HEALTH

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New arrivals: how do we protect the children?

WE KNOW refugee children are vulnerable, yet highly resilient. When working with children we know that physical health screenings are necessary and evidence-based, yet they are rarely carried out in many clinics.

I also believe not enough is known about their psychological wellbeing. If you look through the literature you will find refugee children often experience highly variable rates of anxiety, depression and post-traumatic stress disorder (PTSD), which essentially raises more questions than it provides answers.

We really don't know an awful lot about our refugee children's development, either. One thing that interests me is assessing which children are most at risk and in need of intensive follow-up and which children are most resilient. When I see the latter in my clinic I can say to them: "Off you go, one day you'll be prime minister. I don't need to worry about you."

If you look at the literature on risk and protective factors in refugees, there is much research data collected by mental health services on this subject. Quite a big body of literature tells us that the children most at risk are those whose parents are mentally ill; have limited economic opportunities; cannot work; have spent time in detention in refugee camps; have been exposed to violence in their countries and during their time of transit; and have been discriminated post-arrival. Unaccompanied children and children of single parents are also at risk.

The protective factors evidenced in retrospective studies indicate that those who arrive as young children, if their families are together, employed and have socio-economic support have better chances. Three longitudinal prospective studies include risk and protective factors, right at the beginning. What the studies show is that the longer they have been in Australia, the better the children do and that if they have family and peer support and a sense of belonging and social inclusion, they will do well.

It is interesting to know that it is not only the family's socio-economic status that has an impact on wellbeing, but also their socio-economic status compared to their prior status. If they were wealthy before and suddenly find themselves in a lower social class and unemployed, that's much more traumatic and more risky to their mental health than if they were poor before and remain poor in the new country. While that evidence is there, it wasn't quite what we were looking at. We really wanted to look at children and gather an enormous amount of data about their families, so we embarked on this

longitudinal study with other doctors and refugee nurses working in Wollongong at the time.

The study design was to enrol children early on and follow them up for three years. We were interested not only in their social-emotional wellbeing but also in their physical health and their development, because those areas are not well studied. Our main objective was to identify the risks and protective factors that can classify children into kids who will do well anyway and kids who really need a lot of support from health services.

The child development measure is a play-based observational tool. We play with the child using standardised tools that have been normed in Australian children as opposed to asking parents if they believe their children are having difficulties in their development – because there is good evidence that many refugee parents will say, "No, my kids are fine" or "I'm not worried about my kids". Whether they are or aren't worried is another matter.

For our social-emotional wellbeing measures we used the Strengths & Difficulties questionnaire, a well-validated tool in refugee kids and kids from other cultures.

We have measured risk and protective factors using a bio-ecological model. The factors classically looked at in the child are: the age, gender and physical health and if there's a disability. The family factors cover where they come from and if the family is complete; if it is a case of an unaccompanied child or single parent; if there has been disclosure of parental trauma and torture; and if they have spent a long time in a refugee camp or in detention.

Then we consider settlement factors including the social and environmental factors for which Australia is responsible such as their education, English language literacy, socio-economic resources and access to welfare, housing, healthcare and community support. This amounted to more than 60 questions at each encounter with families.

In 2009 we set up a refugee screening program that enrolled every newly-arrived refugee and linked them to a GP, using it as a platform to ask families whether they would like to be part of a longitudinal study. The strength of this research is that it is a complete population-based cohort, not a cohort of those coming to a mental health service but a completely unbiased cohort of everybody arriving in a particular region. So if anybody was identified by the study as having a problem we could treat it, so ethically it made sense.

During that study time frame (2009-2013) 228 children arrived in the area. We ultimately enrolled 61

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children. Once they were enrolled 85 percent remained enrolled, so there was little dropout.

Many people did not enrol because we didn't have enough interpreters speaking their language or enough nurses or we didn't have a nurse and interpreter available on the same day. So the limitation was largely due to our funding constraints rather than people not wanting to be involved. People are very interested in research. The study sample was very representative of the entire Australian refugee intake at that time, but that is actually no longer the case: the demography has now changed. This shows how quickly research can go out of date.

We had 35 percent children from Burma, 20 percent from the Congo and 16 percent from Iraq: 40 percent of the parents had very low levels of education, 30 percent of the kids didn't have a father present; 14 percent were born in a refugee camp and 11 percent of parents self-disclosed torture and trauma.

In terms of physical health we found nothing new, except for high rates of infectious and nutritional deficiencies. Many people had made the observation that refugee children become overweight with time. In fact, our finding was that they were overweight on arrival and they stayed the same over time. So even in refugee camps there is a proportion of children, 8 to 14 percent, who is overweight, which is very interesting compared to 50 years ago.

In terms of child development, 27 percent had only mild developmental problems detected in year two of the study, a year after they had arrived. All the children were developmentally normal by the third year of follow-up. What that tells us is that these kids are developmentally normal, all their problems were language-based and they all resolved over time. It was incredibly reassuring but, again, things have changed. At the time of the research, no disabled children were allowed to enter the country. Now they are selecting disabled children, so this evidence would be very different.

Coming to the social-emotional wellbeing score, the SDQ, at year two – 13 months after arrival – the overall score was abnormal at 13 percent. That's not borderline, that's purely abnormal. We would expect about 10 percent in Australian children so it was above average, but by year three it was down to 6 percent, actually below the Australian average: a significant difference over time. So in terms of social-emotional wellbeing these kids are doing extremely well, which is good news, even if 23 percent experience emotional symptoms, such headaches, worries, feeling unhappy or fearful. That was not surprising, and by year three it was gone.

The other area where they seem to have difficulty in the first year is in peer relations, so they preferred to play alone, they said they didn't have friends and were bullied at school –an important finding in terms of what we should be doing in the school settings. The high school kids were going to intensive English centres and the primary school kids to mainstream schools.

We put a lot of effort into linking kids with GPs and that was maintained throughout the study. Because of that, they had few presentations to the hospital emergency departments, which we consider a strength of our model. It will interest you to know that the early childhood services – the early childhood clinics, community health centres and the early childhood nursing services (which look after child development and assess whether children are on track for their development) are completely and utterly underutilised by these children. Only 23 percent use them at year two, so in the first year post-arrival and by the third year few kids are accessing early childhood services. If we consider these children at risk of developmental problems or language problems, they're not using the existing mainstream resources.

There were some changes over time. Fortunately parents had increased employment and had improved English proficiency in the case of fathers. The mother filled in the form and said their partner's English had improved, but in fact theirs hadn't and I suspect that's

because women tend to be more isolated. But there was a decrease in stressful life events. That's a standardised measure using the SRRS (Social Readjustment Rating Scale), it's also called the Life Events Score. Between the first year and the second year of being in Australia, people are experiencing a lot less stressful life events, a credit to our support systems.

Participants were widely studying English and accessing government financial support and 75 percent felt supported by their own community and 70 percent also by the general community. I would be very interested to test this today because I think people would feel even more isolated and marginalised with today's attitudes. In their country of origin most refugees were working or productive. About 15 percent were not working at all. In year two, 97 percent were unemployed. In year three, 87 percent were.

How can we know who is going to do well? If children came from Africa, if their father was present when they first arrived and if they had had fewer stressful life events in the previous year, their first year in Australia was less stressful. Those three groups were independently significant, so you could see kids with those three factors would do extremely well.

Other factors are also important, if not as significant. They work synergistically to produce a better outcome: a younger child will do better in cases where parents haven't experienced torture or trauma; in families that have community support; had family in Australia before they arrived; they had not experienced multiple relocations, either of their school or of residence; and they came from families where there was financial and marital stability, so parents hadn't separated during the time.

If you add up all those protective factors, a child who has four or more will be absolutely fine. According to this study, a child who has four or more protective factors will have normal social and emotional wellbeing by two and a half years after arrival and probably doesn't need much in terms of follow-up. But a child who has fewer than four protective factors will experience poor social-emotional wellbeing (high SDQ) and will need a lot of support.

One of the next steps is to develop a tool for asking questions – not 63 questions, but 10! – to identify the kids into these two groups.

We asked parents a lot about how they found this research and all said the questions were easy to answer, they supported the research, it was respectful, and didn't raise uncomfortable feelings for them. This was further demonstrated by the families involved staying in the study.

Thus the research shows most of these children, unless they have an identified disability, will develop normally and psychological wellbeing will improve over time. However, there is a small proportion of children who are not doing well and we can probably identify who they are. From a clinical perspective, if we can identify those kids

heading for a poor trajectory, can we buffer that in some way? Can we add extra resources to make sure they finish up okay?

The health system is about providing services and resources, but there are probably many other thing we can do to assist, interventions that can add value and get them back on track, promote resilience and optimise outcomes.

So if you're thinking of those concentric circles at child and family, if we reduce children's exposure to violence and discrimination, promote stability and a sense of belonging at school, at home and in neighbourhoods, that will improve their outcomes.

If we promote access to health services and mental health services, facilitate integration of children and family into host communities through sporting activities, home programs, tutoring programs that engage refugee families, it will bring positive outcomes. A combination of first refugee-specific services and a gradual integration into mainstream services will provide positive outcomes. Staying too long in the refugee community will only work against overall wellbeing.

We need to prioritise reunification of separated family members and providing support for families to remain intact. There seems to be a significant number, I think about 30 percent, who lost their marital relationships over the first three years of arrival, so we need to be thinking about how we can support those in that situation.

At community and society levels, improvements are needed in the policy and national agenda areas. That's about promoting a welcoming environment, facilitating employment opportunities, and that means recognising previous work experience, qualifications and supporting education – homework support, tutoring, and access to social and economic resources to help refugees move out of poverty.

Wollongong is regarded as a nice place to resettle as a refugee, so it could be that that particular sample is doing well and other samples are not doing so well. I would have loved to have done this study in different settings. Unfortunately we have not got funding to do that, but I would be interested to do so one day. There were also key questions about domestic violence and the psychological wellbeing of carers and exposure to torture, trauma and rape in parents that we knew we should ask, but we could not because it wasn't appropriate with children in the room so we asked these questions in their homes.

I have listed all those interventions and they sound easy – social inclusion, happy school, happy neighbourhood – but we do not know how to achieve that. We have common-sense suggestions, but there aren't good randomised controlled trials or high-quality evidence about exactly how we achieve it. What programs achieve employment? What programs achieve social inclusion? What programs will enable refugee kids achieve their full educational potential?

These issues can be explored in the next research project. We also need to find a tool emanating from the work we've done on risk and protective factors that is clinically useful for the next phase. R