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Mental Health of Refugee Children and Youth: Epidemiology, Interventions, and Future Directions

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Keywords

refugee, children, youth, unaccompanied minors, mental health, interventions

Abstract

The number of refugee youth worldwide receives international attention and is a top priority in both academic and political agendas. This article adopts a critical eye in summarizing current epidemiological knowledge of refugee youth mental health as well as interventions aimed to prevent or reduce mental health problems among children and adolescents in both high- and low-to-middle-income countries. We highlight current challenges and limitations of extant literature and present potential opportunities and recommendations in refugee child psychiatric epidemiology and mental health services research for moving forward. In light of the mounting xenophobic sentiments we are presently witnessing across societies, we argue that, as a first step, all epidemiological and intervention research should advocate for social justice to guarantee the safety of and respect for the basic human rights of all refugee populations during their journey and resettlement. A constructive dialogue between scholars and policy makers is warranted.

INTRODUCTION

The global refugee population has steadily increased in size over the past several years and, consequently, receives considerable attention from international media and policy makers. In 2017, the number of refugees worldwide was at an all-time high of 25.4 million; children and youth under age 18 constitute more than half (52%) of this population (97). A refugee is defined as "someone who is unable or unwilling to return to their country of origin owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion" (96). Currently, almost one-third of all refugees are victims of the civil war in Syria, with large numbers also coming from Afghanistan and conflicts in African countries (97). Roughly 85% of refugees currently reside in countries in developing regions of the world, including Turkey, Pakistan, and Uganda (97).

This article presents an overview of current knowledge of the epidemiology of mental health and psychosocial well-being of refugee children and interventions designed to prevent or ameliorate mental health problems among youth. We first present a framework for understanding risk and protective factors for refugee youth mental health, what is known about the prevalence of mental health problems of refugee youth in both high (HICs) and low- to middle-income countries (LMICs), as well as information on the trajectories of youth mental health over time. Specific to interventions, we describe work being conducted with different age groups on individual, family, and community levels in refugee camps and countries of resettlement. We highlight current challenges and opportunities in refugee child psychiatric epidemiology and mental health services research and present recommendations for moving forward.

EPIDEMIOLOGY

Conceptual Framework: Life Course Epidemiology and Mental Health

A life course approach to mental health consists of examining the biological and social/environmental processes and risk factors that occur during childhood that impact the risk of onset and persistence of psychiatric disorders (5, 41, 43). The social environment, including factors such as socioeconomic status, family relationships, and exposure to stressful events, is dynamic and changing throughout childhood (35). Within the context of a life course approach, becoming a refugee often encompasses a series of experiences that can, on their own, increase risk for mental disorders; in addition, the experience of being a refugee can also lead to exposure to other stressors and adverse events, such as witnessing or experiencing violence, that negatively impact mental health (85, 87).

Historically, research on refugees focused largely on identifying causal relationships between exposure to premigration violence and adverse mental health outcomes; in more recent years, there has been an increase in interest by researchers to broaden investigations to also explore the impact of chronic, daily stressors experienced in resettlement (51). Family- and community-level risk factors for mental health problems among resettled refugee youth include being unaccompanied or living in a single-parent household, having parents with psychiatric problems or who have been exposed to violence, economic hardship, perceived discrimination in the host country, and exposure to postmigration violence (29, 66). Challenges related to adapting to a new culture may create intergenerational conflict in refugee families and cause youth distress (46). Refugee youth underutilize mental health services for reasons such as lack of knowledge about host country services, stigma around mental illness, linguistic obstacles, and lack of cultural sensitivity of service providers (i.e., availability of interpreters/cultural brokers, training of clinicians) (74, 76). Broader societal-level factors unique to individual countries of resettlement, such as policies around refugee claimant detention and access to health care, may also have an impact on youth mental health (29).

We argue that given the recent upsurge in antirefugee sentiment in many countries (15), more research should focus on identifying refugee youth exposure to aggressive discrimination and traumatic events after resettlement. Hostility toward and hate crimes against refugees, in particular those from predominantly Muslim countries, mean that current psychosocial functioning of youth may be affected by not only premigration but also postmigration violence and loss (4). In addition, too many studies still assume that resettlement countries are safe and afford appropriate protection to refugees, rather than adopting a systemic perspective that incorporates the structural violence and discrimination that refugee families endure. In a context of mounting xenophobia and antirefugee sentiments, researchers' careful documentation of the adverse effects of antirefugee policies and institutional procedures is absolutely key to supporting advocacy efforts and protecting children's basic rights.

Of particular interest in life course epidemiology is an examination of the pathways in which exposures impact health. Pathways include the accumulation of adverse exposures over time or a chain of risk in which a specific exposure triggers other risk factors that lead to disease (43). Exposure to adverse experiences such as becoming a refugee has an impact on mental health via both biological and psychosocial mechanisms. Stressful experiences trigger adverse physiological and psychological responses (17, 31), which, when experienced frequently or over long periods of time, lead to a prolonged activation of the stress response system that becomes deleterious to health, known as "toxic stress" (83). Toxic stress can have a lasting effect on brain structure and functioning, resulting in cognitive deficits and increasing susceptibility to poor mental health (38, 47, 48). Exposure to adversities can also alter psychosocial functioning, which impairs coping ability and increases vulnerability and susceptibility to future stressors, leading to adverse mental health outcomes (34, 86).

Central to a life course approach is a focus on time, in terms of being explicit about the temporal order of exposure to risk factors and the mapping of these exposures onto developmental periods (5, 43). The temporal order of exposures is important because it helps explain the causal process by which exposures lead to disease risk (43). The application of a developmental framework is also critical because individuals may be more vulnerable to the negative impact of exposures during certain phases of childhood; in addition, early-childhood exposures can have consequences on developmental processes that go unnoticed until youth are older or become young adults (35, 82).

A life course approach to displacement and refugee youth mental health requires additional consideration of the phases of displacement as an important time axis (85). The displacement experience is characterized as including preflight from place of origin, flight from home and living in transit or transitory placement, and resettlement in a new location or returning home (46). The timing and duration of these three phases can be critical to the mental health trajectories of refugee youth. For instance, exposure to the stressful experience of fleeing home during more sensitive periods of development may increase risk for psychiatric disorders. Thus, while the temporal ordering of exposure to risk factors is important when examining the mental health of refugee youth, so is taking into consideration the timing of these exposures within both developmental and displacement contexts.

Mental Health Challenges and Trajectories

In the past few decades, research on the epidemiology of refugee mental health in general, and youth more specifically, has expanded considerably. More than a dozen systematic reviews have now been published on the prevalence of mental disorders among refugee populations (92). These reviews are typically structured on the basis of refugee country of origin or residence, age groups, or refugees of particular legal status. Bronstein & Montgomery (11) reviewed 22 studies on

the mental health of refugee youth living in HICs. Prevalence of post-traumatic stress disorder (PTSD) ranged from 19% to 54%, with an average of 36% across samples; specific to depression, prevalence ranged from 3% to 30%, with an average of 18%. To our knowledge, Bronstein & Montgomery's work is the only published systematic review on the prevalence of mental disorders that focuses exclusively on studies involving refugee children and adolescents. Another review by Fazel et al. (30), conducted on refugees of all age groups residing in Western countries, included five youth surveys. These youth studies focused on PTSD, with an average prevalence of 11%.

There is much less information on the prevalence of mental health problems among refugee youth living in LMICs. This lack of data is a serious shortcoming, given that the vast majority of refugee populations in the world today reside in refugee camps or are resettled in lower-income, non-Western countries. One review specific to youth mental health in these contexts (66) notes that the prevalence of psychological problems among refugee youth in LMICs is higher than in local populations. A primary challenge to obtaining overall prevalence statistics is the lack of consistency and diversity of outcome measures used by researchers in these settings (66).

Relative to the overall body of literature on refugee youth mental health, there is a dearth of information on the prevalence of psychological disorders and distress in the youngest refugees. The few studies that do exist suggest that, among refugees aged 8 years and under, up to 80% experience problems that include depression, anxiety/PTSD, and behavioral challenges (52). Comparatively, the age group that has received more attention is adolescents; numerous studies have looked more specifically at the mental health of unaccompanied minors, who are acknowledged to be at particularly high risk for mental health problems (37). They are at a greater risk of abuse and exploitation compared with accompanied youth (25, 45, 62, 98).

One of the challenges in refugee youth psychiatric epidemiology is the lack of prospective longitudinal data. The studies that do exist typically follow up with youth 1–3 years after baseline assessments. Although this approach is certainly better than having no information, it provides limited insight into long-term psychosocial functioning of youth into adulthood and prevents researchers from identifying causal mechanisms of change. To date, one of the longest follow-up studies (12 years) specific to refugees who were children and youth at the time of third-country resettlement was conducted by Sack et al. (78) among Cambodian refugees in the United States. A recent systematic review on longitudinal studies of PTSD among refugee youth found that symptoms and diagnoses of PTSD are relatively consistent over time (90).

Identifying Health Disparities

An important issue in refugee youth psychiatric epidemiology is whether, and the extent to which, there are disparities in the mental health of refugee children and youth compared with other migrant groups and host-country peers. Information on health disparities has implications for policy makers and program developers when considering the service needs of refugees relative to other at-risk youth. As evidenced in the section above, estimates of psychological distress among refugee youth vary widely. Some of this variance may be due to measurement issues, with researchers using assessments with diverse cultural groups that have rarely, if at all, been involved in psychiatric research prior to becoming refugees (6). Studies may over- or underestimate the prevalence and severity of mental health problems when assessments are not culturally valid or reliable (33). Equally important is the fact that refugees are far from a monolithic group, with real differences in psychological distress based on the presence or absence of a myriad of risk and protective factors shaped by the uniqueness of refugee experiences around the world (46).

Studies that focus on identifying health disparities use different comparison populations. For refugees who have undergone third-country resettlement, comparisons are frequently made with

the host-country's general population or other immigrant, but nonrefugee, youth (11). In these studies, it is difficult to disentangle associations found between refugee status and mental health from the association between the larger context of forced displacement (war and political conflict) and psychological distress. Some studies have attempted to overcome this challenge by comparing the mental health of refugee youth who have returned to their countries of origin with other war-affected but nondisplaced youth from the same conflict (29). Taking into consideration the diversity of refugees and comparison groups, the presence and magnitude of mental health disparities among refugee youth can vary considerably from study to study. Researchers generally agree that, overall, refugee youth have poorer mental health than do youth in host-country populations (11, 37, 66). Studies that compare refugee youth to other war-affected populations are less conclusive about short- and long-term disparities in mental health (29).

INTERVENTIONS: EARLY CHILDHOOD (AGES 0–4)

Treatments for refugees, specifically those targeting young children, and inevitably their families as well, must be coordinated and comprehensive (9, 56). The National Child Traumatic Stress Network outlines key ingredients when attending to the mental health of refugee children: trauma-informed treatment, strategies for access and engagement of children, provision of culturally competent services, and strategies for coping with resettlement stressors.

Protective factors for young refugees are situated on individual (for example, emotional regulation), family (e.g., caregiver mental health, secure attachment, and social support), and community levels (10). Positive parenting has been shown to buffer the effects of stressful situations (e.g., stress regulatory system), which can have long-term impacts on overall health (42). Despite limited data on infant and early-childhood mental health among refugees, prevalence of impaired mental health and functioning in adults and caregivers raises a high probability of increased risk for poor mental health outcomes in young children (94). Therefore, interventions for young children should target the child's larger social ecology by placing their development and recovery in the context of their caregivers' and larger community's well-being. As in other migrant groups, addressing maternal depression should be a priority. Mental health interventions for young refugee children should utilize a range of strategies, including ecological approaches that involve caregivers, are home based, or are delivered in school settings where young children have increased interactions with teachers, counselors, and social workers. Interventions that represent an added burden for the parents or caregivers may be counterproductive, as are parenting courses, which are often perceived as reflecting the prejudices and normative practices of the host society. For these reasons, embedding early-childhood interventions within extended social networks, schools, and the larger community is beneficial.

Young Children in Transit

Most of the information on mental health interventions for young refugee children in transit focuses on basic monitoring and evaluation trends (i.e., beneficiaries reached) versus outcomes related to effectiveness. War Child Holland (**https://www.warchildholland.org/psychosocial-support/**) has a strong presence in refugee camps providing protection and psychosocial support to Syrian refugees in Lebanon, including caregiver support interventions that target parental well-being and parenting skills as a way to improve the psychosocial well-being of children; child-friendly spaces so that children can access psychosocial supports and participate in recreational activities; and the provision of early-childhood education opportunities for Syrian refugees under age five. The World Health Organization (104), recognizing the prevalence of perinatal depression

and its link with child development, created the Thinking Healthy Program (THP) for use in low-resource settings, humanitarian crises, and refugee camps. THP utilizes several approaches, including psychoeducation and cognitive behavioral therapy (CBT) and is created to be a low-intensity intervention that can be delivered by community health workers who do not have prior mental health experience. Evidence supports the effectiveness of THP when delivered to women with perinatal depression in rural Pakistan (65) with a goal of integrating the program into primary health care in refugee camps.

Resettlement

One family-level intervention for the postresettlement context, PRECURE 0–3, combines elements of narrative exposure therapy (NET) to address maternal trauma along with a review of dyadic interactions between mother and child via home visiting to support responsive parenting behaviors (94). Together, these two elements address the trauma sequelae in refugee mothers while assuming a preventive approach to addressing mental health in children. Although clinical results of PRECURE 0–3 are not yet available, research supports the effectiveness of parenting and family-level interventions on child mental health and functioning (63, 64). School-based interventions also hold promise for the youngest refugees. In Canadian preschools, creative expression workshops led by art facilitators were used as a way for immigrant and refugee children to create visual representations of their emotions (73). Analyses using pre- and postintervention data indicate that youth participating in sand play demonstrated reductions in emotional and relational symptoms according to parent reports.

INTERVENTIONS: SCHOOL-AGED YOUTH (AGES 5–17)

Several recent systematic reviews have highlighted interventions aimed at school-aged refugee children (26, 27, 57, 88, 93). The majority of intervention research with this age group has taken place in HICs, with a few focused on refugee youth in transit or living in LMICs. These interventions include individual psychotherapy, family-oriented programs, school-based work, and multimodal/multilevel approaches.

Youth in Transit

Although refugee camps are supposed to be temporary solutions, in many cases they become long-term housing for families and youth. Thus it is important to provide support to children and families in these low-resource environments. Unfortunately, family-based, ecological interventions for school-aged youth in refugee camps are limited. One such intervention, the Common Elements Treatment Approach for youth (CETA-Youth), was implemented and evaluated in Somali refugee camps on the Somali/Ethiopian border (53). CETA teaches CBT elements common to evidence-based treatments (EBTs) for different mental health issues (e.g., depression, anxiety, trauma) and combines treatment elements based on the needs of youth and caregivers. It consists of 6–12 weekly sessions with the child and caregiver and is delivered by lay providers. CETA seems to be a promising way to reach, scale up, and sustain mental health services in LMICs. The intervention was effective in reducing symptoms of internalizing and externalizing disorders, as well as PTSD (53). Another intervention approach being used with war-affected youth is the Youth Readiness Intervention, which comprises an adapted group CBT intervention integrated into both school settings (8) and youth employment/entrepreneurship programs. A randomized controlled trial indicated significant effects on emotion regulation, daily functioning, social support, and prosocial attitudes and behaviors (8).

Two other individual-level interventions piloted in refugee camps are worth noting. The Writing for Recovery (WfR) short-term group intervention was implemented in a refugee camp in Gaza with adolescents aged 12–17 years (44). WfR is a manual-based group intervention targeting adolescents with a history of trauma and does not require professional mental health workers, making it a suitable intervention in low-resource settings. Adolescents who participated in the intervention reported lower post-traumatic symptoms and depression at follow-up. A second intervention, focused on educational support, also addresses psychosocial issues among refugee youth. Al-Rousan et al. (1) offered full university tuition and a monthly living stipend to a group of Syrian refugee youth living in a camp in Jordan. A mixed-method evaluation of this intervention showed that the benefits went beyond academic and financial outcomes and promoted the psychosocial adjustment of adolescents. There is potential for interventions aimed at providing concrete educational and economic support to also prevent or ameliorate mental health problems among refugee youth.

Resettlement

Interventions are needed for asylum-seeking youth as early as possible after resettlement, starting at temporary shelters, which are increasingly becoming an obliged step for asylum seekers in HICs. The shelter environment is rife with instability and stress, and cost-effective strategies are needed to support children and provide some sense of safety and normalcy. Psychological first aid (PFA) is one promising practice. PFA is defined as the provision of human, supportive, and culturally appropriate support in postcrisis settings with the aim of reducing emotional distress and negative mental health consequences (103). These early interventions were thought to be a way to overcome the lack of evidence and potential for harm of individual debriefing, which resulted in the inappropriate application of Western mainstream psychological practices with diverse populations (68, 102). In this sense, PFA intervention should be careful to work to nurture and supplement healing elements within the local culture and support network. Although promising, evidence-based findings around PFA in the scientific literature are still scarce (84). A preliminary evaluation of a PFA intervention based on creative expression workshops in temporary shelters for refugee claimants in Canada indicates that it is effective in creating a sense of safety and security among asylum-seeking youth (75).

Individual Psychotherapy

With some adjustments, individual therapies for refugee youth have been used in both HICs and LMICs; in general, these therapies require more resources than may be feasible in low-income environments, and there is less evidence of their effectiveness in these settings. Trauma-focused cognitive behavioral therapy (TF-CBT) is a first-line treatment for PTSD and multiple complex traumas in children and adolescents (14, 54), although evidence with refugee youth is still scarce. NET is an intervention for traumatic stress disorders (80). A short-term variant of CBT with a trauma focus, NET has shown to be an effective intervention among adult refugee and asylum seekers with PTSD in HICs (58) and has shown to reduce PTSD symptoms among children (69). KIDNET—an adaptation of NET for children and adolescents—was piloted among traumatized refugee children aged 7–16 years living in Germany, and participants showed significant improvement in psychosocial functioning that remained stable at 12-month follow-up (77).

Other researchers have compared the effectiveness of child-centered play therapy (CCPT) to TF-CBT with traumatized refugee children ages 6–13 who were enrolled in an elementary school in the United States. TF-CBT is an evidence-based manualized treatment for traumatized children and their parents (13), whereas CCPT is a manualized program of sessions focused on

the use of specific toys and therapists' positive regard and empathy to allow students opportunities to communicate their thoughts, feelings, and desires (88). Outcomes of the randomized controlled trial found that both therapeutic approaches decreased the severity of PTSD symptoms in youth according to parent and child reports, with no significant difference in effectiveness for either modality (81).

Family-Based Interventions

Given the relationship between family functioning and youth mental health, interventions situated in families and that target the well-being of entire refugee families are needed. Youth CAFES is an adaptation of the Coffee and Family Education and Support (CAFES) community-based multifamily intervention for families of early and middle adolescents aged 11–15 years (101). Refugee families are provided with information on parenting, trauma, mental health, and available services. Support groups are facilitated by refugees who are trained and supervised to conduct work in community settings. The goal of the intervention is to prevent high-risk behaviors and school dropout among youth. Recently, Betancourt et al. (7) completed a pilot of an adaptation of the family-based prevention intervention designed for refugee families [Family Strengthening Intervention–Refugees (FSI-R)]. The FSI-R is a home-based intervention delivered by refugee community health workers in approximately ten sessions. Each session covers topics such as improving communication, navigating the US education system, and learning positive parenting strategies.

School-Based Interventions

Although the involvement of the family is important when working with refugee youth, caregivers may not be able to be involved owing to personal resistance or practical issues (e.g., work, other resettlement concerns). Hence, it is important to also direct attention to other contexts in which youth are embedded (e.g., school, community). Barrett et al. (3) evaluated an anxiety prevention and emotional resiliency program (FRIENDS) among a young, diverse, non-English-speaking mixed-migrant population (approximately half of whom were refugees) ages 6–19 in Australia. A cognitive-behavior program, FRIENDS promotes important personal development skills such as self-esteem, problem-solving, and self-expression of ideas and beliefs. It also serves to teach children and adolescents how to cope and manage anxiety and depression. Students enrolled in the FRIENDS program exhibited significantly greater self-esteem, fewer internalizing symptoms, and a less pessimistic future outlook compared with wait-list participants at both post intervention and at six-month follow-up (3). In a separate study, Fox et al. (32) piloted an eight-week school-based program designed to reduce depressive symptoms in Southeast Asian refugee children ages 6–15 who were attending an urban public school in the US Midwest. A form of cognitive-behavioral interaction was used for refugee youth and took place after school for one hour, for eight continuous weeks, where strategies such as showing and telling of ethnic traditions, role playing, drawing pictures to express feelings, and completing personal strengths checklists were used. Fox et al. (32) found that symptoms of depression among participating children significantly decreased from pre- to postintervention.

Mentoring Programs

Culturally sensitive mentoring programs may enhance the adjustment of diverse at-risk refugee students entering the school system and promote their sense of belonging (72). A recent review of mentoring projects with immigrant and refugee children suggests that both same- and cross-cultural mentoring relationships can be beneficial, although mentors' training and cultural

competence may influence the quality of mentoring relationships (61). Of the 17 studies reviewed, 6 specifically discussed evaluations of formal mentoring programs. However, several design limitations as well as the lack of specific studies with asylum-seeking or refugee populations compromise the validity of results with this population. Rethinking how to approach refugee youth's host language development in resettlement countries is also a challenge, in and out of school. An ethnographic case study evaluated a community-based initiative in the form of a summer camp for immigrant and refugee middle and high school students in the United States (89). The summer camp was based on a distributed mentorship model and was effective in creating favorable conditions for English language development as well as a sense of belonging and social ties within the community.

Multitiered or Multimodal Interventions

Flexible and multimodel community-based, tiered interventions are needed for refugee youth (67). Developing these types of interventions requires coordination among individuals, communities, and service providers, which is challenging owing to a lack of resources. Indeed, as suggested by Kirmayer (39), when it comes to refugee populations we face "a failure of imagination on behalf of the psychiatric system" (p. 167). Nevertheless, some examples of promising and innovative multimodal interventions span individual, family, school, and larger social systems of influence on youth mental health (2). Specific to the United States, Project SHIFA (Supporting the Health of Immigrant Families and Adolescents) is a multitiered intervention developed for Somali and Somali Bantu refugee youth and families. The program consists of prevention services for the entire Somali community, school-based services for at-risk youth, and individual trauma systems therapy for youth with psychological distress. Evidence indicates that youth who participated in all tiers of the program showed improvement in mental health (23).

A number of promising interventions were developed in the United Kingdom. For example, O'Shea et al. (60) examined a school-based mental health service established to help psychologically distressed youth ages 7–11. Teachers identified pupils with psychological difficulties and referred them to an outreach mental health worker for individual and family-level therapy, which was offered on site. Overall, children who participated exhibited a reduction in internalizing and externalizing symptoms. Fazel et al. (28) studied a program of wrap-around school-based services. The intervention utilized a consultation framework in which teachers referred students to a mental health team to implement and monitor the effectiveness of classroom-based interventions (88). Mental health teams also provided family-level support, group work, and individual psychotherapy, as well as in-home treatment. Participants experienced a reduction in hyperactivity and peer problems from pre- to postintervention. Finally, another UK-based intervention focused on refugee youth, ages 3–17, who were identified by school personnel as struggling with psychological distress. Youth were provided a variety of treatment options, including individual and family-level therapy, as well as referred to outside agencies for additional problem-solving and concrete supports (19). Researchers reported that three-quarters of students who participated demonstrated improvement pre- to posttreatment, as reflected in reduced PTSD and depressive symptoms (88, 93).

INTERVENTIONS: UNACCOMPANIED MINORS

Unaccompanied minors have unique risk factors for psychological well-being, including limited adult social support networks and precarious legal status. In HICs, the provision of accommodation and services to this population is the responsibility of regional or national child welfare agencies or immigration authorities and can be devolved to private or voluntary institutions

(16). Placements include foster care, kinship care, shared housing, independent housing, or group homes. Unfortunately, in contrast with United Nations High Commissioner for Refugees (UNHCR) policies (95), unaccompanied minors are detained in many European and North American countries (49). Reception and detention centers have been denounced for their unsafe and unhealthy conditions, which threaten child development, as well as for the inadequate screening, support, and legal representation offered (12, 21, 55).

Residential Setting

Although not an intervention per se, some research has focused on differential health outcomes of unaccompanied minors in HICs based on the type of residential placement (59). Evidence indicates that unaccompanied minors living alone or in detention centers have worse mental health than do those placed in accommodations with dedicated support, such as foster care (59). Consistency in care and the establishment of new relationships and social support networks may help youth overcome past trauma and mental health issues. Within the context of foster care, culturally sensitive placement (e.g., foster parents and/or presence in the house of other children from the same ethnic background) is associated with better mental health outcomes. Foster care for unaccompanied minors in LMICs, specifically in refugee camps, may be very different. A recent study conducted at Tongogara refugee camp in Zimbabwe found few requirements and standards established for foster caregivers (50). Provision of follow-up care and monitoring by service providers was rare, and youth placed in foster care were often at higher risk of neglect and abuse than were biological children in the same household (50).

Limitations on studies of residential placement include the use of convenience samples, observational, cross-sectional study designs rather than randomized trials, lack of participant demographic data and relevant life experiences, and reliance on youth self-report of psychosocial well-being and functioning. Despite these limitations, the findings challenge HIC governmental policies that favor foster care placement for higher-functioning and younger children and independent or shared housing for older adolescents and those with more mental health challenges. Continuity of care and support may be crucial for all unaccompanied youth, regardless of age and level of psychological distress. In addition, it may be important to develop and maintain links between youth and their ethnic community. Finally, best practices in residential placement should be customized to different contexts (resettlement versus refugee camps) and countries (HICs versus LMICs).

Individual and Community-Based Interventions

A recent scoping review on psychotherapeutic interventions with unaccompanied refugee minors analyzed results from 17 studies (18). Researchers used a variety of psychotherapeutic interventions, such as CBT as well as trauma-focused, systemic, transcultural, and multimodal approaches. Although interventions had some beneficial effects, most were case series or case studies; out of three quantitative studies, only one was a randomized controlled trial of a school-based CBT with a small sample of both accompanied and unaccompanied minors (20). More evidence is needed before any conclusions can be drawn on the most effective psychotherapeutic interventions for this population.

An important element of successful resettlement is the development of relationships between youth and individuals in their new communities (71). A UK-based photovoice project was developed to empower unaccompanied minors living in foster care and to promote positive engagement and dialogue within the minors' community (71). Adolescent participants developed

photographs into posters that were displayed at community events. The sharing of unaccompanied minors' experiences with the local communities and foster care providers served as a forum to dispel negative misconceptions about unaccompanied minors. Another community-based model uses a trauma-informed approach to address newly arrived unaccompanied asylum-seeking youth's complex medical, psychological, social, educational, and legal needs in the United States. To support youth adaptation, Linton et al. (45) created a welcoming space by means of community-based, integrated, coordinated, and colocated services that facilitated youth access to services and communication between providers.

INTERVENTIONS: LIMITATIONS, CHALLENGES, AND FUTURE DIRECTIONS

Focus of Interventions and Existing Research

Several limitations and shortcomings exist that are related to mental health interventions for refugee children, which have been echoed among systematic reviews examining this population. Among preventive mental health interventions for refugee children and adolescents in HICs, few studies assess impacts across multiple domains of the refugee experience; in addition, high-quality research can be difficult to conduct because cultural differences can affect notions of mental illness and the role of research (27). The heterogeneity of the populations studied and the limited number of high-quality studies conducted reflect populations in which research is not a priority (26). Furthermore, interventions aimed at refugee youth in LMICs are limited and need to be prioritized because the majority of the world refugee populations reside in these countries.

The role of the family in successful youth development and the association between positive parenting and youth psychosocial functioning are clear. Unfortunately, of the few interventions that target the entire family, most focus on younger children. Families exert an important role throughout development, and interventions with a family component are needed for older children and adolescents. Because family composition and dynamics are defined within a specific culture(s) and evolve with pre- and postmigratory experiences, these interventions should be developed in close partnership with refugee communities. This concern also applies to unaccompanied minors placed in foster care: It is important to offer support and interventions for this population by also involving their caregivers, given that the unaccompanied minors' new experiences and relationships with the foster family can make a significant impact on their mental health. Foster families need to be supported and trained in their roles as caregivers.

Understandably, most interventions focus on studying the reduction in negative mental health symptoms. However, we also need evidence on positive outcomes and resilience among refugee children and youth. More work is needed on identifying and understanding the trajectories of youth who successfully respond and adapt to the refugee experience. This information includes not only positive mental health, but also overall life satisfaction, sense of purpose, and social functioning. Identifying pathways to success can inform the critical ingredients of mental health interventions.

Study Design

Longitudinal studies are scarce and particularly challenging to conduct, given that refugees are a highly mobile population; this mobility results in a lack of information on long-term benefits of interventions (20, 24). Longitudinal studies are also needed as a way to integrate a developmental, life course perspective on mental health interventions with youth. Psychosocial well-being of refugee youth will undoubtedly vary over time on the basis of age and changes in family dynamics

and the larger social context of which youth are a part. We need to start exploring trajectories of refugee youth over time and develop interventions that are most effective in supporting long-term growth and success. In particular, the present lack of data on infants and toddlers is worrisome, given the critical nature of this developmental period and the very high risk of misdiagnosing problems associated with stress-related disorders as cognitive deficiencies related to autism spectrum disorders, attention-deficit hyperactivity disorder, and oppositional defiance disorder, among others.

Use of control groups is important when evaluating interventions with refugee populations. Given the high prevalence of mental health problems among refugee youth and the need for services, conducting randomized controlled trials may not be ethical or feasible in some settings. Using a wait-list–control study design is one strategy to ensure access to services but maintain a more rigorous evaluation of the effectiveness of interventions. The role of the therapeutic alliance also contributes to the success or failure of interventions. Studies frequently do not report a detailed description of interveners or take the characteristics of the intervener into account when examining intervention effectiveness. Using mixed-methods study designs that include a qualitative evaluation of service providers can provide more information on when and in what ways the therapeutic relationship can be supported and improved upon for acceptability and effectiveness (7).

Refugee Partnerships

Access to and engagement of refugee populations in health services and research are impeded by significant cultural, linguistic, legal, and institutional barriers (36, 74, 76). Overcoming these barriers requires researchers and service providers to reimagine and restructure their relationships with refugee communities. Indeed, research and interventions with refugee populations are now more than ever embedded within a human rights and social justice framework, where both professionals and researchers need to assume an active role in terms of advocacy to reduce the risks faced by refugee populations in resettlement countries (102). In addition, more focus is needed on identifying and addressing the ethical challenges surrounding research with refugee populations more generally, and youth specifically, with regard to things such as ensuring confidentiality, minimizing risk to participants, and having accessible referral and follow-up services available if needed. Research that uses a community-based participatory research (CBPR) framework could be a promising methodology to engage this vulnerable population and empower refugee voices (6, 22, 71). In CBPR, different stakeholders come together around shared goals and interests to build the capacity of community members and facilitate the successful development and implementation of community-based interventions (99). Research that integrates refugees into the design, delivery, and evaluation of interventions to support youth shows promise in terms of improving the acceptability and effectiveness of mental health services.

CONCLUSION

We have provided an overview on the epidemiology of the mental health of refugee children and youth, a wide range of promising intervention research with this population in various settings, and shortcomings in existing research and opportunities for moving forward. None of this work can be done unless researchers in the field of refugee youth mental health advocate for the overall welfare of refugee populations. Current aversive and harmful practices related to refugees have had a negative effect on child mental health, including forced separation policies, detention of children and parents, harsh asylum procedures, and limitations in or absence of access to health care and

education (day care and postsecondary, in particular) (70, 79, 91, 100). In short, research cannot be carried out unless we have first established safety, security, and basic human rights for those refugees in transit, those residing in refugee camps, and those living in countries of resettlement. It is imperative that a refugee child and youth mental health research agenda incorporates the belief that health is a human right and that striving for social justice is a necessary component of all research.

SUMMARY POINTS

1. The psychosocial functioning of refugee youth should be conceptualized within a life course framework that considers the impact of hardship, violence, and loss within the post-resettlement environment.
2. Despite the breadth of research documenting the prevalence of mental health disorders in refugee youth, there are considerable gaps concerning the presence of effective, evidence-based treatments.
3. Of the availability of knowledge concerning refugees and refugee youth, most of it emanates from high-income contexts.
4. Treatments for refugee youth should target the larger social ecology by placing development and recovery in the context of caregiver and community well-being.
5. Unaccompanied minors have unique risk factors for psychological well-being, including limited social support networks and precarious legal status.
6. Scientifically rigorous research designs (e.g., longitudinal studies, wait-list controls, randomization) are needed to enhance the evidence base regarding effective programming for refugee youth.
7. Refugee partnerships are imperative in order to better engage refugee communities in the provision of services and the research process.

FUTURE ISSUES

1. What impact will the current sociopolitical discourse and associated policies and programming have on the long-term well-being and recovery of refugee youth?
2. What can the current knowledge base learn from research that assumes a strengths-based approach that focuses on capacities and resilience?

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