Exploring Service Response to the Mental Health Needs of Refugee Children and Youth - A UK Study

A Research Report for Public Health Insights for Policy and Practice

“We need help with our children’s mental health, if you can help us with something, help us with that, please.”

Research Summary
Multiple stakeholders across three regions in the UK share their perspectives to address the problem of unmet needs among refugee children and youth. A thematic analysis of nine focus group discussions involving fifty-five stakeholders provides new knowledge on risk factors to mental health and service use and the ability and capacity of services to respond to needs. Outcomes provide evidence for the co-development of a needs-led service model that operates as an integrated ‘system’ to overcome silo working and improve service response.

Key Service Recommendations
• Develop networks and orientate linkages to integrate services into a ‘system’
• Establish interrelationships across services in the system to enable knowledge exchange
• Capacity build using knowledge exchange (e.g. knowledge of services, experiential learning, practical experience)
• Implement ‘Refugee Trauma’ and ‘Cultural Training’ across the system
• Develop a centralised communication strategy to maintain a whole systems approach to service response

A 2-Stage Research Project
Research outcomes reported constitute Phase 1 of a 2 Stage research programme. ‘Identifying mental health and service needs of refugee children and youth’. Phase 2 involves the operationalisation and implementation of Phase 1 outcomes ‘The Co-development of a needs-led service model’ measuring outcomes for impact.
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Introduction

Context
Towards the end of 2019 a total of 79.5 million persons were forcibly displaced worldwide, an estimated 40 million of those were children and youth (United Nations High Commissioner for Refugees). Young refugees resettling in high-income countries form the minority of these groups with most resettling in low-middle income countries. Furthermore, there is an under-representation of these groups within the literature related to mental health services research. To bring young refugees into focus, between 2014 and March 2020 over 9,000 children resettled in the UK via the Vulnerable Persons Resettlement Scheme and 1,826 via the Vulnerable Children Resettlement Scheme. In addition at year-end March 2020 35,894 asylum applications were submitted by children, adolescents and young adults. (The Home Office Immigration Statistics Quarterly Release, May 2020. Gov.UK). The migration of young refugees to the UK is not a transient movement but continual with forced migration likely to grow, therefore it is of great importance to increase knowledge and understanding of the mental health and service needs of these vulnerable groups.

Prevalence of Mental Health Problems
The mental health of refugee children and youth is exacerbated by multiple trauma events experienced before, during and after displacement (Sandalio, 2018; Archer, 2017; Reed, Fazel, Jones, Panter-Brick, and Stein, (2012); Bronstein and Montgomery 2011; Fazel et al. 2012; Fazel and Stein, 2002). Given the difficulties encountered during the migration experience, it is unsurprising that mental health disorders; depression, anxiety and post-traumatic stress disorder (PTSD) are consistently reported (Frounfelker, Miconi, Farrar, Brooks, Rousseau and Betancourt, 2020; Rousseau and Gagon, 2020; Richter, Lehfeld, Zaške, Brar-Reissinger and Niklewski, 2018; Turrini, Purgato Balletté, Nösé, Ostuzzi and Barbui, 2017; Tinghög, Malm, Arwidson, Sigvardsdotter, Lundin, and Saboonchi, 2017). Recent epidemiology research shows high prevalence estimates of these specific problems among refugee children and youth resettling in high-income countries, these rates are higher by comparison to host country populations (Henkelmann, De Best, Deckers, Jensen, Shahab, Elzinga, Molendijk, 2020).

Post-Migration -New Challenges
A challenge for many young refugees moving from low-income settings to high-income settings is the complexity of an unfamiliar service system (Fazel and Betancourt, 2017). When considering the mental health of these vulnerable groups, it is of importance to take into account the host country context and post-migratory difficulties that present as risk factors to mental health and wellbeing (Rousseau and Gagnon, 2020; Peterson et al. 2020). Post-migration can be contextualised as a transitional phase in the child’s life that presents a number of challenges, for example, refugee children and youth have no language ability in the host country, no knowledge of systems; societal, community, education, and healthcare. Furthermore, the cumulative effect of these challenges each contribute to experiences of social exclusion and discrimination (Hynie, 2017). The aforementioned epidemiology research supports the view of Blackmore, Gray, Boyle, Fazel, Ranasinha, Fitzgerald, and Gibson-Helm, (2019) who suggest that prevalence estimates provide strong evidence for the necessity to provide mental health services during early resettlement, without such support, the child is at risk of broad and long term implications due to poor social and educational integration, factors that both impact on the child’s life course.

Barriers to Access and Engagement with Services ‘Service User Perspectives’
Young refugees have less engagement with mental healthcare systems by comparison to host country populations (Satinsky, Fuhr, Woodward, Sondorp and Roberts, 2019; Brar-Josan and Yohani, 2019; Michelson and Scclare, 2019; Henkelmann et al. 2020). The perspectives of young refugees indicate a lack of awareness of mental health services available (Valibhoy, Szwarc and Kaplan, 2017) and among those who have knowledge of services, insufficient knowledge of the structure of the ‘system’ in terms of accessing
services, for example, difficulty navigating pathways to care (Byrow, Pajak, Specker and Nickerson 2020). This finding has long been a challenge for refugees resettling in the UK. O’Donnell et al. (2007) report the perspectives of asylum-seeking communities resettling in the UK on service experiences and found low levels of understanding and a lack awareness of how the UK system works including roles and responsibilities across services.

Service users who report their experiences of accessing mental health and psychosocial support describe barriers that inhibit help-seeking, access and engagement. These barriers include low levels of mental health literacy, language difficulties, distrust of service providers, problems of stigma, long wait times and a lack of knowledge of cultural sensitivity among service providers (Byrow et al. 2020; Anstiss and Ziaian, 2009; Frounfelker, Miconi, Farrar, Brooks, Rousseau and Betancourt, 2020). To better support young refugees during post-migration, Vindevogel and Verelst, (2020) suggest a supportive and integrative approach to facilitate navigation of the service system.

**Barriers to Access and Engagement with Services – ‘Service Provider Perspectives’**

In addition to the many challenges faced by service users, service providers too face a number of complex challenges responding to the needs of refugee children and youth. Service providers report a lack of contextual knowledge related to asylum policy and differing cultural concepts of mental health incl. symptom expression (Robertshaw, Dhesi and Jones, 2017; Colucci, Szwarc, Minas, Paxton and Guerra 2014). These deficits in knowledge are widely understood (Sapthiang, Van et al. 2019) and congruent with service user reports of a lack of cultural sensitivity. In addition, trauma informed care is often absent across psychosocial services and in the context of refugee children and youth in resettlement (Ellis, Winer, Murray and Barrett, 2019). To improve service utilization among young refugees Satinsky et al. (2020) suggest building capacity among service providers in addressing cultural-specific barriers to accessing services and improving acceptability of services, building trust and positive relationships with the service providers.

**Service Response**

To improve service response there is a need to contextualize the mental health and service needs of refugee children and youth to their host country situation (e.g. socioeconomic, community and psychosocial support mechanisms) (Ellis et al. 2019). A broader understanding of post-migratory risks i.e. barriers to access and engagement is thought necessary to improve both service design and the effectiveness of service response (Im, Rodriguez and Grumbine, 2020). Service response is increasingly being described as silos of service delivery as a result of a lack of coordinated services (Chiarenza, Dauverin, Chiesa, Baatout and Verrept, 2019). Nasr and Fisk (2019) argue that to adequately respond to the needs of refugee children and youth services must function as whole describing a ‘systems thinking approach’ to service response. Systems thinking has been previously applied to explore the complexities related to systemic support available to refugee families addressing the interrelatedness of sub-systems in the post-migratory setting e.g. school and community (Peters, 2014; Papadopoulos, 2002). School and community environments are increasingly becoming recognized as important platforms for intervention (Eruyar, Huemer and Vostanis, 2018) and described as ‘cultural brokers’, acting as mechanisms for transition between services providing mental health support to young refugees in resettlement (Brar-Josan and Yohani, 2019).

There has been an emerging shift in thinking around service design and response within the literature. Nasr and Fisk, (2019) propose adopting a transdisciplinary approach to service design to enable identification of service system problems from multiple perspectives across disciplines. This is carried forward with the proposal of a model of service delivery that takes a systemic approach Im, Rodriguez and Grumbine, (2020). This model adopts a culture and trauma-informed approach to responding to mental health needs of refugees in resettlement, supporting the mental health and social functioning of the child through linking mental health practice with refugee resettlement programs in order to overcome silo working. These approaches go some way to integrate services, bridging gaps between community and mental health services.
Rationale

To date, research exploring service response to the needs of refugee children and youth has been largely undertaken in low and middle-income countries. This has positioned the UK population of refugee children and youth as an underrepresented population within the literature and service response at a disadvantage due to a lack of knowledge related to needs. This lack of research maintains a deficit in knowledge related to specific factors that act as barriers and facilitators to accessing and engaging with services and hinders service design and development that aligns with the needs of these vulnerable groups.

Until recently, there has been no specific methodology applied to systematically identifying and addressing the mental health and service needs of refugee children and youth in the UK. This research provides new knowledge, gathering the perspectives of both service providers representing multiple services (e.g. community, education, healthcare and public health) and service users (e.g. refugee parents, children and youth) to increase understanding of factors and mechanisms that contribute to service response and the problem of unmet needs. The identification of barriers to access and engagement with services highlights gaps and opportunities for service development. In most cases service structures migrate from existing service typologies and therefore are not needs led.

In support of the emerging literature that posits the need for a culture and trauma informed coordinated service response, services responding to the needs of refugee children and youth need to be recognized as ‘refugee service providers’. To align service response to needs, inclusivity of these vulnerable groups in service design is of great importance.

The present study takes a systems thinking approach to contextualising multiple perspectives on service response to the mental health needs of young refugees in the UK. We explore the determinants of response of services, bringing the perspectives of young refugees, parents and service providers into focus. A critical realist approach to contextualising causal mechanisms providers insight into boundaries across services and opportunities to improve service response.
Methodological Approach

This research provides a qualitative understanding of the mental health service needs of refugee children and youth. The utilisation of qualitative approaches foregrounds children's voices and perspectives and provides a child-centred focus and children's rights ideology. Qualitative approaches are known for their robust theoretical frameworks to ensure that there is quality built into the procedures and consistency in thinking about the values of the researcher and the methodological process. For this particular project the qualitative design was informed by a critical realist epistemology. Put simply, this means that there is a difference between the real world and what is observable. The world as we know and understand it is constructed from our perspectives and experiences, through what is observable, and it is these experiences, that are the core focus of the project. The research question, project aims, and structure of the research project are outlined below followed by a description of the methodological design.

Research Question

- How will the perspectives of service providers, refugee parents, children and youth inform the development of a needs-led service model?

Project aims:

1. To develop an understanding of the mental health and service needs of refugee children and youth through a process of contextual enquiry.
2. To determine contextual factors that act barriers to access and engagement with services.
3. To determine challenges experienced by service providers responding to the needs of refugee children and youth.

Project Structure: There are 2 Phases to this research project outlined below:

Phase 1: To gather multiple stakeholder perspectives to increase understanding of the mental health and service needs of refugee children and youth resettling in the UK.

Phase 2: To take key messages that result of a qualitative analysis of stakeholder perspectives to inform the development of a needs-led service model.

This report presents Phase 1 outcomes of the project. Stages of the project are outlined in figure 1 below:

**Figure 1.** A visual representation each stage of the research process during

Phase 1. Project progress to date and an introduction to Phase 2.

This research is positioned within a critical realist methodological framework. Critical realism supports a qualitative and investigative process of contextual enquiry. Methods applied orientate towards empirical data gathering and in the context of this research, provides a voice to those to whom the research problem applies with the aim to generate new knowledge. To frame the research question and to contextualise the nature of the outcomes we applied systemic thinking to problem structuring. For clarification; a systems thinking approach considers the interrelatedness and components of the sums of parts of a whole. In this
research we relate to services as the sum parts that provide the structure of a service system. A schematic visual representation of the application of a critical realist framework is presented in figure 2

![Diagram of Critical Realist Framework]

**Figure 2.** Theorising an explanatory framework to explain service response to the mental health and service needs of refugee children and youth.

**Inclusion Criteria & Recruitment Strategy – Engaging Service User’s & Provider’s**

Three authorities were identified to meet the research criteria and expressed an interest in the research project. Each authority represents an asylum dispersal area and or had volunteered to participate in a resettlement scheme undertaking the responsibility for the provision of services across education, community and healthcare (Incl. primary healthcare and mental health services). The project was introduced to senior members of public health across each authority and project aims were presented during face-to-face meetings and presentations. Public health members were in support of a stakeholder approach to enable the researcher to develop a stakeholder group. A stakeholder map demonstrates the composition of the stakeholder group illustrated in figure 3.

**Recruiting Service Providers**

In keeping with the definition of ‘Stakeholders’ proposed by (Schmeer, 1999) that is, stakeholders are members who have a vested interest in supporting the development and outcomes of a project, often those who are interested in research based evidence for policy reform. A stakeholder analysis methodology was applied as an analytic tool to identify stakeholders to recruit to the project and assess interest among stakeholders e.g. service providers and their ability to create change or be influenced by change as a result of the research outcomes (Yawson and Greiman 2014; Varvasovszky and Brugha 2000). Therefore, a purposive sampling technique with maximum variation was used to recruit service providers to the project, this method allowed strategic choices to be made in relation to the research aims (Palys, 2008). Stakeholder analysis is often applied within a system’s approach (Yawson and Greiman 2014) and considered fundamental to system change (Ackoff 1974). The conceptualisation of a stakeholder analysis can be described over four stages:

1. **Specification**
2. **Prioritisation**
3. **Mapping**
4. **Engagement**
The stakeholder analysis supported the mobilization of a diverse range of participants relative to the research problem representing a purposive sample. This provided opportunity for the researcher to gain as much insight from as many perspectives as possible on the research problem. Recruitment was conducted at a local level across three participating regional areas. The participant sample is made of three groups:

1. Unaccompanied Youths
2. Parents of refugee children and youth
3. Service Providers.

The stakeholder analysis facilitated an understanding of the system i.e. service provision and its sum parts, by identifying key stakeholders relative to the system of interest (Elias and Cavana, 2000).

**Recruiting Service Users**

Community-based services facilitated recruitment of parents, children and youth, inviting service users to participate in the project. The selection criteria included asylum seeking and refugee parents of school aged children (8-16yrs), school aged children (8-16yrs) and unaccompanied asylum-seeking youths (15-18). Recruitment of service users involved a process of familiarisation, involving open discussions of the research aims at community meeting places during drop-in sessions. Members of the community were able to openly ask the researcher questions related to the research aims and express their interest in participating, at this stage recruitment was based on referral among stakeholders fitting the criteria of snowball sampling or otherwise referred to as chain-referral sampling (Biernacki and Waldorf, 1981) as interested members of the community recommended the research to others. Meetings at community services took place over a number of visits to drop-in sessions and were facilitated by service managers. Working with stakeholders at service locations supported a process of familiarisation and enhanced research practice effectively engaging the ‘voice’ of the community.

![Figure 3](image.png)

**Figure 3.** A schematic representation of the ‘Stakeholder Group’ – An illustration of the typology of services engaged in the project.

**Ethical Considerations**

Ethical approval was granted from the University of Leicester Ethics Committee following submission of gatekeeper letters from Public Health members across each participating authority. In addition, the researcher facilitated a sense of agency among participants, making participants aware that they each have a voice and a right to make a contribution to the research process. All participants were provided written information detailing the project aims and consent was obtained. In addition, the researcher facilitated a
sense of agency among participants, making participants aware that they each have a voice and a right to make a contribution to the research process.

Data Collection – Focus Group Discussions

Focus group discussions were the chosen method of data collection. Data was collected over a period of nine months between 2018 and 2019. Focus groups are often used as a single method in health services research and often to explore the perspectives of a purposefully selected group, in the context of this research both service users and service providers formed the discussion groups as a result of a stakeholder analysis and purposive sampling strategies (Tausch and Menold, 2016). The focus group method has some similar features to the unstructured interview and is used to generate knowledge through collective views and experiences related to the research topic (Gill, Stewart, Treasure and Chadwick, 2008). We chose focus groups to address the research question to gain meaning and understanding related to stakeholder needs.

Focus group question guides were designed by the researcher, our aim was to obtain reliable information about participant views and experiences therefore we undertook the design of question with a realist aim (Willig, 2013). Questions were progressive, that is, the discussion started with open-ended questions. For example, service providers were asked to describe their knowledge of service provision available to refugee children and youth. A number of probing questions were asked to gain in-depth knowledge. An exit question was asked of service providers that centred on what service providers perceived to be service priorities to overcome service challenges identified during the discussion. Nine focus group discussions were conducted comprising of a sample of 55 stakeholders:

- 1 Group - 6 unaccompanied youths
- 3 Groups - 19 parents
- 5 Groups - 30 service providers

It is suggested that focus groups should consist of a maximum of between 6 and 8 participants to ensure all group members are able to actively participate (Willig, 2013). Determining the sample size for focus groups should be determined by the research question. In our sample, some service provider groups consisted of 4 or 5 participants, this worked well with the complexity of research topic and the level of experience among participants. Focus groups were conducted with an interpreter where required keeping in mind cultural milieu among participants (Race et al. 1994). All group discussions were moderated by the researcher, this supported a rich understanding of participant views and experiences in relation to the research question.

Data Analysis

All focus groups were audio-recorded and transcribed verbatim by the researcher. A thematic analysis was used to identify, analyse, organise, describe and report themes and is often the chosen method of analysis to explore individual’s perspectives (Braun and Clark, 2006). According to Braun and Clarke, (2006) thematic analysis can be undertaken from a number of epistemological positions including ‘critical realist’. A critical realist framework guided orientation of data analysis, i.e. using a flexible process of coding to critically engage in participant knowledge and experience. This process of analysis focuses on identifying patterns of meaning across data that provide a response to the research question. We undertook this process following Braun and Clarke (2006) 6 phases to a thematic analysis:

‘A six-phase process of analysis’

1. Familiarisation with the data (becoming immersed with the data)
2. Coding, identifying important features of the data relevant to addressing the research question
3. Generating initial themes, examining codes and identifying broader patterns of meaning
4. Reviewing themes, refining themes
5. Defining themes, developing a detailed analysis of each theme
6. Writing up, determining the context of each theme and applying an informative name to each theme

The process of thematic analysis is recursive, rather than a step-by-step process, this approach allows the researcher to ensure that themes are of importance to the research aims and overall goal of the research project. It enables the researcher to interpret experiences within the context in which they arise. In the present study, we consider multiple stakeholder perspectives on the mental health and service needs of refugee children and youth in the post-migratory setting and situation.
Results- Summary

Taking a contextualist and critical realist approach to data analysis three analytical themes were identified and were named: (1) Community and Culture (2) Pathways (3) Systemic working. These three analytical themes encapsulate factors that contextualise the research problem. They each interrelate providing insight into the mental health and service needs of young refugees and service challenges reported by service providers. The three analytical themes are interpreted using nine descriptive themes embedded within each analytical construct presented in a Thematic Map illustrated in figure 4.

Figure 4. Final Thematic Map, showing the final three main themes. (Adapted from Braun and Clarke, 2006).

Within the three analytical themes presented in the thematic map there are a number of sub-themes (e.g. Language Acquisition, Access and Lack of Integrated Services) that each represent risk factors to mental health and service use among refugee children and youth, these themes often these interrelate. Themes represent challenges experienced by service providers representing barriers to access and engagement with services. Factors discussed can be considered key determinants of service response. The presentation of results that follow provide a description of each analytical theme, sub-themes are supported with data extracts that have undergone a contextualized analysis that has engaged the literature.
Results

**Theme 1. Community & Culture**

1. Community and Culture – Sub-theme Language Acquisition

Refugee children and youth encounter many systemic barriers post-migration including language learning. Being able to speak the host country language enables navigation of the community. Language acquisition prior to commencing school or college was considered a priority to enable participants to start their placement with a basic level of language competency. However, opportunities to access language learning were limited to school placements. Participants discussed the need to engage in contextualised learning to develop community provision. Acquiring the language to be able to 'speak to communicate' was a strong theme across all groups. In addition to factors related to integration, language was related to difficulties accessing and engaging with services.

Learning to speak the language was considered an essential prerequisite to starting school or college among young refugees. A newly arrived adolescent shares her experience of starting college with little linguistic support, unable to understand the teacher. The participant suggests self-learning as a strategy to improve communication between pupils and teachers during the early transitional stage.

… ‘The school, you can’t talk, if you go straight to college, so if the teacher says, “what's your name” How can I answer? So, you, I mean like, so maybe stuff they can teach yourself like what’s your name like, what’s your name…”’

(Youth member)

Speaking the language was the primary language skill required over developing grammar and writing skills. Developing automaticity (e.g. selecting words, applying grammar and pronunciation) requires practice, however, conversation practice was considered too short in time allocated in the classroom environment.

… ‘At college that can teach you formal, and grammar, but if you want to learn how to speak, you need to be confident and friendly, talk with other people if you can, college is not enough time, you know, it's 2 hours, 3 hours a day. You can't have enough time to practice…”’

(Youth member)

Participants related to learning by doing, by engaging in conversation practice in the community.

… ‘Learn more on the street, you learn English from the street, you learn grammar from the school...people learn English from the street, learn grammar from the college…”’

(Youth member)

Limited language proficiency created difficulties in engaging with services among parents.

‘Language problem, they have interpreters, but now they've stopped this service. People are coming from different countries, so they need this service. Initially their language, English language is quite difficult, it's really hard.’

(Parent)

Service providers recognise the difficulty faced by children with limited language proficiency who are unable to express themselves, services require language support to enable improved communication.

… ‘It's just you know if its assessment based, sometime the children they don't even speak English, so how can you decide if they're ok or not? You know when working, when I was working with children I’ve seen children in the middle of lesson, they just start crying, but teacher, she don't know what's wrong with them, she's not even able to say “are you ok?” or “can I help you?” I know maybe it's a lack of language but, again it’s just providing somebody to speak with them, it could be like solutions sometime…”’

(Voluntary Community Support Worker in Education)

However, when children are referred to services for mental health, language remains a problem.
‘When we get these children referred, we rely heavily on the quality of the interpreter when we’re obtaining information, to go from obtaining information for assessment and getting to the realms of providing interventions with the interpreter is very, very difficult, highly labour intensive, and we don’t know what gets lost in translation.’  
(Mental Health Services)

A language barrier impacts, whereby mental health concepts differ between service provider and parents and support is required to help parents identify mental health problems among their children.

‘… We had quite a few couples with children, and the children were for us quite clearly presenting with challenging behaviours because of emotional distress and the parents were like I don’t understand why my child’s doing this. They perhaps might not understand there is an impact on their children, mental health. And I think language plays a big part.’  
(Primary Healthcare Services)

Access to language learning early on during post-migration was important to develop community provision, integrating into the education system, community and developing friendships. Low levels of language proficiency can cause social isolation and can position individuals as victims of bullying and discrimination. Participants demonstrate a willingness to learn the language and describe the facets of a learner-centred approach to increase learning opportunities to enable communication.

Among service providers, language support is required to facilitate identification of mental health problems and improve referral outcomes. Further, language support during consultations may help bridge gaps in different cultural concepts of mental health.

Theme 1. Community & Culture – Sub-theme ‘Contextual Knowledge’

Bringing the mental health and service needs of refugee children and youth into focus has provided insight into opportunities and constraints related to service response. Service providers discussed challenges that present as priorities to improve service provision e.g. a lack of knowledge around expressions and symptoms of trauma, knowledge of different cultural conceptualizations of mental health, and policy.

Often signs and symptoms of trauma among refugee children and youth are not well understood, these children risk going unnoticed and may not be identified as having needs in the educational system.

‘… They can see, but not you know like for somebody is crying all of a sudden, yeah it could be like with the other child something, or something happened, but they don’t take it as maybe be remembered something happened to him. Because some of the children I was working with, they were from Syria, so they witnessed the war, so they’ve got lots of, they’ve been traumatised, definitely…’  
(Educational & Community Support Worker -Voluntary Organisation)

Each refugee child will be processing a unique trauma history and will be expressing signs of trauma at different times and in response to different situations. Understanding the experiences of refugee children is important to understanding the child’s behavior. Some receiving schools have had no knowledgebase of the child and the child’s history prior to placement.

‘The new arrival, they often have no idea, especially if the new arrival child is internalising, so they become an invisible child, and the family become an invisible family to the school because they don’t, like you say they might have to send the children on the bus to school, so the school don’t have that contact with the parent…’  
(Education)

It is important that service provides are able to orientate towards recognizing signs of trauma among children who internalize to ensure that their needs are recognized, and referrals can be made. Educators talked around the difficulty of identifying trauma in the classroom environment.

‘Signs and symptoms of trauma, and how to spot if it looks like a young person needs a referral to a specialist…’  
(Education)
… ‘I think these children become the invisible children and the children that are fighting, breaking chairs, swearing, they’re the ones that are getting referred to our services.’

(Educational Psychology Services)

However, among service providers whom provide access to specialist mental healthcare, gaps in knowledge were evident demonstrating a need for training in trauma specific to refugee children and youth as well as developing an understanding of asylum policy.

… ‘Trauma focussed training and profiling, increased knowledge around asylum system, what we’re looking at is trauma-focussed training specific to these groups, post trauma…’

(Primary Healthcare Services 3)

Specialist mental health services receiving referrals also require contextual knowledge to be able to plan their service response effectively.

……‘To be ready, willing and able to respond to these children, we are not equipped at the moment to be able to respond to them, we don’t understand the language, we don’t understand the cultures, we don’t understand the sub-cultures, we don’t understand the cultural beliefs, and we don’t understand the size of the problem. With regards to asylum, I don’t know exactly what it is, but I’d like to know what it is so that I can plan more efficiently, referral rates. There’s so much that we don’t know. That we’d like to be able to know, I don’t know the detail of the resettlement programmes, the knowledge base around these kids is not great. We learn things anecdotally from experience, to me there’s a great investment in training needed for these members of staff that have to be commissioned to respond to these kids…’

(Mental Health Services)

Theme 1. Societal Barriers: Sub-theme ‘Discrimination & Shame’

Discrimination is often experienced among asylum seeking and refugee children and youth in the post-migratory setting. This can be consequential of systemic discrimination whereby policies place families in a position of low socio-economic status resulting in unequal access to resources in the community. Children and youth report perceived discrimination and experiences of being bullied to their parents. Both affective and behavioural responses to discrimination are evident among the group with reports of feelings of embarrassment and shame related to status and poverty. Children describe avoidance as a key coping strategy to reduce the chance of experiencing discrimination. This behavioural strategy impacts on social relations, putting the child at risk of social exclusion and reduced quality of life. Further, avoidance reduces help-seeking behaviours for mental health problems in the school environment. Parents recounted their child’s experiences of bullying behaviours and were concerned for their child’s mental health. Service providers share an awareness of discrimination experienced among these vulnerable groups. Adolescence fear disclosing their identity related to status and negatively internalise emotions. As a result, children chose to socially withdraw from situations.

……‘My eldest child the big one, the 18 the nearly 18 next month, he feel very embarrassed he feel and say “mummy I can’t tell anyone mummy I am in asylum” and I can’t invite my house because not good things, not good house, all dirty paint and all rough things and carpet is not good and he is very, very stressful…’

(Parent)

Social avoidance occurs when children and youth encounter painful social experiences. Children feared disclosing their status.
… ‘My big son, erm, he feel very shy, he don’t go outside with friends, er his confidence level is very low, and er mum I feel very embarrassed when my friends ask “What’s your status?” and that’s why mamma I can’t understand I can’t er tell him what’s my status. And er that’s why, I can’t, I don’t go with my friends…’

(Parent)

Concerns of disclosure of status impacts on the child’s self-esteem and confidence at school.

… ‘Yeah, my big son be has, I think, he has no confidence…’
… ‘less confidence…’
… ‘yeah less confidence…’
… ‘Less confidence in secondary school…’
… ‘And many time “Mama you don’t share it, we are asylum person…”’
… ‘But the kids doesn’t like us to, to tell anyone we are in asylum….’
… ‘It’s because the perception of the asylum. In this society it’s not acceptable, but the people believe, that you people are relying on our tax money. That’s the thing. Our confidence is very low…’

(Parent)

Parents share their concerns that their children are reluctant to talk about their experiences and that these problems are not shared with the school. Parents describe a lack of support available in the secondary school environment.

… ‘Secondary school, when children go to secondary school, they don’t share their experience.’
… ‘Yes, yes…”
… ‘I think they are start to hide…”
… ‘Yeah…”
… ‘Boys they don’t go and tell I am an asylum seeker or…”
… ‘Yes, yeah…”
… ‘They feel very embarrassed. They don’t want to talk about it…”
… ‘I don’t think the school know a, like a particular like kind of support to, like get these children in, we need to do talk with them, like there’s no privacy, confidential, and go through with them how to cope with the pressure and stress …’

(Parent)

Parents express their concerns about the mental health of their children, disclosing that their children have been victims of bullying related to social discrimination.

… ‘I think I want to say we need help with our children mental health. If you can help us with something with that please because their mental health is more important. Otherwise it will come out later in their lives and which is going to be really, really bad for them, so our main concern is my son. When we moved to xxxxx, we had a new school, you know with children, we can’t, we have limited money, we can’t buy branded shoes, or bags or clothes. Then they are being bullied by the other children, so this is also very bad thing for us, when we hear that from our children, we feel very bad. We can’t buy all this stuff. We don’t, we don’t, we are not allowed to work, and then children coming home and saying “oh that children bullying me, or this children did this to me because of my clothes and my things” which is really…”

(Parent)

Children are discriminated against in their local parks. Playgrounds provide a place for inclusive play. Importantly, play provides opportunity for children to communicate and deal with emotions, it can help children overcome trauma.

… ‘Outside after school, daily there have no park play, but those play areas, they get a lot of racist comments, they don’t feel safe to send their children play….’

(Community Service Provider)

Discriminatory behaviours extend to physical violence as well as psychological.
“Yeah, and other people is sometimes older children they’re bullying mostly youngest. So, they’re, what they do, sometimes they punch them, and kick them and then run away. Yeah, psychically bullying and mentally bully also, and he used to come home and ask me that oh this problem happened to me, and I can’t buy branded….”

(Parent)

A service provider speaks out about concerns of discrimination.

“… I think a huge risk is that I mean I feel nervous about having a practice that is a specialist practice for asylum seekers and refugees in a town where there are marches, sort of right wing demonstrations and things and I don’t want people to know, and I think that’s quiet sad really….”

(Primary Healthcare Services)

Some service providers recognise discriminatory behaviours to be community wide.

‘… Mosty people don’t like asylum seekers, or anywhere I can arrange in a community, you know they say “oh, they are asylum seekers” like you know. Children even ….’

(Service provider)

Raising awareness and supporting service providers to deal with of acts of discrimination may support help-seeking behaviours among refugee children.

“… What is clear is that or lack of understanding and empathy with lots of schools, not just secondary schools, primary schools, as well, so, you’ll find the young people children form this community some of them are resorting to violence to try to defend themselves or to try to maybe gain some respect. Because they report it to the teacher and the teacher ignores. We know of the phrase, “no, they didn’t actually really mean it”, this is some, one young person, a child, who has said something discriminatively who has said, bad to speak to reach out, and the child reports it to the teacher, and the teacher says “no, they didn’t actually mean that”…”

(Education Voluntary Community and Support Worker)

All groups share an awareness of the effects of discrimination experienced by refugee children and youth. Group perspectives conceptualise poverty as a key aspect of social exclusion and as a result of systemic discrimination. Both status and poverty present as key factors that contribute to internalising behaviours and inhibit social inclusion. Of concern, the needs of children who internalise often go unmet. Refugee children and youth experience victimisation due to observed indifferences among their peers. Refugee children and youth find themselves in negative social environments. Discrimination is key social determinant of mental health and is associated with anxiety and depression. Among children suffering with trauma, these post-migratory stressors can exacerbate existing mental health problems. Children are unable to benefit from the protective factors that positive social engagement in the community can provide towards growth and recovery. A systems thinking, system wide approach may support improved inclusiveness.
**Theme 2. Pathways**

**Theme 2. Pathways – Sub-theme ‘Access’**

Refugee trauma comes in many forms often as the result of multiple stressful events, and post-migration stressors can influence emotional wellbeing among refugee children and youth. Many services in the system meet the criteria for ‘frontline services’ e.g. asylum teams, housing (i.e. receiving unaccompanied youths), community organisations, and education. When service providers are cognisant to and recognise signs of trauma there seems to be an absence of pathways between services and as a result, a lack of readiness to respond. It is important that presentations of trauma among these groups are recognised promptly and referral pathways made accessible to respond to needs. However, when needs appear to be acute, service providers would benefit from training in dealing with trauma in real time.

A lack of training in trauma, and difficulty accessing mental health support due to unclear or an absence of pathways are found to be a risk factors to the mental needs of refugee children and youth going unmet in the post-migratory setting.

Service providers receiving unaccompanied youths share their perspectives on recognising needs and a lack of readiness to respond among services.

..... ‘There are pathways, but I think it’s probably the same for someone who is not from an asylum seeker background in that the pathways can be quite complex and er, it’s also, erm that the support might not be as readily available as it sometimes would seem to need to be…’

(Housing)

Recognising the signs, knowing where to refer people, when, when we see those signs and ensuring really that people have fast access to those services. (Housing)

Among service providers who recognise mental health support is urgently required, accessing help may mean that trauma symptoms require managing at that service point, to enable both the individual and service provider to cope. Service providers in frontline roles may benefit from training to safeguard both themselves and the young person.

..... ‘I don’t know whether we should include health services, mental health services as part of the assessment process, that initial screening, should we call in mental health, the young person I talked about earlier on, that’s classic and just because someone has not mentioned that sort of trauma it doesn’t mean it hasn’t happened, that person just, that young person chose to share that, when we say “are you well”? And they say not, and they’re rock and, do you see what I mean, sometimes there are indicators, but it doesn’t mean just because someone has not said it doesn’t mean it hasn’t happened…’

(Asylum Team)

Advice on how to manage situations whereby a service provider identifies needs, and there is no immediate pathway to refer.

..... ‘Well what your having there is a young person exhibiting PTSD trauma symptoms in the room with you and they need to be managed, primarily you need to be managing those symptoms primarily and then getting the information that you need, sort of not secondarily, because that’s your prime purpose, but you first of all have to stabilise them in the room. And then, then you can think to get the information…’

(Specialist Mental Health Services)

Community voluntary organisations undertake an active role in supporting asylum-seekers and refugee families with essential, practical and social support. Well versed in understanding the daily stressors and
difficulties that asylum-seeking and refugee families face. Voluntary service providers recognise the need for pathways to be made clear, and a pathway that provides an immediate response.

…‘An immediate response, he needs to be attended, immediate response, that’s what we lack…’

(Voluntary Organisation)

…‘We need a place like a walk-in centre, because making an appointment with talking therapy takes like a week or so, if the mental health needs to be addressed in the moment…’

(Voluntary Organisation)

Voluntary organisations require a network approach with clear referral pathways to other services in the system.

…. ‘A referral system should not be, “here are the details away you go…”

(Voluntary Organisation)

…. ‘If I recognise that (xxxx) has mental health, if I discover that (xxx) is talking things that don’t make sense, the only thing I can give her is a leaflet, you know what this eh talking therapy MIND can actually help you, you know, that’s the most I can do…’

(Voluntary Organisation)

The impact of ‘wait times’ to access mental health support was disclosed by one parent who had witnessed suffering.

…. ‘It’s very dangerous because when someone had suicidal thoughts, and attempts as well, and if it takes normally the procedure 6 week time to diagnose something, anxiety and depression or things. And if, if someone already have suicidal thoughts it mean they are less than fifty per cent chance they can attempt anytime, anytime or harm…’

(Parent of Refugee Children)

Service providers recognise that all services in contact with families and children require the knowledge and ability to access support, that services do not necessarily understand the system.

…. ‘There are some people we know like people who are coming from Syria, who are coming from traumatic experiences, who immediately need help. That needs to be recognised, not just by maybe the GP only, but whoever is in contact with delivering some services, who is contact with these families, any professional needs to be able to say, if it’s a school, if the children are behaving in a certain way the school need to be looking at the children might be needing support, not all these people, they don’t know the system. Because once it’s like that, once all the professionals are aware, about picking systems, and about where to refer people, the pathways need to be clear. (Education support worker in community voluntary services)

For any professional to be able to say “ok, this is what you need to do”, right now I always ask the question, I said “If I come to you and say, I’ve got mental, health help me, where do you, what do you do?” “Right now, tell me, what do you do?” Pillar to post, because nobody is quite clear about the pathway. So people, remember these are volunteers who are enquiring will they have the patience to keep on enquiring? So the pathway needs to be clear…’

(Voluntary Organisation)

‘We have no clarity where to refer people, getting help at the right time’

(Voluntary Organisation)

Voluntary services felt that signposting to other services was not enough, that those suffering with mental health needs require support to access services.
…. ‘A referral system that, a referral system should not be “here are the details, away you go”. Here is the person who is struggling, can you follow up, can you go to their house? Or, can you go meet them at this person themselves cannot come to your service, but they are waiting for people to go to them. Who is going to bring them? Who is paid to bring them? The community can do so much, that’s where the problem is…. ’

(Voluntary organisation)

When individuals were able to access specialist support, a discrepancy in thresholds between refugee trauma, and mental health problems among norm populations was identified among service providers and needs were often unmet.

So, there is an issue there around pathways and support for certain groups, and it seems that there needs to be some staff development as well, around what thresholds look like. (Mental Health Services)

…. ‘They are either too complex for xxx, or too unstable for the therapies that exist, and then it’s just for the GP to manage.’ (Specialist Health Services)

Educators shared their perspectives on wait times to access services.

…. ‘We were just saying about circle time, some of the children will just share things some of their experiences, and you just know that that’s something that needs exploring further, and we don’t have the expertise necessarily within the school to do that, to really delve down, so if those things come to light then that’s something we’d be thinking we need to explore that a little further- we do have staff in school who are not trained therapists, but they can do art therapy or drawing therapy so we can do sessions informally but then we would be looking at where do we go next from there because there’s always a waiting list, we always have lot’s of children who are waiting to be seen by somebody, we try and do something in school while were waiting for something more formal …’

(Education)

…. ‘Whether it’s a mainstream school or a specialist school, there’s very few services now that schools can access to provide that therapeutic support on we’re the psychology service we are banging our heads against the wall because we can’t offer that support, we haven’t got the resources to do it, but we know these children are there and we know that these children and families need that support……’

(Education)

A lack of knowledge around self-referral systems seemed to exist among parents of refugee children and youth.

…. ‘Mums, she thinks like you know, like you now the child has anxiety, and you know all these things like, he doesn’t want to go to GP, but then, she doesn’t know where to go, like no other support……’

(Voluntary Organisation-Interpreting for parents)

**Theme 2. Pathways – Sub-theme ‘Psychosocial Transitions’**

The migration journey involves life-threatening situations that cause stress, trauma and loss. This life-changing event creates changes in ‘state’ requiring psychosocial adjustment. The amplitude of change to someone’s life post-migration is vast, involving a new language, society and culture. This psychosocial situation is one of uncertainty and uncontrollability. To orientate oneself within the new environment and make a successful transition, support with overcoming deficits such as language, unfamiliarity with systems (education system, community; organisations and networks, health services) requires support and guidance. To be able to adapt and use the environmental resources (e.g. to be able to speak to communicate, identify within the community, develop social relationships, integrate into the education system, and navigate pathways to accessing healthcare) the role of a facilitator was discussed among the youth group. This role was defined as ‘Community Champion’. The youth group described how they felt when they arrived in the
UK, who helped them and what would have helped further during the early transitional stage. A Community Champion was defined as an individual who they themselves had experienced migration. Of importance, participants suggest an individual from their home country and speaking their native language to help bridge gaps in communication.

The role of Community Champion was fundamental to the process of psychosocial adjustment, enabling mastery in one’s new environment and opportunity to regain a sense of agency. When asked what would help the most during early transition, help with gaining an understanding of the cultural norms, and to help adapt and adjust was thought most helpful.

… ‘There is so many reason to help people, but the one best one when they come first, teach them first, because you came from a different country, you have different life, you have different social life so, you need to be like this, you need to be like this, you need to be like this, and then that will be helpful for him.’

Participants felt that an individual from their home country would be of benefit to help and support with speaking to communicate, to overcome the language barrier.

… ‘I think the best one like from my country, because if you don’t speak English, you know the English people, they don’t like it, because you have no English you know what I’m saying?’

An introduction to the education system, school rules and behaviour prior to being placed in the education system was suggested among participants to help better prepare for this transition and to avoid making mistakes.

… ‘When they came first, before they go to college, or somewhere because they don’t know that, but then they can’t make mistake. They think their (that) life will be like their country. So they think, they can’t fight with people, in our country they fight people with each other so, they can’t make a lot of this mistake you know, we need to teach that that thing…’

Understanding the rules in the education system was important to participants, in addition to behaviours with fellow pupils, was developing an understanding or behavioural norms regarding communication in the classroom environment. Having the confidence to speak out in class was something that group members raised as difficult, cultural differences inhibited individuals to have confidence to have a voice.

… ‘In my country, you talk to teacher once, the teacher hit you, maybe ‘go out’…”

… ‘Different thing…”

… ‘Yeah different thing, so that’s why it’s not like here…”

Group members shared similar stories…

… ‘When I was in my country, I was making a mistake, just standing, I put, and you raise both your hands out like that’

… ‘For how long?’

… ‘Until the lessons finished…”

… ‘Lesson time..’

… ‘Yeah…”

… ‘So, would it have helped if someone had like I don’t know, told you that, so said if you get it wrong, it’s fine?’

An induction into the school culture, for example, school customs, rules, values, social behaviour and social norms, was suggested by group members. Group members agreed that an understanding of the general school principals would help avoid mistakes.

Accessing services in the community including health services was problematic among the group with the initial barrier being cultural differences in help-seeking attitudes and behaviours. Participants were asked what the best way might be for them to let someone know that they needed help, whether that be about how they were feeling or information, the group agreed that to get help, they needed to be able to speak
out, so that people understood what they needed. This was on reflection of their experiences and was offered as advisory to others in their situation.

…..’When they came first, they to be confident they need to be open mind you know, they need to talk what they want. So if you know that person what he want, he can be ready to help you, be start to help you, because he had bad time or something like that, but if did not talk to you what he want, you can not help him, because you don’t know him. So that’s why…’

Group members shared their perspectives on what would be the best action to take to gain the help of others during the early transitional stage post-migration. The group developed the role of Community Champion, a native speaker with personal experience of migration who can provide language support to assist with communicating with others.

This role would support the development of a number of social factors in an individual’s life. For example, the Community Champion would provide an introduction into the community with the aim to help develop social relationships and networks of support. An induction into the education system and the school environment would be facilitated. Further, induction into the education system supports integration into the community. Positive interpersonal and social relationships in the psychosocial school environment can influence successful adjustment and provide inclusiveness among youth of minority backgrounds. The role of ‘Community Champion’ would help young refugees to transition and adjust, to develop psychosocial wellbeing in their new environment. In addition, the role of Community Champion would be inclusive of developing knowledge of cultural norms related to help seeking and identifying and accessing services in the community.

**Theme 2. Pathways – Sub-theme ‘Working in Silo’**

Multiple service providers describe a lack of knowledge of existing services. An implication of this is silo working, with stakeholders identifying closed-loop communication across services. Service providers recognise the need to overcome information silos through strategic knowledge exchange, collaboration and integration across service systems: education, primary healthcare, specialist mental health services, and voluntary community organisations. Services are described as a collection of silos and fragmented, rather than the sum parts of a collective system.

A coordinated systems approach to increasing and maintaining knowledge of services, roles and responsibilities among service providers is identified as a need.

…..’It comes down to lack of communication, systems, lack of, things are not easily understood…’
(Mental Health Services)

Service providers recognise that they don’t have the capacity to gather information on other services, that there is no formal support in knowledge sharing.

…..’Different services out there are not very well understood in exactly what they offer, who they are, whether the quality of them is known, and I think it is that to me, that appreciation that, I think there’s almost an expectation that you come to understand this, so that you can understand it, and actually I would say, I would sort of question that, I think it’s almost a full time job for somebody or one person, to understand…’
(Primary Care Services)

The complexity of networking and coordinating information across services is considered problematic in terms of time required to develop knowledge.
... ‘I think it’s very under appreciated just generally, and it’s no different for asylum seekers and refugees how many places there are you can refer to, or signpost to and just how complex that is to stay on top of, and understand you know, one of my primary roles as a GP is really understanding what services are there and how to access them, and purely in a medical sense that is an incredible complex task to understand how to refer somebody with what problem and with what information and what help can be provided to them…’

(Primary Healthcare)

Knowledge exchange and knowledge management are considered necessary to help influence the development of linkages across services and achieve joined working.

... ‘You get this kind of informal knowledge base, experience that’s very patchy and this whole ‘silo’ working thing, and it you know, needs specialist commissioning and it’s joined…’

(Specialist Mental Health Services for Children and Youth)

A lack of joined services is identified as a casual factor to silo working and reduced efficiency in service response.

... ‘Partner agencies, the schools, the social workers. It’s a collective responsibility isn’t it? It’s not just …, it’s not just GP’s, it’s everyone’s business, and as far as I’m concerned there’s got to be a cohesive, there’s got to be a glue that holds it all together, to make it more productive, and efficient, to benefit these children. I didn’t know your service existed…’ (Specialist Mental Health Services for Children and Youth)

In addition, the lack of joined working impacts on the service provider’s ability to plan effectively.

... ‘I think when communication between services, the first time children come into school, we don’t have, we don’t get any information. Nothing on asylum seekers, on the admission forms, they go through the same admission as everybody else. We don’t know where they’ve come from, obviously we ask. We don’t ask their background. Not the time or the place when you’re welcoming the family into your school, it’s not the time to say well tell us … it’s not appropriate, so we don’t know what those children have or haven’t seen. Sometimes you might find out, sometimes you don’t. Sometimes the first time we know there’s issues is when the child, sometimes its attendance issues…’ (Education)

Silo working presents as a barrier for some service providers to working with other services.

... ‘In terms of some of the experiences us as a service who support schools with this population, then when we are involved in supporting schools with this population, we’re not confident that we would have a good understanding or knowledge of the landscape across xxx about what’s available, we wouldn’t feel confident that we know who those partners are… ‘ (Education)

An increase in shared knowledge across services related to children receiving care or waiting for care would help service providers to plan for the needs of children in their care.

... ‘The communication is not always great, xxx don’t have to tell us that people are working with them so, we don’t always get the letters, we don’t always know, if we haven’t made the referral we don’t always know. It’s us knowing about these families so that we can support, I think that’s one of the difficulties we have, there’s so many children that we just don’t know about.’ (Education)

In education, the absence of a collaborative network of support services was described as a potential barrier to addressing needs, demonstrating the need for a strategic approach to networking services.

... ‘You said, could a child’s needs be met earlier, and we’ve talked about the training offer, and I do think there’s something to be said whether we’re talking about refugees and asylum seekers or all children, or some of that does depend on the capacity
and the confidence and capability of the staff at schools, but it also depends on the resources network and the school, and that isn’t a stock or core offer…” (Education)

Voluntary organisations discuss a lack of knowledge about other services acting as a barrier to supporting refugee children and youth with referral pathways.

… ’I think there is a huge gap in the knowledge, whether about mental health awareness, or availability of services for asylum seekers. For example, I had a meeting with one community linked organisation in xxxx so they work with asylum seekers and the founder of the organisation was telling me, because they have a lot of mental health issues due to their vulnerabilities. But they don’t even know where to go, and who to approach and who to talk to, and for her even as a founder, she said like “I don’t even know where to guide them to go to”. So, there is a huge gap in knowledge…” (Voluntary Organisation)

A lack of shared knowledge of specific services, roles and responsibilities was discussed as impacting on time and resource.

…..’We’re a specialist mental health service our business is to do with, to respond to those who have got an actual or a developing mental health disorder. That’s our business, but we’re receiving requests for all sorts of things now to do with behaviour, which isn’t our, well it is it’s coming from. We are working hard behind the scenes to try and help people understand what xxxx is about and what our business is…..’ (Specialist Mental Health Services)

Service planning to improve service delivery through increasing coordination between services was discussed from a systems thinking level referring to targeted funding and needs analysis.

… ‘So it’s the CCG understanding what the local authority are commissioning and the local authority understanding what CCG are commissioning and all the other agencies working together to understand what the needs are overall and how we are going to meet those needs…..’ (Primary Healthcare Services)

Increasing linkages and capacity among services was discussed among group members who recognise the benefits of services being integrated.

… ‘Mixing them up a little bit as well, like, you know, xxxx (Voluntary organisation) to have a hot desk within or something within (our service) wouldn’t that be fantastic, the communication line, same with Red Cross, I mean something that I’ve kind of tried to put forward on a number of occasions, but it never really get’s off the ground…..’ (Specialist Mental Health Services)

A systems level approach to developing an integrated service system captures the summary of needs among service providers.

Communication strategy, funding of. We’ve talked a lot about interpretation and how problematic that is, the directory and pathway in and around services, but also how that’s publicized, disseminated to everybody that need to know what the pathway and the services are. Resourcing the therapeutic need and training for, around the things we’ve talked about, a friendly face when you arrive at a school, and you make an enquiry at the desk about – how do I get a school place. I think training for all of us partners involved in supporting. (Education)

Collaborative systems thinking to move away from silo working, taking a multi-agency approach.

… ’I think one of things we all felt very concerned about, is that, the nature of this business is that it should be multi-agency…..’ (Mental Health Services)
Opportunity to collaborate with other services was identified as a need essential to both the service user and provider.

.... ‘I think that’s it’s working at the grass roots level of building confidence, recognition of service, to have an established relationship, and known person, and also to support often volunteer staff, because they’re working in difficult circumstances and they’re often traumatized, some of the stories they hear, they haven’t got the professional training....’ 

(Mental Health Services)

The impact of silo working on service users.

.... ‘I think the most frustrating things for us and the impact it has on the family’s mental health, and on the children’s mental health is accessing mental health services and joining services up....’ (Primary Healthcare Services)
Theme 3. Systemic Working

Theme 3. Systemic Working Sub-theme - ‘Building Relationships’

Social structures and supports are lost when refugee children and youth leave their home country. A supportive social environment is a predictor of wellbeing therefore gaining an understanding of the factors that contribute to this is fundamental to mobilising a collective effort across services to work towards fostering these developments. The ability and capacity to build relationships is related here to help-seeking attitudes (intentions to seek help) and behaviours among refugee children and youth, specifically, to increase knowledge and understanding of what’s required to enable an individual to access relationships with service providers and receive help and support. Refugee children and youth underutilise services in the post-migratory setting. The relationship between service user and service provider is under compromise due to a number of community and societal barriers (e.g. deficits in language, concerns of discrimination and a cultural distance). In addition, refugee children and youth underutilise services due to distrust. These problems would be best considered in the context of the child’s social environment in resettlement to enable service providers to contextualise the factors that inhibit accessing services and relationship building. Participants were asked how they felt when they first came to the UK, what they were thinking or feeling. Participants described feeling anxious when they first arrived, and lonely with no ability to speak the language.

… ‘First of all, I fee like nervous, cause you know, first time, I meet people, speak another language, and you can like, if you like, from your country, you’re not safe and if you wanna leave your country to a new like. When I first came to the UK I feel lonely, when I first time stay…’

(Unaccompanied asylum-seeking youth)

To understand what path young refugees had taken to seek help in the host country and their new community, we asked whom they would turn to if they felt lonely or sad. We asked who a good person would be to turn to, and what service they would access. Participants described feeling afraid to seek help, to speak out about how they felt, and were unaware that talking about their feelings was something that they were able to do.

…. ‘You wouldn’t talk anyone, because you don’t know what will happen to you, you know that need you to be afraid, don’t tell, don’t say that, don’t do that, don’t ask the schedule, just they make you like, it will be too scary you know what I’m saying, we have the idea now, I get the idea now, I can see people who came with us to England, at that time, you have no idea, you are too afraid to talk people, to ask people, to, you know the same feeling, you know what I’m saying…’

(Unaccompanied asylum-seeking youth)

Participants feared the response of others related to disclosing their feelings.

‘We grow up without freedom in our country we don’t have that, so that’s why when we came here, we are like afraid or nervous to ask….’

(Unaccompanied asylum-seeking youth)

Help-seeking intentions demonstrate cultural variations in attitudes. Understanding these cultural differences would enable services to encourage effective help seeking, for example, when an individual recognises, he or she needs help, they know how to access help for needs recognised, i.e. knowing the best person to approach for help.

…. ‘In this country you feel upset you have to talk, for example, in my country, you feel upset, it doesn’t matter, but here if you’re upset you have to talk…’

(Unaccompanied asylum-seeking youth)
The big difference is when you feel upset, you have to talk, for example in my country you feel upset, you feel happy, it doesn’t matter, what your feeling, you know. But here, if you’re upset you have to talk, I’m upset, so I think a couple of times I am cry, I upset, or I cannot…’

(Unaccompanied asylum-seeking youth)

Counselling approaches, needs and safety. A young adolescent shares his experience of counselling, questions asked about the participants mother created an immediate barrier between the child and service provider. Talking about parents takes time and the development of a trusting therapeutic relationship.

‘One woman she came in front of me, she asked me like, like er, harder than home office question…. “Where is mumi?” … I said to her “no, no, no I’m not going to talk to you about this I left there, I live here”, because she asks a lot of questions.’

(Unaccompanied asylum-seeking youth)

Developing trust, service providers share concerns over involving referrals to other services. A systems approach to knowledge sharing across services when dealing with trauma and disclosures may support the development of trusting relationships and confidence in the system.

‘You don’t want them to repeat their stories, you’re trying to refer them, and you get “it’s not us, it’s not us, it’s not us” and the person get’s frightened, and don’t want to anymore, so we tend to listen to people and make them make the decision whether they want to disclose, because they trust us and they come to us, and or you know we try to empower them, so they’re confident enough to, they won’t trust us again.’

(Voluntary Organisation)

Disclosing problems, a matter of time and trust.

‘I think that there’s that lack of appreciation really that the sort of problems that asylum seekers and refugees have, take time, and trust to develop before they can be addressed, before they’re even declared.’

(Specialist Primary Healthcare Services)

The importance of building relationships from the parent’s perspective, understanding and empathy.

‘They are qualified definitely in their expert area, but they are not exactly know about asylum seeker, what I asylum seeker, what is the circumstances they face every day, so they aren’t very expert in this particular area, yeah you know there is more difference if one lady she knows that oh I’m an asylum seeker, so my circumstances, so she can imagine when I’m talking something, and they don’t know, might be they know other are so they don’t know anything about asylum seeker..’

(Parent)

A number of barriers in the host country inhibit disclosure, for some, until support with deficits and differences in language and cultural have been provided trust cannot be established.

‘When I worked in practices for long periods of time I realized that actually it would take them half a dozen appointments before they’d even tell you what they were really bothered about, and this group are more like that because of the language issues, and cultural issues, takes them even longer to sort of reach that point of trust. So it’s almost like these services are focused on the first twelve months but without much real appreciation for what comes after and actually the fact that it’s not just the first twelve months that matter, we’re here and we’re not going to mislead you, we are trust worthy, it’s that bit that’s really missing for me….’

(Specialist Primary Healthcare Services)
Developing social relationships is a basic need and takes time, particularly in a transitional situation post-migration whereby the child or adolescent has suffered great loss and needs to regain a sense of self and safety. Building relationships is a key determinant of initial help-seeking attitudes and behaviours. Participants described cultural differences in acceptability around talking about their feelings, disclosing a fear related to disclosure. Questions around family and parents were considered inappropriate creating a breakdown in communication between the service user and therapist. Young adolescents were unaware that talking about feelings was acceptable.

A Community Champion may have an instrumental role in initiating help seeking attitudes and behaviours among young refugees. This role could facilitate navigation of an unfamiliar system overcoming barriers of language and providing introductory knowledge of the host country cultural norms related to help-seeking, pathways of access and services available. An integrative approach may support therapeutic relationships among asylum-seeking and refugee children and youth. Further, a systems thinking perspective to addressing the problem of ‘building relationships’ to increase help-seeking and service engagement would be of benefit giving due consideration to the child’s needs both internally and externally in the context of the child’s new psychosocial environment.

**Theme 3. Systemic Working- Sub-theme ‘Psychosocial Support’**

A psychosocial approach considers the individual in the context of the combined influences that psychological and social factors have on mental health and wellbeing. In the context of the refugee child in resettlement, this research presents findings in relation to the child’s connections to social groups and the community i.e. social aspects of the individual’s life that contribute to psychosocial wellbeing. Refugee children and youth report multiple post-migratory stressors that represent societal barriers e.g. their social-environmental and economic circumstances related to housing, status and poverty. These factors inhibit children from socially connecting with their peers in the community through fear of discrimination and shame and reduces opportunity to engage in school-based and community-based social activities. Parents report constraints around access and engagement in targeted social activities provided by schools (e.g. breakfast and afterschool clubs and school day trips). The school setting can provide an inclusive environment; however, poverty restricts participation, placing the child at of risk social exclusion and exacerbating mental health problems. In addition to school-based activities, parents report no means of access to social activities for their family in the community.

Accessing and engaging in social activities supports psychosocial development and wellbeing, in the context of the refugee child, enables the child to psychosocially adjust to their new situation. Resettlement is described as a critical psychosocial transitional stage for the refugee child. Therefore, community provision of psychosocial activities in resettlement is of great importance to promote resilience through participation and foster recovery.

When parents were asked whether their children had the opportunity to develop friendships and engage in social activities in the community, parents described difficulties they had faced related to accessing school-based activities. Parents were unable to afford access for their children, this resulted in social exclusion of the child. Parents associated the problem of social exclusion from school-based activities and having no alternative to their child’s health.

…”I mean at school, some schools they er like the do help them but then sometimes it’s hard for them to join extra curriculum after school, because parents can’t afford and that’s effecting our children’s health as well because they do wanna do those activities, to keep them selves like busy but they just go home and they’re not doing anything…”

(Parent)
In addition to being unable to afford access to after school clubs, school trips were also out of reach for their children. Parents describe the emotional impact on their children in relation to their child feeling excluded from their friends.

‘My daughter went to school and erm the school said they’re sending me a letter about hoopla club, and they said you need to pay five pounds, but I can’t afford sometime five pounds, my daughter was crying she said “mummy my friends went the hoopla club” I think the kids need extra funding for after school clubs and other things for trip, something the trip is not free…’

‘I can’t afford the money (school trip) it’s not, it’s like my daughter say all the time “mummy it’s not my fault” she never says that, but I can see on her face, it’s not my fault we came here…’

(Parent)

Parents describe the need for funding to be allocated to gain access to school based activities for their children. Children report feeling embarrassed by their situation.

‘I think we need more extra funding, because some schools primary school after school clubs, and they said that you need to pay five pounds for that after school club and my daughter for after school club. And sometimes kids feel breakfast club they want to, the school said you don’t have a free, you need to pay, but I can’t afford it and kids feel embarrassed…’

(Parent)

The impact of restricted access to school-based social activities is social isolation, children felt socially excluded from their friends and peers.

‘So she feels excluded from her friends…yeah…’

(Parent)

Poverty inhibits access to social activities. Parents suggest funding to access community services for their older children and for their child’s wellbeing. In addition, parents describe how school holidays are spent with no access to engage in social activities as a family.

‘The children can’t fully when they haven’t got access to things. I think for health and wellbeing, er would help erm our children, some kind of like you know with extra funding to support parents with like kind of activities, they can like, maybe like if the asylum seeker like 16 or 17 like you know an older one to join a gym, that will help that child. There are limitations where they can’t do things, or even where maybe as a family, somebody might fund, are there support them like you know in the summer holiday or Easter. All holidays they spend at home you can’t go anywhere. Home, just home…’

(Parent)

To gain an understanding of community engagement among the group, parents were asked whether it was additional or new services that were required to provide access to social activities. Parents felt that financial support to gain access to existing community services would be of benefit to help them and their children integrate into the community. To access what is already available.

‘Just access those kind of activities that the council will have, or the community will have, just give them the opportunity to pay for that child…’

(Parent)

Parents described activities that they felt would be of help to their children and their wellbeing.

‘Kids need more opportunities for gym, any club…’

‘Yeah…’ (General agreement)

‘Exercise club, football club, any other things….’

(Agreement across the group here)

‘That would help the children…’

(Parent)
Among the youth group, participants discussed access they had to social activities in their community and their social connections. The group described limitations, opportunities to develop and establish social relationships were limited to college and a weekly drop-in session held at a voluntary community-based service.

.. ‘No that much, just I think college.’
.. ‘Just the xxxxx.’
.. ‘Just on a Wednesday?’
.. ‘Yeah, just a Wednesday.’

(Unaccompanied Youth Member)

Participants felt that increased access to the drop in would be of benefit increasing their opportunities to engage in sports activities. Overall, participants felt there was not enough opportunity to engage in activities.

.. ‘Do you think it would help to have more of these sessions at the xxxxx?...
.. ‘The xxxxx is very nice, seven days a week.’
.. ‘More opportunity to play sports together, there are so many things, but not enough you know.’

(Unaccompanied Youth Member)

It is of importance to the mental health and wellbeing of refugee children and youth to ensure school and community services are within reach to provide a psychosocial response to their needs. School is at the centrality of the child’s life and plays a functional role in the psychosocial development of the child. Psychosocial activities can increase language learning, reduces stress and facilitate recovery among refugee children. In addition to targeted and inclusive recreational and expressive activities a school can provide, the position of the school in the context of a ‘system’ is integral in facilitating service response across a number of service systems (e.g. healthcare system, community and society) in resettlement. For example, if schools were joined with other services, the school may be positioned as a referral mechanism within an integrated service system.

No access to social activities available at school and in the community related to poverty reduces opportunity to socially connect with others. Social exclusion described by participants is associated with their socio-economic position. Perceived discrimination, shame and a lack of trust among refugee children and youth each represent risk factors to psychosocial wellbeing.

Effective psychosocial support can be built upon existing community resources enabling access to safe social spaces and reduce the problem of social exclusion. In the context of the refugee child in resettlement, engagement in psychosocial activities aid psychosocial transition, promote socialisation and facilitates integration.

Theme 3. Systemic Working Sub-theme 'Integrating Services'

Research outcomes collectively contribute to the problem of a lack of integrated services.

At the point of reaching post-migratory territory the child begins a new journey of adjustment transitioning into a new community and culture, yet with no language proficiency, no knowledge of cultural norms or services provision. This transition is experienced in parallel to suffering with mental health problems such as trauma, depression and anxiety. In addition, the transition into a new community and culture introduces new and additional stressors that impact further on mental health. To integrate into a new community requires the development of social relationships to support the process of psychosocial adjustment. However, this is impacted upon by experiences of discrimination, shame, and poverty resulting in social exclusion. Parents, children and youth report a number of difficulties accessing and engaging with services including a lack of knowledge and understanding among service providers of both post-migratory
situational factors and life experiences. Service provider reports are congruent with these perspectives describing a lack of contextual knowledge related to refugee children and youth and including cultural conceptualisations of mental health. The need to build linkages across services and to establish a ‘shared knowledge’ is a key finding that was thought to be a priority to build resource and capacity across services. To contextualise findings, a systems thinking approach provides a lens with which to explore the determinants of response across a number of services that each represent the sum parts of a ‘local service provision’.

A lack of knowledge of refugee families and children impacts on the preparedness of services to respond to needs.

… ‘I’d like to know about the numbers, quantifying demand, I don’t know how many you’ve got on your GP practice…’
(Specialist Mental Health Services)

A lack of shared knowledge was a key problem across services. Service providers describe the need to orientate linkages across services to improve communication, to establish a shared knowledge base, increased training and develop an understanding of the pathways.

… ‘A communication strategy, funding of. We’re talked a lot about interpretation and how problematic that is, the directory and pathway in and around services, but also how that’s publicized, disseminated to everybody that need to know what the pathway and the services are. Resourcing the therapeutic need and training. So, I think training for all of us as partners involved in supporting…’
(Service Provider-Education)

An integrated system thinking approach is required to network services and reduce silo working with an increased shared knowledge about roles and responsibilities.

… ‘I think knowledge, communication across professionals. You know, what everyone’s doing, you know, why reinvent the wheel when someone’s doing a good job, so I think that’s one of the most vital things…’
(Specialist GP Service-Primary Healthcare)

… ‘We’re not very good at knowing what other people are doing…’
(Specialist Mental Health Service)

A coordinated service response is described as important to position a central support mechanism engaging services in an integrated service approach that provides information of services and pathways.

… ‘I think there’s lot of like different services so we have interpreters, things that we do, things that you do, and that education so, but in terms a central, something centralized where people know, different other services, you know like, xxx, xxxx, or actually somewhere where it’s, there’s much more sort of funding, into that, so that’s there’s, people know exactly where to go…’
(Service Provider-Education)

Service providers recognize the need to raise awareness among services of the problems experienced by refugee children and youth. A shared knowledge and increased resource to develop training for service providers is suggested to achieve a ‘whole system approach’ that delivers a consistent trauma informed service response. Developing skills among service providers to provide psychosocial support across the system was thought to be a priority.

… ‘There’s a lack of awareness and not out of people not wanting to know, because I just don’t think the information is available in the sense of easily accessible and I think if people knew that and had that better understanding it would give a trauma informed care across the board. And so I think there’s something about training for professionals, erm that is around that psychosocial work that goes a long way, because by just you know, talking generally about feelings helps people helps
people, it kind of de escalates a lot of the anxiety, and so just that general chatter about stuff, in different groups in different environments is really helpful…”

(Primary Care)

Building resource and capacity with the implementation of trauma training across services requires a collaborative service response to dealing with trauma among refugee children and youth.

… ‘I think there is scope for, potentially, because there is a training team, would be a package, but would be specifically about trauma, trauma informed care, about what other services can do and what to expect in these different sort of scenarios…”

(Specialist Mental Health Services)

In addition to increasing resource and capacity across services with trauma informed training, training in trauma was thought to be a potential solution to identifying the child’s earlier.

… ‘You said, could a child’s needs be met earlier, and we’ve talked about the training offer, and I do think there’s something to be said whether we’re talking about refugees and asylum seekers or all children, or some of that does depend of the capacity and the confidence and capability of the staff at schools, but it also depends on the resources network and the school, and that isn’t a stock or core offer. Not all schools receive the same in terms of support services…”

(Education -Service provider)

A further advantage of a whole system trauma informed approach is safeguarding service providers from vicarious trauma, supporting service providers whom don’t necessarily receive training in trauma and would benefit from shared knowledge and training to manage implications of disclosures for themselves and their service user.

… ‘Yeah, definitely because I think that’s it’s working at the grass roots level of building confidence, recognition of service, to have an established relationship, and known person, and also to support often volunteer staff, because they’re working in difficult circumstances and they’re often traumatized, some of the stories they bear, they haven’t got the professional training…”

(Specialist Mental Health Services)

This was a finding was applicable to the voluntary.

… ‘Yeah, the voluntary sector, very often that is what happens – have got the least skills dealing with front end issues, erm, yes they’re not being asked to do therapy, but actually they listen to the story, because the story comes out anyway. Need to tell you and that’s how the process goes. Then they don’t know what to do and how to help them and it leaves them feeling powerless. Leaves the other person feeling, well I haven’t really got any further and it just perpetuates the whole thing. There’s no system, often no system of adequate supervision that helps with that…” (Specialist Mental Health Services)

Building confidence among service providers related to how to manage situations whereby service users disclose may be of benefit. Adequate training and established roles within the service system so that referrals can be made.

… ‘I guess it’s thinking, what is your role in that? Because I think what happens is, when people bear sort of saturated, and they feel responsible, they have to do something and actually a lot of time they’ve done it by listening, they’ve done that, and you know they almost need permission to feel that that’s ok, but actually, where they’re going to link people up to so that they can get that support, they’ll want that, and they might not, so I think it’s, it’s thinking that through with people…”

(Specialist Mental Health Services)

A whole system approach to establishing networks and linkages across multiple services was suggested to improve service response in terms of delivery and timescales.
… ‘I think also lack of partnership working I see that more, less sand less, because everybody is worried about funding cuts, my departments gone, I’ve had funding cuts, they don’t have this, this, constantly talking that there’s going to be review so staff themselves are distressed themselves, so nobody wants to sort of engage together work in partnership, because if they build up that partnership everywhere, with people who are in a voluntary sector and the local authority and public sector, I’m sure we can get a lot of things going, moving, you know quicker, and you know you can plan your services better…’

(Voluntary Organisation)

Considering the collective and consistent perspectives on the need to increase service capacity through increased knowledge, resource and the development of linkages across services. These factors represent potential mechanisms of change that would work to improve service response.

In addition to building an integrated service system, the support of a central figure described by participants as a ‘Community Champion’, would aid an introduction into the community, culture and service provision supporting with access and engagement and reducing an underutilization of services. Service providers describe a welcome programme that incorporates an introduction to local service provision. This resource compliments the role of ‘Community Champion’ with a focus on facilitating integration.

….. ‘A good welcome programme is the one that should be focussing on this is what we have, this is the local offer for you, er the local offer involves you know because we are talking about many things including the wellbeing of someone. If all these are embedded in the welcome programme, not just giving someone a welcome programme and saying “here, read this” it doesn’t make sense at all, because the person will simply focus on their asylum paperwork, So a strong welcome programme that gives people information about what they can do, not what they are not allowed to do…’

(Voluntary-Community-Based Organisation)

The need to adopt a whole systems approach was consistently recognised by all with participants describing deficits in service response and delivery that represent the facets of a joined-up service system. Applying systems thinking may improve services response. Responsiveness is a key objective of systems thinking. An integrated systems environment requires shared knowledge achieved through a network of integrated services and interconnectedness between those services and roles. Establishing the determinants of service response has highlighted gaps and opportunities to improve service delivery establishing potential mechanisms of change. A whole systems approach would overcome the problem of working in silo. Further, a whole systems approach with the role of ‘Community Champion’ embedded into the infrastructure would provide an integration model for refugee children and youth supporting a transition into the community, culture and aid access and engagement with services.
Discussion

The aim of this research was twofold 1) to identify the mental health and service needs of young refugees 2) to identify the key determinants of service response. A critical realist informed analysis identified three global themes (Community and Culture, Pathways and Systemic Working). Further, we incorporated a systems thinking approach to interpret findings presenting public health with an informative and pragmatic framework for service transformation. A conceptual orientation of systems thinking is the perspective that considers connections between different sub-systems. In the context of this research, we consider services as sub-systems contributing to overall service response. A key finding among service providers was the need to integrate services, to build partnerships and capacity to develop a trauma and culture-informed needs-led service model. This finding draws on multiple outcomes discussed. In addition, perspectives of service users unveil a number of post-migratory risk factors that support a contextualisation of outcomes with implications for policy and practice. The below discussion is organised into the three analytical themes; 1) Community and Culture 2) Pathways and 3) Systemic Working followed by a summary of service challenges and recommendations.

Community & Culture

Within this theme there are a number of key messages related to community and culture. Limited opportunity to learn to speak the language had broad implications among the youth group. The language barrier created difficulties for young refugees to integrate into the school and community environments as well as access and engage with local services. Language has long been recognised as a structural barrier to integration (Ager and Strang, 2008). Firstly, to address social integration, our participants disclosed that language prevented them from making social connections, reporting feelings of loneliness. Our findings are consistent with previous research reporting language as a predictive factor of social exclusion (Beißert, Gönültas and Mulvey, 2020; Arsian, 2020). Language plays a functional role in the process of peer inclusion (Beibert et al. 2020; Morrice et al., 2019) and provides opportunity to construct social identity and develop a sense of belonging (Verga and Kotz, 2013; Ochs, 1993; Corre-Velez et al., 2010). Given the mental health status of young refugees and multiple losses they suffer (Bronstein and Montgomery, 2011; Fazel et al., 2005; Hayon and Oates, 2020; Colucci et al., 2015) recognising the role of language in the development of social support structures is of fundamental importance as these support structures enable recovery from trauma (Cairns, 2012). Recent research provides evidence in support of early intervention strategies that target host language acquisition, reporting an association between increased language acquisition and a reduction of symptoms of PTSD and anxiety (Kartal, Alkemade and Kiropoulos, 2019). Our participants suggested a ‘learner-centred approach’ to guide desired learning outcomes i.e. learning to ‘speak to communicate’ through engaging in contextual conversational practice. This approach would support social integration and the ability to express needs to service providers. Language was reported a key service barrier among service providers inhibiting children and youth from expressing their needs. Previous research reports language as a structural barrier to help seeking (Byrow et al., 2020). There are also a number of reported barriers related to language services, e.g. availability of interpreters, knowledge of mental health among interpreters and concerns of accuracy in communication. Findings are consistent with recent and current research that positions language as a key service challenge among healthcare services (Franks, Gawn and Bowden, 2020; Harris, Binderi and Sandal, 2020; Satinsky et al., 2019, Robertshaw et al., 2017).

In addition to language, service providers report a lack of contextual knowledge, related to knowledge of refugee trauma and cultural conceptualisations and expression of mental health problems. These reported deficits in knowledge impact on identification of symptoms of trauma and decision-making during consultation. In consideration of the refugee child, understanding the broader context is important, for example, the totality of the child’s situation is of importance to contextualise the problem. Refugee children and youth experience traumatic stress related to war, displacement, flight, migration, resettlement,
acculturation, and often isolation stress due to loss of social support (NCTSN). According to Weinder, (2004) ‘Contextual knowledge’ provides meaningful information unique to the individual that helps to define features associated with illnesses. In education services, service providers described difficulty identifying expressions of trauma and share their concerns that children who internalize may be missed. Research suggests that the role of context in identifying signs and symptoms of trauma requires a departure from misinterpreting behaviors (Cummings, Addante, Swindell and Meadan, 2017). Without this knowledge differentiating between behaviors has been problematic. A context-based analysis of trauma has previously been suggested by Bell, Limberg and Robinson, (2013) to support educators in identifying symptoms of trauma in the classroom environment (e.g. classroom examples of expression of trauma). This approach seems of value to our findings in terms of providing educators a toolkit to guide identification and response to needs. However, our service providers refer to the need to develop specific knowledge related to refugee trauma. Mayor, (2019) posits a strong argument for not aligning pre-existing general trauma training to the needs of refugee children and youth in the educational environment, but to develop specific training that takes into account contextual factors including forms of trauma unique to war, displacement, and resettlement stressors. Beatencourt et al., (2017) compared trauma, mental health needs and service needs among refugee children and host country norm populations, findings support a rationale for service design to be specific to the needs of refugee children and youth. Trauma-informed training specific to refugee children and youth was the most requested area of training among service providers. Consistent with previous findings (Robertshaw et al., 2017; Colucci et al., 2015) service providers recognise that to fully understand the needs of refugee children, knowledge of cultural conceptualisations and representations of mental health (including culturally salient features of distress and trauma) is required. This development area has recently been explored by Figge, Martinez-Torteya and Taing, (2020) who found that expressions of trauma related to certain symptoms of PTSD and culturally specific trauma related problems, were noticeably present in certain domains of functioning and of importance for evaluation. Increased knowledge of culturally specific trauma related problems e.g. ‘key expressions of trauma-related distress’ informed the development of culturally sensitive assessments and interventions.

The mental health needs of refugee children and youth in the post-migration social context were explored during discussions with parents and highlighted a number of risks that represent societal barriers. These barriers were related to asylum-status and socio-economic status i.e. poverty. These stressors caused children and youth to withdraw from their peer groups due to concerns of exposure of status and being discriminated against for their living conditions. Parents were anxious about the impact of these stressors on the mental health of their children. Discrimination is a social determinant of mental health and a predictor of anxiety and depression (Montgomery and Foldspang, 2007). As a result of poverty, parents have less access to material resources, this often segregated their children from peers. This was a prominent finding among parents who recounted their child’s experiences of discrimination and bullying that resulted in avoidant behaviours. Bullying among refugee children and youth is frequently reported (Samara, Asam, Khadaroo and Hammuda, 2019; Correa-Velez, Gifford & Barnett, 2010). Young adolescents had expressed feelings of shame related to their asylum status and socioeconomic status. In the context of social transitions, shame and humiliation are closely connected to social exclusion (Oravecz et al., 2004). Mechanisms of shame production (i.e. a fear of exposure of status and living conditions) produced psychosocial consequences. In this case, parents report their child’s decision to withdraw from social activities. Our findings suggest that societal barriers prevent participation in social activities. A social exclusion perspective focuses on the extent to which a child is participating in mainstream society via integrating systems, i.e. family, friends and school (Berghman, 1995). According to Giacco, (2020) the transitional phase in resettlement described by our youth participants is a critical time point for mental health, accumulating exposure to risk factors contribute to social exclusion posing a threat to one’s sense of belonging. Further, participants subjective social status is a potential risk factor to their psychosocial wellbeing.
Pathways

Knowledge of existing pathways was considered a barrier to access to services across all participants. Pathways to mental healthcare for young people is an under researched area (McDonald et al., 2018) and currently there are significant gaps in knowledge of pathways to care for young refugees. Routes to mental health services are not specifically organised for refugee children and youth and some key messages drawn from the perspectives of all stakeholders are indicative of the need to establish care pathways that are responsive to the complex and often acute needs of these vulnerable groups. This lack of knowledge of pathways is in part a result of a lack of knowledge of services available and highlights the need for education and training on the organizational context of the current healthcare system and referral pathways (e.g. referral sources, open, direct, number of help-seeking contacts and time frames). These barriers contributed to the perceptions of service providers whom often felt a lack of readiness to respond. In education, some schools provide informal bolt on services (e.g. art therapy) during an interim period of what is perceived to be a long wait time to access care.

Among voluntary organisations, service providers recognise the need for an immediate response to the mental health needs of their service users. The contribution of the voluntary sector to mental health crises is not widely understood among service providers. Newbigging et al. (2020) investigated the contribution of voluntary services to mental health crises in the UK and suggested a whole-system approach to engage public health, voluntary and primary care services in a collaborative effort. Service providers felt they had nowhere to signpost service users to, yet identified that support was required to guide service users who often appeared too unwell to initiate the help-seeking process and access care for themselves.

Parents had limited and often no knowledge of mental health referral pathways other than general practitioners who were considered the prominent referral source. Accessing support thereafter was reportedly difficulty due to constrained consultation times with some general practitioners working within limited timeframes, a finding consistent with that previously reported by Robertshaw et al., (2017) among healthcare practitioners. Help-seeking pathways among the youth group were predominantly accessing support through the general practitioner. However, there seemed to be a lack of understanding of the healthcare system and pathways, for example, onward referral to specialist care was not well understood leaving participants feeling frustrated by the system and wait times. In addition, expectations were misaligned and inhibited onward referral to access specialist care, this finding is consistent across recent research (Khan et al., 2020; Kang, Alkemade and Kiropoulos, 2019; Kohlenberger, Buber-Ennser, Rengs, Leitner and Landsmann 2019; Mangrio and Forss, 2017). At present, services responding to the needs of refugee children and youth are not all recognised as refugee services. Service providers identify the need for a more responsive service system. Reconceptualising pathways to ‘critical pathways’ that take into account mental health representations of trauma among refugee children and youth was suggested among stakeholders. Pathways need to be integrated to adopt a whole-system approach, for example, joining voluntary services with education and public health. These routes to services need to be clearly disseminated to support understanding and navigation of the service system.

Participants reflected on their early integration experiences. Of note, was the unanimous voice of the youth group regarding the need for an introduction into cultural norms and systems to better support new arrivals. Participants discussed the difficult transitions they had experienced and shared ideas to problem solve these stressors developing a support role they titled ‘Community Champion’, an individual who had they themselves experienced transitions in education, community, culture and healthcare systems. It was important that the role would be undertaken by a co-ethnic individual, for he or she would help overcome the language barrier and would be able to relate to needs.
The fundamental goal of this role was to facilitate integration. This would be instrumental in supporting the psychosocial accommodation (e.g. psychosocial functioning and well-being) of newly arrived unaccompanied young persons who had experienced and were experiencing life-altering transitions (Anderson, Keith and Novak, 2002).

Service providers report that they often work independent of one another describing silo working. Knowledge of other services was described as ‘patchy’, due to lack of a coordinated communication across services. Silo working often undermines attempts to share knowledge, for example, previous research has demonstrated that if knowledge is not well managed, the result is often a fragmented service response (Meneses and Caseiro, 2018; Bundred, 2010). Fragmentation is reported as one of the most impactful service delivery challenges (Bunger, 2011). Developing and managing knowledge is a network-centric approach that supports the integration and dissemination of knowledge through relationships between services and organisations (Leischow and Milstein, 2006). Public health research has demonstrated the impact of knowledge exchange in developing partnerships between researchers, schools and public health (Brown et al., 2018). A general consensus among service providers was that responding to the mental health needs of refugee children and youth is a collective responsibility, this is consistent with Nasr and Fisk, (2019) who argue that in order to adequately respond to needs, services are required to operate as the sum parts of a ‘system’. A systems approach orientates towards relationships and in the context of the present study, findings give primacy to interrelationships across stakeholders that each form a part the overall service provision described (sub-systems). The construct of centrality of relationships and orientating linkages among stakeholders applies to findings that demonstrate the need to improve service responsiveness through collaborative activity.

**Systemic Working**

Within this theme, participants spoke of their initial arrival, describing feelings of nervousness, loneliness and sadness, with no language ability and no one to advocate on their behalf. We asked participants how they found help for feelings described and what services they had accessed, with the purpose of identifying participant knowledge of services available and help seeking intentions. Participants feared a response to help seeking. This created a delay in help seeking based on a lack of understanding of cultural norms. Our young participants described how asking-for help was new to them. This finding is consistent with a systematic review conducted by Satinsky et al., (2020), who report underutilization of mental health and psychosocial support services as result of cultural differences in help-seeking. Young refugees find it difficult to trust, trust is a key barrier inhibiting mental health help seeking and engagement with mental health services (Byrow et al, 2020; Colucci et al., 2015). Findings are consistent with previous research that found that past experiences, not knowing people well and concerns about truth telling are reasons for mistrust among refugee populations and rooted in the social context of their pre-migration and post-migration experiences (Ni Raghallaigh, 2013). This problem has recently been addressed, Im et al. (2020) propose that services need to be culturally sensitive to the experiences of refugees and primarily focus on building trust.

A key finding was a lack of psychosocial support available to children and youth. Parents felt that their children were unable to integrate into the community due to no access to school and community-based services describing wraparound school services as ‘inaccessible’. The impact of no access to school-based activities resulted in social exclusion of their children. This outcome is the result of societal barriers (i.e. socioeconomic situation of poverty) and situates the child in a position of social disadvantage. Poverty is a key determinant of social exclusion. Although school-based wraparound services (e.g. breakfast club, afterschool club and holiday care) are not formally recognised as psychosocial interventions they provide many of the benefits. The psychological benefits of afterschool clubs are the very factors that determine psychosocial wellbeing i.e. building new relationships, developing a sense of belonging and in an environment that promotes social skills (relevant to an understanding of social norms and school and
educational milieu). School is often the only place that provides opportunity to develop social support structures in resettlement and is central to integration. Children experience a number of important psychosocial transitions through processes of socialisation in the school environment (Pastoor, 2014). Furthermore, after school clubs have been reported to create an environment for building resilience (Frazier et al, 2007). Keating and Ellis, (2007) explored school belongingness and psychosocial adjustment among young refugees in resettlement, school belongingness was associated with lower depression. Schools are often the most influential service system in resettlement (Keating and Ellis, 2007) and instrumental in facilitating psychosocial adjustment and promoting psychosocial wellbeing (Hebebrand, Anagnostopoulos, Eliez, Linse, Pejovic-Milovancevic and Klasen 2016). Current research on wrap-around school models urge school systems to consider such programmes based on the positive outcomes related to socio-emotional wellbeing (Hill, 2020). Gaining access to this non-specific informal psychosocial intervention could work to re-activate protective factors such as peer relations and promote psychosocial healing (Barenbaum, Ruchkin and Schwab-Stone, 2004). The psychosocial school environment should be considered from a broad public health policy perspective to reinforce a systemic effort to promote psychosocial wellbeing among refugee children and youth.

A theme that draws on many of the implications of Phase 1 outcomes and is a key service priority is the need to integrate services. When service providers were asked how they would prioritise service transformation, they described a systems orientated approach to overcoming a number of service challenges reported (e.g. silo working, a lack of shared knowledge, an absence of knowledge exchange, a lack of awareness of pathways, a lack of critical care pathways and the absence of a core training offer to build capacity in on refugee trauma and culturally informed practice). Of importance are the experiences of voluntary service providers who demonstrate an in-depth knowledge and understanding of post-migratory stressors, mental health problems and often witness trauma. Not only would this tacit knowledge be of benefit to increase contextual knowledge among other services in the system but may support the development of new pathways between voluntary service providers and mental health support services. Participants suggested that a shared awareness of ‘needs’ across services could inform commissioning and target funding of service developments. Some of the key elements of systems thinking are; identification of causality (i.e. influence of interconnected parts of a system) interconnectedness, feedback loops (guiding adjustments) and systems mapping (used to identify interrelated elements of a system to develop interventions or policy decisions) (Westover, 2020). Some types of integrative processes will be more important than others, for example the goals of integration among service providers were to develop joined working to establish structures that support collaboration and coordination to improve service response by way of identifying needs, improving knowledge of pathways, developing pathways between services and building collective capacity by increasing knowledge in refugee trauma and cultural differences in mental health. An integrated needs-led service model has recently been developed demonstrating a departure from traditional service structures with the development of cross-cultural trauma informed training and a new model of service delivery with linkages between resettlement services and mental health services (Im et al., 2020). Evaluation of this development shows significant improvement in service provider’s knowledge of trauma impacts, cultural expressions of trauma and has supported culturally responsive trauma informed care bridging gaps across service providers in community services and healthcare (Im and Swan, 2020). Trauma informed care was regarded as the most helpful and the most sought-after training among partners. The authors propose that culturally responsive trauma informed approaches bridge gaps and overcome silo working. We undertook a systems thinking approach to consider services as the sum parts of a system and to understand the complexity of findings. This practical approach positioned services (e.g. education, community (voluntary), healthcare, mental healthcare and public health asylum teams) as the sum parts of a whole system enabling a contextualisation of causal factors that contribute to service response. We propose integrating services to achieve a needs-led service model that operates as a ‘system’. Systems thinking plans for potential implications of interactions between sub-systems and requires interdisciplinary
thinking, as well as stakeholder engagement of those who have a stake in the outcome and can set a course of change. Applying systems theory to research outcomes positions the service user at the centre of a multi layered, interconnected and interrelated service model. Service challenges and service recommendations are presented in figure 5. ‘Integrating services to overcome service challenges and improve service response’.

**Figure 5.** An organisation of service priorities: Considering all services and their relatedness to the service provider.

In addition to the service developments presented in figure 5, a summary of participant led outcomes are highlighted as insights for future developments in policy and practice that promote social integration:

**Participant led outcomes:**

1. A Learner centred approach to language learning
2. The role of Community Champion to facilitate transitions and access to services
3. Increased access to school and community-based services that provide opportunity to engage in psychosocial support activities.
Conclusion

The mental health needs of young refugees need to be considered within the context of their migration experience. Post-migration is a critical time involving a number of transitions that can exacerbate mental health problems. The shared experiences of young refugees have increased knowledge of the psychosocial needs of children and youth during early resettlement and provided a needs-led support programme to facilitate these early transitions in; education, community, social and healthcare. Insight into service user and service provider experiences highlight a number of service challenges that impact on service response. Two key development areas identified were training in refugee trauma and cultural conceptualisations of mental health. A key outcome is the consensus among multiple stakeholders that services need to integrate to operate as a system. A systems approach to addressing service challenges is proposed as a strategy to develop an integrated needs-led service model. Findings have implications for Phase 2 of this research project whereby stakeholders are invited to consider service priorities and operationalise outcomes.

Phase 2: The Co-production of an Integrated Needs-led Service Model

Stakeholders participating in this research are invited to come together to form an interdisciplinary working group to co-produce a needs-led service model. Key findings presented within this report will be addressed taking a systems orientated approach to develop an action plan that's both realistic and feasible for implementation.


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