Response to the Department of Health and Social Care consultation on mental health and wellbeing

July 2022

The Helen Bamber Foundation (HBF) is a specialist clinical and human rights charity that works with survivors of trafficking, torture and other forms of extreme human cruelty and believes that all survivors should have safety, freedom and power. Our work alongside survivors shows us that with early and appropriate care and support survivors build the strength to move on with their lives. Our multidisciplinary and clinical team provides a bespoke Model of Integrated Care for survivors which includes medico-legal documentation of physical and psychological injuries, specialist programmes of therapeutic care, a medical advisory service, a counter-trafficking programme, housing and welfare advice, legal protection advice and community integration activities and services.

Promoting positive mental wellbeing? (chapter 1)

- Do you have any suggestions for how we can improve the population's wellbeing?

The paper rightly identifies that risks of mental ill-health are higher among "people who have experienced displacement, including refugees and asylum seekers" and "people who have experienced trauma as the result of violence or abuse". Refugees, people seeking asylum and survivors of trafficking are more likely to have specific healthcare needs as a result of their experiences of torture, exploitation and human rights abuses in their country of origin, or during their journey to the UK, and traumatic bereavements and separations. Mental health problems are highly prevalent among this population as a whole – survivors commonly experience physical health problems including illnesses, conditions and injuries, and also mental health problems, with anxiety, depression and complex post-traumatic disorder being the most prevalent. These problems often worsen once they are in the UK as a result of how they are treated.

Key to improving the wellbeing of this population is acknowledging and addressing the systemic failings that cause them harm from the moment they arrive in the UK. These include delays in decision making; an intrusive and re-traumatising asylum process, particularly the interview; and poor housing and lack of financial support. Uncertain immigration status and a feeling of helplessness and living in limbo, whilst also being unable to access employment or education opportunities, can have a significant negative impact on mental health.

Mental health difficulties present a particular re-trafficking risk, as they can result in loss of autonomy and agency; low self-esteem; lack of understanding of boundaries in relationships; lack of willingness to seek help resulting in social isolation and concealment of psychological and physical injuries. Survivors of human trafficking/modern slavery may be at increased risk of entering into dangerous dependency or 'survival' relationships in which they may become entrapped; and they may have difficulty in recognising new threats to themselves or trafficking situations

There are numerous points in the asylum and trafficking systems where the physical and mental health of people seeking protection is worsened by the system we have in place. A particularly stark example is immigration detention. There is a high prevalence of mental illness among those placed in immigration detention[1] and recent experience[2] suggests that persons with significant mental illness (including but not only PTSD), as well as those with evidence of past torture, sexual or gender-based violence, remain detained despite their mental health-related vulnerability and evidence that their mental health deteriorates in detention.[3] Even where there has been some form of assessment of the health of a person following which they have been identified as having an indicator of risk, either self-declared or because of professional evidence (including medical evidence) that a period of detention would be likely to cause harm, such is the priority given to immigration control they continue to be held in detention, despite most going on to be released, their detention having served no purpose either in successfully concluding their immigration case or in securing in their removal from the UK.[4]

[1] Sen P, Arugnanaseelan J, Connell E, Katona C, Khan AA, Moran P et al (2018) Mental health morbidity among people subject to immigration detention in the UK: a feasibility study. Epidemiology and psychiatric sciences, 27(6): 628

[2] Detention of people with mental disorders in immigration removal centres (IRCs). Royal College of Psychiatrists 2021

[3] von Werthern M, Robjant K, Chui Z. et al. The impact of immigration detention on mental health: a systematic review *BMC Psychiatry* (2018) 18: 382. https://doi.org/10.1186/s12888-018-1945-y

[4] Out of the 21,365 people who entered detention in the year ending September 2021, there were only 2,830 enforced returns.

This is an example of a system that harms well-being, and whilst it is not the responsibility of the Department of Health and Social Care, it is the Helen Bamber Foundation's firm belief that an approach to improving well being and addressing mental health can only be achieved through a cross-departmental approach that aims to address *all* factors that worsen mental health as well as helping individuals to respond to health problems. Such an approach would look at ways to improve the treatment of people seeking asylum and survivors of trafficking through, for example, better housing and financial support; a more responsive and trauma-informed asylum system that generates quick but fair decisions and an approach that prioritises welcome, integration and the ability to work.

HBF is a member of the 'Asylum Seeker Health Steering Group Mental Health Subgroup', through which we are work on a 'trauma-informed and culturally competent framework' for organisations engaging with asylum seekers and trauma-informed asylum interviews, but this group has no mandate to address other parts of the process that worsen mental health. As recommended in the recent Safeguarding Adults National Network report on 'The Health, Wellbeing and Safeguarding Needs of Individuals Seeking Asylum':

"As risk factors to mental health are often outside the remit of health policy there is also the need for cross government work on prevention rather than just an enhanced or bespoke mental health offer." [5]

<u>Recommendations:</u>

- Local primary care and mental health services should receive training on identifying mental health problems experienced by refugees, people seeking asylum and survivors of trafficking early and treat them in culturally competent ways - which is likely to require working closely with local community groups to address stigma and to emphasise entitlement to health care (physical as well as mental).
- The government should create a cross-departmental strategy to address the factors that worsen the mental health of refugees, people seeking asylum and survivors of trafficking, as well as ensuring the services and process are in place to best respond to those health problems.

[5] Safeguarding Adults National Network, The Health, Wellbeing and Safeguarding Needs of Individuals Seeking Asylum', National Scope Findings & Recommendations, May 2021

Preventing the onset of mental ill-health (chapter 2)

- What is the most important thing we need to address in order to prevent suicide?

The systemic problems facing refugees, people seeking asylum and survivors of trafficking, outlined in our answer to the first question, all contribute the increased risk of suicide, including poor accommodation, frequent moves [which interrupt care for long-term health problems including mental health problems], forced destitution and ongoing uncertainty, insecurity and fear.

One area of particular concern is the number of instances of death by suicide of young people in the asylum system. Last year, alongside a small community-led London charity working with asylum-seeking and refugee youth from the Horn of Africa - Da'aro Youth Project – we wrote to government ministers alerting them to the death by suicide of 11 teenagers who had arrived as unaccompanied asylum-seeking children over the previous five years.

All of these young people were either children in the care system or care-leavers at the time of their deaths. Some of those who died were still awaiting the outcome of asylum applications and were worried about a negative decision; some had experienced age disputes that had found them to be adults, before they were later brought back into the care system as children; some had difficulties with post-traumatic stress, with misuse of drugs and alcohol, and with accessing mental health care. That these young people, once safe here in the UK, would go on to take their own lives reflects the wider issues of young people's struggle for mental health care and the pressures that are put on young people in the care and asylum systems.

Recommendations

- All local authorities must be alert to the risk of suicide in this group, and to train all persons working with unaccompanied asylum-seeking children in trauma-informed practice and to centre trauma-recovery in care planning.
- All coroner's courts must be required to collect and return information on nationality and immigration status to the Office of National Statistics (ONS) to begin to record and monitor immigration status in deaths by suicide.
- Local authorities must be required to send a serious incident notification to the Department for Education when a care-leaver dies, unlike when a child in care dies, so there is no independent review or learning process.
- The government should provide ring-fenced funding to local areas to ensure all children in care and care leavers have access to early and specialist mental health

support. This includes trauma-informed and culturally appropriate care for young unaccompanied asylum-seeking and migrant young people.
- The government should identify the common areas for concern in the asylum process for children and what actions to take to ensure better outcomes in decision making, including addressing delays in decision making, intrusive interview processes and the inappropriate overuse of age assessments.

Intervening earlier when people need support with their mental health (chapter 3)

- How can we ensure that people with wider health problems get appropriate mental health support at an early stage if they are struggling?

As part of the government's legal responsibility for the health and well-being of asylum seekers, we recommend that trauma-informed care be a basic foundation of the provision of all services to asylum seekers. This would require training and monitoring for all providers. All asylum seekers should also be referred to good quality health care as soon as possible. Further efforts must also be made to ensure culture change within the asylum system and also to increase the opportunities for supporting asylum-seekers and signposting them to further support within the process. This should include:

- Mental health champions to ensure a physical presence with independent mental health professionals working to provide further guidance and help decision makers, case workers and others to think through what a trauma-informed way of working looks like. They would support staff working on locations where people seeking asylum experience key moments of distress, including where interviews take place, in initial accommodation, reception centres, and tribunals.
- Mental health support in these locations to assist with identifying vulnerabilities and ensure that individuals who need further help are signposted to appropriate support where necessary.
- A widespread understanding of trauma-informed care and cultural competency is an important foundation, but it must be accompanied by time and funding for further work to embed cultural change and for actual interventions for those with higher levels and complexity of need – this is invariably more expensive because it requires specialisms and more time. It is important to be mindful of the fact that it can actually be more harmful (and potentially traumatising) for staff and volunteers working with vulnerable people to have a greater understanding of a trauma-informed approach but not feel empowered do anything in response.

A key part of ensuring that survivors get appropriate mental health support at an early stage is 'screening' for mental health problems, vulnerability or indicators of trafficking should be an ongoing process in the asylum journey. Routine screening for PTSD in asylum

seekers is also a recommendation of the NICE guidelines.[6] Effective screening is likely to require some degree of proactive outreach since the most vulnerable are often unable or reluctant to seek the help they need. This process should be facilitated by easy access to medical care, with general practitioners acting as an assessment and triage point for onward referral to mental health care. The usual confidentiality accorded to health information will facilitate effective and trusting relationships with asylum seekers which will facilitate the effective provision of appropriate care.

It is important to note that complex charging structures can deter people seeking asylum and survivors of trafficking from seeking healthcare even when they are entitled to it – we need to see a lifting of charging requirements at best, or, at least, further efforts to ensure that all asylum seekers and survivors of trafficking understand their rights and entitlements to healthcare.

When people claim asylum the asylum screening process is only designed to be a quick initial interview to capture "basic information" on certain factors. It is not designed to identify vulnerability. In some cases, the asylum screening interview will identify high levels of concern about a person's welfare in general (such as if they are identified as a current victim of domestic abuse), but in many cases this very brief screening and routing process will be insufficient to provide all relevant information about a person's vulnerability. For example, the asylum screening questionnaire asks a specific question about trafficking (which in HBF's experience does not reliably identify trafficking) but asks nothing specific relating to torture or trauma. Further opportunities to provide information occur via the 'Preliminary Information Questionnaire' (PIQ) and a form used to assess destitution and eligibility for asylum support,[7] but people can struggle to complete these without sufficient legal advice and support and people seeking asylum may not articulate the symptoms they have as constituting a mental health condition. They may not trust or have confidence to make significant and difficult disclosures to a stranger asking them about housing. Trafficking victims in particular may not identify as such initially, particularly if they do not understand their experiences as falling within the scope of trafficking and modern slavery.

<u>Recommendations:</u>

- The government should undertake a thorough review of the opportunities throughout the asylum and trafficking assessment process for picking up on mental health concerns and vulnerabilities and consider the ways in which they can be strengthened and whether the correct referral processes and pathways are in place when they are. Given these multiple and complex barriers it is also essential that individuals are not penalised in any way for failure to disclose health difficulties or

[6] Recommendations | Post-traumatic stress disorder | Guidance | NICE
[7] Section 14 of the ASF1 form

traumatic experiences to Home Office providers, but that health records be privileged as an alternate source of evidence where relevant. Home Office guidance on decision-making, and accompanying training, must include information on the effect of trauma on disclosure/memory.

- The government should take further steps to ensure that all healthcare professionals, asylum seekers and survivors of trafficking understand their rights and entitlements to healthcare.

Improving the quality and effectiveness of treatment for mental health conditions (chapter 4)

- What needs to happen to ensure the best care and treatment is more widely available within the NHS?

We believe that increasing access to trauma-focused or other evidence-based therapies through the NHS must be a priority, but it is currently a postcode lottery with long waiting lists. This is perhaps more specific to the subset of the clients we see, most of whom have PTSD or complex PTSD. In our experience it is often extremely challenging for them to get proper access to trauma-focused treatment, especially outside of bigger cities, despite their entitlement to such treatment.

Furthermore, when someone is moved from borough to borough, which is common for those in the asylum system who are 'dispersed' across the country, they can slip down the waiting list for mental health care and details about their health can be lost. The introduction of a Patient Held Record would prevent the many gaps in care which occur due to frequent moves (including into and out of Immigration Removal Centres) and different NHS IT systems and also act as a prompt for healthcare professionals to think about the complex health needs of people in the asylum and trafficking systems. It would also prevent individuals having to retell their story and health issues at every consultation.

Recommendations:

- The Department of Health and Social Care and NHS England should develop a Patient Held Record which would allow asylum seekers and survivors of trafficking to carry their own health records with them from the initial assessment onwards. The Patient Held Record would integrate with any Initial Health Screening and NHS records to ensure that there is continuity of care and prevents the trauma of individuals having to discuss their background and ill health with every new healthcare professional.
- The Department should put in place a process that ensures that when people seeking asylum and survivors of trafficking are on waiting lists and are moved to different areas they are not be put to the bottom of the new waiting list but will be

prioritised depending on the time already spent waiting, as currently happens with children.

- Ring-fenced funding should be introduced for NHS specialist trauma clinics and primary care based psychological services to ensure the necessary capacity (and be supported to develop the necessary expertise) to take on people seeking asylum, with assessment and co-ordination of care for PTSD undertaken by the individual's general practitioner, in accordance with NICE guidelines for PTSD.[8] Having additional funding for specific groups in this way would mean they were delivered by a specialist service, integrated with other NHS care and could also increase the prominence of this area of practice and thus the number of practitioners trained in evidence-based trauma focussed work. This should be part of NHS care, with steps taken to address gaps are in NHS services and working out how to ensure asylum seeker health needs are met that way, rather than the government funding a civil society 'shadow' clinical service for asylum seekers.
- The government should take further steps to raise awareness amongst people seeking asylum and survivors of trafficking, and all staff in primary and secondary healthcare, of the eligibility of this group to healthcare.
- The Home Office should address delays in the asylum and trafficking systems so that survivors can then benefit from therapeutic intervention. In our experience, many of our clients have great difficulty accessing psychological therapies (stabilisation and/or trauma-focussed therapies) until their immigration status is settled. In our clinical experience such therapies can be effective so long as they have some degree of situational stabilisation (stable accommodation and a pathway towards legal protection).

Improving support for people in crisis (chapter 6)

- **What do you think are the most important issues that a new, 10-year national mental health plan needs to address?**

A new 10-year national mental health plan should include a commitment to create a cross-department government strategy to address the factors that worsen the mental health of people seeking asylum and survivors of trafficking, as well as ensuring the services and process are in place to best respond to those health problems. As we have argued in the context of the global response to refugees and the conflict in Ukraine:

"A public health strategy, and more specifically a public mental health strategy, is central to an effective response. Such a strategy must recognise both the systemic and the intrinsic barriers to

[8] https://www.nice.org.uk/guidance/ng116/resources/posttraumatic-stress-disorder-pdf-66141601777861

accessing the mental healthcare that many refugees will need, as well as potential 'enablers' such as positive policies and active social support."[9]

- How can we improve data collection and sharing to help plan, implement and monitor improvements to mental health and wellbeing?

The paper acknowledges that "data collection on refugee and asylum seekers' health service usage is limited" and more is required. One of the concerns we have long raised as HBF is the gap in data collection on suicide - coroners are not recording immigration status or nationality on death certificates, and so the Office of National Statistics is unable to provide data on deaths by suicide amongst asylum-seekers, so that trends might be identified. [10] The UK government has a responsibility to prevent suicide but it is unclear how it can do that when there is no record or follow up to the deaths of those in the asylum system. While some of these deaths have resulted in inquests most included no witnesses and no family representation.

Recommendation:

- All coroner's courts must be required to collect and return information on nationality and immigration status to the Office of National Statistics (ONS) to begin to record and monitor immigration status in deaths by suicide.

[9] Mental health responses in countries hosting refugees from Ukraine | Helen Bamber
[10] Cohen, J., Katona, C. and Bhugra, D., 2020. National data on suicide must include ethnicity