The Children's Society

No child should feel alone

Distress signals: Unaccompanied young people's struggle for mental health care

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Foreword

by Professor Russel Viner, President of the Royal College of Paediatrics and Child Health (RCPCH)

I am delighted to welcome the Distress Signals report by The Children's Society. For children and young people entering the UK unaccompanied, the experience can be bewildering and daunting. For some unaccompanied young people, they are escaping persecution and fleeing conflict from their country of origin. During their journey to the UK, many will experience abuse and exploitation. These experiences can have a detrimental effect on their mental health and well-being, and their ability to lead healthy and productive lives in the future. I expect this report to play an important role in raising awareness of the mental health needs of unaccompanied young people and the best practice to support them and their mental health needs.

Since 2013 the number of unaccompanied young people looked after by English local authorities has increased by a staggering 134% .Therefore, there is an urgency in tackling this issue and delivering a coordinated and comprehensive response to some of the most vulnerable young people in England.

Delivering parity of esteem for mental health is essential if we are to tackle the mental health and well-being issues young unaccompanied people are presenting with. Early identification and intervention are essential to ensure that unaccompanied young people can access the services and support they need to offset the effects of mental health problems. All clinicians and practitioners working with and caring for vulnerable unaccompanied young people should be trained to identify mental health problems and know how to intervene early.

Paediatricians are often the first point of medical contact for unaccompanied young people. That is why it essential that they know how to identify unaccompanied young people and any mental health or well-being issues that they disclose in a sensitive, timely manner. It is also essential that they refer these unaccompanied young people on appropriately to other services such as Child and Adolescent Mental Health Services.

The Royal College of Paediatrics and Child Health has produced information to support paediatricians in assessing and managing unaccompanied young people. And earlier this year, the college published a new curriculum which specifically provides a framework for trainee paediatricians to equip them with skills, knowledge and expertise to identify children and young people with mental health and well-being problems. I hope that both of these resources will help to remedy some of the issues raised in this important report.

Paediatricians cannot drive improvements in health outcomes for unaccompanied young people alone. But we are committed to supporting our members and working with service planners and other health organisations to serve the interests of unaccompanied young people and ensure that their right to the best possible healthcare (as enshrined in the United Nations Convention on the Rights of the Child) is delivered.

I urge all health professionals working with unaccompanied young people to read this report and its recommendations. It is time for everyone concerned to work together to ensure every unaccompanied young person entering the UK receives the best possible care in response to their mental health needs. I cannot stress enough the urgency of seizing this window of opportunity to support and fulfil our duty of care to some of society's most vulnerable young people.

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We would also like to thank The Children's Society's staff in projects in London, Birmingham, Manchester and Leeds, as well as all the interviewees from CAMHS services and NGOs across the country, who shared their experience, expertise and case studies from their practice with us. Thank you to Larissa Pople, Ilona Pinter and Richard Crellin for their guidance and support with this project.

Most importantly, we would like to thank the ten young people who access support from The Children's Society across the country, for speaking with us about their experiences for this project. Many of these young people are still struggling to fulfil their goals and achieve the security that they deserve. We wish them every success for the future in achieving all that they hope for. We hope that sharing their experiences in this report will help to improve outcomes in their lives, as well as those of other young people who face similar struggles.

Introduction

Unaccompanied young people fleeing war, persecution and other struggles can take a range of difficult journeys to arrive in the UK and frequently experience issues such as family breakdown, bereavement, exploitation and torture. When they arrive in this country, we expect their hardship to be reduced and their well-being to increase. However, our research has found that this may be far from reality. Young people can face a protracted battle to achieve stability in their lives, with immigration processes, lack of material support, isolation and other barriers stopping them from feeling the safety we would hope to provide for them.

When mental health and well-being concerns arise, we would expect unaccompanied young people to be able to access the range of support available for other young people – but they encounter barriers in doing so. If an effective plan to assist them at the earliest opportunity is not implemented, young people can be left unable to navigate existing systems for support. As a result, their problems can become more complex, leading to long-term difficulties.

This report provides an overview of what is currently known about the mental health needs of unaccompanied young people living in England and Wales. It brings together learning on mental health outcomes for vulnerable young people, with a specific focus on unaccompanied young people and emerging good practice models for supporting them within local authorities and mental health services. It also considers how the best interests of young people can be protected in assessments and decisions about their care, and how their voice and needs can be appropriately centred.

The only official statistics currently recorded on numbers of unaccompanied young people within the UK record the annual number of unaccompanied asylum-seeking children (UASC) in the care of English local authorities. In the last few years, the number of UASC looked after by English local authorities has increased; the total number at the end of 2017 was 4,560 – a 6% increase since 2016 and a 134% increase since 2013.[1] Some of the young people have arrived in England of their own accord, whereas others have arrived through various schemes such as Section 67 of the Immigration Act 2016[2] (otherwise known as the Dubs Scheme) or through the Dublin III Regulation[3] to be placed with family members that are already resident in the UK.[4] Children that have arrived in the care of local authorities unaccompanied, but need to regularise their immigration status through non-asylum routes, will not be included in these figures.

Since most unaccompanied children arriving in the UK were concentrated in a small number of local authorities, in 2016 the Government introduced a National Transfer Protocol[5] to ensure that all local authorities are supporting an equitable number of unaccompanied young people. The protocol has meant that all children's social care teams – including those that historically supported a high number of unaccompanied

asylum-seeking and other unaccompanied migrant children, alongside those that previously supported few children – have had to adapt their practices to be more sensitive to unaccompanied young people's needs.

The availability of local services such as advocacy, healthcare, mental health support and education for these young people has often not increased in accordance with demand, meaning that practice and outcomes across different localities have varied. This report considers some of the ongoing needs of unaccompanied young people supported by services, as well as those left without support.

Mental health needs of unaccompanied young people can result from the stresses of pre-migration events, the journey itself or post-migration experiences. They typically range from difficulties in integrating, building relationships and adapting to their new life, to severe psychiatric issues such as sleep disorders, depression, psychosis and bipolar disorder (among others). It is difficult to quantify the frequency of issues that unaccompanied young people present with because of varying access to services, diagnosis protocols and a lack of any systematic data collection on their needs.

The Children's Society has supported young people from refugee and migrant backgrounds since World War II[6] and we continue to provide this support through our frontline services across England – in Tyneside, West Yorkshire, Greater Manchester, the West Midlands and London – as well as through research and policy work in England and Wales. We also provide mental health services like counselling and drop in centres for all young people, and undertake policy and research work into children and adolescent mental health services and children's subjective well-being.[7,8]

This report is intended as a resource for parliamentarians, policy makers, commissioners, local authorities and others to provide information on the needs of unaccompanied young people and the ways in which they could adapt services and ways of working to better support them. It is also intended to provide information for social care professionals, educators, legal professionals, NGOs, researchers and others that have an interest in the needs of unaccompanied young people.

Although the focus of this report is not clinical, it does explore some common mental health issues that young people present with, as well as effective methods to support them. The aim is not to propose particular clinical interventions for supporting young people, but rather to ensure mental health needs are prioritised alongside material needs. It also aims to encourage an approach of integrated mental health services within a holistic package of support.

Executive summary

Unaccompanied young people fleeing war, persecution and other struggles take a range of difficult journeys to arrive in the UK, frequently experiencing issues such as violence, family breakdown, bereavement, exploitation and torture. Following their arrival in the UK, unaccompanied young people can continue to face significant barriers in achieving stability. This can result in mental ill-health, or exacerbate existing mental health issues that unaccompanied young people may have already been struggling with.

In consultation with key stakeholders, including 10 unaccompanied young people and 10 mental health and advocacy professionals that support unaccompanied young people, this report provides an overview of what is currently known about the mental health needs of unaccompanied young people living in England and Wales. It explores the barriers unaccompanied young people face in accessing mental health support and in receiving a good standard of care, once they are engaged in mental health support services. It then considers best practice models in providing adaptable and sensitive mental health support to unaccompanied young people.

The headline findings from this report are the following:

- The effects of the traumatic events that young people have faced prior to their arrival in the UK can continue to affect them for substantial periods of time through a range of symptoms, such as flashbacks, sleep disturbances, memory impairment, anger and disruptive behaviour, self-harm and even suicide.
- Once young people are in the UK, their mental health can deteriorate if they face barriers in settling their lives and their long-term prospects.
- Self-harm and suicide pose a grave risk for these young people, especially if they are not receiving holistic support. More needs to be done to understand these risks and the network of support that would help to combat them.
- The strengths and difficulties questionnaire (SDQ) – which is the most commonly used tool for identifying an unaccompanied young person's need for mental health support once they arrive into care – is not identifying their mental health needs adequately. Our data analysis has found that, in spite of the acute mental health issues that unaccompanied young people might be facing, the average SDQ total difficulties score for looked after unaccompanied young people is low and suggests they would have little need for mental health support.
- Lack of awareness and training among paediatricians, GPs, social workers and other professionals working closely with young people lead hinder identification of mental health need among unaccompanied young people.
- Language used to communicate with unaccompanied young people about their mental health needs is often inadequate. This is due to insufficient

translation facilities within services and lack of education about mental health issues with the young people themselves. In order to ensure that young people can fully communicate their needs, extensive support is required even after they have been referred into mental health support.

- Immigration and asylum processes to regularise unaccompanied young people's immigration status in the UK are creating stress and mental health difficulties among young people.
- The Government policies that have created the Hostile Environment have made it more difficult for young people to access NHS services and education. Cuts to legal aid are also creating additional barriers for unaccompanied young people, which can create further mental health distress.

We have identified a number of key recommendations for stakeholders on a national and local level to help support the needs of unaccompanied young people, to improve their mental health. This includes:

- More comprehensive tools for assessing mental health need.
- Services that are better connected with young people's communities.
- Providing guardians to represent the best interests of all unaccompanied young people.
- More effective leadership within support services to ensure that all agencies are communicating about young people's needs.
- Targeted training to improve awareness and identification of need among the professionals that are working most closely with young people.
- Creating centres of excellence to share learning and good practice.
- Ensuring that young people are linked in with high quality advocacy services.
- Providing a range of adaptable resources to allow young people to communicate their mental health needs.
- Improving complex and traumatising immigration and asylum processes.
- Ensuring that holistic support is also available for young people that are arriving to be reunited with family members through the Dublin III process.

We have provided examples of effective working, where relevant.

The task ahead in improving access to mental health support for unaccompanied young people is complex, but not impossible. Improving availability of services and identification of unaccompanied young people's needs will also help to develop support for young people from other vulnerable backgrounds. The risks of not developing this support for unaccompanied young people can create potentially grave outcomes, but effective leadership and sensitivity will help to secure young people's lives and futures.

Relevant legislation

UN Convention on the Rights of the Child

As a signatory to the United Nations Convention on the Rights of the Child (UNCRC)[9], the UK recognises that children – owing to their developmental nature and particular vulnerabilities – require additional care and protection while also acknowledging their autonomy as rights-holders in their own right. Since lifting the immigration reservation on the UNCRC in 2008, these articles could be fully applied to all children who are subject to immigration control, regardless of whether they have a regular or irregular immigration status, whether they are claiming asylum or are seeking to regularise their status in the UK for other reasons. While all articles are relevant, we have focused on the following rights that are particularly important to consider for unaccompanied young people:

Article 3 of the UNCRC states that in all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration. Children's rights apply to all children within the state's jurisdiction without discrimination of any kind including national, ethnic or social origin or other status (Article 2). States are obligated to ensure 'to the maximum extent possible' the life, survival and development of all children (Article 6) and that all children have access the best standard of health and facilities for the treatment of illness and rehabilitation of health (Article 24). This includes a duty on the Government to respond appropriately to abolish practices that are prejudicial to a child's health. For these rights to be realised, all children with sufficient capacity for self-expression should be given the opportunities to participate in decisions made about them, particularly within circumstances where judicial and administrative procedures have the power to influence their lives (Article 12). This article places a duty on states to generate favourable contexts and structures for children's self-expression so that they can have some degree of self-determination in terms of what happens to them in formal processes.

Section 55 of the Borders, Citizenship and Immigration Act (2009)

The Home Secretary has a legal duty to consider the best interests of children as part of his immigration, asylum, nationality and other functions, through Section 55 of the Borders, Citizenship and Immigration Act (2009).[10] The Independent Chief Inspector's Office has conducted a recent inspection of how the best interests are considered for unaccompanied asylum-seeking children, including the application of Section 55 and has found a number of areas in which the Home Office is continuing to fall short of this duty.[11]

Children Act (1989)

This legislation is the main framework for child protection procedures in the United Kingdom. It asserts duties upon local authorities, courts and others to safeguard and promote the welfare of children in their care. The main elements of the Children Act that are relevant to the young people in this report are:

- Section 17: This places a duty on local authorities to safeguard and promote the welfare of children in their area who are in need and provide their families with the resources to do so.
- Section 20: This places a duty on local authorities to provide accommodation for children in their area that are in need.
- Section 31: This enables local authorities to create a formal court order to place a child in their care, meaning that they have parental responsibility for the child.

In addition to the overarching guidance and regulations for looked after children and care leavers, which applies to all children regardless of their immigration status, the care provided to unaccompanied migrant children and child victims of modern slavery who are looked after by local authorities is also subject to statutory guidance which was updated in November 2017.[12] This references children's health plans, including their physical, sexual, emotional and mental health.

Summary

Over a decade ago, the removal of the immigration reservation within the UNCRC and the introduction of the Section 55 duty marked important advancement in policy for unaccompanied young people. More recently, the establishment of statutory guidance on the care of unaccompanied young people by local authorities[13] and the recent Safeguarding Strategy – which outlines the Government's commitments to safeguard and promote the welfare of unaccompanied asylum-seeking and refugee children[14] – has seen the Government invest a significant amount of resources and effort into improving support for unaccompanied young people who find themselves in the UK. Nevertheless, as this report will highlight, the impact of immigration and asylum processes still take a heavy toll on children's mental health and well-being, as well as other outcomes. Through this report, we will consider to what extent the healthcare and child care systems, processes, actors and outcomes are:

- Protecting the best interests of all unaccompanied young people
- Preventing the discrimination of young people on the basis of their identity experience or needs
- Accessible for unaccompanied young people to navigate
- Contributing to the long-term development of unaccompanied young people and their transition to adulthood.

Who are the young people?

This report considers the mental health needs of unaccompanied young people ranging from 10 years to 25 years old, and the mental health support that is available to them. Mainstream mental health services for young people cover a range of different age groups across the country; some accept referrals for young people up to 18 years old, while others can support young people to the age of 25.

Although this report focuses on young people into their twenties, much of the relevant literature refers to young people as 'children' if they are under 18. For that reason, we will use 'child' and 'young person' interchangeably in this report, unless there is a specific difference that we are noting.

Unaccompanied young people

Unaccompanied young people are the focus of this report. This includes children under 18, who are often referred to in relevant literature as unaccompanied asylum-seeking children (UASC). These young people have applied for asylum in their own right, are outside their country of origin, and separated from both parents and any other legal primary care giver. The only official, nationally available numbers on unaccompanied asylum-seeking children are Home Office figures on asylum applications[15] and annual local authority figures published by the Department for Education (DfE) on unaccompanied asylum-seeking children in local authority care.[16] It is also important to keep in mind that a large majority of unaccompanied asylum-seeking children currently in local authority care in England (78%)[17] are aged 16 or 17. This has particular implications for the kind of support and accommodation they are provided with, which we discuss later in this report. In this research, we also include the experiences of young people who arrived unaccompanied but are between 18 and 25 years old, in order to represent the issues that occur when children transition into adulthood.

Gender

Official statistics show that 92% of unaccompanied young people in the care of local authorities in England in 2017 were male, as has been the case in preceding years.[18] As a reflection of this, the overwhelming majority of young people referred to in this report are male. Difficulties that young people face in disclosing mental health need and receiving appropriate support can be exacerbated due to gender – owing to stigma and social expectations around mental health disclosures among males.[19,20] We have also previously looked at the impact of gendered stigma on reporting of sexual violence among trafficked boys and young men.[21]

Countries of origin

Recent figures on the most common countries of origin for unaccompanied young people making applications for asylum include Eritrea, Sudan, Vietnam, Albania, Afghanistan, Iran and Iraq. In total, these seven countries accounted for well over 80% of all applications.[22] The young people interviewed for this report originated from Afghanistan, Syria, Vietnam and Eritrea. Based on the most recent data available on looked after children, a large majority (87%) of unaccompanied asylum-seeking children were from non-white ethnic backgrounds – predominantly from Asian, African or other ethnic groups – while 13% were from white backgrounds. Conversely, the overall looked after children population is predominantly from white backgrounds (75% of children) and with only a quarter (25%) from BAME backgrounds.[23]

Other terminology relevant to this report:

- **Separated young people**
  Separated young people are under 18 years of age, outside their country of origin and separated from both parents and any other legal primary care giver, but not necessarily from other relatives. They can be asylum seekers, but are not in every case. Separated young people can be fleeing war, domestic violence, child marriage or conscription. They may be in search of work, education or a better standard of living. Although separated young people might take different journeys to arrive here, they can also suffer from mental health issues that require adequate support and attention.[24,25]

- **Dublin III Regulation**
  The Dublin III Regulation is a European Union regulation that allows young people that are in other EU countries to be brought to the UK to be reunited with family members that are already resident in the UK, if it is in their best interests.[26] Young people that arrive through the Dublin III regulation would usually come under the separated category.

- **Trafficked**
  The report uses the formal definition United Nations (UN) Protocol to Prevent, Suppress and Punish Trafficking in Persons, especially Women and Children.[27] According to the protocol:
  '"Trafficking in persons" shall mean the recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation.'[28]

- **Refugee**
  A refugee is a person who 'owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of [their] nationality, and is unable to or, owing to such fear, is unwilling to avail [themselves] of the protection of that country'.[29] Within British law, those that have applied for asylum and have been recognised by the Home Office as a refugee (in accordance with the Refugee Convention) usually receive leave to remain as a refugee for five years. Following this period, they can usually apply for indefinite leave to remain in the country.[30]

- **Looked after children**
  A looked after child (or LAC) is a child who is in the care of a local authority under either a protection order, or a voluntary arrangement with their parent or

guardian. They can be living with foster parents or at home with parents, but supervised through a local authority children's social care team, in a children's residential home, or any other residential unit. Unaccompanied young people are usually looked after by the local authority and can be living in a range of settings, as described previously.

- **Care leavers**
  When a former unaccompanied asylum-seeking child who was supported by a local authority under Section 20 of the Children Act 1989[31] turns 18, they would generally be entitled to leaving care support under the Children (Leaving Care) Act 2000.[32] Young people are entitled to a range of leaving care support in relation to education, employment, accommodation and more. Care leavers' entitlement to support will depend on factors including how long they had been in care as a child.[33]

- **Person subject to immigration control**
  The Asylum and Immigration Act 1996 defines an individual that is 'subject to immigration control' as a person who requires leave to enter or remain in the United Kingdom.[34] The young people that this report focuses on are all subject to immigration control, and we will explore some of the arenas in which their access to services is prohibited based on their leave to remain in the UK.

Methodology

The report covers the mental health needs of unaccompanied young people and the support that they receive, bringing together research from providers of medical perspective and advocacy support services, alongside perspectives from young people themselves. A mixed methodology was used for the research, encompassing:

- Desk research of existing literature on the mental health needs of unaccompanied young people, as well as existing policy recommendations and processes for adapting to their needs. See the literature review in Appendix 1 for more information.
- Freedom of Information (FOI) requests to the Department for Education on Strengths and Difficulties Questionnaire records for looked after children.
- In-depth interviews conducted with 20 participants in total. Participants included 10 mental health and advocacy service providers (including psychiatrists, psychotherapists and counsellors) with seven mental health practitioners based within voluntary and statutory NHS services, working with a range of therapeutic models. Three advocacy workers were drawn from The Children's Society's practice base across England in order to gain insights into emerging issues across different geographical areas.
- In-depth interviews with 10 unaccompanied young people aged 16–25 that have accessed The Children's Society services across West Yorkshire, Greater Manchester, the West Midlands and London. They had all claimed asylum, some had received positive outcomes, others are awaiting decisions and two had been refused. Discussions focused on their well-being needs, experiences in accessing services and other networks of support.

Previous research has explored the complexities of conducting research with this vulnerable group of young people.[35,36] This report has undergone a thorough internal ethics approval process to minimise any risks to interviewed young people. Due to concerns about re-traumatising young people intrusive questions about their histories and the potentially traumatic events of their past were not posed. Interpreters were provided where young people required them, to ensure comfort with communication.

Case study

Agron is 17 and from Albania. He was referred to The Children's Society's specialist trafficking service by his social worker. He had been identified as trafficked at a carwash in London, where he had been forced to work. He had spent months travelling to the UK and, along the journey, had experienced significant abuse and exploitation.

The Children's Society's practitioners provided one-to-one intensive support focusing on his safety and emotional well-being. They worked closely with his social worker and foster carer, as well as involving Agron, to ensure that effective safety measures had been put in place. They also carried out focused sessions with Agron to improve his understanding of risk, safety planning and the law in the UK. They supported him to access specialist legal advice, and supported him as an appropriate adult when needed. Agron joined the regular The Children's Society youth group where topics such as healthy relationships, sexual health, self-care and self-advocacy were covered. Agron has regularly attended the group, making close friendships with some of the other boys who he has started socialising with at the weekend.

After a few months, Agron began to confide in his support worker about his difficulty falling asleep at night and his recurrent nightmares. His worker started focusing their sessions on discussing self-care techniques and exploring the benefits of engaging in therapy. When Agron felt ready to engage in therapy, his worker facilitated a joint meeting with the in-house therapist. The therapist introduced the service to Agron, explaining how flexible and tailored we could be to meet his needs and how they could work together – focusing on practical tools around sleep and nightmares as an introduction.

The therapist and Agron started work together to address this and explore the origin of his nightmares. Agron slowly began to recognise how his mind was trying to process highly distressing material, resulting in nightmares. Throughout this period, Agron's nightmares initially increased, but Agron recognised that spending more time focusing on his dreams in therapy caused them to decrease. He also felt that he was repairing his own emotional well-being.Agron has now been attending The Children's Society's therapeutic services for three months. He feels he is doing much better, as he feels happier on a day to day basis. He enjoys his education very much and has joined an apprenticeship scheme (his support worker helped with the application process). The frequency of his nightmares has reduced to one a week, rather than five or six. He feels calmer, more in touch with who he is, and less fearful of his traffickers. Agron does recognise that there are still some traumatic experiences that he has not yet addressed. Agron has booked a review session with his therapeutic worker to discuss how he can be supported to address these; this could include either closing the case, if he does not want to address the issues at this time, or continuing if he feels able to.

Chapter 1: Common mental health issues with which unaccompanied young people present

Unaccompanied young people can often struggle with a range of mental health issues connected with their circumstances prior to arrival in the UK, as well as difficulties they might face following arrival. Some young people's mental health needs might be immediately obvious, whereas others can remain unidentified until triggered by specific events, and some may never be identified.

'Sometimes, with the traumatic experiences, they don't even start talking about the trauma before a year of you trying to get their trust and working with them.' **– Mental health practitioner**

Furthermore, overlapping issues such as insecure immigration status and material circumstances can compound young people's mental health struggles. It is therefore necessary for medical and non-medical professionals to be aware of what issues might be affecting a young person's mental health, as well as how they might present. In doing so, professionals can develop better processes to connect young people with support that is adapted to their needs.

In this section, we look at some of the most common issues that young people might be struggling with.

1) Trauma and post-traumatic stress disorder

Unaccompanied young people have often experienced traumatic events in their journeys prior to arrival in the UK. This can include:

- Coming under combat fire and bombing
- Destruction of homes and/or schools
- Separation from, and disappearance of, parents, family members, and friends
- Witnessing violence and death
- Prolonged danger and perilous journeys

Some of these young people will have experienced forced conscription, arrest, detention, sexual violence, physical injuries and torture. Traumatic events are rarely isolated and are commonly associated with poverty, social isolation and lack of health care and education.[37]

Unaccompanied young people have been identified in research as having more traumatic stress reactions than young people that arrived accompanied within a family, or have not recently arrived.[38,39] The prevalence of psychiatric disorders among unaccompanied young people has been found to be higher than for young

people arriving accompanied.[40] Trauma can have lasting impact on a young person's well-being and development.[41]

Symptoms of trauma

Trauma can present as some of the following symptoms:

- Poor concentration
- Memory impairment
- Daydreaming, or intrusive thoughts and images
- Anger and disruptive, aggressive behaviour
- Irritability
- Tiredness or lethargy
- Sleep disturbances
- Confusion
- Loss of interest and motivation
- Being withdrawn and isolated
- Not thriving
- Interrupted or uneven emotional or physical development
- Self-harm
- Unexplained headaches, stomach aches or other body pains
- Bed-wetting or other regressive behaviours

Triggers for trauma

'The level of stress [young people are under] is often related to fluctuating support from the Home Office and local authorities, poor accommodation and subsistence – anything is likely to exacerbate it. They are expected to live with a level of insecurity that a young person cannot cope with.' – **Mental health practitioner**

Following arrival in the UK, unaccompanied young people's trauma symptoms might not be immediately evident until they are triggered by living in an unstable environment, isolation, discrimination and facing difficulties in accessing healthcare, education, appropriate housing and other basic needs.[42]

A practitioner that worked with newly arrived unaccompanied young people identified the risks of upheaval when moving accommodation:

'Once [young people] were moved from the reception centre into the local community, that was quite a big step, and it did seem to create…a trauma response.' **– Mental health practitioner**

Home Office processes such as prolonged decision making, or refusals on applications for asylum and other leave to remain, can be intimately related to trauma responses. We will explore the impact of Home Office processes in more detail in Chapter 2.

Being made to recount their difficult histories to professionals can also be a trigger for a trauma response in unaccompanied young people:

'A young person mentioned last week [that] when someone asks you a simple question like "why did you come to this country?" it is simple, but it is quite loaded for them…They remember a lot of things, [they wonder] why are you asking them and then you're taking them to a place where they would rather not be'. – **Advocacy practitioner**

Some effective ways to mitigate the effects of these triggers include better-supported living arrangements[43] and timely coordination of mental health and other support for young people.

The effects of trauma can remain with young people for years and contribute to a range of negative behaviours when triggered:

'[Traumatic triggers] can cause aggression, traumatic memories and intrusive thoughts, flashbacks during the day and the night, being hyper-aroused and being geared up for action.' – **Mental health practitioner**

Sensitising professionals in young people's lives to the multitude of traumatic triggers can enable them to avoid exacerbating trauma and to develop processes to help mitigate its effects.

Case study

Rosa was born in Albania, where she lived with her family and was studying. Following pressures from her father to marry, Rosa fled with a boy that she had developed a relationship with. When they arrived at the destination, the boy and his father locked Rosa in a room in a house where she and other girls were forced into sex work. The girls were brought food once a day and were not allowed to leave the house. One day Rosa managed to escape and make her way to some of her relatives. They cared for her for a short while and then, knowing that her life would be in danger, helped her to come to the UK. Rosa spoke of one of the Home Office interviews she attended for her asylum application:

'*The interview went on the whole day from about 11.30am to 5.30pm…The interpreter had wrongly translated many things I had said. The interviewer from the Home Office told me I was not telling the truth as I was saying things that he did not have written on his records…He asked me many questions in detail about my sexual experiences, which my lawyer said he was not supposed to ask. I was crying very much and I had a headache. He asked so much detail about what had happened to me. I had been held in captivity, raped and forced into prostitution by a controlling man who kept me as a slave. It was terrible to be asked such detailed questions by a male interviewer who also accused me of not telling the truth. It was especially shocking that he did not allow my female foster carer into the room. She waited outside and I was left in the room with three men being asked detailed and intrusive questions about sexual abuse I had experienced. This experience did not feel at all helpful to me. There was no relief at telling my story to a sympathetic listener. I felt full of shame and had to answer the questions of someone who had no understanding of how I was feeling and who did not give me the opportunity to share my narrative. I was continuously interrupted so he could ask strange questions such as: "What clothes were you wearing when the men had sex with you?" and "Where did the men hit you on your body or your face?"*'

Rosa was initially refused asylum and then granted it following an appeal. Rosa was referred to the Baobab Centre in July 2015 and continues to receive psychotherapy support to explore her experiences of trafficking, sexual exploitation and exile. Rosa says of the support that she has received:

'*I was scared to walk on the streets. I wasn't confident enough to leave the house, even in the daytime. My psychotherapist…is a star...she has been really patient with me and helped me go through my fears… I have found it really helpful and am still going to go there because I know that some days I will be able to put a wall between my past, my present and my future.'*

Rosa has become open to new friendships and relationships with both young women and young men. During this process she is learning about her personal boundaries and learning to take good care of herself, by facing her past and her present difficulties and possibilities. She is now 18 and recently started university. She has friends and a job and loves her studies.

Sleep disturbances

'I wasn't sleeping, I wasn't eating. There was a day when I came to the [youth] group, I was feeling really, really tired. So they asked me what the problem was, I said I wasn't able to sleep at night. When I woke up in the morning, my body was weak and tired. That was when they got in contact with a counsellor'. **– Young person, 18**

Sleep disturbances are common symptoms for young people that have experienced trauma such as physical injury,[44] natural disasters[45,46] and life-threatening events.[47] Disruptions in sleep can impede a young person's development and emotional regulation.[48,49] The extent of sleep disturbances faced by refugee young people can depend on the level of trauma they face, and a supportive family environment has been identified as crucial in alleviating sleep difficulties.[50] For young people in the UK without a familial support network, getting help for sleep disturbances can be a more difficult process.

The interviewed practitioners explained that chronic sleep problems presented in a number of ways, such as difficulty getting to sleep and staying asleep, waking up repeatedly, having nightmares, flashbacks in the night and intrusive memories. These were often heightened when young people had recently arrived, or at particular times of stress.

Many of the interviewed young people spoke about the continued distress caused by sleep issues:

'When I go [to sleep] I [take] my sleeping tablet and my [antidepressants] and still I get nightmares. I still get flashbacks…it gets [to] one o' clock at night and two o' clock, three o'clock and it wakes me up…and the voices start coming in my head – in my head, the voice talking to me. [One day] the voice said to me in the morning… "Go outside, somebody is waiting for you, somebody waiting for you… somebody waiting for you, to kill you."' – ***Young person, 20***

The impact of sleep deprivation can be extensive, creating issues in every arena of a young person's life. A research project completed in partnership between Kent County Council, Kent Clinical Commissioning Groups and Sussex Partnership Foundation Trust focused on methods to encourage sleep for newly arrived unaccompanied young people. Over a three-month period, 83% of unaccompanied young people reported disordered sleep.[51] Young people in the project described the journeys they took prior to arriving in the UK, including how they would travel during the night and sleep in the day. This would happen for several months at a time. Others described becoming fishermen and working through the night to catch fish and then needing to sleep during the day.[52] These nocturnal habits persisted when young people arrived in the UK, creating disordered sleep patterns that impeded their ability to concentrate in college and participate in daily activities.

A mental health practitioner involved in the project spoke about the need to target sleep disruption:

'[Young people were] not turning up to college, or being half-asleep at college, not being able to integrate locally with people, just because they were asleep...So, starting to develop a kind of nocturnal subculture in which everything happened at night. And [this led to a] loss of hope because they weren't able to meet their aspirational targets, which were to get education or to achieve in education...And then [there were young people] who were trying [to change their sleep habits] and who were still nocturnal, then were so sleep-deprived and they became erratic and short-tempered...So really not able to perform.' **– Mental health practitioner**

Trauma and other stresses can prevent young people from maintaining healthy sleep habits, creating emotional distress and a loss of hope when they do not reach their goals. Without effective treatment, this can affect a young person for years. Resources for practitioners on treating disordered sleep are viewable on the UASC Health website.[53] Practitioners can refer to this as a first step in supporting unaccompanied young people with disordered sleep. For areas with higher numbers of unaccompanied young people, commissioners can also look to long-term funding for alternative therapies to meet trauma and sleep needs.

Identifying trauma

Practitioners require robust tools for identifying trauma in order to support young people. However, this can become difficult if the techniques that practitioners rely on for gathering information create distress for young people.

Advocacy practitioners outlined their concerns about assessing young people's trauma, without risking retraumatisation by forcing them to relive past events:

'When a young person presents themselves to us, we don't always have that information about their background...We don't explore that unless they want to share that with us because they might [have experienced] trauma and violence...and we're not trauma counsellors...We know that somewhere along that journey...they have experienced something...the majority of them will say something like "I don't sleep well at night, I have the lights on when I go to sleep because I'm scared of the dark or I have nightmares."' – **Advocacy practitioner**

With adequate training and sensitivity, practitioners can begin to identify the multitude of ways in which trauma presents, without the risk of retraumatising young people. We will explore techniques for this in Chapter 3.

2) <u>Bereavement and missing family</u>

Young people may have lost family members prior to arrival, potentially even witnessing family members being harmed or killed. They may never know what has

happened to family members that have gone missing. They might have family members that are still attempting to be reunited with them in the UK. Without their familial support network around them, young people can often struggle for years after arrival.

One mental health practitioner that worked in a service for trafficked boys spoke about the regularity with which they encounter bereavement among young people they are supporting:

'[We see] a lot of bereavement, [young people feeling that they have] got nothing. And, you know, [they] don't have family. Because people have died, or people have moved.' **– Mental health practitioner**

Other practitioners detailed how bereavement is situated within a wider sense of loss:

'Loss of parents or not being in touch with parents or not knowing the parents are alive…Also loss of country, therefore loss of culture. Sometimes [also] loss of language – "no one speaks my language here." I think a central issue here is about loss, abstract and concrete. The majority of young people are unaccompanied, facing a loss of parents and important relationships, loss of childhood and adolescence, loss of community and culture. Young people often say, "I didn't know this would be like this."" **– Mental health practitioner**

Loss of family members was identified by practitioners to be intimately linked with a sense of wider loss for unaccompanied young people – the loss of the lives they once knew at home. The loss of family members was almost reinforced by the value young people placed on relationships with foster carers and new friends, where they were positive:

'[My foster carers] are, like, my parents…they try to…help me, give me all the support I need and, you know, they are there for me whenever I need them.' **– Young person, 18**

Although young people can be dealing with profound loss, in our practice we encounter positive examples of young people settling into a network of support and developing some stability. However, not all young people will be placed in foster care, or be linked in with an advocacy service, and might not be able to develop these relationships as a result.

3) <u>Post-migration stress</u>

Although there is recognition of the trauma and stress that unaccompanied young people might face in their journeys from their country of origin,[54] misconceptions can exist about the stress of migration ending when young people arrive in their destination country. However, unaccompanied young people can face difficulties in day-to-day life, which can then impact on their mental health.[55,56,57]

'I don't get appetite. I can't get any sleep. I've taken sleeping tablets and I feel a bit drowsy at the minute.' **Young person, 21**

Some of the examples of stressors that were identified by young people and practitioners include living in inadequate accommodation, inability to access to schooling and isolation from support networks. Daily stress can create mental health problems for young people by creating barriers that are difficult for them to overcome.

'[The issues we see are] largely based on Home Office outcomes and decisions, some transition…or housing…Often it's the social factors…which fits with the research…about the expression of psychiatric disorders in refugees and asylum seekers, that it's often how they are treated in the [receiving] country.'[58,59] **– Mental health practitioner**

The daily stressors that unaccompanied young people face whilst settling into their new life can create lasting harm for their mental health if they are left without support. These struggles might also interact with a wider sense of loss that unaccompanied young people are facing, or even trigger trauma symptoms. It is important that practitioners working with young people remain cognisant of the lasting mental health impact of these stressors, and that relevant support to remedy issues is provided.

4) **<u>Access to education</u>**

Interviewed young people and practitioners identified that lack of access to education and training caused deterioration in mental health. Delays in enrolling; being unenrolled following a negative decision on their immigration or asylum application; not being able to prove entitlements to access education; or not being able to enrol as courses are not appropriate to their needs were all identified as causes of particularly acute distress. One study into unaccompanied young people found a link between being enrolled in a supportive educational environment and higher self-esteem, whereas lower self-esteem was connected with young people without that same educational support.[60]

'If they're not able to access services…like college, for a lot of them that is what they'd like to do…if the colleges are full then…it's like their whole world falls apart… any time the answer is "no" [they want to know] why, so they kind of lose themselves.' – **Mental health practitioner**

One mental health practitioner described the work they did with schools to improve young people's mental health outcomes by ensuring they were supported in education:

'Sometimes [young people are refused from school]…We have to try to find out where the school refusal is coming from. Is it to do with learning difficulties? Is it to do with trauma? Is it to do with being capricious?' – **Mental health support worker**

Young people can also face problems with proving entitlements to access services, such as proving entitlements to access education,[61] following changes to Immigration Bail, which we will explore further Chapter 2.

5) Accommodation placements

A lack of secure accommodation can create and exacerbate the mental health needs of young people. If a young person has been accepted into the care of a local authority, support and accommodation must be provided for them in accordance with the Children Act 1989.[62] The interviewed young people were living in a range of placements, including foster placements with a family, semi-supported or supported accommodation provided by the local authority, or asylum support accommodation.[63]

Accommodation issues, such as living in substandard asylum accommodation[64] with adults, were recognised as having a large impact on unaccompanied young people's mental health. One young person, who was living in adult asylum accommodation, described it as follows:

'Like animals. The house is not like a home; it's more like a tip yard.' **Young person, 21**

If unaccompanied young people end up in inappropriate accommodation, without child-specific resources that they require, they may end up without support whilst facing flashbacks and other sleep disturbances in the night, or generally not receiving the wraparound constant support that they require as young people.[65] We also heard of young people being age assessed as adults and placed in adult accommodation – even though multiple professionals identified them as children (see Chapter 2 for more information) – which can expose them to further vulnerability. Several of the mental health practitioners noted that their service was required to intervene where young people were placed in inappropriate accommodation placements, which then helped to secure better mental health outcomes.

We support foster placements for unaccompanied young people, as far as is consistent with the young person's best interests.[66] The full benefits of a foster placement must be explained to a young person by their social worker, particularly as their first impulse might, understandably, be to live somewhere more independently. Young people should only be placed in adult accommodation if a full 'Merton compliant'[67] age assessment has been conducted and any avenues for appealing an assessment are exhausted (there is more information on the mental health distress caused by age assessments in Chapter 2).

6) Social isolation

'For all of them it's a sense of belonging they don't have…they don't have an identity…they don't feel that they belong.' **– Advocacy practitioner**

Social exclusion has been identified in research as a substantial struggle for newly arrived refugee communities.[68,69] especially when young people are required to adapt to a new culture and customs.[70,71] This can create a sense of loss for young people[72] as they struggle to find a position in a new country, or are actively rejected by it.[73]

'Sometimes there's an overemphasis on mental health and…actually what they need is good social care…it doesn't have to be mental health.' **– Mental health practitioner**

Many of the young people interviewed spoke about how seeing friends and engaging in sports and communal activities with other young people helped them when they were struggling with mental ill-health:

'I will go out and talk with my friends, go the gym or play other sports, to relieve the problems.' – **Young person, 18**

'I have really good friends…they know a bit of my situation as well. So, yes, I speak to them…they're really helpful.' – **Young person, 20**

Social isolation and alienation from the community around them can exacerbate young people's mental health conditions. Better efforts at integrating young people into communities would help to alleviate this stress. This requires that practitioners work to overcome barriers that arise if young people are dispersed to distant areas, not able to communicate easily and not aware of the support that is available to them. Many of the interviewed advocacy and therapeutic practitioners offered young people support through group-based activities, which have been recognised as helping refugee communities to navigate and reduce social isolation.[74]

7) Self-harm and suicide

Self-harm and the risk of suicide were identified in practitioner interviews as particular risk factors for unaccompanied young people. Practitioners also spoke about the perceived lack of prioritisation in tackling this issue:

'I am worried this is not getting the attention it needs compared to suicides of young people who are British. I believe suicide risk is often brushed away for this population.' – **Mental health practitioner**

Practitioners identified that a range of issues – such as age disputes, delays in Home Office decision-making, being unable to access necessary support and the impact of previous trauma – can culminate in young people harming themselves, or attempting suicide. Although there was not consensus among practitioners on singular issues that created the risk of self-harm and suicide, practitioners stressed that multiple factors at once can create serious risks of self-harm and suicide.

Although a recent study in Sweden has found the risk of suicide among unaccompanied young people to be nine times that of the rest of the same-aged Swedish population,[75] there is no equivalent study into the risk of self-harm and suicide among unaccompanied young people in Britain. There have been some reports of self-harm and suicidal ideation among unaccompanied young people,[76] as well as the high levels of self-harm and suicide among inmates of detention centres in the UK.[77,78] However, there is no comprehensive analysis of these issues within the non-detained population of unaccompanied young people and young people without a clear guardian (such as those that have exhausted asylum appeal rights and care leavers). Practitioners within our own services spoke about the non-therapeutic methods that they have developed to support young people at risk of self-harm and suicide, including devising a comprehensive safety plan, considering the triggers for harm and what helps to make young people feel safe, ensuring that young people have an adult that they trust to be able to make disclosures to, and more.

In order to measure the risks that self-harm and suicide pose among unaccompanied young people, more research into this area is vital. To help mitigate the risks of self-harm and suicide, it is important to build a foundation of support for young people and ensure that there is at least one key figure dedicated to protecting their best interests, such as a dedicated independent legal guardian (there is more on guardianship in Chapter 3). It is also important to ensure that these guardians are made available for young people throughout their transition from childhood into adulthood.

Conclusion

'I *ring to my friend and my friend ring me and how are you? I ring to my foster carer then sometimes [they know] that I cry all day, I cry, cry, cry. I cry and I close the door and nobody come to my room. I ask for the key I want to close my bedroom, my room then I cry and cry, then I bite my finger…I have a stress ball in one hand…and I cry, cry until I get to sleep…Then wake up…then I use my medication…I eat and [afterwards] get [a] migraine – when I'm stressed out, when I'm crying, every [time] I get migraine.'* **– Young person, 21**

Unaccompanied young people may arrive here suffering trauma, loss and bereavement and more. Although young people might often be safer and more settled when they are in the UK, the loss of their previous lives and all that they have known can continue to unsettle them as they try to adapt to a new environment. The quote above demonstrates the pervasive effects that this can have in an unaccompanied young person's daily life. Their attempts to adapt can be made harder when they are unable to access support that would help them to settle into their new lives. Effective social support to help young people adapt to their new lives must work alongside therapeutic support that they might need to help alleviate these issues.

Our next chapter will look at the barriers that are in place when unaccompanied young people are in need of support, or in the process of accessing support from a service, and how these affect a young person's engagement with services.

Chapter 2: Barriers young people face in accessing support

Unaccompanied young people can face a range of barriers in accessing mental health support services and in receiving an appropriate standard of care. Three main themes emerged from our interviews:

1) Assessing young people's needs
2) Effectiveness of services that support young people
3) Official processes that have a detrimental impact on young people's access to mental health services and support

These three themes cover an unaccompanied young person's struggle to be offered support, the barriers within help that is then offered to them, and the official processes that might influence their ability to access services once they are connected with assistance. At all of these stages, young people will encounter both systemic and individual challenges that prevent them from accessing the help they need. In this chapter, we will assess the impact of these barriers and the ways that services set up to support unaccompanied young people can often remain out of reach.

1) Assessing young people's needs

For unaccompanied young people to be able to access appropriate mental health support, the first step is a full and comprehensive assessment of their needs. A paediatrician will usually conduct the initial assessment of mental health need when a young person arrives into a local authority. This assessment will be conducted as part of a looked after child (LAC) assessment, as outlined in the guidance on promoting the health and well-being of looked after children.[79] Alternatively, practitioners might identify that a young person is in need of mental health support at a later stage. Following identification of need, a referral will be made into a mental health support service. Once a young person is referred into a mental health support service, practitioners in the mental health service will conduct an assessment to identify their needs and whether the service is best placed to support them.

Professionals assessing whether a young person requires mental health support will need to use a range of techniques to assess need, whilst navigating issues like interpreting difficulties, lack of awareness about mental health among young people, poor physical health and immediate material needs that may supersede mental health concerns. Young people are also likely to be without the relationships and networks that are measured as indicators to determine their needs by many screening tools. In particular, the standard tool used to assess the mental health and well-being of children in local authority care (including unaccompanied children) is the strengths and difficulties questionnaire (SDQ). The following analysis

demonstrates that the SDQ may not be the most appropriate means of assessment for unaccompanied young people, suggesting that other modes of assessment might be required.

- **The strengths and difficulties questionnaire**

The strengths and difficulties questionnaire (SDQ) is a brief emotional and behavioural screening questionnaire for 3–16 year olds,[80] as part of their initial LAC assessment, and it is intended to enable professionals working with young people to assess their needs.[81] The Department for Education (DfE) has used the SDQ since 2008 as a screening tool to identify 'emotional and behavioural difficulties' in looked after children. Every child's carer completes the questionnaire and, if the score is concerning, it is triangulated with a teacher questionnaire, or a self-questionnaire completed by the child. If the score is still of concern, the child should be referred for a fuller diagnostic assessment.

The categories for assessment in a Strength and Difficulties Questionnaire are:

1) Emotional symptoms
2) Conduct problems
3) Hyperactivity/inattention
4) Peer relationship problems
5) Prosocial behaviour[82]

The 'total difficulties score' (TDS) is calculated by totalling the scores that a young person has achieved in all scales of the assessment (except the prosocial scale) and the final score ranges from 0 to 40.[83] Any score under 14 is considered normal, 14 to 16 is borderline cause for concern and 17 or over is considered a cause for concern.[84] The TDS does not diagnose mental health conditions – but a high total difficulties score has been linked to mental ill-health. Thus, the SDQ can be used by non-medical professionals to identify where children may require comprehensive assessment by specialist mental health services.[85]

As outlined in Chapter 1, unaccompanied young people can struggle with a range of mental health issues. Their issues must be identified at the earliest opportunity, to ensure support is timely. Research offers conflicting perspectives on the reliability of the SDQ, with varying perspectives on its consistency of analysis.[86,87,88] When used in isolation without other screening tools, the SDQ is often inadequate in determining a comprehensive measure of mental health.[89,90] Recent research into the SDQ and its use in identifying needs in young people from a refugee background has found that it may not effectively detect the lasting psychological effects of trauma.[91] The SDQ has also been found to be inadequate for any young person with more than mild learning difficulties,[92] which often remain unidentified in unaccompanied young people. In Chapter 3, we will look at ways to supplement an SDQ assessment for better identification of young people's needs.

SDQ data on children in care

DfE statistics on children in the care of local authorities provide an annual overview of the recorded emotional and behavioural difficulties experienced by looked after children, recorded through the SDQ assessment tool.[93]

Table 1: Emotional and behavioural health of looked after children – average score for children looked after at 31 March 2017 for whom an SDQ total difficulties score was received[94].

	Percentage of children for whom SDQ TDS is normal (between 0 and 13)	Percentage of children for whom SDQ TDS is cause for concern (17 and above)
Males	52%	41%
Females	61%	34%

Table 1 shows DfE data on the percentage of male and female children in care who received SDQ TDS that were average or cause for concern. This level has remained relatively unchanged for the last five years of recorded data.[95] The DfE only publish figures for the entire looked after population, with a simple age and gender breakdown. There is no specific focus on unaccompanied young people.

Through a Freedom of Information Request to the DfE, we have been able to develop a clearer overview of the recorded emotional and behavioural health of unaccompanied young people, who make up 6% of the entire population of looked after children:

Table 2: Emotional and behavioural health of looked after children – Average score for children looked after at 31 March 2016 for whom a Strengths and Difficulties Questionnaire (SDQ) TDS was received[96]

	Number for whom an SDQ TDS was received [97]	Average SDQ TDS[98]
Looked after children[99]		
Total (age 4 to 17)	30,080	*13.9*
Age 11 to 15	14,010	*14.2*
Age 16 and 17	5,680	*13.2*
Total (age 4 to 17) in foster care	24,460	*13.5*
Total (age 4 to 17) in independent living accommodation[100]	430	*13.9*
Looked after children – unaccompanied asylum-seeking children (UASC)		
Total (age 4 to 17)	620	*7.7*
Age 11 to 15	200	*8.4*
Age 16 and 17	420	*7.4*
Total (age 4 to 17) in foster care	510	*7.5*
Total (age 4 to 17) in independent living accommodation[5]	60	*8.0*

As demonstrated in Table 2, the average SDQ TDS for an unaccompanied young person is just over half the average score for all looked after children. Although the trends are roughly the same, where the highest SDQ score occurs for age 11 to 15 and the lowest for 16 and 17, the average SDQ scores remain between 7–8.5 for unaccompanied young people, whereas they are ranging from 13–14.5 for the entire looked after population.

Government guidance recognises that health issues faced by looked after young people can be more wide-ranging than young people not in care, due to their experiences – with almost half of children in care having a diagnosable mental health disorder.[101] Evidence in Chapter 1 of this report demonstrates that the mental health needs of unaccompanied young people are also acute. However, the SDQ TDS for the general looked after population indicates a higher incidence of emotional and

behavioural difficulties than for unaccompanied young people. This suggests paucity in the SDQ's measure of unaccompanied young people's needs.

What this means

Many professional bodies have been critical of the use of the SDQ model, including the education committee of the House of Commons.[102] The Government has resolved to trial new mental health assessments for children entering care in order to better identify need,[103] which is a welcome step. However, these trials will need to focus on better models for assessing the mental health needs of unaccompanied young people. Issues such as trauma and attachment can affect unaccompanied young people and the general looked after population alike, so it is important for an effective measure of need to consider these. The specific adaptations that will need to be made in these trials for unaccompanied young people will include translated resources, sensitive measures of a young person's environment that take into account issues such as their recent arrival, lack of support network and the impact of Home Office processes.

- **Practitioners' responsible for assessing young people's needs**

The interviewed mental health and advocacy practitioners identified variable practice in the ways that social workers, GPs, mental health professionals, personal advisors and others understood and responded to the needs of young people. This can lead to young people missing necessary support when actors who would be able to refer them into services do not identify their needs.

In this section, we will focus on some of the key actors in an unaccompanied young person's life and how, if not adequately sensitised to the needs of unaccompanied young people, they may risk creating barriers to appropriate mental health support.

Paediatricians and general practitioners

When a young person is first arriving into care, a paediatrician usually conducts their LAC assessment. However, we heard from interviewed practitioners that these assessments can be delayed, posing a risk of young people's needs not being identified in a timely manner in breach of relevant guidance on LAC assessments outlining the need for them to be timely.[104] Without specialist training on the needs of unaccompanied young people, paediatricians can end up missing key mental health (and other health) needs that these young people are presenting with.

Once young people are in the community, GPs can also struggle to support their needs.

'*I'm not sure the GPs made head nor tail of these kids…because GPs are the primary caregivers, there should be training for GPs, and they should know that they should have translation available [in] sessions for these children…there's a [young person that] I've taken to the GP a couple of times recently and not once had the GP thought to have translation.'* **– Mental health practitioner**

If a young person is under the age of 18, a referral can be made into Child and Adolescent Mental Health Services (CAMHS) for support. However, if the young person does not meet criteria for a CAMHS referral, or they are over the age of a CAMHS service's referral criteria, they can be left without support:

'GPs tend to do…a generic letter [referring to a mental health service] that says "they've presented to me; this is what they're saying. Can you do an assessment to find out more?" [This] seems to be…the generic way in which GPs manage things…they make a referral into a CAMHS service, a young person…then doesn't fit within CAMHS. And then they don't get a service.' – **Mental health practitioner**

It is important for young people to be able to access CAMHS support until 25,[105] to ensure consistency in support. However, if young people are not meeting the criteria for CAMHS support, this indicates that supplementary specialist support also needs to be provided in the local area in response to their needs.

Paediatricians – who are often the first medical point of contact for unaccompanied young people – do not currently receive any specialist training on how to support unaccompanied young people presenting to them with mental health issues. This can create problems if the specific needs arising out of their status as an unaccompanied young person are not recognised. When unaccompanied young people are settling in the community, their GP can provide a gateway to access wider health services. If GPs are not able to sensitively identify young people's needs, there is a risk that young people's issues remain unidentified and they may lose out on necessary help.

Social care support

If an unaccompanied young person is in the care of a local authority, they will be allocated a social worker whose duty is to ensure that the young person is linked in with all the services they need. Practitioners identified that social workers often struggled to support unaccompanied young people with mental ill-health and wider needs, such as accessing immigration advice:

'Social services…don't have specialist social workers. Some still don't know the importance of making an asylum claim straight away and what the implications are for children if it isn't [addressed] straight away… [Social workers] can think that all they need to do is give the same time of support as other looked after children when

[unaccompanied young people's] needs are so different, not more important, but there is a real lack of understanding. Then the young person feels misunderstood, not heard and that nobody is there for them. [Social workers feel] that they are becoming a "difficult" young person for the social worker to work with, it can be a vicious cycle.' – **Mental health practitioner**

Social workers without specialist training are less likely to identify the specialist support that unaccompanied young people might need. Our research into legal aid[106] has found that social workers are often not equipped to support young people to navigate immigration and asylum processes, due to lack of specialist training in this area. This indicates a need for local authorities to allocate funding to train all social workers that are supporting unaccompanied young people to understand their comprehensive needs, as well as ways that social workers can support them.

- **Translation**

Inadequate translation can create huge barriers for unaccompanied young people. If unable to explain their needs, they can face being alienated and unable to engage with support. Even if young people are in the process of learning English, mental health language can be complex and, as such, young people face being unable to understand mental health practitioners, or communicate their needs. Practitioners and young people also identified issues when the dialect spoken by a young person does not always match that of an interpreter from the same region.

Young people may not be literate in English, or the language of their home country, which can limit the efficacy of written resources. This is particularly acute if education and awareness raising has not occurred with young people, to help them understand mental health issues and how to articulate them.[107]

'[GPs will] say, "Oh, the English is coming on". Well, yes, it is coming on but there are subtleties in meaning that [young people are] probably not getting.' **– Mental health practitioner**

Young people from unaccompanied backgrounds can often be overrepresented in special educational settings.[108] When a barrier in communication exists, more serious neurodevelopmental issues can remain unidentified, leaving young people without the sensitive support they require.

'[Young people often have learning difficulties]…It's often overlooked because there's a real emphasis on trauma, when…there also maybe inherent learning [difficulties], or even autism…It's terribly difficult to diagnose because…the Western cognitive assessments aren't necessarily very good for people who are non-English speakers…because [young people] are often quiet…I think they are not necessarily picked up.' **– Mental health practitioner**

Supporting young people to understand and articulate mental health needs

Psychoeducation – the process of working with young people to understand mental health needs and how they relate to material factors in their lives – is important to help them to communicate their needs.

A practitioner spoke of a scenario where a young person's lack of psychoeducation meant that he was unable to describe his needs in a key Home Office interview:

'[A young person I am supporting at the moment] was asked by the Home Office, "do you have any medical conditions?" and he talked about having headaches, but he's had a full psychiatric assessment before and he's been diagnosed with clinical depression. That wasn't mentioned at all…But he will tell you for a long time all about his sleep problems [but] he's still not recognising [how these are connected].' **- Mental health practitioner**

Interviews with young people for this study also indicated their difficulties in understanding and explaining what services they were accessing. Even in cases where staff supporting the young person had notified us that they were accessing mental health support, it took several attempts at explaining what mental health services were before several of the young people could confirm that they were accessing them. For young people engaged in services, the volume of different professionals that they deal with can be overwhelming and difficult to differentiate between.

If unaccompanied young people cannot articulate their needs, they risk receiving no support until they reach a crisis point. Greater efforts at psychoeducation from support workers can help young people to understand their specific mental health needs and the support available.

2) Effectiveness of services that support young people

Unaccompanied young people identified as in need of mental health support following assessment can still face barriers in accessing appropriate support. In this section, we will look at some of the ways that services providing support to unaccompanied young people might fall short of providing what they need.

- **Lack of communication between support services**

Services supporting young people can end up operating in isolation, with little communication between them. Without communication, services are not able to implement a fully holistic package of care for a young person and consider their full needs.

For unaccompanied young people to receive the best possible care there must be good communication between their social worker, mental health support workers and other relevant actors in their lives.

'All services are under pressure and they do not talk to each other. [It would be of great benefit] if you create something where they do talk to each other, making that space, to facilitate discussions across professions and a power hierarchy.' – **Mental health practitioner**

The above practitioner identified a need for leadership, to create a forum for all agencies to communicate more effectively. We will explore a good practice example of this in Chapter 3.

- **The Hostile Environment**

Since 2012, the Government has pursued a policy seeking to create a hostile environment for undocumented migrants,[109] which has ended up affecting wider migrant and BME groups.[110] Everyday barriers created by immigration controls can perpetuate insecurity and fear, further alienating young people from support that is already difficult for them to access.

The Immigration Act (2014)[111] and NHS charging regulations (2017)[112] introduced charges for secondary and community healthcare services, including hospital care and NHS care provided by charities.[113] Those not eligible have to pay a surcharge, or upfront costs, prior to accessing this care. Young people can be cut off from NHS support if they are over 18 and have exhausted asylum appeal rights, or are looked after by a local authority and eligible for support,[114] but do not have the documentation to prove it. Recent research has found that even those eligible to access NHS services end up without healthcare[115] because of confusion about entitlements.

'*Often GP surgeries [are] unclear about whether they should or shouldn't take somebody…We have to work with the young person to get them referred into a GP surgery…it's always a challenge to get GPs to refer to mental health services and get [those] services to accept young people, because they do not fit in with the service, but this creates another barrier for those people to access services.'* **– Mental health practitioner**

Under new immigration bail changes introduced under the Immigration Act 2016[116] young people without leave to remain can be subject to immigration bail with a condition preventing access to education.[117] Those affected can apply to have the bail condition lifted, but this is discretionary and young people cannot access education until it is resolved. This can create barriers for care leavers, whose support is predicated on enrolment in education.[118]

Young people's sense of security for the future is often closely linked to educational attainment,[119] yet this government policy enforces a barrier between young people

and their goals. The Government must address and remedy the ways that its own policies are creating barriers for young people whom it has a duty to protect under the UNCRC, the Children Act 1989 and Section 55 of the Borders, Citizenship and Immigration Act (2009).

3) Asylum and immigration processes having a detrimental impact on young people's mental health

In interviews, specific official processes related to young people's asylum-seeking status were identified as creating negative outcomes for their mental health and well-being. These processes often dictate what sort of support young people will receive, and their long-term prospects in the UK. Often, delays, negative decisions on Home Office applications and harsh questioning involved in these processes can severely harm young people's mental health. Here we will look at some of the most common official processes and their impact.

- **Home Office processes and immigration control**

The outcome of an immigration or asylum application will shape the rest of an unaccompanied young person's life. The period in which young people remain without secure immigration status is connected with a number of psychological issues and anxiety.[120,121,122] Young people can feel powerless and unable to influence the outcomes of a decision that will affect the rest of their lives.[123] In The Children's Society's services from 2016 to 2017, we measured that young people were waiting anything from half a year to two years for a decision from the Home Office. Unnecessary and unexplained delays create an environment where young people are unable to move on from traumatic past experiences.[124] During this time, young people's lives can remain in stasis until they know whether their future in the UK is secure. The resultant insecurity for young people can create barriers for mental health professionals seeking to support young people as they face Home Office delays and other difficulties.

'I have lots of insecurity to do with the future, but because I [haven't had my interview for] nearly two years…all my future is connected with my document [for leave to remain] and if I don't get my document, I don't have any future here.' – **Young person, 18**

All 10 of the mental health and advocacy practitioners interviewed for the current study identified Home Office delays and refusals on applications as a key cause of harm for unaccompanied young people.

'Levels of stress depend on fluctuating support from the Home Office and local authorities, poor accommodation and subsistence. [Unaccompanied young people] are expected to live with a level of insecurity that a young person cannot cope with.

[They] have to be very mature to be able to say that this will pass.' – **Mental health practitioner**

'There is a lot of [insecurity] around Home Office [processes]. [Young people think] "I want to stay here, but I'm not sure if I can. But what on earth am I going to do if I have to get back?"… I think a lot of the young people…find themselves torn in half because, on one hand they want to build up a life here [,] they're trying to learn English and they go to college and they're making friends. But there's always the risk of [having] to go back.' **– Mental health practitioner**

One young person, who had recently had his application for asylum refused and whose legal representative was in the process of preparing an appeal, spoke about the resulting changes in his daily life:

'I was coming here to youth group and meetings and we used to go on outings…I was very happy and then God knows what happened. [My] case has been refused; I stopped coming here so I [started] to feel bad.' **– Young person, 21**

As well as triggering traumatic events from a young person's past, one practitioner spoke about Home Office processes themselves being traumatising:

'*The Home Office…system is a traumatising system and…we [have to] keep people at bay…and that's prolonged to the point where that actually is a traumatising process…with [the young people], when they were going to go to see the Home Office for their interview, their trauma levels were sky-high…if you think about previous trauma and not being [secure], having to flee…and that sense of not having a place of safety… it's all linked. A trauma response is all about not being believed and not being understood.'* **– Mental health practitioner**

This young person, who was angry about the harsh questioning he had faced in a Home Office interview, echoes the sense of not being believed:

'Everything they are asking, you're confused they're [trying to catch you out], make you guilty, make out you are lying. That's absolutely what the Home Office is doing but it's very disgusting.' **– Young person, 21**

Unaccompanied young people can face high levels of distress around Home Office processes.[125] We outlined in Chapter 1 how trauma can manifest in complex ways, including memory loss,[126] and the act of retelling their stories to multiple professionals can traumatise young people. The UN Committee on the Rights of the Child latest General Comment on the UK recommends that the best interests of young people cannot be addressed unless mental health professionals are involved in designing and determining the best interests assessment.[127]

This poses an important question for decision makers within the Home Office: to what extent are they willing to allow immigration control to risk the long-term well-being and prospects of young people? The focus on Home Office bureaucratic

processes are demonstrated here to often be in conflict with the long-term needs of unaccompanied young people and their ability to integrate effectively within communities. The Home Office and local authorities must consider the duties they have towards unaccompanied young people, as outlined in Section 55 of the Borders, Citizenship and Immigration Act (2009) and The Children Act 1989, and work to mitigate the harmful effects of Home Office processes.

- **Age assessments**

Young people can also face intensive questioning when they undergo an age assessment. A social care professional or the Home Office usually conducts age assessments when there is significant doubt about an unaccompanied young person's age. The Home Office might conduct an assessment to decide whether a young person should be linked in with child-specific support, when they are identified at an entry point to the country. Once a young person is referred to a local authority for care, they might conduct an age assessment to decide what level of support to offer a young person; young people below 18 receive a different package of support to those above 18.

Official guidance is clear that age assessments *'should only be carried out where there is significant reason to doubt that the claimant is a child'*.[128] The process of assessing unaccompanied young people's age is highly contentious[129] and there is ongoing debate about whether they should be conducted at all,[130] as well as litigation against their lawfulness.[131] There is a body of evidence that finds age assessments to have a negative impact on young people's mental health and well-being.[132,133,134] Previous research by The Children's Society has found that age assessments create difficulties for many young people, especially those that are facing additional vulnerabilities, such as being trafficked.[135] The impact of age assessments creates mental health distress for young people at several points:

- When their identity is challenged and questioned as untrue
- When they are potentially prevented from accessing support as a child, because they have been assessed as being an adult
- In the long-term, if they are unable to access CAMHS or other mental health support that is available for children

Case study

Assadullah is a 17 year old young man from Afghanistan. Assadullah knows his age as his mother had been very clear, the last time they had seen each other, about how many years ago he had been born. He was forced to leave his family and Afghanistan after being taken by the Taliban to a training camp where he was frequently beaten, forced to witness violence against other children, and entered into trained to carry out a suicide mission against his will. The day before the mission was due to take place, a camp guard helped Assadullah to escape and arranged for his uncle to take him to safety.

Assadullah was taken by his uncle across the border to Iran. He was not able to see his mother or siblings before he left, but his uncle assured him they would follow. Assadullah was taken across Europe by people smugglers, and he arrived in the UK without knowing where he was, aged 16. Once in the UK, Assadullah was abandoned by the smugglers and taken to a police station by a member of the public. Assadullah spoke no English and felt terrified to go to the police as he thought that they would beat him.

The police arranged for Assadullah to be assessed by children's social care, who arranged an emergency foster placement. They also conducted an age assessment and judged him to be 20 years old. Assadullah's facial features presented as older than 17 and he was judged to know more than would be expected of a 17 year old. As a result, Assadullah was taken out of the care of the local authority and moved to live in a house with four adult male asylum seekers. Assadullah felt extremely afraid in this house. He did not understand any of the languages that the men spoke, and he also spoke very limited English so felt unable to ask for support from the housing manager.

Assadullah was experiencing regular and terrifying flashbacks from his time in the Taliban training camp. He also missed his mother and did not know whether she was still alive. He began to hear voices akin to his Taliban captors, telling him to kill himself as there was no point in carrying on. He would sometimes think that he saw his mother in his room at night and did not understand why she was not talking to him. Assadullah was referred by his GP to Freedom from Torture, which was able to provide therapeutic support for Assadullah's traumatic experiences and his mental health needs. However, he did not receive age appropriate care, and was unable to access education. This had a detrimental impact on his ability to feel safe in the UK and to engage with a process of recovery and rehabilitation.

Practitioners interviewed for this research also commented on how an age assessment can create a crisis for young person's identity:

'One young person [that was being age assessed] said that his age was what his mum told him, which was then discredited. It was the one thing he had to hold onto from him mum. As well as practical consequences of age dispute, there is a real injury when young people are constantly questioned. There are guidelines on age assessments, they should have benefit of the doubt, but it is hard to see that working for young people.' **– Mental health practitioner**

An unaccompanied young person's age might be the one fraction of their former life that they bring with them. Having this brought into question can disrupt their sense of self. An age assessment that judges young people as older than they are can have grave consequences for their mental health:

'One of the most vulnerable young people I worked with was in [asylum] accommodation at 17, he felt at constant threat…he was very vulnerable. He did have a secondary mental health services team who were very good and understood the concerns…He wasn't able to challenge the age assessment; the solicitor instructed was not able to do this. Everyone was convinced that he was the age that he said he was.' **– Mental health practitioner**

It is crucial that an age assessment is carried out only when absolutely necessary and that it is Merton compliant,[136] with extreme care for the vulnerabilities of a young person. An overview of the mental health impact of age assessments must be explained in relevant Home Office and local authority guidance.

- **Impact of legal aid cuts**

The Children's Society's research about legal aid has found that access to legal services has become more difficult since cuts to legal aid. We have learned that certain parts of the UK have been identified as 'advice deserts' because there is an extremely limited coverage of services.[137] A 2017 independent inspection into Home Office processes has also recorded the impact that an inability to access legal advice has on young people's mental health.[138] Without timely immigration advice, young people face the added difficulty of not being able to successfully challenge a removal decision after exhausting all appeal rights. The effect of a poorly conducted age assessment can be that young people face removal, without the network of support they might rely upon if they are recognised as a child.

Conclusion

In this chapter, we have looked at the barriers faced by unaccompanied young people, in being able to access services, in being supported by services and throughout the official processes that they are required to partake in.

From the tools used to assess young people's needs, to efficacy of statutory and voluntary agencies that provide help for young people – as well as the Home Office processes that young people encounter – young people can face labyrinthine journeys before they get anywhere near to suitable support. In this chapter, we have seen that wide, sweeping systemic change is required to build sensitivity to unaccompanied young people's needs into processes that affect them. Without this, unaccompanied young people continue to be left without therapeutic support that they require. In the next chapter, we will look at the good practice models for providing unaccompanied young people with the best care possible.

Chapter 3: Good practice models for support

Having provided an overview of the mental health issues that unaccompanied young people might be struggling with, and the barriers that prevent their engagement with support services, we now consider good practice for improving support. Although this report is not intended to determine the efficacy of certain mental health interventions over others from a clinical perspective, our research has revealed certain processes that appear to improve engagement between unaccompanied young people and the mental health services that they might need. Earlier in this report, we identified that systems change is required to encourage access to the best quality mental health care for unaccompanied young people, so in this chapter we attempt to map some of the ways of working that could help achieve this.

In this section, we will move through issues ranging from initial engagement with unaccompanied young people and support services, followed by their journey through these services. We will provide an overview of the difficulties that arise from work practices, with examples of emerging good practice and recommendations to improve outcomes. Although the recommendations made here focus on unaccompanied young people, much of the good practice is also relevant to all young people in need of mental health support.

'When [the young people] see that they have an adult to talk to and…the way that we frame things, the way that we actually put things to them helps them…They feel contained and understood.' **– Mental health practitioner**

1) Processes to encourage young people's engagement with support

Under the current system, the needs of unaccompanied young people arriving in the care of a local authority are assessed in accordance with The Care Planning, Placement and Case Review (England) Regulations (2010).[139] This assessment must take into account a young person's permanence, as well as ways for the local authority to meet their needs, with regard to *'health; education; behavioural and emotional development; identity'*.[140] The success of an initial assessment of need conducted by a paediatrician on behalf of the local authority is often a decisive factor in whether a young person is then referred on to mental health services for further support.

Subsequent referrals into mental health support should be flexible, and assessments of young people's need should be thorough, sensitive and adaptable to the needs of young people. Once young people are identified as in need of support, it is necessary for a detailed assessment to be conducted by a therapeutic service. We will look here at some of the processes for referrals into support, and assessments that occur within a mental health service – as well as the ways that existing services

might improve identification of young people's needs and their subsequent outcomes.

- **Tools for assessing initial need for mental health support**

There is an array of mental health tools available to assess young people's mental health[141,142] and attempts have been made to identify measures that might be routinely used by a range of medical and non-medical professionals.[143] The practitioners that we spoke to often devised their own tools, through a combination of other frameworks such as the YP-CORE,[144] which is implemented in The Children's Society's Rise Project.[145] Few reviews have thoroughly evaluated the psychometric rigour and the utility of these measures[146] in a CAMHS setting, for the general looked after population of young people – let alone focused on their use for unaccompanied looked after young people. In order to improve the initial assessments made for looked after children entering care, guidance on promoting the health and well-being of looked after children[147] should be updated to reflect the range of tools that are available for assessing need, and the particular vulnerabilities that unaccompanied young people face.

Many tools ask questions about respondent's lives, such as their relationships and home environments. This may be difficult for unaccompanied young people to respond to with detail, given the insecurity that pervades their lives. There are likely to be other challenges with assessment tools, including language barriers, gaps in psychoeducation among young people, and material deprivation. The sum of these factors can cause many assessment tools to fall short. It is important for professionals to be aware of this limitation and use a range of resources in assessments.

- **The importance of sensitive referral processes into mental health support**

Complex or inflexible referral processes into a therapeutic service, once a young person's need for the service is identified, can make it difficult for young people with vulnerabilities to engage with mental health services.[148] Unaccompanied young people can end up disengaging before they have even had an opportunity to access the support they need. A sensitive, adaptable, community-based initial referral process can help to draw young people into much-needed support.

- **Community-based mental health support services**

Services with strong links within the local community can help to engage unaccompanied young people who might not traditionally present to mental health support. Three of the interviewed practitioners working within a specialist NHS

CAMHS service spoke about community-led efforts to improve access to the service for refugee and migrant young people.

Unnecessary bureaucracy and form filling in the referral process can be one barrier in engaging young people. This NHS mental health service developed connections within the local community so that a referral can be made that way, or even through a friend of the individual being referred, without excessive bureaucracy:

'Whereas other organisations would require that they complete a form. They can come in and say that they need to access support and explain why they want to…see the team and the team can support them to fill in a very brief form.' – **Mental health practitioner**

'*There was a lot of community work, so [young people began] to know the relevant community mental health workers, who are also of the same cultural background and then they can self-refer or, or refer themselves through family members [who have] heard about the service and had a good experience.'* – **Mental health practitioner**

Following a referral, the practitioners contact the young person to explain who they are and what the service does, whereas other services might simply send a letter that the young person will not understand. This has been an important step in developing a supportive relationship with young people.

One young person also spoke about difficulties they face in travelling to therapeutic support services that are not based within their community:

'[It would help if we received] funds for travel, expenses…not everyone will have money for travel. If you are taking two hours on the bus, you are tired by the time you get there already.' **– Young person, 18**

Recent Government work into the area of developing community-led resources for mental health for young people has highlighted the importance of schools in providing this support.[149] However, a young person who is still waiting to access education, or is ineligible for education support, might be unable to access support in this setting. Consequently, mental health support should be more readily accessible within the wider communities that young people reside in through successful relationship building. For young people residing in areas where community therapeutic support is not available, local authorities should look to reimburse their travel costs.

- **Building trust between young people and services**

Building a relationship of trust with vulnerable young people, especially young people that have faced abuse and trauma, creates the foundation for a meaningful support

relationship with them.[150] Asylum-seeking young people can face barriers in trusting authorities and anyone that they consider an authority figure, based on previous negative experiences.[151] It can be overwhelming for unaccompanied young people to deal with the range of professionals that they encounter from different agencies, especially for those that have recently arrived, and it can be difficult for professionals to build a relationship of trust:

'Newly arrived children get so confused…they have lots of people involved in their lives and they cannot distinguish who is who, and why they are coming to see us. We prepare them before they come to see us to have a clear idea about what they will get when they come.' **– Mental health practitioner**

Mental health practitioners we spoke with usually book sessions directly with young people, to ensure that they remember. It is also important for social workers, foster carers and residential support workers to be involved in reminding young people when sessions are, so that mental health support is central to their care.

Practitioners may also end up having to reassure young people that they are not part of the Home Office, to allay young people's apprehensions about the immigration and asylum process, as outlined in Chapter 2.

'[Young people] think that we will report back whatever they say [to the Home Office] so we have to make sure that they are clear [about our role]. We tell them that we are not part of the Home Office, but if they disclose something dangerous and risky then we have [a safeguarding duty].' **– Mental health practitioner**

From the very first point of contact, it is important that young people understand what a service is providing them. Building this relationship of trust can lead to young people staying engaged and beginning to reverse the distrust of adults and agencies that they might have developed as a result of abuse and trauma they have experienced in their past.

2) Best interests assessments and determinations

'In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration.' **– Article 3, UN Convention on the Rights of the Child**

The best interests of young people should be centred in all assessments that are made about their needs and determinations made about their care, as outlined in DfE guidance on the care of unaccompanied migrant children.[152] The General Medical Council has provided non-exhaustive guidelines for assessing best interests of a young person up until the age of 18 years old, which include taking into account

their views, cultural beliefs and values.[153] Research suggests that mental health must be better centred in any best interests assessment because of the high incidence of trauma and mental ill-health among unaccompanied young people.[154] Concurrent with the other ongoing steps to develop referrals into therapeutic services that are sensitive to young people's needs, ensuring that their needs and wishes are centered effectively will help to encourage meaningful engagement.

Referrals and initial assessments within a therapeutic support are the first point of contact between services and young people, making them a key moment for building trust. More community-based and sensitive referrals, in a setting where young people are comfortable when presenting to a service, can work to improve outcomes for unaccompanied young people. As the availability of effective tools for assessing need among this cohort still requires development,[155] adaptable assessment processes must be factored into future development of mental health support for unaccompanied young people.

3) <u>More effective leadership with support services</u>

Effective coordination between services requires better leadership, to ensure sharing information about young people's needs and create processes to help them engage with services more efficiently.

Services that are integrated into a network of support for unaccompanied young people and work collaboratively are an important way to improve access to mental health services for young people.[156,157,158] They can also help to lay the foundations for more preventative mental health work, as outlined by one practitioner:

'If you have a therapy service [integrated] within a local authority, you would be talking to those social workers, dealing with those [young people] all the time…And through those conversations you would know who's coming in, what's going out, what's required. You would be bespoke; you would be nipping things in the bud...If you're part of that system, then you're much more likely to be effective.' – **Mental health practitioner**

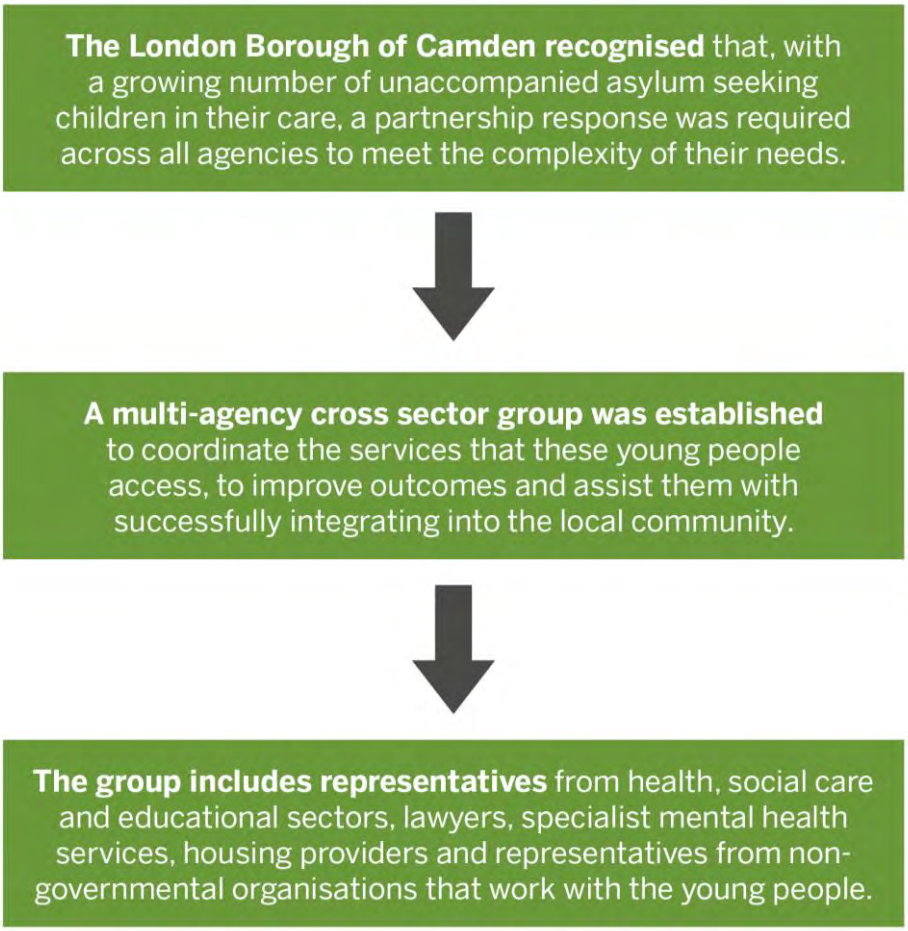
Some local authorities have developed ways to collaborate across stakeholders to improve outcomes for young people. The model on page 50 provides a model for a reference group set up on a local authority level to coordinate relevant services to support refugee and migrant young people that are newly arriving in an area. This has proved to be an effective working model, ensuring that professionals are in dialogue with one another and needs are identified early on. Support that is more comprehensive can then be offered to young people, including specialist mental health services. This sort of model can also help to increase capacity, as the duty to support young people is shared across necessary services. Implementing this sort of working model on a local level does not require additional resource, and it can

drastically improve the outcomes for young people. If a local authority is not able to provide this coordinating function, it can also be led by an agency – such as one of the regional Strategic Migration Partnerships – which are often in touch with the range of support agencies within an area.

Joint working can also enable services to notify each other of arising issues, as young people will be closer to some services than others:

'If I have any problem I...talk with my personal advisor…Before it was social worker, now personal advisor and my support worker as well.' **– Young person, 18**

Joint working good practice on a local authority level



Benefits of this sort of working include:

1) **Rapid sharing of new and emerging issues** – such as identification of latent tuberculosis in newly arrived unaccompanied young people.
2) **Identification of gaps in provision.** Agencies coming together in this way have been able to identify areas where demand for services was not being met, to help develop bespoke services.
3) **Highly effective partnership working.** The local authority was able to commission specialist services to support unaccompanied young people because of this model.

Joint working helps agencies to communicate better and remedy any barriers that arise in providing a young person's care. Statutory services must work alongside voluntary services with specialist experience in therapeutic work and advocacy, as well as young people and the local community. This will strengthen networks of support around unaccompanied young people, and work to improve referrals into specialist support for them.

It is also important for agencies in a local area to be working jointly to troubleshoot where patterns in mental health need among unaccompanied young people are arising. For this reason, Health and Wellbeing Boards should ensure that local Joint Strategic Needs Assessments (JSNAs) explicitly include children and young people's mental health, with attention to the specific vulnerabilities of unaccompanied young people within this, with attention to their specific vulnerabilities. This would allow Health and Wellbeing Boards to assess current and future need and inform commissioning of services.

4) **Training to ensure consistency among services**

As outlined in Chapter 2, the lack of awareness among professionals working closely with unaccompanied young people can create barriers for those that require therapeutic support. Offering an introductory scheme of training on the needs of unaccompanied young people can be an effective way to increase outreach to young people.

The practitioners we interviewed have all been involved in delivering a range of training for professionals, residential workers and foster carers that work with unaccompanied young people, in order to explore their basic needs and issues that might exacerbate mental health issues (as outlined in Chapter 1). They have reported that offering training helped to increase awareness about specialist services that are available for young people, making it easier for them to be referred into the support they need.

Training on the mental health needs of young people

Training that provides an overview of unaccompanied young people's needs can help to improve identification of need and the care that is offered to them. One practitioner spoke about setting up a dedicated project to focus on sleep therapy and physical activity-based therapeutic interventions for unaccompanied young people's trauma symptoms – which included offering training to other practitioners about the good practice models that were developed throughout the project.

Interviewed practitioners reported positive outcomes following delivery of training to other professionals. Skilling up clinical and non-clinical professionals alike on the mental health needs of unaccompanied young people helps to improve identification

and support for these young people. When training is led by the specialist services that are supporting these young people, practitioners are also better equipped to know where to refer young people for support in an informed and timely manner.

Practitioners in our frontline services deliver training on the basic rights and entitlements of unaccompanied and trafficked young people, which is free to attend for relevant professionals.[159] Our Hat·tê·ḇāh scheme[160] as outlined on the next page provides a model for community integrated methods to support unaccompanied young people, whilst increasing awareness among those that are supporting young people. It includes young people leading sessions, which provides a way for their voices to be centred in learning about issues that affect them.

This model of awareness raising on a community level means that even those in a non-professional setting are more aware of the needs of unaccompanied young people, equipping them to plan more innovative ways to support these young people.

The Children's Society Hat·tê·ḇāh training programme

The Hebrew word **hat·tê·ḇāh** is used only twice in the Old Testament, once to describe Noah's ark, and once for the basket used by Miriam to keep Moses safe in the River Nile. Our vision is for our communities to be places of safety, of hat·tê·ḇāh, for refugee children.

Collaborating to support the most vulnerable young people seeking refuge in our country

By combining the Church's direct links into the heart of communities and the passion and enthusiasm of parishioners, alongside The Children's Society's expertise in supporting young refugees, we have developed models of support that can be scaled up and replicated across the country – genuinely transforming lives and communities.

1. **Welcoming communities**

In partnership with the Church of England and Mothers' Union, The Children's Society offers awareness raising training to Church professionals. Clergy and youth workers can ensure their churches and groups are inclusive of refugees, and share awareness raising across their congregations and networks. We offer supporting resources, including 'myth-busting' guides, prayer and theological resources. Skilled practitioners that work with refugee young people across The Children's Society's services, as well as the young people themselves, lead the sessions.

2. **Utilising the skills of Church volunteers**

Working alongside the Church of England, and key partners including Mothers' Union and Home for Good, The Children's Society offers volunteer roles within an orientation programme. Volunteers are carefully trained and closely supervised by The Children's Society's staff to support community orientation, information-giving, befriending and risk-prevention initiatives.

3. **Safer children**

We know from our many decades of work with refugee young people that targeted support in welcoming communities changes their lives. When newly arrived refugee young people access relevant information, support, activities and guidance, they connect with their new community. This, in turn, increases their knowledge of their rights and responsibilities in the UK. They are able to then grow in confidence and make informed choices, pursue help for themselves and feel part of wider society.

Our collaboration project sits alongside existing safeguarding structures, strengthening procedures where needed to ensure that they provide robust and effective protection for refugee young people.

The key areas of focus for trainings with professionals that are working closely with unaccompanied young people, as identified through interviews and the issues identified in the previous two chapters, include:

1. **An overview of the mental health issues that young people might be presenting with and the ways in which they might present, or might cause problems even if they are not immediately detectable.**
   This includes delayed onset trauma, PTSD, sleep disturbance, post-migration and daily stressors etc.

2. **The common barriers that might hinder providing holistic mental health support for unaccompanied young people and an overview of some straightforward processes that can be implemented by a range of professionals, residential workers and foster carers to mitigate these barriers.**

3. **The impact of the immigration and asylum process.**
   This section would stress the importance of ensuring that young people are linked in with high quality, appropriate legal advice as soon as possible. It would indicate the key points at which immigration and asylum processes might affect a young person's mental health and well-being, including when young people face delays or are refused.

All relevant actors working with young people on a regular basis – such as social workers and foster carers – should receive training to develop their understanding of the needs of unaccompanied young people and help minimise some of the harmful situations that have been outlined in this report. For mental health support workers, paediatricians, CAMHS workers, GPs, educators and any other professionals that are coming into contact with these young people in a less frequent support capacity, a centre of excellence in the local area would be a good place for them to receive information and guidance on the needs of unaccompanied young people and ways to support them. This would help to develop positive outcomes for young people, and create a forum for all of these agencies and individuals to talk through their experiences supporting unaccompanied young people, and keep in touch about their work.

Going forwards, local authorities can be thinking about innovative ways to improve training across all agencies that support young people. This training could help to improve identification of issues, and increase the capacity to support young people's needs and work to minimise some of the barriers to accessing support that are outlined in Chapter 2. Joint attention to training that covers mental health and material needs will begin to go some way to developing a more collaborative model for supporting young people.

5) Centres of excellence

Professionals that are doing specialist work supporting unaccompanied young people identified that, as services that have years of experience and expertise, it is logical that they are able to share their resources to up-skill others.

One potential method for doing this is developing a 'centre of excellence' status for services that have particular specialism in providing mental health support to refugee and migrant young people (either within the NHS or an NGO service) which is accredited by government agencies such as the Department of Health and Department for Education. Some input and support from these departments would also enable the teams to develop specific resources and training that can then be disseminated across the country.

'If you said…"let's bring the right clinicians…let's start to do the research and the evidence…really start to make it…an institute from which excellence can emanate", and they can teach…the rest of the country on [the needs of the young people]. Refugee children will always be present and we will always need services that support them…to invest is to gain in the long term'. **– Mental health practitioner**

This sort of recognition of specialism can help to develop learning centrally to then share good practice and learning across the country, as well as with other countries that are supporting unaccompanied young people.

Websites such as the UASC Health site,[161] or the Royal College of Paediatrics and Child Health information page for refugee and unaccompanied young people,[162] are valuable resources for practitioners across the country to access a wealth of knowledge at any time they need. The UASC Health Site also features video content, which can help to explain key mental health issues affecting unaccompanied young people to practitioners and the young people themselves. However, there is no current ongoing commitment to update the UASC Health site and the Government would be well placed to be able to secure this site in the long term with funding.

The Government has previously committed to a brief training programme for professionals that are working with unaccompanied young people,[163] but there has not yet been commitment to specialist knowledge sharing on the needs of unaccompanied young people. Based on our consultation with stakeholders and other available evidence, it seems that this level of commitment could help to improve outcomes for young people; those with existing expertise would be available to share learning with professionals for whom this is a relatively new area of work.

6) Providing holistic support for young people

Throughout interviews with stakeholders, it was made clear that material conditions – such as housing or financial support or the lack of immigration status – have a large bearing on the well-being of young people's need for mental health support services. As such, it is often necessary for advocacy services to be provided in tandem with therapeutic support.

Interviewed young people told us about the range of individuals in their lives that they speak to about their mental health and well-being – including advocacy support workers in The Children's Society, personal advisors, foster carers and staff in their accommodation. It is important that mental health services reach out to these professionals in assessment processes and ensure that they are included in relevant communications along with social workers.

Interview respondents working in NGO sector mental health services are able to provide a range of advocacy and other support services for young people within their services, as this was recognised as necessary for delivering holistic support for young people:

'[Alongside therapeutic support we provide] casework support, a legal team who intervene if there are legal issues with immigration issues and liaising with solicitors.' – **Mental health practitioner**

A young person spoke about the advocacy support that he had received when he faced being evicted from asylum accommodation:

'Since I've been refused [asylum] and I was asked to leave the accommodation, it was [my therapy service] that sorted all that out.' **– Young person, 21**

Services provide advocacy support, support with immigration and asylum applications (through an in-house legal team, or by supporting young people to access professional legal advice), pastoral support, youth groups and activities and other holistic support services. This wraparound support was identified to help improve outcomes for the young people that they are working with, as the material issues that young people are struggling with in terms of Home Office processes, accommodation or schooling issues can all be supported alongside therapeutic interventions. This approach recognises that a multi-faceted approach is the best way to support young people.

Mental health practitioners working in both NHS and voluntary services stressed the importance of building better communications across all of the teams supporting young people. For mental health practitioners to be able to best support a young person, they must be in communication with a young person's social worker,

personal advisor, school etc. The Government has currently committed to providing independent advocates for child victims of trafficking in several locations.[164] However, our research has identified a clear need for independent guardians for all unaccompanied young people, as is available in countries such as Scotland[165] and Sweden.[166] This guardian role will help to ensure that there is a centralised contact for all professionals, as well as ensuring that there is someone acting in the best interests of the young people that they are responsible for. Our research into guardianship for unaccompanied young people provides an overview of the benefits of such a service, with the conclusion that these benefits would substantially outweigh the costs required to implement it.[167]

Local authorities need to be looking to develop closer links with specialist NGO services that are already providing holistic advocacy support, as well as offering funding for them to do so. Partnership working across professionals acting in a young person's interests is also vital. For young people that are formerly looked after and now leaving care, this should include a defined role for their personal advisor, which they would now be eligible to access support from up until the age of 25.[168]

Local authorities are now also required to provide a local offer for all their care leavers[169] to include all support that young people leaving care can access in terms of accommodation, education support, financial support and more. This offer must include a specific and targeted package for unaccompanied young people leaving care. We have produced guidance for local authorities in producing a bespoke local offer, which can be viewed on our website.[170]

7) Language, interpreting and translation

The language used to discuss mental health issues with unaccompanied young people is of crucial importance because they are developing their English language and literacy skills, whilst simultaneously developing an understanding of their own mental health issues and beginning to overcome the stigma they attached to these issues[171] – which can be particularly pronounced based on culture and gender (see Chapter 2 for more information).

It is important for practitioners to discuss mental health in terms that are not constricted to mental health language, which can make it easier for unaccompanied young people to understand. Previous research into the mental health of these groups has also indicated that speaking about mental health by using alternative non-medical phrases has created positive outcomes.[172]

'I would be talking about the impacts of trauma, young people often…don't understand why they have got sleep [issues], why they often have headaches and why they have got this funny feeling in their tummy…So I might be doing lots around anxiety, around sort of how trauma might manifest itself. Trying to normalise them a

lot…because in different cultures…mental health is seen as psychosis'. **– Mental health support practitioner**

The practitioner above describes a common method reported in interviews, which is creating connections between the different physical health conditions that young people might encounter with the underlying mental health issue that might be affecting them in tandem. This helps young people to begin to contextualise mental health and recognise the factors that can cause it to deteriorate.

'[We might ask things like] "if you're feeling happy today, what's made you happy?" or "if you're feeling sad, what's made you sad?" and we do that a lot sometimes in the youth group when we're doing introductions. So "how good was your week, was there anything not good about your week, what happened, why did that happen, is there anything you can do about it?" So we might get around it that way.

But if someone says "I have nightmares when I sleep and then I wake up and I'm sweating" then we always say "maybe you need to speak to your GP about how you're feeling about things because they can give you the right support with your sleep." So, without actually saying "mental health" [which they might not understand].' – **Advocacy support worker**

It is important for non-medical support workers to have a working knowledge of the underlying mental health issues that young people might be facing, so that they can help to build the same connections between mental health and wider health issues. This also goes some way to grounding young people's understanding of mental health in everyday settings.

There is no fixed successful model for communicating with young people with limited English, but this is an area where more innovative techniques and communication through play activities are having some success. They are beginning to give young people space to speak more openly about the range of emotional and mental health issues that they are dealing with, and helping them to understand their own symptoms.

Resources used to discuss mental health

Lack of translated resources can prevent young people from communicating needs to engage in support, which can have acute impacts on their mental health.[173]

One service trains its own interpreters in trauma-related mental health issues and provides them with support, if they require it, for their own experiences. They keep a stock of the most common languages for the area and, where someone does not speak the language, they find an external translator and brief them beforehand.

'*I know that in the NHS they struggle for interpreters, but we have clear guidelines on how the translation will work and what the boundaries are.'* – **Mental health practitioner**

Interpreters without such training struggle to be neutral and objective in sessions:

'[Interpreters'] own experiences might be relatively close to what the young people are experiencing and also what they are hearing can be extremely difficult to stomach. I have had interpreters who've cried in sessions, or sort of overstepped back into re-sharing something…you want to try and talk to them before and after sessions if it's possible…[otherwise] the young people may not want to share things.' – **Mental health practitioner**

Advocacy practitioners within our own services also use a mobile application[174] in conversations with young people, to translate words or phrases into a language that the young person understands. This application was developed in consultation with young people that we support. Practitioners have commented on how this is a useful tool for sessions with young people, when an interpreter is not required for the full session:

'We also use that app quite a lot, because a lot of them will probably be able to have their smart phones on them and it's quite a nice way for them to communicate without struggling and without having someone sat next to them. Because some of them don't want someone to sit next to them to show other people that they don't understand the language, that they don't understand English.' – **Advocacy support worker**

One young person spoke about a project that he has been involved with through The Children's Society, where classes on improving digital skills are also used as an opportunity for young people to have group discussions about issues that they are facing:[175]

'Every Wednesday we have a computer class…for young refugees…and we can go there and talk about if we have any problem…we can talk and share with them.' – **Young person, 16**

More funding needs to be committed to services in order to provide translated resources for young people. As outlined in Chapter 2, language needs can create huge barriers for young people in communicating their needs and understanding the support that is offered to them. Local authority commissioners need to look at ways to ring-fence budgets for translated services and provide training for translators to be objective and professional – as this level of investment for recently arrived young people in particular can work to make a substantial difference in improving outcomes for them in the long term.

The following is a quote from a practitioner about a young person who has been accessing mental health support and is seeing outcomes that are more positive in his ability to communicate his needs as a result:

'[The young person] talks about his mental health freely with anyone and he knows his triggers, he knows when he's going to have a moment so he keeps away and he [says] "I need to go home because I need to take my medication." So, he knows that, and he also encourages other young people by saying, "hey, if something is not right for you I think you should speak with a counsellor."…So I think that that's a positive.' **– Advocacy support practitioner**

A mixed range of resources for communication

Practitioners also spoke about the successes that they have had with visual resources in psychoeducation with young people, where written resources might not be effective.

With advances in technology, websites and online videos and other digital resources can be of great use where young people are not required to read wordy resources.

An advocacy practitioner spoke about the use of visual aids in discussions about mental health with young people and how this simple method is effective for them to communicate need:

'One particular time we had…M&M [sweets]...So I gave them all whatever colour they chose and so… if it was the blue one the question of a blue one was "tell me something that happened that was not good last week and explain why" so the person who had a blue one would explain…So we [find] out how they are and how they're feeling.' – **Advocacy support worker**

Another mental health practitioner spoke about a distress-screening framework that they had created in a project working with recently arrived unaccompanied young people. The visual tool (viewable in Appendix 2) provides a thermometer for young people to identify how distressed they feel on an ascending scale from 1 to 10. This allows a practitioner to work through a list of concerns that the young person might be feeling, listed in categories of 'family', 'emotional', 'physical' and 'spiritual'. There is then a scoring system so that practitioners know what sort of mental health support is required for the young person, based on the score that they have achieved. This combination of visual tool for the young person to identify their own needs, with an inbuilt analysis function for practitioners, enables them to identify needs accurately and develop a system of support accordingly.
As the language of these young people is often limited, basic methods for communication using visual aids can create a supportive environment for them to

explore issues in the time that they are beginning to articulate their needs in mental health-specific language.

8) Consistency of support offered to young people

In our research, there was no specific consensus on the optimum time for mental health work with young people. However, practitioners that were interviewed could end up working with young people over a period of several years. This level of flexibility is recognised as an effective method for long-term support for young people, particularly for issues such as attachment, if such a service is available.[176]

One practitioner spoke about how their service can end up working with young people for an excessive period because they are not effectively linked in with wraparound advocacy support that might attend to their non-therapeutic needs, which is exacerbated by Home Office processes and other crises:

'I think there's a real dilemma, especially with unaccompanied minors who often [have] attachment issues…They [also] get extremely distressed around times of decision [from the Home Office] so it's very difficult to discharge them. But we end up…doing a holding function rather than any specific therapies of intervention…Almost…awaiting the next crisis. And because often their social workers change so much…we [become] a bit like attachment figures.' – **Mental health practitioner**

Another practitioner also highlighted the total disruption that excessively long Home Office processes can create for young people's lives, forcing them back into therapeutic support services that they might have previously been discharged from:

'I was seeing a [young person] two years ago and now he wants to come back [to the service] even though he had a year and half's work with us. His immigration application is still pending…The school referred him back because he is very emotional and he cannot bear to wait [for the outcome of his application for asylum], everything depends on this [application]…He is now going through the panicking stage about refusal [of his application].' **– Mental health practitioner**

When an unaccompanied young person is awaiting responses from the Home Office for years at a time, or struggling to get the support they need from social care or other agencies, their mental health can deteriorate. It is important to ensure that a wide-ranging and robust network of support is available to attend to young people's needs – but overdependence on services must also be managed.

A young person's mental health journey will change over time and the issues that they were once struggling with day to day might become more manageable for them later on. However, to prevent the same issues from harming them repeatedly, an

early intervention model of support that links them in with all of the necessary support can also help to ease the pressure on mental health services that see the same young people present over a period of years.

'[One young person that] I saw for four and a half years…he started off as a very angry young man, very disillusioned, very let down, and then there was something that developed within him, a sort of acceptance I think. And maturity – he wasn't necessarily happy with the situation, but he wasn't so angry… [Young people often develop] a solidness within themselves. And succeeding in their education, developing relationships, having boyfriends or girlfriends, having an idea of a future…and having coped with what the UK is throwing [at them].' **– Mental health practitioner**

Young person enters the care of a local authority.

Young person receives their looked-after children assessment

- This assessment takes place as soon as the young person arrives into care
- All relevant actors in the young person's life are engaged in the initial assessment process
- A range of assessment tools are used to assess needs, considering issues such as trauma and attachment
- The pediatrician conducting the assessment is aware of the particular vulnerabilities of unaccompanied young people and the specific issues that they may be struggling with, even if these are not immediately apparent
- A partnership has been set up in the area, to ensure that any other support that would need to be linked in with the young person is made available, such as treatment for sexual health issues and tropical diseases
- The best interests of the young person are centred in all assessments made about their care.

Young person is identified as in need of mental health support

- The young person is referred to a mental health service as soon as possible
- The initial assessment in a mental health service is comprehensive and sensitive to the needs of a young person
- Translated resources are made available where necessary
- Mental health issues are conveyed to a young person in terms that they understand, using a range of resources.

Young person begins to access mental health support

- Where possible, the young person can access specialist support within their community
- Translated resources are always made available where a young person needs it and interpreters are sensitive and aware of unaccompanied young people's needs
- Mental health practitioners work with the young person to book in sessions and communicate upcoming sessions to any relevant adults in the young person's life, so that they do not miss out
- Young person is also linked in with advocacy support to deal with any other issues that may impact on their mental health and well-being, such as immigration and asylum processes, education and accommodation support.

Young person receives the support for as long they need.

9) Support for young people arriving to be reunited with family[177,178]

Although the focus of this report has been on unaccompanied young people, practitioners raised concerns about young people that are arriving and seeking asylum as part of a family, as part of the Dublin III Regulation,[179] to be reunited with family members already residing in the UK.[180,181] Young people arriving to live with family members might not be able to access the same individualised mental health assessments and support as unaccompanied young people in care.

The Dublin III Regulation for family reunification of unaccompanied children in Europe

The Regulation enables an unaccompanied child to be placed in the same Member State as a family member or relative. Family members are defined as a parent, sibling or child, and relatives includes an adult aunt, uncle, or grandparent. The Regulation requires that an investigation is carried out to ascertain that the relative is able to care for the child and that this reunification would be in the best interest of the child.

Young people that are transferred through Dublin III are often placed in informal kinship care arrangements with family.

Under the current system, families receiving young people arriving through the Dublin III process might be subject to an initial visit from the local children's social care team (and possibly again after arrival). However, there is currently no statutory system of support prescribed beyond this point. Receiving families are not offered additional funding, or supported with registering young people in education, healthcare and other relevant services.

Research we conducted in 2017 found inconsistent support offered by local authorities for young people arriving through the Dublin III regulation, outlining the importance of the young people's needs being framed in accordance with the Children Act 1989,[182] which places a duty on local authorities to safeguard and protect the welfare of children and promote the upbringing of the child within their family (where appropriate). Families also require support with navigating immigration processes and, where necessary, financial support to do so.[183]

The Government has recognised that a portion of family placements through Dublin III have ended up breaking down.[184] Difficulties can arise when young people with high needs are placed with family members with little support. Family members face paying day-to-day costs to support Dublin III young people, as well as potentially paying thousands for their immigration applications without access to legal aid. The family members can range from aunts and uncles, families with young children of their own and siblings who are barely older than their Dublin III siblings are.

Case study

Abdul was 14 when he arrived in the UK in June 2016 from Calais, to be placed in the care of his older brother Mukhtar. The brothers are originally from Afghanistan. The brothers attended the Home Office for a screening interview for Abdul's application for asylum in the UK. They were advised that a social worker from the local children's social care team would be in touch with them soon. Abdul was not able to have a solicitor present at this meeting (as is usually the case) as he was denied legal aid because he was unable to demonstrate that his local children's social care team was supporting him.

No contact was made by the local children's social care team, so Mukhtar made multiple calls for Abdul to access their support. On one of the occasions that he called social care, Mukhtar was told by a social worker that if he was unable to provide for Abdul he should 'send him back to France'. Mukhtar was eventually given the name and contact number of an allocated social worker but, despite multiple attempts to make contact, he was unable to reach them.
Abdul was not enrolled in education of any kind for three months. After three months, he was enrolled in education which was well below his ability. Mukhtar was financially supporting Abdul solely with his earnings and they were living in a shared house with other adults, both sharing a room.

The Children's Society began supporting the brothers and the support worker submitted a further safeguarding referral to the local Multi-Agency Safeguarding Hub (MASH) team due to the inaction of the children's social care team on the case. The support worker continued to chase the unresponsive social worker for two months. No financial or practical support was provided during this time, other than a few bus passes for Abdul to go swimming.
The support worker spoke with children's social care about concerns regarding inadequate housing, lack of financial support, lack of support with Abdul's ongoing claim for asylum, and failure to enrol Abdul in education – but Abdul was not deemed to meet the criteria for social care support. The support worker made a referral to an immigration solicitor, community care solicitor, education services and other appropriate support.

A community care solicitor was instructed to legally challenge the inaction of the local children's social care team and a second social care assessment was scheduled – this was five months after Abdul had first arrived in the area. Abdul was then offered the relevant support from children's social care and placed in education that was better suited to his ability, recovery and rehabilitation.

Mental health support for Dublin III arrivals

'I did a home visit for two children, a 15 year old and one who's about 12, who [had come] over from Calais…they were living with a brother and it was overcrowded…It was utterly stark, they had nothing. [The brother] had two young children, his wife was pregnant…their children were literally climbing the walls because there was nothing… [T]hey now don't live with each other, the two children. [They]…didn't want to contact mental health services, but they needed to. [It's good that we can bring] children over, but what do they come to[?]…[You] begin to feel quite ethically challenged about the whole thing.' **– Mental health practitioner**

Dublin III young people are often unaccompanied until they are placed with family. They will likely experience very similar mental health issues to unaccompanied young people (as outlined in Chapter 1) with an addition complexity when they are forced to navigate the strain their families might face without key support. Yet these young people do not receive a health assessment in government guidance.[185]

Dublin III young people can face pressure if their families are struggling to raise funds to pay for their needs, without access to supplementary welfare support. They can also face social isolation without knowledge of where to seek help. This can leave them without access to mental health services, other advocacy support and youth groups that they might benefit from. Without knowledge of where they can access support, they risk facing undiagnosed physical, mental or sexual health conditions. There is a paucity of research into the availability of support and mental health outcomes for Dublin III young people. The Government has pledged to commission research into this area, which will help to understand the needs of these young people better.[186]

If relationships with their family members do break down, Dublin III young people usually present to a local authority for support as an unaccompanied young person. They can then face a protracted process of proving their entitlements to support – in the face of gatekeeping practices from children's social care teams that can delay or prevent them accessing the support they urgently need.

The Government must standardise a system of assessment and support for Dublin III families. All young people arriving through Dublin III should receive a timely, transition support package to provide financial and integration support until they are able to access other mainstream welfare support. This should be funded for local authorities, similar to the funding provided for the vulnerable persons resettlement scheme[187] and unaccompanied young people. Young people should be assessed under the Children Act 1989 to ascertain whether they require support under Section 17 or 20. A clear pathway to accessing services and therapeutic support – similar to that offered by local authorities to unaccompanied young people – must be made available for Dublin III placements, as their needs are not lessened as a result of

living with family members.

Alongside the Government's commissioned research into Dublin III outcomes, further research is required into any therapeutic best practice and, crucially, what early intervention steps might help to support young people arriving through this route. The Adoption Support Fund (mentioned earlier in this chapter) could be made available for Dublin III families and local authorities supported in applying for this fund. Following the UK's departure from the EU, all of the above changes must be accommodated in the system that replaces the Dublin III Regulation in the UK.

Conclusion

This section aims to provide a practical guide for commissioners, practitioners and others that are trying to think of new and innovative ways for attending to the mental health needs of unaccompanied young people. These recommendations around comprehensive and sensitive referral and assessment procedures, joint working across services, training to upskill professionals and improving language and communication, and consistency among services, will all go a significant way to bridge the chasm that can often exist between young people and effective support from services. Together, they would help to identify unaccompanied young people's needs as early as possible and engage them thoroughly into the support they need.

Conclusion and recommendations

The evidence gathered in this report through analysis of previously available information and in consultation with young people and professionals, demonstrates that mental health support available for unaccompanied young people under the current system is not effectively meeting their needs.

Unaccompanied young people make difficult journeys to arrive here and can be suffering a range of symptoms of mental ill-health because of their experiences. As outlined in Chapter 1, these mental health needs include trauma, sleep disturbances, bereavement and a range of stresses and triggers encountered during their lives in the UK. Young people's attempts to adapt in the UK can be made more difficult without this network of support that we might expect them to be able to rely on, leading to potential negative mental health outcomes. To be able to alleviate these issues, it is important that young people are able to access both mental health support and effective advocacy support.

Young people can face barriers at the point of being able to access support, as well as once they are linked in with a mental health support service. Barriers that unaccompanied young people face in accessing mental health support might include inadequate initial assessments of their needs, inflexible processes for referral into support services and lack of awareness among key practitioners about mental health issues that young people might be facing. Once young people are accessing mental health support, they can face barriers in accessing the holistic support that they need because of problems with:

- Language and communicating needs
- Lack of leadership among the agencies that young people are engaged with
- The Hostile Environment and age assessments
- Asylum and immigration processes creating insecurity and distress

Our research has made it clear that expansive structural change is required in order to build sensitivity to unaccompanied young people's needs into all of the systems that should be supporting them. Unless this happens, unaccompanied young people will continue to be left without the support that they often desperately require.

To ensure that unaccompanied young people are receiving the best standard of care, it is important to take a critical look at the support that is currently available and share good practice recommendations to improve support where necessary.

Improving assessment and referral processes, making services available within the communities that young people inhabit, and building strong trusting relationships with

young people can all begin to do this at the point that they are being recognised as in need for mental health support.

Clearer leadership within support services will ensure that all of the services that should be working to support young people are sharing information about the young person's needs and working collaboratively to solve any issues that arise.

Better language resources and training for key professionals that are engaging with unaccompanied young people on a regular basis will help to skill them up on young people's needs, as well as improve referrals into specialist mental health support services.

Developing centres of excellence to share good practice, and learning and providing advocacy alongside mental health support will also enable better wraparound support for young people, to ensure that their mental health needs are catered to with long-term solutions.

It is also important for all of this support to be available to young people that are arriving to be placed with family members through the Dublin III scheme, as their journeys and the difficulties that they face can often be just as acute as those faced by unaccompanied young people.

The task ahead in improving access to mental health support for unaccompanied young people is complex, but not impossible. Improving service delivery and sensitivity to adapt to the needs of unaccompanied young people will also help to develop support for other young people from at risk backgrounds. The risks of not developing this support for unaccompanied young people are potentially dire, but effective leadership and sensitivity can help to secure young people's lives and futures.

Recommendations

1) **The Looked After Children's (LAC) health and other assessment models to identify initial mental health need among young people are currently inadequate in identifying the mental health needs of unaccompanied young people who are seeking asylum having fled war and persecution, or those who are recovering from human trafficking and modern slavery (see Chapters 2 and 3 for more information).**

- LAC assessments must be conducted by local authorities as soon as a young person arrives into their care, as reflected in 'Promoting the health and well-being of looked after children' and 'Social Services and Well-being (Wales) Act 2014' guidance.

- For England: relevant figures within local authorities, Clinical Commissioning Groups and Health and Wellbeing Boards must ensure that paediatricians conducting LAC assessments are fully trained in understanding and identifying the needs of unaccompanied young people.
- For Wales: relevant figures within local authorities and Local Health Boards must ensure that paediatricians conducting LAC assessments are fully trained in understanding and identifying the needs of unaccompanied young people.
- For England: Health and Wellbeing Boards should ensure that local Joint Strategic Needs Assessments (JSNAs) within areas explicitly include children and young people's mental health, with attention to the specific vulnerabilities of unaccompanied young people within this.
- For Wales: Regional Partnership Boards should ensure that Health, Social Care and Wellbeing (HSCWB) health needs assessments within areas explicitly include children and young people's mental health, with attention to the specific vulnerabilities of unaccompanied young people within this.
- The ongoing UK government trials into mental health assessment tools for looked after children need to take the needs of unaccompanied asylum-seeking and migrant young people into full consideration. This requires other qualitative tools to measure unaccompanied young people's needs including cultural, ethnic factors and differences in their life experiences, to be used alongside the Strength and Difficulties Questionnaire, to capture need more comprehensive. This should include measures of trauma, well-being, attachment and any other issues that unaccompanied young people are commonly presenting with.
- In the new assessment pilots for looked after children's mental health, the UK government should conduct one pilot in a local authority area with greater numbers of unaccompanied asylum-seeking and migrant children. When evaluating the pilot, there should be a dedicated section of the evaluation focusing on unaccompanied asylum-seeking and migrant children's experiences and outcomes.
- Following the pilots, the outputs produced to support local authorities in improving mental health assessments must give specific advice on how to best meet the needs of unaccompanied and migrant children.
- The 'promoting the health and well-being of looked after children' statutory guidance, produced jointly by the Department for Education and Department of Health, requires updating to include a dedicated section on the mental health vulnerabilities of unaccompanied and migrant young people. This must include how young people's needs can be identified in an initial LAC assessment, with the aid of a more comprehensive assessment tool.

- Clinical commissioning groups must ensure that young people are able to access CAMHS support until 25.

- Local authorities and clinical commissioning groups must commit funding to specialist advocacy and mental health services to support unaccompanied asylum-seeking and migrant young people.

2) **There is a lack of specialist knowledge sharing about the mental health needs of unaccompanied young people (see Chapter 3 for more information).**

- The Department of Health must commit to funding the UASC Health website, and updating its resources when they become outdated.

- The Department of Health and Department for Education to consult on jointly developing accreditation for 'centre of excellence' status, or similar mechanisms (like a practice network), for services that have particular specialism in providing mental health support to unaccompanied and migrant young people, either within the NHS or an NGO service. Commitment to support from these departments would also enable the teams to develop specific resources and trainings that can then be disseminated across the country.

- When reviewing Local Transformation Plans (LTPs) submitted by Clinical Commissioning Groups, in areas with larger numbers of unaccompanied and migrant children, the Department for Health should require a care pathway for unaccompanied and migrant young people that meets their mental health needs, both in childhood and early adulthood.

- All local authority areas with high numbers of refugee and migrant children should create a reference group, as outlined on page 49 to coordinate relevant services to support refugee and migrant young people that are newly arriving in an area. This will ensure that professionals are in dialogue with one another and needs are identified early on. If a local authority is unable to coordinate this group, it could be coordinated by one of the Strategic Migration Partnerships (SMPs) within England or the SMP in Wales.

3) **Unaccompanied young people in England and Wales are not assigned an individual that represents their best interests in all decisions and proceedings that concern them.** Unlike in other European countries, there is currently no independent guardianship system for unaccompanied young people in England and Wales to support them through asylum, immigration and other legal processes (see Chapter 3 for an overview of the benefits of guardianship).

While many social workers will do their best to support unaccompanied asylum-seeking children in their care, there is no requirement for them to have specific training or qualifications to understand and keep up to date with the asylum system (see Chapter 2 and 3 for further information). They often do not have legal parental responsibility for the child, who is usually voluntarily accommodated by the local authority. This means they cannot instruct solicitors for the child and there may be a conflict of interest regarding care for the child, such as through protracted age disputes. The stress of these experiences – and lack of a trusting adult protecting their best interests – can lead to negative mental health outcomes and even self-harm, or suicide in some cases.

- We urge the UK Government to reconsider its position on providing independent guardians to all unaccompanied young people, to ensure that they have someone who is advocating in their best interests in all decisions made about them and has a legal power to instruct solicitors. These guardians should continue supporting unaccompanied children into adulthood, to ensure an effective transition.

4) **Although the UK Government has made significant progress and shown a strong commitment to providing training for foster carers and improving supported accommodation for unaccompanied young people, there are still too few unaccompanied young people receiving the supportive accommodation placements that they need to recover and rehabilitate (see Chapter 1 on accommodation placements).** Without effective supervision and support, their placements can create detrimental mental health outcomes.

- For England: whilst the current commitment to increasing foster care capacity is welcome, the Department for Education should commit to long-term funding for all local authorities in England to train foster carers and supported accommodation providers on the needs of unaccompanied young people, so that they can be better supported in their accommodation placements.

- For Wales: Welsh Government should commit to long-term funding for all local authorities in Wales to train foster carers and supported accommodation providers on the needs of unaccompanied young people, so that they can be better supported in their accommodation placements.

- For England: Social Work England should ensure that understanding the needs of, and how to provide the best support for, unaccompanied and migrant young people in care is included in the training standards for social workers in England. The Department for Education must ensure that appropriate funding is available for this to be delivered.

- For Wales: Welsh Government should ensure that understanding the needs of, and how to provide the best support for, unaccompanied and migrant young people in care is included in the training standards for social workers in Wales and ensure that appropriate funding is available for this to be delivered.
- For England: as part of their current duty to provide a local offer for all their care leavers, local authorities must provide a targeted package of support for unaccompanied young people leaving care to include access to high quality accommodation, access to legal advice and funding to regularise their immigration status, and more. We have produced guidance for local authorities in producing a bespoke local offer, which can be viewed on our website.[188]

5) Young people that are arriving through the Dublin III scheme to be reunited with family are often missing out on vital welfare and mental health support (see Chapter 3).

- The Department for Education must commit to updating the 'family and friends care' guidance to include a section on Dublin III placement (or any successor scheme that is implemented following the UK's departure from the European Union) and what support young people and their families should be entitled to.
- The Adoption Support Fund must be made available for families supporting young people that have arrived through the Dublin III scheme (or any successor scheme that is implemented following the UK's departure from the European Union) for family reunion. Local authorities should support families and young people to access it.

6) **Immigration and asylum processes are creating long-term mental health distress for unaccompanied young people – this is made worse when young people are not able to access legal advice and representation (see Chapter 2).**

- The Home Office must commission a consistent programme of training for Home Office immigration and asylum decision makers, to increase the quality of decision-making. This should look at the key areas where Home Office decision-making is creating delays – or decisions which are then overturned following a legal challenge – to ensure that more sensitive and methodical decision making is achieved.
- The Home Office should audit the asylum cases of unaccompanied young people to identify the common areas for concern and what actions to take to

ensure better outcomes in decision making, including addressing delays in decision making and intrusive interview processes.

- The Home Office and local authorities must make sure that children understand all communication – both written and verbal – from the Home Office, and have help to think through the consequences of these communications.
- The Home Office should conduct a consultation with young people to capture their subjective well-being and better understand how asylum and immigration processes negatively impact on young people's well-being, with an action plan for any improvements that need to be made.
- The Ministry of Justice must reinstate legal aid in immigration cases for all young people under 18.

Appendix 1: Literature review

1) **Merredew and Simmonds (2010) 'The Health Needs of Unaccompanied Asylum-seeking Children and Young People'**
https://www.nice.org.uk/guidance/ph28/evidence/looked after-children-ep23-unaccompanied-asylum-seeking-children-john-simmonds-and-florence-merredew2

This report provides a broad overview of the health needs of unaccompanied children that are looked after by local authorities. The report considers the current provision of services for unaccompanied young people in the UK and the structures that are available to support them.

The report introduces some of the issues that young people arriving into the UK face, including fleeing violence, having been orphaned as a result of war or other violence, being victims of trafficking, and facing a 'culture shock' where they are not prepared for life in the UK.

The report provides an overview of the entitlements available for unaccompanied young people in the UK, including legislative frameworks to support unaccompanied young people in the care of local authorities. It also a common misconception about the reasons for young people arriving in the UK, refuting the suggestion that young people predominantly arrive in the UK and place themselves in harm in order to be cared for by local authorities.

There is an overview of some statistics from 2008 regarding the countries that young people arrive from, the quantity of applications for asylum made over the course of the year and some headline statistics on the number of unaccompanied children in the UK. In the period of 2008, the nationalities that are most highly represented are Afghan, Iraqi and Iranian. According to statistics from 2017, unaccompanied young people that were nationals of Afghanistan, Albania and Eritrean made the highest number of applications for asylum. These three countries contributed half (49%) of the 3,175 total UASC applications in 2017. This remains below the peak of 4,060 applications that were made in 2008. Home Office guidance on processing children's asylum claims provides an overview of the key issues that the Home Office is expected to take into account, and strategies it can implement to ensure that 'that the welfare of the child is safeguarded at all stages of the immigration process' – including whether they had addressed the physical and mental health needs of the child, if their emotional and behavioural development is being supported, and whether they have experienced mental or emotional trauma.

In a detailed section on health assessments, the report considers the importance of a thorough health assessment for young people, and outlines some of the ways in which their particular vulnerabilities need to be factored into assessments. This

includes the need for translated resources, healthcare professionals having to navigate a lack of health and family history to refer to, support for young people who have potentially not been able to access healthcare support prior to arrival in the UK, and the need to respond to immediately presenting issues that young people are experiencing, such as trauma. The SDQ model is the standardised measure for assessment that is recommended to local authorities, but we explored in Chapter 2 of this report how this model is potentially inadequate in comprehensively identifying the needs of young people.

The report outlines the importance of accessing CAMHS and other more specialist mental health services, but it strongly identifies the need for these services to understand the plight of young people that they are supporting, which is identified as an issue in Chapter 1 of this report.

2) **Derluyn and Broekart (2007) 'Different perspectives on emotional and behavioural problems in unaccompanied refugee children and adolescents' https://www.ncbi.nlm.nih.gov/pubmed/17364899**

This study is based in Belgium and aims to investigate the prevalence of emotional and behavioural problems in unaccompanied refugee children and adolescents living in Belgium, as well as comparing the perspectives of the adolescents with those of social workers on the adolescents' emotional well-being. The categories for assessment in a Strength and Difficulties Questionnaire are emotional symptoms, conduct problems, hyperactivity/inattention, peer relationship problems and prosocial behaviour. Research into SDQ outcomes among refugee young people has found that adequate emotional expression, supportive family relations, good peer relations, and prosociality comprise key factors for developing resilience among refugee young people. Using this framework is potentially inadequate in measuring outcomes for unaccompanied young people, because they are lacking basic factors that enable the tool to operate effectively, such as peer relationships.

3) **Fazel and Stein (2002) 'The mental health of refugee children' http://adc.bmj.com/content/archdischild/87/5/366.full.pdf**

This report considers the context within which there has been an increase in the number of people seeking refuge across the world; with children forming over half of the world's displaced population (these figures are correct as of 2002). There is also a consideration of the significant risk of developing psychological problems that refugee children face and how, when they arrive in the UK, services may not be well equipped to address their specific needs.

The report categorises the stresses that refugees are exposed to within three separate stages: while in their country of origin, during their flight to safety, and having to settle in their country of refuge.

The report identifies that being unaccompanied is an important risk factor for the emotional well-being of refugee children and adolescents. Therefore, appropriate measures on reception and care should be taken in order to support these young people. The report explores some of the psychological implications of displacement for children, because of exposure to several risk factors, which are identified in a separate table.

The report provides an overview of studies of refugee young people, which show that there is a high prevalence of emotional and behavioural disorders, and the most commonly diagnosed issues include post-traumatic stress disorder (PTSD), anxiety with sleep disorders, and depression.

Two key principles are identified when supporting the mental health needs of refugee young people: the provision of appropriate help for those experiencing mental health issues, and for professionals to focus on developing preventative strategies to support these young people.

The report identifies the need for a variety of different treatments, including individual, family, group, and school based interventions. Techniques such as cognitive behavioural treatment for single traumatic events, play, art, music therapy, and story telling are also identified as working to various levels of efficacy.

The report highlights a key tension in the way that UK immigration law operates and the principle of centring the best interests of a child in all process and decision making that relates to them, as outlined in the UN Convention on the Rights of the Child. The hostility of the UK immigration system and its processes is identified as one area that can cause a negative impact on children.

The report concludes with comments about the multidimensional effects of trauma on children and their families, which are compounded by 'forced uprooting, multiple losses, and the myriad changes brought about by migration'. Refugee children are described as being a 'silent group' that are often overlooked, but that the mental health needs of this cohort require urgent attention from the Government and policy makers.

4) **Ise Derluyn, Eric Broekaert (2008) 'Unaccompanied refugee children and adolescents: The glaring contrast between a legal and a psychological perspective'**

http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.473.2638&rep=rep1&type=pdf

This paper forms part of a larger project looking at the emotional well-being of refugee young people living in Belgium.

The report considers some of the psychological issues that are faced by unaccompanied refugee young people, including multiple losses, traumatic

experiences before leaving their home country, during their journey to the refuge country, and upon arrival into the refuge country.

For refugee young people in need of mental health services in Belgium, the report identifies several problems including misdiagnosis, a language barrier and inappropriate use of translators, poor access to services, lack of funding for services, lack of familiarity with mental health systems, inappropriate treatment methods and difficulty accessing culturally sensitive interventions. The report considers the paucity of mental health support offered by the state for refugees in countries such as Belgium, leading to a high number of reports of emotional and behavioural problems in the centres where unaccompanied refugee minors stay.

The report considers that, when 'a legal perspective is taken as starting point for the construction of [the reception system for refugee young people], the psychological needs of these children and adolescents are hardly considered'. The Belgian case study provided in this report demonstrates how using the legal perspective as starting point for the reception of refugee young people creates a lower standard of care for these young people compared to the support provided for the 'native' population.

5) **Young Minds (2005) 'Minority Voices: Research into the access and acceptability of services for the mental health of young people from black and minority ethnic groups'**
http://www.dawsonmarketing.co.uk/youngminds/shop/PDF/MV.pdf

This report from Young Minds looks at the issues facing young people from a black and minority ethnic background when they come to access mental health services. Services for young people from a refugee and asylum-seeking background are also considered. The report recognises the significant health needs of young refugees and asylum seekers, commonly arising from their experiences of trauma, bereavement, loss and grief, as well as experiencing racial harassment on arriving in the UK.

By attempting to identify the unmet needs of young people from a black and minority ethnic background, the report identifies that a number of the respondents acknowledged the lack of support for young people needing help with grief, past traumatic experiences and bereavement. These respondents also noted that the issues might be particularly problematic for young refugees and asylum seekers, where a lack of understanding around entitlement to services made these young people unable to seek help until they had reached a crisis point.

In consultation with young people, the report identifies other issues affecting access to mental health support, including language barriers, social isolation and lack of knowledge about their local area and how to travel to access services, lack of understanding of how the UK health and welfare system works, a lack of interpreter

services, stigma, a potential lack of staff from a black and minority ethnic background in CAMHS services (which might deter young people from accessing services). Other prominent issues identified by young people from a refugee and asylum-seeking background as affecting their access to services include past traumatic experiences, worries about their legal status and how long they might stay in the UK. The young people disclosed difficulties accessing help and support from services to deal with their past traumatic experiences, losses and grief – a concern that the report has found to be echoed by professionals working with these young people.

Through consultation, young people and practitioners cited drop-in services as an example of good practice, as was flexibility over opening times.

The staff that were consulted were concerned about the ability of their service to address the needs presented by young refugees and asylum seekers – either as a result of young people's problems being so wide-ranging, or because mental health concerns are 'sidestepped' until other more practical matters such as their housing and benefits are resolved.

6) **Viki Elliott 'Interventions and Services for Refugee and Asylum-seeking Children and Families' (2007) in Mental Health Interventions and Services for Vulnerable Children and Young People, Edited by Panos Vostanis**

Viki Elliott, a practitioner within a Leicestershire CAMHS, looks at mental health interventions for unaccompanied and refugee children and their families. Viki looks at the mental health needs of refugee and asylum-seeking young people, including re-experiencing the traumatic event, attempting to avoid dealing with the emotions associated with this, depression, generalised anxiety, separation anxiety, disrupted behaviour, sleep disturbances, and cognitive changes.

Elliott identifies that secondary trauma among refugee and asylum-seeking children is often a greater source of distress than a primary traumatic event – with children citing that they are victims of bullying and racial harassment along with issues of housing, poverty, isolation, difference, and parental bullying, as particular issues of concern. Elliot highlights that services need to acknowledge this past trauma and the current living conditions and circumstances of young people.

In treating young people, Elliott identifies that the diverse needs of refugee and asylum-seeking young people poses a challenge for those designing services to suit their needs, with diverse and multi-agency service provision that is accessible at all levels identifies as best practice. In terms of assessment, Elliott highlights a lack of research on the most effective sort of intervention for refugee and asylum-seeking children. She makes a case for practitioners being open to hearing the views of young people and their families about any symptoms, concerns, and difficulties they are facing and their explanation of the causes of these issues so that a holistic approach is employed.

Elliott stresses the importance of comprehensive assessments to identify the nature and range of presenting issues, and to consider which services and agencies are best placed to meet those needs. This process involves collecting information from various agencies and individuals involved in a young person's life – including parents, carers, and school – and through collaboration with all these different networks. Elliott also speaks about the importance of engagement and a therapeutic relationship between a practitioner and a young person, which may be more important than any specific treatments, urging service providers to establish flexible systems to meet the needs of young people who may not be able to access services so easily.

Elliot concludes that reflective practice is essential as part of a therapeutic service and that clinicians must be open to considering the range of values, attitudes, and beliefs bought to clinical practice by themselves and the others involved in the therapeutic process. The article concludes by stressing that joint working is an essential requirement for high quality service provision, as one service is usually not enough for supporting the multiple needs of these young people.

Appendix 2: Distress thermometer

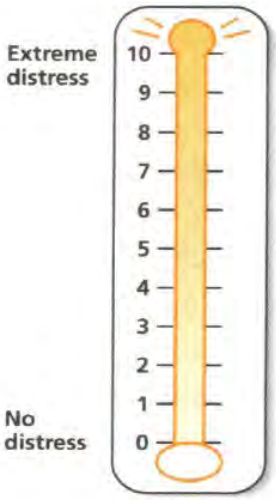
UASC distress screening

coram The Tavistock and Portman NHS

Eat, Sleep, Hope & Fast Feet Forward

Early intervention training to support asylum seeking children

Please circle the number (0–10) that best describes how much distress you have been experiencing in the past week including today.



Concerns list:
Indicate if any of the following have been a concern to you in the past week.

Family:
Bereavement
Loss of contact with family
Concern about family safety

Emotional:
Fear
Anxiety
Nightmares
Hypervigilance

Physical:
Fatigue
Constipation
Sleep
Indigestion

Spiritual:
Loss of hope
Loss of peace
Loss of spiritual practices
Loss of spiritual community
Loss of life choices

UASC distress screening

coram The Tavistock and Portman NHS

Eat, Sleep, Hope & Fast Feet Forward

Early intervention training to support asylum seeking children

Competency based interventions:

0 – 5: **UASC does not require additional EM&WB support. Watch, wait and see protocol to be maintained. Level 2 clinician required from a competencies perspective.**

6 – 7: **UASC requires additional EH&WB support based on the Early Intervention Framework and a level 3 clinician is required from a competencies perspective.**

8 – 10: **UASC requires additional EH&WB support and review based on the Early Intervention Framework and input from a level 4 clinician required from a competencies perspective.**

What has been done:

Is sleep work required and been undertaken?	**Yes**	**No**
Is re-feeding work required and been undertaken?	**Yes**	**No**
Is hope work required and been undertaken?	**Yes**	**No**

UASC distress thermometer

coram The Tavistock and Portman NHS

Eat, Sleep, Hope & Fast Feet Forward

Early intervention training to support asylum seeking children

Solution Focused Process:

Issue of concern **Actions agreed**

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