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The Permission to be Cruel: Street-Level Bureaucrats and Harms Against People Seeking Asylum

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Abstract
Immigration and asylum policies and practices in Britain have turned increasingly hostile. People seeking asylum are exposed to a panoply of control measures and rendered vulnerable. The state has exteriorized its controls and drawn-in various actors and agencies who now enact state power in the control of migration. This article moves away from essentialist and simplistic notions of the state—one that views the state as monolithic and coherent with strictly defined social borders—and explores the role of what Lipsky (2010), in his book *Street-level Bureaucracy*, calls "street-level bureaucrats." It shows the ways in which actors and agencies enact state power and inflict cruelty on asylum seekers through their strategic actions and inactions. Drawing on data from ethnographic research, this article demonstrates how bureaucratic practices create and exacerbate psychological distress among asylum seekers and push them into dangerous and potentially life-threatening situations. By doing so, this article makes a contribution to the literature on migration, state racism and violence.

Introduction and Background

> Living as an asylum seeker is like living in a multi-chambered cage. On certain days I am shown an open door and I try to escape, try to fly—only to find that door has led me to another chamber of the cage. I try again and end up in a different chamber. Flying and escaping is always an illusion. The cage is real. I am living in it—it is everywhere. Seeking asylum is seeking a life in cage… The British government is killing me. I just want to fly.
>
> [Interview with Wasim from Pakistan; translated from Urdu by the author.[1]]

The past five decades have witnessed a rampant racialization and criminalization of asylum and immigration policies (Bhatia 2018; Bovenkerk et al. 1990; Green and Grewcock 2002; Solomos 1993). Those seeking asylum are increasingly considered as "bogus,"

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"fraudulent" and a "threat" (Kundnani 2007). This trend has had a significant impact on the treatment individuals receive, as humanitarian ideals are now replaced by approaches designed to manage the "undesirables" (Agier 2011). Asylum seekers are subjected to a whole host of disciplinary and regulatory technologies and are restricted and immobilized through punitive legislation (Canning 2017; Pickering and Weber 2006). The British state has built a sprawling web of controls that have intensified since the implementation of the hostile environment agenda,[2] resulting in "everyday bordering" (Yuval-Davis et al. 2019: 97–127). Various actors and institutions are drawn into the immigration control arena—such as the police, private security contractors, and those working in health and social services—thereby exteriorizing the state's control of asylum and immigration (Gill 2010). For asylum-seeking individuals, the widening net of controls creates a feeling of omnipresent captivity, a sense of isolation, a (symbolic) distance from the outside world and a lack of ability to envisage a (secure and stable) future. The bureaucratic actions (and inactions) push them into a state of limbo, with an ambiguous and impermanent immigration status—left waiting and dwelling in a traumatic temporality.

It is acknowledged within the literature that those seeking asylum suffer from higher rates of mental or psychological distress when compared to the overall population of the host country (Tribe 2002). Individuals experience symptoms of acute stress, anxiety and depression due to pre-migratory factors and exposure to traumatic events, such as torture, war, and witnessing deaths, as well as separation from family and community (Neuner et al. 2010). In addition to their pre-migration trauma, the harsh and exclusionary policies and practices of the host country result in substantial post-migratory stress and can have adverse effects on the emotional health of these individuals (Carswell et al. 2011; Teodorescu et al. 2012). The international psychiatric evidence indicates that delays in the processing of asylum applications, difficulties in dealing with bureaucratic processes, preclusion from welfare support, material deprivation, and lasting fear of deportation and persecution exacerbate existing or trigger new psychological conditions (Li et al. 2016; Silove et al. 2007; Steel et al. 2004). There is also overwhelming evidence that links mental health deterioration to forced confinement in immigration detention (see Bosworth 2016 for a review of the literature in this area). Furthermore, asylum seekers and unauthorized migrants are racially devalued and rendered as socially dead (Bhatia 2018), making it easier to marginalize and push them into painful conditions. The harms they suffer are sanctioned by the state and need to be considered from state racism and violence paradigms (Goldberg 2002; Green and Grewcock 2002; Grewcock 2010; Michalowski and Hardy 2014; Lentin and Lentin 2009).

This article makes a contribution to the literature on migration, state racism and violence. It uncovers processes through which people seeking asylum are swept to the periphery, subalternized and psychologically shredded by Britain's hostile immigration control machinery. First and foremost, the article moves away from essentialist notions of "the state" in migration control. Often, "the state" is considered to be comprised of a whole apparatus, including administrators, and an essential positioning obscures these actors and their volitional agency in the exclusion and subjugation of asylum seekers in communities (see, e.g., Gill 2010; Michalowski 2013). Instead, this article turns the attention to "street-level bureaucrats" (Lipsky 2010) and the ways in which they enact state power and are put to work in the control of

[2] The "hostile environment" is defined by a set of administrative and legislative measures that was implemented under the Conservative-Liberal Democrat coalition government, and then followed by the Conservative government. The measures were designed to make the lives of people without legal immigration status difficult, so that they are forced to leave the country. The policy also empowers figures across British society to become quasi-immigration officers, such as employers, landlords, and National Health Service administrators.

migration. I argue that (a) actors and agencies treat asylum-seeking individuals as inherently fraudulent and dishonest, thereby viewing their plight with suspicion and reinforcing what De Genova (2002: 493) calls a "spectacle of illegality"; and (b) such bureaucratic actions and inactions cause psychological harm to asylum seekers. Unlike the manner in which Lipsky (2010) sees bureaucrats as negotiating between policy and those at whom the policies are aimed, this article demonstrates that street-level actors are committed fully to the state's hostile policy approaches and/or are unwilling to deviate from formal procedures to alleviate the harms affecting people seeking asylum. To develop these arguments, the two empirical sections uncover the decision-making (or lack thereof) among various actors and agencies that are involved in the control of migration. Each section explains how the disbelief of and denial shown toward asylum-seeking individuals results in neglectful treatment by various street-level actors and the negative impacts on this group. There is a sustained discussion of mental distress, self-harm, substance misuse, racist victimization and suicides, which is linked back to actors and agencies and their decision-making practices. The overall aim is to understand the contemporary forms of subjugation that occur through immigration controls, exposing those deemed as "unwanted" to precarious conditions of life.

This article is based on an ethnographic research project conducted in the North of England. I was embedded as a volunteer support worker with three refugee charity organizations for a period of over eighteen months (for discussions around the role of the researcher in relation to the role of volunteer support worker and the ethical and practical issues faced, see Bhatia 2014). During my time in the field, I was able to gain access to people seeking asylum, follow social/support workers on client visits, communicate with state authorities, analyze documents and case records held by the organizations, and develop an understanding of policies and practices. Around 110 case files were included in the research. I joined the social/support workers on home visits for eighteen clients and I communicated with state agencies on twenty-three separate occasions (although other employees also interacted with state actors and these were recorded in the case files). I conducted in-depth (and, on occasion, repeat) interviews with asylum seekers and undocumented immigrants ($n=22$). These individuals exercised their agency and shared their experiences in order to shed light on their treatment and in the hope of building resistance. Specialist practitioners were also interviewed ($n=6$), which included two charity social workers, a general practitioner,[3] a clinical psychologist and managers from a homeless shelter and a migrant rights charity. All practitioners had more than ten years of experience working with migrants. I also conducted participant observation and maintained a fieldwork journal and gathered various media and research reports.[4]

Departheid's Necropolitics

Through his well-known accounts of biopolitics, Foucault (1978: 138) has drawn our attention to the ways in which modern power works to "foster life or disallow it to the point of death." Biopolitical technologies of governance have extended political control and power over all major processes of life. Diverse managerial and legal apparatuses are used

[3] In Britain, general practitioners (GPs) treat all common medical conditions and refer patients to hospitals and other medical services for urgent and specialized treatments.

[4] This research was approved by an institutional ethics committee and also followed the ethical protocols outlined in the British Society of Criminology Statement of Ethics.

to achieve the subjugation of bodies and control of population groups (Foucault 1982). Foucault (2003: 241) further argued, in *Society Must be Defended*, that this represents one of the greatest transformational shifts, as sovereignty's old right to "take life or let live" is replaced by the power to "make live and let die." Agamben (1998, 2003) explores the "letting die" situations in his seminal work on the relationship between sovereign power and the securitized body. *Homo sacer*, a figure of Roman law, embodies what Agamben refers to as "bare life" or a depoliticized life—a man who committed a certain type of crime—banished from society, with all his rights as a citizen stripped away. This criminal man became a sacred man and was removed from the protection that law guarantees—a "living death" and left to "let die." Agamben (1998) states that the Auschwitz concentration camp is a classic example of "bare life" and biopolitics. The camp is a "state of exception," where the normal legal order is suspended. In the camp, questions of lawfulness, citizenship and individual rights are severely undermined and/or completely rejected. Therefore, exceptions become a zone of indistinction between violence and law.

While Foucault's concept of biopolitics makes us think about the recalibration of power, it does not account for situations where the focus of power is not so much on the *governance of life* as much it is on the *sanctioning of death*. Agamben's influential work extends Foucault's ideas, but Agamben's genealogy ignores the ways in which "bare life" is implicated in the colonial and racist configurations of biopolitics (Ziarek 2008) and it does not consider the theory and history of racism (Whitley 2017). Both Foucault and Agamben operate within a strict Eurocentric framework. Through necropolitics, Mbembe (2003) bridges this gap and explores the modernization of power during the Holocaust, arguing that it was developed through the slave plantation and colonial and apartheid systems. Using a different historical genealogy of state violence—one that puts race and racism at the front and center of his analysis—Mbembe shows how populations are subjected to a racial denial of their humanity and treated as savages, with subsequent brutality administered to their bodies. Necropolitics examines the creation of "death worlds," where racially devalued groups "are subjected to conditions of life conferring upon them the status of living dead" (Mbembe 2003: 21; also see Estévez 2020). The racial "other" is perceived as undeserving and pushed into the death world, which is categorized by being kept alive "but in a state of injury, in a phantomlike world of horrors and intense cruelty and profanity" (Mbembe 2003: 21).

Contemporary immigration controls need to be understood as necropolitical projects—part of an "on-going encounter with the world that is created through more than 500 years of empire, colonial conquest and slavery" (Danewid 2017: 1680). Racism is embedded deeply in Western political thought and practice (Mbembe 2003) and modern nation states are racial states (Goldberg 2002). The controls within the racial state are designed to subject "undesirable" migrants to structured abandonment, which pushes them into pathogenic environments and treats them simply as deportable subjects. Kalir (2019) refers to this as a "Departheid system"—the latest mutation of the colonial configuration of managing racialized mobility internally. "Departheid" is sustained through the daily work of street-level actors and administrators. Although the system does not necessarily evoke any racist rhetoric in its formal operations, which are based largely on laws and regulations, these "laws and regulations always already include racializing and exclusionary logics, so that policy makers and state bureaucrats can then 'simply' apply them as the caretakers of law and order in the society" (Kalir 2019: 14). This theorization parallels the work of Balfour and Adams (2014), who draw attention to a range of bureaucrats in Nazi Germany directly responsible for carrying out the "Final Solution." They argue that administrative evil is masked by packaging

harmful acts as socially normal and appropriate. By obeying the authority, following the procedures diligently, and simply applying the laws and policies, evil practices can be converted to good and can be considered nothing more than an accomplishment of role expectations. The administrative norms narrow the scope of responsibility so that individuals do not feel accountable for their actions and/or organizational/policy outcomes—especially when it brutalizes marginalized and surplus populations (Balfour and Adams 2014).

According to Bauman (1989: 74), racism, like all politics, needs experts, managers and organizations. The decision-making of administrators can be infected with racism, regardless of whether actors bear any racial animosity on an individual level (Shelby 2002). Racism is structural—an invisible evil (Armenta 2017); as Bonilla-Silva (1997: 33) contends, it "is the segment of the ideological structure of a social system that crystallizes racial notions and stereotypes… Racism crystallizes the dogma upon which actors in the social system operate… racism provides the rules for perceiving and dealing with the 'other' in a racialized society." There is now a growing recognition of street-level actors in the management and control of "undesirables." For instance, Armenta (2012) shows that immigration officers pursuing "criminal aliens" operate based on their constructions of right and wrong, as opposed to applying the law. Similarly, Atac (2019) argues that welfare bureaucrats apply the logics of migration control and "deservingness" in their decisions to grant accommodation to rejected asylum seekers in Austria, the Netherlands and Sweden. Hansson and colleagues (2015) highlight the role of Swedish police discretion in the deportation of unaccompanied asylum-seeking minors. The analysis of their data suggests that officers see their role in contradictory terms, first by believing that "forced repatriation" is good for the child and, second, by constructing their own version of what is "dignified treatment" during a removal attempt (Hansson et al. 2015). All of the above research has directed attention to the ways in which bureaucracies have used discretion and rationalized repressive methods in the control of immigration. This article goes a step further and uncovers the impact of bureaucratic decision making (or lack thereof) on asylum seekers in Britain.

Bureaucratic Inactions and Cruelty

In his work, Mbembe (2003: 40) describes spaces where suffering is enacted as "repressed topographies of cruelty." Similarly, immigration control practices in Britain continuously create and expose asylum seekers to harmful spaces, where they experience brutal indignity and victimization. This section explains the cruelty inflicted through substandard privatized housing and the dispersal of asylum seekers and the lack of bureaucratic actions to protect at-risk individuals from harm.

Substandard Housing and Health Deterioration

The discourses of "welfare scroungers" and "bogus" asylum seekers have resulted in restrictive laws and policies (Bhatia 2018; Kundnani 2007). The Immigration and Asylum Act 1999 removed asylum seekers from mainstream benefits and housing provisions. Subsequently, the majority of asylum accommodations was privatized and corporations were

tasked to provide human services. The policy changes not only resulted in the blurring of boundaries between the state and private contractors, but also drew external actors into the realm of immigration control. To date, there have been numerous "scandals" and "inquiries" exposing the substandard housing provisions in various locations across the country, as well as grave failures in health and safety and consequent harms (Home Affairs Select Committee 2017; National Audit Office 2014). Nevertheless, the private contractors involved in the "Departheid system" have never been subjected to criminal sanctions for failing to meet the contractual obligation to provide safe and secure housing.

In my study, I repeatedly observed that housing contractors and/or the Home Office[5] rarely conducted assessments of an individual's suitability for the property to which he/she was assigned. In some of the cases that I witnessed, asylum seekers experiencing severe mental distress or addiction to drugs and alcohol, or exhibiting suicidal and self-harming behavior, were placed together or with otherwise healthy individuals who were coping with mild or moderate Post Traumatic Stress Disorder (PTSD) symptoms, making the living environment seriously unhealthy for all. The stress of such situations occasionally resulted in fights and individuals coming into contact with law enforcement. In one case, a male asylum claimant experiencing PTSD was asked to share a bed with another man and upon his refusal, the matter quickly escalated. He explained:

> They put me in a small room with just one bed. They asked me to share bed with one guy from Afghanistan… I told them: 'No! I can't sleep with another man'… the accommodation person got upset and asked me to leave or else 'I will call the police.' I said no, and she rang the police. The police came. I was standing outside in corridor with my luggage… They asked me to go inside or live out on the street. I said no, how can I live outside? It was so cold outside, they want me to die? I needed accommodation and I refused to share a bed. Then they said, 'if you not listening to us then we will have to use force.' They spray something on me. I was shouting out of pain, it was very painful. They put me in van and took me in the police station. I kept shouting—I did not do any crime and asked them to leave me. They put me in the cell and next day took me to the court… The court dismissed the case.
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> [Interview with John, from the Democratic Republic of Congo.]

Often, the living conditions triggered an unsettling feeling of being trapped in limbo—findings that are consistent with the international psychiatric research evidence (e.g., Li et al. 2016; Steel et al. 2004). Some individuals adopted ways to distort the reality by consuming drugs and alcohol. An asylum claimant from Iran explained his situation:

> The carpet on the floor is so wet, no heating, no hot water and no place to cook. When you called me [to arrange an interview], I was under blankets, you know. If you are in that place, you have to wear four to five clothes and have loads of blankets to keep yourself warm… Every night there is a fight… It is so much noise; I can't handle it. Since the time I have started taking drugs, I feel my pain is reduced. I never did this before coming to this country, never had alcohol or smoked.
>
> [Interview with Mustafa, from Iran.]

[5] The Home Office is a UK ministerial department responsible for immigration and security.

Several requests were made to the Home Office and the housing provider to relocate Mustafa, however, all were ignored. In other cases, houses were infested with insects and rats, had clogged drainage systems, and lacked adequate insulation. Elderly asylum claimants, people with severe mobility issues, women in later stages of their pregnancies, and women with children were also placed in unhygienic properties that lacked proper access and safety provisions. The consequences ranged from accidents and injuries to recurring stomach infections, skin ailments and the deterioration of existing physical and mental health conditions.

The Immigration and Asylum Act 1999 Act also introduced the policy of dispersal of those seeking asylum to various parts of the country, and this study found a strong link between the policy and racial violence directed against these individuals. The process was initially designed to place individuals according to their language clusters, although this was later superseded by the drive to secure cheap and vacant properties in economically-deprived areas (Hynes 2011; Kundnani 2007). Furthermore, tabloid and right-wing press campaigns against asylum seekers have generated hostility and discontent in these areas, and dispersal, in part, has created a narrative that this group is to blame for poverty and lack of resources (Kundnani 2007). A large number of areas are also predominantly white and have little previous history of accommodating people from other ethnic/racial groups; problems of racial harassment and abuse are more extreme in these locations (for instance, see Netto's (2011) work in Glasgow and Grayson's (2016) work in Middlesbrough).

Dispersal, Racial Violence and Police Responses

I encountered four cases in the field where individuals were verbally abused and threatened by locals and feared imminent physical attacks. Several requests were made to the Home Office and/or the housing providers to relocate these individuals. The authorities, however, asked for these requests to be accompanied with "evidence" such as "crime reference numbers" and "details of the attack." The claim of being fearful or anticipating racial attacks was not sufficient and only one out four requests was successful. To be considered for relocation, individuals had to prove they were "genuine victims." Not only does this indicate a lack of a prevention strategy within the Home Office to protect vulnerable groups from becoming targets of hate-related incidents, but it reflects an abandonment of the duty to protect life as mandated by the Equality and Human Rights Commission (Article 2). The relationship of asylum seekers with authorities is what Lipsky (2010: 56–57) describes as "non-voluntary": individuals are in a relatively powerless position and due to these power imbalances, authorities are less accountable for the treatment they offer, even if it is neglectful and results in harms and suffering (Graham 2002).

The dispersal of asylum seekers into such areas, followed by refusals to relocate and consider seriously the high prevalence of pre-existing trauma, has made this group vulnerable to racial attacks.[6] As one participant, a general practitioner (GP) called Dr. McDonald explained, when asylum seekers are placed in less tolerant parts of the country, besides the obvious physical and cultural characteristics, asylum seekers' mental distress and symptoms of PTSD (such as hyper-vigilance, exaggerated behavior, strong feelings of suspicion

[6] There have been several reports from across the country of asylum seekers subjected to racial violence (see, for instance, the Calendar of Racism and Resistance by the Institute of Race Relations (https://www.irr.org.uk/news/type/irr-news/)).

and behaving suspiciously around strangers[7]) are likely to attract further negative attention and put people at an increased risk of violence, which, in turn, can exacerbate any mental health conditions. Their "vulnerability" and "difference" put them at risk of becoming victims of hate crime (Chakraborti and Garland 2012; see also Poynting and Perry 2007). Another participant mentioned:

> whenever I went out, these boys use to look at me in a bad way. At first, I thought it was just me being paranoid and going crazy. I was going to see the doctor again. Then they started calling me with dirty names. That kept happening for some time. Then they started throwing things at me and following me. Then I started opening my window a little bit to see if they are around—if they were standing outside, then I stayed inside. Sometimes they were there all day. I just sit inside and wait for them to leave. My GP write to them [the housing provider or Home Office] many times, and after they months they just move me to [name of] area.
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> [Interview with Nia, from Zimbabwe.]

A few other cases were noted in which individuals suffering from PTSD had been threatened repeatedly with knives, physically assaulted, had burning objects forced through their letter boxes, and experienced dogs being set on them as they walked outside their properties. In one case, stones were thrown at a pregnant woman whenever she opened her door or window. In most cases, individuals informed third-party reporting centers and did not approach the police. Nearly all participants in this study indicated a lack of trust in the police. This distrust was partly due to their traumatic experiences with authoritative figures in the countries of origins from which they were fleeing, and partly due to a strong concern that the police would communicate with immigration authorities and expose them as "troublemakers." Individuals feared that filing a complaint would have a negative impact on their cases and/or result in their being deported. The latter scenario was especially feared by people whose asylum claims were rejected.[8] One participant, who was attacked by three men and who had a bottle broken on back of his head, did not want to approach the police as he was treated in a derogatory manner during a previous encounter. He explained:

> after living for months on streets and homeless shelters, I cried to my uncle [for the] very first time. I was so depressed, man. He somehow managed to send me £1200 from Iran. Police catch me with that money and asked, 'why so much money inside your pocket?', 'where did you get this money?' They seized my money. It was £1200 and in Iran it means something, it is a lot of money! The police said, 'you are bullshit,' 'you are dodgy,' 'you are from Iraq'… they say 'terrorist law.' It was too much headache for me. After too much cry, they give me £500 back at police station…

[7] I noted a range of examples of hyper-vigilant behavior, such as individuals feeling afraid to visit the GP's office due to a security guard standing outside the building, as well as incidences where individuals experienced flashbacks due to fire alarm tests and ambulance sirens. Certain individuals were afraid of a postman knocking at their door and remained hidden even after the knocking had stopped. A large number of those experiencing these symptoms were fleeing persecution.

[8] The Conservative government's hostile agenda have made matters worse as police have engaged in data-sharing by reporting the victims of serious crimes to immigration enforcement. This data-sharing has increasingly deterred victims with a precarious immigration status from coming forward to report crimes. Not only is this a breach of the police's obligation under human rights law to investigate serious crimes, but it is also a violation of the civil and human rights of victims who are treated as "undesirables" and "undeserving" of protection and are therefore exposed to further cruelty (see Bradley 2018).

> [Three months after the above incident.] Racist people attack me, they broke my teeth—see here, see here [showing scars and missing teeth], at nighttime they attack me. With a vodka bottle they broke on my neck and I fall down. They punch me repeatedly. I was in hospital with too much blood, they broke my teeth, they nearly broke my nose. Doctor check me and after some time said you are OK inside. They give me some medicine. I could not sleep for many days… I did not complaint to police. I don't trust them.[9]
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> [Interview with Inam, from Iran.]

In another well-publicized case, an at-risk individual approached the police and filed a complaint about racial abuse. His concerns, however, were not taken seriously and/or were dismissed, resulting in his murder. Bijan Ebrahimi, a forty-four-year-old refugee from Iran with severe disabilities, was beaten to death and then set on fire. Prior to his death, Mr. Ebrahimi had been moved to a less ethnically-diverse area in Bristol (England) and lived in a social housing unit. In the months and years before his brutal murder, Mr. Ebrahimi had made forty-four allegations of racial abuse directed at him (including death threats), but only twenty-three were recorded as crimes by the police. Instead of being considered a victim, he was labeled *the aggressor* and, on one occasion, the police *arrested him* for a breach of the peace under the Public Order Act (i.e., for causing harassment, alarm or distress). The police also called him a "serial complainer" and an "attention seeker" (*BBC News* 2017), and considered him to be an annoyance.

As noted earlier, street-level bureaucrats have underlying assumptions about asylum-seeking groups and, therefore, those considered as inherently "fraudulent" do not meet the "ideal victim" profile. Further, the GP had detailed records of Mr. Ebrahimi and evidence that he was depressed, tearful and frightened. Nevertheless, despite his on-going trauma and mental distress, he was not referred to any specialist mental health services, nor diagnosed with any mental illness (Safe Bristol Partnership Report 2017).

Bureaucratic Disbelief, Denial and Cruelty

In my study, a culture of disbelief and denial appeared repeatedly—one which infected the decision-making among bureaucratic actors and agencies, resulting in multiple and hidden victimization of asylum seekers (see also Bhatia and Burnett 2019; Jubany 2017). These street-level actors viewed this group with suspicion and as "staging" mental distress to improve their chances of success with asylum applications or to deceive the state and/or escape control measures. Their disbelief and denial were widely evident through their (in) actions. Bureaucrats wield considerable discretion and power in the day-to-day implementation of public programs (Lipsky 2010) and such discretion is often used in deciding on the granting of support or the denial of care, as explained below.

Mental Health and Denial

A study carried out by the National Health Service (NHS) [2011 (cited by Mental Health Foundation 2016)] indicated that asylum seekers were five times more likely to have

[9] It was not clear on what basis his money was confiscated.

complex health needs and around 61% would experience serious mental distress. In approximately thirty cases encountered during my fieldwork, however, individuals were not able to register with a GP or receive sufficient medical attention. This was due to GPs in certain (dispersal) areas running at full capacity and not accepting new patients. A number of GP offices turned down asylum seekers and those whose asylum claims had been refused. There was a general assumption that people without a "legal" status were not entitled to free NHS treatment or were entitled only to treatment for common medical conditions. Even when individuals were somehow registered, GPs did not consistently arrange for interpreters and asylum seekers were unable to communicate their symptoms due to their lack of proficiency in English. Individuals also mentioned the feelings of hostility they experienced on certain occasions, which made it extremely difficult for them to trust the doctor, speak about their trauma, and seek treatment and support.

In the absence of medical care, certain individuals resorted to self-medication to recover from distressing life events and/or numb the pain of living in limbo. This resulted in asylum seekers accessing psychoactive medication from the underground market. As these drugs were not prescribed by a medical practitioner and originated from an unknown source, their quality and potency were of a questionable nature. Furthermore, these individuals had no (or minimal) knowledge about the dosage or the extent of physical and psychological damage caused by (unmonitored consumption of) psychoactive substances and, in many cases, had no choice over what drugs were supplied to them, which aggravated their conditions. Individuals often overused or misused these substances, and young men in particular (knowingly or unknowingly) consumed huge amounts of anti-neurotics, anxiolytic sleeping tablets, and benzodiazepines, as well as opiates, and had no awareness of the possible dangers and side-effects, causing further injuries.

The mental distress among asylum seekers often increased with the length of time spent in Britain. Post-migratory factors are therefore extremely important in the study of addiction (see also Ager et al. 2002). As highlighted earlier, the problematic use of drugs and substances was also connected to the precarious nature of accommodation (including when asylum seekers became destitute), exclusion from the formal labor market, and living with liminal status, which resulted in a complete loss of dignity and self-esteem and also induced a feeling of worthlessness and hopelessness. This study's findings indicate that asylum seekers are trapped in a vicious cycle and denied appropriate care, which makes their recovery from the traumatic events extremely difficult, as often their trauma and suffering is ongoing: it is neither episodic nor cumulative, but a quality of life itself. The injuries they suffer are structural and not the unintended collateral damages of otherwise benign policies and practices (Michalowski and Hardy 2014). On occasion, individuals tried to escape their liminal existence through self-harm and suicide attempts. Throughout my fieldwork, I documented sixteen cases (including six of the twenty-two participants interviewed) who had attempted suicide or serious self-harm. One participant highlighted the suicide of his friend during the interview and reasons behind it:

> Hazel was my best friend… She walked from [name of location] to [name of location] and back [around five to six miles] every single day. Whether it be winter or raining, she used to do that every day for two and a half years. She couldn't stay at home, just like me she lived far from city center and felt lonely. She had no money, she couldn't work and she was only 32 years old. She always said that once she gets her papers, many of her problems will be over. Then one day she threw herself from the 13th floor balcony [getting emotional]… she did not die straightaway, because she fell on the grass. They called the ambulance, police came also, she was still breathing

> and after two hours the police announced her death. The problem was because of her situation and all that goes back to Home Office. Claiming asylum and then waiting. When you are waiting, you have nothing, you are nothing…
>
> [Interview with Ali, from Iran.]

Similarly, another case recorded in my fieldwork journal highlights the violent consequences of living in limbo and the lack of mental health recognition and support:

> During the interview, Inam mentioned about paying the drug dealer £20-£30 and pleaded to be injected with a cocktail of class A drugs. After some reluctance from the dealer, he was administered with an overdose of meth and heroine and ended-up lying in a semi-coma like state for over 3 days, in an abandoned council estate building. Later, he woke up weak and assumed that it was his spirit rising [Inam was born in an Islamic family and believed in the afterlife], and then he saw his image in a broken mirror and was faced with the disappointment of the beating heart. He had experienced one of the most powerful ontological confrontations of his [planned and failed] death… only to wake up and regret the survival. Inam was twice as powerless to face the harsh reality of "life."[10]

Often the responsibility of looking after and caring for seriously unwell people fell on third sector organizations, as the state bureaucracies somehow absolved themselves of the responsibility of protecting at-risk and vulnerable groups by abandoning them in miserable conditions. In certain cases, treatments were not initiated and/or were subject to asylum case decision outcomes, and treatments were also denied based on the rejection of asylum claims.[11] Furthermore, the Conservative government's austerity policies and cuts in mental health services made the situation worse (see Cummins 2018). In addition, there was one case recorded in which medical professionals colluded with border agents. An individual suffering from active suicidal ideation and severe mental distress was taken to the Mental Health Team and was monitored for three days; immediately afterwards, he transferred from hospital to an immigration removal center (IRC) and prepared for removal. The individual was given what Burnett (2010) terms "repatriation medicine"—minimal medical care only to temporarily stabilize the condition, so as to initiate removal from the country. The focus of repatriation medical care is not treatment or recovery. The charity social worker overseeing the case then had to interact with several professionals, such as lawyers and a third sector psychiatrist, to stop the inhumane banishment attempt of a mentally unwell man.

Medical Thresholds and Decision Making by Immigration Authorities

After "living" in precarious conditions for extended periods of time, eleven individuals facing severe mental distress and psychological illnesses used their medical condition to submit a "fresh" asylum claim on medical grounds (see Right to Remain 2016, 2019).

[10] At the time of interview (and after months of no medical care), Inam began receiving psychological support and counseling from a third sector organization. No probing questions were used and trauma exploration was strictly avoided. Telephone calls were made twenty-four hours, three days and seven days after the interview, and the respondent did not flag any concerns.

[11] In one case, an asylum seeker who was fleeing persecution had a severe facial disfigurement due to gunshot wounds and was considered for facial reconstructive surgery. He had to wait until the three-dimensional models of his face were finalized, but during this period, his asylum claim was refused, and he was rendered destitute. The hospital refused to treat him due to the rejection of his asylum claim.

Nevertheless, they were met with incredibly high medical thresholds, as the system consistently redefined trauma and the criteria for being "genuinely" ill. On numerous occasions, the Home Office outright refused to consider psychiatric reports and other medical evidence. In one case, a claimant diagnosed with psychosis had a negative decision on his application. This decision was accompanied by a refusal letter written by the Home Office case worker, which stated: "*you are not suicidal*" (emphasis added). The letter (indirectly) implied that to be accepted as "genuinely" ill, the person had to have attempted to end his life and to provide evidence of it.

Due to such high thresholds, certain legal advisors also refused to accept mental health cases as they were likely to be refused and/or fail to meet the threshold for indigent services. Once again, acceptance was dependent on individuals having attempted suicide or gone through a near death experience. These requirements became increasingly apparent during fieldwork observation of an interaction between a social worker and a legal advisor. A rejected asylum seeker who was suffering from severe depression wanted to apply for protection based on medical grounds. The individual had indicated that he would rather kill himself than get deported back to his country of origin and was going through active suicidal ideation. The legal advisor declined to represent him and mentioned the need for stronger evidence, such as a description of the planned suicide or self-harm attempts detailed in the medical notes. Not only was there a constant drive to discredit mental distress as a genuine health issue, but also an *acute* lack of governmental strategy to prevent suicide among asylum seekers. In June 2018, news emerged that three Eritrean unaccompanied teenage asylum seekers killed themselves; the absence of inquest findings, however, made it difficult to assess what prompted them to end their lives (Gentleman 2018). Nevertheless, the statements from their close friends indicated traumatic temporality and the exacerbation of mental distress due to state (in) actions. More recently, forty-five NGOs (which include the United Nations Children's Fund (UNICEF), the Children's Society, and the National Society for the Prevention of Cruelty to Children) wrote to the British Home Secretary, expressing "extreme concern" about the rate of self-harm and suicide among this group due to "gaps in statutory support" and lack of awareness of their vulnerability (Bulman 2019).

The fear of forced removal exacerbates mental distress and can trigger suicidal ideation in some individuals (see Asgary and Segar 2011; Hacker et al. 2011). Claimants using this reasoning in their fresh claim applications are subjected to the "test of causation," which is designed to assess whether individuals will attempt suicide irrespective of being subject to removal or whether the removal attempt is likely to cause individuals to attempt suicide. Home Office case workers (who are not qualified medical practitioners) are responsible for deciding on the cause-effect relationship. According to an official document:

> If the risk of suicide or self-harm exists before the person is subject to removal, caseworkers should consider whether the suicide risk would be affected by the decision to remove. This is a question of causation. The test to be applied is whether there are substantial grounds for believing that there is a real risk of a significantly increased risk of serious harm or loss of life through suicide or self-harm. If the risk is unaffected by the prospect of removal, the risk will not result from IND's actions.[Immigration Directorate Instruction, Chapter 1, Sect. 10, Human Rights].

Increasingly, the burden of proof is being transferred to the claimant who has to demonstrate (with the help of a legal advisor, if any) that proposed removal will "genuinely"

increase the present suicide risk. Nevertheless, erroneous decision making can result in at-risk cases being refused. Anita, a social worker, highlighted the obscenity of the system:

> I am working with a very vulnerable woman. She is being detained twice in past few months, and both the times she slit her wrists in a way that it bleeds the most – on a strong spectrum of suicide. She has also tied shoelace around her neck in an attempt to kill herself. She is scared of being deported and feels that death is better than deportation. They have now refused her fresh claim and she is not able to get Legal Aid anymore.

Between January 2008 and December 2018, 3227 incidents of self-harm requiring medical attention were recorded in IRCs (No Deportations 2017). Individual health conditions often deteriorate after exposure to IRCs (also see Medical Justice 2016). The medical practitioner highlighted her sheer frustration with the system, as people receiving treatment and showing some signs of stability were getting detained abruptly and threatened with removal, and upon release, their conditions were worse than before detention (see also Bhatia 2020).

Here, it is important to note that suicide rates among those seeking asylum and undocumented migrants are unknown because suicide data are not recorded according to ethnicity, immigration status or nationality. While suicides and deaths in IRCs receive media attention, those outside IRC are largely unreported. In addition, research on migrant suicide and deaths in suspicious circumstances have remained sparse.

Conclusion: The Permission to be Cruel

By moving away from the notion of "the state" as fixed and innate, it is possible to dig deeper into the ways in which state power and racism have been extended to and enacted by bureaucrats who are imbued with the responsibility for migration control. This article has aimed to unmask the bureaucratic evil and uncover the cruelty that is inflicted on asylum seekers through street-level actions and inactions—a cruelty that is sanctioned by the state. As evidenced throughout this article, asylum seeking individuals' mental distresses were created and/or exacerbated, resulting in people being pushed into "death worlds." The participants in this study felt degraded and dehumanized, and they described living in a state of perpetual confinement, with their daily lives turned into a prison outside of a prison in which they were subjected to never-ending punishment. The injuries inflicted on them were not miscalculations, but rather embedded structurally. Asylum seekers were not only denied appropriate medical care, but their psychological suffering was also dismissed and considered "ungenuine" and/or was not acknowledged as a genuine health problem. Self-harm and suicide attempts showed the tragic (expected and predicted) outcomes of abandonment and neglect, but also the ways in which the abandoned body tried to exercise control and release itself from exclusionary controls.

The British state, despite being a signatory to numerous human rights instruments and projecting itself as a beacon of refugee protection, has rendered this group vulnerable and has exposed them to cruel, dangerous and deathly situations—and has thus engaged in organized deviance. Here, it is important to note that resistance is also growing from within state bureaucracies which oppose the migration control policies and call out the state for its racist policies. For instance, Docs Not Cops (https://www.docsnotcops.co.uk)—a group of NHS professionals and patients—has highlighted the harms of the hostile environment and

its impact on patients, and has pushed back on turning medical professionals into quasi-border officers, thus rejecting the state's permission to be cruel. Similarly, Dr. McDonald (the research participant mentioned above) resisted such policies and treated people with dignity and care. There is a need to reflect on bureaucracies and their role in migration control in order to understand the multifaceted nature, roots and mechanisms of state control, racism and violence, and build resistance against Britain's racist and violent "Departheid system."

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