

# Clinical guidance for assessing & addressing the health needs of uasc (unaccompanied asylum seeking children) and young people

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For Paediatricians and those undertaking IHAs



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# Section 1: Introduction

Unaccompanied children seeking asylum are children and young people aged under 18 years who have asked for asylum from their home country owing to fear of persecution. Unaccompanied children have become separated from their usual parent or carer, often for reasons such as the death of a care giver or separation during the journey, which is often traumatic, to the host country. Unaccompanied children have substantial health and social care needs, and the prevalence of physical and mental illness is higher in unaccompanied children compared to accompanied peers, or to the indigenous population of children in the UK.

Since August 2015 there have been increased numbers of unaccompanied children in Kent, which is reflective of an international crises caused by conflict in Afghanistan, Syria, and in the Horn of Africa.

## Useful definitions

**Asylum seeker:** applies to be given refugee status under terms of 1951 UNHCR (United Nations Refugee Agency) Convention or someone who says he or she is refugee and has lodged an application for protection on the basis of the Refugee Convention or Article 3 of the European Convention of Human Rights, but their application has not yet been definitively evaluated ([UNHCR](#)).

**Unaccompanied minor:** separated from both parents and no person can be found who by law or custom has primary responsibility (1951 UNHCR Convention)

**Refugee:** leaves or does not return to country of their nationality because of well-founded fear of being persecuted for reasons of race, religion, nationality, membership of particular social group, or particular opinion (1951 UNHCR Convention). This term is widely used to describe displaced people all over the world but legally in the UK a person is a refugee only when the Home Office has accepted their asylum claim

**UASC:** (Unaccompanied Asylum Seeking Children) A person who, at the time of making their asylum application is under 18 years of age or who, in the absence of documentary evidence, appears to be under that age and who is applying for asylum in his/her own right and is without a family member (s) or guardian (s) to turn to in this country. The definition for immigration purposes of an unaccompanied asylum seeking child is given by the Home Office as 'a person under 18 years of age or who, in the absence of documentary evidence establishing age, appears to be under that age' who 'is applying for asylum in their own right; and is separated from both parents and not being cared for by an adult who by law or custom has responsibility to do so'. Children in this situation are also known as separated children or unaccompanied minors (UAM) ([Kamena Dorling and the Migrant Children's Project team, May 2013](#))

**What is "seeking asylum"?** Asking for protection and permission to stay in the UK

## Some UASCs will later become refugees if their claims for asylum are successful

**An age-disputed child or young person:** An age-disputed child or young person- is child or young person whose age has been disputed and has not had their claimed date of birth accepted by the Home Office and/or by the local authority that he or she has approached to provide support or protection. This term is usually used to refer to people who claim to be children, but who are treated as adults by the Home Office and/or the local authority ([Kamena Dorling and the Migrant Children's Project team, May 2013](#))

**A separated child:** A separated child- is a child who has been separated from both parents, or from their previous legal or customary primary caregiver, but not necessarily from other relatives. These may, therefore, include children accompanied by other adult family members. The Home Office definition of unaccompanied children does not include children who arrived in the United Kingdom in

the care of a parent or other adult (for example, a relative or family friend) who by law or custom has responsibility for the child, even if the child is no longer living with such an adult due to the subsequent breakdown of such an arrangement ([Kamena Dorling and the Migrant Children's Project team, May 2013](#)).

**Trafficking:** Trafficking- is the recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation shall include, at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude or the removal of organs. The recruitment, transportation, transfer, harbouring or receipt of a child for the purpose of exploitation shall be considered "trafficking in human beings" – Council of Europe Convention on Action Against Trafficking in Human Beings, ratified by the UK Government in 2008.

## Legal aspects

### Current UK Asylum Process

A refugee wishing to stay in the UK must apply for asylum. To be eligible they must have left their country and be unable to go back because of fear of persecution. Refugees should apply for asylum when they arrive in the UK or as soon as they think it would be unsafe to return to their own country. After applying, refugees will have a meeting with an immigration officer (known as a 'screening') and then an asylum interview with a caseworker.

Decisions about application are usually made within 6 months. Further information can be found on the [Home Office website](#) ([www.gov.uk](http://www.gov.uk)).

### Unaccompanied Asylum Seeking Children and Young People

Following an initial [age assessment](#) by the Home Office and social services, a young person judged to be under 18 years of age, without an adult to care for them, is entitled to the same rights as other looked-after children and young people, including accommodation, some finance, education, statutory health assessments, support and reviews.

This group of young people will most likely be given discretionary leave to remain until 17 ½ years old leaving detailed processing of an asylum application for when they are older. They are entitled to legal aid. Therefore as much information as possible should be gathered using an appropriate interpreter at an early stage as this will be relevant to their application.

### **After full consideration by UK Visas and Immigration there is one of three outcomes:**

#### **Full Refugee Status**

The Young Person meets the definition of a refugee under the 1951 United Nations Convention Relating to Refugees. Granted Indefinite Leave to Remain after being in UK for 5 years. Not sent back.

**Humanitarian Protection or Discretionary Leave** - this replaced Exceptional Leave to Remain (ELR) in 2003. This is time limited and actively reviewed.

Humanitarian Protection : removal places serious risk to life or person

Discretionary Leave: the UASC is allowed to stay until aged 18

**Refusal:** May appeal, if unsuccessful are removed from UK. If UASC, not until 18. It is imperative that that UASC has legal advice during the process.

## Age assessment

Most refugee children and young people will not have a passport, although some may have been given a passport to help them to leave a situation where they are at risk. Sometimes the child's stated age may be disputed; with serious implications for the outcome of their asylum claim and for their

ability to access health services, education and welfare support (Crawley, 2007). Adults indicating that they are children present a risk to younger cohorts if placed into accommodation together. However the converse is true and vulnerable young people should not be placed with adults.

The Home Office and the Association of Directors of Children's Services have produced [joint working guidance 2015](#) about how UK Visas and Immigration decide applications (www.gov.uk).

The Association of Directors of Children's Services have also produced age assessment [guidance \(www.adcs.org.uk\)](#) for assisting English social workers in conducting age assessments of unaccompanied children seeking asylum. This states that the process for age determination by the local authority should take place in the presence of an appropriate adult, by two qualified and one senior social worker, taking into account a number of social and other factors. If in doubt the local authority should give the young person the benefit of the doubt as to their age.

Age assessment guidance has also been developed in [Scotland](#) and [Wales](#).

In these situations, remember that there is no single reliable method for making precise age estimates and the most appropriate approach is to use a holistic evaluation, incorporating narrative accounts, physical assessment of teeth, puberty and growth, and cognitive behavioural and emotional assessment (RCPCH, 2013). The use of radiological assessment is extremely imprecise and can only give an estimate of within two years in either direction and the use of ionising radiation for this purpose is inappropriate (RCPCH, 2007). The British Society for Paediatric Endocrinology and Diabetes are clear that it is not possible to accurately assess a child's age based on physical examination or bone age assessment (Dr Tabitha Randell, Consultant in Paediatric Endocrinology).

A paediatrician has to be honest with the social worker when contacted regarding age assessment, explaining that dental x-rays, bone age and genital examination will not add any further information to the assessment process based on the current evidence available.

Some age assessments carried out by the Home Office have been subject to dispute with some young people subsequently assessed to be minors (Crawley 2007). Further information about age disputes is available from the [Coram Children's Legal Centre, 2013 \(www.childrenslegalcentre.com\)](#).

#### Points to remember:

- >50% of births in the developing world are not registered therefore a UASC's age cannot be validated with written proof.
- Age Assessments should be carried out only if:
  - there is no proof of age
  - Physical appearance/demeanour suggest that they may be younger or older than claimed
  - The Home office has disputed their age
- Carried out by two social workers and the young person has a right to be accompanied by an appropriate adult
- Not a health responsibility but we should comment if appropriate
- 5 year margin of error (15-18)
- If in doubt, assume is a child
- Must follow Merton guidelines
- [http://mertoncs.proceduresonline.com/pdfs/app\\_1\\_age\\_assess.pdf](http://mertoncs.proceduresonline.com/pdfs/app_1_age_assess.pdf)

## Experiences:

### Why unaccompanied?

- Danger of being murdered or imprisoned



- Parents/guardians have “disappeared”
- Danger of being forced to join army/other fighting unit
- Prevented from practicing their religion
- Forced to practice religion
- Intimidated or tortured
- Banned from political activity
- Forced to take part in political activity
- Member of persecuted social, religious, ethnic or political group

### Experiences of UASC:

- War and terrorism
- Civil unrest
- Ethnic persecution
- Political persecution
- Religious persecution
- The journey to the UK
- The asylum-seeking process
- Media reporting

### Possible effects of traumatic experiences

- Brutalised
- Start hating
- Want revenge
- Feel abandoned
- Stop trusting adults
- Wary about making new bonds
- Psychological symptoms

### Key Risk Factors

- Loss of parent or primary caregiver
- Experiences of neglect and poor parenting before exile
- Exposure to violence
- Isolation
- Difficulties in the mourning process
- Difficulties in managing change and other difficult events
- Difficult experiences after arriving in the UK
- Identification with oppressive or aggressive political, religious and ethnic groups

### Key Protective Factors

- Having an appropriate adult to provide care
- Having access to community and social networks and appropriate services
- Being able to encourage a natural healing process
- Being able to integrate into a normal life
- Finding meaning in what has happened and being able to process events
- Finding culturally sensitive ways to express loss and move on



## Health needs overview

While many people seeking asylum arrive in the United Kingdom in relatively good health, it is also recognised that others will have physical and mental health needs at greater prevalence than the general population. Reasons for this include, the experience of imprisonment, torture or physical and sexual violation and the physical and psychological consequences of this; time spent in refugee camps which may be overcrowded and lack access to adequate food and sanitation, the journey to the host country, which is often long and arduous and limited or no access to basic healthcare prior to migration, particularly in people from countries which have or are experiencing prolonged periods of conflict, and the associated instability and destruction of local health infrastructure. Young people may have experienced particular health issues in relation to their age and reason for leaving their home country. For example some young people may be forced into or escaped from becoming child soldiers, or have been exposed to sexual exploitation, rape or trafficking.

The key areas of physical health which should be considered are:

- Communicable Diseases
- Nutrition and metabolic concerns
- Women's health, including family planning and maternity care
- Oral health
- Sexual health

## Access to Healthcare

Refugee and unaccompanied asylum seeking children and young people have rights to primary and secondary healthcare. The Refugee Council provide a [fact sheet \(www.refugeecouncil.org.uk\)](http://www.refugeecouncil.org.uk) in a variety of languages which contains information on healthcare eligibility and access for people seeking asylum in the UK.

For babies, children and young people born outside the UK, the usual route for obtaining an [NHS number](#) is to have one allocated through GP registration. In England, there is no set length of time that a patient must reside in the country in order to become eligible to receive NHS primary medical care services. Therefore all asylum seekers and refugees are eligible to register with a GP practice. For further information, see NHS England's Standard Operating Principles for Patient Registration ([www.england.nhs.uk](http://www.england.nhs.uk)).

Specific guidance on accessing NHS services is available for [Scotland](#) and [Wales](#). In 2015 new regulations were introduced in [Northern Ireland](#) meaning that all refugees and asylum seekers (including refused asylum seekers) are not required to pay for their healthcare treatment, including primary care and secondary care.

Children aged under 16, and children 16-19 in full time education are entitled to exemption from charges for prescription items, free dental services and free eyesight tests following completion of a HC2 certificate. In order for unaccompanied children aged over 16 years and not in full time education to access these entitlements, the local authority must complete a certificate of exemption, HC1, confirming that the young person is on low income. Additionally, the UK Border Agency provides HC2 certificates to asylum seekers on behalf of the Department of Health (6).

Specific guidance for unaccompanied asylum seeking children and young people:

- **England:** [Care of unaccompanied and trafficked children July 2014 \(www.gov.uk\)](http://www.gov.uk)
- **Scotland:** [The Scottish Guardianship Service](#)
- **Wales:** [Safeguarding and Promoting the Welfare of Unaccompanied Asylum Seeking Children and Young People](#)

Specialist referral should be made in the usual way; however the referrer should be aware of factors which may impact on a child or family being able to make appointments such as language barriers and transport.

Where appropriate, a [personal child health record \(red book\)](#) should be issued. These are available from the health visitor and local health clinics and for some local authorities, online.

## Local authority responsibilities for uasc

Corporate Guardianship – where a child comes to the United Kingdom to seek asylum and is not in the care of an appropriate adult, the local authority is obliged to assume the role of the child's 'corporate parent'. This role involves a number of responsibilities outlined below.

Named social worker/case manager - who will coordinate the assessment, planning, protection and placement of the child.

Accommodation – the majority of unaccompanied children require the level of support outlined in Section 20 of the Children's Act, 1989. While this does not define the nature of accommodation, the local authority should, so far as practical, provide accommodation that is suitable to the level of need of the child and in line with his/her wishes. In practice it is common for children under 16 years to be placed in foster care, and for children aged over 16 years to be placed in semi-independent living accommodation with variable additional support. In Kent all unaccompanied girls under 18 years and boys aged under 16 years are placed in foster care, and boys aged 16-18 years are placed in a reception centre for 4 weeks and then moved into semi-independent accommodation. Foster carers and staff working in residential facilities should have an understanding of the particular needs of unaccompanied children. Where there is a concern that the child has been trafficked there should be an escalation plan in so that carers can raise concerns about ongoing risk of trafficking and have an action plan should the child go missing.

Immigration legal advice - Unaccompanied children require support in dealing with immigration questions or proceedings. Immigration legal advice must be provided only by a regulated solicitor or registered with the Office of the Immigration Services Commissioner (OISC) to provide immigration advice to the relevant level.

Role in supporting asylum application – it is critical that the local authority works alongside the child's case manager at the UK Border Agency to support the resolution of the child's asylum application.

Statutory health assessment, which includes an including assessment of physical, emotional and mental health. This assessment will result in a health plan to address any health issues identified during the Health Assessment including a timescale and responsibility for actions.

A personal education plan should be produced as part of the overall care plan. Where English is not the first language of the child, this should include access to English language skills training, as well as opportunities to develop literacy in skills in the child's mother tongue. Schools in which unaccompanied children are placed may require additional support to understand and meet the needs of unaccompanied children.

Rights of care leavers – immigration status does not affect the obligation on Local Authority to provide support to young people who are leaving care. If the unaccompanied young person has been in the care of the local authority for 13 weeks prior to their 18<sup>th</sup> birthday they are entitled to the same care leaver's support as any indigenous looked after child, as outlined in the Children's Act and including having a named personal advisor to support their needs. Leaving care may be associated with increased risk of becoming isolated or vulnerable. Transition planning by the local authority should take into account factors which may decrease this risk, such as language and cultural factors.

### What do we know about the Kent UASCs and their health?

Given the increase in numbers of unaccompanied children who have travelled to Kent in 2015/2016, a health needs assessment was undertaken to review the literature regarding the health needs of this population and to describe the health needs observed in the Kent population of unaccompanied asylum seeking children.

This can be found at [http://www.kpho.org.uk/\\_data/assets/pdf\\_file/0011/58088/Unaccompanied-children-HNA.pdf](http://www.kpho.org.uk/_data/assets/pdf_file/0011/58088/Unaccompanied-children-HNA.pdf)

## Undertaking the initial health assessment

The following processes were developed in October 2015 in Kent to support the increased demand for Initial Health Assessments and can be used as a guide.

### The admin processes:

- Typically 3 young people will be seen per day allowing 90 minutes per case.
- The responsible local authority (LA) will work with the health provider to allocate young people to clinic slots
- The LA are responsible for booking the interpreter
- The LA will complete BAAF Part A with demographic details and a blank IHA assessment tool (Kent) will need to be completed at the appointment Note: Different forms will be used on different areas of the country, the Kent form is provided as a sample
- *Kent clinicians you will be required to type up a summary of the assessment using the IHA summary report template and health care plan at the end of the assessment. The IHA assessment tool can either be handwritten or typed but needs to be legible as this is shared with the young person and the GP. Electronic versions of the assessment tool, summary report template and action letters (to GP, social worker and personal adviser) are available. These have been prepopulated to an extent to make the process as efficient as possible.*

Equipment that you will require:

Scales, height meter, tape measures, Ophthalmoscope, Auroscope/ophthalmoscope, Stethoscope, Gloves, BP machine, Snellen Chart, tendon hammer

Admin resources required:

- IHA assessment form
- IHA information leaflet and consent form (translated)
- Body maps (see appendix)
- Freedom from Torture referral form
- Red Cross family tracing application

Blood borne infections information and consent form (translated)

- Blood forms, TB screening information leaflet (translated) and referral form
- Channel/Prevent referral form
- Other safeguarding

## Working with interpreters

For children and young people with English as a second language any assessment should be undertaken with the support of a culturally appropriate, registered interpreter (considering ethnic and gender issues). It is not appropriate for other children or young people to act as interpreters, or for people not trained as interpreters to perform this role. An interpreter telephone service can be used where access to a face-to-face interpreter is not possible.

It is important to remember that a health assessment/appointment may be the first opportunity that a child or young person has had to talk about their needs with a registered interpreter. Remember to

look at the young person not the interpreter when speaking and use positive, friendly, non-verbal communication.

Previous interviews may have been adversarial so it is important to explain that you are not from the Home Office and they have a choice, explain what you will do with the information

It is important to explain to the young person and their carer that you will see the young person and their carer both individually, and then together. It is useful to discuss the care plan and any other issues (together with family and social worker if present) at the end of the assessment particularly if there is an interpreter present, provided consent and confidentiality issues are considered.

### Guidance on using interpreters in health care settings and appointments

- When using interpreters to assist with assessments or meetings involving UASCs the following advice/information may be helpful: Make sure that your interpreter speaks the same language as the UASC including the same dialect if relevant and is also able to read and write in this language.
- Be aware that if the UASC is from an area of conflict then the possible political affiliation/ethnicity of the interpreter may be an issue for the UASC. If concerned about this check with the interpretation agency when booking or speak with the UASC's social worker about suitable interpreters.
- An interpreter of the same sex as the UASC may be more appropriate especially for those UASC's coming from cultural backgrounds where the sexes are more segregated than in the UK. The UASC will already be familiar with meetings involving the use of interpreters and will already have experienced at least one, probably with UK Visas and Immigration. It may be possible to arrange to book the same interpreter that was previously used – the UASC will probably find the process easier with a known interpreter. The UASC's social worker will be able to advise on previously used interpreters and whether they would be suitable to use in a health care setting/appointment.
- Make sure that the interpreter is clear about the purpose of the session and has been adequately briefed before starting.
- Encourage the interpreter to interrupt and intervene during the interview when necessary, for example if the member of staff is speaking too fast or for too long without pausing or the UASC or interpreter has not understood and needs clarification. But also explain to the interpreter that you want them to translate what the UASC is saying, and they are not to give their own opinion or add extra information unless directly asked by you. You will need to watch the UASC's body language to try to ensure that your questions and their answers are being translated appropriately. They will, however, indicate if they feel the UASC has not understood the question or needs clarification. They will also indicate if there is a cultural reason for a possible misunderstanding and will provide clarification and explanation about the cultural issue.
- Be aware of cultural issues depending on the background of the interpreter. It may not be appropriate to shake the hand of an interpreter from certain backgrounds, for example, especially if they are of the opposite sex. Similarly, it may not be appropriate to maintain prolonged eye contact with them, especially if they are of the opposite sex.
- Make sure that the interpreter is introduced to the UASC and that their purpose at the meeting is explained.
- Make sure that it is made explicit to the UASC that the interpreter will not pass on anything that he/she hears at the meeting – everything is confidential. A UASC may feel particularly worried about someone from his/her own cultural background hearing certain information in case anything is passed back to their country of origin.
- The interpreter should sit next to the UASC to facilitate communication.
- The doctor undertaking the assessment should speak and look directly to the UASC, not the interpreter. Questions should be phrased 'Do you ...' for example, not 'Does he/she...'
- The doctor needs to speak at a reasonable pace and must remember to pause to allow the interpreter to interpret. Do not speak for too long without pausing as this will make it difficult for the interpreter to remember exactly what has been said. The doctor/nurse should use straightforward language and avoid jargon.
- At the end of the assessment check whether the UASC has understood everything and wants to know or ask anything else.

## Consent

The clinician should refer to [GMC guidance](#) information about obtaining consent and what to do if consent is refused. Information is also provided in the RCPCH [Child Protection Companion](#) and in the DOH Reference Guide to Consent for Examination or Treatment.

You must have consent or other authority before examining, investigating or treating a child or young person. Unaccompanied minors may be able to consent to their own treatment however it is always good practice to attempt to contact their parents/guardians for a history and to communicate follow-up management.

In the UK, children and young people, including unaccompanied minors, can consent to treatment if they are deemed [Gillick Competent](#), meaning they can:

- understand the nature, purpose, benefits, risks and consequences of not proceeding;
- retain the information discussed;
- use and weigh this information, and
- communicate their decision to others.

A child or young person with capacity to consent, who refuses, should have their decision respected unless there are exceptional circumstances.

Young people over 16 years should be assumed to have capacity unless there is reason to believe that they have an impairment of mind or brain that affects their capacity for the specific decision at the specific time. If there is doubt about capacity, an assessment of capacity should be undertaken.

Young people aged 16 years or over who are assessed to lack mental capacity for a specific decision at a specific time should have an Independent Mental Capacity Advocate appointed, with the [best interests decision-making process](#) of the [Mental Capacity Act 2005](#) followed. More information on Mental Capacity and Best Interests can be found in the [Disability Matters](#) eLearning Package. Or from your local safeguarding team

*Kent have produced an Initial Health Assessment information leaflet for UASCs, a podcast and a consent form, translated into four different languages. Please see the Kent UASC health website.*

## Confidentiality

As for all children and young people, it should be explained that in the UK health information is recorded on a computer health system and shared with other health professionals, such as the GP and health visitor, and that health information may be shared with other agencies such as school and social services.

It should also be explained that details will not be shared with outside agencies such as legal or immigration officials unless the young person/family consent to this. A copy of the care plan and any information shared with other professionals should be sent to the young person/family in the usual way.

More detailed information about confidentiality is provided in the [Child Protection Companion](#) and the [GMC](#) also provide guidance on this. [Caldicott principles](#) on record keeping and information sharing should be followed.

The Kent IHA information leaflet for UASCs includes a section on confidentiality.

## The initial health assessment:

The statutory Initial Health Assessment should be a thorough and rounded one, and commence with a detailed history, as for any child seen by a well-trained paediatrician.

### AIMS OF THE IHA FOR uasc

- To identify any immediate health needs
- To facilitate effective multi agency planning for the young person.
- To promote the health and wellbeing.
- To fulfil the statutory requirement for health assessment of looked after children.
- To inform agencies who have a corporate parenting responsibility of the health needs of the young person.
- To facilitate effective multi agency planning for looked after children.
- To provide aggregated data to inform community health needs assessment for looked after children.

It is important to allow sufficient time to gather a comprehensive set of information at the initial meeting. This prevents the possibility that a child, young person or family may have to relive trauma and loss repeatedly.

*In Kent, 90 minutes has been allowed per Initial Health Assessment in accordance with BACCH and CoramBAAF guidance.*

Paediatricians should aim to understand the political circumstances of the child, young person or family's country of origin and countries of transit. A brief discussion will provide useful information as well as information about the processing of their asylum claims and any age determination issues. Ask about family members – many will have witnessed family members being killed.

Any assessment should include consideration of what has happened to the child, young person and/or family before entering the UK, en route and at their final destination.

Paediatricians should use a structured proforma to avoid missing any health needs. For the Kent work we have devised our own assessment tool in conjunction with teams who have had a lot of experience in undertaking UASC work and this template should be used. This can help guide the conversation, firstly by discussing with the young person straightforward issues such as demographics and then dealing with subjects that may cause more distress.

PLEASE SEE THE UASC Health website for further tools, guidance and templates including:

TEMPLATE IHA for UASC Assessment Tool

TEMPLATE IHA Summary Report and the

Completed example of IHA UASC Summary Report

## During the health assessment, Drs should check for and ask about the following:

### Demographic Details:

Please fill in all sections. Check the details given against the BAAF Form part A as there are often errors. Ask the young person for their DOB and check this against the BAAF form and document if there are any discrepancies. Fill in sections about legal status. Asylum status is usually the young person's greatest concern and when thinking about how the mental health needs of this population are

met we need to think of all the issues that affect the young person – clearly their stability in the UK will play a huge part in this. Due to capacity issues many will not have had a solicitor allocated to them to assist them through the asylum seeking process and it may be one of your recommendations that the child/YP speak to their social worker or independent advocate about this.

### **Journey Details:**

When thinking about future management whether that be of anaemia, TB risk or blood borne virus testing or risk of having been trafficked, it is important to gather information about the young person's journey to the UK. There is a later section in which to document experiences on route. It is important to sensitively explore the reasons why the young person left their homeland and which countries they have transited through and how. Explore how they managed to eat and drink etc. Many are reporting that they were captured and imprisoned. Ask about how this happened. Some talk about being in suicide bomber training camps – show professional curiosity and gather as much information as possible.

### **Education:**

Please ask about the young person's level of Education in their homeland and their use of English. This (together with your assessment of their independence skills) will help you to consider whether you feel that independent living is appropriate for them.

### **Past health**

Ask about surgery, illnesses requiring treatment, jaundice and fevers. Ask about medication, allergies and immunisations.

### **Preschool children (less likely to see but may see with foster carers):**

- Document perinatal history and any perinatal screening in the home country.
- If there is no history of neonatal screening such as the Guthrie, or hearing screening, be aware that treatable conditions such as hypothyroidism could be missed.
- It should not be assumed that developmental problems are solely due to the displaced and traumatic refugee experience.

### **Immunisations**

Many children and young people of refugee background will have unknown vaccination status, and paediatricians will need to assess the likelihood that standard immunisation protocols would have been followed in the child or young person's country of origin (Simmons and Merredew).

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

### **Dental Health:**

Many of the young people have poor dental health, and may be in pain. Ask if they have a tooth brush and access to tooth paste. Do they brush their teeth? Have they been given any information about dental hygiene? Find out if they have ever seen a dentist.

### **Vision and Hearing:**

Visual impairment has been a common presentation. Some may not be aware but some are complaining of visual symptoms. Ask if they have ever had their eyes tested. Some have experienced bombings/explosions and hearing damage as a result. Explore any concerns. Please test the young person's vision using a Snellen Chart.

### **Screening:**

You need to consider sickle cell status, any haemoglobinopathies, risk of TB and blood borne viruses.

## Family health

- Ask routine history on consanguinity, siblings and family illnesses.
- Siblings and parents may be in detention centres or placed with other families and it is helpful for the young person to know their location and contact details.
- You can raise the question of family members in the context of possibility of family tracing.

## Experiences:

Sensitively explore bereavement, loss, detention and torture.

## Lifestyle Assessment:

Please explore all areas – diet, independence skills, sexual health, budgeting, alcohol, smoking, drug use and exercise.

A number of factors should be taken into account with UASC and sexual health screening. Trauma relating events around rape and torture may be extremely traumatic for the child or young person. Information should be shared with other professionals when appropriate to avoid the child or young person having to repeat the information

## Mental health and emotional wellbeing

- Sleep and behavior disturbances may be common in younger children. Sleep disturbance and reversal of body clock has been frequently reported in the Kent cohort of UASCs. Please explore the young person's sleep patterns.
- Some young people may have been trafficked to the UK and/or experienced past traumas including as a child soldier; this group may suffer a range of psychosocial morbidities related to their experiences in their country of origin, their journey to the UK and entering the country.
- We are using the Moods and Feelings Questionnaire MFQ for this group of young people as this can be completed by the young person in clinic and is easy to score. Please see copy of the MFQ in the appendix. However the SDQ or another screening tool can be used. SDQs have been translated into a range of languages.
- If a child or young person is deemed to be at high risk of mental health difficulties an appropriate referral should be made to looked-after children's CAMHS. A score of 24 or more on the MFQ or 4 or more positive responses in the PTSD screen would indicate a high risk. This is usually the responsibility of the social worker but the Kent LAC CAMHS has agreed to provide a direct consultation with the clinician and then a referral if necessary. It is very important that the young person's social worker is made aware of any concerns and is informed of any referral to CAMHS.
- Mental health screening can be useful to identify (PTSD) and other difficulties such as problems with sleeping, anger or self-harm. It is essential that these questions are asked sensitively such as "this is a question that I ask all young people I see - have you ever hurt yourself or felt suicidal?" NICE guidance on management of PTSD in adults and children provides further details on screening of individuals involved in a major disaster, programme refugees and asylum seekers.
- PTSD screen – this is included in the IHA UASC assessment tool. Please ask all questions. Given their experiences asylum seeking children are at risk of Post-Traumatic Stress Disorder (PTSD) and may require monitoring for up to 12 months.
- On arrival in a new country children, young people and families may experience bullying or racism, lack of social support and/or a lack of access to education which increases vulnerability.

## Social History:

Please explore the areas as indicated on the form. This is particularly relevant for those YP in independent living.

## Developmental screening:

- This is particularly important for the younger UASCs but please fill in if you have any concerns, particularly about social interaction.
- Document developmental milestones, play and learning, including schooling, learning difficulties, outstanding achievements and talents.
- Preschool children should be referred for developmental assessment and further follow up if there are any concerns.

## Physical health

Undertake a complete systems examination including overall appearance, vision, hearing, chest, gut, skin, neurology, co-ordination, gait, cardiac, dental care, assessment of puberty (if indicated) and nutrition. Also check BP and vision.

## Growth and nutrition:

- Document height weight and head circumference using current RCPCH centiles.
- If malnutrition is suspected, document mid arm circumference.
- Look for signs of vitamin deficiency including scurvy/thiamine.
- Ask about diet and constipation.
- Some young people may have experienced extremely poor diets in transfer to the UK, and often do not know how to cook for themselves.
- Many young people arriving in Kent have developed gastrointestinal symptoms upon refeeding so this needs to be explored and an appropriate feeding regime established.

## Other:

- Signs of conditions such as scabies and lice should be sought and documented.
- Injuries should be documented carefully using a body map (see appendix).
- If a sea journey was involved, ask about any near drowning/resuscitation episodes.

## Writing the health care plan:

**The Health Care Plan is a key outcome of the IHA. Avoid medical terminology and make it very clear what has to be done, by when and who is responsible i.e. Fill in all the sections on the health care plan template.**

The child's social worker is responsible for implementing Health Action Plans for [Looked After Children](#), and will do this with the assistance of the named health professionals identified in the Health Assessment and the Designated nurse. Specific responsibilities of the staff/carers will also be identified in the Plan.

- The Young Person's [Independent Reviewing Officer](#) is responsible for reviewing each child/young person's Health Action Plan at the time of each LAC review to ensure health needs identified in the HAP have been followed up.
- Each Looked After Child's [Placement Plan/Placement Information Record](#) must incorporate the Health Action Plan.



- The HAP will be reviewed after each subsequent Health Assessment or if health circumstances change, and at every Looked After Review.
- *The Kent forms have pre-populated fields to make this an efficient process. Delete any that are not relevant and add any additional. Please see below for example:*

**HEALTH CARE PLAN** (Examining clinician to circle those relevant / delete if not)

**CHILD / YOUNG PERSON'S NAME:**

**DATE OF BIRTH:**

**DATE OF NEXT HEALTH ASSESSMENT: .....***Please put a date in e.g. March 2017 (in 12 months time)*

Issues	Action required	By when	Named person responsible
<b>This young person is not fully immunised</b>	Immunisations as per the current UK schedule	<b>Please add a reasonable date by which time the action should have been achieved</b>	Assessing clinician to write to GP to request immunisations
<b>This young person requires TB screening</b>	TB screening		Assessing clinician to write to GP to request TB screening
<b>This young person is considered at risk of blood borne viruses</b>	Blood testing for HIV, Hepatitis B, C and Syphilis		Assessing clinician to write to GP to request blood tests
<b>There are concerns about this young person's vision</b>	Visual assessment by optician required		Personal adviser to assist young person in attending opticians
<b>There are concerns about this young person's hearing</b>	Audiology screening		Assessing clinician to write to GP to request audiology screening
<b>This young person appears anaemic</b> Or <b>This young person appears anaemic and their sickle cell status is unknown</b>	Full blood count and ferritin  Haemaglobinopathy screen		Assessing clinician to write to GP to request blood tests
<b>There are concerns about this young person's dental health</b>	Dental assessment		Personal adviser to arrange appointment with a dentist
<b>This young person has experienced significant trauma / loss and has symptoms of PTSD and/or depression</b>	Referral to CAMHS		Assessing clinician to write to GP to request referral to CAMHS
<b>This young person has given a history of likely torture and is experiencing related</b>	This young person requires a referral to specialist services		Assessing clinician to write to GP to request referral to specialist services such as Freedom from Torture

<b>difficulties</b>		
<b>This young person has been found to have a heart murmur</b>	GP to assess and if appropriate arrange investigation	Assessing clinician to write to GP asking for an appointment
<b>This young person requires support in tracing their family</b>	This young person should be referred to Red Cross family tracing	Personal adviser to liaise with young person and refer to Red Cross family tracing
<b>This young person has a history suggestive of being trafficked and at risk of exploitation</b>	This young person should be referred to appropriate support services such as Refugee Council Trafficked girls or boys projects	Personal adviser to liaise with young person and refer to Refugee Council Trafficked girls or boys projects
	Yes/No	
<b>Allergies</b>		
<b>Immunisations up to date</b>	Yes/No	
<b>Registered with GP</b>	Yes/No	
<b>Permanently registered with GP</b>	Yes/No	Name:
<b>Registered with Dentist</b>	Yes/No	Name:

### Completing the Health Action Plan:

The Health Action Plan will set out what the health and /or emotional issues are for the child/young person, how the health and emotional needs will be addressed and by whom. IN Kent we have adopted the following:

1. **Are immunisations required?** If you recommend an action please write a letter to the GP/HV to ask that this is done – don't just assume that they will read the HCP and realise that they are responsible for a certain action.

The following principles as outlined by Public Health England (PHE) should be followed for individuals with uncertain or incomplete immunisation status (PHE, 2015):

- Unless there is a reliable vaccine history, individuals should be assumed to be unimmunised and a full course of immunisations planned.
- Individuals coming to UK part way through their immunisation schedule should be transferred onto the UK schedule and immunised as appropriate for age.
- If the primary course has been started but not completed, continue where left off – no need to repeat doses or restart course.



- Plan catch-up immunisation schedule with minimum number of visits and within a minimum possible timescale – aim to protect individual in shortest time possible

Further detail contained in PHE's Guidance on Vaccination of individuals with uncertain or incomplete immunisation status ([www.gov.uk/government/uploads/.../PHE\\_algorithm\\_Sep15.pdf](http://www.gov.uk/government/uploads/.../PHE_algorithm_Sep15.pdf))

2. **Please select TB screening** in all cases as they are all considered at risk either as a result of their country of origin or because of the countries that they have transited through and the conditions they have experienced. Please ask the GP to arrange (or refer to TB nurse – see TB section **or** follow local guidance and procedure. There are translated leaflets available for young people about TB screening. Note, TB screening is recommended in these young people even when a BCG scar is visible.
3. **Are blood borne virus blood tests required?** Due to countries of origin and countries that they have travelled through and potential experiences en route. *KENT BBV testing was considered advisable in all situations. An information leaflet and consent form, translated into different languages, together with a podcast has been developed in Kent and are available on the website.*
4. **Vision** – if you ask for an optician appointment please write to the personal adviser to recommend.
5. **Audiology:** If a hearing test is required please ask the GP to arrange or follow local guidance and procedure.
6. **FBC/ sickle cell** etc. We have decided against routine sickle cell test and haemoglobinopathy screening unless there has been a relevant history or the young person is **anaemic** in which case please ask GP to arrange.
7. **Skin:** Suspicion/diagnosis of infestations such as scabies and/or lice should be promptly notified to the GP with a suggested prescription in the referral letter as well as any other recommendations for infectious diseases screening e.g. TB screening or sending stools for culture and parasites if symptoms indicate.
8. **Gastrointestinal symptoms:**
9. **Dental concerns:** All children/YP need to have a dental check-up, please request that the young person's Personal Adviser arrange a dental appointment and write to request this.
10. **Trauma/PTSD:** If CAMHS is required (likely) then the current process is for the young person's SW to refer to LAC CAMHS. *KENT We now have agreement to have a direct consultation with CAMHS and to then make a referral if required but the young person's social worker must be informed.*
11. **Torture:** If there is a history of torture please make a referral to Freedom from Torture – see appendix for guidance and referral form.
- 
12. **Family Tracing:** Please recommend family tracing via the Red Cross. Many will be reluctant to do so as they will be concerned that this will identify their family members to authorities in their homeland and put them in danger.
13. **Safeguarding:** The plan should outline any safeguarding issues including vulnerability to exploitation. Please be aware of trafficking as a possibility and if you are concerned inform the Social worker and make a referral to the Refugee Council – see appendix for referral form
14. **Other:** There is blank space for any other recommendations required

## General guidance on completing health care plans:

- If referrals are required it must be very clear who is doing what and when and write to the relevant person (*Kent pre-populated templates provided*)
- Make it clear when the next health assessment is due, who it should be with (e.g. Dr or nurse) and where. E.g. August 2015 with LAC nurse.
- Fill in the sections on allergies/imms/GP reg for reporting purposes
- *KENT For ease of admin given the remote working we are asking for DRs to type up the assessment. As much as possible will have been pre-populated to make this efficient.*

## Report Distribution:

- The report needs to be available within 20 working days of the YP arriving in the UK (Statutory timeframe).
- *Kent: There is a summary template which you can copy sections of your assessment on to, which must be typed and distributed as follows.*
- Copy list –
  - Young Person – full assessment
  - GP- full assessment and letter highlighting actions required
  - Personal Adviser – Health care plan and letter highlighting actions required
  - Social worker – full assessment or summary and letter highlighting actions required
  - *Kent's Children in Care Co-coordinator Team*

# Section 2: Managing health needs

## Immunisations:

Many children and young people of refugee background will have unknown vaccination status, and paediatricians and or GP will need to assess the likelihood that standard immunisation protocols would have been followed in the child or young person's country of origin (Simmons and Merredew).

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

The following principles as outlined by Public Health England (PHE) should be followed for individuals with uncertain or incomplete immunisation status:

- Unless there is a reliable vaccine history, individuals should be assumed to be unimmunised and a full course of immunisations planned.
- Individuals coming to UK part way through their immunisation schedule should be transferred onto the UK schedule and immunised as appropriate for age.
- If the primary course has been started but not completed, continue where left off – no need to repeat doses or restart course.
- Plan catch-up immunisation schedule with minimum number of visits and within a minimum possible timescale – aim to protect individual in shortest time possible.

Further detail contained in PHE's Guidance on Vaccination of individuals with uncertain or incomplete immunisation status.

[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/525952/PHE\\_algorithm\\_Sep15.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/525952/PHE_algorithm_Sep15.pdf)



## Blood borne virus infections:

The majority of the countries of origin of our UASCs have high risks for BBVs and the young people are also deemed at risk because of the experiences that they may have had during their journey to the UK.

Please refer to the following guidelines for the screening of blood borne infections:-

a) Guidelines for the testing of looked after children who are at risk of a blood-borne infection issued jointly by BAAF and NCB

b) British Association for Sexual Health and HIV Guidelines

<http://www.bashh.org/BASHH/Guidelines/Guidelines/BASHH/Guidelines/Guidelines.aspx>

c) Kent: Local guidelines have been produced based on the above.

A detailed list of countries of origin and information regarding migrant health can be found at <https://www.gov.uk/government/collections/migrant-health-guide-countries-a-to-z>

Afghanistan	This country has an intermediate prevalence of hepatitis B. This country has a considerably higher prevalence of hepatitis C than the UK
Eritrea	This country has an intermediate prevalence of hepatitis B. This country has a considerably higher prevalence of hepatitis C than the UK
Ethiopia	All patients from this country should be offered and recommended an HIV test This country has an intermediate prevalence of hepatitis B.
Iran	This country has an intermediate prevalence of hepatitis B.
Kuwait	This country has an intermediate prevalence of hepatitis B. This country has a considerably higher prevalence of hepatitis C than the UK
Sudan	This country has an intermediate prevalence of hepatitis B. This country has a considerably higher prevalence of hepatitis C than the UK All patients from this country should be offered and recommended an HIV test
Syria	This country has an intermediate prevalence of hepatitis B.
Vietnam	This country has an intermediate prevalence of hepatitis B. This country has a considerably higher prevalence of hepatitis C than the UK

## Anaemia & haemaglobinopathies

Many young people may not be aware of their sickle cell or thalassemia status but given their countries of origin would be at high risk. Universal screening of this group has not been recommended but should be considered on a case by case basis – if there is a history of painful crises or the YP is presenting as clinically anaemic. It is more likely however that any anaemia noted is caused by malnutrition.



- The World Health Organization estimates that 2 billion people, over 30% of the world's population, are anaemic [1].
- Globally the most significant factor causing anaemia is iron deficiency, which is the most common and widespread nutritional disorder in the world.
- Where a migrant patient is found to be anaemic this should be investigated as for any patient. The determination of the cause is assisted by the blood film (microcytic, normocytic or macrocytic).
- Practitioners should be aware of the range of causes of anaemia that may be particularly pertinent to some migrant patients. These include not only iron deficiency but also [haemoglobin disorders](#) and a wide range of infections to which some migrants may be at higher risk.
- The treatment of anaemia should be based on its underlying cause.
- There are [NHS antenatal screening programmes](#) for anaemia and [haemoglobin disorders](#).

## Background information

- Haemoglobin disorders are inherited blood diseases that affect how oxygen is carried in the body.
- They fall into two main categories: sickle-cell disease and thalassaemias.
- WHO estimates that each year over 300,000 babies with severe forms of these diseases are born worldwide; the majority in low and middle income countries.
- Approximately 5% of the world's population are carriers of a trait gene for sickle-cell disease or thalassaemia. As many as 25% of the population are carriers in some regions. Most carriers lead completely normal, healthy lives.
- Disease can occur only when a child inherits the trait gene from both parents (autosomal recessive inheritance).
- These conditions are most prevalent in tropical regions.
- Genetic screening and counselling is the main approach to prevention of haemoglobin disorders.
- NICE guidelines recommend antenatal screening for sickle cell diseases and/or thalassaemias for at risk women by ten weeks of gestation.

## Sickle cell disease

- Sickle-cell disease mainly affects African populations. The gene frequency is one in four in West Africans and one in ten in Afro-Caribbeans. Sickle cell genes are also common in Cyprus, Greece, Italy, the Middle East and in populations who originate from these areas.
- Sickle cell disease is the most common genetic condition in England. One baby in every 2,000 is born with the condition and it is estimated that there are around 12,500 people with sickle cell anaemia in England.
- In sickle cell disease the haemoglobin is abnormal (HbS). It leads to misshapen red blood cells, which have a reduced lifespan and which can cause blockages in small blood vessels. This can lead to:
  - anaemia
  - acute painful 'crises'
  - severe bacterial infections e.g. pneumonia
  - tissue infarction e.g. stroke
- Diagnosis is on the basis of history and blood examination; low haemoglobin, usually around 8 or 9 g/dl, with normochromic normocytic anaemia, and sickle cells present in the blood film. The diagnosis is confirmed by identification of HbS by electrophoresis.
- Patients diagnosed with sickle-cell disease should be referred to specialist services for management.
- The condition can sometimes be cured by bone marrow transplant if there is a suitable donor. This only happens in about one in ten cases.
- Management is based on avoiding factors that may precipitate a crisis through:
  - High fluid intake

- Healthy diet with folic acid supplementation (especially during pregnancy)
- Prophylactic penicillin and pneumococcal vaccination
- Prompt use of antibiotics for infections
- Prevention of vascular stasis and avoidance of the cold
- While sickle cell trait confers some protection against [malaria](#), antimalarials should still be taken if travelling to a malaria risk country. Those with sickle cell disease are very susceptible to severe malaria and travel to malaria risk areas should be discouraged. Renal and liver function should be taken into consideration before prescribing anti-malarials.
- Specialist treatment is required when painful or other crises occur.

## Thalassaemias

- Thalassaemias are the commonest genetic disorders in the world and occur with a very high frequency in a tropical belt extending from Africa, throughout the Mediterranean region, the Middle East, the Indian subcontinent, and throughout South West Asia.
- There are two major types of thalassaemia, alpha and beta, which are named for the two protein chains that make up normal haemoglobin. Alpha and beta thalassaemias lead to variable production of abnormal haemoglobin and have both mild and severe forms. Beta thalassaemia major is the most common and severe form of the condition in the UK.
- The carrier incidence of beta thalassaemia in the UK amongst different Asian communities varies from around one in seven to one in 30. Eight out of ten babies born with beta thalassaemia major in the UK have parents of Indian, Pakistani or Bangladeshi ancestry.
- People with more severe types of thalassaemia are not able to make enough haemoglobin, which means that oxygen cannot get to all parts of the body. Organs then become starved for oxygen and are unable to function properly. Symptoms include:
  - Fatigue
  - Weakness
  - Shortness of breath
  - Jaundice
  - Bone deformities
  - Liver, spleen and gland damage
- Diagnosis is by history and blood test (hypochromic microcytic anaemia) with confirmation by haemoglobin electrophoresis.
- Patients diagnosed with thalassaemia should be referred to specialist services for management.
- Treatment of severe disease is mainly by regular blood transfusions to maintain haemoglobin levels.
- Secondary treatment is also required to manage iron overload resulting from multiple transfusions.
- Thalassaemias can sometimes be cured by bone-marrow transplantation where a suitable donor exists.

## Patient information (English only)

[A parent's guide to sickle cell disease](#) developed by the NHS Sickle Cell and Thalassaemia Screening Programme – [sct.screening.nhs.uk](http://sct.screening.nhs.uk)

Afghanistan	No specific risks
Eritrea	There is a high risk of anaemia in people from this country. Be alert to this possibility and test as clinically indicated.
Ethiopia	There is a high risk of anaemia in people from this country. Be alert to this possibility and test as clinically indicated.
Iran	No specific risks
Kuwait	No specific risks
Sudan	There is a high risk of anaemia in people from this country. Be alert to this possibility and test as clinically indicated.

Syria	No specific risks
Vietnam	No specific risks

## Tuberculosis

For a recent practice guideline See <http://www.bmj.com/content/352/bmj.h6747?sso=>

**Tuberculosis—diagnosis, management, prevention, and control: summary of updated NICE guidance**

### What you need to know

- Undertake tuberculosis (TB) testing in close contacts of people with pulmonary or laryngeal TB, people who are immunocompromised and at high risk of TB, and new entrants from high incidence countries who present to healthcare services
- Seek specialist input in the diagnosis and management of TB in children, and in the management of people with multidrug resistant TB or those with TB and comorbidities
- Consider enhanced case management, including directly observed therapy (DOT), in patients with clinically or socially complex needs
- Apply appropriate infection control measures if a person has suspected or confirmed infectious TB (pulmonary or laryngeal TB)

Afghanistan	Screen all new entrants from this country for TB
Eritrea	Screen all new entrants from this country for TB
Ethiopia	Screen all new entrants from this country for TB
	There is a high burden of Multi Drug resistant TB in this country
Iran	No specific risks
Kuwait	No specific risks
Sudan	Screen all new entrants from this country for TB
Syria	No specific risk but consider countries travelled through
Vietnam	Screen all new entrants from this country for TB
	There is a high burden of Multi Drug resistant TB in this country

**LIBYA** (as many will have travelled through Libya and/or spent periods of time here): Screen all new entrants from this country for TB

## Other Communicable diseases

- The prevalence and nature of bacterial and viral infections will vary across countries.
- A significant number of refugees and asylum seekers arrive from countries where blood-borne infections are highly prevalent, and/or they may have been at exposed to diseases on route to the UK. Paediatricians should consider the possibility of hepatitis, scarlet fever and malaria and refer appropriately.



Afghanistan	There is a risk of malaria in some areas of this country.  There is a risk of typhoid infection in this country.  Polio is <b>endemic</b> in this country. Be alert for <b>signs and symptoms</b> and ensure all new entrants are brought up to date with the <b>UK immunisation schedule</b> , including polio vaccine as required.
Eritrea	There is a high risk of malaria in this country.
Ethiopia	There is a high risk of malaria in some areas of this country  Polio cases have been reported
Iran	No specific risks
Kuwait	No specific risks
Sudan	There is a high risk of malaria in this country.
Syria	For children <5 years please obtain faecal samples for testing of polio virus
Vietnam	There is a high risk of malaria and typhoid in this country

### Be aware of unusual parasitic infections

#### SKIN CONDITIONS:

Tinea Versicolor:

<http://www.nhs.uk/conditions/pityriasis-versicolor/Pages/Introduction.aspx>



Scabies:

<http://www.nhs.uk/conditions/Scabies/Pages/Introduction.aspx>

<http://www.webmd.com/skin-problems-and-treatments/ss/slideshow-scabies-overview>

Infection related dermatological conditions in migrant patients					
Bacterial Skin infections	Creeping Eruptions	Ulcers	Pruritic conditions	Systemic rash with fever	Urticaria



Infected bites Impetigo Cellulitis Folliculitis	Cutaneous larva migrans Scabies Strongyloidiasis (larva currens) Loiasis Gnathostomiasis	Infected insect bites Cutaneous leishmaniasis Rickettsial tick eschar Spider bites Cutaneous diphtheria Cutaneous anthrax M. ulcerans Mycetoma Sexually transmitted infections Genital herpes	Insect bites Contact dermatitis Dermatophytosis Cutaneous larva migrans Scabies Cercarial dermatitis Marine creature contact dermatitis	Consider referral to specialist centre: HIV seroconversion illness Drug reactions Dengue Chikungunya Measles Rubella VHF Rickettsial infection Typhoid Syphilis Meningococcaemia Leptospirosis	Many non-travel/infection related causes, e.g. drug allergy. Helminth infections e.g. Acute schistosomiasis Strongyloidiasis
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## Sexual and reproductive health

- Asylum seeking children may have experienced rape and torture and some may have worked as commercial sex workers either before, en route to, or following arrival in the UK, while others will have been in consensual sexual relationships (BAAF Practice Note 53).
- Paediatricians should carry out a full sexual health review including questions about whether a young person is sexually active and whether they are pregnant as well as discussing contraceptive options. Ideally this should be carried out in the context of a comprehensive assessment, and in association with the local Genito Urinary Medicine service ([BAAF Practice Note 53](#)).

Afghanistan	No specific risks
Eritrea	No specific risks
Ethiopia	Sexually active individuals should be offered full sexual health screen and safer sex health promotion advice.
Iran	No specific risks
Kuwait	No specific risks
Sudan	Sexually active individuals should be offered full sexual health screen and safer sex health promotion advice.
Syria	No specific risk but consider countries travelled through
Vietnam	No specific risk



## Vitamin deficiencies:

### Vitamin a deficiency

- Vitamin A deficiency is extremely rare in the indigenous UK population but is a serious public health concern in many low income countries, particularly in Africa and South East Asia.
- Young children and pregnant women from low-income countries are most likely to be affected.
- Practitioners should be alert to the possibility of vitamin A deficiency in at risk migrant patients and where they suspect it may wish to seek advice on appropriate diagnosis and management from their local endocrinology or paediatric team.
- Vitamin A has teratogenic effects in overdose and the Department of Health recommends that pregnant women, or women who may become pregnant should not be advised to take supplements containing vitamin A and should not eat foods rich in vitamin A such as liver and liver based products.

### VITAMIN D DEFICIENCY

- In addition to the characteristic skeletal disorders resulting from vitamin D deficiency, low vitamin D status has been increasingly associated with a wide range of health problems; however the evidence is inconclusive at present.
- Sunlight is the major source of vitamin D and dark skinned individuals or those who for cultural or religious reasons cover their whole bodies when outdoors are at risk of deficiency, as are those whose diets (vegetarian/vegan) do not contain an adequate vitamin D supply.
- Low status is particularly likely during the winter months for people living in the UK, particularly among those who are dark skinned, wear concealing clothing or are housebound. In the winter months in the UK there is no sunlight of appropriate wavelength for synthesis of vitamin D via the skin and the population relies on body stores and dietary intake.
- Practitioners should be alert to the possibility of vitamin D deficiency in migrants who have the above risk factors and test and treat them appropriately.
- Supplementation is advised for pregnant and breast feeding women and for infants from one month to four years, especially in at risk groups. People of Asian origin, older people and people who rarely go outdoors or who always cover all their skin when they are outdoors, should also consider taking vitamin D supplements.

Afghanistan	Consider Vitamin D deficiency in individuals who may be at risk as a result of their diet, skin colour or lack of sun exposure.  There is a high risk of vitamin A deficiency in this country.
Eritrea	Consider Vitamin D deficiency in individuals who may be at risk as a result of their diet, skin colour or lack of sun exposure.  There is a high risk of vitamin A deficiency in this country.
Ethiopia	Consider Vitamin D deficiency in individuals who may be at risk as a result of their diet, skin colour or lack of sun exposure.  There is a high risk of vitamin A deficiency in this country.
Iran	Consider Vitamin D deficiency in individuals who may be at risk as a result of their diet, skin colour or lack of sun exposure.
Kuwait	Consider Vitamin D deficiency in individuals who may be at risk as a result of their diet, skin colour or lack of sun exposure.
Sudan	Consider Vitamin D deficiency in individuals who may be at risk as a result of their diet, skin colour or lack of sun exposure.  There is a high risk of vitamin A deficiency in this country.
Syria	Consider Vitamin D deficiency in individuals who may be at risk as a result of their

diet, skin colour or lack of sun exposure.

There is a high risk of vitamin A deficiency in this country.

Vietnam	Consider Vitamin D deficiency in individuals who may be at risk as a result of their diet, skin colour or lack of sun exposure.
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## Mental health needs:

- Remember that mental health problems may present in different ways in people from different cultures e.g. with physical rather than emotional symptoms.
- Always use a professional [interpreter](#) to explore mental health issues rather than a family member or friend, and familiarise yourself with both the [cultural background](#) and individual understanding of the patient.
- Be alert to the possibility of post traumatic stress disorder in both adults and children and manage according to NICE guidelines.
- Mental health is fundamental to health; mental health affects physical health and physical health affects mental health. The two are inseparable in overall wellness.
- Standard One of the [National Service Framework for Mental Health](#) (Department of Health, 1999) requires health and social services to promote mental health for all, working with both individuals and communities.
- Although most migrants will not suffer from mental health problems, some may be at increased risk as a result of their experiences prior to, during, or after migration to the UK. Milder mental health issues such as 'home sickness', anxiety or sleep disorders may arise for anyone who is separated from family and friends, or integrating into a new community or culture. For some migrants more serious problems may arise as a result of traumatic experiences in their past. The whole spectrum of mental health problems and substance misuse issues common in the indigenous UK population are also common in all regions of the world, affecting every community and age group.
- Practitioners looking after migrant patients should remain alert to the possibility of mental health problems and be aware that they may present in unfamiliar ways. For example some people may express psychological distress in a very physical manner ('somatisation') i.e. descriptions of physical symptoms rather than directly talking about feelings. It is also important for practitioners to remember that they may bring with them their own socio-cultural constructs in determining what is normal and abnormal experience and hence in diagnosing mental illness.
- Social support can be beneficial for anyone's mental health. Try to find out what groups might exist in your local area for particular communities so that you can signpost them to new arrivals.

## Post traumatic stress disorder

Some migrants may be affected by post-traumatic stress disorder (PTSD), which develops following a stressful event or situation of an exceptionally threatening or catastrophic nature, which is likely to cause pervasive distress in almost anyone. PTSD sufferers may not present for treatment for months or years after the onset of symptoms despite the considerable distress experienced, but PTSD is a treatable disorder even when problems present many years after the traumatic event. PTSD may present with a range of symptoms including re-experiencing, avoidance, hyper-arousal, depression, emotional numbing, drug or alcohol misuse and anger as well as unexplained physical symptoms. Children may present with sleep disturbance. All those suffering from PTSD should be offered the opportunity to benefit from psychological interventions. This can be achieved by the use of interpreters and bicultural therapists.

For more information on recognition and for management guidelines please see the [NICE guideline on post traumatic stress disorder](#).



## Other useful resources

[Mothertongue](#) - multiethnic counselling and listening service is a culturally sensitive, professional counselling service where people are heard with respect to their chosen language.

[Refugee council](#)

[Freedom from Torture](#) - Medical Foundation for the Care of Victims of Torture

[Mind](#) - mental health support for patients and information for health professionals on certain migrant groups in the UK

[Diverse Minds](#) - Black and minority ethnic mental health. Diverse Minds also works with refugee organisations and health providers across England and Wales to improve access to mental health support for refugees and asylum seeker communities.

[Asian Women, Domestic Violence and Mental Health - A Toolkit for Health Professionals](#) by EACH

[Helen Bamber Foundation](#) - working with survivors of cruelty

[Rethink](#) - mental illness charity

[Chinese Mental Health Association](#) - provides a range of services and accepts referrals from GPs and health professionals.

## Vision and hearing

- Remember that communication problems may not just reflect a language barrier. Check that there is no issue with hearing impairment.
- Detecting and responding to hearing impairment in babies and young children is vital for the development of speech and language.
- Provide information to new patients about optician services in the UK.
- Immediately necessary ophthalmology treatment is exempt from charge under the [National Health Service \(Charges to Overseas Visitors\) Regulations 2011](#)

## Hearing

- WHO report that globally, 278 million people are estimated to have moderate to profound hearing loss in both ears [1].
- Eighty percent of deaf and hearing-impaired people live in low and middle income countries and at least half of the total burden is preventable (middle ear infections, excessive noise, inappropriate use of certain drugs, problems during childbirth and vaccine-preventable infections).
- Properly fitted hearing aids can improve communication in at least 90% of people with hearing impairment but in developing countries, fewer than one in 40 people who need a hearing aid have one.
- Hearing impairment in children may delay development of language and cognitive skills, which may hinder progress in school. In adults, hearing impairment often makes it difficult to obtain, perform, and keep jobs. Hearing impaired children and adults are often stigmatized and socially isolated.
- Availability of audiology services is enormously variable between and within countries globally. It is possible that some migrants may have hearing difficulties that have not been detected/assessed/properly managed prior to arrival in the UK.



## Vision

- WHO figures state that about 314 million people are visually impaired worldwide, 45 million of whom are blind [2].
- About 85% of all visual impairment is avoidable globally and about 87% of the world's visually impaired live in developing countries.
- Most people with visual impairment are older, and females are more at risk at every age, in every part of the world.
- Although the number of people blinded by infectious diseases has been greatly reduced, age-related impairment is increasing and, other than in high income countries, cataract remains the leading cause of blindness globally.
- Correction of refractive errors with spectacles could give normal vision to more than 12 million children (ages five to 15), but this option is not available to many.
- Availability of optician/ophthalmology services is enormously variable between and within countries globally. It is possible that some migrants may have visual problems that have not previously been properly addressed prior to arrival in the UK.

## References

1. World Health Organization. [Deafness and hearing impairment factsheet](#)
2. World Health Organization. [Visual impairment and blindness factsheet](#)

## Safeguarding and child protection issues

- Clinicians should also assess a young person's vulnerabilities to sexual exploitation and risk of trafficking.
- Exposure to violence and rape and other trauma should be explored sensitively. Not all young people are able to disclose on first assessment if they have been raped and this will need careful inquiry, e.g. 'Some young people say that they have been injured or raped. Has that ever happened to you?' This line of questioning should apply to young women as well as young men.
- Clinicians should ask girls/young women if they have been subjected to female genital mutilation (FGM). They should be informed that FGM is illegal in the UK, including when a child is taken out of the country for the procedure, and be provided with a copy of the FGM health passport ([www.gov.uk](http://www.gov.uk)). If they have been "cut", a referral should be made to a local specialist unit for a follow-up assessment. See the RCPCH FGM webpage for further information, including mandatory reporting and recording requirements.
- Clinicians should also be alert to the possibility of radicalisation and to consider making a Prevent referral.
- Clinicians should ask about current experiences of bullying or racism and consider whether and how a lack of social support or educational place may also increase their vulnerability.
- Safeguarding concerns may also arise following an unsafe environment for the child in temporary accommodation or due to neglect or physical abuse.
- Further information about safeguarding refugees and asylum seeking children can be found in the RCPCH Child Protection Companion.

## Trafficking:

**Trafficking:** Trafficking- is the recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation shall include, at a minimum, the exploitation of the prostitution of others or

other forms of sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude or the removal of organs ([UNODC website, 2000](#)).

For information about warning signs see:

<http://www.stopthetraffic.org/uk/page/spot-the-signs>

[There may also be local guidance and policy which you will need to follow.](#)

## Cse:

Please be aware of the following guideline and assessment tool:

<http://www.bashh.org/documents/Spotting-the-signs-A%20national%20proforma%20Apr2014.pdf>

There may also be local guidance, policy and tools which you will need to follow.

## Prevent:

### **Please follow your local guidance**

As part of your mandatory training you will have received information on local policy and referral forms

## Health Promotion:

Health promotion messages are important and paediatricians play an essential role in providing early health promotion messages to young people.

Messages should concentrate on well-established areas such as healthy eating, smoking, how to stay safe and avoid danger, good sexual health (including how to access sexual health services) and when to access GP services. Health promotion messages should be continued by other health care professionals, including specialist nurses for looked-after children and school nurses.

## Social Health and Wellbeing

### Young people:

Enquire about a young person's social networks. This should include questions about who they can talk to; have they started to make friends; do they want to access faith or cultural groups; do they know about college placement or local sports access as a way of starting to carry out normal activities to support good mental health.

Encourage and support resilience as well as addressing painful issues and ask about aspirations should the child/young person not be caught up in war.

Sometimes the views and wishes of the young person may be at odds with carers or social workers. Often there is a cultural reason or misunderstanding for this. Having an interpreter present gives an opportunity when the carer and young person are brought together (with the young person's permission) to allow some of these issues to be addressed in a way that acknowledges their needs, together with those of the carer or society, order to make their future easier.

Remember that a young person's expectations can be very different in different cultures, and they may also have had difficult experiences with people in a position of authority in the past.



It is recommended that you also talk to the child, young person or family about their past experience of education.

**With thanks to the RCPCH UASC web based guidances, The Migrant Health Guide and the BAAF publication on Promoting the health of Looked After Children (Chapter on UASCs written by Ann Lorek).**

