Reference: FOI.ICB-2425/349

Subject: Asylum Seekers Healthcare Contract and Spend

I can confirm that the ICB does hold some of the information requested; please see responses below:

QUESTION	RESPONSE
I am seeking information from the ICB on the amount of money spent providing asylum seekers with healthcare in the past 12 months and, where possible, details of the contract, such as the listing that has been published online for tenders. I understand some of these provisions are made to cover more than just asylum seekers (eg also homeless residents or those on the special allocation scheme) in these cases please include details of the overall contract.	No new tenders for provision of asylum seeker healthcare have been published in the last 12 months. Information about services for asylum seekers and refugees (The Haven) can be found here: Asylum Seeker and Refugee Health (Remedy BNSSG ICB). The Haven is provided as part of a larger block contract and as such it is not possible to separate the spend on individual parts of that block contract. Additional services for asylum seekers and refugees are provided via Hope Service. This service helps asylum seekers, refugees and victims of trafficking who have experienced a trauma in adulthood and have a primary diagnosis of post-traumatic stress disorder. Full details of that can be found here: HOPE asylum seekers and refugee trauma service :: Avon and Wiltshire Mental Health Partnership NHS Trust. This forms part of a larger block contract and as such it is not possible to separate the spend on individual parts of that block contract. Further details can be found in the Service Specification enclosed.

	The ICB commissions a range of other services including primary medical and mental health services, which are universally accessible. A number of general practices in the BNSSG (Bristol, North Somerset and South Gloucestershire) area are part of the safe surgeries initiative. A safe surgery practice commits to taking steps to tackle the barriers faced by many migrants in accessing healthcare. This includes ensuring that lack of ID or proof of address, immigration status or language are not barriers to patient registration.

The information provided in this response is accurate as of 31 January 2025 and has been approved for release by Sarah Truelove, Deputy Chief Executive and Chief Finance Officer for NHS Bristol, North Somerset and South Gloucestershire ICB.

The Hope: Asylum Seeker and Refugee Trauma Stress Service Specification

Contextual information

The Hope: Asylum Seeker and Refugee Trauma Service offers a PTSD pathway for asylum seekers and refugees (ASR) across BNSSG, many of whom are victims of human trafficking and modern slavery. The service also supports ASR with other mental health needs, currently housed in Interim Accommodation (IA) hotels and community-based houses across BNSSG. The service sits within the Traumatic Stress Service in AWP Mental Health Partnership NHS Trust.

Research suggests that asylum seekers and refugees are five times more likely to have mental health needs than the general population and 61% will experience serious mental distress in their lifetime[i]. Asylum seekers and refugees, whilst a diverse group of service users, often have histories of multiple and severe trauma, including persecution, torture, and sexual violence (e.g., Carswell et al., 2011[ii]; Robertson et al., 2013[iii]). Many asylum seekers additionally report a traumatic journey to the UK and often re-traumatising experiences navigating the asylum process and ensuring basic needs are met once they are in the UK.

Despite a long-term commitment to addressing health inequalities and delivering more inclusive services, people from ethnic minority communities with mental health problems, including asylum seekers and refugees, are still less likely to access therapy; less likely to have good outcomes and more likely to report negative experiences compared to white majority service users (Mercer et al. 2018, Crawford et al., 2016[iv]). Asylum seekers and refugees also report high levels of social isolation (Schweitzer et al., 2006[v]); poverty (Laban et al., 2005[vi]); concurrent physical pain and high levels of anxiety (Robertson et al., 2013[vii]) often linked to processing their asylum applications (Morgan, Melluish & Welham 2017[viii], Laban et al., 2005[ix]). Areas of unmet need are substantial, and the Covid-19 pandemic further exacerbated existing disparity in access to services (Public Health England, 2020[x]).

ASR service users often do not 'meet' the criteria for either primary care/talking therapies or secondary mental health services – their presentation can be too complex for IAPT and PTSD is not always considered a chronic serious mental illness in triaging referrals to secondary care. Other reasons for not being able to access support include, but are not limited to, language barriers, confusion around insecure immigration status and eligibility, and their mental health problems being viewed as a social problem rather than a component of ongoing trauma.

For these reasons, there is a clear need for continued provision of specialist support for ASR and victims of trafficking.

Impact of the Covid-19 pandemic

Before the Covid-19 pandemic, numbers of asylum seekers arriving in BNSSG represented ~1% of the total number of asylum seekers dispersed throughout the UK, equating to approximately 13 people every week. Since the pandemic, numbers of arrivals have continued to increase significantly. This is due, in part, to global crises, such as the Afghanistan and Ukrainian conflicts, which has led to hotels across BNSSG being recommissioned as IA centres. In December 2022 there were 881 people housed in 10 hotels Across BNSSG. Numbers have been increasing steadily with plans to move more people into community settings[1].

These figures from December 2022 were in addition to the 394 people seeking asylum currently housed in Home Office accommodation provided by Clear Springs Ready Homes in the community and those re-settled as part of the Syrian Resettlement programme, the Afghan Citizen Resettlement Scheme (ACRS) and the Homes for Ukraine scheme.

ASR mental health need in BNSSG

Health and mental health professionals working in the IA hotels estimate that approximately 70-80% of people they support have immediate need for low level mental health and wellbeing support (reassurance, signposting, anxiety management, wellbeing activities); 40% of this group will require a referral to Vitaminds (IAPT); and of this 40% about a third have symptoms consistent with PTSD and will be referred to the Hope Service.

The Hope Service offer (in line with NICE guidelines)

For those people who require specialist mental health support the pathway within the Hope Service is as follows:

Phase 1: 'Moving on After Trauma' (MOAT) seven-week stabilisation course

- Groups are run for men and women separately, with a crèche available when needed and interpreters are always provided.
- MOAT groups often run concurrently and are facilitated by two member of the team. Staff who are of the same cultural community facilitate groups without interpreters.
- MOAT content is delivered on a 1:1 basis if service users are not able to access a group.

[1] Figures accurate as of 6th December 2022

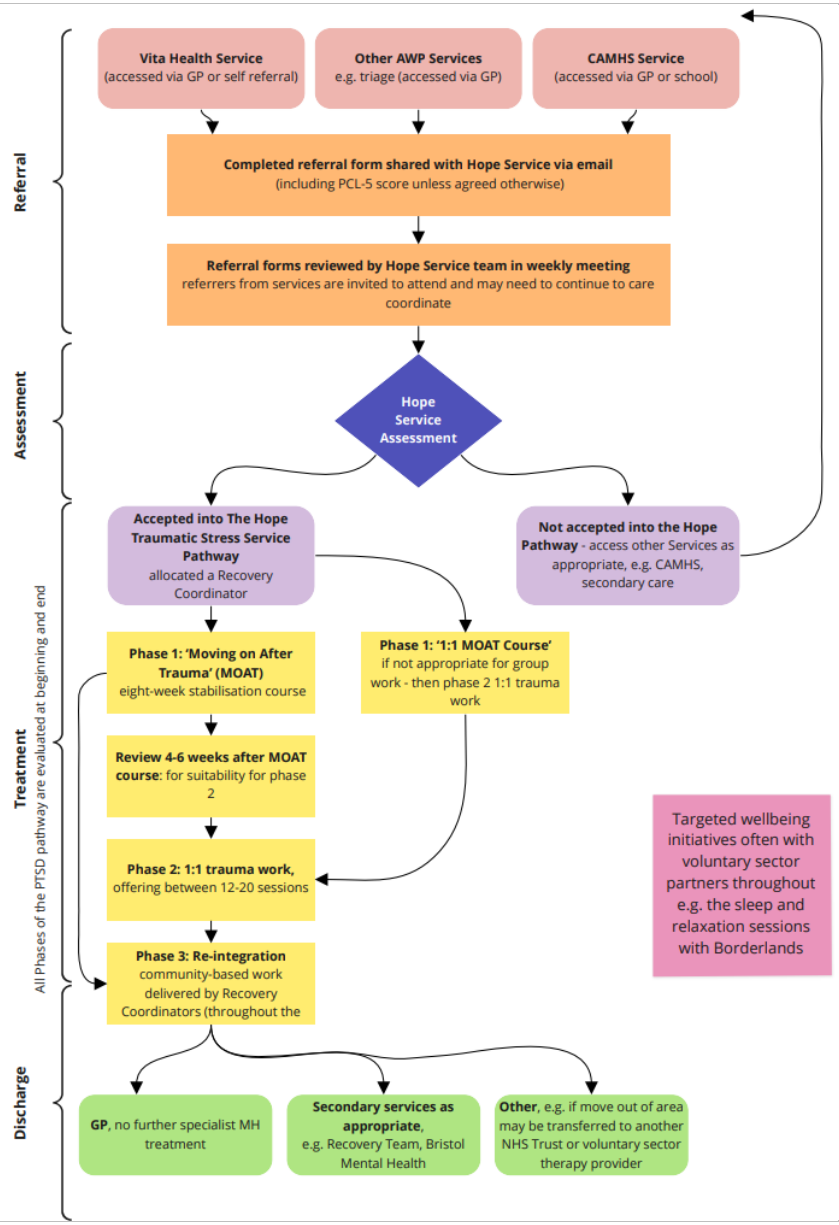
Phase 2: 1:1 trauma work

- Delivered by Psychologists/Therapists/Trainee Psychologists, offering between 6-20 sessions as required and typically via interpreter.
- Therapy is usually Narrative Exposure Therapy (NET), TF-CBT, EMDR or Art Therapy, for which core staff have all received training.

Phase 3: Re-integration/post traumatic growth

- Often forms a key part of trauma therapy and typically extends beyond the end of 1:1 treatment. This support, delivered primarily by Recovery Coordinators, is open to all service users engaged in the PTSD/trauma care pathway.
- Over the last eighteen months, this community-based work has delivered over 30 Sleep and Relaxation sessions jointly with Borderlands Charity; coordinated many walking groups for men and women; organised group visits to museums and provided regular spaces in a Church hall over the winter to offer a safe space to talk while playing cards/board games.
- On a local level, the Hope Service continues to build strong links with the very well-networked and responsive voluntary/third sector services such as Bristol Refugee Rights, Red Cross, ABC Project and Borderlands.

The Hope Service pathway



Increasing demand: the role of Recovery Coordinators

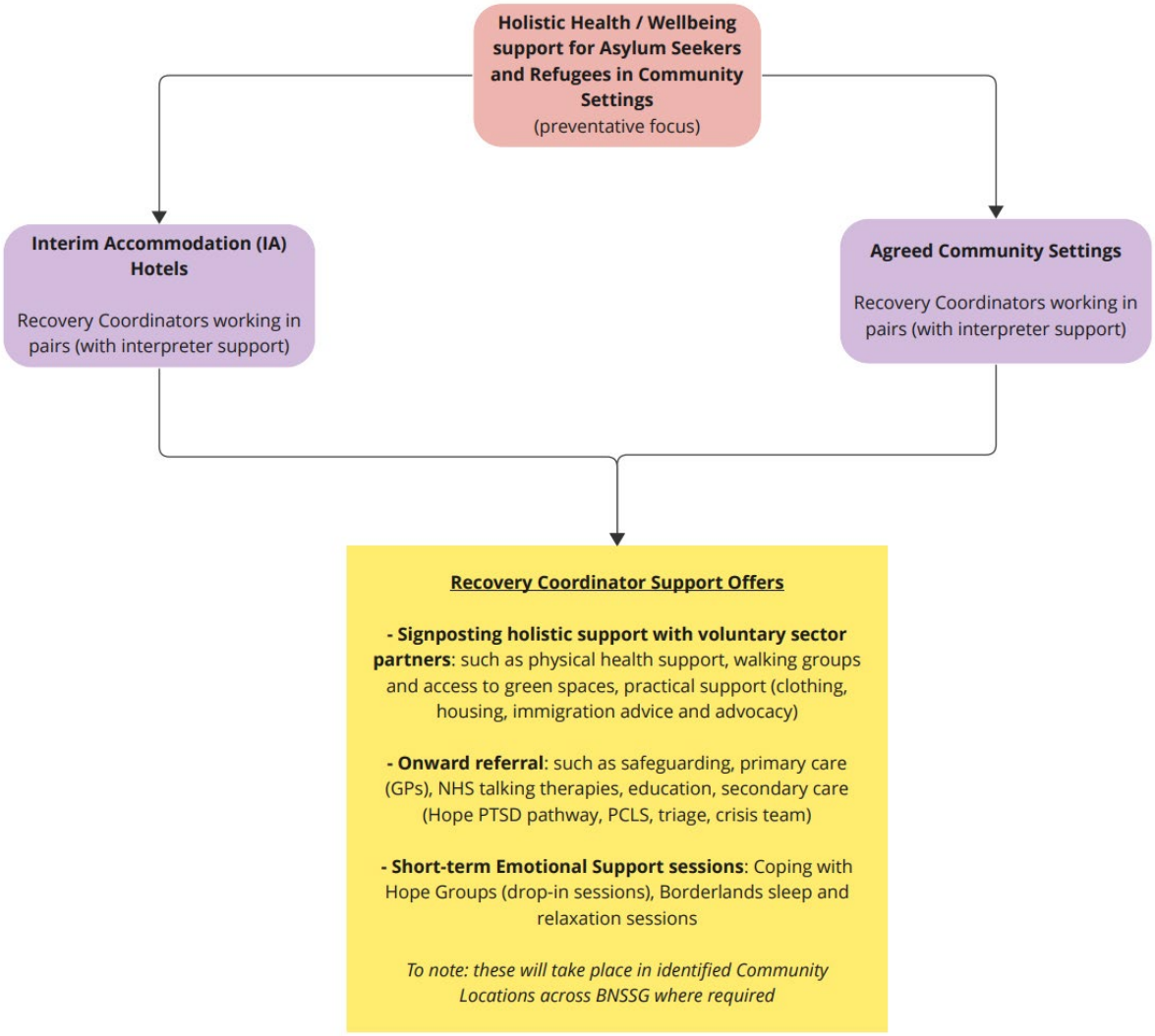
Since the significant increase in numbers of people housed in the IA hotels, the Hope Service has offered more generic mental health support across all the IA sites. Recovery Coordinators and other staff have built on strong working relationships with the Haven and voluntary sector partners, with a focus on promoting wellbeing, managing stress and signposting/referring to other services where required. This reduces the risk of lone working, and builds relationships across existing networks/partnerships (e.g. through the use of a shared calendar). This includes making referrals to Vitaminds and other agencies for health/mental health support and safeguarding; signposting to charities offering clothing and toiletries etc., linking in with projects offering outdoor activities and signposting to legal advice.

The role of Recovery Coordinators has included a strong preventative mental health component, for example, offering emotional support to manage high levels of agitation and hopelessness, talking through anxiety management techniques (including using written translations of the 'Coping Strategies for Stressful times' document) and, wherever possible, normalising responses to highly stressful events. The Hope Service also facilitates Coping with Hope groups, open to any IA hotel resident, which offers a space to share skills and understanding and develop resilience in order to cope with significant levels of stress and loss and typically low levels of empowerment.

There is evidence that in addition to increasing tension within the hotels, many of the hotel residents have resorted to calling ambulances, presenting at A&E and self-harming in a response to high levels of agitation and untreated mental distress. Feedback from residents, primary care colleagues and testimony from Recovery Coordinators has suggested that the presence of Recovery Coordinators and the provision of groups at the hotel offers significant emotional containment and is helping to manage this situation on a day to day basis. Being based in the hotels has allowed the Recovery Coordinators to ensure onwards referrals to mental health are appropriate and, wherever possible, given people both support and skills to manage their own situation. Nevertheless, staff often describe facing queues of people waiting for support, many of whom are highly distressed.

Some of the Recovery Coordinators themselves have a Refugee background and experience of seeking asylum and also speak the same languages as residents in the hotels – this lived experience can be transformational in offering reassurance, orientation and support and facilitating working within different cultural frameworks.

The Recovery Coordination Offer



Feedback from Recovery Coordinators working in the Hope Service (RC's)

"RC's bring significant understanding of cross-cultural mental health – we understand how race, language, faith, spirituality etc. impact mental health as well as how it can improve it and how mental health is described by people from different cultural backgrounds. This also extends to talking about issues such as risk and confidentiality – we use the right language and in an appropriate way, working with interpreters or talking directly with people"

"As RCs, we walk beside the ASRs on their road to recovery and help them to access the services they need and that would be beneficial for them. Due to our ongoing working relationships with the service users, we are able to highlight different kinds of needs and issues that are presented to us, we help to identify gaps that potentially community organisations/other service providers may be able to fill. By having RCs in the community, we will be able to liaise with relevant agencies to ensure that we are feeding back up to date and relevant information to the service users."

"The RC role is crucial as it enables service users feel heard, seen and validated. In my role as a recovery coordinator from the same cultural background with some of the service users I work with, I have noticed that service users are more able to engage with me as they feel our experiences and backgrounds relate. Representation matters."

Service Delivery

Location of services

Services are provided in a range of settings, including:

- Face to face contact at Gloucester House (current base, likely to be the base for the next year);
- Community bases, such as Easton Community Centre;
- IA Hotels across BNSSG;
- Online, email and accessible online/phone facilities.

There needs to be a flexibility of estate provision across BNSSG to provide short-notice provision as required, managed by AWP.

The location will be agreed between the Hope Service and the service user and will balance:

- Most appropriate setting for intervention/activities, in line with best practice and clinical guidelines and taking into consideration service user preferences and choice (e.g., NICE, Health and Safety considerations);
- Cost effectiveness of service delivery.

The safety of the service user and management of risk to staff must take precedence over other considerations at all times.

Hours of operation
The service operates between 9am – 5pm Monday to Friday.
The service does not operate any out of hours provision but links into local services e.g. Response Line, Crisis Teams where indicated.

Referral route

Referrals to the Hope Service PTSD treatment pathway can be through the following sources, through the referral form via email (forms with missing data may be returned to the referrer):

- **Vita Minds/IAPT**: individual service users, GPs or other professionals including voluntary sector partners across BNNSG can refer to Vita Minds for assessment. Vita Minds will assess suitability according to the referral criteria and may allocate either to the Hope Service via the referral form or internally to other provisions with Vita Minds.
- **Secondary Mental Health across BNSSG**: referrals can be made by completing a Hope Service referral form. Referrals may come directly from triage/PCLS or on behalf of service users within secondary mental health teams. In the minority of cases where ongoing input from a Recovery team is indicated (e.g. concurrent other mental illness), a local team care coordinator will be required.
- **CAMHS across BNSSG**: referrals can be made by completing the referral from if the young person is over the age of 16.

Population served

Inclusion criteria
The Hope Service will work with Asylum Seekers and Refugees, including those that have been the victim of human trafficking who fulfil the following criteria:

- Service users should have a GP in the BNSSG area.
- Service users should be 16 years or older.
- Service users should have an asylum seeking/refugee background, including recognised victims of trafficking. Their application may be in process or they may have settled status.
- Developmental trauma may be present, however PTSD symptoms should relate to adult-acquired trauma. We recognise that referrals from CAMHS will have trauma acquired pre-16.Service users should have a PCL-5 score of 31-33 or over, with post-traumatic stress disorder as their primary diagnosis.
- Service users should be willing to engage in psychological work.
- Service users may have concurrent pain/physical health difficulties.

Referrals are discussed at weekly allocation meetings and are overseen by the clinical lead for the service - referrers are invited to join these as required. Referrals may be made back to the referrer should the service user not meet referral criteria. Once the referral form has been received and accepted by the service, the service user details are added to RiO, and the service database (W Drive) and the service user will be allocated to a clinician for a full assessment and ongoing treatment.	• Service users have contact and engagement throughout the process, they are seen within a couple of weeks of the referral, and risk is managed across the team. **Exclusion criteria** The following exclusion criteria apply: • The service cannot accept referrals to treat developmental trauma or personality disorders. • Service users with problematic drug or alcohol use will be assessed with input from drug and alcohol services to ensure that their needs are being met appropriately • The service cannot work with a service user with a complex comorbid mental health unless they are supported by another mental health team. • The service may refer to other providers, service users who are experiencing rumination or worry due to their circumstances rather than presenting with PTSD/re-experiencing of trauma.

Indicative staffing

AWP is responsible for:

- Ensuring sufficient staffing is in place to allow the service to be safe and deliver assertive trauma-informed engagement, strengths-based assessment and support planning and coordinate a multi-agency wrap-around approach.
- Ensuring that staff are suitably trained, qualified, and supported to deliver the interventions proposed in the delivery model.

Provision will comply with all relevant existing and new national standards including:

- CQC registration and compliance;
- NICE guidelines (refers to the NICE Quality Standards and will be reviewed upon the publication of further guidance);
- Legal frameworks;
- Professional guidance.

The service will operate according to relevant legislation and guidance, with particular reference to:

1. Mental Health Act 1983 (amended 2007) and Code of Practice, including protocols for emergency assessment under Section 136
2. Mental Capacity Act 2005
3. Children's and Families Act 2014 including specific duties in relation to children and young people with SEND (further detail can be found here)
4. Equality Act 2010
5. Care Act 2014
6. Accessible Information Standard

Service user involvement

There is an active service user forum which meets every two months to help understand, review and improve the way support is offered. Two members have successfully trained as service user representatives on the Equality, Diversity and Inclusion Lived Experience group. The service user group has helped the service develop a bank of resources into the most commonly used languages[2] including 'Coping Strategies for Stressful Times' document, 'Moving on After Trauma' handbook, relaxation and imagery scripts, all of which are frequently shared with partners and colleagues in other services, including LA and the voluntary sector.

The Hope Service actively links with voluntary sector partners such as Bristol Refugee Rights, Borderlands, Unseen, Wesport and the Red Cross to incorporate feedback and develop services collaboratively. The Hope Service also offers regular training in Trauma/Mental Health to these organisations to upskill volunteers to work confidently with anxiety and distress, effectively reducing referrals to mental health services. This offer increases capacity into the system, building in opportunities for people with Lived Experience from a range of different backgrounds.

[2] Albanian, Dari, Pashto, Tigrinya, Ukrainian, Arabic, Kurdish Sorani and Farsi

Use of interpreters

The significant increase in clinical need has also led to a sharp focus on removing structural barriers to services and support. Currently 85% of service users supported require an interpreter to access support and access to interpreters is critical to the delivery of accessible and equitable services. The Hope Service works closely with the Accessible Information Standard group to ensure that the contract with the interpreting agency is as strong as it can be. The service regularly offers specialist training to interpreters and also facilitate a monthly reflective debrief session[3].

Outcomes and KPIs

Reports (example included in reference documentation) are submitted monthly to BNSSG ICB. These show the number of service users entering treatment, the status of new referrals, number of interpreter sessions and discharges. The service also routinely collects outcome data at various points in the care pathway on: PTSD, Depression, Anxiety, Functioning and a Trauma checklist at baseline, which are in the process of being evaluated now that the service has been in place for 1 year.

Reporting includes:

- Standardised outcome measures currently used at assessment and start/end of MOAT and start and end of 1:1 therapy are: PHQ-9, GAD-7 and the PCL-5 (measure of PTSD).
- The Life Event or Trauma Check List (LEC-5)[xi] is administered at assessment.
- A specialist functioning scale – the Post Migration Living Difficulties Checklist (PLMD) is administered at the start and end of treatment.
- Friends and Family Questionnaire is completed at the end of treatment
- Each MOAT group is evaluated at the end of the course by a member of the service who has not bene involved in delivering the course (sample evaluations are attached with reference documentation).

Locally defined outcomes

- People will live longer
- People will improve their level of functioning
- People will receive timely access to assessment and support

[3] Due to the potentially highly distressing content of trauma work, to try and avoid developing secondary trauma

- People will experience reduced levels of anxiety
- People will maintain a role that is meaningful for them
- People continue to live in stable accommodation
- People will have fewer health problems related to their condition

NHS Outcomes framework domains and indicators

Domain 1	Preventing people from dying prematurely	Y
Domain 2	Enhancing quality of life for people with long-term conditions	Y
Domain 3	Helping people to recover from episodes of ill-health or following injury	Y
Domain 4	Ensuring people have a positive experience of care	Y
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	Y

Service Evaluation

All Phases of the PTSD pathway are evaluated at beginning and end. Evaluation of the effectiveness of MOAT groups has been very positive, showing significant changes in anxiety and depression across 17 groups and significantly positive change in idiographic measures of ‘connectedness’, ‘social role’ and ‘understanding of symptoms’ (Griggs, Liu & Cooper 2021).

Each MOAT group is evaluated using a semi-structured focus group, facilitated by clinicians within the service but not those who have delivered the groups. All service users are invited to complete a Friends and Family form at the end of MOAT and the end of 1:1 treatment. Data relating to community-based wellbeing initiatives is collated (numbers of attendees etc.) and where appropriate evaluated by feedback forms. There is a service user forum which offers feedback on all aspects of the service, including accessibility of information and gaps in provision (examples are included in the reference documentation).

Reference documentation

No.	Document	Attachment
1.	Overview of the Hope Service and evidence base for this approach	Hope Service.docx
2.	Service Referral form	Service Referral Form.docx
3.	Monthly Reporting Example	Hope Service Monthly Report - Febı
4.	Case Study Example	Case Study March 2023
5.	Evaluation of MOAT groups which showed significant positive change in outcome measures (Griggs, M., Liu, C., & Cooper, K. 2022)	BCP-2100028_R.pdf
6.	Evaluation of MOAT men's group	MOAT Evaluation March 2023.docx
7.	Evaluation of MOAT female's group	F-MOAT Evaluation Aug 2021.pdf

8.	Evaluation of MOAT at Mecure Hotel April 2021	 MOAT@Hotel Evaluation April 2021.
9.	Evaluation of Sleep Support April 2021	 Service Evaluation of Sleep Support Sessior
10.	Evaluation of the Tree of Life pilot March 2022	 Evaluation of the ToL pilot March 2022.doc

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