

Unaccompanied Asylum-Seeking Children and Care Leavers (UASC) experiences of Human Rights Violations within Libya's Detention Centre's:

A Clinical Audit on the Implications of Human Rights Violations on the Mental Health Needs and Risks of UASC referred to Child & Adolescent Mental Health Specialist Services (CAMHSS) in Surrey for Multi-Agencies after arrival in the UK

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For a better life

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Introduction

This Clinical Audit was implemented due to the multiple disclosures of Human Rights Violations shared by Unaccompanied Asylum-Seeking Children and Care Leavers (UASC) that arrived in the Surrey, UK having travelled via Libya's Detention Centre's that had been referred to the UASC Specialist Mental Health Practitioner in Surrey Child and Adolescent Mental Health Specialist Services (CAMHSS).

Due to the high levels of distress and associated mental health risks, a clinical audit was carried out on these International Safeguarding Disclosures and the associated implications on UASC mental health needs and risks that had travelled via Libya's Detention Centre's.

The data in this audit has been collated between the 1st November 2017 and 31st October 2019. Since the collation of data for this audit, further multiple disclosures of the Human Rights Violations that UASC have been subjected to in Libya's Detention Centre's have been received from those referred to Surrey CAMHSS. This likely increases the percentages in the data detailed, however is not included due to falling outside the time frame of this audit.

The abbreviation UASC has been used throughout this document to refer to both Unaccompanied Asylum Seeking Children and Care Leavers from which the data and information was collated. However, to ensure the humanity of these children's stories are not lost in terminology they are also referred to as Unaccompanied Children, Minors or Young People.

Background

CAMHSS in Surrey has a specific UASC Specialist Mental Health Practitioner post that straddles both CAMHS Children in Care and CAMHS Care Leavers Teams. UASC referrals were taken from across both services by the post holder; however the majority of UASC referred to CAMHSS were under the Looked After Children's Team in Local Authority Children's Services.

This role was initially funded for two years and extended for a further year. The post outreached into three clinics across the Trust to make the service more accessible for UASC clients, at times also outreaching into housing placements and GP surgeries. The role also carried a remit of providing a service to UASC clients within a 20 mile radius of the Surrey border; therefore clients would also travel in to these clinics to access CAMHSS from outside areas such as London.

Context of the Review

During the period of 1st November 2017 and 31st October 2019, CAMHSS received in total 55 referrals for UASC that had travelled from various areas of the world, 25% of UASC referred disclosed having travelled via Libya. The referrals came from a variety of sources such as Social Workers, Personal Advisors, GP's, Paediatrician's, Looked After Children Nurses and Housing Workers. Of these referrals;

- 20 UASC - referred had travelled from Africa (countries such as Eritrea, Ethiopia and Sudan)
- 16 UASC - assessed by CAMHSS had travelled through Northern Africa
- 14 UASC - assessed by CAMHSS disclosed having travelled via Libya
- 9 UASC - assessed by CAMHSS disclosed they had been detained in Libya
- 4 UASC - at the time of collating data four were awaiting assessment by CAMHSS

Countries of origin of those held in Libya's Detention Centre's;

- 5 UASC – Eritrea
- 2 UASC – Ethiopia
- 2 UASC – Sudan

Data Collated

The following data has been taken from the fourteen UASC (25%) that CAMHSS assessed that had disclosed travelling via Libya. All assessed were offered therapeutic intervention due to their trauma symptomology and associated risks. The information in this review has been collated by either direct disclosure from the young person during assessment, therapeutic intervention and from referral information received by CAMHSS.

Of the fourteen UASC that had disclosed travelling via Libya, nine UASC (64%) disclosed having been detained against their will in detention centre's and buildings in Libya. This was with other child and adult, asylum seekers, refugees and/or migrants.

Some UASC shared that they were initially detained in Libya with their adult relatives with whom they had fled their countries of origin with. However, they were later abruptly and forcibly separated from their relatives once detained. Subsequently, they had lost contact with these relatives who may have remained detained in Libya. Those that had lost contact with their relatives maintained great anxiety and fear for their relative's safety, and whether they were alive or dead. Some feared the guards might have killed them or that they continued to be abused by guards in the detention centre's. Others feared that if their relatives had escaped they may have died on route, for example drowned in the Mediterranean. This unknown fate of family members continued to impact on their distress levels and how they coped after arrival in the UK.

These abrupt separations left Unaccompanied Children to continue their journey without an accompanying adult that they knew. Many travelled to the UK with other Unaccompanied Children with whom they formed strong kinship ties, looked after each other and now viewed these travel companions as substitute family (UASC Health, 2020), thus indicating the strength and importance of some of these friendships to their emotional well-being and sense of safety.

International Safeguarding Disclosures on Human Rights Violations towards UASC in Libya's Detention Centre's

Themes presenting

The following two charts outline disclosures of the Human Rights Violations Unaccompanied Children were subjected to whilst held in Libya Detention Centre's. These Unaccompanied Children directly experienced and / or witnessed these abuses over a sustain period of time and for the duration of their detention;

1. Human Rights Violations and Deprivations directly experienced by UASC detained in Libya's Detention Centre's
2. Human Rights Violations and Deprivation witnessed by UASC whilst detained in Libya's Detention Centre's

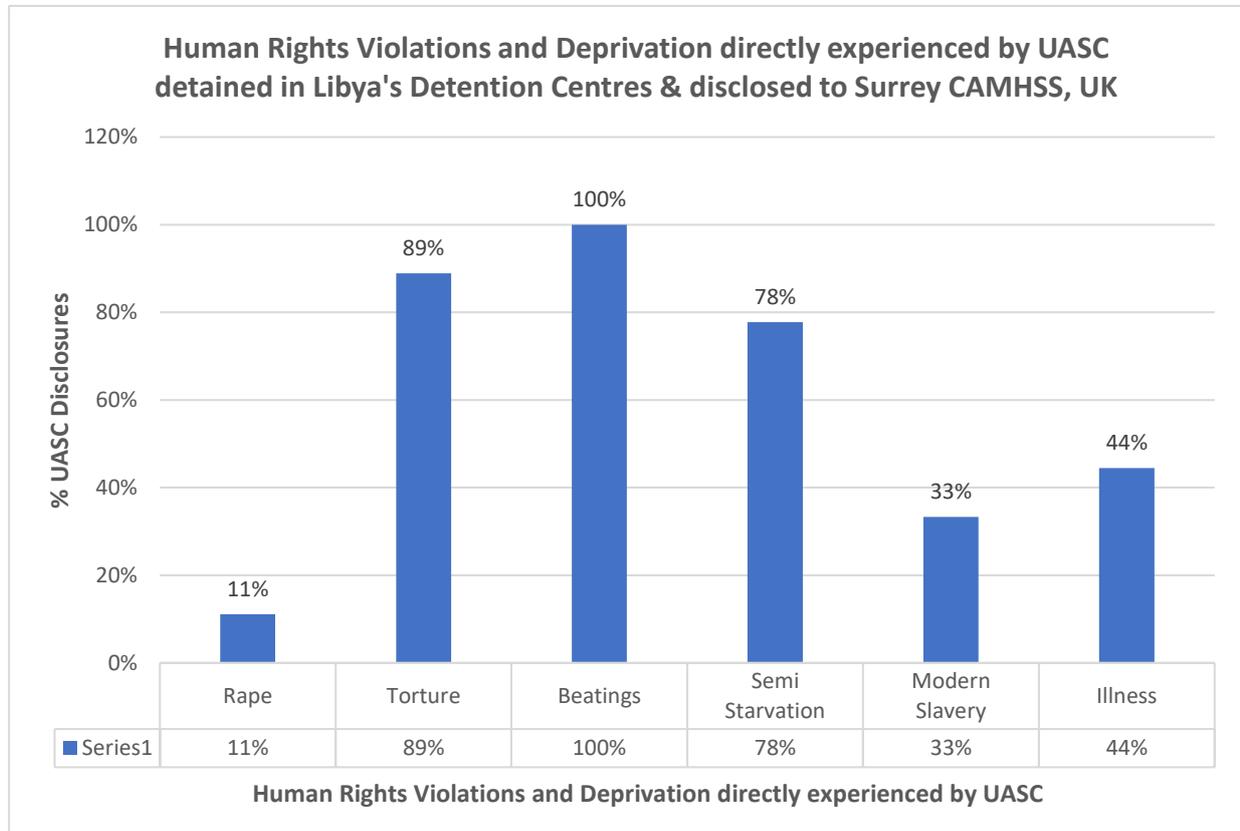


Chart 1

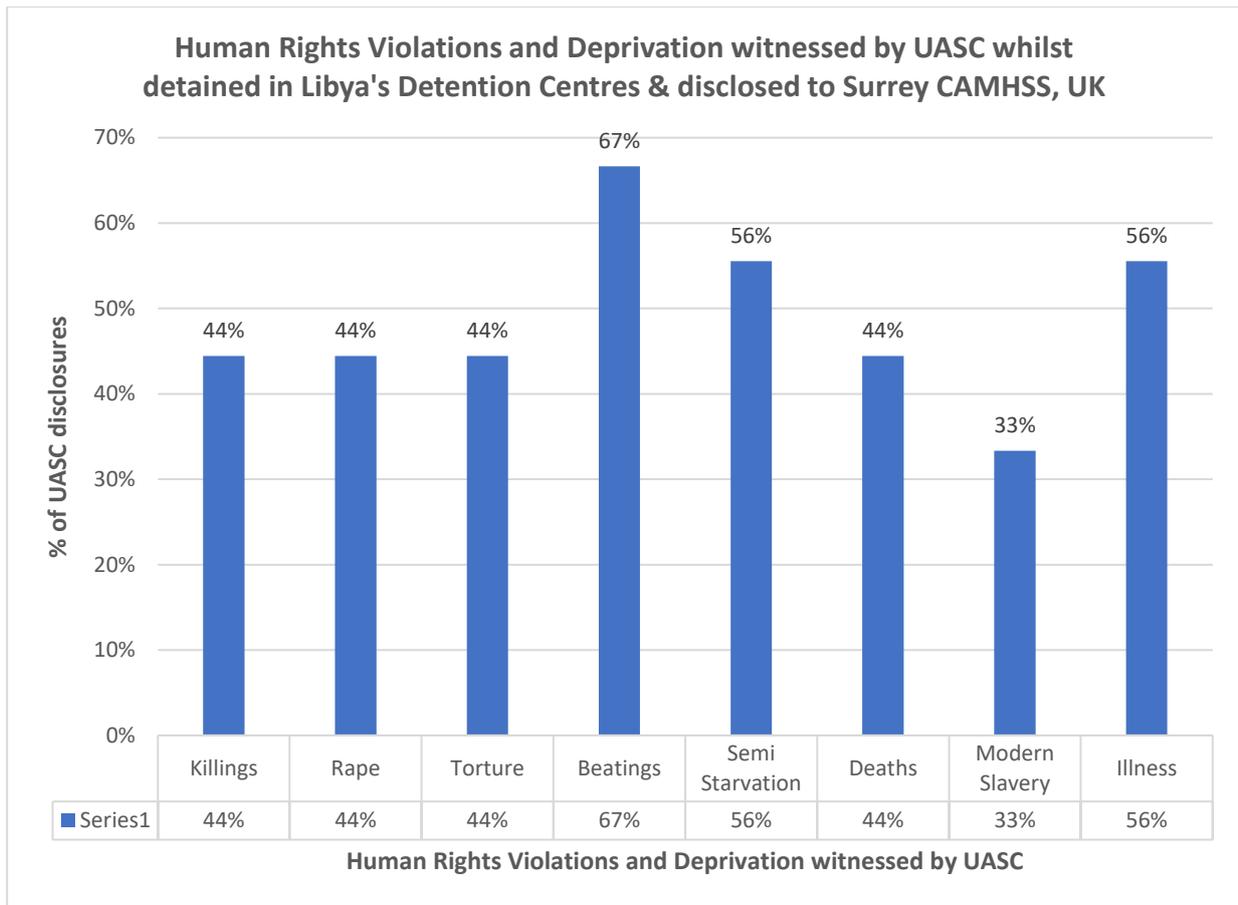


Chart 2

Due to the impact trauma has on the ability of a traumatized person to verbalise their traumatic experiences (Cozolino, 2002), we might presume that many of these percentages are higher than that disclosed to CAMHSS by Unaccompanied Children.

Descriptions of these Detention Centre’s in Libya shared with CAMHSS.

- One UASC described being held in a place that looked like a large “airplane hangar” that held approximately 600 to 700 children and adults “like us”
- Another UASC described being held in a “large warehouse”
- Another UASC described a large building holding approximately 450 “people like me”, “children and adults” crammed into “lots of small rooms” (with each room described as approximately 2.5m x 2.5m holding approximately 25 children and adults in each).
- Another UASC described how he was moved between three different detention centres and then sold into slavery by the guards.
- Some UASC were held in what was described as “large houses” where they were kept tied up in the dark.
- Some UASC had been detained for up to two years.

UASC Descriptions of Experiences inside Libya's Detention Centres

- *"People from different countries were held in there. We were beaten daily. Some were tortured and beaten to death. It was disorganised and hectic. You were just lucky if you lived"*
- *"We were all starved and not given enough food to eat, often for days at a time. The guards would then throw a piece of bread into the group [of detained men and children], just to watch us fight for it"*
- *"I was tortured several times a week. I was tied up and hung upside down and beaten on the soles of my feet"*
- *"I was sold by the guards and made to work carrying metal in a mine". "The guards would beat us [other children subjected to enforced labour] and shoot at us over our heads to scare us into working". "New children were arriving every day"*
- *"I was tortured each day. My hands and feet were tied together and I was beaten across my back and on the bottom of my feet" [sustaining on going injuries as a result]*
- *"It was so painful, I can remember the pain like it's happening now" [on being beaten with plastic wires each day]*
- *"I was beaten on the back with the butts of rifles and pistols" [sustaining ongoing injuries as a result]*
- *"I saw a pregnant girl being beaten with a rifle"*
- *"I was not allowed to go to the toilet and did not have enough food to eat"*
- *"They made me lay on the ground with other men. We were beaten across the back and legs with [what was described as] a plastic tube", "I don't know why they did this to me, I didn't do anything wrong"*
- *"I was raped most nights by a group of guards. I was burnt with hot wires if I refused to have sex".*
- *"We were held in a dark room for months", "I was very ill, they tied my hands and ankles with rope", "they came and took the other girls each night and raped them"*

These children and young people continued to relive these intrusive trauma memories in their daily lives long after arrival in the UK.

UASC Resulting Beliefs Systems

- *“you were just lucky to survive”*
- *“I lived in daily fear that I would be killed tomorrow”*
- *“I can remember the pain like it’s happening now”*
- *“I don’t know why they did this to me, I didn’t do anything wrong”*
- *‘I’m lucky, I’m not disabled like the others that were tortured”*
- *“I can hear now the screams of people being caned”*
- *“we were treated like goods, not human beings”*

The duration and acuteness of their traumatic experiences resulted in many developing belief systems such as these, reliving the horror of their past in the present day.

Themes of the UASC Journey

Crossing the Sudanese / Libyan Desert.

Four UASC also described to CAMHSS highly traumatic journeys involving Human Rights Violations by traffickers when on route to Libya through the Sudanese desert. This encompassed seeing companions, both children and adults, being shot, beaten into submission and beaten to death by traffickers. In addition, witnessing other asylum seekers die from illness and “weakness” in the desert or in the back of trucks, being abandoned to die in the desert by traffickers and not having enough to eat or drink.

Crossing the Mediterranean and the Channel

Six UASC shared that they had witnessed family members, friends and/or travel companions drown in the Mediterranean Sea when their boats capsized on route to Europe. Describing experiencing flashbacks, intrusive trauma memories and associated trauma symptoms when these traumatic experiences were triggered especially when near water or the sea once in the UK.

Other UASC described traumatic experiences of having been locked in with others in the back of trucks, some refrigerated, for long periods of time when crossing the Channel. Some UASC shared their fear of not knowing whether they would survive this part of their journey, or if travel companions, families, children, babies, men and women, had died in the container with them on route.

Sexual Exploitation

Other young people have either disclosed or indicated that they have been sexually assaulted or exploited on route either by traffickers, guards in Libya’s Detention Centre’s, or on reaching Europe where the majority have had to sleep rough, or in camps such as Calais and Dunkirk. The abuses and risks prevalent in these camps that UASC are exposed to are well documented (UNICEF, 2016)

Semi Starvation

Many UASC shared their experiences of not having enough food to eat, one describing drinking sugar and water to survive in the detention centre. Another UASC described detainees in Libya not receiving food for several days at a time. Guards would then play games by throwing one piece of bread into a group of hungry children and adults to watch them fight for the food. Others described food not being readily available on their journey, eating grass and begging for food from locals in Europe. For many this was not considered as an issue in the context of their experiences and they had internalized lack of food as a “normal” way of being after arriving in the UK.

Time travelling from country of origin to UK

This varied from 3-4 months to up to 4 years and appears to be largely dependent on how long Unaccompanied Children were held captive in Libya's Detention Centres. Detention times varying from several months to several years.

One shared how they were sold into slavery to work in mines in Libya, others shared how they were moved around different Detention Centres and made to work. Once in Europe UASC described sleeping rough in cities and in camps along the French coast such as Calais and Dunkirk for several months to a few years where lack of food, medication and abuse continued.

Some UASC shared that they had left their country of origin as pre-adolescents, one as young as 10 years old.

Eferm: A Child's Story

This case study, based on a factious child who will be called Eferm, is developed from a collation of commonly shared experiences and stories via disclosures, articles and documentaries of the Unaccompanied Children arriving via Libya's Detention Centres, rather than any one particular child seen by CAMHSS.

Eferm

Eferm fled Eritrea with his older sister. This was to avoid lifelong servitude in the Eritrean military, defined by the United Nations in 2015;

"Indeed, the indefinite duration of national service, its terrible conditions — including arbitrary detention, torture, sexual torture, forced labour, absence of leave and the ludicrous pay — and the implications it has for the possibility of any individual to found a family, conduct a family life and have favourable conditions of work make national service an institution where slavery-like practices are routine."

(UNHRC, Report of the Commission of Inquiry on Human Rights in Eritrea (2015: 13)
<https://www.ohchr.org/EN/HRBodies/HRC/ColEritrea/Pages/ReportColEritrea.aspx> accessed 11.5.2020)

Eferm travelled for four years before he arrived in the UK as a 16 years old boy, having left Eritrea at 12 years old. In the UK he was picked up by Police at a service station on a motorway, after the driver of a refrigerated truck he had jumped into in Calais had left the doors unlocked.

He had lived in the Calais "Jungle" camp for approximately 18months, sleeping rough under makeshift awnings with a group of other children travelling on their own. He was often cold, wet, hungry and thirsty living there. His best friend that he met in Libya and stayed with in Calais was on the truck with him. They had shared pieces of food with each other that they had found on their journey. Sometimes they ate grass they found in the fields once they had got to Europe, at other times passersby would feel sorry for them and bought them bread.

In the truck was also a young family caring for their baby child. The journey was described as long and frightening as they all had no food to eat or anything to drink. They were in the dark and had not met this family before. Eferm felt like he was going to die from the cold and struggled to breathe. He worried for the baby as it had stopped crying and he did not know if the baby had survived the journey or not. The baby was taken away by ambulance with the family when he and his friend were found by the Police. He felt relieved when he saw the Police, saying he knew he would now get help. Eferm was then assessed as 16 years old and placed in a hostel with other Unaccompanied Asylum Seeking Children. He had a room of his own with a bed and sink in it but his friend was sent away to another part of the country, he had been assessed as over 18years old. He did not have a mobile number for his friend and the separation left him very upset and worried. His friend had looked out for him and helped him on his journey; he was like an older brother to him but now he was on his own again.

Eferm found it difficult to sleep on the bed and slept on the floor. He was taken to meetings with several different people who all asked lots of questions, but he did not know why.

Eferm woke most nights from nightmares and frightening memories of his past that confused him. He also found he could not concentrate during the day in English classes although he wanted to learn. At times,

memories came back to him during the day and he struggled to orientate himself and where he was, he often felt like he was back in the big warehouse in Libya with hundreds of other asylum seekers from all different countries, all huddled together in silence, flinching when guards approached them.

At these times his heart would beat faster and he would sweat when these memories returned. He didn't understand why they kept coming back, he wanted to focus on his future and forget the past. Forget that he saw his sister being raped and tortured in the warehouse until she was killed by the guards. He felt very sad when he thought of her and his younger brother that he had had to leave behind with his mother. He worried about their safety too. He didn't remember his father. He had been taken into the military when he was very young. His mother had said she thought he was dead.

Eferm's sleeping didn't get better and he was referred to CAMHSS. He didn't understand what CAMHSS was or what the NHS was, but the woman he met tried to explain it to him. He felt safe with her and decided to go back and see her. She taught him some things to do that helped with his sleeping and helped him concentrate. He tried these at home and they helped a little. She asked about his family and he told her his sister had died, she looked sad for him but that was ok. He felt sad too. After several months of going to see her, she asked how she had died but also said he didn't have to tell her if he didn't want to. He wanted to tell her but he didn't know how to put into words what he had seen and when he tried to talk the words wouldn't come out and he got muddled and confused. She seemed to know it was difficult and told him he didn't have to tell her anything but could see that it upset him. After a few months he told her that he had been beaten by the guards in the warehouse, not given enough food and sometimes the guards took him and others away to another room where he were tied up with chains, hung upside down by his feet and beaten with wire.

As he talked about this it was as though he could feel the pain again happening right now. He wanted it to go away and he told the woman he wanted to stop talking. This was ok and the woman told him he was very brave for sharing what he had and she then asked about college instead and talked about what he could see outside the window. This helped. He had also been given a bag of lavender and she encouraged him to smell this. He liked the lavender as it reminded him of an herb that grew at home.

As his sessions with the CAMHSS worker progressed, Eferm shared more and more. He felt a sense of relief when he shared what had happened. He told her how he and his sister had been taken to a man on the Sudanese border at night where other Eritrean people fleeing the country were waiting. They were crammed into the back of an open truck and driven across the desert into Libya. The man was a trafficker and the traffickers were not nice to them. They beat them and shot dead another boy that couldn't sit down. The traffickers also left others in the desert to die. He and his sister were very frightened. When they got to Libya they were handed over to men who then said that they now owed them money. They were made to work on a farm and then they were passed onto guards in the warehouse.

Eferm stayed here for approximately 18 months and was tortured most days. The guards would film it and send pictures to his mother in Eritrea, demanding money from them. After his sister was killed, he was then taken and sold to another man that made him work in a mine. Here the men fired shots into the air to make everyone work, this was where he met his friend. They escaped the mine and found a boat crammed with other men, women and children taking people to Europe. The boat was full. There wasn't enough life jackets. There was another boat which left at the same time but this one capsized and he saw everyone drown. He heard their screams for help before seeing their bodies disappear under the waves or float lifelessly on the sea. He still felt sick when he saw the sea in the UK, college had arranged a trip to the sea and it had brought back bad memories. On the beach in the UK it was like he could hear the people screaming for help again and see them in the sea.

Their boat was picked up by a ship and taken to Italy. Here people were nice and gave them food but there was nowhere to stay. They decided to travel with the other boys he met on the boat. They had heard France was nice. They got to Paris and found lots of men, women and children like him sleeping on

the streets. They then heard to get to a place called the Jungle and that here there were trucks going to the UK. Eferm had never heard of the UK before. It took a long time to get on a truck, so he lived in the camp for many months with his friend until he and his friend finally got on one and arrived in the UK.

Eferm now wants to be a doctor and help other people. This he says is because he couldn't help the people in the warehouse in Libya. He saw people there killed and die of injuries and illnesses, and also on his journey. He wanted to help them but couldn't. Now he is going to college and wants to study English so he can learn in other subjects to be a doctor. He doesn't want to try and contact his family in Eritrea via the Red Cross family tracing service as he is scared this will put them in danger from the authorities. He will now have to live his life not knowing if they are safe or not, or whether his younger brother will also flee the country and be subjected to the dangerous, painful and frightening experiences he had or perish on the journey like his older sister did or others that had been killed or died on route.

Eferm had started to have many hopes for the future, but then he started to get letters from the Home Office saying they didn't believe him. His nightmares have returned and he can't concentrate at college. He feels panicky all the time and can't sleep at night. He starts to think he may be better off dead than being sent back to Eritrea to be taken into lifelong military servitude or have to do that journey again.

Mental Health Presentations and Risks

Mental Health Presentations

The majority of the Unaccompanied Children referred to CAMHSS presented with symptoms of complex post-traumatic stress directly related to three core areas of experience (Dr Draper, UASC Health, 2020); their reasons for leaving their country of origin, experiences on route to the UK and after arrival in the UK. These three areas of acute, chronic, multiple and compounded traumatic experiences continue to trigger mental health presentations and associated risk long after arrival in the UK;

1. **The trauma of the UASC's reasons for leaving their country of origin**
(e.g. torture, genocide, enslavement, political persecution, war etc)
2. **The trauma of the UASC journey to the UK**
(e.g. trafficking, sexual exploitation, modern slavery, semi starvation, childhood detention, torture, witnessing suicides, killings, deaths, drownings, modes of travel (e.g. locked in containers), shot at, abuse, sleeping rough, survival in refugee and make shift camps such as the "Jungle" in Calais etc.)
3. **The trauma of the being in the UK**
(e.g. Home Office asylum process, interviews, rejections, age assessments, Hostile Environment, discrimination, ostracisation, social exclusion, pressurised to talk about trauma before emotionally ready (e.g. Home Office interviews), not being believed, discrimination, adjustment process to new systems, culture, language etc)

However, at the centre of these three areas of traumatic experience there is a fourth area of trauma that is held at the heart of every Unaccompanied Child's experience. Presenting in the despair, acute and chronic emotional pain of the unaccompanied child, often internalized, unshared and unheard;

4. **The abrupt and traumatic separation, loss and grief for their significant attachment figures**
(e.g. the separation from and deaths of mothers, fathers, uncles, aunts, siblings, friends, neighbours or travel companions)

The loss of family and friends is also compounded by the Unaccompanied Child's loss of their cultural identities, such as traditions, celebrations, food, religions and faith groups, shared cultural experiences of childhood games and play, and the loss of their homeland's native flora, fauna, landscapes, rural and urban architecture, and the scent and aroma of their country of origin. All are entwined and interwoven within their lost relationships with their families, friends, neighbours and communities.

The following diagram builds on Dr Ana Draper’s UASC Trauma Triangle (UASC Health, 2020) in developing understanding of UASC health needs, risks and services for Unaccompanied Children arriving in the UK. The UASC Trauma Triangle pin points the areas of traumatic experience that the Unaccompanied Child has to survive and negotiate, whilst at the centre holding the loss of cultural identities and the absence of a secure attachment figure to help these children, both before and after arrival in the UK.

The Trauma and Loss Triangle of the Unaccompanied Child

Reasons for leaving country of origin

e.g. torture, genocide, war, enslavement, political persecution



Journey to the UK

e.g. semi starvation, trafficking, detention, torture, killings, illness, abuse, injury, rape, slavery, sexual exploitation

Arrival in the UK

e.g. Home Office interviews, processes and rejections, age assessments, separation from kinship, adjustment to new systems, culture & language

Therapists and services holding in mind these core areas of experience and identified themes, supports the Unaccompanied Child make sense of and develop a coherent meaning to their traumatic experiences on their path to recovery.

Trauma Symptomology and Presentations

The following emotional, psychological and physiological presentations were commonly observed as a result of their traumatic experiences and losses;

- Sleeping difficulties in the form of nightmares, night terrors, sleep paralysis, sleep enuresis and disrupted body clock
- Panic and anxiety, heart palpitations, restricted airways, sweating, hypervigilance (often referred to as paranoia however when assessed in the context of their experiences hypervigilance is identified)
- Difficulties in concentration
- Unexplained headaches and pain
- Flash backs, intrusive trauma memories and dissociative states
- Depressive symptoms, mood disturbance, ruminations
- Self-harm, suicidal thoughts, plans and intent
- Distress, grief, mourning, longing, emotional pain, anger, fear, relief and despair

Unaccompanied Children, often on a daily basis, were observed to be reliving the terror of their past in the present moment. Directly as a result of the acute and chronic, compounded and multiple traumatic experiences and losses they had survived over a prolonged period of time, whilst internalizing the emotional pain and lonely grief for their lost families, friends and communities.

Their emotions, minds and bodies are still responding in ‘survival mode’, albeit having arrived in a safer place, namely the UK. Once in the UK ongoing triggers to re-traumatisation occur, such as transitions, separation from kinship, asylum process, fear of deportation, negotiating the new systems, traditions and languages of an alien culture, all exacerbating their original traumas and impinging on the healing towards recovery.

Self-Harm and Suicide Risk

“Self-harm and suicide pose a grave risk for these young people, especially if they are not receiving holistic support. More needs to be done to understand these risks and the network of support that would help to combat them.”

Distress Signals; Unaccompanied Young People’s struggle for Mental Health Care
(The Children’s Society, June 2018)

The Children Society Report, Distress Signals; Unaccompanied Young People’s struggle for Mental Health Care (June 2018) highlights the high risk of suicide that UASC present after arrival in the UK. UASC being nine times more likely to end their life than the general population (Distress Signals, 2018); the four Unaccompanied friends that were reported to have sadly ended their lives since November 2017, highlight the heightened risk to self and the potential risk of suicide clusters that these Unaccompanied Children and Young People pose, raising this risk to 10 times that of the general population and relating increase risk specifically to Eritrean Unaccompanied Children and Care Leavers (Inquest, November 2019)

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

Distress Signals; Unaccompanied Young People’s struggle for Mental Health Care
(The Children’s Society, June 2018)

The Unaccompanied Children referred to CAMHSS in Surrey, travelling to the UK via Libya’s Detention Centre’s have presented with a contextually higher suicide risk which appears to be linked to the profound Human Rights Violations they have directly experienced and witnessed in Libya. On reviewing the total 55 UASC clients referred to CAMHSS across the identified audit period (inclusive of those that had travelled via Libya’s Detention Centre’s), overall 18 UASC (33%) had experienced suicidal thoughts and / or plans. However, on reviewing specifically those that had disclosed to CAMHSS that they had travelled via Libya’s Detention Centre’s, this figure increases to 56%. Five of the nine UASC having experienced suicidal thoughts and / or plans, with one attempting to end his life which occurred at a transition point in his life.

The high levels of trauma, loss and multiple ongoing near-death experiences they had witnessed and faced over a prolonged period of time when detained within these compounds, continues to resonate and impact on the wellbeing of these children long after arrival in the UK, impacting their perception of and trust in others, in particular it was observed, authority figures.

Therefore, particular attention to monitoring distress levels, mental health risk assessment and management within CAMHS, Social Care and Health is required in order to minimise the risk of these children and young people acting on feelings of despair and ending their lives. Giving empathic attention to their distress will help to ensure the voices and needs of these Unaccompanied Children are heard within UK systems and services and to counter against the speechless terror of their traumatic experiences.

Cozolino (2002) Professor of Psychology, summarises our ever evolving understanding of the neuroscience of trauma,

“Speechless terror, which has been recognized as part of post traumatic reactions since ancient times, now has a neural correlate consistent with what is known about brain functions [Broca’s Area]. Why would evolution select silence in times of crisis? Perhaps when one is threatened it is better to either run or fight or simply keep quiet and hope to stay undetected”

(Cozolino 2002: 267)

What we see in Unaccompanied Children, are children who are still in ‘survival mode’ long after their arrival in the UK. An Unaccompanied Child’s ability to fully verbalise their traumatic experiences is therefore largely impaired whilst being consistently, and unintentionally, triggered by the UK systems they are then required to negotiate, increasing the risk of harm to themselves and mental health deterioration.

Complexity with Physical Health

Alongside long term Mental Health concerns and risks, an added complexity presenting is in relation to the longer term impact of an Unaccompanied Child's Physical Health issues related to malnutrition, undiagnosed infections and injuries that often exacerbate UASC Mental Health presentations. E.g. head injuries, semi-starvation, vitamin deficiencies, STD's, pain from injuries from beatings, torture, stabbings, explosions and shootings etc.

Often injuries or physical health concerns had not always been shared at the child's Initial Health Assessments and were then disclosed after the children had been allowed a settling in period. Those referred to CAMHSS sometime after initial arrival in the UK, often then disclosed these concerns during assessments and interventions when asked, for example, of on-going injuries or pain, after a disclosure of past torture or beatings.

This may be in part due to the overwhelming nature of UK systems, interviews and assessments (police, social care, health etc) that the Unaccompanied Child is initially exposed to shortly after arrival. These factors appear to lead to the already traumatized Unaccompanied Child becoming further overwhelmed and disorientated and therefore unable to fully express their needs when required, with the additional complexity of conversing in a foreign language or through an interpreter. Additionally, their traumatized bodies and minds are still functioning in a 'survival mode', and potentially in a dissociative state, whereby their bodily feelings remain disconnected and therefore, unfelt and not noticed. These children then need help to remind their minds and bodies that they are now in a safer place.

“Dissociation allows the traumatized individual to escape the trauma via a number of biological and psychological processes. Increased levels of endogenous opioids create a sense of well-being and a decrease in explicit processing of overwhelming traumatic situations”

(Cozolino 2002: 267)

The mental health work with the UASC then involved following up on physical health concerns disclosed during sessions which required referral to GP's for investigation. A psychoeducational approach was also taken within therapeutic intervention, for example, in terms of semi starvation the importance of re feeding to counter the impact of semi starvation on their physical and mental well-being (UASC Health, 2020).

Social and Environmental Factors in the UK impacting on Mental Health Presentations and Risks

Further impacting Unaccompanied Children's mental health presentations and therapeutic interventions has been the unintentional impact of changing professionals and transitions in their lives e.g. moving accommodation, distance from friends, kinship and separation from their ethnic and religious communities, changes in education establishment and changes in Social Workers or Housing staff. These events brought a further sense of instability, upheaval and isolation into Unaccompanied Children's lives. Often resulting in an increase in trauma symptomology, heightened levels of anxiety, mood disturbance and/or distress and at times a substantial increase in risk of self-harm and suicide accompanied these transitions. These children under CAMHSS then required additional support and attention at these times from mental health services to help sustain emotional and psychological equilibrium whilst the children negotiated the adjustment process of transitions and mitigate the increase risk of harm, until a further settling in processes had once again occurred.

Risks Associated with the Home Office and Asylum Application Process

Once in the UK the most apparent negative impact on Unaccompanied Children's mental health with an associated increase in mental health deterioration, risks and trauma symptomology, in particular that of suicide, were related to the Home Office Asylum processes that the Unaccompanied Children were subjected to. This often triggered high levels of distress, a sense of hopelessness and despair. These were in the form of the following;

- Home Office interviews that UASC are required to attend were experienced as re-traumatising due to being asked to speak about their traumatic experiences in an un-therapeutic environment and when not emotionally or psychologically ready to, or even able to verbalise
- Being questioned in an 'unbelieving' manner and/or 'not believed' about their traumatic experiences (this also relates to Age Assessment disputes).
- Negative correspondence from the Home Office regarding their asylum applications such as a rejection letter.
- Proceeding with the multiple stages of the prolonged Appeal process
- Persistent delays and long waits in processing of Asylum Claims and receiving an outcome, whether positive or negative.

All the above had a significant negative impact on UASC mental health and an associated increase in mental health risk such as self-harm and / or suicidal thoughts, plans, intent and / or acts, low mood and depressive symptoms. Alongside this an associated increase in trauma symptomology was observed such as heightened states of anxiety, feelings of panic, increase in intrusive trauma memories, flashbacks and sleep disturbance related to nightmares, night terrors, sleep paralysis and sleep enuresis.

The Home Office and Asylum process often left the Unaccompanied Child in a prolonged state of fear and anxiety, namely that they would either become destitute in the UK, or be deported back to their country of origin that many of their original traumas took place in. This also exposed them to the fear and subsequent ruminations that they may have to flee and redo their journey again in order to survive. Albeit now with the additional knowledge of the dangers they had survived and were likely to encounter again on their journey.

Routed deep in their belief systems was the likely reality they would again be subjected to further considerable traumatic experiences and losses on their subsequent journey yet again to another place of safety. Some stating that it would be better to end their lives in the UK than be deported.

Education

This process of rejection and appeal often occurred in the middle of their studies and exams, as they neared adulthood. Impacting their ability to concentrate, learn and achieve at school or college. Education in the UK was a substantial protective factor in that it provided an element of hope for their futures. However, the asylum process often instead left Unaccompanied Children in a state of chronic and acute hopelessness and despair, leading to an increase in risk to themselves with often associated thoughts to end their life, an overall deterioration in their mental health, an increase in trauma symptomology and depressive features.

Additionally impacting these children accessing CAMHSS was the fear and anxiety that their college bursaries would be stopped if not attending college. However, also needing help from CAMHSS. This putting them in an untenable position if their colleges were not understanding of their health needs, and on occasion threats to stop bursaries occurred. In these situations, the pressure of having to choose between two protective factors, college and CAMHSS, that supported their mental health needs and reduced risks, often led to an increase in their symptoms, heightened anxiety, low mood and feelings of hopelessness as the recognition for both at times was unrecognized by education establishments. CAMHSS would explore the best times to support these children and attempt to fit their CAMHSS appointments around their college timetables to reduce this anxiety, such as arranging clinic days in localities when the college where a group of Unaccompanied Children attended were not required to attend to support engagement and access to mental health services.

Interventions

Evidence Base for UASC Mental Health

There is currently no firm evidence base for therapeutic treatment and intervention for Unaccompanied Children's mental health, trauma and loss presentations and the associated risks they present, which were identified during the course of the work with those referred to Surrey CAMHSS. NICE Guidelines for Looked After Children recommend assessing UASC for Attachment Difficulties once in a stable placement and following treatment guidance for Post-Traumatic Stress Disorder (PTSD) if identified. (NICE, 2015) <https://www.nice.org.uk/guidance/ng26/chapter/Recommendations#interventions-for-attachment-difficulties-in-children-and-young-people-in-the-care-system-subject> (accessed 11.5.2020)

The majority of UASC referred to Surrey CAMHSS, presented with the symptoms of Complex PTSD, rather than single event PTSD. The majority described a safe, responsive, attuned and validating relationship with their main care givers (Mothers, Fathers, Uncles, Aunts, siblings etc) that they had then been abruptly separated from, often in extreme and horrific circumstances such as genocide, political persecution and war. During sessions, they also shared experiencing acute and chronic emotional distress and worry for their families. Most were able to sustain strong trusting and supportive bonds with their peers and travel companions. This differing from many in the general Looked After Children population that have often been exposed to very early childhood abuse and neglect by their main care givers and therefore often present with the symptoms of Developmental Trauma Disorder (Professor Van Der Kolk, 2014) .

Complex PTSD diagnosis is a subset of PTSD and can be found in the ICD-11. This is described in the NICE Guidelines NG 116 as;

“Arising after exposure to an event or series of events of an extremely threatening or horrific nature, most commonly prolonged or repetitive events from which escape is difficult or impossible (for example, torture, slavery, genocide campaigns, prolonged domestic violence, repeated childhood sexual or physical abuse). The disorder is characterised by the core symptoms of PTSD; that is, all diagnostic requirements for PTSD are met. In addition, complex PTSD is characterised by;

- severe and pervasive problems in affect regulation
- persistent beliefs about oneself as diminished, defeated or worthless, accompanied by deep and pervasive feelings of shame, guilt or failure related to the traumatic event
- persistent difficulties in sustaining relationships and in feeling close to others”

(NICE, 2018) <https://www.nice.org.uk/guidance/ng116/chapter/recommendations#care-for-people-with-ptsd-and-complex-needs> (accessed 10.5.2020)

However, many UASC described an ability to sustain relationships within their peer group. Individuals and groups who had become substitute family figures when travelling together as Unaccompanied Minors, describing acute feelings of loss and despair if they were separated from these friends, or kinship (UASC Health, 2020). Although, perhaps unsurprisingly, in the context of their traumatic experiences the Unaccompanied Children that had travelled via Libya's Detention Centres, were observed to appear to have more difficulty in trusting authority figures once in the UK.

Nice Guidelines (2018) for Complex PTSD recommend the following to support treatment interventions;

- “build in extra time to develop trust with the person, by increasing the duration or the number of therapy sessions according to the person's needs
- take into account the safety and stability of the person's personal circumstances (for example their housing situation) and how this might affect engagement with and success of treatment
- help the person manage any issues that might be a barrier to engaging with trauma-focused therapies, such as substance misuse, dissociation, emotional dysregulation, interpersonal difficulties or negative self-perception
- work with the person to plan any ongoing support they will need after the end of treatment, for example to manage any residual PTSD symptoms or comorbidities.[2018]”

(NICE,2018) <https://www.nice.org.uk/guidance/ng116/chapter/Recommendations#care-for-people-with-ptsd-and-complex-needs> (accessed 10.5.2020)

These factors were crucial and underpinned CAMHSS intervention with Unaccompanied Children referred to the service in ensuring engagement and success of interventions offered.

In addition, the PTSD pathway advises active monitoring takes place within the first month after a traumatic event. Unless high risk was present such as thoughts of suicide and or self-harm, Children’s Services were advised to allow a settling in period of at least two months after arrival in the UK, or presentation to Children’s Services, in the case of those children who had been held hostage once in the UK).

This was advised so as not to overwhelm the children with further professionals, questioning and meetings in addition to those with Police, Duty Social Workers, Allocated Social Workers, Age Assessments, Initial Health Assessments, Interpreters, Housing Staff, Foster Carers, Solicitors and Education etc. It was also advised to allow the children time to settle into a routine in their new homes and observe any changes or reduction in the initial mental health concerns raised and for a more accurate assessment of longitudinal need to take place.

Therefore, the advice by CAMHSS to Social Workers if concerns were raised regarding an Unaccompanied Child’s mental health, was to allow a settling in period, monitor for signs of distress and / or deterioration and refer to CAMHSS two to three months after arrival in the UK, or presentation to services, if concerns were still present and symptoms persisted. During this time consultation was offered and monitoring the child was advised to Social Care and Housing staff and to refer to CAMHSS for further consultation or if concerns or risk increased before the two to three month period. This then allowed the children time to start to settle into their new homes and start the adjustment process to life in the UK and the significant changes in these children’s lives that were occurring. For example, travelling, sleeping rough, being held against their will, abused and surviving for several years as Unaccompanied Children prior to arrival in the UK or presentation to Children’s Services. UASC Health’s Distress Screening Tool (UASC Health, 2020) was recommended to Children’s Services for regular monitoring and to use at key transition stages.

Assessment Implications specific to Libya's Detention Centre's

During the course of intervention with the Unaccompanied Children who had survived Libya's Detention Centre's it was observed that these children experiences appeared to place them at a higher level of risk of harm to themselves within the UASC population generally, than Unaccompanied Children that had not passed through these detention centres. However, this is not to minimize the high levels of trauma and loss and associated risks that all Unaccompanied Children have experience prior to arriving in the UK.

As previously highlighted in this Audit, The Children's Society identified that Unaccompanied Children are nine times more likely to end their lives than the general population (Distress Signals, 2018). In November 2019 the charity Inquest summarised the death of Osman Abdunur, an Eritrean Unaccompanied Child who became a Care Leaver in the UK. Osman sadly ended his life in April 2018; this was after the death of two of his Eritrean friends a few months before. From this friendship group another Eritrean UASC also later took his life.

At Osman's inquest it identified these deaths as a suicide cluster who were a part of the same friendship group. The Coroner instructed that Local Authorities needed to be aware of the risk of suicide in the Eritrean population arriving in the UK as Unaccompanied Asylum Seeking Children (Inquest, 2019), suggesting this risk of suicide was ten times that of the general population,

“Since Osman's death, a fourth young Eritrean refugee from the same friendship group has taken his life. During Osman's inquest, evidence was heard that UASC's risk of suicide may be ten times higher than their peers and that this specific group of deaths can be characterised as a suicide 'cluster'. The coroner directed the London Borough of Camden to alert other local authorities in England that there may be an increased risk of suicide amongst Eritrean young people who arrived in the UK as UASC.”

(Nov 2019) <https://www.inquest.org.uk/osman-ahmednur-ingest> (accessed 15.5.2020)

An important correlation to highlight is that 55% of the Unaccompanied Children that had disclosed travelling via Libya's Detention Centres were Eritrean. Additionally 55% of all the Unaccompanied Children (from Eritrea, Ethiopia and Sudan) that had been detained in Libya's Detention Centre's had experienced suicidal thoughts and plans, with one attempting to end his life. In comparison, of the total 55 UASC referred to CAMHSS, 25% presented with a risk of suicide.

The Unaccompanied Children who had been held in Libya's Detention Centre's had expressed very high levels of distress and the majority were deemed high risk, fluctuating in severity at various times across the course of CAMHSS intervention. All had chosen to share details of the Human Rights Violations they had experienced in these centre's.

This indicates that the Unaccompanied Children who have been detained in Libya's Detention Centre's are at higher risk of harming themselves and attempting to end their lives. We can draw a direct correlation to the significant and prolonged Human Right Violations these children have been subjected and exposed to in Libya's Detention Centre's, impacting their emotional and psychological well-being and increased mental health risks long after arrival in the UK.

In order to ensure the safety of these Unaccompanied Children and their needs responded to, Multi Agencies coming into contact with those who have survived these centres would need to be aware of the heightened risks of harm to themselves these Human Rights Violations bring.

Therapeutic Assessment

After identifying the theme of those Unaccompanied Children's traumatic experiences that had survived Libya's Detention Centres, this aspect of their journey became a crucial part of the Initial Mental Health Assessment process for those travelling via this region, as would other themes emerging for UASC arriving from different areas of the world. In the case of Libya's Detention Centres, Initial Assessment interviews were adapted and changed to minimise the risk of re-traumatization in these children.

On initially learning directly from those children who had survive Libya's Detention Centres, further research on what was happening in these centres through reports, documentaries and articles took place. This further enhanced the assessor's knowledge of the experiences these children were likely to have been subjected to and survived. This helped inform the assessment process of the areas identified in the charts at the beginning of this Audit, which were then asked through closed ended questioning to minimise the risk of re-traumatization.

Before any questioning took place during the CAMHSS assessment the importance of being safe and keeping the child safe was repeatedly reinforced. That the assessor was there to try and help them with their distress, emotional difficulties and any symptoms that worried them. Providing contextual background and reasoning for the questions that were asked was important to engage these children, reinforcing that these questions were to help the assessor understand how they might be able to help the child further. As previously described, if disclosures arose regarding beatings, torture or semi starvation, for example, the assessor checked with the child for any untreated or on-going physical injury, illness or pain. Explaining and re-iterating the reasons for asking the questions, along with emphasising we wanted to help them keep safe, became a crucial part of the assessment process to help the children understand CAMHSS role.

Questions were asked through exploring in more detail their experiences of detention in Libya by using closed ended questioning and offering the choice not to answer if they did not feel comfortable to do so. On answering, or not, consistent empathic attunement, responses and checking how they were feeling was done with supportive therapeutic interventions to maintain engagement such as validating the emotional impact of their experiences, apologizing for the Human Rights Violations that they had experienced and reinforcing their courage in terms of what they had survived and endured. This was done in order to minimise the potential for re-traumatization and provide a source of validation and relief from the internalized 'pressure cooker' of their traumatic experiences and losses. Thereby also giving opportunity for the 'Voice of the Child' to be heard as required under the United Nations Convention on the Rights of the Child.

Background Information

As much background information as possible was collated from the Allocated Social Workers before meeting the child for Initial Assessments, so as not to overwhelm the child with repetitive questioning for information they had already shared with other services. The child was then asked if they would like to know what the assessor knew about them so they didn't have to repeat their story again. The child was then given the opportunity to correct or add to this information, which the majority participated in. Throughout the reviewing of this background information the assessor regularly checked in with the child as to whether they had the correct information and provide opportunity for the child to confirm, correct or add to it. During this process empathic attunement and responsiveness to the child's underlying emotional themes were provided. This was to validate the child's experiences and enhance the coherency of their emotional narrative.

The assessor researched and kept in mind the themes leading to Unaccompanied Children fleeing their countries of origin and what they might have experienced on route. Those arriving via Africa generally arrived from countries such as Eritrea, Ethiopia and Darfur in Sudan where lifelong servitude, political

persecution and genocide was taking place. This prior knowledge helped form and maintain a connection with the child. For example, some children would comment in surprised that the assessor had heard of their country and knew something of what was taking place there. Having some knowledge appeared to help ease the child into sharing more of their personal experiences which were empathically validated to further support the development of an emotionally coherent narrative to their traumatic experiences and memories.

Easing the child into sharing their experience of Libya, general questions as to what countries they travelled through were asked and how long this took them. Libya's detention facilities would often then be mentioned by the child. At this, the assessor would ensure the child was aware that the assessor knew that "bad things" were taking place in these centres, levelling and simplifying the language via the interpreter. The child was then told that it would help the assessor to know of some of their experiences to think about how to help them, however they didn't have to if they didn't want to. Most of the children agreed and closed ended questioning would then take place as to specific experiences of the child. Ensuring throughout that the context to asking this information, their safety and helping them was the intention behind the questioning, however they did not have to answer if they didn't want to.

A review of the following also took place;

- A checklist of core symptoms of PTSD (sleeping difficulties, nightmares, flash backs, intrusive trauma memories, dissociative states, physiological symptoms such as heart palpitations, sweats, tightening of chest, concentration)
- Appetite and signs of semi starvation, how many meals did they eat a day in their country of origin, was this due to lack of food or choice, what were they eating now?
- Mood, depressive features, history and current thoughts of self-harm and suicide
- Family contact, losses, separation, (if not already covered in background information) and depending on the child's tolerance levels. The Red Cross tracing service was always offered, sometimes the child had already been referred, at others advocacy to their Social Worker was required, or the child did not want to contact families for fear of placing their family members in danger in their country of origin.
- Education both in their country of origin and if they had started school or college in the UK, some were educated to secondary level, others had not accessed any schooling, could not afford it, or had attended only one year. Literacy levels were also checked as some were not able to read or write in their mother tongue. This was to inform future CAMHSS communications.

During this process, tips and advice were given such as trying to eat little and often to counter the effects of semi starvation and provide a taster of how an intervention might help them. Normalisation of physiological and psychological reactions and symptoms to "abnormal" prolonged, dangerous and frightening experiences were also provided to counter any sense of alienation. This also provided a sense of what therapeutic intervention might offer and to enhance engagement.

Interventions

All children assessed were initially offered an intervention on a seven sessions and review basis, with the plan at the start of therapeutic work to explore psychoeducational techniques in the following areas whilst also providing a space for sharing concerns, anxieties or experiences if they wanted to;

Psychoeducational Interventions;

- sleeping difficulties and nightmares
- grounding techniques
- relaxation breathing techniques
- psycho education on the body and minds physiological and psychological responses to trauma
- fight, flight, freeze survival responses educated in a fun and light way utilizing the analogy of a lion or tiger

If ambivalence was shown the children were offered three taster sessions, where the focus was on exploring psychoeducational techniques. Many then chose to continue and access further sessions.

All those that had travelled via Libya Detention Centre's requested help from CAMHSS and accessed therapeutic assessment and intervention for varying lengths of time from three sessions to over two years in some cases. Relief was often expressed by clients accessing support.

Throughout the assessment and during interventions to help the child's tolerance levels, the therapist dipped in and out with lighter subject matter, created a sense of fun during sessions and emotionally attuned to and stayed with the horror and despair the child might share when disclosure took place, whilst also exploring the adjustment process of settling into life in the UK. Throughout the sessions, the child's emotional state and bodily responses were checked on and relaxation, grounding and normalization of the bodily responses to trauma was regularly revisited and reviewed.

Positive memories of their past were explored and brought into consciousness to counter overwhelming trauma memories and install hope, a sense of togetherness and not being alone with their traumatic experiences.

The concept of continuing bonds (UASC Health, 2020) was used to bring bereaved and separated family members into the therapeutic space and memory. This was to bring continuity and coherency into the memory and narrative of the child's lost attachment figures. Asking questions such as "what would your mother say now if she could see how far you had come?" "What dreams did your Uncle have for you?" Often responses would bring into the room the loss however also instill a sense of hope, such as "they wanted me to survive", "they would be happy I am learning at college" and would counter against feelings of hopelessness and despair.

Throughout the intervention identifying childhood interests, what their daily routine might have been before leaving their homeland, favourite activities or school subjects both here and their country of origin, hopes for the future, favourite food, their faith and traditions, were all important aspects to bring to conscious awareness and incorporate into their individual narratives.

Children often identified wanting to train in a helping or caring profession such as doctors, nurses, solicitors, therapists or restart and develop interests linked to their cultures and homelands such as drumming, cooking, barbering or bird watching. Identifying and developing these interests helped install a sense of hope and mitigate against their feelings of loss and despair.

Underlying the above areas the following core relational and contextual therapeutic principles underpinned and were applied throughout the intervention to counter against the Human Rights Violations, deprivations and losses these Unaccompanied Children had experienced;

Core Relational Principles

- Starting the relationship from a welcoming place of trust and curious questioning to create a sense of safety within the therapeutic relationship.
- Offering an open, honest, empathic and compassionate professional relationship was held at the heart of the intervention offered.
- Explaining services, NHS and links with their GP, confidentiality and sharing of need to know and risk information whilst reinforcing the service was to support their health needs and help keep them safe.
- Don't assume anything – many UASC do not know what the NHS is, that therapy and / or medication is free, what a solicitor is for, may have never been to school, or may have attended school all their lives until forced to flee their country. Let them tell you what they know, they are our best teachers. Find out about their country, show interest in their likes and dislikes, what their daily lives were like before fleeing.
- In assessment, within the context of themes such as detention in Libya, a balance of explaining reasoning for questioning, providing choice whether they wish to share their experiences or not and use of closed questioning took place, which may feel counter to therapeutic work. However, assists the traumatized child in minimizing triggers and not becoming too overwhelmed when sharing their traumatic experiences. However, at the same time, supports the child's voice to be heard and witnessed.
- Unfortunately the 'Hostile Environment' in the UK, often served to reinforce a general disbelief and mistrust in these children's experiences by others that they encountered after arrival, often leading to misunderstanding of needs and on occasion exposure to discrimination. On learning and developing English Language skills the ability to read tabloids would often impact their mental health negatively, leading to feelings of social exclusion and alienation from the British culture,

“The complexity of health needs and the other contextual factors identified.. will often mean that assessments take more time and are more resource intensive than even those involving U.K. children looked after”

The Health Needs of Unaccompanied Asylum Seeking Children & Young People (2010)
Simmonds & Merredew

<https://www.nice.org.uk/guidance/ph28/evidence/looked-after-children-ep23-unaccompanied-asylum-seeking-children-john-simmonds-and-florence-merredew2> (accessed 15.5.2020)

Relational Integrative Approach

- Contextualising symptomology in terms of their traumatic experiences and losses helped normalise and validate their emotional, psychological and physiological responses to trauma and enhanced engagement
- A psychoeducational approach was taken to symptomology in terms of the physiology of trauma and survival responses e.g. fight, flight, freeze responses, grounding techniques were offered to regulate intrusive trauma symptoms and reconnect dissociative states, along with relaxation and self-regulation techniques. All concepts that they could practice away from sessions and imbed in their understanding of their symptoms.
- Sleep and relaxation packs were given to aid the techniques taught. These incorporated night lights, lavender bags, lavender oil and stress balls to aid sleep and body clock regulation (UASC Health, 2020)
- Images of relaxing and safe places identified during sessions were sourced and given to the children to place in their rooms to help remind children they were now safer and evoke positive thoughts to aid sleep and relaxation.
- Visualisation and image making of safe, peaceful and calm places that they could access if required was facilitated and identified.
- Exploring in-depth and processing the multiple traumas and intrusive trauma memories was not necessarily deemed helpful at this early stage of their life in the UK, in the context of the instability of their futures. For example, waiting for Leave to Remain, being refused Leave to Remain, transitions between housing placements, social workers and localities. However, if these experiences arose for the child and they chose to share these experiences, which they often did, and express core emotions in the here and now in relation to their trauma such as grief, despair, anger and fear these feelings were empathically validated, responded to and emotionally held in our sessions to allow expression and processing of emotional states.
- Facilitating hope – building on strengths and resiliencies, interests, achievements and identifying relationships, without forgetting or dismissing their past. This was to help regulate their distress and continue to strengthen a widening of their windows of tolerance to their traumatic experiences, losses and history.
- Curiosity about their lives growing up in their country of origin, bringing the lost relationships and traditions into the room and their conscious thoughts to form a sense of continuity after abrupt separations and losses. This at times also brought up long held and unexpressed feelings of loss and grief for the child, however also appeared to instill a sense of hope for the future.
- “What would your mother, father, sister, or uncle say if they could see you now and how far you have travelled, that you’ve started college? What food did you eat in Eritrea, who cooked for you? What’s your favorite meal? Did you know you can find those ingredients in the supermarket here?” This opening a conversation with the child and engaging their interest and them in the therapeutic process and facilitating a vision of a future from their individual pasts.
- Metaphorically sitting alongside, empathically attuning to and responding to the child, emotionally holding, validating and hearing their traumatic stories, memories and their

emotional distress when they chose to share this. This helped draw out their internalized world into a shared therapeutic alliance, whereby therapeutic validation and emotional holding allowed the processing of their emotional content and development of an emotionally coherent narrative to counter against the fragmentation of traumatic memory and experience.

- Asking them to talk about their past, before they are ready, or feel safe to do so, was often described as a re-traumatizing experience when interventions such as Life Story work were applied outside of CAMHSS without an underlying trauma informed approach. This often had the impact of distressing these children further, as some had disclosed in sessions.
- Holding in mind differing cultural contexts and themes e.g. Libya's Human Rights Violations, those fleeing Sudan likely experience genocide
- Therapists having the emotional strength and ability to stay with, hear and emotionally hold the child through the sharing of their horror, despair, terror and hopes when they chose to.
- Checking with clients and ensuring solicitors are made aware of disclosures regarding their reasons for leaving their country or origin. The process of writing CAMHS Supporting Letters when International Safeguarding disclosures were made also appeared to reinforce a sense of being heard and not alone in the process. Letters would be reviewed with the children and copies provided.
- Advocacy of the children's needs was often required, especially when day to day concerns were expressed in sessions when the children had access to an interpreter. After sessions, follow up with Social Workers, Housing or Education was often required.

Outcome Measures

The therapeutic work was assessed by using the following outcome measures, however these were not used on all those from which data was collated from. This was due to the high levels of distress some children presented on assessment or that it risked engagement in the therapy.

Many commented on the amount of paperwork they were presented with at assessment in the UK and at times this inhibited engagement. Therefore, using the measure at these times felt inappropriate and likely to have the impact on the child disengaging from the CAMHSS, albeit they needed support to mitigate the risks they presented. At these times building a relationship that was trusting and open between the child and the therapist was assessed as a priority. The core measures that were then used were the following;

- Children's Impact of Events Scale - CRIES-8 and CRIES-13 (for under 18years). These are recommended by the Children at War Foundation and CYP IAPT.
- Impact of Events Scale - IES-R (over 18years) were used for Care Leavers

These measures were used to assess the likely presence of Post-Traumatic Stress Disorder and identify key symptomology. At times other measures were also used to assess differing presentations, for example PHQ-9 and RCADS for anxiety and depressive symptoms. For those that follow up measures were used on, they showed an overall reduction in symptomology through their scores, this was also observed in their presentation and through their self-reporting. However, scores and risks would also increase and fluctuate across the course of the intervention in relation to transitions in the child's life such as moving accommodation, waiting for an outcome or receiving a rejection from the Home Office, or changes in Social Workers etc. At these times, trauma symptomology and risks to self often increased.

In line with the Children's Society, Distress Signals Report (2018) that do not recommend the use of SDQ's with Unaccompanied Minors, although a requirement for Looked After Children, they felt largely inappropriate to use. The questions unsuitable and alien in context of the concerns, presentations and traumatic experiences that these children were bringing to CAMHSS. However, the Distress Screening Tool recommended by UASC Health (2020), if utilised within Children's Services, would have been useful in monitoring wider distress and risk levels to inform referral criteria into CAMHSS and mitigate the high risk of self-harm and suicide that these children present,

"The strengths and difficulties questionnaire (SDQ) – which is the most commonly used tool for identifying an unaccompanied young person's need for mental health support once they arrive into care – is not identifying their mental health needs adequately. Our data analysis has found that, in spite of the acute mental health issues that unaccompanied young people might be facing, the average SDQ total difficulties score for looked after unaccompanied young people is low and suggests they would have little need for mental health support."

Distress Signals; Unaccompanied Young People's struggle for Mental Health Care
(The Children's Society, June 2018)

Interpreters

Throughout the work, the majority of Unaccompanied Children and Young People required an interpreter for both assessment and the duration of the therapeutic intervention. This allowed them the opportunity to fully express, share their needs and experiences, and receive a response that hopefully helped them feel understood and validated in their mother tongue.

Interpreters, with their own cultural backgrounds and awareness of the general experiences these children had overcome and issues faced within their country of origins, often helped in the assessment and intervention process by filling in contextual gaps in cultural knowledge, traditions or faiths for both parties, realizing their might be a shared misunderstanding. This was based on the interpreters own background experiences, as the majority of interpreters had already travelled to and settled in Britain and into British culture having been through the Asylum process themselves, providing good insight into and understanding of the adjustment process for these Unaccompanied Children.

It was generally observed that having an interpreter that was able to connect with the child, make them feel safe and relaxed helped the child become more open to the therapeutic process. Having a third person in the session also appeared to help reduced the intensity of a one to one therapeutic relationship that may be largely alien to a child from a different cultural background. Consistency of interpreters was also very important to the success of treatment, however difficult to achieve for all Unaccompanied Children that engaged in sessions.

At times, some interpreters experienced a triggering of their own unresolved trauma during session, children generally responded to this with empathy and compassion for the interpreter, and rather than inhibiting their expression as one might expect, this appeared to help the child feel safer and share more of themselves, maybe reducing any feelings of alienation.

To help reduce the intensity of the sessions and for the child to not feel “put on the spot” and to minimise the occurrence of triggering secondary trauma responses in interpreters, when psychoeducation techniques in grounding and relaxation were practiced, the interpreter was invited to join in and practice these together with all present. This created a fun and safe place for the child to practice what the adults were learning and modelling to them and helped further reduced any feelings of difference and alienation the child may have been feeling.

On occasion, some interpreters required emotional and psychological support after sessions due to the emotional intensity of the work. Being allowed time to support and help interpreters regulate themselves after sessions, was beneficial to the work and crucial to the consistency of interpreters returning. Allowing additional time for sessions was also necessary due to the time taken out of the usual process to allow for the interpreting process. This is also recommended in guidance from interpreting agencies.

Summary

The information collated in this audit highlights the atrocities and Human Rights Violations that Unaccompanied Children detained in Libya's Detention Centres are exposed to on route to the UK, the ongoing detrimental impact and increased suicide risk this has on their mental health long after arrival.

With the tenfold increase in risk of suicide and potential for suicide clusters that has been identified within the Eritrean population (Inquest, 2019), it brings into question that rather than being related directly to their nationality the increased suicide risk is related to the atrocities taking place in Libya's Detention Centres, having identified a substantial increase in suicide risk in this audit in those that have been detained in these facilities. In comparison, although 56% detained were of Eritrean origin, those presenting a suicide risk having survived Libya's Detention Centres were also from other nationalities, 22% Ethiopian, 22% Eritrean, 11% Sudanese. Compared to 33% suicide risk across the total UASC referrals during this period to CAMHSS, which includes those that have been detained in Libya.

This highlights the substantial increase in mental health and suicide risk in the Unaccompanied Children who have travelled via Libya and been detained in Libya's Detention Centres and the need for services to be aware of the specific mental health risks associated with this client group in order to respond accordingly. These experiences, where Unaccompanied Children have not been safeguarded by International Authorities, their Human Rights violated and where they have been subjected to and witnessed horrific levels of abuse and deprivation, continue to impact their wellbeing, mental health and heightened risk of suicide long after their arrival in the UK.

There is an urgent need to prevent the continued contravening of Human Rights Violations towards these children, and those caught and detained in Libya's Detention Centres to help mitigate the high level of mental health concerns and suicide risk that present in this population that have survived these horrors long after arrival in the UK.

The United Nations Convention on the Rights of the Child, identify the following Articles that hold particular relevance to these Unaccompanied Children, in particular those that have travelled through Libya and been detained within Libya's Detention Centres;

- **Article 37** (inhumane treatment and detention)
Children must not be tortured, sentenced to the death penalty or suffer other cruel or degrading treatment or punishment. Children should be arrested, detained or imprisoned only as a last resort and for the shortest time possible. They must be treated with respect and care, and be able to keep in contact with their family. Children must not be put in prison with adults.
- **Article 38** (war and armed conflicts)
Governments must do everything they can to protect and care for children affected by war and armed conflicts.
- **Article 35** (abduction, sale and trafficking)
Governments must protect children from being abducted, sold or moved illegally to a different place in or outside their country for the purpose of exploitation.
- **Article 19** (protection from violence, abuse and neglect)
Governments must do all they can to ensure that children are protected from all forms of violence, abuse, neglect & bad treatment by their parents or anyone else who looks after them.

- **Article 6** (life, survival and development)
Every child has the right to life. Governments must do all they can to ensure that children survive and develop to their full potential.
- **Article 39** (recovery from trauma and reintegration)
Children who have experienced neglect, abuse, exploitation, torture or who are victims of war must receive special support to help them recover their health, dignity, self-respect & social life.
- **Article 31** (leisure, play and culture)
Every child has the right to relax, play & take part in a wide range of cultural & artistic activities.
- **Article 13** (freedom of expression)
Every child must be free to express their thoughts and opinions and to access all kinds of information, as long as it is within the law.
- **Article 12** (respect for the views of the child)
Every child has the right to express their views, feelings and wishes in all matters affecting them, and to have their views considered and taken seriously. This right applies at all times, for example during immigration proceedings, housing decisions or the child's day-to-day home life.

A Summary of the UN Convention on the Rights of the Child, UNICEF, https://downloads.unicef.org.uk/wpcontent/uploads/2019/10/UNCRC_summary1_1.pdf?_ga=2.43397868.893885019.1586263848-707403383.1548434702 (accessed 7.4.2020)

Many Unaccompanied Children only shared the detail of their experiences of being detained in Libya after forming a trusting and therapeutic relationship with their CAMHSS worker. For many these were initial disclosures and they had not previously shared their experiences with their Social Worker, other Health Professionals and their Solicitor. This highlights the ethical imperative for the therapist to ensure that specific International Safeguarding Disclosures surrounding Unaccompanied Children's reasons for leaving their country of origin and journey to the UK, are shared with the child's Solicitor at the child's consent to ensure that the Voice of the Child (Ofsted, 2011) is heard and their future safeguarding is ensured.

This also helps to ensure the emotional and mental wellbeing of the child who is otherwise left in a heightened state of anxiety and despair, whose ability to fully verbalise their experiences is initially impaired due to the trauma they have experienced, not knowing how to negotiate the language or new systems they are confronted with in the UK and living in fear of deportation if unable to share their full story when required.

In addition to the appalling Human Rights Violations in Libya's Detention Centres the majority of Unaccompanied Children also disclosed additional significant traumatic experiences as outlined in this review. For example, sleeping rough in Europe, witnessing drownings in the Mediterranean, experiencing and/or witnessing abuses, deprivation, semi starvation, sexual assault and exploitation on route to and from Libya and the UK.

The multiple and compounded traumatic experiences that many Unaccompanied Children have survived due to a lack of Safe Passage to the UK or a country of safety, have an ongoing impact on their emotional and psychological well-being long after arrival and after receiving Leave to Remain, if they do.

Although a relatively small sample, the disclosures made by UASC to CAMHSS about the Human Rights Violations they have experienced and witnessed to both asylum seeking children and adults in Libya's Detention Centres are significant. They will have an ongoing and lasting impact on both their physical and mental health presentations and associated increase in mental health risks. Therefore these health needs should be a continual priority after arrival in the UK, and considered in terms of what is in their 'Best Interest', at both National and Local Governmental level.

“Research suggests that asylum seekers are five times more likely to have mental health needs than the general population and more than 61% will experience serious mental distress. However, data shows that they are less likely to receive support than the general population.”

Mental Health Foundation, (2016) *Mental Health Statistics: Refugees and Asylum Seekers*, <https://www.mentalhealth.org.uk/statistics/mental-health-statistics-refugees-and-asylum-seekers> (accessed 10.4.2020)

Early intervention to provide safe relationships to support adjustment into life in the UK and come to terms with their traumatic experiences, will help mitigate the high percentage that require on-going input from mental health services in adulthood. In economic terms, early intervention should also have a cost saving implication for services as it has been identified with other mental health services.

However, International Safe Passage to safe countries is needed to prevent the exposure to Human Rights Violations and levels of trauma that these Unaccompanied Children subjected to due being detained in Libya's Detention Centre's.

The long-term impact of these Adverse Childhood Experiences (ACE) (Davies, R, Homolova, L. and Bellis, Mark A, 2018), Human Rights Violations, Deprivation and Abuses will likely have a major ongoing impact on the health of these Unaccompanied Children, as reinforced in the evidence of the ACE Studies (Public Health Wales 2018:15). However, the health risks to the Unaccompanied Child who is also going through traumatic grief for their significant attachment figures, their parents, siblings, family members, friends and communities, their physical and mental health risks substantially increase.

The ongoing mental health impact for all Unaccompanied Children is evident, however those who have survived and endured the atrocities in Libya's Detention Centres on passage to the UK, will inevitably require a flexible therapeutic approach with Human Rights and Compassion at its core to help start the healing process and counter the Human Rights Violations the children have endured.

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With Thanks

My hope in writing this Audit is that services will heed the needs of these courageous children to ensure their mental health needs are catered for within services after arrival in a place of safety and protection.

Without the courage of those clients that chose to share their individual stories identifying the continued mental health needs of those that have travelled via Libya's Detention Centre's would not have been possible. Their devastation, their distress, their emotional pain, their courage and their hopes have helped the voices of others be heard, in hope that changes may occur to prevent further children, and asylum seekers generally, be subjected to the grave systemic Human Rights Violations that they have endured, witnessed and survived in Libya's Detention Centre's.