

CURRENT TOPIC

Understanding the needs of young asylum seekers

M A Lynch, C Cuninghame

Armed conflicts and political violence around the globe are forcing increasing numbers to flee their homes and seek refuge in European countries and elsewhere. In this country recent legislation¹ will change the way in which subsistence allowance and accommodation are to be provided, eroding asylum seekers' former rights, including those intended by national and international law to safeguard the welfare of children. Under the dispersal policy it is intended to allocate asylum seekers to selected "cluster" areas throughout the country. Some will find themselves housed where there is little experience of providing health care to refugees. To respond adequately, health professionals must appreciate the problems faced by asylum seekers and refugees and gain some knowledge of the benefits to which they are entitled. Refugee children and young people face multiple disadvantages. Many come from cultural and religious backgrounds with which those in the statutory services who will be responsible for providing care are unfamiliar. They usually speak little or no English and will often have witnessed and suffered events outside the experience of doctors, teachers, and social workers in this country. Promoting these children's physical and mental health deserves special consideration, extending beyond ensuring access to services. The background information presented here is intended to inform those who find themselves providing care to refugee children and their families.

Recognition of refugee status

To become officially recognised as a refugee, an individual must be judged to have left his or her country "owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion".² An asylum seeker describes someone who has crossed an international border in search of safety. Refugee status, which is only granted after investigation by the Immigration and Nationality Directorate (IND) of the Home Office includes the right to bring immediate family to UK. Other outcomes of the investigation are the granting of Exceptional Leave to Remain (ELR), which requires periodic renewal or refusal, and carries the right of appeal. One of the intentions of the new Act is to speed up both the initial application and the appeal process. Under previous legislation the average waiting time was two years.

Under 18 year olds seeking asylum in the UK without parents or other identifiable guardians should have an adult representative to support their case.³ Advisers are usually found through the Refugee Council's panel of advisors, social services, schools, or other refugee organisations.

Most refugees in the UK are "spontaneous" refugees—they make their own way into this country as opposed to "programme refugees" (for example, Vietnam or Kosovo).

Numbers and location

In 1999 over 70 000 applications were made and the backlog rose to over 100 000.⁴ From March to May of this year there was an average of 6255 new applications per month; up 22% compared with the same period last year.⁵ Families seeking asylum are recorded as single applications, making it difficult to be sure of the number of children involved. Home Office figures show that during the 1990s, 87% of applicants were single adults. The number of unaccompanied children seeking asylum is increasing: 1105 in 1997 (5% of total applications)⁶ and 2833 in 1998.⁷ The Refugee Council puts the figure for last year at 3349. The Act¹ specifically precludes the dispersal of unaccompanied children. Stated government policy has been that children seeking asylum with or without their families are not held in detention. However, since January 1997 the Refugee Council has worked with at least 135 unaccompanied refugee children in detention. Some of those detained have been as young as 13 or 14. Furthermore, at least one of the new detention centres has adapted some rooms to accommodate families with children (Immigration Advisory Service, personal communication, 2000).

More than 80% of asylum seekers and refugees are estimated to live in Greater London. It is intended that dispersal will relieve pressure on local authorities in London and the south east by sending new arrivals to multicultural communities elsewhere in the country with available accommodation. The newly established National Asylum Support Service in the Home Office will contract support arrangements with consortia of service providers in receiving areas. A concern must be that placement will be driven by availability of housing and insufficient attention will be paid to the availability of appropriate health provision, school places, or prospects for future employment. Once established, however, consortia

Department of
Community
Paediatrics, Guy's,
King's and St Thomas'
School of Medicine,
Newcomen Centre,
Guy's Hospital,
St Thomas Street,
London SE1 9RT, UK
M A Lynch

Central and East
European Programme,
Save the Children, 17
Grove Lane, London
SE5 8RD, UK
C Cuninghame

Correspondence to: Prof.
Lynch

margaret.lynych@
chsltr.sthames.nhs.uk

Accepted 24 July 2000

could be well placed to provide a vehicle for interagency working at a local level. This should include ensuring that the impact of dispersal is taken into account with regard to education development plans and children's service plans.⁴

Entitlements

SUBSISTENCE AND HOUSING

Prior to the latest legislation, asylum seekers were entitled to income support (90%) and housing benefit. Under the new Act, individuals will receive support only if they are deemed to be destitute. Cash payments have been replaced by a voucher system, which together with £10 in cash per week is the equivalent of 70% of income support rates. A couple with two children will therefore receive £40 in cash and £50.80 in vouchers per week. Under the dispersal arrangements this support is linked with the provision of accommodation. Only one offer of housing is made, without consideration of the family's preferred location. Those who opt to make their own arrangements with friends or relatives may be eligible for "support only". Redemption of vouchers is in specified shops with no change in cash; a transaction which can leave parents humiliated in front of their children.

Asylum seekers are unable to work legally for six months and many with professional qualifications, including doctors, will find them unrecognised here.⁸

If an application for refugee status is refused, families with children, unlike single people, will continue to be supported to end of the appeal process.

HEALTH

All refugees and those with ELR have, effectively, the same rights to health care as British citizens. Asylum seekers and those awaiting the outcome of an appeal continue under the new provisions to have free access to all NHS services.⁹ However, because asylum seekers will no longer receive income support, adults are no longer automatically eligible to free NHS prescriptions, dental, or optical care but must make separate application on form HCl; a complicated form only available in English. Charges do not apply to children under 16 years, but there does not appear to be any clear provision for 16–18 year olds. Asylum seekers are not eligible for welfare foods and vitamins for their babies as this is another provision linked to receipt of income support. All children are entitled to routine child health surveillance, health promotion, and immunisation, including a primary course if this has not previously been completed. However it must be remembered that, until permanently registered with a general practitioner, routine appointments will not be sent.

EDUCATION

All children, whether they are asylum seekers, have refugee status, or ELR, have the right to an education and early years services.¹⁰ This does not guarantee an immediate school place or adequate resources to provide the teaching

of English as a second language. Young people over, or approaching, school leaving age will not necessarily be offered a place in school or further education.

RIGHTS UNDER CHILDREN ACT

Under the new legislation the new National Asylum Support Service takes on the responsibility of providing accommodation and support to refugee families who can prove they need it. There is no longer an obligation under the Children Act for local authorities to ensure refugee children have an adequate standard of living. This is the first time a specific group of children has had rights under the Children Act removed. This would appear to represent a breach of their rights under the UN Convention on the Rights of the Child.¹¹ Although on ratifying the UK government entered a reservation, relating to immigration,¹² it was made clear that this should not inhibit obligations to the protection and care of asylum seeking and refugee children.¹³

Both children of asylum seekers and unaccompanied children can be considered "children in need". Both groups are mentioned in the new Department of Health guidance,¹⁴ which also recommends the European Statement of Good Practice.¹⁵

RIGHTS FOR UNACCOMPANIED CHILDREN

Unaccompanied under 18 year olds have the right to be looked after, to have somewhere to live, and to education and health care.³ Children under 16 are likely to be placed in foster homes or in residential facilities. Young people aged between 16 and 18 years old, however, may be placed in bed and breakfast accommodation. Many authorities do not offer this age group a full needs assessment.⁴ Given that these young people are unlikely to be in full time education and cannot work, how they are to fill their days constructively must become a major challenge.

A further concern is that when the IND assessor believes a young person to be over 18 years old the level of statutory assistance is more limited. Caution should be used in making any medical assessment of a young person's age.¹⁶ The Home Office Asylum Casework Instructions acknowledge that anthropometric measurements can be misleading and consider the use of x rays merely to assist in age determination inappropriate.¹⁷

Child health considerations

Specific health needs must always be met in timely and appropriate ways, but the health of young refugees, as with any young person, must be considered within a wider context, recognising issues which impact on health, such as education, economics, and family stress.

GENERAL HEALTH

Children may have had no previous child health surveillance or neonatal screening for congenital abnormalities or inborn errors of metabolism. Immunisation status should be reviewed and appropriate primary, catch up, and booster immunisations organised.¹⁶ Children may suffer

from malnutrition and a dietary history will be important. Children should be offered routine skin testing for tuberculosis (often done at port of entry), and screening for hepatitis B should be available for families coming from high risk areas.

While most illnesses experienced by children will be those common to all children, it is important to know where to access specialist advice for unfamiliar diseases. Depending on the country of origin, conditions to remember include malaria, hepatitis C, schistosomiasis, diphtheria, and HIV/AIDS. Families with HIV positive members are most likely to come from sub-Saharan Africa where rates are high. Both parents and children will greatly benefit from easy access to specialist clinics familiar with providing treatment and support to African families. Such expertise is likely to remain concentrated in London.¹⁸

DISABILITY

When a child is known or found to have a disability they should be rapidly referred to a local Child Development Service for assessment and support in accessing educational facilities and social services. An unpublished audit from southeast London (O'Sullivan A, personal communication, 1999) suggests that some disabled children can be in the country several years before commencing full time education. Asylum seekers are not eligible to claim Disability Living Allowance either for themselves or for their children.

MENTAL HEALTH

While refugee parents and children may be psychologically distressed it is important that resilience and resourcefulness are acknowledged and respected. Many families will come from cultures where perceptions of mental illness are very different to the ones with which we in the west are familiar and for whom the suggestion of "referral for counselling" is meaningless and therefore unhelpful. This is not to say distress should not be acknowledged or support not offered. Some will have experienced torture and it is important to know of facilities that can offer specialist treatment (for example, the Medical Foundation for Victims of Torture). Some children may exhibit signs of post-traumatic stress, but the majority witnessing violence and conflict do not experience long term behavioural problems.¹⁹ It should also be remembered that response to stress might manifest itself with physical signs.

Children may also be affected by their parents' psychological state. Parents traumatised by their own experiences and preoccupied with making sense of life as an asylum seeker will find it difficult to provide their children with a self confident and strong role model. Nor are they likely to be as emotionally available to support and encourage their children as they might wish.

As families settle, new stresses can emerge with children often adapting to a new culture more rapidly than their parents. According to a young refugee:

My main problem is parents . . . they think everything I do is wrong. But I can't help it that I'm living an English style and they are still in the old Vietnamese model.²⁰

LANGUAGE SUPPORT

Lack of English can become a major obstacle for refugees in accessing services, leading to under use, and the inappropriate use of children as interpreters.²¹ Parents are very aware of their disadvantage. A mother stated:

What I fear most is my children get sick in the night as I don't speak English. I have no transport. I just don't know who to call for help.²²

Those seeing asylum seeking and refugee children need access to good local interpreting services and ideally need to link workers familiar with the family's culture and able to advocate on their behalf.

Conclusion

Young asylum seekers and refugees have the same rights to health, and access to services as all other children in this country. Commissioners and providers must ensure that they do not marginalise the services by which these rights are realised. Experience has shown us that it is unreasonable to expect refugees to slot neatly into existing styles of health care; they require support in accessing services, and health professionals require guidance on how to respond effectively.²³ As dispersal gathers pace health professionals throughout the country must share good practice. Expertise on refugee health is developing within primary care⁹ and paediatrics¹⁶ and a number of non-governmental organisations are active in projects to assist young refugees.¹⁶ Paediatricians have an important role to play in advocating for local services that meet the needs of asylum seeking children in ways that are culturally acceptable and non-stigmatising. Sixteen to 18 year olds deserve special attention. Present arrangements and provision risk making them one of the most excluded groups of young people in the country.

Prepared by Margaret Lynch and Christopher Cuninghame on behalf of the Child Health Advocacy Network (CHANT). CHANT seeks to work collaboratively to promote the health of all children. Membership is drawn from leading professional and non-government organisations. Further information from Lisa Payne: lpayne@ncb.org.uk.

- 1 Immigration and Asylum Act, 1999.
- 2 United Nations. *Convention relating to status of the refugees*. Geneva: UN, 1951.
- 3 Save the Children Fund. *Seeking asylum in the UK*. London: SCF, 1999.
- 4 Audit Commission. *Another country*. London: Audit Commission, 2000.
- 5 Home Office. *Asylum statistics. May 2000*. London: Home Office, 2000.
- 6 Muscroft S, ed. The UK government and the CRC. In: *Children's rights: reality or rhetoric*. London: International Save the Children Alliance, 1999:260-75.
- 7 Home Office Statistical Bulletin. *Asylum Statistics, United Kingdom 1998*. London: Home Office, 1999.
- 8 Berlin A, Gill P, Eversley J. Refugee doctors in Britain: a wasted resource. *BMJ* 1997;315:264-5.
- 9 Levenson R, Coker N. *Health of refugees: a guide for GPs*. London: King's Fund, 1999.
- 10 Rutter J, Hyder T. *Refugee children in the early years: issues for policy makers and providers*. London: Save the Children Fund, 1998.

- 11 United Nations. *Convention on rights of the child*. Geneva: UN, 1989.
- 12 Chatwin N, ed. *Immigration, nationality and refugee law handbook: a user's guide*. London: Joint Council for Welfare of Immigrants, 1999.
- 13 *The UK's first report to the UN Committee on the Rights of the Child*. London: HMSO, 1994.
- 14 Department of Health. *Framework for the assessment of children in need and their families*. London: DoH, 2000.
- 15 International Save the Children Alliance and United Nations High Commissioner for Refugees. *Separated children in Europe programme, statement of good practice*. London: International Save the Children Alliance, 1999.
- 16 Levenson R, Sharma A. *Health of refugee children: guidelines for paediatricians*. London: RCPCH, 1999.
- 17 Home Office. *Asylum casework instructions*. London: Immigration and Nationality Department, Home Office, 1999.
- 18 Himid KA, Zwi K, Welch JM, Ball CS. The development of a community based family HIV Service. *Aids Care* 1998;**10**:231–6.
- 19 Boyden J. Children's experience of conflict related emergencies: some implications for relief policy and practice. *Disasters: The Journal of Disaster Studies and Management* 1994;**18**:254–67.
- 20 Kirby P. *Deptford Vietnamese research report: report into the needs of Vietnamese parents, families and young people in Deptford*. London: SCF, 1999.
- 21 Jones D, Gill T. Breaking down language barriers. *BMJ* 1998;**316**:1476–80.
- 22 Tang M. *Vietnamese refugees: towards a healthy future*. London: SCF, 1994.
- 23 Webb E. Children and the inverse care law. *BMJ* 1998;**316**: 1588–91.

Fat's not funny

From the somnolent and perpetually hungry fat boy of Dickens's *Pickwick Papers* through Billy Bunter, Richards's bespectacled and much bullied "fat greedy owl of the Remove", and onwards, obesity in childhood has been cruelly caricatured, stigmatised, and derided. Now, with an epidemic of obesity hitting Britain and the USA (and other countries), the serious medical consequences of childhood obesity are being better defined. An editorial by Ronald J Sokol in the *Journal of Pediatrics* (2000;**136**:711–13) lists some of these consequences in childhood: slipped capital femoral epiphysis, Blount disease, pseudotumour cerebri, sleep apnoea and hypoventilation, non-alcoholic steatohepatitis, polycystic ovary disease, type II diabetes, hyperlipidaemia, and hypertension. The consequences of obesity persisting into adult life are well known.

Three articles in the same issue are about non-alcoholic steatohepatitis. It has been estimated that up to 70% of obese adults have fatty infiltration of the liver and about a third of these have associated hepatic inflammation and fibrosis. Limited data suggest a similar problem in children. The 1988–94 US National Health and Nutrition Examination Survey (NHANES III) included 2450 children aged 12–18 years with serum liver enzyme concentrations recorded (Richard S Strauss and colleagues. *Journal of Pediatrics* 2000;**136**:727–33). Serum alanine aminotransferase (ALT) levels were raised in 10% of obese adolescents (odds ratio 6.7). Other factors associated with raised ALT in these subjects were moderate alcohol intake, raised levels of glycosylated haemoglobin or triglycerides, and low levels of vitamin E, β -carotene, and vitamin C.

In California (Joel E Lavine. *Ibid*:734–8), serum liver enzyme levels fell significantly in 11 obese children with raised enzymes and diffusely echogenic liver on ultrasound scan who were treated with oral vitamin E. In Italy (Pietro Vajro and colleagues. *Ibid*: 739–43), 31 children were treated with diet and ursodeoxycholic acid (UDCA). Liver enzyme abnormalities resolved in those who stuck to the diet and lost weight, but taking UDCA made no difference.

Childhood obesity presents many medical challenges. Lifestyle and dietary changes are needed in the population as a whole but prevention of obesity may prove difficult and ways to counter some of its most dire consequences are also needed. In his editorial, Ronald J Sokol calls for a new paediatric specialty of "obesitology". Such specialists, he suggests, will need a "high tolerance for frustration". There's no arguing with that.

ARCHIVIST