Rapid Health Needs Assessment for Children and Adolescent Refugee and Asylum seekers in East Sussex

Contents

Introduction

The number of forcibly displaced populations is rising. Risk of death and persecution from war, civil unrest, poverty, natural disasters and climate change are set to continue to drive people away from their countries of origin, often through perilous journeys in search of safety, food security, health, education and employment[i, ii, iii] An important group of refugees and asylum-seekers in the UK is children and young people, who have unique needs.

The U.K. has seen increases in refugees and asylum seekers through ongoing global conflict including the war in Ukraine. Refugees and Asylum seekers have specific health needs and vulnerabilities that need considering in both health care terms and the wider determinants of health. Asylum seekers and refugees have large health inequalities and the need to understand these, address them to enable positive health and wellbeing is essential.

We will analyse the current met and unmet needs of children and young people who are asylum seekers or refugees. This information will be utilised with current evidence on the most effective interventions to inform further work recommendations.

Aims and Objectives

The aim of this health needs assessment is to understand the specific health needs for the asylum seeker and refugee children and young people population up to the age of 25 in East Sussex.

Objectives

- Describe the current national and local context for children and young people who are asylum seekers and refugees.
- Undertake a literature review examining known health and wellbeing needs for children and young people who are from the asylum seeker and refugee population, including interventions that are evidenced.
- Undertake frontline workers survey and semi-structured frontline workers interviews to highlight the met and unmet needs.
- Analyse the current physical and mental health assessments for Unaccompanied Asylum-Seeking Children (UASC) to understand the current picture of physical and mental health in this cohort.
- Undertake focus groups/interviews to understand the experiences and needs of Young People and Children who are asylum seekers or refugees.
- Make recommendations to improve the health and wellbeing of refugees and asylum seekers in East Sussex.

Methods

A combination of methods were used to carry out this health needs assessment.

A literature search was undertaken by our public health librarian to elicit current evidence of the needs and potential interventions for asylum seekers and refugees.

An online survey was undertaken to elicit the professional opinion of noted stakeholders anonymously from the voluntary care sector, primary care, local authority and housing sector (private and public). Their reports undertook thematic analysis to highlight the top themes in each question. A copy of the questions can be found in Appendix A.

Semi-structured interviews were undertaken with frontline health professionals who were working or are working directly with UASC and refugees from Ukraine. A copy of the Questions can be found in Appendix B.

Physical health questionnaire data from UASC Initial health assessments were audited between September 2022 and February 2023 and analysed along with YMCA (Young Men's Christian Association) physical health questionnaire data to present a current physical health picture for the UASC East Sussex population.

Warwick-Edinburgh mental health questionnaires were analysed for UASC living in YMCA accommodation with initial health assessment Strengths and Difficulties questionnaires to present a current mental health picture for the UASC East Sussex population.

Focus groups and interviews were conducted for children and young people who are from the resettlement scheme, homes for Ukraine schemes or who are UASC. (Questions can be found in Appendix C).

Setting the scene

Definitions of Key Terms

The United Nations High Commission for Refugees (UNHCR) provides definitions for our commonly used and misused key terms.

Migrant

A migrant is someone who has moved to another country, irrespective of the reason and their legal status.[iv]

Refugee[v]

Under international law and UNHCR's mandate, refugees are persons outside their countries of origin who are in need of international protection because of feared persecution, or a serious threat to their life, physical integrity or freedom in their country of origin as a result of persecution, armed conflict, violence or serious public disorder.

In the United Kingdom, a refugee is defined as a person who has already had their asylum claim accepted and they have the "refugee permission to stay" for a minimum of five years and therefore refugee status.[vi]

Asylum seeker

The 1951 Refugee Convention on the Status of Refugees states an asylum seeker is someone who enters a country to claim asylum and undertakes the asylum process to gain formal refugee status. [vii]

Failed Asylum Seeker

A Refused/failed asylum seeker is someone whose application for asylum/refugee status has been refused in the United Kingdom (U.K).[viii]

Undocumented Migrant

"The term 'undocumented migrant' refers to someone living in the UK, whom the Government does not consider has the right to remain. This is usually because they are a 'non-citizen' who does not currently have a valid visa or other form of documentation demonstrating their status or right to live in the UK."ix

Stateless Persons

A stateless person is a person "not considered as nationals by any State under the operation of its law".[x]

Unaccompanied asylum-seeking children (UASC)

Children under 18 years old who arrive in a country without a parent or guardian[xi]. They may have been separated during the journey from their country of origin or fled alone.

Picture in U.K.

According to the United Nations High Commissioner for Refugees (UNHCR), there are approximately 30 million refugees and asylum seekers worldwide, half of which are children [xii]. Numbers of children and young people (CYP) who are refugees or asylum seekers entering the UK have increased in recent years with ongoing conflicts in Afghanistan and Syria and now the war in Ukraine[xiii].

These CYP are a very vulnerable group who face many challenges to their health and well-being[xiv]. They face trauma and hardships in their own countries before undergoing perilous and lengthy journeys to a new country, often doing so alone after being separated from friends and family[xv]. Even once resettled in a country of refuge, they face ongoing difficulties including a lack of finances, language barriers, discrimination, poor accommodation and barriers to accessing healthcare [xv].

In the year ending December 2022, the UK offered protection to over 23,000 people in the form of granting refugee status, resettlement schemes and humanitarian protection [xiii]. Furthermore, that year the UK received the highest number of asylum applications for around 2 decades (over 74,000), more than double the number in 2019. Arrivals by small boat accounted for 45% of asylum applications in 2022. Children aged 17 and under accounted for almost 1 in 5 applications (17%) for asylum [xiii]. Of these applications, 12% were male and 5% female. UASC made up 7% of the total applications received.

Unaccompanied Asylum-Seeking Children (UASC):

Figures from the Department of Education have shown that the number of claims for asylum from UASC in England has grown by over 34% from March 2021 to 2022, with the total number reaching an all-time high of 5,570 (figure 1) [xvi].

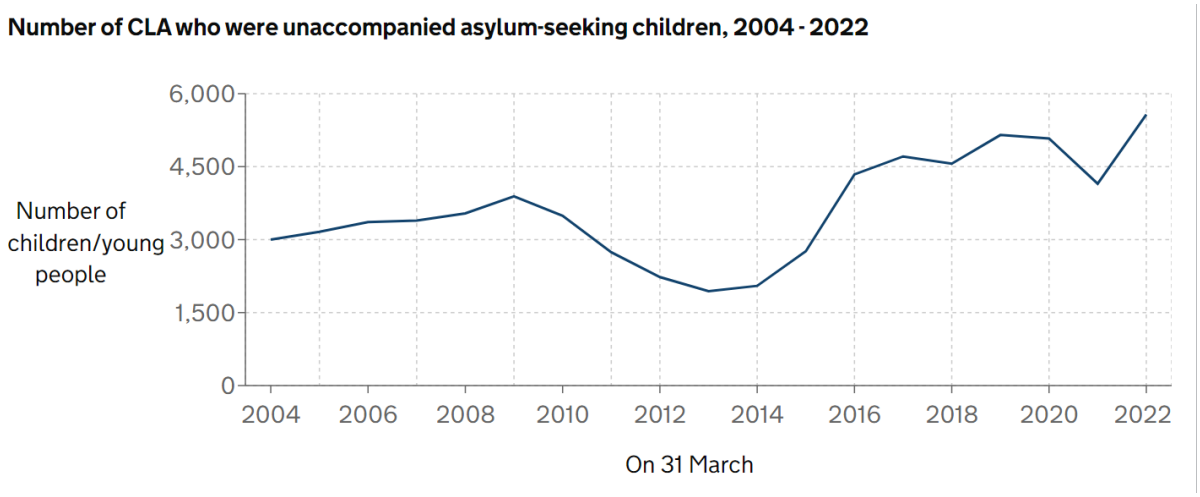

Figure 1- Graph showing numbers of UASC claiming asylum in England from 2004 to March 2022 [xvi]

The majority of UASC are male (95%) and over the age of 16 years (87%)[xvi]. 88% of UASC have a primary need of 'absent parenting', with 7% needing help due to abuse or neglect and 4% due to acute stress in their family. [xvi]

Many UASC arrive in the UK without documentation or with counterfeit or forged documents and do not know their own date of birth [xvii]. As UASC are under 18 years old, under law they are entitled to support and protection. Therefore, if there is doubt around their age, they must be treated as a UASC until a case-law compliant age assessment determines otherwise [xvii].

Initial accommodation is needed for UASC who arrive in the U.K. and whilst in in initial accommodation UASC remain the statutory duty of the home office[xviii]. Due to increasing numbers of refugees and asylum seekers, the capacity of initial accommodation centres has been exceeded so the Home Office has had to seek out contingency (Emergency) accommodation in the form of hotels and other self-contained accommodation [xviii]. There are longstanding concerns around the use of contingency accommodation, typically hotels, for UASC.

Issues include an inability to access basic needs alongside safeguarding risks due to the lack of regulation and concentration of vulnerable children together making these places targets for drug gangs and human traffickers [xviii]. Recent media coverage has made this issue high profile since figures were released detailing the large numbers of UASC going missing from contingency accommodation since arriving in the UK in 2021, of which 200 remain unaccounted for [xix]. A legal challenge on the use of hotels as "routine" accommodation led to the ruling that "the routine use of hotels for UASC" was "unlawful[xx]", leading to the closure of many hotels including two in East Sussex and transfer of many UASC to Local Authority care.

A UASC will become 'looked after' by a local authority (LA) after being housed for 24 hours by the LA under section 20 (1) of the Children's Act 1989 [xxi]. The LA then has the

responsibility to ensure the safeguarding and welfare of these children, giving them the same protection and support as is required for other 'Looked after children' [xvii]. LA responsibilities under law for UASC include [xvii]:

- Corporate guardianship
- Allocation of a named social worker
- Suitable accommodation
- Legal advice including help with asylum applications.
- Initial health assessment with subsequent personal health plan
- Individualized education plan
- Rights of care leavers

UASC have the same access rights to healthcare as other 'Looked after children' in the UK. They can avail of full access to free NHS primary and secondary care services and are exempt from prescription charges.

The national transfer scheme (NTS) is managed by the Home Office and was developed to manage the distribution of UASC across the country [xxi]. It aims to ensure UASC receive appropriate care, support and protection regardless of where they are within the UK. It was introduced in 2016 as a response to the growing number of UASC arriving in the UK [xxi]. In 2022 it became mandatory attempting to relieve pressure on services in port authorities like Kent and eliminate the use of hotels as contingency accommodation. The NTS process is based on a quota system using LA population numbers and the number of UASC already residing there [xxi]. Between April to June 2022 a record number (392) of UASC were transferred under the NTS, with the majority being moved out of the Kent area. LAs are given £143 per child per night by the government for each UASC transferred on the NTS or if the number of UASC in the LA exceeded at least 0.07% of their total child population[xxii]. Otherwise, they are given £114 per child per night [xxii].

East Sussex Picture

There are just under 1000 children who are in East Sussex as a refugee or asylum seeker.

UASC

Data from East Sussex County Council 'Looked after children' services showed that the Council cared for 104 UASC under the age of 18 in 2021-22, an increase from 70 the previous year (figure 2)[xxiii]. They also cared for another 95 care leavers aged 18 years and over, again an increase from the previous year.

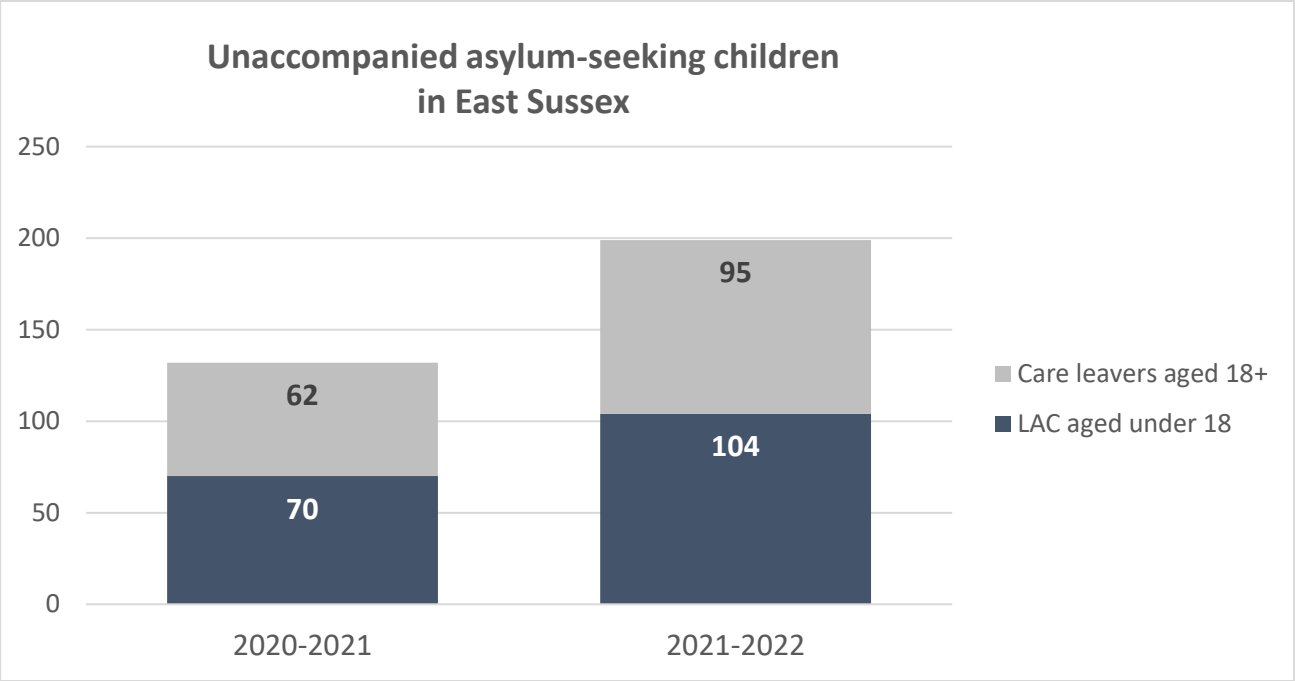

Figure 2- Graph showing numbers of UASC recorded by LAC services in East Sussex for 2021-22.[xxiii]

UASC in East Sussex were mostly of male gender (88%) and aged 16 or over. The youngest documented UASC was aged 13 years [xxiii]. In 2021-22, 25 UASC were brought to East Sussex through the NTS, with the remainder being spontaneous arrivals direct from Newhaven Port or via police involvement [xxiii]. The majority of these UASC were Kurdish, predominantly Iranian, followed by Sudanese and Vietnamese. There were also small numbers of CYP from Eritrea, Afghanistan, Somalia, Ethiopia, Albania, Iraq, Libya, Syria and Egypt [xxiii].

Resettlement schemes:

Resettlement schemes involve people initiating the process of seeking asylum before arriving in the UK[xxiv]. Refugees are selected by the United Nations and then transferred to the UK with government approval. All Districts and Boroughs receive funding to support people arriving as part of resettlement schemes with basic needs like accommodation, education and access to healthcare. Currently there are resettlement schemes available for vulnerable adults and children alongside specific schemes for those from Afghanistan, Syria and Hong Kong [xxiv].

Immigration statistics for the year ending 2022 showed that there were 4 arrivals into Hastings and 10 into Rother for those who applied for any type of resettlement scheme. Since 2016, there have been children settling within East Sussex as part of resettlement schemes including 29 in Hastings, 23 in Rother, 27 Wealden and 46 in Eastbourne and Lewes combined.

Recent data for resettlement schemes in East Sussex shared anonymously from District and Boroughs in March 2023 showed that 44% are under 18 years of age with the majority of these children being aged between 5 and 14 years (30%) (Figure 3).

Age group	Number	%
0 to 4	31	6%
5 to 9	69	14%
10 to 14	79	16%
15 to 17	35	7%
18 to 24	41	8%
25 to 34	99	20%
35 to 44	68	14%
45 - 54	24	5%
55 to 64	23	5%
65+	15	3%
Total (where age known)	484	100%

Figure 3- Table showing numbers of people who have come to East Sussex through resettlement schemes. (District and Borough Data as of March 2023)

Homes for Ukraine and the Ukraine family member scheme:

The Homes for Ukraine scheme applies to Ukrainians with no family ties to the UK and allows them to be sponsored by persons or organisations able to offer a home, for example a spare room or unoccupied unit[xxv]. There is no limit on numbers for the scheme from the government, numbers will be decided by the number of sponsors available. Sponsors are asked to provide accommodation for a minimum of 6 months [xxv]. The Ukraine family member scheme enables immediate and extended family members of British nationals or people settled in the UK to come to or remain in the UK [xxv]. Individuals arriving under either of these schemes can live and work in the UK for up to 3 years alongside having access to healthcare, benefits and education [xxv].

Data, up to date as of 16/01/23, for the Homes for Ukraine scheme evidenced that there are 508 children and young people aged 19 and under staying in East Sussex (figure 4)[xxvi]. Data was suppressed for some areas due to small numbers. These figures exclude 10 guests aged under 20 years whose postcode was not known. 31% of these CYP were aged between 10-14 years, with just over 15% being 4 years old or younger.

	Guests aged under 20 years by district/borough			
	0 - 4	5 - 9	10 - 14	15 - 19
Eastbourne	*	*	22	20
Hastings	*	*	11	9
Lewes	17	24	20	22
Rother	18	26	33	16
Wealden	30	65	76	59
Total**	80	140	162	126

*data suppressed due to small numbers

Figure 4- Table showing numbers of children by district who have entered East Sussex under the Homes from Ukraine scheme [xxvi]

Literature Review

Evidence shows that refugees and asylum seekers are fleeing from war, persecution, violence and from countries who healthcare systems may already be collapsing. Some have journeyed with a lack of access to healthcare, potentially lending to poor chronic health management or new diseases due to injuries, poor hygiene and living conditions enroute. [xxvii]

Asylum seekers and refugees' risk of communicable diseases can be higher due to their potential lack of vaccinations, prevalence of communicable disease in their country of origin and the conditions they find themselves in. [xxvii]

It has been shown to be important to have a medical assessment when reaching the U.K. to understand the health needs of a refugee or asylum seeker.[xxviii] The U.K. migrant health guidance has been created by UKHSA which is directive for refugees and asylum seekers specific to each country they come from. [xxviii]

The literature review explored some of the specific areas of healthcare needs that have been highlighted for this population.

Mental Health

> "When I arrived in the UK, I was happy and thought I will now have a good life. But then everything fell apart when I had my first and now my second rejection. I often feel so stressed and sometimes I feel like doing something really bad. The doctor gave me medication for this. One time I drank bleach. I was feeling really down very often, and I still do very often. But now I have some amazing people who check on me and help me to stay positive But you never know what the Home Office will do next and so you can never feel safe. I want to kill myself - sometimes everyday - but it has made such a big

> difference to receive the amazing support. It helps me to keep my head of water" Asylum seeking young person from Afghanistan, aged 21[lxxxii].

The literature shows that there is a high prevalence of mental health issues amongst refugee and asylum-seeking children [lxxxii, xiv]. Research shows this is due to the increased and exposure to trauma, stressors and loss [lxxxii]. These negative experiences are typically broken down into 3 main categories: 1. Those experienced in their country of origin 2. Those experienced during their journey to safety, 3. Those experienced once settled in a country of refuge. (Figure 5) [lxxxii]

Within their home countries, these children may have been exposed to war, violence, torture and separation and/or loss of close friends and family [lxxxii, xiv]. The onward journey is often distressing, perilous and lengthy. Upon arrival in a new country, they face financial, cultural and social issues as they try and settle into a new society. Language barriers can prevent social integration and access to support like healthcare and education. This new period of adjustment upon arrival is commonly referred to as a period of 'secondary trauma' for these children [lxxxii].

Figure 5. Pre-, Peri- and Post-migratory factors, experiences or traumas that may negatively affect or precipitate mental health illnesses in these children [lxxxii]:

Pre-migration	Peri-migration	Post-migration
• **Witnessing violence or conflict** • **Loss of family and friends due to death or separation** • **Physical violence** • **Sexual exploitation** • **Persecution** • **Torture**	• Loss of family and friends due to death or separation • Physical violence • Sexual exploitation • Starvation • Exploitation by traffickers • Dangerous journeys, usually by road or boat	• Discrimination • Racism • Stress during the asylum application process. • Social isolation • Language barriers • Lack of finances • Barriers to accessing healthcare. • Exploitation

Anxiety, depression, and post-traumatic stress disorder (PTSD) are common, putting this group at risk of developmental delay, self-harm and suicide [lxviii, lxxvii, xxix], as well as alcohol and substance misuse [xxix]. Different cultural viewpoints on conceptualisations of mental health might mean caregivers do not recognise signs as a manifestation of psychological

problems [lxxix] as they may be from communities where emotional containment is traditional practice [xxx]

A recent systematic review of refugee children's mental health found rates of PTSD up to 43% and depression up to 60%, with a greater number of suicide attempts occurring in refugee minors than in the host population of the same age[xxxi]. In addition, a Norwegian study of UASC found that 48% of participants met diagnostic criteria for a mental health illness including PSTD, depression and generalised anxiety disorder[xxxii]. A further study showed rates of anxiety for newly arrived refugee children from around 50-70% [lxxxii].

UASC have been shown to have worse mental health than accompanied children, with higher rates of PTSD and generalised anxiety [lxxxii]. UASC are more vulnerable and have greater risk of being exposed to traumas than those who are accompanied. Up to 1 in 5 UASC may have delayed onset of mental health illness[xxxiii].

Mental Health Support and Treatment

The Royal College of Paediatrics and Child's Health (RCPCH) advise assessment for signs of mental illness should form part of any initial health assessment, ideally by clinicians educated in trauma-informed care [lxxvii], [lxxviii]. Past experiences may lead to difficulties in establishing trust and a therapeutic relationship so it is vital healthcare workers have a sensitive approach [lxxix]. Specific training in trauma-informed care however is lacking [lxxviii].

Clinicians ought also to be aware of transgenerational trauma where trauma in one generation can influence development and wellbeing of the next, assessing the family unit where possible[xxxiv, i]. Early referral to appropriate mental health support or, in cases of complex trauma, depression, anxiety or suicidal ideation, referral to specialist Child and Adolescent Mental Health Services (CAMHS) is recommended[xxxv]. The British Medical Association (BMA) also recommend The Helen Bamber Foundation and Freedom from Torture for children and young people with complex needs [lxxviii].

Regarding management options, evidence shows that narrative exposure therapy achieves good outcomes for PTSD [lxxxii, xxxvi]. Cognitive behavioural therapy by comparison has a large evidence base for anxiety and depression as well as trauma and can be successfully delivered by trained non-clinicians, meaning there is opportunity for a lower cost service where mental health services are stretched [lxxvii, lxxviii, lxxix]. In fact, some studies evidence that refugee and asylum-seeking children and young people may prefer to receive mental health support in non-clinical settings like school or the voluntary sector. [lxxx,xxxvii]. In another paper, Problem Management plus, a rapid and low-intensity psychological intervention was found to have good outcomes for PTSD, gender-based violence, anxiety and depression [lxxxii].

As well as formal mental health support, there is evidence that children and young people benefit from building of social networks. In one paper, peer and parental support and

participation in the host country's society were two of four main strategies associated with resilience, the other two being acting autonomously and performing at school[xxxviii].

Social isolation can lead to loneliness and poor mental health [hlxviii] and there is good evidence that a sense of belonging in the host community is important for good mental health [lxxxii]. One paper found that well-targeted and problem-specific mentoring programmes can help with this [xxxix].

Others show how artistic and cultural activities can be combined to have a positive impact, helping children to make social connections but also to find a voice and learn practical skills useful in the labour market[xl]. Identification with one's heritage culture or faith groups has also been associated with resilient outcomes over time[xli], [lxxxii].

In conclusion, these vulnerable children are at high risk of mental health issues due to the number of severe traumas and negative experiences they undergo in their country of origin, on their journey or on arrival in a country of refuge. Most commonly seen conditions amongst this group according to research include PTSD, depression and anxiety. These children need prompt mental health assessment, community- based support to integrate via activities, faith groups, mentoring and appropriate and timely mental health treatment including CBT if necessary.

Physical Health

While many children and young people arrive in good physical health, others may experience significant difficulties[xlii]. Risk factors for physical health issues in refugee and asylum-seeking children include:

- Undiagnosed or untreated conditions due to limited access to healthcare in their country of origin
- Issues associated with crowded living conditions, poor food and sanitation.
- Lack of nutrition and starvation
- Torture, physical violence and sexual violence including female genital mutilation.
- Injury or illness due to perilous journeys
- Inability to access healthcare in country of refuge due to lack of familiarity or language barriers.
- Incomplete childhood immunisation to vaccine preventable diseases

A recent meta-analysis published in the BMJ Paediatrics in 2019 aimed to review the current literature on the health status of refugee children upon entering reception countries in Europe [xiv]. Results found that refugee children had high estimated prevalence rates of anaemia (14%), chronic hepatitis B (3%), latent TB infection (11%) and vitamin D deficiency (45%) on arrival. Furthermore, nutritional issues were also demonstrated by extremes of weight. Some children showed muscle wasting and stunting of growth due to starvation while another 11% were classified as overweight and 6% as obese. Those

children, especially those from sub-Saharan Africa, had a high prevalence of positive serology for intestinal infections schistosomiasis and strongyloidiasis, suggesting either past or present infection [xiv]. Infections such as HIV and TB can be more prevalent in this population and safeguarding this vulnerable population is also a necessary consideration and both will be discussed further.

Dental issues have been listed as the second most significant health issue for refugee and asylum-seeking CYP, second only to mental health issues[xliii]

Healthcare Assessments

Any unaccompanied child under the age of 18 years becomes the responsibility of the local authority under the Children's Act 1989 meaning that statutory duties of care apply[xliv]. One such duty is the facilitation of an initial health assessment (IHA) to identify physical, mental and social needs for each individual child [xvii], which should ideally be undertaken by both a paediatrician and a psychologist within 20 working days of the child becoming looked after [iii]. For other children and young people, an initial comprehensive health assessment is not routinely performed.

The British Medical Association (BMA) and Royal College of Paediatrics and Child Health (RCPCH) however do publish guidance for doctors on opportunistic health assessments when meeting these children and young people in clinical practice. As well as assessing the child, the health of carers and families is cited as a determinant of child health and doctors are encouraged to signpost families to their GP, Doctors of the World or other local support services where appropriate [lxxvii].

This IHA involves a history, examination and any relevant investigations. The Royal College of Paediatrics and Child Health (RCPCH) released guidance in September 2022 for paediatricians doing IHAs for UASC, including a suggestion of important health investigations which should be completed [lxxvii]. Features of the assessment should include consideration of nutrition, developmental delay, safeguarding and mental health as well as physical examination, screening (and consideration of empirical treatment) for communicable diseases common to their country of origin and an offer of vaccinations in line with the national immunisation programme [lxxvii] (Appendix A and B).

Regarding nutrition, stunted growth is a finding in many, indicating chronic malnutrition in pregnancy and the early years. This stunting can coexist with obesity, increasing risk of adulthood cardiovascular disease. Vitamin D deficiency is also common, one study reporting 66% prevalence [i]. Hunger and malnutrition not only affects a child physically but also negatively affects a child's ability at school. [lxxvii]

Healthcare Access

To support access to healthcare, refugee and asylum-seeking children and young people should be supported to register with a GP and all primary and secondary healthcare is free thereafter. For those whose applications have been rejected, their right to universal access is withdrawn and whilst general practice is still accessible to them, other healthcare access is dependent on factors like urgency of care, with treatment for many communicable diseases and conditions secondary to violence remaining free in A+E [lxxviii].

This complicated system has potential to impact all young people who are often unaware of their rights and may fear information sharing between healthcare professionals and the Home Office. Healthcare staff often find nuances of legality hard to understand themselves and barriers to access can be at registration itself. Reception staff in primary care, for example, commonly incorrectly refuse registration to people without documentation like proof of address lxxviii. In Kent County, the Unaccompanied Asylum-Seeking Children Health Team aim to mitigate these gaps in healthcare worker knowledge by providing a wealth of professional information and patient leaflets in several languages on their website iii.

Other barriers to healthcare include English language proficiency and lack of interpreter use, health literacy, misinformation and transportxlv xlix ii. One paper describes lack of trust in healthcare professionals as a barrier, with concerning evidence of COVID-19 vaccine hesitancyxlvi. The BMA recommend GP practices urge commissioners to fund interpreters and advise clinicians to carefully consider the interpreter's dialect, culture, gender and sexual orientation, encouraging a sensitive and holistic approach lxxviii. Improving education of healthcare workers in cultural and linguistic considerations and skills in engagement with younger people is recommendedxlvii.

Dental Care

Dental issues occur due to a lack of dental services in home countries, a lack of knowledge of and an inability to maintain good oral hygiene. Literature has shown that the prevalence of dental issues can range from 20-50%[xlviii].

Oral health poses another risk to health equity with one paper citing prevalence of untreated oral diseases among refugees as greater than both the host population and other underprivileged groups in the host country[xlix]. Dental caries specifically are of concern in refugee children and research suggests oral diseases have ongoing effects on social interaction and mental health as well as increasing risk of systemic diseases. Barriers to access again include language proficiency and health literacy and factors which have a positive impact on access include having close friends from another culture and preference to use host country's media [xlix].

Communicable Disease

Communicable diseases are those that are transmittable "from one person, or animal, to another, which can cause ill health" [l]. This review discusses immunisations to prevent many communicable diseases, the main communicable diseases seen in refugees and asylum seekers and the screening that should be offered.

Immunisation

There is an increased prevalence of some infectious diseases depending on the country of origin of asylum seekers or refugees. Vaccination regimes and their uptake will differ from the country a refugee or asylum seeker lived as a child or young adult as will the healthcare provisions at time of leaving the country.

Lack of vaccinations can put individuals at higher risk of infectious diseases. All initial health care assessments should include updating vaccinations to the current U.K. regime.[li]

However, studies have shown a lack of training, knowledge in primary care of the need for updating the whole vaccination schedule[lii] They also have cited lack of time and financial incentive to update asylum seekers and refugees' vaccination status. [lii]

Barriers to Vaccinations

Studies have shown that people from ethnic minority backgrounds are less likely to have vaccinations. This was borne out through covid 19.[liii]

Specific barriers to a refugee or asylum seeker receiving or agreeing to have a vaccination have included[liv];

- Language-Lack of accessible information in an appropriate language [liii] and interpreters [lv]
- Lack of trust in the health system [liii]
- Concerns over vaccine side effects [liii]
- Lack of understanding about the need for, or their entitlement to vaccines, and potential stigma [lv]
- health professionals' lack of knowledge of vaccination guidelines for migrants [lv]
- Practical access difficulties; people who moved frequently or had no fixed address could struggle to register for health services, travel to vaccination centres could be costly. [lv]

Interventions to Increase Uptake

Research with asylum seekers and refugees has suggested uptake would increase with improved access to accessible information and access to physical buildings for vaccinations

including trusted places such as community centres and charities. [liii] Increased training in primary care on updating asylum seekers and refugees to the U.K. vaccination schedule and how to implement this has been deemed essential. Potentially having a financial incentive via the quality outcomes framework have been suggested. [lii]

Specific interventions that have evidence of increasing vaccination uptake include;

- Outreach programs, planned vaccinations and educational campaigns (shown to be cost-effective)[lvi]
- Tailored communication about vaccinations, including face-to-face conversations, information about the benefits of vaccination, personalised reminders (nudge behaviours); [lv]
- Clear and sensitive policies, such as screening for vaccination on arrival [lv]
- Community-based interventions, in which community members act as vaccine advocates in collaboration with services. [lv]
- Vaccination offered in convenient and familiar local settings; increasing the number of walk-in clinics. [lv]

Specific Communicable Diseases

Diphtheria

Diphtheria is vaccine preventable bacterial infection that has can have both skin and respiratory presentations and is rarely seen in the U.K. [lvii] Cases of presentation have been documented in asylum seekers and can spread and have severe consequences for those affected especially in those with poor immune systems. Awareness, timely treatment of cases and contact tracing and vaccinations are essential to management.[lviii] Due to the presentation of cutaneous diphtheria all skin lesions in asylum seekers are to be swabbed to understand if they are infected or are another bacterial infection.[lviii]

Tuberculosis (TB)

Tuberculosis (TB) is a bacterial infection which is spread by droplets usually through coughing and sneezing. There are two different forms of TB.

- **Active** TB is both infectious to others and affects the person with symptoms and potential severe complications.
- **Latent** or dormant TB has neither the ability to infect others or physical consequences for the person with latent TB. Certain conditions including diabetes, HIV[lix] and malnutrition can make TB more likely to become active. [lix] The asylum journey itself has also shown to be a stressor in this transformation to active disease[lx].

The U.K. has a low prevalence of TB with 7 cases per 100,000 population. Evidence shows a high prevalence of latent TB and active TB in the asylum seeker and refugee population, with no or limited evidence of spread to host populations[lxi]. The importance of screening and treatment is highlighted and imperative.

Current UK TB guidance stipulates that any country with a prevalence of over forty per 100,000 cases of TB in their population should have active TB screening prior to arrival in the UK[lxii]. Afghanistan, Ukraine, Nigeria, Sudan and Iraq are examples of such countries [lix] and due to the speed of some evacuations from countries this may not have been possible and should be done as part of a healthcare assessment.

Latent TB screening is recommended for those who have arrived in the UK from a country where the TB prevalence is >150/100,000, or for those from Sub-Saharan Africa who have 0arrived within the last 5 years[lxiii].

Active TB screening lix involves a symptomatic screen and chest x-ray (for those 11 years old and over) for those from high-risk countries and a skin prick test (Mantoux) or blood test (IGRA) for latent TB.

BCG vaccination should be offered after Mantoux testing (skin prick testing) to all people from high-risk countries from the age of 0-16 years old[lxiv].

Hepatitis B and C

Hepatitis B and C are viral infectious diseases that can affect the liver and have differing transmission routes. Their prevalence varies among countries, many countries including Syria, Afghanistan and Ukraine have high prevalence levels of hepatitis C and Afghanistan and Syria having a high level of hepatitis B too. Ensuring screening is offered and treatment where necessary is essential for reducing transmission and to prevent morbidity and mortality including from cancer.[lxv]

HIV

HIV in asylum seekers and refugees will vary dependent on the country they have originated from, the area they are moving to and their own risk factors. Screening for HIV in refugee and asylum-seekers arriving in the UK is recommended for those coming from countries where the HIV prevalence is >1%.[lxvi] HIV testing should be offered appropriately as should sexual health screening.[lxvii]

Sexual Health

Sexual health risks and behaviours of this group are similar to other young people but there is a varying level of knowledge and sometimes harmful misconceptions, highlighting

the need for education around sexually transmitted infections including HIV and also contraception[lxviii, lxix].

Barriers to care are the same as young people in the general population and include fear of stigma[lxx], lack of adolescent services, shame of sexual activity and concerns over confidentiality.

Issues specific to the asylum seeking or refugee population are lack of knowledge about sexual health, language and communication barriers [lxx] and a lack of structure needed to build dependable services that go beyond one-time interventions. [lxxi]

Outreach Interventions should focus on language-adapted information about available screening services and where to go for advice on sexual wellbeing and sexual rights. These activities should promote prevention, address activities that increase STI/HIV risk exposure and specifically targeting vulnerable subgroups of migrants.[lxxii]

Special considerations for this group include awareness of evidence of torture, female genital mutilation (FGM), sexual abuse and gender-based violence, which may also act as barriers to accessing care [ii]. Other barriers common in the general population including concerns around confidentiality, community stigma and shame also apply to these young people[lxxiii],[lxxiv].

In one paper, the author posits that 'experiences of forced migration may further impact young people's power and agency to negotiate and make decisions related to their bodies and sexual relationships, thereby putting them at risk of sexual violence, HIV and other sexually transmitted infections (STIs), unintended pregnancies, unsafe abortions and preventable maternal deaths' [ii].

One limitation of the literature was that there were no publications specifically discussing LGBTQ+ challenges, thus highlighting a need for research in this area.

Safeguarding

UASC are a particularly vulnerable group and thus may become victims of human trafficking and suffer exploitation. This puts them at very high risk of experiencing physical abuse, sexually transmitted infections, unplanned pregnancy and substance misuse[lxxv].

Furthermore, in areas of Africa, the Middle East and Asia female genital mutilation (FGM), is common, with over 200 million girls and women alive today who have undergone FGM. FGM involves deliberate cutting of the external female genital organs for non-medical reasons and is associated with significant complications including pain, bleeding, infection and obstetric issues[lxxvi].

Refugee and asylum-seeking children and young people may be at risk of criminal and sexual exploitation and radicalisation due to communication difficulties, inappropriate

accommodation and high levels of exposure to potential perpetrators. Lack of social support and educational place and a fear of authorities relating to previous experiences may mean they are more isolated and vulnerable [iii,lxxvii,lxxviii]. The RCPCH emphasise the importance of safeguarding when caring for these children and young people and advise doctors assess for signs of physical abuse, sexual exploitation, neglect and trafficking. They publish specific guidance to follow should modern slavery be suspected [lxxvii].

In conclusion for children and young people who are asylum seekers or refugees, additional risks to their physical health include risk of communicable diseases, malnutrition, stunted growth and poor dental health. Sexual health considerations may relate to misconceptions about sexually transmitted infections or experiences of abuse. Importantly, all clinicians and care workers should be alert to physical signs of violence, neglect and the possibility of human trafficking which this group are at increased risk of.

Education

> "When you have no friends and just locked inside the room in foster care, you know it's really very very tough… being in school really helps you because you kind of lose that feeling and you focus on a good thing, on education and that makes you optimistic about life." Asylum seeking young person from Eritrea [lxxx]

All children in the UK, regardless of migration status, are entitled to go to school [lxxvii]. For many, school can be a positive channel through which to apply themselves, distract from anxieties around asylum status or stresses at home, find a sense of belonging, overcome loneliness, and build both resilience and enduring social connections [lxxix, lxxx,lxxxi]. To support study in school, young people have expressed need for access to educational resources, in local libraries for example. [lxxx]

Early English language acquisition is commonly cited as having great benefit on mental health and wellbeing of this group, enabling socialisation, independence, employment and protection from exploitation [lxxx],[lxxxii]. In one paper, 40 refugee adolescents in the UK listed English language classes as a priority in how to best support the mental health of newly arrived refugees, as well as extracurricular activities, advice on living in the UK, and help with asylum applications [lxxxii].

For many others, the anxiety of the asylum-seeking process, housing instability and family difficulties distracts from their ability to apply themselves at school and reduces motivation, thus reinforcing the need for a holistic approach to the care of this group [lxviii, lxxx]. The psychological benefit adolescents can derive from the feeling of belonging to a school may be hindered by limited English language knowledge [lxxix] and where many children and young people are quicker to learn English than their parents, they may be burdened with adult responsibilities of translation or involvement with legal work [lxxxiii]. For

these children and young people, consideration of them within the family unit, if they have one, is paramount for individualised care.

Housing

Where refugee and asylum-seeking children and young people live is an important determinant of health, notably mental health. The type of accommodation, the safety and opportunities in the local area and living conditions need all be considered. For unaccompanied asylum-seekers, who like other looked after children and young people are entitled to accommodation [lxxvii], a stable and supportive living environment with low restrictions has been shown to have good outcomes, including better engagement at school [iii,lxxxiv].

On the other hand, there are worrying reports of sub-standard living conditions [lxviii , lxxxii] and instances of sexual assault in asylum accommodation, with one paper describing young people feeling at risk in mixed gender accommodation [iii]. There is also concern that unaccompanied children go missing from accommodation, one paper citing one child goes missing from contingency every week [iii]. Finally, there is a need to support young people as they transition out of asylum accommodation. Refugee Rights Europe raises the point that young people can be given just 28 days to move out of accommodation, leaving them alone in great difficulty as there is commonly an accompanying delay of five weeks until they start receiving support through the Universal Credit system [lxxxii].

One UK case study intervention, aimed at improving young people's experiences of asylum accommodation, is the introduction of a Youth Welfare Officer. Placed in all initial accommodation, the Youth Welfare Office supports 18–25-year-olds by providing a comprehensive needs assessment, onsite psychological and social support, signposting to local services and safeguarding, liaising with local authorities should they have any concerns [lxxxii].

> "there is misunderstanding and mistrust. Sometimes there are leaflets explaining things, but people don't read them often or find it difficult to read and understand them. In cases like this a support worker would be so helpful to explain and sit down and talk you through it. Someone you trust." Asylum seeking young person from Palestine, aged 23 [lxxxii]

Frontline Workers Surveys and Health care Assessment Audit for UASC.

A range of activities were undertaken to understand the current health of CYP who are asylum seekers or refugees in East Sussex. This included;

- Mental health review of asylum seekers through mental health screening at YMCA accommodation (August 2022- February 2023), Paediatric healthcare assessments and frontline workers survey.
- Physical health review of Asylum seekers through health screening at YMCA accommodation (August 2022- February 2023), Paediatric healthcare assessments (September 2022 – end of January 2023).
- A frontline workers' survey.

Mental health of refugee and asylum seeking CYP in East Sussex:

Mental health screening at YMCA accommodation services

UASC age 16-25 years in East Sussex can access YMCA supported accommodation if they are single and at risk of homelessness. UASC will be housed in this accommodation for typically up to 2 years before moving on to live in social housing or other shared accommodation. East Sussex County Council own YMCA properties across the county and fund a number of beds for UASC, with 20 UASC males currently residing here. On arrival at the accommodation, a support plan will be made with the help of their assigned social worker which typically involves signing up to a GP and dentist, enrolment in college and orientation to the area. As time progresses, this is reviewed to include goals focused on independent living skills like budgeting, cooking and cleaning.

As part of this induction, UASC are asked to complete a physical health questionnaire and the Warwick-Edinburgh mental health questionnaire. Data from these questionnaires completed from August 2022 (when the branch opened) to February 2023 in the Hastings YMCA accommodation has been analysed. The service intends to repeat these questionnaires at 6-9 months and prior to departure from the accommodation to re-assess for a change in needs and to allow for comparison.

The Warwick-Edinburgh Mental Well-being Scale (WEMWBS) was developed by researchers at the Universities of Warwick and Edinburgh to better enable the understanding of mental well-being for those aged 16 and above[lxxxv]. It is a 14-item scale covering well-being and psychological functioning, in which all items are worded positively and address aspects of positive mental health. The scale is scored by summing responses to each item answered on a 1 to 5 Likert scale. The minimum score is 14 and the maximum is 70 [lxxxv].

15 WEMWBS questionnaires were completed at the Hastings YMCA accommodation service during the stated time period, one of which was uncomplete, defined as having one or more questions not answered, and thus was not included.

Scores ranged from 43-70, with over half of respondents reaching a total score of 51 points or greater. The WEMWBS has been compared to the Centre for Epidemiological Studies Depression Scale (CES-D), with the suggestion that a score of <40 on the WEMWBS could indicate a high risk of depression as defined by CES-[Dlxxxv]. This considered, none of these UASC fall into the high-risk category, but there were individuals who scored low enough to be deemed at moderate risk. (To few numbers to comment further) The lowest scoring statement for all UASC was 'I've been feeling loved', with 5 CYP rating it as either 'rarely' or 'none of the time'. The statement 'I've been feeling close to other people' also had generally lower scores.

The WEMWBS was not designed to be a screening tool but can show meaningful change in scores when compared over time, therefore this data may become more useful when able to be compared with repeated questionnaires throughout their stay.

Mental health screening during initial health assessments:

All 'Looked after children' including UASC are required to undergo an initial health assessment (IHA). As part of this, UASC are asked to complete the Strengths and Difficulties questionnaire (SDQ). This is a 25-item questionnaire focusing on behavioural and emotional difficulties and is used as a measure of mental health and well-being in children and young people aged 4-17 years.

Total and/or breakdown of SDQ scores were not routinely documented in the IHA reports so detailed statistical analysis was not able to be completed. Key areas mentioned in IHA reports where UASC generally scored highest were overall stress, emotional stress and difficulty getting along with other children. Other issues commonly self-reported during history taking included feelings of loneliness, generalised anxiety, low mood, restlessness and flashbacks to traumatic experiences. 37% (11/29) UASC required onwards referral for mental health issues to Child and Adolescent mental health services (CAMHs) or counselling services.

Service providers perspectives on mental health issues.

Semi-structured interviews were conducted with service providers and staff working with refugee and asylum seeking CYP using the questions included in appendix. Notes were taken during the interviews with consent and content was verbally checked with the interviewee at the end of the interview. Interviewees were aware of the purpose of the interview and that their thoughts and comments may form part of this health needs assessment.

Discussion with service providers in the YMCA Hastings accommodation noted that the UASC who use their service can present or later develop mental health issues related to past traumatic experiences. However, they feel that these UASC have good access to mental health support as they can get appointments quickly with a local GP service. Staff feel that different aspects of their service promotes good mental well-being. They have

received positive verbal feedback from UASC about the fact that they are given their own bedroom and bathroom which gives them privacy and access to a kitchen where they can cook food to their own needs and taste.

Furthermore, the service facilitates them going to college, with a translator if needed, and to other activities like church, which gives them a purpose and schedule. Staff noted the positive integration with the British residents in the accommodation and say they haven't witnessed any bullying or intimidation of the UASC. It would be interesting to see subsequent scores for WEMWBS to help indicate if these measures have improved self-reported feelings of isolation or overall scores.

A semi-structured interview was conducted with a trained therapist working with UASC aged 18 years and under in East Sussex providing 1:1 courses of therapy comprised of around 12 sessions. Referrals are received from designed social workers who work closely with UASC who may disclose issues to them.

Staff reported that the most common mental health issues presenting to this service were symptoms of PTSD including nightmares, flashbacks and intrusive thoughts of traumatic events in their home countries or on their journeys. In addition, anxiety and depression was experienced commonly also, which was exacerbated by social isolation and a lack of connectedness within their new community. Staff felt this service worked well and was able to provide timely support to those UASC referred to them.

A lack of ongoing care after the therapy course was mentioned. Currently, for those who don't respond well to sessions, up to a total of 15 sessions could be offered or onwards referral to children's mental health services if required. However, there is no follow up or support on discharge for those who have responded to sessions or have less acute symptoms. These UASC may have a recurrence of symptoms or development of new mental health issues in future, which research has proven they are at high risk of.

An interview with a representative from children's services discussed the social prescribing service to help promote the mental and emotional well-being of Ukrainian refugees. The service includes trained social prescribers who work directly with Ukrainian CYP, signposting them to established community programmes or approving small pots of funding to allow them to pursue a hobby e.g., purchasing football boots or a musical instrument. This project has supported some other refugee groups and asylum seeking CYP too.

Furthermore, refugee and asylum-seeking children have funded places to attend the 'Holidays, Activities and Food' (HAF) programme in East Sussex which runs during school holidays. Feedback gained from this group during the HAF programme focused on the positive social connections made through new friendships and community connections. Staff working here noted the positive encounters between CYP, sharing words and phrases from their own language and teaching others about their culture.

Mental health Refugee and Asylum Seeker CYP Conclusion:

Relevant literature alongside the findings of this rapid needs assessment both corroborate that refugee and asylum-seeking children are at high risk of mental health issues, particularly PTSD, depression and generalised anxiety disorder. Significant numbers of this group require intervention from mental health services. Furthermore, the theme of lack of social connectedness commonly arose, with the children self-reporting loneliness and feeling a lack of closeness to others. Giving the children their own space, a sense of purpose, a weekly schedule and giving them opportunities to engage with existing members of the community was felt to promote positive mental health.

Recommendations to improve the mental health needs of refugee and asylum seeking CYP:

- Prompt mental health assessment including screening for high-risk conditions including PTSD, depression and generalised anxiety.
- Ensure children are signed up to GP services.
- There should be primary care healthcare assessment for those groups not having UASC Paediatric assessment especially for prompt mental health assessment.
- Ongoing surveillance of mental health and well-being for UASC via screening questionnaires to monitor for delayed presentations- these could be conducted at their place of accommodation or through their named social worker.
- Development of services to support and follow-up those who have had mental health interventions- this could potentially be done via follow-up phone calls.
- Use of new and existing community programmes to promote positive mental health and wellbeing alongside community engagement.

Initial Health Care Audit and Report

Currently in East Sussex all 'Looked After Children', which includes UASC, get referred to the community paediatric service who conduct regular triage of referrals and schedule each child for an IHA. (Appendix D and E)

Many UASC present with no documentary proof of age and will require an age assessment by alternative means to estimate this. Age has implications for the outcome of their asylum claim and, on their ability, to access financial support, healthcare and education. The RCPCH do not advise paediatricians to conduct age assessments as part of the IHA due to ethical considerations and the inaccuracy of current processes to assess age. [lxxvii]

Paediatricians were included in the semi structured questionnaires (Appendix B). The most common health issues reported by consultant paediatricians conducting IHAs for UASC in East Sussex included dental issues, skin conditions like scabies and mental health issues.

Furthermore, several systematic issues were raised by the paediatricians with regards to how the clinics currently run:

- Time pressure of a 90-minute appointment during which consent must be gained, a full history and physical examination conducted, mental health screening questionnaires completed and any other issues addresses. In addition, often all communication needs to go through an interpreter due to a language barrier.
- Interpreters attending who speak different dialects to the UASC making understanding between them slower and more difficult.
- Lack of continuity of care- most UASC are aged 16 years and older, therefore if they need any ongoing care after initial assessment or investigation, they need to be referred to adult services. They are already too old for paediatric services which provide for children up to the age of 16 years.
- Lack of access to in-house investigations- clinics are conducted in a community setting where there is no access to clinical investigations or a laboratory. Basic clinical tests like a urine dip or ECG are not accessible. Also, blood tests can't be taken on-site so the UASC and their social worker are given a blood form and have to make an appointment at hospital phlebotomy services. This means that some UASC are not attending for any bloods and also creates a delay in receiving blood test results for those who attend, thus delaying action on any issues.
- Depending on staff provision, there is sometimes no access to a male doctor which may not be appropriate for some UASC.

To better understand the physical health of UASC in East Sussex, data from IHAs conducted over the past 6 months, from 1st September 2022 and 28th February 2023, has been collected and analysed.

Guidance on routine investigations for UASC undergoing an IHA was taken from the RCPCH guidance for clinicians which was released in September 2022 [lxxvii]. This guidance advised the following investigations to be completed for UASC as part of an IHA dependent on their country of origin:

- Baseline blood tests including FBC, U+E, LFTs
- Blood tests to check for micronutrient deficiencies e.g., Vitamin D, folate.
- HBV serology- HBsAg, anti-HBc, Anti-HBs
- Anti-HCV Ab
- HIV serology
- T-spot/TST for TB
- Serology for strongyloidiasis or stool ova, cyst, parasites
- Serology for schistosomiasis or stool OCP or urine OCP
- Stool OCP for helminths including roundworm, hookworm, whipworm.
- Syphilis serology
- Chlamydia and gonorrhoea- male- urine sample, female- vulvo-vaginal swab

Investigation results for each UASC seen during the 6-month period were checked on Esearcher and ICE systems to capture investigations done by the hospital, GPs and in the Brighton area also. Investigation results were checked up to 6 weeks after the IHA to allow time for the investigations to be completed and results to be reported on the systems.

A total of 29 IHAs for UASC were included, of which 51% (15) had one or more investigations completed and 49% (14) had no investigations. The majority of this group was male.

Figure 6 The numbers of each baseline blood test completed alongside numbers of abnormal results:

Baseline blood test:	Number recorded /15	Number of abnormal results
Full blood count	12	0
Urea and electrolytes	10	0
Bone profile	9	0
Ferritin	8	0
Vitamin B12+/-folate	9	0
Vitamin D	10	10- all insufficient

A full blood count was measured most consistently (80% of the time) amongst the 15 UASC who had blood tests done, with urea and electrolytes, vitamin D and liver function tests being tested two thirds of the time. Ferritin was measured the least frequently (53% of the time), followed by vitamin B12+/-folate and bone profile; all 3 being key blood tests for assessing nutritional status.

Baseline bloods completed were mostly normal. However, for all 10 cases where vitamin D was tested, the levels came back as being in the 'insufficient' category, thus requiring oral supplementation.

Figure 7 The numbers of each investigation completed for each communicable disease alongside numbers of abnormal results:

*suppressed due

Communicable disease test:	No recorded out of 15	No of abnormal results
Hepatitis B virus (HBV) serology	15	*
T spot for TB	13	*
Anti-HCV Ab	11	0
HIV serology	15	0
Serology for strongyloidiasis or stool ova, cyst, parasites	2	0
Serology for schistosomiasis or stool OCP or urine OCP	0	0
Stool OCP for helminths including roundworm, hookworm, whipworm.	0	N/A
Syphilis serology	12	0
Chlamydia and gonorrhoea- urine or swab sample	0	N/A

HBV serology and HIV serology were completed in 100% (15/15) of cases who had one or more investigations done. No positive cases of HIV were found. T-spot test for tuberculosis was completed in 86% of cases. Syphilis serology was tested 12 times and hepatitis C 11 times, neither showing any positive results. Serology for strongyloidiasis was only completed in 13% of cases (2/15) with no positive results. No UASC were tested for sexually transmitted diseases, helminths or schistosomiasis.

A small number of UASC needed further investigation for their hepatitis B and latent TB result.

Other tests completed as part of the IHAs included serum TSH (6/15 cases) with all normal results. Creatinine Kinase was tested twice, and an INR was tested once- the clinical indications for these tests were not clear.

The RCPCH guidance also advises that a nutritional assessment should be undertaken, which includes BMI centile calculation[lxxxvi]. Healthy weight in children and adolescents is defined using a Body Mass Index (BMI) centile, allowing for the fact they grow and develop at different rates[lxxxvii]. This is calculated using BMI (weight divided by height squared), age and sex. The result is then compared to a reference population, demonstrating how their BMI centile compares to that of other children their age and sex. Clinical ranges for BMI centiles used by the NHS are as follows[lxxxviii]:

- Underweight: on the 2nd centile or below
- Healthy weight: between the 2nd and 91st centiles
- Overweight: on the 91st centile or above
- Very overweight: on the 98th centile or above

BMI centiles were calculated if all relevant figures e.g., Height, weight were documented in the IHA report. BMI centiles were able to be calculated for 22 of the 29 UASC. The majority (86.3%) of UASC fall into the healthy weight category with a small number being outside of this range.

Other issues noted from the IHA for UASC data:

- IHA reports noted scabies on physical examination for a small number of UASC which required treatment.
- 51% (15/29) of IHA reports mentioned dental issues which included dental caries and/or toothache requiring an urgent appointment with a dentist.
- IHA reports documented that a small number of UASC were current cigarette smokers.
- No UASC reported that they currently drank alcohol or used illegal drugs.

Hastings YMCA accommodation physical health questionnaires:

As discussed previously, on arrival to YMCA accommodation in Hastings, the UASC are asked to complete physical and mental health questionnaires to help identify areas of need from the outset. Data from questionnaires completed from August 2022 (when the branch opened) to February 2023 has been analysed. 18 questionnaires were identified, with 4 being incomplete which was defined as having one or more questions not answered. Areas were UASC generally scored highest were ‘not having a regular sleep pattern’ and ‘not achieving the recommended daily intake of 5 portions of fruit and vegetables per day’. 27% of the UASC (5/18) self-reported themselves as current smokers, defined as choosing ‘some of the time’ or ‘all of the time’.

Physical health UASC Conclusions:

While some CYP arrive in good health, others will face physical health issues including nutritional deficiencies, skin conditions including scabies and dental issues. These CYP are at high risk of having communicable diseases due to prevalence in their country of origin and experiences on their journey to refuge. Data has shown that around half of UASC do undergo investigations for at risk conditions. This may be deviating from RCPCH guidance, dependent on the country of origin. This may mean opportunities for diagnosis and treatment are missed. In addition, these CYP have self-reported issues around dietary nutrition and smoking.

Recommendations to improve the physical health of refugee and asylum seeking CYP:

- A change to the structure of clinics for UASC- longer appointment times, conducting the IHAs in a setting where there is access to basic clinical investigations including phlebotomy so investigations can be completed same day.
- Further audit considered to understand the country of origin of UASC paediatric health care assessment and if the necessary investigations were undertaken.
- Further audit to understand whether Mantoux testing and BCG's are being undertaken for those eligible.
- Ensuring CYP are signed up to a GP to ensure ongoing health needs are met.
- Ensuring CYP are signed up to a dentist.
- Information sessions for CYP around sleep hygiene, healthy eating, alcohol, smoking and drugs or training of named social workers and accommodation staff to be able to provide basic advice and guidance on these topics.

Social and cultural Needs

During the semi- structured interviews with professionals an issue noted by YMCA staff relates to cultural views of the CYP, the majority of which are male. They had noted issues with the CYP attitudes and behaviours towards females, with deviation away from European expectations. The service had wanted to put on sessions to educate the young males on healthy relationships, consent and acceptable behaviours. However, the staff did not feel they were trained to deliver this information and the service was unable to finance an external educator. Many of these children come from countries where woman do not have the same freedoms and rights as in the UK and men have a more dominant role in society[lxxxix]

Furthermore, there had been incidents where UK employers had tried to exploit the UASC by offering to employ them for lower than the legal minimum wage. This issue was flagged

up by discussions between accommodation staff and named social workers and the young people. These staff members informed the UASC to not accept a job for that pay and gave general advice around seeking employment.

Recommendations:

- Introductory talks for new arrivals including information on cultural norms and behaviours and seeking employment in the UK or training of named social workers or accommodation staff to be able to provide brief interventions and advice on these topics.

Frontline Workers Survey

Frontline workers supporting children and young people who are asylum seekers or refugees were asked to fill in an online survey (Survey questions can be found in Appendix A). The recipients worked in primary care in the NHS, in local authorities, housing or the voluntary care sector.

The survey received 14 responses.

There were six further open questions designed to elicit the needs of the asylum seeker and refugee population and these were thematically analysed.

What is working well?

The frontline workers were asked what was working well with regards to supporting asylum seekers and refugees. The themes will be discussed further.

Social Prescribing Positive Activities Support

The social prescribing activities program was consistently described positively, with " early reporting is suggesting it is helping children and their families". The program itself allows referrals from a number of sources to a social prescriber who works with the child/young person to find fully funded activities for them to engage with, promoting integration and wellbeing.

Children's Services Support System

The team supporting UASC was discussed on multiple occasions including the positivity of having a specific team working in social care for UASC, the commitment staff had shown and the through-care team including personal assistants for those transitioning through to adults.

Language and Schools Support

The necessity of education and language support and the positivity of many of schemes were also highlighted. Specific support included the English as a Second language scheme with specialist teachers, bilingual support officers and extra teaching sessions were described as excellent. ESOL lessons were also described positively in Hastings and Eastbourne.

Housing

Access to housing was described as positive alongside the semi-independent placements.

Health care assessments

The healthcare assessment for UASC were described as very positive allowing time to address healthcare needs and explain how the NHS works.

Refugee council therapy sessions.

The therapy sessions from the refugee council were cited many times as successful and important for children and young people.

Themes of areas which could be improved from the Frontline workers survey.

Education

Frontline workers highlighted education in schools this as extremely important for integration and as a stepping stone to independence. English as a first language support and ESOL have been described as positive, however frontline line workers questioned at times whether needs were being met and that there were gaps in the service. This highlighted potential variability in the support being schools or the knowledge of services available.

Not only was increased support for those with English as a second language sort, but additional needs (learning needs) being addressed and recognised at schools' level and more funding for the English as a second language provisions.

Education was deemed to be the highest priority to focus on from stakeholder, with improving Education for the under 16-year-olds, increasing English as a second language support, more English language lessons and better integration into British cultural and societal norms all discussed.

"More training for schools to be able to provide and education asylum seekers who do not speak English are able to access."

"Educational needs are not met when they are under the age of 16."

Language and Interpreter services

Language and lack of use of interpreter services were deemed to be the biggest barriers to access for support by frontline workers. This included accessing services, education attainment and facilitating NHS appointments.

"Despite requesting, an interpreter is often not booked by the NHS meaning the young person is unable to have a proper consultation."

"GP, hospital to have a better awareness of language barriers. Ensure an interpreter is booked for appointments and speak to the young person rather than to the support worker".

Translation service support especially at healthcare appointments was deemed as a high focus priority by frontline workers to enable young people in the future.

Healthcare

Healthcare was discussed by frontline workers in different forms and will be discussed divided into mental health care and support and physical healthcare.

The healthcare assessment for asylum seekers was highlighted as having the potential for being "re-traumatising" due to the lack of medical records that medical professionals have and thereby asylum seekers having to discuss their personal history. This could be compounded with no interpreter, limiting the consultation entirely.

Primary care enrolment was deemed as essential. Other areas of physical health need were there was a barrier or needing further input included dental access and enhanced sexual health support and relationship advise for asylum seekers and refugees.

Mental health was a theme from the frontline workers survey which highlighted not only the cultural differences in the perception of mental health and the need for health professional awareness but the difficulty in accessing services themselves, specifically for trauma support.

"Those with mental health and trauma related problems have difficulties accessing the offered support".

The Positive activities program which was previously described as open to refugees and asylum seekers in the survey was highlighted as needing more specific funding for activities and needing "specialist provision for asylum seekers and refugee children".

Family

Family was discussed by stakeholders as necessary, as was the need to facilitate contact with family in home countries. To support the young person, there was also a need to include their family, when in East Sussex in this support too.

For example, to support a young person to have stability "supporting parents' English and into work" would help. Lastly if working with a UASC then having more family-based placements rather than semi-independent was described to nurture more support.

Stakeholder communication

Stakeholder communication and the need to "map" the "whole offer" was discussed with "sharing current opportunities" and "better stakeholder communication" shared as areas to work on to improve the ability to understand the offer in East Sussex and take up potential previous unknown opportunities for the young people.

Practical support Needs to foster independence and integration.

Practical support was highlighted in the frontline workers survey to integrate children and young people into the workforce and foster their independence. This was specifically noted in support to access benefits, careers support and advice and volunteering opportunities to aid opportunities for work when the right to remain status is given.

Legal support for the appeal process and support for asylum claims was also discussed by a few frontline workers.

Work with the community to educate on the need for integration and support was also raised for integration process as was the ability to access free or budget friendly transport.

Safeguarding

Safeguarding was raised frequently and the need to educate and protect, with concerns of the "risk of exploitation and grooming" in this group of young people. "In a foreign country with no family around can heighten this risk of latching onto adults who seem familiar." And due to the lack of finances this can lead to "for example, riding a motorbike/moped without passing a test, without insurance, wearing second hand helmets and no safety clothing."

Inequalities in service provision

Inequalities in provision across the groups of young people and children were described in the survey with activities specially focused on Ukrainian refugees and the need to extend

the “high level and quality of provision offered to Ukrainian families extended to other groups” and increasing the “activities for asylum seekers and refugees”.

Housing

Whilst housing access was described as positive from some frontline workers, others reported that more support could be provided. Concerns were raised specifically in supporting those who were working with the through care team and transitioning into adulthood and therefore needing to find their own independent accommodation.

“There is a huge housing issue where many UASC young people will be looking at homelessness situations over the forthcoming months, this is due to closures of hotels and the prospect of little or no housing available in the areas that they have settled in, or not fit for purpose accommodation”.

“Better support for housing and transition for young people moving into adulthood, the settlement process and security and safety procedures met to protect these vulnerable and hugely traumatised young people.”

Housing was the second most common priority for frontline workers specifically “safe and secure” accommodation and support accessing this for those transitioning into independence.

“the risk of homelessness for these vulnerable children, young people and their families in East Sussex is deeply concerning”.

Cultural Awareness

Cultural awareness of the different experiences or belief systems of the young or child by the health professional was raised as a theme and a barrier to accessing services in the frontline workers survey. Specific reference was given to the perception or awareness of “mental health” as a concept that some young people and children did not understand and therefore cultural awareness training was an essential part of communication. Food choices were also mentioned “I do not see all dietary needs such as halal meat being considered”.

“Some cultures do not have the same knowledge around mental health and therefore find it difficult to access as they refer to poor mental health as being "crazy" and it has a negativity attached.”

Which groups of Young People face more difficulty accessing support?

The frontline workers survey illustrated specific groups within the refugee and asylum-seeking Young people and children's groups who potentially needed further support. These included;

- Unaccompanied asylum-seeking children, especially those who were transitioning into the adult service and independence.
- Those "questioning their sexuality."
- People with mental health conditions
- Those living in rural areas.

Focus groups and interviews for UASC, Homes for Ukraine and Resettlement Schemes Children and Young people.

One focus group for Young people who are UASC and several individual and family interviews were undertaken in February 2024 to obtain the voice of children and young people and to understand their experiences and needs.

Discussions took place with a total number of 16 young people. Due to the limited number of young people from the resettlement scheme and UASC who wished to take part the themes are pulled out for all the young people together to ensure anonymity. The themes are described in the following part of the report.

School and Language Acquisition

The ability to speak, write and understand English was one of the most important themes to be expressed by children and young people. It was deemed as necessary to be able to enjoy school, make friends and integrate in East Sussex. ESOL lessons and their value was mentioned many times.

The frequency of lessons and ability to speak the language quickly were deemed important and they enabled autonomy, integration in the community and the ability to improve navigating both the healthcare system and education system. ESOL itself was offered quickly in some cases and slowly in others which was deemed a barrier to learning the language.

The younger someone was and the ability to speak some English prior to coming to East Sussex enabled learning faster. English language support for not only the young people in

school but through peer support for the family, so that parents English improved at the same time was deemed important too. (whole family approach) when it was offered.

“School was quite hard because I didn’t know the language”.

“at least I know the language that has really helped me the first thing” (were learning English before coming to UK to some extent)

“the first couple of months were hard, because it is a whole different environment, you don’t know anyone, you don’t know those around you. But then it got easier, as we started making friends” “We picked up on the English fast , within a month”…….“ it wasn’t really hard for us to make friends, but at first it was quite hard, but then our English got better”. “We had volunteers, who were tutoring us every day for English”…. “And our mother too” “

The support in Schools was fed back as varied, with some having specific support teachers from the country they originated from, which was helpful and other having to adapt themselves using ESOL only and google translate apps. Additional educational needs were expressed as not always considered.

“In terms of school obviously it’s a new environment, when we first came, it was complicated to get help in school, with translations. My English is good but I had friends…. who require additional support”.

“Last year there was a Ukrainian assistant” “but not now”.

“In school I used translators” (google translate)

From an education point of view one of the families expressed the need to understand the education system and how to navigate results (especially in secondary school) and their meaning when thinking about college and the future.

“what does it mean (grades), in terms of next year, of entering college”…local people can read between the lines but I don’t know….“Where are the priorities- what is an email for the sake of an email and what do I have to respond to”.

Dental

The majority of young people interviewed expressed issues with registering with a dentist, the ability to have a dental appointment and knowing what to do in an emergency. This was especially evident if they were under the homes for Ukraine scheme or an UASC. People under the resettlement scheme interviewed had been settled for 4-5 years and had registered with a dentist and also received braces too. They still had problems getting an appointment if they were registered. There was a continued expressed need to see a dentist for specific needs too.

“People took my teeth and there is still hole”-“ every week I have an infection”.

"I got braces off last year and a week after you have them off you are meant to have a retainer" we have been calling them, they wouldn't answer any of our calls, when we finally go through"…. "I now need braces again."

Those who were unable to register with a dentist discussed the anxiety and what they should or could do if there was a dental emergency and also a trend of travelling to another country for dental services.

"we couldn't find any capacity… around in the area"…. "We have already been in Ukraine twice in Western Ukraine"…."it is a bit scary because it (dental issues) can happen at any time and I need to know where to go."

"I don't know what to do if she starts crying and says I have a toothache."

"Our way out is to travel back to the Ukraine in cases of dentistry."

"For dentist go to Turkey- best thing" "English people go abroad too for dentists."

Primary care

There were mixed reviews on primary care with four interesting themes being described through the discussions.

1. Access to primary care
2. The encounter in primary care
3. Understanding how the NHS System works
4. Interpreting services

1.Accessing primary care was deemed difficult by most interviewees due to the lack of appointments and how busy the doctors are. The language barrier at times if there was one worsens this experience. When there is an inability to get a GP appointment confusion and stress and anger were voiced, especially when they were concerned about their health or with respect to the health of their children.

"experience was pretty good" "We could get same day appointment "

"They are busy" , "I am going to lose my eyes because they are busy."

"not that much good" "whenever we call, they are busy".

"To be honest I am trying to avoid getting in touch."

"In case they (children) get ill I do not understand how to deal with it, if I cannot get into an appointment with GP".

"recently x was ill and it seemed to be a serious case and the earliest appointment with GP was 2 months and then how to deal with it?"

2.The difference between the NHS offer and the country of origin was highlighted during the discussions with Young people, especially with expectations of the treatments received when presenting to primary care. When there is an expectation of more than

reassurance for viral infections or a country of origin is set up that people have specialists to book straight in with the difference has been shown to be vast.

“they tell me to go drink lemon and honey.”

“they don’t really do anything they give you a random medicine.”

However ,discussions on the GP’s themselves when they are seen are more positive being “kind and calm” and “attentive” and communicating well.

“he (child) was communicated steps by step what will be done and he appreciated that.”

“Do not understand vaccination program here.”

3. Understanding and navigating the NHS system

Almost all young people expressed the need to understand how the NHS works and the difference between the NHS and how their country-of-origin system worked, whether a paying system or secondary care predominant system. Some preferred the system and others felt their service provided better care. One young person expressed the need to explain the system when someone is moving to the area.

“it is better here- you do not have to pay”.

“Quite complicated to book appointment and wait, when in Ukraine we can book the appointment same day and get all the screenings and tests we need same day”” It is much easier for us”. “we can get GP appointment same day (in Ukraine)”

“We can book private doctor appointment and it is not as expensive as here.”

“If not needing to use services when I do it is really difficult to understand.”

4. Interpreters - even though a young person may have a good English-speaking ability when it comes to navigating healthcare or understanding their healthcare conditions or options, they have voiced the need to consider interpreters to assist.

“Sometimes when I spoke to them- they sent for me an interpreter- other people they don’t.”

“One appointment we had an appointment on the telephone and Dr asked me to explain symptoms….difficult to describe symptom on phone for me.”

“Some people because they know you are a refugee and they know you don’t understand they get you quickly out.”

Health care assessment for UASC

Only UASC at present have statutory health care appointments with a paediatrician. The only feedback on the experience was that this could be more trauma informed in the approach, with explanation on any need for questioning an UASC explained.

"It was not that good, they asked me too many questions not related with health about my journey."… "I went to see the doctor, they did not do anything they just told me to take vaccines, but I don't want to take vaccines and because of this I don't want to see the doctors."

Mental health

Of the young people being interviewed only 2 expressed the need for mental health support, with them receiving it when asked for. The refugee council counselling service was deemed better than the local service. When someone received counselling or wanted to receive it, they would prefer to have this in their own language and if possible, from someone from their own country of origin. Of note there is a disparity between the mental health need in the young people and those we interviewed this is likely to represent interviewee selection bias rather than less of a need in East Sussex.

"Refuge council they helped me a lot "really happy with them" any problem they helped "mentally and immigration if I have any problems " " I appreciated them" "I got help." "I have had contact with them for me it is very special."

" I don't feel that we will be understanding each other in terms of culture- so I would probably prefer to use this type of service with Ukrainians."

Mental health and Activities and Hobbies

A recurrent theme for young people, expressed by their parents or themselves was that having hobbies and activities to undertake facilitated good mental health. The positive activities scheme was specifically mentioned to support young people. Young people also expressed integrating and the openness and welcome of people helped them.

"Their ability and their access to hobbies, like football does support them a lot".

"I really like sports and you have loads of fields and really easy to get into any sports team."

"I don't remember being sad."

"They helped me to get yoga classes, it did help"- positive activities.

Other aspects that facilitated positive mental health were deemed community support including hubs for Ukrainians and also their host families.

"Massive support from host family"

"big Ukrainian community around….we can meet people; we can talk to each other in Ukrainian".

Activities

The specific activities that were deemed important and helpful were;

1. Peter Gordon Lawrence- activities holidays
2. County Council led activities- Positive activities scheme.
3. School run opportunities including NCS for year 11.
4. Local Council led financed opportunities- Jamies farm visit.

“we were able to go to PGL” You go for a week or less , it’s a camp where you go abseiling, canoeing.”

“The Council was really helpful whenever we wanted to do something it was available to us, I got violin lessons” we did dance, violin, guitar and we got a violin and guitar and gymnastics.”

The only issue flagged to accessing these activities if they were available to the person, was transport.

“there are a couple things I would like to do…. We live remotely , it is hard for me to get to class.”

Mental health and Safety

Safety and feeling safe was a theme that came from some of the interviewees with the ability to feel safe. This was in the context of stable and safe accommodation, or good communication and support. Feeling safe and supported was deemed very important.

“It was a really safe area”, “I am really grateful.”

“We feel safe and assured.”

The feeling of that safety being threatened leading to mistrust and a reduction in good feelings of being supported or living in East Sussex.

Safety issues linked to racism were highlighted and the effect on mental health.

“Racism happens … affected me….I used to go to the park but not now.”

Mental health and Community Welcome and Integration

The welcome that a young person perceived to have from those in East Sussex makes a difference to their experience of being here, with those reporting people being welcome and open having better experiences of integrating within the school community and area.

“it’s really easy to get settled in.”

“Quite easy to get friends- because everyone is nice to you and trying to be helpful.”

“School was really welcoming.”

On the converse side as with the racism if you were not perceived welcome a poor experience and perception of East Sussex was expressed

“The way they speak to us if you can’t speak English” ….“Everything is hard”, “every day you wake up morning and go college.”…… “be kind”.

Host families, Support workers.

Young people from Ukraine interviewed only had positive things to say about the support they received from there host families. Support workers for Resettlement schemes were described as helpful or were not remembered.

“they (host family) are like family”.

“we appreciate the experience we had with our host family, because it was a good experience, with respect on both sides. “We value it a lot."

“our support worker would understand and would really help us”.

The UASC young people support from support workers was deemed essential remembering that they have neither family support, other support workers or host families to signpost them or to explain services it shone through the need for support workers especially those in the through care team. This was especially shown in navigating the healthcare system and booking appointments.

“I am actually trying for the last two weeks, I call on Monday, they say they are busy.” (support worker needed to advocate for appointment)

Extra support from Hubs, VCS, statutory groups

From parents of the children there was an expression that Ukrainian hubs and support from VCS staff was invaluable. Examples included support for housing, jobs (including c.v., job interviews) and navigating council tax.

Accommodation

The majority of young people were happy with the support and accommodation they had since reaching East Sussex, with only one concerned with their accommodation.

“when we first came here there was a council house- I really liked that one, it was a really good area”……“met our needs”…. “I think we were really lucky”… “other people had it worse than us in hotels.”

“It is bad so bad, I feel it is like prison” (regards to room)

The subject of renting accommodation from families was raised especially for parents in the homes for Ukraine scheme and the difficulty in renting suitable accommodation. SCDA providing support were deemed essential to navigating this process, especially due to the need to have work to rent accommodation flagged as a barrier.

“it is difficult for you to rent a place”…. “I felt that I totally don’t control it. (the ability to rent)”

Health Needs Assessment Conclusion

To conclude, in this time of global humanitarian crisis and growing immigration policy hostility, special care must be afforded to refugee and asylum-seeking children and young people, so that they may primarily be seen as children and young people - with hopes, dreams and great potential.

Many of the needs of this group are the same as that of their peers: immunisations, good nutrition, sexual health services, creativity, extracurricular activity, social inclusion, educational support and stable home lives.

Extra needs are heterogenous, mirroring the varied demographics and experiences of this group but key themes include consideration of communicable diseases, addressing trauma which is highly prevalent, safeguarding against torture, coercion and human trafficking and supporting socialisation, with English language acquisition a vital part of this.

This work has been collated and the following recommendations have been made.

Recommendations

To improve health and wellbeing outcomes for refugee and asylum-seeking children and young people living in East Sussex, the following is recommended.

Healthcare

- Early comprehensive health assessment of all refugee and asylum-seeking children and young people (not just UASC) which considers nutrition, developmental delay, safeguarding, sexual health and mental health as well as physical examination, screening (and consideration of empirical treatment) for relevant communicable diseases and an offer of vaccinations in line with the national immunisation programme; longer appointment times and access to basic clinical investigations like phlebotomy is recommended.
- All clinicians working with refugees and asylum seekers should have trauma informed training and approaches.
- A change to the structure of clinics for UASC- longer appointment times, conducting the IHAs in a setting where there is access to basic clinical investigations including phlebotomy so investigations can be completed same day.
- Further audit considered to understand the country of origin of UASC paediatric health care assessment and if the necessary investigations were undertaken.
- Early support for families and young people to register with a GP and dentist and guidance on their rights to access healthcare and understanding of how the system works.

- Education of healthcare staff (including reception and administrative staff) on rights of access to healthcare, safe surgeries and trauma informed care.
- Use of carefully considered interpreters in consultations for all healthcare and professional appointments.
- Dental access improved for asylum seekers and refugees.
- Review of the Kent County Unaccompanied Asylum-Seeking Children Health Team's website's resources for healthcare workers and patients with a view to having similar resources in East Sussex
- Education on sleep hygiene, healthy eating, alcohol, smoking and drugs or training of named social workers and accommodation staff to be able to provide basic advice and guidance on these topics.
- ICB clear on NHS vaccination offer for children and young people, what should be given and who is eligible. Special consideration and clarity should be given on how and who initiates the BCG for those eligible.
- Ensure good transition of health care between secondary care paediatric and adult care for those needing further care following the initial healthcare assessment.

Mental health

- Consideration the need for providing extra psychological interventions like CBT in non-clinical settings like schools or the voluntary sector.
- Prompt mental health assessment including screening for high-risk conditions including PTSD, depression and generalised anxiety for all refugees and asylum seekers.
- Ensuring access to support for this vulnerable group
- Ongoing surveillance of mental health and well-being for UASC via screening questionnaires to monitor for delayed presentations- these could be conducted at their place of accommodation or through their named social worker.
- Development of services to support and follow-up those who have had mental health interventions- this could potentially be done via follow-up phone calls.
- Ensure the Positive activities scheme is open to all Asylum seekers and refugees.

Mental health linked work

- Surveillance and sharing of existing community programmes and groups which enable building of social networks through shared creative, cultural or physical activity;
- Exploration of problem-specific mentoring programmes for young people
- Ensure community and education work on integration and targeting racism is continued and further considered.

- Ensure UASC and their lack of family support is considered in their need for further and support to integrate fully, including navigating health, education, increasing social networks and transitioning to adulthood and work and living needs.

Sexual health

- Education for refugee and asylum-seeking children and young people on sexually transmitted infections and contraception, via sexual health outreach team.
- Review of needs for LGBTQ+ refugee and asylum-seeking children and young people in East Sussex

Education

- Review of English language acquisition service to ensure it is sufficient to meet the needs of children and young people in East Sussex (and their families)
- Ensure extra learning needs are identified and addressed.
- Ensure parents supporting their children in East Sussex understand the education system.
- Support for refugee and asylum-seeking children and young people to join public libraries and gain access to educational resources.

Practical and community

- Review of transport as a barrier to accessing services in East Sussex
- Sharing of the “whole offer” for children and young people who are refugees or asylum seekers.
- Introductory talks for new arrivals or training of named social workers or accommodation staff to be able to provide advice on living in the UK, cultural norms and behaviours, seeking employment and help with asylum applications and education on how to safeguard against specific vulnerabilities.
- Ensure the offer of practical support for housing, legal and work is adequate for CYP needs.

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Appendix

Appendix A-Frontline Workers Survey Questions

Question 1- In your professional opinion, what if anything is working well to meet the needs of refugee and asylum-seeking children and young people in East Sussex?

Question 2-What in your opinion could be improved to better support health and wellbeing outcomes for refugee and asylum-seeking children and young people in East Sussex?

Question 3- In your professional opinion are there any needs among refugee and asylum-seeking children and young people in East Sussex which are not being met by current support and service provision?

Question 4- In your professional opinion, what if any are the main barriers that refugee and asylum-seeking children and young people, including their family/carers, experience when accessing support services and wider provision in East Sussex?

Question 5- Through your role, are you aware of any particular groups within refugee and asylum-seeking children and young people in East Sussex who might face more difficulty in accessing support?

Question 6- Considering your previous answers, please tell us what you think are the key priorities (up to three) for planning and provision of services and support for refugee and asylum-seeking children and young people going forwards?

Question 7- Do you have any other comments or suggestions you would like to share about current provision for refugee and asylum-seeking children and young people in East Sussex?

Appendix B

Rapid Needs Assessment- Questions for service providers/professionals(semi structured interviews):

- Could you please provide an overview of what your service provides and which children and young people you work with?
- What do you think is currently working well for or valued by the children and young people and their families with regards to: your service, the wider provision?
- Is there anything within your service that you feels need improved? If so, do you have any ideas how this could be improved, what support would you need to make these changes?

- Do you feel you have enough external support for your service? If not, what would you feel would be helpful?
- What do you feel are the current needs of the children and young people- including physical, emotional and mental health issues- that are not being met?
- Are there any sub-groups within this population who have been identified as having specific needs? e.g., condition, type of behaviour, gender, age groups etc.
- What do you feel are the key priorities that should be addressed to help these children and young people?
- Is there any information or data collection by your service that would be useful for us/ that we could get access to?

Appendix C

Focus group/interview Questions.

Questions

1. Please tell us about your experiences since you moved into the U.K. (Hastings or Eastbourne)
2. Please tell us about the services have you used.
    - what were they like? Good and bad experiences
3. What have you needed but was not available?
4. Was there a service that you needed/wanted to use but were not able to ? why
5. What service/support would you have found helpful.

Topic Questions

1. Housing-
    - please tell us your thoughts on your current accommodation in (place)
2. Social network and integration-
    - Please tell us a bit about how you spend your free time?
    - Do you have some Hobbies? Is there a hobby/activity you would be keen to do?
    - Do you have someone you can go to if you have a problem. (inc. family)
3. Physical health
    - what is your health like?
    - Have you needed support for your health?
    - who has supported this?
    - How was the experience?
    - Was it easy to get healthcare appointments and if no- what were the barriers.

4. Mental health
    - how happy are you 1-5? (rating scale)
    - Do you feel you need some support?
5. Education and language
    - how have you found starting a new school/college?
    - What has gone well/not so well?
6. How have you found learning English and communicating with people?

Appendix D:

RCPCH list of important history and physical examination features to include in health assessments of refugee and asylum-seeking children and young people [lxxvii]

- Vaccination history
- Living in crowded conditions (e.g., refugee camp) or known exposure-risk e.g., tuberculosis with BCG scar present/absent
- Family history of genetic conditions, consanguinity, haemoglobinopathies, infection exposure
- Symptoms of tuberculosis (e.g., persistent cough, fevers, low energy, low appetite/weight loss)
- Micronutrient deficiencies (vitamin B complex, vitamin A, zinc); night blindness is a symptom of vitamin A deficiency.
- History of hearing or visual concerns
- Symptoms of conditions which were missed due to no neonatal screening e.g., hypothyroidism, CF, sickle cell disease, inherited metabolic disease.
- Features of chronic malnutrition e.g., stunted growth
- Signs of iron deficiency anaemia e.g., pallor
- Dental decay, gum disease
- Signs of rickets (e.g., bowing of legs, widened wrist epiphyses, soft skull in infants)
- Scars from previous injuries or medical procedures (helpful to document on a body map)
- Skin features of infections (e.g., scabies)

Consider risk of Female Genital Mutilation (FGM)

Appendix E

RCPCH checklist for care planning and follow up of refugee and unaccompanied asylum-seeking children and young people [lxxvii]

Care plan.

- Paediatricians should write a clear, individualised, care plan and ensure that all information (for looked-after children, see DH/DfE guidance) is shared with the local authority, copied to the GP and made available to the child, young person and/or their family/carer.
- The plan should also outline any safeguarding issues including vulnerability to exploitation.
- The plan should include a checklist of all the key actions that are needed by social workers or others, including different health issues and any community, education or health promotion needs.

NHS number

- If the child/young person does not have an NHS number and/or is not registered with a GP, a paediatrician should ensure that processes are in place to get them registered.

Health visiting/school nursing

- Preschool children should be referred to their local health visitor so that they can be included in the preschool health and developmental surveillance programme.
- School-aged children should be referred to the school nurse/SENCO, with any specific health needs communicated appropriately.

Immunisations

- Paediatricians should give immunisations and/or write a letter to the GP outlining immunisations needed. See guidance from PHE for information about routine immunisation schedule.

Follow-up checks

- Ensure dental, eye and hearing (if any concerns) checks are planned.
- Where required arrange blood tests to check for anaemia, iron status, vitamin D deficiency, hepatitis B, C and HIV as well as sexual health follow up (if indicated).
- Suspicion/diagnosis of infestations such as scabies and lice should be promptly notified to the GP with a suggested prescription / paediatric dosage in the referral letter as well as any other recommendations for infectious diseases screening such as referral for TB screening or sending stools for culture and parasites if symptoms indicate.

Health information

- Paediatricians should provide the child, young person, family/carer with information leaflets in their own language where available/appropriate.
- A copy of the FGM Health Passport should be provided.

Additional health and social needs of child/family

- Pregnant mothers should be facilitated to register with a GP so that the unborn child can be included in antenatal care and neonatal programmes without delay.
- Paediatricians should note any lack of social support, and as appropriate, signpost the child and social worker to local charities and support such as Save the Children, the Refugee Council and other relevant support organisations in the local area.
- Where appropriate, children and families should be referred to the Red Cross international tracing and message service by their social worker or provided with information on how to do this.

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