

Mental health coverage for forced migrants: managing failure as everyday governance in the public and NGO sectors in England

Philipa Mladovsky*

*Corresponding author

Philipa Mladovsky
Assistant Professor
Department of International Development
London School of Economics and Political Science
Houghton Street
London
WC2A 2AE
UK
p.mladovsky@lse.ac.uk

Abstract

High-income countries (HICs) which are said to have “reached” universal health coverage (UHC) typically still have coverage gaps, due to both formal policies and informal barriers which result in “hypothetical access”. In England, a user fee exemption has in principle made access to treatment for post-traumatic stress disorder (PTSD) and other mental health conditions thought to be caused by certain forms of violence universal, regardless of immigration status. This study explores the everyday governance of this mental health coverage for forced migrants in the English National Health Service (NHS) and NGO sector. Fieldwork was conducted in two waves, in 2015-2016 and 2019-2021, including six months of participant observation in an NGO and 21 semi-structured interviews with psy professionals across 16 NHS and NGO service providers. Further interviews were conducted with mental health commissioners and policymakers, as well as analysis of grey literature. Despite being formally covered for certain types of mental health care, in practice asylum seekers and undocumented migrants were often excluded by NHS providers. Undocumented migrants were also often excluded by NGO providers. Several rationalities linked discursive fields to practices developed by psy professionals and other street-level

bureaucrats to govern coverage, in a process of “managing failure”. These rationalities are presented under three paired themes which draw attention to tensions and resistance in the governance of coverage: medicalisation and biolegitimacy; austerity and ethico-politics; and differential racialisation and decolonisation. Rationalities were associated with strategies and tactics such as social triage, clinical advocacy, obfuscation, evidence-based advocacy and silencing critique. The concept of “health coverage assemblage” is introduced to explain the complex, unstable, contingent and fragmented nature of UHC policies and programmes. Misrecognition and underestimation of the everyday work of health professionals in promoting, resisting and reproducing diverse rationalities within the assemblage may lead to missed opportunities for reform.

Keywords: Migrant health services, forced migration, mental health, universal health coverage, neoliberalism, governmentality, NGOs, United Kingdom

1. Introduction: rationalities of universal health coverage

Universal health coverage (UHC) is often conceptualised using a “path” metaphor, which implies that low and middle-income countries (LMIC) need to learn from and “catch up” with, high-income countries (HIC) said to have achieved UHC. This is assumed to require adopting the liberal rationalities of solidarity and the social contract that historically underpinned the principle of equal and comprehensive services for all, based on the right to health, in HIC (WHO, 2010). However, there is a need to complicate and destabilise such mainstream conceptualisations of UHC. HICs which are said to have “reached” UHC typically still have coverage gaps; as demonstrated in this special issue (Probst) certain marginalised population groups lack coverage, and/or services needed by such groups are inaccessible (Cylus & Papanicolas, 2015). A variety of neoliberal and humanitarian rationalities increasingly informs provision of health services to such marginalised groups in the global North *and* populations in the global South. Therefore, rather than LMIC learning from the historical experience of expanding UHC in the global North, the ground may be fertile for learning in both directions (Adams et al., 2019).

This study focuses on a specific area of coverage expansion; forced migrants' access to mental health care in the English National Health Service (NHS). "Forced migrants" refers to heterogeneous forms of migration in which "[...] an element of coercion exists, including threats to life and livelihood, whether arising from natural or man-made causes" (IOM, 2004, 77). Policymakers point to the high burden of mental ill health in forced migrants (WHO, 2018). Among refugees, the literature reports a post-traumatic stress disorder (PTSD) prevalence rate of 9–36%, compared with 1–2% in European host populations. Additionally, refugees who have lived in a host country for more than five years are reported to have higher rates of depressive and anxiety disorders than the host population (Priebe et al., 2016). In the UK, these concerns have converged around reports of unaccompanied teenage asylum seeker suicides (Bhatia, 2020).

A related area of concern for policymakers is that access to health care among forced migrants has become increasingly constrained. The WHO argues there can be no UHC without access for asylum seekers, refugees and undocumented migrants (WHO, 2018). However, ambivalence and undecidability regarding incorporation of these populations into the political body (Diken, 2004) is reflected in national UHC policies, which often restrict their access to care. These policies are often fuelled by fears of so-called "health care tourism" and are increasingly supported by populist immigration policies of deterrence (Shahvisi, 2019). At its inception in 1948, the NHS was a comprehensive service available to all, regardless of British nationality, without charge. Since then, NHS coverage has gradually been eroded with eligibility now being confined to those who are "ordinarily resident" in the UK (McHale & Speakman, 2020). Yet, as in many countries in the global South (Ridde et al., 2012), England has a complex set of health care user fee exemptions. Individuals with a successful or ongoing asylum claim have the same right to access the NHS as citizens, but "undocumented migrants" (namely migrants who overstayed their visa, who entered the UK illegally or who were refused asylum) are charged for using the NHS, except for emergency and primary care. As part of the government's "hostile environment" policy which seeks to deter immigration to the UK, in 2015 fees charged to undocumented migrants were increased to 150% of the actual cost (McHale & Speakman, 2020). However, a further exemption, which provides the focus of this study, is "free treatment at primary, secondary

or tertiary levels in the NHS for physical and mental health conditions caused by torture, female genital mutilation (FGM), domestic violence and sexual violence, provided the patient has not gone to the UK specifically in order to seek that medical treatment” (NHS Charges to Overseas Visitors (Amendment) Regulations, 2015). This means NHS treatment for PTSD and other mental health conditions thought to be caused by these forms of violence is in principle universal, regardless of immigration status.

In UHC policy literature, extending coverage to certain population groups and/or services through user fee exemptions in this piecemeal way has been advocated as “progressive universalism”. This is a technocratic approach to rationing in which policymakers use cost-effectiveness, financial protection and equity data to decide which services and population groups to cover (Jamison et al., 2013). However, critics point out that even when formal barriers to health care such as user fees are removed, multiple informal barriers to access arise, or are left unaddressed. Some informal barriers to accessing health care may be unique to migrants, such as a lack of high-quality interpreters. Other informal barriers are commonly experienced by many marginalised populations due to deficiencies associated with narrow targeting through social safety nets and resulting high levels of health system fragmentation (Mladovsky, 2020a). Such informal barriers include lack of information about which services and groups are exempted from fees, insufficient funding, and poor planning and communication (Ridde et al., 2012).

Indeed, studies seeking to “demigrantize” migrants argue that in the global North, austerity policies following the 2008 financial crisis have resulted in refugees increasingly inhabiting a “shared precarity continuum” with citizens. This is due to “the replacement of both social rights (afforded to citizens) and human rights (afforded to refugees) with humanitarian logics and sentiments” (Cabot, 2019, 747). Therefore, as in the global South, in contexts of austerity in the global North, achieving UHC may merely imply “hypothetical” access which “only ensures nominal, not necessarily effective or realizable, access to health care” (Birn & Nervi, 2019).

Yet informal access barriers analysed in this study derive not only from difficulties associated with immigration and prolonged austerity, but also from specific deficiencies of

mental health service provision. In England, as in most countries in the global North and South, mental health services have long been poorly funded, both in absolute terms, and in comparison to services for physical ailments. Because of this, internationally, the need to expand mental health services is advocated as essential to achieving UHC (Patel & Saxena, 2019). In England, the 2012 Health and Social Care Act created a legal responsibility for the NHS to deliver “parity of esteem” between mental and physical health, but in practice NHS mental health services are still subject to funding cuts, long waiting times and great variability in geographic coverage and quality of care (Cummins, 2018) and as such constitute another case of “hypothetical coverage”. Forced migrants therefore experience multiple, overlapping informal barriers to accessing these services in the NHS.

These overlapping barriers have been quite widely documented, but less attention has been paid to whether and how they can be overcome (Pollard & Howard, 2021). How and why is mental health coverage of forced migrants expanded, maintained or reduced, and by whom? Answering this question requires attending to the everyday practices of public service workers, or “street-level bureaucrats” (Lipsky, 1980), who hold discretionary power in the day-to-day implementation of health services (Gilson, 2015). This study attends in particular to the role of psychology (henceforth “psy”) professionals in deciding which mental health services are offered, how services are offered, and to whom. In doing so, it responds to the call to shift the academic gaze from the large scale suffering of refugees to the bureaucrats who are in the service of both their refugee clients and political state projects (Kalir, 2019).

To study psy professionals’ discretionary power in health coverage, this study draws on the Foucauldian concept of governing through rationalities, also termed “governmentality” (Foucault, 1991). Rationalities emerge in precise sites and at specific historical moments, underpinned by coherent systems of thought, but are often multifarious, competing and contested. They are discursive fields characterized by mutually intelligible explanatory logics, commonly accepted facts and agreement on key political problems. These are linked to practices - specific strategies and tactics - which are also characterized by regularities. Rationalities have a distinctive moral form, embodying conceptions of legitimate authority, including ideals and principles that guide the exercise of authority (Rose, 1999). In the

anthropological literature, one of the most widely studied rationalities of health care provision to marginalised populations is “deservingness” (Holmes et al., 2021). Drawing on this and other literature, this study illuminates how efforts to expand coverage draw on a range of disparate rationalities, borrowed from and exported to a variety of geographic, scalar and sectoral settings.

The study makes three main contributions to the UHC literature. Firstly, drawing on Li’s (2007) conceptualisation of assemblage, it introduces the concept of “health coverage assemblage” to explain how rationalities come together in complex, unstable and contingent ways to govern health coverage. Assemblages are “singular events” that create a momentary sense of order out of “radical heterogeneity” (Nail, 2017), achieved through “the continuous work of pulling disparate elements together” (Li, 2007). While others have analysed how forced migrant mental health services in the NHS are assembled (Brenman, 2019b), this study puts this literature into conversation with studies of UHC globally. The second, linked, contribution is to draw attention to the everyday forms of resistance that emerge in health coverage assemblage in regressive political and/or fiscal contexts, as in the case of forced migrants’ mental health care (Bhatia, 2020). Resistance is here defined as subjects’ invention of alternatives to current governing practices (Mckee, 2009) through the mobilisation of alternative rationalities, or repurposing rationalities to achieve alternative ends (Ferguson, 2010). Thirdly, the study is attentive to the role of ethnoracial hierarchies in producing and reproducing inequalities in health coverage, an issue that has been insufficiently addressed in both the UHC (Adams et al., 2019) and migrant health literature (Viruell-Fuentes et al., 2012).

In the subsequent analysis, rationalities of care are grouped under three paired themes: medicalisation and biolegitimacy; austerity and ethico-politics; and differential racialisation and decolonisation. Overlaps and tensions between and across each pair and implications for health coverage considered. The study finds that despite being formally covered for mental health care, and often despite psy professionals’ progressive intentions, asylum seekers and undocumented migrants were variously excluded by both NHS and NGO providers.

2. Methodology

In 2015-16, I conducted six months of ethnographic fieldwork while volunteering as a fundraising proposal writer at “Sanctuary” (a pseudonym), an NGO in London, England that provides mental health services to forced migrants. In two waves of fieldwork, in 2015-2016 and in 2019-2021, I also conducted semi-structured interviews with 21 “psy professionals” (i.e. clinical psychologists, psychiatrists, psychotherapists, psychoanalysts and counsellors) working with forced migrants across at least 16 different NHS and NGO service providers in London. I conducted a further four interviewees with mental health commissioners in London and national policymakers. Three interviewees (including one from Sanctuary) were interviewed twice, once in the first wave and again in the second wave of fieldwork, in order to gain an understanding of change over time.

I used an interview guide to structure the interviews. Interviews lasted between 50 minutes and 1 hour 45 minutes. I identified interviewees through a combination of online searches and purposive, stratified snowball sampling, to obtain a wide range of stakeholders. Interviews with the psy professionals were conducted until saturation was achieved (i.e. the point at which additional interviews were unlikely to reveal new information).

Due to the COVID-19 pandemic, I conducted the interviews remotely using Zoom, or face-to-face where possible. Interviewees were provided with a consent form. Interviews were recorded and transcribed *verbatim*. To ensure confidentiality, interview quotations were anonymised. I also analysed peer-reviewed and grey literature, including policy documents, and attended several local, national and international specialised conferences and meetings as a participant observer. Data from fieldnotes, interviews and document analysis were triangulated. I analysed transcripts and fieldnotes inductively to identify themes, using NvivoR1. Ethical approval was obtained from the XXX Research Ethics Committee [09579].

3. Medicalisation and biolegitimacy

Interviews with clinical psychologists treating PTSD in NHS secondary or tertiary outpatient departments, termed “trauma services”, revealed conflicting rationalities governing forced migrant mental health service coverage. One important tension related to the UK immigration system’s role in forced migrant trauma symptomology. Several clinical psychologists told me that many of their forced migrant patients would not require PTSD treatment if the asylum system were less hostile:

There are people we see... after sorting out the housing and immigration, they feel okay and they settle in, think about other things like their (English) classes and people they've met, and then the past doesn't bother them anymore, because they feel like they've got a new future. (12, clinical psychologist, NHS trauma service)

Their view is supported by a substantial body of international and UK research demonstrating that immigration regimes contribute to refugees’ and asylum seekers’ deteriorating mental health (Bhatia, 2020; Laban et al., 2005; Silove et al., 2000). In particular, immigration detention has been found to not only exacerbate existing mental health disorders, but also contribute independently to the onset of new ones (Priebe et al., 2016). These findings raise particular concerns in the UK, which has one of the largest immigration detention estates in the world, detains asylum seekers indefinitely and illegally detains those who are deemed mentally ill (Mladovsky, 2020b). The rapid growth of “cimmigration controls” in Britain have also been found to harm forced migrants’ mental health (Bhatia, 2021).

However, perhaps unsurprisingly, the government and its executive health agencies do not seem to subscribe to this view. The treatments for PTSD recommended by NICE (the National Institute for Health and Care Excellence) in its Clinical Guidelines (NICE, 2018) mainly involve three types of therapy, based on evidence of their clinical and cost effectiveness. These are Trauma-Focused Cognitive Behavioural Therapy (TF-CBT); Narrative Exposure Therapy (NET); and Eye Movement Desensitization and Reprocessing (EMDR). Social interventions related to the immigration system are not recommended. Similarly, in Public Health England’s migrant mental health guide (2017), there is no mention of the immigration system or detention as risk factors, the focus being rather on traumatic events

occurring prior to and during the migration journey. The user fee exemption also seems to preclude the possibility of treatment being required for violence experienced in the UK, with the clause: “provided the patient has not gone to the UK specifically in order to seek that medical treatment”. The exemption was indeed interpreted this way by clinical psychologists in the NHS when providing justifications for exempting patients from paying fees to Overseas Visitors Officers, whose role it is to identify ineligible migrants and charge them for care:

they (Overseas Visitors Officers) were trying to charge one of my clients and... there is a clause that if they were a victim of abuse or violence in their home country, then they would be exempt. And she was, so she was exempt of charges (I2, Clinical Psychologist, NHS)

The controversial practice of treating PTSD in immigration detention centres, initiated by a policy amendment by the UK Border Agency in 2010, similarly implicitly assumes migrants’ psychological suffering is caused by violence in their “home countries”. This practice arguably obscures the role of the UK immigration system in forced migrants’ mental ill health and is akin to “*treating burn wounds of people who are still on fire*”, in the words of a refugee activist I met at a conference.

Through such policies and practices, the UK government was able to extend mental health service coverage to forced migrants, including those who were undocumented and / or in detention, without acknowledging the paradox that government policy itself was at least in part causing the mental health problems to be treated. In doing so, the government mobilised “medicalisation” as a powerful rationality of health coverage. In the field of mental health, medicalisation attributes psychological suffering to biological issues within the body and brain and assumes the course and outcome of mental disorders depends solely on access to mental health services and medication (Clark, 2014). Globally, in many diverse contexts, medicalisation of psychological suffering problematizes the behaviours and biology of individuals living in adversity, rather than the structural causes of adversity (Clark, 2014; Summerfield, 2001). This approach subsumes diverse realities under the single concept of “trauma”, so that survivors of many different forms of violence can all receive

the same diagnosis of PTSD and the same medical interventions, regardless of their specific context (Fassin & Rechtman, 2009), as one clinical psychologist explained in regard to NET:

(the treatment's) strongest evidence base is actually with asylum seekers and refugees... (but) I have often done it with white British clients... (it's) a really nice model which came out of... refugee camps in Uganda, (and) other places. (I4, clinical psychologist, NHS)

Following this approach, many clinical psychologists believed treatment was effective regardless of the patient's current living conditions or experiences of the immigration system:

there are people who, no matter what treatment they receive on arrival, they're still going to have PTSD because of what they've been through before they arrive. You could put them up at the Ritz, they will still have that experience. (I13, clinical psychologist, NGO)

However, some NHS clinical psychologists were able to appropriate and repurpose medicalisation as a rationality of health coverage, in order to tackle what they believed to be structural causes of their patients' trauma. They did this by providing asylum seekers and undocumented migrants with social support to counteract some of the harmful effects of the immigration system. This included clinical advocacy in medico-legal, housing and welfare casework, prior to and alongside trauma-focused therapy. In doing so, they redirected NHS mental health care funding to the provision of multi-sectoral social support. For example, they assisted their patients to access improved housing, by demonstrating to housing authorities that their patients' medical condition was being caused or made worse by their housing conditions. All the NHS clinical psychologists who engaged in this type of advocacy justified their approach by citing clinical evidence, in particular the work of Judith Herman (2015) on "stabilisation" which demonstrates that social interventions make psychological treatment more effective. As such, they resisted medicalisation by employing a rationality of care termed "biolegitimacy".

Biolegitimacy is defined as "the legitimization of rights in the name of the suffering body" (Fassin, 2005). In the case of mental health care, clinical advocates using the biological

narrative of trauma have created biolegitimacy for “victims” in diverse global contexts to claim otherwise unavailable social and political rights (Fassin & Rechtman, 2009). However, in the NHS and elsewhere, biolegitimacy has important limitations. It requires medical professionals to reproduce hierarchical power relations by privileging their professional expertise over their patients’ lived experienced (Pushkar, 2019). Furthermore, biolegitimacy is mobilised by a narrow, humanitarian, neoliberal “politics of compassion”, rather than an ethos of social justice, shifting the right of receiver to obligation of the giver (Ticktin, 2011). Hence, forced migrants gained decent housing not because it was their right to do so, but because street-level bureaucrats argued that certain individuals with PTSD deserved to do so. Yet just as bureaucrats’ discretion could be used to grant welfare, it could equally be used to remove it, especially in contexts of resource constraint. As a result, by requiring them to occupy a position of victimhood in order to gain rights, this “deservingness” ultimately provided people with adverse incorporation into systems of welfare or aid.

4. Austerity and ethico-politics

Despite politicians’ promises to “ringfence” health spending, growth in the overall NHS budget slowed under government austerity measures following the 2008 financial crisis (Shahvisi, 2019). Although in 2013 extra funding for mental health was pledged by the government in an effort to achieve “parity of esteem” with other types of health services, these resources were insufficient to redress the effects of austerity and other longstanding deficiencies in NHS mental health care (Cummins, 2018). As a result, NHS trauma services frequently experienced budget cuts and recruitment freezes. This in turn resulted in extremely long waiting lists for treatment of two years or more. In many cases waiting lists were exacerbated by resource pressures associated with the COVID-19 pandemic. As in other contexts (Horton, 2006), psy professionals in the NHS had developed a range of strategies and tactics to continue providing care to forced migrants within the constraints of fiscal austerity. For example, some services had cut the number of therapy sessions offered to each patient from thirty to sixteen, the lowest effective limit determined by clinical studies, according to the clinical psychologists. Patients increasingly received only a minimal package of care, with limited social welfare support. Obfuscation was another important strategy, encompassing many practices. For example, some trauma services had introduced

cheaper and/or less effective forms of treatment, such as using trainee assistant psychologists to provide psychoeducation, in advance of the main therapeutic intervention to “hide” the extent of the waiting list. Austerity was thereby eroding medicalisation and turning NHS trauma services into a “humanitarian bureaucracy” which left patients in a liminal space between failing to “make live” and avoiding to “let die” (Sahraoui, 2021) through suicide. This humanitarian premise similarly characterises UHC policies in many countries undergoing austerity measures in the global South (Prince, 2017).

Alongside these various coping strategies, in the NHS as in the global South, fiscal austerity as a neoliberal rationality of coverage (Sparke, 2017) led to social triage (Biehl, 2009), with street-level bureaucrats rationing care. Crucially, some NHS trauma services had decided to select patients whose living conditions were deemed to have already “stabilised” for treatment. These were mostly patients who had already successfully claimed asylum, but nevertheless continued to experience PTSD symptoms. Patients requiring time-consuming and therefore costly clinical advocacy prior to, or in tandem with, psychological treatment, were no longer accepted onto the waiting list. As a result, undocumented migrants and those with an ongoing asylum claim effectively became ineligible for NHS treatment, rendering coverage through the user fee exemption “hypothetical”. Austerity had rendered social welfare for complex, precarious patients unviable; this in turn resulted in the exclusion of these patients from coverage and deepened inequalities in access to health care (Sparke, 2017). Ironically, the NHS clinical psychologists’ progressive intentions had led to the exclusion of the very patients they sought to support. However, since immigration and asylum data are not routinely collected for clinical monitoring and evaluation purposes (Aspinall, 2014), these inequalities were largely invisible to policymakers and the public. Ultimately, austerity had eroded biollegitimacy as a rationality of health coverage. Some NHS clinical psychologists, out of concern for their patients, tried to continue working on “stabilisation” activities outside their official working hours. However, they were concerned about the risk of burnout and worried that this model of care was unsustainable.

Another strategy to fill service gaps, typical in contexts of austerity, involved shifting publicly provided health services to the private sector (Sparke, 2017). In England, trauma services for forced migrants are also provided by NGOs which specialise in treating PTSD in survivors of

torture and trafficking. These services are provided free of charge. There were various modes of partnership between these NGOs and the NHS, which blurred public / private sector boundaries. For example, sometimes these NGOs were formally commissioned by their local NHS Clinical Commissioning Group (CCG) to provide publicly funded mental health services. In other cases, NHS providers that were unable to provide appropriate care referred individual patients to NGOs in an ad hoc manner. A clinical psychologist in one of these NGOs said the number of referrals from the NHS had been increasing in recent years, due to NHS budget cuts:

It is very concerning that there's a large number of people that are falling in the gaps between (NHS) services very obviously, and they are coming to us hoping that we can plug that gap, but we're not able to. We don't have the capacity, we're a very small charity (15, Clinical psychologist, NGO)

Hence NGOs had become important actors in the expansion of health coverage, as in many other global contexts (Adams et al., 2019). Several clinical psychologists in the NGO sector told me that NHS providers' refusal to treat migrants in the process of seeking asylum was unethical. However, faced with budget constraints, these NGOs similarly engaged in social triage to decide which types of migrants to prioritise. In many of these NGOs, psy professionals took the opposite approach to triage to the NHS; rather than rejecting "unstable" patients, they prioritised precisely those patients who were deemed "unstable", specifically those who were still in the process of claiming asylum:

Our criteria essentially is, has the person been a survivor of human rights abuses? Are they still in the asylum system or immigration system somewhere needing legal protection? (15, Clinical psychologist, NGO)

This was because these NGOs wanted their clients to benefit from the full scope of services they offered, including not only clinical advocacy in medico-legal and housing casework, but a wide array of other forms of support, such as destitution prevention, counter-trafficking, creative arts, gardening and specialised GP consultations. In these refugee-focused NGOs, there was an emphasis on coproduction, involving volunteering and participatory service

delivery, with inputs from forced migrant “experts by experience” resulting in changed care pathways, for example. These various forms of support were neoliberal governmentality techniques, in the sense that they encouraged forced migrants to develop self-reliance, autonomy, active citizenship and resilience (Rose, 1999), as explained by the Clinical Director of Sanctuary:

Our job here is to build the confidence and resilience of people to do their own things... (11, Clinical Director, NGO)

This would in turn help forced migrants “become increasingly valuable members of society in terms of their ability to work, contribute to the economy, study”, as a clinical psychologist from another NGO stated. Hence, in these NGOs which explicitly targeted forced migrants, rationalities of human rights and neoliberal citizen-subject formation converged, both prioritising “individuals who take responsibility for creating the conditions of their own flourishing” (Nash, 2019), in order to govern health coverage. Neoliberal citizen-subject formation is an important rationality of health coverage in other contexts where NGOs have taken on a role in health coverage struggles (Mladovsky, 2020a). Yet patients who were unable or unwilling to engage in responsabilising neoliberal techniques of citizen-subject formation were in practice excluded from health coverage (Biehl, 2009). This was because by prioritising people who were willing and able to benefit from asylum legal support, the NGOs explicitly or implicitly excluded undocumented migrants, who remained outside the asylum system. Hence, again, despite psy professionals’ progressive intentions, the coverage of undocumented migrants was rendered “hypothetical”.

One of the few NGOs that did routinely provide counselling to undocumented migrants described itself as specialising in mental health care for racialised Black communities, including settled and recent migrants and Black British citizens. A counsellor from this NGO explained that due to hostile environment policies, her undocumented migrant clients felt unable to claim asylum, even though they viewed themselves to be refugees. They “paid for this decision with their mental health”, having developed PTSD and other mental health issues, in part due to constant fear of deportation. As a result, they commonly ended up on a “cocktail of medication”. The NGO sought to address these problems by offering talking

therapies free of charge, provided by Black counsellors who volunteered their time. Medico-legal advocacy with the immigration system was not offered, meaning this NGO did not routinely cater to people actively seeking asylum. Rather, a politics of decolonisation was integral to this service:

In our service the client is mirrored by another Black person. This helps the client to see themselves as worthy; they are listened to and understood at the heart of their being. (I14, counsellor, NGO)

Since the late 1970s, a decolonising rationality of coverage has mobilised a campaign against racial discrimination in mental health care in the UK (Fernando, 2017; Nazroo et al., 2020), which has resulted in a raft of policies and services designed to reduce coercive practices in mental health and ethnic inequalities therein (Joint Commissioning Panel for Mental Health, 2014; Wilson, 2009). This campaign was situated within a wider postcolonial “struggle over national belonging (which)... in part took the form of conflicts over racialized inclusions and exclusions within the welfare regime...” (Lewis, 2000, 35) in the UK, which began after the Second World War. This struggle entailed Black and Asian people in Britain both appropriating and resisting the liberal rationality of multi-culturalism, characterised by paternalistic ideologies of assimilation, integration and passive dependence on the state. Appropriation involved embracing the discourse of ethnic minority status, while resistance involved the counter-discourse of “blackness” (Lewis, 2000). The mental health NGO was engaged in both these decolonising discourses. However, the counsellor explained there were now very few similarly specialised mental health NGOs serving specific racialised minorities in London, as, due to austerity, funding had repeatedly been cut. Austerity had once again eroded migrant health coverage expansion. At the same time, undocumented migrants’ incorporation into the NGO’s services according to these decolonising discourses points to the need to attend to the complexity and intersectionality of migrant subjectivities in research on equity and health coverage (Giordano, 2018; Kehr, 2018). It also highlights the utility of the assemblage approach in challenging traditional analytic categories in migration research (Wiertz, 2021). More broadly, it illustrates the need to challenge simplistic social categories related to gender, class and race in UHC and other global health policy debates (Adams et al., 2019).

In sum, each service provider had developed its own apparently progressive ethical framework to justify rationing decisions, often in opposition to another framework deemed regressive or discriminatory. However, this social triage (re)created inequalities by variously excluding asylum seekers and undocumented migrants. This fragmentation and diversity of rationalities, techniques and tactics at play across the public and NGO sector can be thought of as a form of “ethico-politics”. Mental health service providers were nested in communities through which individual identities could be constructed through their bonds to diverse micro-cultures of values and meanings. In neoliberal regimes, these communities are politically objectified and instrumentalised by government (Rose, 1999). As spaces of ethical dispute, these communities provided scope for both expanding and limiting health coverage for forced migrant mental health, by mobilising medicalisation, biolegitimacy, austerity, human rights, multi-culturalism and decolonisation as rationalities of health coverage.

The concept of ethico-politics draws attention to ways in which governance is dispersed through a myriad of micro-centres of knowledge and power (Rose, 1999). This study has highlighted how rationalities of coverage were legitimised, but not determined, by clinical evidence, such as NICE guidelines and Judith Herman’s research. Indeed, almost all service providers in the NHS and NGO sectors used clinical evidence as an advocacy tool to attract funding. This often involved collecting and presenting data in a performative manner, primarily in order to satisfy funders’ demands for evidence in an increasingly fragmented, contested and diverse field of expertise. This is a common practice in global health programmes, termed “evidence-based advocacy” (EBA) (Storeng & Béhague, 2014). On one hand, with its prioritisation of quantitative data, cost-effectiveness studies and randomized control trials, as in NICE clinical guidelines for example (NICE, 2018), EBA represented a “technocratic narrowing” of the types of evidence and arguments that could legitimately be used to allocate funding. The displacement of other forms of evidence and political, social justice-based arguments represents the rise of “calculative accountability” that characterises neoliberalism (Chiapello, 2017; Rose, 1999), global health (Adams, 2016) and contemporary immigration regimes (McPhail et al., 2016).

On the other hand, integral to EBA was resistance and evidence contestation, with efforts to “authorise knowledge” (Li, 2007) constantly evading actors in the assemblage. For example, in the NHS, where senior clinical psychologists are expected to use data to make internal “business cases” in order to fund specialised services, a psy professional told me she had gained funding based on data which she herself described as “thin”, leading her to conclude that the use of evidence in the NHS was “fucked up”. In an NGO providing psychotherapy and psychoanalysis to forced migrants, therapies not included in the NICE guidelines for treating PTSD, psy professionals reluctantly collected quantitative data on their patients’ mental health outcomes so it could be used to generate statistics in order to gain funding, even though they saw no value in this type of evidence. At the same time, some of these psy professionals engaged in more plural and multidisciplinary research which they deemed to be of great value and which they published in specialized professional journals. They argued their so-called “integrative” approach to treating PTSD, founded on this research, was missing from, and largely incompatible with, PTSD treatment in the monolithic NHS structure and culture. Some of these psy professionals argued the diagnosis of PTSD on which NHS trauma services and NICE guidelines are founded was invalid and culturally specific to Western populations (Summerfield, 2001). Hence in the UK and elsewhere (Brenman, 2019b; Giordano, 2018), disputes over authorising knowledge mobilised forced migrant mental health coverage. This illustrates the incompleteness and limitations of neoliberal calculative accountability (Chiapello, 2017).

Yet, as well as fragmentation, a form of alignment had been forged across the NHS and NGOs which catered to different forced migrant sub-groups. It could therefore be said that psy professionals’ governance of forced migrant mental health care was mobilised around a “point of convergence and fracture” (Li, 2007). This segmented provision cannot be viewed as a form of collaboration though. On the contrary, several interviewees argued that collaboration within the sector had been eroded by austerity, with its focus on efficiency and cutting costs:

Everything has to have... an objective and... actually... networking doesn't start that way, because you're exploring what each other's doing... and then maybe two or three years

down the line you go, "Oh, right... here would be an interesting collaboration." All of that stuff has gone... because austerity has just crunched us all down. (18, manager, NGO)

Rather, this segmentation of services can be more accurately interpreted as “managing failure” (Li 2007), having emerged from various rationalities mobilised by psy professionals in an informal and improvised manner in order to maintain the health coverage assemblage in a context of austerity (Prince, 2022). Despite psy professionals’ progressive intentions, ultimately the outcome for undocumented migrants was exclusion from mental health coverage in the NHS and a large part of the NGO sector. Several interlocuters confirmed this finding.

5. Differential racialisation and decolonisation

By rendering undocumented migrants’ (and in the NHS asylum seekers’) mental health coverage largely “hypothetical”, the social triage described above not only reinforced inequalities in access to health care, but also inadvertently reproduced a rationality of differential racialisation. As defined by Erel et al (2016, 1347), differential racialisation situates “racialized subjects through distinct, yet overlapping, hierarchies of legal status, gender, culture, class and social space, facilitating politically discontinuous subject positions”. Differential racialisation promotes multiple and co-existing stratifications in which populations are ranked as more or less belonging to the nation. For example, in the UK, racialised nationals are situated as a precarious ‘us’ in relation to new undesired others, while undocumented migrants are vilified as “bogus asylum seekers” and criminalised (Bhatia, 2021). Yet this racialisation typically takes place without recourse to explicit discourses of race. International immigration regimes similarly silence anti-racist critiques by rarely explicitly evoking racist rhetoric (Kalir, 2019). In the UK and elsewhere, by uncritically employing immigrant categories such as “undocumented migrants” and “asylum seekers” to ration care, street-level bureaucrats may unconsciously serve these racist state projects (Bhatia, 2020; Kalir, 2019). Indeed, by excluding asylum seekers and / or undocumented migrants from mental health services, many psy professionals unconsciously reproduced differential racialisation as a rationality of coverage. Yet because they justified this exclusion using other, often clinical and fiscal, rationalities, they obscured ethnoracial

hierarchical systems of rights which produce and reproduce health inequality (Kehr, 2018; Viruell-Fuentes et al., 2012). Here, as in other assemblages, political decisions about the distribution of resources appeared as technical solutions to technical problems (Li, 2007).

Yet, often prompted by international and national political events, some psy professionals made attempts at resistance through engagement with various forms of decolonising critique. For example, the Windrush scandal in the UK, where predominantly Black people deriving from the Caribbean people were wrongly detained, deported and denied legal rights, including the right to health care (Gentleman, 2019; Williams, 2020) had recently brought to the public's attention the continuity of pervasive structural racism in the immigration system (de Noronha, 2019; Kalir, 2019; Williams, 2020). An NGO director told me that in a private meeting with government officials she had drawn a comparison between racist discrimination against the Windrush generation to the poor treatment of asylum seekers, in an effort to improve conditions in immigration detention. Meanwhile, the international rise of the Black Lives Matter (BLM) movement had prompted some white NHS clinical psychologists in trauma services to address issues of race within their practice for the first time. However, psy professionals experienced many difficulties in mobilising this resistance. For example, white clinical psychologists lacked clarity on how to define racism in therapeutic settings:

...sometimes things happen to them (patients) and I think it's racist, but they haven't viewed it that way. And then you don't know whether it's helpful to get them to see it that way, in case it wasn't. (I2, clinical psychologist, NHS)

Linked to this, they found that patients of Middle Eastern origin often did not identify with the BLM movement and they were unsure about how to frame conversations about race with these individuals. They had started to discuss these various race-related issues in supervision sessions and clinical meetings but complained there was a lack of formal guidance or policy within the clinical psychology profession:

There's no guidelines. I'm sure it's mentioned somewhere that refugees are more likely to experience racism. I think that's a no-brainer... but certainly no guidance about how to consult with individuals. (15, clinical psychologist, NGO)

There were many possible reasons for the lack of guidance, including longstanding institutional racism in clinical psychology itself (Fernando, 2017).

Meanwhile, other types of psy professionals in NGOs delivering intercultural mental health care (Fernando, 2014) were more experienced and adept at discussing race and racism in therapeutic settings. Intercultural approaches incorporated subjective and contextual factors such as ethnicity, race, religion, patriarchy and authoritarianism into psychological treatment. However, these psy professionals, who in some cases had themselves emigrated from the same countries as their refugee patients, were often reticent about making anti-racist critiques publicly. This was due to concerns that such critiques would jeopardise both government and private sources of funding. For example, when reviewing a funding proposal I had written, the Clinical Director of Sanctuary queried the use of the word “racism” in the text and asked me not to refer to racism unless quoting directly from a government source, because “donors don't like it”. A psy professional in another intercultural NGO told me:

As an organization, we cannot be political... we are a (service) delivery organization, rather than political. Also, majority of the time, I've noticed that funding will be affected... I attend different meetings and I can see how the things are being operated. (112, psychotherapist, NGO)

Furthermore, none of the NHS or NGO psy professionals explicitly providing services to forced migrants had participated in the longstanding decolonising campaign against racial discrimination in mental health care in the UK which started in the 1970s (described above). At the same time, the campaign against racial discrimination in mental health care has tended to avoid explicit references to forced migrants. For example, the NGO providing mental health care to racialised Black people discussed above did not publicly frame its service as “migrant” or “refugee” focused and did not engage in clinical advocacy in the

immigration system. Similarly, policies to reduce ethnic inequalities in mental health barely mention forced migrants (Joint Commissioning Panel for Mental Health, 2014; Wilson, 2009). This is not necessarily an “omission”; immigration categories such as asylum seeker and undocumented migrant are primarily administrative definitions and political constructs, not necessarily representations of actual migratory accounts (Zetter, 1991) and their usage is therefore often problematic. Additionally, anthropologists working on migrant health have found that “...categories are always composite and relational, and that refining, splicing, or splitting them is unlikely to make them better or more accurate” (Brenman, 2019a). Nevertheless, a disjuncture had emerged, where the albeit limited resistance to differential racialisation in the forced migrant sector had little to no connection to the longstanding struggle of racialised minorities to combat racism in mental health services more broadly. There is a need to explore this issue in future research, since outside of the US (Viruell-Fuentes et al., 2012), there is a dearth of analysis of how immigration categories obscure the role of ethnoracial hierarchies in producing and reproducing health inequality.

6. Conclusion

This study has drawn attention to a process of social triage which segmented mental health coverage of forced migrants in London, and perhaps more widely in England. Some NHS providers covered only those who had already claimed asylum; while those in the process of claiming asylum were covered by refugee-focused NGOs; and those who were undocumented were covered by a small NGO providing services for racialised Black patients. Emerging from a process of “managing failure”, this coverage was informal and contingent, consisting of various tactics and strategies inhering in several rationalities of care.

Medicalisation enabled the state to formally extend mental health coverage to undocumented migrants through a user fee exemption, obscuring the paradox of the state in part causing, or at least exacerbating, the mental health issues to be treated.

Biogitimacy was a counter-rationality through which psy professionals, acting as street-level bureaucrats, appropriated medicalisation and advocated for social welfare and legal support for their forced migrant patients. While austerity often negated their clinical

advocacy, it also promoted a form of ethico-politics across the NHS and NGO sector, characterised by diverse micro-cultures of values and meanings and micro-centres of knowledge and power. Asylum seekers and undocumented migrants were variously included and excluded from services, as psy professionals pursued diverse rationalities of coverage, such as human rights and decolonisation, in order to “manage failure”. Some rationalities resisted, while others inadvertently reproduced, a rationality of differential racialization, in which immigration categories obscured the role of ethnoracial hierarchies in producing and reproducing health inequality. Taken together, these variously contested, reproducing and overlapping rationalities constituted a form of “health coverage assemblage”.

By analysing rationalities, the study complicates international policymakers’ conceptualisations of both migrant health coverage and UHC reform more broadly. Progressive universalism presumes a formal, technocratic approach to rationing which is belied by a close inspection of everyday governing practices. By “rendering technical” the complexities of the social world (Li, 2007), UHC policymakers commonly overlook the everyday governance of expanding health coverage. This governance involves the imagining and reimagining of services, treatments and beneficiaries by health professionals and other street-level bureaucrats. This involved triaging patients according to a variety of competing and overlapping rationalities, redirecting funding by generating, authorising and disrupting knowledge and tactically resisting but also legitimising state authorities that upheld both structural and physical forms of violence towards the very patients the services sought to support. This can be thought of as a continual process of “re-assembling as the ground shifts”, part of a wider effort to hold disparate parts of the assemblage together (Li, 2007). Misrecognition and underestimation of the everyday work of health professionals and others in promoting, resisting and reproducing the diverse rationalities within the assemblage may lead to missed opportunities for UHC reform, in the NHS and in health systems internationally.

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