A Health Needs Assessment of Unaccompanied Asylum Seeking Children in Leicestershire

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Introduction

- Currently, the world is facing the greatest refugee crisis since the Second World War.

- Over 65 million people worldwide have been displaced and have had to leave their homes with approximately 1 million people coming into Europe seeking safety in the year leading up to March 2018.

- In the last year Britain received 26,547 asylum applications. Of this number 8% were unaccompanied asylum-seeking children (UASC).

- Unaccompanied asylum seeking children are a particularly vulnerable group and have significant multifaceted needs.

- In 2017, there were 2206 asylum applications by unaccompanied children received in the UK.
To collect data, a retrospective approach was utilised.

The Looked After Children (LAC) team based at the Leicestershire Partnership NHS Trust obtained a list from the Leicester City Council of unaccompanied asylum-seeking children (UASC) under the care of the Council over a one-year period (from November 2016 – November 2017).

Sixty children were included in this list with 34 being under the care of the county and 26 being under the care of the city.

System one, the software utilised by community health teams was then utilised to look up the Initial Health Assessments (IHAs) and subsequent Review Health Assessments (RHAs) undertaken for the unaccompanied asylum seeking children,

Data was collected from these assessment forms and collated onto an excel spreadsheet and a descriptive analysis undertaken.
Results – Demographic data

- 58 had IHAs available on system one and 33 had RHAs available on the system.

- Of the 60 children included in this analysis, 55 were male (91.7%) and 5 were female (8.3%).
The top three countries of origin where Afghanistan (33.3%, n=20), Eritrea (15%, n=9) and Iran (10%, n=6).

The age range at the time of the IHA ranged from 10 to 18 years.

Of this cohort of 60, 36 were under the care of the county and 24 under the care of the city.
## Results – IHA data

<table>
<thead>
<tr>
<th>Form utilised</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coram BAAF Form IHA - YP 2004 form</td>
<td>40%</td>
</tr>
<tr>
<td>LPT IHA Health Report form (21.7%)</td>
<td>21.7%</td>
</tr>
<tr>
<td>IHA of UASC or YP form 1</td>
<td>25%</td>
</tr>
<tr>
<td>Northamptonshire NHS Trust format</td>
<td>5%</td>
</tr>
<tr>
<td>BAAF Form IHA-YP 2009 form</td>
<td>3.3%</td>
</tr>
<tr>
<td>Summary report of a BAAF IHA form</td>
<td>1.7%</td>
</tr>
</tbody>
</table>
One UASC was borderline underweight on the 6th centile and the BMI and Percentile for one child could not be calculated, as the height value was not recorded on the IHA form.
Results – IHA data

Vaccination & Antenatal History

- All of the UASC had an unclear vaccination history on arrival into the UK and so were commenced on the immunisation catch up programme. The antenatal and birth history of all with IHA data available was also unknown.

TB

- 6.7% (n=4) were diagnosed with latent TB following screening and commenced on treatment. Only 27 children had TB screening results available on the system. (the prevalence of latent TB within this group would be 14.8%).

Vitamin D deficiency & Anaemia

- Of the 60 children included in this study, 21 had data available with regards to vitamin D levels and deficiency. Of these 21, 81% had levels <50 with 33.3% having levels classed as severe deficiencies. Of the 29 children with Hb levels available, all were within normal range.
Results – IHA data

Blood Borne Viruses

- 25 children had negative results from screening for blood borne viruses. The other 35 children’s BBV status was unknown/not on system one or ICE.

Sickle and thalassaemia status

- 2 of the children had negative results for sickle cell and thalassaemia screening. One child was known to be a sickle cell carrier. The sickle cell and thalassaemia status for the rest of the children was unknown.

Female Genital Mutilation

- Of the 5 female UASC their FGM status was unknown/not documented.

SDQ score

- 7 children had clearly documented and available SDQ scores. The score ranged from 2-8 with a mean of 5.14 and mode of 7.
The rest of the RHAs used a combination of the forms mentioned above including a form from Birmingham City Council.
Results – RHA data

<table>
<thead>
<tr>
<th>BMI Category</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Underweight</td>
<td>0%</td>
</tr>
<tr>
<td>Healthy weight</td>
<td>93.9%</td>
</tr>
<tr>
<td>Overweight</td>
<td>6.1%</td>
</tr>
<tr>
<td>Obese</td>
<td>0%</td>
</tr>
</tbody>
</table>

Two children were borderline underweight on the 5th & 6th centile.
Results – RHA data

Last health care plan

- 30.3% had their last health care plan from their IHAs completed.

- Of the 69.7% who had outstanding issues from their plan, 73.9% was due to incomplete or ongoing immunisations.
Results – RHA data

**TB**

- At the RHA one child had a known diagnosis of TB and had been referred to the TB nurse. Another child had also been referred to the TB nurse but had completed TB treatment about 6 months prior to the RHA.

**Immunisations**

- 51.5% of the UASC were reported as not being up to date with their immunisations
Demographics elicited from the data collected are in keeping with the national statistics.

89% of the UASC were males according to national statistics and from the data collected in Leicestershire, 91% of the UASC were male.

The top three countries from the national statistics were found to be Sudan, Eritrea and Vietnam, this differed partially from the top three countries elicited from the data collected for the Leicestershire region which were Afghanistan, Eritrea and Iran.
Of the forms used for both the IHAs and RHAs, there was a significant variance in the type of forms used with four different types of forms being utilised for the IHA and RHA as well as a combination of forms.

This would have affected the consistency of the data collected due to the different requirements and questions asked on each form.
Anthropometric values collated from the IHAs & RHAs revealed that none of the UASC were underweight.

13.7% and 6.1% respectively were overweight with the rest falling into the healthy weight category.

This is somewhat contradictory to existing literature, which elicits that UASC and refugee children tend to be underweight on arrival into the destination country for various reasons such as harsh conditions and a lack of access to adequate nutrition over extended transit times.
At the IHA, all children had an unclear vaccination history.

The catch up immunisation programme, which takes about 3 months was recommended and included in the health care

At the RHA it was found that over half of the children who had RHAs were not up to date with their immunisations

The RHAs are usually carried out about a year after the IHA which exceeds the 3 months needed to complete the 3 month immunisation programme.

This is a learning point and clearer and more stringent strategies need to be put in place to ensure this occurs in time e.g. pop up reminders on system one.
Discussion

- The results from TB, BBV, Sickle cell & thalassaemia screening as well as SDQ scores were not readily available on the relevant systems well after the IHA & RHA dates.

- Documentation of different screening tests and investigations could be improved.

- Measures need to be put in place to tackle this as it is vital to ensure screening for these conditions which are prevalent in this population are not missed.
No cases of anaemia were noted in the UASC who had results available, however there was a significant prevalence of vitamin D deficiency in this population group with 33% of the UASC who had their vitamin D levels checked having a severe deficiency.

A large proportion of the UASC had no levels available and it is absolutely paramount that levels are checked and documented in order to ensure that the appropriate treatment is given.

At the RHA it was noted that the 3 UASC with levels available had received treatment showing that when a deficiency is detected it is being appropriately treated.
At the IHA & RHA, 23.3% & 15.6% respectively of the UASC were documented as having nightmares, anxiety and other symptoms of post-traumatic stress disorder (PTSD) which affected their sleep.

Emotional concern was documented in 38.3% of the UASC at IHA as well as the bereavement of at least one parent in 25 children.

The mental health effects of the circumstances and experiences of UASC is very well documented in literature and this is also the case in this cohort studied.

9 referrals to CAMHS was noted and 2 of the UASC refused to engage with these services.

In this population group the barriers to seeking mental health must be explored further e.g. the stigma, so as to try and tackle and address these issues to ensure the best possible care for the UASC.
Conclusion

- The health needs of unaccompanied asylum seeking children in the Leicestershire region are numerous and varied.

- A key factor noted is the need for documentation of screenings and interventions to ensure the health needs of this population group are being identified and met.

- Consistency in the data collected at IHAs and RHAs is also key in ensuring these health needs are effectively identified and met. Uniformity in the forms used to conduct these assessments may be one way to tackle this and should be looked into further.

- LPT has developed its own IHA & RHA forms so collaboration and communication across the relevant health professionals should occur to ensure a uniform approach is adopted.

- Regularly auditing these assessments may be a key way to ensure adequate documentation and consistency in data collected. If these occur then the health needs of this population group can be more accurately assessed.

- Changes have now been made & strategies implemented in light of this audit to ensure the best possible care for UASC in the region.
Limitations

- Different forms utilised that meant data collected lacked consistency.
- Handwritten assessments were sometimes illegible post the scanning process meaning vital data may have been excluded.
- Time limit in which to complete this evaluation that meant all aspects of the data could not be explored in extensive detail.
- Unavailability of records on the relevant systems e.g. system one & ICE
- Researcher bias – some responses were not clear cut and were not absolute so were open to researcher/interpreter bias.
Recommendations

- Endeavour to use the same forms for the health assessments, which will allow for more consistent data to be collected.

- Training for all staff who conduct IHAs and RHAs with regards to the assessments to allow for more uniformity in the interpretation of the forms utilised.

- Ensure all relevant screening and tests are done and uploaded on to the system. Pop up reminders on system one may assist with this issue.

- Regular audit cycles to evaluate whether the plans from IHAs and RHAs have been executed within the set time frame (efficiently and in a timely manner).

- Consider typing the health assessment forms when possible to eliminate the issue of illegible handwriting or ensure when the forms are scanned in, the quality is sufficient to allow for the handwriting to be legible for any audit process that may occur.
Thank you for listening.

Any questions?

References available on request