Eur Child Adolesc Psychiatry
DOI 10.1007/s00787-016-0837-2

LETTER TO THE EDITOR

Urgent need for validated trauma and mental health screening tools for refugee children and youth

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Received: 5 November 2015 / Accepted: 28 February 2016

Commentary

Due to the civil war in Syria and other new and on-going conflicts, the number of forcibly displaced individuals worldwide has exceeded 59.5 million [1]. Approximately 19.5 million persons are refugees and in 2014 children below 18 years constituted 51 % of the refugee population which is the highest figure in more than a decade [1]. Both western immigration countries and the sub-regions of conflict areas are annually receiving thousands of refugee children and youth. Despite the scarce literature on trauma and other mental health problems in refugee children and youth compared to adults, available studies indicate a high prevalence of mental health problems among refugee and asylum-seeking children and youth due to a series of factors related to forced migration including displacement, war, violence, poverty and hunger [2, 3]. Unaddressed trauma and mental health problems are of paramount importance as mental health issues may result in increased morbidity and mortality [4]. Trauma and mental health problems are further related to decreased quality of life and mental health problems are in the context of refugees related to poorer social adaptation in their receiving country [5]. To avoid such adverse consequences, early detection and treatment of mental health problems in refugee children and youth is of paramount importance.

A wide range of trauma and mental health screening tools such as brief questionnaires and interview guides exist.[1] Many tools are being used for assessment of trauma and mental health in refugee children and youth despite the fact that their validity has not been confirmed in these populations. In addition to the lack of validity testing, there are contrasting findings questioning the cross-cultural applicability of diagnosis such as posttraumatic stress disorder (PTSD) [6]. Despite this, trauma and mental health screening tools are being used both in- and outside clinical settings. Therefore, it is pivotal that researchers critically evaluate the utility and validity of the most commonly used screening tools. Previous systematic reviews [7, 8] have provided overviews of validated screening tools primarily validated in adults and our systematic literature search shows that only few studies have done this specifically among refugee children and youth (unpublished data). Refugee children and youth constitute an overlooked and vulnerable population. The use of non-validated screening tools jeopardizes clinical assessments and the results of scientific studies as our estimations of, e.g. disease prevalence may be distorted. The value of the results and their applicability are closely linked to the level of reliability and validity of the used screening tool. In practice, the use of non-validated screening tools may result in pathologization of healthy individuals or in overlooking of refugee children and youth with mental health problems and consequently preventing further follow-up and treatment.

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[1] Based on an overview of the use of psychological screening tools in Danish treatment facilities for traumatized refugees and a survey among employees at Danish municipalities.

Published online: 04 April 2016

We need to recognize an urgent demand for a more comprehensive and scientifically sound approach in mental health screening of refugee children and youth. To evaluate and perform rankings of the reliability and validity of screening tools, more validation studies in diverse settings are needed. By testing and validating screening tools in different settings and within various refugee child and youth populations, we can start critically evaluating their overall strengths and weaknesses. In time, this will perhaps allow us to recommend best practices for the use of trauma and mental health screening tools within diverse refugee child and youth populations. It is important to emphasize that an increased focus on mental health screening among refugee children and youth must be accompanied by an expansion of mental health treatment opportunities, something which apparently has been under-prioritized in many western immigration countries in comparison with rehabilitation offers for adult refugee populations. The detection and treatment of mental health issues among especially refugee children and youth should be a top priority both within the scientific community and in practice not only to reduce individual morbidity and mortality, but also to facilitate integration of refugee children and youth and help them ensure the most optimal chances of a healthy childhood where they can thrive both socially and in the receiving countries.

In extraordinary times extraordinary measures must be taken. Consequently, we suggest that that a working group is put together to identify and validate screening tools for use in refugees originating from many different countries and cultures and with the purpose of deriving at a consensus as to which screening tools should be recommended in the setting of refugee children in European immigration countries. The working group should be initiated and coordinated by experts on a transnational level for example through the European Society for Child and Adolescent Psychiatry. The working group should consist of experts within the field of child and youth trauma and mental health including researchers with knowledge on screening tools and how they should be validated as well as practitioners with practical experience regarding screening of refugee children and youth including psychiatrists, psychologist, teachers, humanitarian and social workers.

The working group should explore the cross-cultural validity of available screening tools, i.e. culturally dependent reactions to trauma in refugee children and youth. A homogenous reaction pattern to trauma across cultures has been identified; however, these findings have also been contested. Consequently, it is important to establish to what extent the use of a general screening approach is recommendable among refugee children and youth originating from different countries and cultures. Researchers should draw on existing tools and the work done to validate multiple language screening tools for children and youth with trauma including the Hopkins Symptom Checklist as well as other surveys of the reactions of adolescents to traumatic stress [9]. Practitioners are of utmost importance to include in the process because they possess insights into everyday challenges of implementing screening tools including limited resources and time. They may therefore ensure that the recommendations put forward by the working group are realistic and applicable in a setting that is often complex and stressed.

The working group should perform a rapid assessment of the usability of the five most promising screening tools in different European immigration countries/settings and among refugee children origination from various cultures and countries. The applicability and validity of the chosen screening tools should be tested within a representative refugee child and youth population to ensure that the chosen test population reflects the current influx of refugees. This means that the tools must be tested among children from especially Syria, Afghanistan, Somalia and Sudan who form the majority of refugee children currently. Furthermore, our systematic literature search (unpublished data) shows that a huge lack of screening tools for especially young refugees below the age of six exists. It is therefore of great importance that the working group considers alternative ways to identify trauma and mental health issues among this population, e.g. by the use of doll plays, drawings, etc.

The established working group would work along two tracks: a short-term and long-term track. At the moment, we are facing a reality that cannot rest for a period of years until scientific results are available. It is important to recognize that further research in this field are needed, but we must also face the challenges of today. Until scientific recommendations are available, social workers, teachers and others working with refugee children on a daily basis should form networks where experiences and temporary best practices can be shared. We therefore suggest that the established working group consists of two interlinked sections: one responsible for generating scientific knowledge about the available screening tools and their validity as described above and one with the primary purpose of establishing, organizing and facilitating networks among professionals who work with refugee children and youth on a daily basis. Local, national and transnational networks should be created to ensure that knowledge is distributed to the professionals who daily work with refugee children and youth and to ensure that current best practices are being shared. The local and national networks should have a contact person from within the international working group that they can contact in case they have any inquiries. Who to include in the local and national networks will, of course, depend upon how each country have organized

their refugee services. In Denmark as an example representatives from the Red Cross, general practitioners, case workers and possibly psychologists from the municipality and teachers in 'welcome classes' in public schools should at least be involved. By establishing networks and thereby strengthening intersectoral collaboration, we have a greater chance of detecting mental health issues as early as possible. Host countries will necessarily have to organize networks based on the existing structures of the healthcare and social system that are already in place.

We need a social movement recognizing the right of every child to live a healthy life without trauma and mental health problems. Refugee children and youth have been an overlooked population for too long instead focus has been on screening of adult refugees and providing rehabilitation care for this population. With substantial research showing that also young children and youth are hugely affected by trauma, it is time to recognize that special detection and treatment offers for this particular population are needed. In line with human rights declarations refugee children and youth should receive services that facilitate a healthy life [10]. In a socio-economic perspective, healthy individuals are more likely to contribute to their host country. As such early detection and treatment of trauma and mental health issues in refugee children and youth constitute a moral responsibility of the host countries and furthermore contributes toward cost-effectiveness. We need to recognize and act upon the immense potential that lies within a healthier and happier refugee child and youth population.

Based on the results from our systematic review of validation studies of trauma and mental health screening tools (unpublished data), it is difficult to recommend the use of either trauma specific tools or general mental health screening tools such as the SDQ and CBCL for the assessment of refugee children and youth. We have identified validation studies for the following screening tools: CBCL, CPSS-I, HSCL-37, RATS, UCLA PTSD, PTSS-C and IES.[2] The screening tools have been validated in diverse refugee child and youth populations and different validation measures have been used. These conditions and the context-specific factors related to where the screening takes place complicate an identification of a 'best practice'. As an example screening tools in transit areas need to be brief and due to potential language barriers and limited time resources the use of well-established comprehensive screening tools such as the CBCL can be complicated.

[2] Child Behavior Checklist (CBCL), Child Posttraumatic Stress Disorder Symptom Scale Interview format (CPSS-I), Hopkins Symptom CheckIist-37 (HSCL-37), Reaction of Adolescents to Traumatic Stress questionnaire (RATS), UCLA PTSD Index for DSM-IV (UCLA PTSD), Posttraumatic Stress Symptoms in Children (PTSS-C), Impact of Event Scale (IES).

The establishment of sound trauma and mental health screening practices is challenged by the current situation with increasing pressure on refugee receiving systems and limited resources. Despite challenging circumstances health professionals are encouraged to use screening tools, even if they are not fully validated, especially if the alternative implies that the mental health of refugee children and youth is otherwise ignored. The use even of invalidated screening tools represents a needed attention toward the mental health of refugee children and youth, which is an important and necessary first step when trying to improve the health status of refugee children and youth and ensuring that mental health screening becomes a standard part of young refugees' health evaluation.

Compliance with ethical standards

Funding Funded by the University of Copenhagen.

Conflict of interest The authors have no conflicts of interest to disclose.

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