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Prevention of Psychological Distress and Promotion of Resilience Amongst Unaccompanied Refugee Minors in Resettlement Countries

Abstract
As increasing numbers of Unaccompanied Refugee Minors (URM) are arriving in Europe, there is a need to investigate which factors promote psychological resilience and improve their mental health. This review aims to identify preventive post settlement influences, including living arrangements, access to mental health services and effective treatments that may improve mental health outcomes.

Methods
A systematic literature review was conducted of published papers in any language for children (<18 years) entering a host country, unaccompanied and seeking asylum. Specific studies were eligible if they examined any treatment or non-treatment influences on mental health or psychological resilience for the URM. Thirteen published quantitative studies were identified.

Results
URMs in more supportive living arrangements including foster care had lower risk of PTSD and lower depressive symptoms compared with those in semi-independent care arrangements. URM’s living in reception settings that restricted freedom had more anxiety symptoms.

Regarding help seeking, one study found only 30% of URM’s had foster-parents or guardians who could detect a mental health need. Two papers found the URM’s had low levels of contact with mental health services despite the high prevalence of psychiatric symptoms. URM’s were less likely than accompanied children to receive trauma-focused interventions, cognitive therapy or even practical assistance with basic social needs.

With regard to treatment evaluation, only case series were identified. Three studies found cognitive behavioural therapy improved PTSD symptoms and mental health outcomes. A less structured approach (mental health counselling alone), did not improve functional health outcomes.

Conclusion
Higher support living arrangements with low restrictions are associated with lower psychological distress. Most URM’s are not receiving psychological interventions and there is a dearth of studies evaluating treatment effectiveness for this group. There is an urgent need for more research to investigate pathways to mental health services and treatment efficacy in this vulnerable group.
Introduction

The United Nations High Commissioner for Refugees (UNHCR) found that by the start of 2018, 65.6 million people worldwide were forcibly displaced due to persecution, conflict, violence or human rights violations. 22.5 million individuals were registered as refugees. 55% came from South Sudan, Syria and Afghanistan. The top hosting were Turkey, Pakistan, Lebanon and Iran (UNHCR, 2018). 51% were minors under the age of 18. The numbers of people seeking asylum in Europe significantly increased after 2010; during 2015 and 2016 there were 1.3 million asylum seekers in the region (European Commission 2018). 32% of these were minors under 18 years of age. In 2016 there were 63.3 thousand applications in the EU-28 from unaccompanied minors.

In view of the vulnerability of children and adolescents, they are afforded a special status by UNHCR. An Unaccompanied Refugee Minor (URM) is defined as any young person under the age of 18 years old who has been separated from both parents and is an asylum-seeker, recognised refugee or other displaced person (Bean et al. 2007). It is expected that hosting countries will offer special protection including appropriate care and support, education, housing and legal support (UNHCR, 2018).

It is known that URMs are an especially vulnerable group, by definition, they are unaccompanied by parents or carers. Compared to accompanied minors and non-immigrants they are more likely to have suffered multiple potentially traumatic experiences such as abuse, exploitation and loss of family members, (Fazel et al. 2015). Surviving cumulative harrowing situations, having their education and social lives disrupted, they then have to endure often terrifying migration journeys before settling in a country where they may struggle to learn a new language and assimilate to an unfamiliar culture (Bronstein et al, 2012; Hodes et al., 2008; El Baba and Colucci, 2018). Such background adversities are associated with high levels of psychological distress and increased risk of psychiatric disorder (Bronstein et al, 2011; Fazel et al, 2011; El Baba and Colucci, 2018).

There are large numbers of URM’s entering resettlement countries, including in Europe. In 2015, there were 90,000 applications for asylum by URMs and in 2016, 63,000 applications in the European Union countries (European Commission 2018). Clearly with such large numbers, it is important to assess the extent to which prevention strategies may ameliorate the high level of psychological distress and promote resilience. The arrival of such numbers of URM’s in Europe and in other resettlement countries mean that existing treatment services cannot meet their mental health needs. The gap between need and service provision has been exacerbated by the European refugee crisis and the arrival of URM’s occurring in the years following financial austerity (Anagnostopoulos et al, 2017; Hodes and Vostanis, 2018).
In view of the treatment gap just described, it is important to consider the extent to which preventive approaches may reduce the treatment need. Preventive interventions can take place at a number of levels: Universal, Targeted and Indicated. Universal strategies are aimed at the general population and can be considered as primary prevention. They attempt to reduce a variety of risk factors and promote protective factors, (Greenberg and Riggs, 2015). For URM's, these could be placement in high support living arrangements such as selected foster families, or programs teaching social and emotional skills. Targeted or selective interventions are provided to those individuals that have characteristics known to place them at higher risk of developing problems or have been through a recognised ‘stress-trigger’ event that increases their risk for maladjustment. In the URM population, these could be individuals who have experienced certain kinds of trauma or have a history of mental health problems.

Indicated interventions will be specifically aimed at children who are showing significant levels of distress and may have psychiatric disorder. They are referred to child and adolescent mental health professionals working in community or clinic settings for assessment and interventions. With regard to resilience factors, these are conceptualised as ‘promotive’ factors which are found to predict higher levels of positive outcomes or ‘protective’ factors which are predictors of lower levels of psychological distress. As described by Tol et al. (2013), its evidenced that resilience-focused interventions need to be tailored to specific contexts i.e. targeted or indicated interventions as opposed to universally applied to be most effective.

The implementation of preventive mental health approaches for URM's requires an understanding of a range of policies and practices. This includes the level of social support and living arrangements, for URM's, as well as the extent to which mental health access is available and effective treatments can be provided.

The aim of this review is to identify and appraise the studies of URM's that investigate:
1. the primary prevention of psychological distress, including the identification of optimal care and accommodation arrangements
2. the appropriate access of URM's to specialist mental health services and the factors associated with service access
3. The evidence for effectiveness of treatments for psychiatrically impaired and distressed URM’s.

Methods

Inclusion and exclusion criteria
Studies were sought in all languages, providing adequate translation was available. Published observational studies including children and adolescents i.e. under the age of 18 years who entered a host country unaccompanied, seeking asylum (considered to be refugees) and exposed to variables hypothesised to impact mental health outcomes were required. Studies needed to have specified
the sample size, demographics, nature and intensity of the intervention and the specific outcome measures.

Studies were eligible if they examined any treatment or non-treatment influences on mental health or psychological resilience in unaccompanied asylum-seeking minors. Studies required quantitative outcome measures and use recognised standardised assessment instruments i.e. a questionnaire or psychiatric interview for mental health symptoms or other functional health outcomes as applicable.

Studies were excluded if studies had not specified whether asylum-seeking refugee minors were accompanied or not. Purely qualitative research was excluded.

Search strategy
The study question was broken into 4 concepts ('unaccompanied', 'refugee' or 'asylum-seeking', 'child and 'mental health') and these were applied as search criteria using keywords and synonyms as required. 'Mental health' was searched as the term and 'psych-' as a pre-fix, 'refugee' was searched as the term and 'migrat-' as a pre-fix, 'child' was searched as the term and 'adolescent' and 'minor'.

Four databases using two search engines were searched on the 12th August 2017:

- PROQUEST MEDLine (1946 – current)
- PROQUEST PsychINFO (1946 – current)
- PROQUEST Psycharticles (1946 – current)
- PUBMED (1946 – current)

The reference lists of significant review papers and those identified as relevant papers were also searched for additional studies.

Selection of studies
The search results from both databases were combined and duplicates removed manually. There was an initial screening of the titles and those not relevant were excluded. The abstracts of the papers remaining were then screened against the inclusion and exclusion criteria. A second round of short-listing when studies were read in full and again examined against the criteria produced the final list of studies. The first review author selected studies independently. The second author and supervisor jointly reviewed whether studies met the criteria.

As well as the 12 studies from the literature search, two other papers were found by hand-searching and following up references in other significant papers.

Figure 1: Prisma Flow Diagram: Study selection process

Quality of Studies Analysis
An analysis evaluating the Quality of the individual studies was also carried out using the Newcastle-Ottawa Scale adapted for Cross-Sectional Studies (Wells et al. 2018). This is a scale adapted from the Newcastle-Ottawa Quality Scale for non-randomised studies in meta-analyses. This original scale has been critically reviewed by experts and found to have adequate validity and inter-rater reliability (Oremus et al, 2012). The adapted scale was used to score the individual studies in three key areas: sample selection, the comparability of the groups within the study and the outcome measures (i.e. the reporting and statistical analysis). The studies were scored in the range 1 to 10.

Results

Search results

The PROQUEST database search returned 37 results and the PUBMED search 95 results. 12 papers from the searches were included in the review (see Figure 1) and an additional 2 papers found by cross-referencing.

Figure 1 here

Although some studies used the same outcome measures, heterogeneity in the study characteristics and instruments used meant that no summary estimate or meta-analysis could be carried out (Tables 1, 2 and 3).

Association between the residential setting and psychopathology

All six of the studies that investigated living arrangements found an association between higher support settings and lower psychological distress.

Table 1 here

Three cross-sectional studies (Bean et al, 2007; Bronstein et al, 2012; Hodes et al, 2008) were consistent in finding that care in high support living arrangements associated with fewer PTSD symptoms. Bean et al. compared symptoms in URM s living unsupervised in large reception centres with those placed in foster care or living in small groups with 24 hour supervision, this study also found lower internalising symptoms for those living in higher supported living. Bronstein et al, (2012) compared minors living in a less supervised semi-independent environment versus those in foster-care placement. Hodes et al. (2008) compared URMs living in foster care or a children’s home versus those living independently or semi-independently. Two of these studies were carried out in England and one (Bean et al. 2006) was in the Netherlands.

Further support for the association between high support living arrangement and lower psychological distress was also found in a longitudinal study carried out with URM’s in Norway (Jakobsen et al. 2017). In a study of 138 URM’s there were better mental health outcomes, at both 15 months and 26 months follow-up (as measured by the HSCL-25) for those placed in more supportive reception
centres designed for younger individuals compared to low support reception centres usually for adults.

Another study in the Netherlands investigated outcomes after residence in highly restrictive reception centres that had regimes and conditions almost like that of a prison, (Reijneveld et al. 2005). Follow-up of URMs placed in these settings and compared to a less-restricted, more autonomous group had greater emotional problems on the (HSCL-25). The main effects were more anxiety symptoms. Girls at the restricted campus had statistically significantly higher scores for emotional problems, anxiety and depression than the girls in the routine reception group.

The Geltman et al. (2005) study of Sudanese URMs in the USA found that the ethnic background of the family or individuals in the living arrangement was a significant variable associated with PTSD symptoms.

Overall, the studies were consistent that lower support and more restricted living arrangements have an association with mental health outcomes. The strength of the longitudinal design in the study by Jakobsen et al. (2017) gives further support to this likely association.

Hodes et al. (2008) also investigated whether the time duration of settlement in the host country had an impact the mental health outcomes using the Birleson Depression Self-Rating Scale (BDSR). The study did not find a significant association.

**Influence of the variation in Service Pathways and Access to Services**

Four studies have investigated pathways and access to specialist mental health services.

*Table 2 here*

In the Bean et al (2006) study, 57.8% of URMs perceived a need for help with their psychological distress but only 12.7% had used mental health services (MHS). However, analysing this further, it was found that only a small percentage (30%) of URMs had their emotional distress detected by guardians or teachers. In the Bean et al (2007) study it was interesting to note that there was little correlation found between self-report and the guardian/teachers report of perception of need for mental health services.

In the study carried out in England, only 17% of URMs had MHS contact (Sanchez-Cao et al, 2013). Regarding risk of any psychiatric disorder, URMs were more likely to score in the abnormal range of self-report SDQ scores if they had contact with services (33.3%) than if they did not (6.7%). URMs at high risk for depression were more likely to have MHS contact (41.6%) than those at low risk of depression (6.7%).
Another study from England looked at referrals to MHS (Michelson and Sclare, 2009). URMs were more likely than the accompanied children to be referred by Social Service agencies whereas the accompanied children were more likely to be referred by GPs. With regard to the use of MHS, unaccompanied minors had a higher rate of missed appointments (33%), almost double the rate of missed appointments by the accompanied minors. Looking at the provision of certain types of interventions, despite URMs having a higher risk of PTSD, they were less likely than the accompanied children to get access to and receive trauma-focused psychological interventions. URMs were also significantly less likely to have been treated using cognitive therapy, anxiety management and parent/carer training, as well as receiving fewer types of practical assistance with basic social needs.

One study of treatment access and treatment seeking behaviour in a group of Sudanese URMs in foster care living in USA has been carried out (Geltman et al. 2002). It was reported that those with PTSD were more likely to seek treatment than those with behavioural or emotional problems.

**Psychotherapeutic interventions for URMs**

**Table 3 here**

Few studies have been carried out investigating the effectiveness of interventions for psychological distress in URMs. For the Sudanese URMs in the USA, using the Child Health Questionnaire (CHQ) as the primary outcome measure, Geltman et al. (2008) found that mental health counselling did not improve functional health outcomes. The three other studies looked at cognitive behaviour therapy (CBT) for which there is already a large body of work documented for children exposed to violence and war (Morina et al. 2017). The core components of the therapy i.e. recognising unhelpful cognitions, behaviours and developing personal coping strategies are adapted to focus on different presentations among the heterogeneous groups of URMs, (Demazure et al. 2017).

A study by Unterhitzenberger et al (2015) from Germany reported a case-series assessing the benefit from Trauma–focusses cognitive behavioural therapy (TF-CBT) delivered to six adolescents URMs with moderate to severe PTSD symptoms. TF-CBT was shown to be effective; on both the Clinician Administered PTSD Scale for Children and Adolescents and the Post-trauma Diagnostic Scale (PDS), improvements were found. Only one case still met the DSM-IV criteria for PTSD at the end of the treatment. The two single case-studies, one by Unterhitzenberger and Rosner (2016) and the other by Vickers (2005) in the UK, showed that delivery of TF-CBT decreased PTSD symptoms significantly. Over a period of 6 months from the first CBT session, the girl in the Vickers study no longer met the criteria for diagnosis; on the PDS scale (ranging from 0 to a total severity score of 51), the score dropped from 42, a rating of severe-PTSD to 9, a score consistent with only minor symptoms.

**Quality of Studies**
To judge what may be a ‘high quality study’, the mean quality of studies was calculated (=6.7) to provide a reference point for “high” (scoring > 7.0) versus “low” quality studies. 5 of the 6 studies on the association between residential settings and psychopathology were of a high quality; they all scored above 7 on the Newcastle Ottawa Scale, 1 scored 5, 4 of these 6 studies (2 papers reporting the same study) were cross-sectional, the other 2 being longitudinal; Bean et al (2006) and Jakobsen et al (2017). All three of the papers reporting on service referral and access pathways were cross-sectional. Of the studies reporting on psychotherapeutic interventions, one was cross-sectional, one a case-series and two were single case-studies; these are relatively weaker levels of evidence as compared to the longitudinal case-controlled studies (Aveyard, 2014).

Discussion

The review was designed to identify and appraise studies of URMs that have investigated care arrangements that may prevent psychological distress, access to specialist mental health services and the evidence for effectiveness of individual treatments for URMs.

Three high quality studies found lower post-traumatic symptoms and less distress for URMs living in higher supported arrangements, one study found overall better mental health outcomes (based on the HSCL-50) for those in the less-restricted settings which provided them more autonomy. This is consistent with another study (Reijneveld et al. 2005.) that found fewer emotional problems and lower scores on anxiety and depression scales for those in less-restricted settings.

One study found that URMs placed with ethnically matched family or individuals i.e. Sudanese had better mental health outcomes than those living in a group home or foster care alone with an American family, (Geltman et al. 2005). These are findings related to those documented in a review by O’Higgins et al. (2018). Eight of the nine studies examined in the O’Higgins et al. 2018 review also evidenced a link between accommodation type and mental health outcomes. Meta-analysis found a benefit of foster care over other kinds of care with effect size of 0.3 (O’Higgins et al, 2018) . More specifically, within the foster care placement, those more sensitively ethnically and culturally matched were associated with better mental health outcomes.

Why should psychological distress be lower in settings with greater support compared to settings where individuals are more restricted and have less autonomy?

Social support, whether that be from peers or a parental figures is a protective factor in the face of adversity and loss (Demazure et al. 2017). Having foster carers or guardians in certain placements may give the young people opportunities to better confide and express feelings of despair and hopelessness. Many of the URMs would have lost attachment figures and other family members and with this lost the security that a family can provide; being in a foster
placement with a family structure will provide them with an increased ‘sense of belonging’ again and make assimilation into the local community setting easier too. Having arrived in the host country, many individuals will continue to experience the impact of the social upheaval and ongoing threats of deportation. Placement in a supportive environment as well as autonomy to mix with peers from similar backgrounds and possibly of similar ages reduces distress. URM’s are more likely to benefit from the group effect of sharing the lived experiences whilst getting help from care-givers. URM’s may experience acculturative stress that is associated with increased depressive symptoms, (Keles et al, 2016), and this may be mitigated by placement of URM’s in foster families that are more culturally matched (O’Higgins et al, 2018).

Supportive living arrangements and high quality foster care that facilitate confiding and experience of adult /carer concern and warmth may provide a buffer for ongoing stressors. URM’s experience ongoing stressors and these may be related to persistence of internalizing symptoms (Vervliet et al, 2014). Some studies have found that peer support is relatively low (Mels et al, 2008) which further empathizes the need for and support from carers or foster parents. Interestingly, for URM’s who have contact with their families, this support serves as a buffer against life events and stressors (Sierau et al, 2018).

**Poor recognition of distress and under-utilization of services**

The four studies looking at service pathways showed there is a significant gap in identifying those URMs that need mental health services, referrals and willingness to use the services offered. Bean et al. (2007) found that nearly 60% of URMs reported needing professional mental health care yet only 12% had received any. Only one third had their emotional needs recognised by guardians or teachers and almost a half perceived that their mental health needs were unmet. This suggests a significant treatment gap. The findings suggest that there may be scope for psycho-education on recognising symptoms for carers and teachers but also work to raise awareness with the URMs themselves about what services maybe available to help them and for which problems.

Findings by Sanchez-Cao et al (2013) suggest that URMs may be better able to communicate their mental health needs once they had already had contact with mental health services. It also showed that there was little association between the severity of post-war trauma symptoms and MHS contact, however, depressive symptoms were associated with service contact. This could be because depressive symptoms are easier to communicate or perhaps recognise by the referrers. Like the Dutch study, the UK study also found unmet need.

There has also been inadequate work on screening and early detection for psychological distress amongst URM’s (Fegert et al, 2018), although this an area that is attracting attention since the 2015-2016 European refugee crisis (Gadeberg et al, 2017). In routine practice self-report instruments that may have low sensitivity for depression, anxiety disorders and PTSD such as the Strengths and Difficulties Questionnaire (Goodman et al, 2000), used by social workers for URM’s in the UK (Goodman et al, 2012) may be sub-optimal for
identification and referral of distressed URM’s. Improved screening could lead to more timely referral of the most distressed URM’s to specialist services for indicated treatments.

The reasons may include that even when mental health services are offered to URM’s they may hesitate in accepting help from adults for multiple reasons. Many would have had harrowing experiences in their native country and whilst on their journey, mostly perpetrated by adults including smugglers, traffickers and custom officials. They may find it difficult to trust new people. Other barriers to asking and accessing help from MHS may be fear that expressing their distress and wanting help may compromise their chances of getting asylum. PTSD may also be associated with fear of disclosure, a phenomenon that is perhaps part of the avoidance seen with PTSD.

Language and cultural background are other major factors; many URM’s are from countries where there is no or little mental health service provision and so may not be aware that certain interventions or professionals such as psychologists and therapists even exist. In addition, as with many native children and adolescents, they may not be aware of the services available and so even if distressed, they may not have the language to express this or have the knowledge to know what to ask for.

**Treatment Studies**
Clearly, the review highlights that there is a dearth of studies on treatment for unaccompanied young refugees. All three studies looking at the effectiveness of CBT reported significant decreases in PTSD symptoms but sample sizes were small (a case-series of 6) and two case-studies; these cannot be used as reliable evidence to demonstrate efficacy. Randomised controlled trials (RCTs) are deemed to be the highest level of evidence and so until more are carried out, we need to draw on other studies of PTSD in young refugees and those exposed to war. Studies should also consider a broader range of psychotherapies including expressive therapies such as art therapy, that could be used as targeted or indicated interventions for URM’s. Research is also needed for the subgroup of more impaired URM’s with depression and PTSD who might need drug treatments. Drug efficacy in these URM should be evaluated, alongside exploration of attitudes to adherence related to cultural or religious beliefs.

**Limitations of the review**
The review is limited by the availability of high quality research studies in this field. The studies were limited by relatively small sample sizes and a high proportion of cross sectional studies. The measurement outcomes used are another weakness of the studies. Analysing the instruments used, 9 of the 12 only used self-report questionnaires which may not have been sensitive enough to pick up the complexities of individuals thoughts and experiences. Only the Bean et al (2007) study had additional teacher and guardian reports and two had clinician ratings for mental health disorders (Michelson and Sclare (2009) and Unterhitzenberger et al (2015)). Although all the self-report questionnaires described are commonly used, well validated and tested for reliability they have their limitations. URM’s may be worried that reporting problems could
influence the decisions made about their asylum status or they may exaggerate symptoms thinking they will only get help the more distress they demonstrate; both would introduce a response bias to the self-reporting. It is also accepted that we did not include all studies that identified risk factors for psychological distress such as uncertainty about asylum claims or rejected claims (Jakobsen et al, 2017), or the effects of detention, which is known to be harmful (Entholt et al, 2018; Zwi et al, 2018).

**Conclusions and implications for service planning**

Based on the predictions of greater numbers of URM s fleeing their native countries and coming to Europe and other higher income countries, preventive approaches to psychological distress are required. The available evidence strongly suggests that high support living arrangements and the avoidance of detention are required. Systems for effective early detention of those with higher levels of distress and impairment with timely access to specialist mental health services are needed. Further work using robust designs is required to evaluate psychological treatments for PTSD and depression. More work is needed to include cultural variables in the provision of support and treatment delivery, a topic in which more investigation and research is needed.

**Key Messages:**

- Increasing numbers of Unaccompanied Refugee Minors are arriving in Europe, many of whom have specific mental health needs
- Factors promoting psychological resilience and improved mental health outcomes need to be identified
- The review found that better supported living arrangements and less restricted settings were associated with lower psychological distress
- Despite a high prevalence of psychiatric symptoms in this group, there is poor recognition of the need for help and limited access to services
- There is a need for more research to investigate pathways to mental health services and treatment efficacy for Unaccompanied Refugee Minors
References


Fegert JM, Sukale T, Brown RC. Mental Health Service Provision for Child and Adolescent Refugees: European Perspectives. In: Hodes M, Gau SS-F, de Vries PJ,


Figure 1: Prisma Flow Diagram: Study selection process

PROQUEST: 37 papers

Duplicates removed manually: 118

PUBMED: 95 papers

Titles screened

Rejected at first screening: 70

Abstracts and full test copy of relevant studies obtained and screened against inclusion criteria

Included in review: 12

Rejected: 36

Not a quantitative study: 4

Study population not specified as “unaccompanied”: 2

Intervention(s) not clear or insufficiently measured: 31