Promoting Asylum-seeking and Refugee Children's Coping With Trauma

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Background and Status of Knowledge

Mental health problems and disorders represent major risks for unsuccessful integration into societies' productive institutions, and account for more than half of the health expenses [1]. Moreover, mental health problems increase the risk for social exclusion, peer rejection [2], and school drop-out [3] and is thereby a substantial barrier to social integration of refugees. Research among unaccompanied minor asylum-seekers[1] awaiting a decision on their application for asylum has demonstrated prevalence of symptoms of post-traumatic stress disorder (PTSD) from 54% to 76% [4, 5]. Furthermore, there is high stability of mental health problems and disorders among them after they receive residence [6, 7]. Improving the mental health of this vulnerable group of children may improve the life conditions and opportunities for the children themselves, and can thereby be economically beneficial to the receiving societies.

There is general agreement in the literature that Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is the method of choice for treating PTSD in trauma-exposed children [8]. Nevertheless, health personnel and national health authorities have pointed to the existing challenges regarding both capacity and competence in mental health specialist services to meet the mental health needs of asylum-seekers and refugees [9-11]. In response to the resulting socio-cultural differences in mental health services, commissioned by three directorates, the Norwegian Institute of Public Health (NIPH) has recently implemented a low-threshold evidence based intervention (Teaching Recovery Techniques) to reduce trauma-related mental health problems and promote well-being among asylum-seeking and refugee minors. The overall aim of the proposed PhD project is to evaluate the effectiveness of the intervention, which was delivered by local environmental therapists, school personnel, and health nurses to UMA and URM. The PhD project is based on data that we collected in conjunction with the intervention; consequently, funding of the project will facilitate an immediate generation of new and important knowledge.

Mental health, trauma and psychosocial stressors

The World Health Organization (WHO) defines mental health as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community [12]. In its most recent Strategy of good mental health [13], the Government describes mental health as including good mental health, quality of life, mental health problems and mental health disorders. Quality of life (QoL) involves a range of different positive experiences such as happiness, safety, affiliation, coping, and meaningfulness (p. 9),

[1] *Unaccompanied minor asylum-seekers* (UMA) are children below 18 years of age, who travel without the company of an adult legal caretaker to seek asylum in a foreign country. We distinguish this group from *unaccompanied refugee minors* (URM), who are former UMAs that have been granted asylum and are resettled in municipalities. We refer to them as refugees even if protection was conceded for humanitarian or other reasons rather than to shield from persecution, imprisonment etc.

and is conceptualized in a variety of ways [14]. In the present study, QoL refers to perceived subjective wellbeing and self-efficacy.

UMA and URM all have in common that they have experienced serious losses of or separation from parents and other family members. Additionally, a majority of them have been exposed to an accumulation of traumatic events before their arrival in the destination countries, when they feared for their own lives or for the lives of others [15, 16]. Many children demonstrate adaptive outcomes in spite of the amount of adversities they are exposed to [17, 18]. Nevertheless, war trauma increase the risk of symptoms of PTSD and other mental health problems among asylum-seeking and refugee children and youth [6, 19, 20]. Likewise, war-trauma may be associated with post-traumatic growth in some individuals [21], however, reduced QoL is frequently the outcome [22]. Furthermore, research with older refugees and war-affected populations has shown that asylum-related and post-resettlement psychosocial stressors experienced after residence has been obtained, contribute to the maintenance and development of mental health problems [23-26] and decreased QoL [14, 22]. In Norway, as in Sweden, new and more restrictive immigration policies implemented in response to the unprecedented high numbers of asylum-seekers arriving in 2015 resulted in alarming increases in suicide attempts, self-harm, school-drop out, withdrawal, apathy, and flights among the UMA [27, 28]. However, we lack more specific information about the mental health reactions to the combined impact of traumatic events and asylum-stressors among UMA and URM. Such information may inform about the strengths and vulnerabilities of these children. Moreover, experiences of a substantial number of asylum-related and post-resettlement psychosocial stressors provide a challenging context for the implementation of the intervention we are studying that may interfere with its effectiveness.

Teaching Recovery Techniques: An Effective Short-term Intervention

Teaching Recovery Techniques (TRT) is a manualized, short term, group based intervention, which specifically focuses on children's symptoms of PTSD. TRT was developed by experts of the Children and War Foundation (C&W; www.childrenandwar.org) to heal children's mental reactions to war and disaster-related trauma [29]. The aim of the intervention is to teach children self- help methods, by increasing perceptions of control and self-efficacy in relation to trauma symptoms, based on recommended and evidence based CBT- methods for trauma relief. The five sessions help students to understand the causes of trauma and recognize signs and symptoms. Adolescents are taught a range of coping skills to stop flashbacks and other intrusive images, sounds, or smells. Student hyperarousal is addressed through stabilization and relaxation techniques, and phobic avoidance behavior is gradually desensitized through use of relaxation with anxiety and anger hierarchies.
The program is delivered to groups of 5 - 15 adolescents by local group-leaders in pairs that are trained by representatives from C&W.
TRT has proven to be effective in reducing trauma-related mental health symptoms in contexts of war and disaster when delivered by non-clinicians and "lay" people [30-35]. However, TRT has rarely been implemented with UMA or URM in post-war contexts, who have a longer time span since the traumatic exposure than children in contexts of war, and who are experiencing additional psychosocial challenges. A small study conducted in the

U.K., showed more beneficial mental health effects among refugees than asylum-seekers, and the authors speculated if experiences of post-migration stressors might have reduced the effectiveness in the latter group [36]. A small pilot study in Sweden yielded positive effects of TRT among 48 UMA and URM.
In spite of the focus of TRT to increase coping and self-efficacy, none of the above mentioned studies included any measures of QoL-related constructs. To enhance our knowledge of the effectiveness of TRT in post-war contexts, we expand on the designs of the referred studies by 1) including a wait-list control group; 2) examining longer term effects; 3) including QoL-related outcomes (subjective wellbeing and self-efficacy) in addition to symptoms of PTSD, and 4) taking the psychosocial context into consideration.

Aims

The overall aim is to evaluate the effectiveness on mental health of TRT among unaccompanied minor asylum-seekers and refugees.
More specifically, we will:

Examine the short and long-term effectiveness of TRT in reducing mental health symptoms and promote QoL

- *Primary hypothesis:* The TRT intervention is expected to significantly improve the mental health status (i.e. alleviate symptoms of post-traumatic stress disorder, depression and anxiety and promote QoL) compared to the waiting-list control group.
- *Secondary hypotheses*: 1) Asylum- related and post-resettlement psychosocial stressors predict mental health problems and QoL over and above pre-migration traumatic exposure. 2) Asylum-related and post-resettlement psychosocial stressors predict variation in the short and long term effects of the effect of the TRT.

Method

The study has been approved by the Regional Committees for Medical and Health Research Ethics (REK) ref 2016 / 355.

Power

Several power analyses have been performed to calculate the required sample size, given an α-level of 0.05 and power (1-β) of 0.80. The analyses show that a sample of n=150 will be sufficient to detect standardized regression effects of 0.20 or larger. For intervention effects there will be power to detect effect sizes of d=0.40 or larger. With use of linear mixed effect models and structural equation modelling, and the wait-list design, power will be even higher. Thus, we are confident that the planned sample size is sufficient to address the research questions posed.

Sample

The study involves about 170 UMA and URM > 8 years.

Recruitment involved inviting reception centers and municipalities from all over Norway to participate as a first step. The children in the centers and municipalities that accepted to participate who spoke Pashto, Dari, Arabic, Somali or Tigrinya, were then invited to

participate (see information below).
A total of 18 TRT-groups have been conducted during the project period. To avoid cross-contamination [37] of the intervention, the children were allocated to Intervention or Control groups on an institutional level. We endorsed half of the participating reception centers and resettlement municipalities to Intervention Groups, and the other half to wait-list Control Groups. We did this based on practical considerations related to the data collection, such as time frames of the commission, geographical location of the targeted centers and municipalities, and availability of bilingual research assistants. The Intervention Groups started the TRT soon after the information meeting, and the Control Groups started when they had completed the five weekly sessions and the W2 data collection.

Overview of the recruitment process

Invitation to participate in the study was sent to reception centers and resettlement municipalities, and health nurses of the local primary health care, based on contact information from the three commissioning directorates. Centers / municipalities that agreed to participate assigned a contact person that assisted the research team in the information and recruitment stages of the project. They typically approached the largest language groups in their respective institutions. The research team sent out brief, written information and sound tracks about the project in the respective languages to the children, with an invitation to attend an information meeting. We also invited their legal guardians (representatives), and the TRT-group leaders to the information meeting, where we presented the intervention and the project, with the support of bilingual research assistants in the role as translators.

Inclusion – exclusion criteria

Inclusion criterion was based on the children fulfilling criteria indicative of PTSD on the Children's Revised Impact of Event Scale (CRIES–8), that is, a score $\geq$17 on intrusion and avoidance subscales [38]. Thus, at the end of the information meeting, we asked the children who were interested in participating in the study to fill in the checklist, which we provided both in the five foreign languages and in Norwegian. The bilingual research assistants read the questions in the children's mother tongue.
The names of the children who qualified to receive the intervention were then given to the group leaders, who finalized the recruitment.
Exclusion criteria involved known serious medical condition such as mental disabilities and psychotic disorder.
All legal guardians of the invited unaccompanied minors < 16 years signed a consent form. Children $\geq$ 16 years signed the consent form on their own behalf, but their legal guardians were informed about the project, and encouraged to discuss it with the child they represented.

Procedures

Treatment response was registered by self-report questionnaires administered before upstart of TRT (W1), two weeks after the completion of TRT (W2) and two months after completion of TRT (W3). The questionnaires were translated to the participants' respective languages by standardized back-translation procedures. The children filled in the questionnaires in a group setting. The trained bilingual research assistants read the questions to the children, and assisted them with language issues.

Measures

The included measures have demonstrated good psychometric properties in previous studies of mental health among children of war and disaster, including in TRT effect-studies. They have shown good psychometric properties in former studies in different cultures or involving multi-ethnic groups in Norway.

Mental Health Outcomes

Symptoms of PTSD: Children's Revised Impact of Event Scale, CRIES-8 (31, 39) with eight items of intrusion and avoidance was used for screening purposes, and CRIES-13 (42) with additional five hyperarousal items was used at W1, W2 and W3 [30, 39].

Qualitive of Life: 1)**Subjective Well-being**: Cantril Ladder [40]. The participants are presented with an illustration of a ladder with ten steps, and informed that the best possible life for them being on step10, and the worst possible life being a 0. **2) Perceived Self-Efficacy**: was measured by a short version of five items of The Generalized Self-Efficacy scale, GSE [41] that has previously been used with immigrant populations in Norway [42].

Predictors

Traumatic events: 20 items developed in collaboration with the user groups.

Asylyum-related stressors: 1)Length of asylum process + status of the asylum application, and 2) 13 stressors related to network problems and the psychosocial context in the centers that was developed in collaboration with the user group

Post-resettlement stressors: short version of a daily hassles scale developed by the NIPH for studies of mental health in immigrant and refugee background youth populations [16].

Child demographic background variables: age, gender, country of origin, length of stay in Norway.

Statistical Analyses

Treatment effects will be analyzed using ANCOVA and mixed regression models that may be flexibly adjusted according to the dependency structure in the repeated data.

Relevance and Utility

Developing evidence based interventions to promote the mental health of asylum-seeking and refugee children is highly relevant to major mental health policies and practices. According to an analysis of the health services' psychosocial follow-up of asylum-seekers, [11], only 18% of the specialist mental health services report to have special competence with refugees. Moreover, a high proportion of the municipalities' primary health care experience challenges in collaborating with the specialist services, related to lacking capacity and competence, declined referrals, or that the refugee group is not prioritized (Rambøll, 2016). Evidence based, low threshold selective interventions that can be implemented outside Child and Adolescent Mental Health services, are therefore highly needed. Implementing low-threshold interventions is in line with the Government's strategy to improve the mental health of children and adolescents, which specifically mentions unaccompanied asylum-seeking and refugee minors [13] [12]. The Governments states that low-threshold interventions should be implemented early to avoid the development of serious mental disorders. Offering TRT to asylum-seeking children and young refugees in the early stages of the resettlement process (p. 48), is in accordance with these claims. Immigrant health and evaluation of mental health

promoting interventions that may contribute to better health services for refugees and other traumatized children and youth are important targets in the NIPH strategy [43].

User Groups

At the upstart of the evaluation study, we established a user group of 3 unaccompanied minor asylum-seekers that we have met with 3 times, with one last meeting scheduled in May 2018. In the first meeting we informed about the project and discussed the role of the user group. We also discussed the stressors that asylum-seeking minors experience during their stay in reception centers. Based on this, we developed a checklist of asylum-stressors that we presented to the user group to get their feedback in the second meeting. They also gave input and advice to the content and structure of information we were to use in recruiting of asylum-seeking and refugee participants to the project. In the third meeting we discussed what traumatic events that are relevant and typical to unaccompanied minors, as a basis for the development of a revised checklist of traumatic experiences. The plan for the upcoming final meeting, is to get the users' perspectives on what they consider important topics for future grant proposals.

For the purpose of the proposed PhD study, we will establish a new user group, comprising 3 – 4 unaccompanied minors that has received residence in Norway. We will meet once or twice annually to discuss study questions and interpret the results of the analyses.

Progress Plan

Project period: 20.06.2017- 31.12.2021

2017 – 2018 activities: Recruitment, intervention, data collection. Completed
2019 – 2021 activities: establish and meet with user group. PhD courses. Analyze data and write 5 articles

Project Management, Organization and Cooperation

The proposed study is anchored in the NIPH, Division of Mental and Physical Health. Senior researcher B. Oppedal is the Principal Investigator (PI). Implementation and data collection were funded by The directorate of immigration, The directorate of diversity and integration, and The directorate of children, youth, and family affairs. The scientific dissemination is funded by the Council of Mental Health and The Norwegian Institute of Public Health. In addition to the PI, the research team includes a PhD student, and four scholars with comprehensive, long term experience and state of the art expertise in methodological approaches of intervention research, clinical work and research related to asylum-seeking and refugee children:

Anne Kristine Solhaug, Cand. Psychol, is currently a research coordinator on the NIPH evaluation project. Her empirical master thesis focused on URM, and she has been engaged in voluntary work with refugees from a variety of perspectives over the years.

E. Roysamb, Professor, Department of Psychology, University of Oslo, and NIPH. Co-supervisor. Prof. Roysamb is one of Norway's leading researchers within the field of mental health, in particular within the field of positive mental health. Based on this and his high-level expertise with statistics, he contributes valuable resources to the research team.

R. Calam, Professor Emerita, Division of Psychology and Mental Health, the University of

Manchester, UK. Prof. Calam has years of experience in implementing and evaluating TRT among refugee families in Turkey and Lebanon. Her research group has particularly focused on the role of parents in enhancing the effect of TRT on their offspring. She will contribute her expertise in planning and conducting the evaluation of the effects of the TRT, and giving feedback to the manuscript writing.

A. Sarkadi, Professor, Department of Public Health and Caring Sciences, Uppsala University, Sweden. Prof. Sarkadi has recently pilot tested TRT among unaccompanied minor asylum-seekers in Sweden. She is currently the PI of a recently launched RCT assessing effectiveness of TRT among asylum-seeking and refugee minors in Sweden. A collaboration between the two ongoing Nordic studies of TRT provides a number of opportunities to learn from each other, share data and discuss analytic choices.

Implementation of Research Findings

The main target groups for popular scientific dissemination of results are policy-makers and immigrant-refugee non-governmental organizations, asylum-seeking or refugee children and youth. The NIPH Department of Communication will be involved in planning strategies for communication with these groups through our traditional channels. We will collaborate with the C&W in producing popular scientific reports and fact sheets that can be easily available on various websites. Moreover, we will collaborate with the directorates that commissioned the evaluation study in organizing conferences and seminars to communicate research findings both to the local agents in charge of the care and support of refugee and asylum-seeking minors, and to local primary mental health care service providers.

Ethical Aspects

The proposed PhD study is part of a more comprehensive study to implement and evaluate TRT that has been approved by REK (2016/355). The study protocol that was approved addressed main issues related to doing research in vulnerable asylum-seeking and refugee child populations.

Collaboration with the Council of Mental Health (CMH)

The proposed study is well within the Strategic Plans of the CMH, what regards the focus on promoting the mental health of children and youth, information about refugee population's mental health, and the focus on low threshold intervention. Project coordinator C. Elvedal, CMH, has provided us with valuable input regarding important issues to include in the proposal. She has read a draft of and given feedback to the study protocol. We have discussed a potential collaboration in relation to the progress of the study, the dissemination of important research findings should the study be granted, and how the specific competence of the study team can be made available to the CMH if needed.

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