ASYLUM SEEKING AND REFUGEE CHILDREN –
WHAT ARE THEIR HEALTH NEEDS AND ARE THEY BEING MET IN THE UK?

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SSM 1 – FEBRUARY 2011

DR O’NEILL

WORD COUNT – 3,3000
“I just still remember those eyes. I was so scared, yeh?, but I didn’t want them to see that I was scared. ‘Cos I see worse things yeh? But it was a totally different environment. I didn’t even want to tell them my name or where I came from like .. .. But they treat me like an animal—that is the worst thing.”

Kenneh, aged seventeen came from Liberia when he was 13.(2)
Abstract

Introduction: Thousands of asylum seekers enter the UK every year. Many of them are children and many are unaccompanied. Their health needs are vast and can be physical or mental, stemming from a variety of situations. This review aims to find out how these children’s health needs are being met in the UK.

Aim: To discover the specific health needs of asylum seeker and refugee children in the UK and to see how and if the health services meet their needs. This paper will look at the effect of detention on the mental and physical health of children as well as unaccompanied children.

Method: The search engines AHMED, BNI, CINAHL, EMBASE, Health Business Elite, HMIC, MEDLINE and PsycINFO were used to search for journal articles that were critically appraised before being discussed.

Results: That asylum seeker and refugee children experience a wide range of mental disorders stemming from pre/post/arrival trauma. This can present itself as depression and PTSD in older children or as sleep disturbances, loss of appetite and enuresis in younger children.

Conclusion: Post-traumatic stress disorder is prevalent in these children. As health needs are not met sufficiently so their mental health deteriorates. There is a gap in services for children especially as they become young adults. There is also a conflict of views when it comes to counselling and helping children with mental health problems. There is still a need for more research in relation to the health needs of asylum seeker children in the UK.
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6 – Maslow’s Hierarchy of Needs
7 – Positive Change Diagram
8 – Power point Presentation
9 – Key Contacts
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Learning Objectives

- Explore the specific health needs of asylum seeker and refugee children and assess whether their needs are being met in the UK.
- Investigate the problems that arise when children are detained.
- Discuss the challenges unaccompanied child might face.

Acknowledgements

Thank you to Dr O’Neil and Siobhan Harkin for organising an interesting SSM and giving the group lecture days and the means to visit organisations run for asylum seekers.

Thank you to the many organisations that were visited during the month and the informative information that was provided. These include volunteers and staff from LASAR, Asylum Link Merseyside and the Welsh Refugee Council in Wrexham.

Thank you to Mr. Kieran Lamb at the Fade Library who has helped considerably to the understanding of searching databases and writing up the methodology.

Thank you to Dr Rumona Dickson for giving a very informative lecture tutorial on systematic reviews.

Thank you to the asylum seekers met during the month, especially those at Asylum Link Merseyside who were willing to talk and share their stories.
Introduction

Everyone is entitled to basic human rights, irrespective of age, education, race or economic status. The UN’s Convention on the rights of a child applies to all children, “whatever their race, religion or abilities; whatever they think or say, whatever type of family they come from. It doesn’t matter where children live, what language they speak, what their parents do, whether they are boys or girls, what their culture is, whether they have a disability or whether they are rich or poor. No child should be treated unfairly on any basis.” (3)

This quote states that children all over the world have the same rights and this includes children who are asylum seekers and refugees. The UK signed the 1951 Geneva Convention Relating to the Status of Refugees which states that if an individual is fleeing from persecution or harm then they should receive asylum. (4)

Children are a vulnerable group in society especially when they come from distant countries and cultures. Many have had traumatic and distressing experiences and then suffer the trauma of travelling long distances and settling into new environments. (5) Their experiences can include physical and sexual abuse as well as torture and the emotional trauma of witnessing family members being beaten, raped or killed. (6) Therefore it is essential that such children have good medical care on arrival in the UK.

Asylum seeker children have the same general needs as other children as well as needs unique to their situation. These stem from the fact that they are living in a totally new and different environment to which they are accustomed. There is a three stage experience process which includes the circumstances causing them to leave their country in the first place, secondly the long journey to an unfamiliar place and thirdly, adjusting to a new society and culture. When children arrive in the UK, especially when they are unaccompanied, they will often fulfil the criteria for Maslow’s hierarchy. Maslow’s hierarchy (Appendix 6) runs as follows – physiological needs, safety needs, belonging, esteem and self-actualization. To be able to treat and help them, it is first required to tend to their basic immediate needs. (7)
Asylum seekers are a vulnerable group in society and are often marginalised even in 21st century Britain.\textsuperscript{(8)} This brings up ethical implications for society and to the way health care professions treat all members of society including refugees and asylum seekers. Doctors should always treat their patients on an individual and fair basis and should provide the utmost care for the patients that put their trust in them whatever their social or economic status. Doctors must adhere to the GMC Guidelines the ‘Duties of a Doctor’\textsuperscript{(23)} (Appendix 1) as well as following ‘Beauchamp and Childress’ Four Ethical Principles.’\textsuperscript{(24)} (Appendix 2).\textsuperscript{(9)}

Thousands of asylum seekers enter the UK every year. In 2009, 29,800 people were seeking asylum in the UK. The UK ranks 16th amongst European states for the number of asylum claimants per 1000 inhabitants.\textsuperscript{(10)}

\textbf{Figure 1}\textsuperscript{(10)} - Main nationalities of asylum seekers entering the UK in 2009.

In 2009, the highest percentage of asylum seekers coming to the UK was from countries with a high risk of war, civil conflict and human rights violations.\textsuperscript{(11)}

Figure 2\textsuperscript{(12)} shows the nationalities of unaccompanied children claiming asylum in the UK in 2009. This data shows that the figure of children entering the UK is close to 3,000 and a large number of them are from Asia & Oceana and Afghanistan. Of the asylum seekers from the whole of Africa, 225 out of 630 came from Eritrea.
The Home Office received 23,520 asylum applications in 2006. 12% of these were unaccompanied asylum seeking children under the age of 18, the table below displays what happened to these children.\(^5\)

<table>
<thead>
<tr>
<th>Granted Asylum</th>
<th>Humanitarian Protection</th>
<th>Refused Asylum</th>
<th>Discretionary Leave Until 18th Birthday</th>
</tr>
</thead>
<tbody>
<tr>
<td>7%</td>
<td>&lt;1%</td>
<td>22%</td>
<td>71%</td>
</tr>
</tbody>
</table>

The aim of this SSM is to look at the different health needs that asylum seeking children have and to look at the services provided for these children.
**Definitions**

An **asylum seeker** is a person “who has asked to be recognised as a refugee and is waiting for the government to make a decision. They have made themselves known to the authorities and are part of an ongoing legal process.” *(27)*

A **refused asylum seeker** is a person “who has had their claim for asylum turned down. The Home Office has decided that they do not fall under the definition of a refugee according to the 1951 UN Convention.” *(27)*

A **refugee** “is someone who is in need of protection and would be at risk if they returned home.” They have often “fled danger which could arise from war, political persecution, famine, economic crisis or natural disaster.” *(27)*

A **child** is a “human being below the age of eighteen years unless, under the law applicable to the child, majority is attained earlier.” *(28)*

A **unaccompanied children seeking asylum** is “an individual who is under 18 and applying for asylum in his/her own right, and is separated from both parents and not being cared for by an adult who by law or custom has responsibility to do so.” *(29)*

**Health** “is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.” *(30)*

**Inverse Care Law** states that “the availability of good medical care tends to vary inversely with the need for it in the population served.” *(31)*

**Health inequality** – “Health is profoundly unequal. Health inequality…exists between social classes, different areas of the country, between men and women and between people from different ethnic groups. The story of health inequality is clear: the poorer you are, the more likely you are to be ill and to die younger. That is true for almost every health problem.” *(32)*
The UK Border Agency (UKBA) “is an executive agency of the Home Office. The Agency manages and enforces immigration control in the UK, including applications for permission to stay, citizenship and asylum. It is responsible for policy development in these areas of law.”

National Asylum Support Service (NASS) Dispersal Programme
Asylum seekers are spread across the UK and away from London and the South East of the UK for economic and political reasons. Housing is most expensive and scarce in London and the South East and there is a pressure on the services provided for asylum seekers in these communities. This programme applies to asylum seekers needing long term accommodation and is managed by the Border and Immigration Agency.

Torture
Article 1 of the United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (1984) says
"Any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity.”

Human rights
“The right to life, liberty, to a fair trial, not to be punished for something that wasn't a crime when you did it, education, free elections, the right to marry and to start a family, respect for private and family life, peaceful enjoyment of your property, freedom from: torture, degrading treatment, slavery and forced labour, freedom of: thought, conscience, religion, expression, assembly and association and freedom to express your beliefs.”
**Post-traumatic Stress Disorder (PTSD)**

ICD 10 criteria – “The patient must have been exposed to a stressful event or situation of exceptionally threatening or catastrophic nature which would likely cause pervasive distress in almost anyone. There must be persistent remembering or reliving of the stressor in intrusive flashbacks, vivid memories or recurring dreams, or in experiencing distress when exposed to circumstances resembling or associated with the stressor.” (37)

**Depression**

“Depression is a common mental disorder, characterized by sadness, loss of interest or pleasure, feelings of guilt or low self-worth, disturbed sleep or appetite, low energy and poor concentration. These problems can become chronic or recurrent, substantially impairing an individual’s ability to cope with daily life. At its most severe, depression can lead to suicide.” (38)

**Poverty**

Absolute poverty was defined as "a condition characterised by severe deprivation of basic human needs, including food, safe drinking water, sanitation facilities, health, shelter, education and information. It depends not only on income but also on access to services.” (39)
Key Statistics of Asylum Seekers in Liverpool

The statistics in Figure 4, are a representation of the situation in Liverpool. Although these figures are supported by the Home Office, asylum seekers are moved and there are a number who are unaccounted for as they are destitute.

**Figure 4** – Liverpool’s regional statistics for asylum seekers who are supported by the Home Office.  

<table>
<thead>
<tr>
<th>Year end</th>
<th>Subsistence only support</th>
<th>In supported accommodation</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>25</td>
<td>1375</td>
</tr>
<tr>
<td>2008</td>
<td>40</td>
<td>1205</td>
</tr>
<tr>
<td>2007</td>
<td>80</td>
<td>810</td>
</tr>
<tr>
<td>2006</td>
<td>60</td>
<td>920</td>
</tr>
</tbody>
</table>

This table shows that the number of asylum seekers on subsistence support has decreased over the last four years and that the number in supported accommodation has increased. Asylum seekers who are on subsistence support, live in private accommodation.  

Figure 5 was taken from the paper “Planning Better Outcomes and Support for Unaccompanied Asylum Seeking Children”. After considering London and the South East, the North West comes second to the Midlands in receiving the highest number of asylum seeker children is August 2006.

**Figure 5** – The Total Number of Unaccompanied Asylum Seeking Children in Different Regions of the UK in 2006.
Figure 6, represents the dispersal of asylum seekers in the UK in 2001. This is following the NASS Dispersal Policy which aimed to move asylum seekers in private housing away from London and the South East. After Greater London, the North West (which includes Liverpool) received the highest percentage of asylum seekers. Refer to Appendix 5 for another map of the UK and the world regarding dispersal and migration.

**Figure 6 – The Dispersal of Asylum Seekers in the UK in 2001.**

Asylum seekers are given money to live on every week as they are forbidden to work. They receive cash payments at the Post Office. The current rates are shown below.

**Figure 7 – The Amount of Money Asylum Seekers Receive a Week in the UK.**

<table>
<thead>
<tr>
<th>STATUS</th>
<th>AMOUNT OF MONEY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Couple</td>
<td>£70.34</td>
</tr>
<tr>
<td>Lone parent, 18 or over</td>
<td>£42.62</td>
</tr>
<tr>
<td>Single person aged 25 over</td>
<td>£35.52</td>
</tr>
<tr>
<td>Person aged 16 to under 18</td>
<td>£38.60</td>
</tr>
<tr>
<td>Child under 16</td>
<td>£51.37</td>
</tr>
</tbody>
</table>
Media portrayal of asylum seekers
The media shapes people’s views and perceptions about what’s going on around them. This includes the way the public view asylum seekers and refugees and terms used such as “scroungers”, “illegal immigrant” and “terrorists” can lead to the public thinking of them as inferior people. The information given is often generalised and stereotypes these people. Statistics and information in some of the newspapers for example the Daily Mirror and the Sun are often exaggerated and the statistics aren’t properly referenced.\(^\text{(42)}\)

In October 2010, David Millward wrote the following on behalf of the Telegraph’s “This is an appalling legacy from the previous Government and its impact will be to encourage yet more **bogus** asylum seekers.”\(^\text{(43)}\) This is an example of the way asylum seekers are portrayed in the media.
Methodology

An initial search was carried out online using British websites such as BBC, STAR, Healthy Inclusion, Refugee Council and the UK Border Agency as well as using the Google search engine. Research involving journals, newspaper articles and books relating to asylum seekers and refugees took place in the library. All these searches provided background knowledge and a more detailed idea of the asylum process and its complications.

As well as using background knowledge to define the search, a PICO table was used:

<table>
<thead>
<tr>
<th>Search terms</th>
<th>Population</th>
<th>Intervention</th>
<th>Comparison</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asylum seeker and refugee children</td>
<td>Health care needs</td>
<td>N/A</td>
<td>Health care needs being met</td>
<td></td>
</tr>
<tr>
<td>Unaccompanied refugee and asylum seeker children</td>
<td>Psychological health needs</td>
<td>N/A</td>
<td>Decrease morbidity</td>
<td></td>
</tr>
<tr>
<td>Destitute refugee and asylum seeker children</td>
<td>Emotional health needs</td>
<td>N/A</td>
<td>Easy access to health services</td>
<td></td>
</tr>
<tr>
<td>Destitute refugee and asylum seeker children</td>
<td>Physical health needs</td>
<td>N/A</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

An online search for published papers relating to the question ‘Asylum Seeking and Refugee Children – What Are Their Health Needs And Are They Being Met In The UK?’ was performed by using a number of online databases and the following were used in this report – Ovid, Scopus and the NHS Evidence Health Information Resources website. This search resource included AHMED, BNI, CINAHL, EMBASE, Health Business Elite, HMIC, MEDLINE and PsycINFO. These search
engines were chosen as they contained a large amount of full text journals as well as other articles on health issues which provided a thorough enough search for this report. The Cochrane Collaboration was searched but no applicable articles were found.

Initially, a scoping search was performed and then a more detailed search using a combination of controlled vocabulary and common indexing words such as “asylum seeker”, “refugee”, “child” and “Great Britain”. When searching individual databases on the NHS Evidence website, the ‘map to thesaurus’ option was used to identify controlled vocabulary as in MeSH thesaurus in MEDLINE. As well as this, natural language was used to search multiple databases. These searches produced 260 papers and below is a copy of the search process –

Figure 9 is search performed using the NHS Evidence website, specifically showing the initial Medline search on 01/02/11

<table>
<thead>
<tr>
<th>No.</th>
<th>Database</th>
<th>Search Term</th>
<th>Hits</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>MEDLINE</td>
<td>exp &quot;REFUGEES OR exp &quot;EMIGRANTS AND IMMIGRANTS&quot;</td>
<td>6009</td>
</tr>
<tr>
<td>2</td>
<td>MEDLINE</td>
<td>&quot;asylum seeker&quot;</td>
<td>588</td>
</tr>
<tr>
<td>3</td>
<td>MEDLINE</td>
<td>1 OR 2</td>
<td>6153</td>
</tr>
<tr>
<td>4</td>
<td>MEDLINE</td>
<td>exp &quot;CHILD/&quot;</td>
<td>52082</td>
</tr>
<tr>
<td>5</td>
<td>MEDLINE</td>
<td>child* lab</td>
<td>66552</td>
</tr>
<tr>
<td>6</td>
<td>MEDLINE</td>
<td>4 OR 5</td>
<td>832840</td>
</tr>
<tr>
<td>7</td>
<td>MEDLINE</td>
<td>exp &quot;GREAT BRITAIN&quot;</td>
<td>2311</td>
</tr>
<tr>
<td>8</td>
<td>MEDLINE</td>
<td>(&quot;Great Britain&quot; OR &quot;United Kingdom&quot; OR UK OR &quot;Scotland&quot; OR &quot;Northern Ireland&quot;) lab</td>
<td>66552</td>
</tr>
<tr>
<td>9</td>
<td>MEDLINE</td>
<td>(England OR Wales) lab</td>
<td>52016</td>
</tr>
<tr>
<td>10</td>
<td>MEDLINE</td>
<td>(&quot;New England&quot; OR &quot;New South Wales&quot;) lab</td>
<td>6787</td>
</tr>
<tr>
<td>11</td>
<td>MEDLINE</td>
<td>9 not 10</td>
<td>24229</td>
</tr>
<tr>
<td>12</td>
<td>MEDLINE</td>
<td>7 OR 9 OR 11</td>
<td>102882</td>
</tr>
<tr>
<td>13</td>
<td>MEDLINE</td>
<td>3 AND 6 AND 12</td>
<td>31</td>
</tr>
</tbody>
</table>
**Figure 10** is the second part of the search performed using the NHS Evidence website showing all other databases used on 01/02/11

<table>
<thead>
<tr>
<th></th>
<th>Query</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>14</td>
<td>exp &quot;REFUGEES&quot; OR exp &quot;EMIGRANTS AND IMMIGRANTS&quot;</td>
<td>29425</td>
</tr>
<tr>
<td>15</td>
<td>&quot;asylum seeker&quot; OR ab</td>
<td>3079</td>
</tr>
<tr>
<td>16</td>
<td>14 OR 15</td>
<td>31227</td>
</tr>
<tr>
<td>17</td>
<td>exp &quot;CHILD&quot;</td>
<td>142776</td>
</tr>
<tr>
<td>18</td>
<td>child&quot;ab</td>
<td>2495246</td>
</tr>
<tr>
<td>19</td>
<td>17 OR 18</td>
<td>2490019</td>
</tr>
<tr>
<td>20</td>
<td>exp &quot;GREAT BRITAIN&quot;</td>
<td>9871</td>
</tr>
<tr>
<td>21</td>
<td>(&quot;Great Britain&quot; OR &quot;United Kingdom&quot; OR UK OR &quot;Scotland&quot; OR &quot;Northern Ireland&quot;)</td>
<td>367407</td>
</tr>
<tr>
<td>22</td>
<td>(England OR Wales) OR ab</td>
<td>145030</td>
</tr>
<tr>
<td>23</td>
<td>(&quot;New England&quot; OR &quot;New South Wales&quot;) OR ab</td>
<td>23826</td>
</tr>
<tr>
<td>24</td>
<td>9 not 10</td>
<td>121204</td>
</tr>
<tr>
<td>25</td>
<td>20 OR 21 OR 24</td>
<td>472821</td>
</tr>
<tr>
<td>26</td>
<td>16 AND 18 AND 25</td>
<td>260</td>
</tr>
</tbody>
</table>
Figure 11 is a QUORUM flow diagram identifying the steps taken to decide on the four articles chosen.
The title and abstract of the 260 papers were briefly looked at by doing a hand-eye search to exclude any irrelevant paper not concerning asylum seeker and refugee children’s health.

Inclusion Criteria

- Papers relating to accompanied and unaccompanied children asylum seekers and refugees
- Papers published after 2000.
- Papers of children who had been detained
- Papers concerning the health in the UK
- English language only.

Exclusion Criteria

- Papers including migrant and gypsy children.
- Papers concerning the health outside the UK.
- Papers in a foreign language
- Papers not provided free of charge

The CASP checklist was used to quality assess the four papers and the data was extracted into predesigned tables to illustrate themes in all papers. The data found was qualitative rather than quantitative resulting in the data being presented as a narrative rather than being analysed statistically. The table is shown in the Results section of this paper.

These key studies were chosen because they focus on the health needs of asylum and refugee children in the UK.
Results

The initial search resulted in 260 articles and 17 media related articles unfolding the health of children asylum seekers and refugees in the UK. A large proportion were discarded as they pre dated 2000 and there was 90 duplicate results.

The four articles chosen and are conclusive that all asylum seeking children have negative and traumatizing experiences. All papers were based on asylum seekers entering the UK and were all relevant. Despite this, Hopkins paper focused on Scotland alone and 80% of Chase’s paper focused on asylum seekers in London. Sutton’s paper only tells us that two social services departments were used. As a result these papers aren’t representative of the asylum seeking children population in the UK as a whole.

Lorek’s paper on detention centres is only a pilot study and although there was a detailed analysis and the findings were conclusive, there needs to be further and more in depth research in detention centres concerning children.

The articles that were found and chosen were qualitative and as a result have a small sample size which isn’t representative of the sample population. This is especially apparent in Sutton’s paper. Despite this there is consistency in their findings.
**Figure 12:** Key Subjects and Points in the Chosen Articles

<table>
<thead>
<tr>
<th>STUDY</th>
<th>RCT</th>
<th>Sample size</th>
<th>Gender</th>
<th>Age</th>
<th>PTSD</th>
<th>Depression</th>
<th>Detention experience</th>
<th>Had treatment for condition?</th>
<th>Sample area</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Agency and Silence: Young People Seeking Asylum Alone in the UK. – Chase (2)</td>
<td>No</td>
<td>54</td>
<td>Male and female</td>
<td>9 – 17 years</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>London</td>
</tr>
<tr>
<td>2. The needs &amp; strengths of unaccompanied asylum-seeking children and young people in Scotland. - Hopkins (7)</td>
<td>No</td>
<td>39</td>
<td>Male and female</td>
<td>15 – 17 years</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Scotland</td>
</tr>
<tr>
<td>Study 1</td>
<td>Agency and Silence: Young People Seeking Asylum Alone in the UK. Chase, E. (2)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Study 2</td>
<td>The needs &amp; strengths of unaccompanied asylum-seeking children and young people in Scotland. Hopkins, P et al. (7)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Study 3</td>
<td>The mental and physical health difficulties of children held within a British immigration detention centre: a pilot study. Lorek, A. (15)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Study 4</td>
<td>A qualitative study exploring refugee minors’ personal accounts of post-traumatic growth and positive change processes in adapting to life in the UK. Sutton, V. (16)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Figure 13: Casp Screening Questions**

<table>
<thead>
<tr>
<th>CASP screening questions</th>
<th>Study 1</th>
<th>Study 2</th>
<th>Study 3</th>
<th>Study 4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Was there a clear statement of the aims of the research?</strong></td>
<td>Explore factors affecting emotional well-being of young unaccompanied people.</td>
<td>Examining strength and weaknesses of services provided for unaccompanied minors.</td>
<td>Assess the mental and physical health of children held within a British immigration detention centre.</td>
<td>Explore the process of positive change and post-traumatic growth following trauma.</td>
</tr>
<tr>
<td><strong>Was the research design appropriate to address the aims of the research?</strong></td>
<td>Interviews conducted by other young people, topic guide used to draw out key aspects. Interviews recorded.</td>
<td>Interviews and group work with children and service providers.</td>
<td>Semi-structured clinical interviews and standardised self-report questionnaires.</td>
<td>Semi-structured interviews</td>
</tr>
<tr>
<td><strong>Was the recruitment strategy appropriate to the aims of the research?</strong></td>
<td>Participants chosen from three different teams. 80% from London.</td>
<td>Service providers identified by snowball sampling who then selected children.</td>
<td>Participants received free clinical assessment after responding to a charity offering free legal assistance.</td>
<td>Two social services departments used purposive sampling to identify young people who could give theoretical insight.</td>
</tr>
<tr>
<td>Question</td>
<td>Description</td>
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<tr>
<td><strong>Were the data collected in a way that addressed the research issue?</strong></td>
<td>Detailed notes made on first meeting, subsequent meetings recorded and transcribed.</td>
<td>Transcripts of interviews were coded to identify key themes.</td>
<td>Interviews with children in the presence of a parent. Medical records received from centre</td>
<td></td>
</tr>
<tr>
<td><strong>Has the relationship between researcher and participants been adequately considered?</strong></td>
<td>Initial meeting was informal at a neutral venue, other meetings more formal. Translator provided.</td>
<td>Group work through a social support group for unaccompanied children</td>
<td>Parents always present and siblings were interviewed separately.</td>
<td></td>
</tr>
<tr>
<td><strong>Have ethical issues been taken into consideration?</strong></td>
<td>Yes. Informed verbal consent obtained.</td>
<td>Consent and other ethical issues not mentioned.</td>
<td>Yes. Informed written consent. All answers kept confidential. Ethics committee attached to the author’s university gave approval for the study as did the NHS local research ethics committee.</td>
<td></td>
</tr>
<tr>
<td><strong>Was the data analysis sufficiently rigorous?</strong></td>
<td>Yes. Data matches, former research and the young people had similar opinions. Funded by Department of Health - potential bias.</td>
<td>Yes. Data agrees with former research and also gives insight into the main needs of unaccompanied children.</td>
<td>Yes. Data is supported by previous Australian studies. More research is needed in this area in the UK.</td>
<td>Yes, except the sample size should preferably be bigger.</td>
</tr>
<tr>
<td><strong>Is there a clear statement of findings?</strong></td>
<td>Yes. Findings are discussed in relation to original research aims. Findings have implications on how health professionals engage and work with young people seeking asylum alone.</td>
<td>Yes. Findings are discussed in relation to original research aims and points out where directives are not being met.</td>
<td>Yes. Suggests current UK policies regarding the detention of children should be re-examined</td>
<td>Yes. Professionals can have a role in helping young people rebuild their lives and decrease distress in the future.</td>
</tr>
</tbody>
</table>
Discussion

There are “120,000 refugee and asylum-seeking children in the UK”\(^{(17)}\) and every year around 3,000 unaccompanied children arrive in the UK.\(^{(18)}\) Many of these children are exposed to traumatic experiences before and after they arrive in the UK. They often have less protection than other UK children especially if they have spent time in detention centres and immigration ports.\(^{(17)}\) V. Sutton et al, states that these children are vulnerable and develop a “range of problems in biological, social and psychological functioning following their survival of multiple traumas.”\(^{(16)}\)

Many of the children arriving in the UK experience mental health problems often resulting from the isolation and loneliness caused by family separation. Unaccompanied children are at an even higher risk of medical and social problems as they are put into foster homes and under the care of the social services. As a result the level of care that the children receive is often dependent on the local authority area in which they live.\(^{(18)}\) It is important for these children to have the right amount of care and be provided with specialists to help them “overcome the effects of trauma” because they are “some of the most vulnerable people in society.”\(^{(19)}\)

Many asylum seeker children do not have a choice whether they leave their country or not, and the arrangements are usually organised by an adult in the family. An agent will be paid to take the child out of the country and to the UK.\(^{(2)}\)

There are many reasons why refugee and asylum seeking children may suffer mentally and physically. Many of these children will have PTSD and re-experience their traumas.\(^{(16)}\) Outlined below are the main reasons children can be affected by their circumstances.

**Housing**

The Immigration and Nationality Directorate “spends more than £140m a year” providing adequate care, support, housing and other services to 6,000 unaccompanied children in 130 local authorities around the UK.\(^{(20)}\)

Accommodation and housing is provided to asylum seekers and they are dispersed all over the UK through the NASS Dispersal Programme. Shelter reported in 2000 that the standard of asylum seekers houses was “dangerous” and of “appalling
quality”, 16% of these homes were occupied by children under 18 years old. Half of these children were sharing a single room with their families with basic bathing and cooking facilities. Other dangers in the report included high fire risks, overcrowding, dampness, poor sanitation and infestation. All these factors can have a serious effect on the physical and emotional wellbeing of children. (21)

Unaccompanied asylum seekers need safe, secure and consistent housing and if they have siblings in this country, it should always be a priority to keep them together in the same home. Some unaccompanied children live in hotels and hostels with the homeless which can be a disruptive and abusive environment. Living in these conditions can have a detrimental effect on these children’s emotional state and can increase the incidence of flash backs and PTSD from pre flight experiences. These places often have basic or no cooking facilities and as a result the children eat fast food. This can potentially increase the incidence of stomach aches and the need to see a doctor. (7)

Unaccompanied children can be placed in foster homes which gives them stability and a stable caring environment. (5)

**Detention**

There is a time delay during which asylum seekers are waiting to hear if they are allowed to remain in the UK legally. During this time there is always a possibility of being detained with little or no prior warning. Asylum seekers are often picked up early in the morning and are transported to other parts of the country to be placed in detention. This in itself can be a traumatic experience for children. If families are taken into a detention centre, they can be left for an indefinite amount of time. Children can be separated from their parents in different detention centres or put into foster families. On arrival at a detention centre, asylum seekers have their fingerprints and photo taken. Children are often intimidated by the detention centre itself as there is high security with barred, locked doors, uniformed staff, barbed wire surrounding the building and they are told to carry ID at all times. Chase states that being detained can be a negative experience and “the risk of exposure to additional stressors and trauma is high.....as riots, violence, hunger strikes, and incidents of deliberate self-harm, including deaths due to suicide, have been reported.” (15)
Asylum seekers can be detained for any length of time but even being in detention for a very brief period of time can seriously affect the physical and mental health of children. This can manifest itself in different ways, for example, children may stop eating and enuresis in older children is common. Detention centres have limited resources and so healthcare, education, the standard of daily living and quality of life is often compromised. There is a significant difference between the way patients are viewed and treated within a detention centre; as a result children can miss immunisations or regular hospital checkups for pre-existing problems. (15) (Appendix 3 is case study of a detained family.)

In 2004, there was a series of studies based on families who’d been detained for over a year to find out how children had been affected mentally. This study discovered that all the “children above the age of six fulfilled criteria for both Post Traumatic Stress Disorder (PTSD) and major depression with suicidal ideation.” As well as this, a majority of the children had attempted self-harm. In the children under school age, there was a significant delay in language, social and emotional development. The children experience anger, frustration, depression, anxiety, nightmares, difficulty sleeping and eating disorders. There was also a risk that babies in detention would be malnourished because their mothers were hungry and stressed and as a result their milk wasn’t meeting the babies needs. (15)

**Emotional Problems**

Many young asylum seekers experience emotional problems which range from anxiety and panic attacks to eating difficulties. These may be more apparent in a teenager as they approach their eighteenth birthday because their discretionary leave will be coming to an end and they will fear the possibility of deportation. There is a higher incidence of mental health issues at this time with all asylum seekers. (5)

**Stigma**

Many children and young adults are reticent to disclose that they are asylum seekers to friends because of the stigma and ‘scrutiny’ experienced by British society. Some will avoid situations where they have to disclose their situation, others will give the truth about being an asylum seeker and then “normalise” the judgements people in society and immigration display towards them. (2) Not being able to open up to people
in society, whether they are professionals or peers means that these children have to keep their experiences to themselves and this in itself can be a painful internal struggle. Despite this, some find it easier to “bracket” and not talk about the past and this means they can look forward and focus on the future and the next stage of their life.\(^{(2)}\)

There is also stigma involved with seeking medical/social help about an emotional problem. This often comes from other cultures and societies around the world as they see seeking help as a last resort and something negative. The Western world treats the mind as well as the body which can be confusing when talking about anxiety as often thought to do with “the heart” rather than the “mind”. Despite this stigma and avoidance of therapeutic care, many children do benefit from the help of the social services.\(^{(5)}\)

**Education/Socialising/Integration into Society**

It is important that these children are enrolled in a school as it will provide support, structure and wellbeing. A school environment is safe and secure, it is a normalising experience and although it can be a challenge if these children have had limited education or spoken English, they are often very intelligent and keen students.\(^{(7)}\)

It is important as these children rebuild their ‘shattered’ lives that they try and “include more positive perceptions of the self and others.”\(^{(16)}\)

This paper states that it is important for these children to attend social activities for intrinsic self worth and to make friendships. It is important that these children have an identity and feel they belong in the UK for their social and emotional wellbeing. Unaccompanied asylum seeking children are exposed to the potential experiences of isolation and feelings of loneliness and there is a need for outreach to these children to get involved. A social worker in Hopkins study claims these children need to enjoy life and try and forget their traumatic past. By getting involved and communicating with other people, these children will gain self worth and recognition.\(^{(7)}\)

The young women seemed to turn to church and religion more whereas the young men preferred to keep their faith private.\(^{(3)}\) Being religious also gives children “continuity” which is something that these children and young adults need.\(^{(22)}\)
The emotional needs of these children should be considered through counselling and reconnection with cultural origins whether this is by connecting with family in their home land, through religion or being informed of the political situation in their country. Unaccompanied asylum seeker children face many challenges, but one of the main ones is knowing how to cope with stress, anxiety and trauma relating to their pre flight experience. Hopkins suggests that therapy and counselling should be given after the children have settled and sorted other issues first. (7) (Appendix 7 shows coping strategies following trauma.)

**Health and medical needs**

Children asylum seekers should be immunised against diseases that children in the UK are immunised against. All asylum seekers should be screened on arrival in the UK for infectious diseases such as TB, Hepatitis B, sexually transmitted disease, gastrointestinal parasites and gastrointestinal infections. Unaccompanied accommodated asylum seeker children are often given a thorough medical assessment but older unaccompanied asylum seekers often do not receive this care despite the fact that they have often had more severe and traumatic experiences. (7)

The older an asylum seeker child is on entering the UK, the less support they have because there is an assumption they can look after themselves. Many teenagers arriving in the UK are getting very little support from social services and this could result in a struggle to complete benefit applications and integrate into society. (2)
Conclusion

Asylum seeker children have a range of health needs specifically PTSD, depression and anxiety. It is important to meet the children’s basic everyday needs first and then address their psychological needs regarding past trauma. These children experience stigma from friends and also professionals which can add to their health needs as they are reluctant to disclose information for fear of being stereotyped.

Detaining children exacerbates any pre-existing health problems these children might have whether they are mental or physical. Detention centres are not humane and children should not be detained.

It is clear that there are major inadequacies in the services provided for children asylum seekers. Children should be given as much support from social services and other health professionals as possible. Health providers need to show empathy and patience as these children re-experience and account their stories. This especially concerns older teenagers who at the moment do not receive the amount of care that they need. Unaccompanied children should preferably be put into foster homes with families who know about their culture and language. Service providers need to aim to meet the needs of these children by giving them, access to a range of supportive networks such as religious groups, voluntary work and leisure.\(^{(16)}\)

Despite their health needs scarcely being met, many of these children express positive experiences in the UK, for example “the freedom of speech” and also a “degree of safety, freedom and security that most would not have in their own countries”.\(^{(2)}\)
Anna Wiltshire

Recommendations for the UK and Liverpool

For the UK

- Provide free secondary care to failed asylum seekers like in Wales.
- The asylum application process should be revised to avoid effects it is having on asylum seekers health.
- Provide thorough medical investigations to young adults
- Put a stop to detaining children.
- Train medical professions to effectively treat asylum seekers needs
- Decide ways of decreasing stigma towards asylum seekers.

For Liverpool

- Integrate Global Health into the medical course as a compulsory module.
- To carry on providing services for the refugee and asylum seeking community.
- Social groups targeting children to join their clubs and activities to integrate these asylum seekers into society

Limitations

- Keeping to the 3,000 word limit
- Understanding how to write a structured review in global health
- The referencing software, Mendeley had a corruption known to the site during the month, as a result references in text boxes aren’t referenced in order with the rest of the SSM.
References


9. Gillon R. Medical ethics: four principles plus attention to scope [Internet]. BMJ. 1994 ;309(6948): Available from: http://www.bmj.com/content/309/6948/184.full#cited-by


Bibliography

Rutter J. Refugee Children in the UK. New York, 1999

Barnett C, Bhogal I. Becoming a City of Sanctuary, 2009
Reflection

I have learnt so much in the past month. I started the SSM as a very naïve first year medical student but I can happily say that my attitude towards asylum seekers has significantly changed. My knowledge of asylum seekers and refugees was limited and I was unaware to the extent this population suffers daily. I was shocked to read and hear what really goes on in the detention centres. Many of the people I met were my age or even younger and I have great respect for these people as they have been through more in their lives than I can ever imagine. When I was listening to some of the horrific stories at Asylum Link Merseyside, I felt as though I had gone back in time and I couldn’t understand how the UK could be so harsh towards such vulnerable people in the 21st century. My experiences have been illuminating and will shape the way I approach and treat asylum seekers in the future.

Participating in this SSM has motivated me to want to pursue a career in global health. I also feel it is my duty to tell my peers at medical school about what I have learnt.
Appendix 1

GMC duties of a doctor

Good Medical Practice: Duties of a doctor

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 the 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 2:

Beauchamp and Childress Four Principle Approach to Medical Ethics\(^2\)\(^4\)

This is a widely used ethical framework in medicine:

**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.
Appendix 3

Case Study – James Williams (name changed for confidentiality purposes)

James is from Malawi and came to the UK seven years ago with his wife and two daughters who were two and four at the time following a “political incident”. They initially came to the UK on a five year student VISA and have been claiming asylum for the last two years. They came to the UK because Jennifer (James’ wife) has three aunts who are British through marriage living in the UK.

When the James’ family first started claiming asylum, they didn’t hear anything for eight months and one early morning they were woken up and escorted out of their house and told that they would be going to Heathrow and then flying back to Malawi. The two girls were nine and seven and were getting ready for school. They were told to quickly pack anything they wanted to keep and were all put in the back of a van. Although they thought they were going to Heathrow, the van actually took the family from Preston to Scotland and then to Yarl’s Wood in Bedfordshire. During the journey, all of their conversations were being recorded. Their mobile phones were confiscated; James said it was “like being a hostage”

James and Jennifer were concerned about the welfare of the two girls and wanted them to stay with family members and James asked if he could use the mobile phone of the police who were driving them. They also phoned a friend in Preston who was a solicitor but he refused to represent them as they were over the border.

They arrived at Yarl’s Wood Detention Centre and they were checked thoroughly for chips, it was “awful” and felt “like prison”. The family was given two bedrooms with two beds in each. The two girls didn’t feel safe and so they dragged the mattresses into one bedroom so they were all together. The girls experienced many sleepless nights and couldn’t settle into the centre.

The family spent thirty five days at Yarl's Wood Detention Centre and then James was separated from the rest of the family and taken to Heathrow B Prison with ex-convicts for nine days while the girls were at the Gatwick Prison. As James was telling us his story, it was evident he was very distressed about all that had gone on.
They were informed that Yarl's Wood Detention Centre had the same standard of health care as the NHS although the only pain reliever they would give was paracetamol – whatever the problem. One of his daughters had braces and was due an appointment but wasn’t allowed to go and see an orthodontist and the onsite Doctor responded with “you are fine”. When they were in detention, there was another family with an epileptic mother and the Doctor’s refused to help her when she had a fit and James had to help her. Another family from Uganda had a five month old baby who was struggling to breathe. The onsite doctor gave paracetamol but didn’t help the infection that the baby was suffering from. The family eventually called 999 and the baby was given antibiotics. This Ugandan family was subsequently sent back because they had called 999. James also viewed other children who were about ten years old, self harming. Their youngest daughter who was seven at the time started to wet the bed and her playing attitudes changed completely. The social worker at the centre told them to keep an eye on her for a month because she hadn’t “hit a brick wall”.

Whilst in detention, the two girls didn’t have real classes and school and the girls didn’t particularly like going as they would be separated from James and Jennifer and they would only be colouring in. The teacher’s response was that he would “drag them out of bed if they were late”. This was another traumatising experience the girls faced for which they were later offered Counselling.

James and his family are still seeking asylum but the girls are living with the PTSD of being detained 18 months ago. James recounted that when they had been swimming in the local leisure centre, the girls didn’t feel safe and wanted to leave as the people who were working there were wearing the same SERCO uniforms as the security at the detention centre. They had a similar experience when the gas man came to read the meter and seeing the security officers at Morrisons Supermarket.

They live in fear of what will happen next and scared of having to go back to Malawi. Whenever there is a knock on the door, the girls immediately run upstairs fearing the return of the detention police. James said being “marginalised and abused is icing on the cake....I’m not called James but called an asylum seeker”.
Appendix 4

Schematic representation of themes and possible links between them in describing the process of positive change.\(^{(16)}\)
Appendix 5 – This map represents the geography of asylum around the world. It explains reasons why people move to these countries.\(^{25}\)

**THE GEOGRAPHY OF ASYLUM**

1. Former Yugoslavia
   - 20 per cent. (4,482)
   - Fortified enclaves, cantonments and隔离区
   - Hounded by the Krajina Liberation army, the KLA, began in 1992. Most of the ethnic Albanian population in the Former Yugoslavia during the NATO air strikes of 1999, and included unlawful killings, torture, rape, sexual violence, looting and attempted ethnic cleansing. Deliberate destruction of homes is widespread and systematic.

2. Somalia
   - 25 per cent. (2,995)
   - Since 1991 Somalia has had no central government, police force, judiciary or functioning court systems. Following the overthrow of President Siad Barre's regime in 1991, severe drought and conflict forced millions of Somalis to flee their homes. In the north, UNRISD and the World Food Programme estimate that 75% of the population have been forced to leave their homes.

3. Sri Lanka
   - 7 per cent. (743)
   - Conflict between the Sri Lankan authorities and the Liberation Tigers of Tamil Eelam (LTTE) escalated after 1995. During this time, deliberate killing of members of the security forces and local communities belonging to local political parties became more pronounced. Although the Sri Lankan government took some steps to address human rights violations by security forces, majority rule in October 1997 restored a constitution for democratic elections.

4. Former USSR
   - 8 per cent. (894)
   - Torture and ill-treatment in police custody, prisons and the armed forces have been common throughout the Russian Federation.

5. Afghanistan
   - 30 per cent. (3,940)
   - The period after the withdrawal of the Soviet Union ended with the rise of the Taliban in 1999, armed conflict between opposing political factions continue. The country has been devastated in the process, producing the world's largest single refugee crisis to date, with over 15 million people. In 1999, dhows scaled the Red Sea, the Persian Gulf, and the Indian Ocean, and hundreds of thousands died or were murdered, tortured, raped, and executed.

6. Turkey
   - 4 per cent. (426)
   - The expulsion of successive Turkish governments and their autocratic authoritarianism towards the Kurds, and the strategies of the Kurdistan Workers Party (PKK) and the Kurdistan and Workers Party (PKK) and its supporters, have created conflict in south-eastern Turkey. The United Nations High Commissioner for Refugees estimates that up to 400,000 people living in the region have been displaced since 1999.

7. Chile
   - 25 per cent. (2,657)
   - During the 1970s, Amnesty International documented around 30,000 disappearances in Chile. But 1974 saw the most deaths and wide-ranging mass torture and imprisonment for a decade. These reported killings of applicants, labor rights activists, human rights defenders and members of different social groups, who were victimized as part of a serious and systematic campaign of violence.

8. Pakistan
   - 10 per cent. (1,057)
   - During 1999, mass movements persisted in the country.\(^{26}\)

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\(^{25}\) During 1999, the UK received 2,510 new applications for asylum. They were: 75 per cent. of applications were from unaccompanied minors, 25 per cent. from women with dependents, and the remaining 75 per cent. from single people. Over 60 per cent. of these applications were made by nationals of the eight countries or regions highlighted in our world map.
NASS Dispersal Areas in the UK in November 2000.\textsuperscript{(25)}

Source: NASS Identified Cluster List (November 2000)
Appendix 6

Diagram of Maslow’s Hierarchy of Needs\(^{(26)}\)
## Appendix 7

### Presentation

**Are the health needs of pregnant asylum seekers and children being met?**

![Image of a pregnant woman and child](image)

**Asylum Seekers entering the UK in 2006**
- 23,520 applications received by the Home Office.
- 12% were from unaccompanied asylum-seeking children.
- 71% of these were given asylum mostly up until their 18th birthdays.

**Refugees have unique health needs arising out of their experiences which can often be traumatic and distressful.**

- On arrival in the UK need for immunisations, dental care, screening for infection, counselling services
- Young people may fear deportation which might exacerbate any existing mental health problems.

**Mental Health**
- feelings of isolation and loneliness
- disturbed sleep patterns
- general anxiety
- headaches
- panic attacks
- PTSD
- depression
- eating difficulties
- Some cases - hospitalisation

*Chase, E. Knight, A. Stratlam, J. Promoting the emotional wellbeing and mental health of unaccompanied young people seeking asylum in the UK. Thomas Coram Research Unit, 2008*
Pregnant women face unique difficulties in accessing healthcare -

- Lack of knowledge of the healthcare system
- Lack of knowledge of what they are entitled to
- Information given is often in written form – in English (different to cultures based on oral tradition)
- Dispersal policy of the Home Office prevents women from putting roots down and establishing vital support networks

McLeish, J. [Mother at Risk - Maternity experiences of asylum seekers in England: Maternity Alliance, 2002]

Implications for health professionals

- Beauchamp and Childress' principle of justice
- Pregnant and new mothers need extra support
- Better interpreting services are needed for improved communication, and to ensure patient autonomy in decision making
- There is a need to emphasize the benefits of counselling
- Unaccompanied children should be placed in foster homes of the same culture/language
- For those not in foster care, support through one-to-one key workers should provide personal support

Asylum seeking women are less likely to receive antenatal care
- If antenatal care is available, often there are not adequate interpreting resources available
- Black African women, including asylum seekers and newly arrived refugees are six times more likely to die of maternity-related causes than White women

McLeish, J. [Mother at Risk - Maternity experiences of asylum seeking in England Maternity Alliance, 2002]

Criticism

- Qualitative studies used
- Not representative of the population – small sample size

BUT

- Issues mentioned appeared enough times in the literature to suggest that these are common themes in the experiences of refugees and asylum seekers.

The End
Appendix 8

Key Contacts

FADE Library

Kieran Lamb, Regatta Place, Brunswick Business Park, Summers Road, L3 4BL
Tel: 0151 285 4493 Email: library.services@fade.nhs.uk

Asylum Link Merseyside

Maggie Green, St Anne's Centre, 7 Overbury St, Liverpool, L7 3HJ
Tel: 0151 709 1713 Email: info@asylumlink.org.uk

Wrexham Refugee & Asylum Seekers Support

Zelko, Trinity House, Trinity St, Wrexham, Clwyd. LL11 1NL
Tel: 01978 357 826

Leigh Asylum Seekers and Refuge Support (LASARS)

Fit-4-Life, King Street, Leigh. WN7 4LJ
Tel: 01942 678574 Email: help@lasars.org

Appendix 9
Useful websites

www.star-network.org.uk

www.refugeecouncil.org.uk

www.who.int

www.un.org

www.bia.homeoffice.gov.uk

www.nspcc.org.uk

www.aboutimmigration.co.uk

www.healthy-inclusion.org.uk

www.medicaljustice.org.uk

www.asylumlink.org.uk

Appendix 10

Timetable
### Week 1

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<th>Monday 17/01/11</th>
<th>Tuesday 18/01/11</th>
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<td>Exams</td>
<td>Exams</td>
<td>Lecture day in the Harold Cohen Lecture Theatre. Morning - “What is an SSM? How do you do it and resource it.” Afternoon - “Structured Review”</td>
<td>Reading around the topic.</td>
<td>Sherrington Building “Your SSM, how to write it up”</td>
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### Week 2

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<th>Thursday 27/01/11</th>
<th>Friday 28/01/11</th>
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<tr>
<td>Registration and first meeting with Dr O’Neill. Morning – introduced topic of refugee and asylum seekers. Afternoon – interviewed an asylum seeker and a refugee.</td>
<td>Visited LASAR in Leigh from 12-4pm. Sat and ate lunch with asylum seekers and found some background information about their health needs. Also given a presentation.</td>
<td>Visited Asylum Link Merseyside. The manager, Maggie gave a presentation and then the group spoke to different asylum seekers. Lunch was eaten at the Kensington Methodist Church.</td>
<td>Visited Welsh Refugee Council in Wrexham. Given a presentation and then headed to talk to asylum seekers at Wrexham Methodist Church. In the afternoon questioned two asylum seekers and a case worker.</td>
<td>Attended the FADE Library and met a librarian Kieran Lamb who explained how to perform an NHS database search.</td>
</tr>
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### Week 3

<table>
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### Week 4

<table>
<thead>
<tr>
<th>Monday 07/02/11</th>
<th>Tuesday 08/02/11</th>
<th>Wednesday 09/02/11</th>
<th>Thursday 10/02/11</th>
<th>Friday 11/02/11</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lecture day in the Thomas Yates Building Morning – lecture given by Vicky Canning on Sociology, refugees and human rights:</td>
<td>Writing the SSM</td>
<td>Writing the SSM</td>
<td>Writing the SSM - reflecting on what has been learnt over the month - reading over the SSM</td>
<td>Submit the SSM.</td>
</tr>
<tr>
<td>Afternoon – presentation given by two representatives from STAR and a presentation on HIV by nurse Helen Reynolds, Royal Liverpool Hospital.</td>
<td>Writing the SSM</td>
<td>Writing the SSM</td>
<td>Writing the SSM - reflecting on what has been learnt over the month - reading over the SSM</td>
<td>Submit the SSM.</td>
</tr>
</tbody>
</table>