Promoting the health of children in public care

The essential guide for health and social work professionals and commissioners

edited by Florence Merredew and Carolyn Sampeys

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1 Introduction

Carolyn Sampeys
Chair, BAAF Health Group (2010–2015)

An old man was walking on the beach at dawn and noticed a young man ahead of him who was picking up starfish and flinging them into the sea. Catching up with the young man, he asked him why he was doing this. The reply was that the stranded starfish would die if left in the morning sun.

'But this beach goes on for miles and there are millions of starfish,' countered the old man. 'How can your efforts make any difference?'

The young man looked at the starfish in his hand and then threw it to safety in the waves. 'It makes a difference to this one,' he said.

This story was told by the late David Baum, President of the Royal College of Paediatrics and Child Health and Professor of Paediatrics and Child Health at the University of Bristol. He was also former President of the British Association of Community Child Health. He used it to describe the importance of the individual in community child health services and gave the incoming president of the Association, Professor Leon Polnay, a small starfish to wear as an insignia.

It is repeated here, as in a previous publication (Mather and Batty, 2000), because it contains a message to all who work with looked after children, and in memory of a dedicated paediatrician who cared deeply about the welfare of disadvantaged children all over the world.

I am delighted to introduce this much needed resource for health professionals and others working with looked after children throughout the UK and further afield. I have no doubt it will fill a gap on our bookshelves, bringing together information about quality standards, best practice, evidence, regulations and guidance.

Children and young people who are looked after are a particularly vulnerable group and both require and deserve a quality specialist multidisciplinary health service to meet their needs. Throughout this book, where the term "looked after children" is used, this applies to children and young people up to 18 years of age, currently being looked after and accommodated by local authorities (Health and Social Care Trusts in Northern Ireland), including those for whom the care plan is adoption.

We know that the majority of children enter care due to neglect and abuse and it is essential that we understand the effects of these experiences in the short and longer term.

On entering care, these children experience separation and loss of birth family, including siblings, and friends. For too many looked after children, their difficulties are further exacerbated by placement moves and lack of appropriate resources and timely interventions. For many years, health services have struggled to meet the needs of this vulnerable group of children. Their complex and diverse needs can be challenging for the children, their carers and professionals in health, education and social care. We can only hope to provide a quality health service for looked after children if we work in a multidisciplinary and multi-agency way.

The original purpose of this publication was to provide a resource for those health professionals new to the field, since there is little formal training in this specialist area. However, it soon became apparent that it is important for other professionals to gain an understanding of the wider context of health and how they can contribute to improved outcomes for looked after children. Therefore, this publication is aimed at a much wider audience, encompassing colleagues in commissioning, social care, education and Child and Adolescent Mental Health Services (CAMHS). In the changing NHS, commissioners who may have limited experience of the needs of looked after children will find this publication essential in understanding the role of health professionals in this specialist field. In some ways, commissioning is the foundation on which a child's journey rests and commissioners therefore need to have a sound understanding of the issues.

We have drawn on the considerable experience of medical advisers and specialist nurses working with looked after children across the UK to compile this book. Colleagues with particular expertise in specialist areas have also made valuable contributions, as have a number of legal advisers and social workers. This publication is not a purely medical text; rather, it addresses the challenging task of promoting the health of vulnerable children with high levels of health inequality, within a complex social care context and legal framework.

We hope that this publication will prove to be an essential guide to good practice, in providing quality health care for looked after children, and will signpost professionals to further information, research and references. In addition, information on legislation, regulations and guidance is provided for England, Northern Ireland and Wales. BAAF job descriptions (2008), which outline flexible templates for three roles held by doctors working with adoption and fostering agencies, and Intercollegiate Competencies for health care staff working with looked after children (Royal College of Nursing and Royal College of Paediatrics and Child Health, 2012, revision expected in 2015) are referenced and should be used alongside this book.

If we are to provide a quality service to meet the needs of looked after children, it is of utmost importance that health professionals lead on the development of quality standards and participate in peer review, audit and continuing professional development. We must share best practice, and both contribute to, and keep abreast of, changes in regulations. Our aim is to empower looked after children and their carers to value their own health and equip them with the skills necessary to promote their health as care leavers, or

support them and their adoptive parents through their adoption journey.

As background, let us first consider who the children are, what makes them vulnerable and why they have historically had poor health, education and social outcomes. We will then explore the content of this publication. Finally, we will reflect on how BAAF, and specifically the BAAF Health Group, has evolved over the last few decades alongside the changes in adoption and permanency practice and the care of looked after children.

The children

As mentioned previously, abuse and neglect are the main reasons children enter care. Children who become looked after by the local authority are the same children who have been identified as children in need and may well have been the subject of child protection procedures. We know that chaotic family lifestyles, domestic violence, and drug and alcohol misuse often lead to poor parenting. The child's adverse experiences before entering care are compounded by separation and loss, as well as placement moves, when these occur. There may be a temporary need for foster care for families in acute distress, or where there is parental physical or mental ill-health. Short break care may be required for children with disabilities and some children with complex disabilities may require placement in specialist residential schools.

On 31 March 2013, 68,100 children in England, 5,769 in Wales and 2,807 in Northern Ireland were in the care of local authorities. This represents an increase of 12 per cent in England and 23 per cent in Wales since 2009 (Department for Education (DfE), 2013a; Welsh Government, 2014) and a 12 per cent increase in Northern Ireland since 2011 (Department of Health, Social Services and Public Safety (DHSSPS), 2013a). Most of these children (over 70 per cent) were living with foster carers. The remainder were living in residential settings, children's homes, secure units, hostels, placed for adoption or living with their parents under placement with parent regulations.

Looked after children are a diverse and mobile group, which adds to their vulnerability and exacerbates difficulties with accessing health and other services. In the year ending 31 March 2013, over 30,000 children entered care in England and Wales, with a similar number leaving the care of the local authority during this period (DfE, 2013a; Welsh Government, 2014), with many of them returning home to parents. Within this population, there are a number of sub-groups with particular needs. This includes infants and younger children who may require permanency; children from black and minority ethnic backgrounds, some of whom may be unaccompanied and seeking asylum; children with disabilities and other complex health needs; and young people who need preparation and support to leave care.

Of those children leaving care in 2013, one-third in England, over half in Northern Ireland and half in Wales returned to their birth families (DfE, 2013a; Welsh Government, 2013a; DHSSPS, 2014). A significant number of these children will return to care in the future.

A considerable level of political and media attention has directed the spotlight onto adoption recently and many reforms are under way across the UK. The number of adoptions from care for the year to 31 March 2013 increased by 15 per cent in England (DfE, 2013a), 47 per cent in Northern Ireland (DHSSPS, 2013a), and 33 per cent in Wales (Welsh Government, 2013a) since 2012 (3,980, 88 and 327 respectively).

The introduction of special guardianship orders in 2005 (Adoption and Children Act 2002) led to only a gradual increase in their usage by the courts. However, in the year to 31 March 2014 in England, there was an increase of 22 per cent in the number of special guardianship orders granted (158 per cent since 2010). Residence orders also saw a significant increase (25 per cent since 2012, 77 per cent since 2009) (DfE, 2014). These statistics show that more and more children are achieving permanent placements, which must be applauded; however, we cannot afford to be complacent.

This publication also considers children who live in private fostering arrangements who, although they are not looked after, are separated from their families and may have similar needs to those looked after. Particular concerns about private fostering led to increased awareness and a requirement to register cases. A total of 1,610 children were reported to be in private placements in England (DfE, 2013b) and 42 in Wales (Welsh Government, 2013b), although actual numbers are thought to be considerably higher. Northern Ireland does not produce statistics relating to private fostering arrangements.

An exploration of the chapters

This publication covers a wide range of topics and follows a child's journey through care. Each chapter concludes with key points and a summary of what health professionals should do. The titles of the individual chapters are self-explanatory, but it is helpful to briefly consider their content here.

The book begins with an in-depth look at who the children are and why they become looked after. We explore the health of looked after children and young people and, as you would expect, take a holistic view of health encompassing physical health, development, oral health, mental health and well-being.

We explore how risk factors, such as antenatal exposure to substances, and early life experiences of neglect and abuse can affect all parameters of a child's health and development, and focus on commonly found health issues in looked after children.

Looked after children and young people are at greater risk of mental health issues, conduct disorders and emotional disorders (Meltzer *et al*, 2003; McCann *et al*, 1996), and these are described in more detail in Chapter 4. Assessing attachment and mental/emotional health is explored, together with the effects of contact with birth family and discussion about the availability of therapeutic services and post-adoption support within health services.

To lay the foundation for statutory health provision and the statutory health

assessment, in Chapter 5 we explore the various pathways of a child or young person through the care system, the accompanying legal context and issues of consent and parental responsibility.

In Chapter 7, we describe the process and requirements for statutory health assessments and the roles and responsibilities of health professionals. There is advice on the content and documentation of a holistic health assessment; collation of information; and compilation of a report and health care plan tailored to individual children/young people.

Health promotion is highlighted in Chapter 8 as an essential component of the health assessment. Indeed, any interaction with a looked after child or young person should be used as an opportunity for health education. Health promotion is essential if young people are to be equipped with the skills to make life choices with regard to their health and well-being, and to maximise their health outcomes in the long term. Areas covered in this chapter include lifestyles, sexual health, sleep, behaviour, culture and religion.

There are particular groups of looked after children/young people who may require additional resources and special expertise from their health professionals. Therefore, we look in more depth at disabled children and young people (Chapter 9), black and minority ethnic children (Chapter 10), unaccompanied asylum-seeking children (Chapter 11), and children in private fostering arrangements (Chapter 14).

Disabled children are over-represented in the looked after population (Marchant, 2011). Common disabilities are described, including Autism Spectrum Disorder, Attention Deficit Hyperactivity Disorder, learning disability, and physical disability.

Black and minority ethnic children are also over-represented in the care system. While these children have the same health issues as other children, they frequently have additional needs related to their ethnicity, and practitioners should be culturally competent. We address the importance of considering the child's ethnic, cultural, religious and linguistic identities and their impact on their health and well-being.

Chapter 11, on unaccompanied asylum-seeking and other separated children, reflects the need to understand the individual child's circumstances and therefore their additional needs. It includes the importance of awareness raising and the difficult areas of child trafficking and assessing age.

Health issues and concerns surrounding children adopted from overseas are addressed in Chapter 13, with sources of further information also provided.

We acknowledge the particular area of concern around leaving care with a dedicated chapter (Chapter 12). The transition from adolescence to adulthood is a difficult experience for the majority of young people, but when combined with the complex care histories and journeys of care leavers, this transition can become overwhelming and fraught with anxiety. Health professionals have an important role in promoting health and empowering care leavers to access universal health services and manage any health issues as they prepare to leave care.

The processes and guiding principles for the comprehensive assessment of prospective adult carers, particularly foster carers and adoptive parents, are described in Chapter 15, together with common health concerns and risks which may affect parenting ability and therefore placement stability. This can often be a challenging area for medical advisers, who need to develop a sound understanding of adult health issues relevant to substitute care.

Chapter 16 deals with the management of health records, including the principles underpinning the handling of records, confidentiality and information sharing. The BAAF Health Group continues to lobby for retention of the NHS number after adoption to ensure continuity of health information.

Finally, in Chapter 17 we discuss quality assurance, clinical governance and the importance of conducting audit and service reviews in planning for and providing quality services for looked after children and adoption. Commissioning is an increasingly important area facing health professionals, and helpful advice is given on issues to be considered by commissioners. Health professionals need to highlight to commissioners the needs of this vulnerable group of children, given their corporate parenting responsibility.

Evolution of services for adopted, fostered and looked after children

Adoption services have undergone a complete transformation. Historically, adoption was very much a service aimed at finding babies for infertile couples. Placements were shrouded in secrecy and background information on the child's birth family was extremely limited. The philosophy behind adoption, the numbers of children available for adoption, and the number of adoptions have changed considerably over the last 40 years. In the 1970s, there were in the region of 20,000 adoptions a year. Since then, numbers have fallen, due in part to changes in social attitudes, as well as availability of contraception and abortion. By the 1990s, there were around 5,000 adoptions a year and the number of adoption orders has remained fairly stable since then. Adoption is now a much more child-centred service dedicated to finding families for children, the majority of whom have come through the care system. Children for whom the plan is adoption have far more complex histories. There are a greater number of sibling groups, the children are older and they are likely to have suffered adversity, either antenatally or whilst living with their birth families.

It is important to remember that adoption is not the answer for all children who need a permanent placement. The needs of some children are more appropriately met through kinship care, special guardianship orders (England and Wales), residence orders (Northern Ireland), child arrangements orders (formerly residence orders in England and Wales until April 2014) or perhaps long-term foster care.

Perhaps the biggest impetus to improving services for looked after children was the Government's *Review of the Safeguards for Children Living Away from Home*, by Sir

William Utting (1996) and reported in *People Like Us* (Utting, 1997). This drew attention to the significant concerns regarding education, health and social outcomes for looked after children.

Government initiatives such as *Quality Protects* in England (Department of Health, 1998b) and *Children First* in Wales (Welsh Assembly Government, 1999), and the *Prime Minister's Review of Adoption* (Department of Health, 2000), helped focus on the unmet needs of looked after children and led to improvements in health services for them.

The last twenty years have seen significant changes in health provision for looked after children. This has included the development of the crucial roles of specialist nurses, specialist health visitors and designated nurses for looked after children. These health professionals are skilled at providing holistic health assessments and support for these children, promoting placement stability and empowering looked after young people and care leavers to take responsibility for their own health needs. This has been a significant contributory factor to better outcomes for looked after children.

In many regions, there are dedicated professionals with a clear remit for health provision for looked after and adopted children. There are multidisciplinary teams comprising paediatricians, specialist nurses, CAMHS and therapists helping to meet statutory and non-statutory obligations. Multi-agency working has become more effective and there is much evidence of good practice. The health service is an important partner to the local authority, but the overall responsibility for looked after children rests with the local authority.

Today, the skilled health professional for looked after children recognises their needs and those of their families, and understands the implications of antenatal drug or alcohol exposure and the effects of neglect and abuse on children. These health professionals are involved in educating other professionals and supporting families to be able to provide an environment for these children to flourish. For those children who continue to be looked after in the longer term, the role of the health professional is to enable and empower them to promote and value their own health.

The role of the medical adviser in adoption is defined in statute (Adoption Agencies Regulations 2005 (England), Adoption Agencies (Wales) Regulations 2005 and Adoption Agencies Regulations (Northern Ireland) 1989, with responsibility for providing assessments and reports on children for whom the plan is adoption, together with advice on the health of prospective adopters and information sharing about individual children with adoption agencies, adoption panels and prospective adopters. It is important that the medical adviser is skilled in carrying out this role and has access to support and further advice.

The role of the medical adviser to the fostering panel has expanded to include providing health advice on carers, and to attend the panel. The delivery of good practice means that the same scrutiny and considerations are applied to potential foster carers as to potential adoptive parents. Some children will remain with their foster carer throughout

their formative years and comprehensive health assessment of foster carers is essential to assess health risk, identify needs for health promotion and support, and to ensure appropriate matching, so that decisions taken are in the best interests of children.

The evolution of BAAF and its Health Group

BAAF has gone through evolution itself. A past Chair of the Health Group, Dr Mary Mather, collated information on the history of the BAAF Health Group for a previous publication (Mather and Batty, 2000) and, with her kind permission, it is included below with updating as necessary.

History of the BAAF Health Group

The British Agencies for Adoption and Fostering (BAAF) Medical Group (now the British Association for Adoption and Fostering) was formed in 1964. At that time, adoption was largely confined to voluntary agencies. Apart from the large agencies, fostering did not appear on the agenda of the voluntary sector until later, following the Houghton Committee report on the adoption of children (Department of Health, 1972). The Medical Group is in fact considerably older than BAAF itself. It was set up by the medical members of the forerunner of the Association of British Adoption and Fostering Agencies (ABAFA), which later joined with the Adoption Resource Exchange (ARE) to become BAAF.

Those who think that excellence, quality and the pursuit of standards in clinical practice are phenomena of the 21st century would find an afternoon spent amongst the dusty files of the BAAF library extremely instructive. Over 50 years ago, the small group of dedicated medical advisers who formed the initial group were extremely concerned about the differing standards of medical practice across all the voluntary agencies involved in adoption work. They spent most of their early meetings designing and re-designing health forms in order to ensure overall continuity of practice. This process still continues today and there is no doubt that BAAF health forms, now adopted by the majority of local authorities throughout the UK, ensure that high quality standard health assessments of looked after children are achieved.

The first Chair of the Medical Group was Dr Hilda Lewis, who died three years after the group was formed. In her memory, a trust fund was set up to enable the Medical Group to hold the annual Hilda Lewis lecture. These early lectures were prestigious events and were followed by a buffet reception. Eminent speakers were invited from abroad and the lecture was held in venues such as Great Ormond Street Hospital, the Thomas Coram Foundation and the Central Hall Westminster.

As the numbers of children being placed for adoption declined during the 1980s, the interest in the Hilda Lewis lecture also declined. The tradition of continuing education in adoption practice was, however, maintained in the form of the Annual General Meeting

of the Medical Group. Medical advisers in increasing numbers and from all over the country met at this two-day event to discuss new developments in practice, share problems and explore future developments. It has become generally recognised that continuing medical education and professional development are important for doctors and nurses engaged in this field, and essential to maintaining quality standards for health professionals. The medical education of doctors involved with looked after children and adoption is probably unique in that it has been carried out over the past 45 years largely by BAAF. There cannot be another area of medical practice in which the voluntary sector, as opposed to the medical profession, has been so responsible for medical training.

The Chairs of the Medical Group have been outstanding in the length of time they have committed to the group. Professor John Forefar, from Edinburgh, succeeded Dr Hilda Lewis. Dr Frank Bamford from Manchester then took the chair throughout most of the 1970s, followed by Dr Christine Cooper, Dr Anne Jepsom, Dr Marion Miles, Dr Heather Payne and, more recently, Dr Mary Mather and Dr Catherine Hill. Dr Christine (Tina) Cooper deserves a special mention. She was a much loved and respected paediatrician from Newcastle who was involved in the BAAF Medical Group from the start and was secretary of the group throughout most of the 1970s before becoming Chair in 1982. Tina's records of meetings have provided much of the history of the Medical Group.

For the medical practitioner involved in the care of looked after children, there is frequently a stark contrast between the services offered to this group and those given to every other child/patient. Those doctors who remember the FFI (Freedom from Infection) Inspections will no doubt vividly recall the extra time added onto the end of an outpatient clinic spent seeing "normal children" and their caring, anxious parents. A subdued, unresponsive child, invariably accompanied by a social worker, who knew virtually nothing about her/him, would be undressed and checked for bruises and infestation, a stethoscope would be waved in the general direction of the chest, she or he would be duly declared "free from infection" and the appropriate form would be signed. The child then disappeared, never to be seen again by that doctor or clinic. This almost veterinary procedure did nothing for the child, the doctor, the social worker or indeed human dignity, and thankfully has been abandoned. Interestingly, the usefulness of the process was never questioned or audited at the time.

The BAAF Health Group in the 21st century

The importance of the roles of the medical adviser in adoption, and health professionals for looked after children, have been recognised by our fellow paediatricians. Continued work between the BAAF Health Group and the Royal College of Paediatrics and Child Health (RCPCH) has led to adoption and looked after children becoming specialist areas of paediatrics and the BAAF Health Group is now a special interest group of the RCPCH.

Comprehensive health assessments for looked after children and children going

through the adoption process are crucial to ensure that these children's health needs are addressed and met. The standardisation of health assessments and reports has contributed greatly to this and BAAF has remained at the forefront of raising standards. The almost universally used BAAF health forms are constantly reviewed and revised by the BAAF Health Group Advisory Committee.

We advocate children's full registration with a GP to ensure complete health records follow the child and any gaps in immunisation uptake or health surveillance can be identified.

The health professional for looked after children plays an important role in gathering together health information from multiple sources, conducting and recording quality health assessments, and ensuring that health needs and health promotion are addressed. Liaison with multi-agency professionals is key to ensuring that relevant health information is shared appropriately, to inform the care plan and advise on future implications.

The BAAF Health Group has long advocated that the same standard of comprehensive health and developmental assessment offered to children with an adoption plan should be undertaken for all children upon becoming looked after. The development of the specific role of nurses for looked after children has had an enormous impact on the uptake of their statutory health assessments and in their health outcomes.

The BAAF Health Group today is an active and vibrant group of paediatricians, specialist nurses, psychologists and psychiatrists throughout the UK, at the forefront of developments in the field, with a clear voice advocating and promoting the needs of looked after children and young people. Every opportunity is taken to raise the profile of the work carried out by professionals in the field.

Membership of BAAF is essential for health professionals involved in this area to keep abreast of changes in the legal framework, to contribute to setting quality standards, to be aware of the various political agendas, and to take part in continuing professional development. There are currently over 500 members of the BAAF Health Group. The Chair is supported by a Health Group Advisory Committee, which meets quarterly, and a committed BAAF Health Group Development Officer. The annual health conference attracts around 130–150 delegates and topics are varied and always relevant to members, with positive evaluations and feedback.

In conclusion, I hope you find this publication an important companion in this specialised and rewarding area of work. You may choose to dip into it, read it from cover to cover, or use it as a tool to champion the health and well-being of looked after children in your region.

The BAAF Health Group is justifiably proud of its contribution over the years to the development of health services for looked after and adopted children, and its continuing role in raising quality standards, promoting best practice and advocating for looked after children and the health professionals who are fortunate to support them.

I am indebted to everyone who has contributed to the comprehensive content of this publication, for their hard work and perseverance, and to the BAAF legal advisers for ensuring accuracy.

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11 Unaccompanied asylum-seeking and other separated children

Emma Fillmore and Ann Lorek with Judith Dennis

Although only a small minority of looked after children will be asylum seekers and separated children, health professionals need an understanding of their circumstances and additional needs.

Definitions

Unaccompanied asylum-seeking child

According to the Home Office guidance, *Processing an Asylum Application from a Child* (2013), an unaccompanied asylum-seeking child (UASC) is 'a person under 18 years of age who is applying for asylum in their own right; and is separated from both parents and is not being cared for by an adult who in law or by custom has responsibility to do so'. They further advise that 'where the person's age is in doubt, he/she should be treated as a child unless and until a full age assessment shows him to be an adult'. "Unaccompanied child" is used with the same meaning throughout this chapter.

Trafficked children

Child trafficking is the recruitment, transportation, transfer, harbouring or receipt of a child, whether by force or not, by a third person or group, for the purpose of different types of exploitation. This includes sexual prostitution, exploitative domestic servitude, enforced criminal activity, or the removal of organs (Council of Europe, 2008).

Separated children

Separated children are all those outside their country of origin and separated from their parents or legal or customary primary caregiver (Dorling, 2013). This term is widely viewed as good practice because it describes the situation of many unaccompanied children as being separated from their families abroad. Trafficked children are often, but not always, included and defined as part of the UASC population (Pearce *et al*, 2009).

Age-disputed children

Age-disputed children are undocumented asylum applicants presenting as minors whose claimed date of birth is not accepted by the Home Office and/or the local authority/Health and Social Care Trust (in Northern Ireland) that has been approached to provide support (Dorling, 2013).

Who are these children and why are they in the UK?

Children can be separated from their parents and may seek asylum/protection for a number of reasons, and each child must be assessed with an open mind as to their potential welfare and health needs. Children may come from countries experiencing long-term or more recent conflict, which may be internal or between nations. Whilst the reason for leaving an area of conflict may appear obvious, for others it may be less clear, and local issues, for example, relating to inter-ethnic violence, plus opportunity, will affect the decision to leave their home and country.

Some children are in local authority care following family breakdown after arrival in the UK, for example, if an older sibling can no longer care for them, or due to breakdown of a private fostering arrangement, and others may have been trafficked or abandoned.

In 2013, the most common countries for child applicants to have originated from were Albania, Afghanistan and Eritrea, with an increasing number from Syria, consequent on world events (Refugee Council, 2014). Of 1,265 applications made by applicants seeking refugee status, 323 individuals had their age disputed. Methods of collecting and presenting the national data have been revised, and numbers change dependent on appeal. Most are given leave to stay temporarily.

In recent years, there has been increased recognition that children may enter the UK as victims of human trafficking for the purposes of labour, sexual exploitation and domestic servitude. Although in 2011 there were 234 children referred to the National Referral Mechanism (NRM), the true figure is likely to be much higher as victims of this hidden crime are often unable to come forward, or fear reprisals or problems with their immigration status. Eighty per cent of referred children were between 12 and 17 years old, and slightly more than half were female (Department of Justice, The Scottish Government, HM Government, 2012).

Legal framework

The recognised reasons for seeking asylum are fleeing war, torture, persecution, threat to life or political unrest. The Home Office has operational guidance around the political situation in different countries and when it may not be safe to return a young person (UK Visas and Immigration, 2014), and s.55 of the Borders, Citizenship and Immigration Act 2009 places a duty on them to perform their functions with regard to the need to safeguard and promote the welfare of children.

If the initial assessment by the authorities agrees that the young person seeking asylum is under 18 years old without an adult to care for them, then they are considered to be an unaccompanied asylum-seeking child, and the local authority concerned has a duty to accommodate the young person under s.20 of the Children Act 1989 or Article 21 of the Children (Northern Ireland) Order 1995. UASC will then usually have the right to all the

statutory services available to other looked after children (accommodation, food, financial allowance, education, health assessments, looked after reviews, care plan, leaving care support), provided they meet the criteria. In England, the Department for Education's (DfE) statutory guidance, *Care of Unaccompanied and Trafficked Children* (2014), makes it clear that local authorities should fulfil their duties with regard to the child's circumstances and needs as unaccompanied or trafficked children. Unaccompanied children will usually be able to access legal aid to assist with their claim for asylum, although not for other immigration matters.

There is no specific guidance on the provision of accommodation for unaccompanied children in England and Wales, but they are subject to the statutory guidance, *Provision of Accommodation for 16 and 17-Year-Olds who may be Homeless and/or Require Accommodation* (Department for Communities and Local Government, and DfE, 2010).

Regional operational guidance published by the Health and Social Care Board, *Pathway for Safeguarding and Promoting the Welfare of Separated/Unaccompanied Children arriving in Northern Ireland* (2013), includes guidance on the provision of accommodation for children under the age of 16. Separated children are the responsibility of the Health and Social Care Trusts and are recognised as "children in need" under the Children (Northern Ireland) Order 1995. However, young people aged 16 or over and age-disputed young people may be placed in unregulated supported accommodation if the Trust deems this to be appropriate.

Unaccompanied children and care leavers whose asylum claims have not been finally determined will not be entitled to access social housing in their own right and will need to be provided with foster carers, a residential placement or supported lodgings. Bed and breakfast accommodation is not considered suitable for any looked after child – children under 16 should be placed in foster care or a residential unit. In each case, the needs of the specific child, rather than their status as an unaccompanied child, should dictate the choice of placement.

A child will be accommodated by a local authority under s.20 of the Children Act 1989 and Article 21 of the Children (Northern Ireland) Order 1995 when they are a child "in need" who requires accommodation, unless a person with parental responsibility for that child objects. In practice, a local authority will obtain the written agreement of a parent to a child's accommodation, covering issues such as consent to medical examination. This is clearly not possible for most unaccompanied children as their parents are usually not contactable. Section 20(11) of the Children Act 1989 and Article 22(5) of the Children (Northern Ireland) Order 1995 allow a child aged 16 or over to agree to his/her own accommodation. If the child is of sufficient age and understanding to consent to health assessment, a practitioner may accept that child's consent. If there are concerns that a child is not competent to consent to assessment, the local authority should consider obtaining parental responsibility for that child through a care order, which would enable

the local authority to consent to the child's assessment. As for any looked after child, unaccompanied children should undergo statutory six-monthly health assessments if under five years old, and annual health assessment if aged five years and above.

Unaccompanied children are subject to an asylum determination process that is designed to be more appropriate for a child. They can make an application whilst they are a child, and could be granted asylum as a child. However, because children and young people may be given a form of leave recognising that they cannot be returned to their country of origin (see below), it may be years before a final decision is made on their claim. This can result in living with uncertainty for a long time and may add to the stress a young person goes through at critical stages in their life.

The possible outcomes of asylum application are as follows.

Refugee status

This provides internal protection under the UN Convention relating to the status of refugees. If this is awarded (termed asylum), it provides five years of leave to remain with the right to work and access benefits as appropriate. In 2013, of those unaccompanied children who received a decision whilst still a child, 20 per cent were found to be refugees.

Humanitarian protection

If a child is refused asylum, then consideration is given to human rights issues and humanitarian protection. If awarded, this provides five years of leave to remain with the right to work and mainstream benefits as appropriate.

Unaccompanied asylum-seeking children (UASC) leave

Those refused asylum and humanitarian protection may be granted UASC leave (formerly known as discretionary leave), if there are deemed to be no adequate reception arrangements in the country of origin. This will usually be granted for 30 months or until the unaccompanied child is 17-and-a-half years old (whichever is shorter). Others, including trafficked children, can also be granted this leave.

Refused asylum

When this occurs, the unaccompanied child must return to their country of origin. It is, however, very unusual as the Home Office will not remove an unaccompanied child unless safe and adequate reception arrangements are in place in their country of origin.

Adoption and special guardianship

Rarely, unaccompanied children who are very young may have a permanence plan that involves legal guardianship by an extended family member who is found in the UK, or adoption if no birth family can be traced either in the UK or the country of origin. If the

child is adopted in the UK by British adopters, they will acquire British citizenship and the right to remain. Other permanence options will not confer citizenship and the child will still have to apply for leave to remain in the UK. Special guardianship is also an option, with the majority of orders made to former foster carers (DfE, 2012).

The importance of health assessments

Completion of health assessments and production of informative health assessment reports in a timely manner is important to the young person making applications to the Home Office. The inclusion of information on any early or current health and development difficulties or diagnoses, documentation of injuries with medical investigations, presence of mental health difficulties or diagnoses with prognosis, and any ongoing treatments needed is essential to help inform the correct legal decision around a young person's application.

For example, a young unaccompanied African boy aged 15 presented to the health team with weight loss, cough, lack of appetite and a skin rash. The results of medical investigations showing HIV infection and pulmonary tuberculosis, a plan for treatment, and prognosis without treatment, were included in the initial health assessment report to inform his appeal against the decision not to grant him refugee status. The appeal was successful on the grounds that he would die if returned to his country of origin, due to lack of treatment available for both conditions, and that prolonged treatment was required in the UK.

Young people may be unaware of their legal status and this should be clarified with the social worker. They have a right to receive legal aid to prepare their cases, to be accompanied to interview, to be represented at asylum appeals and to have their claims assessed by a specialist children's unit. Unaccompanied children should not be subject to immigration detention.

Trafficked children should be identified as being vulnerable and, if at risk of further abuse, child protection procedures should be followed. A referral should be made to the National Referral Mechanism, as they remain vulnerable, even if their asylum claim is not being met, and should be safeguarded (Coram Children's Legal Centre, 2012).

Age assessments

This is a complex issue frequently considered by social workers. Many unaccompanied children do not have passports or accurate documents with dates of birth (World Bank, 2012), and the information on record may not be consistent with what they say. Some countries, such as Ethiopia, use different calendars and dates of birth are not always easily interpreted. The child/young person may have had an interview assessment at the Home Office, but screening has been reported not to be child-focused and it is not unusual for

the Home Office assessment not to concur with the social services assessment, as these young people's stories are often received in a 'culture of disbelief' (Crawley, 2007), which is also exhibited by professionals and the public. This replicates the early patterns of disbelief seen in child abuse cases in the 1960s and 70s, where the reports of traumatic experiences of children were not believed because they were so far removed from the cultural system of the listening adult. Similarly, many children who talk of experiences of rape, torture, war and persecution are not believed as these experiences are outside the social "norm" of the receiving country's culture (Children's Society, 2012).

Maturity is related to past experience and ethnicity. Children assessed as older than their actual age may therefore not be eligible for services that they need, and may be subjected to the immigration procedures of an adult, or be placed with an older peer group. Conversely, there is the concern that an adult or older child may be placed with younger children if their age is underestimated.

Royal College of Paediatrics and Child Health (RCPCH) guidance states that as x-rays should *not* be used for non-clinical reasons, they should not be obtained to assess age (Levenson and Sharma, 1999). Age assessment is not an exact science, and depends as much on the social as the clinical presentation. For a detailed discussion of age assessment, see Mather, 2006. There is no statutory guidance for conducting age assessment for unaccompanied children. Instead, there is a body of case law that sets out the process recommended for assessment. Two key judgements are *(R (B) v Merton London Borough Council* (2003) EWHC 1689 (Admin), and *R (FZ) v London Borough of Croydon* (2011) EWCA (Civ 59). More details of these and other relevant case law are contained in Dorling, 2013. The Merton guidance outlines the following.

- The local authority cannot adopt the decision by the Home Office without having gone through the process of age assessment.
- An appropriate adult should be in attendance at the assessment.
- The assessment should be conducted by two qualified social workers, one of whom is to be senior.
- The assessment should take into account: appearance, demeanour, credibility and background (education, health, family, social, culture, ethnicity).
- The young person must be given the opportunity to question or challenge questions or decisions made during the assessment.
- A paediatric assessment does not attract any greater weight than the observation and history taken by the experienced social worker.
- Medical investigations (dental x-rays, bone age, genital examinations) do not lend any further information to the assessment process (plus or minus two years is the most accuracy that can be obtained from bone age and dental x-rays) and are unnecessary.
- If in doubt, the local authority should give the benefit of the doubt to the young person and deem them a child.

It may be helpful to note if the young person presents as consistent with their stated age, whilst recognising that this is an inexact science as children mature at different rates, and are impacted by life events. Medical and developmental information from the health assessment by a paediatrician may assist the decision-maker (social worker) as background to their assessment process, and the final decision is with the local authority. Whilst the majority of these young people are eventually refused asylum, it should be noted that significant numbers are accepted. Home Office documentation may neither agree with what the child says, nor with social workers who carry out independent assessments, and some children assessed to be adult have subsequently found to have documentary evidence that they are minors (Bhaba and Finch, 2006; Crawley, 2007; Dennis, 2012).

Interpreters

Face-to-face, culturally and ethnically appropriate interpreters are essential if young people's voices are to be heard and essential health information shared. In some cases, it may be necessary to ensure that the interpreter is from the appropriate "side" of any divisions in the home country, so that the young person can speak freely. Appropriate training and awareness in conducting medical assessments with interpreters is necessary. It is important to be sensitive to concerns that the young person may have about confidentiality and risk to themselves and family members. They may also feel vulnerable if other people know their whereabouts, especially in situations of internal conflict or persecution in their country of origin. Even when young people become proficient in English, they often find discussing health problems (especially emotional health issues) very difficult if this is not conducted in their first language.

Health assessments

Unaccompanied children require a comprehensive assessment in the same way as any other child in care, but there are important additional factors related to their unique past experiences of loss and bereavement, often including war trauma, torture or trafficking. Unaccompanied children may have specific health issues relating to their country of origin, experiences on their journey, and situation and circumstances since entering the UK.

Knowledge of the medical, social and political situation of the young person's country of origin is paramount in assessment and planning for their health care. BAAF publishes a range of booklets for foster carers (Fursland, 2007), which focus on children arriving from different countries and provide specific information to give foster carers an understanding of the kind of country, society and family a child may have come from. Each booklet includes a general introduction to culture, habits and customs to help readers gain awareness about a child's background, and provides useful information.

Advice is available to GPs regarding the needs of these young people (Burnett and Fassil, 2002), but the statutory assessment may be the first one where time can be spent on a holistic assessment with an interpreter.

Arranging the assessment

An interpreter who is culturally and gender appropriate should be booked for face-to-face sessions. Usually, the local authority will arrange the interpreter as they may use the same person for the UASC in all their consultations (e.g. initial Home Office visit, education, GP, legal services).

At the outset, it is important to explain to the young person that they and their carer will both be seen individually, and then together. It is useful to talk things over together at the end, particularly if there is an interpreter present, provided consent and confidentiality issues are considered as for any young person. Many unaccompanied minors are old enough to consent for themselves (see Legal framework, above).

As for any child in care, it is important to allow enough time to gather comprehensive information at the initial meeting, as it is unfair to espect the young person to relive trauma and loss several times unless in a therapeutic setting, and this may also be one of the few occasions where there is an interpreter present.

Documentation

As for looked after children, a health assessment (generally using BAAF Form IHA–C or IHA–YP) will be required but an additional checklist may make the assessment process itself more appropriate to the young person's experiences and needs, and can include, for example, prompts for family tracing and other specific issues. Completion of the Strengths and Difficulties Questionnaire (SDQ) may not give the full picture for this client group, but is useful in providing additional or background information.

A structured approach will help in gathering more sensitive information, e.g. family circumstances, after more neutral information (demographics, health or education), and ideally should lead from a mental health screening about vulnerability to questions supporting and celebrating resilience. The collection of demographic information is a useful way to start to understand a little about the young person's country of origin and ethnicity. There may be particular issues arising from mixed marriage, or different cultures and religions. There may be specific health issues such as hepatitis B, haemoglobinopathies, vaccinations, and female genital mutilation (FGM).

As the life experiences of these young people may be quite different from those of their peers in the UK, a comprehensive assessment should be tailored to meet the individual needs of the young person, which should include the points detailed below.

Demographics

Verification of demographics from the young person themselves is important as they may have been given official documents that are not in agreement with their own understanding and information, and this can lead to conflict. This usually relates to lack of documentation (common in leaving a country at short notice and where many children worldwide do not have documentary validation of age), the age assessment process itself, and literacy difficulties, but difficulties with some national date systems can also make the interpretation of a birth date complex even for nationals (for example, children with birth dates under the Ethiopian calendar).

Past health and developmental issues

Verification of health history, including immunisations, may be impossible as documents are rarely collected if the young person left home at short notice, and immunisation history is not often known by the young person. The World Health Organisation (WHO) website (2014) provides country-specific information about national immunisation programmes and may be helpful in outlining the immunisation schedule that a child should have received. Whilst some countries have a good infrastructure, if there is no documentation and no definitive history it should not be assumed that the immunisations have been given, as they may have been disrupted by war or travel despite being compulsory in some countries (e.g. Iraq). The young person should be advised about restarting immunisations if there is either no record, or if there appear to be missing immunisations. Guidance for "vaccination of individuals with uncertain or incomplete immunisation status" should be followed (Health Protection Agency, 2012). BCG is often given at birth and a BCG scar should be documented. If there is no BCG scar, the young person may fall into the current Department of Health guidance (2012a) regarding immunisation of at-risk groups for tuberculosis. This should be discussed at the end of the assessment as part of the health plan, as it may involve consideration of screening for HIV before giving Mantoux and BCG. A history of contact with tuberculosis should lead to a referral for screening, irrespective of a BCG scar.

Enquiry about jaundice, fever and other symptoms may indicate past history, for example, of malaria, hepatitis, tuberculosis or haemoglobinopathy.

Injuries and ill-health due to torture, war trauma, and physical or sexual violence in the young person's country of origin and on the journey to the UK should be asked about and documented, and appropriate referrals will need to be made for follow-up of relevant physical and sexual health needs and to support mental health needs.

Education history and ability to read or write in the young person's own language may indicate whether there are previous learning or developmental difficulties or whether they have missed education, for example, due to internal conflict in the country of origin, and so may respond to regular appropriate education.

Current health

Clear history of the young person's concerns about their physical and mental health should be documented. It is helpful to structure the assessment such that more neutral information including demographics, health and social history precedes the history of the young person's exposure to trauma or violence and the outcome for their family. Mental and sexual health screening should also be carried out.

General health

Abdominal pains, backaches and headaches are common in this client group and may be related to stress or gastrointestinal infections. Poor nutrition and constipation are common with the disconnection from the cultural norms for eating and cooking, and introduction to Western foods (often takeaways). Food and behaviours are linked to both survival and a sense of sanctuary (Kohli *et al*, 2010). It is important to ask if the young person is eating a varied diet, has cooking equipment and can cook, and if they know what foods to buy or whether they have someone to support them in this. Parasites such as Giardia and Helicobacter should be considered. Vitamin D deficiency should also be considered, tested for, and treated with diet and supplements as necessary.

Skin complaints and dry skin are common in this group. Many skin complaints and infestations commence on the journey to the UK, due to crowded, poor travelling conditions with inadequate nutrition. Skin infestations, such as scabies and Tinea Capitis, are common and often not recognised by the young person, so may persist without the young person seeking medical care.

Growth

Growth measurements and documentation are important to identify and monitor nutritional and health issues. Note that when plotted onto UK standardised growth charts, many of the ethnically tall (e.g. African) or short (e.g. Thai) minors may appear outside normal centiles, and therefore interpretation of the growth charts should be carefully done in conjunction with the physical examination and body mass index (BMI).

Screening

These young people may never have been screened for vision, hearing and development, so baseline ophthalmology should be booked, and hearing checked if any concerns emerge. Standardised developmental assessments may be required in order to identify and investigate developmental needs. The young person may not have had routine neonatal screening of, for example, haemoglobinopathies, and their mother may not have been screened for hepatitis B, so further screening tests may be needed dependent on the age and presentation of the young person. Risk factors for blood-borne viruses should be considered as part of a comprehensive assessment, and screening for these arranged if

indicated. *Guidelines for the Testing of Looked After Children who are at Risk of a Blood-Borne Infection* addresses this in detail (BAAF, 2008).

Health promotion

Health promotion appropriate for age is discussed in Chapter 8. It should be remembered that many topics and concepts of health promotion will be new to this client group (for example, do not assume that the young person is aware of contraceptives). Healthy eating may be made more complex if they do not have support with shopping for appropriate healthy foods or learning how to cook foods that are new to them.

Patterns of health-seeking behaviour (visits to the GP, etc) should be documented and it should be acknowledged that unaccompanied children will not be used to our health system. UASC often do not use pharmacy advice or over-the-counter remedies and present to a formal medical setting for minor ailments. They may be more inclined to use NHS walk-in or A & E settings rather than a GP surgery where they will have ongoing and holistic care.

Family and social history

It is important to ask what the young person may know of any illness in their family. It is helpful to ascertain whether they have any family living in their own country or any transit country.

From this starting point, the assessment can start to sensitively explore the issue of why they travelled to the UK, if they or their family experienced trauma or if they witnessed something that upset them. If their parents have died, it is important to ask when, and in what circumstances.

Case study

A 14-year-old young man from Afghanistan spoke of his experience of his mother and sister being killed in front of him with bayonets. He spoke of the image being like a veil in front of his eyes through which he had to view everything in his life from that moment onward. At night the picture was clearer as his eyes closed, so he spent all night awake to avoid the terrifying nightmare. He was exhausted, traumatised, falling asleep at school and unable to eat properly. He slowly accepted help from a counsellor at college who was from the local Afghani community, and with consultation from CAMHS he was able to reduce the vision and return to a better sleep/wake pattern. He later completed two years of CAMHS specialist input and progressed through college and on to employment.

Discussion should lead onto the question of family tracing, and whether this may be appropriate for the young person. They may need reassurance that it is carried out by organisations working to careful guidelines to keep them and their family safe. The British Red Cross international tracing and message service (British Red Cross, 2014) can be life-changing for a young person, and they may need support by their social worker to take this route, as their concern about risk to themselves and their families in the process may be high. Many young people express the wish to know what has happened to their families and find the Red Cross work in family tracing very helpful in helping them settle and reduce anxiety. Some can be reunited with siblings and other family members in the process.

Mental health

Documentation of sleeping and eating patterns, any self-harming behaviour, intrusive thoughts/memories, patterns of socialisation, access to education, mixing with local community, connections to faith community, and use of any medications may help build a picture of the young person's current physical and mental health needs.

Screening is needed as otherwise the assessor may miss those with post-traumatic stress disorder (PTSD) or suicidal tendency. A structured approach allows for sensitive questioning of their mood and any depression or suicidal ideation, or PTSD symptoms, as well as what is causing worry for them. Having assessed risk, it is important to lead on to questions of support and resilience. Do they have a trusted adult, or anyone they can talk to in confidence? Where do they get their strength?

It should be recognised that many unaccompanied children come from cultures where there is a different understanding of, and possibly less terminology to describe, mental health issues, and where discussion around mental health is uncommon. Therefore, most mental health issues will present initially as physical manifestations until the young person finds a trusted adult to whom they feel confident enough to open up. Many of these young people say that their experience is too painful to remember or recount and many need a lot of time to feel safe enough to begin to think about their trauma and rationalise it. Counselling is a Western concept and may not always be effective, although specialist input, including group work, is often helpful.

The mental health of refugees can deteriorate in the UK, and they are often under particular stress when their asylum claim goes through various stages, and multiple stresses can have a detrimental effect on children's mental health (Heptinstall *et al*, 2004).

The majority of young people say that the uncertainty of their immigration status is the key issue that causes them anxiety. This is demonstrated in poor mental health, with erratic eating habits, lack of sleep, psychosomatic symptoms, and evidence of depression, self-harm and social isolation (Sanchez-Cao *et al*, 2013).

It is important to advocate for support of mental health needs by normalising life for the young person as much as possible, including education, faith groups and supported

care, as this will provide stability and is protective (Summerfield, 2002). However, some young people will need specialist mental health input to deal with issues of torture, loss, trauma, and bereavement (Sanchez-Cao *et al*, 2013).

Sexual health

Any sexual health needs of the young person should be established, including unprotected sex and contraceptive advice, and past history of being trafficked, sexual intercourse/rape, pregnancy and parenting or whether the young person has been cut by "circumcision" (see below). Some girls will already be pregnant, usually from sexual exploitation on their journey to, or after arrival in, the UK. Recent rape (within the week if a post-pubertal girl, or up to 72 hours for a boy) necessitates forensic medical examiner advice and, if appropriate, forensic child sexual abuse examination (under s.47 of the Children Act 1989), and many will need to be screened for sexually transmitted diseases. Many young people are ignorant of contraceptives and need further advice or signposting to services. Risk factors warranting screening for blood-borne viruses should always be considered and a low threshold for testing applied to all unaccompanied children, considering the high reported rates of sexual abuse/rape/exposure to HIV and hepatitis in countries of origin and during the journey to the UK.

Female genital mutilation (FGM)

Specific questions must be sensitively asked of girls from countries known to practise female genital mutilation (FGM), also called "circumcision" or "cutting". The young girl may not know if she has undergone FGM, but it is important that this is known at some point prior to sexual experience or childbirth, for health and social reasons. An examination by a suitably qualified clinician should be offered if the young woman wants to know her FGM status. The legal situation around FGM in this country should be made clear to the young person and any carers/community support workers from culturally similar backgrounds working with her. They need to understand that it is illegal either for girls to be circumcised in the UK, or for someone to take her to another country to have this procedure carried out. She should be reassured that there are specialist clinics that can provide confidential and specialist advice around childbearing and other concerns that she may have relating to FGM (NHS, 2012).

Safeguarding

It is essential to explore whether safeguarding issues, including any traumatic experiences, experience of abuse, trafficking or being a child soldier, have ever happened to the young person. Many have been trafficked (Somerset, 2004; Serious Organised Crime Agency (SOCA), 2011) or are vulnerable to sexual abuse. They may already have experienced sexual violence, which is more common in areas of conflict, and in the process of migration and settling in a new country (United Nations, 2012).

Try to understand something of what the young person's journey involved – this group of young people, both girls and boys, are particularly vulnerable to rape; explore if this has happened to them. Afghan boys have reported rape as a systematic problem, and around one-third of girls disclose rape, either in their own country or while travelling to the UK, or indeed on arrival as they remain vulnerable to trafficking and prostitution, as evidenced by a number of these young people who have disappeared from care. The possibility of trafficking needs to be considered as both boys and girls are trafficked for sexual or economic exploitation, as reported from a number of countries, including Nigeria, China, Afghanistan, Vietnam and countries in Eastern Europe (Child Exploitation and Online Protection Centre (CEOP), 2009). The opportunity for sexual abuse and trafficking is increased in any country where there is conflict. They may have themselves been perpetrators of violence and, for example, may disclose having been a child soldier, with associated difficulties in acceptance within their own communities. However, many young people do not disclose information until some while after the traumatic events have occurred, and it is important that their carers are aware that their past experiences may surface in discussions or sadness at home.

Experiences in the UK are important to note, such as age dispute and detention as an adult, bullying or other circumstances of concern.

As already noted, some unaccompanied young people have become pregnant, linked to sexual exploitation and vulnerability (United Nations, 2012) while in transit and once in the UK, with most having become pregnant before coming into the care of the local authority (John-Legere, 2012).

> *A number of the girls seen in clinics have been trafficked, or sexually exploited during humanitarian relief, or abandoned after an abusive situation. Thirteen of the first 36 girls seen in a clinic had been raped. An Afghan boy has disclosed that he was raped while leaving the country* (Leather *et al*, 2003).

Safeguarding procedures should always be followed and referrals made to social care for section 47 enquiries if there is knowledge or suspicion that an unaccompanied child is likely to suffer, or actually suffering, significant harm.

Ask whether the young person is making friends, and if they are attending college, what subjects they would like to study and what aspirations they have. An important part of the settling process includes whether they can practise their religion.

If they have a partner or friends, it is important to ask sensitively about them in order to consider risk, and also to ask whether they have contact with drugs, alcohol, gangs or violence in their local area, as it is easy for young people to become particularly vulnerable when alone in a new environment. Questions around contact with the police or youth offending teams will also highlight vulnerability and risk. It is important to know whether they feel safe, and if there are any issues of bullying, risk or problems where they live.

Education

School life is part of the environment needed to support integration and normalising of the situation for these young people. Although they often find it hard to get a school placement, other activities, such as English language learning or a gym plus travel pass, are usually supported by the social worker. Learning may require more detailed assessment, but the commonest issue is the need to support access to an education placement as soon as possible, both from the point of view of learning and to help normalise their lives, and support mental health.

If any significant learning difficulties are suspected, then a clinical or educational psychological cognitive assessment should be considered, whilst recognising that past experience, lack of education and trauma can all cause significant cognitive deficits without inherent learning difficulties.

Educational, cultural and social supports are usually extremely helpful. Good role models are needed early in the placement, as is signposting to organisations, such as the Refugee Council, that have practitioner advice and can provide support, and local refugee support networks in the community for sports and social activities. These activities help the process of adjustment and settling (Brownlees and Finch, 2010). Young people in foster care often appear to fare better when in placements where they have access to support from other children or adults from their ethnic or faith communities (Brownlees and Finch, 2010).

Examination and investigations

A comprehensive physical examination is recommended and more than one consultation may be required to develop rapport and enable this to be carried out. Particular attention will need to be paid to concerns that have emerged from the young person's history, and appropriate arrangements may need to be made for further investigation or referral, and reflected in the health care plan. It is important to document, and if possible photograph, any injuries carefully as they may be relevant to abuse, or to the young person's asylum claim. Always assess the risk of infectious diseases, such as hepatitis B and other sexually transmitted diseases, and screen or refer accordingly.

Health care plan

A clearly written health care plan needs to include identified health issues with plans for involvement of specialist health services as required (e.g. CAMHS children in care service, chest/tuberculosis clinic, GP or immunisation clinic, HIV services, genito-urinary medicine (GUM)/contraception and sexual health (CASH) services, safeguarding services). Actions with timescales and persons responsible should be clearly identified in the plan.

The plan needs to be made with the consent of the young person, with discussion in their first language, as this may be one of the few contacts with health professionals where an interpreter is present.

Current placement

These young people may be placed in foster care, or in semi-independent accommodation. Their needs are unique and may be undisclosed, and foster carers and social workers need to be aware of the possibility of past trauma, as well as sensitive to cultural differences (Amarena and Kidane, 2004; Fursland, 2007). With consent and with the interpreter present, relevant issues can be shared at the health assessment, and this provides an opportunity for the young person to discuss with the carer or social worker if there are any difficulties in the placement that may impact on their mental health status, as well as give the carer or worker a chance to reiterate the health care plan.

Multi-agency approach

Given the complexity of their problems and needs, a multi-agency approach is useful in helping to signpost and provide appropriate care for these young people. This is not always possible at clinic level, but close working with social/children's services is essential to ensure that needs are met holistically. While these young people have needs common to all young people, it is important for someone in health care to develop expertise in dealing with the particular problems of this client group, and some consideration is given below to the option of specialist clinics. There is a strong need for dedicated and interested staff to develop and run specialist services for unaccompanied children, with a non-judgemental and empathetic approach to the young people attending. Good communication with other agencies is essential in order to link in with specialist support services (Chase *et al*, 2008).

Specialist clinics

Unaccompanied children are part of the responsibility of the designated doctor for looked after children, and require statutory assessments. Assessment skills can be obtained by any motivated doctor with an interest in these young people. It is essential that a culturally appropriate interpreter is present in order to assess needs holistically, as young people are often able to communicate socially but not to talk about their deepest needs. These needs are those of any young person, but UASC and separated children have often had past experiences that require understanding in order to explore them in a sensitive way. In one study, of the first 93 children seen in a multidisciplinary clinic, most had experienced traumatic circumstances, almost a third had parent(s) who had died, and half did not

know if their parents were alive or safe (Leather *et al*, 2003). Many did not yet feel safe in the UK.

A specialist in the LAC service needs to understand some of the experiences of child soldiers or children who have undergone female genital mutilation or been trafficked. Specialist social work teams build up experience in addressing particular issues of loss and cultural adjustment. The specialist teams become more skilled in supporting adjustment and referring to specialist services if the child has, for example, depression or PTSD. Exploration of the option of specialist secure Red Cross family tracing is one way of starting to approach past issues and is often missed in generic looked after children assessments. Particular legal issues affect the care of, and contribute to stress within, this group of young people and these are explored in more depth in the next section. In summary, it is important that one member of the looked after team has specialist knowledge and interest relating to unaccompanied children, in order for their needs to be met appropriately, and for wider training to take place.

Common dilemmas

Legal issues

- Unaccompanied children are accommodated under s.20 of the Children Act 1989, but do not have a person with parental responsibility to give consent if the young person does not have capacity or is very young. Discussions with social care about obtaining a care order should occur prior to the health assessment if these concerns are raised early. Local authorities may be reluctant to obtain a care order due to cost and legal complexity. Resultant delay in the young person's health assessment, with no one having parental responsibility for a vulnerable young person, increases the risk of leaving significant health issues unaddressed and the young person not being able to access appropriate health care. Practitioners should keep in mind that parental consent is not required where a local authority has a duty to arrange a health assessment to safeguard the child's welfare, although the child with capacity to consent may refuse the assessment (see Chapter 6).
- The six-month period before UASC leave to remain runs out (at 18 years old) is a stressful period in a young person's life, with increasing concern regarding the threat of removal post-18 if their application is declined. During this period, it is not uncommon for unaccompanied young people to increasingly report health issues such as persistent headaches, eye strain, back pain, intrusive "flashback" memories, disturbed sleep patterns, nightmares, lack of concentration, poor academic progress and clinical signs and symptoms of depression. Patterns of self-harm, lack of sleep, stopping eating, weight loss, intrusive and morbid thoughts develop with increasing frequency and intensity during this pre-18 years period. The need for looked after

children CAMHS increases at this time. Paediatricians who have assessed and examined UASC are often asked for medical reports to support the young person's application to the Home Office for refugee status. Clarity around medical conditions, with evidence of injuries from war, torture or abuse, identified mental health issues, and need for specialist health services and medical treatments, should be included.

- Once a young person reaches 18, they are no longer a child in care and as such do not have the protection and provision afforded for a child in care. Those who qualify will have access to the same provisions as all care leavers, as discussed in the earlier section on leaving care. However, young people without this support often become destitute and isolated, with resultant deterioration in their physical and mental health.
- Failure to achieve refugee status by their claim to the Home Office being declined can also result in destitution. Young people then have the threat or experience of detention and deportation. Some "disappear", often living in poverty and obscurity, not being able to access mainstream health services. Young people are then highly vulnerable to exploitation, with entry into sex working, drug trafficking and unlawful and unprotected work becoming a common practice.
- Unaccompanied children have increased vulnerability to breaking UK law due to lack of knowledge and understanding of the UK law and systems. There are strict and rapid actions if the law is broken by an unaccompanied child – most commonly resulting in immediate detention and deportation. Professionals need to support unaccompanied children by explaining UK law and the consequences of breaking it.

Cultural issues

- Some young men who need health assessments may find talking to a female health professional difficult as this is outside their cultural norm. Also, discussing emotional and mental health issues is often beyond many young people's experience, and therefore obtaining an accurate picture of the young person's mental and emotional health may prove difficult. This needs careful and sensitive timing of questions, with information gathered from key workers, carers or social workers to build a picture of the young person's needs. Many young people do not want to access mental health services initially, due to lack of experience and trust of these services, and unwillingness to "open up" to a stranger.
- Obtaining consent, testing and treatment for blood-borne infections can be difficult, particularly in young people from countries (in Africa in particular) where HIV and AIDS continue to be very stigmatised. Convincing a young person that detecting and treating HIV is possible and beneficial for their health is a sensitive task that requires understanding of their country's belief system and the perceived loss or gain for the young person. Ongoing need for management and treatment for HIV, syphilis or hepatitis is important information that the young person can use in their claim for

refugee status to the Home Office, as treatment for these illnesses in many countries of origin is not available or affordable and therefore the young person would be likely to die if deported.

What health professionals should do

- Designated professionals should ensure that the needs of unaccompanied asylum seeking children are included in the annual report, and should educate and advise commissioners on the health needs of these children to ensure that they make adequate provision, including placements which can effectively meet their complex needs.
- Gain an understanding of the range of experiences of this group and learn about the particular needs that result.
- Develop a database of local and national resources.
- Work closely with social services to ensure good communication, timely assessments and shared understanding of the needs of this population.
- Raise awareness of trafficked and unaccompanied asylum-seeking children with colleagues, and contribute to specialised training where relevant.
- Establish links with CAMHS and encourage development of specialised expertise in areas with significant numbers of unaccompanied children.
- Be an advocate for stability in schooling, leisure and routines, and signpost to relevant organisations.

Key points

- It is inappropriate for LAC health professionals to carry out age assessments, but it may be appropriate to comment if the young person's stated age is consistent with their presentation, or conversely if they appear mature for their stated age, keeping in mind cultural variations in appearance and development, and the effects of traumatic experiences and early responsibility.
- Unaccompanied asylum-seeking and trafficked children may have additional health considerations related to traumatic experiences and forced migration, and possible gaps in surveillance, immunisations and child health promotion.
- Always use culturally appropriate interpreters, subject to the views and wishes of the child or young person.
- Every child is unique – find out about their life journey.
- Screen for mental, physical and sexual health needs and make appropriate follow-up plans.
- Identify support and safeguarding needs (consider trafficking).
- There should be identified pathways for referral, in particular for any mental health and sexual health follow-up, and for BCG and other immunisations.

- The young person may need specialist mental health support, informed key working and advocacy.
- Don't assume that the young person can eat healthily, cook, or knows that it is possible to prevent pregnancy!
- Red Cross family tracing can transform lives.
- Promote resilience (see the section on resilience in Chapter 4).
- Establish good communication pathways with other professionals.

> *Recovery from the catastrophe of war is 'grounded in the resumption of the ordinary rhythms of everyday life – the familial, socio-cultural, religious, and economic activities that make the world intelligible'.*
> (Summerfield, 2002)

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