A Manual for Assessing and Meeting the Needs of Asylum Seeking Children and Unaccompanied Minors in the UK

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The United Nations High Commission on Refugees (UNHCR) uses the words of Euripides, 431 BC, to describe the state of being a refugee or asylum-seeker: "There is no greater sorrow on earth than the loss of one's native land."

Working in a Tier 3 service in Liverpool, I was frequently asked to meet with unaccompanied minors in consultation for assessment. Their stories have taught me how little I know of the worlds they left behind, their journey and the world they now live in.

I have had many unanswered questions and colleagues working with me have contributed much by posing questions themselves.

I decided to aim this research project at answering specific questions posed by professionals in Child and Adolescent Mental Health Services, regarding understanding these children's worlds and knowing what they may need from a mental health service.

I thought it best to start at the beginning, with the simple things and perhaps follow their journey, paying close attention to the social environment and the psychological impact, before aiming to begin to understand the mental health and medical needs possibly existing for some of the children.

With thanks to Prof Charles O' Brian, who worked as a Family Therapist in CAMHS at the Darwin Unit, Cambridge, and who supervised this work. He sits on the board at the Home Office, hearing unaccompanied minors' claims on a regular basis.

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Introduction

Understanding the terminology

Terminology, such as refugee, asylum seeker, unaccompanied minor and separated child, is often used in referring to children's circumstances and it is important to understand the meaning and the implications for the child.

The United Nations defines a Refugee as a person who "owing to a well founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it".[1]

Legally, refugees they are distinguished from asylum seekers and immigrants by acquiring the appellation of "refugee" before arriving in the host country; asylum seekers, by contrast, must declare themselves as such after arrival.[2]

A particularly vulnerable group of refugee children are those who are "unaccompanied" and defined as "separated from both parents and for whose care no person can be found who by law or custom has primary responsibility".[3]

The Home Office defines an unaccompanied minor as "a person, who at the time of making an asylum application is, or if there is no proof, appears to be, under eighteen; is applying for asylum in his or her own right; and has no relative or guardian to turn to in this country." Unaccompanied minor is a term used when a child travels or flees alone.

The definition of the Home Office excludes children accompanied by an adult who is not their parent or legal/customary care-giver, and children reaching the UK immigration controls with an adult that subsequently abandons them, which means the Immigration and Nationality Directorate (IND) does not consider a child to be unaccompanied if he or she is being cared for by an adult prepared to take responsibility for them. IND staff will only involve social services where there is concern about the child's relationship with the 'responsible adult'.[4]

For this reason, the term "separated children" was proposed by the International Save the Children Alliance and the United Nations High Commissioner for Refugees known as the Separated Children in Europe Programme (SCEP). This term will include the unaccompanied minors.

Legal framework
What should be available for the children and how are they being protected?

Children in the UK are protected under the UN Convention on the Rights of the Child 1989 (CRC89). Asylum-seeking children are not included and their rights are not guaranteed.

On the ratification of the Child Rights Convention in 1991, the UK government entered a reservation allowing it to operate its immigration controls without regard to the Convention. The reservation states: "The United Kingdom reserves the right to apply such legislation, in so far it relates to the entry into, stay in and departure from the UK of those who do not have the right under the law of the UK, and to the acquisition and possession of citizenship, as it may deem necessary from time to time." The current government maintains the reservation to the CRC, which certifies of a long-standing conflict between immigration law and children's best interest.

In 1999, the Government submitted its second report to the UN Committee on the Rights of the Child, the body which overseas the implementation of the Convention. The report asserts that UK immigration and asylum policies are in general consistent with the UN Convention on the Rights of the Child. However research and practice have shown the position in the report to be untenable. There is no move for the incorporation of the CRC 89 into the UK law which could mean that the rights contained therein could not be enforceable in the UK courts.[5]

In 2004 the Mayor of London joined forces with charities and groups campaigning for the rights of children, such as Save the Children, Children's Rights Alliance and the Refugee Children's Consortium, in an attempt to urge the government to remove its reservation on applying the CRC89 to asylum-seeking and non-citizen children.[6]

At EU level, immigration control and security considerations also appear to take precedence over the "best interests of the child" principle in the CRC.[7]

The Human Rights Act 1998 is a significant piece of legislation that incorporates the 1950 European Convention of Human Rights and Fundamental Freedoms (ECHR 50) into UK law. The incorporation is significant for children; most of its articles are relevant to them. Some articles are of potential benefit to separated children, such as Article 2 on the right to life, Article 3 on torture and degrading treatment, Article 5 on deprivation of liberty and Article 8 on the right to family life (family tracing, contact and reunification).[8]

The Children's Act 1989 (CA), provides a basic definition of a 'child in need' and separated children fall within this category. The CA89 specifies the duties owed by the local authority to a 'child in need' in its borough. Social Services should establish whether a child is 'in need' and then determine the level of support to be provided either under Section 17 or Section 20 of the CA. Section 17 outlines a local authority's duty to care for the children in need and provide a service appropriate to the child's needs. Section 20 is explicit about the local authorities' duties to provide accommodation. All unaccompanied children should be cared for under this section as it applies to children who are without parent or guardian who is able to care for them. Previously most unaccompanied minors were cared for under the less protective level of support under Section 20 of the CA.

A number of legal and policy developments provide clarity on the social services protection and support entitlements of separated children and young people. In June 2003, the Department of Health issued a Local Authority Circular, LAC (2003) 13 following an amendment to the CA89.

LAC 13 stated that support should be based on a needs assessment and that the majority of separated young people are likely to be assessed as requiring Section 17 support under CA89.

The UK childcare legislation provides children with opportunities to express their wishes and views regarding the provision of substitute care, which means unaccompanied minors have a right to comment on whether they feel their needs are being met.

Local education authorities have a duty to provide full-time education for all children of compulsory school age (5-16 year olds), resident in the area, irrespective of the children's immigration status, as outlined in Section 14 of the Education Act 1996 and in the Home Office Note on Unaccompanied Minors[4]. Between 16 and 19 the child is only accepted in school at the discretion of the head teacher. The Local Authority in all its functions has a corporate parenting responsibility for the children. Schooling is free for asylum seekers, those with leave to remain and with refugee status.

Unaccompanied minors are entitled to medical treatment by the NHS.

There is no requirement under the current asylum legislation that claimants have a legal representative when they make their case for asylum at the Home Office. Strong suggestions have however been made for legal representatives, given the complexity of legal issues.[9] In contrast to many other European countries, separated children applying for asylum have access to legal aid to pay for the services of legal representatives.

The right to family life is stated in Article 8 of ECHR50, incorporated in UK law. Little information is available on family tracing and reunification. The British Red Cross, International Social Services, Refugee Community Organizations and UK Consulates Abroad deal with establishing family tracing and contact. Separated children have no clear entitlement to family reunification in the UK, regardless of their immigration status, because the official policy is based on bringing spouses and children to the UK. In special cases children can apply to bring their parents to the UK, but this is outside the reunification policy and is based on compelling compassionate considerations.

Why are the numbers important?

Ten years ago, it was estimated that there were 53 million people uprooted in the world and that 1 in 115 people on earth had been forced into flight.[10] It was estimated that 27 million people were displaced within their own countries[11] and that three quarters of refugees have fled from one developing country to another.[12] Unaccompanied minors, then, typically accounted for 5% of a refugee population, and often more, as children were frequently lost, separated or orphaned in the panic of flight.[13]

In 2002, five years ago, it was estimated that there were 22 million refugees located throughout the world and that 280,000 were resident in the UK.[14] It was said that approximately half of the world's refugees were children.[15, 16] The ratio of child to adult refugees varied depending on the region. The majority of refugees in Central Africa were children, while only 20% of Central and Eastern European refugees were children.[14] In 2002 an estimation of approximately 50 million people, 1% of the world's population, were displaced and uprooted from their homes.[11]

In the year 2000, 100 000 people claimed asylum in the UK, this shows a 250% increase in the number, compared to 1996.[17]

Recently, documented at the end of 2006, it was estimated that there were 9.9 million refugees globally. For the first time since 2002, a declined trend in the global figures was reversed. This increase arose from two sources. 1.2 Million Iraqis sought refuge in Jordan and the Syrian Arab Republic and changes in the methodology for computing the active refugee caseload also lead to an increase. It is not clear what percentage of this group were children, as information were only available on one quarter of the people. Of the information available, 45% were children, 11% being under the age of 5.[18]

World-wide, 45% of the world's refugees are children and most of them are in Africa. The number of unaccompanied minors claiming asylum in Europe is growing.[19]

In the UK, 3,200 unaccompanied minors were looked after, last year, when a poll was taken on 31 March 2006. It was found that 70% of the children were boys and 30% were girls.[20]

The number of unaccompanied children in the process of seeking asylum in the United Kingdom has risen from slightly over 1,000 in 1997 to well over 5,000 in the first months of 2006. According to Home Office statistics, 760 unaccompanied children arrived in the United Kingdom to claim asylum in the first quarter of 2006 alone.[21]

Most asylum applications are registered in Europe (299,000), followed by Africa (159,000) and the Americas (78,000).[22]

With 53,000 new asylum claims lodged in 2006, South Africa became one of the main destinations for new asylum-seekers. With a cumulative total of 205,000 individual asylum applications since 2002, South Africa is one of the largest recipients in the world. The USA was in second position in 2006, in terms of new claims (50,800), followed by Kenya (37,300), then France (30,800) and then the UK (27,800).[18]

The highest number of new individual asylum claims are filed by the Somalis (45,600), Iraqis (34,200) and Zimbabweans (22,200).[18]

At the beginning of 2005 it was illustrated that of the world's, then 17 million refugees, more than 7 million remained "warehoused" under conditions of confinement.[23] This is still an ongoing concern and it remains illegal under British law, to detain children under the age of 16.

At the end of 2005, the global figure of persons of concern to the UNHCR stood at 21 million. This figure includes refugees, asylum-seekers, returnees who are refugees who have been returned home, internally displaced (within their own countries) and stateless persons. By the close of 2006, the figure stood at 32.9 million, illustrating an increase of 56%. The single largest increase has occurred among the internally displaced persons.[18]

Illustrated by the UNHCR document: 2006 Global Trends[18]

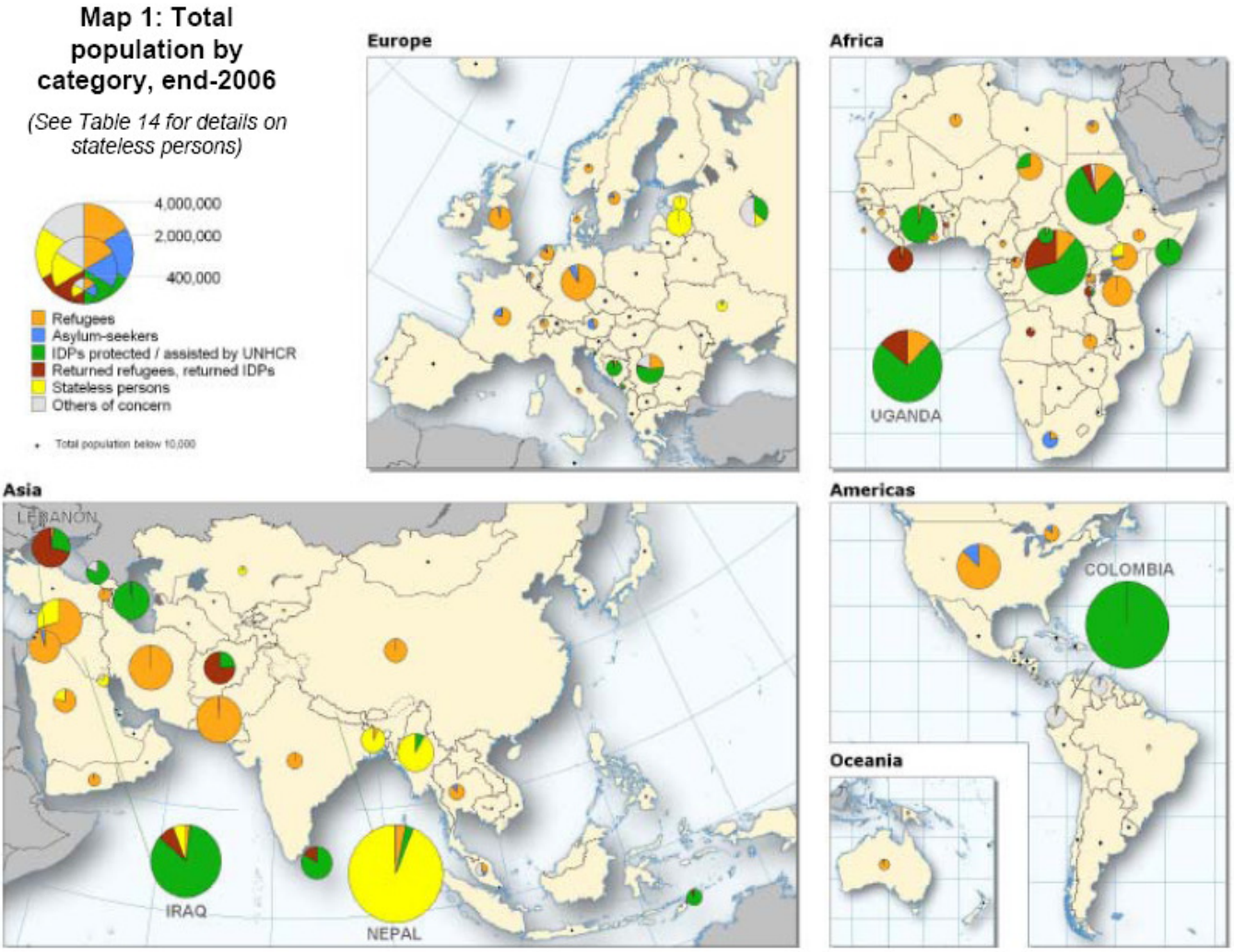
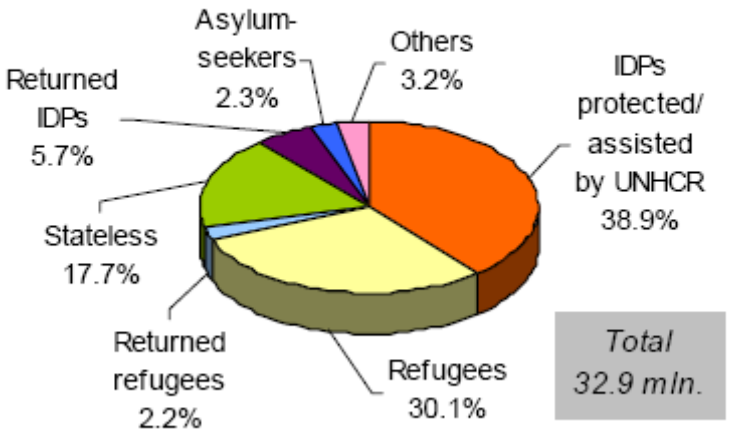


Fig 2: Total population by category, end-2006



Illustrated by the UNHCR document: 2006 Global Trends[18]

Table 1: Refugee population by UNHCR regions

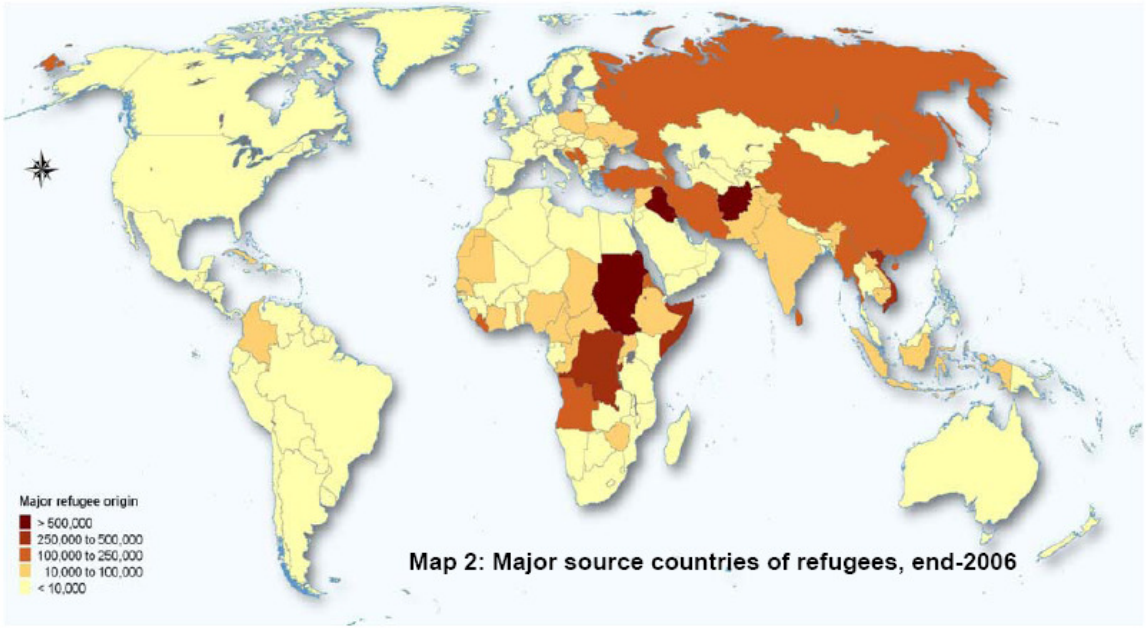
UNHCR regions	Start-2006	End-2006	Annual change Absolute	Annual change %
- Central Africa and Great Lakes	1,193,700	1,119,400	-74,300	-6.2%
- East and Horn of Africa	772,000	852,300	80,300	10.4%
- Southern Africa	228,600	187,800	-40,800	-17.8%
- West Africa	377,200	261,800	-115,400	-30.6%
Total Africa*	2,571,500	2,421,300	-150,200	-5.8%
CASWANAME**	2,716,500	3,811,800	1,095,300	40.3%
Americas	564,300	1,035,900	471,600	83.6%
Asia and Pacific	825,600	875,100	49,500	6.0%
Europe	1,975,300	1,733,700	-241,600	-12.2%
Total	8,653,200	9,877,800	1,224,600	14.2%

* Excluding North Africa.
** Central Asia, South West Asia, North Africa and Middle East.

Illustrated by the UNHCR document: 2006 Global Trends[18]

Internally displaced persons, for the purpose of UNHCR's statistics, are limited to conflict-generated IDP's to whom the Office extends protection and/or assistance.
Returned refugees refer to refugees who have returned voluntarily to their country of origin or place of habitual residence.
Returned IDP's refer to those internally displaced who, being beneficiaries on the UNHCR's protection and assistance activities returned to their areas of origin or habitual residence.

Stateless persons are persons not considered as nationals by any State under the relevant national laws. This includes people with undetermined nationality. Other persons of concern, refers to persons who, while they may fall under any of the preceding categories, have not formally been determined or agreed to be so for one or another reason, but benefit from the protection, assistance or other activities of the UNHCR.



Map 2: Major source countries of refugees, end-2006

Illustrated by the UNHCR document: 2006 Global Trends[18]

Understanding the background

Understanding the psychosocial needs of the children

"In Somalia I was given a special job to do. I had to look after the goats every day. One day a big aeroplane flew over us. It was a war aeroplane. It began to drop bombs. I looked up and I saw the bomb coming towards us. We all ran away. There were lots of goats left in the house. The house was burning. There were ten goats left in the house. They all burned except my goat and her two babies. So we went to a small village and a lot of men followed us. They were soldiers. When my goat looked up she was shot in her leg. Then she ran into the bushes with her two babies following. We hid as well. Then the aeroplane came back and dropped another bomb when they saw us. The babies died. Then my goat died. I cried and I couldn't leave her. So we came to England, and I still remember my goat and her two babies." *South Glamorgan Peace Network, 1994*

Much public attention and concern have been attracted for children who leave their countries to find safety, who embark to cross borders alone.

Three phases of experience or stages of trauma have been described for these children; namely preflight, flight and resettlement.

Children are occasionally sold by their parents but many are sent away, with families often paying large amounts of money to people they don't know well, with the hope that their children will find a better life. Families may not be able to pay for their own travel costs and may have to make this difficult decision to send a child alone. The decision for children to leave their country often involves coercion (trafficking in minors) but it can be voluntary as well with many complex variations of both variables. Children often witness the murder of their parents and often experience detention and torture, forced recruitment into the armed forces, persecution due to ethnic group or political activities of the family, abuse and/or abandonment, poverty, lack of opportunity and debt bondage, when they decide to leave their country.[24]

Refugee children in developing countries are often forced into squalor and deprivation, the characteristic conditions of refugee camps and are at great risk of health problems. One of the most serious problems is malnutrition. There have been significant outbreaks of micro nutrient diseases such as scurvy, beri-beri and pellagra.[25] In Angola, Liberia and the Sudan, the prevalence of wasting is more than 40 percent. In the Goma refugee camp in eastern Zaire in 1994, a cholera epidemic killed 50, 000 people in just one month.[12]

Fleeing for safety can take several months, during which families have very little contact with each other and they often do not know whether their children, siblings and parents are alive or not. Smugglers are frequently approached to ensure a child's escape and the journey is often associated with life threatening conditions.[8]

Children are often lost, separated or orphaned in the panic of flight. In Rwanda at the end of 1994, an estimated 114,000 children had been separated from their families. In Angola, a 1995 UNICEF survey found that 20% of children had been separated at some time from their parents and relatives.[8, 26]

One of the most disturbing cases of lost children emerged in the civil war in southern Sudan. Fearing capture or death, at least 20,000 Sudanese young people, mostly boys between the ages of

7 and 17, fled their homes. These 'lost boys' of the Sudan trekked enormous distances over a vast unforgiving wilderness, seeking refuge from the fighting. Hungry, frightened and weakened by sleeplessness and disease, they crossed from the Sudan into Ethiopia and back. Many died on the journey.[27]

Child trafficking also provides significant risk to unaccompanied minors and was first noticed in the UK in 1995 by social workers in West Sussex Social Services, after a child went missing. Soon after this case, a pattern emerged and it became known that children, mainly Nigerian girls, were being taken to Europe to be prostituted. It has been more than ten years since the first known case of a trafficked minor in the UK, yet very little is known about the actual size of the problem or the operating methods of trafficked channels. ECPAT UK carried out research in 2001 and 2003 respectively into the trafficking of children for sexual purposes.[28]

The research revealed that children arrived at Gatwick airport as unaccompanied minors and claimed asylum at the airport. They were then taken into care by the nearest social services, in this case, West Sussex Social Services. Once in care, they followed pre-arranged plans to contact their traffickers and then went missing from one day to six months after they initially arrived. Evidence from two rescued girls indicated that they were destined to be prostituted in Europe, although some appeared to have been exploited in the UK. The girls were controlled by threats of voodoo and the fear that if they told anyone about their traffickers, they and their families would die. The only way they could lift the curse was to pay 20-40,000 pounds 'debt' that they owed the trafficker for bringing them into the UK.

The research also revealed significant concerns regarding children coming into the country with adults purporting to be their relatives and disappearing into the unknown. This form of trafficking has become more evident over the last five or six years, and continues to reveal that children, particularly from Central Africa, are being brought into the UK to be exploited in domestic work or prostitution.

ECPAT UK research also provides evidence of children trafficked into the UK to deal drugs, or bring drugs and other contraband into the country. Children are trafficked to commit street crimes or for work in restaurants and sweatshops. Traffickers also bring children into the country, to live off their benefits, often to the detriment of the child.

The evidence illustrates that children often form a relationship with the trafficker before leaving their country. The child often believes that she is the girlfriend of her soon to be pimp. These relationships are often characterized by violence, rape and threats to the girl's family to ensure she does not leave. The issue of child trafficking remains unresolved and creates great concern.

Once children have resettled in their host country, proving asylum claims and integrating into a new and unfamiliar society can provide ongoing, significant challenges. This period is often referred to as a period of "secondary trauma".[29]

Children often experience inflexible, unwelcoming responses from agencies. Many spend months in temporary accommodation, having to move frequently and share rooms requiring heating and sanitation. Children often experience physical and racist attacks and often do not know that they are no longer at war.[29]

Research shows that the 'welcome afforded by the host country' has been identified as one of the key contingencies along with pre-migration experiences, likely to affect the development of migrant and refugee children[24] and that we are failing to provide for the children's needs.[31]

Understanding the mental health and medical needs of the children

A presumption that all refugees will have psychopathology should not be made. Many young refugees in resettlement countries, although exposed to terrible events and great adversity, appear to cope well despite the stress and suffering they have experienced. They have good social adjustment and do not have significant psychiatric morbidity. Resilience in children may occur for many reasons, including temperament, coping style, greater commitment to the combatants' own side and the presence of a supportive and harmonious family.[32]

Males and females may have had significantly different exposures to war and other violence, which may affect mental health differently. However, with similar exposure to violence and adverse events, there are inconsistent findings with regard to whether gender is protective. Age is also an important factor. Infants are protected by their cognitive immaturity and their well-being is closely related to that of their carers. For older children, the understanding of the events is important, but findings are again, inconsistent with regard to whether increasing age is protective in coping with adverse experiences.[33]

Nevertheless, the evidence indicates that children are at increased risk, compared with immigrant or indigenous children, for psychological symptoms and psychiatric disorders.[33]

It is estimated that 62.4% of refugee children experience significant psychological distress one year after an experience of war and that 35% fulfilled diagnostic criteria for emotional or behavioural disorders.[34]

PTSD is very common in unaccompanied minors and this increases their vulnerability to other mental health difficulties.[35] In an extreme case illustrated by children from Pol Pot concentration camps in Cambodia, aged 14-20, 50% of the group had PTSD, 12.5% had major depression and 40% had other affective disorders. Twelve years later, 35% had PTSD and 14% had depression.[36]

Refugee children exposed to fewer traumas than the Cambodians, such as a study referring to 50 young Iranian children, on average aged 5 years, left Iran and settled in Sweden. Most of the children had been exposed to bombardment from missiles and had seen assaults on their parents. Twelve months after their arrival in Sweden only 26% were regarded as having good psychological adjustment, with only minor psychological symptoms. At a follow up, 30 months later, 38% were regarded as having good psychological adjustment and 18% had severe PTSD symptoms and a further 18% reached criteria for PTSD. The prevalence of PTSD did not decrease with time.[37]

Among asylum-seeking and refugee children who have largely not been exposed to war, rates of disorder still appear to be significantly higher than in their non-refugee peers. In Montreal, more than 200 adolescents from 35 countries, who were largely not exposed to war settled in with significant difficulties. The rate of psychiatric disorder was 21% compared with 11% in their comparison group. Depression and conduct disorder were twice as high and were associated with significant psychosocial impairment.[38]

Developmental considerations are very important in understanding how children show their distress. Children may be tearful and most children will be troubled by repetitive, intrusive thoughts and flashbacks. Sleep disturbances with fears of dark and bad dreams occur. Separation difficulties are frequent in children and adolescents. Younger children may lose skills they have previously acquired, for example, bladder control. Children can also present with loss of

concentration and restlessness. Refugee children may also, understandably, have disorders and difficulties that may have occurred even if they had not been displaced and become refugees.[39]

Developmental disorders, including speech and language disorders, specific reading disorders and ICD-10 'mental retardation' and neuropsychiatric disorders, such as psychosis and hyperkinetic disorder are seen within this group of children and can lead to a child presenting to services.[40]

The likelihood that unaccompanied minors will develop a psychological disturbance increases greatly, as the number of risk factors accumulates.[41] It is important to understand the threat the child has been exposed to. A very high threat is represented by the proximity to and witnessing of the killing of family or community members and experience of torture or imprisonment. Less threatening is knowledge of war or organized violence.[42]

General health concerns, trauma and malnutrition are very common amongst unaccompanied minors.[25,12] A study in Spain illustrated that 21% of migrants from sub-Saharan Africa were chronic carriers or hepatitis B[43]; hepatitis A and meningitis may be more prevalent[44], depending on the country of origin. HIV prevalence is likely to mirror that in the country of origin, although we know that some refugees have been placed at particular risk.[45] Evidence shows that medical health concerns increases these children's risk for mental health difficulties significantly.[46]

Unaccompanied minors often do not speak English and we know that this too, an inability to express yourself verbally, increases refugee's risks to mental health problems.[47]

In addition to being vulnerable to mental health and medical problems, these children often face challenges to register and access their GP, interpreting support and mental health services.[47]

Risk factors for mental health problems in refugee children

Parental factors
PTSD in either parent
Maternal depression
Torture, especially in mother
Death of or separation of parents
Direct observation of the helplessness of parents
Underestimation of stress levels in children by parents
Unemployment of parents

Child factors
Number of traumatic events, witnessed or experienced
Expressive language difficulties
PTSD leading to long term vulnerability in stressful situations
Physical health problems from trauma or malnutrition
Older age

Environmental factors
Number of transitions
Poverty
Time taken for immigration status to be determined
Cultural isolation
Period of time in a refugee camp
Time in a host country

M Fazel; A Stein
The Mental Health of Refugee Children
Archives of Disease in Childhood; Nov 2002;87,5;ProQuest Medical Library

Culture

An approach to culture

The variations in our lives, which are labeled as "culture" and "ethnicity", have various understandings and meanings and certainly various implications.[48]

We have been informed that people from a certain culture will think and behave in certain ways, will organize their lives in relation to group-defined goals, values, beliefs and pictures of the world, and to an important extent, behave as expected, on the basis of their group membership[49], but can it be this predictable? We know that parents and children, or even siblings often have different cultural affiliations or values.

Culture and ethnicity are difficult concepts to define. It certainly appears as if it may often be dynamic and self-defined. It is a misconception that people form part of just one culture.[50] Most people form a part of many cultures.[51] People often appear to choose which areas of their lives belong to which cultures and naturally, this might change with experience, environment and age.

Problems faced by subgroups within a community may of course, also be completely independent of culture or ethnicity.

If culture and ethnicity is then dynamic and self-defined, why then, is it important.

People may experience and express symptoms very differently and their reactions to their symptoms and psychopathology may vary greatly depending on their culture.[52] Some people will express depressive symptoms by reporting sadness and hopelessness, whilst others may express the same feelings by commenting on somatic complaints or interferences or interpretations of what negative feelings might mean.[50]

One African tribe actually has no word describing sadness or unhappiness in their vocabulary. Evidence shows that GP's are more likely to miss depression in minority ethnic groups.[53]

Cultural differences may also provide risk or protective factors. Evidence shows a marked difference among subgroups of culture in rates of particular disorders. For example, higher rates of schizofreniform disorder have been identified in people of African-Caribbean origin within the UK[54] whilst lower rates of suicide among African-Americans compared with Caucasian-Americans have been identified.[55]

Cultural differences may also illustrate different rates of pre-marital pregnancy and educational attainment and different attitudes towards, for instance, obesity, recreational drugs, physical punishment, confrontational behaviour, psychopathology or self-harm. These factors can be interpreted as potential protective or potential risk factors.[50]

Britain is a multi-cultural society. Minority groups make up 6% of the population in England and Wales.[56] Public services have a duty to promote physical and psychological well-being among all members of this culturally diverse population.

Clinicians need to be aware of the variations in the ways in which different people may express what are basically the same phenomena and, they need to be aware of the variations in the values

attached to these phenomena. Clinicians should however, not try to learn stereotypical differences in different cultural groups, because it will not apply to all the members of those groups. Culture and ethnicity and their implications for psychopathology are indeed multi-faceted and it is helpful to assume as little as possible.[50]

Michael Rutter and Anula Nikapota describes four main messages that should be taken from findings on cultural influences in their chapter: Culture, Ethnicity, Society and Psychopathology in *Child and Adolescent Psychiatry*, Fourth Edition.[50]

1- Cultural influences apply as much within Western societies as in developing countries.
2-Cultural influences are likely to influence psychopathology and service utilization.
3-Cultural influences vary greatly within social groups and over time.
4-The culture, perception and attitudes of parents and children in the same family may not be the same.

Services

Political context

The status of those fleeing persecution is enshrined in international law, the United Nations Convention on Refugees, which resulted from a need to deal with the massive movements of people displaced by or fleeing the Second World War. Countries that have signed the United Nations Convention on Refugees are obliged to consider the application of anyone who claims refugee status and grant that person refuge on the basis of evidence. This is never an easy process for either party. Normally the host country decides whether or not to grant the person the right to refugee status, although the UNHCR may be asked to make the decision. Each case is decided on merits and can take from a number of hours to a number of years.[57]

During the last decade of the 20th century, governments, international organizations and the public became increasingly aware of the problems faced by asylum-seekers, refugees and internally displaced people. This was largely a result of live television reports, which provided dramatic images of desperate people fleeing from places such as Bosnia and Herzegovina, Chechnya, Iraq, Kosovo and Rwanda. It also resulted from the increased scope, in the post-Cold War era, for involvement in situations of mass displacement by humanitarian organizations, human rights organizations, multinational military forces, peace negotiators, war crimes investigators, journalists and a range of other external actors. The problem of forced displacement, however, is not new, and neither are international efforts to alleviate the suffering of uprooted people.[58]

Despite the overall trend in asylum claims, it remains one of the most sensitive political issues in many European Union (EU) Member States. Immigration, which encompasses issues related to both legal and illegal migration, refugees, asylum-seekers and returns, remains very high on the political agenda.[59]

Article 22 of the UN Convention on the Rights of the Child (UNCRC) 1989 provides that States should take the appropriate measures to ensure that a child asylum seeker receives the appropriate protection and humanitarian assistance in the enjoyment of the rights in the Convention itself and

in other international human rights instruments (such as the European Convention on Human Rights).

The power of the UNCRC is somewhat diluted here because of the UK's reservation to it. The reservation says that the UK retains the right to apply conditions relating to entry, stay in and departure from the UK. The precise meaning of the reservation has been the subject of dispute.[19]

The Asylum Act 1999 sought to disperse asylum seekers across the UK and away from London, often to areas with poverty and without the appropriate services to promote refugees' welfare. Extreme racism and homicide have occurred when refugees were moved to dispersal areas. This is at odds with the strong record of social inclusion policies, backed up by "sometimes well-resourced" services to promote welfare.[60]

The UN High Commissioner for Refugees has issued clear guidelines for dealing with asylum claims by unaccompanied minors, but has also complained that the guidelines have often been rendered ineffectual because of a lack of accountability and inadequate implementation.[19]

From a health perspective, concern has been expressed for this vulnerable population, exposed to high levels of war and deprivation and ongoing adversities during migration and settlement.[60]

UK Home Office Minister, David Blunkett, made a statement in the House of Commons regarding the UK's intention to expand its resettlement activities on 29 October 2001. In February 2002 a formal resettlement plan was announced with a quota of up to 500 per year, which will augment the existing *Mandate and Ten or More* resettlement schemes. The plan has been named the *Gateway Protection Programme (The Gateway*). *The Gateway* became operational in 2004. It aimed to process approximately 100 cases (individuals and families) during the first year, increasing capacity to fulfill the 500 placements gradually over ensuing years.

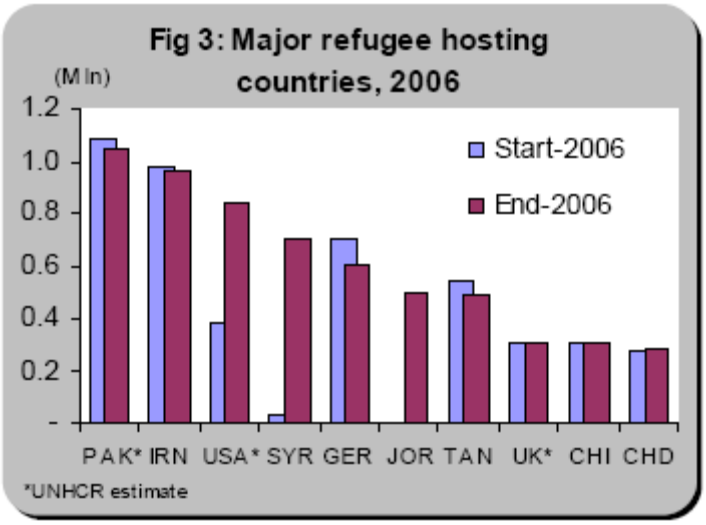
Community Care stated in August 2006 that the Home Office could face a big increase in legal challenges if it implements plans to return unaccompanied asylum-seeking children to their countries of origin. Immigration and Nationality Directorate (IND) papers seen by *Community Care* concede that there are "likely occasions" when removal "is not in accordance with the best interests of the child" but necessary for immigration control. Consideration was given to return children to Vietnam, the Democratic Republic of Congo and Angola. Adrain Matthews, asylum project manager at the Children's Legal Center, stated that forced removal decisions could be challenged on the grounds that they breached the UN Convention on the Rights of the Child or the European Convention on Human Rights. He stated that although the UK has a reservation on the UNCRC for immigration control purposes, courts were most likely to consider whether the Home Office had done enough to ensure a children's safety on their return. He stated that "there could be a massive amount of legal charges" as policy background to these plans clearly states that unaccompanied minors have 'leave to remain' until they turn 18.[61]

Illustrated by the UNHCR document: 2006 Global Trends[18]

Considering the data provided by UNHCR – 2006 Global Trends,[18] Afganistan is the leading country of origin of refugees. At the end of 2006, 2.1 million refugees from there could be found in 71 different asylum countries. This number contributes to 21% of the global refugee population. Iraqi's are the second largest group, with 1.5 million having sought refuge in neighbouring countries. This number has quadrupled in 2006. Sudan, with 686 000 nationals outside its country, is the next largest country of origin of refugees.

Africa hosts a quarter of all refugees, followed by Europe (18%), the Americas (10%) and Asia and the Pacific (9%).

Pakistan continues to be the asylum country with the single largest number of refugees, followed by the Islamic Republic of Iran. The USA is estimated to have 844 000 refugees, the Syrian Arab Republic has 702 000 refugees and Germany has 605 000. Jordan is also one of the top 10 asylum countries, hosting approximately 500 000 refugees from Iraq. The United Republic of Tanzania holds 485 000 refugees. These graphs, helpfully provided by the UNHCR, illustrates how this political need is being met.



Illustrated by the UNHCR document: 2006 Global Trends[18]

It is evident to see that the majority of the world's uprooted people remain in developing nations. In 2005, statistics from the UNHCR show five nationalities accounting for nearly half of the total population of concern to the UNCHR: Afghans (2.9 million), Colombians (2.5 million), Iraqis (2.5 million), Sudanese (1.6 million) and Somalis (839 000). With more than two million people internally displaced, Columbia hosted the largest population of uprooted people of concern to the UNHCR, followed by Iraq (1.6 million), Pakistan (1.1 million), Sudan (1million) and Afghanistan (912 000).

The data[62] illustrates mass movement of new refugees into neighboring countries, so called prima facie refugees, amounted to their lowest total since 1976. A total of 136 000 prima facie refugee arrivals were reported by 19 asylum countries, a 46% decline on the previous year, which is quite significant.

The number of people seeking asylum or appeals last year totaled 668 000 in 149 countries, down 2% over 2004. Some 374 000 or more than half were registered in Europe.

High Commissioner Antonio Guterres made the following comment in July of this year, "*While we have helped hundreds of thousands of internally displaced people go home in Liberia, the Russian Federation, the Balkans and elsewhere, millions are still living like refugees within their own borders. They need much more help than they currently get, and the UNHCR intends to do its share*."[62]

Existing services for unaccompanied minors in the UK

Nationally there is great diversity regarding the mental health service provision for refugees and unaccompanied minors. The dispersal policy has likely contributed to the reduced accessibility of primary care and mental health services for many asylum seekers and refugees.[60]

In the UK unaccompanied minors face the effects of poverty, dependence and lack of cohesive social support.[63] Discrimination and institutional racism are pervasive forces throughout society and part of the web of causation that generates mistrust and compounds the reported disparities in health between ethnic groups in the UK.[64]

No comprehensive specialist statutory services exist for unaccompanied minors in the UK. Considering the countries where specialist service models are available for children, no scientific evaluations have been made.

Recently however, it has been postulated that specialist services might better serve the needs of unaccompanied minors in the UK.

Evidence shows that knowledge of cultural factors and language are improved in specialist services, which may benefit professionals' understanding of difficulties.[65, 66] It is therefore said that patients may feel better understood and may experience professionals meeting their needs to a greater degree. It is hoped that with an improved understanding, less time might be required to conduct and complete assessments and services might be more effective.

The UK government recognizes that unaccompanied asylum-seeking and refugee children are some of the most vulnerable children in England. The level and quality of support provided to these young people has, in the past, varied widely across England and has often been found to be inadequate.[67]

It appears as if services potentially available to help unaccompanied minors are often ill equipped to address the children's needs. Evidence has shown poorer mental health service provision, service use, outcome and satisfaction amongst minority groups in Britain for some years.[31,67, 53]

Developing mental health services for unaccompanied minors in the UK

The dominant model for community psychiatry in the UK advocates that services be based on an assessment of the aggregated needs of the local population. It suggests that existing services need to be modified on the basis of a systematic and regular needs assessment.[68]

This illustrates why it might be important, when considering service development, to start with identifying the medical, mental health and social needs that the children present with.

Education and training are very important components of service development. GP's have an important role in providing services, by identifying and treating psychiatric problems, as they are often the first port of call. Cultural differences, as we know, can imply differences in the way people seek help, differences in the way people express their distress and differences in the impact that problems and services will have on them. GP's may not be skilled in dealing with these difficulties and GP's may not be perceived as part of a trusted community. These are very important issues to prioritize through better training.[69,70]

Four different service models have been described. Dr Kamaldeep Bhui, Dr Dinesh Bhugra and Dr Kwame McKenzie describe these models, as well as the arguments for and against specialist services in the Maudsley Discussion Paper No. 8, Specialist Services for Minority Groups?, Institute of Psychiatry, King's College, London.

Model A receives separate funding, funded by non-health service funds. It functions with separate operational procedures and with different lines of accountability, which means it functions as an entire separate service. Most of the voluntary sector is funded in this way.

Model B, also usually part of the voluntary sector, is funded by the same generic mental health services, but allowed to exist as a separate contractor to deliver services to specialist groups. They are accountable to the funder, but have separate lines of accountability. They represent voluntary and independent providers, who have been successful in attracting funding from the health authority or local authority. This model becomes efficient with shared lines of accountability and shared goals.

Model C, resembles an equal partnership, funded by the same source and required to work in conjunction with generic mental health services. They have clear lines of accountability to their funders and various degrees of shared accountability with generic services. This means a successful interface between providers, regardless of their ideology, needs to develop.

Model D is funded by a single source and imposes responsibility on generic mental health services to ensure care by sub-contracting to a variety of providers and specifying a detailed service level agreement. This can mean an effective integration of statutory and high quality providers, which means that the statutory sector could be helped to set up services with independent and voluntary organizations that have high levels of expertise.

Britain has nurtured models A and B in the voluntary sector on the assumption that this fulfills identical obligations and responsibilities as models C and D.

Models A and B are mainly separate services with specialist skills, but with a limited funding and capacity to sustain a service, often developing on the basis of need in other services.[71]

Models C and D harnesses high quality specialist services and are considered to be part of a comprehensive service with statutory and voluntary providers that have integrated successfully.[71]

Specialist services are usually restricted to the voluntary sector and are set up on budgets rarely sustainable. Service development, evaluation, teaching and training can seldom be accommodated.[72]

Voluntary and independent providers often emerge in response to a crisis in the statutory sector. Voluntary and statutory providers are diverse in their function and are not easily grouped and treated identically. The experiences however, reported of voluntary and independent providers, appears to be favorable.[71]

It is said that the statutory sector could benefit, improving and developing their knowledge and skill, from integrating with independent and voluntary organizations, who have the expertise to work with culturally diverse populations.

Currently we are considering the varieties, the benefits and concerns associated with specialist services and the difficulties in implementing an ideal model. The priority however, is to develop

a culturally competent generic mental health service, with the skill, knowledge and experience to meet the often complex psychosocial needs of this vulnerable group of children.

When planning for the mental health needs of unaccompanied minors, two main areas need targeting. We need to provide appropriate help for those experiencing psychological difficulties and we need to pay attention to develop primary prevention strategies to this high risk group.

There is a need for a variety of different treatments, individual, family, group and school based interventions. [73] Case studies also show that children can benefit from music, drama and art therapy.[74]

Addressing the needs of unaccompanied minors often seem overwhelming for those involved, as they do not easily fit the prescribed care packages. Multi-disciplinary working is essential and agencies often include interpreters, legal/immigration teams, voluntary organizations, ethnic support groups, social services and schools. This requires time and resources.[74]

Successful programmes emphasise the role of cross-cultural teams who can work in an extended outreach manner[74], as home based and school based work has advantages with families who might have a lingering distrust of authority.

Conclusion

People and especially, children who are seeking asylum are not a homogeneous population. It is essential to appreciate the considerable heterogeneity in the experiences of unaccompanied minors.

It is estimated that 9.9 million refugees are located throughout the world and that approximately 50% are children. Of the world's refugees, more or less, 5% are unaccompanied minors. In the first half of 2006, the UK hosted over 5000 unaccompanied minors, seeking asylum.

Until recently research has been focused on adults, but now there is a growing literature on children. Most systemic studies of refugee children have been undertaken in North America. All studies have shown that psychiatric morbidity, especially PTSD, is higher in refugee populations. It is also commonly evident that more than half of the children do not show any type of psychiatric illness or disorder.

Unaccompanied minors are however, a particularly vulnerable group of children.

Evidence shows that we have not been successful in providing these children with adequate services and protection. The government recognizes this as a concern.

Considering providing services and protecting unaccompanied minors, it is important that we prioritize education and training. It is essential that we, as professionals, have knowledge on appropriate legislation, such as the Human Rights Act 1998 and the Children's Act 1989 and helpful resources, such as groups campaigning for the rights of children and charity organizations, which are valuable resources to access up to date information, advice and support for children and services.

It is also essential that we have knowledge of the mental health, medical and social needs and associated risk factors that unaccompanied minors present with.

It is essential to know and understand the child's story to be able to identify the social, medical and mental health risk factors and needs of the child. It might be helpful to divide their experiences into three phases: The preflight, the flight and the resettlement phase.

Starting with their current presentation in their host country, the resettlement phase, we need to pay close attention to the 'responsible adults' in these children's lives and to the activities that they occupy their days with.

Unaccompanied minors need to be in education and close liaison with schools, to support and provide education to staff, is often helpful. Careful consideration needs to be given to their support networks, including adults and children. Unaccompanied minors are often isolated without having activities or hobbies to occupy themselves with. Assisting children in developing social contacts with peers and adults of a similar or different culture, by involving them in normative, meaningful after school activities, is often helpful to them. Close liaison with social services is essential. The quality of their accommodation, the frequency of having to relocate within the country, the amount of people they currently share with and whether they feel and are safe in the community are important issues to address.

Knowing that unaccompanied minors are vulnerable of being exploited by adults, it is essential that when a child is missing and the social worker is unable to locate the child, the Police are informed.

Language barriers and having a different interpreter for every consultation or appointment, or not having one, often provides challenges for unaccompanied minors. Children often face challenges to register and access their GP's, interpreting support and mental health services. There is no requirement under the current asylum legislation that claimants have legal representation when they make their cases for asylum at the Home Office. Children, however often meet with solicitors to state their cases. Unaccompanied minors often find these experiences, with the associated risk of deportation, very challenging.

We know that the children's development is particularly vulnerable to their experiences in their country of origin before they left and their experiences in their host country, the United Kingdom.

We know that medical concerns, particularly trauma, malnutrition and infections, including HIV and Hepatitis B, are common in some refugee children from particular areas. It is important to consider the children's country of origin, together with their past experiences, when considering these risks. Close liaison with pediatricians and tropical medicine specialists are often helpful.

It is also important to consider a child's biological family, whether a child knows where they are and whether a child is afraid for their safety. It is possible to support a child in locating the family, but unaccompanied minors have no clear entitlement to family reunification in the UK. The British Red Cross, International Social Services, Refugee Community Organizations and UK Consulates Abroad can be contacted, as they deal with establishing family tracing and contact.

Considering the first two phases of the children's experiences, the preflight and the flight, it is important to gain an understanding of their environment and experiences in their country of origin. Family history, biological risk factors, psychosocial background and the political environment are all important issues to consider. It is helpful to have a clear understanding of

why the child left, how the child left and where and how the child arrived in the UK. Liaison with social services is essential.

It is important to make children aware of confidentiality and its meaning. Education regarding our services is crucial. Children will need to feel safe and it can take some time before they might feel comfortable to discuss their serious concerns with professionals. Children are often very reluctant to discuss some of their background history, as they often believe it might influence their asylum claim, safety or the safety of their families. Children also occasionally say that they want to protect professionals from hearing their stories.

Evidence shows poorer mental health service provision, service use, outcome and satisfaction amongst minority groups in Britain. When we ask why, we are often pointed to culture.

Culture, although perhaps self-defined and dynamic to an extent, appears to be related to certain risk and certain protective factors, which we need to be aware of. Cultural factors may also have implications on how children experience and express symptoms, their understanding of health difficulties, what it might mean to them and how they might seek help. It is however a misconception that people form part of only one culture or that culture is stable and this is illustrated by siblings and parents often having different cultural values.

Evidence illustrates that knowledge of cultural factors and language is improved in specialist services and that this knowledge may benefit professionals' understanding of unaccompanied minors' difficulties. It is postulated that patients may feel better understood and experience professionals meeting their needs to a greater degree. It is also said that this better understanding will aid service productivity, as less time will be required to conduct and complete assessments. It has therefore recently been postulated that specialist services might better serve to meet the needs of unaccompanied minors**.**

No comprehensive specialist statutory services exist in the UK and we know that there have been no scientific evaluations of special service models in countries where these are available. There has also been no conceptualization of how such services might function in harmony with other generic services. Issues of economic feasibility and ethical dilemmas have also not yet been fully considered.

Considering an economic perspective, there appears to be a need for some co-ordination of services. Government policy has suggested an integration of health and social services to decrease cost and prevent fragmentation of care and this suggestion might benefit our goal for meeting the needs of these children. A multi-agency approach, close and frequent liaison with not only social services, but also pediatricians, education, voluntary agencies and solicitors, are very important to support the children. This clearly requires resources.

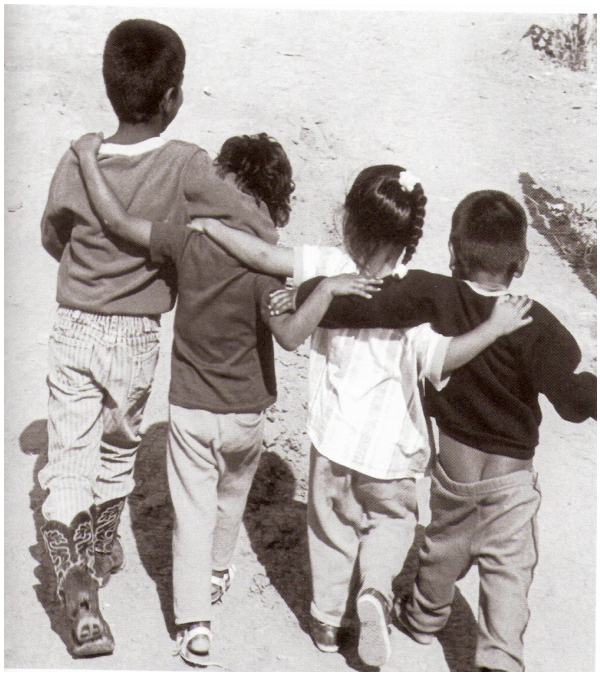
The statutory sector will need to develop and protect their level of skill and knowledge and liaison with the voluntarily sector and independent providers, who can and are providing a high quality of service, will continue to be essential. Clear working alliances and agreements need to be established, education and training need to be prioritized and a commitment, supported by a capacity in organizations, need to be made to develop services.

Perhaps our role, as mental health professionals, in working towards developing a service for unaccompanied minors is rather simple, aiming to understand, not primarily the culture, but the child's world. Respecting culture, by not assuming, but being curious and allowing a child to tell the story that you might not want to hear. A commitment by professionals to gain understanding

from each individual child and act in the child's best interests by knowing the rights of the child, by assessing the needs of the child and by coordinating services for the child is of utmost importance.

I have compiled a grid, which I have called the *Yesterday, Today and Tomorrow Grid*, to act as an aid in helping us recall, not only the complex and diverse, often risk associated, histories some of the unaccompanied minors present with, but also that they, these children in need, have a *Tomorrow* and that we can and should help them plan for this bright day.

"We shall require a substantially new manner of thinking if mankind is to survive."
Albert Einstein



	Yesterday Home country	Transit: Flight to Host country	**Today** In Host country	**Tomorrow** Uncertain
Social Perception of feeling safe in environment	-Yes/no -Why -What was the risk	-Yes/no -Why -What was the risk	-Yes/no -Why -What is the risk	-Plans/hopes for the future to inspire safety
Adults in the child's life (responsible and irresponsible)	Including family	Including family	Including family	-Plans for future, involving adults - employment/travel
Name: Social Worker Section 17/20 (CA 98)			-Name of SW -Section 17 or 20	-Child in Need plan attached
State of accommodation	-State of accommodation -How many others present -Name/age/relation	-State of accommodation/transit -How many others present -Name/age/relation	-State of accommodation -How many others present -Name/age/relation	-Child in Need plan
Number of transitions/moves	-Number of moves	-Number of transit methods	-Number of moves	-Child in Need plan re accommodation
History of detention/ refugee camps	-Yes/No	-Yes/No	-Yes/No	
History of fleeing/ abuse/witnessing abuse of family/others	-Yes/No	-Yes/No	-Yes/No	
Transit		-How long in transit -Time period -Arranged by whom/ how/funding -Method of transit/smuggling		
Location of family during this time	-Location	-Location	-Location -Red Cross involved	-Plans of /for the family
Political context at home during this time	-Good/Poor -Details of culture and risk	-Good/Poor -Details of culture and risk	-Good/Poor -Details of culture and risk	-Possible outcome if returned home *(see Helpful Info)*
Parents' political views and role	-During this time	-Parent's views regarding transition	-During this time	-Family's political plans
Parent's reaction to trauma/abuse in family	-During this time	-During this time	-During this time	-Family's belief of the treatment/cure
Wellbeing/death of family	-During this time	-During this time	-During this time	
Reason for leaving home/the story	-Reason for leaving			-Plans to return or travel
Family Tree &	-Support network	-Support network	-Support network	-Support network
Education	-Educational level -Attendance of school		-Educational level -Attendance of school	-Plans/hopes for future of child -Child in Need plan
Normative meaningful activities during day	-During this time		-During this time	-Plans/hopes and interests of child

Support in the Community. Perception of "welcome" in Host country			-Cultural isolation -Elders/religious support -Peers/adults in community as support network -Charity Organizations involved	Child in Need plan
Immigration status			-Time in Host country -Immigration status -Legal representation	-Plans of Home Office -Implications if returned to Host country
Availability of interpreter			-During this time for Health, Social Care, Imm meetings	
Language barriers	-Spoken language -Language in community	-Language spoken in transit	-Ability to speak English	-Plans to learn English
Finance Able to purchase food and necessary items			-Working with or without earning money	-Working with or without earning money
Psychological Child's beliefs regarding psychopathology and experiences	Be careful to take cultural factors into consideration in understanding explanations.	Be careful to take cultural factors into consideration in understanding explanations.	Be careful to take cultural factors into consideration in understanding explanations.	-Beliefs regarding implications for the future
Mental Health Difficulties	-Behavioural difficulties -Depression -Anxiety – PTSD Sleep disturbances Nightmares Fears of dark Separation difficulties -Somatisation -Other		-Behavioural difficulties -Depression -Anxiety – PTSD Sleep disturbances Nightmares Fears of dark Separation difficulties -Somatisation -Other	-CAMHS involvement and care plan -Voluntary Organizations supporting refugee children
Family's beliefs regarding child's difficulties	-Beliefs re cause -Beliefs re implications -Beliefs re treatment	-Beliefs re cause -Beliefs re implications -Beliefs re treatment	-Beliefs re cause -Beliefs re implications -Beliefs re treatment	-Family's belief regarding treatment/support/ cure
Biological Physical Health	-Infections -Nutritional status -Physical trauma -Developmental history	-Infections -Nutritional status -Physical trauma	-Infections -Nutritional status -Physical trauma -Health reviewed by GP -Health reviewed by Dentist	-Child in Need plan: Risk factors for future concerns - Seek specialist/expert advice if indicated eg Tropical Medicine
Risk Factors	-Family History of mental health, developm, physical problems -Environment *(See Helpful Info)*	-Environment	-Environment	-Child in Need plan to address risk factors

Recommendations for working with Interpreters

Arranging for an Interpreter

- Do not use family members or friends to interpret.
- Use a trained and approved interpreter.
- "The code of ethics" discusses the role of the interpreter.
- Ask the family whether they have used an interpreter before, they might want to use the same one, which you can request, as families often build a trusting relationship with their interpreter, or they might specifically ask for a different person.
- Check the language and dialect. It often takes weeks to locate and arrange for a specific interpreter.
- Take cultural factors into consideration. The interpreter might be in a tribe/cultural group that has strong feelings towards the tribe/cultural group of the patient.
- Consider the age and gender of the interpreter.
- It is often helpful if the interpreter has knowledge and experience in mental health work.

Before the Interview

- Consider the size of the room.
- Consider the time available. You will require two to three times longer than your usual assessments and it is often helpful to break the assessment up in parts.
- Consider the seating. It is often helpful to arrange the seats in a triangle.
- Speak to the interpreter about his/her knowledge and experience in mental health and in meeting with asylum seeking children. Some interpreters have very strong personal views of refugee and asylum seeking individuals or their culture and it is helpful to know this before the interview. Some interpreters have great sympathy for the children and others can feel negatively about the children.
- Spend time discussing and explaining your way of working and if appropriate, the goal of your assessment and give the interpreter time to discuss his/her way of working
- **Ask the interpreter to use the exact words of the child and not to assign meaning to it, to be helpful to you**.

During the Interview

- Start of by explaining the structure and procedure of the interview and everyone's role.
- **Discuss confidentiality and it is often helpful to explicitly say that the Police, Social Care of the Home Office do not have access to the file and will not get information from you and explain the rare circumstances that you will need to break confidentiality.** It is worth taking time to make sure that the patient know his story will not lead to his deportation or detention.
- **It remains just as important to engage with the child or family. Make eye contact with the child, rather than with the interpreter and use non-verbal communication to engage with the child and family.**
- When you ask the child a question, make eye contact and speak to the child, using 'you', rather than speaking to the interpreter, using 'he/she'.
- Speak slowly and clearly, using simple, single questions, avoiding more than one sentence at a time or jargon or expressions that can easily be misunderstood.
- Allow enough time for the interpreter to talk to the child and do not interrupt.

After the Interview

- Give the interpreter time to discuss his/her thoughts with you. Interpreters can often find the histories very upsetting and they might need a few minutes to debrief.
- Interpreters can often shed great light on cultural issues and might be a great source of information.
- It might be helpful to ask the child what his/her experience was of having the interpreter in the room.
- Document the interaction and atmosphere in the room.

References

1. United Nations. (1951) Convention Relating to the Status of Refugees, Article 1, Resolution 429 (V)
2. Doyle, K. (2002) ABC's of immigration: training on basic concepts of immigration law. In: *Massachusetts Immigration and Refugee Advocacy Coalition*
3. Russell, S. (1999) Most vulnerable of them all: The treatment of unaccompanied refugee children in the UK. UK: Amnesty International
4. Home Office Note on Unaccompanied Minors (http://www.ind.homeoffice.gov.uk/ind/en/home/applying/asylum_applications/unaccompanied_asylum.html)
5. Russell S. (1999) Unaccompanied Refugee Children in the United Kingdom. *International Journal of Refugee Law*, **11**(1)
6. Mayor of London. (2004) Offering more than they borrow: Refugee Children in London. Greater London Authority.
7. Sutton, D. and Smith, T. (2005) Is Europe failing separated children? *Forced Migration Review*, **23**, May (http:www.fmreview.org/magsl.htm)
8. Ayotte, W. and Williamson, L. (2001) Separated Children in the UK: An overview of the current situation. London: The Refugee Council and Save the Children.
9. Save the Children. (2005) Young refugees: A guide to the rights and entitlements of separated refugee children. Published by Save the Children England Programme.
10. UNHCR (1995) Office of the United Nations High Commissioner for Refugees, Refugees at a Glance: A monthly digest of UNHCR activities, July
11. UNHCR. Statistics. (http://www.unhcr.ch/statist/main.htm)
12. UNICEF. (2006) Uprooted Children.
13. Ressler, E., Boothby, N., Steinbock, D. (1998) In: *Wars, Natural disasters and refugee movements*. New York. Oxford University Press
14. UNHCR. (2002a), Refugees by Numbers (http://www.unhcr.org)
15. UNHCR. (2002b), Special Feature on the 50th Anniversary of the Convention (http://www.unhcr.org/195convention/index.html)
16. Westermeyer, J. (1991). Psychiatric services for refugee children: An overview. In: *Refugee Children: Theory, Research, and Services* (Johns Hopkins series in contemporary medicine and public health), Athey JL ed. Baltimore: Johns Hopkins University Press
17. Maltz, D., Hill, R., Heath T. (2001) Asylum statistics, United Kingdom, 2000. London: Immigration, Research and Statistics Service, Home Office.
18. UNHCR. (2007) 2006 Global Trends: Refugees, Asylum-seekers, Returnees, Internally Displaced and Stateless Persons.
19. Save the Children. http://www.savethechildren.org.uk/caris/legal/srandi/sr_04.php
20. British Association for Adoption and Fostering http://www.baaf.org.uk/info/stats/england.shtml#uas
21. Home Office Asylum Statistics: First quarter 2006, United Kingdom
22. UNHCR Geneva. (2007) March. http://www.unhcr.org/statistics
23. US committee for Refugees and Immigrants. (2005) *World refugee survey 2005. Warehousing: inventory of refugee rights. 2005.* Washington DC: US committee for Refugees and Immigrants
24. Ayotte, W. (2000) Separated children coming to Western Europe: Why they travel and how they arrive. Save the Children.
25. United Nations. (1994) Update on the Nutrition Situation: A report compiled from information available to the ACC/SCN, Geneva, November, p.58.

26. United Nations Children's Fund, 'Angola: Alliance for life', op.cit.,p. 3.
27. Zutt, Johannes. (1994) Children of War: Wandering alone in southern Sudan, UNICEF, New York, p. 1.
28. Somerset, C. (2001) What the Professionals Know: The Trafficking of Children into and through the UK for Sexual Purposes. ECPAT UK (cited in Save the Children, 2005); Somerset, C., 2004. Update on the Trafficking of Children into the UK for Sexual Purposes. Unpublished, both cited in the Somerset C., 2004. Cause for concern? London social services and child trafficking. ECPAT: UK (http://www.ecpat.org.uk)
29. Richman, N. (1998) Refugees and asylum seekers in the West. In: *Rethinking the trauma of war.* Bracken P, Petty C, New York: Free Association Press. pp:170-86
30. Beiser, M., Vu, N., Dron, R., Gotowiec, A., & Hyman, I. (1995) Immigrant and refugee children in Canada. *Canadian Journal of Psychiatry,* **40**
31. Cochrane, R. & Sashidharan, S.P. (1996) Mental health and ethnic minorities. A review of the literature and service implications. In: *Ethnicity and Health: Reviews of literature and guidance for purchasers in the area of cardiovascular disease, mental health and haemoglobinopathies*. CRD Report 5. NWS Center for reviews and dissemination social policy research unit. University of York.
32. Hodes, M. (2000) Psychological disressed refugee children in the United Kingdom. *Child Psychology and Psychiatry Review*, **5,** 57-68
33. Modes, M. (2002) Implications for psychiatric services of chronic civilian strife: young refugees in the UK. *Advances in Psychiatric Treatment*, **8**, 366-376
34. Ispanovic-Radojkovic, V., Tadic, N., Bojanin, S. et al. (1994) War traumatised children: Reactions, disorders and help. *The Stresses of war and sanctions*. Kolicanin P ed. Belgrade: Institute for Mental Health. pp:113-132
35. Punamaki, R. (1989) Factors affecting the mental health of Palestinian children exposed to political violence. *Int J Mental Health* **18**:63-79
36. Sack, W., Him, C.& Dickason, D. (1999) Twelve year follow-up study of Khmer youths who suffered massive war trauma as children. *Journal of the American Academy of Child and Adolescent Psychiatry*, **38**, 1173-1179
37. Almquist, F. & Broberg, A. G. (1999) Mental health and social adjustment in young refugee children 31/2 years after their arrival in Sweden. *Journal of the American Academy of Child and Adolescent Psychiatry*, **38**, 723-730
38. Tousignant, M., Habimana, E., Biron, C., et al (1999) The Quebec adolescent refugee project: psychopathology and family variables in a sample from 35 nations. *Journal of the American Academy of Child and Adolescent Psychiatry*, **38**, 1426-1432
39. Yule, W., Perrin, S. & Smith, P. (1999) Post traumatic stress reactions in children and adolescents. *Post Traumatic Stress Disorders* (ed W.Yule) pp.25-50. Chichester: John Wiley & Sons.
40. Howard, M.R. & Hodes, M. (2000) Psychopathology, adversity and service utilisation of young refugees. *Journal of the American Academy of Child and Adolescent Psychiatry*, **39**, 368-377
41. Garmezy, N., Masten, AS. (1994) Chronic adversities. *Child and adolescent psychiatry: modern approaches*. Rutter M, Taylor EA, Hersov LA, eds. Oxford: Blackwell Scientific, 191-208
42. Garbarino, J. & Kostelny, K. (1996) The effects of political violenc on Palestinian children's behavioural problems: a risk accumulation model *Child Development*, **67**, 33-45
43. Garcia-Samaniego, J., Soriano, V., Enriquez, A., Lago, M., Martinez, M.L., Muno, F. (1994). Hepatitis B and C virus infections among African immigrants in Spain. *Am J Gastroenterology*. **89**: 1918-9

44. Burnett, A. (1999) Guidelines for health workers providing care for Kosovan refugees. London: Medical Foundation for the Care of Victims of Torture
45. Walker, P.F., Jaranson, J. (1999) Refugee and immigrant health care. *Med Clin North Am*. **83**:1103-20
46. Westermeyer J. (1998) DSM III psychiatric disorders among refugees in the United States: a point prevalent study. *Am J Psychiatry* **145**:197-202
47. Montgommery E. (1998) Refugee children from the Middle East. *Scand J Soc Med Suppl* **54**:1-152
48. Garcia Coll, C., Akerman, A. & Chicchetti, D. (2000) Cultural influences on developmental processes and outcomes: implications for the study of development and psychopathology. *Development and Psychopathology* **12:**333-356
49. Nikapota, A.D. (1991) Child Psychiatry in developing countries. *British Journal of Psychiatry* **158:**743-751
50. Rutter, M., Nikapota, A. (2002) Culture, Ethnicity, Society and Psychopathology. *Child and Adolescent Psychiatry Fourth Edition* (Ed. Michael Rutter and Eric Taylor), 277-286
51. Shweder, R.A.., Goodnow, J., Hatano, G., LeVine, R.A., Markus, H. & Miller, P. (1998) The cultural psychology of development: one mind, many mentalities. In: *Handbook of Child Psychology*, Vol. 1. *Theoretical Models of Human Development*. Damon W & Reiner R eds. John Wiley & Sons, New York. pp:865-937
52. Kleinman, A. & Good, B. (1986) Culture and depression: Studies in the Anthropology and Cross-Cultural Psychiatry of Affect and Disorder. University of California Press, Berkley, CA.
53. Bahl, V. (1999) Mental Illness: a national perspective. Chapter in: *Ethnicity: an agenda for mental health.* Bhugra D & Bahl V ed. Gaskell: London
54. Rutter, A., Pickles, R., Murray & Eaves, L. (2001) Testing hypotheses on specific environmental causal effects on behaviour. *Psychological Bulletin.* **127:** 291-324
55. Nettles, S.M. & Pleck, J.H. (1994) Risk, resilience, and development: the multiple ecologies of black adolescents in the United States. In: *Stress, Risk, and Resilience in Children and Adolescents*. Haggerty RJ, Sherrod LR, Garmezy N & Rutter M eds. Cambridge University Press, New York. pp:147-181.
56. Peach, C. (1996) Introduction to: Ethnicity in 1991 Census Vol 2: In: *The ethnic minority population of Great Britain*. Ed.C. Peach. *ONS*. London.HSMO.
57. Tribe, R. (2002) Mental health of refugees and asylum seekers. *Advances in Psychiatric Treatment*, **8**, 240-247
58. UNHCR. The state of the world's refugees. http://www.unhcr.org/publ/PUBL/3ebf9bb87.pdf
59. UNHCR. Global Appeal. (2007) Western Europe.
60. Hodes, M., Golberg, D. (2002) The treatment of refugees: service provision reflects Britain's ambivalence. *Psychiatric Bulletin* **26**, 1-2
61. Community Care www.communitycare.co.uk
62. UNHCR News Stories (2007) July www.unhcr.org/news/NEWS/48891514.html
63. Connelly, J. Schweiger, M. (2000) The health risks of the UK's new Asylum Act. *BMJ* **321**:5-6
64. McKenzie, K. (1998) Something borrowed from the blues. *British Medical Journal* **328**:616-617
65. Bland, IJ. & Kraft, I. (1999) The Therapeutic Alliances Across Cultures. Chapter in: *Clinical Methods in Transcultural Psychiatry*. Okapaku S eds. American Psychiatric Association Press. Washington
66. Sue, S., Fujino, DC., Hu, L., Takeuchi, D. (1991) Community mental health services for ethnic minority groups: a test for the cultural responsiveness hypothesis. *Journal of consulting and clinical psychology.* **59**(4):533-40

67. Bhui, K. & Olajide, D. (1999) *Mental Health Service Provision for a Multi-cultural Society*. Saunders. London
68. Bhugra, D. & Bhui, K. (1998) Transcultural Psychiatry. Do problems persist in second generation. *Hospital Medicine*. **59**(2):126-129
69. Odell, SM., Surtees, PG., Wainwright, NWJ. et al. (1997) Determinants of general practitioner recognition of psychological problems in a multi-ethnic inner city health district. *British Journal of Psychiatry*. **171**: 537-541
70. Tylee, A. (1998) Education of Primary Care Team. Chapter in: *Preventing Mental Illness.* Jenkins R, Bedhirhan, Ustun T eds. John Wiley & Sons. Chichester.
71. Jennings, S. (1996) The process of partnership. Chapter in: *Creating Solutions. Developing alternatives in Black mental health*. King's Fund. London.
72. Gray, P. (1999) Volunary organizations' perspective on mental health needs. Chapter in: *Ethnicity: An Agenda for Mental Health.* Bhugra D & Bahl V ed. Gaskell. London.
73. Jensen, S.B. & Shaw, J. (1993) Children as victims of war: current knowledge and future research needs. *J Am Acad Child Adolesc Psychiatry* **32**: 697-708
74. Ahearn, F.L., Athey, J.L. (1991) Refugee children: theory, research and services. Baltimore, MD: John Hopkins University Press

Photography

First photo by Isibongo
Second photo by M.I.L.K

Helpful Sources of Information

Helpful Organisations

Save the Children
Child's Rights Alliance
Refugee Children's Consortium
British Red Cross
International Social Services
UNICEF
Office of the United Nations High Commissioner for Refugees UNHCR
Medical Foundation for the Victims of Torture
The Refugee Council
Refugee Action
Asylum Aid
MIND: Ethnic minority mental health issues
National Asylum Support Service

Helpful Websites

www.unicef.org
www.un.org
www.unhcr.org
www.redcross.org.uk/trace
www.refugeecouncil.org.uk
www.savethechildren.org.uk
www.mentalhealth.harpweb.org.uk
www.childrenandwar.org
www.noplaceforachild.org
www.torturecare.org.uk
www.child-soldiers.org
www.refugeesinternational.org
www.refugee-action.org
www.asylumaid.org.uk
www.mentalhealth.harpweb.org
Information on Immunisations: www.nt.who.int/vaccomes/globalsummary/pgs2000.cfm
Information on HIV/AIDS: www.tht.org.uk

Helpful telephone numbers

International Social Services Tel: 020 7735 8941
Asylum Seeker and Refugee Health Network Tel: 0113 254 6605
Medical Foundation for the Victims of Torture Tel: 020 7813 7777
Young Refugee Mental Health Project, Maudsley Hospital Tel: 020 7919 3381
National Asylum Support Services: Law, policies and publications Tel: 0845 602 1739
Asylum Aid Tel: 020 735 49264
Hospital for Tropical Diseases, London Tel: 020 7387 4411
Liverpool School of Tropical Medicine Tel: 0151 705 3205