

Psychological distress and mental health service contact of unaccompanied asylum-seeking children

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Abstract

Background Evidence is emerging that psychological problems, particularly symptoms of depression and post-traumatic stress disorder, are more prevalent in unaccompanied asylum-seeking children (UASC) than their accompanied peers. However, little is known about help seeking and mental health service (MHS) utilization in this group, and how this relates to their psychological needs. This study aims to describe the level of psychological distress among a group of UASC and the pattern of MHS contact.

Method Socio-demographic data on 71 UASC residing in London was obtained and self-report questionnaires were completed regarding trauma events (Harvard Trauma Questionnaire), general psychological distress [Strengths and Difficulties Questionnaire (SDQ)], post-traumatic stress symptoms (Impact of Event Scale), depressive symptoms (Birlerson Depression Self-Rating Scale for Children) and contact with MHS (Attitudes to Health and Services Questionnaire).

Results UASC were mainly male ($n = 48, 67.6\%$), Black African ($n = 39, 54.9\%$) and their median age was 17 years (interquartile range = 15; 17). They had been living in the UK for a median of 18 months. Eight (11.3%) scored on the SDQ borderline/abnormal range for total symptoms, but this was 21 (29.6%) using the SDQ emotional subscale. Forty-seven (66.2%) were at high risk for post-traumatic stress disorder and nine (12.7%) at high risk for depressive disorder. Only 12 (17%) had MHS contact. Predictors of MHS contact were depressive symptoms and duration of time in the UK.

Conclusions UASC had a high level of emotional symptoms, especially post-traumatic stress symptoms. However, only a small proportion of UASC were in contact with MHS. This suggests a high level of MHS under-utilization, and reasons for this are discussed.

Keywords

depression, help seeking, mental health services, needs, post-traumatic stress disorder, unaccompanied asylum-seeking children

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Introduction

There are estimated to be around 269 400 refugees currently living in the UK (based on 10 years of individual recognition of asylum seekers, excluding resettled refugees) (United Nations High Commissioner for Refugees 2010). The country contains the largest number of unaccompanied asylum-seeking children (UASC) in Europe, with around 4000 resident in London alone (Refugee Health Team 2004). In 2009, 3000 asylum claims from unaccompanied children were registered in the UK, the highest number for Europe, although there were 1300 fewer than the

previous year (United Nations High Commissioner for Refugees 2010).

A 'refugee' as defined by the United Nations High Commissioner for Refugees (UNHCR) 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 or her nationality and is unable or unwilling to return to it' [United Nations High Commissioner for Refugees 1951; Article 1A (2)]. The term refugee has also a legal connotation that refers to a person who has been granted official refugee status. By contrast, an 'asylum

seeker' is a person who is waiting for a decision on their asylum or refugee claim.

Unaccompanied asylum-seeking children are defined as 'children under 18 years of age who have been separated from both parents and are not being cared for by an adult who, by law or custom, is responsible to do so' (United Nations High Commissioner for Refugees 1994). They are sent away from their families, or flee from their communities because of fear of, or experience of, persecution, organized violence or war.

The few studies investigating the mental health of UASC have found that they are at greater risk for developing mental health problems than their accompanied peers (Kinzie *et al.* 1986; Felsman *et al.* 1990; Bean *et al.* 2007; Hodes *et al.* 2008). They have elevated levels of post-traumatic anxiety and depressive symptoms. There is strong evidence that greater harm results from the accumulation of multiple psychological risk factors in childhood (e.g. Rutter 1999; Sameroff 2000; Appleyard *et al.* 2005). UASC are likely to have experienced a range of adverse events, including organized violence, forced migration and stressful resettlement in unfamiliar environments (McKelvey & Webb 1995; Sourander 1998; Heptinstall *et al.* 2004; Bean *et al.* 2007; Derluyn & Broekaert 2007; Hodes *et al.* 2008). Unaccompanied refugee minors may be especially vulnerable, given the interaction between traumatic experiences and the loss of primary carers.

From the known literature, there are three stages in the help-seeking process of adolescents (Srebnik *et al.* 1996; Cauce *et al.* 2002): (i) problem recognition; (ii) decision to seek help (internal and external factors); and (iii) service selection/utilization. In relation to these stages, it has been found that the severity of psychological distress and behavioural problems are important predictors of problem recognition (Ford *et al.* 2005). As regards the help-seeking process, for refugee children, similar to their non-refugee peers in the UK, there are a number of potential pathways into mental health services (MHS): referral by parents, general practitioners, paediatricians, schools, social services and, for adolescents, self-referral (Hodes 2000; Howard & Hodes 2000; Hodes & Tolmac 2005). Refugee children compared with non-refugee ethnic minority children or non-minority peers are more likely to be referred by teachers or social workers (Howard & Hodes 2000). Furthermore, UASC are more likely to be referred by their social workers than accompanied refugee children (Michelson & Sclare 2009).

In terms of service use, it is known that many children with mental health problems do not access MHS (Ford *et al.* 2005). However, this could be more so for refugees, who are believed to be at greater risk for mental health problems and for whom accessing services is more difficult for a variety of reasons. Serv-

ices may be inaccessible because of language problems, difficulty in registering with general practitioners who are referrers to secondary services in the UK and many other countries, lack of available services or lack of knowledge about how to access the services, and mobility which disrupts care that started (Hodes 2000; Hargreaves *et al.* 2003; Raval 2005). Regarding UASC specifically, social workers may underestimate their difficulties, including mental health needs (Wade *et al.* 2005). The extent of underutilization of MHS for refugee children is not known. The first study to address this investigated UASC living in the Netherlands (Bean *et al.* 2006). A discrepancy was found between the perceived need for mental health care, as reported by the adolescents, teacher or guardian, and the actual level of MHS contact, which occurred in only a small proportion of the adolescents. The relationship between service need and service use is complex and a range of factors may affect the uptake of services. Nevertheless, in recognition of the possible unmet mental needs of UASC in the UK, recently published guidance for looked-after children highlights the need for appropriate access to MHS (NICE 2010).

It appears that no previous studies have investigated the MHS contact of UASC in the UK and there is a dearth of studies on this topic internationally. This study aims to describe the background characteristics, levels of psychological distress and MHS contact among a group of UASC living in London. Specifically, we wanted to investigate whether higher level of past-war trauma, higher levels of psychological distress and longer duration of settlement were associated with MHS contact.

Methods

Procedures

The study was approved by St Mary's Local Research Ethics Committee.

The UASC were identified by social workers in the City of Westminster Department of Social Services, accessing social work registers. The allocated social workers for young people would discuss the study with the young person prior to the investigator contacting them, and where possible introduce the investigator. The young people were recruited during 2003–2004. The interviews and assessments took place at their place of residence or at social work offices. The majority of the UASC did not need interpreters, as they had at least intermediate-level English. Only two from Kosovo were helped with Albanian-speaking interpreters.

Subjects

The sample consisted of UASC. They all resided in London, and were aged 18 years or less. Eighty-one UASC were identified. In addition, two adolescents from a school sample were UASC so they were included in the unaccompanied group, giving a total of 83 (details given in Hodes *et al.* 2008). One person refused to participate in the study. For 11 individuals incomplete data were collected, so they were excluded. Almost complete data were obtained on 71 children.

Measures

Background data regarding age, gender, time in the UK, living arrangements and region of origin were assessed by structured interview. This information was confirmed from social work case notes.

The questionnaires were completed by the participant or the investigator read the questionnaires. As indicated, two UASC from Kosovo were helped with Albanian-speaking interpreters.

Adolescents completed the following self-report questionnaires.

Harvard Trauma Questionnaire (HTQ; Mollica et al. 1992)

This well-validated questionnaire covers 17 types of maltreatment and war events, which are rated on the basis of proximity to the event (no involvement, heard about, witnessed and experienced). For this study we used the total score and the score for the total number of war events experienced. We also used individual items regarding combat situation and rape/sexual abuse. For these items, witness and experienced options were assigned the same score. The instrument shows good internal consistency with Cronbach coefficient alpha of 0.90 (Mollica *et al.* 1992).

Impact of Event Scale (IES; Horowitz et al. 1979)

This well-validated 15-item questionnaire assesses the degree of subjective distress arising from traumatic events. It measures two dimensions: intrusion (seven items) and avoidance (eight items). Combined, the scale has a threshold for high risk of disorder of 35 (Stallard *et al.* 1999; Sundin 2003), which has also been used as a cut-off point for this study. The scale has good discrimination for cases with a sensitivity of 66.7% and specificity of 92.4% and positive predictive value of 0.77 (Stallard *et al.* 1999).

Birleson Depression Self-Rating Scale for Children (DSRSC; Birleson 1981; Birleson et al. 1987)

This is a well-validated 18-item scale, scored on a 3-point scale. We used a cut-off score of 15 which has been shown to be six times more likely to be associated with a diagnosis of depression (Birleson *et al.* 1987). The scale has good discrimination for cases with a sensitivity of 64% and specificity of 77% (Birleson *et al.* 1987). The internal consistency, estimated by the split-half reliability coefficient, has been reported as 0.86 (Birleson 1981).

Strengths and Difficulties Questionnaire self-report version (SDQ; Goodman 1997, 2001; Goodman et al. 1998)

The SDQ is a well-validated behavioural screening questionnaire. It consists of 25 items, and five subscales, which are: conduct problems, hyperactivity, emotional symptoms, peer problems and prosocial behaviour. All but the last one are summed to generate the total difficulties score. Each item is scored 0, 1 or 2. Sensitivity for risk of any psychiatric disorder is 15.9%, but this rises to 22.1% for any anxiety disorder and 33.3% for any depressive disorder (Goodman *et al.* 2000). The internal consistency, Cronbach alpha coefficient, of the self-report SDQ is 0.80 (Goodman 2001).

Attitudes to Health and Services Questionnaire (AHSQ)

This is a 10-item questionnaire, developed for the Leaving Care Study, looking at young peoples' attitudes to mental and physical health and also accessibility and contact with health services (Fraser 2003). The UASC were asked to indicate if they had experienced contact with child or adult MHS, and their responses were used to assign them to the categories (had or did not have MHS contact).

Analysis of data

Variables were skewed and so non-parametric statistics, Mann-Whitney *U*-test for difference between groups in continuous variables and Fisher or χ^2 -test for difference between groups in categorical variables, were used.

Predictors of contact with MHS were examined using binary logistic regression. Those variables that were significantly correlated to the outcome categorical variable were entered as predictors in the regression, using the Forward: LR method.

Statistical significance was set at <0.05.

Data were analysed using spss 17.

Results

Socio-demographic and migration background

It can be seen from Table 1 that UASC were mainly male 48/71 (67.6%), their age ranged from 13 to 18 years old (median = 17, interquartile range = 15; 17) and they had been living in the UK for a median of 18 months (interquartile range 10; 36). Over half of them (54.9%) were living in independent/semi-independent arrangements and the rest in foster/children's homes.

Unaccompanied asylum-seeking children were mainly Black African, 39/71 (54.9%). There were three main clusters: those from Europe ($n = 25$), predominantly Kosovo ($n = 20$), of whom there was only one girl; a second cluster was from the Horn of Africa ($n = 24$), 14 of whom were female; and a third cluster from Sub-Saharan Africa ($n = 12$), eight of whom were male.

Only 12 (17%) of the UASC group had contact with MHS.

The socio-demographic characteristics (age, gender, time in UK, living arrangement, region of origin and ethnic origin) did not differ between those who had contact with MHS and those who did not. There was a trend for longer time living in UK to be associated with MHS contact (Mann–Whitney U -tests, $P = 0.059$).

The median HTQ score was 29 (interquartile range = 20; 37). The median total number of events experienced was 7 (interquartile range = 4; 11). Forty-three (62.3%) had witnessed/experienced a combat situation and 14 (20%) had witnessed/experienced sexual abuse or rape.

Psychological distress

Table 2 reports the level of psychological distress in the UASC. The median total SDQ score was 10 (interquartile range = 6; 14). Eleven per cent scored in the borderline/abnormal range.

Total IES score median was 41 (interquartile range = 32; 48), while Intrusion subscale score median was 18 (interquartile range = 10; 23) and Avoidance subscale score median was 22 (interquartile range = 16, 26). Sixty-six per cent of UASC scored above the cut-off, indicating high risk for post-traumatic stress disorder (PTSD).

The median level of symptoms on the DSRSC was 10 (interquartile range = 6; 13). Twelve per cent scored above the cut-off, indicating high risk for depression.

Associations with mental health service contact

The HTQ and IES scores did not differ significantly between those who had contact with MHS (median 33.5, interquartile

| | <i>n</i> = 71 | Mental health services contact | | Statistic (<i>P</i>) |
|-------------------------------|-------------------------------------|--------------------------------|---------------------|------------------------|
| | | Yes (<i>n</i> = 12) | No (<i>n</i> = 59) | |
| | Median (interquartile range) | | | |
| Age | 17 (15; 17) | 17 (15; 17) | 17 (16; 17) | MWU 0.726 |
| Months in UK | 18 (10; 36) | 27 (17.75; 52.50) | 15 (10; 30) | MWU 0.059 |
| | <i>n</i> (%) | | | |
| Gender | | | | |
| Male | 48 (67.6) | 7 (14.6) | 41 (85.4) | Fisher 0.507 |
| Female | 23 (32.4) | 5 (21.7) | 18 (78.3) | |
| Living arrangement | | | | |
| Independent, semi-independent | 39 (54.9) | 7 (17.9) | 32 (82.1) | χ^2 1.00 |
| Foster, children home | 32 (45.1) | 5 (15.6) | 27 (84.4) | |
| Region of origin† | | | | |
| Africa | 39 (54.9) | 6 (15.4) | 33 (84.6) | * |
| North | 1 (1.4) | 1 (100) | 0 (0) | |
| West | 2 (2.8) | 0 (0) | 2 (100) | |
| Horn | 24 (33.8) | 3 (12.5) | 21 (87.5) | |
| Sub-Sahara | 12 (16.9) | 2 (16.7) | 10 (83.3) | |
| Europe | 25 (35.2) | 3 (12) | 22 (88) | |
| Middle East | 6 (8.5) | 2 (33.3) | 4 (66.7) | |
| South America | 1 (1.4) | 1 (100) | 0 (0) | |

Table 1. Socio-demographic characteristics of the unaccompanied asylum-seeking adolescents ($n = 71$) and associations with contact with mental health services

*No statistic offered because of the very small cell frequencies. $P < 0.05$.

†North Africa: Sudan; West Africa: Liberia and Guinea; Horn Africa: Ethiopia, Eritrea and Somalia; Sub-Sahara Africa: Burundi, Angola, Rwanda and Kenya; Europe: Kosovo, Macedonia and Albania; Middle East: Afghanistan, Saudi Arabia and Iran; South America: Brazil.

MWU, Mann–Whitney U -test.

Table 2. Psychological distress of unaccompanied asylum-seeking adolescents ($n = 71$) and associations with contact with mental health services

| | $n = 71$ | Mental health services contact | | Statistic (P) |
|--|------------------------------|--------------------------------|-----------------|-------------------|
| | | Yes ($n = 12$) | No ($n = 59$) | |
| | Median (interquartile range) | | | MWU |
| Strengths and Difficulties Questionnaire | | | | |
| Total score | 10 (6; 14) | 11 (4.25; 17) | 10 (6; 13) | 0.503 |
| Emotional subscale | 4 (2; 6) | 4.50 (2; 7) | 4 (2; 6) | 0.587 |
| Conduct subscale | 1 (0; 3) | 1.50 (0; 3) | 1 (0; 3) | 0.937 |
| Hyperactivity subscale | 1 (0; 3) | 1 (0.25; 2) | 2 (0; 3) | 0.531 |
| Peers subscale | 2 (2; 3) | 3 (2; 4.50) | 2 (1; 3) | 0.085 |
| Prosocial subscale | 9 (8; 10) | 10 (9; 10) | 9 (8; 10) | 0.175 |
| Impact of Event Scale | 41 (32; 48) | 39.50 (28; 51) | 42 (32; 48) | 0.724 |
| Depression Self-Rating Scale for Children | 10 (6; 13) | 11 (6; 21.50) | 10 (6; 12) | 0.299 |
| | | n (%) | | Fisher |
| Strengths and Difficulties Questionnaire borderline/abnormal (range) | | | | |
| Total score (16–40) | 8 (11.3) | 4 (50) | 4 (50) | 0.024 |
| Emotional subscale (6–10) | 21 (29.6) | 6 (28.6) | 15 (71.4) | 0.161 |
| Conduct subscale (4–10) | 7 (9.9) | 0 (0) | 7 (100) | 0.593 |
| Hyperactivity subscale (6–10) | 2 (2.8) | 1 (50) | 1 (50) | 0.311 |
| Peers subscale (4–10) | 13 (18.3) | 3 (23.1) | 10 (76.9) | 0.682 |
| Impact of Event Scale | | | | |
| ≥35 | 47 (66.2) | 7 (14.9) | 40 (85.1) | 0.524 |
| Depression Self-Rating Scale for Children | | | | |
| ≥15 | 9 (12.7) | 5 (55.6) | 4 (44.4) | 0.005 |

$P < 0.05$.

Bold value indicates statistical significance at $P = 0.05$ level.

MWU, Mann–Whitney U -test.

range 18.50; 41) and those who did not (median 29, interquartile range 20; 35). SDQ and DSRSC scores did not differ between those with and without MHS contact when considered as symptom scores (continuous variable). When investigated in terms of high risk of disorder (i.e. categorically, with the group dichotomized into those in the normal or abnormal range) significant associations were found. Regarding risk of any psychiatric disorder, UASC were more likely to score in the abnormal range of total SDQ scores if they had MHS contact (4/12, 33.3%) than if they did not (4/59, 6.7%) (Fisher's test 0.024). UASC at high risk for depression were more likely to have MHS contact (5/12, 41.6%) than those at low risk for depression (4/59, 6.7%) (Fisher test 0.005). Half of those with borderline/abnormal total SDQ scores and just over half of those who were above the DSRSC cut-off score had contact with MHS.

Predictors of contact with mental health services

The binary logistic regression model included three independent variables (DSRSC, time in the UK and SDQ total difficulties score) which were those previously shown to be related to the outcome measure. The full model containing all predictors was statistically significant, $\chi^2 (2, n = 71) = 13.353, P = 0.001$, indi-

cating that the model was able to distinguish between UASC who sought help and those who did not. The model as a whole explained between 17.1% (Cox & Snell R^2) and 28.7% (Nagelkerke R^2) of the variance in contacting MHS, and correctly classified 85.9% of the cases. As shown in Table 3, only two of the independent variables made a unique statistically significant contribution to the model (depressive symptoms and time in the UK). The strongest predictor of contact with MHS was depressive symptoms, recording an odds ratio of 13.184 (95% CI for OR = 2.397–72.504, $P = 0.003$). This indicated that UASC who had high risk of depression were over 13 times more likely to attend MHS than those who had low risk for depression, controlling for other factors in the model.

Discussion

Unaccompanied asylum-seeking children in the present study were predominantly from the Horn of Africa, sub-Saharan Africa or the Balkans, and had been living in the UK for a year and a half. They had high levels of psychological distress on self-report, with 66% at high risk for PTSD and 12% at high risk for depressive disorder. However, only 17% were in contact with MHS, and this was predicted by depressive symptoms and time spent in the UK.

| | β (SE) | Odds ratio | 95% CI for odds ratio | | P |
|------------|----------------|------------|-----------------------|--------|--------------|
| | | | Lower | Upper | |
| Step 1 | | | | | |
| Constant | -2.061 (0.401) | | | | |
| DSRSC | 2.285 (0.782) | 9.821 | 2.122 | 45.452 | 0.003 |
| Step 2 | | | | | |
| Constant | -3.311 (0.803) | | | | |
| DSRSC | 2.579 (0.870) | 13.184 | 2.397 | 72.504 | 0.003 |
| Time in UK | 0.044 (0.020) | 1.045 | 1.004 | 1.088 | 0.032 |

$R^2 = 0.112$ (Cox & Snell), 0.188 (Nagelkerke), model $\chi^2 = 8.433$, 1 d.f., $P = 0.004$ (Step 1); $R^2 = 0.171$ (Cox & Snell), 0.287 (Nagelkerke), model $\chi^2 = 13.353$, 2 d.f., $P = 0.001$ (Step 2).

Bold value indicates statistical significance at $P = 0.05$ level.

DSRSC, Birlson Depression Self-Rating Scale for Children.

Depressive symptoms rather than post-traumatic symptoms best predicted service contact indicating that many with emotional distress, particularly post-traumatic symptoms, failed to have contact. This may be because depressive symptoms, e.g. tearfulness or social withdrawal, are more visible to foster carers and social workers, and perhaps also associated with poorer social function, e.g. poorer scholastic attainment, and so result in referral to MHS. Post-traumatic stress symptoms may not be visible and may be associated with good social function in refugee children (Kinzie *et al.* 1986). Post-traumatic stress symptoms are widely experienced by UASC, who may not complain about them, thinking they are an inevitable consequence of their experiences that cannot be alleviated by intervention. Furthermore, some UASC may not wish to discuss their past experiences, especially when their placements are unstable and their legal status is uncertain. Social workers themselves may also be uncertain about who to refer to child and adolescent mental health services (CAMHS), and think, perhaps rightly depending on the local services, that access to effective treatment services is difficult to achieve.

The association between MHS contact and longer duration of settlement is expected. This might arise for a number of reasons. Over time, and surprisingly rapidly, the UASC acquire English language fluency, which would make communication of their difficulties to potential referrers easier. They may acquire more stability in their placements and their legal status may be clarified, so knowledge that they will stay for a defined period may make disclosure and exploration of emotional difficulties easier. In addition, over time the UASC may learn more about their emotional difficulties and treatment services that are available and seek help themselves.

The failure to find an association between past-war trauma and MHS contact is of interest. It is possible that there is an association but this study, with a small sample, in which the UASC had experienced many varied stressors and had been in

the UK for many months, could not identify it. Trauma events are one of many factors that increase post-traumatic stress symptoms (Hodes *et al.* 2008), but these were not associated with increased MHS contact. A further issue is that past-war trauma, which included involvement in combat and experience of sexual assault, might have been associated with increased contact with paediatric and hospital services, but this was outside the remit of this investigation.

Our findings regarding the probable high level of unmet need are consistent with the study of UASC carried out in the Netherlands (Bean *et al.* 2006). This group showed that there was high unmet need for MHS contact, although there were differences of perception of need depending on whether adolescents, guardians or teachers were asked. Internalizing symptoms but not externalizing symptoms were the best predictors of MHS contact (Bean *et al.* 2006).

In terms of factors that have been researched regarding MHS underutilization among young refugees, a range of contextual and practical difficulties affecting the accessibility, suitability and acceptability of MHS have been identified. These include lack of fluency in English, limited awareness of available services, high residential mobility and difficulty in registering with general practitioners (Hodes 2000; Heptinstall *et al.* 2004; Michelson & Sclare 2009). Moreover, personal factors largely mediated by culture, such as recognition of the presence and severity of psychopathology, coping strategies and help-seeking attitudes and behaviour, may affect the uptake of services. As refugee populations acculturate to Western resettlement countries, they may become more receptive to Western mental health beliefs and practices over time (Whittaker *et al.* 2005). Our findings are consistent with those of Bean and colleagues (2006) who suggested that those who had lived longer in the resettlement country were more capable of perceiving their need and conveying it to others, perhaps due to acquiring skills that enable them to know when to ask for help. Some authors claim

Table 3. Logistic regression model predicting contact with mental health services

that the main reason for service underutilization is the lack of capacity and/or willingness among services to accommodate the needs of ethnically and culturally diverse populations (for more detail, see de Anstiss *et al.* 2009). However, this is unlikely to be relevant for this group of UASC as there were close links between the local CAMHS and social service looked-after children's teams.

Strengths and limitations of the study

This study has a number of strengths. A nearly complete sample of all the UASC from one local authority was included (Hodes *et al.* 2008). However, a larger sample size and inclusion of interview measures of psychopathology would have strengthened the study further. The study design, being cross-sectional, is weaker than a longitudinal study, although for the main outcomes regarding depressive symptoms and MHS contact, reverse causality that contact causes higher depressive symptoms is implausible. Nevertheless, collecting data on the duration and amount of MHS contact would have been useful. Future research should investigate MHS use over time as well as factors that enhance service uptake.

Implications for care provision

Our study found most UASC with significant mental health symptoms were not in contact with MHS. Improving access to care is a key element in addressing their needs. This is recognized as a quality standard in recent guidance for UASC, who are looked-after children (i.e. cared for by local authority social service departments) (NICE 2010). In recent years improved screening of looked-after children for psychological distress and behavioural problems with the SDQ has been implemented (Department for Children, Schools and Families 2010). However, our study has shown that the self-report total SDQ scores would not identify those young people at high risk for PTSD (as identified by the IES). It is unclear whether completion of SDQs by foster carers, for the UASC in foster families, would improve detection of those at high risk of PTSD.

Specialist CAMHS involvement with this population requires close liaison between agencies and the availability of appropriate clinical expertise in working with trauma and co-morbidity. Improved training in mental health for social workers working with this group as well as community paediatricians whose remit includes the health of UASC would be appropriate. Sensitive interviewing is required to elucidate the psychological difficulties that may be related to past-war exposure and physical injuries.

From the point of view of the UASC, teaching them to effectively identify and manage emotions can empower them to manage the trauma and stress they have had to endure (Weisz & Hawley 2002) and might lead to positive help-seeking behaviour from their social network, including reducing stigma of MHS contact (Michelson & Sclare 2009).

Key messages

- Unaccompanied asylum-seeking children have experienced a high level of war events and disruptions in their family and community life.
- Many unaccompanied asylum-seeking children are at risk for post-traumatic stress disorder and depressive disorder, but few have had mental health service contact.
- Many unaccompanied asylum-seeking children have unrecognized and unmet mental health needs.
- Social workers and community paediatricians who have statutory contact with unaccompanied asylum-seeking children in the UK and other countries should be aware of the frequent psychological difficulties and be able to help UASC obtain appropriate psychological help.

Conflict of interest

No conflicts of interest to declare.

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