

Beginning to hope: Aligning psychiatric care provision to needs of vulnerable children and young people

Childhood and adolescence is a crucial period for establishing healthy emotional and behavioural capabilities which can sustain a lifetime of positive mental health and well-being. Unfortunately, this period is also a critical window for the onset of potentially lifelong mental health problems, with 50% of lifetime psychiatric conditions estimated to begin by 14 years old.¹ Between 10 and 19 years old, no other health outcome contributes more to global disability than unipolar depressive disorders, with self-harm ranked fifth, and—for women—anxiety disorders are ranked fourth.² These harmful patterns of mental ill health contribute to suicide risk, which is the third leading cause of death amongst 15- to 19-year-olds worldwide, only behind road injury and HIV/AIDS.²

Early therapeutic intervention for mental health problems which emerge in adolescence provides an opportunity to help young people manage and recover from episodes of poor mental health to minimise disruption to their future mental, physical and social well-being. Thus, timely, equitable and appropriate access to affordable psychiatric care—where and when needed—would ideally form the foundation of a just public mental health strategy in any given nation. Such efforts would need to be informed by the ability to identify high-risk subsets of the population. While no one is immune to mental health disorders, certain factors have been identified which increase risk, and which thus serve as potential signposts to aid early detection and treatment. Of particular note, and appearing to act non-specifically across a range of neuropsychiatric conditions and risk-taking behaviours,^{3,4} is the role of adverse childhood experiences, including exposure to bullying, parental loss, maltreatment, violence or other traumatic life events.

Within this context, children and adolescents from refugee backgrounds are likely to have been exposed to severe—and perhaps multiple—traumas associated with malnutrition and famine, conflict, violence and persecution, and stand out as a potential high-risk group for whom mental health services could be readily provided to prevent or ameliorate potentially deleterious mental health problems emerging in adolescence. Previous epidemiological studies have found strong evidence that refugees are—perhaps unsurprisingly, given these patterns of exposure—ten times more likely to experience post-traumatic stress disorder than the general population.⁵ In Sweden, evidence suggests that refugees are also up to three times more likely to experience a psychotic disorder before 30 years old, a risk that is 60% higher than for non-refugee migrants

from the same regions of origin.⁶ And while the risks of both substance abuse disorders⁷ and suicide⁸ are approximately 50% and 30% lower, respectively, for refugees on arrival to Sweden than the background Swedish-born population, these risks converge towards the Swedish rate over time. This suggests that post-migratory environmental characteristics—including barriers to timely, appropriate early intervention—affect the future chances of young people seeking to rebuild their lives following a period of trauma exposure.

In this edition of *Acta Paediatrica*, Berg and colleagues' investigation of psychiatric care utilisation by adolescent refugees living in Sweden elegantly extends our understanding of these needs against the opportunities for intervention available and, in so doing, informs both the clinical and public health agendas for prioritising care provision to some of the most vulnerable young people in our society.⁹ Taking longitudinal, regional health data from over 90 000 adolescents living in Stockholm County—including over almost 19 000 with a refugee background—Berg et al found that rates of first psychiatric care use before age 18 were, on average, 41%-55% lower in refugee teens compared with Swedish adolescents born to two Swedish-born parents, even after adjusting for possible differences in birth year, sex and parental education.

Further investigation revealed notable differences in psychiatric service utilisation by length of time in Sweden, type of residence permit granted to refugees by the Swedish Migration Agency and region-of-origin. First, regardless of permit type, more recent teenage refugee migrants to Sweden were less likely to use psychiatric care services (55% reduction), with the highest rates (although still appreciably lower than in the Swedish-born reference group) amongst Swedish-born teens to refugee parents (41% reduction). Second, refugee teens who were granted residency based on a family reunification permit were found to use psychiatric services to an even lesser extent (63%-75% reduction, depending on time in Sweden), while those granted residency as asylum refugees had more modest reductions in psychiatric care use (between 26% and 41% of the Swedish reference group). Finally, while the authors found strong evidence of lower psychiatric care use for refugee teens from low- and middle-income countries, no differences in rates of psychiatric care use were found between refugees from high-income countries and Swedish-born teens; the large sample size and hazard ratios for this effect, which were close to unity, make power an unlikely explanation of this null result.

The rich and detailed set of analyses provided by Berg and colleagues lead to several important implications. First, and most obviously perhaps, is that despite elevated need, refugee adolescents—in Sweden and perhaps elsewhere—under-utilise psychiatric care services. Under a strict interpretation of the survival analyses presented by Berg et al, the processes which result in this paradox imply that refugee teenagers take twice as long to access first psychiatric care than the majority of Swedish teens. Logically, this implies that a substantial proportion of refugee teens in need of mental health care experience delays in receiving treatment and as a result face greater distress and poorer long-term mental and social outcomes as a result. This has the potential to selectively and inequitably erode the potential benefits of early intervention in psychiatry, which has become a cornerstone of contemporary care in many settings.¹⁰

Second, Berg et al's work emphasises how imperative it is for clinical, academic, social and public health services to work together to identify and remove the barriers that result in delays to care in refugee teens. In Sweden, all residents including refugees can access healthcare services free-at-the-point-of-care and can access compensation for any parental leave from work to care for a child who is unwell. This means both direct and indirect economic barriers to accessing psychiatric care are unlikely to have explained under-utilisation rates in this study, although may still be relevant in other settings. Other, indirect, economic barriers to care may still affect refugee families, including parental leave from paid employment to attend healthcare appointments with their child and potential childcare costs for other children during these periods. Family reunification refugee teens were less likely to use services than those arriving via asylum routes. This may reflect more traumatic experiences or increased access to care for refugees arriving via the asylum route, who are both more likely to be exposed to additional traumas and more likely to receive health checks as part of Sweden's reception programme than family reunification refugees.⁹ Other research has highlighted further important potential barriers, including the lack of culturally appropriate services for some migrants groups, language issues, other intersectional minority issues (including sexual identity¹¹) and the roles of both stigma and racism in accessing mental health services.¹² Interestingly, Berg et al found important socio-demographic differences in their sample that may reveal important, differential patterns of selection into psychiatric care; while Swedish-born teens who utilised psychiatric care were more likely to come from families whose parents had shorter education and lower incomes, the reverse was true for refugee adolescents, whose parents were—on average—more likely to have more education and higher incomes. Although parental education did not account for differences in psychiatric care utilisation in their study, one important implication is that children and adolescents from the most socio-economically disadvantaged refugee families are least likely to access care, despite likely need. This care gap provides a ready target for public health intervention, both in Sweden and other countries. Such initiatives are already underway¹³ and aim to provide culturally appropriate community and individual interventions for child and adolescent migrant mental health.

There is already good evidence about the likely core elements required for successful interventions in refugee mental health, including the use of ethnically matched therapists, availability of services in different languages and the role of 'community peers' to strengthen outreach services.¹⁴ More such initiatives should follow, potentially including trauma-informed models of care which are gaining traction in adult mental health,¹⁵ but still require demonstration of efficacy for children and adolescents. Nordic countries are particularly well-placed to lead this effort, combining their rich, detailed register-based health data with their legacy of compassionate resettlement for displaced individuals. These settings should provide fertile ground for developing and testing (via, for example, randomised controlled trials) clinical and public health interventions targeted at refugee populations, which—when linked with register data—could provide robust evidence of their short, medium and long-term physical, mental, social and economic benefits. The best of these interventions, then, would surely enrich both the lives of refugee communities and the whole population alike. Berg et al's study provides a rallying call to remove disparities in child and adolescent mental health treatment for some of our most vulnerable citizens.

CONFLICT OF INTEREST

The author has no conflicts of interest to declare.

James B. Kirkbride 

PsyLife group, Division of Psychiatry, UCL, London, UK

Correspondence

James B. Kirkbride, PsyLife group, Division of Psychiatry,
UCL, London W1T 7NF, UK.
Email: j.kirkbride@ucl.ac.uk

ORCID

James B. Kirkbride  <https://orcid.org/0000-0003-3401-0824>

REFERENCES

1. Kessler RC, Berglund P, Demler O, Jin R, Merikangas KR, Walters EE. Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the national comorbidity survey replication. *Arch Gen Psychiatry*. 2005;62:593-602.
2. World Health Organization. Health for the World's Adolescents: A Second Chance for the Second Decade. Global Health Estimates. 2014 [cited 2020 Aug 27]. <https://apps.who.int/adolescent/second-decade/>. Accessed September 28, 2020.
3. Norman RE, Byambaa M, De R, Butchart A, Scott J, Vos T. The long-term health consequences of child physical abuse, emotional abuse, and neglect: a systematic review and meta-analysis. *PLoS Med*. 2012;9:e1001349.
4. Hughes K, Bellis MA, Hardcastle KA, et al. The effect of multiple adverse childhood experiences on health: a systematic review and meta-analysis. *Lancet Public Heal*. 2017;2:e356-e366.
5. Fazel M, Wheeler J, Danesh J. Prevalence of serious mental disorder in 7000 refugees resettled in western countries: a systematic review. *Lancet*. 2005;365:1309-1314.

6. Hollander A-C, Dal H, Lewis G, Magnusson C, Kirkbride JB, Dalman C. Refugee migration and risk of schizophrenia and other non-affective psychoses: cohort study of 1.3 million people in Sweden. *BMJ*. 2016;352:i1030.
7. Harris S, Dykxhoorn J, Hollander A-C, Dalman C, Kirkbride JB. Substance use disorders in refugee and migrant groups in Sweden: a nationwide cohort study of 1.2 million people. Alegria M, ed. *PLOS Med*. 2019;16:e1002944.
8. Hollander A-C, Pitman A, Sjöqvist H, et al. Suicide risk among refugees compared with non-refugee migrants and the Swedish-born majority population. *Br J Psychiatry*. 2019;1-7. <https://doi.org/10.1192/bjp.2019.220>. [Epub ahead of print].
9. Berg L, Ljunggren G, Hjern AE. Underutilisation of psychiatric care among refugee adolescents in Stockholm. *Acta Paediatr*. 2020. <https://doi.org/10.1111/apa.15520>. [Epub ahead of print].
10. Byrne P, Rosen A, eds. *Early Intervention in Psychiatry: EI of Nearly Everything for Better Mental Health*. Hoboken: Wiley-Blackwell; 2014:1-432. <https://www.wiley.com/en-gb/Early+Intervention+in+Psychiatry:+EI+of+Nearly+Everything+for+Better+Mental+Health-p-9780470683422>
11. Silberholz EA, Brodie N, Spector ND, Pattishall AE. Disparities in access to care in marginalized populations. *Curr Opin Pediatr*. 2017;29:718-727.
12. Tulli M, Salami B, Begashaw L, Meherali S, Yohani S, Hegadoren K. Immigrant Mothers' Perspectives of Barriers and Facilitators in Accessing Mental Health Care for Their Children. *J Transcult Nurs*. 2020. <https://doi.org/10.1177/1043659620902812>. [Epub ahead of print].
13. Karolinska Institutet. Bridging Barriers to mental health support for newly arrived minors (TINA). [cited 2020 Sep 2]. <https://ki.se/en/gph/bridging-barriers-to-mental-health-support-for-newly-arrived-minors-tina>. Accessed September 28, 2020.
14. Riza E, Kalkman S, Coritsidis A, et al. Community-based healthcare for migrants and refugees: a scoping literature review of best practices. *Healthcare*. 2020;8:115.
15. Bloomfield MAP, Yusuf FNIB, Srinivasan R, Kelleher I, Bell V, Pitman A. Trauma-informed care for adult survivors of developmental trauma with psychotic and dissociative symptoms: a systematic review of intervention studies. *The Lancet Psychiatry*. 2020;7:449-462.