# New developments in the mental health of refugee children and adolescents

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## ABSTRACT

The increase in refugees globally since 2010 and the arrival of many into Europe since 2015, around 50% of whom are under 18 years, have been the stimulus to greater investigation and publications regarding their mental health. This clinical review summarises selected themes in the field as described in the published literature since 2016. The themes include refugee statistics, premigration and postmigration experiences, psychopathology focusing on parent–child relationships, unaccompanied refugee minors and associations between resettlement, acculturation and mental health. Some important reviews and studies are discussed that address service and treatment provision. While there has been a recent increase in research in this field, more is needed into the course of psychopathology, protective factors and the promotion of integration into resettlement countries, as well as models of service delivery and treatment effectiveness.

## INTRODUCTION

As a result of war and organised violence, many people are displaced within their own national borders and some cross national borders to become refugees. Some refugees seek asylum in neighbouring or distant countries, a legal process recognised by the United Nations. A particularly important group are unaccompanied refugee minors (URMs) who are under the age of 18 years and recognised as needing special protection by United Nations High Commissioner for Refugees (UNHCR).[1] The numbers of people affected by war and organised violence has been very high since the 1930s.[2] The numbers of internally displaced people (ie, people within their national border) have also increased and reached 40.0 million by 2017 http://www.unhcr.org/globaltrends2017/. Since 1982, UNHCR figures show that in most years, there have been >10 million refugees, and this has increased since 2010 http://data.unhcr.org/dataviz/, with the greatest numbers reached in 2017, with 25.4 million refugees http://www.unhcr.org/globaltrends2017/. The main originating and receiving countries are shown in table 1.

Unaccompanied and separated child refugee reached 187 700 by 2017 (http://www.unhcr.org/globaltrends2017/).

It can be seen that most refugees originate from and reside in low-income and middle-income countries. However, in recent years, there have been large numbers migrating to Europe. The numbers of asylum seekers in European Union (EU) countries has reached high levels, with 627 000 in 2014 and 1.3 million in both 2015 and 2016.[3] It is estimated that around half of all refugees are children under 18 years. In 2016, there were 63 300 applications from URMs, with 96 500 URMs in EU countries.

It has been established that the adversities experienced by refugees associated with displacement, often arduous journeys and resettlement in host countries are associated with elevated risk for psychiatric disorder.[4–6] Refugees who are settled through UNHCR programmes may avoid exposure to war and adversities that may increase risk for psychopathology.[7 8]. The recent increase in refugee numbers and flows into high-income countries has provided the stimulus for a great increase in research and publications on the topic of refugee mental health. During 2016–2019, at least six journals in the mental health field published special issues on refugees and three of these focused on young people (see box 1).

The increased rate of publication output is reflected in search of PubMed Central using key words children – refugees – mental – health which reveals 1 publication in 1988, 5 in 2000 and 60 in 2017 https://www.ncbi.nlm.nih.gov/pubmed/?term=children+refugees+mental+health.

There has also been an increase in sociological studies of refugees, which has been cogently summarised.[9] Relevant aspects of this work include the deconstruction of the term 'refugee', and the limitations of the superficial dichotomy between refugees, people who migrate for political reasons, to escape organised violence and economic migrants. This is because war and violence undermine economies and community life, which may, in turn, be contributory drivers for migration.[9 10] The work also highlights the adverse environments in which refugee children may have grown up in including parental illness and deaths, poor nutrition and sanitation, and poor access to education.

Given the rapid increase in publications on young refugees' mental health, this clinical review is necessarily selective and considers publications since 2016 focused on three topics of interest: adversities and stressors, psychopathology in specific contexts (parent–child relationships, URMs, adolescents and acculturation) and interventions.

## ADVERSITIES AND STRESSORS

### Premigration and in-flight stressors

Refugees have fled their countries because of fear of or experience of violence, but the actual exposure varies substantially according to age, gender, ethnicity and region.[11] Notorious examples of recent very high violence including killings, rape, enslavement and destruction of whole communities

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**Table 1** Highest originating and hosting countries for refugees in the world (http://www.unhcr.org/globaltrends2017/ accessed 15 September 2018)

| Top originating countries | Top hosting countries |
|---|---|
| Syria 6.3 million | Turkey 3.5 million |
| Afghanistan 2.6 million | Pakistan 2.8 million |
| South Sudan 2.4 million | Uganda 1.3 million |
| Myanmar 1.2 million | Iran 1 million |
| Somalia 1 million | Lebanon 1.0 million |
| Sudan 0.7 million | Ethiopia 0.8 million |

include the atrocities inflicted on the Yazidis and others in Northern Iraq.[12 13] In Syria, the picture has been varied with both destruction of whole communities[14 15] and also the flight of millions of people including whole families anticipating violence. The flight of Rohingya from Myanmar was provoked initially by the destruction of villages and killings, but the continuing low-level violence is regarded as ethnic cleansing to change the population of Rakhine state, according to the United Nations (https://news.un.org/en/story/2018/03/1004232). The heterogeneity of adversities also exists for refugees during their journeys, with some being able to make relatively rapid journeys, for example, by aeroplane. Others travel for weeks or months and experience family separation, privation and often further violence.[14 16 17]

Physical health may be impaired by past experiences and adversities in transit. Reports indicate high prevalence among children of nutritional deficiencies, short stature, infections and injuries.[18–20] This is relevant for mental health given the association between deficiencies and neurodevelopment, cognitive function and mood.[21–24]

### Stressors in resettlement countries

Resettlement programmes may significantly aid refugees and provide a range of supports and help, but they are only available for a small proportion of refugees; for example, 'there were 19.9 million refugees of concern to UNHCR around the world at the end of 2017, but less than 1% were resettled that year'.[7] However, for the majority, stressful experiences typically occur on arrival in resettlement countries and the ensuing months, sometimes continuing for years. The 'refugee crisis' of 2015–2016 and the continuing flow of asylum seekers coming to Europe and North America have been associated with harsher policies toward refugees, intended to deter asylum seekers. The arrival of populist governments since 2016 further intensified this harshness,[25] and 2018 saw the forcible separation of children including infants from parents on the Mexican–USA border.[26] This was fortunately abandoned after strong campaigning, but clearly such traumatic practises have catastrophic effects on child and parental psychological function.[27] However, the USA has the largest immigration detention system in the world, and many of the detainees are asylum seekers from Central America (https://www.globaldetentionproject.org/countries/americas/united-states). Exceptionally harsh detention practices are also followed by Australia, which has detention centres on remote islands which lack services. Detainees including children have a high rate of psychological distress and self-harm[28 29] In Europe, surveys show variable and often negative attitudes to asylum seekers[30] including URMs.[31] A recent review of adolescents has shown perceived racial/ethnic discrimination has a detrimental effect on mental health,[32] and this has been found among adolescent refugees.[33] There are reports from Germany of frequent attacks on asylum seekers and their residences[34] (which may, of course, be occurring in other resettlement countries but with fewer reports). The UK House of Lords review describes a culture of disbelief regarding asylum seekers claims and general suspicion of asylum seekers, in part related to Islamophobia,[30] across the EU.[35] A concrete manifestation of the culture of disbelief is age disputes, in which the young asylum seekers' claims to be aged under 18 years are disbelieved.[36] This will result in the failure to obtain local authority (or local social welfare) support, that is provided for children, and if the asylum claim is refused, detention and deportation[35] may follow.

It has been difficult to investigate the mental health of asylum seekers in detention because of the secrecy and controls imposed by governments and agencies that run the facilities. However, with persistence, such studies can be carried out.[37] Qualitative studies of infants and young children reveal the detrimental effects of the traumatic effects of detention,[38] and quantitative studies show higher levels of psychological distress among children and adults who are detained than non-detained refugees.[37 39] The detrimental psychological effects may last years after release from detention.[27 40]

Refugees may also experience ongoing post-resettlement daily hassles, such as financial hardship, poor accommodation and mobility, and challenges in accessing legal, health and social services.[41 42] These are associated with elevated anxiety and depressive symptoms amongst young people and also adults.

**Box 1 Journal special issues 2016 – 2019 in the refugee mental health field**

Canadian Psychology/Psychologie canadienne. November 2016 http://www.apa.org/pubs/journals/special/5825704.aspx
Clinical Child Psychology and Psychiatry. April 2018 http://journals.sagepub.com/toc/ccpa/23/2
Development and Psychopathology. February 2017 https://www.cambridge.org/core/journals/development-and-psychopathology/issue/69E29E9DF64DD681E03850642CF54BB3European Child and Adolescent Psychiatry. April 2018 https://link.springer.com/journal/787/27/4/page/1
Frontiers in Psychiatry. 26 February 2019 https://www.frontiers.org/article/10.3389/fpsyt.2019.00072
Transcultural Psychiatry. October – December 2017 http://journals.sagepub.com/toc/tpse/54/5-6

## PSYCHOPATHOLOGY

The recent increase in publications on young refugees' mental health has included many questionnaire-based studies of school-age children that find high levels of psychological distress with a high risk of post-traumatic stress disorder (PTSD), depression and anxiety.[17 43–45] However, some previously neglected areas have also been investigated, some of which are discussed here.

Attention has been given to the parent–child relationships and mental health, as a key variable in a broader socioecological perspective.[46] While infants may be too young to appraise the wider significance of the events around them, they have been shown to be highly sensitive to separations from attachment figures that may occur in the context of migration and losses from war, and immigration detention.[27 28 38] Work has also investigated the quality of the infant–parent relationship in the context

of parental psychopathology. A small study of highly traumatised asylum seekers in the Netherlands found that parental symptoms of PTSD were related to infants' insecure attachment.[47] Interestingly most of the risk was attributed to factors related to the infant and parent rather than the whole family. Parental insensitivity was related to parental PTSD.[48] A larger high-quality cohort study found that caregivers' trauma history and postmigration difficulties were associated with greater PTSD, harsher parenting and higher levels of child conduct problems.[49]

It is known that URMs have higher exposure to significant traumatic experiences and losses than their accompanied peers.[50] As expected URMs have a higher prevalence of psychiatric disorders than accompanied refugee peers.[51] Depressive symptoms are associated with postmigration stressors including daily hassles and also acculturative stress.[52] A longitudinal study has confirmed findings from earlier cross-sectional studies that for URMs, lower psychological distress is associated with higher support living arrangements, and a recent systematic review has found an effect size of 0.3 for this association.[53] As expected, psychological distress is increased by unsuccessful asylum claims.[54]

After arrival in resettlement countries, many of which have different cultures and languages to the originating communities of refugees, there is a process of learning and adapting to the new society. This process varies according to age, gender, educational and professional background, and expectations. A large study in Canada showed that for older adolescents and adults, psychological distress was less among those who felt they belonged to their new country had a stronger social network.[55] A number of family issues arise that have been described in more detail elsewhere.[56] These include differential rates of acculturation across generations. Children and adolescents who are enrolled in school, typically learn the new language rapidly and adapt to the new culture faster than parents who may be isolated and until their asylum claims are processed excluded from the workforce. A nuanced qualitative study of Somali Bantu adolescents from refugee backgrounds in Massachusetts, USA, reveals their understanding of these tensions and need to navigate the intrafamilial and extrafamilial cultures.[57] There may be significant strains in refugee families arising from parental separation and later reunion. The parent who later joins the family later, often father who have been combatants or detained, may experience PTSD, depression and physical ill health related to injuries. Family strain can result in discord, separation and even violence, with associated detrimental effects on child mental health.[58]

## INTERVENTIONS

The large numbers of displaced and refugee children and adolescents mean that there is a significant treatment gap between the mental health need and available resources. This exists even in high-income countries, where interventions may be delivered by statutory services, whereas in low and middle income countries (LMIC), they are likely to be delivered by NGOs with some involvement from UNHCR and governments.[59] In LMIC, a key principle for treatment provision is task shifting, in which non-mental health professionals are trained to deliver interventions.[60] In high-income countries, attention has been given to tiered systems in which community practitioners provide early interventions[50] in accessible settings including schools and achieve timely referral for the more impaired children to specialist services. Across contexts, reviews have described the need for socioecological perspectives[61] and a broad understanding of the psychosocial consequences of trauma and loss.[62]

The high prevalence of PTSD and depression, frequently comorbid, has meant that these are the disorders that have been most often targeted in treatment evaluation studies.[50] In recent years, an accumulating body of evidence has been established using cognitive behavioural psychotherapy, narrative exposure therapy and eye movement desensitisation and reprocessing for refugee children affected by war and displacement.[63] For post-traumatic symptoms, one review that included children who experienced man-made and natural disasters found a moderate effect size for the intervention group compared with control groups, without a difference between the three interventions just mentioned.[64] Interestingly a broader skills and activity-based non-CBT intervention delivered by lay adults was found to be effective for child refugees and non-refugee peers in Jordan in reducing psychological distress but not post-traumatic symptoms.[60] There is a dearth of studies investigating interventions of psychological distress in URMs.[65 66]

In both high-income countries and LMIC, interventions may be delivered in community settings such as schools. This has been found to be acceptable to many young people and is felt to be non-stigmatising.[67] However, young refugees may have highly distressing, impairing and more severe psychiatric disorders including PTSD comorbid with depression, suicidality, psychosis and neurodevelopmental disorders, which require the attention of specialist child and adolescent mental health services and disorder-specific treatments.

## CONCLUSIONS

This brief review describes the increasing research and service innovations to address young refugees' mental health. Accumulating evidence suggests that significant levels of psychological distress and psychiatric disorder could be prevented by more welcoming and supportive reception policies including high support living arrangements for URMs. Future work should investigate in more detail parent–child relationships, the long-term implications of child and adolescent psychopathology including the neuropsychiatric consequences,[27] and special attention should be given to URMs. It is also crucial to implement preventive mental health policies and cease the practices that are known to be detrimental to health and abuse human rights.[27 68] Further work is needed regarding service configurations in high and LMIC including better treatment trials across the tiers of the service delivery system.

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## REFERENCES

1. UNHCR. *Guidelines on Policies and Procedures in dealing with Unaccompanied Children Seeking Asylum*. Geneva: UNHCR, 1997.
2. UNHCR. *The state of the world's refugees 2000*. Oxford: Oxford University Press, 2000.
3. Eurostat. Asylum Statistics Eurostat. 2018 http://ec.europa.eu/eurostat/statistics-explained/index.php/Asylum_statistics (Accessed 26th Oct 2018).
4. Fazel M, Wheeler J, Danesh J. Prevalence of serious mental disorder in 7000 refugees resettled in western countries: a systematic review. *Lancet* 2005;365:1309–14.
5. Steel Z, Chey T, Silove D, *et al*. Association of torture and other potentially traumatic events with mental health outcomes among populations exposed to mass conflict and displacement: a systematic review and meta-analysis. *JAMA* 2009;302:537–49.
6. Priebe S, Giacco D, El-Nagib R. *WHO Health Evidence Network Synthesis Report 47. Public Health Aspects of Mental Health Among Migrants and Refugees: A Review of the Evidence on Mental Health Care for Refugees, Asylum Seekers and Irregular*

*Migrants in the WHO European Region*. Copenhagen: WHO Regional Office for Europe, 2016.
7. UNHCR. Resettlement. 2019 https://www.unhcr.org/resettlement.html (Accessed 27 Jan 2019).
8. Lau W, Silove D, Edwards B, *et al*. Adjustment of refugee children and adolescents in Australia: outcomes from wave three of the Building a New Life in Australia study. *BMC Med* 2018;16:157.
9. FitzGerald DS, Arar R. The Sociology of Refugee Migration. *Annu Rev Sociol* 2018;44:387–406.
10. Crawley H, Skleparis D. Refugees, migrants, neither, both: categorical fetishism and the politics of bounding in Europe's 'migration crisis'. *J Ethn Migr Stud* 2018;44:48–64.
11. Stark L, Asghar K, Yu G, *et al*. Prevalence and associated risk factors of violence against conflict-affected female adolescents: a multi-country, cross-sectional study. *J Glob Health* 2017;7:010416.
12. Cetorelli V, Sasson I, Shabila N, *et al*. Mortality and kidnapping estimates for the Yazidi population in the area of Mount Sinjar, Iraq, in August 2014: A retrospective household survey. *PLoS Med* 2017;14:e1002297.
13. Bilukha OO, Sultan AS, Hassan A, *et al*. Injury-related fatalities in selected governorates of Iraq from 2010 to 2013: Prospective surveillance. *Am J Disaster Med* 2016;11:49–58.
14. Mangrio E, Zdravkovic S, Carlson E. A qualitative study of refugee families' experiences of the escape and travel from Syria to Sweden. *BMC Res Notes* 2018;11:594.
15. Mokdad AH. Intentional injuries in the Eastern Mediterranean Region, 1990-2015: findings from the Global Burden of Disease 2015 study. *International journal of public health* 2017 (Published 5 Aug 2017).
16. Crepet A, Rita F, Reid A, *et al*. Mental health and trauma in asylum seekers landing in Sicily in 2015: a descriptive study of neglected invisible wounds. *Confl Health* 2017;11:11:1.
17. Ben Farhat J, Blanchet K, Juul Bjertrup P, *et al*. Syrian refugees in Greece: experience with violence, mental health status, and access to information during the journey and while in Greece. *BMC Med* 2018;16:40.
18. Hermans MPJ, Kooistra J, Cannegieter SC, *et al*. Healthcare and disease burden among refugees in long-stay refugee camps at Lesbos, Greece. *Eur J Epidemiol* 2017;32:851–4.
19. Hirani K, Payne DN, Mutch R, *et al*. Medical needs of adolescent refugees resettling in Western Australia. *Arch Dis Child* 2018:archdischild-2018-315105 (Published 5 Jul 2018).
20. Sandell AMD, Baker RD, Maccarone J, *et al*. Health Status and Anthropometric Changes in Resettled Refugee Children. *J Pediatr Gastroenterol Nutr* 2017;65:569–73.
21. Galler JR, Koethe JR, Yolken RH. Neurodevelopment: The Impact of Nutrition and Inflammation During Adolescence in Low-Resource Settings. *Pediatrics* 2017;139:S72–84.
22. Vohr BR, Poggi Davis E, Wanke CA, *et al*. Neurodevelopment: The Impact of Nutrition and Inflammation During Preconception and Pregnancy in Low-Resource Settings. *Pediatrics* 2017;139:S38–S49.
23. Tomlinson M, Yasamy MT, Emerson E, *et al*. Setting global research priorities for developmental disabilities, including intellectual disabilities and autism. *J Intellect Disabil Res* 2014;58:1121–30.
24. Föcker M, Antel J, Ring S, *et al*. Vitamin D and mental health in children and adolescents. *Eur Child Adolesc Psychiatry* 2017;26:1043–66.
25. Trilling D. The irrational fear of migrants carries a deadly price for Europe. *The Guardian* 2018.
26. Laughland. 'Going through hell' at the border: parents split from children tell of anguish. *The Guardian* 2018 (Accessed 22 Jun 2018).
27. Teicher MH. Childhood trauma and the enduring consequences of forcibly separating children from parents at the United States border. *BMC Med* 2018;16:146.
28. Mares S. Fifteen years of detaining children who seek asylum in Australia - evidence and consequences. *Australas Psychiatry* 2016;24:11–14.
29. Harrison V. Nauru refugees: The island where children have given up on life: BBC News. 2018 https://www.bbc.co.uk/news/world-asia-45327058 (accessed 1 September 2018).
30. Bansak K, Hainmueller J, Hangartner D. How economic, humanitarian, and religious concerns shape European attitudes toward asylum seekers. *Science* 2016;354:217–22.
31. Plener PL, Groschwitz RC, Brähler E, *et al*. Unaccompanied refugee minors in Germany: attitudes of the general population towards a vulnerable group. *Eur Child Adolesc Psychiatry* 2017;26:733–42.
32. Benner AD, Wang Y, Shen Y, *et al*. Racial/ethnic discrimination and well-being during adolescence: A meta-analytic review. *Am Psychol* 2018;73:855–83.
33. Beiser M, Hou F. Mental Health Effects of Premigration Trauma and Postmigration Discrimination on Refugee Youth in Canada. *J Nerv Ment Dis* 2016;204:464–70.
34. Hodes M, Anagnostopoulos D, Skokauskas N. Challenges and opportunities in refugee mental health: clinical, service, and research considerations. *Eur Child Adolesc Psychiatry* 2018;27:385–8.
35. Ho L. *Children in crisis: unaccompanied migrant children in the EU*. Westminster, UK: House of Lords, 2016.
36. Jayaraman J, Roberts GJ, Wong HM, *et al*. Ages of legal importance: Implications in relation to birth registration and age assessment practices. *Med Sci Law* 2016;56:77–82.
37. Sen P, Arugnanaseelan J, Connell E, *et al*. Mental health morbidity among people subject to immigration detention in the UK: a feasibility study. *Epidemiol Psychiatr Sci* 2018;27:1–10.
38. Kronick R, Rousseau C, Cleveland J. Refugee children's sandplay narratives in immigration detention in Canada. *Eur Child Adolesc Psychiatry* 2018;27:423–37.
39. Zwi K, Mares S, Nathanson D, *et al*. The impact of detention on the social-emotional wellbeing of children seeking asylum: a comparison with community-based children. *Eur Child Adolesc Psychiatry* 2018;27:411–22.
40. Ehntholt KA, Trickey D, Harris Hendriks J, *et al*. Mental health of unaccompanied asylum-seeking adolescents previously held in British detention centres. *Clin Child Psychol Psychiatry* 2018;23:238–57.
41. Morgan G, Melluish S, Welham A. Exploring the relationship between postmigratory stressors and mental health for asylum seekers and refused asylum seekers in the UK. *Transcult Psychiatry* 2017;54(5-6):653–74.
42. Heptinstall E, Sethna V, Taylor E. PTSD and depression in refugee children: associations with pre-migration trauma and post-migration stress. *Eur Child Adolesc Psychiatry* 2004;13:373–80.
43. Ceri V, Özlü-Erkilic Z, Özer Ü, *et al*. Psychiatric symptoms and disorders among Yazidi children and adolescents immediately after forced migration following ISIS attacks. *Neuropsychiatr* 2016;30:145–50.
44. Manzanero AL, Crespo M, Barón S, *et al*. Traumatic Events Exposure and Psychological Trauma in Children Victims of War in the Gaza Strip. *J Interpers Violence* 2017:088626051774291 [Epub ahead of print 1 Nov 2017].
45. Eruyar S, Maltby J, Vostanis P. Mental health problems of Syrian refugee children: the role of parental factors. *Eur Child Adolesc Psychiatry* 2018;27:401–9.
46. Cummings EM, Merrilees CE, Taylor LK, *et al*. Developmental and social-ecological perspectives on children, political violence, and armed conflict. *Dev Psychopathol* 2017;29:1–10.
47. van Ee E, Kleber RJ, Jongmans MJ, *et al*. Parental PTSD, adverse parenting and child attachment in a refugee sample. *Attach Hum Dev* 2016;18:273–91.
48. van Ee E, Jongmans MJ, van der Aa N, *et al*. Attachment Representation and Sensitivity: The Moderating Role of Posttraumatic Stress Disorder in a Refugee Sample. *Fam Process* 2017;56:781–92.
49. Bryant RA, Edwards B, Creamer M, *et al*. The effect of post-traumatic stress disorder on refugees' parenting and their children's mental health: a cohort study. *Lancet Public Health* 2018;3:e249–e258.
50. Fegert JM, Sukale T, Brown RC. Mental Health Service Provision for Child and Adolescent Refugees: European Perspectives. In: Hodes M, SS-F Gau, de Vries PJ, eds. *Understanding Uniqueness and Diversity in Child and Adolescent Mental Health*. London and San Diego: Academic Press, 2018:193–220.
51. Norredam M, Nellums L, Nielsen RS, *et al*. Incidence of psychiatric disorders among accompanied and unaccompanied asylum-seeking children in Denmark: a nation-wide register-based cohort study. *Eur Child Adolesc Psychiatry* 2018;27:439–46.
52. Keles S, Friborg O, Idsøe T, *et al*. Depression among unaccompanied minor refugees: the relative contribution of general and acculturation-specific daily hassles. *Ethn Health* 2016;21:300–17.
53. O'Higgins A, Ott EM, Shea MW. What is the Impact of Placement Type on Educational and Health Outcomes of Unaccompanied Refugee Minors? A Systematic Review of the Evidence. *Clin Child Fam Psychol Rev* 2018;21:354–65.
54. Jakobsen M, Meyer DeMott MA, Wentzel-Larsen T, *et al*. The impact of the asylum process on mental health: a longitudinal study of unaccompanied refugee minors in Norway. *BMJ Open* 2017;7:e015157.
55. Beiser M, Hou F. Predictors of positive mental health among refugees: results from Canada's General Social Survey. *Transcult Psychiatry* 2017;54(5-6):675–95.
56. Hodes M, Hussain N. The role of refugee family functioning in child and adult mental health. In: De Haene L, Rousseau C, eds. *Working with Refugee Families: Coping with trauma and displacement in family relationships*. Cambridge: Cambridge University Press. In Press, 2019.
57. Frounfelker RL, Assefa MT, Smith E, *et al*. "We would never forget who we are": resettlement, cultural negotiation, and family relationships among Somali Bantu refugees. *Eur Child Adolesc Psychiatry* 2017;26:1387–400.
58. Timshel I, Montgomery E, Dalgaard NT. A systematic review of risk and protective factors associated with family related violence in refugee families. *Child Abuse Negl* 2017;70:315–30.
59. Vostanis P. New approaches to interventions for refugee children. *World Psychiatry* 2016;15:75–7.
60. Panter-Brick C, Dajani R, Eggerman M, *et al*. Insecurity, distress and mental health: experimental and randomized controlled trials of a psychosocial intervention for youth affected by the Syrian crisis. *J Child Psychol Psychiatry* 2018;59:523–41.
61. Eruyar S, Huemer J, Vostanis P. Review: How should child mental health services respond to the refugee crisis? *Child Adolesc Ment Health* 2018;23:303–12.
62. Silove D, Ventevogel P, Rees S. The contemporary refugee crisis: an overview of mental health challenges. *World Psychiatry* 2017;16:130–9.

63. Morina N, Malek M, Nickerson A, *et al*. Psychological interventions for post-traumatic stress disorder and depression in young survivors of mass violence in low- and middle-income countries: meta-analysis. *Br J Psychiatry* 2017;210:247–54.
64. Brown RC, Witt A, Fegert JM, *et al*. Psychosocial interventions for children and adolescents after man-made and natural disasters: a meta-analysis and systematic review. *Psychol Med* 2017;47:1893–905.
65. Demazure G, Gaultier S, Pinsault N. Dealing with difference: a scoping review of psychotherapeutic interventions with unaccompanied refugee minors. *Eur Child Adolesc Psychiatry* 2018;27:447–66.
66. Mitra R, Hodes M. Prevention of psychological distress and promotion of resilience amongst unaccompanied refugee minors in resettlement countries. *Child Care Health Dev* 2019;45:198–215.
67. Fazel M, Garcia J, Stein A. The right location? Experiences of refugee adolescents seen by school-based mental health services. *Clin Child Psychol Psychiatry* 2016;21:368–80.
68. Pejovic-Milovancevic M, Klasen H, Anagnostopoulos D. ESCAP for mental health of child and adolescent refugees: facing the challenge together, reducing risk, and promoting healthy development. *Eur Child Adolesc Psychiatry* 2018;27:253–7.