

Practice guidelines for clinical psychologists for
supporting appropriate care and treatment for
Unaccompanied Asylum-Seeking Minors
in the United Kingdom

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EXECUTIVE SUMMARY

BACKGROUND

This guidance document has emerged following an acknowledgement of the varied support needs required by unaccompanied asylum-seeking minors and their unique needs compared to indigenous populations of Looked After Children.

In 2018, 19,850 unaccompanied asylum-seeking minors, or separated children, applied for asylum in one of the 28 countries within the European Union (EU); 3,065 of these applications were in the UK (Eurostat, 2019). Within the UK, the majority of applications came from children from Eritrea, Sudan, Vietnam, Iraq, Albania, Iran, Afghanistan and Ethiopia (Refugee Council, 2019a). In March 2019, there were 5,070 unaccompanied asylum-seeking children looked after by local authorities in England; this represents approximately 6% of all children looked after in England (Department for Education, 2019). This figure does not include separated children living in kinship care with family members, therefore there will be higher numbers of separated children living in the UK than this figure indicates.

Children and young people become unaccompanied, separated from their families and are forced to leave their country of origin for a number of reasons, including fear or experience of persecution, torture, imprisonment, violence, human rights violations, war and conflict, trafficking and extreme economic hardship (Hodes & Vostanis, 2018; Kohli & Mather, 2003; UNHCR, 2019a). As a result, separated children are likely to have experienced multiple losses, have had limited or no periods of stability, and have often endured trauma in their country of origin as well as on the journey away from their home country (Fazel & Stein, 2002). Some separated children may have experienced relatively shorter journeys, but others will experience long journeys, taking months or years, with exposure to life-threatening conditions potentially involving sexual violence and other physical harm, and reliance on smugglers (Hodes & Vostanis, 2018; Priebe, Giacco, & El-Nagib, 2016). Disruption within their country of origin and during their journey means that many young people have not had access to formal education or healthcare (Fazel, Reed, Panter-Brick, & Stein, 2012). On arrival in the receiving country, separated children are required to navigate a multitude of systems relating to their legal status, housing, care needs, health and education, while adjusting to a new culture and learning a new language. Separated children often show considerable resilience and resourcefulness however the experiences and adversities they face increase the risk for psychological distress and the development of mental health difficulties (Ehnholt & Yule, 2006) during key developmental periods in childhood and adolescence (S. J. Blakemore, 2012; Konrad, Firk, & Uhlhaas, 2013).

Separated children have multi-faceted, complex needs relating to their physical, social and emotional well-being, safety and legal needs, education and human rights. The receiving country is expected to offer protection and assistance for separated children, including providing appropriate education, housing, legal support and healthcare (UNHCR, 1997, 2017) in the best interest of the child (UNHCR, 2019b).

This guidance aims to offer information relating to the needs of unaccompanied asylum-seeking minors and to outline the roles clinical psychologists may have in supporting the mental health and wellbeing needs of separated children. This guidance is focused on the UK and is not intended to provide detailed guidance on specialist psychological interventions.

This document outlines the potential roles for clinical psychologists in supporting the mental health, legal, social and physical health needs of separated children. A summary of key practice recommendations included are outlined in the diagram below.

Social needs

- Encourage access to education, consulting to providers where required
- Consider developmental needs within intervention delivery and safety planning
- Offer consultation to professional network on mental health needs
- Liaise with advocacy and third sector organisations as appropriate
- Encourage involvement in social activities

Mental health needs

- Routinely screen for mental health difficulties using standardised measures
- Offer evidence-based interventions
- Support socio-political needs using co-produced care plans
- Encourage and support access to trauma-focused interventions
- Actively engage in service evaluation and development

Effective engagement

Advocate for social needs to be met

Be proactive and outreaching in service promotion and delivery

Consider and respond to relationship to help

Support flexible entry into mental health services

Collaborate with young people and their professional networks

Identify mental health needs

Offer support with legal needs

Promote service access

Separated Children

Legal needs

- Be aware of the stages of and procedures within the asylum process and associated stressors
- Liaise with solicitors as part of routine multi-agency working
- Share psychological understanding using professional letters
- Use psychological skills to support clients with asylum-related stress
- Be aware that mental health difficulties are likely to persist beyond the asylum process

Physical health needs

- Signpost to appropriate services for assessment and treatment of physical health needs
- Provide support ahead of potentially aversive appointments
- Advocate for the sensitive delivery of physical health interventions
- Rule out potential organic causes of physiological phenomena

Use well-trained interpreters, where required

MENTAL HEALTH NEEDS

Separated children present with a range of mental health needs which require attention and sensitive responding. The United Nations Convention on the Rights of the Child highlights that every child has the right to the best possible health (Article 24).

CONTEXTUAL FACTORS

The mental health needs of separated children often emerge as a consequence of significant exposure to multiple stressors and traumatic experiences during three different stages; while in their country of origin (pre-flight), during the journey to safety (flight) and when settling in the receiving country (post-flight; (Müller, Büter, Rosner, & Unterhitzberger, 2019; Priebe et al., 2016; Yule, 2002). The number of traumatic experiences has been shown to be one of the most robust predictors of mental health difficulties among separated children (Müller et al., 2019), however other factors such as separation from and loss of family members can increase the risk for developing mental health difficulties and mediate their severity (T. M. Bean, Eurelings-Bontekoe, Mooijaart, & Spinhoven, 2006; T. M. Bean, Eurelings-Bontekoe, & Spinhoven, 2007; Bronstein & Montgomery, 2011; Hodes & Vostanis, 2018).

Following arrival in the receiving country, the absence of protective factors such as a stable and predictable living environment as well as supportive family members who can provide consistent care renders separated children more psychologically vulnerable, increasing the likelihood of mental health difficulties (Derluyn & Broekaert, 2008). Separated children are required to navigate numerous systems on arrival in the receiving country, without access to buffering social support from family members which other refugee children might have. This can result in demands and responsibilities above and beyond what is typically expected of a child. While settling in the receiving country young people often experience daily stressors including displacement, discrimination, racism, social exclusion and an increased sense of isolation; further risk factors for the development of mental health difficulties (Bronstein & Montgomery, 2011; Fazel & Stein, 2002; Jensen, Skårdalsmo, & Fjermestad, 2014; Vervliet, Lammertyn, Broekaert, & Derluyn, 2014). In addition, factors such as uncertainty about the asylum process, reduced social integration and financial hardship can increase the risk for developing mental health difficulties (Hodes & Vostanis, 2018; Priebe et al., 2016).

Protective factors following arrival in the receiving country include those that relate to the individual and the community (Eruyar, Huemer, & Vostanis, 2018). Community protective factors include same ethnic group contact, maintaining connections to their culture (Fazel et al., 2012; Geltman et al., 2005; Hodes, Jagdev, Chandra, & Cunniff, 2008), stable accommodation and minimal moves, connections with mentors or community groups (Carlson, Cacciatore, & Klimek, 2012), peer friendships and other social support (Fazel et al., 2012; Mohamed & Thomas, 2017; Müller et al., 2019), and stability at school (Mohamed & Thomas, 2017). Individual protective factors include coping and problem-solving skills, positive self-esteem, hope for the future, faith or religious orientation (Mohamed & Thomas, 2017; Ní Raghallaigh & Gilligan, 2010), language proficiency (Müller et al., 2019) and physical health (Ehnholt & Yule, 2006).

APPLICATION OF MENTAL HEALTH DIAGNOSES ACROSS CULTURES

Psychiatric diagnoses are designed to enable classification of mental health disorders to promote understanding of patterns of experience and behaviour and support the development and implementation of appropriate treatment interventions. However, psychiatric diagnoses have been a topic of controversy, particularly the application of diagnostic frameworks to non-Western cultures.

Psychiatric diagnoses have been criticised on the grounds of reliability and validity (Aboraya, France, Young, Curci, & Lepage, 2005; Aboraya, Rankin, France, El-Missiry, & John, 2006; Jablensky, 2016) and opponents argue that the application of these to diverse cultures means that normal responses to abnormal experiences are pathologized or labelled as abnormal responses. Psychiatric diagnoses have also been criticised on the basis that they do not account for contextual factors, such as culture, social structures, the environment and individual circumstances (Lewis-Fernández & Aggarwal, 2013), and do not consider the range of losses and adversities people experience (Ehnholt & Yule, 2006).

However, everyone experiences an emotional reaction to extreme events and, although these reactions are understandable given a person's circumstances and context, action should still be taken to alleviate distress, particularly where this distress is having an impact on a person or their functioning. Separated children experience multiple losses and traumatic experiences, which will lead to emotional reactions that any person would experience in such a context (Ehnholt & Yule, 2006). Diagnosis can be a means to understand this distress (Perkins et al., 2018), normalise the response for young people, and mobilise the required resources in order that appropriate treatment can be offered to separated children (Ehnholt & Yule, 2006).

Psychiatric diagnoses are used within this guide to provide a common language to understand the difficulties that separated children commonly experience following arrival and while settling in a receiving country. An individual, collaborative, holistic and culturally-sensitive approach to mental health diagnosis is important (Lewis-Fernández & Aggarwal, 2013; Perkins et al., 2018; Schnyder et al., 2016), however it is also essential that separated children are supported to understand their mental health needs and have access to evidence-based interventions to alleviate this distress (Mitra & Hodes, 2019).

PREVALENCE OF MENTAL HEALTH DIFFICULTIES

Prevalence estimates of mental health disorders in unaccompanied asylum-seeking children range from 41% - 69% (Bronstein & Montgomery, 2011; Coyle et al., 2016; Fazel & Stein, 2002; Jakobsen, Demott, & Heir, 2014). In a recent prevalence study among asylum-seeking children in Germany, Müller et al. (2019) identified high levels of depression, anxiety and PTSD symptoms among refugee children, with the prevalence rates of mental health problems in separated children being almost twice as high as those in accompanied asylum-seeking children; 64.7% of separated children scored above the clinical cut-off for PTSD, 42.6% for depression, and 38.2% for anxiety. However, refugee children can also present with a mixture of symptoms without meeting criteria for a single diagnostic category (Fazel & Stein, 2002). Separated children often present with disrupted sleep and feeding patterns, which can exacerbate emotional lability and distress (Bronstein & Montgomery, 2013; Polivy, 1996).

Fewer studies have investigated rates of psychosis in unaccompanied refugee children. However, Norredam, Nellums, Nielsen, Byberg, and Petersen (2018) have estimated the incidence of psychotic disorders in unaccompanied minors to be 428 per 100,000 person years, which was significantly higher than that estimated for accompanied refugee children (251 per 100,000 person years).

Longitudinal follow up studies have demonstrated long-term persistence of mental health difficulties (depression, PTSD and anxiety) at 18 months (Vervliet et al., 2014) and two years (Jensen et al., 2014) following arrival in a receiving country.

PTSD

Studies in high-income countries have consistently identified that prevalence rates of PTSD in separated children are significantly higher than in accompanied refugee children and children born in

the receiving country (Bronstein & Montgomery, 2011; Hodes et al., 2008; Huemer et al., 2009; Müller et al., 2019; Panter-Brick, Grimon, Kalin, & Eggerman, 2015), as outlined above. PTSD has been shown to be predicted by stressful life events following arrival in the receiving country (Jensen et al., 2014), gender, living arrangements and social support, with the most significant predictor being the number of traumatic events experienced (Hodes et al., 2008; Müller et al., 2019). The mean number of traumatic events among separated children in the study by Hodes et al. (2008) was 28.

A meta-analysis of 27 peer-reviewed studies reviewing natural recovery from PTSD in children in the general population identified that recovery from PTSD without intervention 6 months after the traumatic event is significantly limited (Hiller et al., 2016). Persistence of PTSD symptoms has been noted among individuals who have higher trauma exposure (Hodes & Vostanis, 2018) and both Jensen et al. (2014) and Vervliet et al. (2014) have demonstrated persistence of PTSD symptoms among separated children up to two years following arrival in the receiving country, predicted by increase in stressful life events after arrival and number of traumatic experiences.

Prevalence rates of Complex PTSD, as defined by the International Classification of Diseases, 11th edition (ICD-11, 2018), have not yet been examined in separated children. Although research on Complex PTSD is an emerging field, there is evidence to support a distinction between PTSD and Complex PTSD in children and adolescents (Sachser, Keller, & Goldbeck, 2017). Separated children may be considered more vulnerable to developing Complex PTSD, however it should not be assumed to be present solely on the presence of a complex trauma history (ter Heide, Mooren, & Kleber, 2016), but should be assessed for carefully when conducting assessments with separated children to fully identify mental health needs.

RISK OF SUICIDE IN SEPARATED CHILDREN

It is important to consider the vulnerability in this client group to loss of life by suicide. In a recent study it was identified that 30% of separated children reported suicidal ideation within the previous year (Cardoso, 2018). In Sweden it was found that the risk of suicide among separated children was nine times higher than among same-aged peers born in the receiving country (Hagström, Hollander, & Mittendorfer-Rutz, 2018). In addition, a two year longitudinal follow-up study highlighted a significant increase in suicidal ideation among separated children between arrival in the receiving country and two year follow-up (Jensen et al., 2014).

Psychological research highlights various constructs that predict suicide, including feelings of defeat, entrapment, not belonging, being a burden, future thinking, goal adjustment, reasons for living, and fearlessness of death (Holmes et al., 2018). The interpersonal-psychological theory of suicidal behaviour (Joiner, 2005) discusses three main constructs that are believed to influence suicidal behaviour:

- perceived burdensomeness
- low sense of belongingness and social isolation
- the capability to act on suicidal thoughts and intent

Separated children may experience an increase in perceived burdensomeness as a result of discrimination and instability and often experience a reduced sense of belongingness living in the UK. While settling in the UK young people experience displacement, discrimination, social exclusion and an increased sense of isolation (Bronstein & Montgomery, 2011; Fazel & Stein, 2002), which has the potential to reduce the sense of belongingness. Exposure to traumatic events, such as those experienced by separated children, serve as risk factors for the capability to act on suicidal thoughts. These include increased exposure to pain, injury, life-threatening situations and death. Trauma-

related cognitions include a sense of a foreshortened future, feeling that the world is a dangerous place and that others can't be trusted, as well as increased risk-taking and potentially dangerous behaviour, which may increase the capability to act on suicidal thoughts among some young people.

IMPORTANCE OF APPROPRIATE MEASUREMENT

There is a gap in identifying mental health support needs among separated children (Mitra & Hodes, 2019) and young people from diverse cultural backgrounds may be more likely to identify physical symptoms and difficulties rather than name emotional states (Hinton & Lewis-Fernandez, 2010). One approach to identify mental health needs would be to systematically use standardised measures of mental health difficulties, as this may enable consistent and reliable identification of need (Tolin et al 2016).

Standardised measures can have the benefit of normalising symptoms and provide a helpful starting point for when children and young people may be reluctant to volunteer their symptoms (Smith, Dalgleish, & Meiser-Stedman, 2018). The use of self-report measures is considered to provide an accurate indication of distress among refugee children and controls for cultural bias (Bronstein & Montgomery, 2011). Jensen et al. (2014) have demonstrated a large variation in mental health needs among separated children and suggested the importance of monitoring mental health needs over time.

Listed below are some specific screening tools which may help identify mental health needs in separated children. All questionnaires used as part of clinical assessment should be valid, reliable and sensitive to clinical change. Questionnaires should be used alongside clinical interview, cover a broad-base (for example symptoms of depression, PTSD, functional outcomes, and strengths-based measures) and assessment should include both child and carer views, where possible (Smith et al., 2018).

SELF-REPORT QUESTIONNAIRES: GENERAL MENTAL HEALTH

Currently, the most commonly used measure with routine clinical practice in the UK is the Strengths and Difficulties Questionnaire (SDQ; (Goodman, 1997, 2001). However, collation of evidence of mental health needs of separated children by the Children's Society (2018) identified that the SDQ may not be sensitive enough to identify the range of mental health difficulties experienced by separated children. The lack of sensitivity in identifying mental health needs has also been observed in routine clinical practice with separated children (King & Said, 2019).

The CORE Young People (CORE-YP; (Twigg et al., 2009) is a general measure of global difficulties among young people. This may capture specific needs within separated children including sleep difficulties, distressing thoughts and feelings, and the perceived ability to reach out for support. This measure is being implemented more frequently with separated children (Children's Society, 2018).

The Refugee Health Screener-15 (RHS-15; (Hollifield et al., 2013) is a screening tool designed for use with refugees and asylum-seekers, aged 14 and above, newly arrived in the receiving country to screen for common mental health difficulties and identify where further treatment may be beneficial (Hollifield et al., 2013). This has been found to be a valid, reliable, efficient and effective screening tool (Kaltenbach, Härdtner, Hermenau, Schauer, & Elbert, 2017) and is available in a range of languages spoken by separated children.

The [Child Outcomes Research Consortium](#) identifies a range of additional measures recommended for use with children and young people to identify various mental health needs, functional outcomes and resilience. The [Children and War Foundation](#) provide screening and assessment tools for use with

children and young people who have been exposed to war and disasters worldwide. These measures are translated into a number of languages spoken by separated children. Bean (2006) has developed a set of measures for use with unaccompanied minors which assess mental health needs, adjustment and relationship to help. These can be accessed in the appendices of the following document: [Bean, T. \(2006\). Assessing the Psychological Distress and Mental Healthcare Needs of Unaccompanied Refugee Minors in the Netherlands.](#)

SELF-REPORT QUESTIONNAIRES: PTSD

Because of the nature of avoidance symptoms within PTSD, re-experiencing symptoms, hypervigilance and upsetting experiences are often not voluntarily reported within mental health assessments, therefore direct inquiry regarding these symptoms is considered important. Research evidence shows that the majority of young people report no or low levels of distress when completing trauma screening measures (Skar, Ormhaug, & Jensen, 2019).

The recent National Institute for Health and Care Excellence (NICE) guidelines for PTSD in children (2018) recommend consideration of active monitoring within 1 month of a traumatic event for children with a diagnosis or clinically important symptoms of PTSD. Systematic review evidence has identified that measurement 3-6 months following a traumatic event is considered to be more reliable at identifying PTSD that will persist without treatment (Hiller et al., 2016). Four key tools to screen and assess for PTSD symptoms in young people include the Child Revised Impact of Events Scale (CRIES; (Perrin, Meiser-Stedman, & Smith, 2005), the Child Trauma Screening Questionnaire (CTSQ; (Kenardy, Spence, & Macleod, 2006), the Child and Adolescent Trauma Screen (CATS; (Sachser, Berliner, et al., 2017) and the Child PTSD Symptom Scale (CPSS-5; (Foa, Asnaani, Zang, Capaldi, & Yeh, 2018). Further details about these measures can be found in the appendix of this document.

COMPLEX PTSD

Standardised measures for assessing (ICD-11) Complex PTSD symptoms have not, to date, been developed and psychometrically evaluated for use in children and young people. The International Trauma Questionnaire (ITQ; (Cloitre et al., 2018) is a validated measure of ICD-11 PTSD and Complex PTSD, however this has only been validated with adults in the UK to date.

ACCESS TO APPROPRIATE INTERVENTIONS

Separated children have low levels of contact with mental health services, despite the high prevalence of mental health difficulties within this population (T. M. Bean et al., 2006; Sanchez-Cao, Kramer, & Hodes, 2013). Evidence from a two year longitudinal study suggests that, without treatment, there is no significant change in mental health symptoms in separated children between arrival in the receiving country and two years following arrival, highlighting a potentially chronic course of mental health concerns and the need for separated children to have access to appropriate interventions (Jensen et al., 2014). Additional thought to supporting engagement with services is covered in a subsequent section in this guide.

It has been shown that separated children are less likely than accompanied refugee children to receive evidence-based interventions for specific mental health needs (Mitra & Hodes, 2019). Furthermore, systematic review evidence has demonstrated that non-directive counselling does not improve outcomes for separated children (Mitra & Hodes, 2019), highlighting the need for effective evidence-based interventions to be provided.

Refugees may require a phased model of support due to their diverse social and mental health needs (Grey & Young, 2008). A phased model of intervention and holistic approach to care has been recommended for refugee children and young people (Ehnholt & Yule, 2006; Fazel & Betancourt, 2017; Murray, Cohen, Ellis, & Mannarino, 2008). Phased models of care include establishing safety and trust, trauma-focused therapy, and reintegration (Herman, 1997).

For separated children, phase I stabilisation interventions may include biopsychosocial support such as addressing sleep difficulties, physical health difficulties and eating patterns; supporting young people within the asylum process and the national transfer scheme (see 'legal needs' section below); reducing social isolation, addressing discrimination and racism; engagement interventions (see 'effective engagement' section below); psychoeducation, managing dissociation, grounding and distress tolerance.

Phase II interventions typically include trauma-focused therapies for the treatment of PTSD. However, although many separated children may be experiencing PTSD-related difficulties where trauma-focused therapies are indicated, there may be some who are not experiencing PTSD or for whom trauma-focused therapy is not indicated. Depending on a young person's presenting concerns, other interventions can therefore be offered in phase II, such as interventions for other mental health needs, sleep difficulties or somatic complaints (Ehnholt & Yule, 2006).

Phase III, integration, includes focusing on values, creating a future, developing goals and aspirations, and integrating within the community. Further information about phase-based approaches is well documented in the literature (e.g. (Cloitre et al., 2012; Ehnholt & Yule, 2006; Grey & Young, 2008; Herman, 1997; McFetridge et al., 2017).

Hobfoll et al. (2007) highlight five key principles for interventions for children and families who have been affected by war and mass violence: a sense of safety, calming, a sense of self-and-community efficacy, connectedness and hope. Recent reviews highlight the multifaceted nature of the needs of refugee and asylum-seeking children and adolescents and the importance of considering their wider context and offering interventions at child, family, school and community levels (Eruyar et al., 2018; Fazel & Betancourt, 2017), which can be incorporated into phased models of care. Appropriate interventions to support the mental health needs of refugee children are understood to include psychotherapeutic support in combination with interventions to support resolution to asylum claims, adequate housing and access to skills training and education (Fazel & Betancourt, 2017). It has also been highlighted that the impact of mental health interventions is enhanced by establishing joint care pathways with other agencies and professionals involved in a young person's care (Eruyar et al., 2018). Interventions may also include indirect working, such as training and consultation with professionals in a young person's network.

INTERVENTIONS FOR MENTAL HEALTH DIFFICULTIES

Existing evidence-based interventions, recommended by the National Institute for Health and Care Excellence (NICE), for specific mental health difficulties can be effectively delivered with separated children with appropriate sensitivity to social and cultural needs (Beck, Naz, Brooks, & Jankowska, 2019; Eruyar et al., 2018; King & Said, 2019; Mitra & Hodes, 2019; Said & King, 2019). There has been increasing guidance within the literature on making evidence-based approaches more accessible for individuals and groups with varying needs and differences (e.g. (Beck et al., 2019; Mir, Ghani, Meer, & Hussain, 2019; Mir et al., 2015; Naeem et al., 2016; Rathod, Phiri, & Naeem, 2019); see the appendices for further information.

When working with young refugees and asylum-seekers, psychosocial approaches have been shown to be effective in reducing mental health symptoms and functional impairment and in increasing hope, coping and social support. This has been demonstrated in low-resource settings (Purgato et al., 2018) and in middle- and high-income countries (Ehnholt, Smith, & Yule, 2005; Fazel & Betancourt, 2017; Mitra & Hodes, 2019; Sarkadi et al., 2018; von Werthern, Grigorakis, & Vizard, 2019).

GROUP APPROACHES

Group interventions have been developed to support the mental health needs of separated children. One such approach is the Teaching Recovery Techniques group developed by the Children and War Foundation (Yule, Dyregrov, Raundalen, & Smith, 2013), which is based on psychoeducation and trauma-focused cognitive behavioural therapy approaches. This group includes five sessions for young people and two for their caregivers. There is a group developed and adapted specifically for unaccompanied minors, which has recently been evaluated in Sweden (Sarkadi et al., 2018). This study highlighted significant reductions in both PTSD and depression symptoms and young people found the group to be an acceptable intervention, highlighting the benefits of normalisation of reactions to trauma, social support and developing coping strategies (Sarkadi et al., 2018). More details about this intervention, including training, can be sought from the [Children and War Foundation](#).

Group trauma-focused CBT with 2-4 individual sessions for creating a trauma narrative resulted in significant reductions in PTSD symptoms and psychosocial distress in former child soldiers and war-affected children in the Democratic Republic of Congo (McMullen, O'Callaghan, Shannon, Black, & Eakin, 2013).

A 10 session stabilisation group implemented within accommodation units for separated children in Finland was found to promote social interaction and trust for accommodation providers (Garoff, Kangaslampi, & Peltonen, 2019), however did not lead to change in mental health symptoms. A psychoeducation and skills group for separated children within the United Kingdom identified high levels of engagement and satisfaction and an effect size of $d = 1.08$ for reduction in difficulties measured by the SDQ (King & Said, 2019). Moreover, this group enabled some separated children to engage in trauma-focused interventions.

INTERVENTIONS FOR PTSD

Research evidence identifies the importance of early targeted interventions for children at risk of developing chronic PTSD (Hiller et al., 2016), which includes those bereaved by trauma (Pfefferbaum et al., 1999), those who have significant trauma histories (Copeland, Keeler, Angold, & Costello, 2007) and those with low social support (Trickey, Siddaway, Meiser-Stedman, Serpell, & Field, 2012).

The need for trauma-focused mental health interventions was identified as one of six components of mental health care for refugee children in a systematic review by Eruyar et al. (2018). Given the high prevalence of PTSD among separated children, access to trauma-focused interventions is particularly important.

There are a number of well-evidenced individual trauma-focused interventions for PTSD in children (National Institute for Health and Care Excellence, 2018; Smith et al., 2018); with trauma-focused cognitive behavioural therapy (TF-CBT) interventions being the most researched interventions with the largest effect sizes (see Smith et al., 2018 for a more detailed account). The NICE guidelines for PTSD (2018) include Cognitive Therapy for PTSD (CT-PTSD), Narrative Exposure Therapy (NET), Prolonged Exposure, and Cognitive Processing Therapy (CPT) under the umbrella of trauma-focused CBT interventions. Meiser-Stedman (2002) and Salmon and Bryant (2002) outline the application of

adult models to children, taking into account developmental factors such as language ability, memory and emotion regulation.

In the treatment of PTSD, trauma-focused approaches have been shown to be superior to alternative approaches (Ehlers et al., 2010; Gillies, Taylor, Gray, O'Brien, & D'Abrew, 2013; Gutermann et al., 2016; Morina, Koerssen, & Pollet, 2016; Schnyder et al., 2015). Systematic review evidence has demonstrated that non-directive counselling does not improve outcomes for separated children (Mitra & Hodes, 2019).

There are evidenced effective interventions for PTSD among refugee populations, with particular evidence for NET (Schauer, Neuner, & Elbert, 2011), an intervention designed for people who have experienced multiple traumatic events. Among adult refugee populations, NET is considered to be among the most-effective interventions for PTSD in reviews and meta-analyses (Nose et al., 2017; Robjant & Fazel, 2010; Thompson, Vidgen, & Roberts, 2018). Recent developments in NET have included effective adaptations to support additional needs, such as anger difficulties among former child soldiers (Robjant et al., 2019).

NET has been adapted for children (KIDNET) and trialled by Ruf and colleagues (2010), who identified significant improvement in PTSD symptoms for children receiving NET. A recent randomised control trial for multiply traumatised children, which included separated children within the participant sample, identified a significant reduction in PTSD symptoms; including reduction to below clinical cut-offs among participants who received NET (Peltonen & Kangaslampi, 2019). This effectiveness has been replicated within routine clinical practice with newly-arrived separated children in the United Kingdom (Said & King, 2019). Moreover, qualitative reports from separated children who received NET in the United Kingdom highlighted that they strongly valued this approach and requested interventions to reduce flashbacks and dissociative experiences associated with PTSD (Said, Al Qadri & King, in preparation).

Emerging evidence also highlights the feasibility and effectiveness of enhanced TF-CBT approaches for the treatment of PTSD in separated children (Unterhitzenberger et al., 2015; Unterhitzenberger, Wintersohl, Lang, König, & Rosner, 2019). This approach incorporated support and training for carers of separated children with PTSD (Unterhitzenberger et al., 2015) and was shown to be possible even within uncertain circumstances, including where separated children have not yet received refugee status (Unterhitzenberger et al., 2019).

Eye Movement Desensitisation and Reprocessing (EMDR) has a growing evidence base supporting its efficacy for children and young people with PTSD (de Roos et al., 2017; Smith et al., 2018) and with adult refugees (Thompson et al., 2018). The most recent NICE guidelines for PTSD highlight that EMDR should only be considered for children and young people with a diagnosis or clinically important symptoms of PTSD where they do not engage with or respond to trauma-focused CBT interventions (NICE, 2018).

Within trauma-focused therapy it is important to provide appropriate psychoeducation and symptom management support such as grounding, stimulus discrimination and dissociation management. Chessell, Brady, Akbar, Stevens, and Young (2019) provide a helpful protocol for managing dissociative symptoms in adult refugee populations, which can be adapted for working with adolescents.

COMPLEX PTSD

There are relatively fewer studies investigating the efficacy of treatments for Complex PTSD (CPTSD), however a recent systematic review highlights that trauma-focused therapies are effective

for CPTSD in adults and suggests that the development of effective interventions for CPTSD should build on existing PTSD interventions (Karatzias, Murphy, et al., 2019). There are no studies to date examining treatments for Complex PTSD in the general population of children and young people, or for separated children. Treatment for Complex PTSD should follow existing guidelines, including the NICE guidelines for PTSD (2018), the UK Psychological Trauma Society (UKPTS; (McFetridge et al., 2017) and the International Society for Traumatic Stress Studies (ISTSS; (Cloitre et al., 2012) guidelines which highlight the need for an increased number of sessions and taking a phased-based approach to treatment. However, there are also recommendations that trauma-focused treatments should not be delayed unnecessarily, and should be offered to all refugees and asylum-seekers seeking treatment for PTSD symptoms (ter Heide et al., 2016).

Other treatments emerging as potentially useful approaches within a phased-based approach for the treatment of Complex PTSD include Compassion Focused Therapy (CFT), particularly where shame is the predominant emotional response (see (Au et al., 2017; Irons & Lad, 2017; Karatzias, Hyland, et al., 2019; Lawrence & Lee, 2014; Lee, 2009; Whalley & Lee, 2019) and Dialectical Behaviour Therapy (see (Bohus et al., 2019). These approaches are thought to be useful for addressing the 'disturbances in self-organisation' symptoms of Complex PTSD such as negative self-concept, which includes self-criticism and feelings of shame, and emotion dysregulation, alongside trauma-focused interventions addressing core PTSD symptomatology.

Clinical psychologists are best placed to consider these approaches within individualised formulations and treatment plans with separated children, continue to monitor for developments in the efficacy of these interventions for the treatment of Complex PTSD and should take steps to contribute to the growing evidence base in this field.

PHARMACOLOGY

It may be helpful to consult with MDT colleagues to determine whether pharmacological interventions should form part of a care plan, such as melatonin to re-adjust circadian rhythms and Selective Serotonin Reuptake Inhibitors (SSRIs) to support depression and other mental health symptoms, in line with existing guidelines (e.g. NICE, 2019).

NOTE TAKING

In line with Health & Care Professions Council (HCPC) guidelines, full, clear and accurate records of clinical work should be kept up to date and stored securely (HCPC, (2016). When working with refugees and asylum-seekers, it is important to be aware that clinical notes may contribute to a medico-legal report for a client's asylum claim. It is therefore essential to take careful and accurate notes and be transparent with clients about clinical notes being kept and the purpose of these. It is also advisable to inform clients that assessment and treatment within the NHS are not part of the asylum process and medical records would only form part of this process with their consent.

SERVICE DEVELOPMENT

With service implementation for separated children being in its relative infancy, there is scope to identify levels of service access, mental health needs and potential responses to interventions.

Clinical psychologists can have a central role in service evaluation and development. Clinical psychologists also have a key role within developing, adapting and implementing evidence-based interventions for separated children, including those that focus on key areas such as stabilisation, sleep difficulties and PTSD recovery.

MENTAL HEALTH NEEDS: RECOMMENDATIONS

- It is important to screen for mental health difficulties, particularly PTSD symptoms. It is recommended to screen for PTSD at 3 months and then at 6 months following arrival in the UK. We note this conveniently parallels the timescale for multi-agency reviews for looked after children.
- Evidence-based interventions for separated children will be enhanced by other interventions addressing wider socio-political needs.
- Non-directive counselling does not improve outcomes for separated children (Mitra & Hodes, 2019). Evidence-based interventions should be offered to meet the mental health needs of unaccompanied minors.
- In the treatment of PTSD, trauma-focused approaches have been shown to be superior to alternative approaches, therefore these interventions should be offered to separated children with a diagnosis or clinically important symptoms of PTSD.
- It is possible to effectively implement trauma-focused interventions with unaccompanied asylum-seeking minors even while young people are in a relatively unstable social situation. Awaiting an asylum decision may not be sufficient grounds for refusal of trauma-focused interventions for PTSD.
- Clinical psychologists can play a key role in measuring access and responses to appropriate interventions within services.

EFFECTIVE ENGAGEMENT

There is ongoing documentation of low access to mental health services among separated children, despite high levels of mental health needs within the separated children population (T. M. Bean et al., 2006; Sanchez-Cao et al., 2013). Separated children had a higher rate of missed appointments within child and adolescent mental health services; double the rate of children accessing services with their parents (Michelson & Sclare, 2009). It is considered important while planning implementation of interventions and support to consider effective ways of accessing support.

When both considering how to design services for separated children, the views of separated children and people who support them is essential and a collaborative approach is thought to be needed to ensure work is delivered in a meaningful way. The following recommendations have in part been developed through a listening exercise with separated children in London called Problem Solving Booths (Owls, 2017).

BARRIERS TO ACCESSING SUPPORT

Separated children may be unfamiliar with help seeking for any health need and the idea of psychological support may appear alien and confusing or, for some young people, threatening. Mental health needs are often interpreted differently within the cultures of origin for separated children and seeking support for mental health needs can be highly stigmatised. Initial assessment interviews for mental health services may also replicate interviews which separated children have to comply with as part of their asylum application, potentially making health appointments more aversive.

It is understood that there are a number of barriers for unaccompanied minors attending mental health services (Majumder, 2019; Majumder, Vostanis, Karim, & O'Reilly, 2018), including the perception of therapies and practitioners and the role of individual differences related to power, age, gender and cultural background. Barriers to accepting support that need to be considered may include mistrust of adults following violence perpetrated by adults, perceived impact on asylum claims, and difficulties in disclosure associated with PTSD (Bogner, Herlihy, & Brewin, 2007; Majumder et al., 2018; Mitra & Hodes, 2019). Individual understanding, the model separated children have for mental health services, and limited awareness of the services and support that exists within the UK are also important to keep in mind when working with separated children and their networks.

ENGAGEMENT INTERVENTIONS

Separated children have had difficulties trusting service provision (Majumder, O'Reilly, Karim, & Vostanis, 2015). Concepts such as relationship to help (Reder & Fredman, 1996) and coordinated management of meaning (Cronen, Chen, & Pearce, 1988; Pearce, 1976) can inform understanding of how individuals form relationships with services and institutions, and how difficult initial experiences can shape subsequent interactions. The preliminary contact separated children have with healthcare professionals, as well as individuals who conduct interviews (such as those within the asylum process), may be invasive and at times threatening, making interactions similar to these activities potentially more aversive for separated children.

With these concepts and experiences in mind, the referral process for separated children needs to be carefully considered and flexible modes of accessing mental health services may be required. Clinical psychologists are well positioned to form part of existing health reviews for separated children as Looked After Children, reviewing mental health needs and beginning to deliver psychoeducation to young people and the professional network on their respective needs and healthcare options.

Education for separated children on the different roles professionals hold within their network is considered important to support social stabilisation and there are helpful translated guides available (signposted within the appendix of this document).

Mental health promotion may be required to encourage separated children to access appropriate support. This may be delivered using an outreach or partnership model, making use of culturally sensitive methods of engagement. Separated children have spoken of the value of clinicians visiting their place of residence and offering support within their community.

It is thought helpful to have discussions within first appointments with separated children about how they feel about accessing services, their current understanding of their own mental health needs, the stage of asylum process and current preoccupations. It is also considered helpful to begin with the issues young people consider most stressful, even if these might not be mental health symptoms. It is important to advocate on behalf of young people for social and legal needs to be met to enable effective responses to mental health provision, particularly as their social resources may be more limited.

Support for ongoing attendance at appointments may also require planning and support from the professional network. Accessing mental health treatment is a voluntary decision, however separated children should be supported to understand what access to support may involve in order that they can make an informed choice, with appropriate adult guidance for their developmental level. It is important to note that conditions commonly experienced by separated children such as PTSD (Müller et al., 2019) also involve a significant amount of avoidance as part of its presentation. The NICE guidelines for PTSD (2018) recommend proactive and assertive engagement as a part of effective delivery for the care for PTSD.

Disengagement from services may result in deterioration of mental health needs and escalation of difficulties in other areas such as education and social functioning, which are known to be protective factors. Mental health difficulties commonly experienced among separated children (Müller et al., 2019) are known to involve increased hypervigilance, poor sleep, impulsivity and risk taking, which may have safeguarding implications. There are three documented cases of separated children taking their own lives following disengagement from mental health services in recent years (Gentleman, 2018). Support for carers (hostel staff, foster carers, key workers, social workers and personal advisors) and consultation to the professional network may be a helpful alternative if a young person is not currently ready to access mental health support.

Practical suggestions to support engagement include having documents translated into clients' preferred language, noting client literacy skills where relevant; providing directions and reminders for appointments; provide preliminary information regarding expectations and people attending an appointment; arranging rooms to minimise reminders of traumatic experiences; encouraging access to a prayer room if required; considering the timing of appointments; and supporting with travel reimbursements.

LANGUAGE AND INTERPRETERS

Language spoken should not be a reason to deny access to support and treatment, and information about the service and treatment should be provided to young people in their preferred language. Service delivery should be supported by well-trained interpreters where needed. Research evidence identifies similarly effective outcomes for interpreter-facilitated therapies (d'Ardenne, Ruaro, Cestari, Fakhoury, & Priebe, 2007).

Availability of interpreters and liaison of mental health services with other social agencies has been shown to facilitate help-seeking and utilisation of mental health care among young refugees (Howard

& Hodes, 2000). Best practice guidance for working with interpreters begins with conducting a needs analysis for client's preferred language and dialect, and involves face-to-face interpretation for psychology sessions, promoting consistency of interpreters and considering factors such as gender and cultural group; see British Psychological Society (2017) guidelines for further practical guidance.

There has been recent documentation of interpreters forming part of grooming and re-trafficking processes. It is therefore advised that clinicians establish boundaries around the interpreting relationship and identify suitable interpreters through reputable agencies.

EFFECTIVE ENGAGEMENT: RECOMMENDATIONS

- Proactive and outreach engagement strategies may be required to support identification of mental health needs and service access.
- Clinical psychologists can take a lead role in screening for mental health needs and delivering psychoeducation on difficulties during paediatric health checks, which are a designated part of service provision for Looked After Children.
- Be mindful of different factors which might discourage service attendance and address these within preliminary appointments.
- Support service delivery using interpreters where required and provide appropriate training for interpreters.
- Offer support with social and legal needs as part of a care plan with MDT colleagues.
- Collaborate with the professional network to support attendance and following disengagement from services.
- Consider flexible entry into mental health services.

PHYSICAL HEALTH NEEDS

Separated children may present with various physical health needs including communicable diseases, dermatological conditions, nutritional deficiencies, dental health, sexually transmitted infections and blood-borne viruses, physical injuries as a result of their journey and other previous traumatic experiences such as torture or war, and women's health needs (Hirani, Payne, Mutch, & Cherian, 2016; Pohl, Mack, Schmitz, & Ritz, 2017). Sleep and eating patterns are often disrupted in separated children due to differing patterns on their journey to the UK, where separated children are often required to sleep during the day and travel at night for safety.

As part of routine reviews as looked after children, separated children should receive a health screening assessment following arrival in the UK. It is important that these physical health assessments are conducted sensitively; some young people may have never had contact with a health professional, or this may be associated with threatening or aversive experiences. There are differing cultural beliefs around sexual health and other physical health needs; it is therefore essential that assessment of sexual health and physical health considers cultural and religious needs and addresses health concerns in a culturally appropriate and culturally sensitive manner (Hirani et al., 2016). The purpose of the assessment should always be clearly explained to young people and the preferences of young people, such as gender of the assessing clinician and interpreter, should be accounted for.

Clinical psychologists should ensure that separated children are signposted to appropriate services for assessment and treatment of physical health needs. When working with separated children, it may be appropriate for clinical psychologists to support young people and other professionals in managing potentially difficult or aversive appointments, in a similar manner to clinical psychologists working in physical health settings.

PHYSICAL HEALTH NEEDS: RECOMMENDATIONS

- Signpost to appropriate services including dental, physiotherapy, occupational therapy and general medicine
- Support young people and other professionals ahead of potentially aversive appointments
- Advocate for the delivery of physical health assessments in a sensitive manner
- Confirm that potential organic causes of physiological phenomena such as pain and seizure-like symptoms are ruled out using appropriate medical investigations.

SOCIAL NEEDS

Separated children have multiple needs and a socioecological approach is considered helpful and most effective. Social interventions, in collaboration with joint care providers and community agencies are thought to be an important part of preventing additional mental health difficulties and enabling the opportunity for refugee children, including separated children, to thrive (Eruiyar et al., 2018; Fazel & Betancourt, 2017).

On arrival to the UK, separated children are likely to experience a range of new and different social systems including public transport, housing, finances, education, healthcare, legal, criminal justice, employment and cultural practices. This is being navigated during childhood without the social support of one's family, typically in an unfamiliar language, which is understandably demanding and stressful.

PREPARING TO SUPPORT SEPARATED CHILDREN

The relative vulnerability to developing significant mental health needs is, in part, influenced by a number of social factors which host countries can pre-emptively address in a universal manner for all unaccompanied minors (Eruiyar et al., 2018; Fazel & Betancourt, 2017; Fazel & Stein, 2002). This is especially poignant when considering the loss of parental and family support networks separated children have experienced and that statutory services are stepping into this role, in the absence of *any* familial support, in the context of separated children arriving in a new and unfamiliar environment, following traumatic experiences.

Responses from within school settings to address social well-being may include supporting English language development through additional tutoring, challenging bullying and racism, and maintaining awareness and preparation around social events which may prompt additional feelings of loss such as religious festivities or calendar events such as Mothering Sunday and Father's Day. Separated children may benefit from having a 'buddy' within their year group, having a named point of contact, and having frequent check-ins with a staff member. Schools would be best prepared with the use of emotional and mental health literacy and an appreciation of the effects of trauma on cognitive functions such as attention, concentration, memory and processing speed.

Stable residence is key for the maintenance of emotional well-being. Accommodation providers such as children's homes, semi-independent residences and foster homes would be best prepared to support separated children by preparing an environment which is safe from antisocial behaviour, crime, exploitation and discrimination; which is relatively quiet and where rooms have windows and are designed to elicit feelings of safety. Small rooms can frequently bring back memories of torture and imprisonment experiences and can be highly distressing for separated children, potentially leading to placement breakdown. Support staff and foster carers will be better prepared to support separated children if they have an understanding of sleep hygiene guidance and an awareness of the signs of mental health difficulties, including identification of differential cultural expressions of distress. Separated children are likely to require support with gradual re-introduction to regular meals and may require support via physical health services due to the impact of malnutrition on the journey.

Residential care staff and foster carers are likely to be the main point of contact for separated children and provide the majority of their day to day support. Within the tendering process for hostel accommodation it is advisable to evaluate whether it may be more helpful to accommodate and support separated children within one residence, where staff may have the advantage of additional training and experience, or to consider whether placement in hostels with indigenous looked after children may support integration and equitable provision of care. Staff retention and consistency of provision

may be supported by ongoing training, supervision and staff support (Curry, McCarragher, & Dellmann-Jenkins, 2005); which will then serve to support young people.

Minimising transitions such as placements and schooling is thought to be protective for mental health in separated children (Fazel & Stein, 2002). Supporting access to community resources, such as places of worship and sports and leisure facilities, is considered important to reduce social isolation and boredom and promote maintenance of a routine. In their role supporting adolescents, host networks will be better prepared by supporting separated children with required tasks such as travel skills, budgeting and management of finances, attending appointments, enrolling in education and adjusting to life in a new country, which would be a challenge for any child or young person.

Asylum-seekers are currently (at the time of writing) not entitled to work, however many agencies are challenging this within parliament. Once granted refugee status, people are entitled to work in the UK. Young people under the age of 18 are entitled to work for a prescribed number of hours, on certain days of the week (HM Government, 2019). Young people may wish to work as a source of structure and routine and a desire for increased financial independence. Support staff would be best prepared to support separated children by having conversations about their rights and entitlement to work, depending on their age and asylum status, to support young people who are eligible to work into safe and regulated employment. This will serve to protect separated children from potential exploitation.

EDUCATION NEEDS

Education is considered a key opportunity for meaningful activity and social interaction for children and young people. Young people not involved in education, employment and training are understood to remain disadvantaged in levels of education attainment, are more likely to be unemployed, and are at higher risk of poorer physical and mental health and poor life outcomes for up to 20 years beyond adolescence (Scottish Government, 2015).

Separated children may face barriers accessing education as a consequence of limited access to education prior to seeking asylum, often as a result of war and social disruption, and difficulties engaging with educational content due to poorer concentration, memory difficulties and difficult emotional experiences, as a potential consequence of mental health difficulties. Separated children may also be more isolated from resident peer groups and may experience additional difficulties as a result of racism, prejudice and language barriers. It is important to consider that separated children may have undetected neurodevelopmental or learning difficulties which may pre-date their departure from their country of origin. This may be hard to assess using formal diagnostic assessments conducted in English and validated for western populations.

The expectations for education provision differ depending on the age of an unaccompanied minor. Primary school-aged children would be expected to join primary school and follow mainstream education in English. Separated children between the ages of 11 and 16 would attend secondary education and follow the national curriculum for GCSEs and national qualifications in mainstream lessons conducted in English. Separated children aged 16 and over will be supported to enrol in college for English lessons and additional subjects depending on the institutional offering and attainment in English. All separated children currently claiming asylum have access to education provision up to the age of 19 under Home Office guidance. Despite the Home Office target of accessing education within 20 days, there have been identified barriers to education provision due to waiting lists for education places and logistics around coordination of education provision (Refugee Support Network & UNICEF, 2018). It is important to advocate for young people's right to education if not immediately offered.

Clinical Psychologists can support education attendance and attainment by sharing information and formulations with education providers on different aspects which may impact classroom learning and attendance; and making recommendations for adaptations to education on the basis of mental health and learning needs. These may be understood using culturally sensitive formal assessments and existing evidence on the impact of PTSD and other mental health problems on memory and concentration ability (Elbert et al., 2009; Schweizer & Dalglish, 2011). This information can be used to help advocate for an application of an Education and Health Care Plan (EHCP) and/or Personal Education Plans (PEP) within the respective local authority. As Looked After Children, separated children may also have access to the virtual school team, who can provide additional or tailored education if a young person is not able to access mainstream education.

Schools may also serve as a potential venue for delivering psychosocial and mental health interventions aimed at encouraging integration, reducing isolation and increasing peer support. Interventions specifically designed for refugee populations have proven effective (Ehnholt et al., 2005; Tyrer & Fazel, 2014), and general interventions for mental well-being among young people have also proven to be helpful and acceptable for young people from minority backgrounds (Sclare, Michelson, Malpass, Coster, & Brown, 2015).

SOCIAL NEEDS AS LOOKED AFTER CHILDREN

Following arrival in the UK, the receiving local authority children's social services department has a duty to assess separated children under section 17 of the Children's Act (1989), and then, almost always, to accommodate them under section 20 of the Children's Act. The exception to this is likely to be where a child has family members already residing in the UK, see 'Dublin III' information below. Separated children should be referred to the relevant local authority as soon as possible after arrival in the UK. The local authority in which an unaccompanied minor first presents is the local authority the young person is referred to and who will complete the initial assessment of need. However, separated children can then be referred to a different local authority for longer term accommodation and support under the National Transfer Scheme (see below).

Local authority children's social services departments are responsible for the health, wellbeing, education and accommodation of separated children. Clinical psychologists working within looked after children's services will have responsibilities in line with local authority duties, however all clinical psychologists working with separated children should be aware of and work to support separated children with their social needs due to the known impact this can have on their mental health (Carlson et al., 2012; Mitra & Hodes, 2019).

Children who enter the UK under the Dublin III regulation (see 'legal needs' section below) are typically placed in kinship care with the family member they have joined in the UK. While this process can be successful for some young people and families, there can be considerable challenges within this process that clinical psychologists should be aware of when working with separated children living with family members in the UK. If the family placement is deemed to be suitable for a young person then local authority support is withdrawn. This can leave families feeling unsupported, with a new child to provide care and support for, without any financial support or professional guidance.

Offering training and consultation to staff charged with looking after separated children, such as foster carers and hostel keyworkers, can be a helpful way of enhancing support available. This may include training on understanding of the stressors faced by separated children, different emotional experiences and direct guidance on how to identify and cope with mental health symptoms, such as coping with intrusive memories using grounding, sleep hygiene, and stabilisation for mood difficulties.

Looked after children are entitled to an independent advocate who is entrusted to speak on behalf of the young person where required. Advocates may also offer support to young people during reviews and meetings and can be instructed by young people to file a complaint with a responsible local authority. This may help to support separated children to have their statutory needs met and to advise on what practices may be unlawful. Charities such as Coram Voice can be used to identify local advocacy providers.

SOCIAL NEEDS AS AN ADOLESCENT

The majority of separated children are adolescents (Refugee Council, 2019a). Key psychological tasks of adolescence relate to developing one's own identity, self-concept and establishing additional social relationships. For separated children, the expectations of adolescents within Western society may be different to those within their country of origin whilst, simultaneously, age-dependent aspects of cognitive and neurological development within adolescence may have been impacted due to traumatic pre-flight and flight experiences. Treating separated children as older than their developmental age has been documented to have consequences for their mental health and adjustment within high-income countries (Derluyn & Broekaert, 2008).

When planning support and interacting with separated children, consider their position as young people and the significance of information being accessible to their developmental level, as well as their language and cultural position. It is important to consider the aspects of adolescent cognitive development (S. J. Blakemore, 2012; Blakemore & Choudhury, 2006; Burnett & Blakemore, 2009) which may make planning, coordination of tasks and impulse control more difficult, as this may impact the multiple tasks separated children are expected to contend with and their experience of stress as a result. It is considered in the best interest of separated children to have the opportunity to engage in social and leisure activities to maximize the chance for developing social relationships and in recognition of the role of leisure and friendships can have in protecting against stress.

SOCIAL NEEDS AS SEPARATED CHILDREN

Unaccompanied minors may be separated from their families due to separation on their journey, fleeing independently, parental death or parental imprisonment. Separated children may or may not be aware of where their family are and may have limited contact with their family. This may result in perpetuated distress and phenomena such as ambiguous and traumatic grief.

In the UK, the Red Cross offers a service to separated families to help trace other family members, called the Family Tracing Service. Access to this service is based on individual choice. There might be a range of reasons why a young person may or may not wish to engage with this service, including fear of finding out bad news and fear of risks to family members. Clinical psychologists are well placed to support professional networks to identify an appropriate time to discuss this option with separated children and to reflect on the relative advantages and disadvantages. Should an unaccompanied minor express an interest in family tracing, they may require support with the referral procedure, with attending an initial appointment with the Red Cross, and with emotional support at different stages of the family tracing process. It may also be important to discuss the potential limitations and realistic expectations of the success of this process with young people as this is not an active search and may be limited by data sources in other countries.

At the time of writing (2019), there is an ongoing campaign, the [Families Together coalition](#), to increase the remit of family reunion for separated refugee families, which may increase the opportunities for separated children to be reunited with their families in the UK. Clinical psychologists can offer informed opinion on the potential benefits of this process for separated children's wellbeing.

SOCIAL NEEDS: RECOMMENDATIONS

- Encourage access to education, consulting to providers where required
- Offer consultation to professionals within children's services
- Work in partnership with third sector agencies offering advocacy and support within the asylum process and within services for looked after children
- Consider developmental needs in intervention delivery and safety planning
- Consider the role of cognitive processes within adolescence on planning and organisation
- Encourage involvement in social activities

TRAFFICKING

Human trafficking is the “recruitment, transportation, transfer, harbouring or receipt of persons by means of threat, or use of force, coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation can include different forms of sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude or the removal of organs.” (UN Protocol to Prevent, Suppress and Punish trafficking persons (‘Palermo Protocol’)). There are additional considerations for the trafficking of minors which are outlined in the appendix below.

Children who have experienced trafficking are a particularly vulnerable group of individuals and there are likely to be specific vulnerabilities that have contributed their trafficking. Children may be trafficked for various reasons including forced marriage, sexual exploitation, forced labour or domestic servitude, unpaid work/debt bondage, organ harvesting or criminal activities (e.g. cannabis cultivation).

Health and social care staff working in setting which children may come into contact with need to be aware of signs of potential trafficking. Young people who have been trafficked may only have one contact with professionals; it is therefore advisable to see a child alone for part of the appointment with a qualified interpreter. It is also essential that concerns are acted on quickly as children may not have the opportunity to return or be contacted following the appointment. Further information about identifying the signs of trafficking is included in the ‘key reports and resources’ section of the appendix below.

Child trafficking is child abuse and a human rights violation, therefore clinicians working with separated children who have experienced trafficking should take appropriate steps to safeguard them. When working with separated children who have been trafficked it is essential that clinicians are aware of and take steps to monitor and safeguard against the risk of being re-trafficked; trafficking occurs both across international borders, into and out of the UK, and within the UK. Trafficked children are often at risk of going missing from care, which professionals working with separated children should take steps to prevent. Under EU law, trafficked children are entitled to a legal guardian who is responsible for representing the child’s best interests and all professionals working with trafficked children have a responsibility to safeguard and promote their welfare (Coram Children's Legal Centre, 2017f).

Clinical psychologists working with separated children who may have been trafficked are responsible for providing ongoing psychological support, referring children to the local authority where they are concerned a child might have been trafficked or is at risk of trafficking. It is important that clinicians are aware of trafficking profiles and signs that a child might have been trafficked or is experiencing continued exploitation. Control of the young person may persist beyond direct contact with the trafficker, as traffickers may employ psychological forms of control such as juju. Vulnerabilities to re-trafficking can be long lasting as young people may struggle to identify signs of harm and exploitation in relationships. Additional thought may be required as young people may not consider themselves as trafficked and may still have an attachment relationship to their traffickers.

separated children may go missing or have unexplained absences from their accommodation. Due to the risk of ongoing control and re-trafficking these absences must be followed up immediately and multi-agency safeguarding procedures should be employed.

More comprehensive information about identifying signs of trafficking, safeguarding and trauma-informed ways of working with survivors of trafficking can be found in the guidance recommended in the 'reports and resources' section within this document; it is recommended clinical psychologists working with separated children are aware of these additional documents. Separated children who have been trafficked are likely to have been referred to the National Referral Mechanism (detailed below), therefore clinicians should be aware of the process and stressors young people might experience within this.

The [NSPCC Child Trafficking Advice Centre \(CTAC\)](#) provides advice and support for professionals concerned that a young person may be a survivor of trafficking. The [Modern Slavery helpline](#) can also be contacted for advice or to report concerns. [Every Child Protected Against Trafficking \(ECPAT\)](#) provides direct support for young people who are survivors of trafficking, training for professionals, and campaign and research in the field of child trafficking and further guidance can be accessed on their website www.ecpat.org.uk/guidance-england.

LEGAL NEEDS

Separated children have various legal needs, primarily relating to applying for asylum within the UK and their status as looked after children. This section aims to provide an overview of these needs, however further advice and guidance should be sought from qualified legal representatives and specialist organisations. This section aims to provide an overview of information clinical psychologists should be aware of when working with separated children. It is not intended to provide an exhaustive summary of the asylum and other associated processes. Further information about each stage outlined below can be found under key recommended guidelines and additional resources detailed at the end of each section. A terminology section is included in the appendices.

Key legislation applying to children includes Section 55 of the 2009 Borders, Citizenship and Immigration Act, which states that the Home Secretary has a statutory duty, required by law, to ensure that Home Office decisions concerning children safeguard and promote their welfare. This duty also means that the best interests of the child should be considered when an immigration decision concerning a child is made.

THE ASYLUM PROCESS: STAGES AND STRESSORS

ROUTES TO ARRIVAL IN THE UK

Separated children arrive in the UK by three main different means:

- **Spontaneous Arrivals.** The majority of separated children arrive in the UK by their own means, through smugglers or through traffickers and are encountered at their port of entry, at the Asylum Intake Unit in Croydon, or by police or social services within the UK. The local authority in which the child first presents is typically responsible for their care, however separated children may be transferred to other areas of the UK under the National Transfer Scheme, see below. Separated children are expected to apply for asylum as soon as possible after arriving in the UK and should be supported to do so by the receiving local authority. Delays in making a first application for asylum can be negatively perceived by the Home Office leading to potential consequences for a person's asylum claim. Separated children may also be retrospectively identified as minors, following an age assessment or a successful legal challenge.
- **Dublin III Regulation.** The Dublin III regulation is European Union (EU) legislation. It identifies the Member State (among those which have signed up to the regulation) responsible for determining an asylum application. It makes use of various criteria including family unity, possession of residence documents or visas, irregular entry or stay and visa-waived entry. Family unity is a primary consideration within the Dublin III regulation, which can result in an individual's asylum claim being transferred to the State where their family are "legally present or resident". The Dublin III regulation applies to asylum claims made within any of the EU member states, Iceland, Norway, Switzerland or Liechtenstein. At the time of writing (2019), if separated children are in any of the Dublin Member States but have family members within the UK, they can move to the UK to be with their family and have their asylum claim transferred to the UK. However, at the time of writing (2019), the inclusion of the UK within the Dublin Member States is being re-negotiated as part of the EU withdrawal bill. Where children are transferred to the UK under the Dublin III regulation, the local authority in which the family members of the young person reside is responsible for undertaking family assessments to ensure the placement is suitable. If the placement is deemed to be unsuitable, separated children are typically taken into the care of the local authority, under section 20 of

the Children's Act 1989. If the placement is deemed to be suitable then the local authority will no longer be involved in the care of the separated children. Separated children joining family under the Dublin Regulation is a complex topic, outlined in more detail above.

- **Dubs amendment.** The Dubs amendment, or section 67 of the Immigration Act 2016, placed a requirement on the Secretary of State to relocate separated children to the UK from other countries in Europe. This states that transfer to the UK must be determined to be in the best interest of the child. In 2018, it was announced that children entering the UK under the Dubs amendment would receive a specific type of leave to remain in the UK, section 67 leave, and therefore are not required to apply for refugee status. Like refugee status, section 67 leave lasts for five years, and gives the holder the right to study, work, and to access public funds and healthcare. Following these 5 years separated children with section 67 leave are able to apply to settle permanently in the UK.

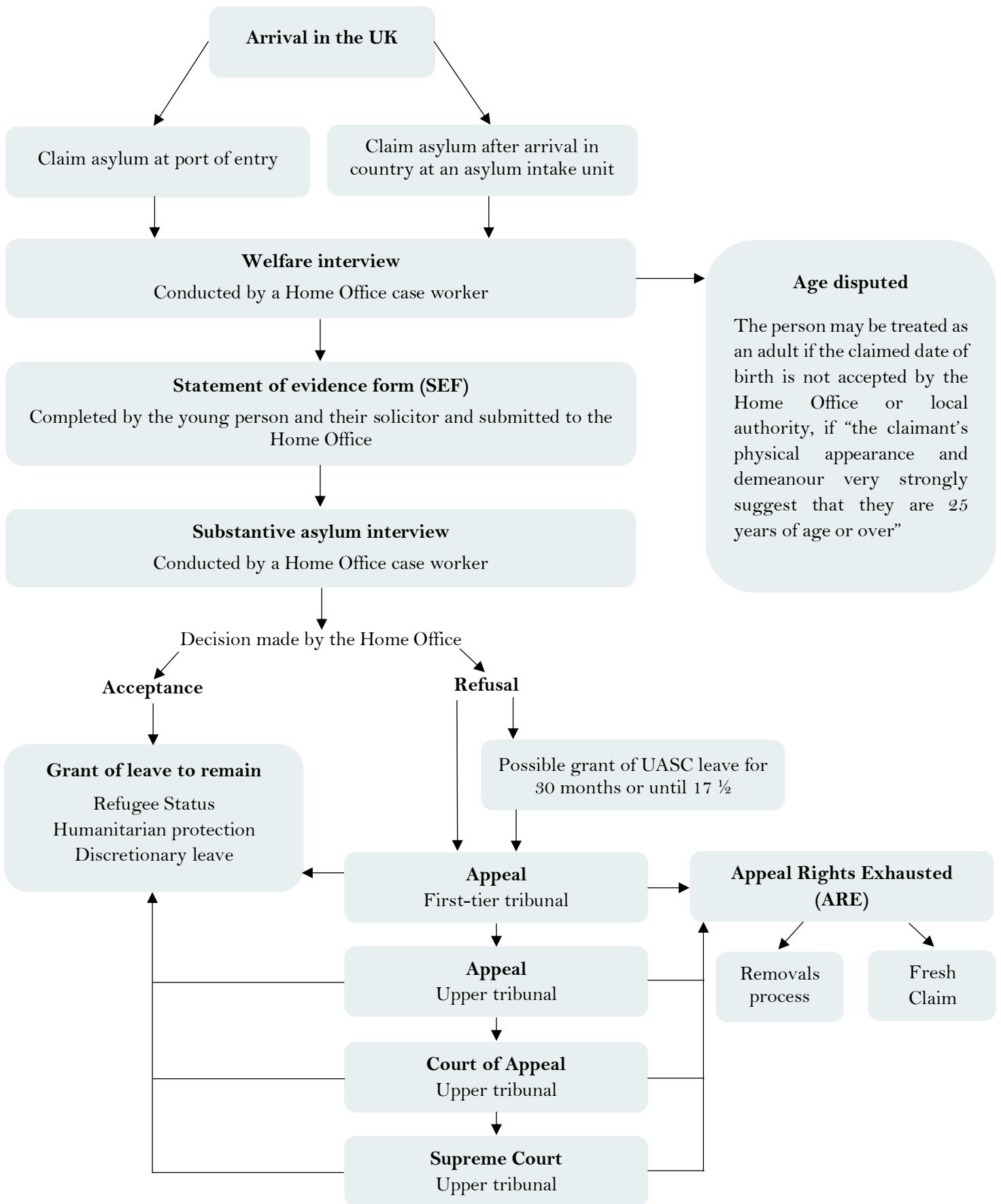
STAGES OF THE ASYLUM PROCESS

The asylum process is a significant aspect of settling in a host country. Separated children seeking refugee status are required to apply for asylum following arrival in the UK; having to contend with processes including giving a detailed testimony, an extended asylum interview, the threat of being returned to their country of origin, and prolonged periods of uncertainty while waiting for a decision. This process and the associated unpredictability and uncertainty can lead to considerable anxiety for young people.

Separated children must be well supported throughout the process of claiming asylum in the UK and should have legal representation to assist them in making their case for asylum to the Home Office. A solicitor should ideally be found to represent a child before they apply for asylum, but if this has not been possible, a solicitor should be found as soon as possible afterwards; this is a requirement for children and if the child does not have suitable legal representation, the Home Office is required to notify the Refugee Children's Panel, who will try to find representation for them. Legal representatives should have appropriate professional registration. Legal aid funding is available for legal advice and representation throughout the asylum process for separated children. More information about legal aid can be found on the [Coram Children's Legal Centre](#) website. It is the responsibility of the accommodating local authority to support the young person to access a solicitor as soon as possible after they come under their care. Young people are able to change their solicitor if there is reasonable cause to be dissatisfied, and young people should be supported to move solicitors should they wish to do so, however there are procedures to be followed for transferring legal aid representation (Coram Children's Legal Centre, 2019)

Separated children applying for asylum within the UK should also be referred to the local authority for protection and care on arrival in the UK.

At the time of writing (August 2019), the process for claiming asylum as a child under the age of 18 in the UK is as outlined in the following flowchart. The process for adults differs slightly and there are specific allowances made for children, such as funding for legal representatives to attend interviews with the Home Office and allowances within the Home Office interviews and decision-making process. UK law states that given their potential vulnerability, particular priority and care should be given to handling the asylum claims of separated children. The Home Office [guide to children's asylum claims](#) (Home Office, 2017) provides further information about these allowances. The Refugee Council's [guide to claiming asylum for separated children](#) is a visual resource to assist newly arrived separated children and care leavers in understanding the asylum process and their rights & responsibilities as looked after children and care leavers in England.



There are reported delays at all stages of the asylum process where many young people wait well over a year, sometimes over two years for a decision (Elder Rahimi Solicitors, 2018). As a result of delays, young people might turn 18 before their asylum interview, which can lead to disadvantages through losing the specific protections in place for those under 18 (Elder Rahimi Solicitors, 2018). Refusals of refugee status can occur around the time of a young person's 18th birthday, at a period of increased transition and reduction in support, creating an increased period of vulnerability and potentially leading to mental health crisis.

Delays can result when newly arrived separated children are not referred for legal advice; Home Office delays in arranging welfare and substantive interviews; delays following the substantive interview prior to any decision; delays prior to appeal hearings and delays in implementing decisions and providing young people with their Biometric Residence Permits, once granted leave to remain in the UK. Delays to the asylum process can lead to significantly increased uncertainty for young people and can negatively impact mental health (Elder Rahimi Solicitors, 2018; The Children's Society, 2011).

Insecurity and instability, often associated with the asylum process, have been cited by separated children as a significant factor impacting their mental health and wellbeing (Chase, 2013). Trauma-related mental health disorders are strongly influenced by asylum status; people who are seeking asylum are significantly more likely to suffer from PTSD and depression when compared to those who received refugee status earlier in the process (Heeren et al., 2014). A long asylum process (defined as over two years living in the host country) is a significant contributory factor for the development and maintenance of mental health difficulties and is one of the strongest predictors of reduced quality of life (Laban, Gernaat, Komproe, Schreuders, & De Jong, 2004; Laban, Komproe, Gernaat, & de Jong, 2008).

Other contributory factors for increased mental health difficulties within the asylum process include the threat of return to the country of origin and increased stress and uncertainty associated with engaging in the asylum process. However, mental health difficulties often persist beyond the asylum process and it should not be assumed that receiving refugee status or other form of leave to remain in the UK will automatically lead to an amelioration of distress or mental health symptoms.

Children and young people report finding the asylum process confusing and complex, with a number of challenges including long interviews where they are asked to describe traumatic and distressing past experiences, difficulties with trusting authorities, being met with a culture of disbelief, written information only provided in English and detailed in complex and technical language, and difficulties with interpreters, such as differing dialects (The Children's Society, 2011) which can exacerbate feelings of anxiety, fear, distress and pre-existing mental health difficulties.

ASYLUM DECISION OUTCOMES

If the asylum claim is accepted separated children will be granted refugee status, humanitarian protection or sometimes another form of leave to remain in the UK.

If the Home Office decides an individual's claim falls under grounds for protection outlined in the Refugee Convention (see 'terminology' section), the individual will be granted **refugee status**. At the time of writing, those granted refugee status are given five years leave to remain in the UK. People with refugee status have the right to work and claim benefits, access to mainstream housing, and are able to apply for a travel document. They are able to travel with the same rights as a British Citizen, however are not able to travel back to their country of origin. At the time of writing (2019), after 5 years of residing in the UK with refugee status individuals can apply for indefinite leave to remain (ILR), also known as settled status, and after 1 year of residing in the UK with ILR it is possible to apply for British Citizenship.

Humanitarian protection is granted when the conditions under the refugee convention are not met, but the person would still be at risk on returning to their home country. Those granted humanitarian protection status are also typically granted five years leave to remain in the UK. This confers similar rights to refugee status, however has different levels of recognition within international law and different implications for renewing leave to remain within the UK, travelling outside of the UK and accessing higher education.

Forms of **discretionary leave** may also be granted, which give an individual leave to remain in the UK. This might be in modern slavery or trafficking cases, for example if an asylum claim is refused or not sought, where Article 3 or Article 8 rights under the European Convention on Human Rights (ECHR) would be breached if the individual were to be removed from the UK. Article 3 states that no one should be subjected to torture or to inhuman or degrading treatment or punishment and Article 8 is the right to family and/or private life.

In the UK, separated children under the age of 17½ who have been refused refugee status or humanitarian protection are granted **UASC leave** which allows them to remain in the UK for a limited period of time, if there are no adequate reception arrangements in the country to which they would be returned. UASC leave is granted until the child turns 17½ or for 30 months, whichever is shorter. More information about UASC leave can be found on the [Coram Children's Legal Centre](#) website.

AGE ASSESSMENT

The majority of separated children arrive in the UK without documentation to prove their date of birth. Age can affect the support an individual receives from the local authority, accommodation, access to education, how their asylum claim is processed, and whether they are liable to be detained. Being disbelieved can significantly negatively impact children and young people and their ability to trust authorities.

A person will be treated as an adult if their claimed date of birth is not accepted by the Home Office or local authority and if their “physical appearance and demeanour very strongly suggest that they are 25 years of age or over” (Home Office, 2019b). Where an initial assessment by the Home Office determines that the claimant’s physical appearance and demeanour very strongly suggests that they are 25 years of age or over, the case must be referred to another officer to act as a “second pair of eyes”. Where there is uncertainty about whether the individual is an adult or child, the individual should be treated as a child and referred to a local authority, with a request for a Merton compliant age assessment; it is only local authorities who can complete age assessments (Merton compliant). Local authority age assessments should be Merton Compliant and follow recognised [best practice guidance](#) on conducting age assessments (Association of Directors of Children’s Services, 2015) and consider self-reported age. Statutory guidance states that “age assessments should only be carried out where there is significant reason to doubt that the claimant is a child. Age assessments should not be a routine part of a local authority’s assessment of unaccompanied or trafficked children” (Department for Education, 2017). This guidance also states that where a person’s age is in doubt, they must be treated as a child unless, and until, a full age assessment deems the person to be an adult. Age assessments can be challenged through judicial review.

There are a number of challenges with the age assessment process, including the impact of past experiences on a person’s perceived age, the impact of trauma on development and communication, differences in developmental stages across different ethnic groups, young people being unaware of their date of birth, and different calendars being used in different countries. Consequences of an inaccurate age assessment process include children being forced into services and accommodation for adults and lack of social care support and protection afforded for children. The route for legally

challenging this assessment is through judicial review however this may, at times, yield findings when it is too late for the young person to benefit from them. There is documented evidence that being treated as older than one's developmental age can have significant negative consequences for the mental, physical and social well-being of separated children (Derluyn & Broekaert, 2008).

THE NATIONAL TRANSFER SCHEME

The National Transfer Scheme (NTS) was introduced in 2016 and is a voluntary transfer arrangement between local authorities for the care of separated children. The aim of the NTS was to ensure that responsibility for supporting separated children did not fall disproportionately to a small number of local authorities at entry points into the UK where separated children first present. Transfer can be triggered when the number of unaccompanied asylum-seeking and refugee children under the age of 18 in a local authority reaches more than 0.07% of the area's child population. At this point, the local authority can request that the child is transferred to another local authority in the UK. This is managed through the Home Office's central administration team.

It is the local authorities' discretion whether to refer a child to the NTS and this decision should take various factors into account, primarily the best interests of the child, the views of the child, access to medical treatment, family ties, legal representation and advocacy, education, ethnic group, religion and continuity of care (Department for Education & Home Office, 2018).

Transfers should ideally take place as soon as practicable after a young person's asylum claim has been registered with the Home Office; guidance suggests that this should be within two working days (Department for Education & Home Office, 2018).

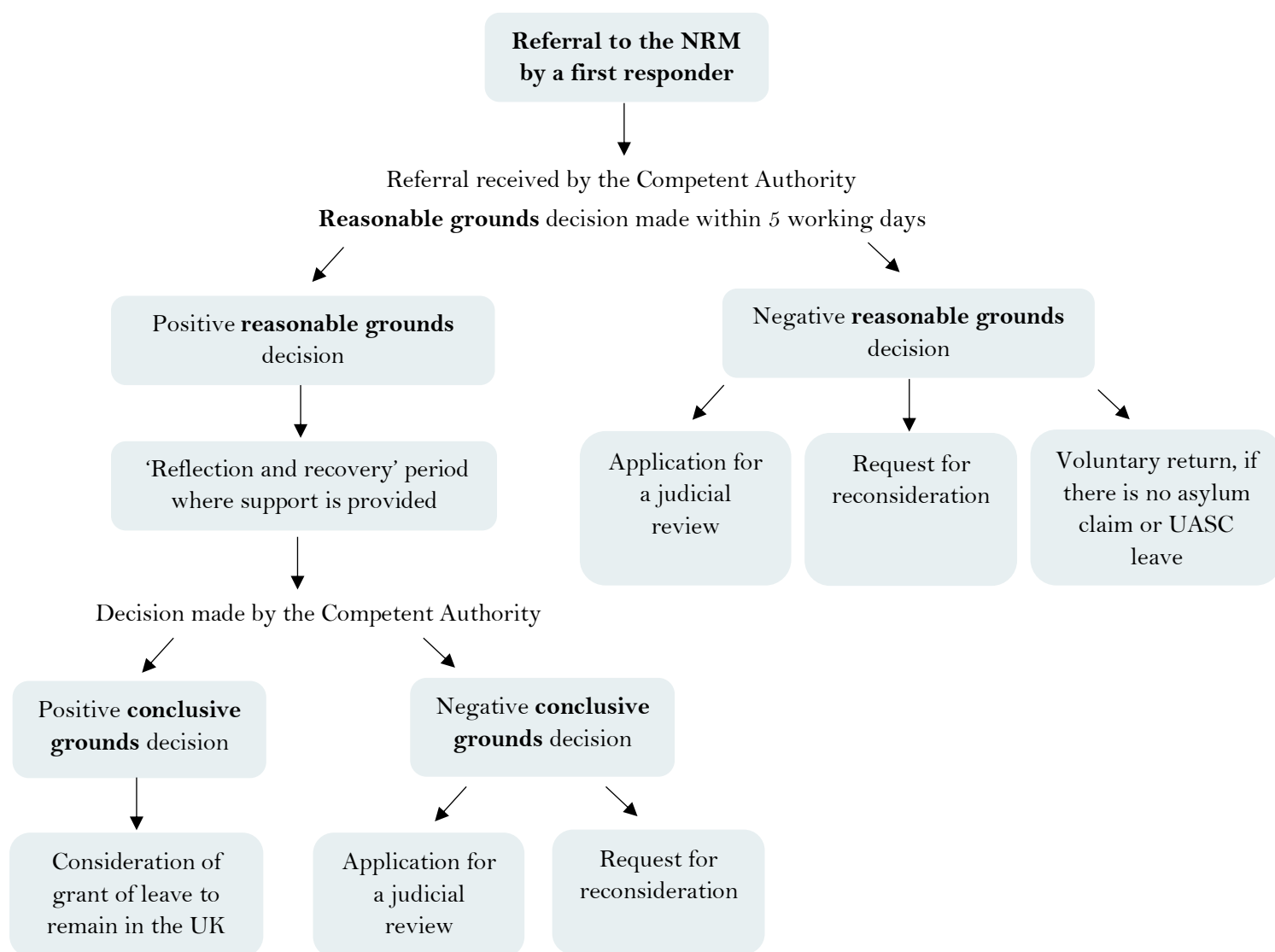
There have been various difficulties with the NTS since its inception. These include considerable delays in moving children to the new local authority, where children are not moved for weeks or months. This can be problematic as children are likely to have settled within the local authority, started to make community connections and further transfer can be distressing and unsettling for young people. Other challenges include delays in access to services and lack of available and appropriate services in some local authorities, difficulties planning treatment when receiving care within initial host locality; children and carers being inadequately informed and prepared for transfer, impact on social work practice and lack of funding for local authorities (Refugee & Migrant Children's Consortium, 2017).

THE NATIONAL REFERRAL MECHANISM

The National Referral Mechanism (NRM) is a framework for identifying and ensuring appropriate support and protection for people who are potential victims of modern slavery. The term modern slavery covers slavery, servitude and forced or compulsory labour, and human trafficking. There is a specific process for referral for children under the age of 18 and children do not need to consent to be referred into the NRM, although can withdraw consent when they turn 18. The NRM is separate to the asylum process, however where a person is also applying for asylum, in addition to being referred to the NRM, the Home Office may delay making a decision on their asylum claim until the conclusive grounds decision within the NRM is made.

Only designated first responders can refer cases to the NRM, therefore if clinical psychologists identify a young person that has potentially experienced modern slavery, timely advice should be sought from the young person's legal representative and appropriate safeguarding authorities. Local authority children's services and the police should be notified to appropriately safeguard the child.

The process within the NRM is outlined in the flowchart below. There have been documented difficulties with the timescales identified, where these are often not adhered to in practice leading to long delays within the NRM process and subsequent care planning for clients awaiting a decision.



There is no right of appeal within the NRM process however, where a negative decision is made, there can be a request for reconsideration or application for judicial review in the High Court. The time scales outlined in the flow chart above are guidelines in which the competent authority aims to make a decision however decisions, particularly the conclusive grounds decision, can often be delayed.

Individuals should have access to support following a positive reasonable grounds decision, including legal aid and access to accommodation, financial support and healthcare. Prior to the reasonable grounds decision support is not available. Separated children should be supported by local authorities under their statutory safeguarding duties throughout the NRM process. Leave to remain associated with the NRM process may have additional allowances but may be a source of ongoing uncertainty and stress, therefore appropriate legal advice should be sought.

IMMIGRATION DETENTION

Individuals who are subject to immigration control in the UK can be detained in different circumstances for various purposes, and in situations where their removal or deportation from the UK is imminent. In 2014, the Immigration Act banned the detention of unaccompanied children for more than a 24-hour period at any one time. However, children who have entered the UK may still be detained when they first arrive, for criminal cases, and during returns. Detention of children can also occur in age dispute cases.

Where separated children have been granted UASC leave, if refused refugee status, they may be vulnerable to detention and removal from the age of 17.5. It is important to remember that refusal of refugee status decisions can be legally challenged as part of the asylum process, even where UASC leave has been granted. Professionals supporting separated children can inform them of this and it may serve to protect separated children from possible detention following expiry of UASC leave.

The fear of detention and removal can serve as an additional stressor for separated children within a period of transition from child services and increased distress and psychological burden. Mental health clinicians can offer emotional support for separated children around the stress of potential repatriation and document the perceived risks of repatriation to the young person's mental health.

The Home Office identify groups of people who are unsuitable for detention, including unaccompanied minors, pregnant women, those suffering from serious medical or mental health issues which cannot be managed within detention and which may inhibit an individual's ability to cope within a detention environment, those who have post-traumatic stress disorder, those who have been tortured and have independent evidence of this, and persons identified as victims of trafficking or modern slavery (Home Office, 2018, 2019a).

Detention has been shown to have a considerable impact on the mental health of separated children. Ehntholt et al. (2018) completed mental health assessments with separated children who had been detained and reported that a diagnosis of PTSD developed in 29% and was exacerbated in 51% of unaccompanied minors, major depressive disorder developed in 23% and was exacerbated in 40%. At 3 years post-detention, 89% of separated children met criteria for psychiatric disorders and reported high levels of PTSD symptoms. There may also be additional harm caused via disruption to treatment which cannot be continued within detention, isolation from support networks and potential re-traumatisation.

THE ASYLUM PROCESS: THE ROLE FOR PROFESSIONALS

In line with the National Service Framework (NSF) for safeguarding children (Department of Health, 2004), multi-agency working is a vital component to support the welfare of separated children. Solicitors are thought to be a significant agent within unaccompanied minors' lives; part of their network in a similar manner as a school or a member of staff from children's services. It is recommended that contact information for solicitors be requested at referral or assessment, and that consent be gathered from young people to initiate contact with solicitors as part of effective care-planning for separated children.

REPORTS AND LETTERS

As children within the asylum process, separated children should be afforded additional protection within asylum interviews (Home Office, 2017). Professional opinion for young people with identified

mental health difficulties can support an interview process which is psychologically-informed and potentially less distressing for separated children.

Professional evidence can be provided at different stages of the asylum process, including before the substantive interview, following the substantive interview, before an appeal or before a decision is made by the Home Office where there is a substantial delay in processing the asylum claim.

When writing a professional letter, it is advisable to request instructions from the client's solicitor outlining the questions they would like answered. It is important to check with the solicitor or legal representative what will be helpful and appropriate for your client specifically; there may be occasions where letters will be beneficial for a specific purpose or might not be advisable for their case at that time.

A professional letter may typically comment on the client's current mental health difficulties and treatment, the psychological impact of their past or current experiences, risk profile and how their current difficulties may impact their ability to give evidence to the Home Office and engage in the asylum process at each stage.

Clinical psychologists are well placed to comment on the implications of mental health difficulties on functioning and on cognitive processes, for example memory and processing speed within PTSD, which can inform asylum interviews and decision making within the asylum process. It is helpful if clinicians use diagnostic terms in professional letters, even if this is something that the clinician would not typically use in routine practice. These are more easily understood by Home Office case workers and legal representatives. When writing about diagnoses and symptom profiles it is advisable to support this with information about how this symptom might be observed clinically and outline occasions where the clinician writing the report or other professionals have observed particular symptoms. Formulation and specific examples to illustrate an individual's current presentation can be beneficial in making reports personal to individual clients.

It is also advisable that clinicians writing professional letters document what their opinion is based on, for example clinical interview, standardised psychometric assessment tools, observation by clinicians or other professions, reading medical records, professional training, research or the evidence base. It is recommended that clinicians provide references for the sources of their information, where possible. The [Centre for the Study of Emotions and Law](#) provides peer-reviewed articles focused on mental health, psychological process and the asylum process, which may be helpful for this.

When writing professional letters, it is important that psychologists stay within their role, not testifying that past experiences reported by a client occurred and not advocating for the client to be granted leave to remain in the UK. Within providing professional evidence, it is not within the remit of a clinical psychologist to assess credibility, however clinical psychologists can discuss psychological processes such as memory, consistency of report and timing of disclosure.

Treating clinicians can provide professional evidence within a young person's asylum claim, as outlined above. Clinical psychologists may also provide expert evidence within the asylum process; in this role they would be acting as an independent clinician with a duty to the court. Medico-legal reports (MLRs) are different to professional letters and writing MLRs is a complex and specialist area. A solicitor will gain additional legal aid funding for an MLR and these should be completed by clinicians with training, expertise and experience in this field. If an MLR is requested by a solicitor, the clinician should only do this with appropriate training, experience and supervision and refer on to a more appropriate organisation should they feel this is out of their area of expertise. MLRs can have a significant impact on a person's asylum claim. Healthcare professionals may be asked to document torture and to provide physical or psychological evidence of this for the Home Office; this requires

specialist training and expertise therefore separated children should be referred to appropriate organisation or professional for this.

In addition to informing the asylum application process, clinical psychologists are well placed to contribute to best interest assessments as part of the National Transfer Scheme, as outlined above. Input and professional letters from clinicians can be provided to the local authority to comment on this process and the best interests of the child.

PSYCHOLOGICAL ASSESSMENT, FORMULATION, TREATMENT AND SUPPORT

Clinicians working with separated children can provide support in preparing for different stages of the asylum process, where these may increase anxiety and contribute to an exacerbation of mental health symptoms. These stages include the substantive asylum interview with the Home Office and any appeal hearings. Clinical psychologists are well placed to assess current concerns, develop formulations with young people and provide appropriate support and treatment in line with routine clinical practice and recommended guidelines. Support may include anxiety management, stabilisation and teaching grounding techniques, thinking about how clients can be supported prior to the interview or appeal hearing, during the interview or appeal hearing and managing any increase in symptoms following these instances.

Clinical psychologists can contribute to safety planning through facilitating sessions with the young person and professionals who will be supporting them during their interview or appeal hearing. This can help with preparation and writing out a care plan and advice for other professionals supporting young people. Examples might include information for key workers on signs of safety and risks and supporting the young person experiencing an exacerbation of symptoms or increase in anxiety or distress.

LEGAL NEEDS: RECOMMENDATIONS

- Clinical psychologists should be aware of the stages of the asylum process and stressors separated children may encounter while navigating this process.
- It is also important for clinical psychologists working with separated children to have an awareness of other processes separated children may encounter, including age assessment, the national referral mechanism and the national transfer scheme.
- It is recommended that clinical psychologists working with separated children should routinely gain consent to contact solicitors working with young people under their care, as a key component of multi-agency working and to promote effective care-planning for separated children.
- Clinical psychologists can support the legal needs of separated children through writing professional letters, ongoing psychological support and safety planning during the asylum process, and referrals for advocacy support.
- Supporting clients with their legal needs can reduce distress, preoccupation with the asylum process and barriers to engagement with formal mental health interventions.
- Mental health difficulties often persist beyond the asylum process and it should not be assumed that receiving refugee status or other form of leave to remain the UK will lead to an amelioration of distress or mental health symptoms.

TERMINOLOGY

Age-disputed child or young person: An age-disputed child is an asylum applicant whose claimed date of birth is not accepted by the Home Office and/or by the local authority who have been approached to provide support. This term is usually used to refer to people who claim to be children, but who are treated as adults by the Home Office and/or the local authority. Whether an individual is treated as an adult or as a child has serious implications for the way in which the person's claim for asylum is treated, and the support received (Refugee Council, 2013).

Application Registration Card (ARC): individuals who have claimed asylum in the UK should receive this card to confirm that they have made an application for asylum. It is also used as evidence of identity and holds identifying information in a microchip within the card. It includes the name of the asylum applicant, date of birth, nationality, the place and date of issue, information regarding dependents, the language spoken and whether the holder is entitled to work or study. NB: ARC cards are no longer routinely issued if lost, therefore if an individual does not have an ARC card this does not mean that they have not claimed asylum in the UK.

Asylum-seeker: In the UK, an asylum-seeker is someone who has lodged an application for protection on the basis of the Refugee Convention or Article 3 of the European Convention on Human Rights (ECHR), which prohibits torture or inhuman or degrading treatment or punishment and prohibits the return of a person to a country where they may suffer a violation of their rights under Article 3 (Refugee Council, 2013).

Competent authority: this is a designated decision maker under the NRM; in the UK there are two competent authorities, the National Crime Agency and the Home Office. The National Crime Agency typically makes decisions regarding British and European Economic Area (EEA) citizens and the Home Office typically makes decisions where the trafficking decision may affect their immigration status.

Conclusive grounds decision: this is where the competent authority determines that, on the balance of probabilities, the person is a victim of modern slavery.

First responders are specified statutory authorities and non-governmental organisations who have a responsibility to identify potential victims of modern slavery and refer cases to the competent authority. Referrals into the NRM can only come from first responders.

Humanitarian protection: Humanitarian protection is a form of immigration status. It is granted by the Home Office to a person who it decides has a need for protection because there is a serious risk that their basic rights would be breached. It is granted for five years in the first instance.

Looked-after child (LAC): A looked after child is a child who is in the care of a local authority under either a protection order, or a voluntary arrangement with their parent or guardian. Looked-after children are accommodated by a local authority, typically under section 20 of the Children's Act 1989. They can be living with foster parents or at home with parents, but supervised through a local authority children's social care team, in a children's residential home, or any other residential unit. Separated children are usually looked after by the local authority and can be living in a range of settings (Children's Society, 2018).

Modern slavery: The Home Office states that modern slavery 'is a complex crime that takes a number of different forms. It encompasses slavery, servitude, forced and compulsory labour and human trafficking.' The UK government passed the Modern Slavery Act in 2015.

National Referral Mechanism (NRM): The NRM is a framework for identifying victims of human trafficking and ensuring they receive the appropriate support. Authorised agencies, such as the police, the Home Office, social services and certain NGOs, who encounter a potential victim of human trafficking refer them to the NRM. This initial referrer is known as the ‘first responder’.

National Transfer Scheme (NTS): The NTS is a voluntary transfer arrangement between local authorities in relation to the care of unaccompanied asylum-seeking minors. Transfer to a different local authority can be triggered when the number of unaccompanied asylum-seeking and refugee children under the age of 18 in a local authority reaches more than 0.07% of the area’s child population. At this point, the local authority can request that the child is transferred to another local authority in the UK. This is managed through the Home Office’s central administration team.

Reasonable grounds decision: this is a decision from the competent authority that there are reasonable grounds to believe that the person is a victim of modern trafficking (i.e. that someone is a potential victim but this cannot be proven at this stage).

Refugee: under international law, a refugee is a person who “owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it.” (United Nations (UN) Convention Relating to the Status of Refugees 1951 and the 1967 Protocol; together referred to as the Refugee Convention).

Refugee status: In the UK, refugee status is granted to someone the Home Office recognises as a refugee as described in the Refugee Convention. In the UK, a person given refugee status is normally granted leave to remain in the UK for 5 years, and at the end of that period can apply for Indefinite Leave to Remain, or settled status (Refugee Council, 2013).

Separated child: Separated children are children under 18 years of age who are outside their country of origin and separated from both parents, or previous/legal customary care giver. Separated children are typically asylum seekers, but not in every case (Refugee Council, 2013).

Trafficking: human trafficking is the “recruitment, transportation, transfer, harbouring or receipt of persons by means of threat, or use of force, coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation can include different forms of sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude or the removal of organs. The recruitment, transportation, transfer, harbouring or receipt of a child for the purpose of exploitation shall be considered "trafficking in persons" even if this does not involve any of the means set forth.” [UN Protocol to Prevent, Suppress and Punish trafficking persons (‘Palermo Protocol’)].

Unaccompanied asylum-seeking minor (UAM), Unaccompanied asylum-seeking child (UASC): UAM or UASC are children and young people under the age of 18 who are outside their country of origin, separated from both parents, are not being cared for by an adult who by law or custom has responsibility to do so, and who have applied for asylum in their own right (Home Office, 2016a). The term **unaccompanied refugee minor (URM)** is typically used to refer to separated children, UAM / UASC who have been granted refugee status.

KEY REPORTS AND RESOURCES

RESOURCES

Asylum Aid: [Going to Appeal](#). Asylum Aid have produced a video outlining the appeals process and rights and entitlements within this process.

Coram Children's Legal Centre [resources and fact sheets](#) relating to legal issues affecting young refugees and asylum-seekers.

Department of Psychiatry, University of Oxford (2019), [series of podcasts on mental health interventions for refugee children](#)

Migrant and Refugee Children's Legal Unit '[Who is who?](#)' guides are guides to help young refugees understand the different professionals they might encounter, the jobs they do, and how they can help. The guide is translated into various different languages.

The [Right to Remain Toolkit](#) is an online resource providing a comprehensive overview of the legal system and procedures, with detailed information about rights and options at each stage. Sections of the toolkit have been translated into languages commonly spoken by separated children.

The Rees Centre, University of Oxford, series of [blogs on unaccompanied refugee children](#).

REPORTS

TRAFFICKING

- Witkin and Robjant (2018). [Trauma-Informed Code of Conduct for all Professionals working with Survivors of Human Trafficking and Slavery](#). London, UK: Helen Bamber Foundation. It is recommended that anyone working with survivors of trafficking are familiar with this guide as it includes comprehensive guidance on trauma-informed ways of working with survivors of human trafficking and modern slavery.
- Royal College of Nursing, [Modern Slavery Wheel](#). This is a tool identify potential signs of trafficking and give advice about following up on concerns.
- London Safeguarding Children Board (2011), [Safeguarding Trafficked Children Toolkit](#). This document details tools to assist in the identification and assessment of trafficked children and information and guidance for professionals working with children who may have been trafficked. This document is likely to be particularly relevant for clinical psychologists working with separated children who may have been trafficked.
- Human Trafficking Foundation (2018). [The Slavery and Trafficking Survivor Care Standards](#).
- HM Government (2011), [Safeguarding children who may have been trafficked](#). This document includes detailed practice guidance and comprehensive information about child trafficking and outlines the roles of specific agencies and services and actions for services, including advice about identifying trafficked children.
- Department for Education (2017), [Care of unaccompanied migrant children and child victims of modern slavery: statutory guidance for local authorities](#). This document outlines the responsibilities of local authorities, information about modern slavery and legal processes, and guidance on assessment and support for children and young people.

LEGAL NEEDS

GENERAL

- Coram Children’s Legal Centre (2017): [Seeking Support: a guide to the rights and entitlements of separated children](#). This document provides comprehensive guidance on working with separated children, including information about the asylum process, legal representation and support for separated children. Further advice and guidance can be found on the Coram Children’s Legal Centre [website](#).
- The [Migrant and Refugee Children’s Legal Unit](#) is a specialist legal and policy centre providing legal representation, advice, guidance, resources and training.
- [Child Law advice](#) are a charity providing specialist advice and information on child, family and education law.
- ECPAT UK provide a comprehensive list of key statutory guidance and strategy on safeguarding unaccompanied asylum seeking and refugee children and child survivors of modern slavery. This list can be accessed on their website www.ecpat.org.uk/guidance-england.

ASYLUM PROCESS

- Home Office (2017): [guide to children’s asylum claims](#).
- Refugee Council: [guide to claiming asylum in the UK for separated children](#). This is a guide for separated children and care leavers to help understand that asylum process and their rights & responsibilities as looked after children and care leavers in England.
- Elder Rahimi Solicitors (2018): [Systemic delays in the processing of the claims for asylum made in the UK by unaccompanied asylum-seeking children \(UASC\)](#).
- Coram Children's Legal Centre (2017e): [Seeking Support: a guide to the rights and entitlements of separated children](#).
- Coram Children's Legal Centre (2017b): [Claiming asylum as a child](#).
- Children’s Society (2011). [Into the unknown: Children’s journey’s through the asylum process](#).
- Asylum Aid: [Going to Appeal](#). Asylum Aid have produced a video outlining the appeals process and rights and entitlements within this process.
- The [Right to Remain Toolkit](#) is an online resource providing a comprehensive overview of the legal system and procedures, with detailed information about rights and options at each stage. Sections of the toolkit have been translated into languages commonly spoken by separated children.

AGE ASSESSMENT

- Association of Directors of Children’s Services (2015): [age assessment guidance](#).
- Home Office (2019b): [assessing age](#).
- Refugee Council (2019b). [Age Disputed Young People in the Asylum System: Policy Briefing](#).
- Coram Children's Legal Centre (2017a): [the age assessment process](#).

NATIONAL TRANSFER SCHEME

- Department for Education & Home Office (2018): [National Transfer Scheme Protocol for Unaccompanied Asylum-Seeking Children](#).
- Refugee & Migrant Children's Consortium (2017): [Briefing on the National Transfer Scheme](#).

NATIONAL REFERRAL MECHANISM

- Home Office (2016b): [National Referral Mechanism: guidance for child first responders](#).
- Every Child Protected Against Trafficking (ECPAT): [National Referral Mechanism](#).
- Coram Children's Legal Centre (2017d): [The National Referral Mechanism](#).
- NSPCC: [National Referral Mechanism – How the NRM works to identify and support victims of human trafficking](#).

SOCIAL CARE AND SAFEGUARDING NEEDS

- Coram Children's Legal Centre (2017c). [Local authority support for unaccompanied asylum-seeking children](#).
- Department for Education (2017): [Care of unaccompanied migrant children and child victims of modern slavery](#).
- Department for Education & Home Office (2017): [Safeguarding Strategy: Unaccompanied asylum-seeking and refugee children](#).
- All Wales Child Protection Procedures Review Group (2011): [Safeguarding and Promoting the Welfare of Unaccompanied Asylum Seeking Children and Young People](#). This practice guidance is designed for all professionals working with separated children and highlights that the underpinning principle is **child first, migrant second** and that all children should receive rights to protection, provision and participation, regardless of their immigration status.
- National Institute for Health and Care Excellence (2010): [Looked-after children and young people](#).

MENTAL HEALTH NEEDS

- British Psychological Society (2017). [Working with interpreters: Guidelines for psychologists](#).
- British Psychological Society (2018). [Guidelines for psychologists working with refugees and asylum seekers in the UK: Extended version](#).
- Children's Society (2018). [Distress signals - Unaccompanied young people's struggle for mental health care](#).
- UNHCR (2018). [A journey towards safety: A report on the experiences of Eritrean refugees in the UK](#).

EXPERIENCES OF URM AND IMPROVING PRACTICE

- UNHCR (2019). [Destination anywhere: The profile and protection situation of unaccompanied and separated children and the circumstances which lead them to seek refuge in the UK](#). This report presents the findings of research into the profile and protection situation of unaccompanied and separated children and the circumstances that lead them to

seek refuge in the UK. It includes a number of recommendations for how the UK government can improve the management and protection of unaccompanied and separated children arriving to the UK to seek asylum, both on and prior to arrival.

- UNHCR (2019). ["A refugee and then...": Participatory assessment of the reception and early integration of unaccompanied refugee children in the UK](#). This report presents first-hand accounts of young refugees and asylum-seekers and those who support them across the UK, to discuss the path from arrival to early integration in British society.
- UNHCR (2019). [Putting the child at the centre: an analysis of the application of the best interests principle for unaccompanied and separated children in the UK](#). This report provides proposals for how the best interests principle for unaccompanied and separated children could be strengthened and implemented comprehensively within and across UK systems and procedures.
- UNHCR (2017). [The Way Forward to Strengthened Policies and Practices for Unaccompanied and Separated children in Europe](#). This report includes recommendations for responses to better protect unaccompanied refugee children in Europe.

CULTURAL ADAPTATIONS

There is a growing evidence base on cultural adaptations of existing evidence-based interventions. The recently published IAPT black and minority ethnic (BME) service user positive practice guide includes extensive information on culturally adapted and responsive therapy and services (Beck et al., 2019). There are a number of publications in the literature regarding culturally adapted therapy, however the recently published special issue of the *Cognitive Behaviour Therapist* on cultural adaptations of CBT (2019) is a good starting point and includes a number of helpful papers to guide clinicians in understanding and developing appropriate adaptations. This can be accessed via the [Cambridge Core website](#).

Rathod et al. (2019) and Naeem et al. (2016) provide helpful frameworks for adapting CBT. Examples of culturally adapted therapies include behavioural activation for treating depression in Muslim communities (Mir et al., 2019; Mir et al., 2015); further information about this and translated manuals can be found on the [University of Leeds website](#).

PTSD SCREENING MEASURES FOR CHILDREN AND YOUNG PEOPLE

There are a number of existing measures for PTSD in children, itemised by [Trickey and Meiser-Stedman \(2018\)](#) and discussed in detail by Smith et al. (2018). The more widely used measures of PTSD are as follows:

CHILD REVISED IMPACT OF EVENTS SCALE

The Child Revised Impact of Events Scale (CRIES; (Perrin et al., 2005) is a self-report measure designed to screen children and young people at risk for PTSD. It is designed for use with children and young people aged 8 and above. There is an 8-item and 13-item version; the 8-item version screens for intrusion and avoidance symptoms of PTSD and the 13-item version has 5 additional items to screen for arousal symptoms. The CRIES is translated into a number of languages spoken by separated children and is freely available on the [Children and War Foundation website](#).

Salari, Malekian, Linck, Kristiansson, and Sarkadi (2017) identified that the CRIES is feasible for use within routine practice with separated children and noted that 76% of separated children participants scored above the clinical cut-off for PTSD symptoms.

CHILD TRAUMA SCREENING QUESTIONNAIRE

The child trauma screening questionnaire (CTSQ; (Kenardy et al., 2006) is a 10-item self-report measure designed to screen for and identify children and adolescents at risk of developing PTSD. This was developed from the adult trauma screening questionnaire (Brewin et al., 2002) and has been designed for use with children aged 7-16. The CTSQ assesses for re-experiencing and hyper-arousal symptoms. This measure is freely available from the authors or can be accessed via the [Children and War Foundation](#) website.

CHILD AND ADOLESCENT TRAUMA SCREEN

The Child and Adolescent Trauma Screen (CATS; (Sachser, Berliner, et al., 2017) is a measure designed to assess for PTSD symptoms in line with DSM-5 criteria and to monitor symptom change during treatment. The CATS includes a trauma exposure screen and a 25-item self-report questionnaire measuring DSM-5 PTSD symptoms. The CATS includes both self-report and caregiver-report versions and is translated into a number of languages spoken by separated children. The self-report version is designed for use in children aged 7 and above and the caregiver version is designed for use in children aged 3 and above.

The CATS is freely available on the authors website, [Ulmer Onlineklinik](#). Scoring sheets are also available on this website.

CHILD PTSD SYMPTOM SCALE

The Child PTSD Symptom Scale (CPSS-5; (Foa et al., 2018) is also designed for use assessing PTSD symptoms in line with DSM-5 criteria and to monitor treatment outcomes. The CPSS-5 includes a trauma exposure screen and a 27-item self-report questionnaire measuring DSM-5 PTSD symptoms. The CPSS-5 has been adapted to include an interview version, which can be particularly useful as part of a clinical interview when assessing for PTSD with an interpreter. In addition, there is a 6-item screening version of the CPSS-5, which can be helpful as an initial screening tool as part of a broad mental health assessment. The CPSS-5 is designed for use in children aged 8 and above. The CPSS-5 is freely available from the authors.

ORGANISATIONS

Asylum Aid	www.asylumaid.org.uk
The Bike Project	https://thebikeproject.co.uk
Breaking Barriers	http://breaking-barriers.co.uk
Centre of the Study of Emotions and Law	http://pc.rhul.ac.uk/sites/csel/
Child Outcomes Research Consortium	www.corc.uk.net/outcome-experience-measures
Children's Society	www.childrenssociety.org.uk
Children and War Foundation	www.childrenandwar.org
Child Law Advice	https://childlawadvice.co.uk
City of Sanctuary	www.cityofsanctuary.org
Coram Children's Legal Centre	www.childrenslegalcentre.com
Coram Voice (advocacy)	https://coramvoice.org.uk
Every Child Protected Against Trafficking (ECPAT)	www.ecpat.org.uk
Foundation 63	www.foundation63.org
Freedom from Torture	www.freedomfromtorture.org
Helen Bamber Foundation	www.helenbamber.org
Hope for the Young	https://hopefortheyoung.org.uk
Just for Kid's Law	www.justforkidslaw.org
Law Centres Network	www.lawcentres.org.uk
Medical Justice	www.medicaljustice.org.uk
Migrant & Refugee Children's Legal Unit	https://miclu.org
Modern Slavery Helpline	www.modernslaveryhelpline.org
My Bright Kite	www.mybrightkite.org
NSPCC Child Trafficking Advice Centre	https://learning.nspcc.org.uk/services/child-trafficking-advice-centre
Red Cross Family Tracing Service	www.redcross.org.uk/get-help/find-missing-family www.icrc.org/en/document/trace-face-people-looking-missing-migrants-europe
RefuAid	www.refuaid.org
Refugee & Migrant Children's Consortium	http://refugeechildrenconsortium.org.uk
Refugee Council – Children's Section	www.refugeecouncil.org.uk/what-we-do/childrens-services
Refugee Council – Refugee Community Organisations	www.refugeecouncil.org.uk/what-we-do/supporting-refugee-community-organisations

Refugee Support Network	www.refugeesupportnetwork.org
Right to Remain	www.righttoremain.org.uk/toolkit/index.html
Rights for Children	https://rights4children.org.uk
Safe Passage	www.safepassage.org.uk
South London Refugee Association	www.slr-a.org.uk
Tarjimly (translation app)	www.tarjim.ly/en
The Entrepreneurial Refugee Network (TERN)	www.wearetern.org
The Voice Collective	www.voicecollective.co.uk
Young Roots	http://youngroots.org.uk

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