demonstrated compassion and care as the care coordinator to Amlika.

Still emotionally burdened by the case Anita reported:

Am not going to judge about that, am not an immigration officer, but with my own job as care coordinator, as health practitioner, it makes my job quite difficult to work in that kind of environment. I went there the other day, the house was infested with bedbugs, it was heart breaking…

Conflicted, Anita continued in her narratives:

'….. *but at the same time, you can't blame the government because they have not contributed anything to the country…to the welfare of the country, the taxes, they pay taxes somewhere else and they have come to live somewhere else..*

Still commenting on Amlika's case, Anita said:

….. but she never contributed to this country. She never paid anything …. This is a woman that if they have to look at it from human rights, they will treat her, but when they keep using human rights law to treat people that come from abroad, by the time people who have contributed to the society need treatment, there will be no funding remaining to treat the citizens. That is why I won't blame the government for putting a tight law on that. But it is sad for me.

These variegated, flip flopping positions and attitudes among professionals characterise the care pathway of a typical service user. There are inconsistencies and contradictions within and across services. These experiences may leave a service user confused, unsettled, suspicious, with distrust and lack of confidence in the system.

It should be pointed out that a typical patient can move across any quadrant any time depending on his or her presentation. For instant, he could move from Q1 to Q4 and vice versa or from Q2 to Q1 or to Q4 and vice versa.

The above conflicted and contradictory experiences of frontline professionals are consistent with the researcher's practice experience as relayed below in his encounter with an NRPF service user

Researcher's Frontline Practice Report and Reflections

As a follow up to my personal history in the introduction, I was motivated to research this area following my encounter with BO, a service user I worked with in 2016 for about 10 months. BO was 29 year old male who came to the UK on student visa to study. Following a relapse in his mental health due to non compliance, he violently assaulted his mum and his brother both of whom are UK residents. He was consequently admitted to a medium secure hospital unit for treatment for about 15 months under section 3. His family did not want to press charges. During this period, his student visa expired. On discharge he was placed in a social services funded supported accommodation under MHA s117 aftercare as he was restricted from returning to the family house. He was placed on stipend of £130 fortnightly by the local social services. He continued his studies pending the outcome of his visa application and subsequent appeal.

I discussed below highlights of my encounter with BO with focus on three of several meetings including my reflections and inferences.

I have had two introductory and exploratory meetings with BO**.** We used these to get to know ourselves, set agenda, and clarify the purpose of the weekly meeting and what BO would like to take away from the meetings.

In the third meeting, I laboured to shift our focus from interrogatory approach and rather use the space for thinking and exploring feelings. I noted we were unconsciously defaulting to obvious and practical issues. Reflecting on these sessions, I noticed that my interaction with BO focussed on addressing practical prevalent issues and concerns in BO's life. I recognised that we were being defensive as we were both preoccupied with why should his University stop him from attending classes, how to resolve immigration problems, why did his appeal fail and how he needs a better solicitor and concerns about his near destitute status. In fact we were responding to dominant mode and giving much attention to all social and welfare issues and how to resolve them, at the expense of feeling and thinking. This confirms the notion that it is difficult to tolerate psychic pain leaving us to acting rather than thinking, servicing rather than serving. Waddel (1989) argued, servicing (acting) urges itself as a

substitute for serving (thinking) because the *not acting* or *serving (*thinking*)* brings us in contact with feelings which are very hard to bear.

As I managed to steer the meeting back to focus I was nevertheless left emotionally enmeshed in BO's predicament and swamped by what I perceive as the enormity of his problems. It was as if I have acquired BO's feelings which are now lodged in me leaving me emotionally unsettled- angry, disappointed and helpless, via projective identification. Trevithick (2011) described the situation as the professional being mobilised by the client to act on his or her behalf. As a mode of communication, projective identification can convey aspects of client's emotional state, which the client disowned or not in touch with. It was as if BO was conveying to me feelings and thoughts which he could not verbalise. Practitioner/client relationship has been described as a communication bridge which provides a vital link across two worlds: the world of the practitioner and that of the service user where empathy and self knowledge act as central tools from which to read the similarities and differences that lie within and across these two words (Sudbery, 2002)

I recalled that in one of the previous meetings, BO narrated how as a toddler, his step mother had physically and emotionally abused him after the departure of his mother to the UK. He also recounted the sense of loss and loneliness he experienced when his brothers departed to join his mother in the UK leaving only him Nigeria. He reported how he was unsettled and was alternating between his maternal grandfather's house and his father's house. Taylor (1999) posited that how we perceive people's 'narratives', and the meaning people give to their experiences within and across different worlds is important. As I reflected on BO's case I noted the important role that past relationships might have played in his current difficulties. Howe(1998) has argued that the poorer the quality of someone's relationship history and social environment, the less robust will be his or her psychological make-up and ability to deal with other people, social situations and emotional demand. The importance of early childhood experiences on the development of personality cannot be overemphasised (Fonagy, 2002). Attachment theory has explained that unwilling separation and loss give rise to many forms of emotional distress and personality disturbance, including anxiety, anger, depression, and emotional

detachment (Bowlby, 1979). BO's early separation from his mother (care giver) and two brothers has probably left a debilitating impact on his psyche.

In addition, research has shown that early experiences of abuse and neglect have long term impact on children's ability to reflect on one's own and others experiences (Music, 2002). Psychodynamic concept of object relations highlights that internalisation of early experiences of a child affects how the child engages in relationships, and with his environment (Gomez, 2007). I realised that BO's childhood environment was not ' a good enough' or enabling to support the development of an emotionally healthy individual.

In a subsequent meeting I noted there was no perceptible relief in the burden I felt for BO as I felt helpless and incapacitated as a result of which I almost suggested a rescheduling of the appointment as I felt exhausted and did not want to attend the session when I was informed of his arrival. I began to query if the sessions are of any benefit to either of us. I had thought coming to UK presents BO an opportunity to make a clean break from the past only to be bedevilled by another round of multiple and multi-layered crisis. I felt responsible to sort him out regarding getting a job, getting his visa through and ensuring his mental health is stable. Trevithick (2003) noted that the suffering caused when people feel abandoned, unwanted, lonely, uncared for, isolated, can be unbearable, as it leaves people feeling depleted, empty, de-energised, lacking in motivation, and without a sense of hope and optimism about their life and future. Over the weeks, I have noted that BO always yawns intermittently as if he had sleep deprivation. But he has consistently denied any form of sleep deprivation. Is this a communication of exhaustion?

In his account I noted BO has experienced a lot of rejection; from parents (mother had left him behind in Nigeria when she came to England for medical treatment with his two younger siblings) , and friends due to stigma of mental illness while in Nigeria. In the UK, the rejection continues: since his admission to hospital immediate family members are not warming up to him, his university rejected him, the government through Home office rejected him, the justice system (loss of appeal), employers/employment agencies (no right to work) and the social services equally rejected him. In an apparent counter transference reaction, I also felt helpless and rejected within me.

I became aware of the dynamics at play in this relationship and tried to understand what might be going on below the surface within me and between us- BO and I. I noted that BO and I share a number of things in common and these might have taint my perception and subsequent feelings. Much more than being a caring and empathetic social worker and care coordinator for BO, could I have been influenced by sameness of nationality as BO? If I have come from a different country or if I were to be a social worker with white background, would I have been as absorbed by BO's predicaments as I had? Secondly, like BO I am also an immigrant in the UK who is looking forward to favourable treatment from Home Office. We both are students, we both share the same faith and we both experienced separation from our parents as toddlers. Trevithick (2003) noted that in understanding counter transference, we run the risk that our own unconscious, unresolved fears and fantasies may enter the picture, to blur reality and our accurate reading of the situation. With reflection, I realised that I needed to sift what is mine and what is being projected to be if I stand a chance of supporting BO in this task.

In addition this session brought to fore issues that triggered powerful emotional feelings in me as it reminded me of my own vulnerability as a migrant whose rights to live and work in the UK were subject to immigration control. I wasn't sure what awaits me in the hands of home office bureaucrats when my renewal is due in a few months away. In addition, it reminded me of my childhood days when I was raised by my maternal grandmother away from both parents and the impact this has on me. Cooper (2012) noted that true emotional contact with our clients involves the necessity of losing boundary between ourselves and then recovering it. The immediate challenge for me therefore, I thought, is to regain and preserve my emotional boundary to enable me help BO by guiding him to develop his capacity to feel and think. Bower (2005) posited that the aim is not to cure but to give the patient insight into aspects of himself and what is going on in their mind and that understanding the truth about oneself is potentially liberating and allows us more control of aspects of our lives. The practitioner contains the disturbing emotional experiences in him thereby allowing meaning, sense and understanding to take shape. Bion (1962 cited in Trevithick, 2011) is of the view that it is the growth of the capacity for thinking about emotional

experiences which enables the individual to learn thereby becoming a different person with different capabilities from the person of the past.

The next meeting reminded me that there is some strength lying below the weakness and vulnerable nature of service users. I noted that BO arrived and his mood was quite bright than what I have known of him. I thought he has had some good news from Home Office or from his university. On direct questioning, he said he has just bought an iphone set. I felt lost, thinking how on earth could he afford an iphone in spite of all he is going through? I later thought, what is wrong with a service user being happy? Perhaps I have been conditioned by my work environment and especially interaction with service users who are hardly seen to be happy whenever they visited the office for clinic or review. My thought here was more of how on earth can you be happy in spite of all that is going on in your life? My construction of service user and especially mental health clients appears to be suggesting, though erroneously, that service users cannot be happy. We all have prejudices about groups and individuals and these determine how we perceive and respond to them. A practitioner's response can be a transference which re-enacts some aspects of the patient's past (Casement, 1985). I felt I was sort of condescending to BO and unwittingly re-enacting the past abuse he had endured.

My reaction when BO told me he has just bought an iphone was also a betrayal of the warped image of BO I was carrying in my mind. The image of a weak, dependent and vulnerable person who has lost personal agency. On reflection, I realised that practitioners, like mothers, may want to be protective and in the process rob the client of opportunity to grow. Capacity develops through action or shrinks through neglect, and can be limited by repressive action or attitudes of others and by failures in development in oneself, (French 1999, p. 1218, cited in Trevithick, 2003). It was as if I think BO cannot afford an iphone based on my knowledge of his limited access to resources and his current needs. The image I had was that of a victim (BO) who needs as rescuer (me) from the grip of the system- the government and its agencies as perpetrator. I noted this narrative in BO statements: *if only the Home Office can grant my visa; this government is unfair to me; my detention in hospital caused all these etc.* There was no reference to personal agency or acceptance of responsibility. Karpman Drama

(1971) triangle described the victim's perception of himself as being helpless and hopeless and denies responsibility to change their negative circumstances.

BO told me he has contacted the Home Office via telephone and letters to follow up his application for judicial review of his case. I commended him for this and noted his resilience and fighting spirit. Contrary to the image of vulnerable person I had, I realised that BO has some strength which if identified and nurtured could help build his capacity for change in his condition.

However, BO's response when I asked what alternative plan he has in case his request for judicial review is refused is a pointer to the fact that he was in denial and unable to think about it as it is a painful subject to bear. This seems to be precluding his ability to think about the possibility of his application being refused or having any future plan. Using denial or pain avoidance as psychological defence; while they may provide temporary relief, it dispossesses the individual of creativity and capacity to make plans to effect change in their condition.

Following my advice to BO to consider alternative plan (s) in case his request for judicial review is refused and the sudden change in his demeanour, I began to wonder what sort of image BO holds of me. That is, what have I become to him? What is his perception of me? Does he see me as a helper to replace lost comfort and care giving authority figure? Or am I a representative of the state in whose hands he has experienced a string of rejections? His image of me will go a long way in determining the quality of our relationship and what we make of the encounter.

BO and I seem to have started developing a mutually beneficial therapeutic relationship. I was receptive to all the avalanche of emotions being projected unto me in this engagement. Employing different defensive strategies, he unconsciously communicated his feelings. Despite tempting invitations to abandon the primary task to attend to practical dominant issues, we managed to stay on course even though with minimal progress.

While BO appears to be coping well outwardly, I felt he needs to develop his capacity for reflection and thinking. He has shown consistently his lack of interest in this endeavour and would rather act to defend. The difficulty of

engaging with his internal self might not be unconnected with the quality of relationships he had encountered from childhood. I felt BO's internal container was not robust enough to host the anxieties generated and therefore unable to tolerate the pain and distress accompanying it. He would therefore rather defend against it. He wanted his visa, wanted a job, wanted to return to University to complete his course, he wanted to be financially sufficient- all at the same time.

BO and I plan to continue with the sessions and hopefully get BO to where he is able to build capacity to develop thinking and feeling skill for personal growth. In a dramatic move however, two weeks after our last meeting BO left the country without informing me or any of his clinical team. He did not inform his mother and siblings either. He only called the staff of his supported accommodation when he arrived Lagos to inform them he has arrived Lagos. He contacted me a week after his departure to inform me he is fine and well.

I carried the sense of loss for a considerable period of time as I ruminated on what I could have done differently to help him. I wondered how much prospects and opportunities he would have had if his visa was granted and or if he was able to secure an employment. I still remember his case from time to time as an unfinished job.

Chapter Summary:

This chapter highlights more findings in the research. It introduces us to the perspectives and practice orientations of the participants. While some are more inclined towards institutional or legal compliance in their practice, others are less inclined. Nevertheless, most of the participants are service user focused. The research also shows us that the ethnic backgrounds of participants may affect their perspectives towards legal/institutional policies around immigration issues. While participants of black minority ethnic backgrounds occupied Quadrants 1 and 2 which indicates that they are more rule following and inclined to legal/institutional policies and regulations on immigration, participants in Q4 all of whom are white British ladies are less inclined. It is expected that with this, they will be able to use more discretions in their dealings with NRPF clients.

The Chapter also highlights what the journey of a typical service user would look like across the various Quadrants and what this could mean for the service user along their care pathway. The Chapter ended with a practice report and reflection of my encounter with one of my service users who had NRPF to draw similarities between my experience and what the research participants experienced.

Chapter Seven

Discussions and Implications :

Introduction

The immediate two previous chapters have provided outlines of the findings of the research, in this Chapter I would like to provide a discussion of these findings and my personal thoughts and reflections on them as an insider researcher. The research set out to explore the practice experience of frontline HSC professionals in mental health with specific focus on their work with service users who are subject to immigration control and have no recourse to public funds.

As indicated in previous chapters, the research has unveiled a number of significant findings relating to frontline practitioners experience in their roles some of which are discussed below.

Emotional Burden

One of the key findings was that frontline work with this client group is characterised by emotional burden. All participants expressed some form of emotional turmoil they experienced ranging from being frustrated, sad, despair, disappointed, heart breaking to anger. They seem to embody significant amount of emotional load acquired in the course of their work with clients with NRPF. While some of these were projected on them by the service users, some were due to structural issues associated with delivery of their services. Lorna said:

I just find it personally really sad. …It was the saddest case that I ever got involved with. I felt really sad for them, because I felt like we had contributed to the government being even more wicked.

Lorna's involvement with this family might have exposed her to projections such that she felt helpless (like them) and sad that she could not bring about a dramatic change in the life of this family. She then felt professionals have contributed to government being wicked (for making exclusionary policies). Lorna's comment here can be explained with the Karpman's model of Drama Triangle. Lorna presented her self as a rescuer of this family who are victims

while the government is the persecutor. This is probably driven by high sense of guilt she has internalised.

Still on emotional burden, there were feelings of helplessness and hopelessness expressed by participants as they struggled with the role. Participants felt the immigration status of these clients hindered their performance of the primary task of providing care and support for them. This resonated with me as my experience with BO also revealed. I felt like a helpless helper who is failing in his duty. Chris described it 'feeling stuck' or 'hitting a brick wall'.

Moral Injuries

Closely related to the above is that participants experienced moral injuries. As earlier on articulated in Chapter 5, moral injury is a strong cognitive and emotional response that can occur following events that violate a person's moral or ethical code. People who develop moral injuries are likely to experience negative thoughts about themselves or others as well as intense feelings of shame, guilt, or disgust. (Greenberg N., et al 2020). There were also expressions of lack of professional fulfilment. Anita said:

So mental health practitioners, when they come in contact with clients with immigration issues, they are not fulfilled in delivering care to this client group

Anita went further:

As I said earlier, it makes you feel you have not actually completed your job because of all these immigration issues

Professional fulfilment is defined as a sense of engagement, reward, and contentment with one's career, through realisation of one's potential (Brown, S. and Gunderman, R, 2006). Research has also shown positive correlation between client satisfaction and professional satisfaction. On the other hand, moral injuries have been associated with absenteeisms, poor job performance and burnouts among health care professionals (Lamiani G, et al, 2017).

Professional Backgrounds May Influence Practitioners' Perspectives

Another key point the research reveals is that participants' perspectives and attitudes towards immigration policies appear to have been shaped by their professional backgrounds. Even though the 7 participants work within the human services sector, they come from 3 different professional backgrounds- psychiatric medicine/nursing; social work and occupational therapy. Of the 7 participants, 3 of them- Chris, Anita and Henry had nursing background while John is a psychiatric doctor- they all have medical background. Two of the remaining three participants- Lorna and Charlene had social work background while Dame's background was Occupational Therapy. The research shows that, by their responses and attitudes, those with medical training gravitated more towards strict observance of immigration policies. They appeared more inclined towards compliance with institutional policies. They seem quick to show deference to institutional rules and policies rather than challenging them. Chris felt stuck as he was following the protocol while seeking support of other services for his client:

As much as you try to do your job and refer them to the right services or providers or activities to improve their life styles, you are stuck, because for them to have access to those resources, someone needs to have recourse to public funds or have some type of visas to be able to access the sort of services we want them to and this is a very difficult situation.

Copper (2005) referred to an atmosphere where clinicians play safe, avoid controversy, and favour compliance. Faced with this dilemma, professionals deployed diverse discretionary techniques to cope with the dilemmatic situations they face in the frontline. Some with positive implications and others with negatives. For instance, Chris said

As health care professional, what I found I end up doing is that at times I have to take money from my own pocket, not that I need them to pay back but when you visit someone, and they tell you that they have not eaten, they haven't got anything to eat

Chris continued:

And there are sometimes you think, is it better to advise this person to just go back because their life was much better than their current situation; now they

are stuck, they can't work. Their life was probably better in their home country, maybe they had better quality of life than here.

Chris was at the verge of crossing the line in client/professional relationship. He appeared to have been sucked into the world of his client by overidentification and he is being invited to step out of role.

Hear Chris again:

As a fellow professional, I feel for him and as a fellow African and migrant myself, you empathise, and you sort of understand where he is coming from. How his life is. Because I can picture, it is very similar to myself.

Cooper (2012) argued that true emotional contact with our clients involves the necessity of losing the boundary between ourselves and them, and then recovering it. This experience speaks to professional vulnerability, in spite of which he needed to recover himself to play the role of a true container. Chris experience here was similar to mine when I had the recurrent urge to advise BO to take up cash-in-hand job so he can have money to spend.

These are participants who populate Quadrant 1 and Quadrant 2 in Figure 2.

Ethnic Backgrounds of Participants may have influence on their Perspectives

Curiously, the four participants in Q1 and Q2 are migrants from black minority ethnic backgrounds. Except for Chris, a closer examination of these 3 participants suggests a persecutory undertone as there is a veiled attempt to hold the service users responsible for their circumstances. This position is consistent with how the researcher also felt when Chris was narrating one of his cases. I had felt why should someone leave his country for England without adequate planning and resources. Of course, not every migrant had the luxury of time and resources I had to plan my migration.

Anita even rose in defence of the government:

….but at the same time, you can't blame the government because they have not contributed anything to the country. To the welfare of the country, the taxes, they pay taxes somewhere else and they have come to live somewhere else. So, you don't have anybody to blame, it's just a sad thing

In contrast to the above, Lorna, Charlene and Dame were more critical of government's exclusionary policies. They were angry about what they described as injustices. They were vocal and vociferous in their condemnation of how the NRPF clients are treated. Interestingly, they are all white British ladies with several years of frontline practice. They spoke with confidence and authority. Their perspectives were coherent and strong. There was a form of consistency in their perception and implications of issues raised. They all were sympathetic to the plight of the service users. They were viewed as having low commitment to institutional/legal matter but more focused on service users interest. They are confident in the use of their discretionary powers in the frontline. Lorna supported her service users to complete Human Rights Assessment to enable him access support. She was flexible in her approach and not prescriptive.She sought relevant information from various sources to help her service user obtain positive outcome. Lorna said:

"Look, do you want to stay in the UK and try and do your studying and have the life that you come here initially to have, or are you happy to go home?" The choice is your own. "I can help you and we have to write it in such a manner,"

In addition, the professional backgrounds of these three professionals are not clinical- being social work and occupational therapy. They came across as strong advocates of their positions. Charlene said:

I feel definitely a sense of injustice and I think I have always felt there are people within the system who don't listen to our individual stories and just want to tick boxes and I feel sad

Charlene continued:

On a day to day basis, I just try to help people to make them feel a bit more.. be strong for them, or linking them with a group that is helpful because you can't change the Home Office, you can advocate, but on a day to day, we have to help

It is my view that their social work identity and professional ethics and values may have influenced their perspectives and how they carry out their duties.

In addition, the ethnic background of a HSCP is probably a huge factor in how they engage with their assignments. Having a voice is deeply internalised and how and where we express ourselves say something about the speaker's internal world. An important tenet of critical race theory is the 'voice of colour' which holds that minority status brings with it a presumed competence to speak about their experience

Implications of Findings

In this section, I attempt to explain what I understand are the implications of the research findings for policy development, for organisations, for practice and for further research.

Implications for Policy Development

The findings of this study highlight the need for clarity of policies. Any ambiguity in policy compounds the work environment and makes the task a lot more difficult to perform. For instance, what is the economic sense in admitting and treating a mental health patient for several months on the ward and discharge him back to the street because he has NRPF only to relapse after a few weeks because of no care and lack of social support and be admitted for several months again at more cost. Therefore, policy formulation process should take into consideration the possible impact of such policies on the implementers of the policies at the street level and those the policy will affect. Policy process should therefore not be top down but rather bottom up, it should not be linear but well thought through and should reflect the views of those who will implement them and other stakeholders. Perhaps an impact assessment should be carried out on everyone who will be directly or indirectly impacted and affected by the policy. Cooper(2009) advocated that policymakers should more listening to, hearing, digesting and ultimately validating painful, conflicted and aggrieved personal and social experiences.

Also government and organisation should not disavow the need for thinking but seek to build capacity to face up to the challenge of processing the

uncomfortable feelings and anxieties rather than entering fight or flight mode and building institutional defence system against anxieties. In order words, policy formulation process should pay attention to the social and psychological wellbeing of the organisation, stakeholders and its members. Cooper (2015) canvassed for an urgent need for emotionally intelligent policy-making, which grapples with and roots itself in the complex realities of social relations, and forges negotiated solutions.

There is also the need to make conscious effort to develop the thinking capacity of the frontline practitioners so that they can be effective containers of the negative projections they are daily assailed with in the course of their duties. Organisations should have well thought out programmes to deliver psychological and intellectual nourishments for frontline practitioners so that they can build capacity to receive, process and give back in digestible forms all the anxieties projected at them by the service users. In addition to the above, organisations and government should also consider setting up a vehicle through which NRPF with mental health should be cared for as specialised service such as perinatal.

There is also the need for home office to deal with refugee and asylum seekers applications with despatch. Waiting several months and sometime for years to hear feedback from Home Office for applications is not good enough. Keeping people in prolonged suspense is not healthy for their psyche as it puts their life on a prolonged pause.

Implications for Practice

The findings call for frontline professionals to be more self aware in the course of their duty. There is need to for them not to lose sight of their conscious and unconscious roles as containers. This demands being in touch with their own feelings however uncomfortable they might be. There is need for individual practitioner to develop their psychological capacity to an extent that they can competently contain whatever the service user is coming up with. Frontline staff are the most exposed to the disturbances that characterise the mental health as they are in direct regular contact with the symptoms of their service users. Professionals should develop their capacity to think more rather than doing. Waddel (1989) spoke about the need for professionals to be serving (thinking)

rather than servicing (acting). Frontline professionals need to develop their understanding of the value of management of oneself in role with the capacity to hold in mind the system as a whole in a Gestaltic approach.

Implications for Organisations

Organisations should avoid scape goating frontline staff as this will drive them into a rigid and compliance driven work mode. Operating in such mode deprives the professional the use of self in relationship based engagement with the service users.

There is also the need to deemphasise the strict adherence to performance management system and target setting that robs people of feelings and their humaness. For instance, it is not all interventions that can be calibrated and measured. For instance, how do we measure Anita's action of mobilising food vouchers for her service users, or Lorna leaving her phone on after work to receive a feedback call from her service user and providing comfort and succour for him rather than asking him to call an out of hour service to speak with someone who does not have a clue about what the case is about.

As earlier stated, the health and psychological wellbeing of professionals are important and should be well cared for and develop. Professionals should also be given manageable caseloads so as to be effective practitioners. There is only so much an individual can do and cope with in order to be effective practitioner. There is also the urgent need to empower minority frontline practitioners to be confident and be able to give their voice to service users from ethnic backgrounds.

Implications for Further Research

This research has highlighted the challenges faced by frontline professionals who work with NRPF service users and how they function in their role. The research also showed the inadequacy of their interventions in meeting the needs of service users with NRPF. Even though there have been researches on frontline workers in mental health and the challenges they face. There have been researches also on mental health of migrants and of migrants who have no resources. This research will add to the existing body of knowledge in this area. The research has shown how the practice orientation and perspectives of

how professionals of minority ethnic background were different from those of professionals of white ethnic background. This is an area that would need further investigation and to know the implications of that have for service. Similarly, practitioners of different professional background differ significantly in their practice orientation and perspectives. While clinicians- doctor and nurses clustered in areas with high legal and institutional quadrants, professionals with background in social work and occupational health's perspectives for legal and institution. How would other professionals such as psychologist, support workers.

Another area for further investigation would be inpatient versus community based practitioners. While the two inpatient based professionals were less service user focussed, others in community setting were more service user focused. All minority participants were of black African background, perhaps future research can have some Asians, Chinese, and people from other minority backgrounds.

This research has thrown up quite a lot of questions to be answered than what the questions it set out to answer in the first place.

Chapter Summary:

This chapter discussed the key findings in the study. These include the fact that frontline practitioners work ion an emotion ladden context, and an important emotional burden they carry was that of moral injury, which states that professionals feel a sense of emotional hurt and deep moral failure because they are unable to meet the needs of their service users. The chapter also reported the findings that the professional and ethnic backgrounds of participants shape their perspectives. The chapter addressed the implications of these findings for policy development and for practice. The section also addressed implications of these findings for professional practice and for organisation and for further research.

Chapter Eight

Conclusions: Thesis Summary; Limitations of Study and Reflection on research journey,

Introduction:

This section provides a summary of the study enumerating what the study set out to uncover and what it eventually found. A key objective of the research was to explore the practice experience of frontline professionals in Health and Social Care. Data collected showed that professionals in the frontline face an enormous amount of emotional pressure which they will have to manage Like every other study, this study acknowledges some limitations which if addressed will pave the way for improving the research for desired outcome The persomal experience of the researcher in the research endeavour was also reported.

Thesis Summary

The aim of the research was to gain some understanding of the challenges that frontline workers face in their work with people who have no recourse to public funds. Because people who belong to the category of no recourse to public funds are almost likely to be immigrants, the research identified factors that produce this phenomenon so we can understand how and why people are so branded. Globalisation and migration are highly implicated. As the world becomes more connected and interdependent, mobility of people became a major factor and consequence of globalisation. An important element in the mix is the predisposition of migrants to mental health and emotional distress which are associated with migration process, either forced or voluntary. As more people migrate, host governments become anxious due to a variety of reasons including scarcity of resources and pressure from citizens, among other reasons. The government therefore responds by making laws and policies that limit migrants' access to state welfare programmes.These policies and many of such are left to frontline practitioners to be implemented at the street level.

Already the frontline practitioner faces a lot of challenges in managing the conflicting demands of his role, the excessive caseloads in addition to on going worker/client relationship which could be emotionally demanding and draining most times, the lack of time and resources to deliver services, and the additional burden of dealing with NRFP. The study conducted in-depth interviews with seven professionals who shared stories of their practice experience caring for NRPF cases and the difficulties they encountered. They reported that the experience made them feel vulnerable and that it was too emotional for them as they had to contend with conflicting policies among others. The participants reported they feel unfilled, disappointed, angry, and demotivated because their patients are denied what they genuinely require to recover from their illness and to function and contribute to the society. From the findings of the research we can deduce the following:

1. Participants feel vulnerable due to anxiety provoking situations they face in the course of the job.- such as dealing with crisis of their clients, required to implement nebulous policies, excessive case loads among others.

2. The research shows that professionals' perspectives about laws and policies around immigration may be influenced by the ethnic backgrounds of the professionals

3. The research also shows that ethnic backgrounds of participants may influence their perception and how they react to exclusionary policies

4. The research has shown that the plight of NRPF mental health service users remains dire. There is currently no articulated policy or approach on how to meet their unique needs beyond ad hoc crisis interventions by services.

5. The research has also shown the voicelessness of the NRPF service users, but much more poignantly is the voicelessness of frontline professionals who work with them. In the introduction to this thesis, I had alluded to a deafening silence of professionals to the unexpressed voices of these people. I had raised concerns that could professionals be colluding in maintaining this silence? I had asked if professionals' voicelessness is mirroring the voicelessness of the service users. Hoggett (2000) asserted that voice gives meaning and expression to people's experience and without a voice people are left with

experience that they have no way of symbolising. Perhaps, the *voicelessness* of this client group and their care givers is indicative of their powerlessness to bring about tangible changes in their shared experiences.

6. All professional groups involved in human services such as health and social care espoused the principles of social justice, equality, advocacy and non discriminatory practices yet we still have an army of people at the periphery of the society living fragile, lonely and unstable lives with little or no hope, and finding it difficult to re-establish their 'place in the world' being unable to reconstruct their sense of self and social identities.

The above findings and reflections have addressed the research questions the thesis seeks to answer. The overarching research question is 'What can we understand by the practice experience of frontline HSCP in their work with mental health service users who have no recourse to public funds'. Other sub questions are:

i. How does HSCP negotiate the conflict between the duty of care and exclusionary policies for service users who have no recourse to public funds?

ii. What are the main challenges faced by HSCP in delivering high-quality care to clients who have NRPF?

iii. As professionals, what can we understand by the plight of patients who have NRPF?

These questions have been adequately addressed by the research findings and my reflections. This research would also complement other previous efforts in scholarship and researches on policy implementation by frontline workers. Drawing from Lipsky's work, Evans and Harris (2004) argued forcefully in their paper Street-Level Bureaucracy, Social Work and the (Exaggerated) Death of Discretion that frontline social workers still have considerable professional discretionary powers in spite of the changes in the nature of social work. They asserted that discretion should not be seen as an all or non phenomenon, and that social workers are required to make decisions and to interpret rules. Maynard-Moody and Portillo (2010)

in their study also noted that Street-Level workers rely on their discretion to manage the physical and emotional demands of the jobs, as well as to claim some small successes and redeem some satisfaction. Similarly there have been researches on migration and mental illness (Bhugra and Jones, 2001; Höschl, C., 2008) but this current effort is unique in that it focussed on practice experience of frontline professionals who work with migrants who have no recourse to state welfare programmes due to their immigration status. As stated earlier, their exclusion from state welfare benefits is an added layer of complexity to their already vulnerable status in the society and it is believed this would constitute additional challenge for professionals working with them.

Limitations of the Study:

The research set out to explore practice experience of frontline practitioners in mental health service. There was no consideration for differences in professional background of the frontline workers even though there are many professions represented in a typical MDT. For instance,professionals with psychology and art therapy backgrounds were not represented in the study.

The research was also limited to one Mental Health Trust in London in the United Kingdom. All participants were drawn from the same Trust even though they came from different services and across four boroughs, all participants are still subject to the same organisational culture, policies and procedures. The findings are therefore limited to what obtains in the Trust. The research is also limited to adult mental health as no participants came from Child and Adolescent Mental Health service (CAMHS), Eating Disorder or Older Adults services.

There was overrepresentation of black minority ethnic practitioners in the study. Four out of seven participants were of black African background while three were white British ladies. There were no Asian, American or mainland European participant in the study. Even though the recruitment process was open to all, no one came from any of these ethnic backgrounds. We are therefore unable to obtain data that reflect their views and experience of working with NRPF.

The study did not compare professionals' experiences with main population of mental health service users who are British born and not subject to immigration

control. The research could not confirm if professionals' experience with service users who are British will be different or similar. The research topic was set up on the premise that the NRPF status added another layer of complication to the vulnerability of a service user which would undoubtedly demand extra effort from the professionals.

Another limitation of the study is that the voices of service users were not captured in the research. While an attempt was made to map the journey of a typical service user's care pathway across the professionals, hearing from service users about their experiences and what they feel about the professionals working with them would have further enriched the research data.

In spite of the above limitations, the research appears to have addressed the questions it set out to answer. In fact, each of the identified limitations provides an opportunity for further investigation and exploration in order to deepen and widen the scope of the study.

My Personal Reflection on the Research Journey

My journey through this programme has been a chequered one, a mix of excitement and psychic pains, and temptations to quit. Not because I was averse to challenges rather it was due to personal challenges I faced in the course of the program. Having successfully passed through the various approval processes UREC, IRAS and local NHS Trust Research Department, I became anxious not knowing what I would meet on the research field. I sent out fliers containing information about the proposed study and requested that people who want to participate should contact me. I got some feedback from a few people who showed interest in participating in the study. However, it was difficult to set up appointments for the interview as they gave different excuses on why they were not available. This is despite informing and reassuring them of confidentiality and an option to withdraw at any stage of the process. Talking about difficult topics like this research can be anxiety provoking. No one wants to talk about his job experience to a total stranger or about race or about immigration issues. I sought the permission of some team managers and ward managers to address the team for few minutes during their weekly team meetings. Eventually, 15 people agreed to participate across Trust which is spread across 4 boroughs. About 11 people were interviewed but only 7 completed the 2 sessions.

As defended subjects, the sessions were quite uncomfortable for us, the participants and the researcher. There were moments of real emotional pain as I sat down listening to participants telling their practice stories and retelling their service users' stories. Moments of moist eyes were common. Participants spoke with passion and from their hearts. The image and memories of those interview scenes stayed with me for a long time. The pain of helplessness and disenchantment, moral injuries of being unable to perform their duty of care because of discriminatory policies evoked raw feelings. Even during transcription several months later, listening to those audio recordings still brought back memories of the encounters. Two of the participants remarked that they felt better after the interview sessions as if they have been waiting to offload to someone. On reflection I wonder how many frontline practitioners are carrying emotional burdens related to the work that they do not know how to handle and have to resort to denial or suppressing them. I noted that the organisation, like most NHS Trusts do not provide thinking space for their staff. With excessive case-load and perennial shortage of staff coupled with urgent and on going needs of service users, the frontline practitioner does not have enough space to think. He is then left to be acting, or doing rather than thinking; servicing rather than serving. He functions perfunctorily, just ensuring he follows prescriptive protocol with limited emotionality. Today as a manager, I encourage those working with me to make out time for moments of reflection regularly or after an incident. This will enable them to be in touch with their inner self and develop capacity to contain projections from the service users.

The group supervision helped tremendously with the field work. Transcript of my first interview was discussed with my colleagues and supervisor and their comments were noted. Apparently because I was anxious due to long pauses, I was asking more questions rather than allowing the participants to absorb and process the pain of silence. It was as if I was trying to rescue her from the pain. People are used to structured interviews and not story telling narratives. I got better using this approach and incorporate it to my personality. I now do more of listening, observing and reflecting. This is a significant change in my personality.

I find the analysis phase of the research very interesting and engaging. With input from colleagues and supervisor, I was able to develop a model to understand and interpret the data. This was a major leap for me as I had literally got stuck at a point

not knowing the way forward. This goes to show the advantage of allowing other pairs of eyes to help you look at issues because your blind spots are open and plain to others who are working with you. Being open and asking for help is not convenient because the ego craves for preservation, as practitioners, we should be ready and willing to be vulnerable to our colleagues so that we can get the necessary help/support in times of need.

Meanwhile I have been buying books on-line on relevant areas of the topic and themes of the research. I also subscribed to various on-line journals and printed to read and study. I however find it difficult to sit down and commence writing for a very long time. In the last few months however, as I began to put my thoughts together as the pandemic slowed down and less pressure in my business, I summoned the courage and resolved to complete the task. The first thing I did was to resign my 9 to 5 jobs as a social worker so I can focus on writing the dissertation.

I have been able to devote time to my study with a view to bringing the endeavour to a close. The experience of the research journey has deepen my capacity to think and be focussed. It has also expanded my capacity to tolerate and process difficult and painful thoughts. I have been reminded again on how pervasive the role of anxiety is in our day to day human transactions with others and within ourselves.

The research area has expanded my knowledge base and I am more aware of undercurrents that influence social relations and how professionals are left to deal with the ‘mess’. As an employer of labour today and running an organisation within the mental health sector, I have in recent time become more aware of how to interact with service users in a more genial way and enter into a more understanding relationship with them.

Chapter Summary:

This chapter summarises the entire study and what it was set up to accomplish. It also captures the key findings of the research and identified the limitations of the study. The section concluded the essay with a report on my reflection on the research journey, the challenges I encountered as a migrant while trying to fulfil a long life ambition.

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Appendix 1

The Tavistock and Portman NHS
NHS Foundation Trust

Directorate of Training and Education
Academic Governance and Quality Assurance

Tavistock Centre

120 Belsize Lane

London

NW3 5BA

Tel: +44(0)20 938 2699

Email: AcademicQuality@Tavi Port.nhs.uk

http://tavistockandportman.uk/research-and-innovation/doing-research

Ayodele Igandan

By email

20 July 2016

Dear Mr Igandan,

The approval of your application to register your thesis: *An Exploration of Health and Social Care Practitioners' Work with Mental Health Clients Who Have No Recourse to Public Funds*

The approval of your Risk Assessment

Course Title: Professional Doctorate in Social Care and Emotional Wellbeing

I am delighted to inform you that the above thesis research proposal was considered by the Chair of the UEL Research Degrees Sub-Committee (RDSC) on the 27 April 2016 and was approved for registration. This means your registration date is February 2016.

Your Risk Assessment was considered and approved at the Trust Research Degrees Subcommittee (TSRDSC) on the 14 March 2016.

Your registration period lasts for a maximum of 60 months and a minimum of 30 months providing this falls within your remaining enrolment period. Your enrolment period lasts for 8 years and is calculated from your year of first entry onto the course. This means your submission deadline is **26 February 2021**.

IMPORTANT: Please note that you must not pursue any research involving human participation (including human participants, human material or human

data) until you have gained the appropriate ethical approval[1]. If you have any queries regarding ethical approval, please see https://tavistockandportman.nhs.uk/research-and-innovation/doing-research/student- research/ethics/

Failure to gain requisite ethical approval before carrying out research on human participants or human data may result in disciplinary action and/or the cancellation of the research.

In addition, you must notify your Research Ethics Committee of any changes you make to your thesis (including change of thesis title).

or details of the following processes please refer to http://tavistockandportman.uk/research-and- innovation/doing-research/student-research

- Ethics
- Registration periods
- Suspension of studies
- Supervision
- Annual Review
- Viva examination
- Research Degrees Subcommittee
- Research Degree regulations

Please do contact me if you have any queries regarding the above, and please keep this letter for your records.

Yours sincerely

Paru Jeram

Secretary to Tavistock Research Degrees Subcommittee Quality Assurance Officer

Cc. Andrew Cooper, Director of Studies and Course Lead Vimala Uttarkar, Second Supervisor

Claire Dee, Course Administrator
Badri Houshidar, Registry
Bhavna Tailor, Finance

Appendix 2

Health Research Authority

Email hra.approval@nhs.net

MR AYODELE IGANDAN

SENIOR SOCIAL WORKER/DOCTORAL RESEARCH STUDENT

07 July 2017

Dear Mr Igandan

Letter of HRA Approval

Study title:	**AN EXPLORATION OF HEALTH AND SOCIAL CARE PRACTITIONERS' WORK WITH MENTAL HEALTH CLIENTS WHO HAVE NO RECOURSE TO PUBLIC FUNDS**
IRAS project ID:	**209309**
REC reference:	**17/HRA/1777**
Sponsor	**University of East London**

I am pleased to confirm that **HRA Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications noted in this letter.

Participation of NHS Organisations in England

The sponsor should now provide a copy of this letter to all participating NHS organisations in England.

***ndix B* carefully**, in particular the following sections:

- *Participating NHS organisations in England* – this clarifies the types of participating organisations in the study and whether or not all organisations will be undertaking the same activities
- *Confirmation of capacity and capability* - this confirms whether or not each type of participating NHS organisation in England is expected to give formal confirmation of capacity and capability. Where formal confirmation is not expected, the section also provides details on the time limit given to participating organisations to opt out of the study, or request additional time, before their participation is assumed.
- *Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* - this provides detail on the form of agreement to be used in the study to confirm capacity and capability, where applicable.

Further information on funding, HR processes, and compliance with HRA criteria and standards is also provided.

It is critical that you involve both the research management function (e.g. R&D office) supporting each organisation and the local research team (where there is one) in setting up your study. Contact details and further information about working with the research management function for each organisation can be accessed from www.hra.nhs.uk/hra-approval.

Appendices

The HRA Approval letter contains th

The attached document *"After HRA Approval – guidance for sponsors and investigators"* gives detailed guidance on reporting expectations for studies with HRA Approval, including:

- Working with organisations hosting the research
- Registration of Research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics and is updated in the light of changes in reporting expectations or procedures.

Scope

HRA Approval provides an approval for research involving patients or staff in NHS organisations in England.

If your study involves NHS organisations in other countries in the UK, please contact the relevant national coordinating functions for support and advice. Further information can be found at http://www.hra.nhs.uk/resources/applying-for-reviews/nhs-hsc-rd-review/.

If there are participating non-NHS organisations, local agreement should be obtained in accordance with the procedures of the local participating non-NHS organisation.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/.

HRA Training

We are pleased to welcome researchers and research management staff at our training days – see details at http://www.hra.nhs.uk/hra-training/

Your IRAS project ID is **209309**.

Please quote this on all correspondence.

Yours sincerely

Nabeela Iqbal Assessor

Email: hra.approval@nhs.net

Copy to: *Prof Michael Seed, University of East London, Sponsor Contact*

Appendix 3

The Tavistock and Portman NHS
NHS Foundation Trust

IRAS Project ID	**209309**

PARTICIPANT INFORMATION SHEET

Research Project: **'Working With Service Users Who Have No Recourse to Public Funds**

Researcher: Ayo Igandan

THINGS YOU NEED TO KNOW BEFORE YOU AGREE TO TAKE PART

The Project

I am a research student and this project is part of my University degree (Professional Doctorate in Social Work & Emotional Wellbeing)

I want to find out more about the practice experience of frontline mental health practitioners who work with mental health service users who are subject to immigration controls and have no recourse to public funds.

I want to listen to experiences of a range of practitioners across professional backgrounds, settings and sectors. This will be through face to face individual interviews.

I also want to facilitate two focus group discussions; with each group made up of 5 to 7 practitioners.

I want to understand how practitioners engage with this category of service users in view of their immigration status and limitation they have in accessing services.

If you agree to take part in the project then we will meet **twice** for the interview.

If you want to participate in the focus group discussion, we will only meet **once.**

You can only participate in either the interview or the focus group discussion.

Each meeting will take between 45mins and 2 hours depending on how long and how much you want to talk for. I will voicerecord the meetings (No video).

Between 18 – 22 frontline mental health practitioners will take part in the project and at the end, I will collate the recordings and any notes I have made to help me write about the practice experiences of mental health practitioners who work with service users who have no recourse to public funds.

During and after the project, I will give talks and presentations about what I am learning at universities and other organizations that are interested in mental health, migration and or practice issues.

I WILL NOT SHARE INFORMATION ABOUT YOU

The records of the interviews and discussions will be kept in a locked place and only I and the person who types it up will listen to the recordings.

I will keep all information in accordance with the University's data Protection Policy

I will take care to make sure that you cannot be recognized. I will not attribute anything you have said in the interview to you in a manner that you can be associated with it. I will not provide any information about the area you live in or organization/team you work with etc.

I will keep what you tell me private UNLESS you say something that shows that you or other people are at risk of immediate harm. Wherever possible, I will talk to you first before sharing any information .

YOU DO NOT HAVE TO TAKE PART AND YOU CAN STOP AT ANY TIME

You do not have to take part in this project. You can stop your participation at any time. If you want to stop, you can do so and you do not have to give any reasons. You just need to speak to me about it

If you agree to take part now, you can change your mind. If you change your mind, you can phone or email me:

Ayo Igandan- 07869910000 a.igandan@uel.ac.uk

NOTE:

This research project has been approved by the Health Research Authority and checked by the University of East London to see it is being carried out fairly.

f you have any concerns about how the research is being carried out, you can contact someone independent at the University:

Catherine Fieulleteau:

Research Integrity and Ethics Manager

Graduate School

UEL University of East London, Docklands Campus, London. E16 2RD

Phone +44 (0)2082236683 Email: researchethics@uel.ac.uk

Appendix 4

The Tavistock and Portman NHS
NHS Foundation Trust

IRAS Project ID	**209309**

CONSENT FORM

Research Project: **'Working With Service Users Who Have No Recourse to Public Funds**

Researcher: Ayo Igandan

I have read the information about the above research project which I have been invited to take part in. I have been given a copy to keep.

I understand why the research is being done. **Ayo** has talked it through with me and I have been given opportunities to ask questions. I know that I don't have to take part unless I want to. I understand what the meeting will be about and that they are recorded. I know that the records will be kept safe.

I understand that the fact I took part in this project, and information about me, will not be given to anyone. Only **Ayo** and the person typing up the recordings will see and hear what I have said in full.

I understand that information about the research might be published but that personal information about me will be changed so that people cannot recognize me. I know that **Ayo** might have to speak to someone if I say anything that shows I or other people are at risk of immediate harm.

I understand that I have the right to stop, or take out any material at any time. I don't have to give any reasons.

I know how to contact **Ayo** if I want more information about the research and how to contact the University if I want to make a complaint.

I agree to take part in the project.

Name …….

Signature & Date ……..

Researcher's Name …….

Signature & Date……..

Appendix 5

ANITA 1st Session

Name: Anita

Sex: Femle

Profession: Mental Health Nursing

Practice setting: Community

Level: Senior Nurse

Ethnicity: Black African

Interview Session

***Question**:*

Thank you for agreeing to participate in this research, I am trying to know more about the experience of front line professionals while working with people that have no recourse to public funds within the mental health service.

I would like to listen to stories of your experience as a frontline practitioner.

***Anita's Response**:*

Currently I have a client that has no recourse to public funds that I am actually care coordinator to at the moment. But in the past, I have some while I was with substance misuse service, and also when I was on the ward. But at the moment, the one I am very concerned about and in treatment with is a lady; a family in short. They have younger children who are twins. Husband and wife, all of them have no recourse to public funds. This lady has got a brain disease which prompts her to have this behavioural personality disorder and due to that diagnosis, she is not able to get proper treatment because she has no recourse to public funds. We would have referred her to medical treatment to have that disease treated, but because she has no recourse, it is quite difficult. They are pushing the ball around, they pushed it to integrated care which deals with people that have organic issue or they have something to do with mental issue and they want to push it back to mental health. But if you look at it very well, I know you could say it's a dual diagnoses issue because the brain disease has now brought on behavioural personality issue into it, so it is very difficult, so you can't get the proper treatment for her. And it is difficult for me, as a practitioner because I just want to achieve what I want to achieve here. . I want to achieve treating my clients, I

want to see her getting better, I want to see her well. So, if you look at it, from the financial aspect of it, you wonder where it's like making the treatment, making your job more difficult because you don't know where to place her. They just give her temporary treatment whereby you don't know what will happen second day because this lady has suicidal ideation She needs a comprehensive package, either to send her to a placement where she gets care 24 hours to stop her from harming herself or trying to kill herself, but because of funding, no one wants to pick her up. Because if you look at it, I can't even complete referral……. Her care needs are not being met. When it comes to getting medication like anti-psychotic medication, she has a GP, and she is able to get this but when it concerns the actual treatment for the brain disease, it is difficult. You send email to this body, they say she has no recourse to public funds and that you should refer her to the other person. So, it's like you go round and round and by the time you know it, it comes back to you. So, it's quite difficult. And sometime this lady……, I go to their house, they need something like…, because they've got children to look after, they are not on any benefit. The children are getting support from Children In Need, and the support is not enough because the support they give to these children…. the amount is barely enough to feed them, but the parents have to feed from this amount. It's from this money they give to them they have to pay bills. So, it's quite…, I would say it is something I really empathise with them. Even though it's no one to be blamed, that is the system now, they have cut down on so many things. Recently, I went to their house, they work with charity, but the charity has to close for refurbishment, and that is where they get most of their food from, then the money they get from children services is about 600 pounds which is not enough; that is where they pay their bills. I find myself going round my colleagues, asking them if they could give me food voucher. These food voucher, according to the instructions laid down….., a family or a person cannot have more than 4 vouchers in a year. So, when you give them food voucher, what happens the following month. I personally went to collect the food for them, those groceries they gave to me, it wont be enough for 2 weeks, because what they gave to me is when I looked at it. It won't be enough for 2 weeks. It makes your job difficult. It's like where am I going, your hands a tied. You are just going round and round without succeeding in what you want to achieve because when people, this family, when they are not getting enough help, they are not getting the minimal food, then their mental state will be unstable .

But at the same time, according to the couple, the man said he was told to make a choice, to return back to his country if he is not happy with what he is getting or stay. Actually, they haven't got a choice to make as they have been here for almost 8 years. . Am not going to judge about that, am not an immigration officer, but with my own job as care coordinator, as health practitioner, it makes my job quite difficult to work in that kind of environment. I went there the other day, the house was infested with bedbugs, it was heart breaking……, I was sending emails to the children social worker, they were just passing me around. In two weeks, nothing has been done. If they are on benefit, or if they have got immigration status right, its like picking up the phone,

calling the council to come and help them control the bed bugs, but council couldn't do anything . It was so much that they ended throwing their mattresses outside, but I had to tell them you can't keep throwing your things outside; because once they take off the sheet from the bed, you see these bed bugs were like you pour sand on the bed. It was so bad they have to put the mattresses outside. I felt like calling the Housing, but that property was not given through the council but through the children, through children in need services. It's quite tight and very sad. You know what to do but you cant do it because there is no recourse to public funds for them . And the man has got heart disease as well. He would have gone for surgery but he can't because he said whenever he goes, they just give him like first aid treatment and then, according to him, they will ask him to bring his passport, they have to verify if he has got right to all these things because these are people's tax money. That is what he said. So that is it.

If I take myself back a bit, I think they are lucky to have got accommodation because of the children. If I take myself back to my experience when I was with drug and alcohol services, inpatient, this was about…. not up to 2 years ago; I had a client coming in for detox. You know if they don't come for detox……, this one is almost going. It's like harm minimisation. They bring them in for detox; after detox, they are homeless. After detox, they are supposed to discharge them to GP but because they have no recourse to public funds, some of them don't even have GP. You try to liaise with the organisation that brought them in, they said oh, they pick them from the streets because people are complaining; there is nothing you can do, you have to discharge them back to the street. I could remember a time I had to call the social services, the Council to see, if they could be given accommodation and they told me I should fax down their passport that shows their visa. When I asked the client, he said he doesn't have one, he came in through the back door. The other one said his passport and visa have expired, so the Council told me, this was in XXXX Borough though , the Council told me if they cannot verify their identity or confirm, I am sorry we can't do much about it, discharge them back to where they came from. It's like a revolving door, you just discharge them. You are not gonna blame the system. Things are not as rosy as it used to be, where everybody could get a place, everybody could get accommodation, everybody could get food, its not as it used to be, so it is quite tight.. It affects we practitioners, we can't actually……, we are not fulfilled in our job to them. We are not after immigration issue, we are not after papers, we are after seeing them getting better, because it is an holistic care, you are there for their social circumstances, you are there for their medical, you are there for their physical. So you treat the physical, treat the mental , then social because nurses are there for wholistic care. When you look at the social circumstances you can not fulfil that. You are stranded, you ask yourself, am I on the right job? Am I doing the right thing? . It's like you are not fulfilled in your job.

Question

How does this make you feel as a professional?

***Anita's Response**:*

As I said earlier, it makes you feel you have not actually completed your job because all these immigration issues, . When you are treating someone with brain disease, which has brought up mental issues, and you know what you are treating mentally is just as if you are covering a wound on top and underneath is a sore, you are not able to refer them to appropriate services, even if you refer them to appropriate services, it comes back to you because they will refer them back to you and say they have checked their system and they are not responsible for them because they cannot confirm their identity. So, it's like, from my point of view, all these things are being dumped on mental health. When people are facing social circumstance, then they get so stressed and they have nervous breakdown. So, all of them come into mental health services because people with stress, wanting to kill themselves, self- harming, depression, name it; they are all under mental health . When they are now with mental health, we don't know what to do with them. We give medication to all of them but is like you are running away from your trouble, but the trouble keeps chasing you, it keeps chasing you. It is not the solution to it. So mental health practitioners, when they come in contact with clients with immigration issues, they are not fulfilled in delivering care to this client group

Question

How does this compare with those who have recourse? You don't encounter similar problems with them?

Anita's Response:

With other clients, I will call it a problem if I compare. Clients without immigration status don't say they don't want treatment, they don't lack insight, they know they have a problem, they are unwell, they want treatment, they want cure. But the ones with Immigration status and have rights to everything; they will tell you they are not unwell, it is you that needs treatment. They have homes, they make their choices and you check their mental capacity, and you find out that they've got capacity to use their money for what they want to use it for instead of sorting out their council tax, utility bills and buying food. The difference between these two groups is quite wide. We have very few people that have issues with their immigration status, yet they lack insight but we have very few of them especially when they are unwell. But when they start treatment and get better, and they start thinking that they don't have papers, no accommodation, they feel so stressed and depressed again and before you know it, they are sick, they become unwell. So I will say yes, this could make them to be unwell

because it's like you don't know where you are going. But the one that have not got problems with their immigration, may be they have organic issues that make them unwell or it is their way of life, it is their choice of life. I know with immigration words and advice that those that have no right, it is their choice to remain, but no one wants to leave a place after you have adapted well to the environment for you to say oh I have had enough, to pick your bags to go. It is only very strong-willed people to say that because you don't know where you are going to, you don't know what has transpired when you left the place. You only know where you are at the moment that is why you find people with no recourse to public funds they've got depression issue, most of them they've got issue with depression.

Question

Why do you think that is so?

Anita's Response

Because they are scared of the future, they don't know where they are going to, what is happening around them have depressed them they look at themselves and look at what is happening, they have dreams, their dream is to work and make money or to live in comfortable home. Their dream is they are coming to England and this is England, a land flowing with milk and honey. They can work, make money and look after themselves and family and probably look after people back home. So, when they find themselves in such a situation, it is quite scary to see that the job is there, but they don't have rights to work. The food is there, you go to ASDA, but you don't have the money to buy, you don't have the money because you don't have a job, you don't have a job because you don't have the papers to work. So, it's quite tough.

Question

What are your motivations in working with these people?

Anita's Response

Actually, my motivation is that I have always been a caring person right from my childhood. Since I was old enough to know what I was doing, I have always a caring person. That actually motivated me to look after other people. If I could say, I used to have a sick brother. Sick in the sense that he was an alcoholic. Then, I used to hear that alcohol is not good. So, from there, for me to know better, I decided to do mental health. So, it motivated me to do mental health. So when I started working with people with substance misuse; you see some of them having Korsakoff syndrome and then some of them having delirium, you start seeing where these lead to- mental health, leading to people with enduring mental health issue. That is how I went into mental health fully, wanting to know what brought that up, wanting to know how they get

better. If they comply with treatment, they are able to continue in community like me and you; but when they are not compliant and they lack insight, they relapse. So, that was how I was interested to know what was happening in the community. When they get better, where do they go to? They go to the community that is why I got to community. How they are stabilised and remain in the community that you won't even know that they were unwell.

Question

For people that has NRPF why do you go extra mile? That is beyond your job description isn't it?

Anita's Response

Yeah, its extra mile like asking my colleagues that have food voucher, please can I have one or two food voucher to give to my clients? Because I know they needed food. There is nothing I could do than to keep pressing social worker because they have children in need . Because it is those children that have that right and in need of protection when they were taken away and later returned. I had to go through the social worker because there is no way the children will eat that their parents won't. That was the only way. It was through those children they gave the family an apartment.

Question

Any other thought? Any other experience?

Anita's Response

That is all for now

Thank you so much for your time.

ANITA 2nd interview session

Question

Thank you very much for coming back for the second part of the interview. I have listened to your narration and have identified a number of themes which I want us to focus on in this session. In the first interview you referred to the challenges of working with other agencies, can you tell me some of your experiences along this line,

Anita's Response

When we talk about inter – agency working, it's like you have a client that has no recourse to public funds, you have treated that client and they are well and you need to

discharge them, probably they have no fixed home address, and you think you need to discharge them to be stabilized in the community or refer them to housing. Housing will look at their records and discover they have no recourse to public funds, they will decline. And if you want to discharge them to bed and breakfast, it is still a housing issue because who will fund the B&B? Because that client is regarded as having not made contribution to national insurance, so it's like they keep passing the buck, back to you. That you have done your bit by treating them and they need to be stabilized in the community, get used to social life in the community. Those with substance misuse, when they are stabilized, they need to go to rehab. Most of the rehabs are being operated by the private sector, they want their money and who is going to pay for it? As a professional, you have completed your referral, but without the funding aspect, they throw it back at you. It's like what contributions have they made to the society? The next thing you speak to NHS hospital or any rehab being funded by the government, but if you cannot put the actual funding approval, they say they can't help you. So, you as a professional, you as a nurse, as a care coordinator, as a substance misuse professional, as a team leader, you then look that there is no where to place this client. And you can't take them to your house, you just have to discharge them back to the streets . If they have family, some of them, because they have no recourse to public funds, they deny them, they don't want to know them because they don't want the financial burden, to come back to them. Some friends and family members will not even give their details. The clients themselves, some of them are aware of what is happening, it is a choice, some of them have made that choice to go into that kind of behaviour. So, presenting that kind of need to management is difficult. They feel it is their choice, so you have to discharge them to where they came for, which is the streets.

However, as a professional, as a nurse, when you treat someone, like an old person who has dementia and has no recourse to public funds, and the children or relatives don't want to put down their details because this client has no place to go to. It is not their fault either is it the fault of you that treated because they need to be in an environment where they can be looked after, because they cannot continue to be in hospital forever. So, you find yourself advocating for that client. That is not a choice, it is an illness. You start advocating for them, you start writing letters, looking for solicitors to fight for them. When you look at this aspect, it is a dilemma The client has no recourse to public funds, the client is unwell, and of course it is not their choice to have dementia.

I had a client like that, the social services and immigration were even involved. This client needed to be discharged into an appropriate placement, as she was occupying the hospital bed. So, we didn't have any other thing to do, because as a professional, I was advocating for her. That this client has an illness, that this client under human rights needs to be looked after, so there was no option for me than to keep advocating. I had to send letters to and fro the home office, do you know what happened? The home office went as far back as to the country of that woman and found out that she has got houses in her country. They then said to the children that they must sell those

houses to fund her care. The immigration went to that extent, and the money they would have used to keep her in placement for a while, they used it to look for rehab back home in Africa and then they said, this woman has got resources to foot her bill, let's send her back there. But at the same time, those properties cannot be sold because she is the only signatory and she does not know what she is doing. This is a woman that you have to help to put on her clothes, if you leave her alone, she will be doing something else. How will she be able to sell those properties to foot that bill? While these letters were going back and forth, we had to tell the solicitor that if they want her to sell those properties, or if they have to get a judge to make the children signatories to her property, they need to take care of her first under human rights while they sort those ones out later. So that was how we were able to overcome that issue. We were able to put her in a care home that was funded under human rights. I can't remember what followed. But those under drug and alcohol, they say harm minimisation, they treat them, and discharge them back to the streets. Normally they should go to rehab, but because there is no funding, because they have NRPF they are discharged back to the streets. They say it is their choice. If they want to continue, fair enough, and if they don't want to continue, they can prepare their life for the future. They could go on to a job, they could do what they want to do. Because we treat them long enough, we treat them for three weeks. Normally in detox, when they are treated for three weeks they are well. They have some groups, harm minimisation groups, psychology groups. They are able to make their choices; if they go back to the streets, it is their choice. You don't feel you are not fulfilled as a professional discharging someone back to the streets. Because this is a society now that if you don't contribute to the society, you can't gain anything out of it. People have contributed, they have paid their NI they have paid their taxes, if you look at it from that point of view. I know I am a professional, if you look at it from the point of view of the government, they are saying the truth. It's like you want to eat your cake and have it. It is not possible. Gone are the days when people eat their cake and have it. Gone are the days when people plant pepper and want to reap ehh ehh rice. It is not happening.

Question

I can imagine how frustrating it will be working with other agencies, for instance housing.

Anita's Response

Housing, rehab, care homes because when you treat the elderly people who have come here, to stay with their children and they become unwell here. It is quite frustrating because you don't know where to put them. They are so unwell they've got dementia, you can't keep them anywhere else. If they have physical health, they go hospice. They can't go to care homes the families are not willing to pay or because they don't have means to pay. So, it's like these clients are being dumbed on you. You know what is

best for them but you canst provide best for them. So, you don't feel fulfilled in your job, but at the same time, you can't blame the government because they have not contributed anything to the country. To the welfare of the country, the taxes, they pay taxes somewhere else and they have come to live somewhere else. So, you don't have anybody to blame, it's just a sad thing.

Question

How do you feel about people that want to contribute but they can't? I mean people who are unwell and have no papers

Anita's Response

That is like people with dementia, they want to contribute but they are unwell. As a professional, I really feel it and I am prepared to advocate. I write letters to home office. Due to the mental torture of not having papers, people can become unwell. They start having mental breakdown, even I have come across many like that. After some time, many are given their papers but because they already have got mental breakdown, they cannot hold down a job, because they already have that stigma. Mental health has got a lot of stigma even if they want to work, they will have to declare their mental illness and most employers will not want to offer them jobs. Sometimes, if they take them on, due to the stress of the job, they become irritable and paranoid at work. Even the medication makes them drowsy that they can't get up to go to work. . At the same time, we should be very careful when we have people with mental illness when they don't have papers. Some will like to claim they are mentally unwell, while they are just trying to get papers out of the system. We are to be very careful to differentiate between them, hiding under being unwell, being mentally unwell to gain their papers.

Question

It can be challenging. Are your above experiences, recent things ?

Anita's Response

It's a recent thing because, in the past, about 18 years ago, when you go to hospital they don't ask about your immigration status, they just treat you. When you want to register with GP they just treat you. But because there is budget cost, people come here on holiday, and they work somewhere else, they pay their taxes somewhere else, and they come on holiday, and register with GP. So, it's like the funding that is meant for the citizens, that contributed to the society is being scattered all over the place. So, they have to put a stop to it because people come from abroad to come and get treated in another country. So, the recent government proposal is to make sure that people that are receiving the treatment are actually the rightful people because there is cut everywhere. Even GP have their own cut, so they have to make sure that the people they are treating have right to be treated.

Like the client I said I had, she has a brain disease, but she never contributed to this country. She never paid anything but her disease, if they had to treat her, it will cost the country nothing less than £30k. This is a woman that if they have to look at it from human rights, they will treat her, but when they keep using human rights law to treat people that come from abroad, by the time people who have contributed to the society needs treatment, there will be no funding remaining to treat the citizens. That is why I won't blame the government for putting a tight law on that. . I am not a politician, I am a professional but if I look at it from my own point of view we just want to achieve what we want to achieve. The client is treated, and they move on.

Question

You talked about this kind of scenario you just painted makes you feel unfulfilled, from your experience, how can professionals be fulfilled

Anita's Response

If we start to look at things more deeply, that is why we professionals are taught not to sympathise rather to empathise. If I say I don't feel fulfilled, yes because of what is happening now in the society, the money is not there. The population of the country, compared with 20 years ago is tripled if not more. So we are being told to empathise, we have to do our own bit, do it properly and make sure there is no negligence on our own part. And if have to discharge them back to the street then we have to. Because every individual has their own choice and if they don't have capacity, like if they are very unwell that they can't make a decision, that is why we have to start to advocate for them.

That is why I said initially that when I had a client that has dementia and that was almost at the final stage of dementia. That is why we have to send letters looking for solicitors and sending letters to home office. But if it is a client that we have treated, and they still have capacity, you just do your own and let them move on. If they have to go back home or move to their family or if they have to be deported, treat them and take them back home where they came from. That is why if you see some hospitals, some NHS trusts, they are very good in sending people back to their country. XXX Trust where I used to work almost on a weekly basis, after treating the client, they send them back to their own country. Nigeria, Ghana,… with two staff nurses they send them back after treating them. They hand them over to the mental health services in that country. They will liaise with mental health service from here. I have had one of my colleagues that took client to Lagos, they hand them over to Lagos psychiatric and then they came back. So instead of keeping them here, they have NRPF and instead of discharging them to the streets, and becoming a nuisance on the street, they send them back. Even those from European Union, they do deport them, they treat them and send them back. So as professionals, we are taught not to sympathise with people, rather to empathise. Because you cannot put human right on that, because it is their choice but when they are mentally unwell, and they can't trace where they came from, they will talk with

them and have psychology sessions with them. And they take them back immediately they agree, even to Canada instead of staying here because when they are not fulfilled as they cannot get what they need to get, they deteriorate in their mental state, because they can not work, they can not look after themselves, so the best thing is to be where they have loved ones, people who can take care of the, then they will have this sense of belonging again.

Question

How does that work? Is it in conjunction with the home office?

Anita's Response

Yes. That is why we have very close link with the home office. When we as mental health nurse are free to call the home office if you are in doubt of their status and you will be told if they have a visa or it is has expired or even if they don't have any recognition at all, they will tell you and once you treat them, because everybody in this country has got right to be treated at first stage. If they are mentally unwell, we are the first stage, we must make them well enough to be taken back home. If they are physically unwell, they must be treated in A&E, make them well and give them first aid. Once they are well enough to go on the plane, to go back home, whether they have money or not, they have that care. But when they need further care or rehabilitation, put them in rehabilitation, that is something that is extreme, you have to take them to where they came from. Where they can rehabilitate them to the society. If you can't take them back home, you have to advocate for them to be treated properly. As professionals you don't sympathise, because if you sympathise, you put sentiment to the job.

Question

As professionals, in embarking on repatriation, do they consider the quality of mental health services in those country?

Anita's Response

No, they don't. they don't look at that quality, the one that was sent to Nigeria, was sent to a federal government hospital so everyone has got right to be treated and once they are well, they are handed over to the federal government. They would have consulted the client's country they will liaise with hospital and liaise with immigration. They will be escorted by staff nurses the one my colleague took to Nigeria, that is what happened. But the one my colleague took to Canada, because the family were waiting to receive him, and they took him to hospital and the client was handed over to the hospital. Family support helps in their mental health.

Thank you so much for your time.