Safe Havens in Health:
Standards of Care for Children and Young People Seeking Asylum and Refugees

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Abstract
This review outlines current literature regarding access to and quality of healthcare for children and young people seeking asylum and refugees (CYPSAR) in the UK. The multiple factors influencing their experiences are explored, alongside the optimal design of services to best address their needs. A consensus view of best practice is described in the form of service delivery standards for care delivered by paediatricians in emergency departments, inpatient, outpatient and other community settings.

What is already known on this topic?

- Children and young people seeking asylum and refugees (CYPSAR) are a vulnerable population with complex intersecting physical and mental health needs.
- There is significant variation in UK practice in the delivery of care for CYPSAR.

What this paper adds?

- There is limited evidence exploring access to and quality of healthcare for children and young people seeking asylum and refugees in the UK.
- We provide consensus recommendations for service delivery standards, within a rights-based framework, to promote best practice when delivering care to CYPSAR.

Key Terms

In this paper 'children and young people seeking asylum and refugees' (CYPSAR) is used to broadly include children and young people:
1) seeking asylum who are accompanied by a parent or legal guardian with parental responsibility (CYPSAR-A); or
2) who are seeking asylum and unaccompanied (CYPSAR-U); or
3) who have been granted refugee status; or
4) with insecure immigration status.

These terms are used to promote clarity and consistency whilst reflecting diverse experiences and challenges faced within and between different populations. It is recognised that the term 'unaccompanied asylum seeking child' (UASC) is used in some UK settings. Throughout this paper, the CYPSAR abbreviation is used in order to promote and protect the rights of children by using 'person first' language.

The United Nations Convention on the Rights of the Child defines a child as any person who has not yet reached their 18th birthday. Throughout this paper, the terms 'child', 'children', 'children and young people' (CYP) and 'children and young people seeking asylum and refugees' (CYPSAR) are used to refer to individuals under the age of 18.

Background

At the end of 2023, 117 million people were forcibly displaced worldwide. Despite representing less than a third of the global population, children account for 40% of all displaced people **[1]**. Children and young people seeking asylum and refugees (CYPSAR) are a vulnerable population with complex intersecting physical and mental health needs **[2]**. Whilst the health needs of CYPSAR are increasingly recognised, there remains a significant gap in understanding their access to appropriate, high-quality healthcare **[3]**. There is notable absence of the perspectives of CYPSAR and limited exploration of best practice to meet their health needs **[4]**. This lack of national guidance or international consensus is accompanied by significant variation in UK practice in this field **[5]**.

CYPSAR may access healthcare in a variety of settings. In the UK, there is a statutory requirement that all children seeking asylum who are unaccompanied (CYPSAR-U) receive an 'initial health assessment' within 20 working days of registration with the local authority. However, there is no standardised point-of-entry screening for CYPSAR who are accompanied (CYPSAR-A) or CYPSAR with insecure immigration status. General practitioners (GPs) are advised to undertake an enhanced new patient check **[6]** but barriers to accessing care may limit the extent of this. While some regions have dedicated services **[7, 8]**, many CYPSAR first engage with UK health services in acute situations, making an opportunistic approach essential to comprehensively identifying and addressing their needs.

Healthcare services must be better equipped to provide appropriate care for CYPSAR. The United Nations Convention on the Rights of the Child (UNCRC), ratified by the UK, establishes every child's fundamental right to health without discrimination **[9]**. As duty bearers to these rights, paediatricians and other healthcare workers, are obliged to ensure these rights are fulfilled **[10]**. The International Child Health Group (ICHG), a special interest group of the Royal College of Paediatrics and Child Health (RCPCH), presents consensus recommendations within a rights-based approach **[11]**. These standards provide a benchmark for service delivery and are intended as a practical tool to support translation of rights to effective delivery of healthcare for CYPSAR. They aim to minimise variation, promote equitable access, and ensure high-quality care across all clinical settings. These standards represent a synthesis of expert opinion of ICHG and are informed by discussions with CYPSAR with lived experience of UK healthcare services, and peer review from relevant professional groups.

What is known about current access to and quality of healthcare for CYPSAR?

The challenge of appropriate care provision for CYPSAR in the UK is not new **[12-16]**. Multiple barriers affect their access to and quality of healthcare. Barriers to seeking or accessing care may include lack of familiarity with available services and entitlements, language and digital challenges, financial difficulties and discriminatory health policies and practices. Cultural expectations and attitudes to healthcare may also differ. Additionally, trauma, prior experience of persecution by state-run services and fear of NHS charging or data sharing with the Home Office may further discourage health seeking behaviour.

Even when healthcare is accessed, quality of care varies significantly **[5]**. Barriers include inflexible entry and referral processes, time constraints, limited understanding of entitlements and needs of CYPSAR among healthcare workers, gaps in expertise and fragmented coordination within and across sectors **[12, 13, 15, 16]**.

Existing challenges have been exacerbated by an increase in the number of forcibly displaced people **[1]**, hostile immigration policies **[14]** and NHS resource and workforce challenges **[17]**. More positively, recent advances include the local development of specialist services **[7, 8]** and growing commitment by national bodies to address health inequalities **[17]**.

What is known about how to deliver services to best address these barriers?

1) Accessibility and coordination of services

What is known?

Lack of familiarity with NHS services is well documented amongst people seeking sanctuary **[12, 13]**. Poor coordination between services and lack of dedicated referral pathways risks inefficient care and delays to necessary support **[12, 15, 16]**.

What should be done?

Healthcare workers should empower service users to access available services, including health promotion and dental services. Services should establish relationships with local advocates and promote agency through co-production. Healthcare workers should advocate for CYPSAR, alongside professional bodies including the RCPCH, in calling for the UK government to abolish legislation on NHS charging and stop data sharing with the Home Office **[18]**.

Healthcare workers should collaborate with service planners and commissioners to ensure an accessible service design, addressing the specific needs and challenges of CYPSAR. Policies should be inclusive and responsive. Examples include extended appointments or bespoke processes to avoid automatic discharge of service users where they have not initiated contact or attended.

Service planners and commissioners should improve coordination and referral pathways between services, both within health, and between health and other statutory sectors. Healthcare workers should have access to specialist multidisciplinary services for complex case management. UK service models of dedicated clinics with established referral pathways for CYPSAR have demonstrated improved integration of physical, sexual and mental healthcare **[7, 8]**.

Models of community care should be expanded. School-based mental health interventions have demonstrated high acceptability amongst CYPSAR in the UK, supporting post-migration adjustment **[19]**. NHS services should establish collaborative relationships with other statutory services and voluntary, community, and social enterprise (VCSE) organisations.

2) Awareness and knowledge

What is known?

Complex NHS entitlements and charging regulations have led to confusion and knowledge gaps amongst healthcare workers, with negative health impacts for service users **[12, 13, 16]**.

Training on experiences and barriers faced by CYPSAR is usually experiential, leading to variable understanding among healthcare workers and leaving many inadequately equipped to effectively identify and address needs **[13, 16]**.

What should be done?

All healthcare workers engaging with CYPSAR should receive training that provides an understanding of forced displacement, health needs, barriers, NHS entitlements and the role of healthcare workers in advocacy **[3, 14, 18]**. Free UK-wide online resources are available **[20]**. Targeted training increases understanding of entitlements, as shown by evaluation of Doctors of the World 'Safe Surgeries' - an initiative aiming to remove GP registration barriers through free training and resources **[15]**.

3) Trauma informed care

What is known?

CYPSAR often experience multiple traumatic events, including violence, exploitation or bereavement, leading to high prevalence of mental health difficulties **[2, 13]**. Trauma-informed care (TIC) is an approach to service delivery that recognises the widespread prevalence of trauma, responds to its impact and aims to prevent re-traumatisation. The Scottish and Welsh governments have established evidence-based frameworks for trauma-informed practice across all sectors of their workforce, with similar strategies yet to be developed elsewhere in the UK **[21]**.

Workforce development, sustainable funding and a coordinated cross-sector implementation strategy are key enablers of TIC **[22]**. Limited evidence highlights knowledge gaps and lack of formal TIC training for CYP healthcare workers in the UK, with no consensus on what constitutes effective training and additional difficulty isolating the specific impact of TIC on outcomes **[23]**.

A trauma-informed approach must also consider the risk of vicarious trauma to healthcare workers. Organisations with trauma-informed cultures enhance service quality and reduce harm to service users by supporting healthcare worker wellbeing **[22]**.

What should be done?

Workforce across all sectors, including social care and education, must receive training in TIC. Free online UK-wide resources are available **[21]**. Further evaluation of TIC approaches across different settings must inform evidence-based consensus on shared practice standards.

Service planners and commissioners must ensure sustainable funding to allow embedding of TIC throughout health, social care and education services **[22]**, with capacity to meet the complex and diverse needs of CYPSAR.

Regular supervision, reflection and wellbeing support for healthcare workers engaging with CYPSAR are crucial to ensuring a safe and sustainable approach **[21-23]**.

4) Culturally competent care

What is known?

Diverse cultural understandings of wellbeing, illness and healthcare may lead CYPSAR to delay, decline or avoid seeking care **[4]**. Perceived or experienced stigma, perpetuated by challenges of integration post-migration, can also lead to mistrust of healthcare workers **[3, 14]**. Mental health in particular may be affected by stigma and cultural barriers. People seeking sanctuary may use abstract or physical language to describe mental health difficulties, which healthcare workers without adequate training may misinterpret **[4]**. Screening and assessment tools based on Western medical models may not adequately contextualise the specific needs of CYPSAR **[13]**.

While multiple interventions promoting cultural competency have been described internationally, a UK-wide framework is yet to be established **[24, 25]**. The evidence base assessing efficacy is limited by lack of consensus definition of cultural competence, lack of measuring tools, and challenges of evaluating organisational processes within complex systems. Perspectives from people seeking sanctuary are starkly missing. There is a lack of UK-based literature exploring the long-term impact

of interventions or the views of healthcare workers, and it is unclear how results from different healthcare models relate to the NHS.

What should be done?
All healthcare workers engaging with CYPSAR should receive cultural competency training. Evaluations of training interventions internationally are consistently positive **[24, 25]**. The World Health Organisation (WHO) has produced global cultural competency standards outlining expected behaviours of healthcare workers engaging with refugees and migrant people **[26]**. Regular reflective practice and wellbeing support are essential for healthcare workers to examine personal biases that may impact their delivery of care.

Services must commit to embedding language and culture of service users at an organisational level, with fair and inclusive policies. Strong partnerships integrating service users and community advocates in co-production can reduce barriers in access and promote engagement **[27]**. Healthcare workers must have access to tools validated for CYPSAR, particularly for screening and assessment **[13]**.

5) Language and communication

What is known?
Communication difficulties are consistently identified as one of the most significant barriers by service users and healthcare workers **[12, 15, 27, 28]**. Although the NHS has a legal duty to ensure services are accessible to all communities, there is wide variation in the use and availability of professional interpretation services **[28]**.

Communication needs of service users are not always recognised or recorded, and service users may be unaware of available support. Even where professional interpreters are used, time constraints, interpreter competency and healthcare workers' unfamiliarity with using interpreters can negatively impact interpretation quality. Poor consideration of a service user's dialect, gender or technology preferences can also limit trust and effective engagement **[28]**. Organisational pressures can lead to use of ad hoc interpretation through untrained bilingual healthcare workers or family or friends. This risks misinterpretation, where the necessary level of health literacy to discuss complex or sensitive topics may be lacking, and may compromise patient confidentiality and safeguarding **[27, 29]**.

Cost of interpreting services can be offset by the benefits of improved healthcare access **[30]**.

Similarly to healthcare workers, interpreters are recognised as being at risk of vicarious trauma through discussions of distressing topics **[29]**.

What should be done?
Healthcare workers should engage a culturally-matched professional interpreter for service users with limited English proficiency. Interpreters should be provided in the service user's preferred modality (face-to-face, video, telephone), and their spoken and written communication preferences should be recorded for future encounters.

Service planners and commissioners must ensure access to high-quality interpretation and translation services, including access to visual and digital resources when required.

Healthcare workers should consider the nature of topics discussed and the impact on the wellbeing of interpreters by offering a debrief, if appropriate **[29]**.

6) Safeguarding

What is known?
CYPSAR face significant risks, including trafficking, modern slavery and exploitation before, during and after their migration journey, with CYPSAR-U a particularly vulnerable group **[2]**. Reduced access to healthcare can exacerbate these risks, with reduced opportunities to identify and prevent harm. Families of CYPSAR may come from cultures with accepted practices that are recognised as harmful in the UK, such as physical chastisement or female genital mutilation.

What should be done?
Mandatory safeguarding training should be tailored to promote recognition and response to specific risks within populations seeking asylum and refugees. Cultural competency and an

understanding of intergenerational trauma must be integrated with a clear understanding of professional responsibility to take appropriate action to protect all CYPSAR from harm.

Partnership working across health, social care and education should focus on responding to concerns about harm as well as enabling access to early interventions for optimal outcomes.

Service delivery standards to promote best practice delivery of care
Note to Editor: *Insert supplemental materials*
Table 1: Good practice service delivery standards for emergency care settings
Table 2: Good practice service delivery standards for inpatient care settings
Table 3: Good practice service delivery standards for outpatient care settings

What next?

1) Application of the standards

The RCPCH-endorsed standards presented here provide the first comprehensive set of recommendations for care delivered by paediatricians in all settings **[11]**. They support healthcare providers in fulfilling the rights of CYPSAR, enshrined in the UNCRC **[10]**, to optimal healthcare and provide a benchmark for the quality of care delivered. It is recognised that services will vary in the type and extent of changes required, including additional commissioning commitments, to achieve these standards. These standards should therefore serve as a basis for discussions between healthcare workers, service planners and commissioners to advocate for high quality care.

The standards are arranged broadly into 'essential', 'desirable' and 'aspirational' sections for paediatricians providing care in emergency department, inpatient and outpatient settings **[Supplemental Materials 1-3]**. 'Essential' standards are regarded as a minimum for all services, while 'desirable' and 'aspirational' standards represent best practice, with recognition that delivery of these may only be feasible within tertiary or specialist services for CYPSAR. All workplaces should have a named 'inclusion health champion', to support implementation.

A national approach must underpin a consistent, high-quality, and sustainable standard for all healthcare delivery at the local level. Development of an audit toolkit will allow self-assessment of performance. National audits of similar intercollegiate service delivery standards have provided valuable insight into patterns of delivery of care **[31-33]**. The standards should be endorsed and adopted by statutory organisations and bodies with significant influence over care delivery, including regulators, members of the Academy of Medical Royal Colleges and the National Institute for Health and Care Excellence.

2) Service development

Improved service models are necessary to address identified gaps in current provisions. There is no UK or international consensus on whether mainstream services with improved practices or dedicated services are better placed to provide initial care for CYPSAR **[34]**. While all services must be adequately prepared to deliver high quality care, international experience suggests single point-of-access models, where health needs are identified and investigations initiated at first assessment, facilitate better care coordination and maximise engagement **[35]**.

Arrangements to upskill capability of mainstream services alongside development of targeted specialist services reflects wider NHS action on healthcare inequalities **[17]**.

Coordination between services as a single, integrated system underpins best practice. Service planners and commissioners must enable clear networked pathways integrating primary, secondary and tertiary healthcare providers. Evaluations of delivery models in the UK are limited but positive outcomes are shown by integrated multidisciplinary networks around dedicated single-point-of-access clinics **[7, 8]**.

Regional networks foster development of communities of practice, facilitating sharing of knowledge and resources. Collaborative commissioning should support centres of expertise to act as hubs within local networks, sharing advice and building capability.

Networks should also connect NHS services with local authority and VCSE organisations, promoting better integration of CYPSAR within local communities. There is significant opportunity for better coordination with other statutory services, including social care and education. Practical approaches to joint working, training and funding should be explored to overcome the current

fragmentation and strengthen the collaborative whole-system approach required to adequately meet the needs of CYPSAR.

Reducing health inequalities is a key NHS priority, with recognition that sustainable investment is essential to driving meaningful change **[17, 36]**. Flexibility in conventional funding approaches may better enable integrated services by removing barriers to cross-sector collaboration and delivery. While service model changes may appear costly, long-term evaluation demonstrates that provision of timely, regular access to care for people seeking asylum and refugees is cost-saving to healthcare systems **[37]**.

3) Collaboration with service users

Partnership working should meaningfully engage CYPSAR in the design, development and evaluation of spaces, policies and services. Advocates with lived experience can provide valuable perspectives with positive outcomes from peer support interventions in other populations with complex needs **[17]**. The RCPCH has developed guidance to support effective engagement with young people **[38]**.

Professional bodies, such as the RCPCH, can amplify the voices of CYPSAR and advocacy groups to shape and advance policies that improve child health. By providing evidence that highlights critical issues, evaluates impacts, and offers recommendations for change, these organisations can support informed decision-making at local and national levels **[14]**. Dissemination of best practice through professional bodies also empowers healthcare workers to better advocate for CYPSAR.

4) Evidence base and research

The limited research into experiences and outcomes of healthcare for CYPSAR, and lack of perspectives from CYPSAR and healthcare workers, must be addressed. Enhancing UK service evaluation, including collection and linkage of surveillance data, is essential to inform policy and guide commissioners and researchers. There is also scope for increased coordination at European and international levels.

Research priorities must be identified involving all stakeholders, including CYPSAR. The WHO and UK bodies are aligned in prioritising evaluation of service delivery approaches and replication of best practice **[39, 40]**. Other priorities include exploring post-migration determinants of health and impact of immigration policies. It is recognised that official data sources fail to capture diverse experiences of CYPSAR and a culturally appropriate approach must be integrated into all research methodologies.

Conclusion

Multiple barriers limit the access to and quality of healthcare for CYPSAR in the UK. The evidence base describing the impact of different health service approaches on health and wellbeing is insufficient.

Experience shows that improving service accessibility, meaningful collaborative working, enhancing healthcare worker competencies and embedding inclusive communication are fundamental to overcoming barriers to high quality care.

Expert consensus on best practice has been developed into best practice service delivery standards. These establish a benchmark for existing and emerging UK services. Future service development must be driven by evaluation of current services and collaboration with CYPSAR and local communities to ensure equitable and sustainable access, experience and outcomes for CYPSAR.

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