5.5.2 Learning difficulties

Poor educational performance is often taken to be due to difficulties experienced with English as a spoken language. Children's comprehension is in advance of their expression and they understand more than they appear to. Two years is said to be the time it takes for the expression of language to reach the equivalent of the indigenous population. However this is too long to wait to detect learning difficulty due to, say, hearing, vision or developmental problems. The school nurse should screen children in the first instance. Pertinent questions are whether or nor there has been disruption of schooling in the home country and if not, whether the child's attainments in school were age equivalent or whether he/she was put back a year in the home country. Children who have had schooling disrupted may have difficulties concentrating initially but if treated with firm consistent boundaries soon settle.

5.6 Puberty and the assessment of age

Paediatricians may be asked to give their opinions on whether a young person is a child under the age of 18. This request may be made by the child's legal representative, who may be seeking to show that the young person in question is under the age of 18, as those accepted as such should not normally be held in detention. The paediatrician's assessment should only be done in the context of a holistic examination of the child. When making their assessments, paediatricians may find it useful to be aware of the Asylum Casework Instructions used by the Immigration and Nationality Department of the Home Office. An excerpt from these is given at the end of this section of the guidelines (see page 14).

In practice, age determination is extremely difficult to do with certainty, and no single approach to this is can be relied on. Moreover, for young people aged 15-18, it is even less possible to be certain about age. There may also be difficulties in determining whether a young person who might be as old as 23 could, in fact, be under the age of 18. Age determination is an inexact science and the margin of error can sometimes be as much as 5 years either side. Assessments of age measure maturity, not chronological age. However, in making an assessment of age, the following issues should be taken into account.

5.6.1 Puberty and anthropometric measures

It is virtually impossible to deduce the age of an individual from anthropometric measures. There are clearly defined methods for rating puberty as described by Tanner and colleagues in 1962[18]. These give the ages of various stages of attainment of pubertal appearances, commencing on average at 11 years in both males and females and going through to the final stages acquired two or three years later. The process involves the acquisition of these stages in a carefully defined order. However, the timing of the onset of puberty is extremely variable. Girls may have the first signs at about the age of 8 or 9 years and boys at about 9 or 10 years of age. Equally, pubertal delay can also take place and the first signs may be significantly delayed to 14 or 15 years in boys. Accordingly, therefore, it is not possible to give a precise age of an individual from these stages.

The situation is complicated in refugees where alterations in nutritional status and illness compound the problem delaying puberty so that a person may actually be older than they appear from pubertal development. Further, there are ethnic differences in the onset of puberty. In particular, in the Indian subcontinent a slightly earlier onset puberty is quite common, so that, for example, a boy with extensive facial and body hair may appear to be older than he actually is, according to Caucasian developmental norms. For these reasons it is simply not possible to deduce the age of an individual from an assessment of puberty, although pubertal assessment should be considered as part of good clinical practice in the assessment of these individuals.

The issue of whether the chronological age can be determined from the estimate of bone age has been discussed at great length in the literature. The answer is that it cannot. The problem is that an adult bone age may be acquired at a range of ages in childhood, although it commonly takes place around the child's 16th or 17th birthday in males and the 15th or 16th birthday in females. These averages are influenced by a range of factors that may affect the timing of the onset of puberty and the whole process of skeletal maturation.[19]

Overall, it is not possible to actually predict the age of an individual from any anthropometric measure, and this should not be attempted. Any assessments that are made should also take into account relevant factors from the child's medical, family and social history.

5.6.2 Assessment of bone age

In 1996, The Royal College of Radiologists[20] gave useful advice to its members about the use of X-rays in the assessment of age. They advised that if an immigration official requests an applicant to have a radiograph obtained to confirm their alleged chronological age, the College would regard it as unjustified. They argue strongly that

ionising radiation should be used only in cases of clinical need. However, if an individual seeking entry wishes to support their case, an X-ray of the hand presents negligible risk of radiation. However, they add that the accuracy of estimation of age from hand radiography amongst groups that have not been studied in detail remains in doubt. The Board of Faculty expressed reservations about advising on bone age for other than personal health issues or research projects approved by appropriate ethics committees.

5.6.3 Dental age

The dental age of the human from birth to 18 years can be judged by a consideration of the emergence and development of the primary and secondary dentitions. Thereafter estimates have to be based on wear of the dentition and are much less accurate.[21] There is not an absolute correlation between dental and physical age of children[22] but estimates of a child's physical age from his or her dental development are accurate to within + or - 2 years for 95% of the population and form the basis of most forensic estimates of age. For older children, this margin of uncertainty makes it unwise to rely wholly on dental age.

5.6.4 How paediatricians' reports on age determination may be received

While some paediatricians have extensive experience in undertaking assessments of age and in writing reports, they seldom have the benefit of seeing how these reports are received by immigration authorities or appellate bodies. Great care should be taken by paediatricians in how reports are presented, and as the BMA advises, medical reports should be "factual, detailed and carefully worded".[23]

In utilising paediatricians' reports, immigration officers and adjudicators should give due weight to social and cultural factors in addition to the physical factors, in view of the difficulties inherent to age determination described above. For example, it may be relevant to relate physical attributes to the child's account of their former lifestyle, eg what responsibilities they undertook in their country of origin, what education they had experienced etc. However, it appears that immigration officers and adjudicators are sometimes more influenced by medical "facts" than by social histories, although social factors may be of the utmost importance. Therefore, paediatricians should always try to explain how and why the social history is relevant to a particular child's assessment. It may not be sufficient to describe social factors and to assume that their relevance will be appreciated and given due weight. It is also important not to take for granted any prior knowledge of variations in the onset of puberty etc. Where a child is from an ethnic group that tends towards an earlier onset of puberty, this should be made clear.

Age determination - a summary

- The determination of age is a complex and often inexact set of skills, where various types of physical, social and cultural factors all play their part, although none provide a wholly exact or reliable indication of age, especially for older children.
- Assessments of age should only be made in the context of a holistic examination of the child.
- As there can be a wide margin of error in assessing age; it may be best to word a clinical judgement in terms of whether a child is probably, likely, possibly or unlikely to be under the age of 18.

Excerpt from the Asylum Casework Instructions, Chapter 2, Section 5. (Immigration and Nationality Department) February 1999

"3.13. Medical assessments of age

If an applicant's age is in dispute and he is unable to supply any reliable documentary proof to support the claim that he is a child, it is open to him or his representatives to obtain a medical assessment of age. Any examination must be voluntary. Therefore it would not be appropriate to insist or even to request that a medical report be submitted. In most cases age assessments are conducted by paediatricians. It is not Home Office practice to commission paediatrician's (sic) reports.

Due weight must be attached to any medical assessment of age that is received, but it should be noted that age determination is an inexact science and the margin of error can be substantial, sometimes by as much as 2 years either side. As the paediatrician can only offer an estimate of age, all estimates should also refer to the margin of error associated with that particular estimate.

The Department of Health's advice is that even the most thorough medical tests cannot provide conclusive evidence of a young person's age as they measure maturity, not chronological age.

It is inappropriate for X-rays to be used merely to assist in age determination for immigration purposes. Under no circumstances should a caseworker suggest that an applicant should have X-rays taken for this purpose."

It is also important to note that estimates of age may lose credibility if they are too precise. A form of words such as "Her/his age may be in the range x-y years" or "He/she is likely to be the age that he/she claims for the following reasons .... [give reasons] may be appropriate.

Wherever possible, paediatricians should be careful in their choice of words so that they do not inadvertently undermine the child's own story. For example, it may be helpful to be wary of making stark statements such as "The child does not know his own birthweight or date of birth". While these statements may be true, they may actually cast doubt on the reliability of a child in a context where he/she may be readily disbelieved.

5.7 Mental health

There are many important factors to consider in relation to the emotional and psychological health of refugee children. Many issues are also relevant to adult refugees, but some factors are specific to children and young people. Children may also be affected by their parents' psychological state and adults pre-occupied with the implications of their refugees' status and the traumas they have suffered may not be as emotionally available to their children as they might wish.

5.7.1 The incidence of mental health problems

It is generally accepted that there is a higher rate of mental health problems in refugee communities[24] and that refugees may experience particular emotional and mental health problems related to their experiences[25,26,27]. It is also important to note that many refugees encounter racism and other forms of discrimination, and even where legal redress is possible, their vulnerability makes it difficult to challenge it effectively. The experience of encountering racism in a place that had been seen as a safe haven is all the more devastating to those who experience it. Experiences of individual and institutional racism may lead to a breakdown in trust, with adverse consequences to people's health. Other factors, such as poverty, poor housing and loss of status may also undermine a sense of emotional well-being in both adults and children. However, the resilience, as well as the vulnerability, of refugees should be acknowledged.

As a report from the Health of Londoners project[28] points out, the mental health problems of refuges can encompass both problems of adjustment and less common, persisting reactions to trauma. The former are common and need good educational and social service support, as well as some specific services such as counselling and appropriate primary care for problems such as depression. The less common persisting reactions to trauma may require specific psychological interventions, and this is discussed further below.

5.7.2 What is pathological?

One of the conundrums for paediatricians is the issue of what is pathological and what is not. Some doctors make the point that some of the common responses to the experiences of refugees should not be looked on as psychiatric conditions[29]. In this situation it is suggested that supportive listening is very valuable, and this may be best undertaken by people from the person's own culture who have become established here, where that option is available.

However, it is also important that children with severe psychological problems should not have those problems unrecognised.

"Some people may well protest that it is "pathologising" or "medicalising" these experiences to be talking about stress reactions at all, let alone talking about PTSD [Post Traumatic Stress Disorder]. ..... there are wide individual differences in response to stress and by no means all children exposed to a life threatening experience go on to develop PTSD. But many do show other stress reactions and, of course, children who have been uprooted from their homes and who may have lost a parent or other loved one during the turmoil may also have other unresolved grief reactions. While recognising that most of these reactions are "normal" in the sense of being understandable, they still require that action be taken by those in authority to alleviate the children's distress."[30]

Paediatricians will, in all cases, need to make careful and culturally sensitive judgements on how to interpret physical and psychological symptoms of stress and trauma.

5.7.3 Different cultural approaches to mental health and mental illness

Paediatricians should be aware that some refugee children will be from cultures where mental illness and psychological distress are taboo subjects, and physical symptoms such as headaches, insomnia, stomach ache etc. may be the way in which emotional distress is presented. Some cultures may have a concept of mental illness only in its most severe form, and may not conceptualise emotionally or psychologically based childhood disorders.[31] There may not be words in all languages to translate English words for various kinds of emotional distress.

5.7.4 Reactions to trauma and loss

Children affected by war and international upheaval may experience a variety of signs of stress. These may include: