

Title: Challenges in meeting the Mental Health and Wellbeing Needs of Refugee Children and Young People in England: Evaluation and Critique of Policy and Guidance

Introduction

In this chapter the foci for examination and discussion are some of challenges in meeting the mental health and wellbeing needs of refugee children and young people in England. While much health policy applies across the UK, we address these issues within the English context. Our work and our writing is informed by a children and young peoples' rights perspective - United Nations Convention on the Rights of the Child (1989, hereafter UNCRC); Ruck et al (2017), and by the understanding that refugee children and young people are children and young people first (Crawley, 2006).

The definition of mental health and wellbeing which we apply is: 'Health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity' (World Health Organization, 2014). And Article 24 (UNCRC 1989) states that all children have the right to the highest attainable standard of health and healthcare services; more recent guidance advising that this includes a focus on health determinants, in addition to primary healthcare (UNCRC 2013). and forced, sometimes undocumented, migrants. The legal definition of 'refugee' is someone who has fled his or her home country, unable to return: '... owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion', and who is awarded some form of recognised legal status in the country in which they have sought asylum. (Convention Relating to the Status of Refugees, 1951). There are no official figures for the number of refugees living in England; no estimate can capture the dynamic changing legal status that can be awarded to individuals submitting asylum applications.

[\(https://fullfact.org/immigration/uk-refugees/\)](https://fullfact.org/immigration/uk-refugees/)

Unaccompanied asylum-seeking children and young people also are a group with particular needs; however due to limitations of space, we cannot address their mental health and wellbeing concerns here. In English law, a child is aged between 0 and 18 years. However, we write ‘children and young people’, describing from birth up to and including 19 years, in recognition of the changing autonomy and competency that evolves throughout the developmental stages from nine years to 18.

To examine how well - or not - challenges set out above are being met, we examine, evaluate and critique one key document which incorporates health policy and guidance. We explore underpinning ideologies and principles; how the document addresses issues of mental health and wellbeing, providing examples of the implications for refugee children and young people. This is followed by a Discussion and Conclusion.

Documentary research is undertaken with a range of materials, including, but not limited to, printed documents. Comparison with other documents is straightforward, as is longitudinal analysis. Document author bias – conscious or unconscious - may be discerned from close and critical reading (Prior, 2003). Documents can be described as text-based arguments: to study them is therefore to understand better what is being argued and which concepts and terms are being deployed to do so. Documentary research permits critical interrogation of language, values, writing style and content: content which is present and that which is ‘significant by its absence’ (Sands and Nuccio, 1992, 492). As in all qualitative research, credibility – respect for the entirety and context of the documentary account – and clarity about researchers’ epistemological position are important (Denzin and Lincoln, 2011): see above at paragraph 1. Firstly however, we briefly review the current English political and policy health and wellbeing contexts within which these two documents are situated.

English political and policy health context

Government austerity measures impact upon mental health policies and service providers such as the NHS, and upon service users, carers and patients, including children and young people. Many in public life: members of Parliament; journalists; cricketers; footballers; younger members of the English Royal Family and others, publicize personal experiences of mental ill-health in order to demonstrate its ubiquity and promote greater recognition of the need for specific preventative and support services to children and young people (Davies, 2017). Currently there is more extensive appreciation of the debilitating effects of mental ill-health for young individual sufferers; those close to them and for society (Young Minds, 2017) and an apparent political will (Frith, 2016) to improve both preventive and support services to children and young people experiencing mental-ill health,

English political and policy wellbeing context

Wellbeing is a fast-developing and controversial field which comprises a variety of meanings and definitions and which is taken seriously by governments of every political inclination (ONS, 2013; ONS, 2015). As with mental health, child wellbeing is affected by austerity measures: a recent UNICEF report found that the UK as a whole lags behind other rich countries in reducing inequality in child wellbeing in relation to income, health, education and life satisfaction (Osborne, 2016). And the understanding that ‘what children become in their adult life is to a great extent a product of their experiences in the early stages of their lives: for example, differences in children’s health..’(ONS, 2013, 5) is well-established in politics and in social policy (Bradshaw, 2016).

Health Child Programme (2009a and 2009b) Underpinning ideologies, principles and approaches

The Healthy Child Programme, Pregnancy and the First Five Years of Life, (DoH & DCSF, 2009a) together with The Healthy Child Programme, 5-19 years, (DoH & DCSF, 2009b) – hereafter HCP - sets out a core Public Health programme of national priorities and statutory responsibilities to guide commissioning and delivery of services in promoting the health and wellbeing of all children and young people in England. The Programme authors' professional background is in health; however the Programme is informed by wide-ranging consultation processes with stakeholder representatives, including parents, children and young people. This reflects the Programme's partnership ethos, multi-disciplinary focus, and recognition that many services contribute to successful health and wellbeing outcomes for children and young people.

The Programme is underpinned by a children's rights ideology, drawing from the then Labour government's Every Child Matters Agenda, (2003), recognizing those rights and outcomes regarded by children and young people as fundamental in their lives. Principles include: primary health prevention; early identification of need and risk; early intervention and support. Such support is a Universal Progressive model, premised upon offering a range of preventive and early intervention services dependent upon identified levels of risk for children, young people, their family and carers.

The 0-19 Programme guidance promotes a seamless, integrated service, tailored to developmental stages of children and young people's physical and emotional development, with pregnancy and the first year of life providing the foundations for future good health. Principles include: a strengths-based approach together with risk assessment; recognition of diverse health requirements; development of local health strategies and services informed by local needs assessments, including those identified by sub-group populations.

An explicit commitment to address the Health Inequalities agenda (Marmot, 2010) through the HCP's Public Health approach is centralized, recognizing the essential role of health determinants in securing good lifelong health (see also UNCRC, 2013). The Programme's presentation in this document is perfused by a conviction that the ideologies, principles and approaches underpinning it are fundamental to achieving successful outcomes, and to its ability to impact positively upon the health of all children and young people, irrespective of their health status or background.

Healthy Child Programme (2009): Exploration of Mental Health and Wellbeing

Programme guidelines centralize proactivity in promoting the social and emotional development of children and young people. While the Programme eschews formal definitions of mental health and wellbeing, a psycho-social model of health pertaining to a positive (rather than a deficit) approach to mental health, is evident. The Programme's stated core aim, achievement of: 'healthier, happier children and young people...able to reach their full potential' (DoH & DCSF, 2009b, 17) together with higher life satisfaction, participation in positive activities and increased resiliency, reflects a positive model of health and emotional wellbeing. Dynamic and complex relationships between physical and mental health are recognized, as is the need for a holistic approach where problems are considered within an individual's life context. Also recognized is the influence of secure infant /child attachment and attuned parenting in the first year of life in future mental health outcomes.

Core health and development reviews are undertaken at scheduled developmental stages during childhood, providing opportunities for parents and health practitioners to identify and discuss the child and families' strengths, needs and risks, from health and mental and emotional health perspectives. Parenting support for families with children under five in

relation to breastfeeding; the promotion of secure infant attachment and the smooth transition to parenthood are emphasized. Improving accessibility to mental health advice and information for parents, children and young people and improving health practitioners' ability to access Children and Mental Health Services (CAMHS) expertise when needed, is attained through providing a comprehensive range of universal services.

Achieving 'young people friendly' universal services is centralized, with whole school approaches to promoting emotional health and wellbeing. These include: promoting individual resilience and self-esteem; meeting, and exceeding, mandatory physical exercise curriculum requirements; supporting extra curricula activities and adopting school-based universal and targeted specific programmes to support emotional wellbeing and mental health. Identification of risks to young people's mental health requires support in developing individual resilience, and specialist input from CAMHS to prevent further serious deterioration of health, recognising that complex or severe difficulties may require either intensive or long term input to reduce risk and detrimental effects upon mental health. Support for parents and carers, including possible referral to adult Mental Health services where risks are associated with adult health or behaviours, reflects a targeted 'whole family approach' (DoH & DCSF 2009b). Additional guidance from the National Institute of Clinical Excellence (hereafter NICE), is integrated into the HCP. Guidelines on identification and management of depression in children and young people (NICE, 2005; 2015) recommend the availability of trained health professionals in primary and secondary healthcare settings and relevant community settings, able to undertake culturally competent assessment of risk factors and diagnose and treat depression.

Specific groups of children and young people are identified as vulnerable to high risk and poor mental health outcomes (HCP, 2009a; 2009b). Refugee children and young people are considered vulnerable because of perceived poor service uptake, or not being well-served by

existing provision. However, refugee children and young people's vulnerability is predominantly implicit within HCP, rather than explicit.

Healthy Child Programme (2009): Examples of Fit and Misfit

Strategic focus and approaches on promoting the mental health and wellbeing of children, young people and their families outlined in the HCP, assumes a relevance and good fit in addressing poor mental health outcomes for refugee children and young people. Drawing upon some of the examples above, such assumption will be critically assessed.

Universal provision and access for parents to a skilled health care practitioner in their child's first year, together with regular health reviews, provides a potentially valuable resource for refugee parents to draw upon in helping manage unfamiliar cultural parenting expectations and practices; build supportive networks with other parents and navigate those services and local resources that are available and offer in supporting their parenting role. Such provision though may be viewed with mistrust, with health practitioners seen to represent State authority and policing, carrying potential threat to parents' legal status and residency.

Admission to experiencing adult mental health difficulties may further reinforce mistrust, along with confusion and concern as to the unknown consequences of referral to an unfamiliar service such as Adult Mental Health (Fazel, 2015). Poor uptake, or disengagement with universal Child Health services needs therefore to be considered and addressed in light of the particular issues and concerns refugee parents may have in relation to them (NCB, 2016).

Schools provide a natural setting to promote and support healthy life styles, emotional wellbeing and resilience for children and young people, allowing for the development of close friendships and peer groups; opportunities for recognition for achievements and

contributions; building self-esteem and contributing to identity formation encountering new learning opportunities and experiences through extracurricular activities, and establishing positive relationships with teachers and mentors. While recognising the relevance and significance of these factors to wellbeing and health outcomes for refugee children and young people, assumptions that the school setting is experienced as a safe and protective place by all children, disregards the threatening, alienating environment it may pose for refugee children and young people. Unfamiliar language, a Eurocentric curriculum, feeling unwelcome and being exposed to racism and discrimination, undermine presumed opportunities presented to build resilience and well-being (Fazel, 2015).

Discussion

The HCP is a national programme of guidelines for commissioning, developing services and promoting best practice in achieving best outcomes for all children and young people's health and emotional wellbeing. However, specific groups of children and young people are recognised as being especially vulnerable to poor health outcomes. Refugee children and young people are designated within a vulnerability category in the HCP due to their perceived poor uptake of services, and/or inadequate or inappropriate service provision. They are noted as a sub-population group with specific health needs, requiring local identification, joint needs assessment with partner agencies, strategic action and evaluation, in response to the wider inequalities agenda (Marmot, 2010), underpinning the HCP.

Logically, recognition of refugee children and young people's specific health and wellbeing needs should be explicit within these national child health guidelines. However, within the HCP document (2009a) the term 'refugee' occurs only four times, so that any reference to or consideration of this 'sub population's' health and emotional well-being remains, like social

justice, implicit. A ‘significant absence’ (Sands and Nuccio, 1992, 492) limits enactment of a child health programme fit to meet the health needs of *all* children (our emphasis).

This highlighting of ‘sub-populations’, including refugee children and young people who are vulnerable to poorer health and wellbeing outcomes and in need of particular support, suggests an underlying social justice agenda driving the HCP Programme. Subsumed within the HCP guidelines is recognition of the influential role of health determinants (see also UNCRRC, 1989; 2013) in securing health and wellbeing, linked to strategic engagement with the inequalities agenda (Marmot, 2010). For refugee children and young people, poverty, social isolation and inadequate housing, are well-evidenced features of everyday life, as are experiences of oppression, discrimination and institutional racism (Burnett and Peel, 2001). The insidious impact of these risks upon health, wellbeing and resilience are well documented (Pinter, 2012). Therefore a strong social justice stance should be embedded explicitly within the HCP guidelines, highlighting existing power inequalities which undermine opportunities for refugee children, young people (and other marginalised groups) to secure health and wellbeing (Aspinal, 2011); propose critical examination of and challenge to inherently discriminatory structures and systems within organisations and service provision and promote an advocacy and empowering approach to meaningful engagement with refugee children and young people. Searching for terms: ‘discrimination’, ‘racism’, ‘advocate’ and ‘empower’ in both the HCP texts (2009a; 2009b) resulted in no references for the first three terms and five references to empowerment, reinforcing the conclusion that a social justice agenda which remains implicit is inadequate in national guidelines intended to meet, and improve, the health needs and outcomes of all children.

‘Culture’ usually refers to shared practices which permeate family and social life and which produce meaning (Calhoun and Sennett, 2007). All families and all societies have such shared cultural practices; however forms of cultural ‘othering’ (Mulvey, 2010), by media and

politicians, influence attitudes and behaviour throughout society, perfusing not only refugees' lives but also (inevitably to some degree), national health policy and practice.

Thus health policy documents and assessment guidances do not fully address issues of diversity. As noted just above, with only four mentions, refugee children and young people almost are invisible in the HCP. Unless health professionals are aware that diversity issues are not explicitly and sensitively addressed in HCP policy and guidelines (Aspinal, 2011), miscommunication and misunderstandings may occur, engendering refugee children, young peoples' and parents' perceptions that health assessments and services are not culturally appropriate, or not relevant for them (NCB, 2016). This might explain why they are deemed not to be accessing services.

The traumatic experiences of refugee children and young people are well-documented and researched. It is widely understood that previous trauma (British Psychological Society, 2007) combined with current poverty, isolation and pressures upon refugee families may result in depression and other mental health conditions (Fazel and Stein, 2003; McColl et al, 2008) in children and young people. Anderman (2002) and Zack-Williams (2006) assert that many current constructions of trauma, its short and longer term impact on refugee children and young people and constructions of resiliency, are from western nations' perspectives: that these concepts, their meanings and the lived experiences of them are mutable, not fixed, and that what may or may not count as trauma for refugees is for themselves to decide and define. And applying medical diagnoses and labels such as post-traumatic stress disorder when young refugees react within the range of normal to trauma experienced, exemplifies how professionals may not recognize individual, family and community strengths (NCB, 2016).

Conclusion

We began by referencing Crawley (2006), acknowledging that refugee children and young people are children and young people first. We noted that mental health and wellbeing are not only the absence of mental illness, they are about positive wellbeing: flourishing; feeling safe and secure emotionally as well as physically (WHO, 2014); that children and young people have rights in having access to and receiving high standards of health care (UNCRC, article 24, 2013)

Having critically considered and analysed the many strengths of the 0-19 HCP guidelines, we have highlighted that although it purports to apply universally to all children, it deals in generalities and refers to ‘sub groups’/sub-populations. It fails to take account of the specific mental and emotional health needs that refugee children and young people experience, and which they have a right to have met. They are rendered invisible within this document. As such, it provides inadequate guidance to commissioners, providers and practitioners for taking forward strategies for improving health and wellbeing outcomes for refugee children and young people.

The UNCRC (1989) centralizes children and young people’s rights. We argue for a rights-based, preventative approach in addressing, responding to and promoting, issues of mental health and wellbeing for refugee children and young people in national health policy and guidelines. ‘Every child does’ – and should – ‘matter’, including also refugee children and young people.

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