

Health Needs Assessment – Unaccompanied children seeking asylum

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Produced by

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| 1. Executive Summary

1.1 Introduction

Unaccompanied children seeking asylum are young people aged under 18 years who have travelled to another country to ask for asylum due to fear of persecution in their home country, and who have become separated from their usual parent or carer. Unaccompanied children are not a homogenous cohort with one narrative but rather, like any group of young people, are children of varying ages and from diverse backgrounds who have had a range of experiences prior to and during their asylum journey. Unaccompanied children may have experienced significant hardship prior to coming to the United Kingdom (UK), including the loss of a parent or carer.

The prolonged conflict in Syria due to the ongoing civil war has led to the displacement of millions of people and precipitated an international humanitarian crisis. Ongoing conflict and instability in Afghanistan and North Africa has also contributed to the numbers of people leaving their home country to seek asylum. The United Nations High Commissioner for Refugees estimates that more than one million people seeking asylum entered Europe in 2015. It is estimated that this includes more than 25,000 unaccompanied children, this is felt to be a conservative estimate. In part due to its geographical location Kent has seen an increase in the number of unaccompanied children entering the county, primarily through the port of Dover. The number of unaccompanied children entering Kent began to increase in 2014 with a dramatic increase from May 2015. Local authorities are responsible for the care and support of unaccompanied children, therefore in Kent this responsibility falls to Kent County Council. The statutory responsibility of local authorities includes facilitating an assessment of the child's health needs and a plan to meet these needs, in addition to responsibilities in relation to social care, housing and education.

The literature suggests that unaccompanied children have significant physical and mental health needs. These are influenced by access to basic healthcare in their home country, their experience of hardship, including the witnessing and experiencing of traumatic events, and the duration of and conditions experienced on their journey to the UK. The most important physical health issues relate to:

- Communicable (infectious) Diseases (e.g. Tuberculosis screening and vaccination)
- Dental Health
- Nutrition (e.g. anaemia)
- Sexual and reproductive health
- Women's health

Unaccompanied children are also at high risk of mental illness. The prevalence of symptoms consistent with a mental illness in unaccompanied children has been reported as up to 48%. The most common mental illnesses reported in unaccompanied children are post-traumatic stress disorder (PTSD), mood disorders and agoraphobia. It is important to note that unaccompanied children may show delayed presentations of mental illness, necessitating ongoing surveillance and repeat assessment. The literature suggests that social workers play an important role in identifying children with symptoms of mental illness early, owing to their experience in supporting young people and the ongoing contact they have with the young person. It is important that health and social care practitioners receive appropriate training so that they can properly support the health needs of unaccompanied children.

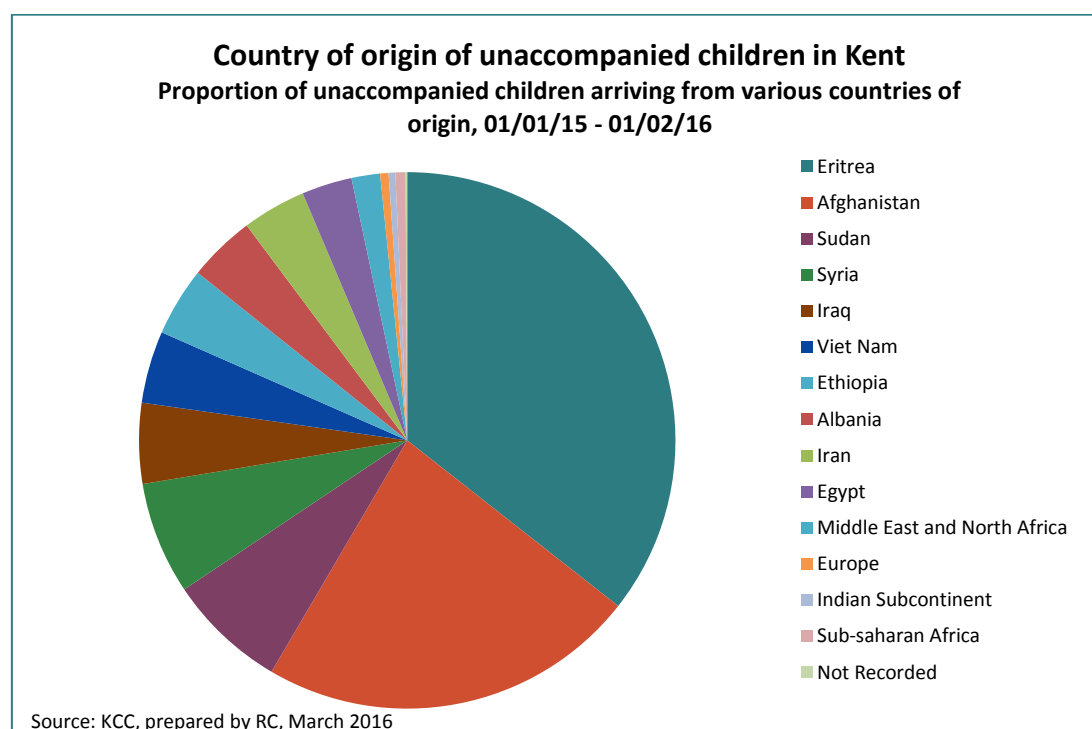
Given the increase in the number of unaccompanied children who have travelled to Kent over the last 12 months, an evaluation of their health needs is required to inform the development of services to support these young people. The purpose of this health needs assessment is to review the literature regarding the health needs of unaccompanied children, and to describe the health needs that have been observed in the population of unaccompanied children in Kent. Current health services will be evaluated to assess their capacity and suitability to meet the identified needs.

1.2 Key Findings

1.2.1 Epidemiological Needs

The recent increase in the number of unaccompanied children arriving in Kent is reflected in the number of new entrants registered by Kent County Council (KCC). Between 2010 and 2013 the number of new unaccompanied children registered by KCC ranged from 141 to 223 per year. This rose to 333 new entrants in 2014, and to 930 in 2015. 96% of unaccompanied children who were registered by KCC were male, and 75% were aged 16-17 years.

Figure 1 County of origin of unaccompanied children in Kent



The figure above demonstrates the country of origin of unaccompanied children registered by KCC January 2015 – February 2016. The largest proportion of children came from Eritrea, 36%, followed by Afghanistan, 23%. Substantial numbers of unaccompanied children came from Sudan, 7%, Syria, 7% and Iraq, 5%.

The Initial Health Assessment

An Initial Health Assessment (IHA) should be carried out on all unaccompanied children (who have consented to the assessment) within 28 days of the child being registered with the local authority. This is a statutory obligation. In Kent the Clinical Commissioning Groups (CCG) are responsible for commissioning this service.

The majority of unaccompanied children who entered Kent in 2015 have not yet had an Initial Health Assessment (IHA). This has been due to a lack of capacity to deliver the IHA and issues with the process of referral for an IHA. Therefore a large number of unaccompanied children have not had opportunity to have their physical and mental health assessed. This means that symptoms of illness could be missed. Opportunities to reduce the risk of physical and psychological illness, through expedient identification and management of symptoms, are being missed. This also puts unfair pressure on non-health staff working with unaccompanied children to recognise physical and/or mental illness in these young people.

The IHA process involves an assessment of physical and mental health by a clinician who asks about the young person's previous history and performs a clinical examination. Currently no tests are carried out during the IHA. If the need for tests or referrals is

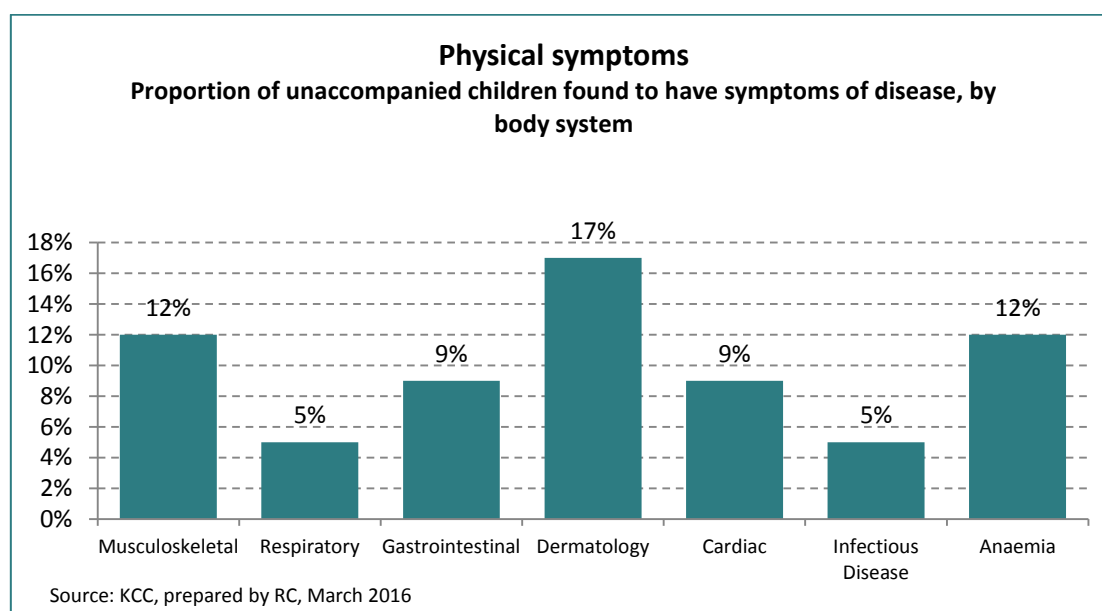
identified the IHA clinician requests that this is done by the young person's general practitioner.

An analysis was undertaken of a sample of IHA which were carried out in 2015. 154 IHA reports were reviewed to evaluate the physical and mental health needs reported in this group of young people.

Physical Health

Dental disease was reported in 43% of children, and visual abnormalities (most commonly refractive errors such as long- and near-sightedness) in 35%ⁱ. The proportions of children with symptoms of physical illness from various body systems are demonstrated in the Figure 2.

Figure 2 Physical symptoms reported in unaccompanied children in Kent



The most common physical symptoms were dermatology, including rashes, scars and fungal infection, anaemia and musculoskeletal complaints. It is important to emphasise that while physical complaints were common, the majority of these related to non-acute, readily treatable conditions. Additionally, a small but significant number of young people had symptoms of acute illness, such as respiratory infection.

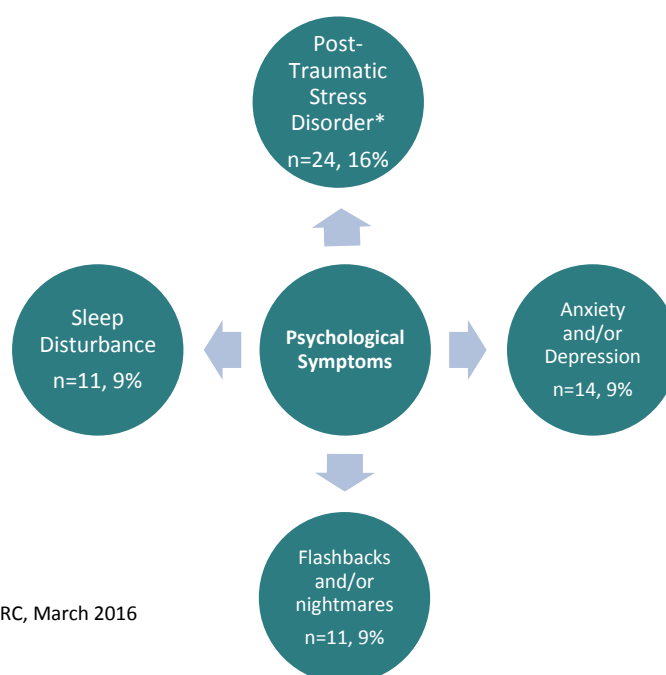
In addition to the findings above there was an almost universal need for catch-up immunisation. The need to screening for latent Tuberculosis was identified in approximately 70% of individuals, based on country of origin.

Mental Health

ⁱ Figure refers to proportion of children in Millbank Reception Centre and Independent Living accommodation; children in Foster Care excluded due to variation in recording of visual assessment.

Psychological symptoms were reported in 41% of children. The most common psychological symptoms noted were of Post-Traumatic Stress Disorder (PTSD), anxiety, and depression. The proportion of children in whom there was concern about psychological symptoms is demonstrated in the Figure 3.

Figure 3 Psychological symptoms reported in unaccompanied children in Kent



Source: KCHFT, prepared by RC, March 2016

Source: KCC, prepared by RC, March 2016

Implications for the wider cohort of unaccompanied children

The results described above indicate that physical and mental health symptoms were common among unaccompanied children. If the rates above were applied to the cohort of 989 unaccompanied young people who entered Kent January 2015 – February 2016 this would amount to a substantial level of need, as detailed in the table below.

Table 1 Projected health needs in unaccompanied children who entered Kent January 2015 - January 2016

	Rate in sample of 154 unaccompanied children (weighted average)	Projected number of wider cohort effected
Physical Health		
Physical Symptoms	55%	544
Dental Abnormalities	41%	405
Visual Abnormalities	34%	336
Mental Health		
Psychological symptoms	41%	405
Tests Required		
Need vaccination	100%	989
Need TB screening*	71%	702
Need Hepatitis B screening	100%	989

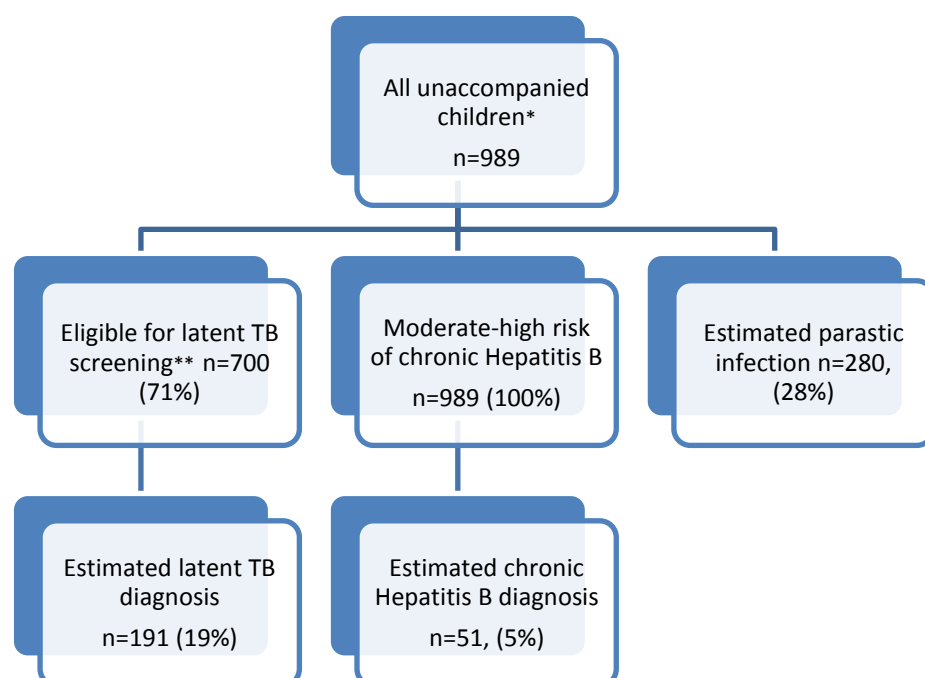
*As per WHO criteria; additional screening may be needed due to exposure during migration
Source: KCC, Kent Public Health, prepared by RC, March 2016

The majority of physical needs in the larger cohort of unaccompanied children are likely to relate to non-acute conditions such as rashes and muscular pain, which can be managed in primary care. There is also a substantial need for preventative interventions such as vaccination and screening. The number of children with psychological symptoms is likely to be substantial, which emphasises the need for a robust system of identifying and supporting these young people.

1.2.2 Modelled Prevalence of Communicable Disease

Modelling was undertaken to estimate the burden of communicable diseases in the 989 young people who were registered as unaccompanied in Kent January 2015 – February 2016. The results are outlined below.

Figure 4 Modelled prevalence of burden of infectious disease in unaccompanied children who entered Kent January 2015 – January 2016



*Includes missing children, (n=69)

**Eligibility by WHO/PHE criteria

Source: Kent Public Health, prepared by RC, March 2016

1.2.3 Corporate Needs

Staff working with unaccompanied children in residential facilities felt that mental health needs were an important issue. It was recognised that staff working directly with unaccompanied children play a role in identifying physical and mental health concerns in these young people, and may require specialist training to facilitate this.

Clarity and consistency is needed regarding the advice given to residential facilities on the management of health issues, in particular in relation to communicable disease. Additionally, staff within residential facilities would welcome a clear process to follow when additional advice or input is needed from specialist health services, including mental health.

1.2.4 Current Services and Gaps

A minority of unaccompanied children have had an Initial Health Assessment due to the overwhelming of capacity to deliver these assessments. Furthermore, the current IHA process, whereby the responsibility for tests or treatments is passed to the GP, creates barriers to the young person receiving the necessary treatment and/or interventions. This creates barriers in access to care. For example, less than 1 in 4 eligible children who have had an IHA have been screened for latent TB.

The current issues with capacity, and process of requesting the GP to arrange necessary tests and treatments, has contributed to a situation in which a minority of unaccompanied children have had an IHA, and even fewer have received the appropriate treatments or interventions. This will negatively impact on the physical and mental health of a vulnerable group of young people.

Increasing the capacity to carry out the IHA within the statutory 28 day timeframe is essential to facilitate the identification and management of physical and mental health needs, and to instigate simple preventative measures. Without this there is a risk of missing these health needs and of outbreaks of vaccine preventable disease. Moreover, simple, cost-effective interventions exist which are effective in reducing these risks. These opportunities are currently being missed.

1.3 Call to Action

It is essential that the capacity to deliver IHAs is increased to ensure that all unaccompanied children in Kent receive this statutory entitlement. The efficiency and effectiveness of the process would be greatly increased if common health needs could be addressed within the IHA, rather than referred to the general practitioner. There are a number of ways the current service could be improved including:

- Increased capacity to ensure IHA are carried out at the earliest opportunity, and within the statutory timeframe,
- Building capacity through training of local interested practitioners to be able to carry out IHA,
- Initiation of vaccination during IHA,
- Baseline blood testing within the IHA, as indicated clinically,
- Direct referral to specialist services such as TB screening and Child and Adolescent Mental Health Services as required.

Mental health issues were commonly reported in the sample of IHAs evaluated. This was consistent with the experiences of reception centre staff working with unaccompanied children. Previous issues with access to mental health advice and input should be addressed through creation of a pathway of access to Child and Adolescent Mental Health Services.

The needs of unaccompanied children are not limited to health, but include a wider spectrum of social care needs including the need for accommodation, support through the application for asylum and educational needs. Social workers and the wider network of social care practitioners also play an important role in the identification of physical and mental health needs within this cohort of young people. It is essential that health and social care practitioners are adequately trained to support unaccompanied children. Close working relationships are needed between health and social care teams to provide an integrated service. These links could be strengthened by clearly outlining the appropriate health professional or service to refer to when acute health issues are encountered by social workers, reception centre staff etc.

Finally, the role of the wider community network of support should be recognised. Building resilience in unaccompanied young people is a key element of supporting their emotional health and wellbeing. The local community, including voluntary sector organisations, has an important role to play. Community resources should be utilised to support the wider needs of unaccompanied children, including the use of specialist agencies with experience in

supporting people seeking asylum. Additionally, opportunities to expand the social network of unaccompanied young people now resident in Kent should be explored through access to education, including language skills, creating networks within groups of unaccompanied young people and signposting of community youth organisations.

1.4 Recommendations

1. Capacity Building

Additional capacity is needed to carry out the Initial Health Assessment at the earliest feasible opportunity and within the 28 day statutory timeframe. There should be consideration of the optimum way to improve capacity to deliver IHA to unaccompanied children in a sustainable way, including training of local GP and paediatric clinicians.

2. Training

Staff working with unaccompanied children should have appropriate training so that they are empowered to identify the health needs of these children. Training is recommended for both health and social care staff.

3. Initiation of immunisation during the IHA

The current process of referring vaccination to the GP creates barriers to the young person receiving this intervention. Initiation of immunisation would improve access to this intervention.

4. Blood tests to be carried out during IHA

As with immunisation the current process of the IHA creates barriers to young people having the appropriate blood tests, which could be improved by initiating tests during the IHA. It is vital that if this recommendation is adopted a system is put in place to ensure results are followed up and communicated to the young person. A full list of recommended blood tests is listed in section 11.

5. Direct referral to the TB screening service

The TB service in Kent is keen to be involved in the screening of eligible unaccompanied children. This opportunity should be utilised.

6. Clinical record templates for IHA

The variation in clinical information available for extraction from IHA carried out in different settings may indicate inconsistencies in the way assessment is carried out. A consistent approach to the IHA, through the use of one template by all providers, would provide quality assurance and improve the quality of data available for future analysis.

7. Treatment protocols

Clear treatment protocols and infection control guidelines are needed, particularly within reception centres. Protocols have been produced for scabies and Hepatitis B.

8. Access to CAMHS

Psychological signs and symptoms were identified commonly within the needs assessment. A clear referral pathway is needed to improve access of unaccompanied children to CAMHS services.

9. Pathways for assessment of acute health problems

Clarification is needed within social care regarding who within the social care team is responsible for a young person who becomes unwell out of normal working hours.

A consistent approach to the assessment of unaccompanied young people would be supported by a dedicated team of community practitioners with an interest in migrant health.

10. Holistic health assessment

While there are many elements of the assessment and interventions which will be relevant to the majority of unaccompanied children, the need for individual risk assessment should not be overlooked. This is particularly true in relation to consideration of FGM in girls from high risk countries, and to sexual health risk assessment.

11. Building a community resilience network

Building resilience is a cornerstone of promoting good emotional and mental health in young people of all ages and backgrounds. There should be consideration of commissioning of voluntary sector organisations to provide support to unaccompanied children in the community.

12. Integrated approach between health and social care

An integrated approach is necessary to support resilience in unaccompanied children including good communication between social care and health, and involvement of voluntary sector organisations.

13. Ongoing data collection

This report adds to the literature on the health needs of unaccompanied children. However an important limitation is the limited follow up information regarding the prevalence of conditions such as chronic Hepatitis B and latent TB. Providers of IHA which include initial investigations should be asked to report on the outcomes of these tests, so that the true epidemiological needs of this cohort can be better understood.

| 2. Introduction

2.1 Background

An asylum seeker is a person who has entered another country to claim asylum on grounds of fear of persecution in their country of nationality¹. Unaccompanied children seeking asylum are children aged less than 18 years who have been separated from their parent or carer, often due to the death or imprisonment of a carer, or to physical or material inability of the carer to make the journey to another country. Many of the health needs of unaccompanied children will be consistent those of with adults seeking asylum, such as risk of infectious diseases and experience of trauma^{2,3}. As with adults, identification of health needs may be complicated by a variety of factors including language, cultural differences, and lack of trust in authority figures⁴. In addition to physical needs, unaccompanied children seeking asylum are at higher risk of emotional problems and mental illness than either accompanied children seeking asylum or the general population⁴.

The prolonged conflict in Syria due to the ongoing civil war has led to the displacement of millions of Syrians and precipitated an international humanitarian crisis. Ongoing conflict in Afghanistan and North Africa has also contributed to the numbers of people leaving their home country to seek asylum. The United Nations High Commissioner for Refugees estimates that more than one million people seeking asylum entered Europe in 2015⁵. It is estimated that this includes more than 25,000 unaccompanied children⁶, this is felt to be a conservative estimate. While asylum support to adults and families claiming asylum is provided by the Home Office, the responsibility for the support and safeguarding of unaccompanied children belongs to local authorities⁷. One of the local authority responsibilities is to ensure that every unaccompanied child is offered a thorough health assessment. Since mid-2014 there has been an increase in the number of unaccompanied children arriving in Kent, with a significant rise in numbers June-October 2015. Therefore, there has been a large increase in need and demand for health and social care support of unaccompanied children in the county. The purpose of this report is to:

- Evaluate the expected health needs of unaccompanied children seeking asylum through reviewing the relevant literature,
- Describe the health needs observed in the population of unaccompanied children currently supported by Kent County Council,
- Review the current services provided to unaccompanied children in Kent, and how well these are able to match their expected needs,
- Make recommendations based on our findings which will improve the care received by unaccompanied children in Kent.

2.2 Definitions

Although the terms asylum seeker and refugee are sometimes used interchangeably the definition of one's status within the asylum process is important as this effects the rights and entitlements of the person. The following definitions have been taken from the Refugee Council¹.

Asylum seeker

An asylum seeker is someone who has lodged an application for protection on the basis of the Refugee Convention or Article 3 of the European Convention on Human Rights.

Refugee

A refugee is a person who "owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of his nationality, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country". In the United Kingdom Refugee status is awarded to someone the Home Office recognises as a refugee as described in the Refugee Convention. A person given refugee status is normally granted leave to remain in the UK for 5 years, and at the end of that period can apply for Indefinite leave to remain.

Unaccompanied children seeking asylum

Unaccompanied children seeking asylum are children, i.e. aged under 18 years, who have applied for asylum in their own right, who are outside their country of origin and are separated from their parents, or from their previous legal/customary primary care giver.

Refused asylum seeker

A refused asylum seeker is someone who has had their application for asylum refused. Where an application for asylum has been refused there may be an opportunity to appeal against the decision. Where opportunities for appeal have been exhausted a refused asylum seeker is compelled to leave the country, either through voluntarily returning home or through forced deportation. For some refused asylum seekers it may not be safe or practical for them to return until conditions in their country change.

Indefinite leave to remain (ILR)

ILR or permanent residency (PR) is an immigration status granted to a person who does not hold the right of abode in the UK, but who has been admitted to the UK without any time limit on his or her stay and who is free to take up employment or study, without restriction.

Economic migrant

An economic migrant is someone who has moved to another country to work. Refugees and asylum-seekers are not economic migrants.

2.3 Local authority responsibility for unaccompanied children

2.3.1 Entitlement to social care support

Local authorities have a number of responsibilities for unaccompanied children in their care⁸. These responsibilities include:

- Corporate Guardianship
- Allocation of a named social worker to each unaccompanied child
- Provision of suitable accommodation – 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 semi-independent accommodation.
- Immigration legal advice - Unaccompanied children require support in dealing with immigration questions or proceedings, this requires specialist input.
- Supporting the unaccompanied child's asylum application – it is particularly important that the local authority works alongside the child's case manager at the UK Border Agency.
- A health plan should include an Initial Health Assessment, including assessment of physical, emotional and mental health.
- A personal education plan should be produced. If English is not the first language of the child the education plan should include access to English language skills training, as well as opportunities to develop literacy in skills in the child's mother tongue.
- Rights of care leavers – immigration status does not affect the obligation on Local Authority to provide support to young people who are leaving care. Unaccompanied children are entitled to the same care leaver's support as any indigenous looked after child, as outlined in the Children's Act 1989.

2.3.1 Entitlement to healthcare

Entitlement to healthcare varies depending on age, and on the status of someone's asylum application. The healthcare to which unaccompanied children are entitled is listed below. A full explanation of the various healthcare entitlements of people seeking and granted asylum is given in Appendix A.

- **Primary Care** – Universal access without charge.
- **Prescription charges** – All unaccompanied children aged under 16 years are exempt from prescription charges following completion of a HC2 certificate. Unaccompanied children aged 16-19 years can also access exemption from prescription charges through initial completion of a HC1 certificate by the local authority.
- **Dental Services** – as per prescription charges.
- **Assessment of eyesight** – as per prescription charges.
- **Secondary Care** – For any person who has an ongoing asylum application, or has been granted refugee status, entitlement to NHS secondary care is the same as for a UK citizen, i.e. full access without charge. It is common practice in the UK that the

final decision on an asylum application in an unaccompanied child is deferred until the child is aged 17.5 years. Therefore the majority of unaccompanied children will have full access to secondary care pending a decision on their asylum application.

- **Secondary Care where an asylum application has been refused –**
 - Emergency treatment - Treatment which could save a life or prevent a condition becoming life threatening should not be delayed regardless of asylum status. However, if it subsequently transpires that the person is chargeable then the charges still apply and the hospital trust should take 'reasonable measure' to recover the charges.
 - Urgent Treatment - Urgent treatment is treatment which is not immediately necessary, but cannot wait until the person returns to their home country. Urgent treatment should not be delayed but will be chargeable. The hospital trust should take 'reasonable measures' to recover the charges. Additionally, treatment for certain urgent conditions is exempt from charges, including family planning, treatment for certain communicable diseases (e.g. Tuberculosis and Hepatitis B), and compulsory treatment for mental health conditions.
- **Maternity Care –** Unaccompanied children are entitled to free antenatal, maternity and postnatal care, where this is necessary. If an asylum application has been refused maternity care qualifies as 'immediately necessary', and therefore should be provided to all women who require this regardless of ability to pay.

Consent

Legally a child aged over 16 can give consent. A child under 16 can be deemed to be competent to give consent if the child demonstrates sufficient understanding of the proposed treatment. If the child is not deemed to be competent to consent it is usual to seek consent from the person who has parental responsibility, however this can be difficult for unaccompanied children, as the local authority does not take on parental responsibility. Where the treatment is felt to be immediately necessary and within the child's best interests, the Department of Health advises that it is lawful to provide necessary treatment.

3. Literature Review

A summary of the results of the literature review are detailed below. The literature review is available in full in Appendix B.

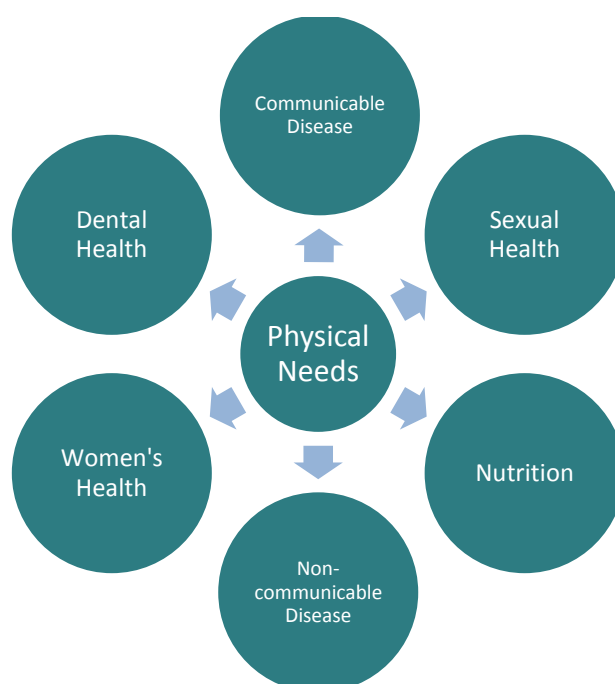
3.1 Physical Health

While many people seeking asylum arrive the United Kingdom in good health, others will have specific physical and mental needs. Risk factors for ill health in unaccompanied children include:

- limited access to basic healthcare prior to migration,
- time spent in refugee camps, which may be overcrowded and lack sanitation,
- limited access to nutritious food during the journey to the UK,
- the experience of imprisonment, torture or physical and sexual violence,
- forced labour and forced military (i.e. child soldiers),
- the journey to the host country, which may be long and arduous^{2,9}.

The key physical health issues in unaccompanied children are shown in Figure 5.

Figure 5 Key physical health needs in unaccompanied children



3.1.1 Communicable Diseases

Risk factors for communicable disease in people seeking asylum include incomplete immunisation to vaccine preventable disease, poor nutrition and experience of overcrowded travelling and living conditions¹⁰.

While infectious diseases should be considered important, it is also essential to recognise and communicate that the population risk of infection, i.e. transmission of infection to the

resident population of the host country, is low¹⁰. Members of the local population may be concerned about the risk of imported infection. Stakeholders should be aware that the risk of infection in the resident population is low and that the risk of communicable disease in people seeking asylum can be reduced through the institution of simple preventative treatments such as vaccination.

Vaccine Preventable Disease

Many unaccompanied young people will not have had access to vaccination and are therefore susceptible to diseases such as polio, diphtheria and tetanus. Practitioners should attempt to verify any previous immunisation history and 'catch-up' immunisation should be initiated if this is incomplete¹¹. Public Health England has produced a schedule for catch-up immunisation which is discussed in section 10.

Since the mid-1990s there have been concerns in relation to low uptake of the Measles Mumps and Rubella vaccine (MMR) in the UK. This has contributed to outbreaks of measles in the UK, most recently in London and the South East of England. This is especially relevant in Kent where MMR uptake is significantly below the national target of 95%. Therefore ensuring that unaccompanied young people have access to catch-up immunisation is a priority.

Polio, which has been eradicated in many countries worldwide, remains an important public health concern in Afghanistan and Pakistan. Practitioners assessing children from these countries should be alert to this, and should ensure that vaccination against polio is given¹¹. This is relevant in Kent because almost one quarter of unaccompanied children who arrived in Kent in 2015 came from Afghanistan.

Blood Borne Viruses

Blood borne viruses (BBV) include Hepatitis B (HBV), Hepatitis C (HCV) and HIV. Chronic hepatitis B and C are associated with liver cirrhosis and cancer of the liver. HBV screening should be considered in people from countries with an intermediate to high prevalence ($\geq 2\%$) of HBV¹¹. All the unaccompanied children who entered Kent in 2015 were eligible for HBV screening. Modelling has been undertaken to estimate the prevalence of HBV in unaccompanied children in Kent, this is detailed in section 5. Screening for HCV should be considered in unaccompanied children from countries with a high prevalence of HCV. The majority of unaccompanied young people who entered Kent 2015 were eligible for HCV screening. Country specific advice on appropriate screening is contained in the Migrant Health Guide, discussed in section 10¹¹.

Testing for HIV should be based on prevalence in the person's country of origin and any risk factors for HIV infection such as unprotected sexual intercourse, including rape. Screening for HIV is recommended when a person comes from a country in which the prevalence of HIV is $>1\%$ ¹¹. The majority of young people who entered Kent 2015 do not come from countries with a high HIV prevalence, however HIV testing should be considered if additional risk factors for HIV infection are present.

Tuberculosis

Tuberculosis screening is recommended in people from a country with a TB prevalence >150/100,000, or who have come from Sub-Saharan Africa, and who have arrived in the United Kingdom within the last 5 years¹². A HIV risk assessment should also be undertaken including evaluation of HIV prevalence in the person's country of origin and risk factors for HIV.

The majority of cases (53.7%) of active TB in migrants are notified within 6 years of arrival¹³. This emphasises the importance of early screening of migrants from high risk countries for latent TB. Modelling has been undertaken to estimate the prevalence of latent TB in unaccompanied children in Kent, this is listed in section 5.

Parasitic Infection

Unaccompanied children are at particular risk of intestinal parasitic infections, such as amoebiasis, lamblasis and schistosomiasis. Marquardt et al reported that the prevalence of intestinal parasitic infection in unaccompanied children varied geographically, with the highest prevalence seen in children from sub-Saharan African¹⁴. Modelling has been undertaken to estimate the prevalence of parasitic infection in unaccompanied children in Kent, this is listed in section 5.

Emerging Communicable Disease Issues

The mass movement of people that is being seen currently in the Middle-East and Europe, combined with over-crowded travelling and living conditions experienced during the asylum journey, has been associated with sporadic cases of uncommon infections in refugee populations in Europe¹⁰. Examples of re-emerging infections include louse-borne diseases such as *Borrelia recurrentis* (louse borne relapsing fever), *Bartonella quintana* (trench fever), and endemic typhus due to *Rickettsia prowasekii*¹⁰. Steps to prevent re-emerging infections include health assessments of people arriving in the UK, provision of sanitary accommodation, and immunisation against vaccine preventable disease. Clinicians responsible for treating acutely unwell migrants should be aware of re-emerging infections. A number of resources which can be accessed by clinicians are listed in section 10.

Antimicrobial resistance has also been reported in people seeking asylum in Germany¹⁵. Two recent studies carried out in Germany demonstrated a high prevalence of antimicrobial resistant gastrointestinal (bowel) bacteria in people seeking asylum^{15,16}. A detailed discussion of the results of these studies is included in Appendix B.

3.1.2 Oral Health

Dental problems are common in people seeking asylum. Dental health has been reported to be one of the most common health needs of people seeking asylum, second only to mental health². The prevalence of dental abnormalities is likely to vary depending on the presence or absence of dental services in one's home country, and knowledge of and ability to maintain oral hygiene prior to and during migration. Reports in the literature suggest the

prevalence of dental abnormalities varies based on country of origin, and may range from 20-48%^{14,17}.

3.1.3 Sexual Health

People seeking asylum may be at increased risk of sexually transmitted infection due to the prevalence of sexually transmitted infection in their home country, access to testing and treatment in their home country and exposure to risk through unprotected consensual sex or sexual exploitation and rape². A risk assessment for sexually transmitted infection should be undertaken with sensitivity. Where appropriate this should be linked with additional psychological support and counselling services.

Unaccompanied children may also be at risk of sexual harassment and exploitation after arrival in a host country. The risk of 'grooming' and harassment is highest in the months following arrival when the young person may have a limited social support network¹⁸. Young people who have been made aware of grooming techniques are more likely to report this than those who have not¹⁸. Staff supporting unaccompanied children should be alert to this risk and should be confident in recognising the signs of sexual exploitation.

3.1.4 Women's Health

Female refugees and asylum seekers have worse outcomes in pregnancy relative to the general population¹⁹. Maternity services are underutilised by people seeking asylum and those granted refugee status with these girls and women being more likely to either book late for antenatal care or to receive no antenatal care²⁰. Despite the legal entitlements of all women to receive maternity care, healthcare providers may not understand the legal entitlements of these women, particularly in women whose application has been refused^{7,21}. Commissioners of maternity services must ensure that providers are aware of the rights of these women, and of their legal obligation to provide maternity care.

Female genital mutilation (FGM), which may also be referred to as female circumcision or female genital cutting, is the practice of deliberate alteration or injury to the female genital organs for non-medical reasons. FGM has no medical benefit and is associated with significant complications for girls and women including pain, bleeding, infection, and obstetric complications. The prevalence of FGM varies globally and is most common in regions of Eastern, North-Eastern and Western Africa, and in some areas in Asia and the Middle East²². This is an important consideration locally as 29 unaccompanied girls (more than 50% of the girls who came to Kent in 2015) came from Eritrea, where the reported prevalence of FGM is 89%⁶.

3.1.5 Trafficked Children

Human trafficking is the recruitment and movement of people, including children, for the purpose of exploitation. It is reported that 44% of people who have been trafficked globally are women, and 33% are children²³. Although females are at greater risk of trafficking, the number of male children who have been trafficked is likely to be greatly underestimated

due to the perception that males are less vulnerable to this type of exploitation²³. Children who have been trafficked are also at risk of physical injury, sexually transmitted infection, unplanned pregnancy, psychological disorders and substance misuse²³.

3.1.6 Nutritional and Metabolic Needs

Unaccompanied children seeking asylum are at risk of malnutrition. The journey from one's home country to the United Kingdom is a difficult process which can take many months. Children are particularly at risk of malnutrition due to limited access to nutritious food during their journey. Marquardt et al reported the prevalence of iron-deficiency anaemia at 17.6% in a sample of 102 unaccompanied children in Germany¹⁴. Other important nutrient deficiencies children are at risk of include Vitamin D and Vitamin A deficiency¹¹.

3.1.7 Non-communicable disease

There is limited data on the prevalence of non-communicable disease (NCD) in unaccompanied children. Marquardt et al reported that the prevalence of NCD was <2% in their cohort of 102 unaccompanied children¹⁴. Diagnosed NCD included obesity, asthma and osteomyelitis. People seeking asylum are at increased risk of disability due to limited access to healthcare in their home country, and the risk of injury during the journey to the host country.

3.1.8 Summary – Physical Health Needs of Unaccompanied Children

Country specific guidance on the physical needs of people seeking asylum can be sought from the Migrant Guide. The key areas of physical health which should be considered are:

- **Communicable diseases**
 - Vaccine preventable disease – all children should have an assessment of immunisation history. Immunisation catch-up should be initiated where this is incomplete.
 - Blood borne viruses – Hepatitis B and C screening will be indicated in the majority of unaccompanied children due to a high prevalence of these conditions in their country of origin. HIV testing should be considered on an individual basis related to the prevalence of HIV in the person's home country and additional risk factors for HIV infection.
 - Tuberculosis screening – Active TB should be considered in any child presenting with symptoms of TB infection. Screening for latent TB should be carried out in children from a country with a TB incidence $\geq 150/100,000$ or from Sub-Saharan Africa. Additional consideration should be given the possibility of exposure to TB during the journey to the UK, and screening should be carried out based on clinical risk.
 - Parasitic infection – Parasitic infection is common in unaccompanied children. A full blood should be carried out to screen for eosinophilia and anaemia.

- Emerging communicable disease issues – Clinicians caring for acutely ill unaccompanied children should be aware of emerging communicable disease issues. Various resources are available to support this as listed in section 10.
- **Oral Health** – Dental abnormalities are common in unaccompanied children. An assessment of dental health should form part of an Initial Health Assessment.
- **Sexual health** – Unaccompanied children may be at risk of sexually transmitted infection, a risk assessment should be undertaken with sensitivity. Unaccompanied children are vulnerable to sexual exploitation and grooming after arrival in the UK. Unaccompanied children should also be made aware of these risks to empower them to recognise and report grooming and harassment.
- **Women's health** – Girls and women seeking asylum are entitled to access to maternity care regardless of the status of their asylum application. Girls and women may be at risk of FGM, this risk varies depending on their country of origin.
- **Trafficked children** – Unaccompanied children are at increased risk of trafficking. Children who have been trafficked are at risk of physical injury, sexually transmitted infection and psychological disorders.
- **Nutrition and metabolic concerns** – Unaccompanied children may have poor access to nutritious food during their journey to the UK. The Initial Health Assessment should include an assessment of nutritional status.
- **Non-communicable disease** – There is limited literature on the prevalence of non-communicable disease and disability in unaccompanied children. The Initial Health Assessment should include an assessment of non-communicable disease.

3.2 Mental Health

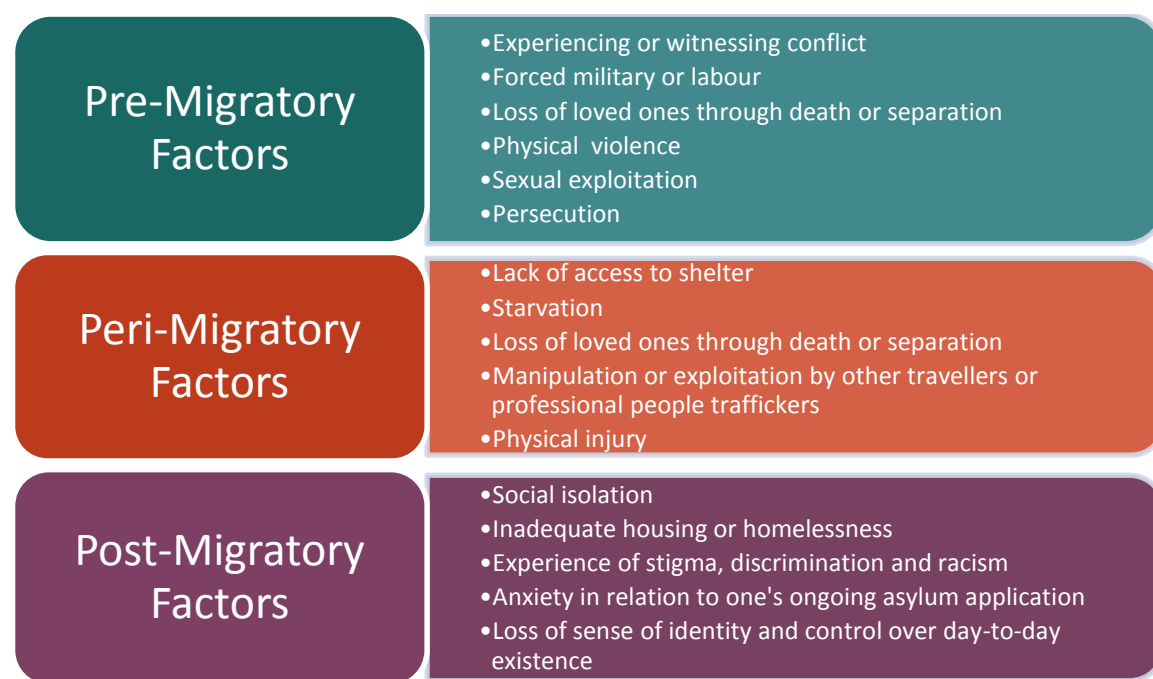
Unaccompanied children are at risk of mental illness^{24,25}. Jakobsen et al, in their study of the prevalence of mental illness in unaccompanied adolescents seeking asylum in Norway, found that 48% met diagnostic criteria for a mental illness, the most common diagnoses being Post-Traumatic Stress Disorder (PTSD), major depressive disorder, general anxiety disorder and agoraphobia²⁶. Unaccompanied children are more likely to exhibit symptoms of PTSD than their accompanied peers²⁷, indicating that making the arduous journey unaccompanied is likely to lead to increased exposure to risk and trauma²⁸.

Delayed presentations of mental illness are also recognised and may affect up to 1 in 5 unaccompanied children^{24,29}. This may be because young people are reluctant to discuss their symptoms due to shame or guilt, or due to cultural differences in interpretation of symptoms of mental illness. Survivors of torture may prioritise focusing on their basic needs, such as stable accommodation, before being willing to discuss their experiences³. Therefore reassessment and ongoing surveillance for signs of mental illness is required.

3.2.1 Risk factors for and protective factors against mental illness

Risk factors for mental illness in unaccompanied children can be conceptualised as those occurring prior to migration, those occurring during the migration journey and those occurring during and after arrival in the host country⁴.

Figure 6 Risk factors for mental illness in unaccompanied children



The relative contribution of different risk factors changes over time. Ongoing stresses within the host country, such as discrimination and racism, play just as important a role as pre- and peri-migratory factors. Important modifiable post-migratory risk factors include:

- Stigma and discrimination
- Living arrangements - Foster care offers the greatest protection against mental illness³⁰.
- Social isolation
- Language skills - Gaining proficiency in the language of the host country may be associated with lower levels of depression and internalizing symptoms.
- The asylum process - Insecure asylum status has been described as “an issue that permeates all other aspects of their lives”³¹, and is an important ongoing source of stress. Professionals working with unaccompanied children should be qualified to support the young person through this process.

Building resilience is likely to be beneficial in managing mental illness in unaccompanied young people²⁴. While it is recognised that unaccompanied children have already demonstrated considerable resilience through the journey they have undertaken²⁵ ‘coping’ can also involve harmful behaviours, such as drug use or sex work²⁴. Interventions to support these children must identify both protective factors against and risk factors for mental illness.

3.2.2 Access to mental health services

Despite a high prevalence of symptoms of mental illness in unaccompanied young people, mental health services are underutilised by this group³². Barriers to accessing mental health services include high residential mobility, language and cultural barriers, lack of awareness of free services and difficulty registering with a general practitioner. It is necessary to ensure that unaccompanied children are aware of the symptoms of mental illness and of how to access the services to which they are entitled.

3.3.3 Summary – Mental Health Needs of Unaccompanied Children

There is a high prevalence of mental health need in unaccompanied children and delayed presentations of mental illness are common. The most commonly reported mental illnesses are PTSD, anxiety, depression and agoraphobia.

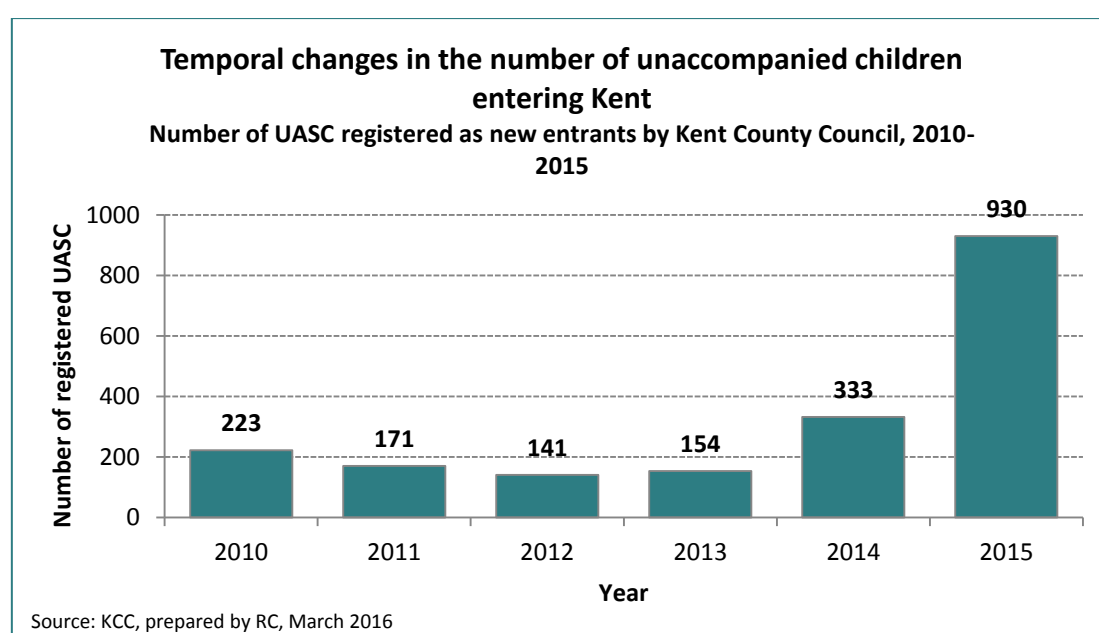
Risk factors for mental illness in unaccompanied children can be thought of as pre-migratory, peri-migratory and post-migratory. Strategies to promote emotional health and wellbeing should seek to build resilience through identifying and promoting factors which are protective for mental health and reducing risk factors for mental illness.

4. Epidemiological Needs Assessment

4.1 Temporal changes in the number of unaccompanied children entering Kent

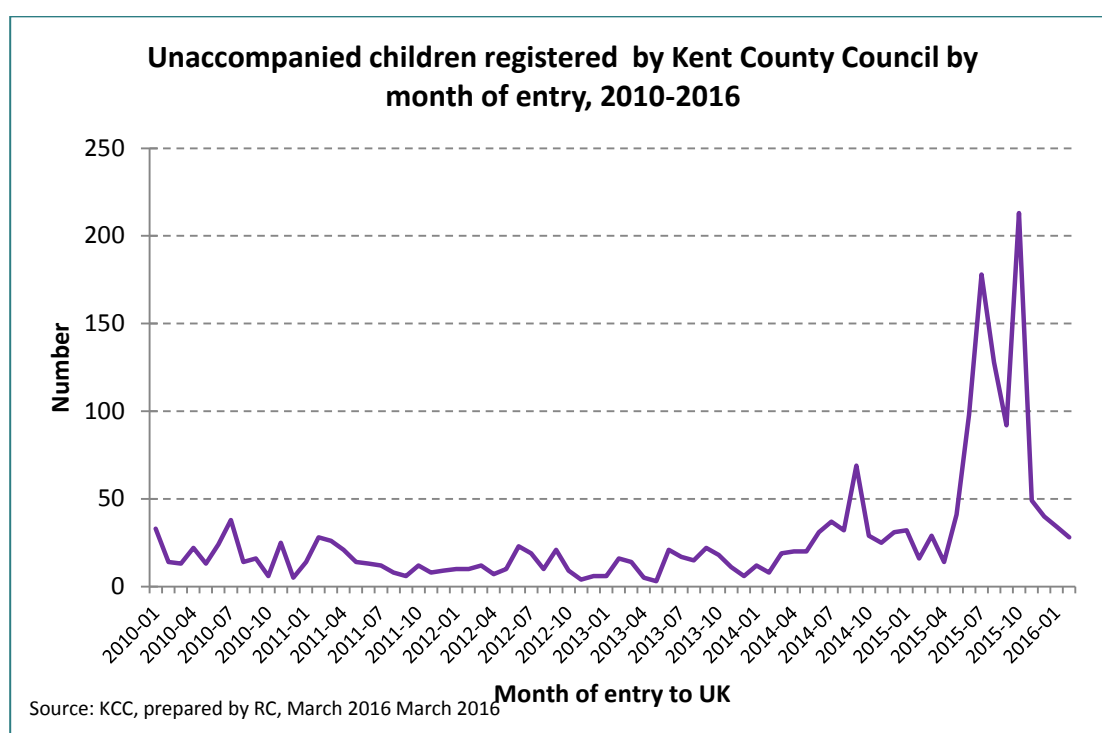
Figure 7 demonstrates the number of young people who have been registered as unaccompanied children by Kent County Council (KCC) 2010-2015. The numbers include all children who have been registered by KCC as an unaccompanied child over this time period, and therefore includes children for whom the case has now been closed and those children who are currently missing.

Figure 7 Temporal changes in the number of unaccompanied children entering Kent



The graph above shows that between 2010 and 2013 the annual number of new unaccompanied children registered by KCC ranged from 141 to 223. Subsequently there was a significant increase in the number of unaccompanied children to 333 in 2013 and 930 in 2015. Figure 8 shows the number of newly registered unaccompanied children 2010-2016 by month of entry to the UK and registration by KCC.

Figure 8 Unaccompanied children registered by Kent County Council by month of entry, 2010-2016

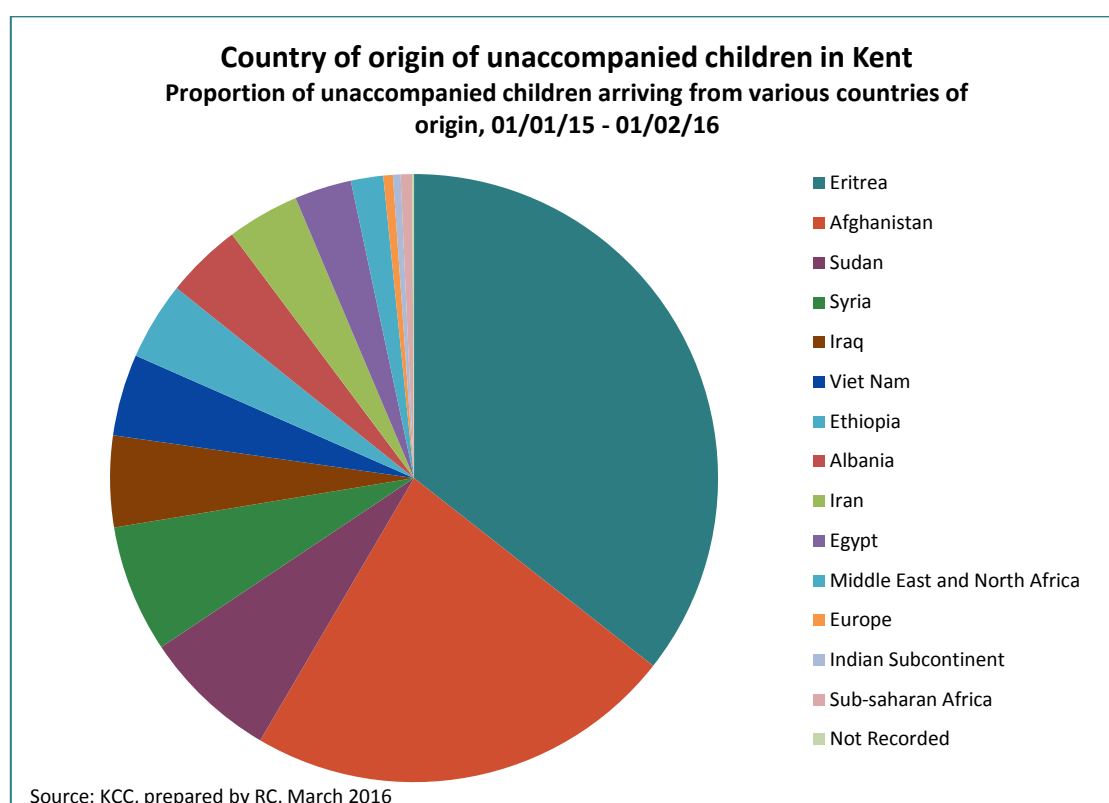


The graph above shows that prior to 2014 the number of unaccompanied children entering Kent per month rarely exceeded 25. The mean number of children entering per month was 19 in 2010, 14 in 2011, 12 in 2012 and 13 in 2013. An increase in the number of unaccompanied children entering Kent began in mid-2014, with a marked increase evident from May 2015 onwards. The peak monthly entry of unaccompanied children was seen in October 2015, when 213 newly arrived unaccompanied children were registered with KCC. There has been some decrease in the number of unaccompanied children entering Kent since November 2015, however the monthly figures remain higher than the pre-2014 average.

4.2 Country of origin

The diagram below shows the country of origin of unaccompanied children who arrived in Kent in 2015/16. The numbers presented relate to new unaccompanied children registered in Kent from 01/01/15 up to 02/02/16; and include both open and closed cases, and those children who are currently missing from care. Children from countries from which fewer than 10 children have come over 12 months have been combined with those from other countries in that WHO region.

Figure 9 County of origin of unaccompanied children in Kent



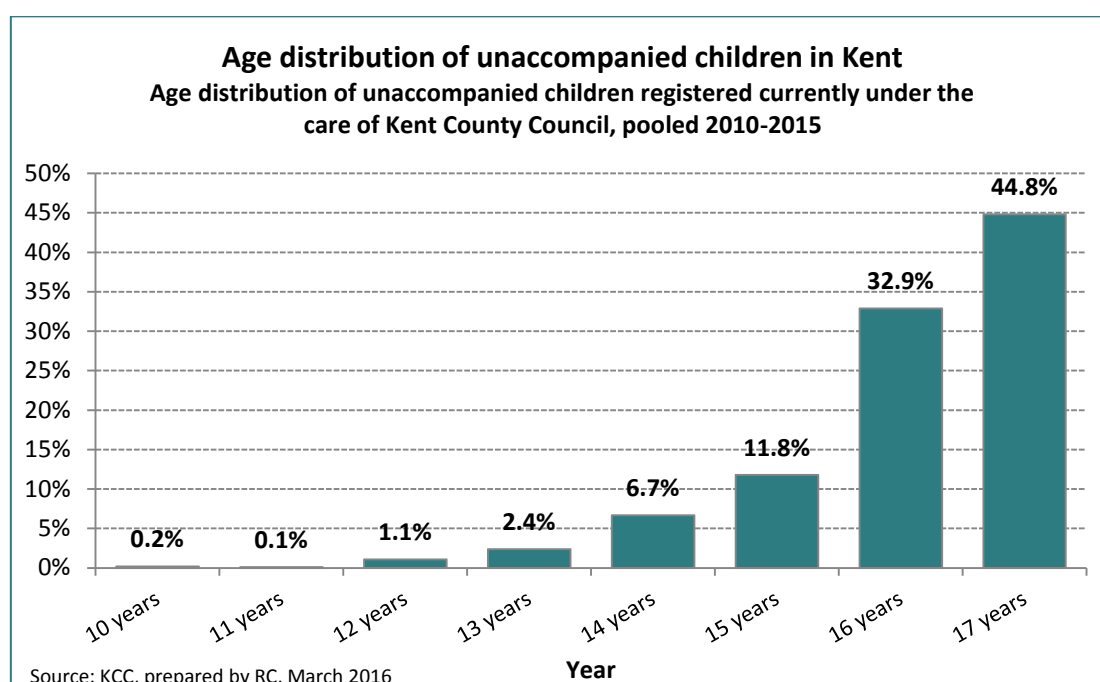
The chart above shows that the largest proportion of unaccompanied children who arrived in Kent 2015-2016 came from Eritrea, 36%, followed by Afghanistan, 23%. In addition, 7% of children came from Sudan and from Syria, and a further 5% of children came from Iraq. Smaller numbers of children came from the other countries and regions listed above.

4.3 Age and Gender

Of the unaccompanied children currently registered with KCC 94% are male, while 6% are female.

Figure 10 shows the age distribution of unaccompanied children currently registered as 'open cases' at KCC. Missing children and closed cases have been excluded.

Figure 10 Age distribution of unaccompanied children in Kent



The graph demonstrates that the number of unaccompanied children aged under-14 years is low. 16 and 17 year olds account for the majority of unaccompanied children in Kent, representing over 75% of unaccompanied children.

4.4 Accommodation

Kent County Council (KCC), in the role of corporate parent, has a duty to provide suitable accommodation to the unaccompanied children who arrive in Kent, in accordance with the Children's Act 1989. The accommodation provided differs depending on the age and gender of the unaccompanied child. Within Kent, as in many local authorities, it is usual that all children under 16 years and girls of any age are accommodated in foster care, and boys aged 16-18 years are accommodated in residential care or semi-/independent living.

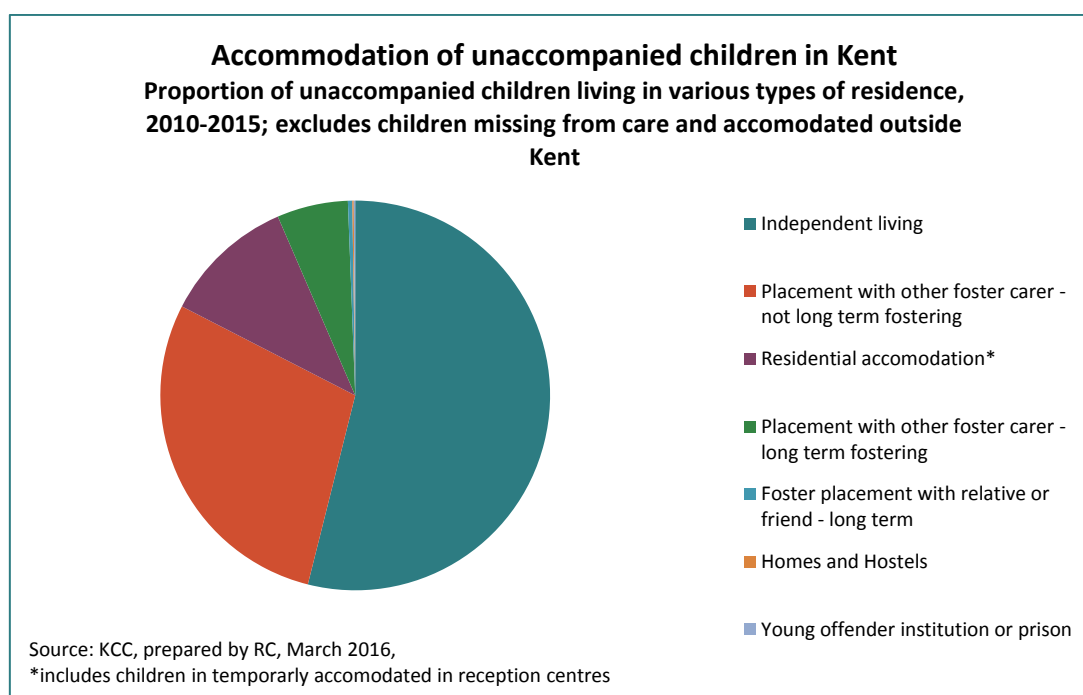
There are two reception centres in Kent which are used to provide support to boys aged 16-18 years while more permanent accommodation is arranged. Boys should be accommodated in the reception centres for a maximum period of 6-8 weeks. During this time boys should undergo an initial assessment which includes evaluation of health, educational and social care needs. The reception centres in Kent are:

- Millbank Reception Centre (Ashford)
- Appledore Reception Centre (West Kent)

A third reception centre, Ladesfield in Whitstable, was opened in 2015 as a short-term measure to cope with the increased numbers of unaccompanied children requiring accommodation. Ladesfield was closed in January 2016.

Data on the accommodation of unaccompanied children in Kent was provided by KCC. The graph below shows the proportion of all unaccompanied children currently living in Kent who are housed in various types of accommodation.

Figure 11 Accommodation of unaccompanied children in Kent



The majority of unaccompanied children, 54%, who are currently accommodated in Kent are in Independent Living. 29% of young people are living in non-long-term foster placements, and 11% are living in residential accommodation, which includes young people who have been temporarily accommodated in reception centres.

4.5 Physical and Mental Health Needs

All unaccompanied children should have an Initial Health Assessment (IHA) carried out within 28 days of entry into the UK, which is an opportunity to assess the young person's physical and mental health. Following an IHA a number of onward referrals may be made, dependant on the health needs identified. For example, people entering the UK from countries with a poor healthcare infrastructure may need vaccination against infectious diseases. The referral for an IHA should be made by the young person's social worker to the Looked After Children administrative team. This referral should then be reviewed and allocated to one of the healthcare providers.

The results of 154 IHA were analysed. This represents 61% of IHA carried out April 2015-December 2015. The sample was selected on the basis of convenience of access and was non-random. The sample included:

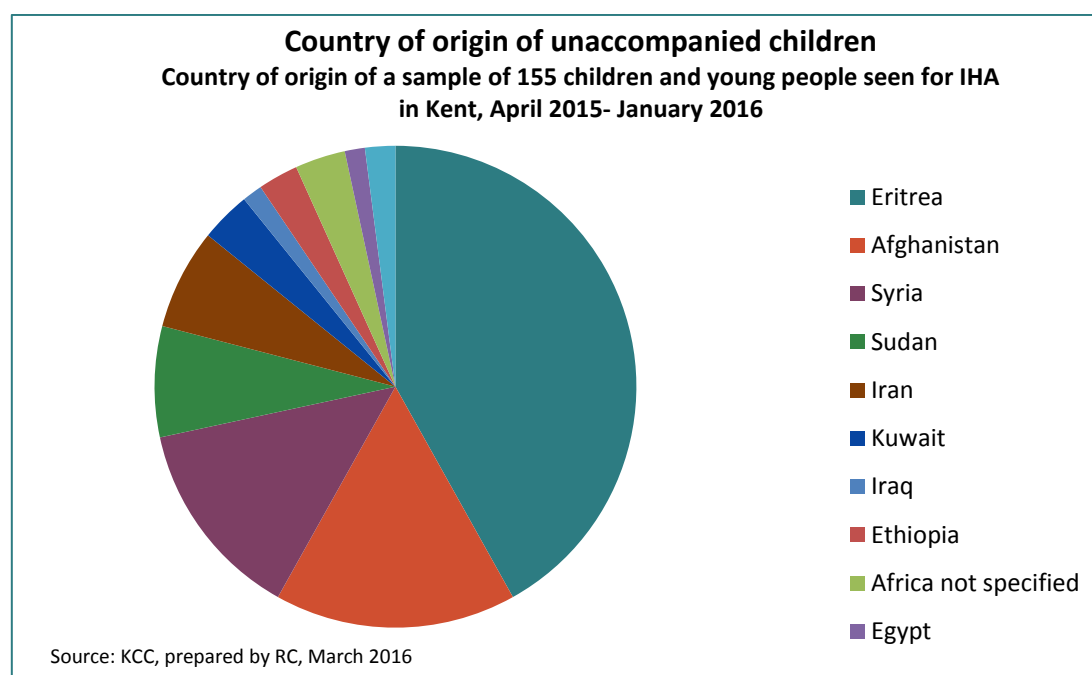
- 96 IHA carried out in a Reception Centre, all male;
- 25 IHA carried out in young people in Independent Living, all males;
- 24 IHA carried out in young people living in Foster Care, all males; and
- 9 IHA carried out in females.

Data was extracted from the IHA clinical record template by a member of administrative staff within the Looked After Children team. This was anonymised prior to analysis by Public Health. It should be noted that the clinical record template used for IHA is not consistent across Kent.

4.5.1 Demographics

The sample was 145 (94%) male and 9 (6%) female IHA. This reflects the gender distribution of the wider cohort of unaccompanied children in Kent.

Figure 12 Country of origin of a sample of 155 unaccompanied children in Kent



The diagram above demonstrates the distribution of country of origin of children and young people within the sample. The most common country of origin was Eritrea, 42%. 16% of children came from Afghanistan and 14% from Syria. Therefore relative to the wider cohort of unaccompanied children the distribution of the sample slightly over-represents children from Eritrea and Syria, and underrepresents children from Afghanistan.

The mean age of the children was 16 years and 5 months, however there was variation between the different accommodation sites as detailed in the Table 2 below. The mean age of children living in foster care was younger than that of children living in a reception centre or independent living, which is expected given that all children aged under 16 years should be accommodated in foster care.

4.5.2 Physical Health Needs

Table 2 Physical health needs by accommodation at the time of assessment

Accommodation Type	Mean Age	Registered with a GP	Dental abnormalities	Visual abnormalities	Hearing abnormalities	Psychological signs or symptoms**
Reception Centre (N=96)	16 years 7 months	93%	47%	37%	<1%	46%
Independent Living (n=25)	16 years 11 months	*	*	24%	***	36%
Foster Care (n=24)	15 years	72%	38%	***	***	30%
Female (in foster care) (n=9)	16 years 6 months	*	56%	***	***	67%

Source: KCC

*Excluded due to missing data

**Includes only children with psychological symptoms/signs; children with history of trauma without signs and symptoms excluded (n=27)

***Data suppressed where n≤3

The prevalence of various physical and mental health abnormalities in each accommodation type is shown above. Data have been omitted where a high number of missing values prevent accurate estimation of prevalence. Owing to variation in the prevalence reported at different sites aggregate values (i.e. for the whole cohort) have been calculated from weighted averages.

Dental Disease

The prevalence of dental abnormalities was 46%. This ranged from 56% in females in foster care to 25% of males in foster care. The most common dental abnormality noted were dental caries and decay, n=43. Other abnormalities included toothache, malalignment and bleeding gums. It should be noted that results from Independent Living were excluded because of missing data, and a further 11 children from foster care did not have documentation of a dental examination.

Visual Abnormalities

Visual abnormalities were documented in 37% of boys in Millbank Reception Centre and 24% of boys in Independent Living. The most common visual abnormality noted was reduced vision due to near- or long-sightedness. Other abnormalities noted in small numbers were asymmetrical vision, watery eyes and conjunctival problems. The assessment of vision documented in boys in Foster Care appears to have been limited to an assessment for congenital cataracts in the majority of children examined, which may explain the variation in the prevalence of abnormalities noted.

Hearing Abnormalities

An assessment of hearing was documented in 132 cases, 86%. Hearing abnormalities were uncommon, being noted in 5 individuals.

Physical Symptoms

Figure 13 Physical symptoms by body system

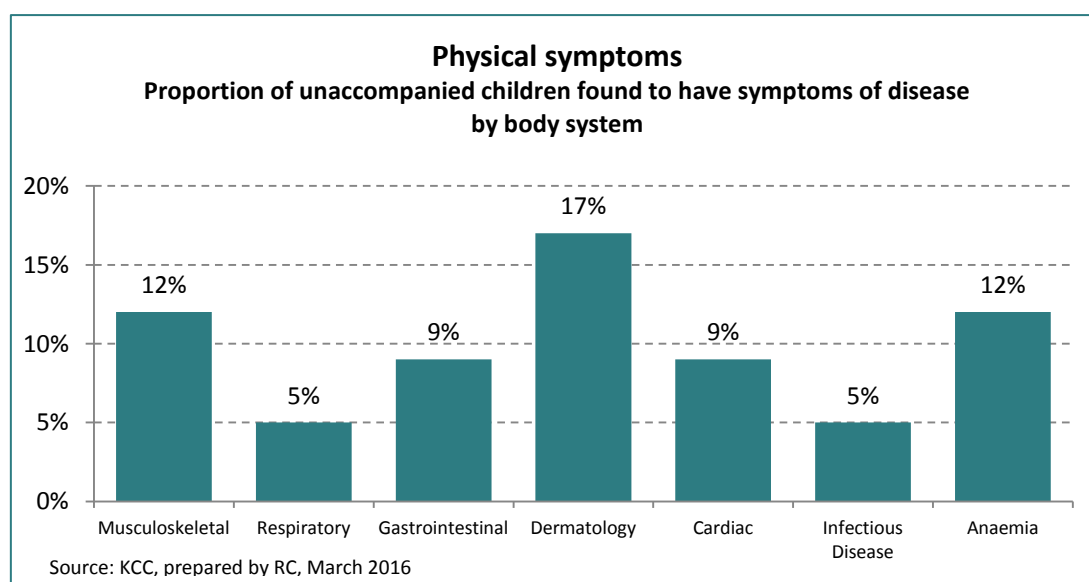
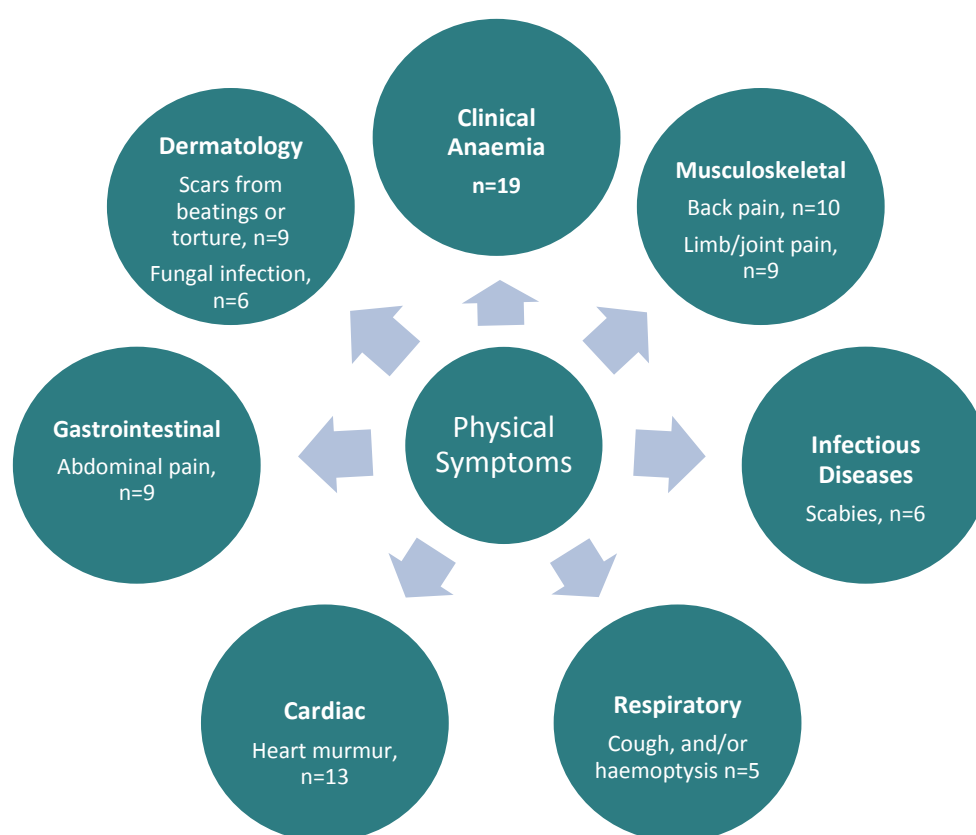


Figure 13 demonstrates the proportion of unaccompanied children who were found to have symptoms of physical illness, by body system affected. The most common physical complaints were dermatology symptoms, clinical anaemia, musculoskeletal concerns, gastrointestinal and cardiac symptoms. Specific clinical conditions/symptoms reported are displayed below.

Figure 14 Causes of physical symptoms in unaccompanied children in Kent



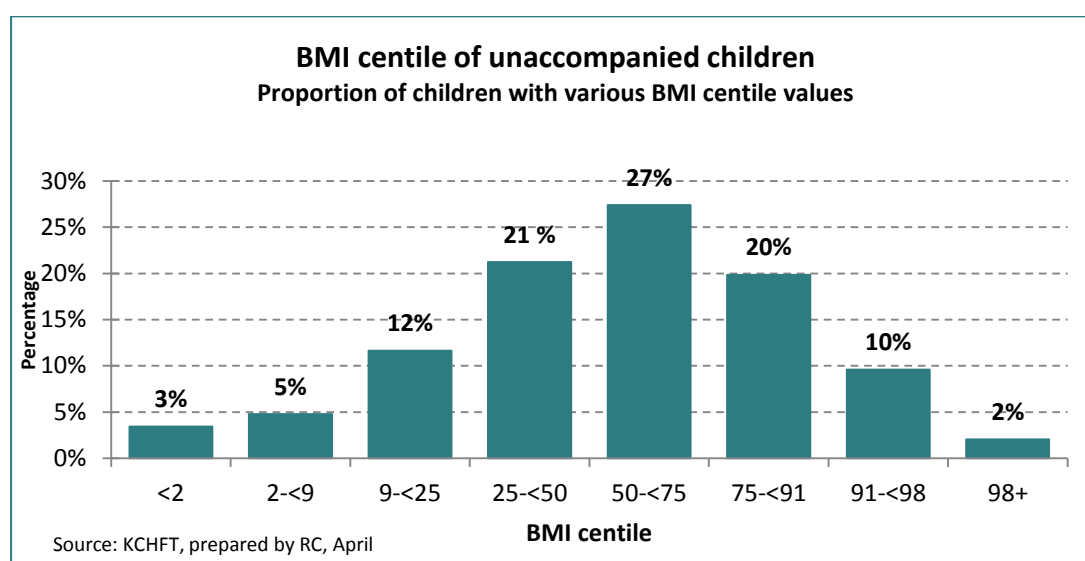
Source: KCHFT, prepared by RC, March 2016

It is important to note that while physical symptoms were reported frequently, the majority of children were felt to be physically well and the conditions/symptoms noted to be readily treatable, e.g. scabies infection. However, a number of young people had signs of more serious physical illness. 5 children, all boys accommodated in Millbank Reception Centre, presented with symptoms of respiratory infection, including cough and/or haemoptysis (coughing blood). These symptoms may reflect a simple chest infection, however other diagnosis such as Tuberculosis would need to be excluded, particularly in the presence of haemoptysis. These cases highlight that although the diagnosis of serious physical illness was uncommon, an early IHA is important to facilitate early identification of clinical problems and their investigation and diagnosis.

Height and Weight

Height and weight centile was recorded in 146 young people (94%). This has been used to calculate the Body Mass Index (BMI) centile, which is a way of displaying BMI relative to other children.

Figure 15 BMI centile distribution of unaccompanied children in Kent



The figure above demonstrates the distribution of BMI centiles in the sample of 154 unaccompanied children. The majority of children (85%) had a BMI between the 2nd and 91st centile, which is a normal BMI. 3% of children (5 children) had a BMI <2, which may reflect undernutrition. 10% of children (14 children) had a BMI in the 91-98th centile, which suggests overweight and 2% (2 children) had BMI above the 98th centile, which suggests very overweight/obesity.

Immunisation and Blood Borne Virus Screening

100% of the 96 boys assessed in Millbank Reception Centre were felt to have an incomplete vaccination history, and therefore to require immunisation as per the PHE protocol for migrants with uncertain vaccination history. Unfortunately due to substantial missing data the prevalence of need for immunisation could not be evaluated for the young people from Independent Living or Foster Care.

Blood borne virus testing was recommended for all 96 boys assessed at Millbank. Additional tests recommended for individual children included a full blood count and ferritin, (which could identify anaemia and signs of infection), and a haemoglobinopathy screen.

Non-Communicable Disease

A cardiac murmur was recorded in 13 children – in the absence of acute signs of illness this is likely to reflect a chronic health illness which may require follow-up.

Sexual Health

Sexual health 'issues' were reported in 6 children (4%ⁱⁱ) however reporting of sexual health issues was inconsistent. For example 'no sexual health issues' were documented in cases of disclosed child sexual assault. It is unclear if this represents a failure to identify the need for

ⁱⁱ Children from Independent Living were excluded from analysis due to missing data.

screening for sexual infection or an issue with the recording of information on the IHA template.

Smoking and Substance Misuse

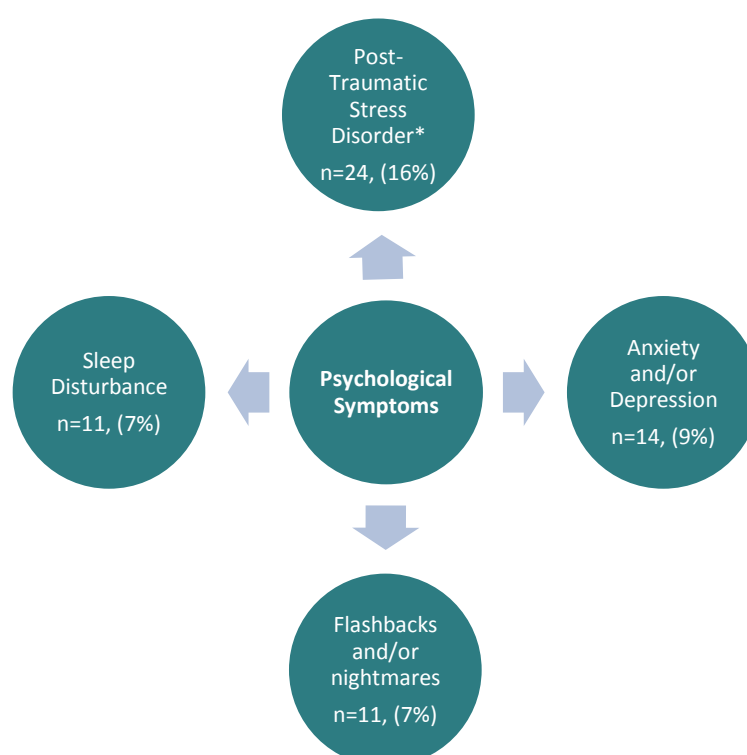
Smoking was reported in 12 children (9%ⁱⁱⁱ). Documentation of enquiry about substance misuse was only recorded for children at Millbank Reception Centre. There was no positive history of substance misuse.

4.5.3 Psychological Symptoms

Psychological symptoms were reported in 63 children, weighted prevalence 41%. It should be noted that this figure does not include children in whom the clinician expressed concern about emotional well-being but in whom no symptoms of psychological illness were noted. Concern about emotional wellbeing was expressed in a further 28 children. As demonstrated in the table above there was variation in the prevalence of psychological symptoms recorded in different settings.

The most common psychological symptoms reported are shown in Figure 16. Where a clinical diagnosis is mentioned, e.g. PTSD or depression, this includes both possible and probable cases.

Figure 16 Causes of psychological symptoms in unaccompanied children in Kent



Source: KCHFT, prepared by RC, March 2016

ⁱⁱⁱ Children from Independent Living were excluded from analysis due to missing data.

The most common psychological condition either diagnosed or suspected was Post-Traumatic Stress Disorder (PTSD), followed by symptoms of anxiety and/or depression; sleep disturbance and flashbacks and/or nightmares. Self-harm and suicidal ideation was also reported.

4.5.4 History of trauma

A history of direct or witnessed experience of trauma was reported in 65 cases^{iv}, 42% of young people assessed. This included experience of physical violence, n=23, witnessing violence or traumatic events, n=25, imprisonment, n=14, and forced labour, n=6. Sexual assault was reported by 6 children.

4.5.5 Implications of findings for the wider cohort of unaccompanied children

Table 3 below demonstrates the number of young people who would be expected to have health problems if the rate of health conditions observed in our sample was applied to the whole cohort of young people who entered Kent January 2015-February 2016, i.e. 989 young people. Owing to the variation in the prevalence of various needs between the different accommodation sites weighted averages have been used. It is noted that this variation may relate to differences in the clinical record template used, as discussed below, therefore it should be emphasised that these figures should be viewed as an estimate and accuracy is influenced by the quality of the data available.

^{iv} Figures will not sum to 65 due to reporting of more than one trauma in some cases.

Table 3 Projected health needs in unaccompanied children who entered Kent January 2015 - January 2016

	Rate in sample of 154 unaccompanied children (weighted average)	Projected number of wider cohort effected
Physical Health		
Physical Symptoms	55%	544
Dental Abnormalities	41%	405
Visual Abnormalities	34%	336
Mental Health		
Psychological symptoms	41%	405
Tests Needed		
Need vaccination	100%	989
Need TB screening*	71%	702
Need Hepatitis B screening	100%	989

*As per WHO criteria, note that extension of these criteria may be appropriate due to risk of exposure during migration

The information in the table above indicates 455 of the 989 young people who entered in Kent January 2015-February 2016 would be expected to have dental abnormalities, the expected number of various physical complaints is given. All 989 would be expected to require vaccination and screening for Hepatitis B and at least 702 to require screening for latent TB. Psychological symptoms would also be expected in around 405 young people.

It should be noted that variation in the prevalence of symptoms was noted between young people in different types of accommodation, and in boys versus girls. It has not been possible to take this variation into account when estimating the number of young people in the wider cohort who would be affected by various health issues. Therefore some caution is needed when interpreting these findings.

Additionally there are a number of health issues which have not been routinely addressed within the IHA but remain relevant. For example the IHA does not contain an enquiry about FGM, however this is likely to be an important issue for number of girls within the cohort, particularly those from North and East Africa. Similarly, sexual health risk assessment was documented inconsistently within the IHA. However a number of unaccompanied children will have sexual health needs which should not be missed – it is particularly important that children who disclose a history of sexual assault are given the opportunity to be screening for sexually transmitted infection.

4.4 Summary

- Physical health concerns were reported commonly in this sample of unaccompanied children. The most common concerns were dental health (46%), dermatology complaints (17%), clinical anaemia (12%), and musculoskeletal complaints (12%).
- The majority of physical health concerns identified were readily treatable, non-acute conditions. However a small number of children presented with symptoms of more serious illness including respiratory infection.
- A high need for immunisation catch-up was identified.
- A high need for blood borne virus screening was identified.
- Smoking was reported in 9% of young people living at Millbank Reception Centre. There were no reports of substance misuse.
- Psychological concerns were reported in 41% of young people, the most common of which were symptoms of PTSD and anxiety and/or depression.
- A history of trauma was reported frequently including experience of physical violence, witnessing violence, imprisonment and physical and sexual exploitation.
- Variation was noted in the comprehensiveness of recording of clinical information. For example the need for immunisation was incomplete for young people living in Independent Living and Foster Care, and the assessment of vision for boys in Foster Care appears to have been limited to the exclusion of cataracts. This may relate to differences in the content of the clinical forms used to record information, or difficulties in data extraction experienced by administrative staff familiar with different clinical forms.

5. Modelling the burden of communicable disease

A limitation of this needs assessment is that it has not been possible to evaluate the true burden of communicable disease. This is because (i) the proportion of children who have had the investigations recommended following the IHA is unclear; (ii) the results of any tests carried out in primary care are not available for evaluation. Therefore modelling of some key infectious diseases has been carried out to estimate the expected number of children affected by Latent Tuberculosis (LTB), chronic Hepatitis B virus (HBV) and parasitic infection.

5.1 Latent Tuberculosis

Based on WHO guidelines 700 children, 71%, of the 989 unaccompanied children who entered Kent January 2015-February 2016 meet criteria for latent Tuberculosis screening. An additional consideration is that exposure to TB may have occurred during the journey to the UK, particularly where a journey has taken many months and involved travelling in overcrowded conditions. Therefore people may be at risk of TB even if their country of origin is not classified as 'high-risk'.

Pareek et al reported the prevalence of latent TB by WHO region. Prevalence estimates were: Europe/America 4%, Middle East and North Africa (MENA) 4%, Other Asia 18%, Indian Subcontinent 20% and Sub-Saharan Africa 28%⁵⁵. These figures have been applied to the population of unaccompanied children who have entered Kent since January 2015. The table below demonstrates the expected prevalence of latent TB in the cohort of 989 unaccompanied children who entered Kent January 2015-February 2016 by WHO region. A more detailed table is listed in Appendix D.

Table 4 Modelled burden of latent Tuberculosis in 989 unaccompanied children who entered Kent January 2015-January 2016

WHO region	Expected prevalence of latent TB	No. children from WHO region	Estimated no. children with latent TB
Sub-Saharan Africa	28%	470	132
Other Asia	18%	269	48
Indian Subcontinent	20%	4	1
Middle East and North Africa	4%	205	8
Europe /America	4%	40	2
Not documented	n/a	1	n/a
Total		989	191

Source: Pareek et al 2011; Kent Public Health; prepared by RC march 2016

Using Pareek et al's estimate of latent TB prevalence 191 of these children, 19%, would be expected to require treatment for latent TB. It should be recognised that the prevalence estimates are based on a cohort of individuals aged 16-35 years, and that the prevalence of

latent TB was noted to be higher in individuals aged 25-35 years, (25%), compared to those aged under 16 years, (3%), and 16-25 years, (15%). The figures above should therefore be viewed as an estimate. This may overestimate the true prevalence of latent TB in the cohort of unaccompanied children in Kent, however the true prevalence will only become clear through evaluating the results of screening for latent TB as this process becomes more efficient.

A HIV risk assessment, including evaluation of prevalence of HIV in a person's home country and risk factors for HIV acquisition, should also be undertaken in individuals being screened for latent TB.

5.2 Chronic Hepatitis B

The prevalence of chronic Hepatitis B varies globally. Chronic Hepatitis B can be diagnosed through a blood test for Hepatitis B Surface Antigen (HBsAg).

Ott et al identified the age and gender specific prevalence of HBsAg in various WHO regions³³. These prevalence estimates have been applied to the cohort of unaccompanied children who entered Kent January 2015-February 2016.

Table 5 Modelled burden of chronic Hepatitis B infection in 989 unaccompanied children who entered Kent January 2015-January 2016

WHO Region	Prevalence of Hepatitis B surface antigen	No. children from region	Expected no. children with chronic HBV
East Sub-Saharan Africa	7%	464	32
West Sub-Saharan Africa	10%	4	0
South Sub-Saharan Africa	7%	2	0
South Asia	3%	230	8
South East Asia	3%	43	1
Middle East and North Africa	4%	205	9
Central Europe	3%	40	1
Not documented	n/a	1	n/a
Total		989	52

Source: Ott et al 2012; Kent Public Health; prepared by RC, March 2016

5.3 Parasitic Infection

The prevalence of parasitic infection is less well characterised than the other infections discussed above. Marquardt et al found that the prevalence of parasitic infection, such as schistosomiasis, in unaccompanied children varied by geographical area with the prevalence ranging from 48.7% in Sub-Saharan Africa, to 13.2% in South Asians and 6.7% in West Asians¹⁴. The author was contacted and kindly supplied the prevalence of parasitic infection

found in unaccompanied children from various other WHO regions. This has been used to calculate the number of children expected to have parasitic infection.

Table 6 Modelled burden of latent Tuberculosis in 989 unaccompanied children who entered Kent January 2015-January 2016

WHO Region	Prevalence of parasitic infection	No. children from region	Expected no. children with parasitic infection
Sub-Saharan Africa	46.7%	470	219
West Asia	6.7%	115	8
South Asia	13.2%	268	35
Other areas	Suppressed*	136	17
Total		989	280

*Unpublished data, therefore region specific prevalence estimates suppressed.

Source: Marquardt et al (2015); Kent Public Health, prepared by RC, March 2016

The table above demonstrates that 279 (28%) of the 989 unaccompanied children who entered Kent January 2015-February 2016 would be expected to have a parasitic infection.

The Migrant Guide recommends screening for parasitic infection in people with an eosinophilia ($>0.4 \times 10^9$ per litre) on full blood count, or with unexplained symptoms, particularly gastrointestinal symptoms. More detailed information on screening for parasitic infection is available from the Migrant Guide (see section 10).

| 6. Corporate Needs Assessment

The purpose of a corporate needs assessment is to understand the perspectives of stakeholders. Semi-structured interviews were carried out with members of the social care team involved in supporting unaccompanied children. Staff interviewed included:

- The strategic lead for unaccompanied children,
- The lead for the reception centre facilities,

Additionally, the lead TB nurses from the three TB screening services which cover Kent and Medway were contacted to discuss screening activity.

The key themes are summarising below.

6.1 Social Care

6.1.1 Experience of supporting unaccompanied children

Experienced social workers in Kent have traditionally been important in identifying young people with signs of mental illness. It is recognised that following the unprecedented increase in the number of unaccompanied children coming to Kent from June 2015 the capacity of the social work team to support these young people was exceeded. This led to delays in allocation of young people to a named social worker and necessitated the recruitment of additional social workers to meet the increase in demand. Traditionally social workers have played a key role in identifying 'at risk' young people, including unaccompanied children. The ability to fulfil this role was compromised for the period during which the service was unable to meet the sharp increase in demand.

6.2.2 Mental Health issues

Staff working directly with unaccompanied children felt that mental health issues among unaccompanied children were significant. Additional triggers for mental illness after arrival in the UK were identified as:

- "Massive pressure" due to the expectations of family remaining in one's home country, e.g. expectation that money will be sent back,
- Frustration due to being unable to work
- Guilt that they are the one chosen to leave their home country while other family members have been 'left behind'.

Concern was expressed that recently recruited reception centre staff may not have sufficient training to enable them to identify 'at risk' children, or to recognise more complex or subtle presentations of mental illness.

Child sexual assault prior to entry to the UK was reported infrequently. Concerns were raised that cultural issues could lead to underreporting of a history of sexual assault.

Access to acute mental health input out of hours was highlighted as a particular issue. It was highlighted that there have been difficulties determining which mental health team a young person should be referred to, as the majority are aged 17-18 years, i.e. a time usually associated with transition from child to adult services. Staff noted that it has been difficult at times to access advice regarding suspected mental illness, and that access to out-of-hours services can be problematic.

6.2.3 Physical Health issues

It was felt that the number of young people who had a serious physical health issue was low, however concern was expressed that staff within reception centres can find it difficult to access advice or support if they are worried about a young person with more serious health issues.

The timing of the IHA was identified as an issue. Due to the issues with capacity this has frequently occurred beyond the statutory timeframe. Consequently if a diagnosis is made during the IHA there may be little time for the young person to process this within the more supportive environment of the reception centre, prior to transfer to Independent Living. An example was given of a young person who was diagnosed with chronic Hepatitis B shortly before he was due to move into Independent Living.

Concern was expressed about the continuity of care once a young person was transferred to community accommodation. A high prevalence of smoking within young people living in the reception centres was noted. There was concern that 'public health' issues such as smoking, substance misuse and sexual health were being de-prioritised relative to vaccination, physical health assessment etc.

6.2.4 Service Delivery

The level of training of staff within the reception centres was highlighted as a potential concern, as discussed above.

Clarification is needed regarding the delegation of responsibility for support of acute health issues out of hours. Currently there are no social care staff in the reception centres overnight, (security staff are present). Although there is a member of senior staff on-call, it is not clear who is responsible for the support of a young person with an acute health issue out of hours.

Staff within the reception centres felt that there is conflicting information given in relation to management of health issues, particularly in relation to communicable disease. For example there has been lack of clarity regarding the infection control procedures needed if a young person is diagnosed with active Hepatitis B, or the extent of contact treatment of scabies with the context of the reception centres.

6.2 Experience of the Tuberculosis Screening teams in Kent County Council

The expected prevalence of latent TB (LTB) is modelled in section 5. Clinicians who identify the need for LTB screening may either refer the young person directly to the LTB screening service, or request that this is done by the young person's GP. This has led to a variation in practice. Clearly the major barrier to LTB screening so far has been the limited number of IHA which have been carried out. Another barrier exists because the responsibility for the referral is usually passed to the young person's GP, rather than made directly from the IHA. This contributes to further delays.

Concerns have been raised that TB screening activity is less than expected given the number of young people eligible for TB screening who have entered Kent in the last year. It has been difficult to estimate the number of young people who are both eligible for screening and have had an IHA due to problems accessing this data. It is estimated that of the 253 IHA carried out April 2015-December 2015 a minimum of 195 were carried out in Kent (as opposed to out-of-area) and of these 195 approximately 137^v would be eligible for LTB screening. This figure relates solely to country of origin and does not account for children deemed to be at risk due clinical symptoms or exposure en route to the UK.

Telephone interviews were conducted with the lead nurses from the East and West Kent TB screening centres and the TB lead nurse in Medway. The key information from these interviews was:

- It is difficult to state with confidence the number of unaccompanied children who have been screening in the TB services over the last 12 months. An estimate of numbers seen in Kent and Medway was less than 50 children between the three screening centres.
- There is substantial capacity to carry out LTB screening within Kent and TB screening services are keen to be involved in screening unaccompanied children for LTB.
- Direct referral of eligible young people for LTB screening from the IHA is acceptable to the leads within the screening service.

Therefore screening activity has been much lower than would be expected within the young people who have had an IHA. There is also substantial capacity for TB screening which is not currently being utilised. Local TB services are keen to be involved in TB screening for unaccompanied children and have willingness to be flexible in their role within this process.

^v Based on proportion of cohort of 989 young people eligible for screening

| 7. Comparative Needs Assessment

Certain areas of England have substantial experience in supporting unaccompanied children due to factors such as geographical location or proximity to Home Office centres. Telephone interviews were carried out with key members of staff involved in the organisation or commissioning of services for unaccompanied children in Croydon and Manchester were contacted to gain an understanding of how services were structured in these locations. The key information gained through this process is outlined below.

7.1 Relationship with Social Care

The beneficial impact of dedicated social workers with experience supporting unaccompanied children was highlighted by clinicians from Looked After Children (LAC) teams in several centres. It was felt that experienced social workers played an essential role in identifying young people with signs of mental illness.

7.2 Role of the Looked After Children Team

The role of a dedicated Unaccompanied Children nurse lead within the LAC team was felt to be beneficial in terms of communication with other key specialists supporting unaccompanied children. Dedicated Unaccompanied Children nurses played key role in communicating with:

- the social work team,
- the Independent Review Officer, who has a role in monitoring the performance of local authority teams supporting looked after children in line with their statutory responsibilities,
- the local TB screening and treatment lead, and
- local GPs caring for unaccompanied children.

7.3 Initial Health Assessments

IHA were delivered by a combination of general practitioners and paediatricians either through general practices contracted to provide IHA, or directly by doctors within the local looked after children team.

It was felt to be beneficial to be able to initiate blood tests and immunisation within the IHA

7.4 Common health issues encountered

The most frequent physical health issues reported by teams supporting unaccompanied children in England were:

- Need for TB screening,
- Dermatology issues, e.g. scabies and fungal infection,
- Chronic Hepatitis B,

- Clinical diagnosis of parasitic infection based on anaemia and eosinophilia.

7.5 Commissioning of specialist services

Croydon CCG currently commissions COMPASS which provides an integrated approach between CAMHS and social care. In recognition of the need for increased specialist mental health input there is now a dedicated psychiatry service working within COMPASS.

Additionally, the CCG has commissioned Freedom From Torture, a voluntary sector organisation which works with people who have experience torture, to provide support services to unaccompanied children.

Manchester's unaccompanied children team has historically worked closely with voluntary sector organisations, such as Barnardo's and the Children's Society, which provide support to unaccompanied children.

| 8. Current Services

8.1 Current capacity to deliver Initial Health Assessments

Currently IHA are delivered by:

- South Ashford Medical Services – 16 IHA a month delivered from Millbank Reception Centre, Ashford;
- Kent Community Health Foundation Trust (KCHFT) – September-December 2015 IHA were delivered by a community paediatrician working from Millbank Reception Centre. This contracted ended in December 2015;
- London IHA – IHA for those children dispersed to London local authorities have been contracted to a London based team linked to Guys and St Thomas' Hospital. IHA began in late January 2016.

As noted above the contract for IHA with KCHFT ended in December 2015. Therefore from December 2015 IHA capacity was limited to the 16 IHA carried out per month by South Ashford Medical Services. Recruitment of additional clinicians to carry out IHA was undertaken in late 2015 to increase the capacity to deliver the IHA. From April 2016 IHA capacity will be as follows:

- Monday – Friday clinics to carry out IHA on young people in Independent Living, 16-20 IHA per week,
- Saturday clinic to carry out IHA on young people in Appledore Reception Centre, 3 IHA per week,
- Medway clinic to carry out IHA on young people in foster care, 3 IHA per week,
- South Ashford Medical Services – 16 IHA a month delivered from Millbank Reception Centre, Ashford;
- Guy's and St Thomas' to provide IHA to young people placed in London, 2-5 IHA per week.

8.2 Unmet need for Initial Health Assessment

Due to the rapid increase in numbers of unaccompanied children requiring an IHA from May 2015, and delays in recruiting additional staff to carry out IHA, capacity to deliver IHA within the statutory timeframe (28 days) was exceeded. As of February 2016 KCC had a record of 484 outstanding IHA. The location of these young people is detailed in the table below.

Table 7 Outstanding initial health assessments by accommodation type

	Children's Home	Reception Centre	Independent Living	Foster Care – long term	Foster Care – not long term	Total
Kent	5	62	119	5	72	263
Medway	2	0	60	0	14	76
Out of area	0	0	48	*	59	108
Missing	0	17	11	0	9	37
Total	7	79	238	6	154	484

*Data suppressed where number <4

Source: KCC, prepared by RC, March 2016

As of February 2016 there were 484 unaccompanied children awaiting an IHA, of whom 263 were in Kent, 76 were in Medway, 108 were out of area and 37 were currently missing.

| 9. Discussion and gap analysis

It is clear that there has been a significant increase in the number of unaccompanied children entering Kent over the last year. Although the average number of new entrants per month has decreased, this remains above the pre-2014 average. It is uncertain if this will be maintained, or if seasonal changes will influence the number of unaccompanied children travelling to the UK to seek asylum. Additionally, the Immigration Bill 2015-16 will consider the role of dispersal of unaccompanied children to other parts of the UK from the area in which they arrived. The third reading of the bill, which represents the last opportunity to amend the Bill, is scheduled for April 2016. If the Immigration Bill is passed this could mean unaccompanied children who arrive in Kent could be moved to other parts of the UK following an initial period of assessment. Therefore it is essential to understand the health needs this group and to maximise the performance of services so that their needs can be assessed and management initiated prior to their movement to other areas of the UK.

9.1 Current Gaps

Firstly it is important to recognise that the services in place in Kent have been insufficient to cope with the increase in demand experienced during 2015. This is particularly true regarding health. As of February 2016 there were 484 IHA outstanding. This constitutes a failure of services to identify and address the health needs of unaccompanied children, which is both a statutory and moral obligation of health services. This is an opportunity to make a difference to the lives of vulnerable young people. The current mechanism of delivering IHA, whereby necessary screening and vaccination etc. is referred on to the GP, creates further barriers to the delivery of simple preventative treatments. This is evidenced by the low numbers of unaccompanied children referred to the TB screening services in Kent. In order to improve the effectiveness of the IHA these treatments/tests should be integrated into the IHA.

A large proportion of the unaccompanied young people in Kent have either not had an IHA, or have not had the necessary preventative treatments. Consequently there is currently a moderate sized cohort of un-immunised young people, many of whom are living together in temporary residential accommodation, who are at risk of vaccine preventable diseases such as measles. These young people are missing opportunities for screening and treatment to prevent illness in themselves and others. It is imperative that health and social care practitioners facilitate the initiation of simple, effective, preventative medicine to avoid both individual infection and the real risk of outbreaks within this population. This is particularly relevant for conditions such as measles given that the population uptake of the MMR in Kent is below the 95% target. Additionally, even within the context of the limited number of IHA which have been completed TB screening activity has been much lower than expected. This indicates that the current process of advising the GP to refer to TB screening is not fit for purpose. Again opportunities for screening and prevention are being missed.

The IHA is an opportunity to assess a young person's mental health and wellbeing. Concern was expressed by clinicians carrying out IHA, as well as by social care staff working with unaccompanied children, about the emotional wellbeing of unaccompanied children. Individuals working with unaccompanied children should have appropriate training to empower them to recognise the signs and symptoms of psychological illness in these young people. Additionally, social care staff need to be supported in managing the needs of these young people through access to advice from specialist healthcare practitioners and clear referral pathways to specialist services.

A robust system of carrying out the IHA expediently is required, as well as a clear process of managing identified need. There are a number of ways the current service could be improved including:

- Increased capacity to ensure IHA are carried out at the earliest opportunity, and within the statutory timeframe,
- Building capacity through training of local interested practitioners to be able to carry out IHA,
- Initiation of vaccination during IHA,
- Baseline blood testing within the IHA, as necessary,
- Direct referral to specialist services such as TB screening and CAMHS as required.

9.2 Observed Health Needs

In the sample of 154 IHA analysed physical and psychological concerns were reported commonly. The most common physical symptoms were dermatological, musculoskeletal and anaemia, as well as a high prevalence of dental disease. The presence of fungal infections and conditions such as scabies are indicative of the overcrowded and unsanitary living conditions experienced by unaccompanied children during their journey. This also highlights the need for robust treatment strategies when communicable disease is diagnosed through the IHA, particularly given that the majority of the children spend some time living in residential facilities. A high prevalence, 12%, of musculoskeletal disorders was also reported. It is difficult to comment possible causes of these symptoms, owing to the limited information available within the IHA. However this is consistent with the reports from reception centre staff regarding unaccompanied children complaining of joint and back pain secondary to injuries sustained through their journey or through experience of physical violence.

It is important to be aware that while the prevalence of physical symptoms was common, in the majority of these cases the symptoms or signs of illness were indicative of non-severe and readily treatable illness, e.g. fungal skin infection. These indicators highlight that while unaccompanied do have physical health needs the majority of these needs can be managed in primary care settings. Additionally, a small but significant number of young people had symptoms of more serious illness, including probable chest infection.

In addition to the need for latent TB screening and immunisation discussed above, blood borne virus testing was also recommended in the majority of individuals. Unfortunately it is not possible to establish how many of these tests have subsequently been carried out, or the results of any tests performed. The lack of follow-up data should be viewed as a limitation of this needs assessment in fully describing the needs of this cohort of young people.

Symptoms of psychological illness were reported in 41% of children. This figure is consistent with the literature documenting the prevalence of mental health issues in unaccompanied children. The most common symptoms were those of PTSD, which was documented in 16% of children, followed by symptoms of anxiety and depression, flashbacks and sleep disturbance. Additionally, the assessing clinician expressed concern about emotional wellbeing in a further 28 children due to their experience of significant trauma. The literature reports that delayed presentations of psychological illness are common in unaccompanied children. Furthermore, it should be noted that the IHA does not involve a definitive diagnostic evaluation for psychological illness, but notes the presence of symptoms suggestive of psychological problems. Therefore these estimates should be treated with some caution. Furthermore the true prevalence of mental illness may change over time.

Finally, it is notable that there was significant variation in the amount of information available from the IHA carried out in various sites. Different clinical record templates are used in different areas. Data was extracted from the clinical records by administrative staff within one LAC team. Therefore the reasons for the variation in the information obtained may relate to differences in the clinical records themselves, and the comprehensiveness of the information collected, or to varying familiarity of administrative staff with the templates influencing the ease of data extraction. This may also explain the variation in the prevalence of particular health concerns reported in children at different accommodation sites. This impacts on the information obtained, and may be indicative of variation in the quality of IHA. A consistent approach to the IHA is needed to assure that quality health assessments are accessible to all unaccompanied children in Kent.

9.3 Social Care Needs

Interviews with staff involved in the social care of unaccompanied children have revealed that there are concerns in relation to:

- Timing of the IHA - In particular it was felt that this should be done expediently so that the young person can be supported through any needs identified or diagnosis made while in the supportive environment of the reception centre,
- The ability of reception centre staff to identify young people with mental illness due to limited training,
- Inconsistency in the advice provided to staff regarding infection control policies within reception centres,

- A lack of clarity regarding the optimal referral process for a young person with suspected acute mental or physical illness for a clinical evaluation,
- An apparent low prioritisation of health promotion, such as smoking cessation advice.

There is a suggestion both that the IHA should be done at an early opportunity, and that there needs to be clear and consistent protocols and advice in relation to the management of health issues which reception centre staff can follow. Reception centre staff can have a key role in identifying health needs of young people within the centres due to the amount of time spent with the young people. Therefore it is essential that they are empowered to do this. Training of staff could help to achieve this.

| 10. Evidence of what works

10.1 Physical Health

Various resources exist which can be accessed by clinicians caring for unaccompanied children.

10.1.1 The Migrant's Health Guide

The Migrant's Health Guide is an online resource published by Public Health England which gives country specific information about health needs in migrants. The guide provides information on:

- Need for various communicable disease testing, including latent TB screening and blood borne virus testing,
- Sexual and reproductive health,
- Nutrition, and appropriate testing and prevention strategies based on the epidemiology of a person's home country.

<https://www.gov.uk/government/collections/migrant-health-guide-countries-a-to-z>

10.1.2. Immunisation catch up for individuals with uncertain or incomplete vaccination history

This resource is produced by PHE and provides advice on how to ensure patients with an uncertain vaccination history are protected against vaccine preventable disease.

<https://www.gov.uk/government/publications/vaccination-of-individuals-with-uncertain-or-incomplete-immunisation-status>

10.1.3 Tuberculosis screening in people from a country with a high prevalence of Tuberculosis

Screening for latent TB is recommended in people coming from a country with an incidence of TB >150/100,000, or from Sub-Saharan Africa. Guidance on screening for latent TB has been produced by Public Health England and by NICE.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/442192/030615_LTBI_testing_and_treatment_for_migrants_1.pdf

<http://www.nice.org.uk/guidance/ng33>

10.1.4 Outbreak information

Various organisations provide up-to-date, country specific information about outbreaks of infectious disease. This may be useful for clinicians treating acutely unwell migrants, particularly those who have recently arrived in the United Kingdom. This should be used in conjunction with seeking advice from local experts in Infectious Diseases and/or Health Protection.

European Centre of Disease Control (ECDC) Weekly Epidemiological Updates -
http://ecdc.europa.eu/en/press/epidemiological_updates/Pages/epidemiological_updates.aspx

Imported Fever Service is a PHE resource clinicians can utilise when treating acutely unwell people who have returned/come from a foreign country. This resource should be utilised after discussion with local experts in Infectious Diseases/Health Protection.

<https://www.gov.uk/guidance/imported-fever-service-ifs>

10.1.5 Maternal Health

NICE has produced guidance for clinicians providing maternal care to women may have additional needs due to complex social circumstances. This should be used in conjunction with NICE guidance on routine antenatal care.

NICE CG110 Pregnancy and complex social factors: a model for service provision for pregnant women with complex social factors <https://www.nice.org.uk/guidance/cg110>

NICE CG62 Antenatal care for uncomplicated pregnancies
<https://www.nice.org.uk/guidance/cg62>

10.2 Mental Health

10.2.1 Tools used to diagnose mental illness

Tools which have been validated for the diagnosis of mental illness in children in high income countries may not be directly transferable to the context of children seeking asylum. In particular there may be concerns regarding the diagnostic thresholds.

Tools which have been validated for use in unaccompanied children include:

- The Hopkins Symptoms Checklist-37 for Adolescents (HSCL-37A) ^{26,34} - which measures internalising symptoms such as depression and anxiety, and externalising behaviours such as 'lashing out'.
- The Stressful Life Events (SLE) checklist ²⁶. The SLE checklist is used to assess the number and type of stressful events a child has experienced, e.g. "have you ever experienced war or an armed military conflict going on around you in your country of birth?"
- DSM-IV diagnostic criteria for PTSD
- The Reactions of Adolescents to Traumatic Stress (RATS) ³⁵ The RATS tool is a questionnaire designed to assess symptoms of post-traumatic stress, based on the DSM-IV classification.
- The Harvard Trauma Questionnaire Part IV ²⁶

10.2.2 Evidence of interventions

There is little published evidence on effective treatment of mental illness in unaccompanied children. While effective treatments for PTSD exist many of these techniques rely on the young person having a support network, such as the support provided by a parent or dedicated carer.

Risk resilience frameworks

There is increasing recognition of the importance of resilience in the context of conflict and trauma, particularly the type of trauma seen and experienced in war affected countries³⁶. Resilience enables a person to cope with adversity and has been defined as an individual's capacity to recover from, adapt and remain strong in the face of adversity³⁷. Resilience is not a fixed quality possessed by some and not others, but changes with time and with exposure to different risks. It is particularly important to note that exposure to different risks can have a cumulative impact on a young person's mental health, and that just because a young person demonstrates resilience in one aspect of life does not mean that they do not need support to cope in other areas²⁸.

Risk and protective factors for mental health and wellbeing are discussed in Chapter 3.

Based on the literature, possible strategies to support mental health and wellbeing following migration could include:

- Recognition of risk and protective factors at the three stages of the asylum journey.
- Access to specialist services for young people who are at high risk of mental illness due to exposure to risk factors pre- and peri-migration.
- Minimising changes of residence, for example by minimising dispersal and securing stable accommodation as early as possible.
- Prioritising reunification with family where possible.
- Ensuring children have adequate and accurate guidance through the difficult process of asylum by having a dedicated social work team for unaccompanied children.
- Encourage social support networks.
- Reinstitution of education should begin as soon as possible. Additional attention should be given to skills training.
- Proficiency in the host language has been shown to be protective. Local authorities have a role in ensuring access to English as a Second Language (ESL) courses/facilities.
- Community level strategies to reduce discrimination.

Therapeutic interventions

There is some evidence on therapeutic interventions to treat mental illness in children seeking asylum and child refugees, however there is very little relating to unaccompanied children. The lack of or limited social support network of unaccompanied children may be a barrier to safe and effective treatment. Clinic based interventions are more likely to be

effective if they are carried out in combination with community and/or family based interventions.

A recent systematic review of school or community-based interventions to support mental well-being in child refugees and asylum seekers identified the main types of interventions reported as verbal processing, creative art techniques, or a combination of the two³⁸. Verbal processing techniques include Cognitive Behavioural Therapy (CBT), Trauma Focused Cognitive Behavioural Therapy (TF-CBT), Narrative Exposure Therapy, Eye-Movement Desensitisation and Reprocessing (EMDR) and Trauma Systems Therapy (TST). Creative therapies include a range of art, dance and drama therapies.

The lack of evidence regarding effective therapeutic interventions to support the mental health and wellbeing of unaccompanied young people has recently been recognised by the European Society of Child and Adolescent Psychiatry (ESCAP)³⁹. Hebdebrand and colleagues outline the need for a collaborative, multi-national approach to supporting the health needs of unaccompanied children and young people given that current knowledge of and techniques for supporting mental health in unaccompanied children is limited³⁹.

10.3 Service Delivery

Different models of care have been adopted internationally to support health and wellbeing of adults and children seeking asylum including⁴⁰:

- General Practice led services, i.e. responsibility for health assessment and treatment is led by general practitioners, who may (or may not), have an interest in migrant health;
- Paediatric led services – specialist paediatric clinics located either in the community or hospital. These clinics may be led by clinicians with a responsibility for Looked After Children;
- Family screening clinics – In these clinics both children and their parents/carers can be seen together. Ideally these clinics would be supported by a combination of different staff with expertise in paediatrics, infectious diseases, adult general medicine and psychology.

There are advantages and disadvantages to different models, for example GP led services link the person to a primary care provider for ongoing care but may struggle to meet the substantial health needs of people seeking asylum and to link with effectively with secondary care providers. Similarly, while paediatric led services may be able to coordinate subspecialty services for children with complex health needs, they may be difficult to access due to location and may find it difficult to hand care back to primary providers for ongoing care⁴⁰.

Woodland et al cite key elements of a framework to address the physical and mental health needs of refugee children as⁴⁰:

1. Comprehensive health screening
2. Co-ordination of initial and ongoing health care
3. Integration of physical, developmental and psychological health care
4. Consumer participation
5. Culturally and linguistically appropriate service provision
6. Inter-sectoral collaboration
7. Accessible and affordable services and treatments
8. Data collection and evaluation to inform evidence-based practice
9. Capacity building and sustainability
10. Advocacy

10.4 Additional Resources

Cultural competence is essential in supporting young people from various countries and cultures. The Cultural Orientation Resource Centre has produced a range of country profiles which may be useful for clinicians caring for unaccompanied children:

<http://www.cal.org/co/>.

The European Society for Child and Adolescent Psychiatry has set up an online knowledge forum which is a resource that can be utilised by professionals involved in the care of unaccompanied children to share knowledge and experiences.

<http://www.escap.eu/care/organizing-the-knowledge-to-support-mental-health-care-for-refugee-children/>

11. Recommendations

1. Capacity Building

Additional capacity is needed to carry out the IHA at the earliest feasible opportunity and within the 28 day statutory timeframe. There should be consideration of the optimum way to improve capacity to deliver IHA to unaccompanied children in a sustainable way, including training of local general practice and paediatric clinicians.

2. Training

Staff working with unaccompanied children should have appropriate training so that they are empowered to identify the health needs of these children. Training is recommended for both healthcare and social care staff working with unaccompanied children. Various organisations can deliver specialist training, such as Freedom from Torture.

3. Initiation of immunisation during the IHA

The current process of referring immunisation initiation to the GP creates barriers to the young person receiving effective, preventative interventions. Initiation of immunisation would improve access to these interventions and reduce the risk of vaccine preventable disease.

4. Blood tests to be carried out during IHA

As with immunisation the current process of the IHA creates barriers to young people having the appropriate blood tests. This could be improved by initiating tests during the IHA. Blood tests which should be included are:

- Full blood count – for haemoglobin and eosinophilia. Where eosinophilia is detected screening for parasitic infection should be considered.
- Hepatitis B testing – risk assessment based on country of origin and risk factors; all young people within 2015/16 cohort met criteria for Hepatitis B screening;
- Hepatitis C testing – risk assessment based on country of origin and risk factors; all young people within 2015/16 cohort met criteria for Hepatitis C screening;
- HIV – risk assessment based on country of origin and risk factors; the majority of young people within 2015/16 cohort do not come from countries with a high prevalence of HIV, however screening may be appropriate if additional risk factors are present.

It is vital that if this recommendation is adopted a system is put in place to ensure results are followed up and communicated to the young person.

5. Direct referral to the TB screening service

The TB service in Kent is keen to be involved in the screening of eligible unaccompanied children. This opportunity should be utilised. This must fit within the statutory timeframe, in particular if a dispersal system is implemented. Additionally, a contingency plan is needed to ensure that TB screening is not missed if a child moves to another area of Kent after the IHA.

6. Clinical record templates for IHA

The variation in clinical information available for extraction from IHA carried out in different settings may indicate inconsistencies in the way IHA are carried out. A consistent approach to the IHA, through the use of one template by all providers, would provide quality assurance and improve the quality of data available for any future analysis.

7. Treatment protocols

Clear treatment protocols and infection control guidelines are needed, particularly within reception centres. Protocols have been produced for scabies and Hepatitis B.

8. Access to CAMHS

Psychological symptoms were identified commonly within the needs assessment. Additionally, access to specialist mental health advice and services has been problematic at times. A clear referral pathway is needed to improve access of unaccompanied children to CAMHS services.

9. Pathways for assessment of acute health problems

Clarification is needed within social care regarding who within the social care team is responsible for a young person who becomes unwell out of normal working hours.

A consistent approach to the assessment of unaccompanied young people would be supported by a dedicated team of community practitioners with an interest in migrant health. For example general practitioners with a special interest in migrant health could be offered specialist training to develop their skills in assessing unaccompanied children. This would work best if a number of primary care practitioners across Kent were trained so that this resource was accessible and sustainable.

10. Holistic health assessment

While there are many elements of the assessment and interventions which will be relevant to the majority of unaccompanied children, the need for individual risk assessment should not be overlooked. This is particularly true in relation to consideration of FGM in girls from high risk countries, and to sexual health risk assessment.

11. Building a community resilience network

Building resilience is a cornerstone of promoting good emotional and mental health in young people of all ages and backgrounds. There should be consideration of the commissioning of voluntary sector organisations to provide support to unaccompanied children in the community.

12. Integrated approach between health and social care

An integrated approach is necessary to support resilience in unaccompanied children including good communication between social care and health, and involvement of voluntary sector organisations.

13. Ongoing data collection

This report adds to the literature on the health needs of unaccompanied children. However an important limitation is the limited follow up information regarding the prevalence of conditions such as chronic Hepatitis B and latent TB. Providers of IHA which include initial investigations should be asked to report on the outcomes of these tests, so that the true epidemiological needs of this cohort can be better understood.

14. Welcome pack

A 'welcome pack' should be produced that can be given to unaccompanied children which explains how to access the NHS, what health services they are entitled to and the rationale and process for the Initial Health Assessment, including the tests that would be offered as part of this process. Information should be produced in a format which is suitable for the range of young people who will be receiving it, and in a range of languages. There should be consideration of alternative media for information giving, including online resources such as podcasts.

| Appendix A

Healthcare entitlements

Primary Care

Access to primary care is universal regardless of immigration status⁷. All people who have an asylum application in progress or who have been granted refugee status are entitled to register with a GP. It is the decision of the general practitioner/practice whether to register a person in whom an asylum application has been unsuccessful or who is who are deemed to be in the country unlawfully, however where registration is refused this must be done on reasonable grounds and irrespective of age, gender, race, socioeconomic status etc. However, that someone with a failed asylum application can register with a GP is widely misunderstood and often the advice and information given to people attempting to register is misleading or incorrect.

Additionally, children aged under 16, and children and 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 Health⁷.

Secondary Care

People who are successful in their claim for asylum are granted refugee status, and are entitled to full access to primary and secondary care in the NHS. Where an asylum application has been refused, and a person has exhausted avenues for appeal, or where a period of leave to remain has expired, the persons entitlement to secondary care changes.

Emergency/immediately necessary treatment – Emergency or immediately necessary treatment is treatment which could save a life or prevent a condition becoming life threatening. Such treatment is available to people who have failed in their asylum application and should not be delayed. However, if it subsequently transpires that the person is chargeable then the charges still apply and the hospital trust should take 'reasonable measure' to recover the charges.

Urgent treatment – Urgent treatment is treatment which is not immediately necessary, but which the clinician feels cannot wait until the person returns to their home country. The decision on when to treat requires knowledge of when a person is likely to return to their home country in order to judge the (un)acceptability of delaying treatment. Urgent treatment should not be delayed but will be chargeable. The hospital trust should take 'reasonable measures' to recover the charges. Additionally, treatment for certain urgent conditions is exempt from charges, including family planning, treatment for certain

communicable diseases (e.g. Tuberculosis and Hepatitis B), and compulsory treatment for mental health conditions.

Maternity Care

Women with an ongoing asylum application or who have been granted refugee status are entitled to free antenatal, maternity and postnatal care. Women who have had an asylum application refused, or who are deemed to be in the country unlawfully are entitled to access maternity care but may be asked to pay for services. Of note NHS guidance states that maternity care, which covers antenatal care, birth care and postnatal care, constitutes care which is 'immediately necessary' and therefore must be given regardless of ability to pay.

| Appendix B

Literature Review

Physical Health

While many people seeking asylum arrive 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^{2,9},
- limited access to basic healthcare prior to migration.

Additionally risks to health to which young people are particularly vulnerable include forced labour or forced military, i.e. becoming child soldiers, and sexual exploitation.

The literature in relation to the physical health of unaccompanied children is sparse. A recent cross-sectional study of physical and mental health of 102 unaccompanied adolescents in Germany reported a high prevalence of infections (58%), mental illness (13.7%) and iron deficiency anaemia (17.6%)¹⁴. A low prevalence (<2.0%) of non-communicable disease was reported. Lifson et al, in a cross-sectional study of 2,545 adult and child asylum-seekers found that >30% of those aged <18 years tested positive for a parasitic infection, compared to <15% of those aged over 18⁴¹.

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

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

Communicable Diseases

The likelihood of communicable (infectious) disease relates to local epidemiology in the country of origin. Risk factors for communicable disease in people seeking asylum include incomplete immunisation to vaccine preventable disease, poor nutrition and experience of overcrowded travelling and living conditions¹⁰.

While infectious diseases should be considered important, it is also essential to recognise and communicate that the population risk of infection transmission, i.e. to the resident

population of the host country, is low¹⁰. Members of the local population may be concerned about the risk of imported infection, particularly given the recent high-profile outbreak of Ebola. It is important that key stakeholders are made aware that the risk of infection in the resident population is in fact very low.

Vaccine Preventable Disease

Many young people who enter the United Kingdom (UK) to seek asylum will not have had access to immunisation against vaccine preventable illness, such as polio, diphtheria, tetanus etc. Practitioners assessing unaccompanied young people entering the UK should attempt to verify any previous immunisation history¹¹. Where immunisation has not occurred or is incomplete, this should be instigated in the host country. Public Health England have produced a schedule for immunisation where this is required.

Young people who have not been vaccinated are susceptible to vaccine preventable disease. Since the mid-1990s there have been concerns in relation to low uptake of the Measles Mumps and Rubella vaccine (MMR) in the UK. This has contributed to outbreaks of measles in the UK, most recently in London and the South East of England. This is especially relevant in Kent where MMR uptake is significantly below the national target of 95%. Therefore ensuring that unaccompanied young people, who are particularly vulnerable to infection during an outbreak, have access to catch-up immunisation should be a priority.

Polio, while eradicated in many countries worldwide, remains an important public health concern in Afghanistan and Pakistan, which are the only countries in which the virus remains endemic. Practitioners assessing children from these countries should be alert to this, and should ensure that vaccination against polio is given¹¹.

Hepatitis B

Chronic Hepatitis B (HBV) is associated with liver cirrhosis and hepatocellular carcinoma (cancer of the liver). The rate of HBV varies between countries. High levels of chronic HBV ($\geq 8\%$) are seen in south-east Asia, sub-Saharan Africa, parts of the Middle East, the central Asian Republics, the Pacific Basin (excluding Japan, Australia and New Zealand) and some countries in Eastern Europe. Moderate levels of chronic HBV (2-7%) are seen in Russia and the Russian Federation, Southwest Asia, Central and South America and some countries in Eastern Europe.

Hepatitis B screening should be considered in people from countries with an moderate to high prevalence of HBV¹¹. This will be the case for the majority of unaccompanied young people seeking asylum.

Hepatitis C

The prevalence of Hepatitis C (HCV) varies globally. Screening for HCV should be considered in unaccompanied children from countries with a high prevalence of HCV. Advice on appropriate screening is contained in the Migrant Health Guide¹¹. The majority of unaccompanied young people who entered Kent 2015/16 are eligible for HCV screening.

HIV

Testing for HIV should be based on prevalence in the person's country of origin and any risk factors for HIV infection such as unprotected sexual intercourse, including rape. Screening for HIV is recommended when a person comes from a country in which the prevalence of HIV is $>1\%$ ¹¹. The majority of young people who entered Kent 2015/16 do not come from countries with a high HIV prevalence, however HIV testing should be considered if additional risk factors for HIV infection are present.

Tuberculosis

Tuberculosis screening is recommended in people from a country with a TB prevalence $>150/100,000$, or who have come from Sub-Saharan Africa, and who have arrived in the United Kingdom within the last 5 years¹². NICE recommends screening with a Mantoux test, although recognises that in situations where this is impractical, e.g. where large numbers of individuals need to be screened, an Interferon Gamma release assay (IGRA) test may be more appropriate⁴².

Data on active TB cases from PHE demonstrates that the majority of cases (53.7%) of active TB in migrants are notified within 6 years of arrival¹³. This emphasises the importance of screening migrants from countries with high rates of TB to prevent activation of infection. The highest number of cases of active TB in the UK 2014 were in people from India, Pakistan and Somalia¹³.

Parasitic Infection

Unaccompanied children may be at particular risk of intestinal parasitic infections, such as amoebiasis, lamblia and giardia. Lifson et al reported that the prevalence of intestinal parasitic infection was significantly higher in children and young people aged <18 years compared to people aged >18 years⁴¹. Marquardt et al reported that the prevalence of intestinal parasitic infection varied geographically, with the highest prevalence seen in children from sub-Saharan African¹⁴. Currently screening for parasitic infection is not recommended in the UK. Canadian guidelines for immigrant health recommend screening for Strongyloides and Schistosomiasis in people from high risk countries⁴³.

Emerging communicable disease issues

The current refugee crisis has been associated with an unprecedented number of children and adults travelling long distances to seek refuge in both Middle Eastern and European countries. These people are travelling huge distances, often over many months, and may be living in overcrowded and unsanitary conditions. Additionally people coming to Europe may have had very different experiences of healthcare prior to leaving their home country. Consequently there are emerging communicable disease concerns in addition to those described above. The key issues are summarised below.

Antimicrobial Resistance

Many people seeking asylum, including children, come from and travel through countries in which the prevalence of antimicrobial resistance (AMR) is higher than in the United Kingdom¹⁵. AMR is important because it limits the range of effective treatment, and because additional infection control precautions may be necessary to prevent transmission of resistant bacteria, for example within a hospital setting.

Two recent studies carried out in Germany involved screening populations of people seeking asylum for drug resistant *Enterobacteriaceae*^{15,16}. The prevalence of drug resistant *Enterobacteriaceae* in 119 asymptomatic unaccompanied minors was found to be 35%, compared to a prevalence in the general German population of around 6.3%¹⁵. In another study in which 143 inpatient refugees were screened for AMR drug resistant bacteria were found to colonise 60.8% of patients, compared to 16.7% in German residents with a history of hospital treatment in a country with a high prevalence of drug resistant bacteria¹⁶.

The authors of these papers recommend screening for colonisation with drug resistant organism in people seeking refuge, who come from countries with a high prevalence of antibiotic resistance. However it is not clear if this strategy should be applied only to people admitted to hospital or to all people 'at risk' of colonisation.

Re-emerging infections

Sporadic cases of infections which have previously been rare in high income countries have been reported in refugee populations in Europe during 2015¹⁰. Examples of re-emerging infections include louse-borne diseases such as *Borrelia recurrentis* (louse borne relapsing fever), *Bartonella Quintana* (trench fever), endemic typhus due to *Rickettsia prowasekii* and murine typhus¹⁰.

Poor living conditions and overcrowding during the migration journey also puts people seeking asylum at increased risk of infestations such as scabies. In addition, outbreaks of meningococcal disease (causing meningitis and meningococcal sepsis) have been reported in association with overcrowded living conditions, such as may be encountered in refugee camps¹⁰. There have not been any reports of re-emerging infections in people seeking asylum in the UK to date, however recent cases of louse borne relapsing fever have been reported in Germany, the Netherlands, Sicily, Switzerland and Finland⁴⁴, and a case of respiratory diphtheria has been recently described in Finland⁴⁵.

Steps to prevent re-emerging infections includes prevention through provision of sanitary accommodation and health assessments of people arriving in the UK to seek asylum, and immunisation to vaccine preventable disease where appropriate (e.g. meningococcal disease and diphtheria). Additionally, it is important that clinicians responsible for treating acutely unwell migrants should be aware of re-emerging infections.

There are a number of resources which can be accessed by clinicians which can be accessed by acutely unwell migrants which are listed in section 10.

Sexual Health

People seeking asylum may be at increased risk of sexually transmitted infection for several reasons including the prevalence of sexually transmitted infection in their home country, access to testing and treatment in their home country and exposure to risk through unprotected consensual sex or through sexual exploitation and rape². A risk assessment for sexually transmitted infection should be undertaken with sensitivity. Where appropriate this should be linked with additional psychological support and counselling services.

The experience of sexual harassment and maltreatment of unaccompanied children after arriving in a host country has been described. Lay et al interviewed 53 unaccompanied children living in London, who had experienced sexual maltreatment. The majority of sexual maltreatment, which included harassment and rape, occurred in the first 12 months after arrival in the UK¹⁸. Many also described being groomed and experiencing sexual maltreatment from people from their country of origin, or from other asylum seekers living nearby. Children who had been made aware of grooming and sexual harassment were more likely to report this than children who had not¹⁸. Recommendations from these interviews include safer living environments, preferably single sex, monitoring and supervision, access to interpreters and language skills development, information about sexual harassment and about access to the health system, and training of staff to spot signs of sexual harassment/exploitation.

Trafficked Children

Human trafficking is the recruitment and movement of people, including children, for the purpose of exploitation. The most common types of exploitation are forced sexual exploitation, forced labour and servitude, or forced criminal activity. Estimating the number of people who have been trafficked globally is very difficult, although the number is believed to be in the millions. It is reported that 44% of people who have been trafficked globally are women, and 33% are children²³. While females are at greater risk of trafficking, it should be recognised that the number of male children and men who have been trafficked and have been/are at risk of being exploited is likely to be underestimated due to the perception that males are less vulnerable to this type of exploitation²³.

Children who have been trafficked are likely to have experienced physical violence and psychological manipulation and sexual abuse. Consequently, they are at increased risk of injury, sexually transmitted infection, and psychological disorders. Substance misuse is also common in this group due to either forced alcohol and drug use, or the use of narcotics as a coping mechanism²³.

Women's Health

Female refugees and asylum seekers have worse outcomes in pregnancy relative to the general population¹⁹. Maternity services are underutilised by people seeking asylum and those granted refugee status with these girls and women being more likely to either book

late for antenatal care or to receive no antenatal care²⁰. Female asylum seekers are three times more likely to die in childbirth compared to the general population of the UK, and are four times more likely to experience postnatal depression²¹. The challenges faced by these women include cultural, medical and psychosocial issues, including dispersal of women late in pregnancy²¹. Unfortunately, despite the legal entitlements of these women to receive maternity care, this may be misunderstood by healthcare providers, particularly in relation to women whose application for asylum has been refused^{7,21}. Commissioners of maternity services must ensure providers are aware of the rights of these women, and of their legal obligation to provide maternity care.

The impact of early migration on the reproductive history of World War II evacuees has been evaluated⁴⁶. Compared to children who have had no separation experiences children who were sent unaccompanied to foster families in Sweden and Denmark experienced earlier menarche, earlier age of first born child (men), more total children born (women) and shorter birth intervals (men)⁴⁶.

Female Genital Mutilation

Female genital mutilation, which may also be referred to as female circumcision or female genital cutting, is the practice of deliberate alteration or injury to the female genital organs for non-medical reasons. FGM is a cultural practice. It is not associated with any medical benefit. FGM is associated with both short term and long term consequences for girls and women including pain, bleeding, infection, chronic difficulties with urination (including recurrent urinary tract infection) and significant obstetric complications. FGM is recognised internationally as a severe violation of the human rights of girls and women²².

The prevalence of FGM varies globally. It should be emphasised that FGM is a cultural, and not a religious, practice. The practice is most common in regions of Eastern North-Eastern and Western Africa, and in some areas in Asia and the Middle East²².

Oral Health

Dental problems are reported to be common in people seeking asylum. Indeed dental health has been reported to be one of the most common health needs of people seeking asylum, second to mental health². The prevalence of dental abnormalities is likely to vary depending on the presence or absence of dental services in one's home country and knowledge of and ability to maintain oral hygiene prior to or during migration. Reports in the literature suggest the prevalence of dental abnormalities varies based on country of origin, and may range from 20-48%^{14,17}. Access to dental services within the UK may also be difficult, despite the legal entitlement of unaccompanied children to receive free dental care. An assessment of dental health and symptoms of dental problems should be sought during initial health assessment.

Disability

There is little published literature describing the prevalence of disability in people seeking asylum, including both adults and children. People seeking asylum, including children, are at increased of disability due to limited access to healthcare in their home country, and the risk of injury incurred during the long journey to the host country. Of note people in whom an application for asylum is in process are not entitled to Disability Living Allowance¹⁹.

Nutritional and Metabolic Needs

Unaccompanied children seeking asylum are at high risk of malnutrition. The journey from one's home country to the United Kingdom is a difficult process which can take many months. Children are particularly at risk of malnutrition due to limited access to nutritious food during their journey. In the longer term, young asylum seekers are at ongoing risk of both under- and over-nutrition⁴⁷.

Marquardt et al reported the prevalence of iron-deficiency anaemia (IDA) at 17.6% in a sample of 102 unaccompanied children in Germany¹⁴. IDA was more common in females, as would be expected due to menstrual blood loss. Other nutritional deficiencies which unaccompanied children are at risk of include Vitamin D and Vitamin A¹¹. Clinicians caring for recently arrived children seeking asylum should be aware of the possibility of nutritional deficiencies.

Non-communicable disease

There is limited data on the prevalence of non-communicable disease (NCD) in unaccompanied children. Marquardt et al reported that the prevalence of NCD was <2% in their cohort of 102 unaccompanied children¹⁴. Diagnosed NCD included obesity, asthma and osteomyelitis.

Mental Health

Unaccompanied children are at high risk of mental illness, including post-traumatic stress disorder (PTSD), depression and anxiety^{24,25}. Bean et al reported that mental illness in unaccompanied children tend to be severe and chronic²⁹. Jakobsen et al, in their study of the prevalence of mental illness in unaccompanied adolescents seeking asylum in Norway, found the 48% met diagnostic criteria for a mental illness, the most common diagnoses being PTSD, major depressive disorder, general anxiety disorder and agoraphobia²⁶. Delayed presentations of mental illness are also recognised, and necessitate ongoing surveillance for signs of and repeat screening for mental illness²⁴.

Risk Factors for and Protective Factors against Mental Illness

Risk factors for mental illness in unaccompanied children can be conceptualised as those occurring prior to migration, those occurring during the migration journey and those occurring during and after arrival in the host country⁴.



Risk factors are cumulative and the relative contribution of different risk factors changes over time. Ongoing stresses within the host country, such as discrimination and racism, play as important a role as pre- and peri-migratory factors. Ongoing psychological stresses are a risk factor for depression in particular⁴. In contrast pre-migratory experiences of trauma are more important than host country experiences in the development of PTSD. Identification of risk factors for and protective factors against mental illness can form part of strategies to reduce the burden of mental illness in this population. Modifiable post-migratory risk factors include:

- Stigma and Discrimination - Discrimination in the host country is associated with psychological problems. Consideration is needed regarding the language used in relation to people seeking asylum, including children³⁹. As professionals we must be aware of the role of language in perpetuating stigma, including in language used to the public. In particular care should be taken to avoid de-humanising language, and that which separates the humanity of an individual from their sociopolitical situation. It is paramount that unaccompanied children must be considered first as children and only after that as 'asylum seekers'²⁴.
- Environment - Living arrangements can influence the risk of emotional and behavioural problems. Foster care offers the greatest protection against mental illness³⁰. In their cross-sectional study of unaccompanied adolescents Hodes et al. identified low-support living arrangements as a risk factor of psychological distress, along with female gender and history of traumatic events⁴⁸.
- Social connectivity - A sense of belonging is shown to be effective in protecting against anxiety and depression. In contrast, low belonging is associated with poor self-esteem and higher rate of externalising behaviours⁴.

- Language skills - Gaining proficiency in the language of the host country may be associated with lower levels of depression and internalizing symptoms.
- The asylum process - There is evidence that children who spend time in detention facilities are at higher risk of developing psychological problems⁴, as are those who were transferred to a different regional²⁹. Insecure asylum status, which has been described as “an issue that permeates all other aspects of their lives”³¹, is associated with a range of psychological problems. In the UK (at the time of writing) most unaccompanied children receive discretionary leave to remain until they are 17.5 years, at which point a final decision is made regarding their asylum application. It is felt that this lack of resolution contributes to anxiety and psychological distress experienced by unaccompanied children.

Building resilience is important in promoting mental health and wellbeing. Interventions should seek to promote this through adaptive pathways at the individual, family and community level. More research is needed to investigate the interaction of factors and pathways which influence mental health and wellbeing in children including longitudinal research to evaluate outcomes in medium to long term. Formal assessment of interventions which promote integration and language acquisition are needed⁴.

Delayed Onset Mental Illness

Signs and symptoms of mental illness may not always be visible at an initial health assessment. Delayed onset PTSD has been reported²⁵. A study carried out in the Netherlands found that the prevalence of delayed onset PTSD in a sample of over 500 unaccompanied children was 19%²⁹. Reasons for delayed onset of mental illness may relate to reluctance to discuss symptoms due to feelings of shame, guilt or simply wishing to avoid revisiting severely traumatic events; cultural differences relating interpretation of symptoms of mental illness and perception of their significance; and lack of trust in authority figures, including healthcare professionals³. Additionally, it is recognised that survivors of torture may prioritise focusing on their basic needs, such as stable accommodation and resolution to their asylum application, before being willing to discuss their experiences³.

Post-traumatic stress disorder (PTSD)

The prevalence of PTSD in unaccompanied children has been estimated to lie between 20 and 53%⁴⁹. Differences in the population assessed, delayed presentations of mental illness and differences in screening methods are likely to explain the variation. Unaccompanied children are more likely to exhibit symptoms of PTSD than their accompanied peers²⁷, indicating that making the arduous journey unaccompanied is likely to lead to increased exposure to risk and trauma²⁸.

Despite the increased risk of PTSD in unaccompanied children, these children are less likely than accompanied peers to receive trauma focused therapies²⁷. Promising treatments which

may be effective for unaccompanied children include cognitive behavioural therapy (CBT), narrative exposure therapy (NET) and eye movement desensitisation and reprocessing (EMDR)⁵⁰. A risk-resilience model is likely to be useful, whereby protective factors are identified and risk factors are addressed²⁴. It is recognised that unaccompanied children have already demonstrated resilience to the experiences they have had, through the journey they have undertaken²⁵. However 'coping' can also involve harmful behaviours, such as drug use or sex work²⁴. Interventions to support these children must recognise this.

Depression and Anxiety Disorders

Depression and anxiety disorders have also been reported in unaccompanied children at higher prevalence than the general population. Jakobson et al estimated the prevalence of major depressive disorder at 9.4% in a group of 160 boys aged 14-18 years seeking asylum from Afghanistan, Somalia, and Iran²⁶. Post-migratory risk factors experiences of discrimination, and the stress associated with an unresolved asylum application, are particularly important risk factors for depression and anxiety disorders.

Other mental illness

In addition to PTSD, mood disorder and anxiety, psychological problems which have been reported in unaccompanied children include agoraphobia, dysthymic disorder and specific phobias²⁶.

Access to mental health services

The literature suggests that the process of young people seeking help involves three stages: Problem recognition, which includes recognition of symptoms and presence of psychological distress, decision to seek help, and availability and choice of services. Sanchez-Cao et al carried out a survey of unaccompanied children in London to evaluate the presence of symptoms of emotional and psychological distress, and the utilisation of mental health services³². Results showed that despite a high prevalence of symptoms of mental illness in the young people, there was a significant underutilisation of services with only 17% having had any contact with mental health services³².

Barriers to accessing mental health services for unaccompanied children include high residential mobility, language and cultural barriers, lack of awareness of free services and difficulty registering with or seeing a general practitioner. Ensuring that unaccompanied children are aware of the symptoms of mental illness, and of how to access the services to which they are entitled is necessary.

Appendix C

Country of origin	WHO Region	No. children from region	Latent T B prevalence (%)	TB Incidence per 100,000	Meets WHO criteria for TB screening	No. eligible for TB screening	Estimated no. latent TB
Albania	Europe	40	0.04	19	no	n/a	2
Afghanistan	Other Asia	226	0.18	189	yes	226	41
Algeria	MENA	1	0.04	78	no	n/a	0
Bangladesh	Indian Subcontinent	2	0.2	227	yes	2	0
Botswana	SSA	2	0.28	385	yes	2	1
Chad	SSA	2	0.28	159	yes	2	1
Egypt	MENA	30	0.04	15	no	n/a	1
Eritrea	SSA	352	0.28	78	yes	352	99
Ethiopia	SSA	41	0.28	207	yes	41	11
Ghana	SSA	1	0.28	165	yes	1	0
Guinea	SSA	1	0.28	177	yes	1	0
Iran	MENA	38	0.04	22	no	n/a	2

Iraq	MENA	48	0.04	43	no	n/a	2
Kuwait	MENA	7	0.04	21	no	n/a	0
Libyan	MENA	1	0.04	40	no	n/a	0
Morocco	MENA	3	0.04	106	no	n/a	0
Pakistan	Indian Subcontinent	2	0.2	270	yes	2	0
Sudan	SSA	71	0.28	94	yes	71	20
Syria	MENA	67	0.04	17	no	n/a	3
Tunisia	MENA	1	0.04	33	no	n/a	0
Turkey	MENA	5	0.04	18	no	n/a	0
Viet Nam	Other Asia	43	0.18	140	no	n/a	8
Yemen	MENA	4	0.04	48	no	n/a	0
Not Recorded	n/a	1		n/a		n/a	0
Grand Total		989				700	191

*Data suppressed where n<3

Source: Pareek et al 2011; Kent Public Health, prepared by RC, March 2016

Country of origin	WHO Region	Prevalence of Hepatitis B surface antigen (HBsAg)* (%)	No. children from region	Meets WHO criteria for Hepatitis B screening	Expected no. children with chronic HBV
Afghanistan	South Asia	3.4%	226	yes	8
Albania	Central Europe	3.0%	40	yes	1
Algeria	MENA	4.2%	*	yes	0
Bangladesh	South Asia	3.4%	*	yes	0
Botswana	South Sub-saharan Africa	6.6%	*	yes	0
Chad	West Sub-saharan Africa	10.0%	*	yes	0
Egypt	MENA	4.2%	30	yes	1
Eritrea	East Sub-saharan Africa	7.0%	352	yes	25
Ethiopia	East Sub-saharan Africa	7.0%	41	yes	3
Ghana	West Sub-saharan Africa	10.0%	*	yes	0
Guinea	West Sub-saharan Africa	10.0%	*	yes	0
Iran	MENA	4.2%	38	yes	2
Iraq	MENA	4.2%	48	yes	2

Kuwait	MENA	4.2%	7	yes	0
Libya	MENA	4.2%	*	yes	0
Morocco	MENA	4.2%	*	yes	0
Pakistan	South Asia	3.4%	*	yes	0
Sudan	East Sub-saharan Africa	7.0%	71	yes	5
Syria	MENA	4.2%	67	yes	3
Tunisia	MENA	4.2%	*	yes	0
Turkey	MENA	4.2%	5	yes	0
Viet Nam	South East Asia	2.5%	43	yes	1
Yemen	MENA	4.2%	4	yes	0
Not Recorded	n/a	n/a	*		n/a
Grand Total			989	988	52

*Data suppressed where n<3

Source: Ott et al2012; Kent Public Health; prepared by RC, March 2016

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