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Practitioner Review: Mental Health Problems of Refugee Children and Adolescents and their Management

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Abstract

Background

Since 2010, the numbers of refugees has increased and around half are under 18 years of age. It is known that experience of organised violence, displacement and resettlement increases the risk for psychiatric disorders and psychosocial impairment. This review integrates recent research into the risk and protective factors for psychopathology with service and treatment issues.

Methods

We draw on and critically evaluate key systematic reviews in the selected areas, innovative robust studies, and relevant government reports.

Results

Many refugee children show resilience and function well, even in the face of substantial adversities. The most robust findings for psychopathology are that PTSD, and posttraumatic and depressive symptoms are found at higher prevalence in those who have been exposed to war experiences. Their severity may decrease over time with resettlement, but PTSD in the most exposed may show higher continuity. More severe psychiatric disorders including psychosis may also occur. Service delivery needs to take into account socioeconomic and cultural influences but, given the high level of unmet need even in high-income countries, stepped care delivery is required. The evaluation of psychological interventions, often delivered in group settings, suggests that they can be effective for many distressed children; however, for the more impaired, a greater range of disorder-specific therapies will be required.

Conclusions

Child and adolescent mental health clinicians and service providers need to be aware of the specific needs of this population and systems for service delivery.

There are significant knowledge gaps in understanding risk and vulnerability, service delivery and treatment effectiveness.

Introduction

The experience of organised violence and persecution may have adverse effects on mental health (Hodes, 2008 , Fazel et al., 2005, Priebe et al., 2016, Steel et al., 2009). The associated distress may be heightened when individuals or families need to leave their homes and communities which might have been destroyed in the conflict. It is known that such experiences increase the risk for psychopathology, as well as raising important challenges to the sense of belonging and identity. These are increasingly important issues for young people, who make up around half of the world's refugees (UNHCR, 2017). While most youngsters cope well and are surprisingly resilient, there are many who experience distress and will benefit from intervention programmes and mental health service access. This practitioner review provides an accessible account for clinicians, firstly of the experiences frequently encountered by refugees, the impact on mental health, and implications for social function. The second part addresses some key issues for service delivery and treatment issues in both high- and low/middle-income countries (LMIC).

It is known that most displaced and refugee people live in LMIC (UNHCR, 2017). However, many readers of this journal work in high-income and resettlement countries. The very different contexts with regards to socioeconomic factors, health service infrastructures, and also cultural influences are important in thinking about how to address psychopathology and provide appropriate interventions for young refugees. This review has a broad scope in addressing both global aspects of refugee mental health and also key issues for practitioners in high-income countries. It is acknowledged that the review is unavoidably selective, especially given the

recent burgeoning literature in the refugee mental health field, and the interested reader will be able to follow-up any topics.

It is appropriate to provide some definitions of the related categories, as well as discussing the demographics that relate to these terms. Refugees are people who, as a result of persecution or feared persecution and violence, have left their countries and live outside their national borders (UNHCR, 2000). Asylum seekers seek legal rights to settle in host countries. Unaccompanied asylum seeking children (UASC) (or minors) are asylum seekers are aged under 18 years of age, without any parents or caregivers. All these groups are of concern to the United Nations High Commission for Refugees (UNHCR). The UNHCR also regards internally displaced people as being of concern to the agency, and reports them in their statistics.

The numbers of these groups has remained high since the 1990s, with the outbreak of war in the Balkans. There has been ongoing conflicts in Afghanistan, the Horn of Africa, Central-Southern Africa, and Iraq, and since 2010, the war in Syria has resulted in millions of displaced people . In 2017, there was rapid flight of Rohinga refugees from Myanmar to Bangladesh. UNHCR (http://www.unhcr.org/uk/figures-at-a-glance.html) reported "An unprecedented 68.5 million people around the world have been forced from home. Among them are nearly 25.4 million refugees, over half of whom are under the age of 18". The countries that produce the highest number of refugees and receive the most are displayed in Table 1.

Insert **Table 1** about here

The numbers of asylum seekers in European Union countries has also shown significant increase, from 627,000 in 2014 to around 1.3 million in both 2015 and 2016 (Eurostat, 2018a). The recent conflict in Ukraine has resulted in 1.6 million internally displaced people by 2016. Further information about European refugee statistics is available at http://www.unhcr.org/uk/europe.html The high numbers of UASC's in Europe, peaking in 2015, is given in figure 1. The majority of these URM's are male and aged 16-17 years.

Insert **Figure 1** about here

Refugee experiences

The term 'refugee' is a legal category that relates to the reasons for migration. However, the experiences that refugees have encountered are varied, and of course the impact varies according to the person's age and understanding of the events, which are mediated by cultural and social influences. From a temporal perspective, the experiences can be described in terms of those which occur prior to migration, during the migration, which can vary in tome from hours to months or years, and finally during the resettlement phase in the host country. Some refugees have experience prolonged adversities and high violence exposure, such as young people detained in concentration camps by Pol Pot in Cambodia during the 1970s (UNHCR, 2000, Sack, 1998, Kinzie et al., 1989). Others experience high violence and witnessing of killings, but over a shorter time period, as happened in parts of Syria (Mokdad, 2017, Cetorelli et al., 2017). The nature of the violence may vary, with sexual assault prevalent in some conflicts (Skjelsbaek, 2001), as was documented in the Bosnian war (1992-5) and in the North of Iraq by Yazidis

(Hillebrecht et al., 2018, Cetorelli et al., 2017). In others children may be forced to become combatants (Betancourt et al., 2010, Derluyn et al., 2015). At the other end of the continuum are child asylum seekers who have heard about war and organised violence, and flee with their immediate family intact. Many refugees from Syria came to Europe with their whole families, as indeed was possible for the Rohingyas travelling to Bangladesh. For others migration may involve children and mothers, as fathers were lost or killed, or stayed behind as combatants, or because they were detained. By contrast, for fear of, or involvement in war and excessive hardship, many refugees from Eritrea and Afghanistan are adolescent or young adult males travelling alone (UNHCR, 2017).

The migration journeys are also varied. Some refugees will anticipate an impending war and persecution and plan their journeys. If they have sufficient material means, they may travel by train or plane, without the need for involvement with people smugglers, and seek asylum on arrival at the port of entry in the resettlement country. Others may have long and arduous journeys, during which they are exposed to both dangers from the physical elements (rough seas, freezing walks), as well as abuse, assault, and robbery from people smugglers (UNHCR, 2000, Priebe et al., 2016). The journey may take a long time, over weeks, months or even years, during which time the families' members may be separated and some detained (Fazel et al., 2014, Kronick et al., 2017a, Newman et al., 2013)).

On arrival in resettlement or third countries, the refugees may experience a high level of ongoing hardship (UNHCR, 2017). They may have limited material resources and live in temporary accommodation, and many live in refugee camps in tents that

provide limited protection from the physical elements. Access to food and water may be a struggle, even in high-income countries, where the provision of financial allowances or tokens restricts their availability. Families may experience social isolation, high mobility and difficulties regarding access to welfare and health services (Goosen et al., 2014). Regarding schooling, children and adolescents may have had no formal education or had disrupted educational experiences for years. This disruption can continue in resettlement countries, when they are placed in temporary housing and experience high mobility (DeJong et al., 2017, UNHCR, 2016).

The refugee experience in transit and resettlement countries is deeply tied to the social meanings attributed to the term "asylum seeker" and policies of those countries. In the later decades of the 20th Century many countries had an ambivalent response to refugees, wanting to appear welcoming and humane, but also restricting the numbers entering and granted refugee status (UNHCR, 2000) . Since the start of the 21st Century, and following the attacks on the twin towers in New York on 9/11 and the Afghan wars, there has been increasing suspicion of asylum seekers and greater restrictions for entry to resettlement countries (Kirmayer, 2007, Lucassen, 2017, Crepeau et al., 2007, Mountz, 2011). Governments had sought to remain within the UNHCR definitions of refugees, but redefine who is worthy of refugee status. This requires using rigid categories for the refugees (Zetter, 2007), whose real experiences often consist of flight from economic, social and ecological degradation that may be provoked by persistent organised violence (Crawley and Skleparis, 2017 , FitzGerald and Arar, 2018). However categories may be variably applied to the same person. As FitzGerald and

Arar, (2018) explain “The same person who is a “refugee” in Kenya could be a “guest” in Jordan, an “asylum seeker” in Germany, a “migrant worker” in the United Arab Emirates (UAE), or an “irregular arrival” in Canada”. Immigration authorities consider evidence that asylum seekers have been exposed to organised violence or threat of violence, and medico-legal assessments that report posttraumatic stress disorder (PTSD) or physical injuries may be taken as evidence of the authenticity of war experiences to justify refugee status (Fassin and Rechtman, 2009) . The problem here is that the absence of such evidence is erroneously interpreted as the absence of war exposure, and detention or deportation may follow. A further aspect of the culture of disbelief is the frequency of age disputes (House of Lords, 2016). These may occur when adolescents claim to be under 18 years, but immigration officials disbelieve this, and assign an age of 18 years and over (Aynsley-Green et al., 2012, Jayaraman et al., 2016). As a result, age-disputed adolescents may not obtain the higher level of services and support to which children are entitled, and when their asylum application is being processed they may be held in detention (House of Lords, 2016). Since 2017 many countries have shown open disrespect for international agreements and law of asylum, with widespread detention and deportation (Trilling, 2018). The world’s largest immigration detention system in 2018 is in the country with the largest economy – the USA (https://www.globaldetentionproject.org/countries/americas/united-states). In 2018 thousands of children, including infants, were separated from their parents at the USA – Mexican border and detained (Laughland, 2018). This is both an appalling attack on children’s rights and highly detrimental to their mental health and well-being (Teicher, 2018). The socio-economic background to the increased harshness towards asylum seekers in many resettlement countries can be

related to the growth of Islamophobia in the context of terrorist attacks in European and North American cities, the coincidence of the refugee crisis with the aftermath of the financial crash (Anagnostopoulos et al., 2017), welfare cuts and the growth of inequality (Lucassen, 2017, Kirmayer, 2007, Messing and Ságvári, 2018) . There has been widespread reports of hostile attitudes to asylum seekers and refugees and significant numbers of attacks on them (Plener et al., 2017, Hodes et al., 2018).

Child psychopathology: High- and low/middle-income countries

The psychological consequences of refugee experiences can be regarded as arising from threat and loss events. Of course, these often co-occur. The effects of the former, when involving life threatening events, will be to increase arousal and anxiety, and when this is persistent may result in stress reactions, adjustment, and posttraumatic stress disorder (PTSD). Losses include separations from family members, and also loss of home, community, country and culture. Such experiences may cause sadness, bereavement and also depression. The emergence of psychiatric disorders relates to individual vulnerabilities, including age, gender and attributions; family factors, including cohesion, parental mental health and function, family/social supports; and sociocultural variables, including culturally belief systems, attitudes to the conflict and combatants, and the effects of cultural differences and acculturation for those in resettlement countries. The effects of these adverse experiences are cumulative, and a risk factor model has strong empirical support, such that the greater the number and duration of exposure and proximity to the

events, the greater the risk of psychological distress and disorder (Garbarino and Kostelny, 1996, Reed et al., 2012, Fazel et al., 2012).

For infants, adjustment relates crucially to the quality of care and relationships with caregivers. It is well known that prolonged or repeated separation from caregivers causes distress. It has long been known that violence exposure in infants and older children and adolescents may result in increased fear of separation and clinginess. Recent research has addressed the effects of parental PTSD on infant attachment, which has been shown to be associated with an insecure type (van Ee et al., 2016). It has also been shown that infants exposed to violence may later develop PTSD (Almqvist and Brandell-Forsberg, 1997). Similar responses may also be seen in infants who have been held in detention centres, who have often witnessed violence and separation from parents (Kronick et al., 2017b). A series of studies have shown that the usual diagnostic criteria for PTSD (American Psychiatric Association, 2013) need to be modified for infants (Scheeringa et al., 2003, Scheeringa et al., 2006).This entails dropping the required numbers of criteria for avoidance.

The most investigated psychiatric disorders amongst young refugees are PTSD and depression. Important developmental considerations in adolescents include the recognition of reckless and self-destructive behaviours as part of the PTSD phenomenology (American Psychiatric Association, 2013). Reviews have shown a high prevalence of PTSD amongst child and adolescent refugees in resettlement countries, at 11 %, with a rate of depression of 5% (Fazel et al., 2005). This high quality review included only interview-based studies. There are a number of important observations regarding prevalence data. Amongst those with high

exposure to war and violence, there is higher prevalence of PTSD. For example, it was almost 20% amongst adolescent and young adult survivors of Pol Pot regime in Cambodia (Sack et al., 1994). The prevalence of PTSD and posttraumatic symptoms are much higher than amongst non-refugee same age peers. Children and adolescents in LMIC, including those in in refugee camps have also been investigated mainly with questionnaire methods, and have also been found to have high levels of posttraumatic symptoms, with 20% or more, at high risk of PTSD (Betancourt et al., 2013; Panter-Brick, Grimon, & Eggerman, 2014; Ceri et al., 2016; Eruyar, Maltby, & Vostanis, 2018). This is in keeping with the large global study of 81,866 adult refugees and other conflict-affected persons, which found an unadjusted weighted prevalence rate for PTSD of 30.6% (95% CI, 26.3%-35.2%) and for depression 30.8% (95% CI, 26.3%-35.6%) (Steel et al., 2009). Depressive disorder and depressive symptoms may occur with or without PTSD. Many studies of refugees have found higher levels of depressive disorder or risk of disorder, ranging between 10-50% (Eruyar et al., 2018, Servan-Schreiber et al., 1998, Panter-Brick et al., 2009, Sack et al., 1994, Kinzie et al., 1989).

Regarding the course of the disorder, both PTSD and especially depression tend to show reduction over time, with resettlement and social integration, but this is more rapid when resettlement stressors are low (Sack et al., 1999, Betancourt et al., 2013, Michelson and Sclare, 2009, Heptinstall et al., 2004, Oppedal and Idsoe, 2015). Some individuals may experience PTSD for many years (Sack et al., 1999, Sack et al., 1994, Beiser and Wickrama, 2004, Sagi-Schwartz et al., 2003). There are substantial reports of intergenerational transmission of PTSD, which could occur by

altered family interaction and learning, as well as epigenetic mechanisms (Field et al., 2013, Kellermann, 2001, Lehrner et al., 2014).

PTSD diagnosis is easiest to recognise following single traumatic events. However it is known that many refugees will experience multiple traumatic events and losses over prolonged periods of time. For this group, in addition to the core PTSD symptoms (re-experiencing, arousal, and avoidance) there may also be disturbances in affect regulation, self-concept, interpersonal relationships and dissociation (Hyland et al., 2017b), a combination that will be recognised in ICD-11 as complex PTSD (Brewin et al., 2017). Initial cross- sectional studies suggest validity of this new disorder (Hyland et al., 2017a), including with refugee samples (Nickerson et al., 2016). Further work is required to delineate the validity, clinical utility and treatment implications of complex PTSD, but the disorder has been recognised in children (Ottisova et al., 2018). Awareness of complex PTSD will alert the clinician to consider this broader range of symptoms and impact on social functioning.

The experiences of migration, family changes and losses, social isolation and loss of community support and culture, may contribute to changes in family organisation, routines and quality of care. These are risk factors for the emergence of antisocial behaviour, and it has been found that even refugee children who are predominantly not war exposed are at increased risk of conduct problems in resettlement countries (Tousignant et al., 1999). Heightened risk for conduct, mood, anxiety and posttraumatic symptoms in children may occur because of parental PTSD and depression (Panter-Brick et al., 2014, Eruyar et al., 2018). Additional risk factors for the children are parental discord and conflict that may escalate into violence (Panter-Brick et al., 2014, Catani et al., 2008 , Timshel et al., 2017). Cohesive families that

have a positive outlook regarding the country of settlement are more likely to have better adjustment (Taylor et al., 2016a, Beiser and Hou, 2017). Greater social support for parents and better relationships with school are associated with better child mental health (Beiser et al., 2011). Attitudes to asylum seekers impacts mental health. A Canadian study that sampled children aged 11-13 years across the country found that perceived discrimination was a significant predictor of emotional symptoms (Beiser and Hou, 2016).

Unaccompanied refugee minors are a particularly vulnerable group (UNHCR, 1997). They have been separated from parents and carers who may have died, and have often experienced hazardous journeys, that could have exposed them to further abuse and hardship (Bronstein et al., 2012). The evidence is substantial that they typically have experienced higher levels of war events than accompanied refugee peers (Hodes et al., 2008). Consequently, they have high risk of PSTD and depression (Bronstein et al., 2012, Bronstein et al., 2013, Hodes et al., 2008, Geltman et al., 2008, Bean et al., 2007, Jakobsen et al., 2014). Unaccompanied minors' distress is lower in high support living arrangements and when they experience less acculturation stress (Hodes et al., 2008, Jakobsen et al., 2017, Oppedal and Idsoe, 2015).

While most of the evidence addressed concerns PTSD and depression, it is also known that refugee children and young people in resettlement countries are also at high risk of severe psychiatric disorders. Refugees are at high risk of psychosis (Hollander et al., 2016, Priebe et al., 2016), and this can apply to adolescents (Tolmac and Hodes, 2004, Fearon et al., 2006, Kirkbride et al., 2006). Other

problems associated with despair and hopelessness include self-harm (Plener et al., 2015, Patel and Hodes, 2006) and severe chronic fatigue syndrome (somatoform disorders) that has been described in Scandinavia (Aronsson et al., 2009). Refugee children may also have neurodevelopmental disorders unrelated to migratory experiences, but many originate from LMIC that have high rates of intellectual disorders that arise because of prenatal and perinatal risks (Maulik et al., 2011, Tomlinson et al., 2014).

Service delivery in high-income countries

Despite the different systems and contexts, a number of consistent and generalisable themes emerge from recent service-based research. In contrast, the range of available interventions is promising, but its implementation and evaluation are still constrained by methodological limitations.

Refugee and asylum-seeking children are faced some of the same service barriers in access and engagement as other vulnerable groups (in care, homeless or youth offenders). These are compounded by specific challenges related to culture, language, and the parallel legal process (Hwang, Myers, Abe-Kim, & Ting, 2008). There may be institutional barriers to service provision for asylum seekers or those who are undocumented, and in addition many health providers may be unaware of their rights (Rousseau et al., 2013, Rousseau et al., 2017, Ruiz-Casares et al., 2010, Ruiz-Casares et al., 2013). The Convention on the Rights of the Child (UNHCR, 1990) should ensure that children's mental health needs are met but sadly this is often not the case (Taylor et al., 2016b, Ruiz-Casares et al., 2010).

Furthermore, fear of, and threats of deportation may make engagement in mental health services and building trust difficult (House of Lords, 2016).

All these factors are even more pronounced for unaccompanied minors, who are variably accommodated in the care system in different countries, ranging from foster care placements to large residential settings (Kalverboer, Zijlstra, van Os, Zevulun, ten Brummelaar, & Beltman, 2017). The care quality of settings such as detention centres, prolonged legal processes and multiple carers are additional risk factors in *both* developing mental health problems *and* not accessing appropriate services (Kronick, Rousseau, & Cleveland, 2016; Mares, 2016).

Understanding help-seeking patterns and existing care pathways are crucial starting points in improving service delivery, taking into consideration the substantial body of evidence on service underutilisation by refugee children (De Anstiss, Ziaian, Procter, Warland, & Baghurst, 2009). Mistrust of authorities, stigma of mental illness and low prioritisation of mental health compared to basic needs are key reasons behind refugee children's and, notably, parents' reluctance to seek help and attend mental health service appointments (O'Reilly, Majumder, Karim, & Vostanis, 2015; Children's Commissioner for England, 2017). These factors are pronounced among unaccompanied minors, who have gone through a number of assessments with various agencies as part of the legal process (van Os, Kalverboer, Zijlsra, Post, & Knorth, 2016). Conceptualisation of mental health problems, frequent expression of distress through somatic complaints, fear of sharing trauma-related experiences, and lack of knowledge on appropriate sources of help and agencies are additional barriers.

Instead, refugee children and their families are more likely to seek informal help through relatives, friends and communities (De Anstiss, & Ziaian, 2015; Valibhoy, Szwarc, & Kaplan, 2017). Although awareness of mental health presentations has improved in recent years, early recognition in various care settings often remains problematic. This, despite the concurrent of mental health problems with other physical, developmental, educational and social care needs (Betancourt et al., 2012). Negative public attitudes can reinforce reluctance to pursue formal supports (Plener, Groschwitz, Brahler, Sukale, & Fegert, 2017), as well as restrictions of accessing the health system of the host country (Ostergaard, Norredam, de Luna, Blair, Goldfeld, & Hjern, 2017). Relations between the refugee and the host country communities compound families' lack of access and engagement with services, should thus be central to service development initiatives.

The next stage for policy and service planning is the establishment of refugee children's service activity patterns and understanding the underpinning reasons for those. The paradoxical inverse correlation between high level of complex needs and service underutilisation (thus high extent of unmet mental health needs) has been established in several countries (Colucci, Szwarc, Minas, Paxton, & Guerra, 2014; Barghadouch, Kristiansen, Jervelund, Hjern, Montgomery, & Norredam, 2016; Betancourt, Newnham, Birman, Lee, Ellis, & Laynes, 2017). As with other vulnerable groups, lack of needs-led care pathways in the community often leads to crisis-driven responses through tertiary health services. For example, in Sweden, Ramel, Taljemark, Lindgren, and Johansson (2015) found that unaccompanied minors were over-represented on an adolescent in-patient psychiatric unit, predominantly

presented with deliberate self-harm, and were more likely to be admitted involuntarily; this, despite 86% of their presenting problems being reported to be linked to stressors in the asylum process. Similar findings from community services studies reflect lack of co-ordinated pathways, access and engagement, with refugee children attending fewer appointments and being more likely to drop-out of psychological therapies, than the average client population (Michelson, & Sclare, 2009).

The assessment process is often constrained by lack of knowledge of the child's developmental history, potential learning difficulties, lack of corroborative information, and working through interpreters (Rousseau, Measham, & Moro, 2011). These challenges can lead to differential diagnostic uncertainty between developmental, trauma-focused emotional, behavioural or psychotic disorders for commonly presenting symptoms such as aggressive outbursts, somatisation, beliefs or sensory phenomena (Betancourt, Frounfelker, Mishra, Hussein, & Falzarano, 2015). Assessments also need to consider intellectual ability and possible cognitive difficulties. There is little systematic data on this topic with refugee children (Graham et al., 2016), but it is known that many refugees come from low and middle income countries in which intellectual disability has higher prevalence than in high income countries (Maulik et al., 2011) in part because of nutritional deficiencies (Vohr et al., 2017). In addition privation, inadequate or absent schooling, and language and culture change may make assessment of developmental difficulties hard to assess. The practical implications are that verbal and language based therapies need to be adapted for the particular child's intellectual and language abilities.

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Preparation of the child, corroboration with agencies involved, and minimisation of the child's distress by not unnecessarily going through their traumatic experiences can enhance initial engagement and build trust by listening to what is important for them, especially unaccompanied minors.

Addressing service gaps require co-ordinated responses at policy, practice and service level. The existing evidence on refugee children's largely unmet mental health needs, and the reasons behind them, should inform both national and local policy and strategy. This should incorporate key principles and standards of good practice, preferably as a comprehensive service model. For example, Woodland, Burgner, Paxton, and Zwi (2010) identified key indicators of good health practice for newly arrived refugee children in Australia, which included integrated and co-ordinated physical, mental health and social care; culturally and linguistically appropriate provision; accessibility; capacity-building; and user participation. This framework led to high uptake primary health care screening programme, with 88% of children screened within one month and 96% within six months of arrival, although mental health issues were not included at that stage (Zwi, Morton, Woodland, Mallitt, & Palasanthrinan, 2017).

Integrating care pathways with refugee services, schools and communities has been shown to increase recognition, access and engagement by maximising informal help-seeking and supports from religious and community leads, teachers and youth workers (Ellis, Lincoln, Charney, Ford-Paz, Benson, & Strunin, 2010). Establishment of service and support networks that actively involve child mental health services can

enhance further access and engagement, thus provide seamless and comprehensive care, instead of ad hoc crisis-response. Such networks will improve carers' and professionals' agreement and corroboration on presenting concerns, and integration of mental health and other community interventions. They can also play an important role in facilitating ongoing mental health awareness programmes for frontline staff, volunteers, carers and interpreters; and more targeted training related to agency roles and requirements. The range of evidence-based interventions is being discussed in the next section. As with the above service components, interventions should be needs-led and integrated to meet such complex and continuously changing needs throughout the migration process. These are increasingly being influenced by the socioecological systems framework, of supporting children at an individual, family or carer, school and community level (Bronfenbrenner, 1979; Jordan et al., 2010). This approach has been adopted in the structure of the following sections in both high- and low/middle-income countries.

Interventions placed within a socioecological context

The social and contextual factors that have been discussed in earlier sections impact on refugee children's mental health. They have also influenced the development, adaptation and implementation of interventions. This diversity has affected the quality of evaluation of such interventions, and as a result caution is needed in generalising from the emerging findings for practitioners in this field.

The established mental health problems and resulting service barriers for refugee children indicate that these should be targeted in an integrated way, whether through one comprehensive service model, which is obviously more difficult and initially

costly to establish (although likely to be more cost-effective long-term), or the more realistic adaptation and co-ordination of existing services. The synthesis of interventions increasingly points in this direction. Service concepts used in the literature include continuum of care, multi-level and cross-sectoral models (Fazel & Betancourt, 2018), integrated responses and multi-tiered range of services (Ellis, Miller, Abdi, Barrett, Blood, & Betancourt, 2013; Ellis, Miller, Bladwin, & Abdi, 2017); needs-led programmes (Birman, et al., 2008); and eclectic approaches, that address children's and families' needs in conjunction with liaison and consultation to other agencies, problem-solving and practical support (Dura-Vila, Klasen, Makatini, Rahimi, & Hodes, 2013). Earlier focus on pre-migration trauma has increasingly become more balanced with service attention on post-migration acculturation and adjustment difficulties (Hadfield, Ostrowski, & Ungar, 2017). Practice issues to consider at each level are highlighted below, with supporting evidence. This structure is, however, somewhat artificial, as interventions at each ecological level should be inter-linked in order to strengthen the child's resilience.

Theoretical underpinning and implementation issues

A number of factors have to be considered before planning an intervention. The child's readiness, engagement and understanding of the goals are pre-requisites that require extensive preparation and cross-checking with their carers. The context of the intervention is also important, depending on availability and appropriateness of resources and skills (frontline universal or specialist agency) and the outcome of the mental health assessment that took into consideration the child's holistic needs. A hierarchical distinction can be made between enhancing the child's sense of safety,

adaptive functioning and coping strategies, before delving into trauma-related therapeutic input (Vostanis, 2016).

Indeed, this distinction is important in terms of refugee children's stages in the migration journey, transient or relatively stable nature of their placement, clarity on their legal status and likelihood of moving on and, crucially, their physical and emotional safety. All these are largely indicators for building resilience strategies through psychoeducation and skills-based programmes rather than through trauma-reprocessing therapies. Nevertheless, the development of psychosocial programmes has challenged some theoretical notions, in particular the 'either or' position of sharing any of the child's experiences. Whilst exposing a child's traumatic experiences without the safeguards of working through them is risky, recent programmes also appear to acknowledge that dissociating practical strategies from the child's experiences can be a missed opportunity. For this reason, practitioners can use the child's narratives for a specific therapeutic purpose such as enhancing their problem-solving or emotional regulation capacity (El Awad, Fathi, Petermann, & Reinelt, 2017), but with skilled boundary-setting and closure that protects the child from open-ended sharing of experiences that require a more focused and competencies-based approach.

Available programmes have broadened opportunities for frontline practitioners, albeit with expectations on available training, supervision and, ideally, direct links to mental health services for those children who may not respond, have comorbid disorders, or whose mental health symptoms deteriorate. Such interventions (e.g. problem-solving) are often informed by the same framework (such as cognitive-behavioural

therapy – CBT) that may be used in different ways (such as trauma-focused CBT). The context of the delivery and role of the therapist should not define per se the goals and nature of the intervention either. For example, versions of narrative exposure therapy (NET) can be delivered at both frontline LMIC and high-income countries specialist settings (Ruf et al., 2008; Schottelkrob, Doum, & Garcia, 2012; Kangaslampi, Garoff, & Peltonen, 2015).

Child-focused approaches

As both statutory and non-governmental organisations (NGOs) increasingly address refugee children's psychosocial needs, a number of approaches, programmes and associated training are available. These are mostly provided in groups and on average for eight weekly sessions, both for economic reasons, and in order for children to share experiences and enhance peer interaction. However, setting up groups for children or young people with similar characteristics, and ensuring their engagement and regular attendance, bring their own logistical problems. Psychoeducation can help the child and caregivers gain some understanding and mastering of their symptoms, thus enable other supports take effect. The programme Teaching Recovery Techniques is based on the CBT framework (Smith, Dyregrov, & Yule, 2008). Its objective is to educate about symptoms, and to help the child develop adaptive coping strategies, rather than challenge traumatic memories and cognitions. This was found to be associated with improvement of depressive but not of PTSD symptoms of refugee children in Australia, which highlights the importance of matching children's needs with therapeutic frameworks, goals and outcomes (Ooi, Rooney, Roberts, Kane, Wright, & Chatzisarantis, 2016). This study did not involve parents. More positive results in a pre-post treatment comparison of

unaccompanied minors in Sweden found improvement in both PTSD and depressive symptoms (Sarkadi et al., 2018). Some parental involvement through homework was reported by Qouta, Palosaari, Diab, and Punamaki (2012), who also detected a small improvement in PTSD symptoms among boys; and more promising impact in reducing both PTSD and depressive symptoms in the face of ongoing violence in the Palestinian Territories were found by Barron, Abdallah, and Smith (2016). Psychological First Aid aims at reducing initial stress by promoting safety calming, self- and community efficacy, and connectedness, and by instilling hope, although so far there is limited evidence on its effectiveness (Brymer, Steinberg, Sornborger, Layne, & Pynoos, 2008).

Mental health practitioners also have an increasing range of therapeutic approaches and emerging evidence to draw from. Although the methodological quality of evaluation varies, with some programmes being less structured or validated, overall there are positive findings of symptom reduction through cognitive-behavioural, expressive, exposure, testimonial, creative, interpersonal, and eye-movement desensitization and reprocessing (EMDR) therapies (Ngo et al., 2008; Ruf et al., 2008; Vostanis, 2014). These use different techniques and underpinning theories to help the child re-frame the complex relationship between traumatic memories, cognitions and/or emotions, and current symptoms (predominantly PTSD). These approaches are no longer viewed as mutually exclusive from also enhancing adaptive functioning, as long as there is clarity in the goals and fidelity in the approach. There is also wide acceptance of the need for adaptation of interventions and development of therapist skills to address specific factors such as cultural identity and acculturation tensions, migratory paths, religious or spiritual beliefs, and

gender issues (Ndengeyingoma, de Montigny, & Miron, 2014; Marshall, Butler, Roche, Cuming, & Taknint, 2016; Killian, Cardona, & Hudspeth, 2017).

Pharmacological treatment is only indicated for comorbid, rather than for stress-related disorders per se, at least as first line response (Rousseau et al., 2012; Pacione, Measham, & Rousseau, 2013), with lack of sufficient evidence that this should be recommended for children with PTSD only instead of psychological interventions at this stage (NICE, 2010). However, given the frequent association of of PTSD with moderate to severe depression in refugee children and adolescents seen in specialist child mental health clinics, SSRI antidepressant may sometimes be appropriate (Brent and Maalouf, 2015). The use of medication should be based on a thorough diagnostic process, ascertainment of disorders for which it is indicated, , and clear communication with families and agencies involved.

Intervention for parents and families

Parallel contextual, cultural and therapeutic issues need to be considered in involving parents and families. Family interventions should be linked to addressing parents' own mental health needs where appropriate (Fazel, & Betancourt, 2017), providing practical support and establishing community networks (Birman et al., 2008). Reported models are usually multi-family groups influenced by systemic and narrative theories. These combine psychoeducation with specific themes like families in transition, impact of past and current trauma on the family unit, role changes and coping strategies by family members (Bjorn, Boden, Sydsjo, & Gustaffson, 2013; Osman, Klingberg-Alvin, Flacking, & Schon, 2015; Slobodin, & de Jong, 2015). Parenting interventions such as the Parent Management Training (Bjorknes, &

Manger, 2013) and Parenting in a New Culture (Renzaho, & Vignjevic, 2011) have been culturally adapted with similar positive outcomes as in the general population, albeit with a concurrent focus in reducing harsh discipline and instilling positive skills. The influence of attachment theory has led to similar adaptations of interventions to build a parent-child secure relationship, and has shown that, if engaged, refugee parents can utilise reflective approaches (Osman, Flacking, Schon, & Klingberg-Allvin, 2017). Involving trained facilitators from the same ethnic background can enhance engagement and cultural connectedness (Weine et al., 2008; Osman et al., 2017), although all therapists need to develop cultural competencies in engaging refugee families (Guregard, & Seikkula, 2014). Involving fathers is a challenge, which should take into account both cultural and socioeconomic factors (van Ee, Sleijpen, Kleber, & Jongmans, 2013). Involving refugee families in the planning of services can help overcome many of these barriers.

School and community involvement

School is an important entry point for access and interventions, at least for those refugee children already in education. Three models have been described in the literature, all with promising evidence (Sullivan, & Simonsem, 2006). Some programmes are similar to those already described, i.e. based on CBT, verbal or creative expressive approaches, and delivered in schools, usually in groups (Schottelkorb, 2012; Tyrer, & Fazel, 2014; Ooi et al., 2016). These interventions do not necessarily extend to the rest of the school, for example by adopting a whole-school approach, but require cultural adaptation. On other occasions, mental health services have been developed and delivered specifically through schools (Fazel, Doll, & Stein, 2016). Most refugee children favoured this location to attending mental

health services (Fazel, Garcia, & Stein, 2016). Finally, schools can be the hub of a multi-modal programme ranging from helping refugee children adapt to the host society to forming links with community agencies (Rousseau, 2008; Beehler, Birman, & Campbell, 2012). In this model, teacher training is paramount (Ellis et al., 2017), which can be extended to interprofessional networks with the involvement of community leads. Purposeful use of sport and other leisure activities can help bring down societal barriers with peers and adults from the host country (Spaaij, 2015; Marshall et al., 2016).

As indicated in the earlier section, some refugee children and young people have disorders associated with high distress and impairment that requires referral to specialist child and adolescent mental health services. These include severe depression, self-harm with high risk involved, somatoform disorders, neurodevelopmental disorders, and psychosis. The heterogeneity of disorders and range of problems require careful assessment to elucidate the complex mix of developmental, family and social factors that are integral to the formulation. This will inform the appropriate intervention that will often require a multimodal approach and multi-agency involvement, such as educational and social services support.

The wider context of low- and middle-income countries (LMIC)

Although the theoretical principles of interventions are not substantially different, a number of factors need to be taken into consideration for refugee children in LMIC. The key differences lie in the conceptualisation of mental health and associated stigma, need for cultural adaptation of interventions, and limited or lack of specialist child mental health services (Getanda, O'Reilly, & Vostanis, 2017). Consequently,

psychosocial responses often need to target affected populations, and be integrated with economic and community rebuilding efforts (Betancourt, & Williams, 2008). In that respect, the sociecological framework is even more pertinent (Vostanis, 2017), as past (or recurrent) trauma and social adversities are more difficult to disentangle than among refugee children in high-income countries (Eruyar, Maltby, & Vostanis, 2017).

Implementation of interventions relates to different levels, namely: tackling attitudes and developing more child-centred environments such as in refugee camps; promoting nurturing among caregivers and practitioners, like humanitarian staff and volunteers; building resilience through schools and communities; maximising existing strengths and resources of non-specialist practitioners; targeting refugee children at risk or those who have developed mental health problems through evidence-based psychological interventions; and using the sparse specialist resources effectively for non-responsive children with more severe and entrenched psychiatric disorders (Eruyar, Huemer, & Vostanis, 2017, p8). Capacity-building should be a priority for LMIC settings. Several studies have reported interventions delivered by trained lay community counsellors (Jordans, Tol, Ndayisaba, & Komproe, 2013), paraprofessionals (Tol et al., 2010), teachers (Baum et al., 2013), and school counsellors (Barron et al., 2016). However, careful planning should precede skill-acquisition, as the level of training has been found to predict better child mental health outcomes (Newman et al., 2014; Brown, Witt, Fegert, & Keller, 2017). An additional factor is that in many target regions, practitioners have also been affected by collective conflict in their civil life, which requires additional training, supervision and support (Shamia, Thabet, & Vostanis, 2015).

Despite the increasing body of research in LMIC, research findings with refugee children are both limited and difficult to interpret. A number of interventions were implemented with internally displaced children and families, while others targeted broader war-affected groups. Nevertheless, as some key principles and findings of these studies are relevant to refugee children in LMIC, selected evidence was considered. Interventions for children and young people usually involve large groups, and are delivered through schools and communities. Their modalities include psychoeducation (Lange-Nielsen et al., 2012), CBT-based (Barron et al., 2016), and expressive frameworks (Catani et al., 2009; Ugurlu, Akca, & Acarturk, 2016; Brown et al., 2017); or a combination of techniques in an ecological resilience-building model (Tol et al., 2010). Overall, there is more promising evidence on reducing PTSD symptoms rather than depression or functional impairment, or indeed enhancing quality of life (Morina, Malek, Nickerson, & Bryant, 2017). This possibly reflects the initial therapeutic underpinnings of interventions and the methodological designs of their evaluation. As parental engagement is often a key barrier, some programmes have either combined psychoeducation for children with their caregivers (Betancourt, Yudron, Wheaton, & Smith-Fawzy, 2012; Jordans, Tol, Ndayisaba, & Komproe, 2013), or have integrated psychoeducation with basic needs interventions such as infant emergency feeding (Morris et al, 2012). There is less knowledge on how community strengths can be maximised, although factors such as peer support have been found to contribute positively (Morley, & Kohrt, 2012).

Conclusions

The increasing numbers of refugee and displaced children globally indicate that there is a high need to address their mental health and wellbeing, and this should be given a higher priority by organisations providing support as well as health planners. Clinicians need to be aware of the experiences that many refugees encounter, as they often have an impact of the development of psychopathology as well as the ability to access and use mental health services. Stepped care approaches are needed in view of the large numbers of refugee children, and in low and middle-income countries that have a dearth of mental health specialists, task shifting involving teachers and others is important. There are significant knowledge gaps regarding systems for service delivery and treatment effectiveness in a range of settings, and for vulnerable groups, including URMs.

Key points

1. Key Practitioner Messages

1. Young refugees may have experienced disrupted early lives, high violence exposure and further adverse experiences in resettlement countries.
2. Studies on the mental health of refugee children have heterogeneous findings, because of variable risk exposure, and varied individual, family and social vulnerability and protective factors.
3. The most prevalent problems are PTSD, depression and anxiety, but conditions such as developmental disorders can also occur.
4. Support for refugee communities and families will enhance child refugee wellbeing.
5. Stepped care and tiered systems of delivery are needed, because of high and complex needs.
6. A number of interventions, including CBT, EMDR and narrative exposure therapy have an accumulating evidence -base in high and LMIC.

2. Areas for Future Research

1. Establishment of risk and resilience factors in varied settings, including what promotes lower distress.
2. Further studies of high risk groups such as refugee mothers and infants, unaccompanied refugee minors, and children exposed to impaired parenting and family conflict.
3. Investigation of systems of delivery in community settings, e.g. primary care, child and parent or family refugee services, school settings, and specialist agencies, including child welfare.

4. Further robust evaluation of interventions for psychologically distressed children.
5. Investigation into what promotes good adjustment and social integration of refugees into resettlement countries.

Clinical Commentary

The global refugee situation means that at population level, experience of war, displacement and often associated poverty and marginalisation will account for a high level of psychological distress and disorders amongst refugees. Clinicians in many settings will encounter such children. They need to be aware of the disruption to young refugee children's lives and experiences they may have encountered. These experiences place them at high risk for PTSD, depression, anxiety disorders and psychosis. In addition they may have developmental problems that can occur in all children such as ASD and intellectual disability, which are highly prevalent in many regions of the world from which refugees originate. CAMH clinicians may also have roles as advocates, and as informed influential figures may contribute to policy to help address children's high mental health needs. Given these high needs and cultural issues, stepped care approaches need to be adapted and integrated into the existing health care delivery systems. There are significant knowledge gaps and further research is needed, particularly in a service context.

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Table 1

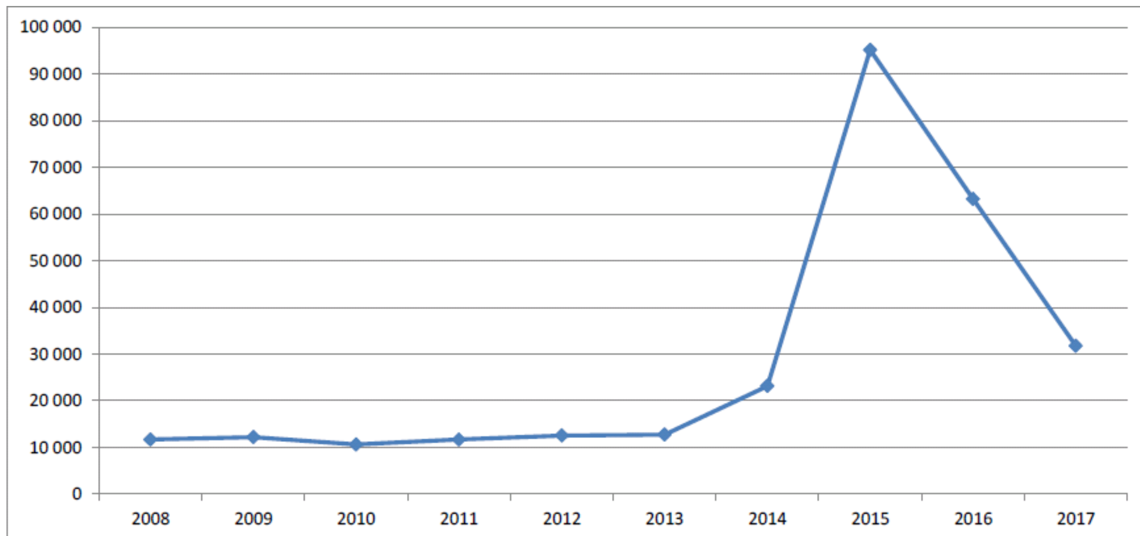
Highest originating and hosting countries for refugees in the world

(http://www.unhcr.org/globaltrends2016/ accessed 30th March 2018)

Top Originating Countries	**Top Hosting Countries**
Syria 5.5 million	Turkey 2.9 million
Afghanistan 2.5 million	Pakistan 1.4 million
South Sudan 1.4 million	Lebanon 1.0 million
Somalia 1 million	Iran 979,4000
Sudan 600,000	Uganda 940,800
DR of Congo 600,000	Ethiopia 761,600

Figure 1

Asylum applications considered to be unaccompanied minors in the European Union* Member States 2008-2017



*Excluding Croatia for the period 2008-2011

Source: Eurostat (2018b):