# Unaccompanied Asylum Seeking Children

<table>
<thead>
<tr>
<th>Title of Guideline (must include the word “Guideline” (not protocol, policy, procedure etc))</th>
<th>Advocating for the health of unaccompanied asylum seeking children and young people</th>
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</thead>
<tbody>
<tr>
<td>Contact Name and Job Title (author)</td>
<td>Dr Catherine Carus, Teaching Fellow Child Health Dr Emma Fillmore, Consultant Paediatrician</td>
</tr>
<tr>
<td>Directorate &amp; Speciality</td>
<td>Directorate: Family Health – Children Speciality: Safeguarding</td>
</tr>
<tr>
<td>Date of submission</td>
<td>November 2016</td>
</tr>
<tr>
<td>Date when guideline reviewed</td>
<td>November 2019</td>
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<tr>
<td>Guideline Number</td>
<td>(Allocated by Guideline Lead)</td>
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<tr>
<td>Explicit definition of patient group to which it applies</td>
<td>Any child or young person who is seeking asylum in the UK and is not accompanied by an adult family member.</td>
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<tr>
<td>Abstract</td>
<td>This guideline advises on the common and important issues relating to the physical, mental and emotional wellbeing of unaccompanied asylum seeking children who may come to attention through acute paediatric, outpatient or adoption/fostering services and primary care. It is relevant for all staff involved in the assessment and care of these children and young people, in particular within health and social care.</td>
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<tr>
<td>Key Words</td>
<td>Paediatrics. Children. Unaccompanied. Asylum seeking.</td>
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## Statement of the evidence base of the guideline – has the guideline been peer reviewed by colleagues?

1a meta analysis of randomised controlled trials

2a at least one well-designed controlled study without randomisation

2b at least one other type of well-designed quasi-experimental study

3 well–designed non-experimental descriptive studies (ie comparative / correlation and case studies)

4 expert committee reports or opinions and / or clinical experiences of respected authorities X

5 recommended best practise based on the clinical experience of the guideline developer

## Consultation Process

Staff at Nottingham Children’s Hospital via the Guidelines E-mail process.

## Target audience

Staff at the Nottingham Children’s Hospital

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*This guideline has been registered with the trust. However, clinical guidelines are guidelines only. The interpretation and application of clinical guidelines will remain the responsibility of the individual clinician. If in doubt contact a senior colleague or expert. Caution is advised when using guidelines after the review date.*
Document Control

Document Amendment Record

<table>
<thead>
<tr>
<th>Version</th>
<th>Issue Date</th>
<th>Author</th>
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<tr>
<td>V1</td>
<td>November 2016</td>
<td>Dr Catherine Carus, Paediatric trainee</td>
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<td></td>
<td></td>
<td>Dr Emma Fillmore Consultant Paediatrician</td>
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General Notes:

Summary of changes for new version:

Statement of Compliance with Child Health Guidelines SOP

This guideline has followed Child Health Guideline SOP. It has been circulated to all Paediatric Senior staff and comments incorporated before uploading to the Trust Guideline site.

Martin Hewitt
Clinical Guideline Lead
04 November 2016
Advocating for the health of unaccompanied asylum seeking children and young people

A guide for those working in health and social care, responsible for the wellbeing of unaccompanied asylum seeking children

The full guideline follows this quick reference chart: please refer to it for more detail and further information

Anyone, regardless of age or background, is entitled to free emergency treatment in the Emergency Department. Any child or young person, up to the date of their 18th birthday, who is in the care of the Local Authority is entitled to NHS care. They will be in possession of an NHS number by virtue of being a ‘Child Looked After (CLA).’ In the event a young person arrives at a hospital or GP surgery prior to contact with the Local Authority, and therefore prior to being issued with an NHS number, any treatment beyond emergency care in the ED would be chargeable.

For further information, see the ‘Overseas Visitor Policy’ and https://www.gov.uk/guidance/nhs-entitlements-migrant-health-guide

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<tr>
<th>PHYSICAL HEALTH</th>
<th>Immediate actions</th>
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<tr>
<td><strong>Health promotion</strong></td>
<td><strong>Growth, nutrition, immunisations, optician/dentist/hearing assessments</strong></td>
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<tr>
<td>1. Growth assessment – height/weight/OFC</td>
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<tr>
<td>2. Enquire about immunisation history including BCG. Information regarding catch-up schedule available at <a href="http://apps.who.int/immunization_monitoring/globalsummary/schedules">http://apps.who.int/immunization_monitoring/globalsummary/schedules</a></td>
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<td>3. Recommend routine appointments with optician/dentist, consider hearing screening test</td>
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<td><strong>Known problems, family history</strong></td>
<td><strong>Be aware of pre-existing health conditions</strong></td>
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<td>Underlying health difficulties may not have had attention for some time and therefore may need acute treatment, as well as referral for ongoing management. A family history of health problems is unlikely to need urgent attention but may justify consideration of outpatient referral</td>
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<td><strong>Results of travelling</strong></td>
<td><strong>Parasitic conditions, infections, TB</strong></td>
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<td>Consider some of the common/likely issues resulting from travelling and living in cramped conditions i.e. headlice, scabies, risk of TB, diarrhoeal illnesses, hepatitis A, worms, leishmaniosis.</td>
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<tr>
<td><strong>Sexual health</strong></td>
<td><strong>Awareness of risk of sexual assault, BBI, STIs and FGM</strong></td>
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<td>Young people may need pregnancy tests, referral to sexual health services if risk of STI/BBI. A guideline specifically about FGM is available via the intranet.</td>
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### EMOTIONAL WELLBEING

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<tr>
<th>• Background, trauma</th>
<th>Understanding of the trauma of fleeing home country, witnessing conflict, loss of loved ones or uncertainty regarding their whereabouts/wellbeing, torture.</th>
<th>Cultural differences mean some young people will be reluctant to discuss these difficulties. If they do wish to however, time and privacy is important. In some cultures, emotional difficulties are described in terms of physical complaints.</th>
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<tr>
<td>• Support</td>
<td>Placement, school, family/friends, access to cultural and religious support</td>
<td>As for anyone, appropriate support is vital. Explore how the young person feels about their current placement (foster home, residential care) and from whom they access support</td>
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### MENTAL HEALTH

| • Past | What have they witnessed? Consider difficult memories and flashbacks, are they willing to talk about their past or not? | As described above, some young people will find this very difficult to discuss. Some languages do not have terms for mental health difficulties as there are in English. Use of a culturally appropriate interpreter may help. |
| • Sleep/self-harm/substance misuse | Consider sleep disturbance, self-harm, alcohol/drug misuse | These may be manifestations of emotional or mental distress. They will typically need longer-term support, however may need emergency treatment in the meantime (e.g. for cutting, overdose) |
| • CAMHS referral | See full guideline for when this may be appropriate, and how to do so | Refer to Trust procedures for investigating safeguarding concerns |

### SAFEGUARDING

| | As for any child/young person, ensure they are being kept safe | The full guideline follows this quick reference chart: please refer to it for more detail and further information |

### LEGAL STATUS

| | | There are different types of legal status determining a young person’s right to remain in the UK. Anyone in the country, regardless of legal background, is entitled to emergency NHS care. |
Physical Health needs

Children and young people recently arrived into the UK should have their physical health assessed, with treatment provided or recommended as appropriate. Particular areas to consider will include:

a. Known health difficulties
b. Traumatic injuries/scars/burns/bruising/branding
c. Growth and nutrition
d. Immunisations
e. Common/likely issues resulting from travelling and living in cramped conditions i.e. headache, scabies, risk of TB, diarrhoeal illnesses, hepatitis A, worms, leishmaniosis.
f. Physical manifestations of emotional distress – headaches, abdominal pain, non-specific aches
g. Optician, dentist, hearing assessment
h. Risks of BBV, STI, pregnancy, genital mutilation
i. Age assessment
j. Familial conditions

Known health difficulties:

Any pre-existing medical conditions need to be explored with the young person, including any investigations that may have been carried out, or those which may need completing or repeating, treatments which have been given previously, or referrals which need to be made. Individuals with known conditions may have suffered set-backs in their health as a result of absent/reduced healthcare provision in their country of origin, inability to access healthcare whilst making the journey to the UK or an inability or unwillingness to seek out healthcare in the UK.

Traumatic injuries/scars/burns/bruising/branding:

Children and young people may have received traumatic injuries accidentally or intentionally either in their home country, during their journey or after arrival in the UK. Ensure any injuries do not need acute medical care. If fractures have not been properly managed they may need orthopaedic intervention – improperly set bones for instance, especially if they are affecting limb function.

Growth and nutrition:

Careful attention should be paid to the child/young person’s weight, height (if > 2yrs old) or length (if < 2yrs old) and head circumference (if < 2yrs old). Growth charts are available in the Trust or online on the RCPCH website. The diet should be enquired about, ensuring a well-balanced intake (bear in mind cultural variations) and that enough food is available.
In addition record mid arm circumference to monitor nutritional status if growth charts not culturally appropriate.

Investigations to be considered: FBC/Ferritin, Vit D, (metabolic investigations as clinically indicated), haemoglobinopathy screening depending on country of origin

Markers of malnutrition may include:
- Underweight
- Lethargy
- Poor attention/concentration
- Poor condition of hair (patchy, thinning)
- Bone pain/aches, bowing of tibia
- Pallor

**Immunisations: (ctrl + click to open links)**

[http://apps.who.int/immunization_monitoring/globalsummary/schedules](http://apps.who.int/immunization_monitoring/globalsummary/schedules) is an online tool to find out the vaccination schedule for every country. War, civil unrest and economic instability are just a few of the reasons why a child/young person may not have received their planned vaccinations. It would be unusual for an unaccompanied asylum seeking child to arrive with a record of their immunisation history, so if there is any uncertainty about what vaccinations they have received, if any, they should receive the catch-up programme available here.


**Common/likely issues resulting from travelling and living in cramped conditions:**

Particular conditions are more likely in individuals living in cramped conditions, including headlice, scabies, tinea capitis and tuberculosis. Children and young people may also have evidence of diarrhoeal illnesses and hepatitis A. Intestinal worms are also common in children who have eaten rotten or partially cooked food on their journey. Leishmaniosis is a risk for children from African countries.

A careful clinical examination should reveal the first three; symptoms suggestive of TB should be enquired about, to include:
- Fevers
- Night sweats
- Persistent cough
- Blood stained sputum
- Weight loss
If TB is suspected, a referral to the Nottingham Tuberculosis Clinic should be made. The paediatric TB service is run by Nottingham Children’s Hospital Respiratory Service. Referrals can be made by:

1. Telephone on ext 56051 (via Nottingham City Hospital switchboard on 0115 969 1169)
2. Email via TBTEAM@nuh.nhs.uk
3. Fax on 0115 9628075

The information required, as far as is possible, is patient name, K number, date of birth, reason for referral and language spoken (if an interpreter will be required).

Dermatological opinion may be needed for skin conditions needing more complex advice and treatment.

Empirical anthelminthic treatment should be given if intestinal worms suspected or likely from story of journey.

**Physical manifestations of emotional distress:**

In some cultures, open discussion of emotional and mental distress is not common and these difficulties can manifest as non-specific physical complaints, commonly headaches, non-specific abdominal pain or all-over aches and pains. An awareness that this might be the beginning of someone wanting/needing to be able to describe emotional challenges is the first step; however this may be the beginning of a slow process. Explaining that there are people available with whom these difficulties can be discussed is important, and knowledge of local services is key. CAMHS is a good starting point; primary care may also be able to signpost to available services.

**Optician, dentist, hearing assessment:**

As for all children and young people in the UK, it is recommended that unaccompanied asylum seeking children be registered with a local optician and dentist, with any treatment and subsequent appointments to be advised upon by them. Screening questions regarding hearing difficulties, visual disturbance or dental symptoms should be asked.

Generally, in the absence of a specific problem, the advice is that children and young people are seen every 6 months by a dentist and every 1-2 years by an optician.

A single hearing test should be considered in all children as there is unlikely to have been previous screening.

**Risks of BBV, STI, pregnancy, genital mutilation:**

Children and young people, of both genders, may be/have been sexually active. This may be consensual, rape or sexual exploitation, either in their home country, in ‘payment’ on their
journey to the UK, or on arrival in the UK. Unaccompanied children and young people are especially vulnerable to sexual exploitation, and this needs to be very carefully and sensitively explored.

If there are concerns regarding unprotected sexual activity then blood borne virus (HIV, hepatitis B & C, syphilis) testing should be carried out. There is commonly fear of HIV testing as in many countries, this diagnosis remains a death sentence, without effective treatment and a cause of huge stigma. Careful explanation of the availability and effectiveness of treatment will be very important. If there are concerns about sexually transmitted infections, consent for blood borne viruses should be sought and bloods arranged or referral to Victoria Health Centre sexual health services.

Advice to see the GP would be recommended.

Discussion about the C-Card scheme allowing young people under 25 to access free condoms may also be appropriate.

If a girl is concerned she may be pregnant, or knows she is, she needs to be advised to see her GP for referral to antenatal services. If she is considering a termination of pregnancy, the GP would again be able to refer.

Unaccompanied asylum seeking young girls may have access to the Family Nurse Partnership Service to support through pregnancy and first 2 years of the child’s life. Referral can be made through the children in care specialist nurses or midwifery services.

Female Genital Mutilation (FGM) should be considered and discussed with girls and young women from countries known to practice FGM. Using terminology such as cutting/female circumcision may help open conversations about the young persons’ views, beliefs and family practice around FGM.

Young people often know the FGM practice in their country of origin and enquiry about method of FGM (including instruments used) helps indicate type of FGM performed.

Physical symptoms associated with FGM may include genital pain, infection, bleeding, dysuria and abdominal pain. Mental and emotional health problems are associated with the memory of the trauma of FGM.

Young people may need advice as to the type of FGM they have undergone and physical examination of genitalia by health professionals trained in this examination may be indicated. Advice can be sought via the Safeguarding Office in QMC (ext 56757).

Mandatory recording and reporting of FGM is required by health providers and all cases identified are entered onto a NUH trust database via the safeguarding office at QMC.

Advice to girls and young women regarding the illegal status of FGM practice (within this country or sending girls to countries to perform FGM) is important to raise awareness of protection for girls not circumcised, but at risk from the community or culture they are living in.
**Age assessment:**

Many children and young people will arrive with no documentation of their date of birth. Whilst age assessments used to be conducted by health professionals, this has now been tested in case law and found to have no place in current practice. There is huge variation in maturity and rates of both bone and dental development. Official guidance from the RCPCH is that X-rays *not* be used for non-clinical reasons such as age assessments. Definitive guidance from RCPCH on use of dental x-rays is awaited.

An age assessment, if deemed necessary, should be carried out by two qualified social workers and should take into account appearance, demeanour, credibility and background. Medical investigations (dental X-rays, bone X-rays and genital examinations) *do not* add any further information to this process and should not be carried out². Paediatric advice and guidance on development of children or young people may contribute to social care age assessments but is not definitive.

**Familial conditions:**

There may be a need to investigate for inherited conditions, though it can be hard to clearly establish a level of risk where family histories are heard second-hand and from a country where medical care may not have allowed for thorough investigation and management. Bear in mind higher regional risks of certain conditions: thalassaemia (Mediterranean Europe, SE Asia), sickle cell disease (Africa and the Caribbean), G6PD (Mediterranean Europe, SE Asia).

**Emotional wellbeing needs**

a. Recognition of trauma
b. Understanding individual background – orphaned, family dispersed, family whereabouts/wellbeing unknown
c. Support networks
d. Development/educational support
e. What type of accommodation is the child in, is it suitable, appropriate?

**Recognition of trauma:**

Simply by being an unaccompanied asylum seeker, the child/young person will have experienced significant trauma. This may include exposure to war and conflict, witnessing injuries or the death of family/friends, torture, rape, separation from/loss of family, uncertainty about wellbeing/location of family, an arduous journey and isolation in an unfamiliar culture. This list is not exhaustive.
Whilst some individuals will talk about their experiences, others will find this incredibly difficult. Their distress may manifest as physical symptoms (see above), mental disturbance (low mood, poor sleep, nightmares) or challenging behaviour. CAMHS can provide counselling and psychological support, but the support from others in a similar situation, others who have a better understanding of the difficulties encountered than we can ever have should not be underestimated.

Understanding individual background:

Gaining some basic information about the country of origin and journey to the UK helps gain knowledge relating to the young person’s possible health difficulties. Discussion with the social worker or searching on the internet is useful prior to the health assessment.

Take some time to get to know where the child/young person fits into their family, and allow them to explain what they know about the whereabouts and wellbeing of family members. The Red Cross international tracing and message service (http://www.redcross.org.uk/What-we-do/Finding-missing-family/International-family-tracing) can be invaluable in finding and getting in touch with loved ones.

Support networks:

Consider who is supporting the child/young person now.
- Do they have a trusted individual to talk to?
- Which adult is responsible for their day-to-day care – foster carer, residential home care worker?
- Are they in contact with any extended family members within the UK?
- Do they have friends?
- Are they attending school?
- Do they have access to youth groups, sports clubs, music groups, faith groups etc?
- Are they in contact with the Refugee Forum? (see website; http://www.nottsrefugeeforum.org.uk/)

Development/educational support:

Young children need access to toys, books, music, playgroups etc to provide developmental opportunities – as well as a responsible adult invested in helping them develop. Older children should have a place in school. It is not unusual that they arrive in the UK having never attended school, or having only had early primary level education. They may therefore need significant support accessing education, not least of course to help them learn English.

What type of accommodation is the child in?
Are they in a foster placement, a residential home, or supported independent living? Is this placement suitable and able to meet their needs? If living independently, ensure the young person is able to manage money, shop for food, cook, do their laundry and know where to access support.

**Mental Health needs**

a. Sleep  
b. Have they had any bad experiences – conflict injuries, rape, torture, been witness to any such events?  
c. Do they want the chance to talk about any of these experiences?  
d. Self-harming behaviours  
e. When to consider referring to CAMHS  
f. Substance misuse  
g. Hopes for the future

**Sleep:**

Ask if the child is sleeping well, and if not, what the reasons for this are. Nightmares are common, flashbacks of traumatic events when eyes are closed are also common and a reason why children and young people may ‘delay’ going to bed for as long as possible. Other reasons for poor sleep may include hunger, pain or not feeling safe.

**Have they had any bad experiences?**

By this we mean for example: witness to war and conflict, subject to traumatic injuries, witness to the injury or death of others (particularly family and friends), rape or sexual assault, torture. Any of these events may happen in their country of origin, in refugee camps, during their journey or after arrival in the UK. These experiences may be incredibly difficult for the child/young person to discuss – if they come from a country where mental health is stigmatised, they may not even have the language to describe their memories/feelings. When they are ready to work through what they have experienced/witnessed, counselling or work with CAMHS may be appropriate.

**Self-harming behaviours:**

As described by the NICE guideline (2011)³, the term self-harm refers ‘to any act of self-poisoning or self-injury carried out by an individual irrespective of motivation.’ The guideline includes:
- Self poisoning – overdose of prescribed or over the counter drugs
- Self injury – cutting, burning, hanging, jumping from a height

Other behaviours may be self-injurious and a cry for help: excess alcohol, use of illicit substances, over- or under-eating, mismanagement of physical health condition (e.g. omitting insulin in type 1 Diabetes Mellitus).

**When to consider referring to CAMHS:**

CAMHS offer a consultation service for looked after children, available to their social worker and foster carer. Paediatricians can either recommend the social worker seek consultation for identified concerns or make a direct referral.

There are numerous reasons why consultation might be appropriate, including the traumatic experiences described above, altered affect (mood), self-harm, or emotional difficulties impacting sleep quality, concentration, ability or willingness to engage in social activities.

**Substance misuse:**

Consider misuse of various substances including alcohol, illegal drugs, legal highs or prescription drugs. Support may be accessed via primary care, charities, CAMHS or specific drug and alcohol liaison teams.

**Hopes for the future:**

It is important to acknowledge hopes, ambitions and dreams – and ensure the child/young person is receiving appropriate support in reaching for these.

They may have dreams regarding getting information about/from loved ones at home, making contact with extended family believed to be in the UK, developing friendship networks or relationships, or having a family. These are clearly all valid hopes and ambitions and should be recognised as such.

**Legal status:**

UASC are under section 20 (voluntary accommodation) and as such their birth parents retain parental responsibility (although absent). Young people can consent for themselves if deemed to be competent (but will very likely need an interpreter for fully informed consent).

Any concerns that a young person is unable to consent should be shared with Childrens Social Care who may need to provide legal advice as to who can sign consent, or pursue a legal care order.

UASC at the first health assessment are likely to have temporary leave to remain.
All UASC are under Home office policy and have to attend interviews with the Home office with an advocate present.

UASC may be undergoing age assessment determination through the courts. Once decided this may lead to permanent leave to remain status being granted.

**Safeguarding concerns:**

For any child/young person, there may be concerns around safeguarding. By virtue of being unaccompanied, in a foreign country and culture and by having no/little English, this group is at higher risk of all forms of abuse:

- Physical abuse
- Emotional abuse
- Neglect
- Sexual abuse (including grooming and exploitation)

If there are any concerns about safety, these can be discussed with the named doctor for safeguarding: Dr D Emmanuel (City) or Dr N James/Dr A Taylor (County).

Please refer to the relevant Trust Safeguarding guidelines for further advice, for example FGM guideline, Child Protection Documents (available via intranet, Paediatric Medicine – Forms blank).

**Guidance for recognition of cultural norms and differences:**

a. Language, appropriate interpreters
b. Common ground – ‘safe’ topics of discussion
c. Religion/faith needs/community support

**Language:**

Interpreters are often essential to enable open discussion. It can be important to ensure that an interpreter is not from a different ethnic group despite being from the same country where civil war is why the child/young person has fled their home country.

**Common ground:**

Despite significant cultural differences, there are ‘safe’ topics for conversation that transcend national and cultural borders. Sport (especially football), music, and an interest in their own appearance (clothes, hairstyles, make up etc) are often good places to start!

**Religion/faith:**

Enshrined in the Universal Declaration of Human Rights is the right for everyone to have the ‘freedom, either alone or in community with others and in public or private, to manifest his
religion or belief in teaching, practice, worship and observance.’ Children and young people must be allowed freedom to access faith communities where they may also access support from others who share their sense of religious identity.
### Suggested timescale for information gathering and formulation of a management plan in the given key areas:

<table>
<thead>
<tr>
<th><strong>Physical Health</strong></th>
<th><strong>Address now</strong></th>
<th><strong>Within 3 months</strong></th>
<th><strong>Within 6 months</strong></th>
<th><strong>Within 12 months</strong></th>
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<tbody>
<tr>
<td>Consideration given to any problems with:</td>
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<tr>
<td>Known health difficulties</td>
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<td>Traumatic injuries</td>
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<td>Growth and nutrition</td>
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<td>Risks of BBV, STI, pregnancy</td>
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<td>Physical manifestations of emotional distress</td>
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<tr>
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<td>Consideration given to any problems with:</td>
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<td>Recognition of trauma</td>
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<td>Understanding individual background</td>
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<td>Sleep</td>
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<td>Self-harming behaviours</td>
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<td>Arrange CLA-CAMHS team consultation</td>
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<tr>
<td>Support for substance misuse (consider Drug and Alcohol Liaison Team referral)</td>
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<td>Consider family finding</td>
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<tr>
<td><strong>Legal status</strong></td>
<td>Clarification of accommodation status e.g. Section 20, Interim Care Order, Full Care Order appropriate to consent issues for the child</td>
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<td></td>
<td>Provision of medical report if requested for Home Office and decisions regarding refugee status</td>
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<tr>
<td><strong>Safeguarding</strong></td>
<td>Address any outstanding safeguarding issues with the Social Worker and/or Police</td>
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</tbody>
</table>

References:

1. [http://www.rcpch.ac.uk/growthcharts](http://www.rcpch.ac.uk/growthcharts)
3. Self-harm in over 8s: long-term management Clinical guideline Published: 23 November 2011 nice.org.uk/guidance/cg133