

CR242

Protecting the mental health of people seeking sanctuary in the UK's evolving legislative landscape

October 2024

COLLEGE REPORT

Contents

Foreword	5
Executive summary	7
Recommendations	15
Recommendations for the government	15
Recommendations for the Royal College of Psychiatrists	16
Recommendations for integrated care systems and NHS trusts	16
Recommendations for clinicians	16
Terminology	18
Individuals	18
Regular and irregular routes	19
A note on stigmatising and dehumanising language	19
Glossary	20
Report authors, acknowledgements and timeline	21
Authors	21
Acknowledgements	22
Timeline of writing	22
Introduction	23
Overview of report	23
The UK asylum context up until 2022	25
Mental health in the sanctuary-seeking population	25
The ‘hostile environment’	25
Immigration limbo	25
Detention	26
Hotel accommodation and quasi-detention	29
A timeline of the Nationality and Borders Act 2022, the Illegal Migration Act 2023, and the Safety of Rwanda Act 2024	30
Diagram 1 – Flowchart of new changes to the UK asylum process	31

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Part 1: The mental health consequences of the new legislation	33
1.1 Key changes introduced by the Illegal Migration Act 2023	33
1.2 Inadmissibility and safe third country agreements	35
1.2.1 Legal changes	35
1.2.2 What is a 'safe third country'?	35
1.2.3 Mental health concerns relating to the Illegal Migration Act 2023	39
Increased periods of immigration limbo	39
Accommodation centres and quasi-detention	42
Harms from threat of removal	43
Harms following removal	44
1.3 Immigration detention	45
1.3.1 Legal changes	45
1.3.2 Mental health concerns	46
1.4 No appeals rights except 'serious and irreversible harm'	47
1.4.1 Legal changes	47
1.4.2 Mental health concerns	47
1.5 The Nationality and Borders Act (2022)	49
1.5.1 What is the NABA?	49
Increased standard of proof	50
Mental health concerns	50
Lowering of the serious crime threshold	50
Mental health concerns	51
Removals to safe third countries under the NABA	52
Appeals	53
Part 2: Impacts of legislation for specific groups	54
2.1 Survivors of human trafficking	54
2.1.1 Legal changes	54
The Illegal Migration Act 2023	54
The Nationality and Borders Act 2022	54
2.1.2 Mental health concerns	57
2.2 Children, adolescents and parents	59
2.2.1 Inadmissibility and safe third country agreements	59
2.2.2 Long periods in limbo	60
2.2.3 Immigration detention	61
2.2.4 Family reunification	61
2.2.5 Age assessments	62
2.2.6 An accelerated process	63
2.2.7 Trafficking	64

2.3	Older adults	64
2.3.1	Older adults and the asylum system	64
2.3.2	Mental health concerns	65
2.4	Women	66
2.4.1	Women and the asylum system	66
2.4.2	Changes to detention rules: implications for women	67
2.4.3	Inadmissibility and 'safe third country' agreements: implications for women	67
2.4.4	NABA: implications for women	68
2.5	People with intellectual disabilities	69
2.5.1	Mental health concerns	69
	Identification of intellectual disabilities	69
	Trauma and mental health burden in people with intellectual disabilities	70
	Immigration detention	70
2.6	LGBTQI+ individuals	70
	Part 3: What can psychiatrists do?	73
3.1	Notes for all psychiatrists working in general NHS settings	73
3.1.1	Direct clinical care	73
3.1.2	ICB, trust and service-level care	76
3.1.3	Research and clinical governance	78
3.1.4	Policy and advocacy level	80
3.2	Medico-legal report writing	81
3.3	Ethical and human rights concerns for psychiatrists	82
	Conclusion	85
	References	87
	Appendix A: Recommended reading list	95
	Appendix B: Example letter to establish asylum seeker mental health champions	97

Foreword



It is often said that how a society treats its most vulnerable members is the true measure of its humanity. A crucial test of our society in the UK, therefore, will be how the government and its agencies choose to address the needs of those seeking sanctuary within our borders.

Many have left countries in which they directly experienced, witnessed or were at risk of being subjected to some of the worst traumas that can be visited on an individual, such as rape, imprisonment and torture. During their journeys, they have been vulnerable to further trauma, sometimes at the hands of traffickers, occasionally caused by other people seeking sanctuary, and even by the local population in the countries they are passing through. For many people who reach the UK, the final part of their journey on 'small boats' can be particularly hazardous and traumatic.

As a result of these factors, it is not surprising that many people experience significant mental illness and are at risk of re-traumatisation because of the treatment they receive on arrival. We, as a country, must ensure that through our legislation and practice, we make their lives better and not worse.

The College is concerned that the immigration legislation passed by the previous government has the potential to cause substantial harm to people seeking sanctuary, particularly those with pre-existing mental health problems.

This report outlines the considerable harm caused by the rapid introduction of immigration legislation since 2022, including the Nationality and Borders Act 2022 (NABA), the Illegal Migration Act 2023 (IMA), and the Safety of Rwanda Act 2024. These policies will compound mental distress and illness by prolonging periods of uncertainty, increasing rates of immigration detention, limiting opportunities to seek legal support, and exacerbating pre-existing barriers to healthcare.

However, these harms can be mitigated by policymakers, mental health professionals and the services in which they work. This report will assist mental health clinicians, as well as commissioners and managers, to identify and address the potential impacts of new legislation on individuals and at service level. As psychiatrists, we have a duty to champion the provision of equitable needs-based care for all in society and, as this report highlights, people seeking sanctuary require specific focus.

If implemented, the clinical care recommendations outlined in this report will provide the added benefit of improving clinical competencies in relation to the treatment of people who have experienced trauma more generally, as well as providing much needed additional capacity in mental health services for people who present with similar symptoms.

Crucially, this report was produced with the involvement of experts with lived experience of forced migration and the UK asylum system. In addition to outlining the conditions they had to endure, these experts highlight the negative psychological impacts of both dehumanising language and the culture of rejection and disbelief that is encapsulated within recent legislation and prevailing

public narrative. They remind us of the importance of carefully considering our choice of words, and of taking an empathetic, non-judgemental stance towards others – things in which we, as psychiatrists, are well versed and which should especially apply to this population.

Produced by the College's Working Group for Mental Health and Forced Migration and Human Rights Committee, this report forms part of the College's continuing efforts to advocate for the mental health needs of people seeking sanctuary. This includes our campaigning work on the potential mental health impacts of recent legislation as it went through its tortuous journey through parliament and our [2021 position statement on immigration detention](#). Training in this area has been included in the 2022 Core Psychiatry Training Curriculum, which states that psychiatrists should understand the impact of forced migration on mental health presentations.

Sadly, and as this report suggests, the need for us all to retain our focus on forced migration is likely to increase in the coming years. A robust immigration policy can still be guided by human kindness and be compatible with providing mental health services for some of the most vulnerable people coming to the UK. Also, changes should be considered that would allow people to work while their claims are processed, as this would have the potential to not only benefit the individuals concerned, but also provide economic benefit to the country.

The new Labour government has an opportunity to ensure its new immigration policies and legislation explicitly protect people seeking sanctuary who have mental illness. It should act upon the recommendations outlined in this report.

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Executive summary

People who have been displaced and are seeking refuge and protection may have faced violence, danger or exploitation and lost loved ones. These can be deeply traumatic experiences and increase the risk that someone might develop a mental illness such as anxiety, depression or post-traumatic stress disorder.

This report, developed and revised over the past two years, addresses the profound implications of asylum legislation introduced by the previous government, including the Nationality and Borders Act 2022 (NABA), the Illegal Migration Act 2023 (IMA), and the Safety of Rwanda Act 2024. The rapid introduction and implementation of these laws have raised significant concerns among professionals and advocacy groups regarding their impact on mental health. In our view, there is now an important opportunity for a new government, as well as the Royal College of Psychiatrists and mental health professionals, to take action to mitigate this impact.

The report is aimed at all stakeholders who are involved in, or whose decisions affect, the care of asylum seekers – including the government, NHS Trusts and clinicians. Each of these stakeholders will need to make changes to ensure the mental health of asylum seekers is better protected, which is why the report offers practical and actionable recommendations for each.

Overview of legislation

The NABA, which came into force in 2022, introduced several provisions that significantly altered the asylum process in the UK, making it much more onerous for people to navigate – particularly those with significant mental health problems. This legislation imposed higher evidentiary standards, tighter deadlines, and accelerated procedures. The threshold of crimes for which someone can be removed from the country after receiving leave to remain has been lowered, which may now involve less serious, non-violent, crimes. Additionally, NABA introduced provisions for offshore processing and differential treatment based on the mode of arrival, with those arriving irregularly, such as by small boat, being given fewer rights. Although the differential treatment aspect was later revoked, the concerns about its impact on mental health persisted around its other provisions.

The IMA further exacerbated the situation by criminalizing irregular arrivals, rendering their claims ‘inadmissible’ and mandating their transfer to “safe third countries” for asylum processing, with a permanent ban on re-entry to the UK. This legislation significantly narrowed appeal rights for removal, effectively excluding the majority of people seeking sanctuary from the UK asylum system, including victims of trafficking. These IMA provisions were met with widespread dismay from campaigners and legal experts for breaching the UK’s international human rights obligations. Furthermore, the IMA also introduced provisions for increasing the use of immigration detention and of limiting appeal rights following being detained.

In conjunction with these changes, the UK government established an arrangement with Rwanda to outsource responsibility to the Rwandan authorities to process claims with a view to successful applicants being granted asylum in Rwanda (rather than the UK). This arrangement faced substantial criticism due to concerns about Rwanda's safety for various individuals, particularly regarding their sexual identity, healthcare needs, and the risk of being returned to their country of origin where they may face persecution. Despite legal challenges, including a ruling from the Supreme Court that Rwanda was not safe for everyone, the Safety of Rwanda Act 2024 was brought into force. This new law declared Rwanda safe for all individuals, effectively overriding judicial assessments.

By early 2024, the government had not yet sent anyone to Rwanda but this policy had nevertheless caused significant distress, particularly among those notified of potential removals, as well as leading to a pause in asylum decisions in anticipation of individuals' future removal.

Following the General Election in July 2024 and the Labour Party's victory, significant policy shifts were announced. The new government declared that the agreement with Rwanda would be terminated, and that all asylum claims previously deemed inadmissible would be processed within the UK, with executive powers being used to choose not to enforce inadmissibility provisions, such that nobody currently entering the UK will be deemed inadmissible. This decision is a positive development, as it is likely to reduce some of the anticipated mental health harms associated with forced removals to Rwanda. However, the Labour government has not repealed either piece of legislation, nor have they ruled out future agreements with other safe third countries or for offshore processing arrangements, which may still pose risks to mental health. Additionally, plans for a fast-track asylum system have been announced, though detailed implementation strategies are yet to be disclosed.

Key findings

Language and rhetoric

Consultation with experts by lived experience highlighted the importance of language and rhetoric in this area. Hostile language, or language which refers simply to immigration status or route of arrival, can contribute to feelings of dehumanisation and stigma, and is vital in building trust and a context of safety for people seeking sanctuary.

Forcible removals

The new government has announced that they will not send any people seeking sanctuary to Rwanda. They have not, however, committed to repealing the IMA, leaving open the possibility that in the future there may be inadmissibility provisions enforced and 'safe third country' agreements

made with other countries. Evidence gathered by organisations working with individuals who received Rwanda removal notices suggests that mental health difficulties were exacerbated, fear, uncertainty and confusion were triggered, and that the risk of self-harm and suicide was increased. Many of the individuals selected for removal showed evidence of serious mental illness, and/or having survived trafficking and torture. Any policy which involves forcible removal of people seeking sanctuary to another country is likely to have similar effects and would be highly concerning on both health and humanitarian grounds.

Offshoring

The new government has announced that all current asylum claims will now be processed in the UK, however, it has not ruled out the possibility of processing those claims offshore rather than in the UK in the future. Offshoring is the process of people being held in, or forcibly removed to, offshore locations or other countries, where their claims will be processed. This policy has been used in Australia, where extensive research evidence indicates that such a policy can compromise human rights and health, with high rates of post traumatic stress disorder (PTSD), depression, self-harm and suicidality amongst those held offshore.

Limited appeals rights

Under the IMA, the appeals rights available to stop forced removals are significantly limited, with appeals only permitted on the grounds that removal would cause “serious and irreversible harm.” It is not yet clear how these provisions might be used given the new government’s stated intentions to not send anyone to Rwanda. However, if used in any future policies, these limits to appeal rights would disproportionately impact those with mental health difficulties, who would find it more difficult to marshal the required evidence. Furthermore, as mental health clinicians we know that it can be almost impossible to predict the trajectory of mental health at an individual level, as would be required in these cases, despite evidence at a population level that traumatic life events can cause impacts that are both serious and potentially life-long.

Fast-track processes

The NABA introduced new tight deadlines for providing evidence, with penalties for missing deadlines such that less weight is given to any ‘late’ evidence. There are significant potential problems associated with accelerated procedures, which remain concerning given the new government’s stated intentions to develop new fast-track procedures to process asylum claims. Fast-track procedures and tight deadlines may hinder comprehensive evaluations of asylum claims, including psychiatric assessment and, as previously mentioned, those with existing mental health difficulties are likely to disproportionately find it difficult

to gather the evidence, including medico-legal reports, required. Given the ambiguity around what constitutes acceptable reasons for providing evidence late, it is not clear how grounds related to mental health will be interpreted by decision-makers. People with mental health difficulties or histories of trauma are at particular risk of enforced return to their countries of origin despite significant vulnerabilities that would have come to light were their claims to have been assessed in a more appropriate time period. For context, a previous iteration of fast-track procedures, the ‘detained fast track’ policy, was described as “structurally unfair and unjust” and was ultimately found to be unlawful by the High Court in 2015.

Immigration limbo

Long periods of immigration limbo are characterised by uncertainty, fear of detention or forced removal and even destitution. Provisions in the IMA increase these periods in limbo, although it is unclear how this might change with the new government’s proposals. During the long asylum process, people seeking sanctuary are isolated from the wider community in a variety of ways, including through lack of access to work or education, restrictions on housing and benefits, poor standards of accommodation, expectations of regular Home Office reporting, and barriers to accessing healthcare. Offering longitudinal support for mental health difficulties can be very challenging due to relocation or detention at short notice, leading to lack of continuity or follow-up. Because of the ongoing uncertainty that individuals face, this context does not allow for the psychological safety required for recovery from trauma and can leave clinicians morally injured when unable to offer much-needed therapies.

Immigration detention

The UK is the only European country in which there is no maximum time limit on immigration detention. The IMA introduced detention as a fundamental part of the removal process and gives powers to detain for as long as the Secretary of State considers “reasonably necessary” to examine their case or remove them. We highlight evidence and a 2021 RCPsych Report into the harms of immigration detention, showing considerable adverse effects on mental health. Mental healthcare in detention is poor overall, with little provision of appropriate screening, assessment, monitoring or treatment. Inadequate staff recruitment and retention, lack of private clinic space and inadequate funding all contribute to poor healthcare.

Hotel accommodation and quasi-detention facilities

The use of hotel accommodation and large-scale quasi-detention facilities has been concerning, and evidence suggests that physical and social isolation are common, as well as re-traumatisation through the often military or prison-like nature of the buildings, sleep deprivation and restriction and surveillance of residents’ movements. The Bibby Stockholm barge, for example, was frightening for individuals who could not swim and who had made dangerous journeys

across the sea. Several such facilities have been closed due to health and safety concerns. It is important to ensure that future asylum accommodation is fit for purpose and does not exacerbate mental health problems.

Impacts of legislation for specific groups

Victims of trafficking

The NABA and IMA both present trafficking as an 'illegal immigration' concern rather than (as was previously and rightly the case) as primarily a safeguarding issue for victims. The NABA introduced additional barriers to the identification of victims of trafficking and narrowed the support for those who are able to enter the National Referral Mechanism. For those who arrived irregularly and were to be deemed 'inadmissible' and removed to a 'safe third country,' there was to be no exception for victims of trafficking. The 'rest and recovery' period has been reduced from 45 to 30 days, and similar tighter deadlines for providing evidence have been introduced. There is a high prevalence of mental disorders among survivors of human trafficking, especially anxiety and trauma-related conditions, and they are more likely to fall into the category of those who find it difficult to disclose trauma, as they may additionally fear retaliation from their traffickers towards themselves or their families.

Children

For children, the IMA provided for children who had arrived irregularly to remain in the UK, but with a view that they be removed once they turned 18. This would prevent social integration and any sense of psychological safety, as the threat of removal may last for years. This would have added to the anxiety that many children and young people who have received temporary Unaccompanied Asylum-Seeking Child (UASC) leave already experience about turning 18, when their leave is reviewed, and they may not receive further leave to remain. The IMA reverses previous legislation which banned the detention of unaccompanied children for more than 24 hours, and now allows for the potential indefinite detention of children, although this has not yet been brought into force.

The impact of detention on children's wellbeing and mental health is likely to be significant. The increased risk of detention and removal for children, as well as for adults, is likely to contribute to people removing themselves from the oversight of the asylum system and becoming 'undocumented.' This would place children, as well as adults, at risk of trafficking, exploitation, sexual violence and criminal gangs, in addition to the impacts from loss of oversight or protection from Children's services and loss of education.

The NABA has introduced new regulations relating to age assessments with mandatory so-called 'scientific' methods, which have received criticism from the medical and dental communities as evidence suggests these methods are unreliable. Furthermore, refusal to undergo these 'scientific' methods may now lead decision-makers to find a child less credible, negatively impacting their claim. This process of age assessment is moving more towards oversight of the Home Office rather than the local authority, which may lead to assessment outcomes being biased by political pressures. The impacts on a child of mistakenly being treated as an adult are significant and include missed educational opportunities, being housed alongside adults with subsequent safeguarding concerns, the undermining of trust between the child and services, and impacts on identity and self-esteem.

Older adults

Older adults seeking sanctuary may be particularly vulnerable, and may have already found the journeys from their country of origin to be challenging due to frailty or disability. The social isolation experienced by older adults in host countries can be significant, and they may find it harder to integrate due to having less ability to learn a new language or access online support, as well as challenges accessing healthcare. Both the NABA and the IMA have introduced changes that will severely hinder the ability of diaspora communities to offer safe and stable communities, and family and community support is often a key source of support for older adults in migrant communities.

Women

The increased risk of becoming undocumented applies to everyone under the new legislation, however, women are at higher risk if they are to become undocumented or destitute, for example from modern slavery and sexual exploitation. Women may face heightened challenges due to a new higher standard of proof required to demonstrate abuse, and the narrowing definition of "particular social group" under the NABA further restricts their ability to seek asylum.

People with intellectual disabilities

The UK asylum system's complexity poses significant challenges for people with intellectual disabilities, who already face barriers to accessing specialist assessment and care. While the IMA and the NABA do not specifically address intellectual disabilities, their provisions may disproportionately affect this vulnerable group. The lack of screening for intellectual disabilities and the unrealistic legal expectations and timelines for appeals exacerbate these challenges. Diagnosing intellectual disabilities is time-consuming and may be hindered by language barriers, lack of developmental history, and cultural differences. The absence of basic screening means many individuals may remain unsupported, unable to navigate the asylum process, and may face increased risk of removal. Additionally, the restrictive nature

of immigration detention settings can heighten anxiety and aggression in people with intellectual disabilities, who require specialized clinical care often unavailable in such environments.

LGBTQI+ individuals

LGBTQI+ individuals seeking sanctuary often face severe persecution, including violence, harassment, and mental health issues, both before and after arrival in host countries like the UK. The UNHCR has noted an increase in LGBTQI+ asylum seekers, many of whom qualify for protection under the “membership of a particular social group” clause of the 1951 Refugee Convention. Policies such as ‘safe third country’ arrangements or offshoring policies complicate this situation through the use of blanket ‘safe’ lists, which may not be safe for LGBTQI+ individuals due to discriminatory laws and hostile environments. The IMA’s increased provision for detention and rapid timelines for claims and appeals further exacerbate the challenges LGBTQI+ asylum seekers face, often forcing them to hide their identities and increasing their vulnerability to trafficking and abuse.

What can the government do?

The government has a moral and ethical obligation to ensure all immigration legislation explicitly protects and supports those with mental illness. In order to do this, it must carry out a review of all current relevant legislation in terms of its potential impact on mental health, before considering making any further changes to law.

The government’s actions and policies should not make someone’s mental health worse through detention. It should ensure that people with mental disorders, or who have experienced torture or other severe abuses of their human rights, are only subjected to immigration detention in very exceptional circumstances. Even in such circumstances, the length of detention should be short and the availability of alternative settings should be considered at every stage.

Ensuring people receive the mental health care they need is a priority. If individuals with severe mental illness are detained on an exceptional basis, they should be based in a mental health setting in which they can receive appropriate care.

The government also needs to ensure there is funding for medico-legal reports (MLRs) and to develop a plan for independent specialist training for clinicians writing them, given the predicted significant increase in need for them to be produced. Training must be developed with the input of mental health experts to ensure its appropriateness.

What can psychiatrists do?

Psychiatrists in general NHS settings can support asylum seekers through direct clinical care, service-level changes, research, advocacy, and public health initiatives, and in all contexts, understanding cultural differences in expressions of distress and practicing cultural humility are key. Psychiatrists can help people seeking sanctuary at an individual level by supporting them to secure legal representation and being aware of local support resources. Social prescribing to combat loneliness and small adjustments to usual practices, like clarifying roles and taking a trauma-informed approach, can improve care. In addition, documentation should be mindful of legal implications, ensuring accuracy and sensitivity to patients' histories and mental states. Mental capacity assessments may be necessary, particularly for those with cognitive impairment or severe mental disorders, to ensure they can make informed decisions about their asylum cases.

Psychiatrists can support asylum seekers at team, service, trust, and integrated care levels by ensuring staff receive appropriate training on trauma-informed care, advocating for the establishment of immigration hubs or leads within larger trusts, and advocating for the recruiting of psychiatrists with forced migration backgrounds. Research on the mental health impacts of new immigration laws is essential, using both primary and pre-existing data, and should ideally be co-produced with individuals with lived experience. Clinicians can also undertake audits, service evaluations, and quality improvement projects to assess and improve service provision.

Advocacy at the policy level is crucial, as the new laws violate medical ethical principles, necessitating action to mitigate their negative mental health impacts. Psychiatrists are encouraged to support professional bodies and organizations working with forced migrants to advocate for more ethical and just policies. Solicitors representing asylum seekers may request a psychiatric medico-legal report (MLR) if they suspect their client has mental health issues, necessitating formal assessment by trained clinicians. With the projected increased need for timely MLRs following the new immigration legislation, psychiatrists should consider training in this area.

Psychiatrists may face ethical dilemmas and moral injury through, for example, conducting assessments in unsuitable environments or assessing fitness to fly despite moral objection to forced removals. The legislation is considered by many to violate the UK's international human rights obligations, impacting both asylum seekers and therefore vicariously also clinicians. To mitigate harm, support structures like peer networks, supervision, and reflective spaces are recommended for mental health professionals working with people seeking sanctuary; enhancing their capacity to cope with the ethical challenges posed by the new laws.

Recommendations

Given that we predict the new pieces of legislation will have profound implications for mental health, risk levels, and UK mental health services and mental health staff, as well as raise significant human rights and ethical concerns, we recommend that the government, the Royal College of Psychiatrists, integrated care systems, NHS trusts and individual clinicians take immediate steps to address the concerns set out in this report.

Recommendations for the government

- Ensure all immigration legislation explicitly protects and supports those with mental illness and carries out a review of all current legislation with mental health impacts in mind before consideration of any new changes to law.
- As previously outlined in our 2021 College Position Statement regarding immigration detention,⁽⁴⁾ we continue to recommend that people with mental disorders, or who have experienced torture or other severe abuses of their human rights, should only be subjected to immigration detention in very exceptional circumstances. Even in such circumstances, the length of detention should be minimised and the availability of alternative settings considered at every stage.
- Ensure that individuals with severe mental illness for whom detention is appropriate on an exceptional basis are placed within an appropriate mental health setting so that they can receive the care that they need.
- Develop a plan for independent specialist training of clinicians in medico-legal report (MLR) writing and for the funding of such reports, given the predicted significant increase in need for such reports. This must be done with the input of mental health experts.
- Develop a plan for increasing the availability of legal aid across the country, where it can be very challenging for people seeking sanctuary to get the legal support that they need, particularly in view of the narrowed scope for appeals and the accelerated timelines.
- Working with the NHS, develop a plan for the funding and development of new specialist mental health trauma centres across the UK, with those seeking sanctuary a key group who would benefit from such access to this type of specialist care but also will meet the needs of wider patient populations. These need to be staffed by clinicians with appropriate specialist training to provide trauma-informed care.
- Develop more detailed guidance to accompany the Nationality and Borders Act 2022 (NABA) and the Illegal Migration Act 2023 (IMA) as to the type of medical evidence that will be required in decision-making processes and in cases where decisions are challenged. This must be done with the input of mental health experts.
- Reconsider healthcare charging regulations in light of the predicted significant increase in people who may find themselves ineligible for NHS treatments under the immigration legislation set out by the previous government, and the potential increased need for physical and mental healthcare. There should be no inherent disincentives for those needing treatment to come forward. When individuals do not seek care, the consequences are not just on an individual level. It often costs the system more when these individuals eventually engage with services at crisis point, and require more resources to address their needs.
- Promote the development and use of language and terms that promotes an understanding of the need to treat those seeking sanctuary in a fair and equitable way.
- As this legislation is new, and based on the evidence currently available, it will be vital that these outcomes are monitored, and we recommend that research is commissioned into the outcomes and impacts of this legislation.

Recommendations for the Royal College of Psychiatrists

- We welcome the inclusion, in the 2022 College curriculum, of the health needs of people seeking sanctuary, and recommend the continued development of CPD resources and training packages in this area for clinicians of all grades.
 - Examples of topics that should be included are the implications of NHS fees for those seeking sanctuary and the possible implications that certain treatments and clinical documentation could have for someone's asylum claim. As fitness to fly assessments and assessments of the impact of immigration detention or removal are likely to increase in need, these could usefully be included.
- The College Ethics Committee should periodically review immigration legislation and, where appropriate, highlight particular issues faced by psychiatrists, which can be fed back to clinicians and to the government.

Recommendations for integrated care systems and NHS trusts

Based on the [example of good practice service](#) in the body of this report of an existing specialist clinic designed around the needs of people seeking sanctuary, we recommend that consideration be given to developing and funding such services.

- We recommend the provision of centralised resources where clinicians can access information on immigration issues. This may involve a designated person who is tasked with keeping updated with immigration policy, and who can signpost clinicians to appropriate national and local services. We include an example job description for what might be included in such a role.
- Audit and quality improvement projects are encouraged to assess how well the needs of people seeking sanctuary and refugees are being met.

Recommendations for clinicians

- When seeing a patient who is seeking sanctuary, consider:
 - whether they have experienced a traumatic or upsetting event in their country of origin or during their journey to the UK – and whether to ask them specifically about this
 - what elements of mental state, risk, or vulnerability factors might be helpful to cover in a clinic letter.
 - whether there are any clinic issues that may affect their ability to give an account of their experiences, e.g. lack of interpreter, barriers to access.
 - whether they have any legal representation or immigration advice support – ask if unsure and signpost them towards relevant organisations.
 - which support charities and organisations may be able to provide them with support and advice – signpost them to relevant organisations, if appropriate
 - whether the patient has been moved, or is at risk of being moved to different asylum support accommodation, and the potential impact this may have on continuity of assessment and treatment.
 - whether they might fear being charged for any recommended treatment and discuss this with them (although clinicians don't routinely ask patients about their finances, it may become pertinent to do so if finances are a potential barrier to accessing care).
- For clinicians who routinely see people seeking sanctuary in their practice, we recommend joining or forming [Balint groups](#) or equivalent peer support groups

as sources of support, particularly in the face of the likely large increase in health burden amongst this population. We provide an [example of setting up a Balint group dedicated to this topic](#) in the body of the report.

Terminology

Individuals

Different terms, like 'asylum seeker', 'refugee' and 'migrant' are often used interchangeably and, at times, inaccurately. For clinicians, this can be confusing, and it can sometimes be difficult to know which term to use.

A **refugee (in common parlance)** is someone who has fled war, conflict, or persecution, and crossed an international border to find safety in another country. The 1951 UN Refugee Convention, to which the UK is a signatory, provides a narrower but internationally recognised definition of a refugee as someone 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 [or her] nationality, and is unable or, owing to such fear, is unwilling to return to it."

A person may be said to have **refugee status** when their application for asylum has been formally accepted by a state, and they are officially recognised as a refugee under the UN Refugee Convention. In the UK, this will mean they are eligible to work, and receive other benefits, such as access to welfare benefits and the right to family reunion, that they may not have been otherwise entitled to. Refugee status is not permanent, and only lasts for 5 years, after which someone can apply for **indefinite leave to remain** (permanent residence), the outcome of which will depend on their circumstances and the circumstances in their country of origin.

It is important to remember that there may be multiple reasons why a person, who essentially is a refugee, might not – or might not yet – have refugee status in the UK. This in itself does not mean that a person is not a refugee, or that the history they provide is inaccurate or unreliable. For example, it is not uncommon for people to have their initial asylum claim refused, only to be granted refugee status on appeal, or at fresh claim stage (i.e. on making a further application after the initial claim has been refused), often subsequent to having had access to a quality lawyer with appropriate experience, or medico-legal evidence. Even those who may have had an appeal refused and might have been labelled as **appeal rights exhausted**, may simply not have had access to the quality and experienced legal support or medical evidence that they required to fully present their case.

An **asylum seeker** is a term commonly used for someone who has made an application for asylum in another country, and this application has not yet been determined, or is being appealed, i.e. they have not yet been granted official refugee status. There is a legal right to seek asylum under international law and, even in such instances where an application for asylum is subsequently refused, this does not mean that the application was illegal or illegitimate.

The term **migrant** has no legal definition and is often used as a generic term for people who have moved to the UK from another country, for a variety of reasons. This may include people who have been forcibly displaced. Within popular discourse, it is often used loosely, and can conflate issues of immigration status, race, ethnicity and asylum.⁽¹⁾ In practice, within the context of refugee issues, it can be used as a way to indicate the 'genuineness' or 'deservingness' or otherwise of different types of refugees and forcibly displaced people, such as those from particular countries or regions.

Increasingly, terms such as 'asylum seeker' and 'migrants' have come to have negative connotations for some people, and have been criticised as being pejorative and dehumanising by focusing on defining a person fundamentally according to their immigration status.

Within this context, the term **person/people seeking sanctuary** has been proposed as a general term which is both accurate and meaningful, and not demeaning to the people involved. In this report, where general references are made, in accordance with principles of using non-stigmatising and non-hostile language, and following feedback from the experts by lived experience who were consulted, we will be using the term 'person/people seeking sanctuary.' In instances where a specific term is required, such as where a distinction is legally meaningful, alternative terms may be utilised for the purposes of clarity.

Regular and irregular routes

People who enter the UK, including people seeking sanctuary, do so by various different means. The UK government has immigration checks at airports, sea crossings, and the Channel Tunnel. People who arrive at airports or ports with the required documents and subsequently make an asylum claim, are often referred to as having arrived via **'regular'** routes. This includes people who travel on a work, travel or student visa and who 'overstay' their visa.

For various reasons, many people may not be able or permitted to arrive in the UK using regular routes (see [Box 4: Are there 'safe and legal routes' for people seeking sanctuary?](#)). As a result, people may turn to **'irregular'** routes – such as crossing the Channel in a small boat, or stowing away in a lorry – and subsequently make an application for asylum once they have already entered the UK.

These are sometimes referred to as **'legal'** and **'illegal'** routes. We have preferred not to use this terminology, as everyone has a legal right to seek asylum under international law.

However, this is likely to become an increasingly complicated area from a legal perspective. The IMA states that a person who arrives in the UK indirectly via an irregular route and seeks asylum has acted in contravention of UK law, even if they subsequently would have been eligible for refugee status. Whilst we acknowledge the changes and proposed changes to UK immigration law, we continue to advocate use of established and accurate terminology that is both in accordance with international law, and meaningful for use in clinical practice.

A note on stigmatising and dehumanising language

Clinicians should be mindful of the terminology they use and ensure it is accurate and appropriate, and not incorrect, dehumanising, stigmatising, or unnecessarily hostile – this includes describing people as 'illegal' or 'failed'. Alternative descriptive terms should be used, clarifying, for example, that a person has arrived in the UK through an irregular route, or that their asylum claim has been refused and is being appealed, or that their appeal rights are exhausted. Using accurate and respectful language is a crucial part of creating a climate of trust, in which patients can feel safe to access healthcare. It also serves to enhance therapeutic relationships, improve engagement and maximise the potential for recovery. This is particularly important for people seeking sanctuary, who may be feeling disproportionately vulnerable when they come into contact with healthcare services.

Defining people in a negative way according to their immigration status alone is often experienced as dehumanising, and in our clinical experience, can contribute towards or even directly lead to discriminatory practice. *Good Medical Practice* requires doctors to show respect for patients, and to treat patients fairly and without discrimination.⁽²⁾ The Royal College of Psychiatrists' framework of core values for psychiatrists also emphasises fairness and trust, and treating people with dignity and respect,⁽³⁾ and these qualities should be borne in mind when providing mental healthcare to people seeking sanctuary.

Lived-experience insight: From a member of One Strong Voice

Box 1: Bravo

We spoke to Bravo (pseudonym) who has experience with UK immigration detention. He noted that inflammatory language and politicisation are among the new legislation's most damaging impacts, further alienating and dehumanising refugees and people seeking asylum in the UK. Bravo highlighted that people's safety is under threat due to the normalisation of inflammatory language. He considers it a deliberate tactic to create division between the public and people seeking sanctuary. The division resulting from the inflammatory language has a severe impact on people's emotional well-being and causes feelings of unsafety and hopelessness.

“It makes you feel it is unsafe to ask for help. If you go to the shop, you fear that people will start attacking you. If you have been attacked by the system itself, you feel like you are being attacked by the government and the community where you live because they do not want you to live there. So now, together with your mental health, when you already have PTSD and other mental health issues, you don't want to wake up in the morning.”

Glossary

APPG	All-Party Parliamentary Group
BMA	British Medical Association
CPTSD	Complex Post Traumatic Stress Disorder
DOTW	Doctors Of The World
ECAT	Council of Europe Convention on Action Against Trafficking
ECHR	European Convention on Human Rights
EU	European Union
FREDA	Fairness, Respect, Equality, Dignity and Autonomy
ICB	Integrated Care Board
ICIBI	Independent Chief Inspector of Borders and Immigration
ICS	Integrated Care Systems
IRC	Immigration Removal Centre
IMA	Illegal Migration Act 2023
LGBTQI+	Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, Intersex and Other Sexual and Gender Minority
LTR	Leave to Remain
MHA	Mental Health Act
MLR	Medico-Legal Report
NABA	Nationality and Borders Act 2022
NRM	National Referral Mechanism
PRN	Priority Removal Notice
PTSD	Post Traumatic Stress Disorder
RNLI	Royal National Lifeboat Institution
UASC	Unaccompanied Asylum-Seeking Child
UN	United Nations
UNHCR	United Nations High Commissioner for Refugees

Report authors, acknowledgements and timeline

This report has been jointly written by members of the RCPsych Working Group on Forced Migration and the RCPsych Human Rights Committee.

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We are especially grateful to the experts with lived experience who contributed their expertise and personal stories to this report, who we cannot name individually for confidentiality reasons.

Collecting these personal accounts were Ana Asatiani and Mishka Pillay, of Ana and Mishka Consultancy, who work to inspire positive change for migrants, refugees, and people seeking asylum. They conducted consultations with individuals through One Strong Voice, the UK's first coalition of campaigners with lived experience of the immigration and asylum system, including those affected by torture, trafficking, and modern slavery.

As steering committee members, Ana and Mishka provided lived-experience insight at every stage of this report, from conception to completion.

Lived-experience insight: From a member of One Strong Voice

Contributions and input from members of One Strong Voice are shown in yellow boxes, like this one, in relevant sections throughout the report.

Timeline of writing

June 2022	Steering Group initial discussions
June – December 2022	Draft x 7 with steering group comments
October 2022 – January 2023	Consultation with professional experts
January – June 2023	Consultation with experts by experience
June – August 2023	Editing following the passing of the IMA
September 2023 – Feb 2024	Final reviews from experts
March – August 2024	Consultation with RCPsych and edits following the general election

Introduction

Overview of report

We recognise that this report is unusual in the amount of legal content included. The legislation that we are addressing is extraordinary and shocking in many respects, and we therefore feel it is important to include these details to set the context for our concerns as they relate to the mental health of people seeking sanctuary and wider mental health services.

This report focuses on the mental health implications of new UK immigration and asylum legislation that has been introduced over the last two years, specifically the NABA in 2022, the IMA in 2023, and the Safety of Rwanda Act 2024.

There are widespread concerns about the detrimental impact that these pieces of legislation will have for the mental health of those seeking sanctuary, whether that be those arriving with mental illness or those at risk of developing a mental illness because of their treatment on arrival. Indeed, multiple joint statements and evidence were submitted to Parliament and the House of Lords, including from the Royal College of Psychiatrists, which warned of the significant concerns and risks both to individuals' mental health, and for systemic impacts on local services, the NHS and third sector organisations. However, the timetable adopted meant that the opportunity to address and act upon these concerns was not taken, with the consequential risks to those affected by the legislation.

In this report, we aim to offer an overview of how the UK asylum system has been transformed, and to highlight the many adverse mental health impacts that we anticipate seeing in the coming months and years unless there is immediate action to mitigate against the risks.

- We begin by setting the scene of the UK asylum context prior to 2022, introducing some key themes and concerns.
- We then focus on the specific legal changes that have occurred with the introduction of the NABA in 2022, the IMA in 2023, and the Safety of Rwanda Act 2024.
- Throughout the report we identify approaches that safeguard the mental health and enhance the integration of people seeking protection in the UK and of those granted such protection.

We offer some reflections on the likely mental health impacts of these, both to individuals and systemically to the NHS and to wider local services. We also propose some ways that psychiatrists can engage with some of the legal and ethical questions that are raised by the legislation as it affects people's mental health, and offer some practical tips, and signpost to resources, regarding ways clinicians can be better equipped to serve people seeking sanctuary – whether that be in specialist roles or in their daily clinical practice. We offer recommendations for wider mental health services to better accommodate the increasing and varied needs of people seeking sanctuary.

Lived-experience insight: From a member of One Strong Voice

Box 2: Nadine

Nadine spoke to us about the impacts of the new legislation on the people with lived experience of the UK asylum and immigration system.

Having lived in the UK for over a decade, Nadine compared the current situation (created by the new legislation applicable to seeking asylum in the UK) with the immigration system back when she initially claimed asylum in the UK. She highlighted the recurring negative impacts of the new legislation on her mental health, and on many other survivors of torture she works with. Even though she secured her British citizenship, she said she still feels unsafe considering the ongoing hostility against refugees.

“I know from my personal experience as somebody who came to this country seeking asylum that I benefited from a law that provided more protection to me at that time than it would do now, and I understand very much how important it is to feel safe. When I speak about safety, I mean it is one thing to be safe and feel safe. Because of the NABA, people needing safety will be unfortunate, and we’ll be experiencing a lot more hardship while navigating the asylum system.”

This report does **NOT** aim to:

- offer a comprehensive overview of the many ways in which individuals’ mental health can be impacted by fleeing a country of origin, making often dangerous journeys to the UK, and by navigating the complex immigration system on arrival.
- replicate several thorough texts that offer practical advice to professionals on the process of assessment, formulation and mental health interventions for people seeking sanctuary, nor will it cover global migration trends and underlying causes of forced migration.

We do, however, recommend some helpful resources where many of these themes are covered in more detail, such as reports and research documenting:

- The UK’s ‘hostile environment’ towards people seeking sanctuary
- Issues relating to indefinite detention
- The criminalisation of asylum
- Accommodation centres
- The culture of disbelief
- NHS charging policies
- Challenges in access to healthcare.

These can be found in the [reading list in Appendix A](#).

The UK asylum context up until 2022

Mental health in the sanctuary-seeking population

While there are important critiques of Western models of trauma and diagnostic systems, particularly for cross-cultural use,⁽⁵⁾ several research studies have identified higher rates of mental illness in people seeking sanctuary. For example, a systematic review conducted by Blackmore et al (2020) concluded that of 5,143 refugees and people seeking sanctuary across 15 countries:

- 31.5% had PTSD
- 31.5% had depressive disorders
- 11.1% had anxiety disorders, and
- 1.5% had psychoses.⁽⁶⁾

This highlights, in a very broad sense, the significantly higher rates of mental illness in people seeking sanctuary than in the general population. It also emphasises the importance of closely examining the ways in which we might be doing harm through our policies, as well as the importance of exploring ways that mental health can be improved in this group.

The ‘hostile environment’

Applying for refugee status and navigating the UK’s asylum system has long been a stressful process. However, over the last decades in particular, the asylum environment has become progressively more hostile, even being described by government ministers themselves as the ‘hostile environment’.⁽⁷⁾ The Commission on the Integration of Refugees has produced a report, [A Broken System? Asylum Reform Initiatives 1997–2022](#), which offers a more thorough overview of how policies have developed.

The policy that has operated for the past decade is designed to act as a deterrent to people seeking sanctuary by preventing people arriving irregularly from accessing things that the Government might regard as ‘pull factors’ but, in reality, include essential services such as healthcare and legal protection.

These policies continue to have significant negative effects on the mental health of many of those seeking sanctuary. We recommend the 2022 RCPsych publication [Seeking Asylum and Mental Health – A Practical Guide for Professionals](#)⁽⁸⁾ which offers a more detailed overview of the longstanding challenges associated with seeking sanctuary in the UK.

Immigration limbo

Lived-experience insight: From a member of One Strong Voice

Box 3: Sepideh

“It’s a very difficult situation to go through. It is like, you are stuck in this because you don’t know anything about the process and how long it is going to take what will happen to you. It’s unknown. The future is unknown. You’re constantly under pressure, stress, anxiety and trauma.”

– Sepideh

One aspect of navigating the asylum process is the period of ‘limbo,’ in which people can be waiting months or even years for an outcome of their asylum application. These extended periods in immigration limbo may be characterised by uncertainty, fear of detention and/or removal, and near destitution. During this period, after having had

Home Office interviews (which are often re-traumatising, particularly if not undertaken sensitively by appropriately trained and monitored staff), they are isolated from the wider community in several ways.

- They are generally not allowed to work and are therefore at risk of being deskilled and socially isolated.
- They cannot access any higher education or study at all, sometimes with the exception of very limited English classes.
- They have restrictions on housing and welfare benefits and, therefore, have to rely on the limited statutory and third sector support available to meet their housing and essential living needs. Many are living in very poor housing or are destitute.
- They are expected to report regularly to Home Office locations and are liable to be detained in Immigration Reception Centres (IRCs) for a wide range of reasons, such as failing to report, not living at their designated address, or simply if their claim has been refused and removal is being envisaged.

Furthermore, many barriers exist to accessing healthcare, and the aforementioned publication, *Seeking Asylum and Mental Health* offers a helpful overview of some of these barriers.

The issue of immigration limbo is becoming increasingly problematic as the number of people awaiting Home Office decisions remains high, despite attempts to address the 'backlog.' In March 2023, there were 172,758 people waiting for an outcome on their initial asylum claim,⁽⁹⁾ of which 75% had been waiting for over 6 months.⁽¹⁰⁾ While the 'legacy backlog' of claims made prior to 28 June 2022 has since been reduced by 96%, the 'flow' cases of claims made after this date have doubled over the past year meaning that, as of December 2023, there were 128,786 people awaiting an initial decision.⁽¹¹⁾ The percentage of people who had made an asylum claim and who received an initial decision within 6 months has fallen over the last decade, from 87% in 2014, to 10% in 2022.⁽¹²⁾

Under this new legislation, periods of immigration uncertainty are set to increase further.

Detention

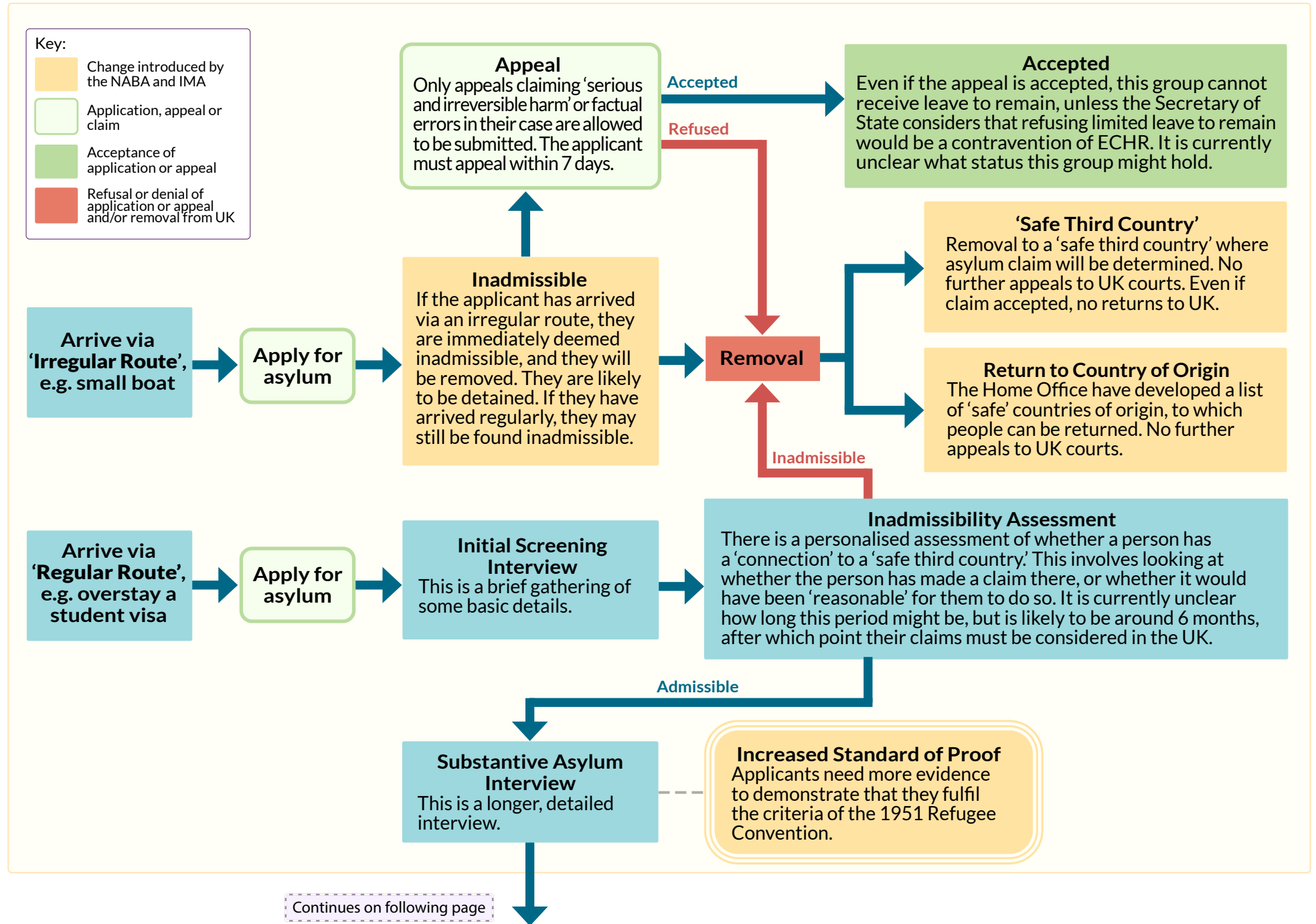
The UK is unique in Europe in that there is no maximum time limit on immigration detention. There is also no statutory judicial process to review continued detention automatically, in contrast to detention under the MHA, which has built-in provisions for Tribunals and Managers' Meetings. We recommend reading:

- The [2016 report to the Home Office 'The Shaw Review'](#)⁽¹³⁾ for further information about the welfare of people detained in IRCs.
- The [2022 ICIBI \(Independent Chief Inspector of Borders and Immigration\) Inspection Report on Adults at Risk in Immigration Detention](#).⁽¹⁴⁾ These inspections were started as a result of the Shaw Review but, concerningly, were stopped by the previous government following publication of the report in September 2022.⁽¹⁵⁾
- The [RCPsych 2021 Position Statement on the Detention of People with Mental Disorders in Immigration Removal Centres](#).⁽¹⁶⁾

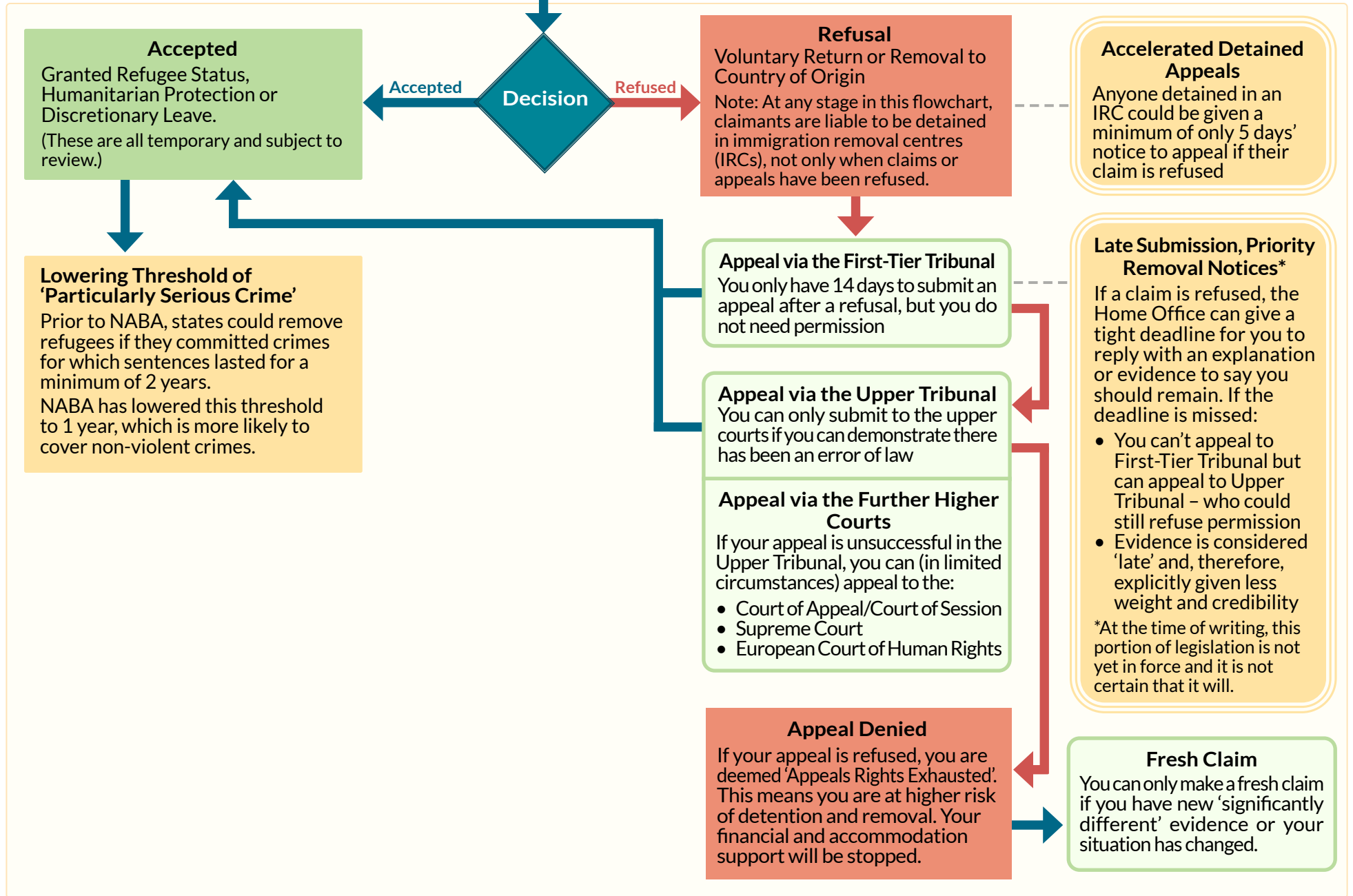
These reports conclude that there is considerable evidence that immigration detention has adverse effects on mental health, especially in the context of the UK's indefinite detention that keeps people stuck in uncertainty for weeks, months, or even years. An inquiry into a specific IRC, Brook House, was published in September 2023 and outlined shocking and disturbing patterns of mistreatment of many detained people.⁽¹⁷⁾

Under the new legislation, there is set to be a significant increase in numbers of people detained in IRCs, a wider scope of groups who can be detained, less mental health screening prior to detention, and less judicial oversight and opportunity to appeal.

Diagram 1 – Flowchart of new changes to the UK asylum process



(Diagram 1 – Continued)



Hotel accommodation and quasi-detention

The increase in backlog of initial decisions has meant an increase in the need for accommodation to house those waiting. The mainstay of accommodation, since 1999, used to be via a 'dispersal' policy, in which people seeking sanctuary would be 'dispersed' across the UK to properties while awaiting an outcome of their claim. Ten years ago, the use of hotel accommodation was very limited. The Refugee Council report, 'Lives on Hold'⁽¹⁸⁾, outlines the significant increase in hotel accommodation over the last decade, in part due to the Covid-19 pandemic. The report concludes that prolonged hotel accommodation is damaging to mental health.

The cost of hotel accommodation has been a recurrent headline in the UK media from 2022 through to 2023. In response, the government has proposed the development of large scale 'accommodation centres,' purportedly for the rapid processing of asylum claims. Proposals have included large accommodation barges, such as the 'Bibby Stockholm' that has been widely reported in the media and on which there has already been the tragic suicide of an individual held there.⁽¹⁹⁾ The new government elected in July 2024 has announced that the Bibby Stockholm will close in January 2025 for cost-saving purposes.

We recommend reading the 'All-Party Parliamentary Group (APPG) Report of the Inquiry into Quasi-Detention'.⁽²⁰⁾ This report outlines the "alarming" situation in which they found physical and social isolation, re-traumatisation through the military/prison-like nature of the accommodation buildings, lack of privacy, and sleep deprivation. They note the restriction and surveillance of residents' movements, the targeting of such places by far-right groups, poor safeguarding, inadequate provision of healthcare and legal support, inadequate food and nutrition, poor cleanliness, intimidation and mistreatment by on-site staff, and highlight the difficulty of disclosure of sensitive information in such settings. The evidence is clear that such large-scale quasi-detention settings are associated with poor mental health and physical health outcomes,⁽²¹⁾ which risks further widening the mortality gap affecting those with mental illness in this population.

The new legislation includes plans to increase the use of these quasi-detention settings.

Case study 1: Hotel accommodation

Samira is a 25-year-old Kurdish woman who came to seek help for her mental health from her GP, and was referred to a local community mental health team. She and her husband live with their 6-month-old baby in hotel accommodation. She came to the UK while pregnant, and although the hotel accommodation is said to be a temporary placement, she has spent over nine months here.

She is struggling with her mental health difficulties – reporting poor sleep, poor appetite and low mood. She finds it difficult to introduce even simple homemade food to her baby as the hotel rules forbid any type of cooking or meal preparation in the rooms. Therefore, she is only giving her baby milk and some ready-made foods. She worries that the lack of access to fresh foods will affect her child's nutrition and development. During the assessment, her husband was very upset and shouted, "We are treated like animals, and we don't have any human rights here. The system makes us feel unwell."

A timeline of the Nationality and Borders Act 2022, the Illegal Migration Act 2023, and the Safety of Rwanda Act 2024

Between March 2018 and March 2023, the government estimated that there were 88,221 people arriving by small boat, a significant increase in numbers from previous years. Of these, 80,989 made an asylum application. Of all asylum applications submitted by those arriving via small boat during this period who have received a decision, 64% of claims were granted on refugee or humanitarian grounds at their initial decision.

The Nationality and Borders Act 2022 (NABA), which was first proposed to Parliament in June 2021 and passed into law in June 2022, was the first piece of legislation to discriminate explicitly based on method of arrival to the UK, regardless of whether or not someone met the criteria for refugee status. The key change introduced by NABA in this regard was the creation of a 'Two-Tier' asylum system, whereby a claimant's method or route of arrival would determine the rights linked to their status, even if they went on to be recognised as a Refugee under the 1951 Convention once their claim was assessed.⁽²²⁾

It also created new 'inadmissibility' criteria that meant someone could be removed from the country if they had 'connections' to a 'safe third state.' This means that if someone had travelled through a 'safe' country and could have 'reasonably' been expected to make a claim for asylum there, the Home Office could deem their claim 'inadmissible' and it would not be assessed in the UK.

The new two-tiered system was introduced with the explicit purpose "to discourage asylum seekers from travelling to the UK other than via safe and legal routes".⁽²³⁾ Under this system, those crossing the English Channel in small boats or arriving irregularly would be placed in 'Group 2'. This section of the NABA authorised discriminatory treatment of Group 2 claimants, who could be treated differently in a variety of ways, such as being denied family reunification rights, denied access to public funds, and being given only temporary leave to remain in the UK and a more prolonged route towards citizenship.

In June 2023 (and following intense pressure from the charity sector and within the House of Lords), the UK government announced that this aspect of the NABA would be retracted, and that those who had been given a 'Group 2' status would have their rights and protection aligned to those of 'Group 1' refugees. This reversal was done in the name of reducing the backlog of asylum cases. Celebration amongst campaigners was muted, as the IMA (then *Illegal Migration Bill*) was going through parliament, the provisions of which would go on to override this 2-tier system and replace it with an entire denial of the right to seek asylum for those who arrive irregularly.

In March 2023, when the government announced new immigration legislation in the form of the *Illegal Migration Bill*, campaigners referred to this as the "Refugee Ban Bill"⁽²⁴⁾ due to the criminalisation of seeking asylum in the UK via irregular routes, which represents the vast majority of those seeking sanctuary in the UK. The Bill was introduced to Parliament as part of one of the Prime Minister's key priorities to 'Stop the Boats', and rapidly progressed through parliament.

In the first half of 2023, the *Illegal Migration Bill* went through the 'ping pong' stage of being sent back and forth between the House of Commons and the House of Lords for amendments. There was significant opposition towards many of the provisions in the Bill, and the House of Lords attempted to block some of the government's plans to try to mitigate some of the worst harms. However, on 20 July 2023, the *Illegal Migration Bill* passed into law as the *Illegal Migration Act 2023*. Many of its provisions, however, have not yet been implemented.

It is a controversial piece of legislation which is widely argued by advocates, campaigners and legal bodies as being inconsistent with the spirit of the UK's international obligations under the UN Refugee Convention. It is difficult to see how the IMA will be implemented

in practice, given multiple ethical and practical barriers, and there will be many organisations following developments with interest and concern.

The day after the IMA was passed, the UN High Commissioner for Refugees, Filippo Grandi, said: *“For decades, the UK has provided refuge to those in need, in line with its international obligations – a tradition of which it has been rightly proud. This new legislation significantly erodes the legal framework that has protected so many, exposing refugees to grave risks in breach of international law.”*⁽²⁵⁾

In April 2024, the Safety of Rwanda Act came into force, which paved the way for removal flights to begin. In the weeks following the UK General Election in July 2024 and the Labour Party forming a government, there were significant announcements about their policy intentions with regard to these new pieces of legislation. They announced that they would not be sending any people seeking sanctuary to Rwanda and announced that their agreement with Rwanda would end. They also announced that they would use executive powers to choose not to enforce of the core tenets of the IMA, that of inadmissibility, meaning that, currently, everyone who arrives in the UK to seek sanctuary, regardless of their means of arrival, will enter into the UK asylum system and have their claims assessed in the UK.

Diagram 1 – Flowchart of new changes to the UK asylum process

The UK asylum context, even prior to the NABA and IMA, was complex and difficult to navigate. Diagram 1, starting on the following page, is a highly simplified flowchart, which aims to show the pathway from arrival to the UK, through making an asylum claim, to the various outcomes of this claim. In the yellow boxes, we have highlighted some of the changes that have been introduced by the NABA and IMA, prior to the government's announcement that they would not enforce the inadmissibility provision of the IMA. They have not, as of yet, committed to this long-term, however.

This flowchart is not comprehensive, and more detailed resources are recommended in our [reading list in Appendix A](#).

Box 4: Are there 'safe and legal routes' for people seeking sanctuary?

It is important to be clear about what 'safe and legal' means in practice. International Refugee Law has its foundation in the 1951 Refugee Convention. In the Convention we find the definition of a refugee, an overview of the rights afforded to refugees, and an overview of the legal obligations of states towards refugees. A key right outlined in Article 31(1) is that of non-penalisation, that is, that all people who are fleeing persecution and seeking sanctuary in another state, have a right to not be punished, or penalised, for entry to a country in a manner that would otherwise be considered 'illegal'.

The IMA represents a departure from these international obligations in that arriving indirectly and irregularly will potentially be in contravention of UK law. The UK government, in response to concerns about this departure, has defended this policy by outlining the availability of 'safe and legal' routes which can be used as an alternative.

When the UK government and the media use the phrase 'safe and legal routes', they are referring largely to resettlement schemes, which involve offering immigration status to an individual or a family while they are still outside of the UK. Documentation and accommodation is ordinarily arranged before entering the UK, and individuals arrive with a legal status that allows them to begin to integrate, settle and build community. This is widely accepted to be the most desirable route to protection in the UK, despite often being an arduous and lengthy process. There is no need for dangerous journeys, much less uncertainty, and on arrival to the UK, resettled refugees are provided with housing and receive support for a year to help them access employment and services. This support is not offered to refugees who have gone through the asylum process in the UK. There are no 'asylum visas' which would allow someone to travel to the UK for the purpose of seeking asylum. This makes resettlement an entirely different process to that of seeking asylum on entry to the UK.

Resettlement routes are therefore to be encouraged globally, and we support initiatives to expand resettlement opportunities to the UK. The key problem, however, is availability. Government statistics suggest that the significant majority of resettlement options are for people from only four countries.

Even when not taking into account the country-specific nature of most of the available resettlement schemes, the number of refugees resettled is small compared with the number of refugees who have gone through the asylum process.

For example, in the year between March 2022 and March 2023 approximately 23,000 people received protection in the UK. Of these, 17,000 received refugee status **via the asylum system** (many of whom will have travelled via irregular routes) and 4,500 received refugee status **via resettlement routes** (3,500 of whom were via Afghanistan-specific schemes).

Amongst those who are eligible for resettlement programmes, the majority will be living in high-risk situations, for example, Afghans facing torture and death while waiting long periods to be accepted onto the Afghan Citizens' Resettlement Scheme. Many will be living in refugee camps.

Therefore, while further resettlement schemes should be strongly encouraged, this should not be in parallel with criminalising and penalising other routes, which remain the only available option for the majority of people globally fleeing persecution.

Part 1: The mental health consequences of the new legislation

We present a detailed overview of the IMA (2023) in this report, and have started with this because it represented the most significant departure from previous asylum law and, to a certain extent, superseded many of the provisions in the earlier NABA (2022) for the majority of people who will go on to claim asylum in the UK, those who arrive via irregular means.

The new government's announcement in July 2024 that all those seeking sanctuary will have their claims assessed in the UK is encouraging, and means that the inadmissibility and 'safe third country' provisions are not currently being enforced for those arriving irregularly. However, there remain concerns about other aspects of the IMA, and as it remains unclear at time of publication how new policies will be developed, it remains important to recognise the significance of the existing legislation, which could still be enforced in the future.

We also provide an overview of the mental health consequences of the NABA, the provisions of which impact anyone who has their claim processed in the UK.

1.1 Key changes introduced by the Illegal Migration Act 2023

- Anyone who arrives in the UK irregularly (starting from 20 July 2023) would be deemed 'inadmissible' and would not have their asylum claims considered in the UK. This would apply regardless of persecution that they may have faced. No Home Office interview would take place to determine circumstances, nor would there be any screening interviews carried out for any vulnerabilities, or medical and mental health needs. The government is currently using executive powers to choose not to enforce this provision.
- A duty has been placed on the Home Secretary to arrange for the removal of anyone arriving irregularly. For unaccompanied children, there is no duty to remove until the child turns 18. The government is currently using executive powers to choose not to enforce this provision.
- There are now significantly increased powers for the Home Office to detain people in IRCs, and there will continue to be no time limits as to how long people can be held before being removed from the UK. Children and pregnant women can now be detained, but with some time limits. This marks a reversal of longstanding commitments to not detain children and to limit the use of detention for vulnerable adults. For those who are detained, there would be no right to apply for bail in the first 28 days, meaning no legal oversight of this deprivation of liberty.
- New limits apply to the appeals process. The only basis on which someone can appeal removal to a 'safe third country' is if they can demonstrate that they would face 'serious and irreversible harm' were they to be removed or they can bring a 'Removal conditions suspensive claim' which argues they do not meet the removal conditions (for instance, because they did not, in fact, arrive in the way the government claims, or are not the person named in the removal notice). Any other claim, including those

relating to human rights, would only be considered once a person had already been removed from the UK. It is unclear how these appeal rights will apply given that the inadmissibility provision of the IMA is currently not being enforced.

- People arriving irregularly are now less likely to receive the full support and protections under the National Referral Mechanism (NRM, the framework for identifying and referring potential victims of modern slavery and ensuring they receive appropriate support) and are generally excluded from Modern Slavery protections. A referral into the NRM will no longer be a barrier to a person's removal if inadmissibility provisions are enforced.

Box 5: A lived-experience perspective of the Illegal Migration Act (IMA)

“For us, as people with lived experience, the IMA is about taking away the fundamental right to seek asylum. As a signatory of the 1951 Refugee Convention, the UK takes responsibility for providing sanctuary to the people once they are recognised as refugees. However, since the IMA has been introduced, people are not be able to exercise their fundamental rights since they cannot even claim asylum in the first place.

Most people who come to the UK to seek asylum are unaware of these hostile policies, and we are concerned for thousands of people who reach the UK hoping to find sanctuary, but they will be either detained or removed to their country of origin or another country where they have never wanted to go. We have reached the reality of no clarity on who can seek asylum in the UK.

When the IMA was introduced, it was said to save people's lives. We all see that these policies are not stopping people from arriving, and we think they will also not stop in the future. Instead, thousands of people will be detained, including children and pregnant women.

One of the most concerning consequences of the hostile immigration approach is that it normalises the detention of people who seek asylum and criminalises them in the public eye, causing stigma and discrimination.

Considering all the above, the UK will have to become a vast prison detaining all the people, which is neither ethical, humane, nor realistic. Therefore, these policies will not serve the purpose for which they were introduced.

After endless years of waiting, both of us currently have secured status in the UK. However, recent developments around asylum and immigration have taken away our sense of belonging, safety and security from us. We feel that we are constantly walking on “eggshells” without knowing what will happen next if someone decides what is “best” for us on our behalf. We are unable to plan our future. While being a refugee is not a choice, compassion is.”

– Ana and Mishka

1.2 Inadmissibility and safe third country agreements

1.2.1 Legal changes

The concept of inadmissibility was introduced in the UK in 2021 to replace the 'Dublin' Regulations (see more in the following section) which were no longer applicable after the UK's exit from the European Union (Brexit). However, under the NABA, someone arriving in the UK and claiming asylum would generally be 'accepted' into the UK asylum system to have their claims considered if they could not be removed to a 'safe third country' in a reasonable period of time, regardless of their method of arrival, meaning that the majority of people seeking sanctuary would receive an interview and have the possibility of receiving protection in the UK if their claims were accepted.

NABA represented, however, the first piece of primary legislation which discriminated based on whether someone had 'come directly' to the UK, with people who travelled through other countries to reach the UK, facing higher risks of removal and, if their claims were dealt with in the UK, having fewer protections and appeals throughout the asylum process. While this aspect of NABA was reversed, the IMA goes further in its inadmissibility criteria. Anyone arriving by any irregular route from 20 July 2023 was immediately deemed inadmissible.

Once a claim has been deemed inadmissible (which would have applied to the majority of asylum claims), the Secretary of State was to have a duty to make arrangements for the person to be removed from the UK either to their country of origin, if it is on the 'safe list,' or to a 'safe third country', and they would never have been 'accepted' into the UK asylum system for their claim to be assessed, unless they are able to make a successful challenge against their removal on the very limited grounds available to them. This was the case from 20 July 2023, when the previous government paused asylum processing, but this decision has now been reversed by the new government, using executive powers. This means that even a survivor of torture or human trafficking would never be able to claim asylum in the UK if they arrived irregularly. Someone deemed inadmissible would no longer be able to appeal this decision (except under extreme circumstances as outlined below), and they would never be granted any form of leave to remain.

Countries on the list of 'safe states' include all the member states of the European Economic Area plus Albania. The only barrier to removal to these states would be if the Secretary of State considers there to be exceptional circumstances.

1.2.2 What is a 'safe third country'?

Under international law, states are required to assess claims for asylum made in their territory. However, certain states, including the UK, have a workaround procedure that allows for the 'return' of people seeking sanctuary to other states deemed to hold responsibility for the claim by virtue of a person having travelled through them. This arrangement is based on the assumption that anyone who was truly in fear of their lives would claim asylum in the first 'safe' country to which they came. There are several problems with this arrangement, however. Firstly, there is no international legal obligation for someone to seek asylum in the first country where protection is available. Secondly, the arrangement does not recognise that a country might be 'safe' for one person but not 'safe' for another based on individual circumstances. Thirdly, it assumes that every person seeking sanctuary has complete choice and full agency as to their destination country.⁽²⁶⁾

Prior to the NABA and the IMA, in some circumstances, claimants were removed to 'safe third countries' (specifically EU countries) they had passed through, if they had had their fingerprints taken in that country or there was clear evidence of a significant connection

to the country. These provisions were found in the Dublin Regulation⁽²⁷⁾ reflected in the UK's Immigration Rules,^{(28),(29)} although between 2016 and 2020, only 1,250 people were removed to EU countries. Since Brexit, this Dublin Agreement no longer applies, and all EU states have declined to accept 'returns' of people who have travelled through on their way to the UK, meaning that the UK government has needed to make individual agreements with other non-EU states which are deemed 'safe third countries'. There is no longer any requirement for a claimant to have a connection with the 'safe third country'.

The only 'safe third country' with which the UK has been able to make an arrangement with is Rwanda. This arrangement was not implemented by the previous government due to legal challenges. The new government have ceased their arrangement with Rwanda and have said they will not enforce the inadmissibility provision. We have, however retained the discussion relating to it in this report because we feel that there are lessons to be learned – both in terms of policy terms and mental health practice (in relation to the mental health harms of such threatened action on the refugee and asylum community as a whole and on those providing them with care and support). Crucially, we want to emphasise that, unless the legislation underpinning the Rwanda policy is revoked, there is nothing preventing 'safe third country' arrangements with other countries being established in the future. (More information on the Rwanda Agreement can be found in [Box 6](#) below.)

There are no specific criteria for what makes a country 'safe' but considerations should include human rights protections, protection against *refoulement* (a legal term referring to a fundamental principle of international law that forbids a country receiving people seeking sanctuary from returning them to a country in which they would be at real risk of persecution),⁽³⁰⁾ and an effective and fair legal system where appeals are possible. The UNHCR, which is the UN Refugee Agency, cautions against any policies in which there are simply blanket lists of 'safe' countries and no examination of individual circumstances.⁽³¹⁾

Yet, the Safety of Rwanda (Asylum and Immigration) Act 2024 deems Rwanda to be a safe country for the purposes of relocating people for the following reasons: it is possible to send someone there from the UK without breaching any of the UK's international obligations, there would allegedly be no risk of *refoulement* attached to doing so, and the individual would be able to present an asylum claim there. These are the only bases on which the Act determines whether Rwanda is safe, and consideration of an individual's circumstances is only permitted without reference to the general safety of Rwanda itself.

Box 6: Rwanda – A timeline of a 'safe third country' agreement

In April 2022, the UK made its first individual 'safe third country' agreement, the 'Migration and Economic Development Partnership', with the government of Rwanda. The arrangement allowed the UK government to send people whose cases have been deemed inadmissible to Rwanda, regardless of which other country they may have travelled from, or through. Once there, they would be eligible to apply for asylum in Rwanda where their claims would be assessed. They will not be able to return to the UK, regardless of the outcome of their asylum claim.

The first chartered flight to Rwanda was scheduled for 14 June 2022 and over 100 people who were detained in IRCs received "Notices of Intent" stating that they were under consideration for removal to Rwanda.

Following several failed applications to the domestic courts, the European Court of Human Rights granted an injunction which prevented the individual passengers from being removed, only 2 hours before the flight was due to take off.

In December 2022, the UK High Court ruled that the Rwanda agreement, overall, was lawful. They stated that each of the eight individual cases they had looked at had not been properly considered. They also stated that the Home Office had not considered pieces of evidence such as medical or expert evidence that highlighted a claimant's vulnerability, and that vulnerable people with histories of torture, trafficking and mental illnesses had been selected for removal.

Box 6 continued...

In June 2023, the Court of Appeal concluded that the Rwanda plan was not, overall, lawful. They stated there were substantial grounds for believing that, if sent to Rwanda, individuals would be returned to their countries of origin where they may face persecution, and that Rwanda could not, therefore, be considered a 'safe country'.

The UK government appealed this decision to the Supreme Court in November 2023 but lost the case as the Court confirmed that there were issues which meant it was not possible to regard Rwanda as a safe country. The Supreme Court was not asked to review the overall principle of sending people seeking sanctuary to a 'safe third country' – it was only asked to review whether Rwanda could be regarded as safe – leaving the option open for the government to make arrangements with other countries.

Concerns raised about Rwanda specifically include a lack of interpreters and legal representation, discrimination in access to asylum, and discrimination towards LGBTQ+ individuals.⁽³²⁾ The UNHCR raised concerns in their submission to the High Court in December 2022 that Rwanda did not have the "competence and capacity" to effectively determine asylum claims.⁽³³⁾ Another concern is mental health provision in the country, as Rwanda has 0.06 psychiatrists per 100,000 population, which contrasts with 6.4 in the UK,⁽³⁴⁾ suggesting that accessing mental healthcare will be much more challenging.

A treaty with Rwanda,⁽³⁵⁾ agreed in December 2023, aimed to address some of these concerns, including an agreement that people would not be sent to any other country, even if their claim for asylum is rejected.

In response to the Supreme Court's decision, the government introduced a new Bill, the Safety of Rwanda Bill,⁽³⁶⁾ which would 'conclusively' designate Rwanda a 'safe' country, and limit the ability of courts to challenge removal decisions to Rwanda, including under provisions of the Refugee Convention, the European Convention of Human Rights and the Human Rights Act.⁽³⁷⁾

In April 2024, the Bill passed into law following multiple rounds of 'ping pong' between the House of Commons and the House of Lords.

Following the UK general election in July 2024, the new Labour government announced within weeks that they would end their partnership with Rwanda and did not intend to pursue a policy of sending people seeking sanctuary to Rwanda. Nobody had been removed to Rwanda under this legislation, although 4 individuals went under a voluntary scheme.

Lived-experience insight: From a member of One Strong Voice

Box 7: Bravo

Bravo (who has lived experience of immigration detention) started with the mental health impacts of the Rwanda plan. He covered double adverse effects on people's mental health when forcibly sent to Rwanda, and also, having fled from the African region himself, he was concerned about the potential human rights violations people could face in Rwanda. He also highlighted the challenges survivors of torture with trauma and PTSD would meet in Rwanda due to the lack of access to specialised therapeutic services he is currently receiving in the UK.

"People are not supposed to be detained in the first place. You will suffer much worse mentally than the people who are not detained. This is because you're not being believed, there's no medication, you can even be deported to Rwanda. Your mental health capacity or mental health issues are not being considered. In a country like Rwanda, I doubt there will be facilities to take care of us. We have severe mental health issues like PTSD. People will suffer a lot. How can we recover? It will affect people's mental health."

An important distinction is that the 'safe third country' provision is not the same as 'offshoring', a process by which people seeking asylum are held in 'offshore' territories, and asylum decisions are undertaken there, but if their claims are accepted then there is a possibility of returning to the mainland (see Box 8 below).

Box 8: Offshoring – an alternative solution?

'Offshore processing', otherwise known as 'offshoring', is a method of immigration control that involves the forcible transfer of people seeking sanctuary to another state while their asylum applications are processed. It is distinct from the 'safe third country' agreements permitted by the IMA, in that offshoring itself does not outsource the state's responsibility for managing asylum claims. At time of writing, the new UK legislation has not thus far made explicit plans for offshoring. However, the Nationality and Borders Act includes provisions for 'overseas asylum processing,' and it reportedly was considered as an alternative to the Rwanda policy in the run-up to the 2024 General Election.⁽³⁸⁾ While offshoring may, at surface level, appear to be a more humane approach compared to safe third country arrangements, experience of such policies in other countries has highlighted the potential devastating impact on mental health.

Australia is often cited as a case example of offshoring. Following an initial offshoring policy between 2001 and 2008, it was reintroduced in 2012.⁽³⁹⁾ It involved both 'turning back' boats carrying people seeking sanctuary trying to reach Australia, and offshoring, whereby boats were intercepted, people seeking sanctuary were taken to Australia, and then forcibly transferred to either Papua New Guinea or the island country of Nauru. Once there, they were held in detention centres indefinitely and faced long delays and uncertainty around their asylum claims.⁽⁴⁰⁾ While still official policy, since 2014 the Australian government has shifted focus away from offshoring and towards returning asylum seekers to their country of origin from the outset.

The Australia example serves as evidence for how such a policy can compromise human rights and health, and the UNHCR has called for its termination.⁽⁴¹⁾ In March 2017, the Australian Senate Legal and Constitutional Affairs Committee published the findings of an inquiry into allegations of poor living conditions, physical and sexual abuse on Nauru.⁽⁴²⁾ It concluded that the findings paint a picture of a "deeply troubled asylum seeker and refugee population, and an unsafe living environment – especially for children".

The mental health consequences of the conditions on Nauru have been well documented. When the UNHCR visited in April 2016, it reported that 83% of the 53 asylum seekers and refugees surveyed were suffering from PTSD and/or depression, and that there were persistently high rates of self-harm and suicidality.⁽⁴³⁾

Similarly, the charity Médecins Sans Frontières (MSF) reported that of the 208 asylum seekers and refugees they treated, 62% were diagnosed with moderate-severe depression, 60% reported suicidal ideation and 30% had attempted suicide.⁽⁴⁴⁾

Both family separation and the indefinite nature of the isolation on Nauru were cited as contributing factors towards the high burden of mental illness and distress. MSF also documented that mental health services on Nauru were under-staffed and poorly equipped to manage the high level of need, but stressed that in their opinion, no level of mental healthcare would have been sufficient to mitigate the adverse impacts of being held indefinitely on Nauru.

1.2.3 Mental health concerns relating to the Illegal Migration Act 2023

Increased periods of immigration limbo

A prolonged period of uncertainty and lack of sense of safety has been shown to be related to the development of mental disorders among people seeking asylum.⁽⁴⁵⁾ The state of limbo is often described as one of the hardest periods, with high levels of uncertainty and anxiety for the future. Increasing wait times for asylum outcome decisions are of great concern, and waiting times have been increasing for over 10 years.⁽⁴⁶⁾

The introduction of the IMA means, theoretically, that there would have been a significant decrease in numbers of new asylum claims, and resources could be focused on clearing what the outgoing government called the 'legacy backlog'.

There are some immediate problems, however, as the IMA is entirely dependent on there being 'safe third country' agreements in place to accept all those who are deemed inadmissible, namely, those arriving irregularly. For example, even if the Rwanda agreement had progressed, there would currently be insufficient capacity in Rwanda to process and accommodate the numbers of people arriving and there is little evidence that the Rwandan authorities would have been able to scale up their asylum system quickly. For example, in 2020, Rwanda made 228 decisions on asylum claims, in contrast to 19,000 made by the UK.⁽⁴⁷⁾ Given that in 2022, there were 45,700 people who arrived via small boat, it seems unlikely that Rwanda would be able to accept the ongoing high numbers of people arriving irregularly, with Rwanda stating they could only accept 1,000 people in the initial 5-year trial period.⁽⁴⁸⁾ This would only have represented a very small fraction of the overall population of people seeking sanctuary and so raises significant doubts as to what the deterrent value of this policy could have been. Any arrangement with another 'safe third country' may well face similar challenges.

Under the IMA, those who arrive irregularly have done so and been informed that removal is likely, but with no timeline for when removal would happen, and with no opportunity to tell their story via an asylum interview, nor was there to be any hope of being assessed through the UK asylum system and for their physical journeys to be over.

This would be a very new type of limbo for people seeking sanctuary in the UK, with further research required into the mental health impacts of such a hopeless limbo. Given the harms that are already known to occur through long periods of uncertainty within the UK asylum system, the consequences would likely be significant. Individuals in this kind of limbo would still require mental health support and input, and it would be a challenge to consider what forms of therapeutic intervention can be offered by clinicians when an individual is facing inevitable removal to another country on an uncertain timescale.

In a situation where people arriving irregularly are offered no route to protection, but where it is unlikely that there will be capacity to detain everyone in IRCs or quasi-detention settings, people who are released into the community have further incentive to become 'undocumented'. Living as an undocumented person in the UK has devastating consequences for both physical and mental health, as it means that people are deterred from accessing health services and therefore any health conditions that arise are likely to go untreated. Beyond the humanitarian and public health arguments against such consequences, there is also an economic argument; there will be higher costs for the NHS in the long term, as people will present to services in more advanced stages of illness. People with significant mental health problems may not come to the attention of services unless, or until, their condition deteriorates to such an extent that they need to be detained under the Mental Health Act, which is a much more costly as well as more restrictive – and therefore undesirable – option compared to early intervention. This will also be the case with physical health conditions.

Since June 2022, NABA provisions, and then IMA provisions from July 2023, have meant that far fewer new asylum claims have been processed,⁽⁴⁹⁾ so despite there being significant progress in reducing what has been known as the “legacy” backlog, there exists now a new ‘backlog’ of those who had been deemed inadmissible. The number of appeals that are outstanding have also increased and require processing. So, while it is encouraging that the new government has stated that these claims will now be processed in the UK, people are still facing a significant wait for their claims to be processed. Initial proposals by the new Home Secretary to prioritise claims by those for whom refusal is most likely are of concern, as this strategy prolongs the period of uncertainty and prevents the possibility of earlier integration and work for those who are most likely to have their claims accepted.

Lived-experience insight: From a member of One Strong Voice

“It is important not to make people wait for years and years and years. Because at the end of the day, this will impact them, you know, recovering from the crimes that they had faced.”

– Angela

Box 9: Cautions of fast-tracked assessments

A particularly concerning change permitted by the NABA is to allow accelerated or ‘fast-tracked’ asylum applications – which increases the speed at which decisions about asylum claims are made. This has been cited as a potential solution to the growing asylum backlog, alongside ‘safe third country’ arrangements. However, unless carefully implemented, a fast-track asylum system would increase the risk of mistakes and the likelihood that important factors, such as a person’s mental health, not being taken into account. Furthermore, people with mental illness would be disproportionately affected.

Priority Removal Notices

This portion of the legislation is not currently in force, and it is unclear if it will ever come into force.

Under the NABA, the Home Office now has new powers to accelerate a person’s removal from the country. For people who are living in the UK without any immigration status, the NABA introduces ‘priority removal notices’ (PRNs), in which the person is given a tight deadline to reply to the Home Office with an explanation and evidence proving why they should remain. If that deadline is missed, then there are two significant implications.

Firstly, the person has more limited rights to appeal than would previously have been available. They will not be able to access a First-Tier Tribunal, although their case could be sent to the Upper Tribunal. If the Upper Tribunal refuses, then they do not have the opportunity to appeal to the Court of Appeal. This means fewer opportunities, and less time, for medical evidence to be sought by the claimant’s legal team.

Secondly, if the person misses the PRN deadline, any evidence they later submit is considered ‘late evidence’, and this evidence can be treated as less important. Section 26(2) states “Unless there are good reasons why the evidence was provided late, the deciding authority must, in considering it, have regard to the principle that minimal weight should be given to the evidence,” and that they will be required to “take account, as damaging the [individual’s] credibility”. There are no guidelines currently as to what would constitute ‘good reasons’.

Given we know those with severe mental illness are less likely to be able to self-advocate and comply with tight deadlines, they again are disproportionately more likely to be negatively affected by these changes.

Box 9 continued...

Accelerated detained appeals

For those who are in immigration detention after making a claim, the NABA has introduced a scheme called 'Accelerated Detained Appeals'. For claims which the Home Office deems likely to be dealt with quickly, people can be given only 5 days to appeal if their claims are refused. The First-Tier tribunal will then have 25 days to make a decision.

For context, a similar scheme called the 'Detained Fast Track Scheme'⁽⁵⁰⁾ was found to be unlawful by the High Court in 2015⁽⁵¹⁾, with Lord Dyson MR summarising:

"The time limits are so tight as to make it impossible for there to be a fair hearing of appeals in a significant number of cases... The system is therefore structurally unfair and unjust. The scheme does not adequately take account of the complexity and difficulty of many asylum appeals, the gravity of the issues that are raised by them and the measure of the task that faces legal representatives in taking instructions from their clients who are in detention."⁽⁵²⁾

Mental health concerns

People with a significant mental illness may be impaired in their ability to self-advocate and to marshal evidence at speed in an accelerated process. Given the ambiguity around what constitutes 'good reasons' for providing evidence late, it is not clear how grounds related to mental health problems will be interpreted by decision-makers. There is a growing body of evidence which highlights how PTSD and depression affect one's ability to recall significant events, particularly in the context of an interview, and discrepancies are likely when interviews are repeated, and may increase with the length of the application process.^{(53),(54)} As psychiatrists, we hope that we will be able to argue that mental illness is a 'good reason' to consider late evidence fully and for such delay not to have an adverse effect on someone's credibility. However, with fewer opportunities for claimants to appeal a decision, and for the rapid turnaround of the accelerated detained appeals, it is not clear whether there would be sufficient time for psychiatrists to intervene.

The changes to consideration of late evidence disproportionately affects those who are more vulnerable, for example, those with PTSD, and survivors of torture, human trafficking and sexual violence. Research conducted with people seeking sanctuary has highlighted the importance of PTSD symptomatology, dissociation and shame in non-disclosure of information during Home Office asylum interviews,⁽⁵⁵⁾ and the importance of time to process traumatic events and to establish trust in disclosure.⁽⁵⁶⁾

Home Office staff may not have the necessary skills or time to enable accurate and full disclosure by people seeking sanctuary in their asylum interviews. Although this was also the case before the introduction of the NABA, the tighter deadlines and fewer opportunities to appeal will further challenge the ability of claimants to disclose sensitive information pertinent to their asylum claim, such as sexual violence, as there will be even less time for building relationships and trust. Furthermore, the changes introduced with the NABA do not allow sufficient time for claimants to source legal representation, nor medical evidence which may be relevant to their claim.

Accommodation centres and quasi-detention

The increasing numbers of people seeking sanctuary in immigration limbo need a place to stay. The previous government has responded to this heightened need for accommodation by housing people seeking sanctuary in hotel rooms across the country, however, this has now become a highly politicised topic, and there has been mounting pressure to find cheaper alternatives. There have been significant numbers of hotels which have been removed from the list of places available to accommodate people seeking sanctuary, but this has not been done in a way that is aligned with need; it has led to people being moved quickly between places with all the resulting increasing uncertainty and isolation.

Several alternative forms of accommodation for people seeking sanctuary have been introduced, including military barracks, an airfield and the Bibby Stockholm floating barge, which will cease to house people seeking sanctuary in January 2025. Critics of these accommodation settings say they amount to little more than quasi-detention centres, as residents are effectively still segregated from the wider community and have restrictions on their comings and goings and access to services, as is the case in IRCs.

Both direct and indirect implications for mental health have been raised. Direct impacts include the potential for retraumatisation of survivors of torture and other forms of persecution at the hands of authorities, by being housed in former military barracks.⁽⁵⁷⁾ Living on a floating barge may be especially frightening for individuals who cannot swim (thought to be the case for many people seeking sanctuary, especially those from landlocked low- and middle-income countries) or those who have made dangerous journeys across seas on their route to the UK.⁽⁵⁸⁾ More generally, settings that resemble immigration detention can leave residents feeling as though they are being treated as criminals, even though they have not committed a crime. This sense of injustice and lack of freedom is likely to impact individuals' wellbeing, sense of self and sense of empowerment and may lead to the development or exacerbation of mental disorders.

Importantly, access to mental healthcare is extremely limited in these settings, with the government not yet having conducted thorough needs assessments, or invested in boosting local mental health services that may be expected to provide for residents, many of whom will be experiencing mental health difficulties. With mental health services already operating well below the resources needed to meet the needs of the local population, providing care to those people seeking sanctuary may not be given the priority it deserves. Doctors of the World reported a significant burden of depression and PTSD symptomatology among the residents of Napier Barracks on whom they conducted medical assessments.⁽⁵⁹⁾ NHS Trusts who had clinical responsibility for residents of Napier and Penally barracks were only given around 2 days' notice prior to these sites opening; residents often had to disclose sensitive medical information to non-clinical staff at the barracks before getting access to a medical professional, highlighting a clear lack of planning and inadequate, undignified healthcare provision for residents.⁽⁶⁰⁾

Other concerns about accommodation centres have indirect but nonetheless important implications for mental health. Particular elements which are thought to contribute towards symptoms of psychological distress and worsen mental health include:

- isolation from communities
- perceptions of being unwelcome
- shared facilities/lack of privacy
- lack of freedom of movement.⁽⁶¹⁾

Specific concerns have also been raised about inadequate public health measures to prevent the spread of infectious diseases, as well as poor sanitation in these settings. Examples include a failing to contain the spread of Covid-19 at Napier barracks,⁽⁶²⁾ a diphtheria outbreak at Manston airfield,⁽⁶³⁾ radiological contamination at Wethersfield ex-RAF site,⁽⁶⁴⁾ and the finding of Legionella in the water supply of the Bibby Stockholm barge, leading to its subsequent evacuation.⁽⁶⁵⁾ Worrying over one's physical health in these situations will undoubtedly cause additional stress and anxiety.

There is also concern over lack of access to community support services, such as organisations that help people seeking sanctuary obtain access to legal advice. This restricts residents' ability to exercise their rights in claiming asylum,⁽⁶⁶⁾ which can add to feelings of helplessness about being in immigration limbo. A High Court case *R (SA) v SSHD* [2023],⁽⁶⁷⁾ in which the Secretary of State was found to have breached their duty to provide 'adequate accommodation', summarises many of the concerns that arise out of hotel accommodation and the lack of control of one's environment, including lack of play spaces for children, privacy and having to eat, sleep and live in the same space.

Overarching all these concerns is the fact that there is no evidence that these quasi-detention accommodation centres are actually cost-effective, or that they act as deterrents to those seeking sanctuary in the UK, which calls into question why they should exist in the first place. Calls have been made to expand community alternatives to both immigration detention and quasi-detention settings, with the adverse mental health impacts on a population already vulnerable to mental disorders used as a key argument.⁽⁶⁸⁾⁽⁶⁹⁾ Such an approach would allow people seeking sanctuary to integrate with their local community, have freedom of movement, and access to health services, legal advice and community support.

Harms from threat of removal

There is no provision in the IMA for screening prior to individuals being sent to 'safe third countries', meaning that those who already have (or who are especially vulnerable to developing) mental illnesses would not be identified, provided with access to appropriate treatment, or have their mental health considered as part of their asylum claim.

The charity Medical Justice produced a report detailing the experiences of 36 people they had worked with from May to September 2022 who were initially selected for removal to Rwanda⁽⁷⁰⁾ (under the NABA rather than the newer IMA). They found that vulnerable individuals were selected for removal, including those with a history of torture, trafficking, and those with diagnosed mental disorders. Medical Justice completed MLRs for 17 of the individuals. Of these:

- 11 had a diagnosis of PTSD or Complex PTSD
- 14 had depression
- 1 had bipolar affective disorder
- 2 had psychotic symptoms
- 1 required urgent investigations to exclude a recurrence of a brain tumour.

Their clinicians found that for some, the risk of self-harm and suicide was increased by the prospect of removal to Rwanda, with some considered to be at high risk of suicide. There is no reason to believe this would have been different were the 'safe third country' agreement made with any other country. The report provides evidence that individuals with pre-existing mental health concerns were being selected for removal, and that the threat of removal is likely to increase the risk of harm. Under the IMA, there will be a blanket approach to removal to third countries without any screening, and the likelihood has significantly increased that many vulnerable people with serious mental illness will be removed to a 'safe third country'. It is this failure to protect those with, or at risk of, mental illness that differentiates this legislation from other legal frameworks that exist. With any offshoring policy which involved forcible removal to a third state we would anticipate similar impacts.

Lived-experience insight: From a member of One Strong Voice

“ We know a few people who received a notice for Rwanda. It's had a big impact on their mental health. Those people had a reason for choosing the UK. And now to say that their cases are inadmissible and that people will be sent to Rwanda – it is not fair. These people are seeking sanctuary in this country and the UK government should be responsible for them and not delegate responsibility to another country ”

– Nadine

Harms following removal

There are considerations about what level of healthcare would be available to treat those with serious and enduring mental illness in any 'safe third country', as well as individuals' ability to access MLRs to support their asylum claims in the 'safe third country'. Individuals who are given notice of removal to 'safe third countries', whether or not they have the possibility of eventual return to the UK, may lack capacity to understand and to challenge the process and, when such tight deadlines are given for appeals and submission of evidence, there is a danger that such lack of capacity may not be detected or addressed, particularly when there are already significant difficulties accessing MLRs or other important evidence, especially for those in detention. Significant numbers of initial decisions in the UK are overturned once medical evidence has been added to their appeal.⁽⁷¹⁾ Many countries do not have these resources, hence applicants being unable to access the required evidence.

In the UK, for those seeking sanctuary who are struggling or even who become destitute, there remains the possibility of receiving support from charities. The third sector can sometimes provide housing, welfare and legal advice, food, clothes, and even small payments to help with subsistence. Quantitative data regarding the scale of support that is offered is limited, however, an impact report on third sector organisations that support people seeking sanctuary outlines how, even in 2017 when the report was published, there was increasing need and a growing number of organisations emerging to meet need.⁽⁷²⁾ For those who are removed to 'safe third countries,' permanently or temporarily, the loss of this third sector support is difficult to quantify, but is likely to be significant.

Once a person has been removed from the UK, there are several factors which may influence their mental health. Being in such a situation is likely to worsen or contribute to the development of mental disorders by virtue of a lack of psychological safety during the processing of asylum claims in a completely unknown cultural context where they have not consented to be.

This has been documented in the context of the Australian offshoring system (see [Box 8: Offshoring – an alternative solution?](#)). Evidence highlighting the detrimental mental health impacts of the Australian system^{(73),(74)} suggests that consideration must be given to suicide risk, both in the UK when a person is issued a removal notice, and afterwards once they are in the 'safe third country'. For some people, this may be the first time they are at risk of suicide, and this may have been partially mitigated by living in the UK with family members and/or community networks.⁽⁷⁵⁾

Establishing safety is a key component of treatment for PTSD. This first step can reduce risk presentations and improve concentration and memory – all important for enabling an individual to participate fully in their asylum application process. It is also necessary for proceeding with further mental health treatment. The person might not feel safe due to unfamiliarity with the 'safe third country'. Potentially limited availability of mental health services in the host country compared with the UK will only aggravate the feelings of being unsafe. Under these circumstances, a country judged to be safe by the UK government might feel exactly the opposite for the person who is being removed.

Furthermore, if people find themselves in a country where they have not chosen to be, and do not want to be there, they may be highly vulnerable to trafficking/people smuggling because people smugglers will be keen to profit from their wish to leave.

1.3 Immigration detention

1.3.1 Legal changes

Detention has now been introduced as a fundamental part of the removal process for all people arriving irregularly. The IMA gives new powers to the Home Secretary to detain individuals. Previous regulations stated that only those people could be detained who were being prepared for removal from the UK, and only for a period of time deemed necessary for the removal process to be carried out. There were no hard time limits on detention and, therefore, in practice, people could be detained for long periods. The IMA goes further and states that anyone who has arrived irregularly into the UK will be liable to detention for as long as the Secretary of State considers reasonably necessary to examine their case or remove them. This will require a large expansion of the detention estate with a significant increase in numbers. There is no opportunity to be granted bail for the first 28 days, and this time limit also applies to accompanied children.

Prior to this new legislation, pregnant women or unaccompanied children could not be detained. The IMA has reversed this ban. Pregnant women can now be detained for up to 72 hours – although, if authorised by a Minister, this can be extended to 7 days – and, once released, they can be re-detained. Unaccompanied children can also now be detained. They can be granted bail after 8 days in limited circumstances.

Furthermore, the right to seek judicial review to assess the lawfulness of one's detention has now also been removed during the first 28 days.

1.3.2 Mental health concerns

There are multiple ways in which being detained in an IRC can be profoundly harmful to someone's mental state, whether or not they have a pre-existing or emerging mental illness or vulnerability. Mental healthcare provision in immigration detention has already been unable to provide appropriate screening (including PTSD screening), assessment, monitoring or treatment for the numbers detained, with various contributing factors including difficulty recruiting and retaining healthcare staff, lack of private clinic space, and inadequate funding. The expansion of the detention estate and the significantly increased numbers of people who will be detained can only exacerbate this and is therefore of profound concern.

We recommend reading [RCPsych's 2021 Position Statement on the Detention of People with Mental Disorders in Immigration Removal Centres](#). It provides more comprehensive details on the harms of detention, including:

- limitations in available healthcare
- re-traumatisation, social isolation
- the uncertainty of indefinite detention.

These all lead to significant deteriorations in mental health in most cases, and increase the risk of suicide. For other reports into the harms of immigration detention, we recommend resources from Medical Justice, a charity which supports people in detention centres,⁽⁷⁶⁾ and produces reports on a variety of harmful aspects of the immigration detention system.

The Home Office have amended the Adults At Risk policy,⁽⁷⁷⁾ acknowledging that more vulnerable adults will now be detained.⁽⁷⁸⁾ The Home Office has to assess the likely risk of harm to a person if detained for the period identified as necessary to effect removal, but will balance this against immigration factors. The removal of access to judicial review for the decision to detain individuals or to review inadmissibility decisions is of serious concern, as it is likely to lead to deprivations of liberty for people in immigration detention.

Lived-experience insight: From a member of One Strong Voice

Box 10: Bravo

Bravo explained the concerns he had about the increased numbers of immigration detentions as a result of the new legislation and the impact of this on people's mental health. He has lived experience of UK immigration detention and knowledge about the effects of detention on people's mental health.

Bravo perceives what happened to him essentially as punishment for migrating, and he suffered from isolation, depression and lack of support leading to suicidal thoughts. He stated that there is already limited mental health support in UK immigration detention centres. And now, as a result of the new legislation and the expansion of immigration detention, further strain will be placed on mental health services and therefore cause more suffering for people in detention

“You have the fear of being deported and what happens then is that we’ll find out people committing suicide or abusing others. I nearly killed myself, but I was lucky enough that I had the support behind me from the doctors and then some of the charities who were visiting me in the detention centre. I feel more and more anxious and I’m taking more antidepressant medication because, after this law, I do not know what is happening to my life and do not know where my future is.”

1.4 No appeals rights except ‘serious and irreversible harm’

1.4.1 Legal changes

The IMA limits the types of appeals that can be made. The only appeal that can be made to prevent or even pause removal is a ‘removal conditions suspensive claim’ requiring a person to provide ‘compelling evidence’ that they do not meet the removal conditions, or a ‘serious harm suspensive claim’, which means that a person who has been served a third country removal notice would need to demonstrate that they face a ‘real risk of serious and irreversible harm’ if removed from the UK to the country or territory in question.

There was little suggestion initially as to what would constitute ‘serious and irreversible harm’, which was included in the proposal stages of the Bill, however the IMA now provides some examples, which are:

- death
- persecution
- torture
- inhumane or degrading treatment or punishment.
- onward removal from the country to another territory where someone might face a real, imminent and foreseeable risk of any harm.

It also includes some examples of what would *not* be considered ‘serious and irreversible harm,’ which include:

- harm resulting from someone being removed to a country with a lower standard of healthcare, including that which results in a poorer prognosis.

The claim period specified in the IMA (during which time a person can make a suspensive claim) is only 8 days, meaning that what is supposed to be a safeguard would likely remain inaccessible to the majority of those to whom it would apply. It is unclear whether these limited appeal rights may apply to any future overseas processing arrangements.

1.4.2 Mental health concerns

There already exist many barriers and challenges to individuals accessing expert advice or gathering the necessary evidence to support their case. Additionally, people with a severe mental illness may be impaired in their ability to self-advocate and to marshal evidence at speed in an accelerated process, meaning that some of those who are most in need of protection on the basis of suspensive claims will be least likely to be able to make their needs clear. This discrimination inherently built into the process for those with mental illness runs entirely counter to wider thinking and consensus in society – that we should be seeking to achieve parity of esteem between physical and mental health.

Evidence and experience tells us that people seeking sanctuary can show remarkable apparent resilience,⁽⁷⁹⁾ and therefore may not demonstrate the features of a mental disorder during the time when their claims are assessed or questioned, and the chances of detection are even less likely in the absence of any form of screening under IMA provisions. People seeking sanctuary may also be reluctant to make their distress and vulnerability clear and may not even admit it to themselves. This does not mean that their experiences have not left them vulnerable to the development and consequences of mental illness, especially if they are living in poor conditions and with prolonged uncertainty after arriving in the UK.

Case study 2 – Difficulties in disclosure

Aram is a Kurdish 17-year-old asylum seeker from Iran. He fled his country as he was facing persecution for helping an anti-government Kurdish group there. He was exposed to significant traumatic events as he was forced to work as a smuggler of goods on the border with Iraq since he was 15 years old following his father's illness. In the UK, he presented with significantly poor appetite and low weight, and he was extensively assessed by the specialist eating disorder services, but they couldn't find evidence of a mental disorder.

While in the UK, he was a victim of a hate crime when a group of white men assaulted him when he was out with a friend. He always maintained that his mood was 'fine' and he had no mental health problems. Trauma-informed assessment by a specialist helped him recognise the impact of these experiences on him, and he could talk more about his symptoms. He was diagnosed with post-traumatic stress disorder but remained reluctant to accept further treatment as he found it difficult to discuss these symptoms.

With sustained traumatic experiences, such as repeated sexual violence and long periods of persecution, violence, trafficking and exploitation, there can be changes to the very structure of people's personalities, their sense of self, their ability to manage stress, with increase in anger and hostility, and their ability to sustain relationships.⁽⁸⁰⁾ Further periods in immigration limbo, periods in detention, and forced removal to another country could well contribute to these presentations. These changes may or may not meet diagnostic thresholds for PTSD or complex PTSD, however, it would be difficult to describe these kinds of fundamental personality changes as anything less than 'serious'. Regardless of the diagnostic labels, if any, that we might offer to these changes, we know that they can be both severe and difficult to treat – 'irreversible', even – and certainly long-lasting. This is particularly the case for children, when disruptions in stability can have a lifelong impact on their mental health, and adversely impact their development and, therefore, the whole trajectory of a child's life. However, as clinicians, we know that it is almost impossible to predict the trajectory of mental health at an individual level, and it is difficult to predict what 'compelling evidence' might be required of psychiatrists to meet this test, which would represent a person's only opportunity to submit a suspensive claim.

If mental illness and suicide risk are considered under the umbrella of 'serious and irreversible harm', which we would strongly advocate that they are, despite it not being clear whether the legislation will be interpreted this way by the Home Office, there will be a significant increase in demand for expert MLRs in any cases where this threshold is applied. There are currently only a small number of psychiatrists and other clinicians who are adequately trained and who have the necessary time to write such reports, and there is already significant need. Increasing the demand for MLRs will require a significant up-scaling of current training opportunities. Professional organisations need to take heed of this and call for more training in this area. Consideration will also need to be given as to how many psychiatrists – working in an already overstretched NHS – would be willing to take on this work and if so, how they would balance their workloads. In this way, the harmful policies towards people seeking sanctuary harm everyone living in the UK by further stretching our NHS resources.

Lived-experience insight: From a member of One Strong Voice

“Instead of receiving the support they deserve, they're being made to feel like petrified survivors, which is not how it should be, and no one should have to experience those things. And nothing about the new Borders Act is tackling any way of improving the support people need.”

– Angela

1.5 The Nationality and Borders Act (2022)

1.5.1 What is the NABA?

Just one year before the IMA, a new set of immigration legislation had come into force in the UK, called the Nationality and Borders Act 2022 (NABA). When it was first proposed, campaigners widely referred to it as the 'Anti-Refugee Bill'.⁽⁶¹⁾ The provisions contained in the NABA reflect a more restrictive process of seeking asylum, meaning that once someone's claim for asylum was being investigated by the UK, it would be harder for them to gather sufficient evidence, harder to make appeals, and more likely that they be removed in the future. A list of key changes brought about by the NABA can be found in Box 11 below.

The more recent IMA was designed to criminalise and 'ban' the seeking of sanctuary in the UK. In this regard, it would have made many of the provisions in the NABA much less relevant, as the vast majority of those who seek asylum in the UK enter through irregular means and would therefore already be excluded from making a claim. However, with the new government's expressed intent to process all asylum applications, the NABA provisions are set to be much more widely applicable.

Box 11: Key features brought in by the Nationality and Borders Act 2022

- A proposed two-tier system, which was revoked in June 2023 but outlined in the earlier [timeline of legislation](#).
- The standard of proof required to demonstrate that someone meets the criteria for the 1951 Refugee Convention has been increased.
- There are new tight deadlines imposed for providing evidence and appealing decisions. Any evidence which is submitted late is given less weight. In cases where someone is detained in an IRC, they may be given only 5 days to appeal a refused claim.
- There are new fast-tracked processes introduced, which increase the speed at which asylum decisions are made but increase the risk of important factors in someone's claim not being sufficiently considered. These are likely to disproportionately impact those with mental health difficulties.
- When someone is offered leave to remain, or refugee status, they can still be removed if they commit a serious crime. The NABA has reduced the threshold for crimes which could lead to removal and will include more non-violent crimes of lower severity.
- It is harder to receive support and protection under Modern Slavery regulations.
- Removal to a 'safe third country' remains an option under the NABA, including for the purposes of offshore processing.
- There are new provisions for controversial age assessments for those who are claiming to be children but are thought to be over 18.

Lived-experience insight: From a member of One Strong Voice

“We know very well that people don't discuss torture at first instance, people need to feel safe and find themselves in the right place in mind, and some people don't even know what constitutes torture. So, it really takes a lot of training. It takes a lot of mental well-being to feel able to begin to disclose torture, which can be playing a really big wait on someone's asylum claim. Now to penalise [for this]... I think it's very wrong. People need a chance their stories to be told.”

– Nadine

We have outlined the new fast-track processes include priority removal notices and accelerated detained appeals in [Box 9: Cautions of fast-tracked assessments](#). Further provisions of the NABA are outlined in more detail below.

Increased standard of proof

The phrase ‘standard of proof’ refers to the level of evidence that is required to satisfy a claim. For different contexts, the standard of proof that will be required is different. An example of a standard of proof is ‘beyond reasonable doubt’.

Table 1: Changes in the required standard of proof to satisfy a claim following NABA

Aspect of case	Required standard of proof	
	Pre-NABA	Post-NABA
Do you have a protected characteristic as defined by the 1951 Refugee Convention?	Reasonable degree of likelihood	Balance of probabilities
Do you have a subjective fear of persecution in your country of origin?	Reasonable degree of likelihood	Balance of probabilities
Will you be persecuted (and not protected) if you returned to your country of origin?	Reasonable degree of likelihood	Reasonable degree of likelihood

Prior to the NABA, when asylum claims were being assessed, there was only one standard of proof that applied to all aspects of a case when determining whether someone met the criteria for refugee status as outlined in the 1951 Refugee Convention, and that was ‘reasonable degree of likelihood,’ as summarised by Table 1. There is case law that indicates the requirement to have an ‘anxious scrutiny’⁽⁸²⁾ of this evidence, as they are cases in which life or liberty is at stake, and therefore the consequences of incorrect decisions can be fatal.

The NABA has introduced an additional, higher, standard of proof for two specific criteria of a case. For these two criteria, it has increased the standard of proof to ‘balance of probabilities’ (i.e. that it is more likely than not). This represents a higher standard of proof than ‘reasonable degree of likelihood’.

If these first two criteria are satisfied, then the decision-maker can consider other aspects of the case on the lower standard of proof (‘reasonable degree of likelihood’), such as whether the person will be persecuted and not receive protection, were they to be returned to their country of origin.

Mental health concerns

Increases in the standard of proof required to satisfy a claim will have systemic implications for people with mental illness, as there will be a far greater pressure for expert evidence, including MLRs, from the very beginning of a claim. For many people who have fled persecution, the only evidence they are able to provide is their own testimony. The standards of proof required can already be a barrier to receiving protection, and a barrier that disproportionately affects the most vulnerable groups who do not have access to documents. For those whose credibility is in question, an MLR to consider issues such as memory and psychiatric symptoms will be vital. There is already a need for more psychiatrists to write MLRs in asylum cases, and this need will only increase under this new legislation.

Lowering of the serious crime threshold

Article 33(2) of the Refugee Convention 1951 allows states hosting refugees to remove a refugee “who, having been convicted by a final judgement of a particularly serious crime, constitutes a danger to the community”. Prior to the NABA, a ‘particularly serious crime’ meant a crime for which a prison sentence lasting two years or more was imposed. The NABA will see this threshold change to a sentence lasting one year or more, which will now include some less serious and non-violent crimes,⁽⁸³⁾ including working with false documentation.

There is also an indication that migrants ineligible for, or unable to access, appropriate mainstream NHS mental healthcare are being referred to Prevent Vulnerability Support Hubs as an alternative, thereby securitising and potentially criminalising people who require mental healthcare, and associating them with terrorism risks within the context of the hostile environment and charging regulations.

It is also pertinent to note here that the 2023 Shawcross Review of the Prevent programme,⁽⁸⁴⁾ which was already widely criticised for its lack of independence, has specifically recommended extending the Prevent Duty to the immigration and asylum sectors, through the UK Border Force, Immigration and Protection Directorate. This was a recommendation fully accepted by the UK government, and although Prevent already applies to these areas, it indicates that within the context of a wider hostile environment for people seeking sanctuary, both in popular discourse and legislation, there will be further focus on the securitisation and criminalisation of people in vulnerable situations, adding to the fears of stigmatising and discriminatory practice related to Prevent which are well established.

This stigmatising and alarmist messaging that emerges from these approaches is detrimental not just to those seeking sanctuary but also to wider society, where it creates unnecessary worry and concern through the direct links made between those seeking sanctuary and criminal or terrorist activity.

It is likely that alongside the NABA and IMA, increasing the use of Prevent within the immigration and asylum sectors will have a further adverse impact on the human rights, civil liberties and mental health of people seeking sanctuary.

Mental health concerns

The NABA increases the risk that people seeking asylum may become involved with the criminal justice system. This is because those seeking asylum are now more vulnerable to destitution and becoming 'undocumented', as well as being coerced into criminality, particularly in the context of trafficking.

An absence of effective access to mental health care can lead to higher rates of alcohol and drug use, which can in turn lead to involvement in the criminal justice system. Furthermore, there is a risk that racial profiling may contribute to increased refusals for people of certain ethnicities. People from minority ethnic backgrounds are disproportionately represented at all stages of the criminal justice system and are also at higher risk of being diagnosed with a mental illness, although caution must be shown when approaching this question, with regard to whether this increase is real or determined by inadequate cultural sensitivity. Regardless of the reasons for this statistic, it is likely that people from minority ethnic backgrounds will be even more likely to be removed under these new measures. There are broad concerns in the UK about recognition of mental illness in criminal justice settings,⁽⁸⁵⁾ and this raises the possibility that people seeking sanctuary who commit crimes in which mental illness is a contributing factor may not receive the appropriate support with their asylum cases.

Up to half of those referred to Vulnerability Support Hubs are born outside the UK.⁽⁸⁶⁾ The Prevent programme has been widely criticised as racially discriminatory, particularly against Muslims.⁽⁸⁷⁾ Prevent referrals have been flagged to immigration enforcement agencies, and may have led to detention and/or deportation of the individuals concerned.⁽⁸⁸⁾ There have also been major concerns regarding confidentiality due to data-sharing agreements, and even details of malicious or mistaken referrals are stored on police databases for many years.

Structurally embedding the vilification of people seeking sanctuary as potential terrorists by default will affect the racialised and minoritised groups already disproportionately affected by Prevent, who are in fact more likely to be the targets of extremist activity (such as far-right activity) rather than sources of such activity. Overall, although the specific details of how this will be operationalised remain unclear, it is likely that alongside the

NABA and IMA, increasing the use of Prevent within the immigration and asylum sectors will have a further adverse impact on the human rights, civil liberties and mental health of people seeking sanctuary.

Given this background, and securitisation and potential criminalisation disproportionately affecting people from minority ethnic backgrounds, there are concerns that lowering of the 'particularly serious crime' threshold makes such people even more vulnerable, magnifying consequences of potential discrimination and increasing the risk of deportation.

Removals to safe third countries under the NABA

The NABA introduced broad criteria for what constitutes an 'inadmissible' claim, including a condition in which it would have been 'reasonable to expect' a person to have made an asylum claim in a safe third country instead of travelling onwards to the UK.

Given the introduction of the IMA and the clear scope for who will be considered inadmissible and who will be removed, it is not clear how the courts will interpret the 'reasonable to expect' condition, given the subjective nature of the term 'reasonable to expect', and lack of clear and specific definitions or guidance offered to the legal professionals or decision-makers.⁽⁶⁹⁾ Because of this uncertainty, it is likely that medico-legal evidence will be required in many cases to assess an individual's decision-making capacity, understanding, and their own assessment of risks when they were passing through other countries, to ensure that these aspects of 'reasonableness' are not overlooked by decision-makers.

What should be included in a 'reasonable to expect' assessment?

We propose that it is essential to consider the following factors, all of which could be expected to impact on a person's ability to make an asylum application within a designated timeframe:

- being under the control of traffickers or coercion from other parties
- fear of being targeted in nearby or neighbouring countries
- homelessness
- language skills
- knowledge of the asylum system in the UK and in countries passed through
- mental state at time of passing through third country
- mental capacity
- level of vulnerability
- trauma history
- psychiatric history
- operating under guidance or coercion to give false information by, for example, people smugglers.

It remains unclear whether anyone may still be found 'inadmissible' under NABA provisions in the future, however, if this provision is used, there is no guidance offered on what criteria will be used to decide on removal. This lack of clarity as to who will be sent to safe third countries raises an important question about the possibility of discrimination. It is possible that discrimination based on country of origin and race will play out in 'safe third country' arrangements in the absence of clear guidelines.

In the absence of specifics relating to how the 'safe third country' scheme will work outside the strict entry criteria of the IMA, we can only try to predict factors that the courts may consider when deciding to remove someone to a third country under the NABA if this is ever considered by the new government. As well as the presence and severity of any existing mental disorders, we expect that the courts will likely consider whether the person is mentally fit enough to be able to participate in the legal proceedings around claiming asylum in the third country, and whether their mental condition is likely to interfere with their agency to proactively access medical treatment in such a third country, as well as

the consequences for their mental health if they are unable to seek such treatment, including risk of self-harm or suicide.

Appeals

Under NABA, there is a provision to appeal removal on the grounds of 'exceptional circumstances', although there is no guidance on what might constitute exceptional circumstances, or whether mental illness would be considered in this category.⁽⁹⁰⁾ Another point of ambiguity is the grounds which lawyers can use to argue against any removal to a third country; currently they need to prove their client has a 'significant vulnerability', however there is no guidance on what this constitutes, or whether mental illness would be considered as part of this.

Lived-experience insight: From a member of One Strong Voice

I call it 'present trauma'. So, I feel even the therapists, when they talk to refugees or people seeking asylum, heavily focus on PTSD, but they do not talk much about the present traumas created by laws such as the NABA—the impact of policies such as Rwanda policy. We must also consider the impact of systematic racism inherited in these policies and legislation. All these have built an unseen curtain between us and the public, creating division. In Iran, I was suffering from systemic sexism and systemic misogyny. Now in the UK, I'm suffering from systemic racism.

– Nadine

Part 2: Impacts of legislation for specific groups

2.1 Survivors of human trafficking

2.1.1 Legal changes

For several years, the government has been raising concerns about the ‘misuse’ of the protection system for survivors of trafficking, despite there being no available evidence to corroborate this. Alongside the trend towards the criminalisation of seeking asylum, there has been a corresponding trend of trafficking moving away from being primarily a safeguarding and protection issue, towards being purely an immigration issue.⁽⁹¹⁾

The Illegal Migration Act 2023

The IMA significantly restricts access to support for possible victims of trafficking and modern slavery.

If the government decide to enforce inadmissibility provisions under the IMA (which they are currently choosing not to do), people who arrive irregularly would be disqualified from any protections to prevent or delay their removal as victims of trafficking via the NRM. This would exclude many victims and survivors of trafficking from modern slavery protections and specialist support under the Modern Slavery Victim Care Contract.⁽⁹²⁾

There is one exception for removal found in Section 22. An individual may have their removal temporarily paused if they are participating in a criminal investigation relating to their trafficking which requires that they remain in the UK. There may however be multiple reasons why a survivor of trafficking may not be participating in a criminal investigation at the time, without this meaning that they have not been trafficked. For example, mistrust and fear of traffickers and police, as well as precarious mental states can contribute, and there will inevitably be cases where police decide not to pursue further investigation.⁽⁹³⁾ The IMA also dramatically increases the government’s powers to detain survivors of trafficking, something that has been found to have a detrimental impact on their mental health and increases risk of re-trafficking or further harm.⁽⁹⁴⁾

The Nationality and Borders Act 2022

Overall, the changes brought in by the NABA lean towards viewing trafficking as a problem situated within ‘illegal immigration’ concerns, rather than as a safeguarding issue for victims where it has been previously rightly situated. There are survivors of trafficking in the UK who do not have Leave to Remain and would not fall within the definition of a ‘refugee’ as outlined by the 1951 Refugee Convention.⁽⁹⁵⁾ However, the NRM currently exists as a means for them to receive some form of protection in this country, including full access to mental health support for those with existing or emerging mental illness.

The NABA introduced additional barriers to the identification of victims of trafficking and narrowed the support for those who are able to enter the NRM. The definitions of trafficking and modern slavery that are outlined in sections of the NABA differ from previous definitions and, although they are explicitly linked to international definitions such as that provided by ECAT (Council of Europe Convention on Action Against Trafficking in Human Beings), the newer definitions only meet the bare minimum required to qualify under the new guidelines. Therefore, we have lost more generous definitions previously established in the UK.

Previously, for example, when considering personal factors in identification of a possible victim of trafficking, the 2015 Modern Slavery guidelines stated: “any of the person’s personal circumstances (such as the person being a child, the person’s family relationships, and any mental or physical illness) which *may make the person more vulnerable than other persons*”.⁽⁹⁶⁾

NABA offers a higher threshold for identification in stating: “any of the person’s personal circumstances (such as the person’s age, the person’s family relationships, and any physical or mental disability or illness) that *significantly impair the person’s ability to protect themselves from being subjected to slavery, servitude or forced ... labour*”.⁽⁹⁷⁾

There are other ways in which the language used for definitions has changed and which led to concerns from a variety of stakeholders.⁽⁹⁸⁾ This could lead to victims, who would otherwise fall within definitions of trafficking under international guidelines, not being identified and therefore being ineligible for support and assistance.

The NABA has reduced the ‘rest and recovery’ period from 45 to 30 days. This period represented time after receiving a positive ‘reasonable grounds’ decision before which a conclusive decision could be made, to allow someone to begin to recover from their experiences without the threat of removal.

Under Section 58, those who make a protection or human rights claim can be served with a ‘Slavery or Trafficking Information Notice’, which requires the claimant to provide evidence, with a deadline, regarding their claim to be a victim of slavery or trafficking within a specified period. Section 59 states: “*In determining whether to believe a statement made by or on behalf of the person, the competent authority must take account, as damaging the person’s credibility, of the late provision of the relevant status information, unless there are good reasons why the information was provided late.*” This creates a context in which late disclosure of trauma is penalised, with potentially serious consequences despite the wealth of clinical research which sets out why a person may have difficulty disclosing their traumatic experiences.⁽⁹⁹⁾

Following the NABA coming into force, the Modern Slavery Statutory Guidance was updated in January 2023.⁽¹⁰⁰⁾ This revised guidance stated that a potential victim would bear the burden of producing a credible account of being trafficked such that “the decision-maker must agree there are reasonable grounds to believe, based on objective factors, that “a person is a victim of modern slavery” (where it used to say *may be* a victim).⁽¹⁰¹⁾ This revised guidance has already resulted in more victims receiving negative decisions and therefore being denied vital support under the NRM. In the first quarter of 2023, there was a significant drop of 30% in positive reasonable grounds decisions made.⁽¹⁰²⁾ However, In June 2023, following a legal challenge,⁽¹⁰³⁾ which set out the barriers survivors were experiencing in providing ‘objective’ evidence, the Home Office agreed to withdraw, review and revise its new policy. The updated policy now makes it clear that decision-makers should consider “*whether it is reasonable in all the circumstances*” to expect supporting evidence or corroborating information. The guidance now makes specific reference to the reasons why victims’ early accounts may be impacted by trauma and they may be distrustful of authorities and states that “*a decision-maker is entitled to consider all*

forms of evidence in reaching their conclusion – this is not restricted to objective evidence to prove or disprove an account”.

There are additional grounds for disqualification from protection in the NABA for those who have “*claimed to be a victim of slavery or human trafficking in bad faith*”.⁽¹⁰⁴⁾ There are also grounds for disqualification from protection if someone is deemed to be a “*threat to public order*”,⁽¹⁰⁵⁾ which could relate to certain criminal convictions. This means that even if they are recognised as a survivor of human trafficking, they will not benefit from protection from removal from the UK and there will be no requirement to grant them leave to remain.⁽¹⁰⁶⁾ This includes foreign criminals, who would be subjected to automatic deportation, and anyone for whom there are grounds to believe that they have been involved in terrorist activity, whether or not this activity is attributable to the person being trafficked. This ignores the fact that trafficking victims are often forced to engage in criminal activities by the traffickers, such as working in prostitution or in cannabis production ‘factories’. Such victims would be subject to automatic deportation under the NABA. On 30 July 2023, a legal challenge was raised against these public order disqualifications, and an order was made that an assessment must be carried out before any disqualification.

If someone is disqualified under the ‘public order’ or ‘bad faith’ exclusions, there is no mechanism to appeal. Rather, their temporary permission to stay as a victim of trafficking is removed.⁽¹⁰⁷⁾ Children are, however, exempt from the ‘bad faith’ disqualification.

On 30 January 2023, Home Office policy was changed in order to reflect Section 65 of the NABA, with the scope made narrower as to who will be able to seek protection, temporarily, in the UK. In accordance with this policy, ‘Temporary Permission to Stay’ will be only granted to confirmed victims of trafficking in order to:

- Assist the person in their recovery from any physical or psychological harm arising from their exploitation. However, if the person can get assistance in their home country, then permission to stay may not be granted.
- Enable the person to seek compensation if they are unable to pursue this remotely.
- Enable the person to cooperate with authorities in connection with an investigation or criminal proceedings. Again, it must be confirmed that it is necessary for the person to be physically present in the UK to cooperate with the investigation or prosecution.

The new requirement to consider whether a person can pursue treatment, compensation or engage with an investigation whilst not living in the UK is creating yet another hurdle for survivors of trafficking, who will now have to provide evidence in support of this element as well. In addition to contributing to fear of return, this has the effect of making the process even more burdensome and potentially creating further delays.

This approach fails to address the comprehensive needs of survivors when assessing whether to grant leave, including looking at risks of re-trafficking if returned to their country of origin, safety and protection and all the needs of the survivor.

Box 12: Angela

The working group spoke to Angela about the mental health impacts, as well as the wider impact, of the new legislation on people with lived experience of the UK asylum and immigration system.

While some survivors of modern slavery are aware of their trauma and the support needed, others are not even aware that they are/were being abused. Instead of introducing all relevant mechanisms to increase the opportunities for supporting people, the new legislation creates further barriers to tackling the issues, negatively impacting survivors' mental health.

“Some survivors don’t even know how to describe their experiences to make the direct link and say, “I’m a survivor of trafficking or modern slavery,” because it’s not until somebody explains what they’ve been through that you get the concept of what they’re trying to tell you what happened to them and why.”

Angela highlighted the issue of impacts on people caused by the short timescale to provide evidence. Survivors of modern slavery and trafficking expect assistance with obtaining evidence. However, Angela thinks that the new legislation does the complete opposite:

“What the authorities should be concerned about is trying to find a way of you getting the justice that you need and recover from the atrocity that you had to face, but the Act doesn’t do any of that. It does all the opposite. They say we’re going to vilify you put you under stress, and re-traumatise you and to make things even more difficult, you don’t have a lawyer. So, there’s a legal aid aspect attached to all of this, which makes people feel even worse.”

The UK authorities often mention that the UK has a proud history of providing sanctuary to the people and that the new legislation is designed to save lives and improve the UK immigration system. However, the legislation removes already limited existing support from survivors of trafficking and modern slavery and is focused on punishment rather than providing justice to the people.

“We can still send you to Rwanda, for example, or to another safe country if you came from Calais or France, not understanding that [there are still] many layers to the trauma that somebody has been through and very many reasons why they’ve ended up here and not somewhere else. So, one of the things I found about this Act is that it’s extremely draconian and causes human suffering.”

2.1.2 Mental health concerns

There is a high prevalence of mental disorders among survivors of human trafficking, especially anxiety and trauma-related conditions. A systematic review including 342 survivors of human trafficking identified a prevalence of:

- complex PTSD of 41%, and
- a prevalence of PTSD of 14%.⁽¹⁰⁸⁾

Complex PTSD is often more difficult to treat and requires more specialist psychological interventions, which are of a longer duration and higher cost.⁽¹⁰⁹⁾

During the government’s initial attempts to remove people to Rwanda, it became clear that survivors of trafficking were amongst those served with ‘Notices of Intent’. With any policy which doesn’t include any screening interviews, it would be inevitable that many survivors of trafficking would be removed from the UK to ‘safe third countries’.

Lived-experience insight: From a member of One Strong Voice

“And I can’t stress this enough because looking at some of the proposed changes to the legal legislation in regards to getting legal aid, and the government’s focus on removing people very quickly means that survivors are going to be denied access to essential legal support, which means there is no doubt that some survivors of modern slavery and trafficking are going to get caught up in this rapid deportation plan that will make them suffer even more.”

– Angela

Identification of victims of trafficking requires decision-makers to consider factors (including mental illness) which “*significantly impair the person’s ability to protect themselves from being subjected to slavery, servitude or forced ... labour;*” whereas, previously, factors could be considered which “*may make the person more vulnerable than other persons.*” For a clinician to assess and demonstrate that a mental illness *may* make the person more vulnerable than other persons is a much lower threshold, and allows for the uncertainty that characterises many psychiatric assessments. The new definition in the NABA, which was written up without consultation from experts in the anti-slavery sector,⁽¹¹⁰⁾ requires more certainty from a clinical assessment (if a case reaches the stage of an MLR) than is often possible, and there is little guidance as to how ‘significantly impair’ might be interpreted.

Penalising individuals based on late submission of evidence disproportionately affects those who find it difficult to disclose trauma.⁽¹¹¹⁾ Survivors of human trafficking are likely to fall into this category, as they may fear retaliation from their traffickers and fear for their and their family’s safety. They may also have difficulty trusting Home Office officials over and above other people seeking sanctuary, due to previous negative experiences of authority figures or experiences of being disbelieved.

Disqualifying from protection those who have criminal convictions will impact on many survivors of trafficking. It is well known that some traffickers make their victims commit crimes and use their victims as shields against detection by law enforcement and prosecution.⁽¹¹²⁾ Examples include using victims to advertise illicit services (such as drugs or weapons), recruit new victims, or maintain a sense of control over other victims. It is likely that those with intellectual disabilities or mental health conditions would be more vulnerable to exploitation, and therefore at greater risk of being forced to commit crimes on behalf of their traffickers.

The lowering of the threshold for exclusions based on criminal records may also disproportionately affect those most likely to have poor mental health. One study of UK immigration detainees found that foreign national ex-prisoners had greater levels of unmet mental health needs and high prevalence rates of certain mental illnesses compared to other detainees.⁽¹¹³⁾

The changes will also apply to survivors of trafficking who are considered to be involved in terrorist activities. This has particular implications for survivors with mental health difficulties, as the government’s counter-terrorism Prevent programme has been found to disproportionately identify individuals with mental health conditions,⁽¹¹⁴⁾ and disproportionately affects racialised groups, and those of migrant backgrounds.

2.2 Children, adolescents and parents

2.2.1 Inadmissibility and safe third country agreements

As stated earlier, the new government has stated that all claims will currently be processed in the UK, including those which have been deemed inadmissible since 20 July 2023, and we encourage the new government to keep to this commitment permanently due to the potential harms of the IMA provisions outlined here.

The IMA asserts that all asylum claims made by people who have arrived in the UK via irregular routes would be deemed inadmissible, and this includes those made by accompanied and unaccompanied children.⁽¹¹⁵⁾ This has been criticised for undermining the principles of the UN Convention on the Rights of the Child and the Children Act 1989.

When it comes to the duty of removal from the UK, the IMA does make an exception for unaccompanied children, although they may subsequently fall under the duty to remove once they turn 18 years old. Furthermore, although the Secretary of State does not have the duty to remove unaccompanied children, they still retain the power to do so.

Prior to this legislation, unaccompanied children in the UK were able to make an asylum claim which would be assessed in the UK. If this claim was refused, and there were no 'safe, adequate' reception arrangements in their country of origin, they may be offered a temporary form of leave called 'Unaccompanied Asylum-Seeking Child' (UASC) leave. This leave would be reviewed until the child turned 18, at which point they would not be offered further leave to remain. If a child had not had their claim processed and they turned 18, their claim would be assessed as an adult, and they would not receive any child-specific protections at their interview. The IMA does not provide for assessing children's claims in the UK, and instead will deem claims from children 'inadmissible' just as they would adults, if they arrived via an irregular route.

Already, children and young people who have not yet received a decision on their asylum claim, or who have received UASC leave, face a great deal of anxiety about turning 18 (often referred to as 'ageing out'). This is because, on turning 18, their temporary UASC leave would not be renewed and they would not be offered further temporary leave to remain, and they face the possibility of removal if their claims are denied when assessed as an adult.⁽¹¹⁶⁾

The IMA would have resulted in a burden of additional stress and anxiety for these children, as they would also face the likely prospect of removal from the UK when they turn 18 years old, with no possibility of their claims being processed in the UK. Living with this threat would be likely to have a significant impact on a child's mental health and development, as well as their ability to carry on with normal life, including sleeping well and, for some, their ability to concentrate on educational activities. For many, education provides them with a continued sense of purpose, and they can often manage despite underlying stress and anxiety. However, the prospect of removal is likely to be disruptive.

Under the IMA, children who are not removed and remain in limbo in the UK are likely to go missing during this period due to fear of removal when they turn 18, and will be at higher risk of abuse and exploitation alongside physical and mental health concerns.⁽¹¹⁷⁾

In cases where claims from families with a dependent child are found inadmissible, the IMA would have removed the requirement for the Home Office to consult with a family returns panel on safeguarding the welfare of children in the returns process, although it is unclear what this will mean in practice.

The IMA makes clear that children may be removed for the purposes of family reunion or to a 'safe' country of which they are a national, if their country is on the 'safe list.' However, there are currently no plans to send unaccompanied children to 'safe third countries'. That said,

there is the potential for children to be removed if errors were made in their age assessments and they were deemed to be adults. This is increasingly likely to happen, given the increasing presumption by the government that there is significant ‘gaming’ of the system, by which adults pose as children. Yet, this assertion does not have an evidence base to support it.

The removals process has a very short timeline built into it during which children and young people would have been able to make appeals. This time constraint would have made it extremely difficult to gather the necessary documentary evidence to support their age claims, and increases the risk that a child would mistakenly be deemed to be an adult. Unless there is appropriate legal provision available in ‘safe third countries’, it is unlikely that such a mistake would be rectified following removal.

2.2.2 Long periods in limbo

Children and adolescents need stability in all contexts (including home, social relationships and education) to promote healthy development. Longer periods in immigration limbo are likely to lead to uncertainty and more disruption, which have a cumulative impact.⁽¹¹⁸⁾ Particularly for children, it is important to consider not only the impacts of the disruption at the time, but the evidence that it can cause lifelong mental health impact and, indeed, adversely affect the whole trajectory of a child’s life.

Young people flourish when they are helped to participate in age-appropriate community life. Young people seeking sanctuary may sometimes wait several years for assessment, whether that is for a screening or a substantive interview. Those who arrive in the UK via irregular routes will now be able to remain in the UK until they reach the age 18, but know they will then be removed from the country. These long periods of uncertainty create a context of vulnerability that can contribute to mental health problems, eroding protective factors such as friendships and stability. Young people can struggle to know how to access resources, which means they can lose out on opportunities for support in participating in community life. Access to community life is a ‘protective factor’, and barriers to participation in the life of the wider community have a profound impact on mental health, leading to unstable functioning, low self-esteem and self-confidence, and difficulties in self-care and in relationships with others. Good practice can be seen in some schools and colleges which have programmes of social integration which can reduce marginalisation and the sense that a young person feels invisible and expendable.

There are also issues to consider with regard to the intergenerational transmission of trauma. A child with symptoms of PTSD may be more likely to have a family member with similar symptoms, and support for the whole family may be needed. The uncertainty and stress that parents face during this process will certainly have impact on their children, and may affect the parents’ ability to provide the stable and safe emotional spaces that children need to flourish.⁽¹¹⁹⁾

The increased risk of detention and removal for both children and adults is likely to contribute to people removing themselves from the oversight of the asylum system and statutory authorities, and becoming ‘undocumented’. There are major concerns associated with ‘undocumented’ children and adolescents, as they are at increased risk of trafficking, exploitation, sexual violence, and criminal gangs.⁽¹²⁰⁾ They are also not be able to access education, and have no oversight or protection from Children’s Services.. It is difficult to completely mitigate the longer-term adverse impact of this period – particularly for adolescents who may have missed opportunities for education and career planning, etc. – even in instances where immigration issues are later resolved.

2.2.3 Immigration detention

The IMA reverses the 2014 Immigration Act ban on the detention of unaccompanied children for more than 24 hours (and accompanied children for up to 72 hours), and instead allows for the potential indefinite detention for children. For unaccompanied children who are detained pending removal, there is no option to apply for immigration bail in the first 8 days. For children who are detained on arrival to the UK, it is not possible to apply for immigration bail in the first 28 days. This poses real risks for the welfare of children who may already be in the midst of a severe mental health crisis.

The new provision to detain children was disputed heavily in the House of Lords in the amendments stages of the Illegal Migration Bill, and led to widespread condemnation from organisations working with adults and children seeking sanctuary, including the Royal College of Paediatrics and Children Health,⁽¹²¹⁾ who noted the “severe consequences [to] health, well-being and development” that children would face. The BMA summarised, in their joint statement to parliament on the predicted impact of the legislation, that, amongst detained children and young people, “symptoms of depression and anxiety were common, along with sleep problems, somatisation, poor appetite, and emotional and behavioural difficulties.”⁽¹²²⁾ Despite this, the new expanded detention powers have now come into law. The impact of detention on children’s wellbeing and mental health is likely to be significant, both directly and indirectly, from challenges in accessing education in the context of school or college, and the adverse impact on development through isolation and lack of social networks that would be available in the community.

Case study 3 – Samir

Samir is 16 years old. He left Sudan and travelled to Libya where he was held in captivity with many others, tortured over four months, had significant demands for cash from members of the armed militias and experienced further torture when he could not give more funds. When released from prison, he embarked on two journeys – Libya to Italy and then Calais to the UK. In both cases, he travelled by plastic dinghy, all the while believing he was likely to drown. He was rescued by the RNLi in the Channel and taken to Dover where Immigration Officers told him he was 25. When interviewed he was unable to focus or think or understand the system. At no point was he interviewed in his mother tongue. The two Home Office assessors deemed him to be over 18, and he was placed in detention where he shared a room with an adult man. He was not offered information about any appeals process.

Under the IMA, Samir would be served with a Notice of Intent, and removed to a ‘safe third country’.

2.2.4 Family reunification

The IMA significantly restricts possibilities of family reunion. The UK has never officially allowed families to join children who arrive in the UK and seek sanctuary, although this has sometimes occurred in exceptional circumstances. However, adults whose claims were accepted in the UK were allowed to sponsor spouses and children to come and join them. The IMA, in its duty to remove anyone who arrives via an irregular route, would have meant that only a small minority of people seeking sanctuary would have been given leave to remain in the UK and, alongside this, the opportunity to apply for family reunion. As we have outlined, we expect a large increase in numbers of people in immigration limbo for many years, who may still be unable to bring their children to the UK.

In the UK we are unlikely, therefore, to see firsthand the burden on children that this will cause, as children will remain at risk in their countries of origin. As family relationships are the most important factors to support children in coping after traumatic events, such as armed conflict, not only is ensuring support for the whole family vital,⁽¹²³⁾ but it

is of great concern that those who may need their families the most would be denied this under the new legislation.

We are likely, however, to see the significant impact on parents who are unable to bring their children, and indeed spouses, to join them in the UK, and for whom separation from their children and partner is likely to increase their distress and contribute to worsening mental health. It remains unclear what family reunification rights will be available with the new government's proposed policies.

2.2.5 Age assessments

The NABA has introduced new regulations relating to age assessments. Despite the newer, restrictive laws for children and adolescents, there are still international and national laws and frameworks that provide for specific care for younger people. The process of age dispute and age assessment is therefore crucial for ensuring that children are protected and safeguarded.

Before the introduction of the NABA, age assessments in the UK drew evidence primarily from documents and interviews. The NABA and IMA now pave the way for so-called 'scientific' measures to be utilised, which supporters argue will reduce subjectivity and the potential for abuse and discrimination in the system. The types of 'scientific' methods which the IMA permits include physical examinations, imaging, and analysis of saliva or other samples (which may be used to analyse DNA). Such measures have received significant backlash from the medical and dental communities, as the evidence indicates that they are unreliable.⁽¹²⁴⁾

The changes in NABA also allowed for negative inference on credibility to be taken if a child refuses to undergo a 'scientific' process. The IMA includes a regulation-making power to make an automatic assumption that a person is an adult if they refuse to undergo scientific methods of age assessment without good reason.

The measures in the NABA also proposes a new National Age Assessment Board (which would be run by the Home Office) which can undertake age assessments on the request of the local authority as well as giving the Home Office the power to refer children to the National Age Assessment Board to undertake assessments.⁽¹²⁵⁾ Social Workers have been recruited for this Board to carry out assessments,⁽¹²⁶⁾ although their employment under the Home Office, which has an immigration-focused remit, raises concerns about independence and impartiality, and the British Association of Social Workers has recommended its members against working for the National Age Assessment Board due to concerns that their professional judgement could be impaired by political pressures.⁽¹²⁷⁾ Overall, the impact will be for the government to have more power over age assessments.

The age assessment process has myriad potential adverse implications for mental health.⁽¹²⁸⁾ The assessment itself can be anxiety-inducing and contribute towards an ongoing sense of uncertainty and fear. Some may feel humiliated by the process, and the introduction of physical examinations and tests permitted under the NABA could prove psychologically damaging for young people who have experienced physical or sexual abuse. Human rights bodies have raised concerns that these methods violate children's rights to privacy and bodily integrity under Article 8 of the ECHR,⁽¹²⁹⁾ and may lead to significant risk of re-traumatisation. It is also unclear how the process of seeking informed consent would take place, and what the consequences would be for a young person who refused to undergo examinations or investigations as part of age assessments.

More broadly, the process prevents young people from accessing education while their age is disputed, which may lead to missed educational opportunities and contribute towards social isolation and loneliness. Furthermore, there is no reassurance that people claiming to be children will be treated as children until it is established that they are not. The mental health impact for those young people who are deemed to be adults (either without undergoing an age assessment or as a result of one) is likely to be far-reaching.

Children and young people's psychological wellbeing relies upon having a stable and safe living environment, and this is especially important for those who are unaccompanied and, therefore, lacking supervision and support from family members. Being accommodated alongside adults puts them at heightened risk of exploitation and abuse, and those with poor mental health may be more vulnerable to this. For those who are placed in shared accommodation with adults there are serious safeguarding issues to be considered.

Perhaps most importantly, the psychological impact of receiving an outcome of an age assessment in which the young person is not believed cannot be underestimated. This can have profound impact on identity, confidence and self-esteem. It may also further undermine trust between the young person and authority figures, which can make it even harder to gain insight into their mental health, and offer timely and appropriate mental health intervention.

In addition to the concerns about the accuracy and intrusive nature of new 'scientific' techniques to determine age, there remain concerns about how age assessments are currently undertaken. Cultural factors may not be adequately taken into account, and cross-cultural assessment of age is more likely to be biased and inaccurate. The assessments are often carried out by border force staff who do not have sufficient training and experience to be able to consider, holistically, the factors that might contribute to a child's presentation, particularly when these decisions are being made under time and resource constraints.

2.2.6 An accelerated process

The NABA introduces measures to try to speed up the asylum determination process through priority removal notices and accelerated detained appeals. As these shorter timelines may impact on ability to arrange legal advice, and indeed childcare in the time available, children may find themselves inappropriately exposed to aspects of the asylum process that may be stressful and even traumatic for them. Such stressful aspects might be indirect – through being present during their parents' assessments – or direct – by being interviewed themselves.

The need to allow sufficient time to complete a holistic assessment of young people is well documented. It must involve professionals from different disciplines. Young people struggle to understand the asylum process, and have more difficulty in sharing details about their experiences than adults.⁽¹³⁰⁾ There would be significant concerns for any young person who is required to engage quickly in what can be an overwhelming process.

More broadly, when administrative and service provision is reduced, children may take on a role akin to young carers for their parents, particularly where their parents may have their own unmet mental health needs, and the impact of this burden should not be underestimated. Having a parent with a mental health difficulty is a recognised risk factor for a child developing their own mental health difficulties.^{(131), (132)}

Having a faster interview process means there is less time for information-gathering, and this runs a risk that the Home Office may use information gathered from other sources when considering applications, including, for example, from children when considering family applications.

It remains unclear whether children would be interviewed or how any information provided by children may be used for the claims of family members due to data-sharing agreements between the NHS and Home Office. In 2019, the Home Office was criticised for using a child's psychiatric notes from an A&E assessment to undermine her parents' asylum claim. In her interview, 48 hours following an overdose, she stated that her family had travelled to the UK for better healthcare for her father. Despite the family's lawyer explaining that the child would not have been told the full extent of the danger faced by the family, the judge sided with the Home Office in rejecting the family's claim.⁽¹³³⁾

There are many issues with this approach; children and young people may develop a deep sense of mistrust if information they have revealed in confidence to healthcare or other professionals, is used in this way. Furthermore, parents may not tell their children all the details around the circumstances of them coming to the UK, leading children to provide incomplete accounts that could be used by the Home Office to discredit their parents' claims.

Furthermore, when children's accounts are deemed to lack credibility, it is even more important to have time for full assessment of the extent to which their still developing memory functioning is contributing to their accounts.⁽¹³⁴⁾

2.2.7 Trafficking

Concerns about the exclusion of protection for survivors of human trafficking apply to children and young people as well as to adults. Children, especially those with intellectual disabilities and mental health difficulties, may be even more vulnerable to being forced into criminal activity by traffickers than adults. A survey of 130 survivors of trafficking in the United States found that 91% had been arrested at least once, 42% of whom were first arrested as children,⁽¹³⁵⁾ which means that they are at risk of being excluded from protection and removed based on 'public order' arguments.

2.3 Older adults

2.3.1 Older adults and the asylum system

People aged 60 years and over are thought to represent around 6% of all forcibly displaced people worldwide.⁽¹³⁶⁾ While forced migration has been associated with various negative mental health difficulties in general, older people seeking sanctuary may be particularly vulnerable. Older age has been found to be associated with a higher risk of severe psychological stress⁽¹³⁷⁾ and negatively associated with health-related quality of life in people seeking sanctuary and refugees.⁽¹³⁸⁾ For example, in a sample of Bosnian refugees in the United States, certain psychological symptoms such as avoidance and re-experiencing were more prevalent among older forced migrants.⁽¹³⁹⁾

Many pre-migration and post-migration factors could lead to worse mental health outcomes for older people seeking asylum. Pre-migration factors include a higher prevalence of physical health problems, lack of access to good quality medical services in their country of origin, or being unable to afford treatment for chronic diseases such as diabetes and cardiovascular disease. Family issues, such as caring responsibilities, may be exacerbated by forced migration, and some older people may experience various types of abuse from family members who migrate with them. Older people are likely to find the already difficult journey to their host country especially challenging, due to frailty, disability, or physical health concerns.

A number of factors can impact on the mental health of older people seeking sanctuary once they have arrived in their host country. A key post-migration factor is social isolation, which may arise as a result of separation from extended family, difficulties learning a new language, inability to access employment and education opportunities, physical disabilities, and experiences of discrimination. Older people seeking sanctuary report more difficulties with acculturation⁽¹⁴⁰⁾ which leads to poorer social integration, fewer social networks and difficulties in trusting others. They have reported losing the sense of meaning and purpose which they may have had before leaving their home country⁽¹⁴¹⁾ – part of this can include the loss of higher status that comes with old age in many non-Western cultures which contrasts with a Western perception of older adults

as being unable to contribute economically.⁽¹⁴²⁾ As such, older adults may have a stronger desire to return to their home country, while younger people are more likely to focus on integration and rebuilding their identities in their host country. All of these factors are associated with worse mental health outcomes post-migration.

Older age also has implications for access to treatments for health conditions. Older people seeking sanctuary have been found to encounter more difficulties in accessing medication in host countries, compared to younger people.⁽¹⁴³⁾ A loss of sense of identity or hope could prevent older people from seeing any benefit from receiving treatment. They may question to what extent physical or mental health interventions can improve their quality of life if they are unable to find meaning in their life themselves. This becomes more problematic in older patients who may decline life-saving treatments for physical health problems due to their hopelessness. Health professionals working with older people seeking sanctuary should be aware of these challenges. Due to their relatively small numbers among the wider forced migrant population, they can be 'invisible' and easily missed from accessing services, especially with various services and research tending to focus on younger age groups.

Case study 4 – Salim, an older adult

Salim is a 65-year-old Syrian refugee who came to Norwich with his family under the Syrian Resettlement Scheme. He presented with significant physical health symptoms (back pain, abdominal pains, weight loss, poor appetite and cognitive difficulties).

No organic cause was found for these problems. He was also reviewed in the pain clinic, and treatment was unsuccessful in reducing his pain.

Salim is very worried about using any medication for fear of side effects. He is particularly against using any psychotropic medication and worries that he would become addicted to them.

He reported feeling very distressed and socially isolated. He spoke about how he prefers to withdraw from social activities and stay alone, even at home. This is a significant change in his personality, as he used to be very socially outgoing.

He spoke about his traumatic experiences back in Syria, including burying the bodies of small children killed during the conflict. He was almost killed by a sniper when he and his family left their home to seek refuge in another city.

He often reminisces about his high social status in his own town as a very respected businessman, an estate agent and head of his big family. But unfortunately, he lost all that social position, which affected his self-esteem and resulted in his feelings of helplessness and that nothing would bring him back what he lost.

Salim also developed significant symptoms of health anxiety. He is always worried that he could have a heart attack or a fall, which increases his social isolation as he becomes housebound and never leaves home except with his son.

He was unwilling to learn English and refused to attend classes or groups. He doesn't feel that he fits anywhere in his new life here.

Unfortunately, he was also unable to engage in any psychological therapy interventions as he is also focused on his physical health and does not think that addressing some of his negative thoughts could help to improve his feelings.

2.3.2 Mental health concerns

The mental health implications of the NABA and IMA discussed above also apply to older adults; however, there may be additional implications to consider. Broadening the inadmissibility criteria and denying asylum to those arriving irregularly may have particularly affected those older people who may have been misguided, or perhaps even provided with false information by family members or traffickers. They may not have had access to the documents they need to support their asylum application, either

because they never had such documents in the first place, they left them behind, or a family member has them in their possession. Furthermore, it is not yet clear whether older age in itself would have been considered a 'significant vulnerability' and, as such, be taken into account when making decisions about removal if their claims are considered in the UK under the NABA.

Although it is important not to generalise, older people may be less resourceful and adaptive than younger people seeking sanctuary. For instance, they may find it more difficult to access and utilise technology, and therefore struggle to find a solicitor (and hence benefit from any necessary MLR required to support their case). This may be especially important as deadlines for providing evidence are shortened and the standard of proof required to support asylum claims increases. Lack of access to the internet may also limit older people's means of integrating, forming social connections, and supporting their mental health. For example, they may not be able to access online translation tools or find information on local support groups or health services.

Reduced access to family reunification options is likely to disproportionately affect older people, who may depend more on care from family members. It is more likely that younger people will make the initial journey, possibly under work or student visas, and then be unable to bring their older relatives to the UK when they make an asylum claim, however from a global perspective this will still lead to impacts on older adults who will be affected by family separation.

Older people seeking sanctuary would be particularly affected by any limits placed on access to financial support, and would be especially vulnerable if made destitute. For instance, homelessness has been found to exacerbate declines in the physical health of older adults, and lead to poor emotional health and social exclusion.⁽¹⁴⁴⁾ Being new to the UK and lacking knowledge of support systems or how to access help would contribute to the vulnerability of destitute older people seeking sanctuary.

Looking further to the future, as people seeking sanctuary in the UK at a younger age grow older here, there are implications for longer-term healthcare and social support. Research suggests that for older immigrants and forced migrants, the importance of minoritised ethnic and diaspora communities is significant, and these communities offer informal social care support to older adults. The ability of these communities to offer support, however, depends on the social capital and collective resources that have been built up over time. Both the NABA and the IMA have introduced changes that will severely hinder the ability of individuals to form safe and stable communities through prolonged periods of uncertainty, increased risk of immigration detention, and increased hostility from UK host communities. As these community bonds are weakened over time, there is likely to be a reduction in the social support and care offered to older adults in the community, and an increase in demand for state-funded healthcare and social care.

2.4 Women

2.4.1 Women and the asylum system

Although males seeking sanctuary often receive more media attention, a significant number of women will also be impacted by the new immigration legislation. In the year ending March 2023, 13% of people arriving by small boat were women.⁽¹⁴⁵⁾ In a world full of civil conflict, war, and human rights violations, women are the main caretakers and very often experience various forms of oppression from society. Women in general, and especially women seeking asylum, often face human rights abuses related to their gender, including sexual exploitation, rape, domestic abuse, forced pregnancy, trafficking and other forms of harm. The IMA and NABA remove the right of women to seek asylum or protection under the NRM.

2.4.2 Changes to detention rules: implications for women

A key concern of the Illegal Migration Bill when it was first introduced was the removal of protections for pregnant women in relation to detention. Since 2016, a limit has been in place preventing pregnant women from being detained for more than 72 hours.⁽¹⁴⁶⁾ However, the Bill originally sought to remove this limitation and permit pregnant women to be detained indefinitely.⁽¹⁴⁷⁾ It also sought to remove two other key protections for pregnant women in detention; firstly, that they would no longer have the right to apply for immigration bail within the first 28 days of their detention, and secondly, that the lawfulness of their detention could not be examined through judicial review within the same period.⁽¹⁴⁸⁾

A joint position statement released by organisations representing the interests of pregnant women (including the Royal College of Obstetricians and Gynaecologists)⁽¹⁴⁹⁾ called for these aspects of the Bill to be removed, citing the detrimental impacts of immigration detention on the health of both the pregnant woman and the developing foetus, and inadequate access to antenatal care in detention.⁽¹⁵⁰⁾ In the amendments stages of the Bill, the 72 hour time-limit on pregnant women in detention was reinstated, with a maximum time limit of 7 days in cases where a longer period of detention is authorised by the Minister of the Crown.⁽¹⁵¹⁾

Immigration detention undermines the dignity of both men and women, including issues related to accessing healthcare services.⁽¹⁵²⁾

Lived-experience insight: From a member of One Strong Voice

Box 13: Sepideh

The new legislation expands immigration detention for everyone, including women, contributing to the existing culture of disbelief and forcing them to provide evidence about their traumatic experiences as soon as possible. Therefore, it creates further barriers for women, resulting in extensive negative impacts on their emotional wellbeing.

“I’m just talking about myself, but this can be applied to the general majority of women who are taking this route. You are already traumatised when you leave your country. Imagine you are just separated from your family and loved ones and you don’t know when you’re going to go back and if you see them again or not. Once you are in a position that means you have a hope that you are looked after and that you will be listened to and, all of a sudden, you’re detained.”

– Sepideh

2.4.3 Inadmissibility and ‘safe third country’ agreements: implications for women

The increased risk of becoming undocumented out of fear of removal is particularly concerning for women, who would be left vulnerable to harms such as modern slavery, sexual exploitation and destitution.⁽¹⁵³⁾ Hiding from the authorities also will mean they avoid accessing healthcare, mental health support and other essential social services. This would be detrimental to any woman’s health, but would have additional adverse consequences for pregnant women, as it may mean they do not seek antenatal care, with the associated risks to the developing foetus that would bring.

The prospect of removing women to ‘safe third countries’ for permanent removal or under offshoring provisions is also concerning given the proposed plans for ‘blanket’ lists of ‘safe’ countries, as there may be countries which are much less safe for women, especially if the third country does not have robust women’s rights records, and will not protect them from abuses.

The comments made by the former Home Secretary that it should no longer be possible to claim asylum on the basis of gender or sexual orientation,⁽¹⁵⁴⁾ while not enshrined in the new legislation, suggest that some senior decision-policymakers deem women to be unworthy of protection from persecution.

2.4.4 NABA: implications for women

For women who arrive in the UK and apply for asylum, the increased standard of proof required may affect them in particular ways. They will need to prove that it is more likely than not that they have been abused, otherwise, they will be denied protection. This puts the onus on women to prove they have been abused, which is extremely difficult to do for a number of reasons, but may be especially challenging for women with mental health difficulties. The culture of disbelief will remove the benefit of the doubt from vulnerable women and is likely to have a negative impact not only on their asylum case, but also on their mental and physical health.⁽¹⁵⁵⁾

The definition of the term 'refugee' in the UN Refugee Convention does not include gender or sex. Having a protected characteristic is an essential element for someone to be recognised as a refugee, however the 1951 Refugee Convention was not written with specific considerations for women who have undergone various human rights violations purely due to being female. For this reason, case law has established that women could be considered a member of a 'particular social group' in asylum claims, and this was the hope for many women to qualify for protection.

Section 33 of the NABA imposes a further risk to women as it restricts the definition of 'particular social group' as one of the grounds of persecution under which a person may qualify as a refugee under the Convention. The NABA will make it harder for women to rely on this category and secure protection from the country.⁽¹⁵⁶⁾

Lived-experience insight: From members of One Strong Voice

Box 14: Sepideh and Nasrin

Sepideh mentioned that the majority of women claiming asylum in the UK are victims of modern slavery, trafficking and sexual violence. Yet, instead of providing specialised support and treating them with compassion, the new legislation will criminalise and detain them for exercising their human right of claiming asylum in their country of choice where they feel safe.

She raised concerns that rejection and dehumanisation will increase the number of self-harm/suicides which is already an issue for women seeking asylum in the UK. In addition, women separated from their children will be at more risk as uncertainty about their reunion will have a catastrophic impact on their mental health.

Nasrin thinks the new legislation will harm all refugees and people seeking asylum in the UK. However, women, in particular, will be more affected by the legislation. Like Sepideh, Nasrin noted that many women had already faced traumatic experiences such as persecution and sexual and gender-based violence, even before they arrived in the UK and during their traumatic journeys to arrive in the UK. The new legislation will further lead to women's exploitation and put them at inevitable risk.

"I mean, it is inevitable that women will be more impacted by the NABA, including mental health impact. Women could face destitution if they do not have access to benefits depending on their situation, and this could lead to exploitation, such as sexual exploitation."

2.5 People with intellectual disabilities

2.5.1 Mental health concerns

The UK asylum system is highly complex and can be daunting for people seeking sanctuary to access and navigate, particularly in times of great distress and vulnerability. People seeking sanctuary who also have intellectual disabilities have added vulnerability and are already at higher risk than the general population of facing barriers to access to specialist assessment and care, all in a broader context of accessibility problems, inadequate funding, provision and quality of specific services, and an understaffed workforce and insufficient training.

There are no legal changes in the IMA or the NABA which relate specifically to people with diagnosed or suspected intellectual disability. However, the concerns that we have raised in this report about this new legislation may well impact people seeking sanctuary with intellectual disabilities in particular ways.

Identification of intellectual disabilities

We have outlined how the pathway in the IMA for removal from the UK does not include any screening or assessments for vulnerability, relying on individuals to make rapid appeals within limited grounds if they want to pause or stop their removal. For the majority of people seeking sanctuary in the UK, these legal expectations and timelines would have been unrealistic, but even more so for individuals with an intellectual disability, particularly those who are travelling alone and do not have family members or friends who can advocate for them.

Even in developed countries such as the UK it can be difficult to find consensus on what might constitute a clinical intellectual disability. To enable such a diagnosis to be made, there is a requirement for various relevant information to be collated, including a detailed developmental history (with focus on sensory and motor milestones), educational reports, psychological assessments including cognitive examinations, adaptive behaviour functioning feedback etc. Such information is provided by families and local authorities to help build a picture of the nature and degree of intellectual developmental deficits if any and whether it qualifies for a disability. These are time-consuming assessments. Among people seeking sanctuary there is a high likelihood of challenges in language and communication, a lack of developmental history from family informants or school records and other socio-cultural characteristics which could prevent a suitable assessment (or even referral for an assessment) until and unless the person is in an appropriate supported setting.

Another related issue is that the recognition of intellectual disabilities in other countries, particularly economically developing ones. Assessment and diagnosis depends on many local factors which influence interpretation of the standard measures used in the UK to measure intellectual and adaptive functioning. Such factors include expectations arising from educational provision and adaptive capacity.

Evidence supports sociocultural factors as the key feature determining what is seen as competent and appropriate behaviour. Within Western high-income countries, the construct of intellectual disabilities has been defined to meet the needs of urban, industrialised societies, with the identification of large numbers of individuals with below-average intellectual functioning coinciding with the industrial revolution and the growth of schooling. In non-industrialised societies, competence may be demonstrated through collaborative, interpersonal problem-solving skills.⁽¹⁵⁷⁾ Thus, different concepts of intellectual disability could also prevent recognition of intellectual disability even if the person has family members or relatives with them.

The absence of even a basic screening interview means there is no opportunity to identify people with intellectual disabilities at any level of severity. This means it is likely that many people with intellectual disabilities will be left unsupported, unable to navigate the complex requirements in the timeframes required to appeal against their removal to a safe third country.

Trauma and mental health burden in people with intellectual disabilities

The mental distress faced by people seeking sanctuary with intellectual disabilities could present in unconventional manners given the limitations in communication and cognition they might have. These could include a range of passive or active distress behaviours, such as impulsive violence and self-harm.

The risk of diagnostic overshadowing is a significant risk in this population as their behaviours could be misinterpreted. Provisions in the NABA that might be particularly harmful to those with intellectual disability and associated impulsive aggression may be the reduction of the threshold of crimes which would lead to removal, and those in trafficking regulations which include exclusions from protection on public order grounds (which are likely to include acts of aggression).

Immigration detention

People with intellectual disability require particular clinical skills, and specialist input from clinicians and professionals with experience in the assessment, care and management of intellectual disabilities, particularly when they have comorbid mental illnesses. Specialist services are unlikely to be available in immigration detention settings or quasi-detention accommodation. As people with intellectual disabilities can find emotional and behavioural regulation challenging, the setting of restrictive containment has the potential to increase anxiety and possibly aggression amongst people with intellectual disabilities.⁽¹⁵⁸⁾

2.6 LGBTQI+ individuals

Lesbian, gay, bisexual, transgender, queer/questioning, intersex, and other sexual and gender minority (LGBTQI+) people seeking sanctuary can face significant persecution before, during and after their arrival to host countries, including the UK.

While there are no accurate statistics on LGBTQI+ people seeking sanctuary, the UNHCR reported an increase in the number of these individuals seeking sanctuary globally in the last decade, noting that most of them qualify for protection under “membership of a particular social group” under the 1951 Refugee Convention.⁽¹⁵⁹⁾

People seeking sanctuary from LGBTQI+ groups face significant risks of physical and sexual violence, intimidation, and harassment and have higher rates of developing mental disorders, such as anxiety, depression and PTSD,⁽¹⁶⁰⁾ with studies suggesting that they are among the most vulnerable groups among people seeking sanctuary.⁽¹⁶¹⁾

One of the concerns that has been raised about the inadmissibility and ‘safe third country’ policy is that having a general list of ‘safe’ countries does not take into account the different reasons people may have fled their homes, and that a country which may be ‘safe’ for one person may not be safe for someone else. This is particularly relevant

when considering LGBTQI+ people seeking sanctuary, as it has been highlighted that several countries on the 'safe' list have themselves discriminatory laws or poor records of treatment of LGBTQI+ communities.

This applies to any countries with which the government may make 'safe third country' agreements or offshoring agreements. For example, there have been concerns raised about Rwanda's treatment of this community, with the Home Office acknowledging in their own impact assessment that LGBTQI+ individuals could be persecuted if sent to Rwanda.⁽¹⁶²⁾

These concerns are not specific to Rwanda. Several other countries have hostile environments in relation to sexual orientation and gender identity, including ones in which having an LGBTQI+ identity is criminalised. There are also other countries in which having such an identity, while not formally criminalised, holds significant social taboo for which people face persecution from non-state actors, and states fail to provide protection against such persecution.

The projected longer periods in immigration 'limbo' may particularly impact on LGBTQI+ people. This group has higher rates of trafficking, reflecting increased vulnerability as a result of rejection or violence from their families, bullying, and physical, sexual and emotional abuse. They are also likely to be more vulnerable to trafficking or modern slavery if they go missing from Home Office accommodation due to their fear of removal.⁽¹⁶³⁾

There is some evidence that LGBTQI+ individuals have faced verbal and physical homophobic abuse both from other individuals being held in immigration detention, as well as from IRC staff members. As such, the increase in rates of detention that will result from the IMA may disproportionately adversely affect LGBTQI+ individuals. It is possible that some individuals may feel compelled to hide their sexual or gender identities to maintain their safety.⁽¹⁶⁴⁾

For individuals who attempt to appeal their removal via 'serious and irreversible harm' suspensive claims, the very short timelines for providing evidence disproportionately affect this community. LGBTQI+ individuals already face significant challenges in providing 'evidence' that is acceptable to the Home Office to demonstrate their sexuality or gender identity; a shortened timeline makes gathering such 'evidence' even less attainable. If the prospect of removal is more likely, then individuals may be more reluctant to disclose details of their sexual or gender identity to officials for fear that this information would be communicated to officials in their country of origin and place them at even higher risk.⁽¹⁶⁵⁾

Concerns about changes to the protections available for people with regard to their gender identity and/or sexuality were fuelled by a public announcement made by Suella Braverman when serving as Home Secretary, in which she stated that fearing discrimination on the basis of gender or sexuality should no longer be sufficient grounds to claim asylum in the UK.⁽¹⁶⁶⁾ In response, a letter signed by 246 human rights organisations was sent to the then prime minister, stating that the rights of women and members of the LGBTQI+ community fall under the protection of the Refugee Convention, and highlighting the great difficulties that these individuals already face when trying to 'prove' their sexual orientation or gender identity.⁽¹⁶⁷⁾ As people from the LGBTQI+ community are already especially vulnerable to mental health illness and are disproportionately represented in deaths by suicide, singling them out as being untrustworthy or as being likely to perpetuate false identities in order to manipulate the asylum system may contribute a sense of not being believed, and likely increased levels of anxiety and distress.

Case study 5 – LGBTQI+ person seeking sanctuary

Mohamed is a 24-year-old asylum seeker from Iraq. He presented with features of PTSD and experienced traumatic events, but he was reluctant to discuss them in more detail. After a couple of assessments with the specialist, Mohamed disclosed that he is gay, and that because of this he was assaulted and faced persecution and death in his country of origin. He felt unable to disclose this information in his asylum application due to fears of being disbelieved, as well as fearing that if other people seeking sanctuary knew about his sexual orientation, they would target him.

He lives in a shared accommodation with four other males (who come from similar cultures and have strong homophobic beliefs) and is terrified that they will know about his sexual orientation. He asked the clinician not to mention this information in their letter to the GP, but it was explained to him that this information would only be shared among professionals who are involved in his care and that they would signpost him to support from specialist organisations. After this explanation, he agreed for this information sharing between professionals.

Part 3:

What can psychiatrists do?

3.1 Notes for all psychiatrists working in general NHS settings

There are several levels at which psychiatrists can act to support people seeking sanctuary in light of the hostile environment and new immigration legislation. They can support individual patients directly in clinical care settings and by driving changes as a service and trust level. They can also engage in research and quality improvement in this area and by advocating and campaigning at a policy and public health level.

3.1.1 Direct clinical care

All psychiatrists will be aware that conceptualisations, representations and experiences of distress can differ across cultures and as a factor of one's beliefs. For example, people from some cultural groups may be more likely to describe distress in somatic terms, while people of certain religious backgrounds may be less likely to report suicidal ideation. However, some psychiatrists may feel unprepared to explore the mental health impact of the asylum process itself with patients. It is important to remember that one does not need to 'know' all the answers in order to make a difference. Practising 'cultural humility', that is, being open and willing to learn from our patients about their experiences and being aware of the impact of one's own culture on the doctor-patient interaction,⁽¹⁶⁸⁾ can help to minimise power imbalances in clinical settings and is a helpful stance to take when entering unfamiliar territory. Allowing patients to tell you their story and validating their difficulties is an important foundation upon which to build.

One of the most important interventions a psychiatrist can offer a patient seeking asylum is to establish whether they are receiving legal representation and, if they are not, seek advice regarding local solicitors to whom they can be referred. It is important that they understand their eligibility for legal aid and to seek out specialist lawyers with relevant experience. Unfortunately, the significant increase in need already means that in many parts of the country it is very difficult to get any free legal advice at all, even before considering the particular specialties of a particular legal representation so this is not always possible despite it being vital as a first option to try.

Where this is not possible, psychiatrists should, as a minimum, be aware of how and when to advise their patients to seek legal advice about whether they require an MLR, by referring them to legal organisations or medical organisations which can provide such a service.

In the absence of a centralised Immigration Hub or local Immigration Lead, clinicians can try to establish contact with local bodies like Citizens' Advice Bureau or local refugee support groups to ensure that such advice is available for their patients where required. For a person who falls within the Mental Health Act or Mental Capacity Act, it is essential to do so, but these principles also apply to persons who are not detained.

Another important factor to consider is social prescribing, as many people seeking sanctuary who are not allowed to work report loneliness. It is important for clinicians to understand what personal support networks are already in place in order to identify

where there may be gaps. Signposting to local community groups can make a significant difference to their mental health and wellbeing.

Psychiatrists can make a significant improvement to the experience of mental health care by making small adjustments to their usual practice when encountering a patient who is seeking sanctuary. For example, clarifying their role and independence from the Home Office, and taking a trauma-informed approach to assessments. Further guidance on this is provided elsewhere.^{(169), (170)} We recommend the RCPsych Textbook 'Seeking Asylum and Mental Health - A Practical Guide for Professionals,' for a more thorough overview of assessment, care and management of patients who are seeking sanctuary.

We would also recommend the resources available from the charity Solace, who have developed an e-learning package on "Understanding Refugee/ Asylum Seeker Mental Health" which is available for free, see 'Recommended Reading' for further details.

It is also crucial that health professionals are mindful of the contexts in which their clinical observations may be considered, and therefore mindful of what and how they choose to document following their encounters with people seeking sanctuary, as all medical documentation may later become part of a court 'bundle' in their asylum case. It is possible that information documented in clinical notes could be utilised by the Home Office in immigration proceedings to discredit an asylum claim, as described earlier in the case of the child's A&E assessment following an overdose. For example, difficulties may arise when documenting that a patient is at 'no acute risk to themselves or others' or has 'no mental illness'. Such phrases may potentially be used to discredit claims that a person would likely suffer negative mental health consequences if returned to their country of origin.

If clinicians receive requests for medical notes from solicitors, then, in cases in which consent is given by the patient, it is likely to be helpful to add a note about the nature of medical notes explaining that it is normal for there to be some inconsistencies and that this does not necessarily reflect inconsistencies in a patient's narrative. Additionally, it should be noted that as medical notes are written from one medical professional to another, they are not intended for non-medical practitioners to read, and may contain information different from that which is most likely to be of assistance to lawyers, officials or judges. It is rarely the case that anyone checks with the patient whether or not the factual account recorded in medical records is accurate or complete, as would happen with an asylum statement.

Some principles that should be kept in mind when documenting :

- Small factual errors in recording a history of a person seeking sanctuary can be given disproportionate legal weight. Therefore, when recording a history, it is helpful to stick to details that are clinically relevant, and only those that have been communicated directly to you by the patient, rather than risk making an error about, for example, a family member or journey that has been copied from previous incorrect notes. Make it clear when information has been copied from existing records.
- It can be helpful to document the psychological impact that a period in immigration limbo is having on an individual, or that a previous period in immigration detention has had. If it is possible to identify periods of exacerbation in symptoms in relation to periods in detention or timings of refusals, then it would be useful to record this.
- When commenting on an absence of symptoms, it can be helpful to be specific. Instead of using a phrase such as "no evidence of serious mental illness," to mean an absence of signs of psychosis, it can be helpful to say, for example, "no signs of active psychotic mental illness".
- Where signs and symptoms of an illness are present, but do not meet the diagnostic threshold, it can be helpful to comment, for example, mention symptoms of anxiety, low mood, stress, emotional dysregulation, while still stating that they do not qualify for a diagnosis.

- Similarly, if an individual is having difficulties discussing their history or symptoms, it would be useful to note this. Any aspect of someone's mental state that is affecting their ability to offer a clear and coherent account of events or personal experiences should be recorded.
- If the person was unwell, distressed and/or had trouble remembering certain events, document this. These observations could be helpful indicators of why the person's history may contain inaccuracies.
- When referrals for secondary mental health interventions or psychological therapy are rejected for reasons of social instability, unhelpful phrasing can be used in rejection letters, such as "the patient's priority is stable housing". It would be helpful to if this could be rephrased, for example, as follows: "We are unable to accept for treatment due to lack of stable accommodation, as intervention is unlikely to be effective unless the patient is housed in safe and stable accommodation."
- Every individual seeking sanctuary should be asked, sensitively but directly, about human rights abuses and other adverse experiences in their country of origin and on their journey to the UK.
- If individuals deny any previous adverse experiences, as a clinician, you should always remember that people seeking sanctuary may have many reasons not to trust you, and may not always disclose information. There may be significantly more trauma history than they have told you, and it can be helpful to document this in a manner that doesn't exclude further disclosures, for example, "they did not disclose torture at this point" instead of "no history of torture".
- Similarly, when asking about reasons for coming to the UK, there are many reasons why someone might choose to state that they came for a 'better life', for example, but it can be helpful to document that they "did not disclose ill-treatment at this point" instead of misinterpreting this statement and documenting that, for example, the person "came for economic reasons."
- When documenting risks, it can be helpful to be more specific and nuanced. Rather using a broad phrase like "no risk to self or others," it can be more useful, and accurate, to document "did not disclose suicidal thoughts to me today" or "explicitly stated that, were they to be removed, they would attempt to take their own life." In times of significant emotional distress – such as, being forced onto a removal flight (something which is going to become a regular occurrence) – there can be risk of death by misadventure were that person to carry out a dangerous act when in distress or acting in protest, particularly if they have a history of similar actions under similar circumstances. This would be relevant information to include, even if there is no history of suicide attempts with intent to die and/or in the absence of current symptoms of depression. It may be helpful, if possible, to document the circumstances in which an individual's suicide risk may warrant an urgent review.

Given the potential for significant impact on the person's wellbeing, the psychiatrist should engage in open discussions about potentially stressful events, such as immigration hearings. This includes exploring how to manage the mental health effects of adverse judgments, akin to how they might help patients prepare for other challenging life events, like painful anniversaries.

For example, they can consider advance planning for particular stressors, such as court hearings, interviews or reporting to the Home Office. Safety plans may be especially useful to manage distress, self-harming or suicidal behaviours that may arise around these times. Psychiatrists can also help to mitigate against so-called 'medically unplanned transfers', i.e. when patients are dispersed from one area to another by the Home Office with little to no warning, or detained in IRCs, thereby damaging the continuity of any healthcare they are receiving. Steps that can be taken include providing all people seeking sanctuary with a print-out of their summary care record, providing advice sheets explaining their rights to access NHS care (written in their preferred language), and auditing the impact of such transfers on patients' health.⁽¹⁷¹⁾

An often-overlooked aspect of caring for people seeking sanctuary in mental health settings is mental capacity. In some cases, psychiatrists will need to assess whether their patient has mental capacity to make decisions about their immigration case. This will be especially important in people with cognitive decline, such as in dementia, but may also apply to other circumstances, such as people with intellectual disability or those experiencing acute symptoms of a severe mental disorder. Enquiring about the progress of their asylum case would help a psychiatrist to consider the possible impact of a patient's asylum claim and associated factors on their mental health and current presentation, as well as the impact of a person's mental health on their asylum claim, and their ability to navigate the complexities thereof.⁽¹⁷²⁾

3.1.2 ICB, trust and service-level care

Psychiatrists can also respond to the IMA and NABA at the level of teams, services, trusts or integrated care services. Psychiatrists responsible for service delivery should ensure that appropriate training is available to all staff relating to the specific clinical issues that are relevant when working with people seeking sanctuary, particularly the principles of trauma-informed care.⁽¹⁷³⁾ Professional organisations like the Royal College of Psychiatrists should play an active role in offering such training and calling for such training to be more widely available.

Psychiatrists can advocate, depending on the size of need for their trust or integrated care service area, to set up an immigration hub in larger trusts, or an immigration lead who can advise on any aspect of immigration legislation as applied to the UK, which might affect patient care, for example, immigration status, entitlement to services, access to legal advice on immigration. If necessary, this could be a partnership between primary and secondary care. Particularly given the quickly changing legal landscape, having a designated lead who can confidently offer support and advice is vital. The charity, Solace, have developed a proposed job description for this role 'Asylum Seeker Mental Health Champion' in organisations including NHS trusts, and we would support the development of this model across NHS trusts. The proposal by Solace is attached as Appendix C, and can be adjusted to suit local requirements.

Having discussions with senior management staff about the importance of providing timely, holistic, trauma-informed and culturally appropriate care could lead to opportunities to improve services for people seeking sanctuary, employ staff members with relevant expertise and embed them within existing teams, or even commission new services.

We encourage the Royal College of Psychiatrists to consider advocating for the recruitment and support of psychiatrists with forced migration backgrounds in the NHS workforce, and to consider more active outreach to involve them in faculties, committees and decision-making positions. This may involve the existing Medical Support Worker (MSW) pathway.⁽¹⁷⁴⁾ We would be cautious about recommendations that are driven by workforce needs, however, there may be potential to adapt the initiative to make it more specific for forced migrant psychiatrists.

The overarching aim should be to make mental health services as responsive as possible to the changes in legislation, in order to mitigate detrimental impacts on the mental health of people seeking sanctuary.

Box 15: Service example

The SHIFA Clinic (Supporting Holistic and Integrated Assessment for Forced Migrants) Clinic for People Seeking Sanctuary, Norfolk and Suffolk NHS Foundation Trust

What is the SHIFA Clinic?

The SHIFA Clinic offers trauma-informed, culturally sensitive assessments and treatment for forced migrants and aims to work closely with primary and secondary care providers to provide holistic support to this vulnerable group and reduce the burden on secondary care.

The clinic's name serves a double purpose. Not only is 'SHIFA' an acronym of description of the clinic's ethos (Supporting Holistic and Integrated Assessment for Forced Migrants) but it also means 'healing' in Arabic, Farsi, Pashtu and Turkish, which are some of the main languages spoken by many people seeking sanctuary.

How was the clinic set up?

In 2018, Dr Yasir Hameed, a consultant psychiatrist in Norwich, who was a refugee from Iraq, volunteered in a local charity (New Routes Integration) to help people seeking sanctuary in his city. He met nurses and workers from a local service involved in initial assessments of people seeking sanctuary in Norwich (City Reach service). This service was one of the first points of contact these clients had with health services when they came to Norwich.

Dr Hameed volunteered to see patients once a month in this service and continued to do this work until the Covid-19 pandemic in 2020.

There was no formal process of referral to his clinics. The patients were discussed with him by the nurses and GP working at the City Reach services and also by professionals from the People from Abroad Team (Norfolk County Council). He reviewed patients, gave them advice on diagnosis and treatment, and signposted them to further help and support, if needed.

The feedback from primary and secondary care colleagues was positive. The clinics were based in a primary care setting away from the psychiatric hospitals and clinics, which many patients fear visiting due to stigma. He also ran clinics in the local library and at a church where the patients would attend other activities; hence the attendance at these clinics was good.

No funding was received for these clinics.

In April 2022, Dr Hameed and a GP with a special interest in forced migrants' mental health, Dr Hannah Fox, set up a similar clinic model. Norfolk and Suffolk NHS Foundation Trust chose this model as part of its commitment to the Advancing Mental Health Equality (AMHE) Collaborative of the Royal College of Psychiatrists. Although no funding was granted to these clinics, Dr Hameed and Dr Fox were supported by various colleagues in their Trust to get two assistant psychologists to help with the administrative tasks and collect and analyse data from the clinic's work. The clinics brought together many professionals and service user representatives to work together to support forced migrants in Norwich.

What does the clinic offer?

This NHS clinic is held once a month in the MIND REST Hub in Norwich, a bright and welcoming building. This venue was chosen to avoid the usual psychiatric settings that patients might find stigmatising. A formal referral system was set up so that primary and secondary care professionals could refer patients to these clinics for a specialist, trauma-informed assessment and giving opinion on various diagnostic and treatment issues.

Box 15 continued...

The clinic works closely with various other service providers, such as social services, charity organisations and psychological treatment services, to ensure continuity of care and proper signposting and referrals. This is done by having monthly or bimonthly meetings with these services to discuss these patients. This collaborative approach ensures that gaps between services are minimised and that various teams and services are aware of what is provided to the patient and by whom. It also helped to get a robust MDT approach for the most complex patients.

The clinic also offers training opportunities for other professionals, student nurses, trainee psychologists, psychiatrists, and medical students, to gain more experience working with people with a history of trauma from a forced migration background.

The clinic also aims to reduce referrals to secondary mental health services by offering advice on management to the patients and their primary care professionals in a timely and efficient manner.

In June 2023, the local Integrated Care Board (ICB) granted limited funding for six months for the clinic to continue its work and to recruit a psychologist and admin support. It is hoped that further funding will occur as the clinic continues to collect and analyse data and multisource feedback to support its business case.

Could a similar model be set up in any other trust?

Yes. All that is needed is the will and hard work of a few people passionate about reducing barriers to accessing mental health services by people seeking sanctuary. Funding can be difficult to secure as most mental health services are under significant pressure and resources are limited, but with good data collection and a business plan backed with evidence that this service is needed and could improve the quality of the care provided for these patients, funding could be offered.

Feedback from a patient who accessed the clinic:

"I felt much better after I spoke to the clinician. He listened to my story and understood my concerns. When I was referred to the clinic by my GP, I was desperate because of my situation and my separation from my family. I felt low and had suicidal thoughts. I hated going to hospitals or seeing doctors, but when I visited the clinic, it was not in a hospital but in a nice place with a cafe, and people welcomed me there. At the beginning of my assessment, the clinician asked me, "What is the most urgent thing you need help with now, and how can we work with you to resolve it?" This helped me focus on things I could change rather than feeling overwhelmed with everything else happening to me, such as my asylum application."

3.1.3 Research and clinical governance

Researching the mental health impacts of the new legislation will be crucial for providing evidence that can be used at a policy level to advocate for people seeking sanctuary. Currently, we can make well-founded predictions based on experiences of working with people seeking sanctuary and the impact of legislative changes in other countries. However, it will be important to gather rigorous scientific evidence in the coming months and years to shed light on the extent of the consequences of the new legislation as it plays out. Such evidence will be invaluable for understanding how best to meet the needs of people seeking sanctuary at an individual and health-service level, but also for advocating for change at political and policy levels.

We encourage psychiatrists with interest and skills in research or clinical governance

(including audit and quality improvement) to consider undertaking projects that will aid in the gathering of high-quality data to capture the impact of these new laws – and also to consider dissemination and potential policy impact when designing the study.

A gold standard approach would be to collect longitudinal primary data (both quantitative and qualitative) to measure indices of mental health and related sociodemographic factors. However, such studies require significant resources, including time and funding, and we recommend that the government provides funding for such projects. There are also many practical challenges to conducting primary research with people seeking sanctuary, including difficulties recruiting participants due to mistrust, loss to follow-up due to frequent relocation of participants, and the need to ensure that the measures and data collection methods used are culturally appropriate. In settings where recruitment and retention may be helped by having a pool of participants in one location, such as immigration detention centres, health professionals working there should be encouraged to conduct and lead research projects co-produced with other relevant parties, including people with lived experience. Agreement on key outcome measures and collaboration to pool and collate data may be important aspects in planning and delivering such research.

The challenges to conducting primary research make the use of pre-existing data (such as electronic health records) more attractive. As it stands, forced migration is not a field routinely captured in most clinical records, which is a serious limitation for using them to research the experiences of people seeking sanctuary accessing health services. Actions to overcome this may include advocating for clinicians to document immigration status clearly during clinical encounters, making use of data linkage with other datasets (e.g. census data) that better document immigration status (although very few datasets currently exist in the UK which specify forced migration status), and exploring the potential application of newer techniques such as machine learning.

It is important that research projects are co-produced with people with lived experience of the asylum system and other organisations and professionals working with them in order to ensure the questions being asked are important and helpful, and that the research procedures are appropriate. The findings of research studies should also be made publicly available, so they can be applied and replicated in different settings.

Audit, service evaluation and quality improvement projects may be more accessible and feasible for the majority of clinicians who do not have the time, skills or resources to conduct formal research studies. Capturing data such as the number of people seeking sanctuary using your service, the types of problems they present with, whether they receive timely and gold-standard clinical care, and staff knowledge and understanding, would go some way to assessing whether your service adequately caters for the needs of people seeking sanctuary.

Understanding whether, for example, there has been an increase in referrals to your service since a new accommodation centre or hotel housing people seeking sanctuary has been set up in your local area, would provide invaluable real-world data that could be used to advocate for increased service provision and as evidence of an increased need related to political and policy decisions. Sharing the findings of these projects with other professionals, for example, at conferences or through publication, would help to build an understanding of the types of projects that are feasible and can be reproduced on larger scales.

Box 16: Nasrin

Nasrin is a refugee from Iran. She shared why she thinks talking about the impact of the new legislation on people's mental health is essential. She also mentioned why people choose to flee their countries. While people flee war and terror in search of safety, they arrive in the UK and often face more terror, impacting their mental health.

"I think it's important because it's about me and other refugees. I was imprisoned in Iran for eight years. And I left Iran because I was traumatised. When I came to the UK, the situation was not like now. It has deteriorated and has become much harsher for refugees. I would be more traumatised if I came to the UK after the NABA. So, it's traumatising people, you know, refugees and people seeking asylum in the UK."

3.1.4 Policy and advocacy level

Psychiatrists are guided in their clinical practice by the 'four principles plus scope' approach of medical ethics, consisting of:

- autonomy
- beneficence
- non-maleficence, and
- justice

along with concern for their scope of application.

The NABA and the IMA violate all four of these principles of medical ethics. They compromise the autonomy of the target population by not allowing them control of their own lives. They do not provide any benefit to the patient population, compromising beneficence. They cause harm, thus breaching non-maleficence, and with regards to justice, the legislation aims to limit access to justice for the target group. Thus, out of concern for the scope of application of these four ethical principles by which psychiatrists are bound, the only way to achieve an ethical balance is to speak out against the effects of such legislation, in keeping with the wider role of doctors from a public health perspective. This could be done by writing to the local Member of Parliament to call on them to vote against further legislation which may be detrimental towards the mental health of people seeking sanctuary, but also through supporting professional bodies like the Royal College of Psychiatrists to express serious concerns to the government about the effects of such legislation. It would therefore be an ethical imperative for psychiatrists –to fulfil their advocacy role and lobby the government and Parliament to seek a remedy that will allow for more ethically balanced clinical practice.

Psychiatrists can also join or support organisations working with forced migrants who have healthcare needs, such as MedAct, and those pursuing legal review of the IMA and NABA, such as Detention Action or Freedom from Torture. For further details see our [reading list in Appendix A](#).

3.2 Medico-legal report writing

At any point in the asylum process, a solicitor representing a person seeking asylum may suspect that their client has mental health difficulties, which might be pre-existing mental disorders or those which develop or are newly diagnosed as a consequence of in-flight or post-flight factors. In these cases, the solicitor may wish to obtain a formal assessment of their client's mental health and the implications of this for their asylum case. They do this by instructing a clinician to write a psychiatric MLR.⁽¹⁷⁵⁾ Clinicians acting as expert witnesses may do this as independent professionals, or through organisations such as Medical Justice. Nonetheless, as with any medico-legal expert witness work, they will require specific training and supervision initially.

For further information see the [reading list in Appendix A](#) and the list below for organisations which provide MLR training for clinicians. Clinicians will also require specific professional indemnity to cover this work, which is sometimes provided directly through organisations. There is a significant need for more report writers, which provides an opportunity for collaboration between doctors and lawyers working in this area.⁽¹⁷⁶⁾ There is likely to be an increased need for timely MLRs following the introduction of the NABA and the IMA, as turnaround times will be shorter and more stringent evidence will be required. We encourage interested psychiatrists to consider training in this area and working with one of several third sector organisations who specialise in MLRs.

MLRs commonly require psychiatrists to provide an opinion on fitness to fly, and the new legislation may make these much more likely. Any policy which involves forced removals of any kind, even temporary, would make them almost inevitable. Such an assessment will require familiarity with the UK Civil Aviation Authority guidelines on fitness to fly, and we suggest that psychiatrists do not offer an opinion on fitness to fly unless they have the necessary clinical expertise and experience. The Civil Aviation Authority Guidance for Health Professionals offers [guidance on assessing fitness to fly](#). The key questions from a psychiatric point of view are whether flying will interfere with the safe conduct of the flight or will the flight environment exacerbate the mental health condition. For individuals whose behaviour is unpredictable, disorganised or disruptive, air travel would be contraindicated, and where a patient's psychiatric conditions are neither fully treated, nor stable, or there are concerns regarding risk, then this should be commented on to reduce the risk of an unsafe removal. Often, psychiatrists might also be asked to comment on the level of supervision that will be required prior to boarding the flight and after arriving at the destination airport.

With provisions now in law that make it possible for the UK government to transfer significant numbers of people to 'safe third countries' at very short notice, it is important for the psychiatric profession as a whole to be prepared to answer questions on fitness to fly assessments, and we recommend that a more detailed guidance document is developed as we predict these questions may start to be asked of general psychiatrists who may not have received appropriate training/CPD.

Organisations that provide training for clinicians on psychiatric MLR writing:

- Medical Justice:
<https://medicaljustice.org.uk/volunteering/doctor/>
- The Helen Bamber Foundation:
<https://www.helenbamber.org/sites/default/files/2021-06/HBF-psychologist-psychiatrist-MLR-leaflet-1.pdf>
- Torture ID:
<https://tortureid.org/info-for-clinicians/>
- Freedom from Torture:
<https://www.freedomfromtorture.org/>
Enquire via the online form about any upcoming training.

3.3 Ethical and human rights concerns for psychiatrists

While the recommendations for psychiatrists specified in the previous section are important and can have real-world benefits for people seeking asylum, they all constitute mitigation, rather than resolution. For psychiatrists, the challenges to delivering safe and effective, high-quality mental healthcare, raised and/or exacerbated by the NABA and IMA may bring them in conflict with the core duties of a doctor, as illustrated by the four principles approach of medical ethics. Working within a system which challenges one's ethical framework, by being legally bound to perform certain duties, has the potential for clinicians to develop 'moral injury', i.e. impaired functioning or long-term psychological harm that results from a sustained period of feeling limited in one's ability to take an ethically correct action.⁽¹⁷⁷⁾ Psychiatrists may also feel that they do not have the time or capacity within the scope of their clinical work to explore and address the issues discussed in this report, further adding to moral injury. The lack of agency, or feeling helpless to change it, worsens the situation for those feeling this moral injury.

Possible examples of ethical conundrums that psychiatrists may find themselves in may include conducting home-visits in hotel rooms or in quasi-detention settings, despite being aware that living in such accommodation is having a detrimental impact on their patient's mental health. They may be concerned that their patient lacks capacity to instruct a solicitor to assist their asylum case, but the patient does not have any family members or an advocate to support best interest decision-making. Psychiatrists may find it challenging offering an assessment of fitness to fly if they object morally to the new legislation. Another example is a psychiatrist wanting to initiate a patient on an antipsychotic medication but fearing they may be dispersed, detained or removed without warning, thereby being unsure of the opportunities for review and monitoring.

The removal of protection for many victims of trafficking may also be a problem for clinicians working in acute services such as emergency departments, who will be faced with a very difficult ethical dilemma when enquiring about a patient's history of trafficking or modern slavery. Any discussions about approaching the authorities for support must be had with the knowledge that support may not be forthcoming, and that their approach will be met with detention and possibly threat of removal. Instead, with a view to 'do no harm', clinicians may well conclude (and therefore have to advise) that seeking government protection or support may not be in the best interests of a particular sanctuary-seeking patient.

This same principle would apply to any 'undocumented' person seeking asylum, who may risk detention and removal were the government to access their details. These scenarios will undoubtedly contribute towards moral injury among clinicians, who will likely be conflicted about which course of action is in their patient's best interests. Psychiatrists may be especially affected by this, as they tend to spend longer with patients than other clinicians by the very nature of their assessments. They are also very likely to enquire about social history, living circumstances and safeguarding concerns as part of their assessments.

From a human rights perspective, migration poses one of the key global challenges for health, including mental health.⁽¹⁷⁸⁾ Inability to access mental health services and arbitrary detention are included in the list of the commonest human rights violations, and the risk for both is increased by the IMA and NABA. One link between mental health and human rights is through the formulation of legislation which is human rights compliant. Human rights compliant practice in health should follow the principles of fairness, respect, equality, dignity and autonomy, also referred to by the acronym FREDA.⁽¹⁷⁹⁾ When the IMA and NABA are examined through the

prism of FREDA, it is very clear that they fail the needs of the affected group in all five counts. It follows that the policies which will flow from both of these pieces of legislation will affect the mental health of the target population and infringes their human rights, which should concern psychiatrists.

Inadmissibility and 'safe third country' plans have attracted concerns about possible breaches to international legislation. This includes the 1951 Refugee Convention,⁽¹⁸⁰⁾ to which the UK is a signatory, the core principles of which are non-penalisation, non-discrimination and non-refoulement. Psychiatrists should also be aware of concerns that the IMA and NABA may breach the European Convention on Human Rights (ECHR).⁽¹⁸¹⁾ Articles 2, 3 and 8 of the ECHR ('the right to life', 'the prohibition of torture and inhumane treatment' and 'the right to respect for private and family life') have been highlighted as most at risk. The UK still currently remains under the ECHR, though this has remained under attack from some supporters of the current government. Withdrawal from the ECHR would reduce the opportunities for legal action against the IMA and NABA. The human rights implications for psychiatrists are thus considerable.

While we would advocate for there to be sufficient provision of mental health services in any 'safe third country' to which people seeking sanctuary are removed, this does not compensate from an ethical perspective for harms that are caused by the legislation in the first place, and an increase in the provision of healthcare is not sufficient to mitigate our concerns about the forced removal of the majority of people who seek sanctuary in the UK.

We maintain our position that the new legislation is going to increasingly expose physicians to moral injury regardless of their place of work, and is therefore likely to cause harm to psychiatrists. This is our primary concern with the legislation, and we suggest the following ways to mitigate harms in the absence of any reversal of these policies. More support has been called for to assist clinicians working with forced migrants, for example, in IRCs or quasi-detention centres.⁽¹⁸²⁾ It has been suggested that such clinicians would benefit from peer networks, in which they can share experiences and learning, as well as regular supervision.⁽¹⁸³⁾ We suggest that all mental health professionals who encounter people seeking sanctuary facing the difficulties established by the hostile environment, and further perpetuated by the IMA and NABA, should have access to reflective spaces and learning opportunities to help mitigate against the development of moral injury. The increase in the use of online platforms to host such spaces should improve access across the devolved nations.

Box 17: Example of peer support – Setting up a Balint group

Written by Dr Mustafa Alachkar, Dr Hannah Fox and Dr Durga Sivasathiseelan

The idea for a Balint group for clinicians working with people who are forcibly displaced began at Doctors of the World (DoTW) in 2022, with the aim of creating a safe space for volunteer clinicians to share and reflect on cases that have had an impact on them or stayed with them. This aligned with conversation that had been happening within DoTW about vicarious trauma and supporting volunteers beyond training and debrief sessions after clinic.

We sent a call out for a Balint facilitator and were really fortunate when Mustafa Alachkar responded and volunteered his time. Mustafa is a consultant psychiatrist and psychotherapist working in the North West. Mustafa is from Syria, moving to the UK in 2005 and has been involved in working with refugees and supporting clinicians working with them through supervision, training and reflective practice and Balint groups.

Box 17 continued...

The group has evolved to include a wider multi-disciplinary team, including people working in NHS as well as tertiary sector. We have a health visitor, paramedic and support worker, asylum link worker, as well as GPs and a psychiatrist. This is unusual for a Balint group, which traditionally comprises only doctors. Mustafa's skill in facilitating the relational aspects of cases means that the group dynamic works well and the different perspectives add depth to discussion. The group make-up reflects the need for a cohesive network of professionals and organisation to work alongside patients whose journeys enter a new phase when they arrive in the UK. It also reflects the complex nature of the needs of people seeking sanctuary who may not present to healthcare professionals with purely medical or psychological needs.

Another aspect that makes this experience different from traditional Balint groups is that the group participants often share encounters they had had with a family, rather than an individual – again reflecting the nature of the needs of this group of people and their lived experience, which is often felt in a more collective and less individualistic way.

A strong supportive element runs through the Balint group experience, with an emphasis on exploring participants' experiences, thoughts and feelings and validating them without judgement and through a shared sense of the emotionally challenging nature of the work.

Quotes from participants:

“I think this should be available to as many people as possible and not just doctors – it has been so helpful for [the health visitor] and [asylum link worker] in our team. I think Balint has helped them avoid burnout and stay well.”

“The Balint group feels like a safe warm space where group reflection aids exploration of conscious and unconscious thoughts and feelings. This clarity, acceptance and deeper understanding allows practitioners to continue to work with their patients in a healthy and beneficial way.”

Conclusion

Lived-experience insight: From members of One Strong Voice

Box 18: Sepideh and Nasrin

Sepideh shared her views on the recommendations. She believes that mental health reports and research will play a crucial role in providing solid evidence to the policymakers and demonstrate the human impact of the hostile policies included in the new legislation.

Sepideh also highlighted the importance of collaboration with people with lived experience. She thinks more resources must be provided to unite people, hear their voices and work on solutions.

“I think there should be amendments using this research and these stories. They need to work on solutions instead of creating other schemes, creating something that will help and reduce the negative effects of the Act on people’s life. Treat people with compassion, humanity and dignity.”

Lastly, Nasrin also talked about the recommendations and Like all One Strong Voice members, she thinks the best solution is to reverse the new legislation. She also thinks that more resources should be allocated to create an effective mechanism of mental health impact assessments on women.

Recent immigration legislation (the Nationality and Borders Act 2022, the Illegal Migration Act 2023, and the Safety of Rwanda Act 2024) has been – and continues to be – a source of profound concern for psychiatrists and other mental health professionals. These laws are likely to have far-reaching consequences for the mental health of individuals seeking sanctuary and for broader mental health services.

At a time of increased hostility towards migrants and the criminalisation of asylum, this legislation paves the way for extended periods of immigration limbo, the expansion of immigration detention and quasi-detention accommodation, serious limitations on appeal rights, and the forceful removal of those arriving in the UK via irregular routes. Evidence suggests that these factors will contribute to significant deterioration in the mental health of those affected.

We are particularly concerned about the disproportionate impact this legislation is likely to have on individuals with serious mental illnesses and on those vulnerable to developing mental illnesses. Specific groups, including children, older adults, women, LGBTQI+ individuals, survivors of trafficking, and those with intellectual disabilities, are at heightened risk of adverse mental health impacts.

In addition, the wider political and media discourse surrounding the new legislation has included the use of highly dehumanising and stigmatising language against people seeking sanctuary. This only serves to worsen discrimination against them, hinder their integration, and further reduce their ability to build a new life for themselves in the UK. All these factors are detrimental to their mental health and wellbeing, and the new government has an opportunity to shift not only policy direction but also the language and rhetoric used when discussing this topic.

We consider the new immigration legislation and its impacts to be a public mental health concern. As psychiatrists, we must continue to advocate for the fundamental human rights of our patients and society at large, fostering a sense of hope in those we care for. This report outlines recommendations for the government, integrated care systems, trusts, the Royal College of Psychiatrists, and individual clinicians on how to navigate this new legal and policy landscape.

As rates of forced migration increase, psychiatrists and other mental health professionals will encounter increasing numbers of people who have fled their countries of origin to seek sanctuary in the UK. The recent legislative overhaul of the asylum and immigration system will affect what psychiatrists can do for their patients and may present them with ethical dilemmas in balancing their obligations to act in their patients' best interests against those arising from the requirements imposed by the new legislation. The demand for medico-legal evidence in asylum cases is also likely to rise, necessitating more psychiatrists to be trained in these skills and in the broader assessment and management of the mental health of people seeking sanctuary. This report provides recommendations for training and continuing professional development in this area.

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Appendix A:

Recommended reading list

Understanding the process of Seeking Asylum, the appeals process and migration statistics

- Right to Remain – [Asylum Toolkit](#)
- [A Broken System? Asylum Reform Initiatives 1997 – 2022](#) Commission on the Integration of Refugees, November 2022
- [From Arrival to Integration: Building Communities for Refugees and for Britain](#) Commission on the Integration of Refugees, March 2024.
- ‘Lessons Not Learned: The Failures of Asylum Decision-making in the UK’, Freedom from Torture, 2019
- ‘Lift the Ban’ Refugee Action 2020 [Outlining the policy that those seeking asylum are barred from working. Campaigning for the right to work]
- The Migration Observatory, University of Oxford
- House of Commons Library Research Briefing, Delays to processing asylum claims in the UK, 20 March 2023

Asylum, assessment and mental health implications and treatment

- ‘Detention of people with mental disorders in immigration removal centres (IRCs)’, RCPsych Position Statement, 2021
- Seeking Asylum and Mental Health 2022 – Maloney et. Al., RCPsych and Cambridge University Press
- The impact of immigration detention on mental health: a systematic review (2018) – von Werthen et al.
- Assessing asylum seekers, refugees and undocumented migrants (2019) BJPsych Bulletin
- Free [e-learning packages](#) via Solace

Immigration detention

- Abuse by the system: Survivors of trafficking in immigration detention”, Helen Bamber Foundation, Focus on Labour Exploitation, ATLEU and Medical Justice, 2022
- [Third annual inspection of ‘Adults at risk in immigration detention’ June – September 2022](#) – Independent Chief Inspector of Borders and Immigration.
- [Brook House Inquiry](#) (September 2023)
- Harmed not Heard: Failures in safeguarding for the most vulnerable people in immigration detention, Medical Justice, 2022
- Detained and Discarded: Vulnerable people released from Immigration Detention in a medically unsafe way, Medical Justice, 2022
- Fast Track to Despair, Detention Action, a report on the ‘Detained Fast Track’ programme
- [Locked up, locked out: health and human rights in immigration detention](#). BMA Report (2018)
- [Shaw Review: Review into the Welfare in Detention of Vulnerable Persons – A Report to the Home Office by Stephen Shaw](#) (January 2016)
- [Position Statement on the Detention of People with Mental Disorders in Immigration Removal Centres](#). (2021) Royal College of Psychiatrists

Medico-legal report writing

- [Psychiatric Reports: Preparation and use in cases involving asylum, removal from the UK or immigration detention](#), RCPsych College Report CR199 (2015)
- [Proving Torture: Demanding the Impossible. Home Office mistreatment of expert medical evidence" Freedom from Torture](#) (2016)

Accommodation centres and 'quasi-detention'

- The Medical Consequences of 'Contingency Accommodation' for People Seeking Asylum (2022) – Medact Migrant Solidarity Group.
- The All-Party Parliamentary Group on Immigration Detention's [Report of the Inquiry into Quasi-Detention \(2021\)](#) – House of Commons Library Research Briefing, Asylum Accommodation: hotels, vessels and large-scale sites, 7 July 2023
- [Lives on Hold](#), Report by the Refugee Council. Access to healthcare and NHS charging
- [They just left me – Asylum seekers, health, and access to healthcare in initial and contingency accommodation](#). Doctors of the World (2022)
- ["We also want to be safe" Undocumented migrants facing covid in a hostile environment](#). The Joint Council for the Welfare of Immigrants. (2022)
- ['Patients Not Passports' campaign](#)

The Rwanda policy

- [Who's Paying the Price? The Human Cost of the Rwanda Scheme](#), Medical Justice, 2022
- [Joint statement from the BMA and other organisations to oppose Randa expulsions on medical, ethical and humanitarian grounds – Public Letter on the Dangerous Health Consequences of Rwanda expulsions](#).

Illegal Migration Act

- Royal College of Psychiatrists' Briefing to the House of Lords
- Illegal Migration Bill – Assessment of impact of inadmissibility, removals, detention, accommodation and safe routes. A briefing by the Refugee Council
- Women and maternity care – <https://www.refugeewomen.co.uk/>
- Maternity Action – <https://maternityaction.org.uk/>

Children

- Refugee and Migrant Children's Consortium briefings on the Nationality and Borders Bill and Illegal Migration Bill: Briefings - Refugee Migrant Children's Consortium (refugeechildrensconsortium.org.uk)
- What Have I done? – The experience of children and families in UK immigration detention: Lessons to Learn. Save the Children. <https://resourcecentre.savethechildren.net/pdf/5485.pdf/>

LGBTQI+ communities

- LGBT Health – Asylum seekers and refugees support: lgbthealth.org.uk
- Stonewall: <https://www.stonewall.org.uk/>
- Rainbow Migration: <https://www.rainbowmigration.org.uk/>

Organisations

- Migrants Organise
- Detention Action
- Right to Remain
- Freedom from Torture
- Medical Justice
- Helen Bamber Foundation
- Women for Refugee Women
- MedAct
- Torture ID
- Solace

Appendix B:

Example letter to establish asylum seeker mental health champions

(Provided by Solace and included in this report with their permission)

solace
surviving exile and persecution

1 Manor House
Manor Street
Leeds
LS7 1PZ
Charity no. 1104507 Company no. 4733478



Asylum Seeker Mental Health Champions

In the UK, the numbers of people seeking asylum have risen following the global Covid pandemic. In contrast to the past few decades, many are being housed in various forms of large residential accommodation and they may be dispersed anywhere in the UK. Further as asylum seekers are five times more likely to have mental health needs and about 60%+ experience serious mental distress (Aspinall and Watters 2010^{A1}) asylum seekers will need to access mental health support. Currently, access to specialist counselling services for asylum seekers and refugees is erratic. In some areas, the National Health Service has developed some specialist provision as have some voluntary sector agencies such as Freedom from Torture and Solace, however the need outstrips the available resources. Thus Solace's proposal to enhance access to appropriate therapeutic services nationally is to develop a network or community of practice of Asylum Seeker/Refugee Mental Health champions, both with the NHS and voluntary sector.

Within the NHS, there are many specific populations that require services tailored to their unique needs, thus not all mental health practitioners can be experts in understanding the world that asylum seekers inhabit or skilled in how to work confidently with them therapeutically. Asylum seeker mental health champions both would involve delivering therapeutic services directly as well as supporting the work of their non-specialist colleagues. Mental Health Service providers, in both primary and/or secondary care would identify an experienced Therapist who has an interest in and commitment to delivering a culturally sensitive, trauma informed, appropriate therapeutic service to asylum seekers. The Champion would be supported in their role to develop their knowledge and skill, through training and the provision of ongoing specialist supervision and support. In each area, NHS and voluntary sector mental health services would need to collaborate together to foster mutual understanding and to deliver effective psychological therapy and mental health support.

A proposed Job Description would include the following:

- 1 Delivering therapeutic services directly to refugees and asylum seekers in the voluntary sector or in NHS primary or secondary mental health services, based on models of best practice.
- 2 Offering consultation and supervision to non-specialist mental health practitioners and therapist colleagues who work with refugees and asylum seekers.

^{A1} Aspinall PJ and Watters, C (2010) Refugees and asylum seekers: A review from an equality and human rights perspective, Research Report 52. *Equality and Human Rights Commission*. https://www.equalityhumanrights.com/sites/default/files/refugees_and_asylum_seekers_research_report.pdf

- 3 Developing and maintaining up to date knowledge of the asylum context in the UK and connect to relevant organisations to maintain an awareness of any changes in legislation or practice that may impact people seeking asylum, for example UK legal or administrative changes, changes in mental health legislation or access to services.
- 4 Undertaking specialist training to work therapeutically with asylum seekers by:
 - a. Completing the Solace Understanding Refugee and Asylum Seeker Mental Health e-learning (Course 1).
 - b. Completing the Solace specialist e-Learning course for Therapists, which addresses the salient mental health issues for asylum seekers, and adapting your therapeutic modality (Course 2).
(both above courses available from: www.solace-uk.org.uk/training/new-free-e-learning)
 - c. Attending ongoing training sessions
 - d. Participating in RAS champion 'community of practice' network meetings to offer mutual support and address relevant issues.
- 5 Taking responsibility for scoping out the refugee support services available in their locality and facilitate working together, which would include such services as:
 - The local City of Sanctuary group <https://data.cityofsanctuary.org/groups/list>
 - Providers of specialist legal advice (OSIC) registered
 - Providers of free ESOL classes and conversation clubs
 - Free local resources, e.g. gardening groups, women's groups
 - Befriending and mentoring
 - Refugee Community Groups
 - Safe places to meet, socialise
 - Help to navigate the health service.
- 6 Collaborating with Equality and Diversity staff to evaluate their service's performance in providing good quality care for asylum seekers and refugees, which would include systems for obtaining feedback and developing strategies to addressing the needs for change.

In developing this model of 'champions' we are aware that each region will have their own structures of mental health support and their own particular ways of offering support to refugees and asylum seekers, thus there can be no 'one size fits all approach'. This proposal is a guide to develop a means of mental health support for those areas where there is little in place, and an encouragement to work together collaboratively to support this vulnerable group. It is important to recognize that it isn't just frontline practitioners that have the responsibility to support the mental health needs of asylum seekers, but all who are involved in organizing, managing and delivering the various aspects of the service to adapt to the needs of asylum seekers.

The benefits of having a Refugee & Asylum Seeker Champion include:

- Supporting staff in many roles throughout the NHS or other mental health services who often do not understand the particular needs of this client group and are therefore ill equipped to support them and which may cause anxiety in their work.
- Enabling provision of an equitable and good standard of care for everyone accessing NHS mental health services. Refugees have distinct needs, which are unlikely to be well met by staff without adequate training and support.
- Supporting the fulfilment of the NHS's public sector equality duty in line with the Equality Act 2010. Refugees have very specific vulnerabilities and are at high risk of being systematically discriminated against
- Minimising the risks that may be associated with failures to provide appropriate care.