

Severely Impaired Young Refugees

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ABSTRACT

This article is concerned with the small numbers of refugee children and adolescents who, for psychiatric reasons, have significant social impairment, with difficulties in functioning within their families and in school. Data from recent studies carried out in London are presented regarding the characteristics of this group. The studies show that the impaired refugee children are psychiatrically heterogeneous, but had high exposure to past violence and losses, and they experience high levels of isolation, compared with non-refugee peers. These adversities are particularly likely to occur among those who are psychiatrically admitted, including those who have psychoses. A high level of cooperation between agencies, especially mental health and social services, is frequently required to meet the complex needs of this group. Implications for service provision and clinical management are discussed.

KEYWORDS

asylum-seekers and refugees, children and adolescents, psychoses, PTSD, services, social impairment, unaccompanied

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PEOPLE BECOME REFUGEES to flee from organized violence and persecution. Many children asylum-seekers arrive in resettlement countries without one or both of their parents, who may have been detained or killed. Such experiences may increase psychological distress and risk of psychiatric disorders (Fazel & Stein, 2003; Leavey et al., 2004; Tousignant et al., 1999). There is a burgeoning literature on the effect of war and displacement on children's adjustment. Much of the research is concerned with common problems such as anxiety, affective and post-traumatic symptoms and disorders (Barwick, Beiser, & Edwards, 2002; Hodes, 2000; Lustig et al., 2004). Most refugees will cope remarkably well with the losses and changes they have to endure, and even those who are distressed tend to become more settled over time (Barwick et al., 2002). However, for some young refugees even these common disorders may occur in severe form, and be associated with severe impairment of function and high-risk behaviours such as self-harm (Sack, 1998; Westermeyer, 1991). There are also small numbers of young refugees who have less common disorders such as eating disorders (Kope & Sack, 1987; Stein, Chalhoub, & Hodes, 1998), psychoses (Tolmac & Hodes, 2004), and also severe developmental disorders including autism (Westermeyer, 1991). The more severely impaired young refugees will have a high level of contact with child and adolescent mental health services (CAMHS). The difficulties in functioning within the family and in school make this group an important one for mental health professionals and others.

The aim of this article is to describe the psychiatric, family and social backgrounds of severely impaired young refugees. It is written from a clinical and service perspective, so illustrative case vignettes are included. It begins with an explanation of the concept of social impairment, and how it can be measured. Data regarding social impairment, psychiatric, family and social complexities of young refugees are presented according to the tiered model of CAMHS (Health Advisory Service, 1995). Specifically, the data are presented to show that there is greater impairment and complexity in passing through the tiers. In this service model tier 1 corresponds to all children in the community, who will have contact with teachers and general practitioners (family doctors). Tier 2 refers to children who may have distress associated with symptoms or minor psychiatric disorders and but be seen in community settings such as schools by solo child mental health professionals. Tier 3 refers to those who attend out-patient CAMHS, and receive help from multidisciplinary teams of professionals. Tier 4 refers to those who are so impaired they require psychiatric admission.

The article draws on our ongoing research programme with refugee youngsters, using three recent studies carried out in London. The first will be mentioned briefly, and concerns a study of a community population of young unaccompanied asylum-seekers (Fraser, 2003). There is discussion of the characteristics of refugee children and adolescents seen in a tier 3 out-patient setting (Howard & Hodes, 2000) and tier 4 in-patients settings (Tolmac & Hodes, 2004). Only selected information is given about the methodology and results, as the details are available elsewhere (Howard & Hodes, 2000; Tolmac & Hodes, 2004). Some of the data presented have not previously been published. The final sections describe legal and service implications. It is not possible here to address specific treatment issues, although these are apparent from the illustrative case vignettes.

In this article, for the sake of brevity, the term 'refugee' is used to include those who are asylum-seekers as well as those who have entitlement to remain in the UK, unless the distinction needs to be made.

What is social impairment?

Social impairment refers to role performance of an individual in adapting to their social environment (Bird, 1999). This is related both to developmental and sociocultural context. Impairment is assessed in four domains: interpersonal relationships, academic and work performance, social and leisure activities, and ability to enjoy and obtain satisfaction from life (Bird & Gould, 1995). Relationship difficulties may include avoidance or irritability, defiance, oppositional behaviour and conflict with parents, siblings or peers. Simply asking children about their functioning will be inadequate, and information should come from multiple sources including children, parents and teachers.

It is believed that measures of social impairment have some cross-cultural validity as the scores are derived from information from multiple informants including the children and parents (Bird & Gould, 1995). The informants describe the level of functioning in locally, culturally specified age and gender-appropriate roles, rather than in roles defined by outside investigators. The investigator assigns a numerical score as a measure of the deviance from those locally defined roles. Thus, social impairment has both a local (emic) meaning, that is, it takes into account the family and perhaps culture-specific views about social role, as well as a universal (etic) component, specifying that the impairment can be 'objectively' defined.

A very frequently used measure of social impairment is the Clinical Global Assessment Scale (CGAS; Shaffer et al., 1983). Some detail about this is provided as it has been used in a number of studies described later in the article. The measure is a composite that combines information about symptomatology and psychosocial functioning into a single score. The scale runs from 0 to 100. The lower the score, the greater the number of symptoms and level of impairment. A score of 0–40 would indicate very severe impairment, with a high level of supervision necessary, and typically institutional care. A score of 40–70 indicates significant symptoms, distress, and impairment, and would be characteristics of those children and adolescents who attend CAMHS out-patient clinics. A score of 70–90 occurs among those who may have symptoms, but many of whom would not seek help, whereas those with a score of 90–100 would only rarely have symptoms if at all and would be well functioning.

Unaccompanied asylum-seeking children

This group may be at high risk of psychiatric disorder, in view of their experiences and unaccompanied status (McKelvey & Webb, 1995). They tend to have internalizing disorders, and their distress may not be visible. It may, therefore, be overlooked by social workers who are more familiar with adolescents who are showing antisocial behaviour. Indeed the social function of the unaccompanied asylum-seekers overall may be better than their non-asylum-seeking peers who are looked after by local authorities, who show more visible disruptive behaviour.

In a recent study of 110 young adults (aged 16–21 years, $M = 18.1 = SD 1.3$) leaving care in Westminster, London, almost half, 54, were unaccompanied asylum-seekers, mainly from Kosovo and the Horn of Africa (Fraser, 2003). The other 56 had mainly been born in the UK, had English as their first language, and were predominantly white British or black African-Caribbean British. In this study, using an appropriate composite of information from the young people and social work notes, the asylum-seeking group had better social adjustment, reflected in a mean CGAS score of 68.2 ($SD = 22.4$), whereas for the others it was significantly lower ($M = 59.7, SD = 18.5, p = .032$). Nevertheless, the CGAS of the asylum-seeking group did indicate a high level of impairment

and distress for a community sample, who were predominantly not attending mental health services. Clearly, given the distribution of scores, many would have had a CGAS score below 60 and this group would be as impaired as many attendees in a tier 3 CAMHS.

Young refugees at the CAMHS (tier 3)

Tier 3 CAMHS receives referrals of youngsters with severe and complex problems, with high levels of psychiatric morbidity with significant social impairment. They will have more complex family and social situations than would be managed in tier 2 community settings by single-handed mental health practitioners.

A study of attendees at our tier 3 clinical department in Paddington, London compared 30 refugee children with two groups of children who were age and sex matched (Howard & Hodes, 2000). One of the comparison groups was non-refugee immigrant children from the same culture area as the refugee children, and the other was children from white British backgrounds. The children had a mean age of 9.8 years (range 0.5–17 years), and came mainly from the Middle East, in particular Iraq, Sub-Saharan Africa, and the Balkans.

Refugee children as compared with immigrant and white British controls tended to have more psychosocial disorders (e.g. depression, post-traumatic stress disorder, anxiety disorders) and fewer neuropsychiatric disorders (e.g. pervasive developmental disorders, obsessive-compulsive disorder, hyperkinetic disorder). The refugee children were psychiatrically heterogeneous, and presented with varied disorders such as anxiety, affective, eating, sleep and conduct disorders. Others had as a main problem learning difficulties and pervasive developmental disorders. Interestingly, they were not more likely to have post-traumatic stress disorder than the children in the other groups, despite the high level of war exposure. In part this was because some children in all three groups had witnessed traumatic events such as the deaths of family members, and domestic violence was witnessed by similar numbers of children in all three groups. However, the refugee children were significantly less likely to have conduct problems at school, and tended to be less likely to have a diagnosis of hyperkinetic disorder that required stimulants.

Regarding social impairment, the refugee children had a mean CGAS score of 55.4 (SD = 12.8), which was similar to that of the immigrants ($M = 54.2$, $SD = 14.9$) and white British children ($M = 51.4$, $SD = 14.3$). This is interesting as it indicated that for this group of refugee patients, against expectations, they did not have to be more impaired to get referred to the service than other children.

Despite a far greater involvement of interpreters and the ongoing social and economic difficulties, the refugees were no more likely to dropout of treatment prematurely. The implications of this study are that tier 3 services have an important role to play in addressing the mental health needs of the more psychiatrically impaired young refugees. Because they will attend regularly, and make good use of the services but have a high need for interpreters there are substantial resource implications.

Among the refugee children in the out-patient psychiatric service, described earlier (Howard & Hodes, 2000), 15 of 30 (50%) lived with both parents, 14 (47%) lived with one natural parent, and one (3%) was without parents. Refugee families compared with immigrant and white British families were much more isolated. They were significantly less likely to have relatives and friends in Britain.

For most people, employment is an important aspect of social contact. Asylum-seekers are unable to obtain employment in the UK, and this contributes to their isolation and

financial hardship. For the refugee children seen in the out-patient service, unemployment occurred in 21/30 (72%) of the families, which was much higher than the rate among immigrant and white British comparison groups (9/30, 31% and 11/30, 38%, respectively).

In the study of children referred to the tier 3 service, children from refugee backgrounds were more likely to be referred by social services and education than doctors (general practitioners and paediatricians) compared with children from other backgrounds (Howard & Hodes, 2000). Some families also had social workers because of child protection concerns. Among the psychiatric outpatients, 11/30 (37%) of the refugee children had social work involvement. This was a similar level of involvement compared with the other two groups. The proportions of children with social work involvement were similar.

The following case vignette (appropriately anonymized) illustrates some points made in the preceding section about asylum-seeking children, the role of social services in providing support and making referral, the delays that may occur until there is a wish to confide about traumatic memories, and the need for multiple therapeutic modalities. This case vignette also illustrates some elements of the 'non-specific' aspects of psychotherapy, including the relationship with the therapist, and increased 'attachment' behaviour that occurs at times of stress and transition.

Case vignette 1

He was a 16-year-old boy from the Balkans, who was referred by his social worker to the tier 3 service. He was an unaccompanied asylum-seeker, who had arrived in the UK aged 14 years. During the Balkan war, while away from his house a bomb had fallen on it killing his parents. When he returned to the house he saw the dead bodies of his parents. He escaped to a refugee camp in a nearby country, and remained there for 6 weeks. He travelled to the UK in a lorry with strangers. For the first 2 years he lived with an English foster family who he liked, and has continued to visit them. At the time of referral he was living in a supported hostel, with other young asylum-seekers. He attended college regularly.

He was troubled by intrusive thoughts of the past war events, including images of his dead parents, nightmares and avoidance of reminders of war events (on television, police in the street, loud noises, etc.). He explained that during the previous 2 years that he had been in the UK he had not been able and ready to talk about his difficulties and what had happened to him. Diagnostically he had typical post-traumatic stress disorder and depression. Specific elements of treatment included relaxation training, imaginal exposure and an SSRI antidepressant. There was ongoing liaison with his social worker. Over 18 months he made very significant improvements. However, he was still unable to discuss the most disturbing image, the sight of his dead parents. He started to attend less regularly, but made more frequent contact as he approached the age of 18 years and was moved to his own flat, and his asylum application was being reviewed.

Adolescent psychiatric in-patients (tier 4)

It is well known that on rare occasions young refugees may be so psychiatrically disturbed and impaired that they need admission (Westermeyer, 1991), but there has been little systematic investigation of their problems. We carried out a study recently that sheds some light on the issue.

We investigated ethnic variation of adolescents aged 13–17 years from London who were psychiatric in-patients (Tolmac & Hodes, 2004). The one-day census obtained data on 110 (97%) of the 113 psychiatrically admitted adolescents. It was found that black adolescents were significantly more likely to be admitted than white adolescents for

psychosis (odds ratio 3.7, confidence intervals 2.0–6.7). Among the 110, there were 15 refugees, of whom 10 had psychoses. Eight of the ten adolescents with psychoses were from black African backgrounds, and so were an important sub-group contributing to the over-representation of black adolescents.

The five refugee adolescents who did not have psychoses had varied disorders such as depression, adjustment disorder with deliberate self-harm, and eating disorder. Some of the adolescents had post-traumatic stress disorder comorbid with other disorders including psychoses. They were from Kosovo, Iraq and countries in Africa.

The black adolescents were more likely to be admitted under the Mental Health Act, rather than on a voluntary basis. When refugee in-patients were compared with the non-refugees, there was a higher proportion who were detained, 5/15 (33%) compared with 14/70 (20%) non-refugees, but this failed to reach statistical significance (Fisher's two-tailed test .156).

The rate of unemployment found among the parents for the refugee adolescent in-patient group (87%) was similar to the rate of unemployment among the psychiatric out-patients. Regarding living arrangements, the refugee group were much less likely to be living with one or both parents rather than with foster families or hostels than non-refugees (refugee group 10/15, 66%, with parent(s) compared with non-refugee group 77/85, 91%, Fisher's two-tailed test $p = .0242$). Only three refugee adolescents who were in-patients were living with both parents.

Among the in-patient refugee sample of 15 adolescents, the level of family loss and traumatic events was very high. Six (40%) had one parent who died (all fathers: killed in civil war, tortured for political reasons, chronic medical conditions); in one of these cases the mother was also missing, presumed dead. For another two adolescents the whereabouts of the mother was not known and for another, both parents were missing in the home country. For three other adolescents, their fathers had returned to the home country and the rest of the family stayed in the UK. One adolescent's father was living elsewhere, but outside the UK.

Among the in-patients, there was social service involvement in 5 of the 15 cases. For two adolescents this was due to domestic violence and in three cases the adolescents were unaccompanied asylum-seekers and required social service support.

The links among family loss, displacement and psychiatric disorder are illustrated by the following case vignette. In order to preserve anonymity this is a composite, taking information from a number of the refugee adolescents assessed in the psychiatric in-patient study (Tolmac & Hodes, 2004).

Case vignette 2

He was a 15-year-old boy from Africa. At the age of 13 years he experienced a series of catastrophic traumatic events. First, his mother died. His sister, who was his only sibling, was raped and killed by soldiers from the opposing side. Later that year, his father went to the funeral of his own sister and did not return. He was then arrested, and held in solitary confinement and tortured. He was able to escape and get to Belgium, and then he travelled to the UK, when he started to live in a hostel. Soon after arrival he presented to the local emergency psychiatric services following a suicide attempt, by overdose. He was discharged, later reassessed and admitted to the psychiatric in-patient adolescent unit under section of the Mental Health Act. The provisional diagnosis was post-traumatic stress disorder and possible psychotic episodes. When assessed by the research investigator, he was diagnosed as having psychosis not otherwise specified. He was discharged to a hostel. For follow-up he attended the local CAMHS and Medical Foundation (a service in London that provides psychological and medical support for victims of torture).

Legal issues

Asylum-seeking children and refugee children have the same rights as other children. This means they are entitled to support under the Children Act 1989 (England and Wales). The unaccompanied asylum-seeking children described here are one group who require support in relation to their specific circumstances. However, as described previously, there are others who may require family intervention because of impaired parenting and child protection concerns. These points are relevant for refugee children generally, as well as those who are showing significant social impairment. It has been cogently argued that in recent years in the UK, and perhaps other countries, the rights of asylum-seeking children are being eroded: that they are being regarded as asylum-seekers first, rather than children (Fazel & Stein, 2004). This could result in less actual support being provided under the Children Act 1989, and equivalent laws in other countries.

Child and adolescent mental health professionals may be requested to write reports to support asylum applications. Many of the issues are well described by Tufnell (2003). The report needs to obtain information from relevant and appropriate informants including parents, school reports and other information from the solicitor. The interview with the child and parents needs to cover the traumatic events, and how they have affected the child. The report also needs to consider how the child will be affected by being sent back to his/her country of origin. The possibility that these topics can be covered in interviews with the young person assumes an adequate level of social function, and ability to communicate about them. In an out-patient setting this will usually apply. However, the severely impaired asylum-seekers described here may be unable to give their account of these events at the time the request for the report is made, in which case the timetable may need to be extended. It is widely believed that well-written psychiatric or psychological reports may strengthen asylum claims. Anecdotal evidence also suggests that asylum claims are not more likely to be refused for individuals who have a high level of need for psychiatric care, including in-patient treatment.

The severely impaired young refugees may require management under the Mental Health Act. Because some of these young people, especially unaccompanied asylum-seekers, will be entitled to support under the Children Act 1989, their needs should be considered within the framework of the two pieces of legislation. Hopefully, the complementary nature of these acts will ensure that their rights are met. However, at a practical level this may increase complexity, such as the possible need to involve an approved social worker as well as the field social worker (who may work in the local authority asylum team or with looked after children).

Implications for service provision

From the preceding description, it will be realized that the severely impaired refugees have psychiatric disorders or developmental difficulties that other young people, including other migrants, may have. However, the prevalence of psychiatric disorders and psychological distress may be higher in refugee children and adolescents than a non-refugee peer group (Fazel & Stein, 2003; Leavey et al., 2004; Tousignant et al., 1999). With regard to disorders that cause high levels of impairment, psychoses may be more prevalent. Recent investigation in West London has also suggested that violent deliberate self-harm among adolescent female refugees is more common than among non-refugee female peers (Patel & Hodes, submitted).

Second, cultural considerations need to be taken into account. Refugees are of course

culturally heterogeneous and so their disorders may be influenced by cultural factors. The extent to which this is the case has been the subject of heated debate within medical anthropology, but emerging studies do suggest that culture has some influence on symptom profiles for some disorders (Mezzich, Kleinman, Fabrega, & Parron, 1996).

Third, there may be specific issues with regard to assessment of intellectual ability and assessing scholastic attainment. It is well known that many asylum-seeking children who have come to resettlement countries have been unable to attend school on a regular basis, if at all, because of political and safety issues. Considerable help, such as language support, may be required for such children to be integrated into mainstream education, which will also facilitate adjustment within the new society (Rutter & Jones, 1998). From a more clinical perspective, difficulties may arise in assessing speech and language delay in children who come from families, for whom English may be an additional language. Refugee children may have experienced considerable hardship, including separation from family and carers, and neglect. Some children, even those of primary school age or younger, may have spent considerable periods of time in jail, and such environments may contribute to delays in cognitive development, difficulties in attention regulation, and formation of normal attachments and relationships (Roy, Rutter, & Pickles, 2004).

Fourth, it is very important to consider the effect of time. It has been found in numerous studies that over time young asylum-seeking children and refugees show considerably improved mental health (Almqvist & Broberg, 1999; Becker, Weine, Vojvoda, & McGlashan, 1999; Sack, Him, & Dickason, 1999; Weine et al., 1995), although the extent to which this occurs for adults is more variable (Kivling-Boden & Sundbom, 2001; Lie, 2001). Thus data regarding psychiatric disorders and social function need to be contextualized within a longitudinal framework, in which the timing of events including war exposure, and resettlement are located.

Fifth, the characteristics of psychiatrically impaired refugees seen in mental health services will be influenced by central government policies regarding settlement and local authority influences on housing. To take the UK as an example, for decades, and indeed centuries, London has been a cosmopolitan city that has received large numbers of refugees (Bardsley & Storkey, 2000). The Asylum Act 1999 which came into effect in 2000, introduced a system of dispersal, and from that date many asylum-seeking families were required to live in towns that had not previously received large numbers of refugees. As a result of these policies, in recent years, the asylum-seeking and refugee communities in London may include a higher proportion of families who have refugee status and more permanent housing, compared with those in dispersal areas. One consequence of this based on clinical impressions from inner London is that CAMHS, including tier 3 services, are starting to see more refugee children with neurodevelopmental disorders, including pervasive developmental disorders, and learning difficulties, as schools and other agencies become aware of problems that might have occurred in the children even if they had not become refugees.

General principles of service provision have been described previously and are not repeated here (Hodes, 2002; Westermeyer, 1991). These include the need for multi-agency work (mental health, social services education) and consideration of services that may be universal, indicated (because of high risk), or targeted at those with impairment or disorder.

Regarding CAMHS, tier 2 practitioners will have an important role in identifying and referring to tier 3 young refugees with more severe impairment and disorder. The available evidence described earlier suggests that social services and schools will also play an important role in referring distressed young refugees and so appropriate links, for example, consultation will be needed with those agencies. It would also appear that

refugees referred to CAMHS will use them well, and given the increased need for interpreters there will be substantial resource implications. Involving interpreters may at least double the length of consultations (Raval, 2005). Additional work may arise given the need to respond to asylum-seeking families' requests for support for housing and sometimes school access.

There are also significant implications for the planning of psychiatric beds, and related services such as day provision, as the refugee group had increased need for in-patient care. There will also be an implication for services for early-onset psychosis.

Concluding remarks

This article is concerned with only a small proportion of asylum-seeking and refugee children. Nevertheless, this group of more impaired young people have complex problems, in view of the need to consider psychiatric disorders against a background of cultural and language change, privation, and difficult family, social and legal situations. Young refugees may require multi-agency involvement to address their needs, especially as they may have less social support than those who can plan their migration and non-migrant peers. It is hoped that greater understanding of this group's complex needs will enable treatments and services to be delivered more effectively.

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