TORTUREID
THE SERVICE TO IDENTIFY AND DOCUMENT INTERNATIONAL HUMAN RIGHTS ABUSES

TRAUMA SCREENING AND HEALTH ASSESSMENTS FOR UNACCOMPANIED ASYLUM-SEEKING CHILDREN

EVALUATION OF TID PILOT PROJECT

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EXECUTIVE SUMMARY

> *" it enabled me to better understand the young person's presentation and better support him through the asylum claim process and interview"* (social worker)

The project

Young people seeking asylum are at high risk of having experienced human rights abuses, including psychological, physical and sexual abuse, trafficking and exploitation. Their young age at the time of experiencing this trauma significantly increases their relative risk of physical and mental health consequences, especially if they lack support, safety and stability.

We evaluated a project that piloted medical screening assessments with a trauma and human rights focus.

27 assessments were conducted, each leading to a report that included specific recommendations. The assessments differed from routine health assessments provided through GPs and Social Services in that they specifically aimed to a identify any history of traumatic experiences, and health issues linked to these or relevant to the young person's asylum claim.

Evaluation findings

For many young people the assessments identified clinical findings of which the referring social worker had been unaware, most commonly:

- Unrecognised psychological and risk issues,
- Clinical findings likely to be consequences of mistreatment and
- Psychological factors affecting the young person's ability to recount their experiences

For seven individuals whose trauma screening report could be compared with their GP and/or Local Authority health assessments, in all cases the trauma screening assessment identified clinical issues not previously recorded.

Feedback from stakeholders indicated that assessments were acceptable to the young people and that the reports increased awareness of the role of trauma and its consequences within the multi-disciplinary systems providing health and social care for young people.

Through the reports, legal representatives and decision-makers had available to them expert clinical information to take into account in their decision-making. This is information that they would otherwise not have had.

Implications

It is possible that similar outcomes may be achieved more efficiently if the health assessments routinely offered to young people by GPs and Local Authority paediatricians have a clear aim of identifying trauma and its sequelae, and clinicians are trained and supported to provide this.

1. INTRODUCTION: TID

TortureID (TID) was set up to improve access to early identification and documentation of human rights abuses among people who have sought asylum in the UK. The aim is to support their rehabilitation in two main ways: firstly through communicating treatment recommendations to health and social care providers; secondly by improving provision of clinical evidence that can facilitate appropriate decision-making on asylum claims at an early stage.

TID's underpinning principles are that:

- Survivors of human rights abuses have the right to be identified, documented and recognised.
- Rehabilitation needs should be identified as soon as possible to give them the best chance of being addressed.
- Asylum claims can only be properly and fairly determined by UK decision makers if people have the opportunity to submit any medical evidence detailing their history of ill-treatment and any physical or psychological evidence of this. Health and legal professionals should be under a professional and ethical duty when working with people seeking asylum to identify and record torture and severe ill-treatment, for in the absence of this, the true scale of the violations and their impact on individuals cannot be quantified or understood

TID's long term aim is to ensure that everyone reporting human rights abuses seeking asylum in the UK, whether young or adult, can access a specialist health assessment, and a report that is free, produced quickly, and in a format that is accessible to decision makers as soon as possible after arrival to the UK.

Among those seeking asylum in the UK, there is currently a large unmet need for assessment and reporting of human rights abuses soon after arrival to the UK. Although those newly arrived may be offered a general health assessment by GPs (and in the case of young people also by Social Services), these general assessments are not designed to identify human rights abuses or assess their impact. There are very few organisations in the UK offering specialist health assessments to people reporting human rights abuses

The TID approach to assessment and report writing was first piloted between May 2019 and January 2021. The evaluation of this pilot concluded that it had demonstrated advantages to obtaining a medical assessment report at an early stage in the asylum process, both in terms of the client's wellbeing and in facilitating the legal process , (https://tortureid.org/wp-content/uploads/2022/11/TortureID-pilot-project_evaluation-report.pdf). There was some indication that this may have been particularly valuable for clients who were unlikely to be able to provide a detailed and consistent account of their experiences due to the psychological impacts of the abuses they had experienced.

2. RATIONALE FOR THE PROJECT

Following the above pilot, the TID Board identified a case for exploring the particular benefits of early assessments for separated young people, commonly referred to as unaccompanied asylum-seeking children and young people (UASC).

Young people seeking asylum are at high risk of having experienced human rights abuses, including psychological, physical and sexual abuse, trafficking and exploitation. Where trauma has been

psychological, this may have consequences for physical as well as mental health. Being a child at the time of experiencing trauma significantly increases the relative risk of physical and mental health consequences, especially if they lack support, safety and stability.

All UASC entering the care of Social Services are offered a medical assessment, usually by a community paediatrician. However the physical and psychological effects of past human rights abuses can, for several reasons, still go unnoticed. The focus of the paediatric assessments is on current health, concentrating on issues such as immunisations, screening for infectious diseases, dental health etc Paediatricians do not conduct the assessments with the intention of assessing evidence of past human rights abuses, and do not necessarily have the skillset to do so. The young people are not necessarily asked about past ill-treatment. For reasons such as lack of trust, fear, shame, and reliance on interpreters many find it difficult to disclose even if asked, let alone spontaneously. The assessments which young people receive in primary care varies between practices. For all these reasons, young people who have experienced human rights abuse often do not have the clinical effects of these documented, and do not access the treatment and support they may need. This affects their development and life chances, obstructing their right to rehabilitation in its fullest sense.

Prior to this project, about a third of reports written by TID were for UASC referred by their solicitors. Many of these would be granted asylum without a report, but reports were being used by solicitors to protect clients from the unnecessary traumatisation of an interview, or to explain their difficulties in giving their account. Because these reports were being prepared on instructions from a solicitor, they were lengthy, and accessible to only a limited number.

A trauma screening and health assessment by a specialist clinician was proposed as a way of producing something shorter and more clinical, but taking account of the legal context. It was hoped that such briefer reports would have the potential to record and explain young people's experiences of human rights abuses in a form that would: enable greater understanding of their situation; encourage referrals for support and treatment; record clinical evidence of ill treatment; identify cases whether a medico-legal report could be useful; and document psychological reasons why they may struggle to explain themselves for example at an Asylum Interview or Tribunal hearing.

3. DESCRIPTION OF THE PROJECT

In 2021 TID began a new project offering trauma screening and health assessment to UASC referred by Social Services.

Initially the project was offered only in Kirklees, West Yorkshire. Subsequently The Evan Cornish Foundation (a grant-making charity) provided funding to expand the project by offering these assessments through Social Services and Looked After Children's teams in Leeds and Bradford. The areas selected have large numbers of UASC dispersed to them from south east England. In these areas TID had some links with legal representatives, specialist GP practices and Social Services that could be built on for the project.

The criterion for referral to the project were:

- The young person had arrived as a UASC and was under the care of Social Services
- Referral by a social worker or Looked After Children's Nurse (LACN)

An information leaflet was developed to explain the project to potential referrers and clients. (Appendix 1). In Kirklees the project involved working with Kirklees Council to create a service specification and a protocol devolving referrals to individual social workers (Appendix 2). In Leeds the project was promoted by one senior social worker who made all the arrangements for referring young people in her area who might benefit.

Young people were referred to the project by a social worker, using a referral form (Appendix 3). Referrers were asked to give detail of concerns, including whether the young person had disclosed abuse, whether they had mental health difficulties, injuries, or problems with disclosure and whether there were any safeguarding concerns

Young people were offered a single appointment, lasting up to 1.5 hours, with an interpreter where needed. The information leaflet (Appendix 1) explained what would happen at the assessment.

The assessments were conducted by a single doctor who was very experienced in working both with young people and survivors of human rights abuses. The doctor began each assessment with an explanation of the assessment and report to allow informed consent, and also sought the young person's consent for TID to approach their social worker, GP, legal representative and themselves, as part of the evaluation of the project. The assessments aimed to identify past traumatic experiences and how these might be continuing to affect the young person, and included psychological assessment and physical examination if indicated. At the end of the appointment young people were given a leaflet about self-care (Appendix 5)

The reports produced used a templated format to document the clinician's key findings (Appendix 4). Contents included:

- Brief background including any account given of traumatic experiences
- Sections on physical and psychological health
- Assessment of risk and safeguarding concerns
- Recommendations to the young person's GP and to Social Services
- Information about primary care for young people who have experienced human rights abuses (Appendix 6)

Completed reports were sent to the referring social worker. In Kirklees it was arranged that the Looked After Children team would upload the report on to the GP computer system and alert the GP. The Kirklees social worker made the decision as to whether to also use the report with a solicitor or the Home Office. In Leeds the social worker was asked to forward the report to the GP and solicitor.

The initial plan was to offer around 36 assessments and reports over a 12-month period in either Bradford and/or Leeds beginning early 2022.

Initial cost estimates used in the grant application were, for each client:

- Doctor :£300 (4 hours)
- Interpreter: £25 (1 hour).

From February 2023 the option became available of referral of TID clients to the social prescribing charity, Survivors of Torture Activity Fund (STAF).

4. EVALUATION AIMS AND METHODS

Aims

The aim of this evaluation is to assess the impact of the reports produced by TID, and the processes through which any impact is achieved.

Methods

We studied referrals between July 2021 and March 2023 using

- Information from the TID database (e.g. dates of referrals, assessments and reports)
- Information from referral forms (indication of concerns regarding disclosure of human rights abuse, safeguarding, psychological health, physical health)
- Information from the reports
- Feedback forms completed by young people at the time of the assessment (n=17)
- Feedback from participating social workers (13 social workers provided feedback about 14 clients. 12 were invited to respond to a survey, 5 responded, giving information about 7 clients; an email request for briefer feedback generated a further 8 responses, covering 7 additional clients)
- Interview with the doctor conducting the assessments

We considered sending further questionnaires to the clients, but translation issues were a barrier. It was not possible to identify those legal representatives or GPs who may have received the reports so no feedback from them was possible.

5. REFERRALS

Sources of referral

At the start of the project Kirklees Social Services were already referring young people for TID assessments, but in limited numbers. Subsequently Bradford and Leeds Social Services were also invited to establish an arrangement with TID to offer assessments to their UASC clients.

Between July 2021 and February 2023, 34 referrals were received.

Kirklees made 21 referrals.
Kirklees Social Services set up arrangements where individual social workers referred to the project directly. The numbers of referrals increased from 1-2 per month to 5 in March 2023. Towards the end of the project, the referral rate increased as Kirklees accepted more UASC dispersals and social workers became familiar with the arrangements with TID. Informal feedback was that social workers found the process of referral easy, and as the project went on, heard good feedback from colleagues who had sat in on assessments. Initially Kirklees wished to refer only its older 'care leavers' but later began referring younger more recently arrived clients as well .

Leeds made 13 referrals between March and May 2022, and none at all after this.

The referral process had not been devolved to individual social workers, instead all the referrals had come through a single individual.

Bradford did not reply to the invitation email, so TID was unable to provide assessments there.

Young people referred

34 young people were referred

Age: mean age 17.6, median 17, range 16-21.
Young people referred from Kirklees tended to be slightly younger than those referred from Leeds (Kirklees mean age: 17.2, median: 17; Leeds mean age 18.1, median 18)
6 referrals mentioned that the young person's age had been disputed.

Gender: 32 of 34 were male, 2 were female

Country of origin: There were 10 young people from Iran, 4 from Iraq, 3 each from Eritrea, Ethiopia and Sudan, 2 each from Somalia and Vietnam, and 1 each from Egypt, Libya, Gambia and Syria.

Stage of claim: 20 had not yet had their substantive interview, 8 had had an interview but not had a decision, 3 had had a decision (1 positive, 2 negative). For 3 there was no information.

Concerns mentioned in referrals. Referrers were asked to tick boxes to indicate areas of concern. Around two thirds indicated concern about mental health, over one third indicated possible physical or psychological injuries.

Table 1. CONCERNS METNIONED IN 34 REFERRALS

History of human rights abuse	5	(1 said no history, 10 not known)
Physical or psychological injuries	12	(7 said no injuries, 15 not known or not mentioned)
Mental health concerns	23	(4 said none, 7 not known)
Problems with disclosure	8	(15 said none, 16 not known or not mentioned)
Safeguarding concern	1	(33 said none)

6. ASSESSMENTS

27 assessments were completed.

Process of assessment

Cancellations Of the 34 referrals, 7 did not go ahead:

- 2 clients did not attend. In one case the appointment was rearranged, and the client also did not attend the second appointment due to a significant physical health problem. In the second case the client did not attend, but the appointment was not rearranged as the project had ended.
- 1 client's social worker did not respond to a request for further information to enable the referral to be taken on
- 4 assessments were cancelled as clients were granted leave to remain prior to an appointment being booked.

Location. The Kirklees assessments took place in the health centre where the doctor worked. The Leeds assessments took place in Social Services offices.

Support. In most but not all cases there was someone from Social Services present in the interview

Interpreters were used in 23 appointments.
The doctor felt it was helpful having face to face interpreters rather than telephone interpreting and noted that often the interpreter was often familiar to the young person. She felt that this helped the young person feel 'safer'. (Interview with doctor)
Of those who did not use an interpreter, 2 young people did not require one; 1 preferred not to use an interpreter as she did not want another person present; 1 proceeded without an interpreter due to an error in the interpreter booking.

Duration. Interviews took around one – one and a half hours in contrast to the two hours previously allocated for assessments in response to solicitor referrals. An hour was usually sufficient but an extra 30 minutes was needed to make sure that all parties were present and not late. (Interview with doctor)

The doctor's view was that in an hour it is possible to obtain quite a lot of information, "not everything, but an impression". (Interview with doctor)

Explanations. The doctor found that a lot of time was needed at the beginning of each appointment to explain what the appointment was for. Even though the social worker might have explained, she found that many young people did not properly understand why they were there, especially if they felt they were doing OK. The doctor felt a lot of time needed to be spent on building trust and gaining consent, making sure the young person was aware that the assessment was not just about helping their asylum claim (as that seemed to be a short cut that some referrers had used in their explanations). The doctor wanted to be sure that the young people understood that the assessments were more about helping them understand what they were experiencing and helping others understand this. (Interview with doctor)

Screening questionnaires for depression and PTSD were used, with the interpreter translating questions from the English versions. The doctor found it was difficult to elicit psychological symptoms without direct questions such as these instruments provide. (Interview with doctor)

Occasionally the CRIES-8 PTSD screening tool could not be used because the young person did not understand some of the questions.

Feedback from the young people assessed

At the time of their appointment, 17 young people completed feedback forms rating items as good, OK or bad.

Table 2. FEEDBACK FROM YOUNG PEOPLE

	Good	OK	Bad
Doctor listened well	17		
Felt safe & comfortable Doctor was thorough	16	1	
Clear explanations about appointment Doctor was polite and respectful	15	2	
Clear explanation about use of report	15	1	1

In the free text section of the questionnaires, there were no negative comments. 10 young people made a positive comment:

- *Nothing went badly. Happy about this service existing. Felt the doctor was attentive and listened to all the matters discussed*
- *It was good because it felt good to talk about myself and my problems. I found it hard to talk about some topics*
- *Everything was great and I felt a bit better talking to someone about my situation*
- *Very happy with appointment. Nice doctor*
- *It is good to see doctors*
- *I feel everything went well. I have no concerns*
- *I like this appointment because I hope it will help me and she was a lovely doctor because she was polite and helpful. And I appreciate her help!!*
- *Everything went very well*
- *She was professional and explained everything very well*

Feedback from professionals

13 **social workers** provided feedback either through responding to a survey or by email.

- *Thank you for dealing with this in a sensitive manner*
- *Very insightful and thoughtful with the questioning. I feel the sessions are useful*
- *Appointment was managed well, and child focused*
- *Appointment went well and was managed in a child-focused way*
- *All positive, doctor's relaxed, calming and reassuring style helped to engage the young people really well and reassure them about the purpose of the assessment*
- *Doctor's approach was child-centred which made it easy for the young person to speak to her*
- *The young person felt he had been dealt with in a supportive manner*
- *He felt at ease and pleased he had it*
- *The young person felt they would benefit from further appointments*
- *They found it helpful to discuss their problems*

The doctor described the process of conducting assessments as a positive experience, and thought that the social workers did also. Her impression was that the young people generally seemed positive about the assessments. (Interview with doctor)

The doctor commented:

- Many of the young people appeared to *"downplay"* or mask symptoms. Sometimes difficulties were apparent even when both social worker and young person had commented on the young person being fine and having 100% college attendance.
- There was *"a lot of sadness"* around separation from family.
- There is a *"small"* group of young people "*damaged in a more complex way, where personality and trust are showing signs"*. This seemed to be often where abuse began earlier.

7. REPORTS

For the 27 assessments, 26 reports were issued. In one case, instead of a report, a letter was written to the client detailing the findings.

Writing of reports

The doctor aimed to make the reports shorter than those written previously for TID, aiming to communicate with social workers and health care workers rather than writing primarily for a medico-legal context. The rationale was that people are increasingly unwilling to read lengthy documents, that the way information is presented affects how easy it is to grasp and process, and that care is needed to maintain the reader's focus and attention. The doctor took the view that every opinion does not need to be backed up as the reports are not going to be scrutinised as in a medico-legal context. She found that although much shorter, the reports still took a significant amount of time to complete, an estimated two hours per report (in comparison with 6-7 hours for a report in response to a solicitor's referral). Time was taken up with condensing information and organising it, deciding what goes best where, and writing up may also have taken longer because the doctor felt under-confident about writing less. (Interview with doctor)

Timeliness of reports

Time from asylum claim to referral: Median 169 days (mean 205.7, range 8=469)
(Date of arrival was known for 19 young people only, so these figures apply to this subset only)

Time from referral to assessment: Median 50 days (mean 51.1, range 11-95)

Time from assessment to report Median 7 days (mean 9.3, range 0-46)

Of 5 social workers responding to the survey, 4 said they were unsure if having the report sooner would have made any difference.

Content

The majority of reports documented some findings relevant to the young person's rehabilitation, safeguarding and/or their asylum claim.

Table 3. ISSUE MENTIONED IN REPORT

Human rights abuse	22	15 mentioned mistreatment during their journey, in 6 the mistreatment disclosed was only during their journey
Difficulty with disclosure	17	This figure includes any mention of potential difficulties specifically relating to the individual. It excludes mention of possible future difficulties where none were observed at interview and general comments on potential difficulties
Possible physical injury	7	Includes physical signs that could possibly have been caused by the mistreatment reported
Possible psychological injury from mistreatment	17	Includes psychological symptoms that could possibly have been caused by the mistreatment reported (mainly PTSD symptoms)
Mental health concerns	22	Includes possible diagnoses (there were few firm diagnoses), and subthreshold symptoms. 17 had PTSD symptoms, 14 had depressive symptoms, 2 suspected intellectual disability
Safeguarding concern	10	The majority were indications of heightened risk of suicide, including past thoughts of suicide. (This figure does not include those where the only indication of

		heightened risk was past thoughts of dying before arriving in the UK)

Feedback specifically on reports

One social worker wrote in feedback: *"Thank you for the report it was really insightful, the interpreter read it and the client was in agreement with everything in there.*

8. NEW CLINICAL FINDINGS

Comparison of report findings with referral forms

A number of TID reports identified an issue that was not mentioned in the referral

Table 4. ISSUE MENTIONED IN REPORT BUT NOT IN REFERRAL
(Total number of cases where referral and report could be compared: 26)

Human rights abuse	5	4 where referral said 'not known', 1 where referral said 'none'
Difficulty with disclosure	16	9 where the referral said 'not known' 7 where referral said 'none' These 16 were all cases where the doctor identified specific issues that interviewers needed to be aware of
Possible physical injury from mistreatment	3	1 where referral said 'not known', 2 where referral said 'none'
Possible psychological injury from mistreatment	8	5 where referral said 'not known', 3 where referral said 'none'
Mental health concerns	6	5 where referrals said 'not known' 1 where referral said 'none'
Safeguarding concern	9	In all cases referral said 'none' In one case immediate action was recommended because of a risk of exploitation

		In the other cases the concern was frequently about possible future risk of suicide

Comparison with LA medical assessments and GP records

8 young people were already patients of the assessing doctor in her role as a GP. For 7 of these there was a Local Authority (LA) health assessment in the notes. The doctor conducted an audit that found a number of TID reports identified issues that were not found in the LA health assessment or GP record.

Table 5. ISSUE MENTIONED IN TID REPORT BUT NOT IN LA REPORT OR GP RECORD
(Total number cases where TID findings and another record were compared: 7)

Human rights abuse	2	1 rape, 1 threatened sexual assault
Possible scars from mistreatment	1	
A mental health concern	7	4 probable PTSD, 3 low mood or depression, 1 developmental delay
Safeguarding concern	1	Risk of sexual exploitation

Additional information from the audit gave some indications of possible reasons for added value of the TID assessment.

- In some cases it was recorded that the young person had not wanted to discuss their history of mistreatment. This was mentioned in relation to both GP and LA cases.
- In some GP records and LA reports there was no indication that the young person had been asked about psychological symptoms.
- In some cases, there were possibly clues in the history that were not followed through (In one case where the TID assessment identified rape and PTSD, the doctor felt that the GP and LA records contained hints about this).

(Conversely, in two cases the TID assessment did not include information available elsewhere. In one case there was an age dispute mentioned in the LA assessment. In the other case the young person did not want to disclose a history of abuse.)

Social worker feedback

5 of 13 social workers approached responded to a survey. 3 mentioned that the assessment and/or report had helped them better understand the person's issues. In two cases this related to possible PTSD, and in one case the scale of the mistreatment and trafficking during the young person's journey:

- *Enabled me to better understand the young person's presentation and better support him through the asylum claim process and interview*
- *Clarified whether there was an emotional issue*
- *A better understanding of the trauma he suffered.*

9. HEALTH BENEFITS

Actions recommended in reports

All reports included general recommendations for primary care of young people who have experienced human rights abuses. In all reports the doctor referred to these, and also made a general recommendation to social services about the importance to mental health of matters such as stability, friendships, and education. In addition, in all but 3 cases, the doctor made recommendations specific to the individual young person. For most recommendations there is no information about whether they were followed through.

Table 6. RECOMMENDATIONS MADE IN THE TID REPORTS

Psychological therapy	12	Includes recommendations that referral is made and recommendation that therapy is considered
Other psychological care	2	2 recommendations for medication (Recommendations only for review are not included)
Actions re physical health	10	3 recommendations for screening for sexually transmitted infection, 3 for further assessment or treatment of tiredness, 2 for assessment or treatment of rash, 1 each for tattoo removal, assessment of leg pain, assessment of weight loss
Safeguarding	11	7 recommendations for reassessment of suicide risk if situation changes, 1 each re grooming risk, sharing risk information even if no consent, considering need for further assessment of risk of harm to others, risk of purchasing medication for sleep
Attention to clinical issues when interviewing	19	Includes 7 cases where there is a note that the young person's presentation may hide their vulnerability
Other recommendations to Social Services	6	2 about avoiding accommodation move or disruption of attachment, 1 for considering referral for possible trafficking, 1 for health education (drugs &sleep), 1 about further assessment of possible intellectual disability, sex education and safeguarding, 1 for continuing support beyond 18

Social worker feedback

Feedback was only possible for Kirklees cases as the social worker in Leeds who was the only link to the project became unavailable.

12 'Survey Monkey' forms were sent out and 5 returned. Other social workers sent comments by email (some of these may have referred to the same individuals written about in the Survey Monkey forms) Feedback mentioned the following:

- *Report was useful in getting meds for sleep. He said it was helpful*
- *Report identified PTSD symptoms which he is not being treated for – this needs review*
- *Useful in getting appropriate therapeutic support in place. I used it to support a referral to CAMHS and he is now receiving support weekly.*
- *The young person was happy about the outcome – he was prescribed medication and it helped.*
- *He took medication found it helped but did not want to continue treatment*
- *It supported removal of tattoos which the young person was finding upsetting*
- *One young person had a finger deformity as a result of an injury while he was trafficked. The report helped to highlight and reinforce the need for clinical intervention*
- *The young person wants a referral to Solace (a specialist psychological therapy service)*

Among the five survey respondents, all 5 said that the report made a difference. 1 did not mention health benefit. 3 mentioned better understanding of the person's issues, implying that this was helpful:

- *Enabled me to better understand the young person's presentation and better support him through the asylum claim process and interview*
- *Clarified whether there was an emotional issue*
- *A better understanding of the trauma he suffered.*

One said that it influenced their work more generally: *"It made me more aware of my work and my approach"*

Information from the project doctor

The doctor was aware of another individual case where the assessment appeared to have had a specific benefit, in that it led to a review of the plan to move the young person out of his placement when he turned 18. He had been assessed as not in need of psychological support but the assessment identified significant mental health issues and risks. (Interview with doctor)

The doctor felt there were a few cases where social workers were aware of issues but not aware of their significance, or were making assumptions that support was not needed. Although they were often aware of risk issues, suicidal thoughts were sometimes more prominent than they had realised. (Interview with doctor)

Referrals for social prescribing

Towards the end of the project, an opportunity became available to refer young people directly to a charity offering social prescribing and after this point all young people were referred, 5 in total. Through this source, one young man received funding for a Manchester United kit, and one received a guitar and arrangements were being made for him to also have lessons funded.

10. IMPACT ON ASYLUM PROCESSES

Clients granted leave to remain

By July 23, there was feedback on the outcome for 19 young people, of whom 9 had been granted some form of leave to remain.

Of the 7 individuals for whom we know the date of this grant, for 5 of the 7 the date of the grant was compatible with the TID report having been available to the decision maker.

At least 6 of the 34 clients referred received a grant of asylum without the decision-maker having had access to the TID report. 2 had had an assessment but the grant was made before the TID report would have been received. 4 were granted leave to remain following referral and did not go on to have an assessment.

Clinical evidence of mistreatment

The majority of reports contained information relevant to the asylum process.

Table 7. INFORMATION IN REPORTS THAT MIGHT BE RELEVANT TO THE ASYLUM PROCESS

Physical injury (scars or deformity)	7	In 2 cases the referral had said there were no injuries 4 were injuries sustained during the journey
Possible psychological injury	17	Generally PTSD symptoms. Some reports also described changes in the person's demeanour as they described mistreatment
Comments on potential difficulties giving their account	19	This includes potential difficulties specific to the individual, (not a general potential for difficulties). Common examples were PTSD symptoms while recounting traumatic events, and potential for misinterpretation of presentations that conceal vulnerability

		Other reports also usually contained a general comment about the possibility of psychological factors affecting the young person's ability to give their account

Social worker feedback

Additional feedback was received from 5 social workers responding to the survey, and 8 responding to email enquiry. Feedback was received for 14 clients.

5 of the 5 social workers asked directly if they had shared the report with the legal rep, said that they had done so.

Other comments from social workers covered the following issues:

- The Home Office understood the issues better and it helped to inform their decision making
- The medical report about trauma made the decision quicker.
- In both cases the report supported a positive asylum decision. (Comment from one social worker who had had two clients assessed)
- The report was used to evidence the impact that the asylum process had on the young person. (In this case the grant of asylum was 7 months after the report was issued)
- The young person was granted asylum prior to his 18th birthday. The social worker understood that he did not have an interview because of difficulties outlined in the report
- Unsure if the report made a difference; it was sent to the Home Office but the young man was interviewed anyway
- The solicitor did not use the report

11.DIRECT BENEFITS TO YOUNG PEOPLE

Feedback from young people

Some of the free text comments in the 9 questionnaires completed by young people at the time of their appointment suggested that some may have experienced their assessment as beneficial in itself:

"It was good because it felt good to talk about myself and my problems."
"I felt a bit better talking to someone about my problems"
"I like because I hope it will help me. "

Feedback from survey of social workers

Among 5 social workers responding in the survey, comments included that the young person:

- Felt at ease and pleased they had the assessment
- Thought they would benefit from further appointments
- Found it helpful to discuss their problems

12.COSTS

TID had estimated that the medical and interpreting costs of the screening would be £325 per client (Section 3). The true cost of the project is difficult to assess precisely.

Medical input. During the project, TID paid the assessing doctor £45 per hour, to a maximum of 4 hours per assessment, ie. £180 per assessment. This is significantly less than the actual costs.

The medical input needed for each individual assessed was estimated to be on average 5 hours:

- Admin around referrals: 30 mins
- Preparation for visit: 30 mins
- Conducting the assessment: 90 mins
- Travel: 60 mins to Kirklees; 120 mins to Leeds (usually 2-4 were seen for each journey), an estimated average of 30 mins per case.
- Writing up reports: 2 hours on average

£45 per hour is well below the hourly rate a GP would normally expect to be paid. For example, standard Legal Aid payments to GPs for medico-legal work are £79.20 per hour for clinical work and £40 per hour for travel.

Thus if paying for the doctor's time at standard Legal Aid rates the cost would have been £79.20 per hour for the 4.5 hours clinical work, and £40 for 30 mins travel, and the cost per individual assessed would have been approximately **£376.40** on average**.**

In addition, during the project the doctor conducted a significant amount of work pro bono (all preparation, meetings, material development, travel etc).

Interpreting was required for most (23 / 27) assessments, on average 1 – 1.5 hours per assessment

In the project, the Social Services departments paid for interpreting. At typical rates of £36-£49.50/ hour for interpreting, the costs would be £36-£74.25 per individual assessed – say **£55 on** average.

TID administration input was estimated to be 0.5 hours per client.
At a rate of £16.50 / hour the cost per individual would be approximately **£8.25** on average.

Total TID costs TID actual payments during the project thus amounted to £188.25 per client (covering doctor and admin time).

However the true costs of the project, covering doctor, interpreter and admin time per client, (but not including project development costs) were approximately **£439.65 per client**.

Other costs not covered above include time for Social Services personnel accompanying the young person, admin time for Social Services and room costs. These costs were borne by the Social Services department concerned.

13.CONCLUSIONS

Key findings

Referrals. 34 clients were referred. There were significant differences between different Social Services authorities in their response to the offer of assessment, in arrangements for referral and pattern of referrals, and one authority did not take up the invitation to refer. Of the young people referred, 94% were male, the median age was 17, nearly one third were from Iran, the majority were pre-decision. In two thirds there was indication of concern about mental health, in over a third possibly physical or psychological injuries.

Assessments. 27 assessments were conducted, each around 60-90 minutes. Time was taken to ensure the young person understood the purpose of the appointment. Psychological screening questionnaires were used where appropriate. The assessments were well received. 17 young people who provided feedback on the appointment were generally very positive about them and feedback from social workers was also positive. Both young people and social workers commented appreciatively about the doctor's manner.

Reports. Reports took longer to complete than hoped. The median time from asylum claim to referral was 169 days, from referral to assessment 50 days, from assessment to report 7 days. Many reports identified psychological problems. In a majority of reports there was documentation of a history of abuse, mental health concerns, psychological concerns that might affect the young person's ability to give their account and / or possible psychological consequences of mistreatment. Nearly half of the reports mentioned a safeguarding issue, almost all highlighting possible future risk just one identifying immediate risk.

Did the assessments identify new clinical findings? Many reports mentioned clinical findings not mentioned in the referral. These included: problems with giving their account (16); safeguarding concerns (10); possible psychological injury from mistreatment (8); mental health concerns (6); a history of human rights abuse (5); possible injury from mistreatment (3). When 7 TID reports were compared with information available in the GP record and the Local Authority medical report, TID reports often mentioned an issue not mentioned elsewhere: a mental health issue (7); a history of human rights abuse (2); a safeguarding concern (1); possible scars attributed to mistreatment (1). Of 5 social workers responding to a survey, some mentioned how the report had helped them better understand the young person's issues (3).

Did the assessments lead to any health benefits? All the reports included generic recommendations, and all but 3 included specific recommendations, most frequently for attention to clinical issues when interviewing the young person (19); psychological therapy (12); safeguarding actions (11); actions re physical health (10). Social workers providing feedback noted multiple ways in which they thought the reports had helped, including accounts of where the report had led to specific actions. Once the option of referral to a social prescribing charity became available, all young people assessed (5) were referred to this.

Did the assessments have an impact on the asylum process? At July 2023, 9 of the 27 young people assessed had been granted some form of leave to remain. The majority of reports contained information relevant to the asylum process. This included: potential difficulties for the young person in giving their account (18); psychological findings (17); physical findings (7). Amongst the 34 young people referred, 6 were granted leave to remain without the TID report having been available to the decision maker. It is unclear how much impact the TID reports may have had on decision making.

Did the assessments directly benefit young people? Comments from a very small number of young people and social workers suggested that at least for some the assessment itself may have felt beneficial. A perception of the discussion as beneficial may be particularly significant for those with a history of trauma, where sharing the story may be a necessary step towards recovery.

Costs It has not been possible to make a precise estimate of true costs. It is estimated that these assessments may require on average 4.5 hours of doctor time, plus travel, and 1-1.5 hours of interpreter time: so the approximate cost per person, using fully costed professional time, is estimated to be around £450.

Limitations of the evaluation

Care needs to be taken in generalising from this evaluation. The sample is small, and all the assessments were conducted by a single doctor, who was highly skilled and experienced. It is worth noting that of the 10 young people who made positive free text comments, half referred specifically to the doctor.

The information here does not tell us about the overall population of unaccompanied asylum seeking children who are looked after by Local Authorities as we do not know what proportion were referred, or what biases there may have been in the referrals. Similarly it is not possible to know whether or not the project failed to target girls, as we do not know the gender distribution of the potential pool of referrals.

The frequency with which the assessments found information new to Social Services may have been overestimated. There may have been important differences in the definitions used by the person completing the referral, and in this evaluation. For example, in this evaluation a 'safeguarding concern' was recorded if there was any factor that would heighten future risk, and a 'problem with disclosure' was recorded if the report mentioned any potential difficulty for that individual. Also, those completing the referral form may have been unaware of information available to others in their service.

It is difficult to draw conclusions about the extent to which the assessments led to benefits for the young people because, in most cases, it is impossible to know if any of the recommended or actual clinical interventions, or positive asylum decisions would have happened without the TID assessment. It is also impossible to know how far the recommendations were followed through. The exception to this are the referrals for social prescribing with their reported direct benefits to the young people, but these involved small numbers and it is also not possible to know if these positive experiences translated into long-term health benefit.

Discussion

There were fewer referrals than first expected. In Leeds, the referrals appear to have stopped because they had all been made through a single manager, with no mechanism for social workers to refer directly. The high referral rate in Kirklees at the end of the project may relate to increasing awareness among social workers and their views about its usefulness.

Each assessment and report took at least 4 hours, excluding travel. The project used assessments that were significantly briefer than those conducted in response to solicitors' referrals for medico-legal reports. Although the reports also took less time to write, the doctor was not able to reduce the writing up time as much as hoped. The assessments and documentation in this project take more time than is available to an NHS GP, and so if done in NHS GP practice, it would need to be funded.

We did not identify any negative impacts, but cannot conclude that there were none. The most likely immediate negative effects are that young people may have been distressed by the assessment, or experienced an exacerbation of symptoms following it. If the benefits of the assessment were limited, this would be an important consideration.

In this sample there were no instances of the doctor finding material that might be detrimental to the young person if documented, for example risk to others, or concerns about possible terrorism risk. However this is a theoretical possibility that needs to be held in mind.

The assessments appear to have frequently identified concerns that were previously unknown, particularly about psychological issues and suicidal thinking. There are various possible reasons for this. Timing may matter, as there will be times when young people feel it less useful to talk about mental health, for example when recently arrived and starting to feel better, or when overwhelmed by multiple events. It might relate to the young person's choice not to talk about difficulties, perhaps because of post-traumatic avoidance or their being unaware that their mental health difficulties could be relevant to their asylum claim. In addition, post-traumatic symptoms fluctuate and may have been less prominent at the time of referral. Additionally, the doctor had more time to spend on the interview than in routine general practice and had a clear plan for approaching the appointment. The structure around the appointments may also have helped. For example, prior to each assessment the social worker would have talked to the young person about its purpose, so that they would arrive prepared. The doctor's skill and experience may also have made a difference.

In all cases where the report was submitted to the Home Office clinical evidence was made available to a decision maker, enabling them to have fuller information on which to base their decisions. Where there was clinical evidence supporting the young person's account of human rights abuses, or of psychological factors likely to affect their ability to give their evidence, it appears highly unlikely that the decision-maker would have had this information without the report. The findings of previous evaluation of TID reports suggest that when these reports are produced in appeal hearings they do have a positive impact on legal outcomes due to the credentials of the doctor involved, and the manner in which the reports are written. The reports produced in this project although shorter were by the same doctor and in similar style. However, it is also possible that the decision maker in the cases under evaluation would have granted leave to remain without requiring any clinical evidence. The overall grant rate is currently high (73% in the year to March 2023), and in this pilot, grants of asylum also occurred in some cases without a TID report. It is thus difficult to know how whether or not the reports impacted any asylum decisions.

In all cases the young person will have had their experience recognised and documented. This could in itself have a positive effect on wellbeing.

To our knowledge there is no published evidence on the impact of providing early clinical assessments to young people seeking asylum, so the findings are of interest despite the limitations of the evaluation.

14.IMPLICATIONS

For TID

- **Dissemination of findings**. Findings from this project may be of interest to those providing health assessments for people seeking asylum, to others working with this group (Social Services and schools), to legal representatives and those deciding asylum claims. Key findings are that for many young people there appear to be
    - unrecognised psychological and risk issues,
    - clinical findings likely to be consequences of mistreatment and
    - psychological factors that affect the young person's ability to give a detailed and consistent account of their experiences

  and that these issues can be identified in a focused assessment of around one hour.

- **Future trauma screening for young people seeking asylum.** This might be more efficiently carried out by other organisations who are already seeing young people for health assessments, for example through ensuring such assessments routinely include enquiry about experiences of abuse, the consequences of this, and young people's difficulties recounting their history. There may be a useful role supporting others to deliver such enhanced assessments, for example community paediatricians. This role might include considering how to support clinicians fearful of disclosures that they feel ill-equipped to deal with.

- **Future TID projects**. There may be other groups amongst those seeking asylum where clinical evidence would have greater potential to impact the asylum claims.

For those conducting assessing health assessments

- **Service development.** The project documents and evaluation provide material that may be of use in training and for improving routine screening for trauma, for example developing assessment structures that adequately explore trauma history and psychological issues.

- **Screening instruments**. Standardised screening for PTSD and depression symptoms (CRIES-8 and MFQ) may be useful. It would be worth considering using standardised translated versions.

- **Increasing efficiency of trauma screening.** Whereas the assessment itself is the core intervention, the time taken to write the report adds considerably to the cost of each screening and there may be scope to further reduce this, for example by more use of templated material about common issues that need to be explained. Perhaps findings could be presented in the form of letters rather than as formal reports?

For Social Services

- **Commissioning trauma screening**. The evaluation provides material that may be of use in considering the need to commission either trauma screening in the form used here, or a form of routine health assessment that focuses on trauma and psychological issues.

- **Referral for trauma screening.** If trauma screening is available, referral processes need to be properly embedded and accessible to front-line social workers.

- **Awareness raising**. It may be useful for social workers to be aware of key findings from the evaluation, for example that it may be not uncommon for social care staff to be unaware of significant psychological and safeguarding issues.

- **Explanations for young people.** To encourage young people to disclose difficulties in health contexts, it may be useful when they first arrive in the UK to introduce the idea of talking about mental health.

For legal representatives and Home Office decision makers

- **Awareness of the kind of information that may be generated by a brief trauma screening**. This may be useful both in deciding whether to seek clinical evidence, and in being aware of the potential gaps in information without it.

- **Awareness of the impact of psychological issues on young people's ability to give their account.** This may be useful to anyone interviewing traumatised young people.

Appendix 1: Client leaflet: trauma screening assessments

Why have I been offered an appointment with a doctor from TID?

Your social worker has invited you to an appointment with a doctor to talk through any problems you are having. They have done this because they think you might have been hurt in the past and may be feeling sad, worried or stressed about your past and/or your situation in the UK. The appointment is to see what might help you.

The doctor has special training and lots of experience of working with young people who have been hurt. They will see you for one appointment with an interpreter. The appointment is one hour long. Please arrive at least 15 minutes before the appointment starts so we do not lose any time.

The doctor works for a human rights organisation. They have no connection to the Home Office or UK Government. The interpreter also has no connections.

The doctor meets with you just once. They will be able to give advice on what might help you. They will offer to write a letter/report to your social worker to help explain what has happened and how it affects you. What you tell the doctor will be confidential (private). They will explain to you, at the appointment, what this means. Your social worker will talk to you about whether you want any letters/reports to be shared with anyone else, for example your solicitor and GP.

What will happen at the appointment?

1. The doctor will check you understand and agree to the appointment
2. The doctor will listen to your concerns and ask you some questions about what has happened to you. You do not have to answer questions if you do not want to.
3. If you have an injuries or scars from being hurt, the doctor will offer to look at them and make a record. You do not have to be examined if you are nervous. No one else will be present except the doctor for examination and you will not be examined in private areas. It helps if you come to the appointment wearing loose clothes. The doctor will offer to make drawings or photographs of any injuries.
4. If your social worker is present, the doctor will ask you if the social worker can give an update on your welfare.
5. The doctor will talk to you about things that might help you.
6. The doctor will check that you are happy for her to write a letter/report.
7. The doctor will look after your personal information with care. There is more information about this on our website or you can ask for more information at your appointment.

After the appointment

You might feel good or ok after the appointment. But it can be very normal to feel worse than usual after the appointment. This is because you may have discussed difficult thoughts, fears and memories. Your sleep might be worse for a while and you might feel more anxious. This will pass. It is important to try and eat and sleep as you normally would, to spend time with other people and to exercise. It is good to talk to your social worker about how you will get home after the appointment and also to make a plan for what you will do afterwards. The doctor will give you a leaflet at the end about tips and how to get help.

If you have any feedback about the doctor, the process or the service please tell your social worker or email us at Admin@tortureid.org. We are keen to improve our work.

Appendix 2 : KIRKLEES: Pathway for UASC Trauma Screening (25.9.22)

What is Trauma Screening?

A trauma screen is an assessment to identify and document historical trauma and to describe how it may be continuing to impact on a young person. It is a stand-alone appointment (lasting up to 1.5 hours) with an experienced GP who will conduct psychological assessments and physical examination if indicated. A report will be produced. TortureID does not offer follow-up or therapy. The report will contain recommendations and can be shared, with client consent, to obtain services and support.

Criteria for Referral

Any unaccompanied asylum-seeking child (UASC) or care leaver, who arrives as a UASC, under the care of Kirklees Social Services
Referral must be from Social Worker or Looked After Children's Nurse (LACN)

Refer if

The young person is showing signs of psychological distress or it is suspected because of difficulties with relationships, behaviour, learning or other reasons

OR

A history of child abuse, torture, trafficking, FGM or witnessing violence etc

OR

The young person has medical conditions, injuries or scarring relating to ill-treatment.

NB.
Documentation of any of the above can assist the young person in accessing services and presenting their asylum claim.

Don't refer

The young person does not want to be seen

OR

The young person is not stable enough to be seen (i.e. they are disturbed to a degree that they need to be under the care of mental health services e.g. suicidal, significantly self-harming or a risk to others.) They can still be seen but this decision should involve their treating mental health team.

NB

- They are not to be referred for standard GP care. They should already be registered with a GP.
- They are not to be referred for therapy or treatment. The service is a one appointment trauma screen only.

Social worker to email Dr Jo Miller on admin@tortureid.org to request a trauma screen. Please note this is not a secure email address so you need to encrypt or password protect personal information
Please use the referral form and complete all details where possible

TortureID to offer dates and times for appointments to social worker (2 week response)
The social worker needs to be in charge of co-ordinating the appointment or to delegate this to a carer

Social worker to arrange a qualified interpreter (ideally face to face and to fund this)

Young person attends appointment (up to 1.5 hours)
They need to be reminded and brought to the appointment by a carer or social worker
The carer or social worker can sit in the appointment if the young person wants them to
Appointment is at XXXXXXX

TortureID to provide a report with findings and recommendations to be emailed[1] to Social Worker (2 weeks).
TortureID to copy in the LAC team on XXXXXXX
TortureID will provide the young person with information on after-appointment care and mental health support (This is in English currently)

LAC actions

To forward a copy of the report to the client's GP (for the time-being TortureID can upload the report to Systmone Records of Whitehouse Centre patients but not for other GPs)

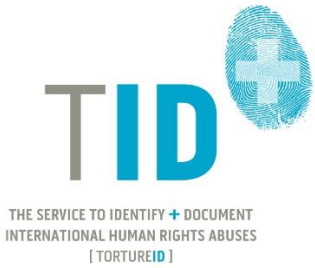
Social Worker actions

Social worker to consider with their client whether to share the full report with legal representatives, GP, carers, school.
Social worker to encourage and report any feedback about the assessment to TortureID

Later: To assist TortureID with audit and evaluation if requested (consented)

[1] Via NHSnet or password protected document.

Appendix 3: UASC trauma screening referral form



Referral Form for Social Services for UASC Trauma Screening

Referrer details (essential)	
Name	Click here to enter text.
Organisation Address	Click here to enter text.
Telephone	Click here to enter text.
Email	Click here to enter text.
Date of Referral	Click here to enter text.

Details of person referred (essential)	
Name	Click here to enter text.
Current Address	Click here to enter text.
Telephone	Click here to enter text.
Country of Origin	Click here to enter text.
Date of Birth and Age	Click here to enter text.

Social Services (essential)	
Name of Social Worker and Team if not the referrer	Click here to enter text.
Address	Click here to enter text.
Telephone Number	Click here to enter text.
Email Address	Click here to enter text.
Does social worker wish to be at the appointment? (This is a choice – but especially vulnerable young people should be accompanied)	Yes ☐ No ☐ N/K ☐
Name and contact for anyone else relevant e.g. foster carers	Click here to enter text.

Gender	Male ☐ Female ☐ Other ☐
Is an interpreter needed?	Yes ☐ No ☐
Preferred language	Click here to enter text.

Referral criteria	
Young person is struggling with mental health	Yes ☐ No ☐ N/K ☐
Young person has been abused/tortured	Yes ☐ No ☐ N/K ☐
Young person has injuries (physical and/or psychological) which should be recorded for asylum claim	Yes ☐ No ☐ N/K ☐
Young person is having problems with disclosure (e.g. at interview with Home Office)	Yes ☐ No ☐ N/K ☐
Please give details (please tell us here what you're concerned about and what you have done, so we can avoid recommending things you have already implemented)	Click here to enter text.

Health (essential)

GP	Click here to enter text.
GP Address	Click here to enter text.
GP Telephone	Click here to enter text.
Any known medical problems	Click here to enter text.

Safeguarding (essential)

Are you aware of any risk to self or others?	Yes ☐ No ☐
If yes, please give details	Click or tap here to enter text.

Stage of asylum claim (if known)

Date of Arrival in UK	Click here to enter text.
Date of Asylum Claim	Click here to enter text.
Stage of Asylum Claim	Pre SEF ☐ Post SEF ☐ Post decision ☐ Positive decision from Home Office ☐ Refused and pre-Tribunal ☐ Positive decision from Tribunal ☐ Refused by Tribunal ☐ Other Click here to enter text.
Dates of any upcoming interviews etc	Click here to enter text.
Any other information of relevance, e.g., disputed nationality or age	Click here to enter text.

National Referral Mechanism progress (NRM)

First responder	Click here to enter text.
Date referred	Click here to enter text.
Reasonable grounds decision status	Click here to enter text.
Conclusive grounds decision status	Click here to enter text.
Is the client in a NRM local decision making pilot?	Yes ☐ No ☐ N/K ☐

Client Consent

Have you consented the client to referral?	Yes ☐ No ☐

Other

Please confirm that you will book an interpreter for 1.5 hours	Yes ☐ No ☐
Please confirm that someone who knows the young person will attend with them	Yes ☐ No ☐
Please send or bring any information about their experiences the young person has already disclosed eg legal statements. This can reduce the need to ask them unnecessary questions.	

Please email your referral to Admin@tortureid.org
Please note that this is not a secure email and you would be advised to password protect the form and/or send encrypted. Passwords should be shared by another contact method e.g. by phone.

03/02/2023

Appendix 4. Trauma screening report contents

TRAUMA SCREENING REPORT

Contents

Appendices

Appendix 5. Client leaflet: self-care after the appointment

After your appointment

Thank you for coming to your appointment today. You have done really well to come and to talk. Many young people find it a hard thing to do.

You might find that you feel OK after the appointment. Or you might find that talking has made you feel worse.

Many young people do feel worse after talking about bad memories. You may feel angry, upset, ashamed, sad or confused. It may be hard to sleep or to settle down again. This is normal. These upset feelings will go away with time.

Things that can help

There are some simple things that can help you feel calm:

- **Keep to your normal routine**. Try not to miss college or change your bedtime or stop doing anything you would normally do.
- **Distract yourself** from thinking too much. Going for a walk or doing some other kind of exercise can really help. So can spending time with friends or playing games or watching TV. Things like this can help take your mind off memories and let the upset feelings go away.
- **Eat normally** and drink water even if you do not feel like it.
- **Talk to someone**. (See next page)
- **Use relaxation and mindfulness exercises**. You could try the breathing exercise in the box. Or you could try another breathing or mindfulness exercise that you already know. Many people find apps useful. You could the app *Headspace.* Some people find 'butterfly hugs' helpful – You Tube has videos that show you how to do these.

A breathing exercise
Find a comfortable position
Breathe in through your nose while you count steadily from 1 to 5. Let your breath flow into your belly. Don't worry if you can't get to 5 at first.
Now breathe out through your mouth while you count from 1 to 5.
Keep doing this for at least three minutes.

Talking about how you feel

It can help to talk to someone you like and trust, like a teacher, foster carer or friend. Sharing your worries with someone can be hard but it also often helps.

If you don't feel you can speak to anyone you know, there are organisations that can help you. There are safe online forums like The Mix and Young Minds Crisis Messenger where you can text to ask for help. There are also helplines like the Samaritans who can ring you back with an interpreter if you need one. There is a list of helplines and services available to you at the bottom of this card.

You can also speak to your GP about how you are feeling. This can be scary, but your GP will have heard from lots of young people who are feeling upset. They will know what support and services are available in your local area.

Finding services that can help (These are free of charge)

- **Samaritans** Phone 116 123 to speak to a trained volunteer. You can ask for an interpreter.
- **Young Minds** Text YM to 85258. A trained volunteer will text you back
- **Childline** www.childline.co.uk. Try the 'Get support' tab. Or phone 0800 1111
- **The Mix** www.themix.org.uk Try the 'Get support' tab. Or phone 0808 808 4994
- **Boloh helpline** Phone 0800 151 2605 for free online advice, emotional support and therapeutic support. Advisers and therapists speak a range of different languages and have access to interpreters. For more information or to use webchat- https://helpline.barnardos.org.uk

If you feel really bad

If you feel really bad, unhappy or agitated, then it is especially important to tell somebody.

If you are experiencing very disturbed sleep, many more nightmares or are thinking about dying do not keep these thoughts secret.

In an emergency, you or someone helping you can ring your GP or ring 111 for advice on getting help urgently.

Appendix 6.

Primary care for young people who have experienced human rights abuses

The following are general suggestions for GPs and other primary care providers.

1. Developing a therapeutic relationship

Opportunity to develop trust in an individual clinician in primary care can be really helpful. Young people seeking asylum can find it difficult to discuss mental health. Fears of madness and of being rejected or locked up are common[2]. Successful treatment, whether therapy or medication, is likely to depend on the therapeutic relationship in which it is offered[3].

2. Somatic symptoms

Somatic symptoms are common in psychological trauma. Whilst it is important to exclude other serious causes of each presenting complaint, a focus on such complaints without enquiry into the person's psychological condition and life circumstances is unlikely to result in significant improvements. In addition, young people may have very limited understanding of psychological symptoms.

Somatic symptoms are also common among torture victims. They may be a direct physical consequence of torture or of psychological origin. Typical somatic complaints include back pain, musculoskeletal pain and headaches, often from head injuries. Pain may be the only manifest complaint and may shift in location and vary in intensity. Headaches are very common among torture survivors and often develop into chronic post-traumatic headaches. They may also be caused or exacerbated by tension and stress.

3. Psychological therapy

Many people, whether with post-traumatic or other difficulties, find that psychological interventions help them to manage symptoms, and to feel supported and more able to move forward with their lives. Where possible, it is useful to refer to an organisation experienced in working with people seeking asylum.

First line treatment for PTSD and complex PTSD is psychological therapy focusing on the traumatic experiences. There can be limits to how successful this is until the person has secured permanent protection in the UK[4]. However, this should not be a barrier to psychological input as trauma-focused work can be helpful for some even while still waiting for an asylum decision.

Symptom-focused medication prescribing in young people (not children, who need secondary care input) may sometimes be useful, especially when provided within a trusting therapeutic relationship and with close follow-up. However, treatment should ideally still include psychological therapy.

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[2] **Perceptions.** Majumder and O'Reilly (2014). 'This Doctor, I not trust him. I'm not safe.' The perceptions of mental health and services by unaccompanied refugee adolescents. International Journal of Social Psychiatry; 61(2)

[3] **Trust.** NICE PTSD full guideline (2018) states 'A priority is to support the development of a trusting relationship that can help in the provision of other phases of the intervention'

[4] **Impact of immigration status on PTSD treatment**: In people with PTSD, being safe from further persecution is required to optimise treatment and in some cases to make effective treatment possible. According to NICE, '*Until there is safety from further persecution, there may be a limit to the depth of therapeutic work that can be delivered. It can be hard to confront trauma memories anyway, but if the PTSD sufferer faces a realistic prospect of being returned to face more trauma, then it can be impossible.*' National Institute for Health and Care Excellence Post Traumatic Stress Disorder 2005. National Clinical Practice Guideline No. 26. Full Guideline Section 10.5. p.120-21. Accessed on line https://www.nice.org.uk/guidance/ng116/evidence/march-2005-full-guideline-pdf-6602623598 (Although NICE guidance on PTSD was updated in 2018, this part of the full guideline was not changed).

4. **Prognosis and risk management**.

In survivors of human rights abuses, post-traumatic symptoms are frequently re-triggered by adverse life events and can play out as chronic ill health, with remission and relapse. People seeking asylum are particularly vulnerable to relapses of depression and PTSD because the asylum process can perpetuate uncertainty and fear of the future or trigger new fears.

Risk assessment should be considered at any point when there is a negative development in an individual's circumstances. Suicide and self-harm risk may escalate rapidly in an individual who receives bad news from home, is faced the prospect of being returned to a place which frightens them, or who loses hope.

5. **Screening for blood borne viruses**

If not already done, it would be appropriate to offer blood tests for hepatitis B and C and HIV. There is a risk of blood borne virus transmission during torture and sexual abuse, including through the use of implements, and bleeding injuries

6. **General advice about mental health**.

All young people benefit from basic information about mental health and wellbeing and in particular encouragement to eat well, to be outdoors and physically active and to pay attention to sleep patterns. Sometimes advice needs giving many times as young people seeking asylum may have very little prior knowledge of how to be healthy, especially when they come to a new culture. The Doctors of the World website has a useful leaflet of wellbeing guidance, translated into different languages[5].

Social interventions may help. The mental health of young people seeking asylum is likely to be helped by developing stable new attachments, peer relationships and educational achievements and from progressing towards their life goals. Disruptions to new attachments, including those with health professionals, may be disturbing, and should be planned and gradual.

7. **Coding of records**.

The addition of codes and problem headers to patient records highlights that human rights abuses have taken place. Human rights abuses are major life events which, in many cases, will have a significant impact on an individual for the rest of their life. It is easy to lose this information in medical records especially when individuals affected are often transient across services.

8. **Interpreters**

People using NHS care have a right to language support if they need this (Gov.UK, 2021). If your practice does not have access to telephone interpretation at no cost to the practice, this needs to be taken up with commissioners. It is not safe to use family members and friends as interpreters and certainly not children.

[5] https://www.doctorsoftheworld.org.uk/translated-health-information/?_gr=wellbeing-guidance