Unaccompanied asylum seeking minors:

emotional and mental health issues and service provision

"I have nobody, I feel awfully alone..."[2]

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SSM5

ABSTRACT

Background

Every year, thousands of unaccompanied children under the age of 18 arrive in the UK hoping for a better life. Although almost half of all refugees seeking asylum globally are children, unaccompanied minors remain a hidden group within these statistics.

Separation of children from their families and guardians is seldom an event that takes place without the occurrence of other desperate circumstances such war, death, sexual violence and persecution. Exposure to such horrifying events, in addition to feelings of grief and displacement, make this group extremely vulnerable in terms of emotional and mental health problems.

Aims

To explore current literature on the topic of child and adolescent refugee health, with a specific focus on unaccompanied minors. This is with a view to discovering their pre-flight experiences, their well-being and health upon settling in a new country, and the provision of care afforded them.

Method

A variety of primary and secondary sources were explored to gain a working knowledge of the subject. A literature review utilising Medline, EMBASE, CINAHL and PsychINFO amongst others enabled identification of the most relevant and up-to-date articles. Additionally, the experience of talking to members of various organisations as well as asylum seekers themselves, proved invaluable in formulating the paper.

Results

It is evident that this particular group of asylum seekers are more vulnerable than most in terms of exploitation, health and general well-being. The children have often experienced more pre-flight trauma and loss than their accompanied counterparts, and consequently have very high levels of severe anxiety, depression and post traumatic stress in addition to their high levels of internalising. Girls, those with low-support living arrangements and those who experienced the greatest numbers of traumatic events were particularly vulnerable, high-risk groups. Services to meet these specific needs are lacking.

Conclusion

Being unaccompanied is a significant risk factor for emotional and mental morbidity. It is therefore essential that appropriate care and services are provided to help deal with these complex needs. Furthermore, it is essential that this group are treated, ultimately, as children and not merely as ‘asylum seekers’.

CONTENTS

Learning Objectives:

1. To understand the extensive reasononing behind peoples' decision to flee their country and seek sanctuary elsewhere, including the obstacles they face and the complexities and ambiguity of the asylum process in the recipient country.

2. To understand the health issues that this group face, specifically those pertaining to mental health and well-being. Particularly, to explore the complicated issues that unaccompanied minors have to navigate, largely on their own, and the impact this has on their overall welfare.

3. To investigate Government policy, and NHS and Non-Governmental schemes that are specifically aimed at meeting the needs of unaccompanied asylum seeking minors (UASMs).

Core Learning Activities:

1. To meet and discuss with asylum seekers their reason for flight, their experiences and their thoughts about life in this country.

2. To spend time with local services in Liverpool that cater for asylum seekers in order to gain an insight into daily life for asylum seekers and their specific needs.

3. To spend time in a healthcare setting providing help/medical assistance to asylum seekers in order to understand the specific needs of asylum seekers and how these are met within this country (particularly considering the many barriers to medical assistance i.e. Governmental policy regarding provision of care).

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The asylum seekers that kindly shared their stories with me.

Introduction

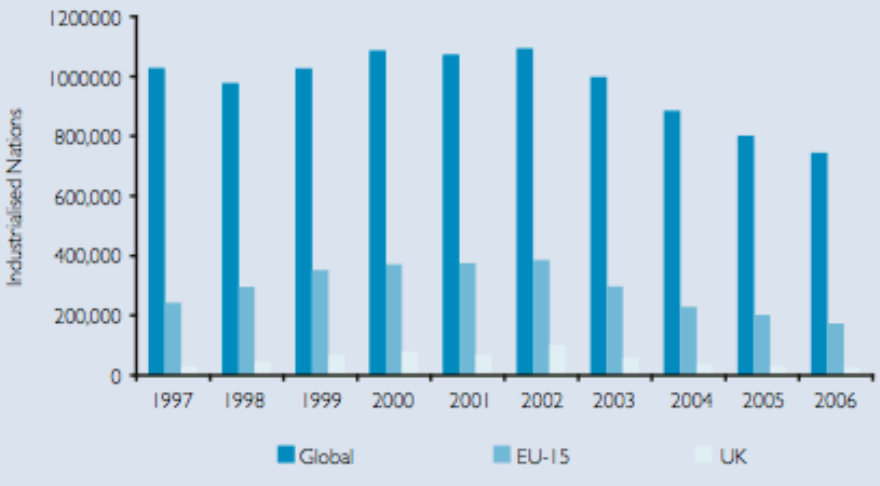
Those that flee their home countries often do so under fear of death or persecution, war and forced recruitment, or sexual violence and trafficking[3-7]. Many have already witnessed unimaginable atrocities, and suffered extreme losses.

In the UK in 2008, there were 5 asylum applications for every 10,000 resident people (the same as the EU average) and much lower than many other states[8]. The majority of principle asylum applications came from Afghanistan (14%), Zimbabwe (12%), Eritrea (9%), Iran (9%) and Iraq (7%)[8].

The choice of the UK as a destination is often not an express decision[8]. On the occasions that it is, reasoning is complex and multifactorial with factors including colonial links and family ties, knowledge of the language and a belief that Britain is a fair, democratic society[4,8,9]. This is at odds with the myth/general belief that 'pull factors' such as the benefits system are the main draw. In fact many asylum seekers have little or no knowledge of the UK's policy upon their arrival[8].

Following a general global trend, asylum applications are currently down, as illustrated by figure 2[8]:

Figure 2 : Asylum applications 1997-2006



Source: UNHCR and Eurostat

The Debate

There are many issues surrounding the asylum debate. These issues relate to the asylum seekers themselves, the Government, Public and Media, and the voluntary sector which is often left to play a crucial role within the process.

The Government has passed increasingly aggressive and restrictive legislation on asylum in an attempt to limit numbers, primarily as a knee-jerk reaction to public opinion and media input[8-10]. The system is a complex one, and as such will always be difficult to manage well. However, the current system of ambiguities, quotas, minimal legal aid and inconsistent decision-making has been the subject of much recent debate[10]. The adversarial approach to applications, in addition to the enforced destitution and lack of encouragement in repatriation has been described as 'inhumane and counterproductive'[8] and is at odds with other more successful countries such as Sweden which follow a policy of engagement and co-operation[8].

Public opinion

The policy of detention has also been attacked by various sources, including the recent Marmot Review, as a political gesture that serves no purpose of benefit to the public or the asylum seeker[11]. Similarly, there has been a public loss of confidence in the system, and in politics in general[8]. Most of this mistrust stems from misunderstanding; asylum and immigration are seen as interchangeable issues in the minds of many, despite the fact that asylum applications accounted for only 4% of the total UK immigration figure in 2007[12]. Sensationalisation and voyeurism on the part of the tabloid press has merely exacerbated the issue.

Resultant Issues facing asylum seekers

These issues mean that asylum seekers and refugees often experience high levels of stress when attempting to settle[3,7,9,13]. Displacement, social exclusion, isolation and even the experience of racism can have profound consequences[3,8]. This, in addition to the pre-flight and flight trauma they have faced, means that many are more prone to problems such as depression, anxiety, insomnia, behavioural issues and post-traumatic stress disorder (PTSD) to name but a few[3-9,13]. Conditions such as TB and HIV/AIDS are also of greater concern within this community[3].

Children

With regards to children, both accompanied and unaccompanied, their status and treatment primarily as asylum seekers/refugees rather than as children can be of great detriment[14]. Unaccompanied refugee and asylum seeking minors (UASMs) are an often neglected group that have a complex set of needs[13]. They are at great risk of mental health problems and exploitation without adequate support[13,14].

Sadly, it is this support which is so often lacking as a result of enforced destitution upon failure of application[8,15]. However, The Children Act of 1989 ensures that social services provide support for UASMs regardless of any other factors until they turn 18, and in general, most UASMs are given temporary leave to remain until this time[10]. This is of course providing there is no age dispute (1,915 applicants in '08)[12]. After this time they receive the same treatment as adult asylum seekers[10]. This policy leaves many UASMs in the incredibly stressful state of 'limbo'; not knowing whether in several years they will be forced to return home. Roughly 4% are given indefinite leave to remain[10].

Statutory Instrument 614

An important element of failure of application now concerns health care provision. 'Failed' asylum seekers are no longer entitled to any new secondary NHS care unless it is deemed to be 'immediately necessary or life threatening'[8,10,15]. Even in this situation the individual is treated and then charged[15]. Only public health issues (infectious diseases) are exempt[15]. This raises wide ethical and moral issues, particularly for the Doctors in charge of care as GP's are allowed to treat failed asylum seekers 'at their own discretion'[15]. In this situation, the Beauchamp and Childress principles of medical ethics would appear to come to the fore:

- **"Respect for autonomy:** respecting the decision-making capacities of autonomous persons; enabling individuals to make reasoned informed choices.
- **Beneficence:** this considers the balancing of benefits of treatment against the risks and costs; the healthcare professional should act in a way that benefits the patient.
- **Non maleficence:** avoiding the causation of harm; the healthcare professional should not harm the patient. All treatment involves some harm, even if minimal, but the harm should not be disproportionate to the benefits of treatment.
- **Justice:** distributing benefits, risks and costs fairly; the notion that patients in similar positions should be treated in a similar manner"[16].

In this case, it would appear that 'justice' is not seen as an absolute when it comes to the care of failed asylum seekers. It also raises issues of human rights, inequalities and the inverse care law:

- **Human Rights:** 'human rights are rights inherent to all human beings, whatever our nationality, place of residence, sex, national or ethnic origin, colour, religion, language, or any other status. We are all equally entitled to our human rights without discrimination. These rights are all interrelated, interdependent and indivisible. Universal Human Rights are often expressed and guaranteed by law, in the forms of treaties, customary international law, general principles and other sources of international law. International human rights law lays down obligations of Governments to act in certain ways or to refrain from certain acts, in order to promote and protect human rights and fundamental freedoms of individuals or groups'[17].
- **Health Inequalities:** 'health inequalities can be defined as differences in health status or in the distribution of health determinants between different population groups... Some health inequalities are attributable to biological variations or free choice and others are attributable to the external environment and conditions mainly outside the control of the individuals concerned...'[18]
- **Inverse Care Law:** 'states that "the availability of good medical care tends to vary inversely with the need for it in the population served"'[19].

Asylum Statistics (UK and Liverpool):

Some key statistics are also important to aid better understanding of the situation:

- 82% of all refugees globally are hosted by developing countries[8].
- Only 3% of the total world population of refugees and asylum seekers reside in the UK (making up ~0.5% of the UK population)[12]. In a MORI survey, however, the average answer given by the public for the proportion of the worlds population living in the UK was 23%[8].
- 3,970 unaccompanied children applied for asylum in the UK in 2008 (up 13% from 2007)[20].
- In December 2008, 40 under 18's were detained under the Immigration Act[20].
- A total of 15,682 asylum seekers entered detention in 2009 (150 for more than one year)[20].
- Liverpool City Council estimates that ~ 4-5,000 asylum seekers are living in the City, although the exact number is unknown[21].
- A survey on destitute asylum seekers around the country found that
  - 78% were between the ages of 21 and 40, many having arrived in the UK as unaccompanied asylum seekers[8].
  - only 12% had exercised a choice in coming to the UK[8,20].
- Annual totals for 2009 show that 73% of initial decisions were refusals, 17% grants of asylum and 10% grants of Humanitarian Protection or Discretionary Leave[8].
- In the UK, 21% of repatriations are voluntary compared with 82% in Sweden[8].
- *78%*: the proportion of the public surveyed that thought the main reason asylum seekers came to the UK was the benefits system[8].
- *57%*: the proportion of the public surveyed that thought that asylum seekers received the same or more than someone on basic income support[8].

The Media:

The media has not helped to create a balanced and informed public perception of asylum seekers. In fact it could be said that tabloid-propagated falsities and the linguistically hysterical approach some papers favour has garnered misunderstanding and created social tensions. They have also influenced political policy aimed to appease public opinion, itself fueled by media sensationalism[8,11,15].

Figure 3

During a 31 day period in 2003, when asylum applications were at their peak, the Daily Express had 22 front page stories regarding asylum that persistently used words such as 'sponger,' 'bogus' and 'foreign criminal'[8]. Some Daily Express headlines are shown here in figure 3[8].

Indeed in many situations, words such as 'asylum seeker,' 'refugee' and 'immigration' are used almost as form of abuse, and as synonyms for words such as 'race,' 'difference' and 'dislike.'

A recurring issue is that of the ethical responsibilities of tabloid papers, often running stories based on false claims that so clearly foster misunderstanding and public mistrust. A more reasoned, logical presentation of facts would clarify and publicise the often vague and ambiguous areas that surround asylum seekers and their plight. A simple explanation of the differences between asylum seekers/ refugees and other forms of immigration would be of use to many people, as it is something the majority are unclear about[8,9,15].

Public debate, conservative use of language and balanced politics not merely attempting to canvass votes would be immensely beneficial in assuaging public fears and promoting integrated communities.

Case History:

Miss X was originally from Eritrea. She had fled her country through fear of violence, seeking a better life elsewhere. She came to Britain partly through chance, having initially merely wished to get safely to Europe. She felt that Britain would offer her the opportunity to build a new life in safety and in relative comfort.

Her asylum application failed last year.

Miss X is currently in the appeal process and living in hostel-style accommodation with other asylum seekers. Her plight is compounded by the fact that whilst in Britain, Miss X has become pregnant with her first child. During discussion, Miss X reveals that the pregnancy was a result of non-consensual sex, although she declines to refer to this as 'rape'. The father of her child is also an asylum seeker.

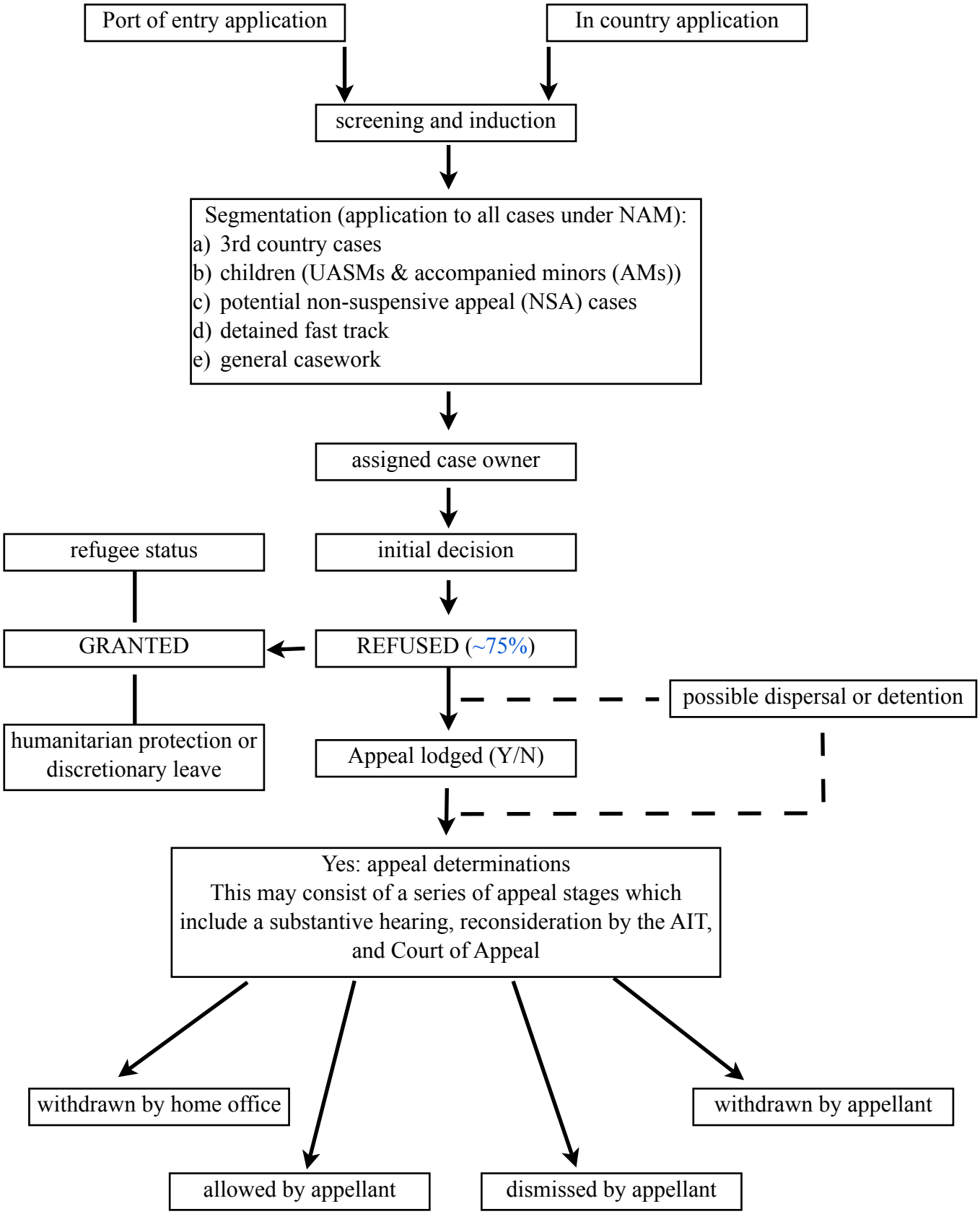
The issue of pregnancy in failed asylum seekers is a difficult one, owing to the negligible access to secondary care. Financial benefits are also scarce (and meagre compared to UK nationals), with a small amount received towards the end of the pregnancy[15]. There is also the issue of raising the child in the UK during the asylum appeal procedure (which may last several years) only to be removed from the country upon failure.

Additionally, Miss X has shown a reluctance to attend sessions primarily for pregnant asylum seekers, and was also distrustful of her translator during the consultation. Her experiences in Britain had, she said, led her to be cautious of anyone but herself. This had, in part, stemmed from the dispute surrounding the age on her passport (she was 17 upon arrival). She felt she had been unfairly scrutinised and constantly feared the "police would come" to take her away.

Although Miss X expressed a strong desire to remain in the UK, she felt "saddened" by her experiences. She expressed her loneliness and "tiredness" with regards to the situation, although she was looking forward to the birth of her child the following month.

When asked about improvements to the current system, she merely felt that the environment in which she had been placed (akin to living "like cows") served only to exacerbate the problems she faced. She felt lonely and vulnerable, and wished to have a better quality of life in which to raise her child. She felt, primarily, that this lay in her being able to work and "make a good life" for her child over the coming years.

Flowchart of the asylum process:[8,12,15,20]



Other issues facing asylum seekers whilst awaiting result, or following failure of application:

Asylum seekers receive their accommodation along with £35 of food vouchers per week[20]. They receive no additional money to enable them to travel to the immigration authorities or to the voluntary services to which they are entitled.

They are not allowed to work unless the initial decision on their application has been pending for over one year[8]. If this is the case they are entitled to apply to work, although this is rarely granted[8]. This enforced dependency and loss of autonomy is a factor that greatly impacts on mental health and self esteem[2,8]. Such a period out of work also serves to demoralise and deskill qualified and competent workers[2].

Three out of four asylum seekers are refused asylum[8,20]. They receive 28 days notice in which to arrange their removal. Forced removal is commonplace, and detention for indefinite periods is not unheard of[8].

Upon failure of application, asylum seekers are made destitute. It is often these people using the services of the voluntary sector in order to survive[10,12].

Pregnancy after refusal of a claim is also a relatively common occurrence[8,15]. Whether this be a coincidental result of prostitution or rather a desperate attempt to increase the chance of receiving Section 4 support and the right to remain is irrelevant. It illustrates the depth of desperation felt by these women when faced with the prospect of destitution and removal.

Statutory Instrument 614 created in 2004, stated that individuals not 'lawfully resident' in the UK would be subject to NHS charges[15]. This revoked the right to secondary care for failed asylum seekers except in the case of a life threatening emergency or in order to prevent wider Public Health implications. (In the case of life-threatening care, asylum seekers are now treated and then charged)[15]. Primary care may be available at the discretion of the GP as an individual[15].

Aim:

To explore and evaluate current thinking relating to the mental healthcare issues and emotional needs of unaccompanied asylum seeking minors, and the services offered to address these needs.

Method:

I utilised several books from the University libraries, along with numerous resources on the Internet such as the World Health Organisation (WHO) and MedAct etc to gain a solid background understanding of the issues relating to asylum seekers, and specifically to unaccompanied children. An assortment of medical databases were then searched to find current papers/research on my chosen topic. Table 1 (below):

Table 1:

Keywords (used in isolation or in combination)	Inclusion/exclusion criteria
Asylum	• the articles must be in the English language • they must be published within the last 10 years • full text must be available • they must be applicable to current practice • in the case of trials the following must be considered: the duration of the trial and follow-up, the design and clarity, the numbers participating (their relevance and comparability) and steps taken to allow for control of confounders etc. • the articles must be specific to asylum seekers, particularly to children.
Asylum seeker	
Flight	
Experiences	
Torture	
Mental health	
Emotional Health	
Welfare	
Need	
Services	
children/youth/adolescent/minor	
unaccompanied	
displaced persons/people	

Results:

Table 2 shows the number of 'hits per database search:

	Keywords												
	1	2	3	4	5	6	7	8	9	10	11	12	13
	Refugee(s)*	Asylum	Asylum Seeker	displaced person/ displaced people	1 or 2 or 3 or 4	child*	minor	youth	adolescent	6 or 7 or 8 or 9	unaccompanied	10 AND 11	12 AND 5
Medline	1869	686	39	5	2198	61,853	133,220	21,744	51,961	263,609	1033	48	9
CINAHL	1198	532	39	0	1442	95,013	5482	7314	11,212	111,994	92	47	24
EMBASE	477	469	36	5	854	268,176	33,039	9982	24,244	317,453	221	65	21
PSYCH INFO	1305	839	57	9	1854	155,318	5010	21,163	27,973	186,866	410	84	42
BNI	71	154	6	0	217	9605	264	181	812	10,464	12	7	4
AHMED	15	14	0	0	25	7234	740	313	594	8505	3	0	0
In addition to AHMED; Science Direct, Scopus and Web of knowledge etc also provided no relevant results													
Once duplicates were taken into consideration, a core selection of between 20-30 articles were established. Those deemed most relevant and contemporary were selected for discussion. References and citations of certain articles were also searched to look for other relevant articles. UK based studies were scarce, and as such articles from the Netherlands and Belgium were deemed appropriate for inclusion as the issues tackled were identical.													

Critical Appraisal of two articles:

'I was running away from death' - The pre-flight experiences of unaccompanied asylum seeking children in the UK. Thomas S, Thomas S, Nafees B and Bhugra D. Child: Care, Health & Development 2004; 30(2): 113-122

This an original study aiming to better understand the reasons for flight experienced by unaccompanied minors in order to better support and provide services to meet their needs.

Strengths

In contrast to similar papers, it is a UK based study. Its aim is also a unique one, as it seeks to explore a very specific topic pertaining to unaccompanied minors. Several studies have focused on the mental and emotional problems identified upon arrival, but few on the background traumas experienced and their correlation with these issues.

The study utilises several forms of written evidence and interviews in order to create the most complete and accurate overview, and to enable identification of any inconsistencies between sources. All of these sources were combined, ranked and assessed by an experienced team in this field. The subjects themselves were chosen using a random computer sequence to avoid bias and confounding. The sample of 100 (20 exclusions for various reasons) is substantial given the largely qualitative nature of the study.

The results and discussion focus on a multitude of relevant issues. As well as identifying the implications of its findings, it discusses its relevance for the children themselves, for services, and for healthcare teams. It gives excellent future research suggestions, building upon its findings and even identifies its own limitations.

Weaknesses

Clearly, given the autobiographical nature of all the data sources, there will be inaccuracies and discrepancies throughout which may skew the data. It is a valid point to suggest that the truth, may in some cases, have become distorted.

The exclusion of 20 of the originally selected subjects for reasons such as 'deemed to vulnerable' is, although ethically correct, a source of confounding. Perhaps those too vulnerable have been subject

to the greatest pre-flight traumas? The nature of ‘pre-flight trauma’ is also difficult to define and pigeon-hole into one category, and as such the data may not accurately reflect the true experience.

However, as a first foray into this area of interest, the paper creates an excellent baseline for future work and is meticulous in its level of ethics, compassion and understanding.

Unaccompanied Refugee Children
Huemer J, Karnik N, Steiner H
Lancet 2009; 373: 612-614

This article is a comment paper by three psychiatrists, designed to give a personal narrative on the issue of mental and emotional health problems amongst unaccompanied minors. Its purpose is to identify the problem, address the inadequacies of current service provision, and make suggestions for future improvement.

Strengths:

The paper gives an excellent overview of the issue of emotional and mental well-being and supports its statements with relevant statistics. It references two other papers frequently, and as such is almost an addendum to these studies, providing additional opinion and professional insight into the topic. It emphasises the need for change throughout, and sets out ideas for this relating to policy, healthcare and research. With its summary of the current issues, written by psychiatrists highly experienced in this field it is a good, concise starting point for those unaware of the plight of UASMs.

Limitations:

The paper is merely a comment article; it therefore parallels existing literature rather than adding new research. It is also a paper of opinion and personal viewpoints. Although it addresses the issues well, the use of language is generally rather emotive and as such is not entirely objective.
It is also commentary, whereby suggestions for future changes are made, and the case is stated for what *should* be policy at present. However, it is rather an idealistic stance that doesn't fully elaborate on how proposed changes should be enforced.

However, all things considered, this paper does what it sets out to do. It should be seen in the context of its aims. As a commentary on the current system from a professional's point of view, with their experience and insight, it is invaluable.

Discussion:

Unaccompanied refugee children are a particularly important group within the already emotionally vulnerable asylum seeker population[3,13]. The legal and health issues that they face are numerous and complex, increasing the levels of stress to which they are already subject[3-10,13,14].

In 2008, the greatest numbers of UASMs were arriving from Afghanistan (42%), Iraq (11%), Iran (9%) and Eritrea (9%)[20]. The age distribution for 2007 was as follows (figure 4)[20]:

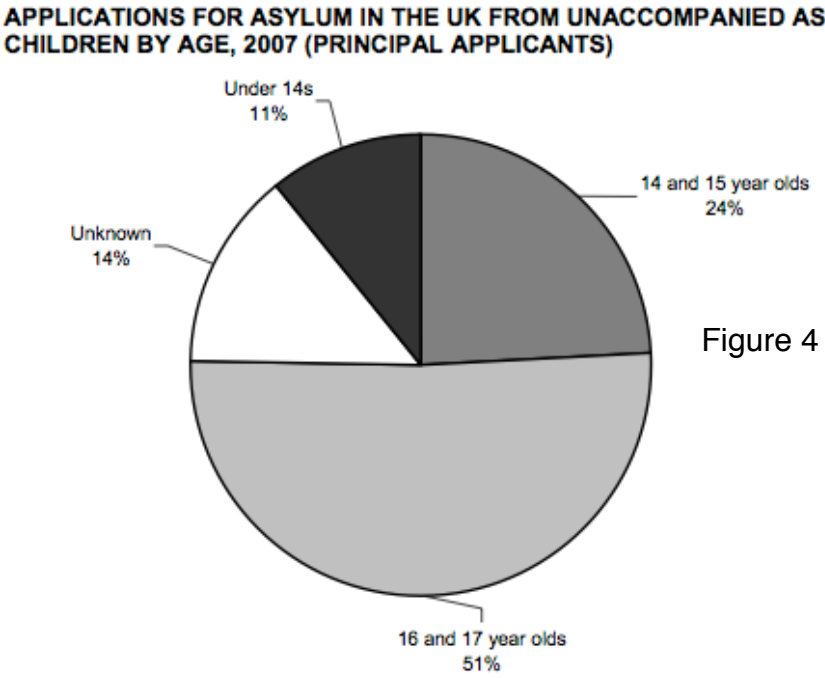


Figure 4

These children have, in general, witnessed, and been affected by greater levels of trauma, and experienced greater losses than their accompanied counterparts[3-9,13,22]. Significantly higher levels of enforced separation, murder or unnatural death of family/friends, torture, kidnap, ill health and life endangering experiences including physical/sexual mistreatment have been described by the unaccompanied cohort[4-7]. This has been a consistently reproducible finding in several studies comparing the pre-flight experiences of unaccompanied and accompanied children[4-7].

Primary reasons for flight amongst this group have often been attributed to (table 3)[4]:

table 3	**Primary reason for flight**
1	death or persecution of family members
2	persecution of young person

table 3	Primary reason for flight
3	forced recruitment
4	war
5	trafficking
6	education
Sexual violence has also been cited by up to a quarter of various girls. It is also relatively common amongst the males[4].	

Trauma

When it comes to the number of extreme traumatic events, UASMs (63%) were more likely to have experienced four or more episodes than those with families (16%)[22]. This is of importance as it is known that the number of traumatic episodes experienced correlates with the presence of PTSD and other emotional problems[3-7,22]. It is for this reason that UASMs are such a significant group with regards to service provision.

Mental Health

UASMs have been shown to exhibit a significantly higher prevalence of depressive disorders, borderline personality disorders and psychosis than their accompanied counterparts. Indeed, between 37-47% of a sample of UASMs in Belgium were shown to have severe or very severe symptoms of anxiety, depression and post-traumatic stress on the basis of several questionnaires (HSCL-37A, SDQ-self, RATS)[5]. A high prevalence of internalising problems and, in some cases, externalising problems were also identified by social workers[5].

Unaccompanied children also often have great regulation difficulties, such as sleeping and eating, as well as somatic complaints (often stomach pain and headaches), depressive feelings and hallucinations/delusions[3-6,13,22]. The frequency of PTSD and depression (according to DSM-IV criteria) has been put as high as 85% and 36% respectively within this community according to two studies[5,22].

Particularly vulnerable groups within the UASM population are girls, those witnessing a high number of traumatic events and those living in low-support living arrangements[3-6].

It has been shown repeatedly over the past century that asylum seeking children are a vulnerable group in terms of emotional and mental health, as well as behaviourally. This has been identified during war-time migration in the '30s and 40's and in more recent conflicts[3]. However, it is only more recently that unaccompanied minors have been identified as such a particularly high risk group. With unquestionably higher levels of PTSD, anxiety, depression and bereavement than their accompanied peers (and certainly their non-migrant counterparts[3-7,13,14,22]), the issue as to what type of services should be commissioned and what specific needs must be met remains.

Legal Issues and Service Utilisation

Referral pathways to mental health clinics has been shown to differ greatly between different groups due to the levels of aid available[7,23]. Whilst accompanied children were often identified by nurses working in their specialist hostel or even by their GPs, UASMs with little access to the same services (particularly the hostel nurses) were primarily referred by social services[23]. Even upon referral, the UASMs attended fewer, and missed significantly greater numbers of appointments[23].

There are also other unexplained discrepancies between the groups. Although trauma focused interventions differed little between accompanied and unaccompanied minors, the accompanied children received a greater variety of stabilisation work and were more likely to receive cognitive therapy, anxiety management and carer training[23]. Another unacceptable finding was that the UASMs were significantly less likely than their accompanied peers to receive assistance with education and leisure activities, crucial in improving their integration into UK society[9,10,23]. Similarly, they were significantly less likely to receive legal assistance, thus exacerbating anxiety of their insecure asylum status[10,23].

Unmet Need

These findings imply the lack of a continuity of care package within the UK for such vulnerable groups as well as highlighting the numerous barriers in accessing health-care and other services. For those unfamiliar with the UK system, language and culture this merely serves to enforce social isolation and adversity[10,13].

It was also shown in one sample that due to the relatively older age of UASMs as compared to accompanied minors, 43% were receiving the lower tier of support under Section 17, thus facing the minefield of accessing mental health services without the assistance of a social worker/foster carer and with only negligible funds[23]. In addition to this, counselling to deal with grief is often scarce.

Only 36% of UASMs and 31% of AMs had received some level of this despite the fact that 96% and 48% respectively had suffered bereavement[23]. Numbers such as these would indicate that there is a significant level of unmet need amongst the community.

Solutions

With the need for improved services and policy evident, the question remains how to go about tackling the issues. Several methods have been proposed, although the effectiveness of these proposals is unknown as various cultural and social issues play a role in their acceptance[23,24]. Mistrust of authority, the idea of 'shame' and the stigma reserved for mental health issues are barriers to uptake that must first be addressed[15,23,24].

Perhaps the most easily recognisable solutions are those that have been identified in several studies. It is known that those UASMs who have contact with peers from a similar ethnic background/ nationality and live in high-support environments have lower levels of mental and emotional health problems[5,7,9,23]. A sense of belonging in situations where the vital protective influence of a parent is absent is essential in improving overall well-being[9].

Indeed, the most obvious measure of improvement is the closure of living environments that reduce autonomy, that mean living alone or that restrict interaction with similarly aged and culturally alike children[5,7,23,24]. Full-time education that encourages integration rather than merely assimilation, has also been highlighted as a necessity[24]. The ability to learn the language, socialise and have contact with teachers (who should take a more active role in identifying emotional problems) has been a positive suggestion[23,24]. A high-support living arrangement and way of life would, it has been hypothesised, result in less psychological distress to the child[9,23].

Another study that reevaluated 11 asylum seekers in Sweden 20 years after their initial arrival raised the issue that although the majority had integrated well into society, most were still socially restricted to those of their own ethnic group; contact with others being limited to the work environment[2]. Most were content, although loneliness was an issue addressed by several. The authors also highlighted the need for health care professionals to be sensitive to the needs of asylum seekers long after their arrival in the host country, as symptoms of PTSD persist and still have significant impacts on their lives[2],

With all of these issues in mind, it has also been suggested that victimisation, and application of the sick-role to asylum seekers (and children in particular) can be detrimental and counterproductive, with resilience of the UASMs being underestimated[7]. Opportunities for social integration, building of friendships, education and ultimately a sense of belonging within a society were said to be the most important focus for any future schemes[7].

In Summary

Ultimately, it has been said on innumerable occasions that asylum seeking children should, first and foremost, be considered as children rather than merely a subgroup within the asylum seeker population[14]. The fact they are unaccompanied is something that has not occurred in isolation without the influence of other traumatic and sometimes prolonged experiences of violence and fear[3-7].

The arduous and unknown journey they have faced to escape these problems, and the shock of culture, language and occasionally racism and distrust they have received upon arrival in their host-country contributes to their significantly elevated levels of mental, emotional and behavioural problems[3-8,13-15].

It is vital that these issues are addressed and all possible assistance is given to aide their transition into a new society. Policy, quotas, political and media spin are irrelevant in cases of child health. It is a Global Health issue that children in this situation are protected and incorporated fully into the health system[15]. Likewise it is essential that the international community does its upmost to the resolve conflicts, dictatorships, natural disasters and famine that are responsible for these displaced peoples[25].

Too much onus is often placed on voluntary groups and organisations in the assumption that they can manage the workload[8]. Whilst non-governmental organisations do, and should, have an important role, this should not be a role placed on them by governments too keen to pass the buck and garner votes. The right to health, well-being and acceptance should not be something that must be fought for.

Global Health perspective on asylum and related issues:

> *" Today, we recognise the millions of people who count on us for their very survival. The one billion people affected by hunger. The tens of millions forced to flee their homes because of disaster and conflict. The children who die from diseases we know how to cure. The women and girls who are brutalised by sexual violence. We need to tackle these problems at their root. But until we do, lives will hang in the balance. And the humanitarian community will be on the scene, rushing bravely towards danger, determined to help people in need"*[25]
>
> UN Secretary General Ban Ki-Moon
> Remarks to launch the first World Humanitarian Day, UN Headquarters, 19 August 2009

The above quote illustrates the work done by the United Nations and the vast number of non-Governmental organisations who work tirelessly to improve the lives of asylum seekers and those in need. The process is not merely reactive, but instead serves to prevent disasters (natural or man-made) wherever possible[25]. War and conflict, a source of incomprehensible trauma, are tackled head on with diplomacy to reduce, as much as possible, the human and emotional impact. Natural disasters are also addressed by the provision of 'early warning systems' which give countries time to prepare for the impending onslaught[25].

Similarly, climate change is a subject of extensive research and plentiful resources. The impact of climate change on the world's poorest people will be, and indeed already is, profound. The spread of disease, flooding, direct deaths, conflict, scarce water supplies and agriculture all lead to immense human suffering and the displacement of vast numbers of people[26]. Sustainable development and the reduction in biodiversity are issues currently being targeted[26]. The provision of clean, safe drinking water and sanitation is also a priority[26].

However, potentially one of the most important issues relating to asylum and flight from ones native country, is that of equity. It has been said that, "...the lifesaving potential of improving equity is far greater than that of any new technology or combinations of technologies that could be introduced in the future."[27]

This is particularly the case relating to gender equality. Currently, of the 100 million children not

attending school, two-thirds are girls[26]. In this sense, these young girls are missing out on the opportunity to break free of the cycle of poverty. They are constrained by their lack of education, and this impacts not only on their own future but that of their children[26].
Educated women have healthier children, increased life expectance and economic productivity, and decreased levels of poverty amongst others[26].

It is by facilitating the health and well-being of children that nations can rise from the cycle of poverty and conflict. Millennium Development Goal 4 states that, "children are a critical component of healthy communities. If they are to contribute to the security, economic growth and civic stability of nations, they must be healthy, well-educated and survive to adulthood."[26] It is the role of the Global Health Council to facilitate the success of the Millennium Development Goals scheme, which should improve the lives of people around the world[26].

By improving the health and well-being of nations at their heart, the number of people who feel their only choice is to flee should be markedly reduced. The resolutions of conflicts; the awareness of, and preparedness for impending natural disasters; fair and democratic societies with good healthcare and education systems are all essential in saving and improving lives globally. The dedicated work of the many organisations and individuals within this field continues to raise the hopes that global improvement and equity are not merely a naive fiction, but a distinct possibility, and a Right for all.

Conclusions

- Social awareness of the perils faced, and trauma experienced by displaced peoples and asylum seekers is sadly lacking. The working knowledge of the general public and the myths propagated by the tabloid press have led to unnecessary and unwarranted anger and distrust.
- The plight of children, especially those who are unaccompanied, is an oft neglected area of discussion within the literature and amongst the 'asylum sector' as a whole. The provision of services for those with specific needs and for those who are most vulnerable, is limited, underfunded and of only moderate benefit. Children are often seen, and treated as *asylum seekers* rather than *children* and this is to the detriment of the integration and education within their new country.
- The current asylum system is contradictory and at worst unfathomable. The difficulties faced by asylum seekers in finding appropriate translation and legal services, and the aggressive, adversarial nature of the process causes further upset and emotional stresses. The vagaries and complex nature of the process, coupled with the policy of destitution upon failure of application clearly does not work and merely erodes a persons' dignity and human rights.
- Removal of healthcare provision is a subject of much debate. It ignores a persons right to health and it leaves healthcare professionals with an impossible ethical dilemma. The use of detention centres (often cited as a political gesture) is also an inhumane, ineffectual policy that should be addressed.

Recommendations

- Improve the quality and consistency of decisions on who should be given asylum. The system should be inquisitorial and non-aggressive, seeking to better understand a persons plight, and should reach a fair decision, even if this means simply granting a temporary right to remain for those who cannot return home.
- Housing and financial support should be fair, adequate and continuous. Asylum seekers should receive a sufficient amount of money (rather than vouchers) to live on, that is in line with current UK costs of living. The use of vouchers enforces poverty and does not aid integration into the wider community. Housing should also be adequate and properly habitable. The use of housing in deprived areas, often predisposes to poverty and the experience of racism and distrust.
- Those asylum seekers who are refused asylum should not be made destitute and forced removal should be an absolute last resort. Voluntary return should be encouraged, as this is a scheme that has been used to great success in Sweden and Canada.

- The public should be made better aware of the distinction between the different forms of immigration, and should be aware of the workings of the current system.
- Detention centres should be abolished. No purpose is served but that of politicians satisfying media hysteria.
- Further research should be commissioned that will allow better service provision for asylum seekers. A better understanding of needs and culturally appropriate services would be greatly beneficial. The needs of specific groups, specifically children should also be adequately researched.

Limitations/further study:

Limitations
The literature on the specific topic (that of the mental health of UASMs) was scarce. There were only a handful of studies exploring this area, and as such it is difficult to expand too much or draw ones own conclusions.
The vagaries of the asylum system mean that some articles are themselves contradictory or are subject to confounding. Also given the mainly qualitative nature of the literature, it was often difficult to assess and select articles that did not show bias or some level of inaccuracy.
The word count is a difficult restriction as it does not enable in depth discussion. With a subject so complex and so many issues to address, this is a genuine barrier.
The constraint of one day per week in which to attend various centres, research and write up was very difficult in the context of all the other work ongoing from the course.
This paper focuses on only one, very narrow, subject of interest. This can only be viewed as part of the bigger picture. A much broader, encompassing paper, which allows the issue of unaccompanied minors to be seen in the context of the asylum system as a whole would be an ideal, and perhaps a subject that could be addressed in future.
Further study: - to further explore the impact of flight and asylum seeking on children, and the consequences of this experience as an adult (i.e. a longitudinal approach). - to further explore the provision of services for asylum seekers: how these are decided upon and commissioned, and on the basis of what research etc.

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Appendix 1

Reflection

Throughout this SSM I have, unfailingly, been amazed by both the issues and the people I have come across. I have been astonished at the plight of asylum seekers and the frankly embarrassing reception they receive upon arrival in the UK. Admittedly, I had previously been rather ignorant with regards to asylum seeking (in fact, I probably wouldn't have been able to accurately define 'asylum seeker') and my knowledge was based purely on the contents of the 6 o'clock news.

This 20 week exposure to asylum health and government policy etc, has been nothing short of an eye-opener. I would go as far as to say it has changed my perspective on a variety of issues and has made me far more appreciative of the liberties which we take for granted as UK nationals.

The people I have met, their characters and their astonishing resilience will certainly stay with me for the duration of my career, and I hope that the insight I have gained will enable me to be a better doctor in the future.

I would strongly recommend this SSM to anyone, and feel that all students would benefit immeasurably from exposure to the issues and plight of asylum seekers.

From a personal point of view, my enjoyment of this SSM has led to me becoming a committee member of Liverpool Friends of Medecins Sans Frontieres and, additionally, despite being placed in Blackpool for the duration of next year, I will be endeavouring to stay involved with services for Asylum Seekers based in Liverpool and the wider North West region.

Appendix 2

DEFINITIONS

- A **refugee** is a person who "owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of his nationality, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country…"

This is in contrast to:

- "An **asylum seeker**: someone who has travelled to another country and exercised their right to apply for protection by making themselves known to the authorities.
- A **'failed' or 'refused' asylum seeker**: someone who has applied for protection in a country but that application has been refused and they have not gone home.
- An **illegal immigrant**: someone who has entered another country and not made themselves known to the authorities or entered legally for a temporary period but overstayed their visa or permit's duration.
- An **economic migrant**: someone entering another country primarily to look for work"[8].

- An **unaccompanied minor** is : "a person who at the time of making the asylum application
    - Is or (if there is no proof) appears to be under 18
    - Is applying for asylum in his/her own right
    - Has no adult relative or guardian to turn to in this country."[10]

- **Depression:** is a common mental disorder that presents with low mood, loss of interest or lack of pleasure derived from previously enjoyable things, feelings of guilt or worthlessness, disturbed sleep or appetite, lethargy and poor concentration amongst others. This may ultimately lead to substantial reductions in an individuals capacity to take care of his or herself and their responsibilities. At its worst depression can lead to suicide[9,15,24].
- **Suicide:** is the process of purposefully ending one's own life[9,15,24]

- **PTSD:** an anxiety disorder that develops after exposure to a terrifying event or ordeal in which grave physical harm occurred or was threatened[24]. The symptom(s) seriously interfere with leading a normal life and may include:
    - flashbacks/nightmares (reliving the episode); avoidance of social contacts or reminders of the event; losing interest in life; dulled emotions and a sense of derealisation; constant anxiety; and somatic symptoms (e.g. insomnia)[9,15,24].

Appendix 3

The Millennium Development Goals[29]:

1. Eradicate extreme poverty and hunger
   - Halve, between 1990 and 2015, the proportion of people whose income is less than $1/day.
   - Achieve full and productive employment and decent work for all, including women and young people.
   - Halve, between 1990 and 2015, the proportion of people who suffer from hunger.

2. Achieve universal primary education
   - Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling.

3. Promote gender equality and empower women
   - Eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015.

4. Reduce child mortality
   - Reduce by 2/3, between 1990 and 2015, the under 5 mortality rate.

5. Improve maternal health
   - Reduce by 3/4, between 1990 and 2015, the maternal mortality ratio.
   - Achieve, by 2015, universal access to reproductive health

6. Combat HIV/AIDS, malaria and other diseases
   - Have halted by 2015 and begun to reverse the spread of HIV/AIDS.
   - Achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it.
   - Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases.

7. Ensure environmental sustainability
   - Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources.

- Reduce biodiversity loss, achieving by 2010, a significant reduction in the rate of loss.
- Halve, by 2015, the proportion of the population without sustainable access to safe drinking water and basic sanitation.
- By 2020, to have gained a significant improvement in the lives of at least 100 million slum dwellers.

8. Develop a global partnership for development
   - Address the special needs of the least developed countries, landlocked countries and small island developing states.
   - Develop further an open, rule-based, predictable, non-discriminatory trading and financial system.
   - Deal comprehensively with developing countries' debt.
   - In co-operation with the private sector, make available the benefits of new technologies, especially information and communication.

Appendix 4

The GMC Duties of a Doctor[30]

Patients must be able to trust doctors with their lives and health. To justify that trust you must show respect for human life and you must:

- Make the care of your patient your first concern.
- Protect and promote the health of patients and the public.
- Provide a good standard of practice and care
  - Keep your professional knowledge and skills up to date.
  - Recognise and work within the limits of your competence.
  - Work with colleagues in ways that best serve patients' interests.
- Treat patients as individuals and respect their dignity
  - Treat patients politely and considerately.
  - Respect patients' right to confidentiality.
- Work in partnership with patients
  - Listen to patients and respond to their concerns and preferences.
  - Give patients the information they want or need in a way they can understand.
  - Respect patients' right to reach decisions with you about their treatment and care.
  - Support patients in caring for themselves to improve and maintain their health.
- Be honest and open and act with integrity
  - Act without delay if you have good reason to believe that you or a colleague may be putting patients at risk.
  - Never discriminate unfairly against patients or colleagues.
  - Never abuse your patients' trust in you or the public's trust in the profession.

You are personally accountable for your professional practice and must always be prepared to justify your decisions and actions.

Appendix 5

10 best resources/key contacts

- Dr Joseph O'Neill
  Global Inclusion
  Telephone: 0151 355 4008
  Email: global.inclusion@yahoo.co.uk

- Siobhan Harkin
  as above

- Dr Carmen Camino Maroto
  Anson House
  25 Anson St, Liverpool
  LATH LSTM
  Telephone: 0151 291 2751
  Email: ccamino@lath.com

- Asylum Link
  7 Overbury Rd,
  Kensington, Liverpool
  Telephone: 0151 719 1713

- Nurse Sue Rixon
  LINK Clinic
  Liverpool Women's Hospital
  Telephone (via Susan Smith): 0151 708 9988
  Email: susan.smith@lwh.nhs.uk

- Kieran Lamb
  Fade Library
  Regatta Place, Summers Rd

Brunswick Business Park, Liverpool

L3 4BL

Telephone: 0151 285 4493

- HMP Kennett

  Parkbourne, Maghull

  L31 1HX

  Telephone: 0151 213 3146

- STAR Asylum Women's Group

  International Group,

  2nd Floor Liverpool Guild of Students,

  Mount Pleasant, Liverpool

- Merseyside Network for Change

  35 Bold Street, Liverpool

  L1 4DN

  Email: info@merseysidenetworkforchange.org

- The Liverpool 'Health Inequalities on the Undergraduate Medical Curriculum' Conference.

  Liverpool Medical Institution,

  114 Mount Pleasant, L3 5SR

10 best websites

- WHO: www.who.int
- Global Health Council: www.globalhealth.org
- The United Nations: www.un.org
- The Refugee Council: www.refugeecouncil.org.uk
- Medact: www.medact.org
- The Centre for Social Justice: www.centreforsocialjustice.org.uk
- Refugee Action: www.refugee-action.org.uk
- Home Office (statistical bulletins): www.homeoffice.gov.uk
- Department for International Development: www.dfid.gov.uk
- World medical Association: www.wma.net

Useful books:

Asylum seekers and refugees in the contemporary world [electronic book] by David J. Whittaker.

Broken spirits : the treatment of traumatized asylum seekers, refugees, war, and torture victims. Edited by John P. Wilson, Boris Drozdek

Timetable:

Month	Week beginning	Activity
1	4 Jan 2010	Introductory session at Sheill Park with Health Visitors 1st convenor review at Brook Place
	11 Jan 2010	Session at the FADE Library
	18 Jan 2010	Global Health Session with Dr Camino in Anson House
	25 Jan 2010	Scheduled session at Asylum Link
2	1 Feb 2010	Attended LINK Clinic at Liverpool Women's Hospital. Sat in with Sue Rixon's during the morning clinic. Was able to write a case history for one of the patients.
	8 Feb 2010	Private study: began background reading on the topic of asylum. Chose an article on which to do my Journal Club presentation
	15 Feb 2010	Convenor meeting at Everton Rd Health Centre. Presented Journal Club Article Attended STAR Asylum Women's Group Session at the Guild of Students.
	22 Feb 2010	Private study: further background reading
3	1 Mar 2010	Attended HMP Kennett for prison visit. Was given a tour and sat in on the morning clinic with GP.
	8 Mar 2010	Private study: began researching more specifically on my chosen topic.
	15 Mar 2010	Private study: reading through potentially relevant articles
	22 Mar 2010	Private study: further article research and appraisal. Email correspondence with Merseyside Network for Change and LASAR to find out about relevant schemes and services.
	29 Mar 2010	Private study: began to structure my ssm and commit to paper
4	5 Apr 2010	Continued writing up my ssm with ongoing critical appraisal.
	12 Mar 2010	Finished researching statistics for my ssm. Further writing up.

Month	Week beginning	Activity
	19 Apr 2010	Prepared a poster and accompanying presentation for the 'Health Inequalities in the Undergraduate Medical Curriculum' conference.
	26 Apr 2010	Presented poster with accompanying powerpoint handouts at the Conference. Continued writing up my ssm, moving onto the discussion section.
5	3 May 2010	Completed methods section of my ssm.
	10 May 2010	Completed the discussion and global health section of my ssm. Convenor review at Everton Rd Health Centre: rough copy of ssm seen.
	17 May 2010	Finalised references, checked spellings and grammar.
	24 May 2010	Printed and bound final copy of ssm. Hand in