



Unaccompanied Asylum Seeking Children – Health and Wellbeing Needs Assessment

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Produced by
Dr Malick Dansokho
Public Health
Halton Borough Council

About the author

Malick Dansokho is a Foundation Year 2 doctor at Warrington and Halton NHS Foundation Trust. He is currently working in the Public Health Department of Halton Borough Council. Malick is of German and Senegalese origin. He studied medicine at Charite University Berlin, Germany and at Universidad de Oviedo, Spain. During his medical studies, he worked for the Office for Medical Assistance for Refugees in Berlin and helped to coordinate access to health services for refugees and asylum seekers. In November 2015 he volunteered in a non-medical capacity at the Calais camp in northern France. These experiences have fuelled his desire to explore, in greater depth, the health needs of unaccompanied minors as a particularly vulnerable group among migrants.

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Tracey Holyhead	Board Manager, Halton Safeguarding Children Board
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John Davis	Development Officer, Together Liverpool
Steve Reddy	Executive Director, Families & Wellbeing, Warrington Borough Council
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Executive Summary

Background

The number of Unaccompanied Asylum Seeking Children (UASC) in the UK continues to rise. For the years 2014 and 2015 there has been an increase of over 53%, respectively. Last year, a total 3,043 UASC applied for asylum. In April 2016, the government announced the resettlement scheme for vulnerable children of the Middle East and North Africa (MENA) region. In May 2016, the former Prime Minister David Cameron committed to the resettlement of UASC from Greece, Italy and France as a response to the 'Dubs amendment' to the Immigration Bill. With the recent dismantling of the refugee camp in Calais, northern France, the UK government committed to accelerating the transfer of further UASC to Britain.

Under the Children Act 1989, support for UASC is the responsibility of the local authority's social services, regardless of the child's immigration status.

Their main countries of origin include Eritrea, Afghanistan, Sudan, Syria and Iraq. Most of UASC are male and aged between 14 and 17 years. The majority of female UASC come from Eritrea.

A few local authorities including Kent County Council harbour the majority of UASC living in the UK. In order to yield a more equitable distribution across the country, the government launched the Interim National Transfer Protocol for UASC, which is operational since July 2016. This policy identifies a process of redistribution of UASC throughout the country to relieve the strain of those authorities currently looking after the highest numbers of children. The policy suggests that the number of UASC in any given locality should not exceed the ceiling of 0.07% of a local authority's child population. Councils currently receive a daily rate of £114 (£798 per week) for UASC younger than 16 years and £91 for 16-17 year olds (£637) transferred under the new scheme. However, examples from Kent show that the average weekly cost for one UASC arriving in the Council has been as high as £1,211. This poses serious financial challenges to local authorities considering the health and wellbeing of UASC.

Overall, local authorities have had limited experience working with UASC. At present there are 136 UASC estimated to live in the North West of England. Applying the 0.07% threshold, this would leave space for another 924 UASC to be resettled in local authorities across the region.

There are currently 3 UASC estimated to live in Halton. According to the transfer mechanism, this allows another 17 UASC to be placed within the local authority area of Halton.

Aims

There is limited knowledge within local authorities across the North West about the specific health and wellbeing needs of UASC. Hence, this paper aims to:

- anticipate the health and wellbeing needs of UASC coming to Halton and the North West of England
- identify strengths and gaps within the local child care systems across the region
- inform strategies and the development of services

Methods

A detailed review of published academic and grey literature, including reports from the Home Office and UK refugee and asylum charities, was carried out to gain insights into previously identified needs and priorities of this population and to describe the legislative background in the UK. Available national and local-level epidemiological data relating to numbers, characteristics and trends in UASC were considered. Engagement and consultation were undertaken with key regional and local stakeholder groups such as the Regional Strategic Migration Partnership as well as experienced third sector organisations.

Results - UASC Health and Wellbeing Needs

Asylum seekers face a large variety of physical, psychological and social challenges. These challenges have previously been described in relation to four distinct phases of experience: pre-flight, flight, temporary settlement and resettlement. These phases have a considerable impact on UASCs' physical and mental health.

Trauma experienced by UASC may include conflict, starvation and limited access to health care in their home country, physical violence, trafficking, female genital mutilation, sexual exploitation and discrimination. This will require good access to primary and secondary care facilities including mental health services. Furthermore, a high need for immunisation catch up and screening for infectious diseases was identified.

The health and wellbeing of UASC will also depend upon wider determinants of health. Further areas of need were identified with regards to Accommodation, Education, Language and Social and Community Factors including leaving care legislation. This document provides recommendations to local authorities for the successful consideration of the complex health and wellbeing needs of UASC.

Matters for further consideration and action**Physical Health:**

- **Training needs for health professionals and frontline staff in migrant health, culture and working with interpreters**
- **Initial Health Assessment for each UASC which should consider both physical and emotional wellbeing**
- **Consideration of the availability of primary care and dental health services for UASC**
- **Identification of capacity and referral pathways for secondary, maternity, mental health and other specialist services**
- **Access to preventative treatments, health care guidance and support including immunisation, nutrition, culturally sensitive sexual advice and contraception**
- **Safeguarding procedures for victims of Trafficking, Child Sexual Exploitation and Torture**
- **Implementation of local protocols for FGM assessment setting out clear arrangements for how cases will be managed**

Mental Health:

- **Prioritisation of mental health when considering the health and wellbeing needs of UASC**
- **Discussion and implementation of strategies for the prevention, identification and treatment of mental illness in UASC**
- **Training needs for health professionals and frontline staff in migrant and refugee health, particularly in relation to mental health needs and culturally acceptable, effective treatments**
- **Training for frontline staff in residential settings where UASC are housed to identify and support emotional health issues**

Homes for UASC:

- **Availability and location of varied accommodation options for UASC**
- **Full needs assessments for each UASC are carried out to inform best placement option**
- **The choice of accommodation for UASC should be guided by their needs rather than age**
- **Training, support and equipment for carers of fostering services and other accommodation options looking after UASC**
- **Try to provide the highest level of support possible in living arrangements**

Education:

- **Ensure UASC's basic and psychological needs are fully met providing the basic requirement for educational success**
- **Culturally sensitive and linguistically appropriate initial assessment of educational needs for each UASC**
- **Robust procedures including education plans to monitor educational progress and a culture of proactive commitment to secure the highest educational outcomes for UASC**
- **Provision of access to English language skills training, if English is not the first language of the child**
- **Consider opportunities to develop literacy and language skills in the child's first language**
- **Facilitate access for UASC to educational support services available to pupils**

Language:

- **Adequate interpreting and translation service provision across all sectors (Health, Education, Housing, Social Work)**
- **Consider joint funding of interpreting and translation services across the North West**

Social and Community Networks:

- Individual integration plans for UASC to facilitate social connections with host community, groups and services such as mentoring or community support services
- Better communication between refugee support agencies and local youth support projects and sports clubs such as football clubs/leagues/associations
- Identification of local and regional community and ethnic minority voluntary sector organisations to support integration and access to services
- Collaboration and partnership between local authorities in order to share best practice and expertise
- Identification of local and regional community and religious organisations to support integration and access to services
- Communications strategies for local host community to facilitate social connections and support cohesion
- Close collaboration with politicians, migrant communities and their organisations
- Positive links with the local media

Leaving Care:

- Rapid identification of all looked after UASC with outstanding immigration matters before their 18th birthday
- Appropriate steps to obtain legal advice and resolve their cases
- Good partnership working with the Home Office to identify appeals rights exhausted care leavers who are not expected to be returned to their country of origin successfully
- Consider integrating the impact of immigration status into pathway planning
- Appropriate training and information on the impact of immigration status for staff providing leaving care support
- Consider the increased risk of further exploitation by traffickers in former UASC and trafficked children leaving care, particularly with regard to arranging accommodation
- Identification of strategies to improve community cohesion in anticipation of increasing numbers of people with no recourse to public funds (NRPF), among others due to UASC without legal immigration status turning 18
- Consider the financial impact on local authorities supporting former UASC who have become vulnerable adults with NRPF

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1 Introduction

1.1 Definitions

There are different terms used to refer to Unaccompanied Asylum Seeking Children. Table 1 displays the definitions proposed by the United Nations High Commissioner for Refugees (UNHCR) and UK Visa and Immigration.

Table 1: Definitions

<u>UNHCR</u>	<u>UK Visa and Immigration</u>
Unaccompanied Minors	Unaccompanied Asylum Seeking Children (UASC)
<ul style="list-style-type: none"> • aged less than 18 • separated from both parents • not being cared for by an adult who by law or custom have responsibility to do so 	<ul style="list-style-type: none"> • appears to be under 18 • applying for asylum in his or her own right • fleeing persecution from their own country • no adult relative or guardian to turn to in this country

1.2 Unaccompanied Asylum Seeking Children – Children in Care

Under the Children Act 1989, support for UASC is the responsibility of the local authority's social services, regardless of the child's immigration status.

The social services' duty of care includes assessing the needs of UASC. The assessment will determine whether the child's needs fall under Section 17 or Section 20 of the Children Act 1989, which will define the level of support provided.

Children supported under Section 17 are also referred to as "children in need". They are entitled to payment for subsistence and, if needed, basic accommodation such as hostels (1). Section 17 support also means that the local authority has a general duty to safeguard or promote the welfare of a child in need. Usually, for those children, there is already a person with parental responsibility. Under Section 17, the child is not looked after within the meaning of the 1989 Act.

According to Section 20 of the Children Act 1989 the duty to "look after" children lies with the local authority. This includes providing children with a wide range of services and accommodation. Scenarios where Section 20 is usually applied include situations where there is no person who has parental responsibility for the child or the child is lost or abandoned.

Unaccompanied children new to the local authority require an individual needs assessment. They should be cared for under Section 20 of the Children Act 1989 throughout the assessment process as stated in Local Authority Circular (LAC (2003) 13) issued by the Department of Health in June 2003 (1).

1.3 Background

According to the UNHCR's annual Global Trends Report the number of people forcibly displaced at the end of 2015 had risen to 65.3 Million compared to 37.5 million in 2005. More than half the world's refugees were children below 18 years (2). One of the main concerns is the lack of provision of adequate reception conditions for UASC (3). There were nearly 90 000 UASC registered in Europe in 2015, compared with 23 000 the year before (4). The UK Home Office recorded 3,043 asylum applications from UASC in 2015, an increase of 56% compared to 2014 (5). In Kent, where large proportions of UASC entered the country through the port of Dover and the Channel Tunnel, the numbers of new entrants rose from 333 in 2014 to 930 in 2015 (6).

In April 2016, the government announced the resettlement scheme for vulnerable children of the Middle East and North Africa (MENA) region (7). In May 2016, the former Prime Minister David Cameron committed to the resettlement of UASC from Greece, Italy and France as a response to the 'Dubs amendment' to the Immigration Bill (8). With the recent dismantling of the refugee camp in Calais, northern France, the UK government committed to the accelerated transfer of further UASC to Britain. [Appendix E](#) provides an overview of the different asylum and resettlement schemes and distinguishes between schemes for families or adults and children.

At present, a small number of local authorities look after the majority of UASC. In order to yield a more equitable distribution across the country the government launched the Interim National Transfer Protocol for UASC which is operational since July 2016. This policy identifies a process of redistribution of UASC throughout the country to relieve the strain of those authorities currently looking after the highest numbers of children. The policy suggests that the number of UASC in any given locality should not exceed the ceiling of 0.07% of a local authority's child population. Local authorities with lower proportions of UASC will be expected to accept transfer of children from other local authorities such as Kent County Council where the number of UASC lies above that threshold. In Kent there are over 500 UASC eligible for transfer according to the government's national transfer scheme (9). The [Transfer Flow Chart](#) illustrates the different stages in the process of transfer of UASC. Funding available to local authorities receiving UASC under the transfer scheme is subject to annual review. Until March 2017 Councils will receive a daily rate of £114 for UASC aged under 16 years and £91 for 16-17 year olds transferred under the new scheme (10).

Overall, local authorities across the North West have had limited experience in working with UASC. There are 136 UASC currently estimated to live in the North West of England. Applying the 0.07% threshold, this would leave space for another 924 UASC to be resettled in local authorities across the region. In Halton, in July 2016, there were 3 UASC living in the local authority area. Applying the national transfer mechanism, this would allow another 17 UASC to be placed in Halton. In response to the above, engagement and consultation is currently being undertaken with the local Multi Agency Forum, the Regional Strategic Migration Partnership, and experienced third sector organisations within Liverpool.

1.4 Aims

There is limited knowledge within local authorities across the North West about the specific health and wellbeing needs of UASC. Hence, this paper aims to:

- anticipate the health and wellbeing needs of UASC coming to Halton and the North West of England
- identify strengths and gaps within the local child care systems across the region
- inform strategies and the development of services

2 The population of Unaccompanied Asylum Seeking Children in the UK

Since 2012 the numbers of asylum applications by UASC continue to rise. Particularly for the years 2014 and 2015 there has been an increase of over 53%, respectively. In 2015, a total 3,043 applications were recorded. Figure 1 illustrates the numbers of annual asylum applications in the UK over the past five years (11):

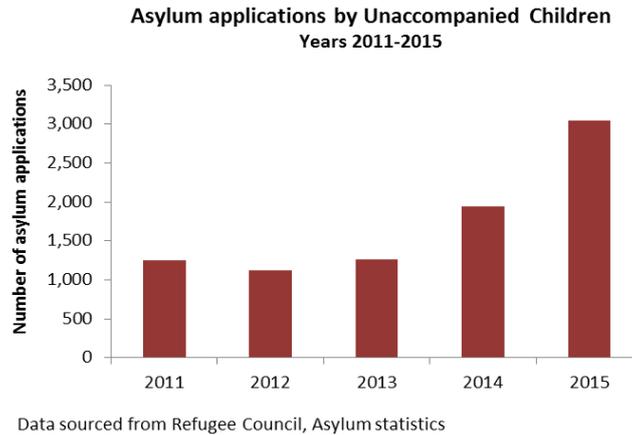


Figure 1: Asylum applications by unaccompanied children, Years 2011-2015. Data sourced from Refugee Council, Asylum Statistics (May 2016 and September 2012)

Kent County Council currently hosts one of the largest UASC populations in the country. The below pie chart (Figure 2) illustrates the proportion of UASC in Kent arriving from various countries of origin in 2015. Over one third of UASC in Kent were from Eritrea. Afghan minors represented the second largest group of UASC (23%) followed by children from Sudan, Syria and Iraq. These 5 countries produced over 75% of UASC in Kent.

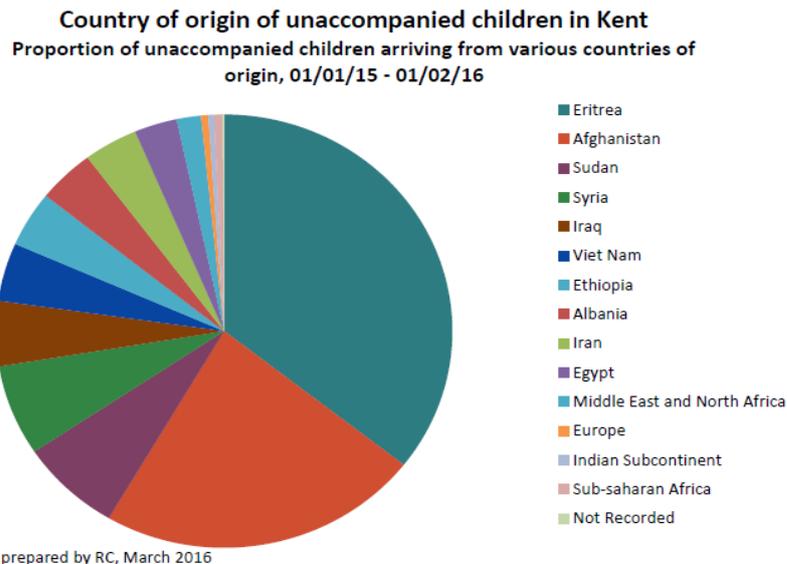


Figure 2: sourced from Kent County Council, prepared by Rachel Coyle (March 2016) *Health Needs Assessment – Unaccompanied children seeking asylum*. Kent Public Health Observatory. Available from: http://www.kpho.org.uk/data/assets/pdf_file/0011/58088/Unaccompanied-children-HNA.pdf

Figures reflecting the age profile of UASC living in Kent County Council reveal that there are close to nil individuals younger than 10 years old. Pooled data from 2010-2015 on the age distribution shows that the majority are aged 16-17 years (77.6%), followed by 18.5% of 14-15 year olds. Only 3.5% of UASC were aged between 12 and 13 years (6).

Most of UASC are male (93% of applicants in early 2016) (11). The main countries of origin for unaccompanied girls seeking asylum in 2015 were those shown in Table 2. There was a sharp increase in applications by Eritrean girls in 2015.

Table 2: Applications by unaccompanied children seeking asylum (girls only) (11)

Year	2014	2015
Eritrea	57	102
Vietnam	36	39
Albania	41	38
Somalia	11	18
Ethiopia	4	10
Nigeria	13	10

The above data show how wide-ranging the background of UASC in the UK is. They are vulnerable in many ways and have complex health and wellbeing needs.

3 Unaccompanied Asylum Seeking Children – Health and Wellbeing

The Dahlgren & Whitehead model (1991) following below illustrates the main determinants of health and is a useful tool to identify the health and wellbeing needs within a population. It acknowledges the universal nature of health and considers age, sex and constitutional factors, as well as individual lifestyle factors, social and community networks, living and working conditions and general socioeconomic, cultural and environmental conditions (Figure 3).

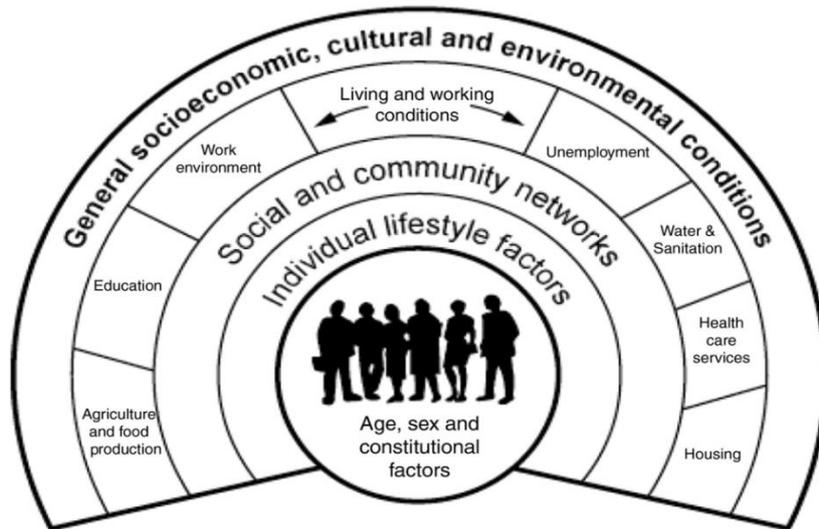


Figure 3: sourced from Dahlgren, G. & Whitehead, M. (1991) *Policies and strategies to promote social equity in health. Background document to WHO – strategy paper for Europe*. Stockholm: Institute for Futures Studies. Available from: http://s2.medicina.uady.mx/observatorio/docs/eq/li/Eq_2007_Li_Dahlgren.pdf

Asylum seekers face a large variety of physical, psychological and social challenges. These challenges have previously been described in relation to four distinct phases of experience: pre-flight, flight, temporary settlement and resettlement (12). A 14 year old girl who left Eritrea to seek asylum in the UK has shared her story with the BBC. Figure 4 is extracted from animated video that illustrates the different stages of [her experience](#) (13).



Figure 4: Ruth's story: One child refugee's journey from Eritrea to England, July 2016 sourced from BBC Newsround; available from: <http://www.bbc.co.uk/newsround/36714334>

3.1 Pre-flight

The pre-flight stage refers to the period characterised by a number of circumstances that are forcing people to leave behind their homes, possessions and land. It may be an extended period of time involving social disruption, physical violence including torture, sexual exploitation and political oppression (12). The spectrum of these push factors is likely to cause or coincide with limited access to education and health facilities.

Detailed country specific information on health profiles, can be accessed through Public Health England's (PHE) [Migrant Health Guide](#).

Many of the UASC come from countries where they are exposed to infectious diseases such as Tuberculosis, HIV, Hepatitis B and C and parasitic infections including Malaria. Health conditions and infections as a result of poverty may be of additional concern such as cholera, dysentery and malnutrition (14). Female Genital Mutilation (FGM) of varied prevalence has been recorded in 30 countries, mainly in Africa and the Middle East (15). A large number of unaccompanied asylum seeking girls in the UK come from Eritrea where the prevalence of FGM is approximately 90%. Countries with equally high FGM prevalence include Sudan, Egypt, Somalia, Ethiopia, Guinea and Mali.

Many UASC flee from countries such as Afghanistan where decades of conflict led to poorly developed healthcare structures. This includes impaired access to health services owing to poor communication and security as well as shortage of skilled health providers (16).

In addition to the above push factors there are other motives such as the desire of liberty and safety as well as structural supportive factors that might pull young people into a journey full of challenges (17).

3.2 Flight



Figure 5: A group of refugees arrive on the Greek island of Lesbos after crossing the Aegean Sea from Turkey; Photo: © UNHCR/I.Prickett. Available from <http://www.unhcr.org/europe-emergency.html>

The circumstances faced on the journey to Europe bear a high risk of causing psychological and physical trauma (3, 18). These challenges include:

- Starvation
- Persecution
- Lack of access to shelter
- Lack of access to health services
- Risk of Exposure to infectious diseases
- Risk of death
- Loss of loved ones through death or separation
- Physical injury due to unsafe travelling or physical assault
- Dangers faced while entering the EU irregularly
- Lack of protection while following EU migration routes undetected
- Vulnerability to manipulation, sexual violence, sexual exploitation and trafficking
- Lack of reliable information and advice, including information about trafficking
- Measures to prevent movement to their preferred country of destination
- Use of invasive methods to assess age, with variable results and reliability

3.3 Temporary Settlement

Large numbers of people are finding temporary shelter in camps in Africa, i.e. in Kenya, Tanzania, Uganda, South Sudan or Libya. Further camps emerged in Mediterranean countries such as Turkey, Italy, Greece and France.

Research undertaken by Human Rights Watch in 2016 highlights a chronic shortage of suitable accommodation and a lack of a comprehensive protection system for UASC. As a result, they face prolonged arbitrary detention in protective custody at police stations, in pre-removal detention centres, and in closed facilities on the Greek islands while they await transfer to dedicated shelter facilities. The average time spent in Greek police custody was one month. Some UASC, however, had been detained for three months in pre-removal detention centres. They are often unable to receive counselling, information about the reasons for and duration of their detention, and legal aid. Further practical barriers to provide care and information include the lack of interpreters (19).

Many people who to seek asylum in the UK stay in one of the various camps alongside the coast of northern France such as Calais (Figure 6). Even for children, traffickers charge large amounts of money per person to cross the English Channel. They also charge an entry fee for new arrivals to the camp. Those unable to pay are forced into laborious tasks (20). About 1,300 unaccompanied minors are estimated to live in the camp (21). The average stay in these camps is estimated to be five months, but reports state that some children stayed for up to nine months.

Access to health services is difficult and limited. There is a free but overstrained clinic close to the Hospital in Calais that provides emergency care. Concerns have been raised with regards to the provision of medical healthcare to migrants by French authorities. There are reports that insufficient medical treatment has been provided when treatment was sought in local hospitals. This included examples where painkillers and crutches have been refused to migrant patients suffering from leg fractures (22). Ambulances do not enter the camp. On-site basic medical assistance is provided by Doctors of the World and Doctors without Borders.

A video supporting Citizens UK's petition for family reunion illustrates the [dreams and hopes](#) of UASC living in the camp.



Figure 6: Camp site in Calais. Photo: Mohammad Ghannam/MSF. Available from: <http://www.msf.org/en/where-we-work/france>

In 2015, the University of Birmingham carried out an environmental health assessment in the French camp outside Calais also known as 'The Jungle' (22). The following issues were identified:

- Poor housing in commonly overcrowded tents or shacks vulnerable to the difficult weather conditions. Most camps sites are unlit at night.
- Limited or lack of access to safe food and water supply for drinking, washing, cooking and personal hygiene
- Poor Hygiene with an insufficient number of usable toilets for a large population
- Communicable disease outbreaks of vaccine preventable germs such as Chickenpox (23) or Measles in January 2016 (24)
- Physical trauma associated with dangerous living conditions, attempted border crossings, physical assault by police officers and other groups and insufficient treatment at French medical facilities
- Exacerbation of mental health issues and insufficient support for refugees with mental health problems and psychological trauma.

The French Government has recently announced the dismantlement of the camp, which is currently being carried out. The approximately 9,000 adults and families are being moved to reception centres across France. However, there is a supposed lack of emergency accommodation for UASC. This is putting large numbers of unaccompanied children at risk of becoming homeless (25). The dismantlement has accelerated the process of bringing unaccompanied children to the UK under the Dubs Amendment. The first children transferred under this agreement have recently arrived in Britain (26).

In an Inquiry on UASC in the EU before the House of Lord's EU Committee the situation of UASC was summarised as follows:

"On their journey they have been focused entirely on survival, the journey and arrival, and when they get to their destination country they are entirely depleted, but then of course they have to face a whole new set of challenges, so we have to be mindful of all they have gone through" (3).

3.4 Resettlement

In line with the 1989 Children Act, the Local Authority will facilitate access to safeguarding and social care services. Furthermore, the local authority will deliver accommodation provision, initial reception arrangements, education including English for Speakers of Other Languages (ESOL) classes. The Home Office previously commissioned the 'Indicators of Integration study' which considered the factors of refugee integration within the UK. Subsequently, an evidence-based conceptual framework (Figure 7) defining 10 core domains of integration was further developed by the researchers Ager and Strang (27).

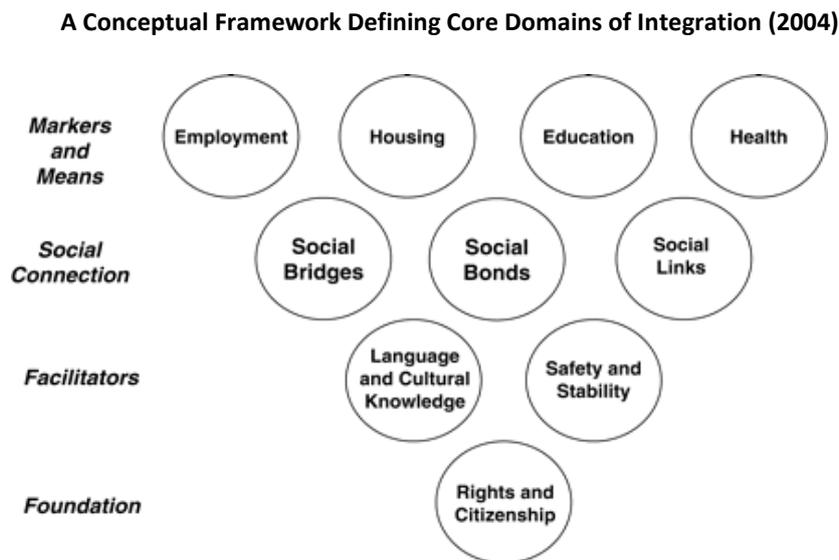


Figure 7: A Conceptual Framework Defining Core Domains of Integration (2004);

Figure sourced from Home Office (2004) Indicators of Integration final report, available from <http://webarchive.nationalarchives.gov.uk/20110218135832/http://rds.homeoffice.gov.uk/rds/pdfs04/dpr28.pdf>

Housing, Health, Education and Employment are recognised as major critical factors in the integration process. Integration and access to state and voluntary agencies upon resettlement can be aided or impeded by language, reciprocal cultural knowledge, social connections, safety and stability.

Sufficient funding to enable local authorities to provide the support UASC require will be important. At present, the government's 'Funding Instructions for UASC' under the age of 16 provide £114 per day or £798 per week. For 16 or 17 year olds an amount of £91 per day (£637 per week) is reimbursed (10). However, examples from Kent show that the average weekly cost for one UASC arriving in the County Council has been as high as £1,211 (29). These 'Funding Instructions' set out 'the terms under which the Home Office will make funding available to local authorities in respect to their costs of supporting Unaccompanied Asylum Seeking Children' (10). It is therefore designed to cover all arising costs including for Health, Education, Accommodation, Social Services and Interpreting and Translation Services. This poses serious financial challenges to local authorities considering the health and wellbeing of UASC.

3.5 Physical Health Needs

A health needs assessment conducted in Kent identified a number of key physical health issues of UASC (6):

- Dental health
- Dermatology complaints
- Clinical anaemia
- Musculoskeletal complaints
- Communicable Diseases: high need for immunisation catch-up and screening
- Nutritional deficits such as Vitamin A, Vitamin D and iron deficiency
- Sexual and Reproductive Health and Women's Health:
 - Female Genital Mutilation
 - Sexual Exploitation / Rape
 - Maternal Health
 - Contraception

It is important to carry out an Initial Health Assessment for UASC, which is the opportunity to provide the necessary preventative treatments and screenings. In many cases these initial assessments and opportunities for vaccination and screening were being missed (6).

A Health Checklist for migrants new to a primary care facility has been developed in cooperation with Public Health England ([Appendix C](#)). Public Health England also provides guidance for the immunisation of individuals with [uncertain or incomplete immunisation status](#). A [Health Guide](#) for UASC and staff working with UASC has recently been created. This web page is designed to share expertise acquired from working with large numbers of UASC in Kent. It also offers online blood borne infection information and consent forms in a variety of languages ([Appendix D](#)).

UASC might have experienced FGM. The [FGM Multi-Agency Protocol](#) (29) by the Local Safeguarding Children and Adults Boards of Merseyside provides background information and guidance for the response to FGM. Frontline staff should also be mindful of the sexual health needs of UASC and the difficulties in accessing information and advice. UASC might not be aware of the basic concepts of sexual health and contraceptive clinics. Given different cultural backgrounds UASC might not be familiar with fundamental principles of medical practice such as consent. This adds to the clear need of culturally sensitive information provision identified.

In Halton, the Child in Care (CIC) health team ensures that all children and young people are allocated a health practitioner. It consists of a Specialist CIC Nurse and a CIC administrator who are based within Safeguarding. Health practitioners are expected to have a role in care planning arrangements and to liaise with the child's Social Worker. Initial Health Assessments for children in care are carried out by a Bridgewater Community Paediatrician. Review Health Assessments are undertaken by Health Visitors, School Nurses or the CIC Nurse. Further Bridgewater services include Speech and Language Therapy, Paediatric Continence service and a Children's Hearing Screening service.

Matters for further consideration and action:

- **Training needs for health professionals and frontline staff in migrant health, culture and working with interpreters**
- **Initial Health Assessment for each UASC which should consider both physical and emotional wellbeing**
- **Consideration of the availability of primary care and dental health services for UASC**
- **Identification of capacity and referral pathways for secondary, maternity, mental health and other specialist services**
- **Access to preventative treatments, health care guidance and support including immunisation, nutrition, culturally sensitive sexual advice and contraception**
- **Safeguarding procedures for victims of Trafficking, Child Sexual Exploitation and Torture**
- **Implementation of local protocols for FGM assessment setting out clear arrangements for how cases will be managed**

3.6 Mental Health Needs

The process of UASC resettlement again bears a high risk of causing or exacerbating mental health issues. Fazel et al. highlighted a number of risk factors for mental illness in unaccompanied children arriving at their destination (18):

- Social isolation and absence of supportive relationships
- Inadequate housing or homelessness
- Experience of injustice, stigma, discrimination and racism
- Anxiety in relation to the asylum application
- Loss of sense of identity and control over day-to-day existence

In addition to the above risk factors, the European Union Committee of the House of Lords summarised the problems faced by UASC arriving in the UK as follows (3):

- Lack of safe reception, reception capacity
- Procedural and other obstacles to family reunification
- Risk of administrative detention, including in inappropriate conditions
- Lack of legal advice and support
- Age dispute
- Use of invasive methods to assess age, with variable results and reliability

These factors contribute to psychological symptoms found in UASC. The most common diagnoses include Anxiety, Depression and Post-Traumatic Stress Disorder. Self-harming behaviour and suicidal ideation have also been reported (6).

UASC who had experienced trafficking might have become victims of Child Sexual Exploitation and Torture. They continue to be at risk of returning to their traffickers following resettlement. This may lead to further exacerbation of mental health issues. UASC who go missing from care are particularly vulnerable to trafficking. Where trafficking is suspected a child protection plan may be required to protect children from further harm. The government provides guidance for the [care of unaccompanied and trafficked children](#).

Given the complex mental health needs combined with cultural and language barriers, effective treatment of mental illness will be challenging. Hence, preventive strategies to lower the risk of mental health impairment and their exacerbation will be important. These include the provision of access to adequate accommodation, education, social networks and community support.

Early identification of Mental Health problems can be challenging. Regardless of language barriers, traumatised children might not volunteer the disclosure of distressing experiences such as torture, sexual exploitation, trafficking and witnessing the death of others. UASC might also struggle sharing private information with constantly changing interpreters where there is no opportunity to build a trustworthy relationship. They might present with subtle signs and symptoms which have initially been missed in a number of cases. GP staff, Mental Health and Social Care Professionals working with UASC as well as interpreters should have cultural awareness training to empower them to recognise the signs and symptoms of psychological illness in UASC. Mersey Care NHS Trust provided [Guidance](#) for frontline staff working with asylum seekers.

Halton commissions a Child and Adolescent Mental Health Service (CAMHS) from 5 Boroughs NHS Foundation Trust which is available to Children in Care and their carers. It delivers specialist assessment, consultation, diagnosis formulation and treatment in a range of settings, including community and locality settings (30). There is also provision of inpatient services for young people which provides assessment, intervention and in-patient treatments. Initial assessments are carried out by the CAMHS Assessment and Response Team and sign posted to the appropriate service.

Matters for further consideration and action:

- **Prioritisation of mental health when considering the health and wellbeing needs of UASC**
- **Discussion and implementation of strategies for the prevention, identification and treatment of mental illness in UASC**
- **Training needs for health professionals and frontline staff in migrant and refugee health, particularly in relation to mental health needs and culturally acceptable, effective treatments**
- **Training for frontline staff in residential settings where UASC are housed to identify and support emotional health issues**

3.7 Homes for Unaccompanied Asylum Seeking Children

Secure accommodation is probably the most basic need for any asylum seeker or migrant in general. It enables migrants to use support services, providing an address from which to apply for benefits, training etc., and establishes entitlement to a school place (31).

UASC aged 16 and 17 were often placed in independent or semi-independent accommodation (6; 32). This may include residential care supported by key workers, emergency use of bed and breakfast accommodation and supported hostels. Kent County Council harbours one of the largest numbers of UASC. Over 50% of those children have been placed in independent living arrangements followed by nearly one third of UASC in non-long-term foster care (6). Foster care has been usually used as a placement for children under the age of 16 and girls (32). The Home Office's UASC Funding Instructions commit to an age-based daily amount of money granted to local authorities looking after UASC. The highest sum is reimbursed for children aged younger than 16 years (10).

The form of accommodation will have a considerable impact on UASC's safety, security and wellbeing and, hence, on their future personal development. The form of accommodation provided for UASC should therefore be focussed on their health and wellbeing needs rather than age. The young person's views should also be taken into account. A full assessment of the child's need will help to ensure that the child or young person is cared for in the most appropriate placement option (33).

It has previously been acknowledged that outcomes for UASC treated as fully looked after (as per Section 20 of the Children Act 1989) tend to be better (34). Outcomes included school attendance, criminal activity and substance misuse. Among various types of accommodation foster care provides the greatest protection against mental illness (6). A cross-sectional study by Hodes et al. suggests that low-support living arrangements are a risk factor for psychological distress and behavioural difficulties in UASC. However, ultimately, the experience of good foster care may also depend on how inclusive carers or families are (32).

According to the National Institute for Health and Care Excellence (NICE) local authorities are expected to have a variety of placement options available. This will help to meet the individual needs of each child. Options should include foster care, residential care, special guardianship and adoption (33).

In Halton, gaps in the provision of foster care placements have been identified. Accommodation in residential homes has recently been limited. There has been limited experience with the placement of UASC in Halton Borough Council. A small number of foster care placements have previously been arranged. Experienced challenges included cultural differences which can be barriers for social support even in foster care. This may lead to exacerbation of underlying mental health problems and increase the risk of religious radicalisation. Placement in a more urban setting with better social network support may in some cases decrease the risk of religious radicalisation. Few other examples exist where UASC have been placed in other local authorities where the support for UASC was deemed to be more adequate.

Matters for further consideration and action:

- **Availability and location of varied accommodation options for UASC**
- **Full needs assessments for each UASC are carried out to inform best placement option**
- **The choice of accommodation for UASC should be guided by their needs rather than age**
- **Training, support and equipment for carers of fostering services and other accommodation options looking after UASC**
- **Try to provide the highest level of support possible in living arrangements**

3.8 Education

UASC new to the UK education system will have complex educational needs. Maslow's hierarchy of needs illustrates the psychological needs that UASCs will have on their arrival at their new school. Self-actualisation such as achieving ones full educational potential is a long way up the pyramid. Basic needs like physical health and safety as well as psychological needs such as self-esteem and belongingness provide the fundament for successful learning. UASC therefore need to be enabled to meet these basic requirements for educational success (35).

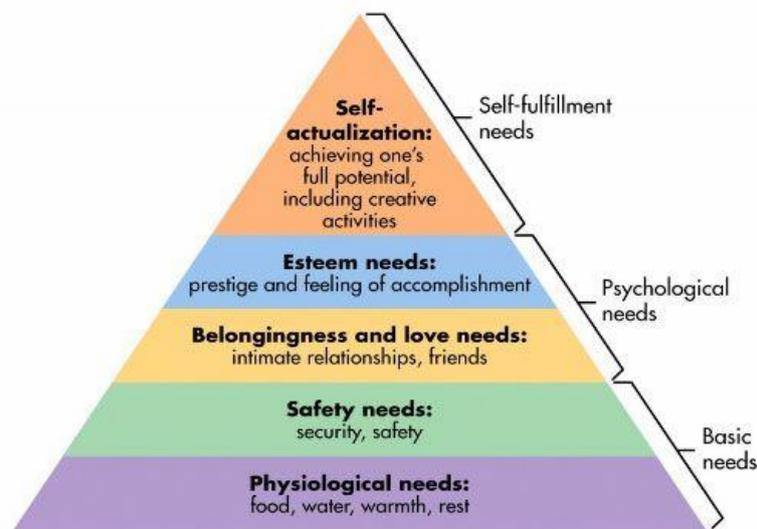


Figure 8: Maslow's Hierarchy of Needs, by Saul McLeod, published 2007. Available from: <http://www.simplypsychology.org/maslow.html>

UASC resettled within a local authority will be likely to have a varied educational background. The level of education might range from regular school attendance receiving high quality education in their countries of origin to entirely interrupted education owing to conflict and journeys (32). This also applies to their language skills. They may have had little or no contact with the English language or the Roman alphabet. Some UASC may not be literate in their home language. They need to be able to maintain and develop their home language. Those who are able to do so tend to learn English more rapidly. The development of their first language is also important for UASC who may return to their country of origin (36).

Local education authorities have a duty to provide full-time school education for children of compulsory school age (5-16) as per Section 14 of the Education Act 1996. School is free for asylum seekers, for people with leave to remain and for refugees.

'Buddy schemes' introduced at schools in Liverpool have proven useful in helping migrant children to integrate into the local school system. Similar schemes could be applied in schools across the region receiving UASC.

In Halton, all schools must give priority to applications from the parents or carers of children in the care of the local authority. Services available to pupils include careers information, advice and guidance for 16 -19-year-olds, special educational needs and disabilities support, and outreach services for pupils with behavioural or emotional difficulties (30).

There are enough school places available to children in the Halton local authority area and this would leave sufficient space to integrate UASC into the local educational system.

There is an English as an Additional Language (EAL) Service for Halton funded by Halton Schools. It comprises a team of 5 teachers who work across all Primary and Secondary Schools where there are EAL pupils. The EAL teachers are proficient in many of the Eastern European languages that have been spoken by most of the New Arrivals to Halton's EAL Service. They carry out initial EAL language assessments to inform the potential school about a child's proficiency in English.

Across the Halton local authority area most schools have an EAL Policy in place identifying Inclusive practice. EAL teachers are always present at the admission of pupils to assist with language and cultural needs. And they are always available for interpreting at parent teacher meetings and often translate school reports and letters.

Matters for further consideration and action:

- **Ensure UASC's basic and psychological needs are fully met providing the basic requirement for educational success**
- **Culturally sensitive and linguistically appropriate initial assessment of educational needs for each UASC**
- **Robust procedures including education plans to monitor educational progress and a culture of proactive commitment to secure the highest educational outcomes for UASC**
- **Provision of access to English language skills training, if English is not the first language of the child**
- **Consider opportunities to develop literacy and language skills in the child's first language**
- **Facilitate access for UASC to educational support services available to pupils**

3.9 Language

UASC are a diverse group of children with different cultural backgrounds and a wide range of languages. Language is cross-cutting across all domains such as Health, Housing, Education and Social Networks. It is a crucial factor for facilitating access to public services and integration.

English may have been taught within the education system of their country of origin. For some UASC there may have been complete interruption of education for a longer period of time owing to conflict. Acknowledged International English Language Testing Systems such as the British Council's IELTS are based on the assessment of four key competencies. These are Speaking, Listening, Reading and Writing. Arriving in the UK UASC will need to use and develop all four competencies in order to ease integration and access to support services. Proficiency of English language in all of these categories cannot be assumed when communicating complex information (e.g. health information).

The table below illustrates the differences between some of the languages spoken by UASC. It highlights how difficult it can be to access written information that is based on a foreign writing system:

Table 3: Languages commonly spoken by Unaccompanied Asylum Seeking Children

Language	Script Sample	Countries of origin where spoken as first language
English	Sun	UK, USA, Australia, Canada, etc.
Tigrinya	ጸሓይ	Ethiopia, Central Eritrea
Sorani	هه	Northern Iraq and Iran
Somali	qorraxdu	Somalia, Djibouti, Ethiopia
Pashto	لمر	Afghanistan, Pakistan
Farsi	آف تاب	Iran, Afghanistan, Uzbekistan, Tajikistan
Arabic	شمس	Middle East and North Africa, e.g. Syria, Iraq, Sudan, Lybia
Urdu	سورج	Pakistan, India, Bangladesh

Language will form the basis of any successful or unsuccessful interaction with services and social networks UASC may need to access. Where a language barrier cannot be overcome UASC will be at high risk of becoming socially isolated and this may impact both emotional and physical wellbeing.

Video Material for UASC is available on the Kent [UASC Health](#) Webpage. It provides information about initial health assessments and blood borne infections in a variety of languages such as Pashto, Arabic and Tigrinya.

Service providers might face situations where there is no availability of qualified interpreters of certain languages or dialects. For example, this has recently been an issue in the North West with regards to Anuak, a language which is spoken primarily in western parts of Ethiopia. In many of those cases, the last resort has been to ask a friend or family member to act as interpreter. This,

however, can be inappropriate in many settings including health and mental health assessments or sexual and reproductive health service provision.

Language has been identified as an area of need which may require further resources. Where an UASC arrives in a local authority an initial needs assessment has to be conducted as quickly as possible. This will help to provide vulnerable children with the services they require in a timely manner. In many cases interpreting services will be required for these needs assessments. At present the cost for interpretation services including translations of relevant documents required for full needs assessment is perceived to be clearly under-resourced. There is anecdotal evidence that the cost for a session of one and a half hours duration can cost up to £700. This is more than the weekly governmental funding provided for a 16 or 17 year old UASC. Supplementary funding of Interpreting and translation services may therefore require consideration.

Issues related to working with asylum seekers who require interpreting services include (37):

- Uncertainty over what language is required
- Lack of a shared understanding of health issues and healthcare systems.
- Interpreter has not been booked in advance
- Difference in understanding of health, disease and treatment.
- Different expectations.
- Unwillingness to talk freely (eg, due to interpreter, due to fears of persecution)
- Poorly trained interpreters (lack of neutrality; breaking confidentiality; personal/cultural bias)
- Lack of time to address complex problems
- Extra time needed to consult with an interpreter.

Competencies in cultural awareness for staff working with asylum seekers and interpreters will be important. Front line staff working with UASC will need to be mindful about potential tensions that might exist between the interpreter and the UASC. Such tensions may arise where interpreter and UASC are not of the same cultural background. For example, longstanding conflicts between different religious groups such as Shiites and Sunnis may affect the relationship between UASC and interpreter. As a consequence, this may affect the quality of any service provision relying on this particular interpreter. Therefore, matching interpreters for gender, ethnicity, country of origin and religion may be useful.

Matters for further consideration and action:

- **Adequate interpreting and translation service provision across all sectors (Health, Education, Housing, Social Work)**
- **Consider joint funding of interpreting and translation services across the North West**

3.10 Social networks and community cohesion

Like adult refugees and asylum seekers UASC face an increased risk of becoming socially isolated where they resettle. This may be due to cultural and religious differences as well as language barriers. Overall, there is limited opportunity for interaction with the wider population. Therefore, facilitating access to meaningful social networks will be very important for UASCs' emotional wellbeing.

Large proportions of social and community support for Asylum Seekers stem from the voluntary and community sector. In Halton, there has been limited opportunity to acquire experience in working with migrants. In more metropolitan areas such as Liverpool and Manchester there is a longstanding history of supporting asylum seekers and refugees. At present, it is perceived that the stronger social network support in urban areas is a potential pull factor for UASC placed in less urban communities. Third sector organisations and support networks in those urban centres have gained considerable expertise. However, those are mainly working with adults. In Liverpool, for example, there is no project specifically working with UASC for the purposes of integration and building social networks for these young people. There is a general need for social and community support. On the other hand, there is a variety of networks and community support projects for young people in the North West. These have the potential of becoming a means of social support and integration for UASC. Platforms helping UASC to integrate into local communities may include schools, sports clubs, community centres, religious groups and mentoring schemes.

Physical leisure activities such as team sports may be a useful means for integration. Everton Football Club is running an [Asylum Seekers Support Project](#) for adults offering regular high quality football sessions in partnership with Asylum Link Merseyside.



Figure 9: Everton Football Club, Asylum Seekers Support Project; available from: <http://www.evertonfc.com/community/health-and-wellbeing/the-projects/asylum-seekers-support>

In Halton, there are opportunities to connect people into the amateur sports network that exists in the Borough and into the [Widnes Vikings Sports Foundation](#). This charity of the Widnes Vikings Rugby League Club provides a way of building social networks and keeping people active.

Mentoring schemes may help to assist UASC in finding their space within society. The Kent Refugee Action Network offers a [Mentoring and Befriending Scheme](#) which enables volunteer mentors to provide one to one support to a young asylum seeker. Mentors provide emotional, practical, educational, and/or English support to a young person. This may help socially isolated young migrants to ease their integration into local community life. The Scheme offers UASC opportunities to build their self-esteem, confidence and language skills. The [Youth Federation](#) is working with vulnerable and disadvantaged young people across Cheshire and offers similar mentoring programmes. UASC coming to the North West may benefit from those pre-existing structures if they can be tailored to their needs.

The [Canal Boat Adventure Project](#) in Halton offers a social inclusion project working with young people who have had traumatic experiences such as abuse, neglect, crime, bullying and social isolation. The project offers emotional support and engages young people in workshops to help them develop skills in a plethora of areas such as:

- Cooking and shopping
- Life skills
- Outdoor activities
- Personal development
- Confidence building
- Health Alcohol and drug awareness sessions

There are a number of other organisations supporting children and young people such as Wellbeing Enterprises, Catalyst Children's Rights Adventure project, Changing Lives, West Runcorn Youth Centre or Four Estates. There are many young persons in the North West who have social and emotional needs that may overlap, despite cultural differences, with some of the needs UASC may have. Services and charities supporting local vulnerable and disadvantaged children and adolescents have invaluable expertise in their field. Figure 10 illustrates how connecting those pre-existing youth support structures with asylum seeker and refugee charities and support services may be a key strategy to create supportive social and community networks for UASC.

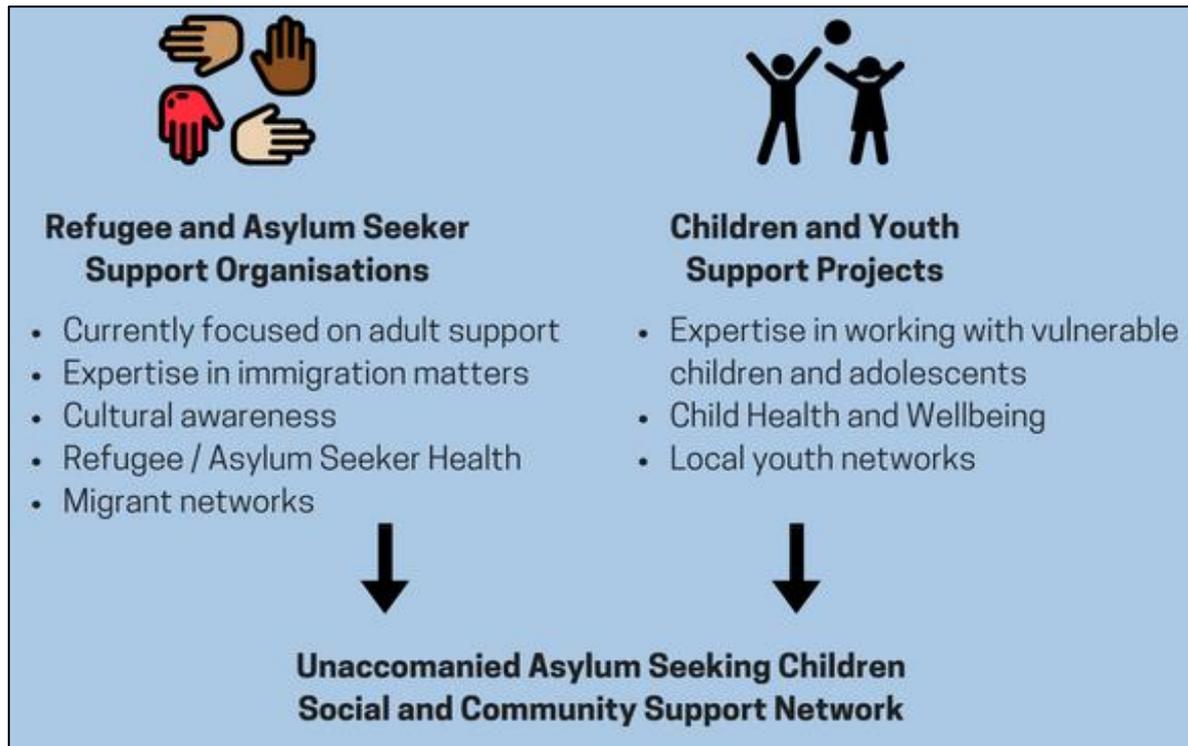


Figure 10: Best practice model for creating social and community support structures for Unaccompanied Asylum Seeking Children. Icons by Freepik, sourced from <http://www.flaticon.com/>

[Halton and St Helens Voluntary and Community Action](#) is an infrastructure organisation that provides advice, information and development of support services to voluntary, community and faith organisations and volunteers. It could act as a local platform to establish links between both youth support schemes and organisations working with asylum seekers and refugees. The structures resulting from such collaboration may offer a best practice model for community support of UASC.

Matters for further consideration and action:

- **Individual integration plans for UASC to facilitate social connections with host community, groups and services such as mentoring or community support services**
- **Better communication between refugee support agencies and local youth support projects and sports clubs such as football clubs/leagues/associations**
- **Identification of local and regional community and ethnic minority voluntary sector organisations to support integration and access to services**
- **Collaboration and partnership between local authorities in order to share best practice and expertise**

3.10.1 Faith Perspective

Historically, the Halton population has been largely white British, with only a small proportion of the population identified as being from a Black, Asian or Minority Ethnic Group (2011 census). The majority of the Halton population speak English and report Christianity as their religion.

UASC coming to Halton may have different religious backgrounds. It is anticipated that some of them may be Muslim. This implies that some UASC may have special nutritional requirements such as a pork free diet and halal foods. At present, there are no Mosques in Halton. Therefore, access to the closest Mosques will require consideration. However, it is important to acknowledge that young people's concepts of religion, culture and identity are fluid and may change over time. Hence, it is generally difficult to make assumptions about their cultural and religious needs (38).

The church provides spiritual support where needed but also intends to strengthen community cohesion. Across the North West, churches and faith-based projects offer social support for refugees and asylum seekers. Together Liverpool, for instance, is a joint venture of the Diocese of Liverpool and the Church Urban Fund who sponsored a city-wide congress titled "Safe Haven or Storm". The congress inspired the production of a Guide called "[Welcoming the Stranger](#)" which provides information and guidance to distinguish facts from prejudice. It also encourages the creation of a more welcoming environment for asylum seekers and refugees coming to the UK.

There is a weekly 'Welcome The Stranger Café' in St Helens which creates a community space for intercultural exchange. At the same time this can be used for asylum seeker and refugee support initiatives, such as case work provided by the Red Cross as well as English for Speakers of other Languages (ESOL) classes. UASC and young persons are likely to benefit from being integrated into suchlike welcome projects. The project could also provide opportunities for UASC to come into contact with and learn from resettled adult asylum seekers and refugees and their children as well as locals.

Because of what they experienced many UASC may be particularly vulnerable. Being displaced and feeling culturally uprooted may push them to seek spiritual guidance in form of fundamentalist ideation (39). Measures aimed at increasing community cohesion and inciting intercultural exchange may help UASC integrate and protect them from religious radicalisation.

Matters for further consideration and action:

- **Identification of local and regional community and religious organisations to support integration and access to services**

3.10.2 Community Safety and Public Debate

Resettlement of asylum seekers has the potential to increase community tension within a local authority. These tensions might be amplified by activities of far right extremist groups to stir up racial hatred.

It will be necessary to ensure close co-ordination between agencies and a clear communications strategy. Councils have a vital role to play in building community cohesion and preventing extremism. Furthermore they have the duty to ensure the victims of hate crime are able to access suitable support and are encouraged to report the matter to the police. Community safety partnerships should actively involve refugee communities and refugee community organisations for integration and prevention of harassment and racial discrimination (40).

The local government association provides an overview of the [guidance](#) in place for communities that are facing hate crime. The Joseph Rowntree Foundation published a practical [guide to housing and support services for asylum seekers and refugees](#) which suggests a community support plan in order to help facilitate community integration of asylum seekers and refugees. It summarises the key challenges for local multi agency fora fighting hate crime:

- improving personal understanding between people
- providing information and “myth busting”
- devising ways of bringing people together
- creating local networks of service providers
- helping people feel secure by tackling issues like racist attacks
- changing perceptions more widely, including challenging inaccurate media representation

Matters for further consideration and action:

- **Communications strategies for local host community to facilitate social connections and support cohesion**
- **Close collaboration with politicians, migrant communities and their organisations**
- **Positive links with the local media**

3.11 Leaving Care and the Transition to Adult Services

Many UASC are aged 16 or 17 years and will quickly face the transition to leaving care services. This will require transition planning for each individual in order to help UASC to prepare for the new challenges and issues they are facing. This may include preparing for independent living, further educational opportunities, additional support in understanding the institutions and systems they will need to engage with. Many young people reach the age of 18 without having received a final decision on their asylum case. The government guidance on [planning the transition to adulthood for care leavers](#) therefore recommends that social workers should help young people prepare for different possible outcomes of the asylum process (32).

These include:

- Long-term planning to prepare young people for life in the UK if they receive indefinite leave to remain
- Transitional planning to meet young people's needs while they are in the UK without a longer-term immigration status
- Return planning to prepare young people for return to their country of origin if all appeals are exhausted or they return voluntarily.

Leaving care issues have also been addressed in the government's guidance for the [Care of Unaccompanied and Trafficked Children](#). For UASC and trafficked children in particular there is an increased risk of becoming isolated on leaving care. Language and cultural background are key factors that need to be considered in order to reduce this risk. Trafficked children may also be at risk of returning to their traffickers and further being exploited on leaving care. This should be taken into account, particularly with regard to arranging accommodation (41).

According to the Children's Act 1989 local authorities have clearly defined responsibilities for the children who are leaving their care. Once they have turned 18 years, former "looked after children" are entitled to accommodation, financial support, contact, a personal adviser, a regularly reviewed pathway plan, funding for education or training and 'staying put' with foster carers.

Within the current legal framework, the immigration status of UASC aged under 18 years does not affect the support they are entitled to. So far, largely, immigration status has not affected the duty of a Local Authority to provide support to young people who are leaving care. According to the Children's Act 1989, UASC are entitled to the same care leaver's support as any other looked after child (42).

However, there have recently been amendments to the government's Immigration Bill. These are based on the rationale that the support of adult migrants who "have no lawful basis on which to remain here and who should be leaving the UK" (43). This includes care leavers who have no immigration permission when they turn 18. These cases are not considered to have a long-term future in the UK. The Home Office's main objective for these young people is to arrange for their removal from the UK. Therefore, the 1989 Act is not deemed to be the appropriate mechanism for providing support prior to the young person's departure.

A [fact sheet](#) produced by the No Recourse to Public Funds (NRPF) Network summarises the changes in legislation expected to come into force in April 2017. The local authority will no longer have the

general duty to safeguard and promote the wellbeing for a number of young people. This will apply to former looked after children aged 18 or above who are visa overstayers, have never regularised their status, or are “appeal rights exhausted” following an unsuccessful asylum claim. These young people will only be entitled to accommodation and funding provided by the Home Office or Local Authority, if very specific circumstances apply (42). It is therefore expected that, from April 2017 on, many former UASC leaving care may become destitute.

For local authorities looking after migrant children this means that all outstanding immigration matters should be identified quickly and appropriate steps should be taken to obtain legal advice and resolve their cases before their 18th birthday. It will be important to establish how many UASC are expected to leave care without valid immigration permission. These young people will be expected to return to their country of origin. Such a return, however, is not successful in all cases. Those care leavers who are not returned will be at high risk of becoming destitute. A need for close collaboration with the Home Office has been identified. This should include sharing information both about the number of UASC leaving care who will be receiving a negative decision and the number of those who are returned to their country of origin successfully. At present, in the North West, these figures are not available. This means the true scale of young people leaving care without access to mainstream benefits and at risk of destitution is largely unknown.

UASC leaving care may become vulnerable adults, e.g. owing to acute mental health issues. Local authorities have a duty to provide ‘NRPF support’ to families and vulnerable adults under social services legislation (44). Given the high risk of mental illness in UASC, this means that Councils may be required to provide unfunded financial assistance to former UASC as vulnerable adults with community care needs. The financial impact for local authorities supporting vulnerable adults with NRPF may therefore need to be considered.

Increases in the number of people without access to public funds are likely to have a noticeable impact on community cohesion and Safeguarding. The information centre about asylum and refugees summarised the key effects of destitution (45). These include:

- Street homelessness
- Illegal working
- Vulnerability to sexual exploitation and trafficking
- Increased criminal activity
- Increased susceptibility to physical illness
- Increased risk of mental health impairment
- Social problems resulting from dependence on “good will of others
- The spiralling nature of destitution

Anecdotal evidence from local authority members as well as refugee charities across the North West confirms the above implications of destitution. This will need to be considered at a local level in partnership with all other interested parties.

Matters for further consideration and action:

- **Rapid identification of all looked after UASC with outstanding immigration matters before their 18th birthday**
- **Appropriate steps to obtain legal advice and resolve their cases**
- **Good partnership working with the Home Office to identify appeals rights exhausted care leavers who are not expected to be returned to their country of origin successfully**
- **Consider integrating the impact of immigration status into pathway planning**
- **Appropriate training and information on the impact of immigration status for staff providing leaving care support**
- **Consider the increased risk of further exploitation by traffickers in former UASC and trafficked children leaving care, particularly with regard to arranging accommodation**
- **Identification of strategies to improve community cohesion in anticipation of increasing numbers of people with no recourse to public funds (NRPF), among others due to UASC without legal immigration status turning 18**
- **Consider the financial impact on local authorities supporting former UASC who have become vulnerable adults with NRPF**

4 Appendices

4.1 Appendix A: Audio-visual Media:

The story of an Eritrean girl seeking refuge in the UK is available from:
<http://www.bbc.co.uk/newsround/36714334>

'We have a dream', video in support of Citizens UK's petition for family reunion. Available from:
<https://vimeo.com/152158988>

Unrest in Calais ahead of camp demolition. Available from:
<https://www.theguardian.com/world/video/2016/oct/24/unrest-in-calais-ahead-of-camp-demolition-video>

4.2 **Appendix B: Recommendations to clinicians caring for UASC:**

- WHO's recommendations for interrupted or Delayed Routine Immunisation
http://www.who.int/immunization/policy/Immunization_routine_table3.pdf?ua=1
- Working with Asylum Seekers and Refugees. A Guide for Mental Health and Social Care Professionals in Merseyside, Mersey Care NHS Trust; March 2016.
<http://www.cph.org.uk/wp-content/uploads/2016/05/Working-with-people-seeking-asylum-and-refugee.pdf>
- PHE's Migrant's Health Guide
<https://www.gov.uk/government/collections/migrant-health-guide-countries-a-to-z>
- Vaccination of individuals with uncertain or incomplete immunisation status
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/533831/phe-algorithm-2016-08.pdf
- TB screen: Individuals should be tested for LTBI if they are aged 16 to 35 years, entered the UK from a high incidence country ($\geq 150/100,000$ or SSA) within the last five years and been previously living in that high incidence country for six months or longer
[https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/442192/030615 LTBI testing and treatment for migrants 1.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/442192/030615_LTBI_testing_and_treatment_for_migrants_1.pdf); see also
<http://www.nice.org.uk/guidance/ng33>
- European Centre of Disease Control (ECDC) Weekly Epidemiological Updates -
http://ecdc.europa.eu/en/press/epidemiological_updates/Pages/epidemiological_updates.aspx
- Imported Fever Service is a PHE resource clinicians can utilise when treating acutely unwell people who have returned/come from a foreign country. This resource should be utilised after discussion with local experts in Infectious Diseases/Health Protection.
<https://www.gov.uk/guidance/imported-fever-service-ifs>
- The Health of Refugee Children - Guidelines for Paediatricians:
http://www.rcpch.ac.uk/system/files/protected/news/refugee_1.pdf
- NICE CG110 Pregnancy and complex social factors: a model for service provision for pregnant women with complex social factors <https://www.nice.org.uk/guidance/cg110>
- Mental Health:
 - The Hopkins Symptoms Checklist-37 for Adolescents (HSCL-37A) - which measures internalising symptoms such as depression and anxiety, and externalising behaviours such as 'lashing out'
 - The Stressful Life Events (SLE) checklist 26. The SLE checklist is used to assess the number and type of stressful events a child has experienced
 - DSM-IV diagnostic criteria for Post-Traumatic Stress Disorder (PTSD)
 - The Reactions of Adolescents to Traumatic Stress (RATS)
 - The Harvard Trauma Questionnaire Part IV

4.3 **Appendix C: Public Health England - Migrant Health Checklist for Primary Care**

Protecting and improving the nation's health

Migrant Health Primary Care New Patient Checklist

Pre –appointment	<input type="checkbox"/> Country of Birth <input type="checkbox"/> Migration history (others countries lived in) <input type="checkbox"/> Reason for migration (Work/Study/Family/Asylum/Refugee) <input type="checkbox"/> Date of arrival in the UK <input type="checkbox"/> Language and dialect spoken - is an interpreter required? Is the interpreter acceptable to the patient? <input type="checkbox"/> Cultural sensitivity eg. female GP or chaperone required <input type="checkbox"/> Disability
Routine New Patient Health Check	<input type="checkbox"/> Past Medical History <input type="checkbox"/> Medication <input type="checkbox"/> Allergies <input type="checkbox"/> Family History <input type="checkbox"/> Social History <input type="checkbox"/> Height and Weight <input type="checkbox"/> Urine – diabetes and kidney function <input type="checkbox"/> Blood pressure <input type="checkbox"/> Lifestyle - Alcohol/Smoking/Physical Activity <input type="checkbox"/> Full Vaccination History - checked against the PHE Incomplete Immunisation Schedule
Review Country Specific Health Issues	<input type="checkbox"/> PHE Migrant Health Country Specific Guide <input type="checkbox"/> Risk of Communicable Diseases <input type="checkbox"/> Nutritional or Metabolic considerations <input type="checkbox"/> Ethnicity and increased risk of health problems
General Health	<ul style="list-style-type: none"> • Dental Health • Vision and Hearing (including child screening) • Explain UK Health Screening Programmes (Cervical/Breast/Bowel/Diabetic Eye Screening/Abdominal Aortic Aneurysm) when appropriate • Be alert to signs of neglect or physical abuse
Sexual Health	<input type="checkbox"/> Sexual Health history <input type="checkbox"/> Sexually Transmitted Infections <input type="checkbox"/> Contraception needs <ul style="list-style-type: none"> • Questions in this area require care and sensitivity
Mental health	<input type="checkbox"/> Consider mental wellbeing needs and assessment <ul style="list-style-type: none"> • Be aware of PTSD, depression, anxiety and underlying mental health disorders
Orientation	<ul style="list-style-type: none"> • Explain how to access healthcare and services (NHS111, GP, Urgent Care, Pharmacy, A+E) • Referral to health and third sector services

(Hyperlinks to resources highlighted in red)
TS/HTT/July2016

4.4 Appendix D: Kent UASC Health - Information and Consent Form for Young People



Blood Borne Infection Information and Consent Form for Young People

The doctor who has recently assessed your health has recommended that you have a blood test. The blood test is looking for the following infections: Hepatitis B; Hepatitis C; Human Immunodeficiency Virus (HIV), and Syphilis. It is your decision whether to have the blood test and we want you to be fully aware of why this test has been recommended before you agree to the test.

Information on these infections

What is Hepatitis B virus?

Hepatitis B is a virus that causes swelling and loss of function (inflammation) of the liver, which can result in damage that may lead to scarring of the liver and increased risk of liver cancer in some people.

What is Hepatitis C virus?

Hepatitis C is also a virus that causes swelling and loss of function (inflammation) of the liver. The majority of people infected will get only mild liver damage. However, in some people hepatitis C progresses over 20–30 years to cause serious liver damage.

What is HIV?

HIV is a virus that attacks the body's defence against infection (immune system) making it vulnerable, over time, to infections that a healthy immune system would fight off.

What is Syphilis?

Syphilis is a bacterial infection that in adults initially causes sores and then progresses to give rashes and generalised symptoms. Over many years, untreated syphilis can cause serious damage to many systems in the body and may result in death. Congenital syphilis (babies and children who acquire syphilis from their mothers during pregnancy) can result in multisystem organ damage (e.g. to the brain, bones, teeth and eyes).

Why would you have these infections?

Children and young people who have these infections usually have had the infection transmitted from their mother during pregnancy or after birth. These infections are also passed from person to person by sexual intercourse, or from sharing needles or other equipment when using drugs. Your doctor may also be concerned that you have come from a country with a high rate of these infections.





Why is it useful to know if you have an infection in the blood?

Due to improvements in the treatment of Hepatitis B, Hepatitis C, HIV and Syphilis infections, there are real advantages in finding out whether you have these infections. Children and young people who have contracted these

infections from their mothers or for other reasons can remain in good health for many years so they may not realise that they have an infection. There are treatments available for these infections that enable people to have healthy lives. However, without treatment and monitoring, all of these infections can cause people to become severely ill or even die. It is also important to know if you have an infection so that you can take extra precautions to prevent passing this infection onto another person.

It is not uncommon for people to have more than one of these infections at the same time, which is why we recommend that you be tested for all four of the infections.

Practicalities of testing

You will be seen by a doctor or nurse for the blood to be taken and the results will be ready usually within three weeks. Your GP will be informed of the results and you will be asked how you want to be told of the results e.g. by telephone, by letter or face-to-face etc. If you have concerns about this, please discuss with your doctor or social worker.

What will happen if you have one of these infections in your blood?

If you have one of these infections your health will need to be monitored and for some of the infections treatment is available. You will need to be seen by a specialist doctor and this will be arranged for you.

Who will know whether I have an infection?

The results of your blood test are confidential between you and your doctor and only you can decide who you want to know about this. However it is important that you have support in managing your health so you may want to discuss this with a trusted adult.





CONSENT FOR BLOOD BORNE INFECTION TESTING

To be completed by the examining health professional and retained within the young person's health record.

Consent by the young person with capacity to consent is essential.

Does the young person have capacity to consent? Yes/No

If not then consent will need to be sought from a senior social work manager (this is not the young person's social worker)

Has the young person undertaken any of the following activity to support their understanding of blood borne infections and consent?

- a) Read the printed leaflet Yes/No
- b) Watched a Podcast on blood borne infections Yes/No
- c) Conversation with their interpreter prior to the appointment Yes/No
- d) Other information Yes/No

Consent by the young person	
I understand the need for a blood test to look for Hepatitis B, C, HIV and syphilis and I agree to the blood test. I understand that following this blood test I will be informed of the results and if there is a positive result I will be referred to a specialist doctor.	
Signature young person	Date
Signature of the interpreter	Date
Signature of the examining health professional	Date



4.5 Appendix E: Asylum and Resettlement Schemes for families, adults and children

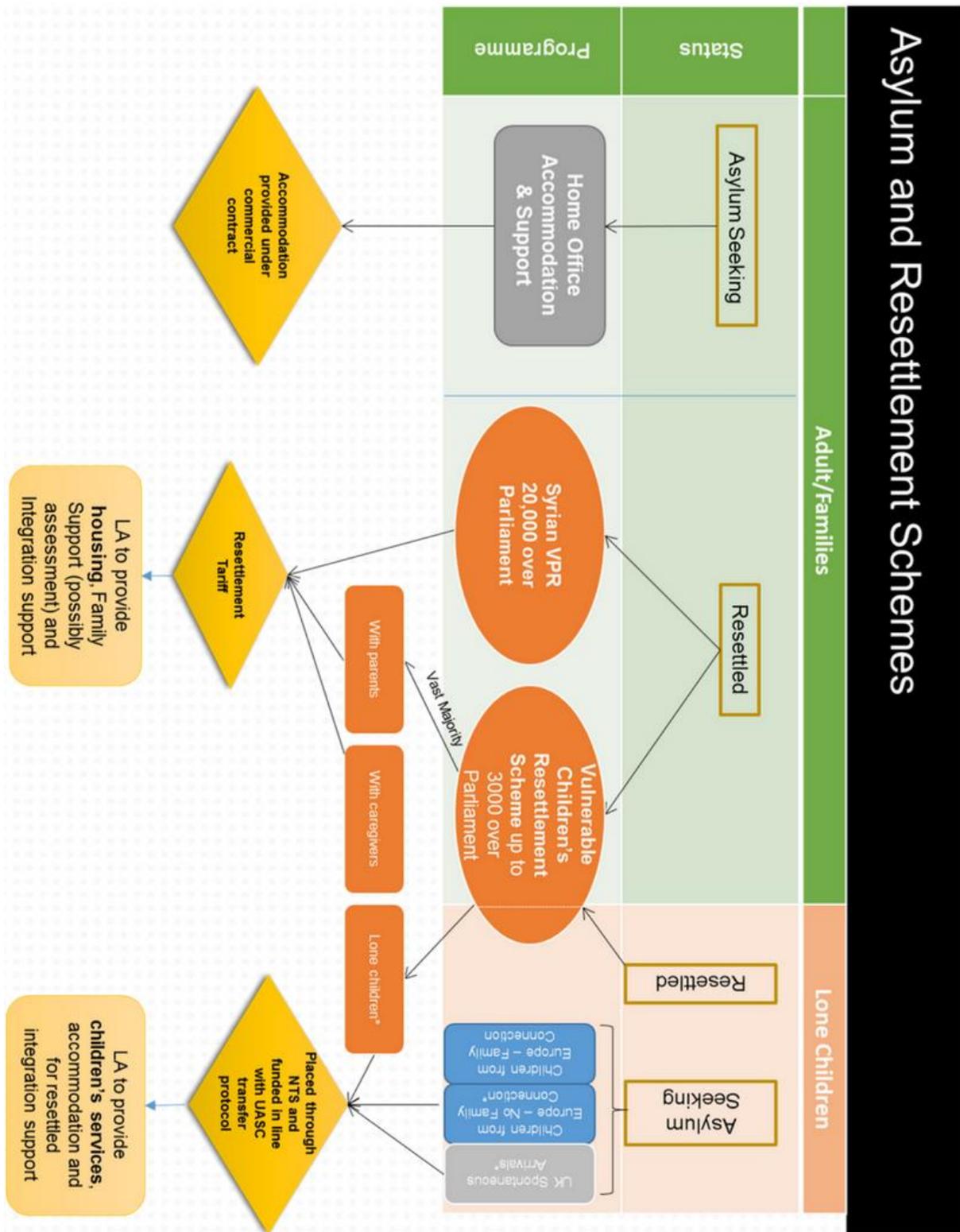


Figure 11: Asylum and Resettlement Schemes. Home Office. LA = Local Authority; NTS = National Transfer Scheme; UASC = Unaccompanied Asylum Seeking Children; Syrian VPR = Syrian Vulnerable Person Resettlement.

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