Refugee and Asylum Seeker Health

(1)

What are the implications on mental health for unaccompanied refugee minors? And are they more at risk when compared to accompanied refugee minors or non-refugee children?

"For me, my story has a common theme, a common denominator - that of being a "refugee". What do you know of this word, of this title which after a while becomes a name which one bears - some people all their lives, others with a small amount of luck become citizens of their host countries, while others, the majority, keep the consequences all their lives. This name, this title, is the one which I have today - it is my life, it is me…One day, I will no longer cry because of this title of "Refugee". One day, I will not be a problem for England. I will return and I will no longer be a burden on anybody"

Carman- aged 17. A refugee from Burundi(2)

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Abbreviations used in the study:

UASRM: Unaccompanied asylum seeking/refugee minor

AASRM: Accompanied asylum seeking/ refugee minor

PTSD: Post traumatic stress disorder

PICO: Population, Intervention, Comparison, Outcome

CASP: Critical appraisal skills programme

Abstract

Background:

Every year thousands of children across the world flee their home country in search of sanctuary. The trauma they have suffered in their home countries is often hard to imagine. A growing number of these children arrive unaccompanied without the support of a family. These children have to cope with the asylum process and other problems sanctuary seekers face upon arrival as well as dealing with the memories of what they experienced before seeking asylum. This is what is suggested to be the cause of these children being at high risk of psychological disorders.

Aims:

This study aims to systematically review the appropriate literature to compare whether UASRMs are at a higher risk for mental health disorders than AASRMS or non refugee children. The findings will then be applied to clinical practice by recommending how the health service should deal with these children. Areas of further research will also be suggested.

Method:

A research question was decided upon after background reading. It was then developed using PICO and the keywords involved were defined. Journal articles and relevant databases were then searched resulting in 41 relevant matches. The abstracts of these studies were read and an inclusion/exclusion criteria was applied to narrow down the search.

Results:

After application of the inclusion/exclusion criteria, 4 studies were left. The full text of these was then read to further determine their suitability. All of these studies were considered appropriate and were critically appraised using a CASP checklist.

Conclusion:

All the studies used showed that accompanied and unaccompanied asylum seeking children were at a high risk of psychological disorders and had experienced various traumas in their home countries. The results of the study that also included non refugee children as a sample group highlighted that asylum seeking children experienced more mental health problems than native children. All the studies also highlighted how unaccompanied asylum seeking children were at a higher risk than the children who arrived with families.

Awareness needs to be raised amongst health professionals, teachers, social workers (and anyone else who works with this highly vulnerable group) on the high susceptibility they have to psychological disorders. This means that the appropriate action and support can be put in place.

Introduction

The Human Rights Act 1998 states that everyone has the right to life, prohibition of torture and the right to liberty and security[3]. These rights, among many others, are taken for granted by most and abided by without question. However, in some countries this isn't the case. People there begin to feel so threatened by internal conflict and abuse of rights that they look for safety in other countries. These people are asylum seekers.

> "*An asylum seeker is someone who has applied for asylum and is waiting for a decision as to whether or not they are a refugee. In other words, in the UK an asylum seeker is someone who has asked the Government for refugee status and is waiting to hear the outcome of their application*."

UNHCR: UN refugee agency's definition of an asylum seeker. [4]

There is often confusion due to the fact that the terms 'refugee' and 'asylum seeker' are used interchangeably, despite them having distinct meanings.

> *"A refugee is 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 to or, owing to such fear, is unwilling to avail himself of the protection of that country.."*

UNHCR: UN refugee agency's definition of a refugee [4]

The UK is a signatory to the Geneva Convention 1951 Relating to the Status of Refugees which means it must offer asylum to those who meet its criteria.[5] This obligation- combined with Article 14 of the Declaration of Human Rights ("everyone has the right to seek and to enjoy in other countries asylum from persecution")[6] suggests why in 2009 the UK received 30,679 applications for asylum.[7] This is a relatively small number however when compared to the countries below.

Top asylum seeker destinations (as defined by number of applications) in 2009 (4)	
Country	Number of asylum applications
South Africa	222,000
United States	47,900
France	42,100
Malaysia	40,100
Ecuador	35,500
Canada	34,000
United Kingdom	30,700

The Asylum Process

To receive asylum status a person must have arrived in the UK after fleeing their country for fear of persecution due to race, religion, nationality, political opinion or membership to a particular group(8). Applying for asylum begins in Croydon or Liverpool, where the individual will undergo a screening interview upon presentation of the correct identification and travel documents. After this there will be a first reporting event where the individual is allocated a case worker who deals with all aspects of the case.(9) After a few weeks the asylum interview is held. This is where the individual explains why they fear return to their country and any other reasons for seeking asylum in the UK.

While a decision is agreed upon as to whether the person in question can be granted asylum they must continually report to the Home Office UK Border Agency and abide by their conditions. These include not leaving the UK, obeying the law and cooperating with the Agency. Other restrictions include a ban on employment. (9)

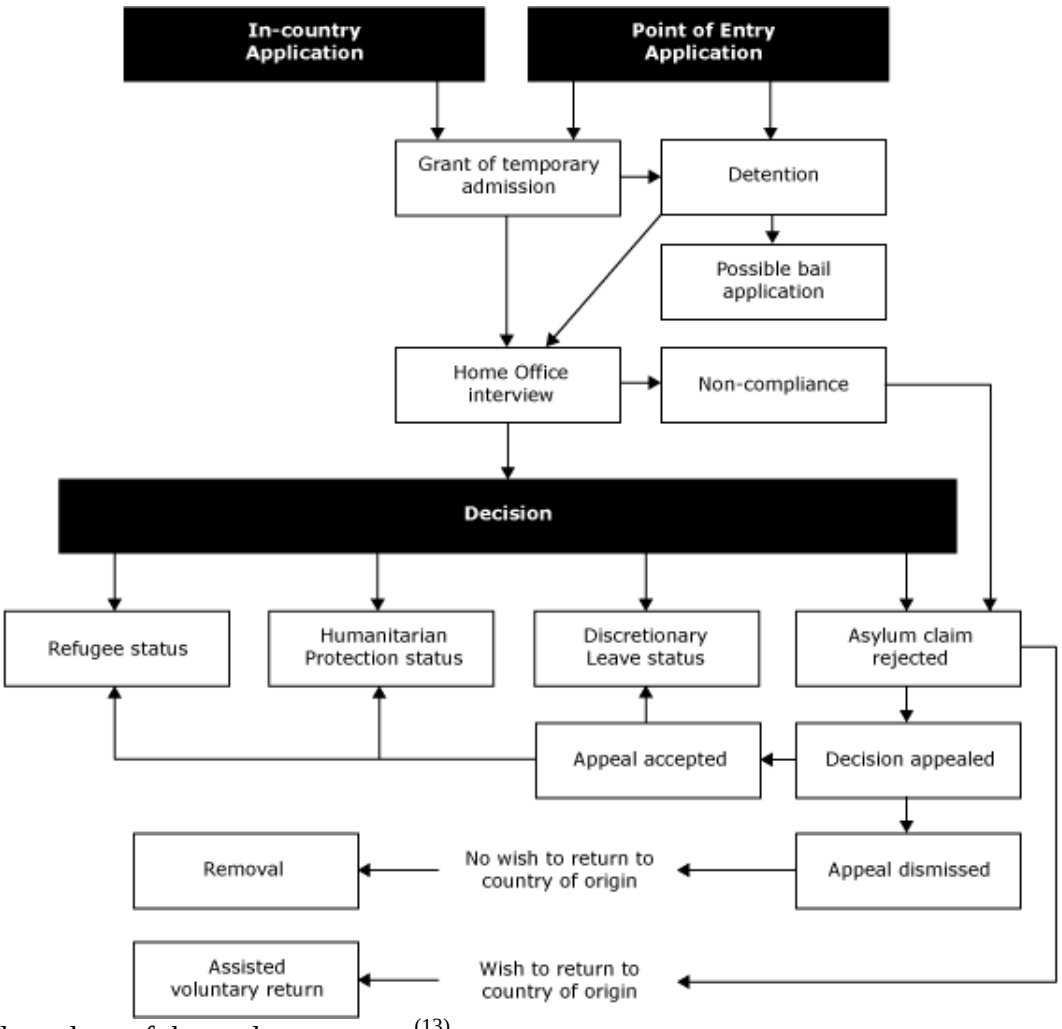
During this time however, the individual may be eligible for support through NASS (National Asylum Seeker Support). This is in the form of money and accommodation if needed. Even if an asylum claim is refused, according to the Asylum and Immigration Act 1999, accommodation and vouchers to be used in specific places may be still provided(10).

The combined amount of cash or vouchers paid to an asylum seeker is 70% of that paid to someone on income support. (11)

If asylum status is granted the individual has a right to remain in the UK for a 5 year period, however if asylum is refused the person in question will be told to leave the country.[8] Despite this, the individual has the right to appeal against the refusal within a certain time limit.
In 2009 72% of all decisions in the UK were refusals. [12]

> *"..The Home Office…it's their job to deter people…not let people in"*

Miss X- Arrived from Zimbabwe in 2005 but was refused asylum.



Flow chart of the asylum process [13]

Unaccompanied Asylum Seeking Minors.

Half of the world's asylum seekers and refugees are children and between 3 and 5% of them are unaccompanied children.[14] In 2009 the UK documented 2990 asylum applications from children who arrived in the country alone.[15]

> *"The Immigration Rules define a child as a person who is under 18 or who, in the absence of documentary evidence, appears to be under 18. An unaccompanied asylum-seeking child is one who is applying for asylum in his own right and who has separated from both parents and not being cared for by an adult who by law or custom has responsibility to do so."*

Home Office definition of an unaccompanied asylum seeking minor. [16]

The experiences of these children are often hard to imagine. In a retrospective study of pre-flight experiences of UASRMs it was found that 47% had experienced separation from or loss of parents and a further 41% had been subject to or witnessed violence. Sexual violence was reported by 24% of African girls in the study. [17] After these traumatic experiences the children also face the difficulties of living alone in a foreign country with potential language barriers.

The asylum process for unaccompanied minors is similar to that of anyone seeking asylum (as described above). The main difference is that age must be assessed at the screening interview. If the individual has no documents to prove that they are under the age of 18 their age has to be assessed by a social worker.[18] The social worker assesses the individual on factors such as level of eye contact, demeanor and body language. However, how accurate this may be is extremely subjective. Asylum seeking children have had very different life experiences to UK children which could cause them to mature faster and appear older than in actual fact. There may also be cultural differences that the social worker may not be familiar with. These cultural differences could cause a false estimation due to the differences they cause in the measured indicators of age. If the individual is assumed to be over 18 they are classed as an adult and treated as so in the asylum process. If not they are treated through social services while waiting for their asylum decision, allocated a

social worker and fostered or given accommodated in a children's home until they reach 18.

Asylum seeking children arriving in the UK –accompanied or unaccompanied- all have the same rights as any UK born child[14] according to article 17 (It shall be the general duty of every local authority to safeguard and promote the welfare of children within their area who are in need by providing a range and level of services appropriate to those children's needs) and article 20 (Every local authority shall provide accommodation for any child in need within their area who appears to them to require accommodation as a result of there being no person who has parental responsibility for him or due to being lost or having been abandoned.) of the Children Act 1989.[19]

Mental Health

> *"Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity".*

World Health Organisation definition of health.[20]

The above definition shows that a large part of good health is good mental wellbeing. The asylum process is a stressful one and when combining the difficulties of moving to a new country and the problems they face upon arrival it is not surprising that asylum seekers and refugees are a high risk group for stress related disorders. Children are particularly affected as the asylum process happens at a time that could affect their development and cause feelings of vulnerability and confusion. Without parents for support it could be inferred that unaccompanied minors would be worst affected. Problems they face are language barriers and stigmatisation that prevent the integration into society which is needed for normal healthy development. Symptoms often consist of sleeping problems, nightmares, concentration difficulties, irritability and hypervigilance. Somatic symptoms can be head and stomach aches among other pains. Other difficulties include feeling depressed, lonely, desolated and having changes in self-perception, relationships with others and interpretation of social context. [21]

Media Portrayal

> A BOGUS asylum seeker who butchered two sisters may have committed other murders, say cops.[26] – (The Sun –23rd May 2009)

> A WOMAN custody officer is suing for £100,000 after being bitten by an HIV-positive asylum seeker.[27] – (The Sun- 29th June 2009)

> COPS are today hunting an Iranian asylum seeker at the centre of a cunning £5million 'cash for crash' scam. [28] – (The Sun- 19th March 2009)

Taking into account the above newspaper article titles it can be seen why the terms "asylum seeker" and "refugee" have such an attached stigma. The media often portray asylum seekers and refugees in a very negative light, viewing them as criminals and frequently exaggerate the actual number of asylum seekers that arrive in the county. These articles often give a false impression to readers causing the formulation of biased and unfair views. These opinions can then be enacted as prejudices towards refugees and asylum seekers.

Aims and Objectives

The literature on unaccompanied asylum seeking minors is scarce due to them being a minority group, however the mental health effects they suffer can be substantial and often ignored. Article 24 of the Convention of Rights of a Child aims to "recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health.".[22] As mental state is a large part of overall health and as the above article shows every child has the right to the highest standard of health, this should be considered an important area of research. This is why the aims of the review are as follows:

- To examine the extent to which the asylum seeking process affects the mental health of asylum seeking and refugee children.
- To focus specifically on the extent to which the mental health of unaccompanied asylum seeking minors is affected. To then compare this to a control group of accompanied asylum seeking children or children who haven't sought asylum (native children).
- To appraise the relevant literature systematically to help address these aims.
- To suggest what the findings show and how they can be applied to clinical practice.
- To suggest further areas of research that could be executed to help answer the research question in more detail.

Method

To gain basic understanding on the refugee and asylum process background reading was done on websites such as the UN Refugee Agency's website and the Refugee Council's website. Basic definitions were also established and news and journal articles were searched for anything relevant to the topic. After initial reading the common problem of refugee and asylum seeker mental health was identified and combined with the topic of interest of UASRMs. This enabled a research question to be created.

To begin, relevant journals such as the BMJ and the Lancet were searched using the university's electronic library to look for any studies or articles that could be included.

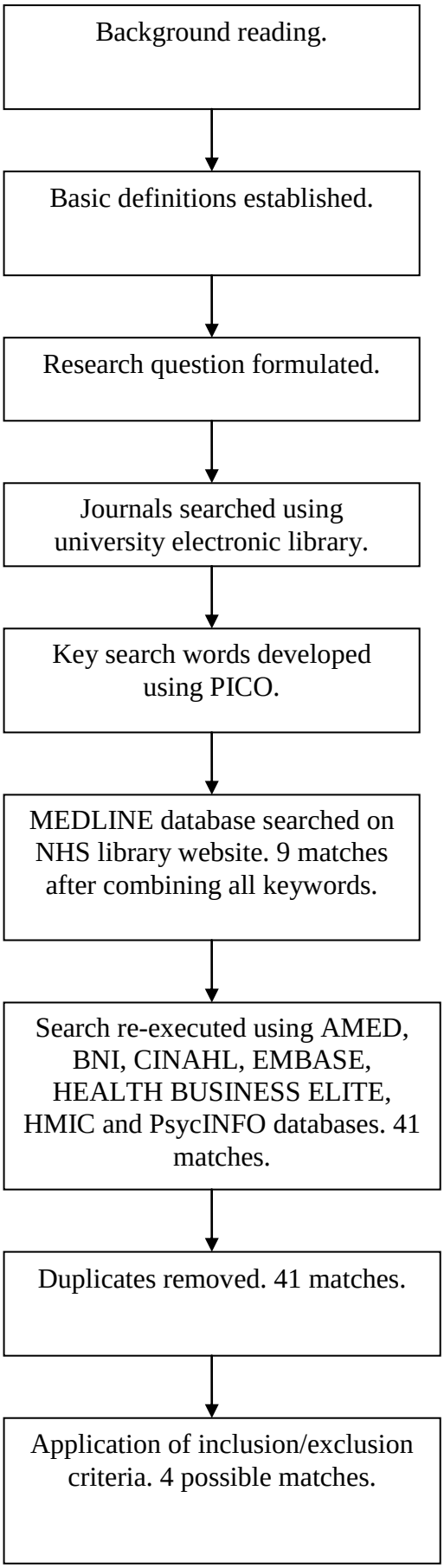
The NHS online library database was then used to firstly search the MEDLINE database to establish the search terms needed. To develop the search, PICO (patient/population, intervention, comparison, outcome) was used to enable the best keywords to be found.

Keywords: Refugee, asylum seeker, mental health, child, unaccompanied

Each keyword was mapped to thesaurus. This used MESH terms to maximise findings. Selected alternatives were then "exploded" and selected as a "major descriptor" to ensure that it was a main theme of the retrieved texts. Following this, searches were conducted of the natural and controlled language of each term and truncated if possible so that all relevant literature could be found. Different searches were combined with Boolean operators "AND" or "OR" to increase the accuracy of retrieval. The same search was then run again with the other following databases: AMED, BNI, CINAHL, EMBASE, HEALTH BUSINESS ELITE, HMIC and PsycINFO to make sure the NHS library resources were exhausted. After this duplicates were filtered leaving 41 possible matches.

Search Strategy:

(below: flow chart of search strategy)


Background reading.
Basic definitions established.
Research question formulated.
Journals searched using university electronic library.
Key search words developed using PICO.
MEDLINE database searched on NHS library website. 9 matches after combining all keywords.
Search re-executed using AMED, BNI, CINAHL, EMBASE, HEALTH BUSINESS ELITE, HMIC and PsycINFO databases. 41 matches.
Duplicates removed. 41 matches.
Application of inclusion/exclusion criteria. 4 possible matches.

Search History:
1. MEDLINE; exp *REFUGEES/ OR exp *"EMIGRANTS AND IMMIGRANTS"/; **5991 results.**
2. MEDLINE; "asylum seeker*".ti,ab; **564 results.**
3. MEDLINE; 1 OR 2; **6134 results.**
4. MEDLINE; exp *CHILD/; **52082 results.**
5. MEDLINE; child*.ti,ab; **802742 results.**
6. MEDLINE; 4 OR 5; **831880 results.**
7. MEDLINE; unaccompanied.ti,ab; **1079 results**.
8. MEDLINE; exp *MENTAL HEALTH/; **9655 results**.
9. MEDLINE; ("mental health" OR "mental illness" OR psychlog* OR psychiat*).ti,ab; **191051 results.**
10. MEDLINE; 8 OR 9; **194496 results.**
11. MEDLINE; 3 AND 6 AND 7 AND 10; **9 results**.
12. AMED, BNI, EMBASE, HMIC, MEDLINE, PsycINFO, CINAHL, HEALTH BUSINESS ELITE; exp *REFUGEES/ OR exp *"EMIGRANTS AND IMMIGRANTS"/; **29399 results.**
13. AMED, BNI, EMBASE, HMIC, MEDLINE, PsycINFO, CINAHL, HEALTH BUSINESS ELITE; "asylum seeker*".ti,ab; **3075 results.**
14. AMED, BNI, EMBASE, HMIC, MEDLINE, PsycINFO, CINAHL, HEALTH BUSINESS ELITE; 12 OR 13; **31199 results.**
15. AMED, BNI, EMBASE, HMIC, MEDLINE, PsycINFO, CINAHL, HEALTH BUSINESS ELITE; exp *CHILD/; **142598 results.**
16. AMED, BNI, EMBASE, HMIC, MEDLINE, PsycINFO, CINAHL, HEALTH BUSINESS ELITE; child*.ti,ab; **2402300 results.**
17. AMED, BNI, EMBASE, HMIC, MEDLINE, PsycINFO, CINAHL, HEALTH BUSINESS ELITE; 15 OR 16; **2477023 results.**
18. AMED, BNI, EMBASE, HMIC, MEDLINE, PsycINFO, CINAHL, HEALTH BUSINESS ELITE; unaccompanied.ti,ab; **2905 results.**
19. AMED, BNI, EMBASE, HMIC, MEDLINE, PsycINFO, CINAHL, HEALTH BUSINESS ELITE; exp *MENTAL HEALTH/; **55193 results**.
20. AMED, BNI, EMBASE, HMIC, MEDLINE, PsycINFO, CINAHL, HEALTH BUSINESS ELITE; ("mental health" OR "mental illness" OR psychlog* OR psychiat*).ti,ab; **781240 results.**
21. AMED, BNI, EMBASE, HMIC, MEDLINE, PsycINFO, CINAHL, HEALTH BUSINESS ELITE; 19 OR 20; **796625 results.**
22. AMED, BNI, EMBASE, HMIC, MEDLINE, PsycINFO, CINAHL, HEALTH BUSINESS ELITE; 14 AND 17 AND 18 AND 21; **41 results**.
23. AMED,BNI,EMBASE,HMIC,MEDLINE,PsycINFO,CINAHL,HEALTH BUSINESS ELITE; Duplicate filtered: [14 AND 17 AND 18 AND 21]; **41 results.**

To filter these down, the abstract of each match was read and an inclusion/exclusion criteria applied.

	Inclusion	Exclusion
Study Design	• English language • Year 2000 onwards • Full text • Studies not reviews	• Any foreign language • Before year 2000 • Abstract only • Reviews
Population	• Male and female • Large study group (over 100 children in total)	• Single gender studies • Small study group (under 100 children in total)
Comparison	• Control group used (accompanied refugees or native children)	• No control group
Outcome	• Investigations into psychological effects	• Any studies that don't investigate psychological effects
Conflict of interest	• No conflict of interest.	• Any conflict of interest.

Results

Four articles remained after the inclusion/exclusion criteria had been applied. These were:

Study number	Title	Authors
1	Risk and resilience for psychological distress amongst unaccompanied asylum seeking adolescents.	Matthew Hodes, Daljit Jagdev, Navin Chandra and Anna Cunniff
2	Comparing psychological distress, traumatic stress reactions, and experiences of unaccompanied refugee minors with experiences of adolescents accompanied by parents.	Tammy Bean, Ilse Derluyn, Elisabeth Eurelings-Bontekoe, Eric Broekaert and Phillip Spinhoven
3	The mental health of asylum seeking and refugee children and adolescents attending a clinic in the Netherlands.	Elizabeth Batista Pinto Wiese and Ingrid Burhorst.
4	The behavioural and emotional problems of former unaccompanied refugee children 3-4years after their return to Vietnam.	Maryanne Loughry and Eirini Flouri

Critical appraisal of studies.

To identify the strengths and weaknesses of each study, CASP checklists were applied.

	Study 1 [23]	Study 2 [24]	Study 3 [21]	Study 4 [25]
Journal where published	Child Psychology and Psychiatry	Journal of Mental and Nervous Disease	Transcultural Psychiatry	Child Abuse and Neglect
Year research was carried out	2002-2003	2007	2003-2004	2000
Country where research was conducted	United Kingdom	Belgium	The Netherlands	Vietnam
Appropriate research design	Cross sectional survey	Cross sectional survey	Elements of retrospective cohort study	Cross sectional survey
Sampling	UASRM's recruited through Westminster local council by assessing social work registers. All aged 18 or less. 81 potential individuals identified but complete data	4000 UASRMs randomly selected from Central Register of Nidos. 920 gave permission to be involved in the study. Native children and AARMs were	All asylum seeking and refugee minors intake reports were used from the clinic in question. The patients were then divided into UASRMs (sample of 59 used) and AASRMs	238 UASRMs participated in the study. To get a sample of children who had never been refugees of similar age and background each child was asked to nominate someone they knew of

	was only found for 78. AASRM's were identified in a secondary school in Westminster. All aged 13-18. Out of the possible 70 individuals 35 had complete data and were eligible for study.	selected from 10 secondary and 3 trade schools in the country. 1187 out of the 1294 identified AARMs and 976 out of a possible 1059 native children consented to the study.	(sample of 70 used).	similar age and gender to be part of the study. A sample of 217 non refugee children was found. All children in the study were aged between 10-22.
Data collection	Structured interviews with investigators were carried out to assess background information. This was then compared to social work case notes. Individuals then completed the Harvard trauma questionnaire for past war	Self report questionnaires used. Hopkins Symptom checklist-25, Stressful Life Events and Reactions of Adolescents to Traumatic Stress.	Data taken from patient (0-18years old) intake reports from the clinic in question. The data was then put into a structured questionnaire. Intake reports consist of 1-3 interviews with the child and guardian lasting approximately 90minutes	Self report questionnaires in the form of Youth Self Report, Social Support, Perceived Self-Efficacy scale and Exposure to Traumatic Events scale.

	trauma, the Impact of Events Scale to assess posttraumatic symptoms and the Birleson Depression Self-Rating Scale.		each.	
Ethical Issues	Social workers of UASRMs explained the study to the children. Interviews and questionnaires took place at their places or residence. Most individuals spoke at least intermediate English so the assessment took place in English. One individual required the questionnaire translated into Chinese. With	Ethical approval to conduct the study was given by the Medical Ethics Committee of Leiden University Medical Centre. Both the minor and their guardian was sent information of the study (available translated) and both had to give written consent. Assessment took place in	Interpreters were present if necessary. Multicultural sample used.	Children were paid a small amount of money for incentive to participate. The study of the UASRMs took place 3-4 years after their return to Vietnam after fleeing.

	AASRMs, they and their parents had the process explained to them and were asked for consent. Assessments took places in school.	schools, regional centres or the child's residential setting. Questionnaires were given in translated forms done by professional translators. There was cross-cultural analysis to check that the translation had the same meaning as original. Multicultural sample used (except in the native group).		
Data Analysis	Differences between groups for continuous variables were assessed using t-tests. Categorical data was	Homogenous groups of all 3 samples were created for comparison. T tests and multivariate analysis were used to look	Non-parametric MacNemar and Fisher's exact tests were used to compare UASRMs and AASRMs.	The two groups of children were compared to see if they differed on demographic characteristics. Data analysed

	assessed using Chi-squared statistic. Statistics where $p<0.05$ and 95% confidence intervals are used. Predictors of assessment results were examined using hierarchical regression analysis.	for group differences in assessment scores. Hierarchical regression analysis used to measure causality strength between demographic variables and assessment results. Due to a large sample size, 0.01 was the significance level set.		using multivariate analysis of variance.
Value of the research	Studies by Geltman et al (2005) and Bean et al (2007) reported similar findings. All questionnaires are universally recognised ones with high percentage	Assessments of the study are universally recognised. Limitations of study evaluated and implications for clinical practice suggested.	Results replicated by Derluyn (2005). Suggests implications for UASRM health.	Assessments of the study are universally recognised. Implications for clinical practice suggested.

	specificity and sensitivity. Areas of future study suggested.			

All the studies included used self report questionnaires to assess the children's mental health. Although these can be subject to recall bias this is the only way that the child's experiences and feelings can be truly taken into account. This recall bias could have been limited however if the studies had consulted others who knew what the child have been through rather than just asking the child themselves. This would have made results more reliable. Moreover, none of the studies used any historical records to prove the traumas experienced by the children, making the results highly subjective.

Studies 1, 2 and 4 used universally recognised assessments which have been specifically developed to measure certain outcomes, standardised and utilised many times before by other research companies. This made their results more valid as the questions had been tailored to measure certain outcomes as accurately as possible. Study 3 however used intake reports and applied them to structured questionnaire to obtain their information. This could have caused problems in that the individual children could have answered the questionnaire differently to how they answered the interview questions. Another problem would be if there was a large time difference between the intake report interview and it being applied to the questionnaire as there could have been a change of perspective of their feelings. This change of perspective could also be inferred from Study 4 as the study was executed 3-4 years after fleeing.

Study 3 was also different in that all the children in the study had already been admitted to the clinic for mental health problems. This meant that all subjects already had the desired outcome of study.

Studies 1, 2 and 4 documented the drop out rate of their studies and reasons for this lack of participation. Study 2 even stated how there was no significant differences between participants and non participants and mentions how their studies sample was statistically representative of the total UASRM population in

that country. This makes their research more widely applicable and it could be argued that this could limit ecological fallacy when applying findings to the whole UASRM population in that country.

If necessary, translators or translated questionnaires were used so that children from different countries could be included in the samples. Study 2 even used professional cross cultural analysis to make sure that the translated sample had the exact correct meaning. None of the other studies used any measures such as this so there could have been slightly different meanings or misunderstandings in the translated scripts.

Studies 1, 2 and 4 all sought informed consent from child and guardian before the study. This was a factor not mentioned in Study 3. From the text it can be inferred that the data from all their appropriate patients was used which raises issues of confidentiality and lack of consent. In Study 4, children were paid a small incentive to participate. This suggests ethical issues as it could lead to a higher number of less affluent children participating (or perhaps forced into participating by parents/guardians) for the money incentive or perhaps feeling that they have no choice but to participate for the money meaning the sample was no longer statistically representative of the whole population.

Studies 1, 2 and 4 all analysed for covariates to control for outside variables affecting the dependent variable which would have improved the accuracy of results. Studies 1 and 2 also mentioned using hierarchical regression analysis to measure the strength of associations between different variables.

All studies clearly stated their aims and methods from the beginning and used accurate statistical analysis to gain results.

Discussion

Study number	Results of study
1 [23]	• Number of PTSD symptoms: Male UASRMs: mean 36.98 (SD=12.974) Male AASRMs: mean 15.33 (SD=20.580) Female UARMs: mean 42.27 (SD=14.487) Female AARMs: mean 21.88 (SD=16.594) • Percentage of sample at high risk of PTSD 61.5% male UASRMs 14.3% male AASRMs 73.1% female UASRMs 35.5% female AASRMs • Number of depression symptoms: No significant differences between groups.
2 [24]	• Emotional distress and behavioural problems UASRMs have higher internalising, anxiety scores than AASRMs who have higher scores than non refugee children.
3 [21]	• Percentage of sample experiencing the following psychiatric complaints: Borderline personality disorder: 22% UASRMs. 9% AASRMS (p=0.045) Psychosis: 15% UASRMs. 1% AASRMS

	(p=0.005) Relationship disorder: 7% UASRMs. 50% AASRMS (p=0.001) Learning disorder: 0% UASRMs. 21% AASRMS (p=0.001) Developmental disorder: 0% UASRMs. 17% AASRMS (p=0.003)
4 [25]	No significant difference between groups of internalising or total number or problems. No significant difference in perceived self efficacy. UASRMs had fewer externalising problems than AASRMS.

All the appraised studies showed that UASRMs were more affected mentally by the asylum process than AASRMs. Although there are some contradictions in findings, this could be due to a large number of explanations such as different populations studied or the time difference between the asylum process and the questionnaires being completed.

It is interesting to note that AASRMs were more prone to relationship, learning and developmental disorders in Study 3. An explanation for this could be that these are factors that parents would acknowledge and record rather than the child themselves.

Without parental guidance UASRMs have to deal with the asylum process alone, often excluded from society by cultural and linguistic barriers. In addition, the number of traumatic events experienced by this group was found to be much higher than in AASRMs in all four studies. This means that as well as the problems of arriving in a foreign country and trying to seek asylum, the unaccompanied children also have to live with the memories of what they have experienced in their home lands. Study 3 showed that 63% of UASRMs and 16% of AASRMs had experienced four or more traumatic events. Shockingly, 0% of UASRMs had experienced no

traumatic events.[21] This makes the high prevalence of mental disorders in this group seem unsurprising.

Even though these studies show that UASRMs are most severely affected, they also show that AASRMs are still significantly at risk of mental disorders and have also been exposed to major traumatic events.

Case Study A: Mr Y left his country due to political problems with his wife and two daughters. Below he speaks about his children while they were in detainment.

"My children developed some strange behaviours. One of my daughters, she'd be playing in the yard and then suddenly she'd run. She'd really quickly run as if she was desperate to get somewhere, to find us. When she found us she'd just say "hi" then walk back to go play again. We think she was checking that we hadn't left her. She would do this often… Another boy, he had to look after his mother who had epilepsy. The doctors, they wouldn't believe her so she got no treatment. In the night she would have fits and he would come to find us for help. But we didn't know what to do… There was a girl we saw in there and she was cutting herself. I think she was about 10… My children started to show aggression to others, they fight, this is something they've never done before…My other daughter, even after detainment, her behaviour was never the same. She spends lots of time in the toilet, just sitting there… And both of them, they run and hide upstairs when they hear a knock on the door."

These children are also often subject to stigma upon arriving in the foreign country. For example, in school sometimes other children see refugee and asylum seeking children as different, perhaps due to different cultures or languages, which can lead to social exclusion. There can also be enacted stigma towards these children which can be fuelled by the biased media analysis or lack of understanding.

Case Study B: Mrs Z left her country as she faced being imprisoned back home due to her opposing political opinion. She brought her two children with her and below she speaks of some of their experiences.

"My children realised they were different when they went to school. They couldn't go on school trips and do things the other children did because of the asylum restrictions and because we didn't have enough money…One of my daughters she loved acting and we found some auditions for her but below in small writing it said "you must be a British citizen"… We were moved to Ainfield- but they didn't like foreigners. We received lots of abuse and my children did too. Sometimes they people said things in the street. This makes my children very conscious of how they should act. In winter with the dark nights they don't go out. They both have counselling."

The literature on UASRMs is scarce, particularly literature that compares to AASRMs or non refugee children. However, the studies that are available all show similar findings of asylum seeking or refugee children –whether accompanied or unaccompanied- being a high risk group to PTSD, depression and other mental disorders.

Limitations of the review

Word count	The word count of 3000 words +/- 10% meant that less detail and explanation could be included.
Time limit	A 3 week period was given for the full project. This had been shortened from 4 weeks from last year and meant that less time was available for visiting various institutions and charities and writing the review.
Scarce literature	Few articles were relevant to the research questions. This meant that for enough literature to be found, articles from up to 11 years ago had to be included. The data in these studies could have been out of date.
Language of studies	Out of the few articles that were relevant, some weren't written in English, which meant that they were excluded. This could have lead to the exclusion of important results.
Journal Articles	Some journals aren't readily available as readers need subscriptions. There are also few journal articles that are relevant to the subject in question.

Conclusion

It is paradoxical that families and children fleeing from the trauma and conflict they have experienced in their home lands actually find a multitude of stigmas, barriers and isolation in the place where they thought they could seek sanctuary. From this, mental health problems seem an obvious outcome. This is particularly problematic for children as the asylum process comes at a stage of development, and for the children without parents the lack of emotional support would magnify any problems.

- *Suggested further areas of research.*

Most research conducted on this subject is cross sectional which means causation can only be inferred. Areas of further research would be more longitudinal studies to determine whether these experienced mental health effects are temporary or chronic. An interesting area of study could be to examine whether these mental health effects began before the asylum process due to the trauma experienced in the child's home country. The actual mental health effects of seeking sanctuary could then be analysed to determine whether it caused the health problems, added to them or made no significant difference. It could also be suggested that randomised controlled trials could be carried out to determine what type of intervention or treatment would best cure or prevent the further development of certain psychological problems.

- *Implications for clinical practice.*

Increasing the number of studies done in this area would also increase awareness. This is vital as health professionals need to be aware that any child of an asylum seeking background is at high risk of certain mental health problems so the correct treatment can be put in place or the so the child can be monitored to check for the development of such problems. Teachers, social workers and anyone else working with these children should also be aware that they are a high risk for these psychological disorders so they are able to give the appropriate support.

- *Recommendations for improvement.*

Although NHS budgets are stretched, refugees and asylum seekers should still be seen as part of society and have their health needs acknowledged fairly. As the results show that the asylum process psychologically affects most children, it could be suggested that all minors arriving in a foreign country to seek sanctuary should be given counselling to allow them to deal with what they have faced in their home land

and to give them support in integrating into society. Health professionals should recognise these children as vulnerable to mental health problems and monitor them from arrival right through the asylum process. Particular thought should go to the children who arrive without parents who are the group at the highest risk.

In schools, teachers should support these children in learning the language of the country they arrive in. Integration with other pupils should also be encouraged rather than separating asylum seeking and refugee children by putting them in special support classes. This could minimise any social exclusion that could add to any psychological complaints and increase the other pupils' awareness and understanding of children who come to the country to seek sanctuary.

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Appendix

Reflection

Coming from a very small area, I'll admit that before these past few weeks, refugees and asylum seekers were only people I'd heard about on the news. I chose this SSM to extend my knowledge on different cultures and gain an understanding on the asylum process but I definitely gained more than that. This SSM has opened my eyes to the problems that refugees and asylum seekers face, even once they've arrived at their supposed country of sanctuary. It was the effects on children that I was hearing about that really disturbed me and that is what led to the development of the research question.

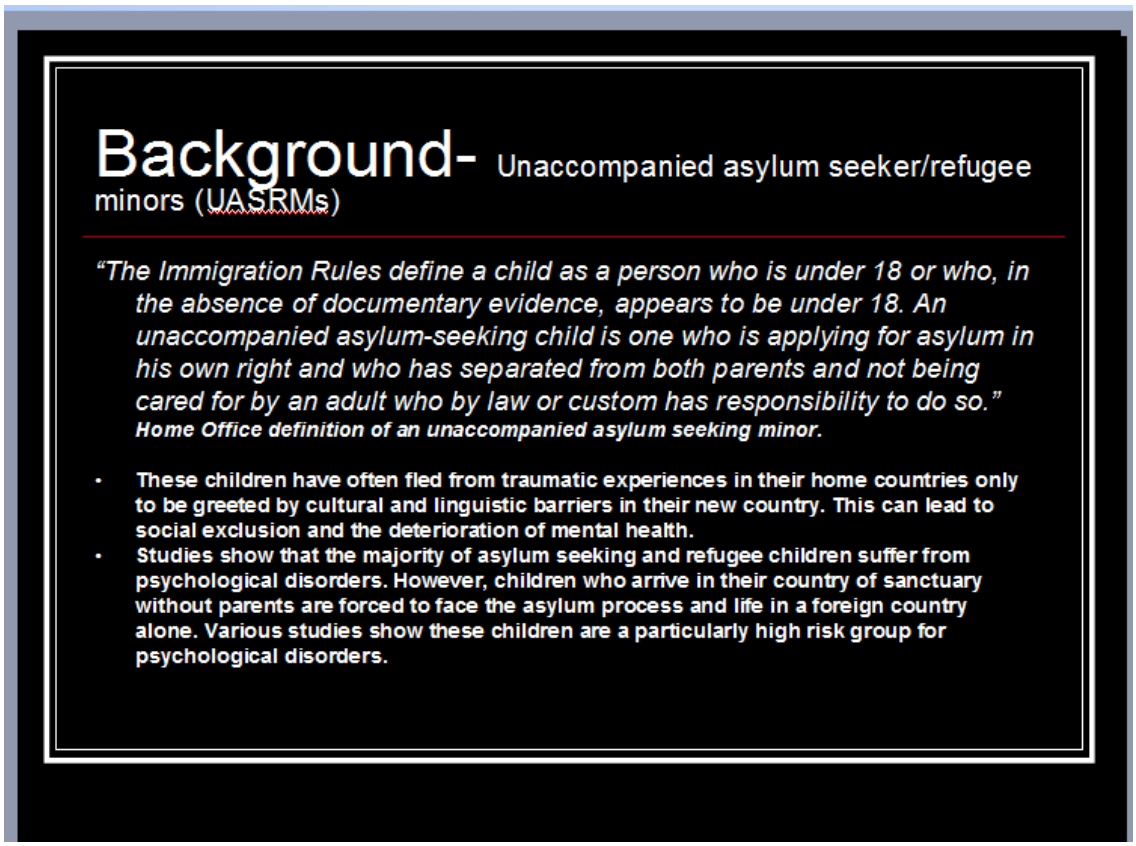
I was so shocked at the stories I was being told, of what the asylum seekers were fleeing from and also of the lack of understanding and empathy shown to them by people in their country of asylum. Something that really stood out to me was the compassion fatigue shown to these people by doctors- especially in detention. Although this is speaking prospectively, it is now an aim of mine to never show this "compassion fatigue" as a future doctor to anybody and to treat people individually rather than as a group with an attached stigma.

Interviewing asylum seekers was at times very emotionally distressing but I believe that my communication skills-particularly with different cultures and across language barriers- have benefitted greatly. It has also made me appreciate the country I live in and things that used to be taken for granted. I enjoyed experiencing the different views different cultures have and think that this SSM and the opportunities it has given me will make me into a more understanding and empathetic doctor. I am very pleased at my decision to choose this SSM topic and would recommend it to anyone.

Timetable

	Monday	Tuesday	Wednesday	Thursday	Friday
Week 1 (24th Jan-30th Jan)	Attended Healthy Inclusion introductory day- Ellesmere Port, Chester	Visited LCIP and LASAR- Leigh	Visited Asylum Link Merseyside- Liverpool	Visited the Welsh Refugee Council- Wrexham	Attended the Fade Library introductory session- Liverpool
Week 2 (31st Jan-6th Feb)	Ran internet searches on the subject in question. Added to background knowledge of the asylum process.	Finalised research question. Searched the university's electronic library for any relevant journal articles.	Searched the appropriate databases and found relevant studies. Read and highlighted studies.	Began writing review. Drafted background and aims and objectives.	Convenor review at Healthy Inclusion- Ellesmere Port, Chester (Unfortunately, this wasn't attended due to family reasons)
Week 3 (7th Feb-13th Feb)	Attended lecture day- Liverpool University.	Completed method and critically appraised studies.	Wrote conclusion, limitations, reflection and bibliography.	Wrote abstract, acknowledgements, contents and finalised references.	Proof read and finalised lay out. Submitted to TURNITIN before 4pm.

Refugee and asylum health powerpoint



Reported traumatic event	% of unaccompanied children claiming to have experienced event	% of accompanied children claiming to have experienced event
Separation from family and friends	76	43
Experienced physical violence	59	29
Exposed to threats of life	53	16
Witnessed killing	41	19
Experienced torture	34	7
Maltreated	31	6
Imprisoned	27	4
Sexual abuse	36	7

Wiese & Burhorst- Children and adolescents seeking asylum- Transcultural Psychology
(See reference 18 in review for full details)

Psychiatric Complaint	% Unaccompanied child reporting complaint	% Accompanied child reporting complaint
Regulation difficulties	97	69
Anxiety	59	49
Depressive feelings	56	30
Hallucinations/delusions	27	0
Somatic complaints	64	23
Behavioural problems	66	49

Wiese & Burhorst- Children and adolescents seeking asylum- Transcultural Psychology
(See reference 18 in review for full details)

Article: "Risk and resilience for psychological distress amongst unaccompanied asylum seeking adolescents"- Journal of Child Psychology and Psychiatry-Matthew Hodes, Daljit Jagdev, Navin Chandra and Anna Cunniff. (see reference 22 in review for full details)

- Cross sectional survey carried out over the period of 2003-2004 in the UK
- Complete data was found for 78 UASRMs and 35 AASRMs all aged 13-18.
- Despite this drop out rate, there was found to be no significant difference between participants and non participants.
- All eligible candidates were given self report questionnaires in the form of the Harvard trauma questionnaire for past war trauma, the Impact of Events Scale to assess posttraumatic symptoms and the Birleson Depression Self-Rating Scale. These are internationally renowned assessments which have been developed and standardised to measure the desired outcome accurately, making the results more valid.
- Informed consent was sought from child and parent/guardian before participation.
- Translation of the questionnaire was performed if necessary, however no back translation or cross cultural analysis was mentioned to have been used, therefore there could have been alternative meanings or misunderstandings in the translated script.
- The data was analysed for covariates and differences between groups was assessed using t-tests.
- The results showed that both groups of children presented a high level of psychological disorders, however this was particularly high in UASRMs. Both groups of children also reported high numbers of traumatic experiences back in their homelands. Again however, the number was higher in UASRMs.

Improvements for the study:

- If possible the use of historical records to prove the traumatic life events experienced. This would help reduce recall bias.
- Consulting more than just the child upon their experiences and upon any symptoms of psychological disorders they may have shown. This again would help reduce recall bias.
- The study used a multi cultural sample. An area of further research could be to analyse people from specific countries as different nationalities may have had different experiences and this could lead to different predispositions to mental health problems.

Implications for clinical practice/recommendations for improvements:

- Health professionals, teachers, social workers and anyone else working closely with these children need to be aware of the high risk of psychological disorders that they have- in particular UASRMs. This would allow the appropriate support to be given.
- It could be suggested that all children arriving in their country of asylum should be given counselling to help them deal with the traumas they have fled and to help in integrating into society to make the move to a foreign country less stressful.
- Refugee and asylum seeking children should undergo periodic screening for any symptoms of mental health problems. Detecting the problems early could make them easier to treat.
- The children could be taught psychological interventions such as relaxation techniques and self-reflection to help regulate emotions.