

The Health Needs of Unaccompanied Asylum Seeking Children and Young People

John Simmonds, Director of Policy, Research and Development

Florence Merredew, Health Group Development Officer

British Association for Adoption and Fostering.

1. Introduction

The needs and circumstances of unaccompanied asylum seeking children share many of the characteristics of other UK children looked after but in many other respects they are quite different. As a group, unaccompanied asylum seeking children are unified by their separation not only from their family of origin, but from their community and country of origin and are seeking refuge from political, cultural, religious or other forms of persecution including armed conflict and war. Their experiences may include direct experience of beatings, rape or torture and they may have been witness to the beating, rape, torture and killing of others including family members. Some may have been 'child soldiers' or fleeing from attempts to enlist them as 'child soldiers'. Their journeys to the U.K may include the payment and the involvement of human traffickers and those journeys may have been lengthy and fraught with danger and uncertainty. For some, the death of companions may have accompanied the journey and the possibility of death may never be far away. Arrival in the U.K. will be met by a massive culture shock where language, food, routine, religious observance, attitudes to animals, education, sexuality, gender, dress, alcohol and those in authority including parental figures may be very different and even objectionable as previous expectations and experiences of custom and culture are breached. The police, border agency staff, social workers and others may be feared because of previous experiences of state officials in home countries who demand payments and may routinely use force or threats.

Unaccompanied minors may be orphaned or they may be orphaned in experience, being unsure of the whereabouts and status of their parents, siblings or other family members. Some may be separated from their parents or other family members sent to the U.K. for protection, welfare and opportunity but expecting to remain in contact and be re-united with family members at some, probably distant point in the future. For some, the expectation will be that they seek employment in order to pay traffickers often under threat or maybe to support families in the country of origin.

Unaccompanied asylum seeking minors will have legal status under the Children Act 1989 and the Children (Leaving Care) Act 2000 in England and Wales and other primary and secondary child welfare statutes. Their primary need code is 'absent parenting' for the vast majority although this barely addresses the abuse and neglect they may have experienced in their own country and on their journey although this is unlikely to result from experiences in their own families. Their legal status is also defined by their asylum application and immigration laws. Although it is hard to characterise their attitude towards the U.K., it is almost certainly going to be mixed. Most U.K children in public care do not strive to become looked after or actively put themselves in peril on the journey to become cared for.

To actively seek protection, welfare and opportunity is not normally associated with U.K. children's view of care although that is not to say that it does not exist. However, it is also hard to characterise what a minor from a country such as Afghanistan, the Democratic Republic of Congo or Iraq might imagine or expect of the U.K. except generalised images of safety and opportunity. A highly organised public care system for children and a state welfare system including health is almost unimaginable in a war torn country or one that is either a developing country or emerging into a developed country. So while relief and heightened expectation may form part of the experience of an unaccompanied minor, confusion may also be significant as the young person encounters suspicion about their asylum claim, disbelief about their story and maybe their age as well. At the same time there will be an insistence by 'officials' on procedural compliance in relation to their immigration status and asylum claim and their welfare status and needs assessment including social care, education and health. They will encounter negative portrayals of asylum seekers in the media, racism and stereotyping in their daily lives. There is a risk that their asylum claim will be refused and they will be returned to their country of origin. This may for some include detention as these issues are worked through.

What is remarkable from this characterization of the extreme challenges and difficulties faced by so many unaccompanied minors are that they are keen to positively engage themselves in making use of those opportunities that are provided for them in the U.K. - especially education. Whatever experiences of trauma, loss and separation, disconnection and uncertainty about the asylum application and treatment by the authorities and more generally about their future, many unaccompanied asylum seeking children like and even enjoy their experiences in the U.K., want to remain and make a positive contribution to society. They have a resilience probably established by good early experiences and sometimes marked social and material advantage with their families of origin which contrasts significantly to the maltreatment and material disadvantage experienced by many U.K. children who become looked after. While the circumstances in their own country may have been dangerous, the fact is that the opportunity to flee probably indicates connections to people who have the material resources and knowledge to arrange their escape. (Kohli & Mitchell, 2007)

2. Basic Statistics

The countries unaccompanied minors originated from numbered 35 in 2008. The largest number of applications came from Afghanistan at 1,740 followed by Iraq at 475 and Iran at 375. The total number of asylum applications was 3905. In 2008, 285 applications resulted in the granting of asylum, 1,790 were granted discretionary leave¹, 15, humanitarian protection² and 585 were refused. The DCSF

¹ Discretionary Leave can be considered for people that have not been considered for international protection, or have been excluded. Discretionary Leave may be granted if the applicant is an Unaccompanied Asylum Seeking Child (UASC) for whom adequate reception arrangements in their country are not available, or if the person is able to demonstrate particularly compelling reasons why removal would not be appropriate. Discretionary Leave can be granted for a period of three years or less. For UASC's it can be granted for three years or up until their 18th birthday, whichever comes first.

² Humanitarian Protection is leave granted to a person who would, if removed, face in the country of return a serious risk to life arising from the death penalty; unlawful killing; or torture or inhuman or degrading treatment or punishment. If a person has been refused asylum they may still be considered for this status. Humanitarian

numbers of unaccompanied asylum seeking children looked after in 2008 was 3500. Of these 2300 were over 16 and 1200 were under 16. By far the greater majority were male at 2900 with 660 females. The implications of this overall set of statistics for health planning any unaccompanied minors health are that in the main this is likely to be for adolescent males albeit adolescent males located by culture and time in a way that does not bear direct comparison to U.K. born male adolescents.

3. Health Care – Primary Prevention and a Secure Base

The *Care Matters* White Paper confirmed the Government's policy that for the majority of unaccompanied asylum-seeking children they should enter local authority care. As children looked-after they should benefit from all the services, support and care that any looked-after child can expect. This will require a comprehensive assessment and the arrangement of a suitable placement to meet their needs. As with the placement of any child or young person, it is intended to provide a secure base for the young person to settle and is core to their long term welfare. There are a wide range of characteristics associated with secure placements but a relationship with a key adult – a foster carer or a residential staff carer – is core this. Providing secure long term placements and relationships are difficult at the best of times. There are particular difficulties with unaccompanied asylum-seeking children brought about by their age and circumstances and in particular decisions on their asylum claim including a refusal. In one study (Sinclair, Baker, Lee, & Gibbs, 2007), 40% of placements had lasted for less than 6 months.

Although many adolescents will begin to take some responsibility for their own health care, parental figures who know them well and are committed to their short and long term welfare are key in advising, supporting and advocating for their health needs. The need for parental support couldn't be any less true for unaccompanied asylum seeking minors especially given their lack of familiarity with the U.K. health system and their different expectations of what health care means or how it works. But for many unaccompanied minors, primary prevention, advice, monitoring, access and advocacy are very much in the hands of a number of professionals who may well be a changing cohort of people with a well defined or limited responsibilities who cannot replace what most young people instinctively rely on to keep them healthy – their parents. This is so in relation to physical health and emotional health and well being and each domain, relationships are key.

4. Health Assessments

The 2002 guidance (Department of Health, 2002) and revised draft 2009 guidance stresses the importance of a comprehensive initial health assessment for all children on becoming looked after that should be completed by the time of the first review at 28 days.

It is a social care responsibility to notify health services when a child becomes looked after, and there is general acknowledgement in practice that this is a system that has significant limitations to it. It is essential that effective notification systems are in place, accompanied by effective guidance on process and careful consideration of security, confidentiality and recording of information.

Protection is normally granted for a period of 3 years, after which the person can apply for Indefinite Leave to Remain. A person who is granted Humanitarian Protection is allowed to work and has access to public funds.

In one research study (Wade, Mitchell, & Baylis, 2005) while the evidence was that most initial needs assessments by social workers included health, the detail was sketchy and included general phrases such as 'no major health problems', appears in good health' or needs to register with a G.P. (page 131). Basic health needs were usually routinely assessed through the local system used for all children looked after. However, successful registration with a G.P. was difficult to identify from social work case files being absent in 31% of the sample and in relation to registration with a dentist absent in 48%. The direct involvement of social workers, foster carers or residential workers made a significant positive impact on health needs being attended to although there were a number of examples of this responsibility being left to the young person themselves. In this study, 49% of young people were identified as having health problems that required one-off or longer treatment while 13% had longer term health problems.

Assessments will need to reflect the likelihood that the young person's language is not English and that even if they speak English, expression and comprehension may be limited. Access to interpreters is likely to be the norm for many initial assessments. Cultural differences may also be significant and that may include expectations and attitudes to the exposure of the body especially across genders. Access to family history may be limited and any young person's previous health history may also be limited by personal recall and understanding. Routine or specific health care may have been absent or limited in the country of origin and where it was available, this may include the use of localised procedures and beliefs about the causes and remedies of illness that would be considered dangerous or poor practice in the U.K. There may be immediate issues arising from the situation in the country prior to departure especially conflict or war and the trauma of the journey including malnutrition, undiagnosed and untreated infections and injuries.

The complexity of health needs and the other contextual factors identified above will often mean that assessments take more time and are more resource intensive than even those involving U.K. children looked after. The skill, knowledge and support of medical practitioners and other health professionals including nurses and CAMHS professionals will also need to reflect the particular issues described above.

Informed Consent will need to follow standard protocols taking into account a young person's age and level of understanding.

In any assessment, there a range of considerations that would need specific consideration. (King's Fund and Royal College of Paediatrics and Child Health, 1999; British Medical Association, 2002) BAAF publish standardized assessment (British Association for Adoption and Fostering, 2004) forms for use with U.K. children who become looked after. This enables assessing doctors to pay attention to the wide spectrum of health and developmental delays and other issues brought about by abuse or neglect. In addition doctors assessing unaccompanied minors will need to assess specifically given the context (British Association for Adoption and Fostering, 2004)of the young person-

- The likelihood or absence of standard immunisation protocols having been followed in the country of origin
- Screening for T.B., Hepatitis B or C, HIV, intestinal parasites, malaria and other tropical diseases not common in the U.K. (British Association for Adoption and Fostering, 2008)

- The likelihood of the effects of temporary or long term malnutrition
- Physical injury including torture, beatings and war wounds
- Pregnancy including the possibility of this resulting from rape
- Sexual exploitation
- Female genital mutilation
- Preventative and healthy care guidance and support including nutrition, sexual advice and contraception, alcohol, smoking and illegal substances

5. Emotional Well Being and Mental Health

The assessment of emotional health and well being and mental health is a complex (Chase, Knight, & Statham, 2008). The circumstances of unaccompanied asylum seekers have been identified above as unusually stressful resulting from a combination of the circumstances in the country of origin, the journey to the U.K. and arrival and settlement in the U.K. and the possibility of a refusal and return to the country of origin. These are all marked by the likelihood of trauma of various kinds, separation and loss, dislocation, rupture and uncertainty. Given this, emotional well being is likely to be extraordinarily challenging and the likelihood of clinically significant disorders especially post traumatic stress disorders, depression and anxiety very high. Many of the sources of stress are located outside of the young person including contact with the border agency, children's services and other state services. However, the impact may be primarily felt inside the young person and manifested in the kinds of disorders identified. Added to this complexity is the culturally situated construction of the causes and explanations of mental distress which may radically differ to that commonly used in Western and U.K. settings.

Primary prevention will be core to addressing these issues including high quality placements, establishing meaningful and long lasting relationships with adults, establishing friendships networks, culturally relevant networks including those that meet religious, dietary, dress beliefs and needs. Advice and advocacy and links with community networks will also be significant. Contact with or information about family and friends in the country of origin may also be very important. It is essential however, that any of this is driven through consultation and discussion with young people themselves. The resolution of the asylum application will also be very important. (Kohli & Mather, 2003)

Beyond this, the assessment and provision of services for those that are suffering from clinically significant emotional distress and identifiable mental health problems will be important. Accessing CAMH services and other specialist mental health services will be important. But many studies emphasise the need for these services to fully understand the plight and circumstances of unaccompanied minors.

6. Leaving Care and the Transition to Adult Services

Given the age profile of most unaccompanied asylum seeking minors, they will quickly face transition to leaving care services where what is made available to them will depend on their eligibility for a pathway plan under the Children (Leaving care) Act 2000. In addition their asylum application may well be re-visited depending on their status especially those with discretionary leave. There may be for some a decision that includes return to their country of origin. Any of these transitions may have an impact on health care assessment and planning including the continuation of existing treatments.

7. Age Assessments

The issue of determining age has had a controversial history in this area. For some young people, they may not have access to certification of their age and date of birth by the very nature of their arrival in the U.K. The controversy has centred around medical practitioners being asked to determine age by using a variety of techniques including ionising radiation and dental examination. This has produced both ethical issues about invasive or other health procedures being used for administrative purposes as well as the accuracy of any of the methods being used. (see (King's Fund and Royal College of Paediatrics and Child Health, 1999) page 13-15) The determination of age for health purposes is clearly relevant in its own right and practitioners will have access to relevant protocols depending on need and purpose.

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