

REVIEW

The mental health of refugee children

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The UK is facing a major increase in the number of people seeking asylum each year, of whom approximately a quarter are children. The stressors to which refugees are exposed are described in three stages: (1) while in their country of origin; (2) during their flight to safety; and (3) when having to settle in a country of refuge. The evidence concerning the impact of displacement on children's mental health is reviewed and a framework for conceptualising the risk factors is proposed. The available literature shows consistently increased levels of psychological morbidity among refugee children, especially post-traumatic stress disorder, depression, and anxiety disorders. The principles underlying the delivery of mental health care for these children are also considered. It is argued that much primary prevention can be undertaken in the school context. Some key aspects of British immigration law are examined and the tension between the law and the best interests of the child principle is discussed. There is particular concern for the plight of unaccompanied children. Attention to the mental health needs of this vulnerable group is urgently required.

that more than two million children have been killed in conflict, with a further six million wounded and one million orphaned.⁵ The 1989 UN Convention on the Rights of the Child offers an important theoretical and legal framework for the protection of children; however, national immigration law is often the arena where human rights and national self interests clash and the principle of promoting the best interests of refugee children can be overlooked. Refugee children are at significant risk of developing psychological problems, and although in the UK they will have arrived in one of the richest countries in the world, the services potentially available to help them are often ill equipped to address their needs, and imminent legislation might even exacerbate their problems.

THREE STAGES OF TRAUMATIC EXPERIENCES

The stresses to which most refugees are exposed can be understood as occurring at three different stages: (1) while in their country of origin; (2) during the flight to safety; and (3) when having to settle in a country of refuge.⁶

- (1) In their native countries many refugees have experienced considerable trauma. They have often been forced to flee their homes because of exposure war or combat and hence witnessed violence, torture, and losses of close family and friends. Refugee children might have no memory of a period of stability; their school education, if any, is likely to have been disrupted; and parental distress and general insecurity are common experiences.⁷
- (2) The journey to a country of refuge can also be a time of further stress. It can take many months and expose the refugees to more life threatening dangers. Refugee children at these times can experience separation from parents, either by accident or as a strategy to ensure their safety. As international immigration controls tighten, more children are being placed in the hands of smugglers to ensure their escape, either as the only representative their family can afford to send away or in the hope that the child alone would have better chances of gaining refugee status.⁸
- (3) The final stage of finding respite in another country can be a time of additional difficulty as many have to prove their asylum claims and also try to integrate in a new society.⁹ This period is being increasingly referred to as a period of "secondary trauma" to highlight the problems encountered. On arriving, a refugee child will need to settle into a new

One per cent of the world's population, 50 million people, are currently uprooted—23 million are refugees who have sought safety in another country, and 27 million are displaced within their own country.¹ In the past decade the worldwide refugee population has increased tenfold and all indicators show that this number will continue to rise.² (A refugee is defined as: a person who, "owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear is unwilling to return to it".³) The UK is facing a major increase in the number of people seeking asylum, with 100 000 applications made in the year 2000, representing a 250% increase in just four years.⁴ However, other countries are facing more formidable challenges; for example, Tanzania in 1999 received more refugees than the whole of Western Europe combined.¹

Over half of the world's displaced population are children. In the past 10 years it is estimated

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Table 1 Risk factors for mental health problems in refugee children

<i>Parental factors</i>
Post-traumatic stress disorder (PTSD) in either parent ⁴⁹
Maternal depression ²⁴
Torture, especially in mother ¹⁴
Death of or separation from parents ^{24, 50}
Direct observation of the helplessness of parents ^{12, 14}
Underestimation of stress levels in children by parents ⁵¹
Unemployment of parents ¹²
<i>Child factors</i>
Number of traumatic events—either experienced or witnessed ⁵²
Expressive language difficulties ¹⁴
PTSD leading to long term vulnerability in stressful situations ⁵³
Physical health problems from either trauma or malnutrition ⁵⁴
Older age ¹²
<i>Environmental factors</i>
Number of transitions ³⁶
Poverty ⁶
Time taken for immigration status to be determined ⁵⁵
Cultural isolation ²⁴
Period of time in a refugee camp ¹⁴
Time in host country (risk possibly increases with time) ²¹

school and find a peer group. Children might have to prematurely assume adult roles; for example, as a vital language link with the outside world.

PSYCHOLOGICAL IMPLICATIONS OF DISPLACEMENT FOR CHILDREN

There is considerable evidence that refugee children are at significant risk of developing psychological disturbance as they are subject to a number of risk factors. Table 1 provides a framework for conceptualising these risk factors. Refugee children suffer both from the effects of coming from a war zone and of adjusting to an unfamiliar culture. These stressors also affect their families.^{10, 11} Moreover, consistent research findings show that as the number of risk factors accumulates for children, the likelihood that they will develop psychological disturbance dramatically increases.¹² In particular, Rutter has shown the synergistic effects of multiple risk factors on adverse child outcome.¹¹

Studies of children in exile show that the prevalence of emotional and behavioural disorders is high, with the most frequent diagnostic categories being post-traumatic stress disorder (PTSD), anxiety with sleep disorders, and depression. The incidence of these disorders is difficult to estimate but most studies have found significantly raised levels of disturbance compared to control populations. For example, studies of newly arrived refugee children show rates of anxiety from 49% to 69%,^{13–17} with prevalence dramatically increasing if at least one parent had been tortured or if families have been separated. Table 2 lists common presenting symptoms of the different disorders.¹⁸ Children, however, often present with a mixture of the symptoms listed and not necessarily fulfilling a single diagnostic category, for example with a mixture of post-traumatic and depressive symptomatology.

Cambodian refugees are the most widely studied group; in a study of 46 children followed up over a number of years, 47% had an Axis I diagnosis and comorbidity was common. In particular this study found rates of PTSD at 40%, depression at 21%, and anxiety at 10%. Three years later, levels were still high, with 48% manifesting PTSD and 41% depression. After six years, PTSD was still prominent and a strong relation was found between PTSD and later stressful events, suggesting that the child is left more vulnerable to later traumatic experiences.^{16, 19–21}

Table 2 Summary of common presenting symptoms of psychological disorders in refugee children

<i>Post-traumatic stress disorder</i>
Persistent avoidance of stimuli: specific fears; fear of being alone; withdrawal
Re-experiencing aspects of the trauma: nightmares; visual images; feelings of fear and helplessness
Persistent symptoms of increased arousal: easily aroused; disorganised and agitated behaviour; lack of concentration
<i>Other anxiety symptoms</i>
Marked anxiety and worry: irritability, restlessness
Other sleep disorders
Somatic symptoms including headaches and abdominal pain
<i>Depression</i>
Low mood
Loss of interest or pleasure
Declining school performance
<i>Conduct disorders</i>

Some studies have attempted to identify protective factors that enable children at high risk to be more resilient. These include: (1) a supportive family milieu; (2) an external societal agency that reinforces a child's coping efforts; and (3) a positive personality disposition.¹² The response and functioning of a parent during and after stress can also have a profound effect on child behaviour.²² Brown and Harris found a greater vulnerability to depression in adults who lost a parent in childhood, and that the key predictor of this vulnerability was the quality of care giving the child received after the loss itself.^{22a}

In addition to the mental health needs of refugee children, there have been studies that have highlighted considerable physical health problems. A study of newly arrived refugee children in New York showed that 30% had conditions that required further medical attention.²³ Anaemia, parasitic infections, and dental caries were the most frequently presenting problems; in addition, 43% were positive for hepatitis B surface antigen and 20% were found to be latently infected with the tuberculosis bacterium. Another study in Sweden found 15% of refugee children had iron deficiency anaemia.¹³

PRINCIPLES OF MENTAL HEALTH CARE

When planning for the mental health needs of refugee children, two main areas need targeting: firstly, the provision of appropriate help for those experiencing psychological difficulties; and secondly, to pay attention to develop primary prevention strategies to this high risk group.

Traumatic events can have an effect on a child's emotional, cognitive, and moral development because they influence the child's self perceptions and expectations of others. However, finding appropriate ways to treat these problems is hampered by the lack of reliable evidence for the effectiveness of clinical therapeutic interventions with refugee children as most of the research has been conducted following single traumatic events (such as floods, single school shootings). Many refugee children, however, have experienced prolonged and repeated trauma.

The general consensus is that there is a need for a variety of different treatments, including individual, family, group, and school based interventions.^{24, 25} Cognitive behavioural treatment for single traumatic events has been used,^{26, 27} and a number of case series and single case studies have reported good results for treatments including play, art, music therapy, and story telling.^{6, 24, 27–29} Of added significance are the post-traumatic symptoms of parents and the impact of these on their capacity to parent.³⁰

Table 3 Possible impact of aspects of existing and imminent immigration law on the mental health of refugee children

Policy aspects	Description and background	Example of possible impact on children
Dispersal	Refers to a forced resettlement of asylum seekers If a refugee decides not to move they then lose entitlement to benefits and accommodation	Yet one more forced relocation for children and moves children away from a school they might have settled in Can be moved to an area without important statutory and non-statutory services
Accommodation centres	New pilot policy to build three accommodation centres for up to 750 asylum seekers to live until their status is determined	Children for first six months to be educated on these sites and away from mainstream education
Reporting centres	Centres to be set up throughout the country, where refugees will have to report in person at regular intervals	Adds to the uncertainty of the refugee determination process and inability of families to settle, as each reporting time might imply sudden departure to an unknown destination
Detention centres	The government goal is to be able to detain up to 4000 asylum seekers. In 2001, four new detention centres were built, increasing the total in the UK to eight	Detention of children under the age of 16 is against British law; however, this is being increasingly ignored for asylum seeking children No statutory provision for those that are detained
Tighter immigration controls	Placing a fine on carriers Improving border controls, e.g. gamma scanners	Greater likelihood to turn to illegal and/or dangerous means to enter the country, and exposure to other forms of abuse by traffickers

No studies have evaluated the benefit of group treatments, however, based on evidence for groups in other circumstances, it would appear that this may be a good way to help children develop a sense of coping and mastery and sharing ways of solving common problems.²⁶ A number of children's disorders could be addressed directly; for example, many suffer from depression and common sleep problems for which psychotherapeutic treatments and medication are available.^{31 32}

Addressing the treatment needs of refugee children can often seem overwhelming to those involved as they do not easily fit with prescribed care packages²⁸ and often require working with many different professionals and agencies such as interpreters, legal/immigration teams, voluntary organisations, ethnic support groups, social services, and schools. This unavoidably requires more time and resources.^{27 33} Successful programmes emphasise the role of cross-cultural teams who can work in an extended outreach manner.²⁷ Some programmes have also tried to integrate traditional healing methods to try and enhance the effectiveness of treatment.²⁹ Home based or school based work has advantages with families who might have a lingering distrust of authority.

Importance of schools

A vital aspect of care for refugee children is in primary prevention; schools are uniquely placed to undertake such work. The goals of primary prevention can include enhancing resilient behaviours in children; schools offer an excellent framework for this, as well as monitoring of academic progress, and behavioural and social adaptation.^{31 33 34} Schools provide a place to learn, facilitate the development of peer relationships, and help provide a sense of identity.^{35 36} In particular, for refugee children, schools can play a vital part in their integration by becoming an anchor, not only for educational but also for social and emotional development, and as an essential link with the local community for children and parents. There is good evidence that a proportion of children at high risk of developing long term psychological sequelae do however become competent young adults. One of the

key protective factors in influencing this outcome is the school that acts as a stable social support.³⁷ This support helps to develop children's resilience by enhancing their individual competencies, in turn adding to their self worth and sense of control over their environment.³⁸

TENSIONS BETWEEN BRITISH IMMIGRATION LAW AND THE BEST INTERESTS PRINCIPLE

The rights of asylum seeking children in the UK are limited. When the UK government ratified the UN Convention on the Rights of the Child in 1991, it entered a reservation in applying this legislation to refugee children "in so far as it relates to the entry into, stay in, and departure from the UK on those who do not have the right under the law of the UK to enter and remain in the UK".⁷ This reservation is one of the rare areas of UK law concerning children where the best interests principle does not play a part or where the protection of the child is not the paramount concern.

The UK ranks ninth among European countries in terms of asylum seekers per head of population.⁴ Statistics from the year 2000 show that the largest numbers arriving in the UK were from Iraq, Sri Lanka, the Federal Republic of Yugoslavia, Iran, and Afghanistan. Less than one third of asylum applications were allowed to stay (for example, 11% were granted full refugee status and 23% Exceptional Leave to Remain—a status which is reviewed after five years).^{4 39}

Since the influx of refugees into Britain significantly increased following the Balkan conflict there have been four major changes in UK National Immigration law in eight years. The most recent change in the 2001–02 parliamentary session has placed new emphasis on induction centres, accommodation centres, reporting centres, and rapid removals. The policy of dispersing asylum seekers around the country will continue and the number of places in detention centres will increase fourfold.⁴⁰

The thrust of these changes has been to deter non-political refugees from entering Britain. Whether it has achieved this

objective is unclear; however, it is evident that it has made life much "less welcoming" for those who have entered the country. The possible impact of these policies on children can be substantial and needs to be carefully planned (see table 3). For example, the government has stated that it is "committed to removals and the use of dedicated detention facilities", but how this can be done humanely, especially when children are involved, needs careful consideration. In fact, it may be that such removals may infringe children's rights.

When considering the impact of the dispersal system on refugee children, this newer government policy may have further aggravated their plight. The aim of this policy is to lift the burden of numbers away from the southeast of England. However, it disrupts the education and stability of children who have been placed in local schools by forcing them to move suddenly or risk losing any rights to future support. School transition is a significant event for any child and can lead to a decline in the perception of support from school⁴¹; frequent relocation is associated with failing academic achievement and behavioural difficulties.^{36 42 43}

Unaccompanied children

A particularly vulnerable group of refugee children are those who are "unaccompanied" and defined as "separated from both parents and for whose care no person can be found who by law or custom has primary responsibility".^{7 8} The numbers of unaccompanied children are rising significantly in Western countries and are estimated to comprise 2–5% of any refugee population. At any one time there may be up to 100 000 separated children in Western Europe alone. Their vulnerabilities are not only because they are bereft of support systems such as family and often community life,^{12 20} but also because they are at increased risk of neglect, sexual assault, and other abuses.⁴⁴ It may, however, be that the kind of children that manage to get to the UK in the face of all the adversity are a relatively resourceful and resilient group.⁸

The smuggling of children across borders has become a growing international concern. Children can be exposed to potential abuse and exploitation en route or in the country of destination. The children often arrive with false documents or with no papers at all. Many are unwilling or unable to tell their age.⁸ Relatively few separated children applying for asylum are awarded refugee status; the average recognition rate in 1999 for Europe was around 5%. In the UK the majority are granted Exceptional Leave to Remain up to the age of 18 when their status is reviewed. While this provides temporary protection, it leaves the child with major uncertainties about his/her future that can be emotionally demanding as well as having significant consequences on education and integration.⁸

INTERNATIONAL AGENDA

A number of United Nations Charters have addressed the needs of refugee children underlining the principle of the universality of the rights of children. These include the UN Convention on Refugees,⁴⁵ the Universal Declaration of Human Rights (Article 14 (1) states that "everyone has the right to seek and to enjoy in other countries asylum from persecution")⁴⁶ and the 1989 UN Convention on the Rights of the Child (Article 22 tries to ensure that refugee children should have the same rights as citizen children).⁴⁷ All countries except the United States and Somalia have ratified the latter Convention.

It is now widely recognised that children may be refugees in their own right. In 1996, Canada's Immigration and Refugee Board issued Guidelines on Child Refugee Claimants, the first produced by any country operating a refugee determination system.⁴⁸ Two years later, the United States Immigration Service published its own Guidelines for Children's Asylum Claims. Both recognise that children may experience persecution differently from adults, and that child sensitive status

determination procedures are needed. Important aspects include special training for refugee determination officials, legal representatives, guardians, interpreters, and others who come in contact with children to understand the principles and standards of the Convention on the Rights of the Child and other international laws. They need to have knowledge of the children's countries of origin and of relevant cultural issues. Learning how to conduct child sensitive interviews, especially with children who might have experienced previous trauma, can help to ensure that children's needs are properly assessed and addressed.

CONCLUSION

The multidimensional effects of trauma on children and their families are compounded by forced uprooting, multiple losses, and the myriad changes brought about by migration.²⁸ Children as a group have greater dependence on outside sources for their protection and care and have their own specific developmental and emotional needs. However, immigration law in the UK does not appear to have always taken account of the best interests of these children.⁴⁷ Refugee children are a silent group that are easily overlooked. Attention to the mental health needs of this vulnerable group by government and other policy makers is urgently required.

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