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Mental health challenges and interventions for refugee children

An APA-UN intern highlights the children's mental health aspect of the growing global refugee crisis.

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The 1951 Refugee Convention defines refugees as people who have been forced out of their homes because of conflict or crisis. Refugees have a fear of persecution for various reasons, including religion, nationality, political opinion or membership in a particular social group, and are therefore unable to return home (UNHCR, 1951). The world is currently witnessing the highest level of displacement on record, with 68.5 million individuals forcibly displaced as a result of persecution, conflict, violence or human rights violation (UNHCR, 2017).

Refugee children take a number of extreme risks while traveling with or without their parents for a chance at a better life. There are 50 million children on the move around the world, and 28 million of them are fleeing violence and insecurity, including children from war-torn and conflict-ridden countries like Syria, Iraq and Afghanistan trying to make their way to Europe (UNICEF, 2016). While moving to a new location may provide many of them with a safer life and better opportunities for education (Reale, 2008), leaving their homes puts all children at an increased risk of neglect, violence, and economic and sexual violence (UNICEF, 2016).

Unique challenges for mental health professionals

"Another problem is that many of those needing treatment have failed to come forward. Even if you have suffered abuse, even if you are suffering from PTSD, even if you're traumatized, that momentum to keep moving [was] still there." — Boris Cheshirkov, spokesperson for the UNHCR in Greece, explaining how mental health is usually not a priority for a population that has been struggling to survive (Dedman, 2016).

The global refugee crisis is a mental health catastrophe. To this date, mental health professionals in countries receiving refugees are struggling to deal with the issues related to refugee and asylum-seeking children. Greece has seen an unprecedented number of new arrivals since 2016, as an increasing number of refugees are passing through the country (Kitsantonis, 2019). However, during same period, Doctors without Borders had only 20 field psychologists working with approximately 53,000 refugees in Greece (Dedman, 2016).

The limited access refugee children have to psychiatric healthcare services is further demonstrated by a study in Denmark that found only 3.5% of refugee children access psychiatric facilities compared to 7.7% of their Danish-born peers. This difference may be explained by a number of barriers refugee children are likely to experience while attempting to access psychiatric help, including: a lack of awareness regarding availability of services; worries about discrimination in services; difficulties in communication because of language differences, and; views of parents or relatives about the Western diagnostic paradigms (Barghadouch et al., 2006).

UN efforts

The promotion of mental health and well-being were recognized as health priorities for the first time by world leaders through the Sustainable Development Goal 3.4 (WHO, 2019). Specifically, paragraph four and 23 provide a strong basis for inclusion by calling upon nations to leave no one behind, including refugees, internally displaced persons, and migrants. These three principles come into play in documents that have been adopted globally, including:

- The New York Declaration for Refugees and Migrants, adopted in 2016, expresses the political will of world leaders to save lives, protect rights, and share responsibility on a global scale. The declaration not only contains commitments to refugee children, but also mentions plans on working on those commitments. Specifically, point 26, 29 and 32 in the declaration stress the importance of addressing needs of refugee children who have been exposed to physical or psychological abuse. Furthermore, they commit to work on the psychosocial development of children who are refugees.
- The New York Declaration laid the groundwork for "global compact for safe, orderly and regular migration" and a "global compact on refugees," both of which were adopted in 2018. In the Global Compact on Refugees, commitments (point

72 and 73) have been made on expanding and improving health care systems to accommodate refugees and host communities, including children. Furthermore, it is notable that the compact specifically mentions commitments and actions required to include mental health facilities.

Mental health status of refugee children

“Detention is detrimental to the well-being of a child, produces long-term severe adverse impacts on children and cannot be considered in their best interests. It also exacerbates the trauma that many migrant children suffer along their migration journeys.” — U.N. Special Rapporteur on the human rights of migrants, Felipe González Morales (Chile), Dec. 2018

In this statement, the U.N. Special Rapporteur captured the plight of children who are refugees. Traumatic events can be very debilitating and long lasting; they include shelling, fear of persecution and loss of loved ones. These are further aggravated by difficulties children face once they settle in host countries, such as lack of education, language barriers, and discrimination.

Research indicates that the various stressors refugee children experience before, during and after displacement are associated with various types of mental health problems. For instance, evidence suggests that 25% of refugee children suffer from loneliness and 24% report feeling depressed (Hamdan-Mansour et al., 2017). Additionally, there are reports of high rates of probable PTSD (30.4%), generalized anxiety (26.8%), somatization (21.4%) and traumatic grief (21.4%). These symptoms are usually accompanied by academic problems (53.6%), behavioral difficulties (44.6%), and attachment problems (38.89%) (Betancourt et al., 2012).

It should be noted that referrals are mostly made based on the Western diagnostic perspective. As a result, 95.8% of the referrals for refugee children are of concerns that match the DSM categories and only 4.2% of the referral reasons mention factors that do not match the DSM categories, but are of significance in terms of helping refugee children, such as asylum stress, extended family issues and problematic upbringing (Driscoll, Serneels & Imeraj, 2016).

Suggested interventions

There are a number of steps that can be taken to address some of the issues raised here. Firstly, research suggests that refugee families and children prefer mental health services that are culturally and linguistically adapted, particularly in the assessment of language and learning difficulties, which can be mistaken for more serious learning problems that can exacerbate their emotional adaptation to a new culture. The treatment drop-out rates for such services are comparable to those of host country peers (Howard & Hodes, 2000).

Secondly, it is important to ask clients where they would prefer to be seen for ongoing treatment, since evidence shows that children overwhelmingly choose their educational establishment (Chuimento et al., 2011).

Thirdly, research indicates that only 2% of referrals were made by a family member. Therefore, it is important to have professionals, such as teachers, pediatricians and nurses trained in the detection of mental health difficulties of refugee children, and be present in their direct environment so these problems do not go unnoticed (Driscoll et al., 2016).

More respect and understanding needs to be shown to the cultural background and specific needs of refugee children. These children develop a number of strengths as they face different challenges before, during, and after displacement. These areas of strengths need to be recognized and supported as refugee children adapt to their new environments.

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