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The Mental Health Needs of Child and Adolescent Refugee and Asylum Seekers Entering Europe

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Abstract

Children and adolescents constitute more than half of the global refugee population and almost one-third of first-time asylum seekers in the European Union (EU) during 2015 were under 18 years of age. Syria in particular accounts for a substantial proportion of young refugees and asylum seekers because the ongoing civil war has led to almost five million Syrians fleeing their country and becoming refugees during the past seven years. Being a child or adolescent refugee or asylum seeker carries an increased risk of developing mental illness, and such displaced young people are known to experience problems in accessing healthcare support. The present paper draws on examples from Syria in order to (i) highlight mental health issues that typically arise in children and adolescent refugees and asylum seekers entering Europe, and (ii) discuss how changes to health systems and policies in European countries receiving refugees and asylum seekers can be better aligned with global efforts to improve the mental health of young displaced immigrants. In general, research findings indicate that there is a need for better awareness, intra-agency collaboration, and cultural sensitivity towards the mental health needs of this immigrant population. Furthermore, there is also a need for EU countries to better respond to post-traumatic stress disorder and other typical refugee and asylum seeker mental health problems by more closely aligning national policies with global initiatives to improve the mental health of young displaced immigrants.

Introduction

A refugee is an individual who has been forced to flee their own country and who is recognized under the United Nations Refugee Convention as being legally resident in a contracting state. Individuals waiting to be granted such refugee status are classed as asylum seekers. Over 65 million people currently alive have been displaced from their home, and approximately 21 million of these are classified as refugees.^[1] More than 50% of the global refugee population derive from Syria, Afghanistan, and Somalia, and approximately 17% of individuals displaced from these countries are received by European states.^[1] Syria, in particular, accounts for a sizeable proportion of the aforementioned refugee figures because the ongoing civil war has led to almost 12 million Syrians being displaced since 2011, of which approximately five million Syrians have fled their country and become refugees. The principal reasons for leaving Syria are the risk of being killed or injured, persecution, property damage, and/or a breakdown of the country's health systems and economic infrastructure.

Children and adolescents under the age of 18 years constitute more than 50% of the global refugee population,^[1] and there are an estimated 5.4 million child and adolescent refugees and asylum seekers in Europe.^[2] Furthermore, almost one-third of first-time asylum seekers in the EU during 2015 were under 18 years of age.^[3] In the UK (where the present authors reside), over 8,500 applications of dependants for asylum (i.e., allied to a family member who had previously successfully sought asylum) were received in 2016, most of which were from children and adolescents.^[4] In addition, in 2016 over 3,000 unaccompanied asylum-seeking adolescents and children pursued asylum in the UK.^[4]

Children and adolescents in migration are deemed to be young people “*in search of survival, security, improved standards of living, education, economic opportunities, protection from exploitation and abuse, family reunification or a combination of these factors. They may travel with their family or independently (unaccompanied child) or with an extended family or a non-family member (separated child)*”^[5] Being a child or adolescent refugee or asylum seeker carries an increased risk of developing mental illness,^[6] and transnationally displaced children and adolescents are known to experience problems in assessing healthcare support (that is generally not developed with the needs of young asylum seekers or refugees in mind).^[1]

This brief paper draws on examples from Syria in order to (i) highlight mental health issues that typically arise in child and adolescent refugees and asylum seekers entering Europe, and (ii) discuss how changes to health systems and policies in countries receiving such individuals can be better aligned with global efforts to improve the mental health of young displaced immigrants.

Key Mental Health Issues

In a systematic review of 46 studies, the prevalence of post-traumatic stress disorder (PTSD) in asylum seeker and refugee children and adolescents being received in European countries was reported as being 20-84%, with unaccompanied children being at greater risk than those accompanied.^[3] This is consistent with findings from a study based on a Syrian refugee camp in Turkey, where 45% of child refugees were found to have PTSD, and where war-related traumatic events (e.g., persecution, witnessing

atrocities, rape, loss of family members, etc.) predicted the occurrence of PTSD several years after becoming a refugee.^[7]

The aforementioned systematic review also found that depression and anxiety reflect key mental health issues in child and adolescent refugees, with higher rates of occurrence typically observed in newly arrived children and adolescents. For example, one study showed that almost half of Syrian refugee children and adolescents in Turkey had levels of anxiety and withdrawal that were clinically significant.^[8] Furthermore, the systematic review found that while refugee boys tended to exhibit externalisation in the form of behavioural problems, refugee girls tended to exhibit internalisation in the form of loneliness and emotional problems.^[3]

Post-migration factors reported in the systematic review to negatively impact on the mental health of refugee children and adolescents included lack of citizenship status, financial and legal insecurity, lack of access to social capital, frequent dislocations (e.g., changing home and schools), discrimination, restrictions on working, loneliness and boredom, and cultural dissonance more generally.^[3,9] Indeed, empirical research has shown that child refugees in the UK who are exposed to such post-migration stressors for longer than two years have a greater likelihood of being referred to health and social services due to behavioural issues versus refugee children that have been settled in the UK for a shorter duration.^[10] However, although Curtis et al.'s^[3] systematic review provides a useful overview of the psychological health of child and adolescent migrants received by Europe, findings should be interpreted with caution as they are not necessarily representative of all European countries because research into the mental health of youth refugees is not evenly distributed across European states.

Another factor that appears to exacerbate mental health issues in refugee and asylum-seeking children – including those from war-torn countries such as Syria – is a general reticence for such displaced youth to discuss their (or their family's) health needs, and this appears to be associated with the stigma of being a migrant.^[9] There also appears to be a general distrust amongst Syrian and other transnationally displaced young people of the receiving country's national health service, as well as confusion over how it works and what access rights are available to refugees and asylum-seeking children and adolescents.^[3,9]

The Need for Health Systems and Policy Changes

In the UK and other high-income receiving countries, the welfare and housing of child refugees, including those from Syria, is typically overseen by national or regional child welfare agencies alongside immigration authorities and non-governmental organisations.^[11] In addition to providing accommodation, such organisations typically help to coordinate access to health and education services, including mental health support services. In the UK, foster care appears to be the preferred means of accommodating and supporting unaccompanied young refugees, but in other European countries, popular accommodation options can also include kinship care (placing the child with an extended family member), residential housing, shared housing, independent accommodation, and detention centres.^[11]

In line with the socio-ecological model, the health and mental health of child and adolescent refugees and asylum seekers is influenced by factors operating at the level of the individual (e.g., coping strategies, adaptability), micro-environment (e.g., schools,

teachers, and parents) and macro-environment (e.g., religion and culture)^[7] The socio-ecological model highlights the need for joint care pathways in receiving countries, whereby child and adolescent psychological health services actively collaborate with social care services, non-government organisations, and also community-level stakeholders such as schools.^[12] Effective joint care pathways help to foster knowledge and best-practice sharing, and can limit delays in young refugees gaining access to education, housing, and healthcare support services.^[7] Furthermore, such collaborative multi-agency approaches are also in the interests of tailoring refugee mental health support provision to meet the specific needs of child and adolescent service users. For example, better mental health outcomes are typically observed when youth refugees are placed with people of the same ethnic background versus individuals of different ethnicity.^[11] Furthermore, a systematic review and meta-analysis of nine studies of unaccompanied refugee children reported a small-to-moderate effect size (Cohen's $d = 0.33$) for better mental health outcomes among children living in foster care versus other forms of accommodation.^[11]

In various studies, parent-related factors have also been shown to assert an important mediating role in the onset and prognosis of mental health problems in cross-nationally displaced youth. For example, refugee parent's levels of mental health are closely associated with children's PTSD and anxiety symptoms, as well as children's internalising and externalising symptoms.^[13] Conversely, positive parental mental health and parental support are understood to have a protective role in the development of mental health problems in refugee children and adolescents.^[11]

In addition to collaboration between healthcare stakeholders, there is a need to offer evidence-based interventions that are geared towards addressing mental health issues commonly experienced by child and adolescent refugees and asylum seekers. For example, in countries such as the UK, asylum seekers and refugees have access to psychological support under the National Health Service (NHS), which includes some specialist PTSD treatment services, including some multi-lingual services dedicated to the treatment of PTSD amongst refugees. More specifically, since 2012, the NHS in England has operated an initiative known as Improving Access to Psychological Therapies,^[14] which includes the provision of CBT-based psychotherapy for children who have experienced PTSD.^[4]

European mental health systems are generally orientated towards offering support to child and adolescent asylum seekers and refugees in the form of approaches based on Cognitive Behaviour Therapy, Narrative Exposure Therapy, Eye Movement Desensitization and Reprocessing (EMDR), and one-to-one multimodal therapies focusing on alleviating PTSD symptoms.^[9] However, a key consideration in respect of effectively implementing these strategies is culturally adapting the intervention to better meet the needs of the refugee or asylum seeker population in question. For example, in the case of Syrian youths, in addition to modifying the language and context, this also means modifying values and meanings to align with Muslim and other religious beliefs common throughout Syria.^[9] Furthermore, in the case of Syrian refugees, randomised controlled trials have shown that EMDR can be effectively modified to help reduce PTSD symptoms in a manner that is culturally syntonetic for transnationally displaced Syrians.^[15,16]

It should also be noted that sometimes, young immigrants also respond well to non-traditional approaches, such as healers and community-based support initiatives.^[17]

In terms of up-scaling interventions and rolling them out to large refugee and asylum-seeking populations, the World Health Organization^[18] recommends the implementation of task-shifting, which involves a qualified mental health professional supervising specialised lay mental health workers to administer all or parts of the intervention. According to Sijbrandij et al.^[9] task-shifting is appropriate for European health systems because such systems promote the use of stepped and collaborative care models in order to help minimise costs. However, although task-shifting can be a useful upscaling method, a critique of such an approach is that it typically yields high drop-out rates at the point responsibility for intervention facilitation shifts to volunteers or lay helpers.^[9]

Another intervention upscaling approach that appears to lend itself to implementation amongst refugee and asylum seeker child and adolescent populations is the use of e-mental health interventions.^[9] E-mental health interventions help to minimise obstacles caused by geographical, cost and resource constraints, and they can also help to circumvent the stigma associated with seeing a mental health worker^[19] For example, one study showed that 90% of refugee Syrian participants had a mobile phone, and that 60% had access to the internet via their smartphone.^[20] Therefore, interventions delivered online and via mobile phone apps may be a pragmatic approach to ameliorating mental health issues amongst transnationally displaced children and adolescents from countries such as Syria^[9] as has been demonstrated among other stigmatised groups such as addicts.^[21]

In conjunction with a more collaborative and culturally syntonc approach to improving the mental health of young asylum seekers and refugees, policy change is also required to address the mental health needs of this immigrant population. For example, in the UK (and in other countries such as the USA), asylum seekers and refugees may sometimes avoid accessing healthcare due to fear of being deported.^[17] Indeed, in 2016, approximately 6,000 patients were traced by UK immigration authorities following information passed to the UK Home Office by the NHS.^[17]

A greater focus in national policies on improving the mental health of refugee and asylum seeker children and adolescents would be more aligned with global efforts to respond to the health needs of young people who have been forced to leave their homeland. For example, the 2018 United Nations' report *Making Migration Work for All* outlines global policies that (i) support the provision of healthcare regardless of immigration status, and (ii) increase the number of temporary stay permits. Furthermore, in 2017, the International Society of Social Paediatrics and Child Health issued a policy statement – entitled *The Budapest Declaration for Children and Youth on the Move*^[22] – which highlights the need for healthcare providers to be more aware of transnational movements amongst displaced children, as well as the impact this can have on their health and psychological wellbeing.

Conclusions

In recent years, there has been an influx of asylum seeker and refugee children entering European countries, including from Syria where there has been a civil war since 2011. Children and adolescents that have fled their own country, sometimes on their own without the company of a family member or guardian, are of a vulnerable status and are likely to

have experienced psychological trauma in one form or another. Furthermore, upon arriving in a receiving European state, such individuals are often unfortunately exposed to factors that can exacerbate their mental health problems. This is concerning because with better awareness, intra-agency collaboration, and cultural sensitivity towards the mental health needs of this immigrant population, many of these exacerbating factors could be mitigated or eliminated. Considering cultural factors and the health systems of the source country is particularly important because in countries such as Syria where only 2% of government health expenditure has typically been directed towards mental health needs, discussing mental health problems with healthcare professionals is not commonplace.^[9] Also of key importance is the need for European countries to better respond to PTSD and other typical refugee and asylum seeker mental health problems by aligning national policies with global initiatives to improve the mental health of young displaced immigrants.

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