NHS
Kent and Medway
Clinical Commissioning Group

Early health outcomes of unaccompanied children in the care of Kent County Council

Dr Rosaleen Odoherty
General Practitioner Registrar

Naomi Finch
Commissioning Project Lead Looked After Children's Team

Dr Sue Leather
Designated Doctor Looked After Children Kent and Medway

Contents

Rationale for audit

The Kent Public Health Observatory undertook a Health Needs Analysis (HNA) of unaccompanied children seeking asylum in April 2016.[1] This had a number of recommendations including ongoing data collection. An important limitation to the HNA was identified as the incomplete follow up information regarding the prevalence of conditions such as chronic Hepatitis B and latent Tuberculosis (TB) that had been modelled as a significant risk within this cohort of young people.

There was a recommendation that providers of Initial statutory health assessments (IHAs), which include initial investigations, should be asked to report on the outcomes of these tests, so that the true epidemiological needs of this cohort could be better understood. Review statutory health assessments (RHAs) are undertaken one year after the IHA for all young people under 18 years. These assessments are undertaken by Looked After Children Specialist Nurses. They have access to the provider health records and also contact the General Practitioner (GP) ahead of the review appointment so they have as full health information as practically possible.

The Kent and Medway Looked After Children's Designate team data collection project was set up to ascertain:

- the identification of ongoing health issues at RHAs and
- the recording of outcomes of recommendations made at IHA

It was hoped that the project would contribute to the developing understanding of the overall health needs of the cohort of vulnerable young people so that practical measures could be proposed to improve health outcomes.

Method of audit

Reports were requested from the providers of the Looked After Children's Specialist health service in Kent. Anonymised data was collated from the Looked After Children's health team records of IHAs and RHAs of Unaccompanied children and young people cared for by Kent County Council. Doctors and a project lead participated in inputting data in a wide range of health related factors identified. The data was re-checked and cases excluded from analysis were there was insufficient data available or reports had not been sent. The audit included data from a total of 146 unaccompanied minors that comprised some of the children and young people who were newly arrived, unaccompanied asylum seeking children in Kent during 2015 - 2016.

[1] *Health Needs Assessment – Unaccompanied children seeking asylum R Coyle, S Bennett.* Kent County Council. 2016 https://www.kpho.org.uk/__data/assets/pdf_file/0011/58088/Unaccompanied-children-HNA.pdf

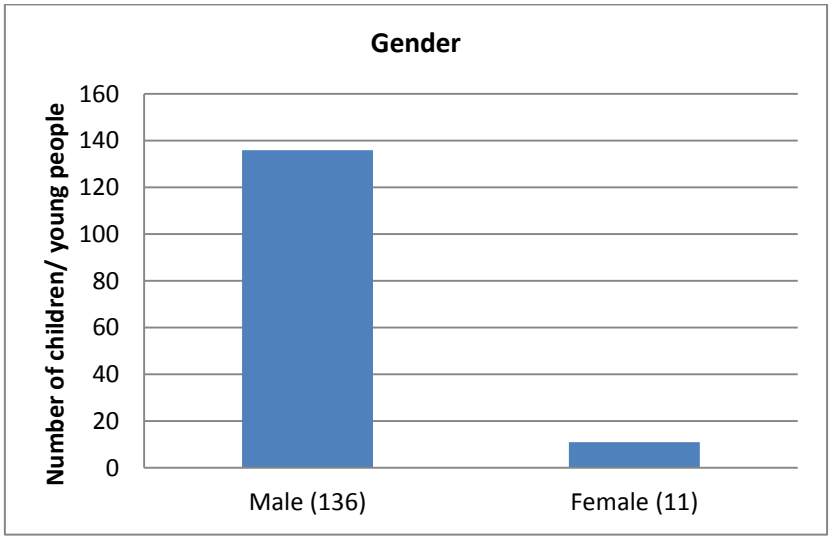
Findings

Characteristics of the cohort audited

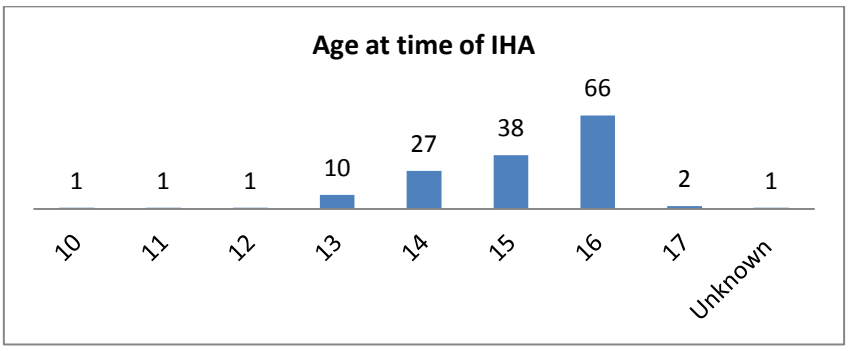
Globally there are over 26 million refugees.[2] Of all the 79.5 million people displaced, including those internally displaced, 40% are children. Among these children are a significant proportion of unaccompanied or separated children. 25,000 children applied for asylum worldwide having arrived in a 'safe' country without a parent or guardian. Although UK is not overall a 'top' destination for asylum seekers, it does receive applications from over 2,800 unaccompanied minors each year.[3]

Kent County Council received 984 newly arrived unaccompanied asylum seeking children in 2015, with 213 arriving in October alone. Pre 2014 numbers had been 150 – 200 received annually.

The majority of unaccompanied children in this cohort are male.

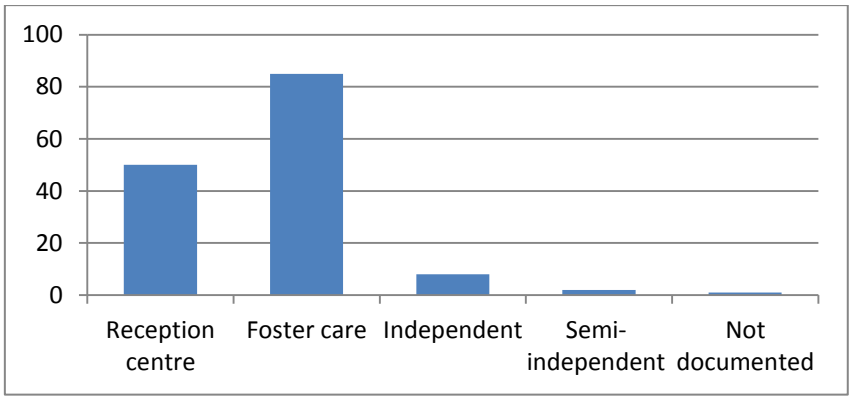


The unaccompanied young people studied were predominately aged between 14 to 16 years old on arrival in the UK. This was a slightly younger cohort that the age spread of all newly arrived young people seeking asylum. This would be due to older young people having been excluded from this data collection having reached 18 years old within one year of arrival in the UK and therefore not being eligible for a statutory health review.

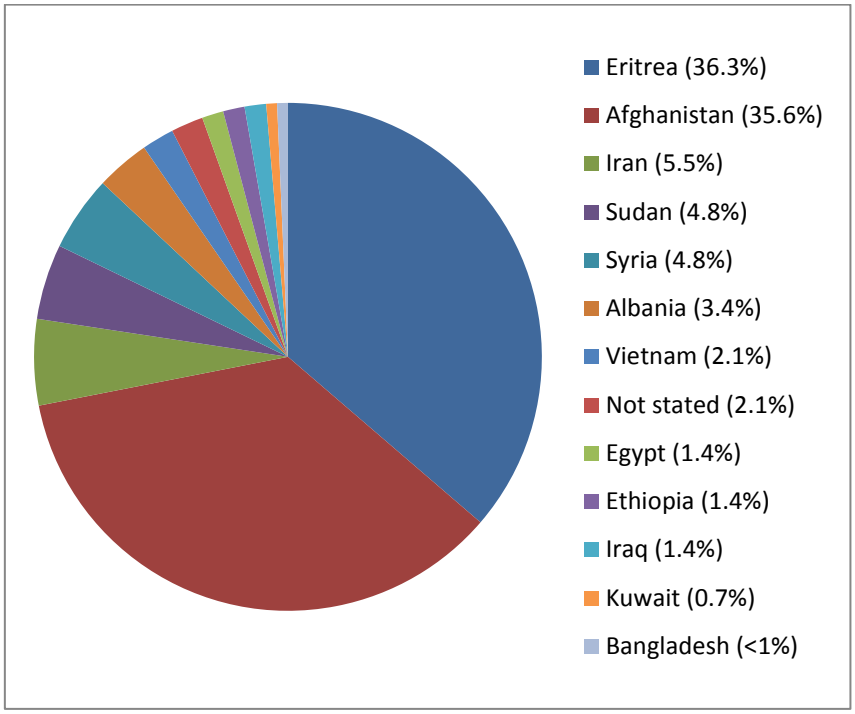


[2] *UNHCR statistics*
[3] *Facts about separated children.* Refugee Council. https://www.refugeecouncil.org.uk/information/refugee-asylum-facts/separated-children-facts/

The younger age group is reflected in the accommodation type at IHA with a significant number of young people recorded as in foster care at that time. Kent County Council accommodates all unaccompanied girls, all boys 15 years and under and any identified as vulnerable in foster care placements. Most of the older boys are initially accommodated in reception centres and then in shared accommodation with other unaccompanied minors.



The young people are predominantly from countries of origin in conflict and those from Eritrea and Afghanistan make up 105 (72%) of the cohort of 146. A further 22 (15%) are also from countries or origin in conflict - a combination of Iran, Sudan and Syria.



The different languages spoken were diverse and predominantly Tigrinya (49), Pashto (40), Arabic (16), Dari (9) and Kurdish Sorani (7). The religion of the young people was not recorded in either IHA or RHA in 25% of cases (37). Of the whole cohort 49.5% of the young people were recorded as Muslim (67) and 28.1% as Christian (41) – with the majority Christian Orthodox (27).

Familial risk factors

Very few children or young people reported a familial health risk. There was one young person with a possible family history of mental illness; six young people gave a family history of heart disease or hypertension; two young people had a close family member who had had Hepatitis and one mother was reported as having had TB; two had a close family history of diabetes, one of asthma and one of anaemia.

Physical health issues

Unaccompanied asylum seeking children have rights to primary and secondary healthcare. They can immediately register with a GP on arrival, as children looked after by the local authority. They are allocated an NHS number and an HC2 certificate that gives exemption from prescription charges, dental services and eyesight tests.

All young people who enter care in the UK have an IHA by a medical practitioner. This should be within 20 working days of entering care and include a physical examination. After one year they are reviewed by a specialist nurse who will enquire about physical health issues but will not examine the young person.[4]

It was encouraging to note that over 97% of the cohort was registered with the GP by the IHA.

Weight

Malnutrition is a known public health issue among refugees worldwide and likely to be a risk to those unaccompanied minors originating or spending time in refugee camp situations or experiencing protracted homelessness on the journey. Nutrition is well recognised as an important aspect to early care of newly arrived refugee children in order to address potential effects on cognitive development and future well-being.[5]

There were a proportion of children with notably low weight on arrival requiring review. However, BMI was not recorded 'in centiles' (appropriate way to identify risk of malnutrition or obesity in young people up until 20 years old) and so the following information had to be extrapolated from the recorded BMI rounded to closest whole number and the closest centile.

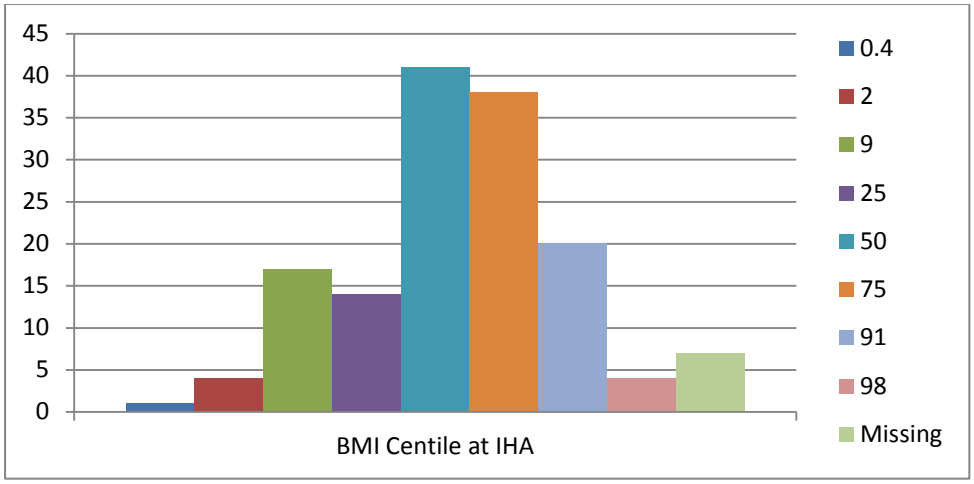
At the IHA, only one young person had a BMI indicating risk of malnutrition on the 0.4th centile and four had a BMI on the 2nd centile. Conversely four young people had a BMI of 98th centile indicating clinical obesity.

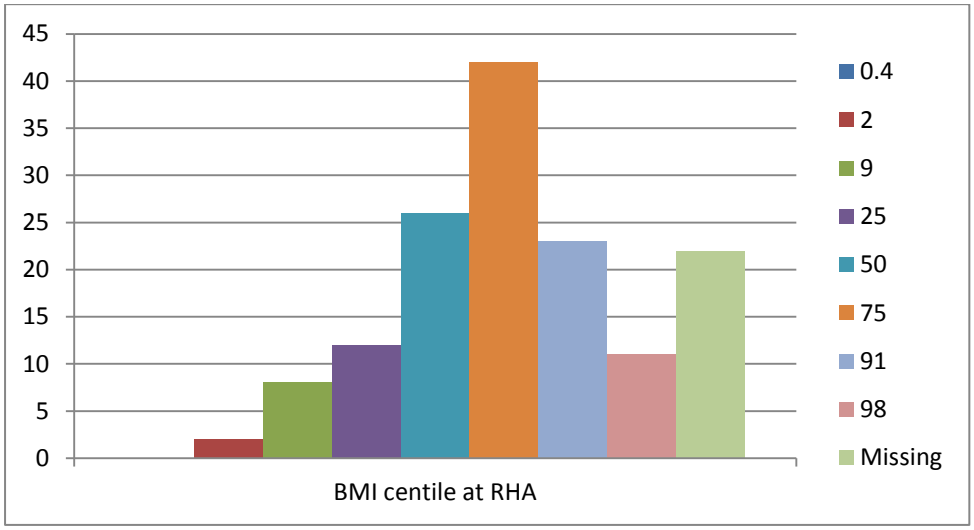
Most young people had a BMI recorded for both IHA and RHA though a greater number did not have a BMI recorded at RHA (22/146) with only a few missing at IHA (7/146). Exact dates of RHA could not be extrapolated from data at the analysis stage so the a presumed one year gap was used to look at the spread of BMI centiles found at RHA. It was noted that the mean BMI centile of the cohort had

[4] *Promoting the health and wellbeing of looked-after children.* DoE DHSC March 2015 https://www.gov.uk/government/publications/promoting-the-health-and-wellbeing-of-looked-after-children--2

[5] *Malnourished children in refugee camps and lack of connection with services after US resettlement.* Lutfy C, Cookson ST, Talley L, Rochat R . *J Immigr Minor Health*. 2014;16(5):1016-1022. doi:10.1007/s10903-013-9796-6

increased by RHA with a larger number (11) with a BMI on 98th centile indicating clinical obesity. Five of those were aged between 10 and 14 years on arrival and would still be in foster care. Two young people with a BMI of 15 kg/m^2 had gained weight at a satisfactory rate – the one young person with a BMI on 0.4th centile had a BMI on 9th centile by the RHA.





Oral health

Dental care has been described as a major unmet health need of refugee children who have often not received oral health care prior to arrival in the 'safe' country or had the benefit of common preventative oral health measures.[6] There is a known high level of dental needs among this cohort and concerns about ongoing access to dental care.[7] Encouragingly by the RHA 134 of the young people (92%) had been seen by a dentist. 13 (9% of cohort) young people had been screened by the dentist and did not require any treatment. 120 (82%) of these had treatment completed or planned. One young person had refused orthodontic treatment. Only 12 young people were waiting for a dental appointment.

[6] *Dental caries of refugee children compared with US children.* Cote S, Geltman P, Nunn M, Lituri K, Henshaw M, Garcia RI. Pediatrics. 2004 Dec;114(6):e733-40. doi: 10.1542/peds.2004-0496. PMID: 15574605

[7] *Dental Care for Asylum-Seekers in Germany: A Retrospective Hospital-Based Study.* Freiberg A, Wienke A, Bauer L, Niedermaier A, Führer A. Int J Environ Res Public Health. 2020 Apr 13;17(8):2672. doi: 10.3390/ijerph17082672. PMID: 32295091; PMCID: PMC7215588

Immunisations

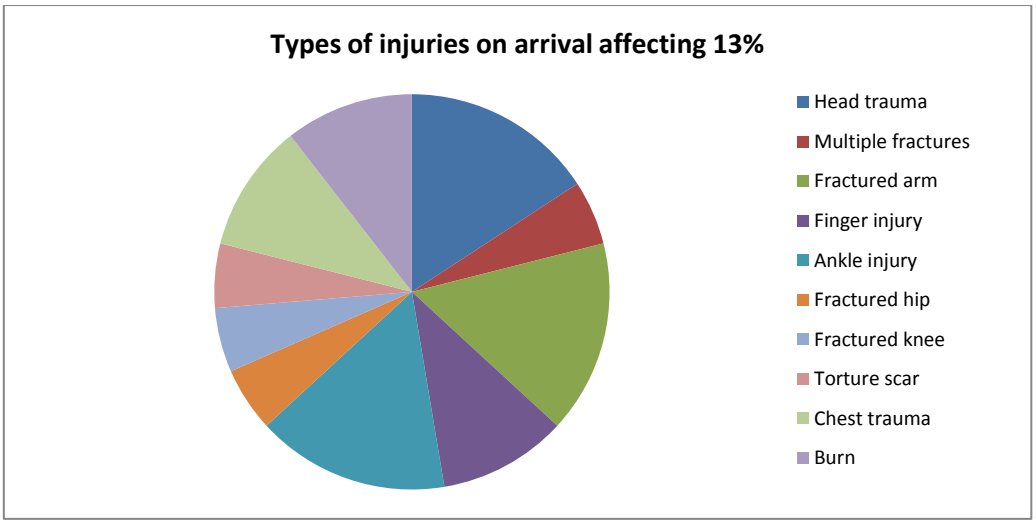
Accentuated by conflict and the different and lower coverage rates of vaccinations, there is an expectation that the majority of young people arriving in the UK will require a catch up programme 'for those with unknown or incomplete vaccination status.'[8]A large retrospective study in Denmark of routine statutory health screening assessing vaccination status demonstrated that children from Afghanistan and Eritrea were the least likely to have been vaccinated.[9] These nationalities comprise the majority of the young people in this cohort.

Invariably a referral for immunisation through the GP was made at IHA. At the RHA 100 young people had completed their catch up programme. A further 23 had started the programme but not completed. A further 23 young people were recorded as not having started their immunisation programme.

Physical injuries on arrival to the UK

Of the unaccompanied minors in this data collection project, 19 of the 146 young people (13%) had a significant physical injury at IHA sustained prior to their journey or during migration. Two young people, both originating from Afghanistan, were found in the back of a lorry on different occasions of their respective arrival in the UK. Both were unconscious having sustained serious head injuries though no detail was available of how these were sustained (non-accidental or accidental). Another had multiple fractures on arrival having travelled underneath a lorry.

Other injuries acquired in migration included a significant burn to the foot, non-accidental burns to thigh and eye, fractured hip, fractured arms, chest wall trauma, ankle injuries, right knee fracture, dislocated finger and finger nail avulsion. One young person reported a left loin injury from torture.



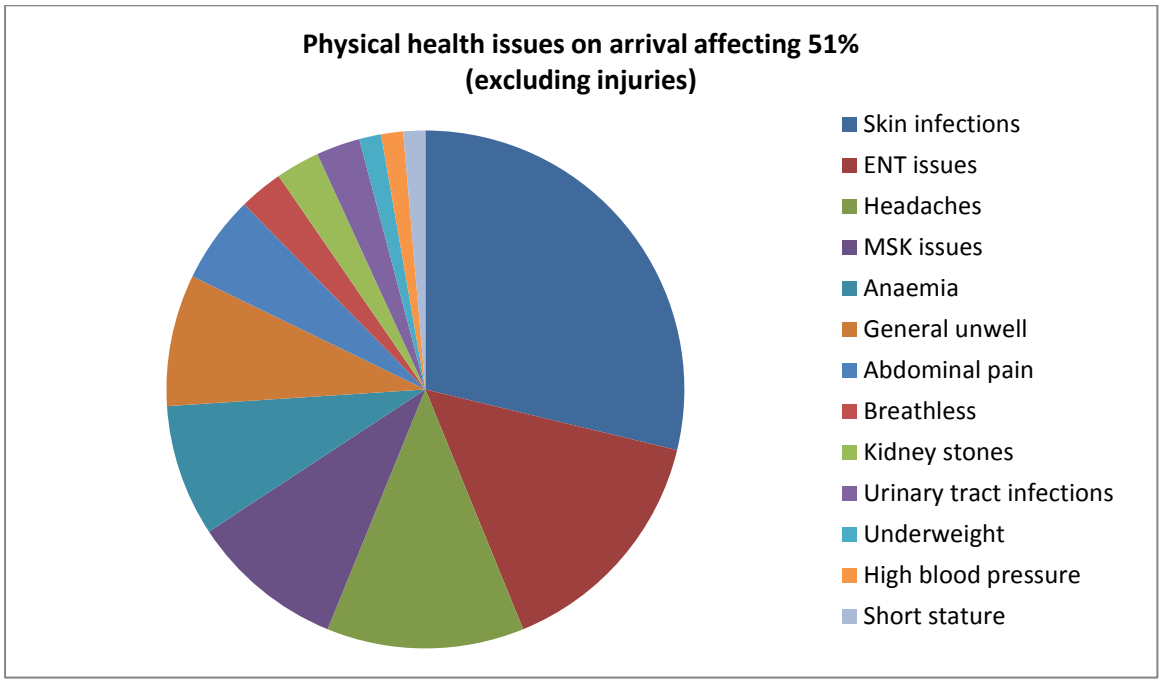
[8] https://www.gov.uk/government/publications/vaccination-of-individuals-with-uncertain-or-incomplete-immunisation-status
[9] *Vaccination status and needs of asylum-seeking children in Denmark: a retrospective data analysis.* Nakken CS, Skovdal M, Nellums LB, Friedland JS, Hargreaves S, Norredam M. Public Health. 2018 May;158:110-116. doi: 10.1016/j.puhe.2018.02.018.

Physical injuries at review after one year in country

By the RHA, only one young person in the cohort remained under long term hospital follow up for a physical injury on arrival. However a number of these young people had mental health issues by the RHA albeit no confirmed direct link to previous trauma – for example one young person who had reported past physical abuse was requiring ongoing support for thoughts of self-harm; another who had had an ankle injury had high levels of stress; another who had arrived with a dislocated finger reported post-traumatic stress symptoms and anger outbursts and a young person who had reported torture was having flashbacks.

Other physical health issues on arrival

Of the cohort studied in this data project, 74 young people (51%) reported physical health issues on arrival to the UK in addition to the injuries and burns as detailed above. These included skin infections (21 in total – 12 scabies; 9 other), ENT issues (11 – 3 had hearing loss), headaches (9), non-specific musculoskeletal pain (7), anaemia (6), generally unwell (6), breathlessness, epilepsy, underweight, high blood pressure, past kidney stones, urinary tract infection and short stature.

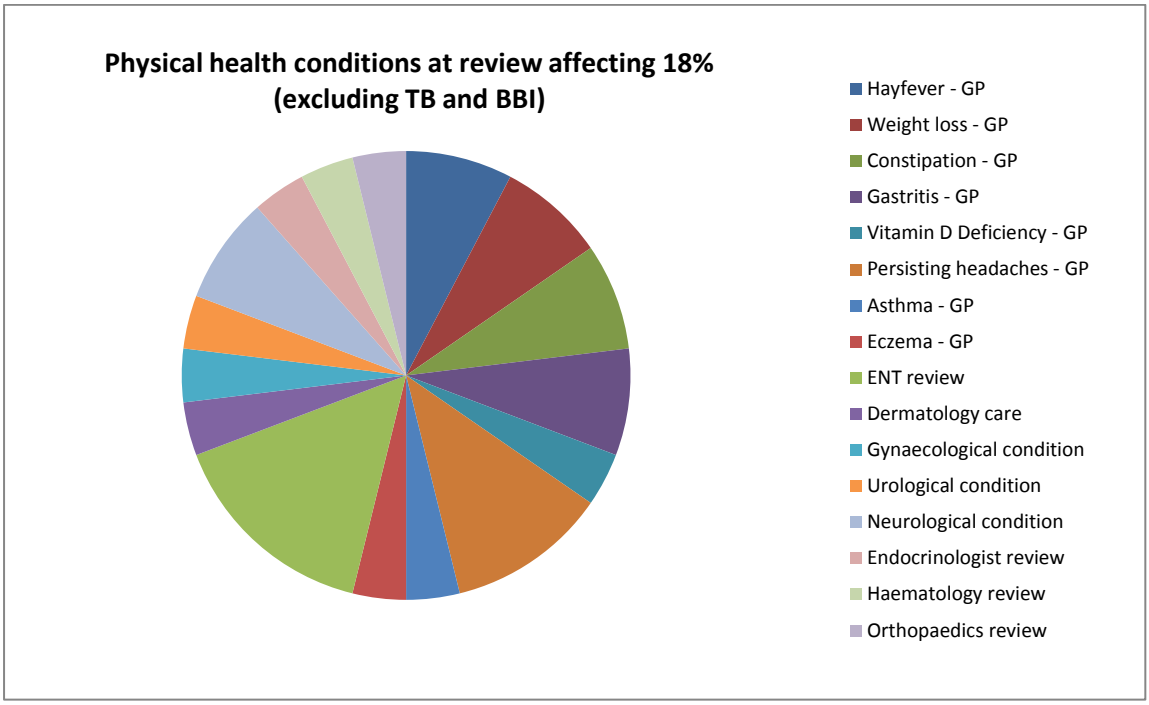


Other physical health issues at review (excluding communicable diseases)

Most of the health conditions present at IHA had resolved by the RHA. However a number of young people (8) remained under hospital care for the original presenting issue. Others of the cohort (14) were under GP care for conditions such as constipation, gastritis, vitamin D deficiency, persisting headaches, asthma, eczema, hay fever, and ongoing investigation of weight loss. There had been some new significant health issues that had arisen or come to light in-between initial and RHA including conditions requiring referral to hospital specialists (4). Several of the conditions noted might have been identified if there had been neonatal screening available in the country of origin.

Overall 26 of the 146 young people had physical health conditions being managed by GP or hospital care at RHA excluding those being treated for communicable disease. These comprised a wide variety of predominantly common conditions that were being managed with an appropriate range of different medications.

Allergies identified and recorded were few (5). No nut allergies were recorded.



Tuberculosis among cohort

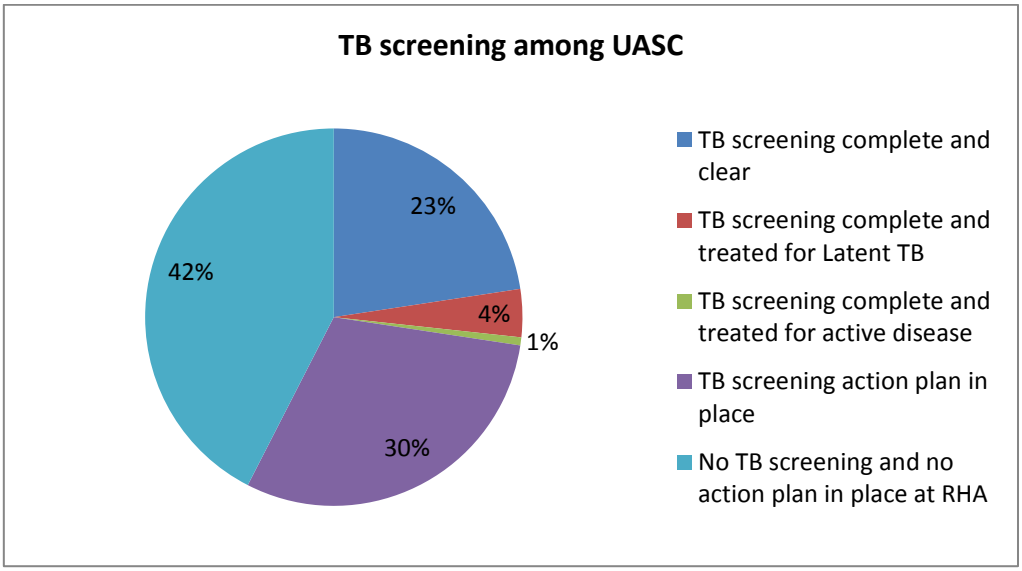
A BCG vaccination scar was recorded as present at the IHA in 55 of the cohort (37.7%) and not present in 58. However there was no record of whether BCG scar was present or not in 33 (23%).

Complete tuberculosis screening results were recorded at RHA (at least one year after arrival in the UK) in only 40 of the 146 young people (28%). For those with completed results, 33 of the 40 were recorded as 'complete and clear.' Six young people had been treated for latent tuberculosis and one had been treated for active disease.

Of the 40 young people with complete Tuberculosis (TB) screening recorded, 17.5% required TB treatment – the majority for latent TB (asymptomatic). The rate of 17.5% requiring treatment (175 in 1000) is extrapolated from a small number and may not be statistically significant to generalise. Modelling from the Kent Public Health Needs Analysis estimated 19% diagnosis of latent TB among unaccompanied asylum seeking children in Kent.[10] The 'true' rate requiring TB treatment among the cohort studied could be higher or lower as screening of the cohort is incomplete; however the rate found among those known to have been tested is close to the HNA estimate of 19%.

[10] *Health Needs Assessment – Unaccompanied children seeking asylum*. R Coyle, S Bennett. Kent County Council. 2016 https://www.kpho.org.uk/__data/assets/pdf_file/0011/58088/Unaccompanied-children-HNA.pdf

No result of TB screening was recorded at RHA of the remaining 106 young people. From the 17.5% rate found and the HNA estimated rate requiring treatment of 19%, there could be a further 18 - 21 young people among this cohort (146) who have been 'missed' for treatment to date. 42 of these remaining 106 were recorded as "referred for TB screening" at the RHA; 14 of these 42 referred had not been recommended for TB screening at IHA. A further two had been tested with the results being waited for. 30% of the overall cohort then had an action plan regarding TB screening put in place. However, 62 young people (42%) had no identified plan in place in respect of TB screening.



Blood borne infections identified among cohort

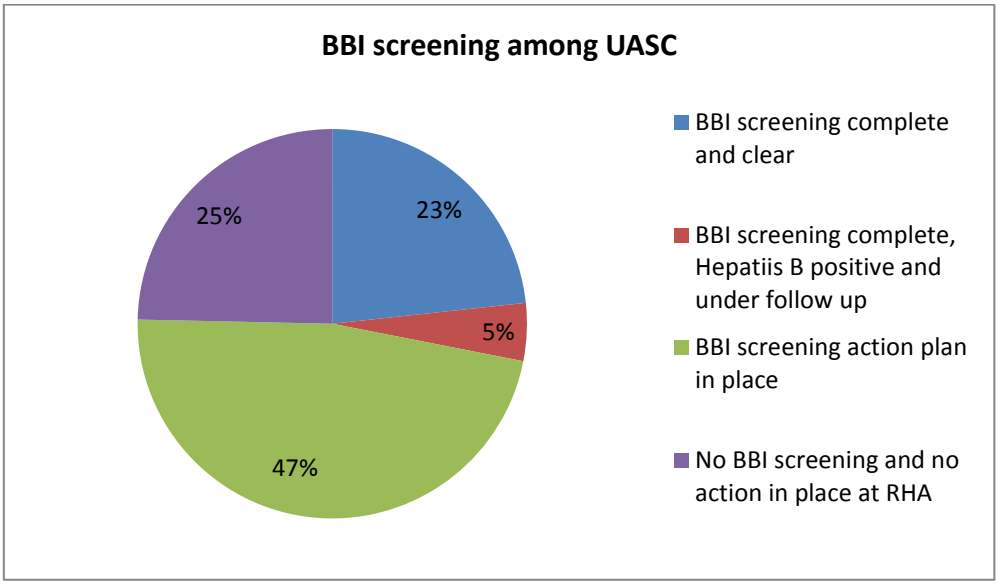
Modelling from the Kent Public Health Needs Analysis estimated 5% diagnosis of chronic Hepatitis B among unaccompanied asylum seeking children in Kent.[11] Only one young person had an identified known Hepatitis B positive status at the time of the IHA.

Complete blood borne infection (BBI) screening results was recorded at RHA (at least one year after arrival in the UK) in only 41 of the 146 young people (28%). For those with completed results, 34 of the 40 were recorded as 'complete and clear.' Seven young people were under follow up in respect of positive Hepatitis B status. No recorded positive Hepatitis C or HIV cases were recorded in the RHAs.

Of the 41 young people with complete BBI screening recorded, 17% required follow up by a gastroenterologist in respect of Hepatitis B. The rate of 17% requiring follow up (170 in 1000) is extrapolated from a small number and may not be statistically significant to generalise. The 'true' rate requiring Hepatitis follow up could be higher or lower given the incomplete screening of the cohort; however the rate among those known to be tested is higher than the HNA estimated 5%.

[11] *Health Needs Assessment – Unaccompanied children seeking asylum*. R Coyle, S Bennett. Kent County Council. 2016 https://www.kpho.org.uk/__data/assets/pdf_file/0011/58088/Unaccompanied-children-HNA.pdf

No result of BBI screening was recorded at RHA of the remaining 105 young people. Using the HNA estimated 5% rate requiring follow up for chronic Hepatitis B and higher 17% rate found among this cohort, there could be none or up to a further 19 young people among this cohort (146) who have been 'missed' for follow up to date. 69 young people of those not screening to date had an action plan in place following the review in order to address the missing screening. However, 36 young people (25% of cohort) had no such identified plan.



Emotional well-being and mental health

Unaccompanied asylum seeking children are children and young people with the same universal needs as others including 'the need for a secure attachment relationship offering age appropriate nurture, care, encouragement, support and love'. They are also children and young people with additional needs because of their experiences 'in their countries of origin, during the journey here and once in the UK.'[12]

Risk factors identified from experiences in country of origin or during journey

Young people gave reports of never knowing their parents or being raised in an orphanage (2), parent(s) killed in conflict (25), parent(s) deceased unspecified (18), one or both parents 'arrested' or in prison in country or origin (8), parent disabled following road traffic accident (RTA) or injury in conflict (4), parent missing (6) or parent and/or siblings reported as 'lost' on journey (4). Those whose parents or siblings had been killed frequently reported finding their family member dead or witnessing the event. There was a report of sexual harassment in the country of origin. Both of those without knowledge of their parents had ongoing issues with relationships: one described as having no concept of family and the other having difficulty making friends. Unaccompanied minors, as with all refugees, have experienced much loss – at times loss of prestige, loss of place, loss of education, loss of stability and most significantly in this cohort a loss of close family.

[12] *Safeguarding Children from Abroad: Refugee, Asylum Seeking and Trafficked Children in the UK,* Edited by Emma Kelly and Farhat Bokhari, Jessica Kingsley Publishers, London 2012

Structured proformas are used for the IHA of unaccompanied minors include specific questions about their experiences on the journey. Social workers are asked to provide as much information as possible to minimise the times a young person needs to tell their story. It is important that the level of adverse childhood experiences is understood by those care planning in order to mitigate as possible against risks of future mental health or other issues.

There were many reports during the health assessments (from 38 young people) of distressing experiences on the journey to the UK with a large number recalling a significantly long and traumatic journey. Experiences included having to walk long distances, crossing the desert, being held in overcrowded conditions, being kept locked in a house, being taken 'hostage' on the journey, being kept in a room with many others and having to sleep sitting up, fear of suffocation when being transported in lorries, containers or a car boot, lack of food and witnessing others including companions dying on the journey. There were reports of emotional abuse on the journey and many of indiscriminate beatings. Some continued to describe experiencing flashbacks of their past experiences at the RHA.

Factors impacting general well being

A large number of young people (51) reported sleep difficulties at either IHA or RHA. Similarly a large number reported at the RHA that they had current concerns or stress symptoms related to their home country or family or related to their journey (67), or concerns originating from issues in the UK (30). In the UK these included anxiety regarding asylum claims and housing situations. Many reported missing family and some described loneliness and a lack of friends.

A significant proportion of the cohort was in semi-independent unregulated accommodation.
Challenges in preparing for independence cited in different RHA reports were as expected in this age group. These included time and money management issues, having to learn to cook, wash clothes, self-hygiene and independently using public transport.

Housing issues reported were related to difficulties with other young people in the accommodation. No adult resides with the young people in the semi-independent settings.

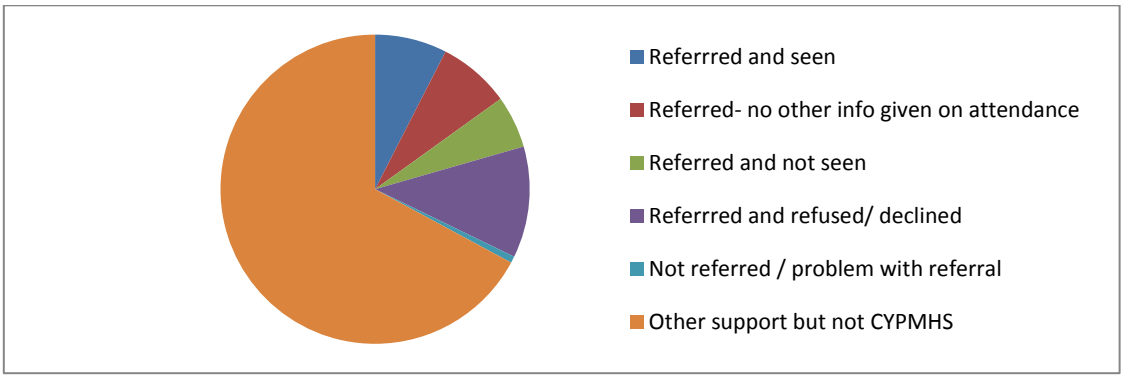
Various preferred activities, typical of this age group, were mentioned including attending church, youth club, playing sports including bike riding and gym, working, cooking, time with friends or listening to music or dancing, watching films and TV.

The majority of the young people had educational aspirations and had progressed onto college. There was a diversity of past educational experience; some had attended school or had home education in their country of origin and others had had limited education; a few reported being unable to read or write in their first language. Many of the young people were studying English as an Additional Language at college or through voluntary sector provision. Friends and relationships were reported as an important aspect of school or college. There was a mix of poor attendance and clear enjoyment of learning.

Out of the 146 young people, health assessment reports recorded that 72 (49%) had some form of contact with family members either in UK (27) or in country of origin (28) or unspecified (16). Family members in the UK included parents, aunts, uncles, cousins and siblings. A further 29 young people had been referred to the Red Cross Family Tracing service to attempt to find family members. No contact existed or no information was given about family contact for 45 young people.

Referral to Children and Young People Mental Health Services (CYPMHS)

By the RHA 47 young people had been referred to CYPMHS (32%). A total of 11 young people in the cohort were recorded as having been seen by the service. 17 of the 47 referrals had been declined (36%). There was missing information regarding a further 11 who had been referred to CYPMHS. 98 young people were recorded as receiving other support with well-being but not CYPMHS. This included low level emotional support through the voluntary sector.



Discussion

Discussion regarding cohort

The unaccompanied young people studied were predominately aged between 14 to 16 years old on arrival in the UK. The needs identified may be reduced or amplified in the broader older age group of 14 – 17 years encompassing all newly arrived unaccompanied young people.[13]

The majority of unaccompanied children in this cohort are male as reflected in the proportions of male/female unaccompanied minors arriving in Europe. The young people are predominantly from countries of origin in conflict and those from Eritrea and Afghanistan made up 72% of the cohort. A further 15% are also from countries or origin in conflict - a combination of Iran, Sudan and Syria. This also reflects the European data where it is noted that most asylum applications made by unaccompanied and separated children are those that originate in Afghanistan, Eritrea and Syria.[14]

Discussion of physical health findings

NICE guidance regarding malnutrition[15] advises nutrition support should be considered in people who are malnourished. In children a BMI on or below the 0.4th centile is of concern as well as unintentional weight loss within the last 3–6 months. There is also a risk for those who have eaten little or nothing for more than 5 days and/or are likely to eat little or nothing for the next 5 days or longer. Nutritional deficiencies that unaccompanied children are at risk of include Vitamin D and Vitamin A deficiencies.

Malnutrition was not noted as a significant finding in the IHAs of this cohort with only one young person presenting with a BMI on the 0.4th centile. However several young people had lost weight over the year and were additionally being assessed to look for causes of weight loss.

It is unclear from IHA or RHA reports how nutrition has been supported and concerning that a higher number of young people did not have their BMI measured at their RHA. However, there had been a rise in BMI among the cohort measured at both assessments – with a further 7 young people in the clinically obese range - and perhaps an early indication that weight needs to be reviewed again in due course given the higher rates of both under and over nutrition among young asylum seekers.[16]

The commonality of oral health issues among those seeking asylum is highlighted[17] and it was encouraging to find the majority of young people in the cohort had accessed dental care. It was also reassuring that the majority of young people (68%) in the cohort had completed the catch up immunisation programme recommended for those with unknown vaccination status[18] and many others (16%) were in the process though not all.

[13] https://www.refugeecouncil.org.uk/information/refugee-asylum-facts/separated-children-facts/
[14] https://ec.europa.eu/eurostat/documents/2995521/9751525/3-26042019-BP-EN.pdf/291c8e87-45b5-4108-920d-7d702c1d6990
[15] NICE guidance on Malnutrition: https://www.nice.org.uk/guidance/cg32/chapter/1-Guidance
[16] Fabio M. Nutrition for refugee children: risks, screening, and treatment. Curr Probl Pediatr Adolesc Health Care 2014 Aug;44(7):188-195.
[17] Aspinall, P (2006) A review of the literature on the health beliefs, health status, and use of services in the refugee and asylum seeker population and of appropriate health care interventions. Welsh Assembly Government. Cardiff.
[18] https://www.gov.uk/government/publications/vaccination-of-individuals-with-uncertain-or-incomplete-immunisation-status

The UNHCR in a report "Desperate Journeys" outlines the dangers of the journey by land and sea to reach Europe and the UK. The report describes how many people die along the route and reported that 44% of those interviewed having crossed to Italy had witnessed deaths during their journey. It catalogues the adverse experiences that asylum seekers face on their journey and highlight the increased risks to unaccompanied children.[19]

The most common health problems noted at a Medecins Sans Frontieres clinic, for refugees newly arrived in camps in France, were respiratory problems, skin problems (eczema and scabies), dental problems, injuries (often from accidents or falls from lorries), stomach problems and burns from improvised cooking devices.[20]

The need for a physical examination on arrival is exemplified through this data collection by the high rate of physical injuries found (13%) often relating to trauma experienced on route and by the rates of physical health issues requiring treatment or onward referral (51%). This included overall 14% of the young people with skin complaints on arrival particularly scabies.

Refugee children have been identified as having a high rate of latent tuberculosis and an important group to test and where appropriate treat.[21] Modelling from the Kent Public Health Needs Analysis estimated 19% diagnosis of latent TB among unaccompanied asylum seeking children in Kent.[22] The importance of identifying latent TB has also been recently highlighted by a case when TB spread to a foster family.[23] There are loud calls for universal screening for latent TB among all asylum seeking children.[24] It is therefore important that screening is undertaken in a robust manner following statutory IHA.

It is of concern that result of TB screening was only available for 28% of the cohort studied. Among those tested the rate of Latent TB requiring treatment correlated with the expected rate from the Public health modelling and as such there may be a significant number not as yet identified.

The anticipation is that the majority of unaccompanied children and young people arriving in the UK will require screening for blood borne infections.[25] Modelling from the Kent Public Health Needs Analysis estimated 5% diagnosis of chronic Hepatitis B among unaccompanied asylum seeking children in Kent.[26] Again among those screened the rate correlated with anticipated but again the

[19] *Desperate Journeys. Refugees and migrants arriving in Europe and at Europe's borders. January* – December 2018. UNHCR. https://www.unhcr.org/desperatejourneys/#
[20] *The migrant camp that doctors built*. BMJ 2 April 2016 p11 https://www.bmj.com/bmj/section-pdf/920509?path=/bmj/353/8051/This_Week.full.pdf
[21] *Prevalence of latent tuberculosis among refugee children in Malaysia.* Wong YJ, Lee SWH. ERJ Open Res 2020; 6: 00254-2019 DOI: https://doi.org/10.1183/23120541.00254-2019
[22] *Health Needs Assessment – Unaccompanied children seeking asylum*. R Coyle, S Bennett. Kent County Council. 2016 https://www.kpho.org.uk/__data/assets/pdf_file/0011/58088/Unaccompanied-children-HNA.pdf
[23] *Tuberculosis in a victim of human trafficking- a missed opportunity* Devaraja J, Dockery M, Kurian M G286(P) Archives of Disease in Childhood 2019;104:A116-A117
[24] Mueller-Hermelink M, Kobbe R, Methling B, Rau C, Schulze-Sturm U, Auer I, Ahrens F, Brinkmann F. *Universal screening for latent and active tuberculosis (TB) in asylum seeking children*, Bochum and Hamburg, Germany, September 2015 to November 2016. Euro Surveill. 2018 Mar;23(12):17-00536. doi: 10.2807/1560-7917.ES.2018.23.12.17-00536. PMID: 29589578
[25] *Blood borne infections (BBI) in looked after children* Dr Steven Welch, Consultant in HIV, Infectious Diseases and General Paediatrics, Birmingham, Paediatrics and Child Health. 2018 DOI: https://doi.org/10.1016/j.paed.2018.11.004
[26] *Health Needs Assessment – Unaccompanied children seeking asylum.* R Coyle, S Bennett. Kent County Council. 2016 https://www.kpho.org.uk/__data/assets/pdf_file/0011/58088/Unaccompanied-children-HNA.pdf

results were only recorded in 28% of the cohort and there may be a significant under ascertainment of cases of chronic Hepatitis B.

Studies have demonstrated the complex disease burden among child refugee populations. A study in Germany[27] found a high prevalence of infections (58.8%), and iron deficiency anaemia (17.6%) and a very low prevalence of non-communicable diseases (<2.0%). 20% of children were infected with parasites. Sub-Saharan Africans showed the highest prevalence of infections (86.7%) including highest prevalence of parasites (46.7%). A further large cross-sectional study[28] of 2,545 adult and child asylum-seekers found that >30% of those aged <18 years tested positive for a parasitic infection. The modelling from Kent Public health had indicated a likely prevalence of parasitic infections as 28% among the unaccompanied asylum seeking children in Kent. Iron deficiency anaemia has been found to be common (17.6%) among a similar cohort in Germany.[29]

Screening for eosinophilia (which would point towards possible parasitic infection) or anaemia has not been a routine part of screening at IHAs locally and results, even if these had been subsequently requested by GPs, were not available at RHAs.

Issues that may have impacted on the physical health findings and screening

Health expectations

Young people are seen for an IHA very soon after arrival in the UK and may not realise the need to disclose symptoms or may not want to give too much detail to authorities at this stage. The data collected is only as good as the information that could be extrapolated at a respective health assessment and the recording of this.

Physical examination

Young people are not examined at the RHA and less likely to be measured so there may have been further health issues that would have come to light if an examination had been included.

Non-attendance

We have been informed of non-attendance as an issue at TB clinic and this is reflected in the high level of re-referrals at RHA for both TB clinic and BBI blood tests. For example, most young people were re-referred for BBI testing at RHA. It is not clear from this data why the recommendations at IHA were not followed through by the RHA.

No referral made at IHA

No referral for BBI screening at IHA may have led to 4 occasions when BBI screening was not reconsidered at RHA and so led to a lack of re-referral. However there were 26 young people who had a recommendation on their healthcare plan at IHA for BBI screening but this was not revisited at the RHA and there was no evidence of a plan to address. This raises a potential training need

[27] L, Kramer A, Fischer F, Prufer-Kramer L. Health status and disease burden of unaccompanied asylum-seeking adolescents in Bielefeld, Germany: cross-sectional pilot study. Trop Med Int Health 2015 Nov 26.
[28] Lifson AR, Thai D, O'Fallon A, Mills WA, Hang K. Prevalence of tuberculosis, hepatitis B virus, and intestinal parasitic infections among refugees to Minnesota. Public Health Rep 2002 Jan-Feb;117(1):69-77.
[29] L, Kramer A, Fischer F, Prufer-Kramer L. Health status and disease burden of unaccompanied asylum-seeking adolescents in Bielefeld, Germany: cross-sectional pilot study. Trop Med Int Health 2015 Nov 26.

regarding BBI/TB risk and the importance of making every contact count. Very few referrals were made for a full blood count (eosinophilia/anaemia) at IHA again raising a potential training issue.

Lack of recording

It may be that screening tests had been undertaken, including some initiated by the GP if not at IHA, but results were not on the provider health record nor recorded on GP information supplied for the RHA. Additionally there are different electronic health record systems across providers and it is a challenge for LAC specialist nurses to check different systems for results.

Refusal

It may be that young people have previously refused to attend for screening. However, there were no recorded refusals to screening by the young person found in this data collection.

Discussion of findings regarding emotional and mental health issues

Many of the young people in this cohort had experienced a range of adverse childhood experiences including witnessing violence and the loss of a parent. They additionally had several ongoing risk factors for poorer emotional well-being including a high number living in unregulated or semi-independent accommodation without an adult. There were many reports of distressing experiences on the journey to the UK and reports of emotional abuse. These findings should not be a surprise. Many separated children who seek political asylum have already been subject to violations or have witnessed the violations of others.[30] They have often experienced high levels of pre-departure violence, including sexual violence. In many cases, children face dangers in transit as serious as those they fled from.[31]

Médecins Sans Frontiers (MSF) has considered it necessary to design a programme to offer health advice before migrants travel as they identify that health consequences derive mainly from the journey made. They report that certain routes produce certain health problems including most commonly sexual violence, discontinuation of treatment for chronic illness and mental health problems. MSF aims to alert people to get vaccinated before travel and to inform them where they can access medical services that will not discriminate against them.[32] The risks are amplified among unaccompanied children without family to look after them as they journey.

A system model was developed in Austria outlining the 11 main risk factors impacting on the mental health of unaccompanied minors. The most important risk factor identified was social contact and relationships in the host country and the second on the placement type with foster care placements being more protective. Access to health assessments and psychological treatment was also listed high as well as the importance of advice and advocacy. Other key determinants were daily structure

[30] *Working with Unaccompanied Asylum Seeking Children: Issues for Policy and Practice*, Ravi K.S. Kohli and Fiona Mitchell, Palgrave Macmillan, Hampshire 2007
[31] *Safeguarding Children from Abroad: Refugee, Asylum Seeking and Trafficked Children in the UK,* Edited by Emma Kelly and Farhat Bokhari, Jessica Kingsley Publishers, London 2012
[32] *The migrant camp that doctors built.* BMJ 2 April 2016 p11
https://www.bmj.com/bmj/section-pdf/920509?path=/bmj/353/8051/This_Week.full.pdf

and leisure activities and access to education and training.[33] It is interesting that social contact and appropriate placement are also identified in preventing unaccompanied minors from going missing.[34]

Most of the older boys arriving in Kent are initially accommodated in reception centres and then in shared accommodation with other unaccompanied minors; these are the placements associated with poorer outcomes. Studies suggest that foster care and placements that are culturally sensitive may be associated with better mental health outcomes. Even if in an ethnically diverse family placement if placed with a child of same ethnicity do better.[35] It is of concern that inappropriate accommodation provision and a lack of consistent support from a trusted adult are cited as two of the key risk factors for unaccompanied children going missing.[36] The Children's Commissioner, Anne Longfield, in calling for the Government to change the law to stop councils placing under 18s in care in unregulated accommodation. Unaccompanied asylum seeking children make up one in three of the children in such placements in England.[37]

The rate of referral to specialist mental health services by one year after arrival is considered appropriate given prevalence of mental health issues. However, the small percentage actually recorded as having been assessed is of concern including a high percentage of referrals that were declined by the CYPMHS. It is known that there is a high incidence of post-traumatic stress symptoms and signs of depression among refugee minors including high support needs on arrival.[38] Poorer mental health correlates with an increased exposure to violence. Social support and family security were important in reducing the rates of post-traumatic stress disorder (PTSD) and clinical depression.[39] Unaccompanied minors from Afghanistan, who make up a high proportion of unaccompanied minors in Kent, were found in a large Swedish study to be at particularly high risk of PTSD and considered an especially vulnerable group.[40] A study in Norway found that many continued to have symptoms two years after arrival and again found high rates of post-traumatic stress symptoms and depression. The high rate of children identified above clinical cut-off on symptoms scales and with suicidal ideation in the study indicated that many may be in need of treatment and by implication we would expect a high rate in need of treatment among the cohort in Kent.[41]

---

[33] *A System Model of Post-Migration Risk Factors Affecting the Mental Health of Unaccompanied Minor Refugees in Austria-A Multi-Step Modeling Process Involving Expert Knowledge from Science and Practice.* Hynek N, Franczukowska A, Rössl L, Schreder G, Faustmann A, Krczal E, Skrivanek I, Sommer I, Zenk L. Int J Environ Res Public Health. 2020 Jul 14;17(14):5058. doi: 10.3390/ijerph17145058.

[34] *Still in harm's way. An update report on trafficked and unaccompanied children going missing from care in the UK.* Ecpat uk; Missing People 2018 *https://www.ecpat.org.uk/Handlers/Download.ashx?IDMF=27ebad70-3305-4e41-a5ca-7a1f24cba698*

[35] *What is the Impact of Placement Type on Educational and Health Outcomes of Unaccompanied Refugee Minors? A Systematic Review of the Evidence.* O'Higgins, A., Ott, E.M. & Shea, M.W. Clin Child Fam Psychol Rev **21,** 354–365 (2018). https://doi.org/10.1007/s10567-018-0256-7

[36] *Still in harm's way. An update report on trafficked and unaccompanied children going missing from care in the UK*. Ecpat uk; Missing People. December 2018 https://www.ecpat.org.uk/Handlers/Download.ashx?IDMF=27ebad70-3305-4e41-a5ca-7a1f24cba698

[37] *Unregulated.* September 2020. https://www.childrenscommissioner.gov.uk/wp-content/uploads/2020/09/cco-unregulated-children-in-care-living-in-semi-independent-accommodation.pdf

[38] *The mental health of unaccompanied refugee minors on arrival in the host country.* Vervliet M, Meyer Demott MA, Jakobsen M, Broekaert E, Heir T, Derluyn I. Scand J Psychol. 2014 Feb;55(1):33-7. doi: 10.1111/sjop.12094.

[39] *The epidemiology of PTSD and depression in refugee minors who have resettled in developed countries*. Reavell J, Fazil Q. J Ment Health. 2017 Feb;26(1):74-83. doi: 10.1080/09638237.2016.1222065.

[40] *Children at risk: A nation-wide, cross-sectional study examining post-traumatic stress symptoms in refugee minors from Syria, Iraq and Afghanistan resettled in Sweden between 2014 and 2018.* Solberg Ø, Nissen A, Vaez M, Cauley P, Eriksson AK, Saboonchi F. Confl Health. 2020 Oct 2;14:67. doi: 10.1186/s13031-020-00311-y

[41] *Development of mental health problems - a follow-up study of unaccompanied refugee minors*. Jensen, T.K., Skårdalsmo, E.M.B. & Fjermestad, K.W. Child Adolesc Psychiatry Ment Health **8,** 29 (2014). https://doi.org/10.1186/1753-2000-8-29

Recommendations

Health practitioners to continue to undertake relevant up to date training and to follow clinical guidance developed in 2016[42] as well as guidance from the RCPCH.[43]

- Clinical guidance is sited on the UASC Health website and on the RCPCH website. Clinicians are responsible for ensuring they are following best practice.
- Nutritional status should be more carefully described and monitored including calculating centiles.[44] Nutrition support needs to be better explained and promoted as per NICE guidance and healthy eating promoted at IHA.

Continue to use standardised UASC IHA proforma across providers in Kent and Medway and request completion for YP placed out of area

- The proforma will require regular review to ensure it aligns with current best practice. Last update May 2020. This proforma is being used nationally and the UASC Health team therefore have a responsibility to ensure any updates are clearly publicised.

Consider development of a standardised RHA proforma

- It would be useful to have prompts mirroring the expected recommendations at an IHA.

Screening pathway

- The Health Needs Assessment of April 2016 highlighted the need to expedite screening and this should be initiated in entirety at the IHA.
- Robust processes should be in place to ensure recommendations for screening for BBI and TB are followed and results recorded on the health records held by the LAC Specialist team.
- An improved system using blood testing for latent TB (rather than the two appointments for Mantoux) and more joined up follow up of results with primary care will reduce the potential public health risk posed by untested young people.
- Screening for parasitic infections and iron deficiency anaemia should be added to the routine testing.

Access to patient records by LAC Specialist team

- Alignment of electronic patient records across providers and improved access by the Specialist team, including access to GP records across region, would improve recording and increase efficiency in screening and follow up of other health recommendations.

Young Person held health records

- As recommended at a training event, personally held health records may improve the recording of outcomes as well as prompting the completion of health actions as outlines in healthcare plan.

[42] *Clinical Guidance for assessing and addressing the health needs of UASC.* https://www.uaschealth.org/resources/paediatrics/#1490284388881-f29da208-8e9d

[43] *Refugee and unaccompanied asylum seeking children and young people - guidance for paediatricians.* Health Policy team RCPCH. Updated November 2019. https://www.rcpch.ac.uk/resources/refugee-unaccompanied-asylum-seeking-children-young-people-guidance-paediatricians

[44] https://www.rcpch.ac.uk/sites/default/files/2018-03/boys_and_girls_bmi_chart.pdf

Promote (peer) mentoring

- Mentoring would assist with understanding the UK health system and relevance of health appointments and to facilitate attendance.
- It would help with access to activities and services that aid physical and mental well-being.
- Young people could be helped to access advocacy to address issues that may be affecting their well-being such as bullying and accommodation issues.

Advocate for reduced use of unregulated accommodation for unaccompanied young people[45]

- The Children's Commissioner, Anne Longfield, in calling for the Government to change the law in order to stop councils placing under 18s in care in unregulated accommodation.

More bespoke mental health assessment and therapeutic provision

- Consideration should be made of a more targeted approach to early mental health assessment and development of bespoke therapeutic packages of care for unaccompanied asylum seeking children arriving in the region including longer term follow up.

[45] *Unregulated.* September 2020. https://www.childrenscommissioner.gov.uk/wp-content/uploads/2020/09/cco-unregulated-children-in-care-living-in-semi-independent-accommodation.pdf