Child refugees and asylum seekers: oral health and its place in the UK system

A.V. L. Fennell-Wells¹ and **H. Yusuf²** explore how the dental team can contribute to the holistic resettlement of a vulnerable population group.

Introduction

Current conflicts occurring around the world have given rise to unprecedented levels of movement of populations, including unaccompanied children. Since the migration crisis of 2014 and 2015, which resulted from the Syrian war, there has been a huge leap in the number of unaccompanied child refugees. The year 2016 saw the highest levels of displacement on record, with over 22.5 million refugees forcibly displaced from their homes due to conflict or other threat to personal safety.¹ Over 50% of these refugees were estimated to be children below the age of 18. It is estimated that nine in ten of the world's refugees are actually sheltered by developing countries rather than European Union member countries.² The five EU member countries receiving the most applicants for asylum in 2016 were Germany, Italy, France, Greece and the United Kingdom, although the UK's intake was the lowest of the five, receiving fewer than 40,000 compared with Germany who received nearly 750,000.³

A refugee is a person who cannot remain in their country of origin owing to fear of persecution, or, having left their country, is unable or unwilling to return as a result of such persecutory events.¹ An asylum seeker is a person who has left their country of origin and formally applied for asylum in another country, but whose application has not been concluded.^{1,4} In the UK, a person is officially a refugee when the government has accepted their claim for asylum. A refused asylum seeker is a person whose asylum application has been unsuccessful and, who has no other claim for protection awaiting a decision⁵ (Fig. 1). Some refused asylum seekers return home voluntarily. Others are forcibly returned; despite the fact that it may not be safe or practical to do so.

Asylum seekers are looking for safety; they are fleeing persecution, conflict, violence, having evacuated their country of origin.^{1,6} War experiences and human rights violations can include: witnessing physical, sexual or murderous violence towards family members; separation and forced migration; terrorist attacks; child-soldier activity; bombardments and shelling; witnessing parents' fear and panic; physical injuries and war-related disability of the child; imprisonment or detention; experience of trafficking; scarcity of resources, famine and torture. The repercussions of deeply traumatic events echo throughout a person's existence, and commonly lead to mental health problems.^{7,8,9,10}

This vulnerable and diverse group of people seeking asylum arrive with a myriad of problems and are presented with multiple barriers to seeking, let alone achieving, legal refugee status, in addition to the catastrophic trauma already experienced. Asylum seekers are subject to racial violence, homelessness, professional de-skilling, language difficulties, uncertain residency status, loss of cultural identity, struggles with integration and acculturation to the host country and imprisonment.¹¹

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Fig. 1 Healthcare available to refugees and asylum seekers

Seeking asylum – the process in the UK

Upon entering the UK, the path from asylum application to resettlement is potentially long and difficult and involves navigating the UK legal system. Once an application has been made, a meeting or 'screening' is held between the applicant and an immigration officer, followed by an interview with a caseworker.¹² A decision should be made within six months, but during 2016 nearly 9,000 refugees were left waiting longer.⁴ In 2016 only 9,391 of 400,000 displaced minors under the age of 18 applied for asylum in the UK. Two-thirds of these applications were submitted as dependents and the remaining third as unaccompanied minors. Although unaccompanied, asylum seeking children represent a small percentage of children in care (approximately one in 20), their situation needs to be documented accurately to ensure provision of appropriate support. Unaccompanied minors are entitled to the same rights as any other child, including accommodation, education and health

assessments as well as general support and regular review. Unaccompanied minors who were interviewed in London reported little knowledge of the asylum process and often attended the required Home Office interviews alone. They found the interactions frightening and struggled to answer questions. Despite numerous aid organisations offering help, refugees felt they were given little information and also that their social needs were actually neglected by the social services.¹³

Acceptance of minors into the host country

Unaccompanied asylum seeking children will most likely receive 'discretionary leave to remain' until the age of 17-and-a-half years.¹⁴ This means that such a child does not qualify for refugee status but the Home Office cannot return them to their home country due to inadequate reception arrangements; this is a form of temporary leave to remain and is not a route to settlement – it is a refusal of the child's asylum claim.

Refugee and asylum seeking children,

especially those who are unaccompanied, have an increased risk of harm with regard to poverty and social integration.⁶ Refugees are subject to episodes of aggression, open hostility and violence by resident citizens perpetuated by daily levels of harassment in many areas of the UK.¹⁵

Health assessment protocol: child refugees and asylum seekers arriving in the UK

Currently, the health protocol governing pre-entry health assessments for UK-bound refugees aims to identify treatment and screening needs to settle refugees safely and appropriately.¹⁶ A child's first contact with medical staff could take place before the individual arrives in the UK, possibly carried out in the country where the refugee has sought protection. It is recommended that this assessment should include an oral component. If a child misses this entry assessment, the next opportunity for a health assessment arises only when an unaccompanied asylum seeking child is placed under the care of a local authority, which notifies the health services.¹⁷ The initial health assessment should be carried out within 28 days after registration.¹⁸

The authority responsible for an unaccompanied child must take all 'reasonable steps to ensure that the child is provided with appropriate healthcare services in accordance with the health plan, including medical and dental care and treatment, and advice and guidance on health, personal care and health promotion issues'.¹⁹ The Royal College of Paediatrics and Child Health recommends the use of a structured proforma which includes a dental care component.²⁰ A compulsory dental examination is not referenced in legislation. Much can be learned from the Department of Health and Human Services of Victoria, Australia, where a weekly multi-disciplinary Immigrant Health Service has been implemented, providing medical care and advice, free of charge, to all asylum seeking and refugee children.²¹

Physical health

There is limited data on health of refugees and asylum seekers especially in relation to children in the UK. A small number of studies among adults reveal that one in six refugees has a physical health problem severe enough to affect their life.²²

A study among adult Kosovan refugees in the UK showed high rates of diabetes, hypertension, and coronary heart disease.²³ Studies from Western Australia have revealed that many refugees and asylum seekers have

Fig. 2 Potential clinical care pathway to access dental care for children arriving in the UK

poorer health than their host population due to precarious medical infrastructures; rudimentary or non-existent public health services; and lack of health literacy.²⁴

A 2007 systematic review of the prevalence of infectious diseases among the adult and child UK asylum seeker and refugee populations found the prevalence of human immunodeficiency virus (HIV), tuberculosis (TB) and hepatitis B (HVB) was 10–100 times higher than the overall UK population prevalence.²⁵

Data collected at a Kent County clinic in 2015 from a sample of 75 unaccompanied children showed 47% presenting with diseases that are both preventable and manageable. These included scabies, anaemia, malaria, typhoid, active hepatitis and vision problems.²⁶ In addition, there were concerns about inadequate immunisation records and mental health.

Mental health

The prevalence of specific types of mental health problems is influenced by the nature of the migration experience, in terms of adversity experienced before, during and after resettlement.²⁷ Undoubtedly, displacement of children has considerable impact on mental health and wellbeing. There are broadly three factors that may impact on child mental health:²⁸

- Parental factors: post-traumatic stress disorder (PTSD); maternal depression; torture; separation from parents

- Child factors: language and behavioural difficulties; compromised physical health
- Environmental factors: length of time and number of displacements; structural factors in the host country.

Unaccompanied child refugees and asylum seekers have complex health needs¹⁹ which are often overlooked by the host country.

Oral health

Despite the importance of good oral healthcare on the quality of life, there are only limited data available on oral health of refugee children and asylum seekers in the UK. Risks to oral health include tooth decay, poor diet, lack of access to oral healthcare, trauma and increased susceptibility to chronic disease.

Oral health assessments for refugees entering or residing in the UK have been largely sporadic. Many asylum seekers arrive with poor dental health and may need urgent dental treatment.⁶ Data collected at a Kent County clinic in 2015 for 75 unaccompanied children showed 65% of this group presented with dental decay,²⁶ more than twice the national average of 24.7%.²⁹ Infectious diseases such as HIV, syphilis, and tuberculosis are associated with dental developmental abnormalities, the oral manifestations of which may be diagnosed in this population group.²⁵

The adverse life events endured by these children are associated with poorer outcomes across social, education and health experience.³⁰ An audit of the initial health

assessments of unaccompanied asylum seeking children at a UK teaching hospital found that, despite clear guidelines and an electronic proforma, there was dramatic variation in the initial health assessment of 25 unaccompanied male teenagers.³¹ A social worker was present during only one assessment, while interpreters were absent in five cases, and dental treatment was needed for nine patients. These findings demonstrated inconsistencies in health assessments, which may compromise management plans.

Dependent children, unlike unaccompanied child asylum seekers, have no structured pathway for such statutory medical assessment. Section 9 of the Asylum and Immigration Act³² allows the withdrawal of Government support to families whose claim has been denied.³³ Should the local authority, obliged to act in the best interest of children, assume responsibility of the dependent child, the child becomes eligible for the care entitlement of 'looked-after' children but may be legally and forcibly separated from their families – potentially replacing the problems of a dependent child with those of an unaccompanied minor.²⁸

Accessing dental care

Although there is no agreed clinical care pathway for accessing dental care (Fig. 2), it is important to pilot different pathways to ensure timely care. Refugees and asylum seekers may be in contact with a variety of organisations and services, who should

ideally signpost them to the relevant local NHS dental services. Guidance ('NHS entitlements: migrant health guide') is readily available regarding migrant access to general medical service from www.gov.uk.³⁴ Refugees and asylum seekers are entitled to receive healthcare through primary care, secondary care, and accident and emergency/urgent care centres. Families and carers may not be aware of the availability of dental services, methods of access and the importance of regular reviews.

According to Public Health Guidelines, exemptions for NHS dental care are subject to age, pregnancy, or income status.^{34,35} Children under 18 years of age, including child asylum seekers and refugees, are exempt from paying for NHS dental services.

O'Donnell *et al.*⁴² discovered that access to dental care for asylum seekers was more difficult and less supported compared to medical care. There were large discrepancies in dental access experience ranging from: limited information; referrals from GPs; or simply difficulty in finding a dentist who would treat asylum seekers. It appeared that respondents attended the dentist only when there was a clinical need.

Treatment that a clinician decides is urgent or immediately necessary must be provided regardless of whether advance payment has been received. The decision lies with the clinician and failure to provide immediately necessary treatment may be unlawful under the Human Rights Act 1998.^{43,44} Asylum applicants are advised to contact the NHS 111 service or Dental Advice Lines regarding seeking

of these vulnerable groups to healthcare.

Families applying for asylum accompanied by children, as well as unaccompanied children, may be unaware that effective preventions and interventions are available – and may not be prioritising oral health.

Primary care dental services are most likely to encounter the child if suffering acute oral problems. The clinician has to treat the child within the constraints of limited time and resources. Compounding challenges such as language, culture and health knowledge mean dental practitioners feel frustrated in their efforts to improve and promote good oral health for this group of patients.^{45,46} Previous dental history and experience of intra- or extra-oral torture are specific factors which can affect the dental appointment. Some immigrants living in the UK have shown signs of infant oral mutilation, where a child is at risk of forced removal of primary tooth germs and the sequelae of non-sterile instrument use.⁴⁷ Simple tasks such as reclining the dental chair and using the light to examine a patient can evoke past memories of interrogation, loss of control and subsequent abuse.²⁴

Provision of effective dental care

A number of approaches could be adopted to ensure provision of continuous, good quality dental care to child refugees and asylum seekers.

- Ensuring healthcare professionals, including dental teams, are aware of entitlements for these vulnerable groups. Training of the dental team including receptionists, nurses, dental care professionals and dentists is recommended. Knowledge of service entitlements and willingness to learn about different cultures, engenders a sympathetic, personalised approach to each patient⁴⁸
- Children's Society has a useful refugee toolkit, which can support different agencies to understand the needs and entitlements of young refugees and asylum seekers⁴⁹
- A detailed oral health assessment should be carried out, with emphasis on prevention
- Interpreting services are readily available. It is important that children are not expected to translate for adults
- Dental teams need to be aware of the impacts of torture and imprisonment on the provision of dental treatment
- Providing additional time and resources for oral health assessments and treatment
- Referral to other health and social professionals such as health visitors and school nurses, can provide cohesive efforts to alert teams to children at risk, providing care in a timely manner⁵⁰
- Consultation with children and young

'Children under 18 years of age,

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and refugees, are exempt from paying

for NHS dental services.'

In comparison, exemption is more complicated for adults. According to the British Refugee Council, all adults involved in the asylum process (applicants, refusals and acceptances) are eligible for free NHS dental treatment.³⁶ However, legislation does not explicitly state that asylum seekers, (whether refused or accepted) are eligible for free routine dental care based on their migrant status alone. To access chargeable primary healthcare services (for example, prescriptions, dental treatment, sight tests, etc) without charge, asylum seekers – both refused and accepted – need an NHS HC2 certificate.³⁷ Completion of an HC1 form (for which help can be sought from charities such as Asylum Help or PAFRAS)³⁸ enables the applicant to benefit from the NHS Low Income Scheme, which offers full help with health costs.³⁹ Eligibility for secondary dental care is as per general eligibility for NHS medical treatment in hospitals: free to asylum applicants, refusals and refugees – who have been classed as 'exempt'.⁴⁰

Following dental treatment, further costs may be incurred collecting prescription medicines. If asylum seekers have resources to do so, and/or if possessing only a partial exemption certificate, they may be expected to contribute to healthcare costs by paying for prescriptions in England. These are free of charge in Scotland and Wales.⁴¹

emergency treatment or registration with a dental practice.

It is important that children and their families receive timely dental treatment with a focus on evidence-based prevention. Multiple factors need to be considered when developing oral health promotion interventions for this vulnerable population, namely consideration of culture, language, beliefs and attitudes. Co-developing programmes with migrant health workers, charities and care providers can ensure that programmes are relevant. Multi-sectoral collaboration with health, education, voluntary organisations and community groups will ensure interventions maximise reach to local communities.

Barriers faced during service provision

A range of barriers faced by asylum seekers when pursuing healthcare included access to interpreters, language barriers, difficulty obtaining appointments and different expectations of healthcare.⁴² Refugees and asylum seekers are considered to be a mobile population and may need to move locations before they are settled permanently in the host country. Furthermore, refugees and asylum seekers may be turned away by front line staff due to lack of awareness on the rights

people and their families in addition to community groups to ensure that services are sensitive to their needs.

Implications for research and policy

There are a number of policy and research implications that would improve child dental health. Primarily, there is a need to clarify the terminologies of 'refugee, asylum seeker and migrant.'

Other recommendations include:

- A health assessment incorporating oral health should be conducted for all refugee and asylum seekers on entry to the UK. Any urgent conditions such as pain, facial swelling or dental trauma should be dealt with immediately
- Development of surveillance systems to understand the unmet needs of child refugees and asylum seekers. For example, using integrated databases from different sources may be helpful in identifying health needs and monitoring them longitudinally
- There are ethical considerations for conducting research within this vulnerable population. Pragmatic research strategies could encompass using existing health databases to determine oral health status and outcomes. Crucially, utilising migrant health workers who are refugees themselves to explain remits of research, provide cultural relevance and help with language barriers may encourage recruitment and retention of study participants. Additionally, working with recognised voluntary organisations could support the uptake of research
- Ensuring equitable access to health services
- Multi-sectoral approach to health promotion: health is largely determined by socio-environmental factors. Therefore, the UK has responsibility to ensure that adequate housing, education, employment, and access to health services are readily available. Integration policies should be implemented by equipping them with language and cultural skills
- Clarification of the asylum process. Transparency may prevent asylum seekers to go 'undocumented'
- Upskilling and supporting those with healthcare qualifications to pursue their careers and seek employment in the UK. This can be done through mentorship, financial assistance and government support, but requires facilitation by the dental community. This will result in financial independence and improved quality of life for the individual and families.

Conclusion

Access to healthcare is a human right. Under the Children's Act, all children are eligible for support irrespective of their immigration status. Emergency primary care, for both general and dental health, is free at the point of delivery for asylum applicants, claiming or refused, refugees and children under 18 regardless of age. Access to dental care is fraught with legal subtleties and confusing lexis, understandably making the whole process overwhelmingly complex. The dental community has much to contribute to delivering a holistic service, thereby improving patient experience, knowledge and health outcomes. This cannot be achieved without the support from government, policy makers and those working in health, social care and education services.

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