

**Unaccompanied Refugee Minors' Experiences
of Mental Health Services**

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By

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ABSTRACT

Unaccompanied refugee minors' experiences of mental health services

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Background

The current evidence shows that unaccompanied refugee minors have poorer adjustment and greater psychiatric morbidity than the general population. Despite the availability of some treatment options, there have been widespread concerns about poor access and utilization of mental health services in this population. Very limited research evidence is available on their perceptions and experiences of treatment for mental illness and mental health services.

Research aims

The aims of this research were to explore the unaccompanied refugee minors' experiences of mental health service, the factors contributing to the experiences and their perceived ways of improving these services.

Methods

A clinical sample of 15 unaccompanied refugee minors and their carers were recruited from consecutive referrals to a specialist Children and Adolescent Mental Health (CAMHS) team for looked after children. Young people and their carers were interviewed using a semi structured interview schedule. Interviews were audio taped, transcribed verbatim and analysed by a thematic framework.

Results

The main emerging themes related to participants' understanding of mental health, experiences of services and interventions, and suggestions for future improvement. Young persons' limited knowledge of mental health services, lack of trust and fear of stigma were perceived as main factors affecting their engagement. They preferred not to talk about their past at this stage, but rather expected clinicians to help them address their present needs. Activity-based interventions were favoured over talking treatments. Strategies to engage the young persons, and connecting with other agencies and communities were recommended by the participants.

Conclusions

The findings provide support for the role that preparation, engagement, and communication between agencies and communities may play in the unaccompanied refugee minors' experience. These findings are discussed in the context of previous evidence. Clinical and service implications as well as recommendations for future research are considered.

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DECLARATION

This is to declare that this thesis is the student's own work, and has not been submitted in substantially the same form for the award of a higher degree elsewhere.

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CHAPTER ONE
UNACCOMPANIED REFUGEE MINORS: MENTAL HEALTH NEEDS
AND INTERVENTIONS

1.1. DEFINITIONS, POLICIES, LEGAL AND EPIDEMIOLOGICAL ACCOUNTS

1.1.1. Definitions

The founding mandate of UNHCR (United Nations High Commissioner for Refugees) in 1951 formulated the definition of refugees as people who are outside their country and cannot return, owing to a well-founded fear of persecution because of their race, religion, nationality, political opinion or membership of a particular social group. The term 'refugee' refers to all people who are subsumed under the 1951 Convention relating to the Status of Refugees, its 1967 Protocol, and the 1969 OAU (Organization of African Unity) Convention Governing the Specific Aspects of Refugee Problems in Africa. This group relates to people who fulfil the UNHCR Statute, as well as individuals with 'complementary forms of protection' and 'temporary protection'. Complementary protection signifies a formal permission to individuals under national law, established on humanitarian grounds to reside in a country, although they might not fulfil refugee status under the conventional refugee criteria. Temporary protection is provided for those who arrive in large numbers due to conflict and violence, and who subsequently do not require formal or individual status determination (UNHCR, 2007a). 'Asylum-seekers' are individuals who have sought international protection, and whose claim for refugee status has not yet been determined. When people leave their own country to seek safe shelter in another state, they often have to apply for 'asylum,' which is the right to be recognized as bona fide refugees and receive legal protection, as well as other assistance (UNHCR, 2007b).

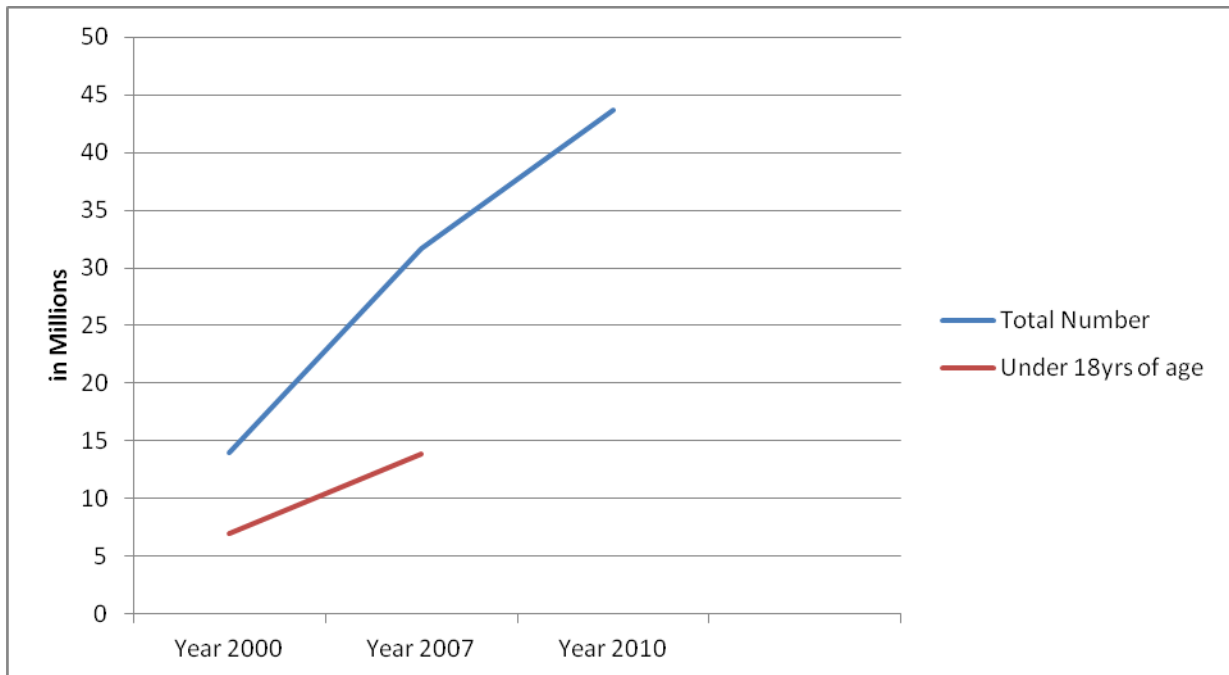
When considering under age asylum seekers, internationally used definitions of 'child' and 'unaccompanied/separated children' have been central in establishing their status. The word 'child' is mostly used in accordance with the definition determined in Article 1 of the Convention on the Rights of the Child (CRC). The CRC states that a child means every human being below the age of 18 years unless, under the law applicable to the child, adulthood is attained earlier. Unaccompanied children and adolescents or unaccompanied minors, according to the CRC, have been separated from both parents and relatives, and are not being cared for by an adult who, by law or custom, is responsible for doing so. Separated children and adolescents are those not accompanied by parents, or their previous legal or customary primary care-giver, but not necessarily parted from their relatives. All member states of the UN, except the United States of America and Somalia, have ratified the CRC (United Nations Convention on the Rights of the Child, 1989).

1.1.2. International trends in refugee figures

In the new millennium, the United States Committee for Refugees reported that, of the estimated 14 million people displaced due to war and persecution worldwide, approximately half were children (United States Committee for Refugees, 2000). Unfortunately, the number of refugees in the world shows no signs of decreasing, and current world politics indicate the continued traumatising of children around the globe (Goodman, 2004). By the end of 2007, the total population under the responsibility of the United Nations High Commissioner for Refugees (UNHCR) amounted to 31.7 million. Among this large population, nearly 44% are under 18 years of age and 10% are under the age of 5. At the end of 2010, some 43.7 million

people worldwide were forcibly displaced due to conflict and persecution, the highest number in more than 15 years (UNHCR, 2010).

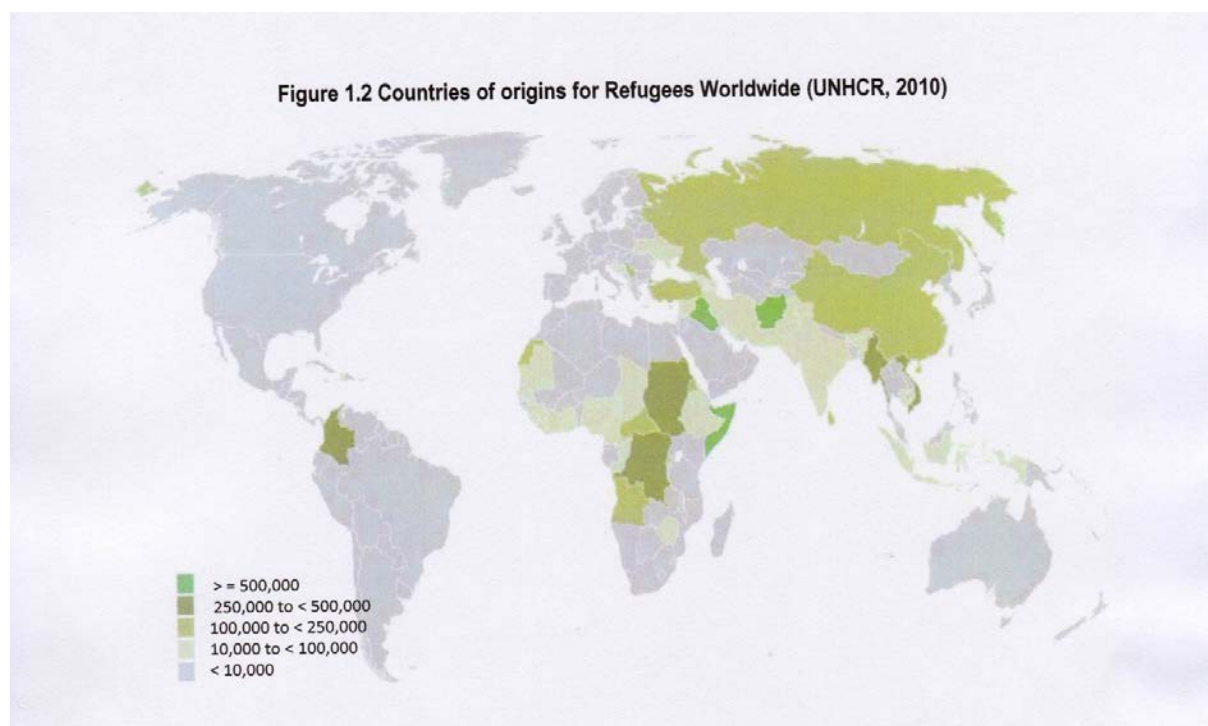
Figure 1.1. Displaced persons worldwide



Unaccompanied refugee minors (i.e. children without parents) are a hidden population within many of these statistics and are increasingly regarded as an important group (Huemer et al., 2009). More than 72,000 unaccompanied minors lodged asylum claims over the past five years. In 2010, more than 15,500 unaccompanied or separated children, mainly from Afghanistan and Somalia, filed an asylum application in 69 countries worldwide. This constitutes about 4% of the total number of asylum claims lodged in those countries, and is consistent with the percentage observed in 2009. In absolute terms, however, the number of separated children seeking asylum has decreased compared to 2009 (18,700 claims in 71

countries). This trend is consistent with the overall decrease in the global number of asylum-seekers recorded. Europe received 11,500 (74%) of these 15,500 claims.

Contrary to previous years, when the United Kingdom registered the highest number in Europe, in 2010 Sweden and Germany received most claims. While in Sweden, and particularly in Germany, figures went up significantly (6% and 49% increase respectively), in the United Kingdom they dropped by almost half (47% decrease). Kenya and India were important destination countries for unaccompanied minors outside Europe, with 1,100 (209% increase) and 430 (10% decrease) asylum claims respectively. The available information indicated that 5,400 unaccompanied and separated children were recognized as refugees or were granted a complementary form of protection in 2010. This figure was lower than in 2009 (7,700 positive grants). Europe accounted for 68% of all positive decisions rendered. Afghan and Somali children accounted for almost half of all claims in 2010 (UNHCR, 2010).



1.1.3. Policies and statistics in different parts of the world

1.1.3.1. United States

In the US, the enactment of the Refugee Act of 1980 and the Immigration and Nationality Act define an 'unaccompanied refugee minor' (URM) as a child who is under the age of 18, and who entered unaccompanied by and not destined to (a) a parent; or (b) a close non-parental adult relative who is willing and able to care for the child; or (c) an adult with a clear and court verifiable claim to custody of the minor; and who has no parent(s) in the US (Immigration and Nationality Act, 1965). In the US, 7,000 to 9,000 unaccompanied children and adolescents have been referred to the Office of Refugee Resettlement (ORR) by the Department of Homeland Security since 2005. They primarily include those who have entered illegally and who are not being considered as refugees (Byrne, 2008). Between 1999 and 2005, 782 new URMs were enrolled in a programme specifically for unaccompanied refugee youth (Unaccompanied Refugee Minor Programme). During this period, the originating geographical areas for the majority of these URMs were Sub-Saharan Africa, Central America and the Caribbean, and the Middle East. In contrast, in the 1980s, when the programme was initially developed, most of these children and young people without a guardian had originated from Southeast Asia. Since its inception, almost 12,000 minors have entered the programme (Haddal, 2008).

1.1.3.2. Europe

Policies in terms of asylum seeking and legislative frameworks differ considerably throughout Europe. The idea of a common European policy on immigration was first discussed at the Seville European Council in 2002, based on The Amsterdam

Treaty, which has been in force since 1999, by recognizing that immigration and asylum questions could not be solved purely at national level (Huemer & Vostanis, 2010). The Separated Children in Europe Programme (SCEP) was established in 1997 as a response to the increasing number of separated children in the continent. The network aims at improving the life conditions of this vulnerable group by means of research, policy analysis and advocacy at national and regional levels. SCEP was founded by UNHCR and the International Save the Children Alliance, based on the complementary mandates and expertise of the two organizations. Its membership includes 25 European Union (EU) countries as well as Bulgaria, Croatia, Norway and Switzerland. In terms of URMs and separated children, UNHCR also co-operates with other networks, such as Le Réseau Euro-Méditerranéen pour la Protection des Mineurs Isolés (REMI) and the Council of the Baltic Sea States, which have organized expert groups on children (Huemer et al., 2009).

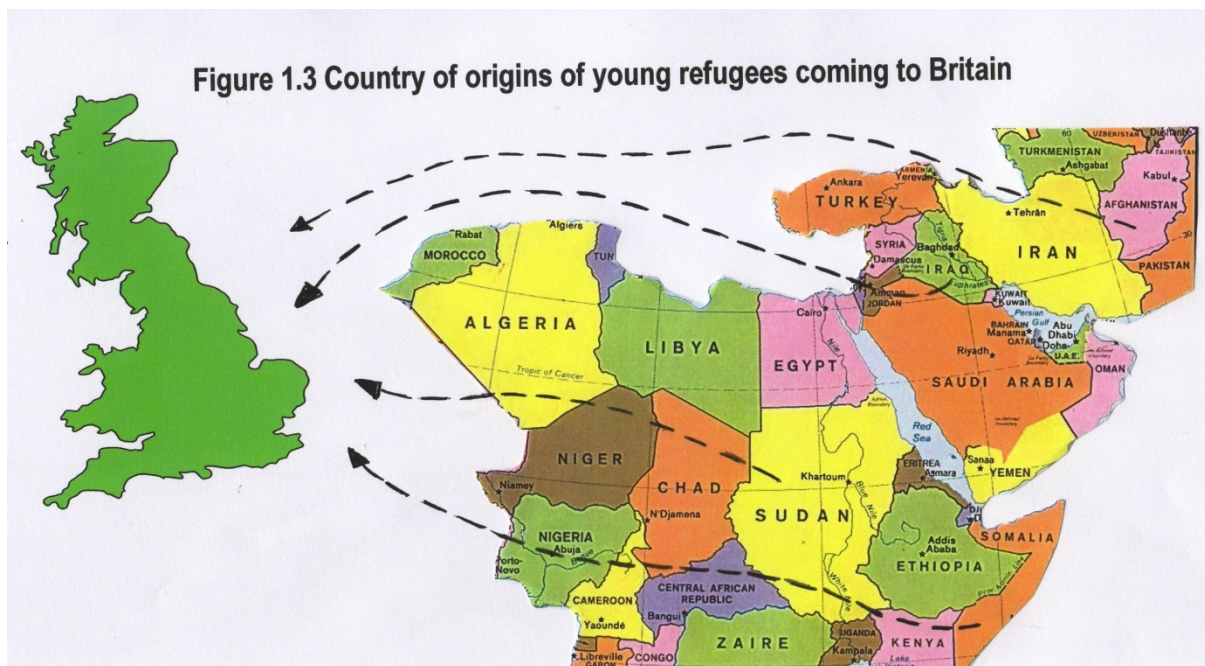
1.1.3.3. United Kingdom

In 1991 the UK government set a precedent when ratifying the UN Convention on the Rights of the Child (CRC) by expressing a reservation on Article 22, which guarantees all rights in the CRC for asylum seeking and refugee children. The justification for this was to discourage children from coming to the UK solely to benefit from rights under the CRC, and to stem immigration flow into the UK (Harvey, 2002). The 2003 Green Paper by the Department of Health, 'Every Child Matters', drew attention to unaccompanied minors seeking asylum as a vulnerable group in need of protection. It recognised unaccompanied asylum seeking minors as children first and asylum seekers second (Department of Health, 2003). In the UK, 'Unaccompanied Asylum Seeking Children' (UASC) is used as the legal term

equivalent to unaccompanied refugee minors. According to the legal definition provided by the Immigration and Nationality Directorate (IND), UASC are under 18 years of age, separated from both parents, and are not cared for by an adult who, by law or custom, has a responsibility to do so (IND, 2002).

The Home Office definition of UASC is a person who, at the time of making the asylum application:

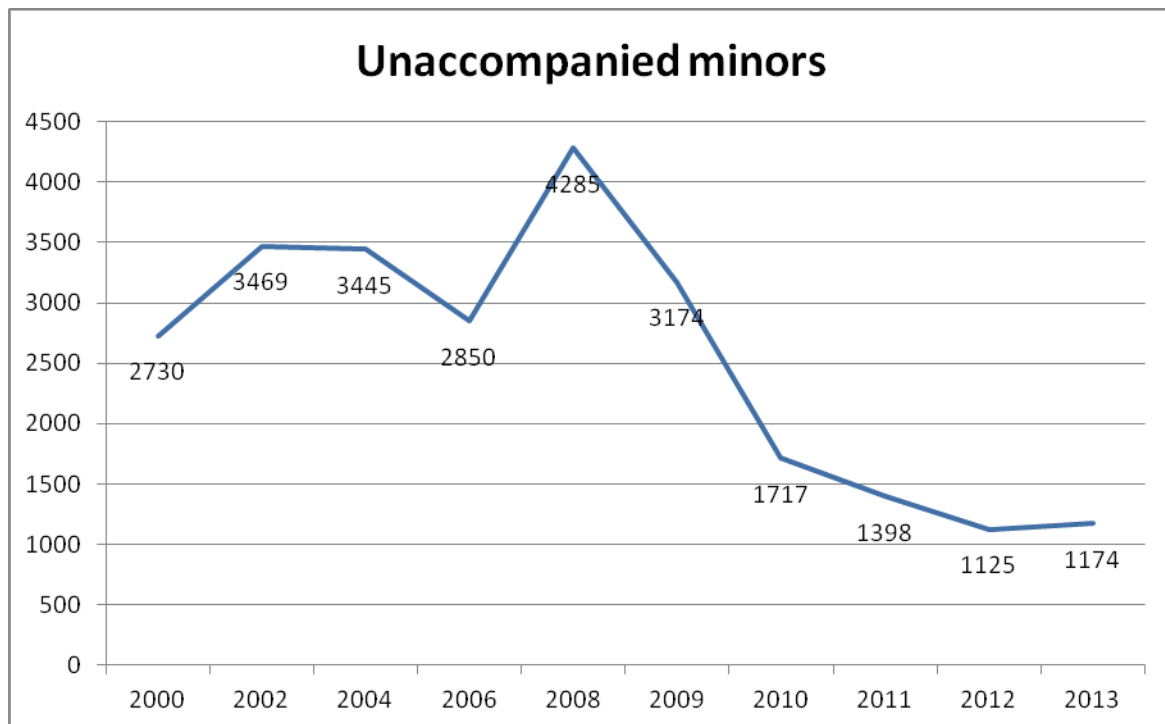
- Is or (if there is no proof) appears to be under 18
- Is applying for asylum in his/her own right
- Has no adult relative or guardian to turn to in this country (Kralj & Goldberg, 2005).



Between 1990 and 2000, 450, 000 people applied for asylum in the UK. At least 40% were under 18 years of age, including many unaccompanied refugee children (Webb et al., 2005). This is comparable with the proportion of young refugees worldwide

(44%). From 2000 to 2001, the number of UASC applying for asylum in the UK increased by 27%, from 2,730 to 3,469 (Heath & Hill, 2002). A total of 3,445 unaccompanied children sought asylum in the UK in 2003, only 4% of whom were granted indefinite leave to remain (Casciani, 2005). For the whole of the year 2006, 23,520 asylum applications were received by the Home Office. Of these applications, 2,850 (12%) were from unaccompanied asylum-seeking children and young people, 7% of whom were eventually granted asylum. Less than 1% of applicants (10 young people) were granted humanitarian protection, 22% were refused, and the remainder (71%) were awarded discretionary leave until they became 18 (Chase et al., 2008). In 2008, 4,285 unaccompanied or separated migrant children arrived in the UK and claimed asylum. In addition, 1,400 other individuals applied for asylum in the same year but their ages were disputed, and this had not been resolved for half of them (785) one year later. Their asylum applications were, therefore, processed as adults (Brownlees & Finch, 2010). The number of unaccompanied asylum seeking children in the UK has gradually decreased over the last six years, i.e. since 2008. According to the recent data from the British Refugee Council (2014), the number of UASC was 3,174 in 2009 (26% decrease), 1717 in 2010 (46% decrease), 1398 in 2011 (19% decrease), 1125 in 2012 (16% decrease), and 1174 in 2013 (4% increase). This trend might, however, change again, depending on the political stability of different world regions.

Figure 1.4. Trends of UASC in the UK



Since 2004, the UK law (section 17 or section 20 of the Children Act, 1989) dictated that unaccompanied minors must be supported by the Local Authority and not by the National Asylum Support Service (NASS). Despite this legal framework, the details of support arrangements vary locally and change over time. Unaccompanied children arriving in the UK are supposed to be referred immediately to a designated Local Authority social worker for unaccompanied minors. In reality though, Coker et al. (2004) reported that only 1 in 6 had a named case worker. Unaccompanied children must be considered as 'children in need' under the Children Act (1989); and according to the Department of Health framework (Lynch, 2001). Unaccompanied under-18 year olds have the right to be 'looked after', to have somewhere to live, and to have access to education and health care (Save the Children Fund, 1999).

1.1.4. Difficulties in policy implementation

It is essential to ensure that unaccompanied young asylum seekers are specifically included in local provisions to improve their health and educational outcomes. The reality, however, is that many 15-18 year-olds are placed in adult accommodation and, significantly, many authorities do not offer this age group full needs assessments leading to individual care plans (Audit Commission, 2000). Until recently, if the asylum claim was refused for an unaccompanied child less than 18 years of age, discretionary leave (DL) might be granted until s/he reached 18 (Webb et al., 2005). For all decisions made on or after 1 April 2007, where asylum or Humanitarian Protection has been refused, discretionary leave must only be granted up to the age of 17.5 years (or for three years, whichever is the shorter period). The young person's access to support should not be affected by this change. Unaccompanied asylum seeking children are supported whilst they remain in the UK under the terms of the Children Act 1989, and this support is not dependent upon a grant of discretionary leave. As a consequence of the 2007 amendments by the Home Office, under section 83 of the Nationality, Immigration and Asylum Act 2002, anyone aged 16.5 years or over will not be entitled to appeal, as they will have been only granted less than twelve months of leave.

When considering application for asylum by a young applicant, decision-makers should always give consideration to whether satisfactory reception and care arrangements exist in the country of nationality (or former habitual residence, if appropriate), which would enable the child's removal to take place. If child applicants are found no longer to qualify for Discretionary Leave because there are now satisfactory reception and care arrangements in place in the country of origin, they

will be refused further leave to remain unless decision-makers are satisfied that they qualify for an extension on other grounds. Applicants who are refused should be advised of the reason why they no longer qualify and, subject to the outcome of any in-country appeal, they will be expected to leave the UK (Home Office, 2010). Prior to the 2007 amendments to the Nationality, Immigration and Asylum Act 2002, asylum seekers had access to a two-tier appeal system, which has now been reduced to one. Unfortunately, as clearly detailed in an Amnesty International report, the quality of Home Office decisions varies, with initial decisions being deemed wrong in as many as one in five cases (Amnesty International, 2004).

1.1.5. The impact of age on the asylum process

If an unaccompanied minor receives an initial refusal, he or she may submit a further application for leave to remain on reaching 18. At 18 years, if the young person arrived after 7 November 2002, their care will be transferred from the Local Authority to NASS. If the young person arrived before 7 November 2002, they should remain the responsibility of Social Services under the Children (Leaving Care) Act, 2000 (Coker et al., 2004). Many 16–17 year-olds have their age challenged by the Home Office, who may claim that they are over 18 years. Usually the only document of identity possessed by the unaccompanied minor is the Application Registration Card (ARC) issued by the Home Office, stating that the person's date of birth is disputed. Social Services often carry out an age assessment on behalf of the Home Office. The method of age assessment varies between areas, but usually entails medical or dental examinations and a full report by Social Services. The Immigration and Nationality Department, the Royal College of Paediatricians, and the Immigration Law Practitioners Association clearly state, in line with advice from the Department

of Health, that age assessment is not a conclusive procedure, as this can be complicated by several factors and there is a wide margin of error. The Home Office, nevertheless, instructs immigration officers to treat the young person as an adult if their appearance suggests that they are over 18 years. This is only to be reversed if there is credible evidence to the contrary (Kralj & Goldberg, 2005).

The impact of these complex bureaucratic processes as well as the unaccompanied refugee young persons' experiences before reaching our shore on their overall well-being, and mental health in particular, will be discussed in the next section. These can be part of a number of vulnerability (risk) factors for mental health problems. On the other hand, there are also factors that are protective in building up resilience against developing mental health problems.

1.2. RISK, VULNERABILITY AND RESILIENCE FACTORS FOR MENTAL HEALTH PROBLEMS IN UNACCOMPANIED ASYLUM SEEKING CHILDREN

Our understanding of the mechanisms by which risk and protective factors operate has progressed significantly in the last half century. Individual differences are important in determining the way young people respond to stress and adversity. A correlation between a risk factor and the development of psychopathology does not necessarily imply a causal link between the two. There can be a range of alternative possibilities, and researchers have aimed at establishing mediating mechanisms (Rutter, 2009). Over the last few decades, the concept of protective factors has also become firmly established in mental health research. This is related to the notion of resilience, a term used to describe the positive end of the spectrum of individual differences in people's response to adversity. The negative end of the same spectrum can be defined as the concept of vulnerability (Rutter, 1987). In the context of global concern about the consequences of stress and extreme adversities, research findings are accumulating, and are increasingly being integrated from studies on risk and resilience across family, school and community systems, in order to help promote positive adaptation of young people faced with extreme adversity (Julianna et al., 2011). In this section, I shall discuss the different risk and protective factors that might be impacting on unaccompanied young asylum seekers' mental health.

1.2.1. Historical background

In the late 1980s, war forced young Sudanese children to flee their burning villages as their parents and families were often killed. They reportedly witnessed significant atrocities, such as seeing immediate family members stabbed or mutilated. Seeking

refugee in Ethiopia, an estimated 25,000 children trekked hundreds of miles across the savannah and desert. Along the way, hyenas and lions stalked, injured, and killed many of the youth. In 1991, the Ethiopian government expelled the Sudanese refugees, with many fleeing to Kenya in the face of attacks from soldiers and helicopter gunships. In these migrations, the children forded rivers in which many drowned, nearly drowned, or were killed by crocodiles. Once in Kenya, thousands of the Sudanese registered at the Kakuma camp, where they lived in small groups sharing shelter and other resources, or with foster families. Most received some limited but voluntary education and other assistance, though violence, hunger and inadequate living conditions remained. These Sudanese children eventually migrated further to become the largest group of unaccompanied refugee minors to have been resettled in the United States (Geltman et al., 2008).

In 1979, Soviet forces invaded Afghanistan to support the then government against an internal insurgency, following political coups earlier in the decade, which had left Afghanistan in a politically challenging situation, and their national army close to ruin. What followed was a period of civil warfare and fractional divides until 1997, when the radical Islamic group, the Taliban, seized control of Kabul. Since 2001, Afghanistan has been attempting a process of reconstruction. This was illustrated by the Bonn agreement in 2001; a new national Afghan army and police force; and with foreign peace keeping troops in place since January 2002 to date. In 2004 and 2005, following the establishment of a constitution and an elected government in Afghanistan, the UK Home Office witnessed the lowest number of asylum applications made by Afghan nationals. However, the Taliban have continued to be an insurgent force within Afghanistan and in 2009 violent fighting reached its highest

recorded level. Today the political situation in the country remains extremely volatile, with ongoing fighting between national and foreign troops, and insurgent groups. Consequently, unaccompanied minors from Afghanistan constitute a significant proportion (51%) of URMs making asylum applications to the UK (Jones, 2010). This shows the repercussions of globalization, with population movement across continents rather than country borders, following conflict in remote parts of the world.

Every week at British ports, vulnerable children from many other troubled countries are found crammed in the boots of cars, hidden in lorries and hanging underneath trucks. Many have travelled for months, alone, under the control of abusive smugglers. They arrive exhausted, traumatised, hungry and often sick or injured. Many have not slept or eaten properly for days. Upon arrival in the UK many of them have been arrested, detained for up to 24 hours, denied vital medical attention and sometimes food, before being subjected to an arduous interview about their immigration status by the UK Border Agency (RMJ, 2010). Throughout the different phases of their ongoing ordeal, they are exposed to a multitude of factors that impact on their psychological functioning and likelihood of developing mental health problems.

Table 1.1. Risk and protective factors for mental health problems in refugee children

	Risk Factors	Protective Factors
Pre-migration	Exposure to violence and trauma Bereavement	Socioeconomic status (Evidence less clear)

	<p>Female gender (Evidence less clear)</p> <p>High education (Evidence less clear)</p> <p>Unmet basic needs</p> <p>Displacement</p> <p>Persecution</p>	<p>Faith/Religion</p> <p>Traditional upbringing</p> <p>Supportive family relations</p>
Post-migration	<p>Younger age (Evidence less clear)</p> <p>Restrictive reception (detention)</p> <p>Accommodating in shelter</p> <p>Isolation</p> <p>Discrimination</p> <p>Bullying</p> <p>Uncertainty</p> <p>Marginalisation</p> <p>Relocation</p>	<p>Younger age (Evidence less clear)</p> <p>Socioeconomic status (Evidence less clear)</p> <p>High education (Evidence less clear)</p> <p>Integration</p> <p>Foster care</p> <p>Peer relationships</p> <p>Social support</p> <p>Connectedness to school and neighbourhood</p> <p>Acculturation</p> <p>Support with living</p> <p>Time since arrival</p> <p>Rapid resolution of asylum claim</p> <p>Coping strategies</p> <p>Belief systems</p> <p>Communal self</p> <p>Cultural meaning</p> <p>Faith/Religion</p>

1.2.2. Risk factors in refugee children

1.2.2.1. Violence and trauma

Exposure to trauma and violence has been associated with an increased likelihood of poor mental health outcome in refugee children. Thomas (2004) analysed pre-migration experiences of unaccompanied asylum seeking children in the UK. Almost half (47%) had experienced loss of parents and/or family members, and a further 41% had personally experienced or witnessed violence. In another study by Wiese & Burhorst (2007), extreme traumatic events, such as having witnessed the killing of parents, living on the streets, or being kidnapped and living with rebels, were experienced by 6% of children with families and 25% of unaccompanied children. The severity of post-traumatic stress symptoms has been found to be associated with personal experiences of traumatic events, especially those occurring when away from home (Geltman et al., 2005). Internalising symptoms following displacement were associated with exposure to traumatic events before migration (Montgomery, 2008), and the rates of sleep and anxiety problems were also higher among children with direct exposure to such events before migration (Hjern et al., 1991).

The degree of perceived personal threat during traumatic exposure can be a determinant of anxiety and post-traumatic stress disorder (Angel et al., 2001). Moreover, migration journeys and post migration experiences are usually highly distressing. Cuban children who witnessed violence while they were detained in a refugee camp en route to the US showed more withdrawn behaviours than did children without exposure to violence in the camp (Rothe et al., 2002). Exposure to violence and traumatic events, after entry into the host country, is found to be

associated with negative mental health outcomes in most of the studies. Some types of parental exposure to trauma are more strongly associated with children's mental health problems than are children's own exposure, particularly if parents have been tortured or are missing (Fazel et al., 2011).

Fazel et al. (2011) described that cumulative exposure to traumatic events is associated with a range of mental health problems in refugee groups exposed to violence. In some studies, the number of traumatic events before migration was not a predictor of post-traumatic stress disorder. Number of lifetime exposure to traumatic events could be a more important factor than pre-displacement exposure to violence and trauma, emphasising the importance of these young persons' life experience rather than just the pre-migration trauma (Berthold, 1999; Montgomery, 2010). However, a high number of adverse events before displacement has been seen to affect the mental health even nine years after arrival to the host nation, but those who recovered are likely to have suffered fewer additional adverse events after displacement than the refugee minors who were still suffering from mental health symptoms (Montgomery, 2010).

There seems to be quite a robust evidence base, through studies conducted in various settings and replicated on multiple occasions, in support of the negative impact of exposure to violence and trauma on the mental health of unaccompanied refugee young persons. More recent research and review papers indicated that the impact of collective exposure to trauma and violence, pre- and post-migration, may be stronger than the effect of trauma prior to these young persons' migration to the host nation, as may have originally been perceived. This research evidence,

however, is lacking specificity on the effect of various types of violence; links between domestic, structural and collective violence; and individual, family, community and social contexts affecting their experience of violence and the impact on their mental health outcomes.

1.2.2.2. Sexual assault

Many young refugees report having been raped before leaving their country of origin, with around half of these reporting multiple rapes. Rape as a weapon of war is not a new phenomenon; refugee women are at high risk of rape during conflict and flight. However, it is not only girls who are the victims of sexual violence. A number of times boys also reported that they were raped or sexually violated, either before leaving their country of origin or on their journey to the UK (Thomas et al., 2004). Sexual abuse has been found to be much more frequent among unaccompanied minors compared to children with families (Wiese & Burhorst, 2007). A significant number of unaccompanied minors are not only involved as child soldiers, but have been recruited under different roles. Whilst girls appear to have 'domestic' roles within rebel factions, the brutal experiences of kidnap, rape, violence and drugging are similar to those of boys. Some authors have commented that child soldiers seem to revert quite quickly to being 'normal children' once removed from the brutality of war (Ashby, 2002), in contrast to others who highlight the potentially devastating long-term effects of such trauma (Levy & Parker, 2000). Whilst personal, social, cultural and situational factors may differentially determine a young person's ability to cope with such extreme negative life events, an additional vulnerability factor for unaccompanied refugee young persons as compared to their accompanied counterpart is being alone. This has particularly important ramifications for health

and social care services. Although the impact of sexual assault on these young persons' mental health outcome falls under the wider rubric of research on violence and trauma, specific studies exploring the short- and long-term effect of sexual violence is lacking, thus requires further attention.

1.2.2.3. Displacement

While there are a reasonable number of reports about children exposed to conflict, the importance of displacement as a separate variable has only been assessed by four Croatian studies involving displaced and non-displaced local and Bosnian refugee young persons (Fazel et al., 2011). PTSD, depression, and somatic complaints were found to decrease with time in internally displaced and non-displaced children, but were significantly more likely to continue in displaced children (PSIH, 2000). A study comparing refugee children from Bosnia and internally displaced and non-displaced Croatian children showed that the refugee children had increased levels of anxiety and fewer coping strategies to manage stressful situations than the other two groups (Kocijan-Hercigonja et al., 1998). However, in another study (Zivcic, 1993), the prevalence of depression in internally displaced Croatian children was not different to that in non-displaced children. No difference was found either in the prevalence of hopelessness, post-traumatic stress disorder, or depression in a comparison between internally displaced Croatian teenagers who had returned home after seven years, and those who were displaced for less than six months (Grgic et al., 2005).

These results are far from conclusive; therefore, further investigation is required to explore the effect of displacement on the mental health outcome of refugee young

persons, and whether they have different needs from local children, who are also exposed to similar type of conflicts. Neither is there conclusive evidence on the effect of the time since displacement on mental health outcomes among these young persons. Further research on the long-term effect of forced migration or displacement on individual psychological outcomes of unaccompanied refugee young persons is, therefore, needed.

1.2.2.4. Demographic factors

The age, gender and educational level of asylum seeking young persons have been shown to have implications on their psychological adjustment and mental health outcome. However, the research findings on these associations are not as clear cut as some other variables that have a relatively more robust evidence base of how the impact on young persons' psychological outcomes.

These outcomes are particularly concerning because of young people being exposed to adversities at a formative developmental stage of their lives. Different confounding variables appear to underpin the relationship between age and mental health problems. The overall model becomes complex, as variables interact with one another, such as the nature and duration of adverse exposure, affecting age-specific responses. Potential confounders may include age at the onset of adverse events; age at migration; and age-related policies for education, accommodation and decision-making processes for asylum in host countries. If adolescents are exposed to a short period of trauma or violent conflict, they are likely to have already benefited from a normal emotional development, whereas younger children growing up while experiencing longstanding war and conflict are likely to have been exposed

to a greater degree of cumulative stress. This might increase the risk of adverse mental health outcomes in these young persons, or conversely, strengthen their internal resource or resilience (Fazel et al., 2011). Sourander (1998) found that younger unaccompanied refugee children are especially vulnerable to emotional distress, when compared with older URMs, and also have significantly more severe behavioural problems.

On the contrary, in the study by Hodes, Jagdev, Chandra and Cunniff (2008), in Unaccompanied Refugee Minors, age was associated with an increase in PTSD symptoms, whereas accompanied children had fewer problems with increasing age. In the light of immigration policy in the UK, this might be reflecting a potential difference in immigration status. Unaccompanied young asylum seekers might have feared possible deportation after the age of 18 years, whereas most accompanied adolescents had been granted the right to remain in the UK as refugees. Accommodation of young people in asylum centres has been shown to have an effect, particularly on children less than 15 years of age (Sourander, 1998). From the existing literature, therefore, there is a sense that the association between age and mental health outcome may be influenced by other related demographic, socio-environmental and clinical variables rather than the effect of age per se. This is supported by the finding that no independent association was found between age and mental health outcome in most of other studies (Berthold, 1999; Angel et al., 2001). It can be thus concluded that the existing evidence of the association between age and mental health outcome in unaccompanied refugee young persons remains unclear.

The evidence on the relationship between gender and mental health outcome in young asylum seekers is not consistent either. In a significant proportion of studies the prevalence of mental health disorders, particularly depression and sometimes also PTSD, was higher in females than in males (Hodes et al., 2008). In other studies, however, no gender differences were noted in terms of mental health outcome of unaccompanied refugee youths. In this context, the interaction between gender and age is not conclusive from the available limited evidence base (Fazel et al., 2011). Male gender in unaccompanied minors has been found to have a protective effect on internalising mental health disorders like depression (Reed et al., 2011), which is consistent with findings from studies with non-refugee populations (Green et al., 2004).

Although there seems to be some indication of female gender being a risk factor for the development of emotional / internalizing mental health conditions, there is not enough clarity on the underpinning mechanisms. Similar to the association between age and mental health outcome, it is plausible that other confounding are also in play. As several studies have failed to establish any such association between gender and mental health outcome, it is also possible that additional factors may have a part that was not established by earlier research. Such possible mediators can be biological factors that are differential or different social trajectories experienced by the minors of both genders. Exploring these potential variables and the underlying pathways involved would require further, and preferably longitudinal research.

Although there is some evidence on the association between high educational achievement and PTSD symptoms (Slodnjak et al., 2002), the duration of being in formal education before displacement was not found to be related to mental health problems post settlement in one study (Bean et al., 2007). A long-term follow-up study by Montgomery (2010) showed that young refugees with better mental health outcome after 8–9 years were more likely to be in education or employment as compared to those with poorer mental health outcome. This finding, however, does not infer a causal link, or a direction of the association between education and mental health outcome. Plausible explanations can, therefore, be that education and employment contribute to recovery, and/or that refugee children with persistent problems are unable or tend to withdraw from opportunities of continuing with education or employment.

Not enough investigation has been carried out to explore this specific variable and its impact on the outcome of these young persons. The available research also shows contradictory findings, whereby education was found to be both a risk and a protective factor for developing poor mental health outcome by different studies. Neither do we have a clear understanding of the underlying mechanism of how the level of education and mental health outcome in refugee minors may be linked. The existing literature on the effect of education on the mental health outcome of this group is therefore inconclusive, and invites further investigation.

1.2.2.5. Socioeconomic status

The current evidence on the effect of socioeconomic status of young refugees on their mental health is not conclusive. Most studies exploring the links between pre-

migration economic status and mental health outcomes have failed to establish any such association (Montgomery & Foldspang, 2006; Rousseau et al., 1998). There has been relatively more evidence suggesting that economic circumstances after displacement can affect the child's psychological functioning. For example, poor socioeconomic status of Bosnian refugee adolescents post migration was linked to more depressive symptoms and poor self-esteem (Sujoldzic et al., 2006). In contrast, two other studies found no clear association between post migration socioeconomic status and mental health outcome (Hjern et al., 1998; Tousignant et al., 1999).

High socioeconomic status can be indirectly protective by making it easier to access resources that could allow the young person to escape from the conflict zone early, thereby reducing the cumulative exposure to traumatic and adverse experiences (Goldin et al., 2001; Mghir & Raskin, 1999). However, low socioeconomic status, and the mental health consequences of its associated everyday stressors should also be taken into consideration in drawing any conclusion from such associations. Studies attempting to unravel the potential underlying mechanisms by establishing any possible links with markers of socioeconomic status such as parental employment status or parental education did not lead to consistent findings (Fazel et al., 2011).

Research that explored the relationship between socioeconomic status and mental health outcome in refugee minors, including mediating variables, has led to contradictory results. It is also difficult to generalize these findings because of the heterogeneity of samples and settings. Overall, there is not enough evidence to establish the effect of socioeconomic status, and it is even harder to interpret the

causal pathways, as the designs of the existing studies are not comparable, with each considering a different range of co-variables.

1.2.2.6. Social integration

The acceptance, rejection and overall integration of young refugees into the host society can be an important factor that influences their vulnerability and resilience. Experiences of pre-migration violence and persecution may lead to difficulties with identity and integration in the new country (Closs *et al.*, 2001). The experience of the unaccompanied asylum seeking migrants following their arrival can, nevertheless, be an equally or even more significant contributing factor in the development of mental health difficulties. Research by Rutter *et al.* (2007) involving Afghan refugees identified that key factors for integration in the UK were secure immigration status, tolerance, secure housing, fluency in English language, social networks and long-term professional support. Of those interviewed by Rutter *et al.*, two-thirds had been victims of racial harassment implying intolerance by some members of the local community.

How young people perceive being accepted by the host country also seems to have a significant impact on their psychological functioning. In particular, discrimination can be related to poor psychosocial stability. Sujoldzic *et al.* (2006) showed that peer violence and discrimination in the host community were associated with lower self-esteem. Boys reported discrimination more often than girls. In another study, perceived discrimination predicted poorer mental health outcomes that included depression and PTSD in refugee young persons from Somalia who sought asylum in

the United States (Ellis et al., 2008). This association, however, was not replicated in a study of Vietnamese young refugees in Finland (Liebkind, 1996).

Young people who make fewer friends in their new country are more likely to show poor ability to adapt to their new environment (Almqvist & Broberg, 1999; Montgomery, 2008), whereas perception of a high degree of peer support is related to improved psychological functioning (Berthold, 2000; Kovacev, 2004). It can be stated that belief and perception of being accepted, especially with regard to peer relationships, are important for a healthy psychological outcome.

Similarly, a perception of belonging in the school has been associated with lower rates of depression and anxiety (Sujoldzic et al., 2006). Feeling safe at school was also associated with a low risk of developing PTSD in young unaccompanied Sudanese refugees resettled in the United States (Geltman et al., 2005). On the other hand, an eight-year follow-up study in Denmark showed that poor attendance at school was predictive of high level of externalising behaviours in young refugees (Montgomery, 2008). Although change of school as such has not been associated with deterioration in mental health (Bean et al., 2007), low social support at school was correlated with depressive symptoms, while strong school connectedness was positively linked to self-esteem (Sujoldzic et al., 2006). It can thus be concluded that a sense of safety and integration in the school has a positive impact on learning and social functioning.

There seem to be adequate research evidence suggesting the role of social integration as a protective factor for mental health outcome in refugee minors.

Studies exploring various aspects of integration (such as peer support and acceptance, tolerance, lack of discrimination, and perception of safety and belonging at school) indicate that these have important impact on their mental health outcome. It is not, however, clear how these may interact with other factors, and longitudinal studies are so far lacking.

1.2.2.7. Social isolation

To date there has been limited evidence on the effect of social isolation on mental health of unaccompanied refugee minors. Social isolation or lack of connection with the neighbourhood has been linked with depression (Sujoldzic et al., 2006). Among unaccompanied young refugees living in residential or foster care, the opportunity to be in contact and socialise with others from the same ethnic background has been associated with a better mental health outcome (Geltman et al., 2005; Porte & Torney-Purta, 1987). Liebkind (1996) showed that having contact with peers of the same ethnic origin is protective against anxiety symptoms. This association, however, was not found in young refugee boys from the same country of origin. Hjern et al. (1998), in contrast, found no direct association between the degree of social network and psychological functioning of refugee children in exile.

Samples of these existing studies are mostly heterogeneous. So are the outcome measures, areas or domains assessed and collected socio-demographic variables. Therefore, it is difficult to comment on the exact effect of isolation on the mental health outcome of these young persons. There is no evidence base on the long-term impact of isolation, or its underpinning mechanisms.

1.2.2.8. Acculturation

Quantifying acculturation is a complex process. This happens slowly, is subtle and continuous. Acculturation is usually measured by proficiency in speaking the new language and the duration of stay in that country. There are, however, other components of acculturation. These have been measured by scales of self-worth, peer acceptance, attitudes and adoption of cultural customs, habits, and language of the country of settlement (Kovacev, 2004; Rousseau et al., 2004). Integration with the new culture while maintaining one's own cultural identity can be a protective factor. Kovacev (2004), for example, found that young refugees who settled in Australia and maintained their own cultural values, while at the same time becoming involved in the socio-cultural activities of the new country, were better adjusted psychosocially. Separating oneself from the host culture and maintaining only their own, or adapting only to the values of the host culture (assimilation) did not predict better outcome; while marginalisation had a negative effect.

Achieving competency in the new language has been found to be associated with a reduced likelihood of experiencing depressive and other internalising symptoms (Sack, 1998; Montgomery, 2008; Leavey et al., 2004). In the study of Vietnamese refugee young persons in Finland (Liebkind, 1996), adhering to the cultural values of family hierarchy according to age and gender, and a positive attitude towards the new culture was associated with a better psychosocial functioning. Refugee young girls from Somalia who were re-settled in the USA had better mental health outcome if they were closely associated with the Somali culture, whereas closer association with the American culture predicted better mental health outcome for boys (Ellis et al., 2010). When combined with the effect of gender, the least acculturated boys

seemed more vulnerable than girls (Rousseau et al., 2004). In other studies with young unaccompanied refugees from Sudan (Geltman et al., 2005) and Somalia (Ellis et al., 2008), feelings of isolation, loneliness and difficulty in integrating with the American society were associated with high PTSD rates. Those young refugees from Bosnia who felt connected to the neighbourhoods of their country of settlement showed low rates of depression (Sujoldzic et al., 2006), and refugee young people settled in Australia who were supported by their friends had better psychosocial functioning (Kovacev, 2004).

There seems to be a reasonable degree of consistency in the findings of different studies suggesting that integrating within the host society while maintaining a connection with the culture of origin is beneficial for refugee minors' mental health. These findings, however, also indicate that the association between acculturation and mental health outcomes is complex. A number of variables appear to compound this relationship, including gender and the associations between the experiences of the adolescent, family and society. Such interactions are consistent with the ecological model of concentric spheres of effect (Bronfenbrenner, 1979). This model depicts a young person's experience by use of concentric circles, placing him at the centre of the impact of different factors, like individual, family, community, and societal influences.

1.2.2.9. Faith

The evidence for the impact of religious beliefs on the unaccompanied refugee young people's mental health is overall positive. In refugee young persons from Bosnia, increased frequency of participation in religious activities and presence of a

high degree of personal religious beliefs was associated with lower anxiety and depressive symptoms (Sujoldzic et al., 2006). Refugee young persons resettled in Denmark, who practiced Islam or Christianity, were found to have lower scores for internalising problems than those who either belonged to another minority religious group, or who had converted or abandoned their faith (Montgomery, 2008). There is some evidence of the protective effect of attributing the meaning of adverse events to religious faith. For example, in unaccompanied Sudanese refugee adolescents, attributing adverse life events to God contributed to adaptive psychological functioning (Goodman, 2004).

There is not enough evidence, however, on the underlying mechanisms or on the predictors of which young persons would benefit more from having a faith. There is a research gap, particularly in robust qualitative research, that would enable us to understand in more depth the relationship between faith, spirituality, meaning and psychological adaptation. For the vulnerable population of young unaccompanied refugees, whose lives are laden with adverse experiences, the role of spirituality, religious belief, faith, hope and sense of coherence and responsibility appears to be complex and intertwined, although emerging evidence indicates that these are important factors in building up their resilience.

1.2.2.10. Relocation

Relocation, living in camps and adverse experiences at the camps seem to have negative effects on the mental health of young refugees. In one study, more than four moves between locations during the asylum process were associated with

poorer mental health outcome (Nielsen et al., 2008). Those who were transferred and relocated to different regions of the country displayed higher rates of internalising symptoms than those who had not been relocated. In contrast, two other studies did not establish any significant association between living in camps on the way to the UK, or adversities in those camps and their mental health outcome (Tousignant et al., 1999; Fox et al., 1999). Loughry et al. (2001) examined the behavioural and emotional problems of former unaccompanied refugee children and adolescents who had repatriated to Vietnam from refugee centres in Hong Kong and South East Asia. The results suggested that the experience of living without parents in a refugee camp did not lead to increased problems in the immediate years after repatriation.

Although a change of guardian in unaccompanied asylum seeking young persons did not show any adverse affect on psychological functioning or behavioural control, living in highly supported accommodation appears to have a protective effect (Bean et al., 2007). When unaccompanied refugee minors were accommodated in foster care or they lived alone, their psychological functioning was found to be better than when they lived in refugee centres (Derluyn & Broekaert, 2007). Even though the quality of the accommodation has not been identified as a risk factor per se (Ellis et al., 2008), feelings of safety have been associated with low occurrence of PTSD (Geltman et al., 2005). One can, therefore, argue on the basis of the existing evidence that the more important factors related to relocation that determine mental health outcome are mostly the sense of safety, stability, privacy and being supported, rather than the quality or location of the living arrangements. The current research evidence also seems to indicate that the experience of relocation in the

host country post-migration tends to impact mental health outcome more than the young persons' experience of relocation or living during the migratory journey.

1.2.2.11. Immigration process

The impact of the immigration process can be largely divided into factors related to the period of arrival and the post-application period. Detention in centres following arrival to the new country can adversely affect the mental health outcome of refugee young persons (Rothe et al., 2002). Reijneveld et al. (2005) examined the effects of different reception policies and processes on unaccompanied adolescent asylum seekers' mental health. Outcomes revealed significantly more emotional problems among the youth in a restrictive reception centre, particularly among females. Even in the period following their detention, the prevalence of psychiatric disorders, as well as of post traumatic intrusive memories, were found to be higher (Steel et al., 2004). These experiences of detention, care at the centre, asylum application and immigration interview can be distressing for asylum seeking young persons that compound the adverse psychological affects of experiences prior to and during migration, thus placing them in situations that can be perceived as being worse than the adversities before migration.

The uncertain status of the asylum application has been associated with poor psychological functioning. Quicker resolution of asylum claims, on the other hand, reduces the period of uncertainty and insecurity associated with the process of asylum application and the related distress (Bodegard, 2005). For unaccompanied refugee minors, proving that they are less than 18 years old can be a matter of significant stress. The challenges of asserting an accurate age can mean that cases

can last well over a year, thus increasing their sense of insecurity (Jones, 2010). This can hinder their ability to settle and integrate, hence causing unnecessary anxiety about deportation or forced return home (Thomas et al., 2004). The same authors found little consistency between those who received full refugee status, and others who remained with temporary or uncertain decisions. There was also little consistency in the time periods it took to receive decisions.

With the majority of asylum applications being refused, feelings of hopelessness, alongside a fear of return are key issues for the mental health of someone going through the asylum system. For some this pressure has even resulted in a fatal outcome; an 18-year-old Afghan boy committed suicide a few days after his application was refused, and another unaccompanied refugee young person, also from Afghanistan, hung himself in his flat unable to cope with destitution (Atwal & Bourne, 2007). Research into destitute asylum seekers, has found that destitution made it much harder to access support, and the majority reported that their mental health had deteriorated since being in the UK (Social Perspectives Network & London Development Centre, 2006). In a recent UNICEF report (Brownlees & Finch, 2010), children and young people talked about their concerns and volunteered information about their well-being. While some talked about the past and their concerns for their family, their main anxieties appeared to be linked to present circumstances, overwhelming concerns about their asylum applications, and their loneliness and isolation.

There appears to be robust research evidence including, some larger and multiple small scale studies, which indicates the adverse impact of restrictive reception policy

in detention centres on the mental health outcome of unaccompanied refugee young persons. There is also evidence that the uncertain and lengthy asylum application process can have a similar effect. This is largely based on quantitative methods, one study, and case reports. More qualitative research is, therefore, needed to explore young people's experiences of these procedures, and their perceptions of the impact that these may have on their psychological well-being.

1.2.2.12. Accompanied versus unaccompanied refugee youth

Unaccompanied refugee minors show a significantly higher prevalence of PTSD, anxiety (Derluyn et al., 2008) depressive disorder, borderline personality disorder and psychosis (Wiese & Burhorst, 2007) when compared to minors accompanied by their families. Among refugee young people, those who are unaccompanied are at higher risk because of the interplay between traumatic experiences and separation from significant emotional relationships. Parents often buffer the effects of difficult experiences in a child's life, and family and community support are important requisites for the successful coping of children traumatized by war or violence (Bat-Zion & Levi-Shiff, 1993; Jensen & Shaw, 1993; Macksoud et al., 1996). Refugee children who have experienced the loss of their family and community have shown more emotional distress and poorer adjustment than children who experienced the refugee process with their families (Masser, 1992; Melville & Lykes, 1992).

Derluyn et al. (2008) compared 1,249 migrant and 602 native Belgian adolescents between 11 and 18 years. Migrant adolescents experienced significantly more traumatic events than non-migrant adolescents. Gender significantly influenced the prevalence of emotional and behavioural problems, with girls being more vulnerable.

Although there were no significant overall differences on the prevalence of emotional and behavioural problems between the two groups, the unaccompanied subgroup within migrants reported more emotional problems, including anxiety, depression and PTSD symptoms, than accompanied migrant adolescents. Hodes et al. (2008) compared unaccompanied refugee youth, predominantly from Africa and the Balkans, with a group of accompanied refugee youth living in London. Unaccompanied refugees had been affected by greater war trauma and losses, and had elevated posttraumatic stress symptoms. Low-support living circumstances, number of traumatic experiences, increasing age, and being female predicted posttraumatic symptoms among the unaccompanied group. Another study compared unaccompanied refugee with accompanied refugee youth, and with youth from the general population. They found that the young person's gender moderated internalizing emotional and externalizing symptoms in the two comparison groups but among unaccompanied refugee minors there was no gender difference in the presentation of these symptoms (Bean et al., 2007).

On the contrary, Michelson and Sclare (2009), in their study comparing unaccompanied minors and young persons accompanied to the UK by one or more primary caregivers, revealed similar levels of post-migration stress and overall psychological morbidity. However, unaccompanied children experienced significantly more traumatic events prior to resettlement, and so were more likely to exhibit symptoms of post-traumatic stress disorder (PTSD) than their accompanied peers. Other studies replicated this finding of unaccompanied refugee youth experiencing a higher number of traumatic life events in comparison to the other groups, in particular "loss of loved one." This group also reported significantly high levels of

exposure to physical and sexual maltreatment, which were strong predictors of post-traumatic and other internalizing symptoms (Bean et al., 2007).

From these findings, unaccompanied young refugees appear to be a particularly vulnerable group in developing mental health difficulties. The mental health and emotional well-being of unaccompanied refugee and asylum-seeking children and young people have, therefore, received increasing attention in recent years (Chase et al., 2008). Most of the literature and research to date, has, however, been informed by clinical constructs of mental health, with relatively little attention being paid to the broader aspects of emotional well-being. Above all, little research has attempted to understand, from the viewpoint of unaccompanied young people themselves, how their experiences of leaving their country of origin and seeking asylum in a foreign land have affected their emotional well-being, and how this in turn might shape the kind of help and support that they perceive they need.

1.2.2.13. Overall evidence on vulnerability factors

Refugee young persons experience a number of losses, separations, persecution, and threats. Current procedures for dealing with asylum-seekers may contribute to high levels of stress and emotional symptoms in young persons who have already been sensitized by their pre-immigration experiences. Their mental health is of particular concern because of their experiences at a formative stage of child development. The combined weight of socioeconomic adversity and exposure to violence in their countries of origin, followed by migration and finally resettlement into a new context, exposes them to several cumulative risks for their physical, emotional

and social development. Risk factors affecting children's mental health can be conceptualized as personal, social, and environmental factors.

Children who are resettled in low-income or middle-income countries might be exposed to ongoing threats to their security and welfare, whereas those in high-income countries have to cope with a different social milieu and often complex asylum processes (Reed et al., 2011). Mental health problems and disorders in childhood and young life are associated with a range of environmental factors, both chronic and acute, within the child's family, school, and wider community. Such factors may interact with a child's intrinsic characteristics, in predicting severity and continuation of mental health problems in later life. Although it is difficult to determine the extent of children's vulnerability, some young population groups often stand out in their exposure to multiple risk factors due to their unusual life experiences. These experiences have not only a direct impact on their mental health and well-being, but also indirect effects through secondary social and cultural difficulties, and multiple changes in their life circumstances such as being placed in public care or becoming homeless. Certain factors are of prominent risk for refugee children, and these are related to both their previous experiences and their adjustment to a new society (Huemer & Vostanis, 2010). These vulnerabilities are, however, moderated by a range of protective factors, whose role will be discussed in more detail.

1.2.3. Protective factors and resilience in refugee children

There has been much interest in the notion of resilience, which has been defined as the process of overcoming rather than succumbing to the effects of exposure to risks

during an individual's life (Rutter, 1987). Resilience is not a fixed and immutable trait that is present or absent, but rather a process that develops responsively in the face of adverse challenges. Unaccompanied minors settled in different countries appear to be at particularly high risk for distress-related symptoms and are less likely than other refugees to receive psychological care; yet some appear to be somewhat resilient psychologically (Rousseau et al., 1998).

Research has found that, despite their experiences of disruption and trauma, many children and young people appeared to be coping quite well emotionally. In the qualitative interviews conducted during a UNICEF project (Brownlees & Finch, 2010), practitioners expressed awe at refugee children's ability to cope. One of the theories to explain this is the term Papadopoulos (2007) has coined, called "Adversity-Activated Development" (AAD) to describe the positive response resulting from exposure to adversity and traumatic events, frequently revealing aspects of resilience a person did not know they had, experiencing a transformative renewal that encourages reevaluation of one's epistemology. The main factors explored in the existing research in the context of resilience are belief systems, coping strategies, social factors (Lustig et al., 2004), individual characteristics, family protective factors, community factors (Huemer & Vostanis, 2010), emotional expression, family and peer relations, and pro-social development (Daud et al., 2008). The key resilience factors will be discussed in more detail, because of their established role and specificity in this group.

1.2.3.1. Belief systems

A relatively limited number of studies has explored how children derive meaning from their traumatic and/or violent experiences. Even fewer have done so in the context of understanding its cultural dimensions. Lustig et al. (2004) argued that, although child and adolescent refugees suffer from significant conflict and displacement related exposures, the reactions to these stressful events may be mediated by their belief systems. Goodman (2004) commented on meanings attached to the adverse experiences as one of the potential protective factors, and gave the example of beliefs such as “If God wishes may be I will be alive” from the themes of qualitative interviews conducted by him. Rousseau et al. (1998) outlined that to predict the effect of trauma, the individual experience of adversity of the unaccompanied refugee minors needed to be mapped on to the collective cultural belief of the stressful life events.

1.2.3.2. Coping strategies

Goodman (2004) explored how unaccompanied refugee youths from Sudan, who grew up amid violence and loss, coped with trauma and hardship in their lives pre- and post-migration. The author used a case-centred, comparative, narrative approach to analyze the narratives of unaccompanied refugee minors from Sudan recently resettled in the United States. She analyzed narratives for both content and form, and identified four themes that reflected coping strategies used by the participants. These themes were: (a) collectivity and the communal self; (b) suppression and distraction; (c) making meaning; and (d) emerging from hopelessness to hope. The findings underscore the importance of understanding the cultural variability in responses to trauma and in relation to coping strategies. The

above findings are consistent with those of Rousseau et al. (1998), who interviewed Somali unaccompanied refugee young persons, as well as key informants and representatives of their host community in Canada. The investigation involved young persons' self-report of their migratory experience, their notion of what other young men of their community experienced, and how they handled or coped with the migratory process. The authors raised the issue of the culturally based coping strategies these children used to live through those situations. Brownlees and Finch (2010) hypothesized that having had positive family backgrounds equipped some of the refugee minors with adoptive coping skills.

1.2.3.3. Social factors

Miller (1994) in a mixed method study assessed the mental health difficulties of accompanied Guatemalan Mayan Indian children sheltered in refugee camps in Mexico. The findings did not indicate any significant evidence of post traumatic stress symptoms or high levels of any other types of mental health problems. The authors attempted to explain these findings by the hypothesis of "the recreation of normality" within the social context of the refugee camps. Lustig et al. (2004) argued that social relations and networks of the young person can be one of the important factors in mediating the reactions to the stressful life events they experience. Concepts of resilience were discussed by Rousseau et al. (1998), in the framework of two normative systems, including the traditional upbringing in Somali culture and the experience of forced exile in North America. Huemer and Vostanis (2010) divided the concept of resilience in children into individual, family and community factors. It is clear that these children's responses to trauma cannot be understood by focusing only on individual mediating factors, deficits and pathology. The mediating effects of

the social, political, and ecological contexts must be considered in conjunction to develop a framework to explain the effect of both risk and resilience (Punamaki, 1989).

A range of resilience factors such as the young persons' belief systems, coping strategies and other social factors in protecting them from poor mental health outcomes can be understood by exploring their experiences, beliefs and perceptions of adversity in their subjective individual and cultural contexts through qualitative research. However, most of these qualitative studies have been carried out with heterogeneous and small samples, used different methodological and analytical frameworks, and proposed inconsistent findings and theories. The amount of overall qualitative research with this population is minimal at present, and thus requires greater attention to help us develop a more comprehensive understanding of how these factors operate.

1.2.4. Overview of the effect of risk and protective factors

Unaccompanied asylum seeking children and adolescents are a highly diverse group. Their different ethnic backgrounds, possible influences on upbringing, temperament and other intrinsic characteristics, along with the multiple motives and circumstances of leaving their country of origin affect the parameters of psychopathology. Despite this diversity, they are collectively vulnerable due to the legislative situation, their stressful past, and the sensitive developmental period of their lives during which these events are occurring. Exposure to violence has been particularly shown to be a key risk factor, whereas stable settlement and social support in the host country have a positive effect on the child's psychological

functioning. Carer and family factors and living arrangements have also received much attention in recent research. Overall, the ability to integrate into the host society while maintaining a sense of one's cultural identity is protective, but its effect has not been quantified. Further research is required to identify the relevant processes, contexts, and interplay between the predictors of positive mental health. Future research should enable the investigation of individual, community, and societal as well as cultural contexts, rather than being restricted to the investigation of the associations between adverse exposures and psychological symptoms (Fazel et al., 2012).

Despite the evidence of remarkable resilience against the affects of difficult pre- and post-migration life experiences, the collective effect of all the factors discussed above leads to the sound conclusion that unaccompanied refugee young persons are a highly vulnerable group, who have poorer psychological adjustment and higher psychiatric morbidity than the general population. In the next section, the different types of mental health problems experienced by unaccompanied asylum seeking children and young persons will be discussed.

1.3. MENTAL HEALTH PROBLEMS IN UNACCOMPANIED MINORS

1.3.1. Application of mental health concepts and challenges

The concept of mental illness and its treatment in the context of the refugee population has raised some debates in recent years. Summerfield (2000) questioned the extent to which the pain, suffering and difficult experiences of child refugees can be reduced to a matter of mental health. The issues that this debate raises include, how can the predicament of refugee children be framed, and when can their suffering legitimately be seen as mental health problem? Can it be assumed that stressful past experiences and refugee status render children psychologically vulnerable? And, should the bad memories of refugee children be worked through by therapies?

There also appears to be a tension between the rights of a refugee child to access or refuse services. On one hand it is important to ensure that this vulnerable group is not deprived of treatment. There is, however, a risk of misinterpreting the experiences of these young persons as diagnostic categories of western systems of psychiatric classifications and therapies without paying heed to the young persons' own perception of their experiences and wishes within their cultural norms (O'Reilly et al., in press).

1.3.2. Prevalence and extent of mental health problems

Huemer et al. (2009) stated that unaccompanied asylum seeking children and young people are a highly vulnerable group who are more likely to suffer from psychiatric morbidity than other comparable populations. Discussing the prevalence and extent of mental illness in unaccompanied refugee minors can be a starting point in

understanding the young people's needs. The available literature shows consistently increased levels of psychiatric morbidity among refugee children, especially post-traumatic stress, depression, and anxiety disorders (Fazel & Stein, 2002). A UNICEF report (Brownlees & Finch, 2010) presented the accounts of emotional well-being of unaccompanied asylum seeking and refugee children and young persons in three Local Authority areas of England. Out of the 59 unaccompanied refugee young persons interviewed, nine were suffering from severe depression, post-traumatic stress disorder (PTSD) or anxiety. Many of these children and young people suffered from headaches, sleep problems and other symptoms of depression. This mirrors other studies, which have also found that a higher proportion of unaccompanied minors suffer from mental health problems, which include depression, suicidal thoughts, PTSD, repetitive and intrusive thoughts, sleep disturbance, poor concentration, fear about the future, worries and guilt about the past and those they have left behind (Kohli & Mather, 2003). Crowley (2009) reviewed the literature on the mental health needs of refugee children resettled in developed nations. This suggested that, while many of them are likely to suffer from post-traumatic stress disorder, depression, and anxiety, many other children will not be affected in that way. Early detection is, therefore, important by maximizing young people's contact with primary care and other agencies.

Derluyn and Broekaert (2007) found that between 37–47% of unaccompanied young refugees suffered from severe internalizing symptoms. Several reports have also indicated a high incidence of behavioural problems, suicide attempts, somatization and transitory psychotic episodes (Charron & Neww, 1981; Pask & Jayne, 1984; Ressler et al., 1988). Leavey et al (2004) examined the prevalence of mental health

problems among refugee school children compared to their UK-born peers, and established rates of 25% and 10% respectively, i.e. a 2.5:1 ratio. The risk factors that were found to be associated have been discussed in the previous chapter. Geltman et al (2000) surveyed a clinical sample of Bosnian refugee children and young persons at the International Clinic of Boston Medical Centre, the largest refugee health assessment provider in that state, which was linked to mental health services. Behavioural problems were reported in 77% of the attendants, although interestingly, only one of them expressed interest in receiving psychosocial services.

1.3.3. Post-traumatic stress disorder (PTSD)

It has been repeatedly shown that the experiences of war and political violence have considerable impact on the psychosocial well-being and mental health of children and adolescents. Among mental health problems, PTSD and its co-morbidity spectrum have been most extensively studied (Geltman et al., 2005). There are still some controversies on the use of structured interviews and western classification to diagnose PTSD in a culturally different and diverse population group. It is, therefore, worth discussing the studies exploring different aspects of PTSD in unaccompanied refugee minors separately.

Geltman et al. (2005) examined the mental health of unaccompanied refugee children from Sudan who were resettled in the United States. Of those, 20% suffered from PTSD, and these had significantly worse functional impairment than those who did not have a diagnosis of PTSD. Refugee minors suffering from PTSD are also likely to present with anxiety and depression, anger and violence, psychological numbing, paranoia, insomnia, and a heightened awareness of death. Depressive

disorder can commonly be present as a comorbid condition with PTSD. Social isolation and personal injury in unaccompanied minors is found to be associated with a diagnosis of PTSD. Severity of trauma and presence of psychopathology before trauma have been found to predict the development of PTSD in this population (Huemer & Vostanis, 2010).

Checklists or structured interviews that focus mainly on posttraumatic symptoms may fail to capture the whole range of psychological problems refugee children experience, such as loss, grief and adjustment difficulties. Diagnostic systems that are culturally biased can generate misdiagnoses and may fail to identify mental health problems in people from other cultures (Lustig et al., 2004). A comparison of Central American and Southeast Asian refugee children resettled in Canada has been used in depicting the significance of cultural idioms of distress. (Rousseau et al., 1996). This indicates how similar traumas or stressors can lead to different manifestations of post traumatic symptoms in different cultural groups.

1.3.4. Other mental health presentations

Although the studies on PTSD revealed higher levels of symptoms in unaccompanied young persons in comparison to the general population and accompanied refugee children, the literature on mental health issues among unaccompanied refugee minors other than PTSD is relatively limited (Huemer & Vostanis, 2010). This is surprising as response to psychological stress might manifest itself with other emotional, physical or somatic symptoms (Lynch, 2001). Unaccompanied refugee young people reported a wide spectrum of mental health symptoms other than PTSD, ranging from sadness, worry, tension, loss of pleasure,

cardiac and respiratory symptoms of anxiety, excessive perspiration, headaches, lack of appetite, disturbed sleep patterns, generalised anxiety, panic attacks, depression and eating difficulties (Obradovic et al., 1993). Some had more severe mental health problems requiring specialist support and even psychiatric hospitalisation (Chase et al., 2008).

Although unaccompanied refugee minors with mental health difficulties are a clinically heterogeneous group, most have high exposure to past violence, losses, and isolation. These adversities are found to be associated even with the onset of mental illness such as psychosis (Hodes & Tolmac, 2005). While PTSD has been associated with past trauma, depressive disorders were predicted more by adversities in the present life situation (Sack, 1993). A strong association has been found between depressive symptoms in young accompanied refugee girls and physical and psychological distress in their mothers, which implies that an emotional or physical absence of parents may increase the likelihood of the refugee young persons developing depressive psychopathology (Miller, 1994).

1.3.5. Long-term mental health outcomes

The long-term outcome of mental illness in this group has also been explored in different studies. In a longitudinal study the prevalence, course, predictors and concordance of mental health problems were examined in unaccompanied refugee minors over a period of twelve months. The results showed persistent, significantly increased prevalence of severe mental health problems in comparison with the general population (Bean et al., 2007). In the longitudinal studies of Cambodian children living in the US followed-up over a number of years, 47% had a DSM IV

Axis 1 psychiatric diagnosis, and co-morbidity was common. These studies found PTSD rates of 40%, depression 21%, and anxiety 10%. Three years later, morbidity levels were still high, with 48% manifesting PTSD and 41% depression. After six years, rates of PTSD were still high and a strong relationship was found between PTSD and later stressful events, suggesting that the unaccompanied refugee minors remain vulnerable to subsequent or ongoing traumatic experiences (Sack et al., 1993; Boehnlein et al., 1985; Kinzie et al., 1989).

Wallin et al. (2005) approached this question through a qualitative study on how unaccompanied refugee young persons experienced their own living situation and well-being seven years after acquiring permanent residency. Most of the participants expressed satisfaction with their lives after gaining residency status, with only one participant still suffering from PTSD. The majority of participants had successfully worked through the problems that typically affect refugees and had adapted to their new residence. One should however, be mindful of the possible methodological flaw that the 23 young people out of 34, who dropped-out of the study might be living a more stressful life and suffering from PTSD and depression more frequently.

Grant-Knight et al. (2009) launched a nationwide survey in the US to systematically explore issues involving the adjustment and adaptation of Sudanese youth. The findings suggested that these unaccompanied refugee young persons exhibited generally good long-term functional outcomes, despite years of deprivation, trauma, and separation from their families during childhood. It can be inferred from the existing research that good outcomes are predicted by less pre- and post-migration adversity, quick resolution of asylum claim, settled status, presence of a family,

adequate living arrangements, integration with the host society and good psychosocial support. Therefore, efforts to provide safe and supportive environments and appropriate interventions for these traumatized young persons can be associated with positive mental health and psychosocial outcomes. In the next section of this chapter, the evidence of efficacy of different interventions and service provision issues will be discussed.

1.4. INTERVENTIONS AND SERVICE PROVISION

The assessment and care of these children involves special knowledge and skills. Planning of interventions for refugee children with mental health problems must therefore take into account their specific needs and approaches to assessment and treatment (Westermeyer, 1991). It is a valid assumption that such knowledge and understanding is essential in designing policies and intervention programmes. The plight of refugee children has been discussed in relation to the child itself, the referred problem and the refugee context (Davies & Webb, 2000; Athey & Ahearn, 1991). Because of the significance of developmental factors relating to the vulnerability of refugee children and young persons in the host culture, a co-ordinated and culturally sensitive approach to their care is also paramount. In this section, different psychosocial interventions for mental health problems in this population, the patterns of utilization of mental health services, description of similar services from different parts of the world, and in particular some of the significant school-based services for refugee minors will be discussed.

1.4.1. Evidence of interventions used

The emerging consensus from the literature is on the need for a variety of different treatments, including individual, group, and school-based interventions, to address different types of problems and meet a range of needs (Lustig et al., 2004). Promising interventions in this population are mostly trauma-focused and include cognitive-behavioural therapy (CBT), testimonial psychotherapy, narrative therapy, and eye movement desensitisation and reprocessing (EMDR). However, other than descriptions of some innovative programmes, the actual evidence base on efficacy

of specific treatment modalities still remains scarce (Huemer & Vostanis, 2010; Entholt & Yule, 2006). It is, nevertheless, important to consider the emerging evidence in more detail.

Table 1.2. Different modalities of psychosocial interventions

1	Cognitive-Behavioural Therapy (CBT)
2	Narrative Therapy
3	Testimonial Psychotherapy
4	Psychodynamic Psychotherapy
5	Eye Movement Desensitisation Reprocessing (EMDR)
6	Multimodal
7	Group Intervention
8	School-Based
9	Pharmacological
10	Social (environmental)
11	Preventive

1.4.1.1. Cognitive-behavioural therapy (CBT)

Cognitive-behavioural therapy is an expanding and empirically supported treatment for a range of child and adolescent mental health problems. The principles of this modality is based on the premise that cognitions or thoughts can influence emotions

and behaviours across a variety of situations, thus altering maladaptive, distorted or deficient cognitions can be effective in treating various forms of psychopathology (Lochman & Pardini, 2008). Cognitive-behavioural therapy for PTSD has been well evaluated in the general population and in clinical samples, such as children exposed to natural disasters but not robustly among refugee children and young persons (Lustig et al., 2004). There have been some reports of cognitive-behavioural therapy being successfully used for single traumatic events in unaccompanied refugee minors (Fazel & Stein, 2002). It has also been proposed as a promising component of a holistic multimodal model of intervention for this group (Entholt & Yule, 2006). A large proportion of preventive work with refugee children and young people has used CBT principles, especially in addressing their negative cognitive patterns (Peltonen & Punamaki, 2010).

1.4.1.2. Narrative therapy

The interest in meaning systems and their influences on shaping interactions have always had their place in family therapy. However, more recent developments have placed narratives at the centre of several therapy approaches, in particular narrative therapies. This approach has been the most overtly embedded in a social constructionist understanding, which emphasizes the relativity of observed reality and sees language and narratives as the vehicle through which one acquires their definitions of self. Individual problems are understood to be the result of the filtering of experiences through narratives that people have about themselves. These individual narratives are seen as being embedded in wider cultural, political or educational systems. Although a narrative approach is theoretically distinct, there is also a clear overlap with cognitive therapies; both at a conceptual level and in

practice. For example, both approaches view meanings and beliefs attached to problems as central treatment targets. They also borrow each other's intervention techniques, like the use of behavioural scaling techniques by narrative therapists or the use of externalization in some CBT approaches (Eisler & Lask, 2008).

Henderson et al. (2010) argued that utilizing a narrative framework to address core issues in mental health and psychosocial services for young refugees may help to improve upon the current models, not only in treating mental disorders, but also in reclaiming the childhood gaps for those affected by violence and displacement. This means listening not just to young people's stories about themselves; but also adults' stories about their childhood; as well as stories of parents, grandparents, other family members, teachers, clergy, professionals and lay helpers. This may also mean listening to the stories the clinicians tell when psychosocial interventions are designed. These stories can form the basis for the social construction or reconstruction of childhood.

A psychotherapy model for children caught in the midst of catastrophic situations has been proposed by Rothe (2008). A review of the literature reveals that negative, long-term mental health outcomes in these populations are related to autonomic dysregulation and distorted narratives of events, which result from exposure to overwhelming stress. The author combined case material from his own clinical experience treating Cuban children and adolescents inside refugee camps, with the available literature, in order to design the model. The role of the therapist involved: a) intervening to decrease hyper-arousal and protect the refugee young person's neuroendocrine integrity; b) helping them construct a cohesive narrative of the

events during the peri-traumatic period; and c) becoming an advocate for the refugee young person, helping them to attain mastery and control over the forces that threaten their coping capacities.

Narrative exposure therapy (NET) was developed for the treatment of PTSD as a result of organised violence. This is a short-term approach based on CBT exposure therapy, which is specifically developed for survivors of war and trauma. In this treatment clients are repeatedly asked to talk about the worst traumatic event in detail and to re-experience the emotions associated with the event. This causes habituation of the emotion response to the traumatic memory and reconstructs a consistent autobiographic narrative (Lim & Koike, 2010). Onyut et al. (2005) reported on the use of narrative exposure therapy in the treatment in six Somali children resettled in Uganda, who were suffering from PTSD. They found a reduction in symptoms after treatment and at nine-month follow-up.

1.4.1.3. Testimonial psychotherapy

Cienfuegos and Moreli (1983) developed the use of this treatment modality in Chile. Testimonial psychotherapy invites refugees to transcend their persecution by using the testimonies for purposes of education and advocacy. The survivor and the therapist produce a written testimony that could be further analyzed and used as a indictment against the torturers. This brief individual psychotherapy for torture survivors is both a private and public means to personal recovery. This is achieved through bearing witness to historical and social consequences of violence, as well as through the narration of a person's experience of collective traumatization in a new context in which their memories can be used to develop new understanding of

personal history (Lim & Koike, 2010). Weine (1998) emphasizes that this therapy allows the survivor to put seemingly unrelated fragments into a coherent story, creating a social context that is important to them. The promising prospect of testimonial psychotherapy, particularly in refugee minors, has been described by Entholt and Yule (2006), although there have only been preliminary studies available so far. A pilot study of testimonial psychotherapy with Sudanese adolescent refugees supported its safety and feasibility (Lustig et al., 2004).

1.4.1.4. Psychodynamic psychotherapy

Psychodynamic therapies aim to strengthen patients' capacity to understand the motivations and meanings of their own and others' subjective experiences, behaviour and relationships. In this sense there is an overlap with cognitive-behavioural therapy (CBT), which also has psychodynamic origins; although, unlike CBT, psychodynamic therapists strive to understand the organization of the young person's mind in its full complexity, the social influences on the emotional experience, and the ways in which the young person's subjectivity has adapted to internal and external pressures. The therapist aims to expand the young person's conscious awareness of these mechanisms and influences, so that they are more able to use their increased emotional awareness to manage continuing pressures. Comprehensive reviews of outcome studies of psychodynamic approaches in generic child and adolescent populations are few, and there are few randomized controlled trials of psychodynamic psychotherapy. Those few trials are underpowered and suffer from other methodological limitations (Fonagy & Target, 2008).

Psychodynamic principles of psychotherapy have been mostly used in the young refugee population through different indirect expressive techniques like play, art, drawing and drama, rather than through 'talking'. A number of case series and single case studies have reported positive outcomes for play, art, music therapy, and storytelling (Fazel & Stein, 2002). The key aspects of play therapy are described as helping the child process and understand the traumatic events (Bevin, 1999). In a case report of a nine-year-old refugee boy from Nicaragua who was referred to a mental health service with symptoms consistent with posttraumatic stress and dysthymic disorder, Bevin (1999) used play therapy. Posttraumatic play was described as it occurred spontaneously, as well as in situations pre-arranged by the therapist to elicit the re-enactment of traumatic events.

Miller and Billings (1994) described a mental health intervention undertaken in Guatemala, which focused on the mental health and psychosocial development of refugee children. A variety of expressive arts techniques were used to assist children in safely and creatively exploring salient issues related to the experience of growing up in exile, through individual and collective drawing, role playing and socio-drama. The goals were to communicate and share their thoughts and emotions, thus creating a supportive context in which they could examine positive aspects of their life and culture, thus facilitate their capacity for creative thinking and activity. The existing evidence seem to suggest that psychotherapy should have clear objectives in enhancing the normalization of emotions, exploration and understanding of experiences and coping strategies (Huemer & Vostanis, 2010).

1.4.1.5. Eye movement desensitisation reprocessing (EMDR)

EMDR is an empirical treatment with little theoretical underpinning. There is some controversy about the active components of this treatment. Essentially, the patient is asked to focus on a traumatic memory while simultaneously following the moving fingers of the therapist. This dual attention task is thought to help them confront the frightening memory, therefore process the emotional reaction to that memory. EMDR has been described as one of the effective treatment modalities for PTSD and trauma-related mental health problems in adults. Oras et al. (2004) examined the effects of a psychodynamic approach of Eye Movement Desensitization and Reprocessing (EMDR) in the treatment of traumatized refugee children, and found significant improvement in their functioning and re-experiencing symptoms. There are also a number of case reports claiming the effectiveness of EMDR in treating PTSD in children and young people, but a dearth of published randomized controlled trials or other robust evaluation designs (Yule & Smith, 2008).

Although research evidence with unaccompanied refugee minors has been limited (Ehnholt & Yule, 2006), there is some evidence, mainly in the form of case reports, in the adult refugee population. Ilic (2004) described the successful use of EMDR in a case example of a Croatian refugee in Serbia. According to the author, the Centre for Rehabilitation of Torture Victims in Belgrade used EMDR in treating over 160 clients with PTSD. The success of the therapy depends on client motivation, whereas secondary gain and acceptance of the victim's role can be the main obstacles to improvement. Bower et al. (2004) described a case of successful treatment of PTSD and depression in a refugee woman that a combination of antidepressant medication, traditional talking treatment and EMDR provided a

holistic approach which resulted in improvement. These findings suggest that EMDR can be a promising treatment modality in young unaccompanied refugees with trauma related mental health problems.

1.4.1.6. Multimodal interventions

Therapists should keep an open mind whether children from non western cultures can utilize 'talking' therapies', or whether other means may be preferable, at least at the beginning. It is always useful to consider children's own choices, guided by the definition and perception of their difficulties. There is emerging evidence that refugee children have a range of mental health treatment needs, and that trauma-focused therapy is not always the indicated intervention. Entholt and Yule (2006) proposed a phased model of intervention for refugee young persons in the context of a holistic framework. They detected promising findings from studies of cognitive-behavioural therapy, testimonial psychotherapy, narrative exposure therapy, and eye movement desensitization and reprocessing, and suggested that interventions for unaccompanied refugee minors should include a combination of different modalities of treatment, depending on their individual and complex psychosocial and mental health needs.

1.4.1.7. Group interventions

Kinzie et al. (1988) argued that, as refugees can often live an isolated life, group interventions give them a chance of sharing their experiences as well as benefitting by interacting with other refugees who share a common past and language. Social activities reinforce group cohesion and support, and promote cultural identity. Loss is a frequent group theme, as are generational and cultural conflicts. Attempts to

introduce elements of formal psychotherapy to adult refugee groups showed mixed results (Lim & Koike, 2010). No studies carried out specifically with unaccompanied refugee minors have evaluated the benefits of the group process. However, based on evidence for groups in other circumstances, it would appear that this may be a positive way of helping unaccompanied asylum seeking young persons develop a sense of mastery and sharing ways of solving common psychosocial problems (Fazel & Stein, 2002).

1.4.1.8. School-based interventions

School-based interventions have advantages for all children, but especially for those who might have a lingering distrust of authority (Fazel & Stein, 2002). School belonging was found to be associated with self-efficacy among Somali adolescent refugees settled in the United States (Kia-Keeting & Ellis, 2007). A school-based, trauma and grief focused group psychotherapy programme improved posttraumatic stress, depression, and grief symptoms among war exposed, Bosnian refugee adolescents (Lustig et al., 2004). With joined up strategies, there can be more effective collaboration between mental health services and schools or higher education settings (Thomas, 2007). Further evidence on the efficacy of school-based interventions will be discussed later in this section in the context of service provision.

1.4.1.9. Pharmacological treatment

Although not usually the first line of treatment, some psychiatric symptoms can be controlled by using psychotropic medicines, thus enabling psychological therapies to take effect. For example, many unaccompanied refugee minors suffer from depression and common sleep problems, for which medication is available (Fazel &

Stein, 2002). In general, the effectiveness of medication has not been specifically evaluated among the young refugee population, although it is potentially useful for the relief of acute and more severe presentations, including anxiety and PTSD, among the generic child and adolescent patient group and in combination with psychosocial approaches (Lustig et al., 2004).

1.4.1.10. Social interventions

Intervention should have a clear hierarchy of needs, beginning with safety and survival following the Maslow's model (Maslow, 1943). Refugee youth often initially seek education, welfare benefits, and employment (Geltman et al., 2000). From an ecological perspective, any effective intervention should invoke individual or environmental protective factors to improve outcome. Another important treatment goal is to reduce risk factors that may contribute to poor outcomes, often requiring interventions at multiple levels of social ecology. Empirically tested interventions operating across interacting ecological levels appear promising but require further empirical investigations (Lustig et al., 2004).

1.4.1.11. Preventive interventions

Although an increasing amount of research evidence is available on the predictors of child mental health and optimal development in trauma-induced conditions, less is known about how to translate these findings into effective interventions. Peltonen and Punamaki (2010) reviewed the effectiveness of preventive programmes for refugee and traumatized children in the context of armed conflicts, like war, military violence and terrorism. While the authors suggested that systematic preventive interventions were effective in decreasing PTSD and depressive symptoms among

young refugees and children traumatized due to armed conflict, the actual results of the meta-analysis and the weaknesses in the designs of selected studies indicated caution in generating firm conclusions. Additionally, the majority of the reported interventions focused only on children's biased negative cognitive processes, while only a few aimed at influencing multiple domains of child development, thus aiming at enhancing emotional and social functioning. Substantial research still needs to be carried out in developing effective preventive interventions and treatments for traumatized refugee young persons.

1.4.1.12. Conclusions

There are different frameworks of interventions for refugee children and young people with mental health difficulties, with no specific advantage of any model detected by the literature so far. Thus, based on this evidence, we can conclude that, regardless of the theoretical orientation of the mental health professional, the emphasis should be on how to acquire ways of becoming more empathic, flexible, non-prejudiced, and open minded when listening to the narratives and needs of refugee children and young persons; and cultural attributes must be integrated into psychodynamic, family, group, cognitive, and behavioural approaches (Azima, 2002). However, addressing the treatment needs of refugee young persons can often seem overwhelming to those involved, as they do not easily fit with prescribed care packages and often require working with different professionals and agencies such as interpreters, solicitors, immigration teams, voluntary organizations, ethnic support groups, social services, and schools. This unavoidably requires more time and resources. Successful programmes emphasize the role of cross-cultural teams who can work in an extended outreach model. Some programmes have also tried to

integrate traditional healing methods, which may be more culturally acceptable to some young people (Fazel & Stein, 2002).

Traditional western mental health approaches have not always been effective with immigrants and refugees, more so with unaccompanied refugee minors, who often under-utilize mental health services. Barriers to service utilization include the stigma associated with mental illness and treatment in their countries of origin, a dearth of clinicians who speak their language, and low priority given to mental health among other overwhelming needs (Lustig et al., 2004). In the next section, the patterns of service utilization by unaccompanied refugee minors will be discussed.

1.4.2. Service utilization patterns

Despite of the increasing availability of the above described modalities, there are concerns on the restricted utilization of specialist mental health services by the refugee population as a whole, and in particular by unaccompanied refugee minors. In 2005, a case was brought in Australia on behalf of a child refugee, Shayan Badraie, and an Iranian man, Parvis Yousefi, against the Department of Immigration and Citizenship and the detention centre operators. In *S v Secretary, Department of Immigration and Multicultural and Indigenous Affairs* [2005] FCA 549, Justice Paul Finn held that the Commonwealth had breached its legal duty to ensure that reasonable care was taken of two Iranian detainees, 'S' and 'M', in relation to the treatment of their respective mental health problems. The lack of proper psychiatric care at the Baxter Detention Centre was also highlighted in the Palmer Inquiry into the detention of Cornelia Rau (McSherry & Dastyari, 2007). In this section, the evidence on the current state of service utilisation by this population and the

associated factors such as service access, concepts of mental health, cultural factors, help-seeking and inter-agency issues will be discussed.

1.4.2.1. Service access

There seems to be a general agreement that refugee adolescents with mental health problems do not access care adequately (Griffith & Chan-Kam, 2002). A study by Bean et al. (2006) addressed mental health needs and service access among these young persons. Data was collected from unaccompanied refugee young persons and other professionals, including carers and teachers. Their well-being, mental health need and service utilization were compared with a non-refugee group. The findings suggested that unaccompanied refugee young persons who reported a need to access mental health services also experienced a higher degree of distress than local young persons. Professionals, however, overall failed to detect distress and service needs in the majority of refugee young persons. Their referral to specialist mental health service appeared to be initiated by the professionals' perceived needs, and not by what these young persons themselves felt. About half of the refugee young persons eventually reported their mental health needs as unmet. In the absence of parents or other family members, the available carers or guardians should be conscious of these young persons' potentially unmet need to access mental health care, despite their frequently limited information on the past or even recent history.

Sanchez-Cao et al. (2012) investigated the mental health needs and service access pattern among 71 unaccompanied young persons in London through the Harvard Trauma Questionnaire, Impact of Event Scale, Strengths and Difficulties

Questionnaire and Birlson Depression Self-Rating Scale for Children. Data on service utilization was collected through the Attitudes to Health and Services Questionnaire. Although two thirds (66.2%) of the sample had high levels of post traumatic stress symptoms, only 17% had any kind of contact with specialist mental health services. Symptoms of depression, rather than post traumatic stress disorder, and duration of stay in the host nation predicted contact with mental health services. This is consistent with the earlier findings of under-utilization of services. Language barriers; lack of knowledge about services; high frequency of relocation; and varied cultural understanding of psychopathology, treatment and attitude towards help-seeking were discussed as underlying factors influencing service access in unaccompanied refugee minors. Bean et al. (2006), as well as Sanchez-Cao et al. (2012), suggested that the young persons who remained in the host country for longer and had an adequate opportunity to acculturate and be accustomed with local health beliefs and practices, showed a better chance of acknowledging needs and asking for help, thereby accessing and utilizing specialist mental health services better.

Vaage et al. (2007) conducted a case-control study based on a review of clinic records to compare service utilization between refugee and Norwegian children referred to a child psychiatry department in southern Norway. Surprisingly, the authors found no significant difference in referral or service utilization rates between the two groups. This inconsistency could be explained by the methodological limitation of this study such as its retrospective nature or could reflect differences in the quality of service provision in different healthcare systems. Interestingly, compared with Norwegian children, refugee children were diagnosed more

frequently with post-traumatic stress, affective and other emotional disorders, and less often with pervasive developmental and attention deficit-hyperactivity disorders.

There is a paucity of qualitative research evidence on service utilization and help-seeking patterns. Most research to date has centred on the generic adolescent population, and even this remains limited. De Anstiss and Ziaian (2010) held 13 focus groups in Australia with 85 refugee adolescents aged 13-17 years from Afghanistan, Bosnia, Iran, Iraq, Liberia, Serbia, and Sudan. The findings indicated that most were very reluctant to venture beyond their close friendship networks for help with their psychosocial problems due to a range of individual, cultural, and service-related barriers. Michelson and Sclare (2009) found significant differences in referral pathways and service access between unaccompanied and accompanied refugee minors. Unaccompanied asylum seeking children and young persons were more likely to be referred by social care rather than health agencies. They also attended fewer sessions, and missed a greater proportion of scheduled appointments. Despite their elevated risk of PTSD, they were less likely than accompanied children to have received trauma-focused interventions, cognitive therapy, anxiety management and parent or carer training, and also received fewer types of practical assistance with their basic social needs.

Although many studies have evaluated ways of increasing engagement for hard to reach populations such as at risk youth or the severely and persistently mentally ill, few have examined those for refugees per se. Some researchers suggested a lack of eagerness or capacity of services to address the needs of refugee young persons as a reason for service under-utilization (de Anstiss et al. 2009). A study in Chicago

(Harris, 2008) examined an outreach model for refugee children in improving access and engagement. Clinicians tended to extend outreach prior to enrolment in treatment more frequently to children and young persons with refugee status, and to those with greater deprivation of basic needs. Findings also suggested that young persons who received outreach prior to enrolment in the clinic were less likely to drop out of treatment. This suggests that clinician outreach may help refugee children and young people overcome barriers to accessing and engaging in treatment. Social workers and paediatricians who have regular contact with unaccompanied refugee young persons are often aware of their psychological difficulties; and so should be well positioned to facilitate their access to mental health services (Sanchez-Cao et al., 2012). It has been recommended that periodical mental health assessments would enhance recognition and appropriate referrals (Bean et al., 2006).

Self-reports should be taken seriously in the decision-making process. Caregivers and teachers, who provide a secure base, should be adequately trained to offer psycho-education and coping strategies to those young persons with a higher level of needs. It is also important that legal guardians and specialist mental health services work in partnership to improve carers' awareness (Bean et al., 2006). Overall, there still appears to be a general lack of appropriate mental health services that social care and general practitioners can refer these young people to. Additionally, there is a gap in appropriate transitional services for refugee young people once they become 18 years old (Chase et al., 2008). Transition can be problematic for all young people, but more so in this group because of restrictions

imposed by regulations on their further stay in the host country, and also a lack of adult services specific for this population.

1.4.2.2. Help-seeking

Refugee young people have been found to be reluctant to ask for help from professionals, and their help-seeking mostly remains confined to their close friends circle (De Anstiss & Ziaian, 2010). They may be even more reluctant to seek help from traditionally western services. Health promotion and health education could play a vital role in improving help-seeking and inter-agency partnerships could facilitate the development of such programmes (Thomas et al., 2004). Negotiation between the health beliefs of refugees and those of the host country could be an important step in this process (Palinkas et al., 2003).

Past research has found that a significant proportion of refugee children and young people are reluctant or ambivalent towards psychodynamic or other talking therapies. There are a range of views on why existing mental health services are usually unsuccessful in reaching and helping these children. Many suggest that until the children's practical needs have been met, particularly their asylum claim, they would not be ready for this type of service (Brownlees & Finch, 2010). Although unaccompanied refugee minors describe both positive and negative interactions with their general practice and specialist health services, there is a need to find ways to explain the benefits of therapeutic input, in a way which is easy to understand and does not intimidate them (Chase et al., 2008). Along with health services, welfare supports should be incorporated, which may be more acceptable to the young people and their communities.

1.4.2.3. Constructs of mental health

Research data has highlighted that young refugees are particularly disadvantaged in relation to accessing mental health services as a result of political, administrative, language and cultural factors. Discourses on mental health in the western context may not be sufficient in understanding refugees' interpretations of their own needs, experiences and perceptions of mental health. A study assessed the Somali community's own perception of mental illness and some of the barriers to accessing and utilizing services in the London Borough of Camden. Results indicated that the Somali users made considerably less use of mental health services mainly on the basis of cultural factors, and due to pre-occupation with perceived greater priorities of post-migration such as asylum, housing and socioeconomic status (Palmer, 2006). Models recommending negotiation between the health attributions of refugees and those of their new homes offer evidence in favour of the availability of culturally appropriate social and psychological support services (Thomas et al., 2004).

Beliefs about the treatment of mental health problems are a critical area for examination among immigrant and refugee populations. One study evaluated explanatory models of treatment among Cambodian refugee young persons in the US. Comparisons were made between perceptions of treatment for an externalizing problem like antisocial behaviour and an internalizing problem like depression. Contrary to earlier findings among Asian Americans, the use of mental health services was generally endorsed (Daley, 2005). However, replication of such qualitative studies has been conspicuously absent from the literature. Research in this area of clinical care is limited by the use of western diagnostic symptoms and

instruments, and the complications inherent in the westernized medicalization of what elsewhere may be viewed as religious or social issues (Lustig et al., 2004).

A number of case studies of traumatized and displaced children and young persons have been reported, where participation in traditional ritual practices was perceived as a process toward healing from war trauma. The social and cultural notions of physical, mental health and healing that apply to these children is often very different from the Eurocentric view of these terms, and addressing such culture-specific perceptions may be fundamental in improving their well-being (Honwana, 2006). Some of these young people thus originate from cultures with perceptions of mental illness that are markedly different to western constructs, and for whom the suggestion of talking therapy can be quite meaningless, thus initially unhelpful. This, however, does not mean that their distress should not be acknowledged or that support should be withheld (Lynch, 2001).

1.4.2.4. Cultural factors

While there are serious concerns about the lack of access to mental health services for these young persons, another significant concern raised in the 2010 UNICEF report is the appropriateness of existing services and approaches. Many refugee young people looked after by social services are placed in predominantly white middle class areas, and there is an identified lack of appropriately skilled mental health professionals who are experienced in working with unaccompanied refugees. As a result of this, mental health problems may not be recognized (Brownlees & Finch, 2010). Moreover, there is substantial variation in the quality of care and health agencies in contact with this group, and often a lack of knowledge and experience of

their specific cultural needs. This is partly explained by the lack of appropriate training for primary care and other social care professionals to assist them in correctly identifying mental health problems experienced by unaccompanied refugee minors (Chase et al., 2008).

Lynch (2001) argued that, especially 16 to 18 years old unaccompanied refugees have more difficulty in obtaining referrals to specialist mental health services. Many of these refugee young persons come from cultural and religious backgrounds which are unfamiliar to staff in local statutory services. They usually speak little or no English, and will often have witnessed and suffered events outside the experience of most health professionals in the UK or other western countries. Nadeau and Measham (2006) explored the reasons for differences in mental health presentations and service access of these youth when compared with those from the host culture, thus examining the contributions of culture, context, and perceptions. The authors consequently recommended changes in our current models of mental health care to improve access for refugee young persons. These included the use of interpreters, addressing the debate around ethnic matching between therapists and patients, promoting sensitivity to otherness, mediation, and the importance of choosing the right time to intervene.

1.4.2.5. Inter-agency issues

Huemer et al. (2009) suggested that interventions for these young persons need to take into account the interfaces of institutional systems which they are living in. Moreover, it has been suggested that support for unaccompanied refugee minors needs to be multi-faceted, aiming to provide them with as normal a life as possible

(Burnett & Peel, 2001). Inter-agency partnerships may, therefore, be helpful in the development of comprehensive care (Thomas et al., 2004). Asgary and Segar (2011) commented that barriers to the care of unaccompanied refugee minors are inter-related and should be addressed by individual professionals, service providers, policymakers, and regulators by collaboration between governmental, non-governmental, health, and legal agencies. Along with providing appropriate health care, treatment facilities should provide targeted social care and facilitate community support. They also argued the importance of effective documentation of any adversities in the asylum process. Equally important is the improved and clear confidentiality policy to address the uncertainties surrounding detention and deportation, in developing trust and thus proper engagement between the young persons and mental health services.

1.4.3. Service models in different parts of the world

New models of care, involving increased collaboration between professionals from different agencies, need to be devised to facilitate the mental health care of refugee children and young persons. Potential modifications of care provision required to engage young refugees in making use of the much needed mental health services have been examined by researchers worldwide. The consultative as well as clinical role of child mental health professionals has been found to be equally valuable in engaging both young refugees and local front line service providers to work more collaboratively. The most salient features that have been found to be linked with the effectiveness of such service models were, improving service access,

communication, addressing cultural differences, and collaboration with other professionals (Nadeau & Measham, 2005).

1.4.3.1. Improving service access

Nationally and internationally, there is a struggle to provide adequate and equitable health care access to refugee young persons. To assess whether mental health and other health services were associated with functional health outcomes, Geltman et al. (2008) surveyed 304 Sudanese refugee minors in foster care through the Unaccompanied Refugee Minors Program (URMP) in the US. Although they reported high rates of counselling (45%), this was not associated with a better health outcome. Through the efforts of the URMP, the Sudanese unaccompanied minors received high levels of psychosocial support despite the absence of their biological parents, although those with worse mental health problems and more severe functional impairment were no more likely than others to have received specialist mental health care. The Department of Family Medicine at the University of Colorado Health Sciences Centre, in partnership with the Colorado Refugee Services Program, developed a comprehensive refugee health screening and assessment programme that was designed to ensure quick access through a single point. During the first 30 months of this programme, more than 1,600 refugees engaged for comprehensive assessments (Kennedy et al., 1999). A tier based structure of mental health services can address the issue of providing appropriate access. This is done by offering lower tier, community-based services to children and young persons with less complex needs, and higher tier, specialist services for only those whose problems are more complex and associated with greater impairment (Hodes, 2002).

1.4.3.2. Improvement of communication

Effective communication has been reported as an important factor in developing mental health services for unaccompanied refugee minors. One of the key features of a programme described by Kennedy et al. (1999) included full availability of appropriate interpreting services for comprehensive health assessments that included mental health screening, data collection and evaluation, and education of health care providers to communicate effectively and deliver culturally responsive care. As a result, full health assessments were successfully completed with a large number of refugees included in this programme.

1.4.3.3. Cultural differences

A transcultural child mental health service was developed in Canada in 1995 to meet the needs of the diverse child immigrant and refugee population of Montreal and Quebec. Assessment and treatment modalities were modified to meet those needs while reflecting the philosophical underpinnings of the practicing clinicians. In this model of service delivery, mainstream mental health care practice was thus adjusted to address the social specificities and cultural diversity of its target client group (Measham et al., 2005). The misunderstood perspective of child and adolescent psychiatry has been described by Hodes (2002) in the context of unaccompanied refugee minors. Questions have been raised on the validity of multi-axial understanding of psychiatric disorders such as post-traumatic stress disorder and depression in young refugees, and the culturally appropriate interventions for these presentations. This demands a better understanding of the differences in the cultural perceptions of mental health and illness.

1.4.3.4. Collaboration

Hjern and Jeppsson (2005) presented an ecological model that identified some of the major factors that should be taken into account in the provision of mental health care to refugee children. They proposed an alternative approach based on social support and intervention. The situation of refugee young persons living in a new country and culture makes interventions at a societal level particularly important. Collaboration with professionals in hospitals and in the community, both multidisciplinary and multiagency, has thus been proposed as an essential ingredient of a successful service for unaccompanied refugee young people (Nadeau & Measham, 2005).

1.4.4. School-based services

Prevention is a vital aspect of care for refugee young people, and schools are uniquely placed to undertake such work. Primary prevention aims at enhancing resilience in children and young people. Schools offer an excellent framework for this through academic attainment, emotional literacy and social adaptation. Schools thus offer a learning environment, facilitate social relationships, and help develop a sense of identity (Mortimore, 2001). In particular, for the refugee youth, schools can play a vital part in their integration by becoming an anchor, not only for educational but also for social and emotional development, and eventually as an essential link with the local community. There is evidence that even children at high risk of developing long-term psychological sequelae, can make a successful transition to adulthood. School is a key protective factor in this process by enhancing children's individual competencies, in turn adding to their self-worth and sense of control over their

environment (Fazel & Stein, 2002). The two main mechanisms through which school-based interventions have been found to make an impact are by facilitating integration of the unaccompanied refugee minors into the host society and by improving these young people's access to global and specialised mental health care services.

1.4.4.1. Improving social integration

Refugee children and youths have been shown to have poorer overall adjustment as compared to the indigenous population, particularly in their emotional and peers problems domains (Fazel et al., 2009). The transcultural psychiatry team at the Montreal Children's Hospital, in partnership with schools, implemented creative expression workshops for kindergarten, elementary, and high schools to help refugee children and young persons bridge the gap between past and present, i.e. the cultures of the origin and host societies. The workshops provided a safe space to express, acknowledge and value diversity, allow the establishment of continuity, and facilitate the transformation of adversity. These inter-sectoral programmes targeted exclusion, and supported a sense of empowerment (Rousseau et al., 2005). Kia-Keating and Ellis (2007) examined school belonging and psychosocial adjustment among a sample of Somali adolescents resettled in the US. A greater sense of belonging was associated with lower depression and higher self-esteem, regardless of the level of past exposure to adversities. These results suggest that investigating ways of improving school experiences would be particularly useful towards facilitating social integration, thereby achieving positive mental health outcomes.

1.4.4.2. Improving service access through schools

Because refugee youths tend to under-utilize mental health services, schools have a key role in helping them adapt to their host country, and can thus become the focal point to prevention and service access for mental health problems. Davies and Webb (2000) argued that a service that responds to the mental health needs of the refugee children and young persons should support schools in providing a safe environment, and in effect to become Tier 1 providers of child and adolescent mental health services (CAMHS). Fazel et al. (2009) described a school-based mental health service for refugee children and young persons. This was made available to three schools and followed a consultative framework. Refugee children were discussed with the mental health team, with the majority being managed at school level, and the more complex cases being assessed by mental health specialists. This model indicated that interventions which involve collaboration with teachers, in an environment where these young persons spend much of their time, can be more resource-effective and engaging.

O'Shea et al. (2000) described a similar school-based mental health service, where teachers identified refugee pupils with mental health concerns and referred them to an outreach mental health worker, who provided treatment on the school site. A range of psychological interventions were offered, in addition to consultation to teachers. This model was found to lead to a significant reduction in mental health problems and severity.

Another programme, the "Haven", was established in 2003 for refugee and asylum seeking young persons in schools across Liverpool. This provided therapeutic

support for psychological difficulties based on modalities such as art therapy, psychodrama and horticulture. These therapies were shown to help overcome cultural and language barriers, whilst enabling the child to distance themselves from past adverse events when this was considered appropriate. The programme was also found to have a high rate of success in helping refugee children and young people access appropriate mental health services if needed (Chiumento et al., 2011). Retaining commitment to a systems perspective, the Haven ensured active partnerships with each of the schools, maintained good communication with the clients, and ensured flexibility in service delivery. Being integrated with both specialist child and adolescent mental health services and the education setting, the Haven thus acted as a crucial link between the health and education sectors; thereby encouraging mutual understanding, collaboration and integration. It has been suggested that this model of working can be considered for replication in other areas as it could maximize available resources.

1.4.4.3. Challenges for school-based services

Stein et al. (2002) described a collaborative research model for testing school-based mental health services for refugee minors. This model described the establishment of an academic and community partnership during the development, evaluation, and implementation of a school-based service called the Mental Health for Immigrants Program (MHIP). The authors demonstrated the challenges of collaborative research in this area. Schools also face a number of challenges in setting up such programmes. These include resource-intensity, cultural training and support for teachers, and changes in the school ethos to accommodate more culturally appropriate activities (Bates et al., 2005). Although such obstacles can hamper the

development of school-based mental health programmes, there are also a number of promising initiatives. The consensus so far is that more inter-disciplinary work is needed to develop and evaluate school-based joint education and mental health initiatives that can respond to the diverse needs of this group (Rousseau & Guzder, 2008).

1.5. SUMMARY OF THE REVIEWED LITERATURE

Refugees are described as people outside their country and who cannot return, owing to a well-founded fear of persecution because of their race, religion, nationality, political opinion or membership of a particular social group. The number of refugees in the world has kept increasing in recent years, and a significant proportion of them are minors. When considering the application for asylum by an unaccompanied refugee minor, decision-makers should always give consideration to their well-being. However, the quality of Home Office decisions varies, with initial decisions being deemed wrong in as many as one in five cases (Amnesty International, 2004). Age assessment is not a conclusive procedure, as this can be complicated by several factors and it has a wide margin of error. The Home Office, nevertheless, instructs immigration officers to treat the young person as an adult if their appearance suggests that they are over 18 years. This is only to be reversed if there is credible evidence to the contrary. Complex bureaucratic processes in addition to the unaccompanied refugee young persons' earlier experiences adversely impact on their overall well-being, and mental health in particular. Research has shown that these can be moderated by factors that are protective and help build up resilience against mental health problems.

In the context of global concern about the consequences of trauma and extreme adversities, research evidence is accumulating by integrating studies on risk and resilience across different systems. The combined weight of socioeconomic adversity and exposure to violence in children's countries of origin, followed by migration and finally resettlement into a new life context, exposes unaccompanied refugee minors to several cumulative risks to their physical, emotional and social development. Young refugees resettled in low or middle-income countries are exposed to ongoing threats to their security, whereas those in high-income countries face a different social milieu and complex asylum processes. Exposure to violence has been shown to be a key risk factor, whereas stability and social support in the host country have a positive effect on the young person's mental health. Carer, family and living arrangements have also received much attention in recent research. The ability to integrate into the host society while maintaining a sense of one's cultural identity seems to be protective, although its effect has not been quantified. Overall, unaccompanied refugee minors are a highly vulnerable group, who have poorer adjustment and greater psychiatric morbidity than the general population.

The available literature shows consistently increased levels of psychiatric morbidity, especially post-traumatic stress, depressive, and anxiety disorders among this group of young people. Many of them have been reported to suffer from headaches, suicidal thoughts, repetitive and intrusive thoughts, sleep problems, poor concentration, fear about the future, and worries and guilt about the past and those they have left behind. Several reports have also indicated a high incidence of behavioural problems, somatization and transitory psychotic episodes among unaccompanied refugee minors. The evidence on the long-term mental health

outcomes is not conclusive. It can, however, be inferred that positive outcomes are predicted by less pre- and post-migration adversity, quick resolution of asylum claims, settled status, presence of a family, adequate living arrangements, integration with the host society, and good psychosocial support.

Because of the significance of developmental factors relating to the vulnerability of refugee children and young persons in the host culture, a co-ordinated and culturally sensitive mental health care approach is required for these refugee youths. It is evidenced that there is a need for a variety of different approaches, including individual, group, and school-based interventions to address their mental health needs. Promising treatments for alleviating mental health problems in this population include cognitive-behavioural therapy, testimonial psychotherapy, narrative therapy and eye movement desensitization and reprocessing (EMDR). However, the evidence base on the effectiveness of specific treatment modalities still remains scarce.

While this evidence demonstrates the vulnerability of unaccompanied refugee minors in developing mental health problems, there has been limited research on which service models should best meet the complex mental health needs of this group. Despite the availability of the above mentioned modalities, there have also been concerns about the restricted utilization of mental health services. This is attributed to limited access, concepts of mental health, cultural factors, stigma, help-seeking patterns, and inter-agency issues. School is central for universal provision and prevention, while improving access to specialist mental health services, and

facilitating integration into the host society. The most salient features that have been found to be linked with the effectiveness of mental health care are, facilitating service access, improving communication, addressing cultural differences, and collaboration between professionals and agencies.

Most of the available evidence is based on service statistics, as well as measures of mental health functioning. Consequently, there is a pressing need for further investigation into the unaccompanied refugee minor's perceptions of the available treatment options, and whether these are suitable to meet their perceived needs for help. This is important in developing effective interventions and services, and appropriate policies. It would be particularly valuable to address this research gap by understanding young people's experiences of services in the context of their culture, conceptualization of mental health, adjustment to the new country, and its health and welfare systems. This was the rationale for this study, which had led to the aims, objectives and research questions. These are outlined in the next chapter.

CHAPTER TWO

METHODS

It is evident that additional research is required to address the gap in knowledge and facilitate our understanding of unaccompanied refugee minors' experiences of psychological interventions. This requires a methodologically robust study that allows for depth and breadth of information. This chapter will initially define the aims and objectives of this study, followed by the questions this research aims to answer. It will then describe the different aspects of the methodological design and will provide a clear rationale, including the research procedure and the analytic plan. It is imperative that these procedures are outlined transparently and followed systematically, to avoid subjectivity, and to optimise the reliability of the results.

2.1. RESEARCH OBJECTIVES AND AIMS

The main objective of this research is to contribute to knowledge on the experiences of unaccompanied refugee minors regarding their contact with specialist mental health services. Such evidence-base will inform improvement in service provision. Therefore, the identification of specific service areas for improvement in relation to unaccompanied refugee minors is also an objective of this study.

The specific aims are to explore:

1. Unaccompanied minors' experiences of mental health services.
2. Factors contributing to these experiences.
3. Their perceived ways of improving these services.

The research questions are:

1. What are unaccompanied refugee minors' experiences of specialist mental health services?
2. What are the factors perceived to influence these experiences?
3. How could mental health and related services address the needs of this vulnerable group in the future?

In order to achieve the aims and objectives of this study, a number of methodological options were considered, before concluding and justifying which ones would most appropriately address the research questions. In this chapter an outline of these methodological choices is provided in order to highlight their rationale. This chapter will cover the setting, sampling, measurement, procedural and analytic aspects of the methods.

2.2. QUALITATIVE DESIGN

2.2.1. Qualitative framework

A qualitative approach was utilised to explore unaccompanied refugee minors' experiences, beliefs and perceptions of their contact with specialist mental health services. Using a qualitative approach allows the researcher to achieve both depth and range of information, explanation and interpretation of the research findings. Qualitative methods provide a rich and in depth data set, concerned with words, descriptions and meanings rather than numbers and statistics. This is compatible with the aims of this research. By recruiting a smaller number of participants as compared to those utilised in quantitative research, this method is concerned more with the depth and details of their subjective experiences, rather than with the scope

of results (Wilkinson et al., 2004; Bauer et al., 2000; Braun & Clarke, 2006). To ensure achieving this depth and richness during the analysis, a qualitative research method is a data-driven process. This means that the study aims to explore what the participants feel and believe, rather than addressing the researcher's own agenda or a pre-formed hypothesis. This allows the researcher to consider a phenomenon from the participant's point of view that helps make sense of their experience, perceptions and beliefs. In contrast with a quantitative study, such a process of data collection is not structured, in order to enable flexibility in participant responses (Bryman, 2008b). This is essential for the research findings to be grounded in the data derived from the responses of the participants. However, even in the case of qualitative research, the researcher may inadvertently follow their own agenda. In the process of exploring participants' subjective views on the topic, the researcher may often compile extracts from the data set that are then used to support the researcher's argument, depending on their social construction and epistemological position (Fine, 2002). How this issue is attempted to be tackled in the present research is being discussed in the section on the analysis of transcribed interviews.

The value of qualitative research methods lies in their ability to address research questions that are of different kind, to those considered by quantitative research. These research questions explore a particular field of knowledge through narratives rather than statistics. Overall, the analysis of qualitative material is a subjective process capitalizing on the researcher's appreciation of the enormity, contingency and difficulties around generalizing findings from one particular observation on the basis of the concept of statistical significance. Indeed, one of the principal reasons for using this method is, precisely, to bring to light the meaning, richness and

magnitude of the subjective experience of social life (Altheide and Johnson, 1994). Meaning can only be understood within a social context (Saussure, 1974), so the very notion of objectivity independent of social constructions is rejected in qualitative research, thereby rendering analysis outside such positivistic endeavours (Denzin, 1994). Considering all these characteristics, a qualitative design was considered best suited to the aims, objectives and research questions of this project.

Qualitative analytic methods can be roughly divided into two types. Within the first, there are those tied to, or stemming from, a particular theoretical or epistemological position. For some of these, such as conversation analysis (CA) (Hutchby & Wooffitt, 1998) and interpretative phenomenological analysis (IPA) (Smith & Osborn, 2003) there is relatively limited variability in how the method is applied within that framework. In essence, the framework guides the analysis. For others, such as grounded theory (Strauss & Corbin, 1998), discourse analysis (DA) (Burman & Parker, 1993; Willig, 2003) or narrative analysis (Murray, 2003; Riessman, 1993), there are different ways of implementing the methods from within the broad theoretical framework.

In the second group, there are methods that are essentially independent of theory and epistemology, and can be applied across a range of approaches. Although often implied as a realist/experiential method (Aronson, 1994; Roulston, 2001), thematic analysis is actually firmly in the second group, and is compatible with both essentialist and constructionist paradigms within psychology. It differs from other analytic methods that seek to describe patterns across qualitative data such as DA, IPA and grounded theory. Both IPA and grounded theory seek patterns in the data,

but are theoretically bounded. IPA is attached to a phenomenological epistemology (Smith & Osborn, 2003), which gives experience primacy (Holloway & Todres, 2003), i.e. understanding people's everyday experiences of reality in great detail, in order to gain an understanding of the phenomenon in question (McLeod, 2001). The goal of grounded theory analysis, on the other hand, is to generate a plausible and useful theory of the phenomena that are grounded in the data (McLeod, 2001).

The term 'thematic discourse analysis' is used to refer to a wide range of pattern-type analysis of data, ranging from thematic analysis within a social constructionist epistemology, where patterns are identified as socially produced, but no discursive analysis is conducted, to forms of analysis very much akin to the interpretative form of DA (Clarke, 2005). Thematic decomposition analysis (Stenner, 1993; Ussher & Mooney-Somers, 2000) is a specifically named form of thematic discourse analysis, which identifies patterns, themes and stories within data, and theorizes language as constitutive of meanings, and meanings as socially constructed. These different methods share a search for certain themes or patterns across an entire data set, rather than within a data item, such as an individual interview or interviews from one person. In this sense, they more or less overlap with thematic analysis. In contrast, individual data items are analyzed in the case of biographical or case-study forms such as narrative analysis (Murray, 2003; Riessman, 1993).

2.2.2. Quality assurance in qualitative research

If qualitative research is to yield meaningful and useful results, it is imperative that the material under scrutiny is analysed in a methodical manner. In qualitative research, there has been considerable discussion of how quality assurance might be

demonstrated by researchers. Indeed, researchers cannot omit the 'how' question from accounts of their analyses (Lee & Fielding, 1996), as reporting the techniques employed in detail serves to enhance the value of the interpretations (Diversi, 1998). A greater disclosure and transparency in qualitative analysis can be achieved by clearly recording, systematizing and discussing the methods of analysis. The issue of bias due to subjectivity is tackled through increased transparency in accepting and embracing the possibility of subjectivity in all research rather than avoiding it.

Discussions of quality in these types of research encompass how interview questions are asked in practice, how studies are designed and conducted, and how interviewing as a method fits with the underlying theoretical and epistemological assumptions. Caelli et al. (2003) suggested, noting the researchers' position, making the research process rigorous, and identifying the researchers' analytic lens as basic requirements of a good qualitative study. Methodologically sound qualitative research is conducted by learning how to ask questions in ways that may be understood by participants, reflexivity in the research process and conceptualizing interviews as meta-communicative events (Briggs, 1986). Study participants usually have an inner authentic self, not necessarily publicly visible, which may be revealed through careful questioning by an attentive and sensitive interviewer who contributes minimally to the talk (Foddy, 1993). It is ideal to attempt to elicit spontaneous, rich, specific, and relevant responses from the interviewees. The interviewer should follow up, clarify the meanings and attempt to verify the interpretations of the answers throughout the course of the interview (Kvale, 1996).

By using these approaches in the interview interaction, quality data can be generated, from which valid findings may be produced. In this approach to quality, the focus is on demonstrating that the data generated is credible through showing that both the participant and the researcher were reliable and accurate witnesses and reporters of the data gathered. Moreover, the methods and strategies used for interpretation of qualitative data should be consistent with the theoretical underpinnings of the study. Such interpretation is carried out by critical reading of the transcripts that can challenge normative discourses. Kvale (1996) proposed that findings of qualitative research can also result in participants contributing to actions towards positive changes. Overall, the quality indicators that should be ensured while carrying out a qualitative project are transparency, reflexivity, transferability, ethics and integrity (Spencer et al., 2003). However, the researcher's theoretical assumptions may have implications on how research projects are designed and conducted, research interviews and questions are structured, research questions asked, data is analysed and represented, and how the quality of research is judged (Roulston, 2010).

At this point, it is important to acknowledge the researcher's own theoretical positions in relation to qualitative research. A 'giving voice to the participants' approach involves inadvertently extracting unacknowledged pieces of narratives that are selected, edited and deployed to prove the argument and position of the researcher themselves (Fine, 2002). It is, however, also acknowledged that there is no ideal theoretical framework or one method for conducting qualitative research. What is important is that the theoretical framework and methods match what the

research questions aim to explore, and that the researcher recognises and acknowledges their choices and decisions.

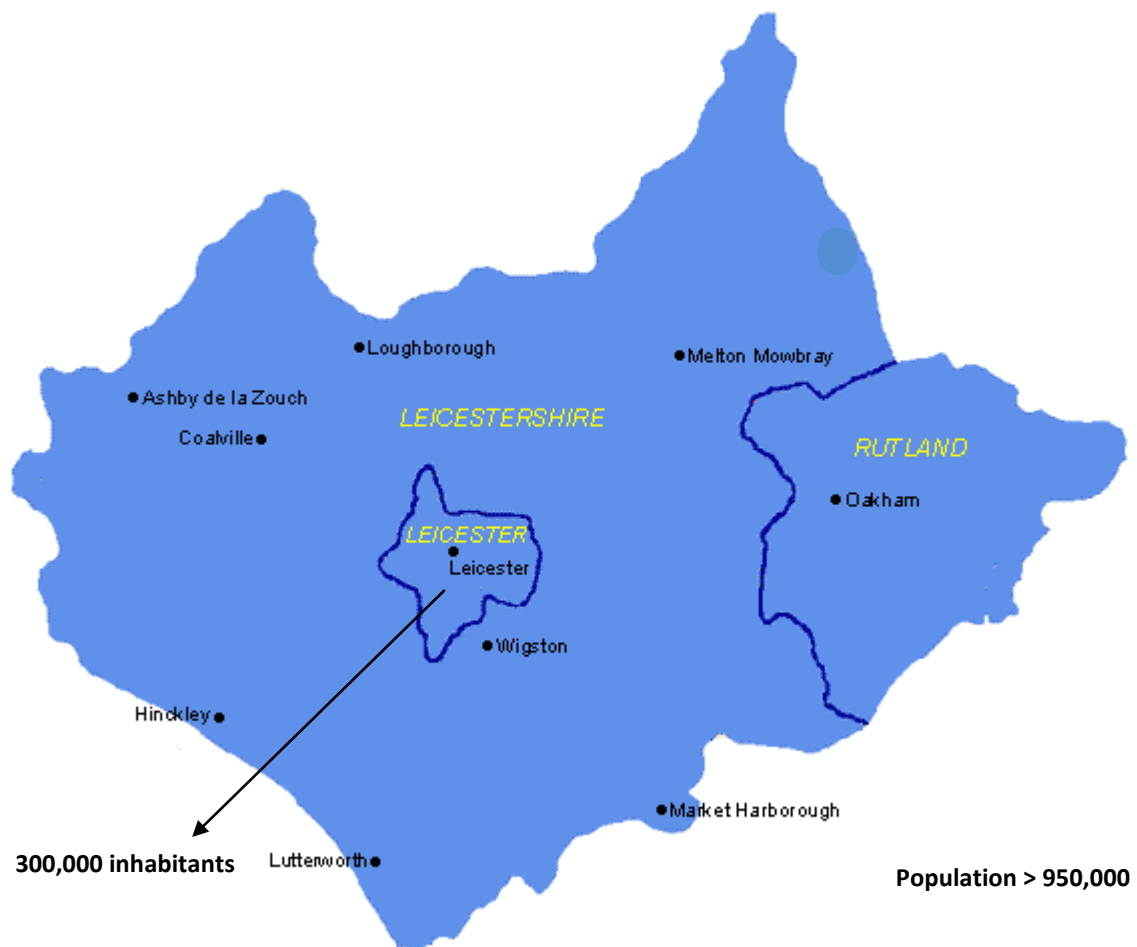
2.3. RESEARCH AND SERVICE CONTEXT

This project recruited participants who were unaccompanied refugee minors and their carers, from a mental health service providing specialist input to looked after children from three Local Authorities, including unaccompanied asylum-seeking children.

2.3.1. The service setting

Leicestershire health services provide for the needs of the residents of the counties of Leicestershire and Rutland, and the City of Leicester. The population served is approximately 950,000. This is a mixed population, both urban and rural, with marked variations in density. Leicester city is a multi-racial, multi-ethnic and multi-cultural city with over 300,000 inhabitants (Figure 2.1). Leicestershire Partnership NHS Trust (LPT) is the local mental health care service provider for Leicester, Leicestershire and Rutland. The Child and Adolescent Mental Health Service (CAMHS) provides input to children and young people living in this health sector.

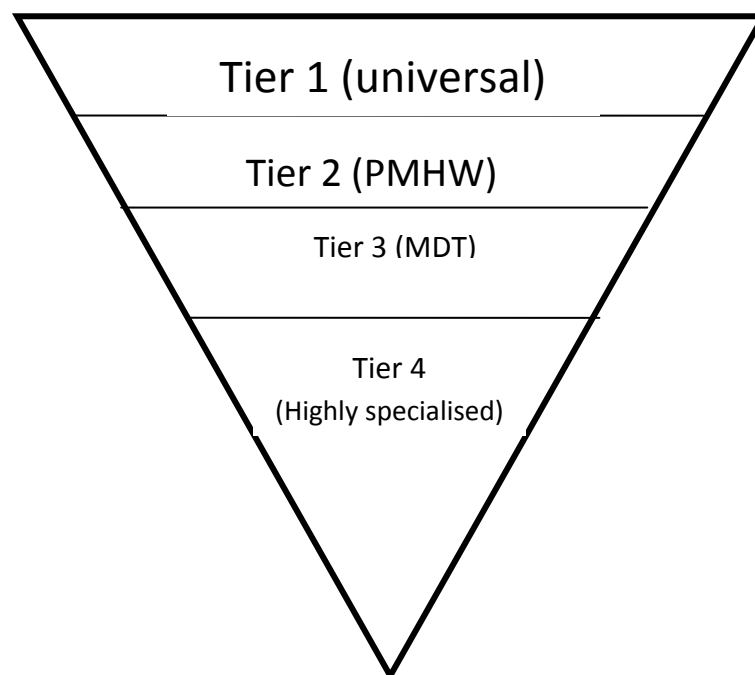
Figure 2.1. Leicester, Leicestershire and Rutland



Child mental health care in the UK has undergone a transformation in the last 30 years. The previous model involved specialists largely working individually in child guidance clinics. At present, there is more emphasis on early interventions and multidisciplinary teamwork. Key messages of policies such as the Children’s National Service Framework (NSF) (DoH, 2003) highlighted the need for high quality commissioning, working with children and young people up to the age of 18, a comprehensive and seamless provision, and routine evaluation of service outcomes.

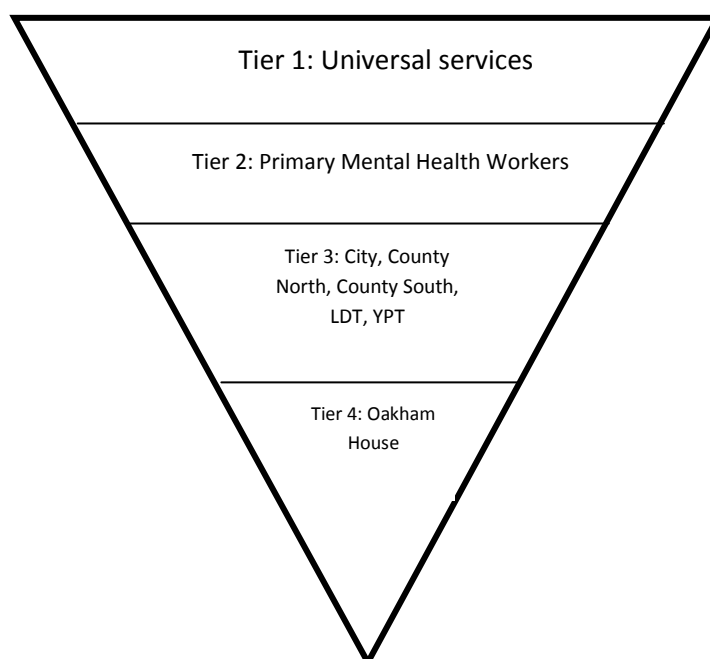
The adopted CAMHS model is structured along four tiers. Tier 1 consists of frontline primary care practitioners such as school nurses, health visitors, teachers and social workers working with common behavioural and emotional problems. Tier 2 consists of mental health specialists such as Primary Mental Health Workers (PMHW) offering support to those Tier 1 professionals on the assessment and treatment of less complex problems. Tier 3 consists of specialist multi-disciplinary teams in community-based clinics. These include psychologists, nurses, psychiatrists and therapists. Mental health problems dealt with here would be too complex or severe for tier 2 such as self-harm, depression, ADHD or autism. Tier 4 consists of specialised day and in-patient units, where young people with more severe disorders such as psychosis or anorexia nervosa can be assessed and treated (Figure 2.2).

Figure 2.2. The four-tier structure of CAMHS



The CAMHS included in this study is representative of this UK model. It includes tier 2, 3 and 4 teams offering services on the basis of population needs. The tier 2 and tier 3 CAMHS is divided into the City, County North and County South teams, which are structured according to geographical boundaries. In addition, there are two specialist community teams that provide care to children and adolescents with specific needs. These are, the Learning Disability Team (LDT) for children and young people with moderate to profound learning disability and comorbid mental health difficulties or behavioural problems; and the Young People's Team (YPT), which is responsible for addressing the mental health needs of vulnerable children and young people who are either looked after, adopted, homeless or who offend. Tier 4 services are provided by the adolescent psychiatric in-patient unit (Oakham House) (Figure 2.3).

Figure 2.3. Tiered structure of CAMHS in LPT



Looked after children include unaccompanied refugee minors under Local Authority care who have thus been referred to the Young People's Team (YPT). The Young People's Team has been developed to provide overarching mental health input to vulnerable children and young people (looked after, adopted children, young offenders and homeless families). The team comprises Community Psychiatry Nursing, Clinical Psychology (2.0 wte), Primary Mental Health Work (1.5 wte), and Psychiatry staff (1.0 wte Consultant Psychiatrist and often a Higher Specialty Child Psychiatry Trainee). These posts are hosted by CAMHS within the NHS Trust. The remit and staffing of the team has expanded incrementally and evolved since its inception in 1999, although it remains subject to complex commissioning arrangements from different sources, which impact on its model of service delivery. The Young People's Team provides a service across three Local Authorities (Leicester, Leicestershire and Rutland), and the team operates at tier 2/3 level, which means a secondary and tertiary specialist mental health service that works alongside the corresponding social care systems.

The service is commissioned through joint funding arrangements between the local NHS commissioners, the Local Authorities and the provider NHS Trust. The principles of this team are based on national policies such as Every Child Matters Framework (DCSF, 2004); Standard 9 of the National Service Framework for Children, Young People and Maternity Services (2007); and the National CAMHS Review (2008). The vision of this multidisciplinary team is to work in collaboration with children, young people and their families, and the key partner agencies in social care, education and social enterprises, to improve and promote the mental health

and well-being of children and young people by providing good quality, culturally appropriate, locally accessible, cost effective and evidence-based care.

2.3.2. Sample

The sample of this study consisted of asylum-seeking children and young people who were unaccompanied. Participants were recruited using convenience and purposive sampling strategies (Mertens, 2010). The sample was collected from consecutive referrals to the Young People's Team (YPT) over two years. All unaccompanied young people who were on the database of the Young People's Team were invited to participate in the study. There were 21 unaccompanied refugee minors in total, who received treatment from the Young People's Team (YPT) in the years 2010 and 2011. At the time of interview, eight were open and 13 were closed to the service. Out of these young persons, 16 initially agreed to participate but one later withdrew consent. Finally, 15 young persons provided informed consent and were subsequently interviewed. Out of the 15 young persons, only one (young person 10) was interviewed accompanied by his carer, while the other 14 were interviewed on their own. The study sample consisted predominantly of older boys from Afghanistan. Out of the 16 carers who agreed at the time of contact, one later declined to participate. The final number of carers interviewed, therefore, was also 15. The demographics of the final sample are outlined below (Table 2.1. and 2.2.). The age range for inclusion in the study was from 13 to 18 years.

Inclusion Criteria:

1. Age between 13 years till 18 years.

2. Being referred to and having attended at least one appointment with the Young People's Team for mental health problems in the last two years.
3. Refugee or asylum seeker according to the definition of the UNHCR's (United Nations High Commissioner for Refugee) founding mandate of 1951.
4. Not accompanied by a parent/ relative/ adult with a court mandate of custody.

Exclusion Criteria:

1. Compromised capacity to consent due to mental illness.
2. Suffering from active symptoms of psychosis.
3. Not able to communicate.

Table 2.1. Sample of unaccompanied refugee minors

Number	Gender	Age in years	Nature of the mental health problem	Length of stay in the UK (at the time of interview)	Number of contacts with CAMHS	Country of origin
1	M	18	Depression, Self-harm	5 years	19	Afghanistan
2	M	15	PTSD, Anxiety	2 years	6	Iran
3	M	17	PTSD, Depression, Anxiety	3 years	4	Afghanistan
4	M	17	Self-harm, Adjustment reaction	3 years	2	Afghanistan

5 (Declined)	F	18	PTSD, Substance misuse	4 years	2	Somalia
6	F	17	PTSD, Depression, Self- harm	1 year	16	Eritrea
7	M	15	Learning difficulties, Dissociative disorder, PTSD	1 year	10	Afghanistan
8*	M	17	Psychosis	5 years	5 (plus 1 period in in-patient and 1 in secure forensic unit)	Somalia
9	M	16	Self-harm, PTSD, Anxiety	3 years	6	Afghanistan
10	M	17	PTSD, Depression	3 years	11	Afghanistan
11	M	16	Self-harm, Adjustment reaction	2 years	8	Iran
12	M	17	Self-harm	2 years	3	Afghanistan
13	M	18	Depression, Adjustment reaction	3 years	1	Afghanistan
14	M	15	Depression, Self- harm, Substance misuse	3 years	7	Afghanistan
15	M	18	PTSD, Self-harm	4 years	4	Afghanistan
16	M	18	PTSD, Impaired	5 years	5	Afghanistan

			sleep			
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* This participant was admitted to a secure in-patient psychiatric unit

Table 2.2. Sample of carers

Number	Nature of carer	Gender	Nature of mental health problem of the child	Ethnicity/culture of the carers	Child's country of origin
1	Foster	F	Depression, Self-harm	Black African British	Afghanistan
2	Foster	F	PTSD, Anxiety	Black African British	Iran
3	Foster	F	PTSD, Depression, Anxiety	Black African British	Afghanistan
4	Foster	F	Self-harm, Adjustment reaction	Black African British	Afghanistan
5	Residential	F	PTSD, Substance misuse	British Indian	Somalia
6 (Declined)	Foster	F	PTSD, Depression, Self-harm	British Indian	Eritrea
7	Residential	M	Learning difficulties, Dissociative disorder, PTSD	Black African British	Afghanistan
8	Social worker	M	Psychosis	British Indian	Somalia

9	Foster	F	Self-harm, PTSD, Anxiety	British Indian	Afghanistan
10	Foster	M	PTSD, Depression	British Pakistani	Afghanistan
11	Foster	M & F	Self-harm, Adjustment reaction	White British	Iran
12	Foster	M & F	Self-harm	White British	Afghanistan
13	Residential	F	Depression, Adjustment reaction	White British	Afghanistan
14	Residential	M	Depression, Self-harm, Substance misuse	British Indian	Afghanistan
15	Foster	F	PTSD, Self- harm	White British	Afghanistan
16	Foster	F	PTSD, Impaired sleep	British Indian	Afghanistan

In qualitative methodology the number of participants required depends on the complexity of the topic. Since qualitative research is predominantly concerned with the richness of information, the focus is more on the adequacy of the sample to achieve depth of information rather than the actual size. Therefore, the statistical calculations used in quantitative studies to determine power and sample size are not appropriate in qualitative research. To ensure that thematic saturation has been reached, data collection should continue until no new ideas, patterns or themes are generated (O'Reilly & Parker, 2013; Guest et al., 2006; Francis et al., 2010).

Consequently, recruitment of participants in this study continued until thematic saturation was reached in each group. Data was collected from 15 young persons and their carers. This was following the guidelines of 12 interviews to cover 97% of all important themes, and three additional interviews as a 'stopping criterion' to ensure complete saturation (Francis et al, 2010). By the end of the data collection phase, responses from 30 participants in total were available for the analysis.

2.4. RESEARCH PROCEDURE

The potential candidates were identified by the clinicians of the local mental health service if they fulfilled the selection criteria. The chief investigator subsequently contacted each young person's social worker and explained the aims of the study. Social workers were requested to contact the young persons and their carers, before they could be approached by telephone or in writing. Geluda et al. (2005) alerted researchers wishing to contact children and young people that they must foresee third party co-operation and consent as a major encumbrance, and to take steps in advance to overcome this potential obstacle. Gaining access to unaccompanied refugee minors is not just about securing agreement about who will participate. There is also a social component to consent and access, and this is connected to how well researchers are able to construct a strong relationship with all stakeholders (Munford & Sanders, 2004). Keeping this in mind, extra care was taken to establish and maintain an effective relationship with Social Services Departments as well as individual social workers. I found establishing partnerships with service providers and also refugee organisations invaluable in the development of a sensitive and effective approach to research with unaccompanied refugee minors. If in agreement, a convenient date and venue were arranged for data to be collected.

A formal invitation letter was sent prior to participation in the research. The letter was accompanied by information sheets for the young person and the carer that described the process in which the research would be undertaken and what it involved, and a reply slip for acknowledging the receipt of the invitation letter. It might be difficult for this particular group of young people to understand the research process. To deal with this issue, the information leaflet was written in an easy and clear way. The potential participants and their carers were expected to respond within one week to let their wish to participate or otherwise known to the investigator. They could contact the investigator to clarify anything or ask any questions about the research before deciding to participate. Young people's clinicians were also contacted and kept informed about the inclusion of their patients. Young people's general practitioners were formally informed about their participation.

Prior to their participation, the young persons and their carers were again informed about the study face-to-face in more detail, with help from their carers and interpreters if required. Impaired capacity to understand, retain, communicate or weigh up the decision to consent due to mental illness or any other reason was one of the exclusion criteria of the study. If they were in agreement to participate, young people were asked to sign the consent form. As the subjects of our study were unaccompanied by definition and therefore had no one with parental responsibility, consent could not be sought from a guardian. As social workers were legal guardians, block consent was initially obtained from the Social Services Departments (Appendix 15 & 16). In addition, foster carers or residential workers consented for their own participation in the study.

2.4.1. Semi-structured interview process

Face-to-face interviews were conducted, as these were considered to be a more efficient tool for gathering qualitative data as compared to telephone interviews, by promoting engagement (Holbrook et al., 2003). These also allowed for an appreciation of facial expression, tone of voice and other non verbal cues in pursuing further prompting questions.

Semi-structured interviews explored the experiences, perceptions and beliefs of unaccompanied refugee young persons in regards to their contact with specialist mental health care services. These interviews are conducted according to a schedule of questions and a list of prompts that the researcher uses to address their research questions. Construct validity is the psychometric property of the strength and soundness of the measures used to operationalize the variables being investigated. Problematically, construct validity is difficult to achieve in refugee research. Researchers need to explore variables related to a particular aspect of their lives, but this is a difficult task as they may miss key components, simply because they are not aware of them, hence they are unlikely to add this aspect to the interview schedule. This may lead to findings lacking validity. One way of overcoming this problem is by using less structured interviews, which give discretion to the interviewer and interviewee, but their conversational tone may prompt particular responses or may inadvertently direct the answers (Jacobsen & Landau, 2003).

The nature of a semi-structured interview schedule allows the young person to freely talk about their experiences. This method was deemed appropriate to allow the

participants space to be reflective, without imposing the restrictions and constraints that other methods like questionnaires or structured interviews are more likely to impose (Wilkinson et al., 2004). Although semi-structured interviewing is not completely free of flaws, and the extent to which exploration can be carried out has its limitations (Potter & Hepburn, 2005), this method allows the young persons to express their viewpoint seamlessly and with minimal influence from the interviewer.

2.4.2. Development of the interview schedule

In semi-structured interviews, specific open-ended questions can be supplemented by non-specific follow-on questions or probes. This encourages further clarification and expansion on the initial responses of the study participant. These non-specific probes are essential in complementing the more structured pre-decided interview guide. This approach is effective in guiding the interviewer through the research topics, allowing for elaboration of abstract concepts and areas relevant to the participant's experience (Wilkinson et al., 2004). This is particularly pertinent for refugee young people because of the potential challenges they face in communicating complex ideas.

To address the research questions of this project, the interview schedule was constructed around unaccompanied refugee young people's experiences, beliefs and perceptions of mental health services. This was developed on the basis of the existing literature (Bryman, 2008a; Wilkinson et al., 2004), recommendations from the pilot interviews and regular internal peer reviews. A similar line of open-ended and follow-up questioning was used with carers. The interview schedule covered the following areas:

Introduction and basic demographics

This facilitated building up rapport and putting the participant at ease with the interviewer, thus setting the ground work for later free and elaborate discussion of the topics of interest. Along with the necessary demographic details, open questions were asked about the reasons for referral to the mental health service. This was followed by additional probes, depending on the initial responses, to further elaborate on young people's understanding of the service.

Overall experience of the service

Broad questions were asked about the young user's overall experience of the mental health service. Follow-up questions explored their understanding of mental health, mental illness and related services.

Strengths

This explored the participant's views on the strengths of the existing mental health service. Follow-up questions were utilised to elicit further elaboration on the responses. In so doing "why", "how" or "what is it about" questions were preferred over "what" or "when" questions, thus retaining the open-ended nature of the interviewing and giving the participants opportunity to bring in their own narrative in every instance.

Barriers

This usually followed on from the previous section, with an expected considerable overlap when participants volunteered their views on the perceived barriers and weaknesses, when asked about the strengths of the service, and vice versa. This

helped explore their perceptions of the gaps in the existing system of mental health care.

Suggested improvement

This was linked to the section on barriers. Participants were asked open-ended, non directive questions about how they believed the existing pattern of provision of care by the mental health service could be further developed. Ample opportunities were offered to the participants, by using appropriate probes, to bring in their own viewpoints on how a mental health service tailored to the specific needs of unaccompanied refugee minors should be delivered.

Continuation of care

Questions were asked about the young person's views on their reasons for continuing to receive input from the mental health service, if they were still open to the service; and their understanding of the reasons for no longer receiving such input if they had been discharged.

Final questions

This allowed an opportunity for the participants, both the young persons and their carers, to raise anything they felt had not been covered in the previous sections of the interview. It was planned that, instead of using the phrase "is there anything else?", "what else is there?" would be used to evoke a more likely response.

2.4.3. Pilot interviews

To ascertain the appropriateness of the questions as well as the quality, coherence and flow of the interview, it was deemed necessary to pilot it with young people. The original version of the interview schedule was piloted on an unaccompanied refugee young person who was not receiving specialist mental health service input. The rationale behind this pilot interview was to find out whether the questions devised were pitched at a level appropriate for a young person of a similar cultural background and language proficiency.

Following this pilot interview, the transcript and the suggestions offered by the young person were presented to the internal academic peer group. The suggestions that emerged from this discussion with regards to content, language and approach were integrated to develop the interview schedule further. These included starting with more general terms, like 'person', allowing young people to come up with more specific terms like 'doctor' or 'nurse', thus letting their interpretations to come through. Secondly, having an alternative explanation of mental health problems available, as the young person might not fully comprehend culturally influenced meanings attached to terms such as hyperactivity.

It was also suggested that it was evident from the transcript that focusing on the primary needs of Maslow's pyramid hierarchy of motivation (Maslow, 1943), i.e. accessing shelter and safety before exploring emotional issues, was likely to be a prominent feature in this sample. Therefore, it was important to clarify the role of the interviewer at the beginning of the interview, so that the participants were not apprehensive of their primary necessities such as their immigration status, being

jeopardised or themselves getting into trouble. It was further suggested that, after ethical approval was granted, pilot interviews should be carried out with a few more young persons who had already received input from the service, in order to capture their mental health perspectives.

At the next step, individual sessions with the research supervisor were arranged to further develop the qualitative interviewing techniques, and to integrate this particular approach with the content and focus of the interview. Emphasis was placed on rapport building, using neutral topics as ice breakers, and offering a detailed explanation of the purpose and remit of the interview. The young person's engagement was encouraged by using longer pauses, nodding, affirmative sounds, facial expression and body language. Their understanding was enriched by using more frequent summarizing statements, clarification, paraphrasing, rephrasing or offering alternative definitions and explanations, if the young person struggled to understand a question.

In order to further improve the depth and richness of the data derived from qualitative interviewing, more "why", "how" and "what is it about" probing questions were planned. It was decided that greater emphasis would be placed on exploring the young persons' cultural and national identity, belief systems around well-being and health, mental health, mental illness, interventions and mental health care services. It was agreed that more pilot interviews would be carried out with young persons from the indigenous population as well as unaccompanied refugee young persons, who were open to the mental health service. The purpose of this was to develop the

final version of the interview schedule, practice and further refine the qualitative interviewing skills of the interviewer.

Subsequently two more pilot interviews were completed with adolescents who were in contact with the Child and Adolescent Mental Health Services (CAMHS) but were not refugees, in order to obtain their perspectives on different aspects of the interview schedule, including the appropriateness of the questions with regards to age or developmental stage; and on the questions exploring their perceptions and understanding of the mental health service. One final pilot interview was completed with a refugee young person who was open to CAMHS, in order to integrate all these issues in a holistic understanding of their views of the interview schedule.

Table 2.3. Participants in pilot interviews

Participant number	Gender	Age in years	Nature of the mental health problem	Country of origin	Service user?
1	M	16	None	Afghanistan	No
2	F	17	Self-harm, Anxiety, Personality difficulties	UK	Yes, open
3	F	15	Psychosis	UK	Yes, open
4	M	17	Self-harm, Adjustment reaction	Afghanistan	Yes, closed

As a result of these pilot interviews, a number of additional points on terms used to describe perceptions of the mental health service were modified or added. For example, words like ‘professionals’ and ‘services’ were removed, as the young

persons struggled to fully comprehend them. Some specific phrases such as “is there anything else?” were replaced by phrases like “what else is there?”, as the initial expression did not seem to encourage discussion. Some repetitions were omitted and minor alterations in the question order or phrasing of questions were made. These ensured that the questions followed a logical and smooth order, and that they were as clear as possible. The final interview schedule was approved between the researcher and his research supervisors before applying it in the main study.

2.4.4. Interview process

Being a psychiatrist, I was trained in clinical interviewing skills, but I was also conscious of the importance of distinguishing clinical interviewing from qualitative research interviewing. Before taking up the task of commencing the interviews, I had specialized training in qualitative interviewing, to ensure adequate knowledge of the basic skills and techniques required to successfully elicit rich information from the participants. A list of criteria for a successful interviewer was proposed by Kvale, which included sensitivity, openness, interpreting without imposing pre-empted meanings and a thorough familiarity with the main focus of the interviews (Bryman, 2008a). The pilot interviews discussed above allowed an opportunity to practice qualitative interviewing and to initiate the process of ongoing discussion and supervision to further enhance the researcher’s skills in this area.

A one-to-one semi-structured interview lasting for up to one hour was carried out with each participant. The average length of an interview was approximately 45 minutes. The venue for the interview was decided according to the choice and

convenience of the participants. This was usually either at the clinical base of the mental health service, or at a convenient place for the participant, including their place of residence. Some interviews took place at the base of non-statutory community projects. Carers were interviewed either at their residence or at the clinic. Rooms were chosen if they were convenient for using recording equipment, and provided necessary privacy and lack of interruption required to facilitate the participants' engagement.

It could be inconvenient for the research participants, considering their variable language, cultural background and mental health difficulties, to be able to communicate effectively their experience of mental health services to the interviewer. Guidelines recommend the use of interpreters when working clinically with this population (Rousseau et al., 2011). The British Psychological Society Guidelines for working with interpreters in health settings (BPS, 2008) provide a good practice model. Interpreters working in the area of child mental health should have, whenever possible, life experience in both the host and the country of origin of the refugee young person. The interpreter should ideally also have some basic knowledge of child development, and cultural differences in its representations; similarly, understanding of age-related verbal and non-verbal language and their intercultural differences. Knowledge of the key differences in education, family roles and values between the country of origin and the host country, and legal challenges and stereotyping could equip the interpreter to overcome the anxiety associated with the uncovering of difficult arising issues, and to function as a mediator.

However, using interpreters with children who also have mental health difficulties can also be challenging. Interpreting the meaning of language can be hard, in addition to the question of whether and which child mental health problems are valid cross-culturally (Canino & Alegria, 2008). It was useful to organise a brief meeting with the interpreter before the interview to introduce its aims, establish a working relationship, and discuss the potential challenges of forming an alliance with the participant. This was also helpful in conveying to the interpreter that the researcher did not believe that the host society norms are the only truth; and that he was aware of the potential harm associated with stereotyping, which made it easier to establish rapport with the interpreter and, through him/her, ultimately with the participant. The interpreter was encouraged to have an age-appropriate conversation with the young person. Their mastery of both cultures was used to legitimize their views of the world, thus engage the young person. As far as possible, it was attempted to keep the same interpreter as for the previous clinical encounters in order to maintain consistency, trust and confidentiality (Rousseau et al., 2011). Although there was always provision of interpreters, whenever required, only two young persons used an interpreter to communicate with the interviewer. The rest had adequate fluency in English and chose to converse with the interviewer directly.

The young people made the choice whether their carer would join them during their interview with the researcher. Carers were interviewed separately, usually before the interview with the young person. As there was a possibility that the young person might have felt embarrassed to share their negative experiences with the mental health service, the interviewer clearly explained his neutral position outside the clinical team and stressed that their responses would be made anonymous. It was

also clarified prior to the interview that any clinical or legal matter that might arise during the interview would be passed on to the responsible clinician or care co-ordinator for appropriate action.

Before commencing the interview, the interviewer checked that the participant understood the information sheet (PIS), and offered them an opportunity to raise any unanswered questions or clarify any points discussed so far. It was confirmed that the participant agreed for his/her interview to be audio-tape recorded, and it was reiterated that the whole data set would be anonymized before using it for research purposes and reporting the findings (Wilkinson et al., 2004). The consent form was signed and dated by the participant.

2.4.5. Recording and transcription

Audio-recording and transcribing the interviews, instead of relying on the interviewer's hand written notes, allows for a more accurate record of the interview, as it does not rely on human memory. This is also free from the potential bias or assumptions that may be present in retrospective notes by the researcher. Moreover, as the interviewer does not need to take notes, he can focus on eye contact and other important non-verbal aids to facilitate engagement. Transcribed interviews allow repeated examinations of the participant's responses, and its first-hand evidence of the reliability of the analysis (Bryman, 2008a).

Although some of the existing literature cautions against tape-recording participants' responses, due to concerns about making them self-conscious or evoking participant bias by causing them to answer in ways that make them appear more socially

desirable, there is general agreement that using recording equipment is a beneficial and effective way of capturing qualitative data (Speer & Hutchby, 2003). In order to reduce the possibility of participant bias, they were reminded that all data would be kept confidential. Rapport was built with each of the interviewees, fostering an open environment and encouraging honesty (Wilkinson et al., 2004).

Interviews were transcribed by an experienced transcriber. Data was anonymized by the researcher once the transcription was completed. Using a professional transcriber is resource-effective and ensures good quality transcripts that are essential for accurate data analysis.

In thematic analysis, it is the content of the conversation that is the focus of the analysis, rather than the sequential nature of conversation and social construction of meaning. Therefore, in thematic analysis readability and interpretability of transcripts are essential, while transcription of specific details of conversation structure, such as pronunciation details, would have been unnecessary (Flick, 2002). Although the young persons' difficulties in communicating in English reflected on the quality of some of the transcribed material, it did not interfere with the overall interpretability of the content and the themes. Basic paralinguistic features such as pauses and laughs were added to the transcript. These included the non-verbal details which helped to clarify some of the meanings attached to the statements. The researcher went through all the transcripts at least once after the transcription was completed by the professional transcriber. This provided an opportunity to confirm the accuracy of the transcript and to become familiar with the data corpus (Braun & Clarke, 2006).

2.5. ETHICAL CONSIDERATIONS

Young people are considered a vulnerable group to participate in research. Refugee minors, by virtue of their unaccompanied status, add to their vulnerability of being coerced into a process they may not be comfortable with. These young people are from a different culture and speak different languages, which increases their vulnerability of being misheard or misunderstood, and compromises their ability to communicate their intentions effectively. This is compounded further by the presence of mental health problems. This group, therefore, raises ethical implications, as well as specific ethical issues, which were addressed in this research project, both at the beginning of the process through formal ethical review, and iteratively as the process unfolded. Ethics are an iterative consideration (O'Reilly et al., 2011) and thus it is imperative to revisit key ethical principles throughout the research.

2.5.1. Consideration of broad ethical issues

The aim of human research is to create generalizable knowledge that could benefit future individual and collective needs. In this context, it also faces a risk of compromising the interests of research participants for the greater good of society. Ethics guidelines exist to minimize that risk (Millum & Emanuel, 2007). Research ethics guidelines in the United Kingdom predominantly reflect requirements for medical and clinical trials, but also apply to all types of research conducted in the NHS, including qualitative research. The Department of Health made ethical review mandatory for all types of health research including social research in 2001 (Department of Health, 2011). Guidelines emphasize the protection of an individual's autonomy and rights, and the avoidance of harm, particularly to vulnerable people. Typically this is based upon the philosophical position of deontology, which

advocates four key ethical principles to guide research in practice. These are that researchers respect an individual's autonomy, apply the principle of justice, and ensure beneficence and non-maleficence (Beauchamp & Childress, 2008). Notwithstanding the potential for overlap or conflict between these principles, an adherence that is too rigid, or lacks reflexive appreciation can also result in the exclusion of and discrimination against marginalized and vulnerable groups by denying them the right to participate. This ethical tension can be dealt with through a rigorous consideration of all the potential ethical issues, or else the general validity and reliability of research findings could be compromised.

The concept of responsible advocacy, with due consideration of beneficence, non-maleficence, autonomy and justice are essential for all research, but are particularly relevant in research with vulnerable groups (Smith, 2008). There are a number of additional ethical issues that arise in relation to qualitative health services research. Risks which can be present in any type of studies but are commonly encountered in participants of qualitative health research include anxiety and distress, confusing the research process with a therapeutic encounter, coercion, identification of need for further help, and misrepresentation (Richards & Schwartz, 2002).

2.5.1.1. Ethics of research with children and young people

Research ethics in relation to children and young people has been a fruitful ground in exploring issues such as power and protection, researcher responsibility, and social versus individual good. Recruiting children and young people as research participants can be a difficult process. Ethical issues often revolve around two perceptions, of them as vulnerable and as lacking competence to make informed

decisions about matters that affect them. These social discourses of children as vulnerable and incompetent, and the problematizing of children through the research agenda have meant that we do not as yet have a culture of listening to them. Neither do we have a universally accepted set of procedures in engaging with them as potential research participants (Munford & Sanders, 2004). The following discussion draws out the ethical issues raised when researching with children and young people, and locates these within the context of the wider social discourse.

Children and young people have historically been marginalized in research, with proxies used as appropriate sources of information about their experiences, perceptions and understanding (Carter, 2009). However, there is an increasing interest in involving them in research that has been influenced by the recognition of children's rights, and by their reconceptualization within social sciences as active agents rather than objects of research (Kirk, 2007). Researchers believe that it is ideologically desirable to include children and young people in research, and that hearing their perspectives is in keeping with the requirements to take note of user viewpoints. Article 12 of the Conventions of the Rights of the Child creates a tension between these two opposing views, namely that children are not capable of taking responsibility for their own decision-making and are therefore dependent on adults for their protection; and that children have basic civil rights, including to participate fully in decisions that affect them such as research (Carroll-Lind et al., 2006). This is a potential conflict as, while researchers are expected to elicit the views of children and treat them as active, capable and competent beings; yet they are cautioned to be aware of their vulnerability and their potential for exploitation.

The recent drive to include children and young people in research has thus brought numerous challenges for researchers, and the notion of vulnerability is central to the dissonance that may occur between researchers and ethics committee reviewers. The responsibility for managing risk and protecting children is shared by both researchers and reviewers. Exercising this responsibility is challenging and requires a sophisticated appreciation of the competing legal requirements, power differentials and children's vulnerabilities when designing a study (Carter, 2009). Despite the previously held view of children as developing individuals who only reach their full status when they reach adult life, there is a growing recognition that they should be given an opportunity to express their feelings about the issues that affect them. The balance between protecting young people's interests and recognising their right to participate may best be judged in relation to their developmental capacity on the cognitive, emotional and social domains (Claveirole, 2004).

Two key methodological issues can thus be identified in relation to conducting research with children. One is epistemological and relates to the different cultures of childhood and adulthood; the second relates to the heterogeneous nature of childhood itself. The imbalance of power between adults and children raises concerns about how free children are to refuse to participate in a study, or to subsequently withdraw from it (Kirk, 2007). Given the relatively powerless position that youth occupy in society, most research involves researchers approaching adults for their agreement (Murray, 2005). Conversely, there is an argument which suggests that the emphasis on widening children's participation and opportunities to talk and contribute can risk creating a culture in which children are expected to talk (Aubrey & Dahl, 2006). Each individual child needs to be assessed for their ability to

fully understand the implications of consenting (Balen et al., 2006), and their informed consent should be sought together with their carer's or guardian's consent if we are to take children's rights seriously (Taylor, 1998).

It has been argued that informed consent is largely an unworkable ethic, in that researchers can never fully know the extent of what participation really means for the young people, nor can they predict in advance all potential outcomes of participation. Nevertheless, the principle of informed consent is essential. Competency is essential in retaining informed consent, in that research participants are able to express agreement in the process, and that their ability to express agreement arises from their competency in decision-making (Heath et al., 2007). A child or young person can be seen as an individual with needs that evolve with maturity and age, and whose well-being should be paramount when they participate in research. Conventional informed consent procedures may need to be modified to ensure their understanding.

Christensen (2004) suggested that the researcher should establish a relationship with the young participants and directly present the aims of the study to them. There should be an underlying dialogue that children have control over and that allows independence in their conversation. The child's openness and engagement can be restricted by shyness or anxiety, particularly if meeting the researcher for the first time. It is, therefore, necessary for the researcher to be familiar with the child's vocabulary and to use age-appropriate communication techniques.

It has been reported that the majority of children and young people give consent freely and are not exposed to any undue pressure from the researchers. Older children in particular have sufficient knowledge of what their participation would involve, comprehend confidentiality, and understand the purpose of the research (Hurley & Underwood, 2002). From a researcher's perspective, good practice should consist of 'observing systematically', 'recording accurately' and 'listening carefully'; whilst bearing in mind academic, policy and professional agendas. Much research, particularly of quantitative nature, still treats the child as a subject, but there is also increasing emphasis on children as social and cultural actors, and this is more prominent in qualitative studies. Respect for children's status as social actors, however, does not diminish adult responsibilities. These include structuring the children's environment, guiding their behaviour, and enabling their social participation consistently with their understanding, interests and communication (Woodhead & Faulker, 2000). Mayall (1996) described three pre-requisites for locating children at the centre of research; they should be regarded as competent and reflexive when they report their own experiences; should be given a voice through the researcher; and the research should be *for* them rather than *on* them.

2.5.1.2. Ethics of research with minors with mental health problems

Child mental health research is relatively recent in comparison to the adult field, but spans across a rich variety of research contexts. When a study involves children or young people, who may be at risk or who manifest emotional or behavioural problems, troublesome areas such as defining vulnerability, determining the extent of autonomy, obtaining consent, or avoiding coercion require careful consideration (Hoagwood et al., 1996).

Fisher et al (2002) argue that the existing codes of conduct are incomplete and fail to adequately identify or resolve ethical issues relating to mental health research, particularly when involving children from ethnic minority backgrounds. Researchers have a key responsibility to ensure that their methods and processes are scientifically sound, morally just and culturally valid. Subtle or overt forms of prejudice and discrimination encountered by children and adolescents can threaten their mental health because of culturally marginalized identities and stereotypes that lower self-esteem and increase anxiety. When researching mental health in children from ethnic minority backgrounds it is preferable to have access to a research team representing multiple perspectives, although including researchers from a variety of ethnic backgrounds does not itself assure sensitivity or competence in such research. Therefore, the members of the research team should be provided with training in cultural competencies in order to ensure the highest quality of data collection. As a qualified child and adolescent psychiatrist, the researcher acquired the desired competency in various aspects of equality and diversity as part of his clinical training. An examination of the researcher's own biases, self-reflection and exchange of views is particularly important when conducting research with ethnic minority children and adolescents with mental illness.

Among individuals with mental health problems and who are in contact with mental health services, their mental state should be considered as an important component of their capacity to participate in research. Children with the maturity to consent should not, however, be excluded on the basis of impaired mental state alone. Young people with psychotic illnesses should be able to give their views at a time when their thought processes are clear and when their welfare is not endangered by

interview participation. At the same time, they should have available support in the event of them becoming distressed by the research (Claveirole, 2004).

Problematically, an invitation to participate in research could cause confusion or lead to a fear that failure to comply will result in less than adequate service provision. There may also be misperceptions over the role of a researcher and a clinician. These remits should thus be clarified from the outset. Researchers should ensure that participants understand that declining to participate or withdrawing at any stage will not have negative consequences on their care. The researcher should identify the appropriate contact persons and agencies should a referral on their input be required. The specifics of confidentiality and disclosure must be explained to potential participants (Fisher, 2002). This means explaining that all the contents of the interviews and other identifiable personal data will be kept confidential, other than in exceptional circumstances when a risk to the participant or others is identified that entails confidentiality to be overruled.

Children with mental health problems may be particularly vulnerable to stigmatization and discrimination. Grodin and Glantz (1994) suggested that children with limited abilities need protection from their carers. When a child is mentally unwell there is an even more compelling moral obligation of the society to provide protection. The same authors also suggested different protective measures such as improved scrutiny in the selection of subjects to ensure that the risks and benefits of research are distributed fairly, justification for the recruitment of children with mental disorders, scrutiny concerning undue inducement and coercion, special attention to the

agreement of the young persons, minimization of risk by use of information gained during regular treatment, and attention to the milieu in which research takes place.

2.5.1.3. Ethics of research with children who are looked after

Children who are 'looked-after' are considered to be among the most vulnerable in society due to the fact that they have no parents/guardians in their lives; and many having suffered abuse and neglect. Because of their life experiences it may be difficult for them to trust professionals, which adds to the complexity of engaging them in research. The ethics of research with looked after children should involve a careful consideration of all these factors. Ethical principles of capacity, risk and truthful disclosure in minors consenting to healthcare can be applied to looked after children consenting to participate in research (Rew et al., 2000). In cases where a parent's or guardian's permission is not sought, it is important that an appropriate safeguarding mechanism is in place (Fisher, 2002).

As children looked after by Local Authorities often have multiple carers and/or responsible adults, the process may require contact with Social Services managers, social workers, foster carers or residential staff. These adults' wish to protect them, may result in gatekeeping them from participating, even when they express a wish to do so. Co-operation of Social Services is especially required to help identify children who meet the inclusion criteria and to liaise with foster carers. If the study involves more than three Social Services departments, then there is a standard application to the Association of Directors of Social Services (ADSS) in the first instance. If it is less than three, then individual departments need to be approached. Depending on individual social workers can be problematic, as a particular social worker may

withhold some information or decline to co-operate because of their own beliefs on what might cause harm to a young person under their care (Heptinstall, 2000).

Trust is a central feature of the relationship between researchers and these hard-to-reach participants, and yet building up a trusting relationship can be difficult. The position of the researcher is one of an outsider. To facilitate the building of trust it is important that the researcher is empathic towards the participant, and for this to be achieved it may be necessary for the researcher to immerse themselves at the research site, spending considerable time amongst the community. It is important to build up a rapport with each individual to foster trust and to reduce the power relationship that may exist (Emmel et al., 2007).

2.5.1.4. Ethics of research with asylum-seeking and refugee people

There are a number of reasons why refugee populations are vulnerable in research. Firstly, they are vulnerable due to their political status, as they inherently possess fewer defined political rights than those who are able to claim citizenship. Secondly, refugees are often fleeing from hostile environments and this can be problematic in terms of access and communication. Thirdly, the universal ethical guidelines do not address the special circumstances of recruiting refugees to research. There can also be barriers with this group in terms of applying the basic ethical principles such as informed consent. Culture, language, social norms and educational background can make it difficult to truly acquire voluntary consent. Another concern regards beneficence, in terms of whose interests are being served by the research. The mobility and fluidity of refugee populations mean that there is little opportunity for a study to have direct benefit to them (Leaning, 2001).

Entering the refugee community is a difficult and complex process which requires time, negotiation and respect. Access to refugee camps or projects, and undertaking research in individuals' space is notoriously difficult. These tend to be carefully regulated and monitored by the authorities, and it can be difficult to be granted permission to join. The importance of developing mutual trust with this group prior to research access is particularly salient with marginalized and politically oppressed communities. The concept of trust as a methodological concern is rarely considered in the quantitative literature and, although this oversight may be due to a number of factors, it could also be related to the use of positivist methods and theories, where trust is seen as largely irrelevant. The process of research in these communities where issues of trust are particularly prominent is inseparably embedded within an interpersonal context that affects both the process and outcome of the research. Consumers of this type of research thus need to have sufficient understanding of the relational context in which data is gathered. Without that, it is not possible to adequately evaluate the validity of data and the conclusions reached (Miller, 2004).

Culturally bound notions of autonomy, freedom and self-determination are inherent to the concept of informed consent. In research with refugees from different cultural backgrounds, these values may not be congruent with the mainstream framework of informed consent (Ellis et al, 2007). Although refugees constitute a particularly vulnerable group and there are fears of eroding their rights in the process of research, ethical studies with this group is possible, and safeguards do exist to ensure that consent is sought appropriately and adequately. Some argue that these populations are less free to provide consent to participate, as they are in a position of oppression. The key argument with this stance, however, is that neither researchers

nor clinicians should take a paternalistic position that somebody cannot provide informed consent because of their refugee status. It is questionable whether their autonomy is compromised by approaching them to participate, and whether relying only on secondary sources of information provides valid representation of their views. In reality, it is argued that all groups have the right to agree to participate in research, as being excluded denies them opportunities to contribute to future improvements for themselves or others (Strous & Jotkowitz, 2010).

In recent years, there has been an increase in research with refugees and asylum seekers, which is inevitably undertaken in complex, and sometimes difficult and dangerous situations. In this type of research there is ultimately a power differential in the relationship, which places a significant responsibility on the part of professionals. It is, therefore, argued that standard approaches to ethics are insufficient for research with refugee populations. Autonomy is a capacity that is socially acquired, and which can be enhanced or undermined in different ways. The principle of informed consent does not go far enough in this vulnerable population, because of the assumptions on which it depends in relation to how individuals are able to actually achieve moral autonomy (Hugman et al., 2011). To conduct research with refugees requires researchers to think beyond standard recommendations, particularly as these groups uphold cultural standards that diverge from western philosophies and values.

Although refugee populations are difficult to access, participants should be recruited fairly based on scientific questions of interest, and should not be selected or excluded solely due to convenience (Ellis et al, 2007). When recruiting refugees to a

research project, the researcher needs to be mindful of the process and of the relationship with the participants. They also need to be aware of their own role in seeking consent, and to avoid coercion or come across as patronizing. A relational approach to the question of autonomy enables researchers to think in more subtle ways about their obligations (Hugman et al., 2011). Sensitivity and concerns are central when engaging refugees in research, particularly if they have been traumatized and currently grieving, therefore researchers should undertake appropriate training, and obtain adequate social and empathic skills. Ultimately, they should be confident that the informed consent is genuine and not a case of the refugee feeling in debt to the service, agency or host country (Dyregrov et al., 2000).

2.5.1.5. Ethics of research with unaccompanied refugee minors with mental health problems

As already discussed, children constitute a vulnerable group, but unaccompanied refugee minors are especially vulnerable as they are likely to have been persecuted or to originate from unstable social situations. Young people who are also refugees are typically characterised by troubled backgrounds, consequently they are likely to be wary of researchers asking questions about their experiences which are loaded with pain and guilt. In addition, refugee minors may be stigmatized or risk reprisal merely by entering a study (Thomas & Byford, 2003). These, as well as concerns related to language, culture, religion, social norms and experiences of oppression are magnified among unaccompanied minors. Such barriers may make it difficult to obtain truly informed and voluntary consent, or accurate responses to research questions. Although it is essential that we undertake research to improve the quality of care, if this is conducted inappropriately it can also prove harmful. Therefore, the

methods and language should be appropriate, distress is avoided, and the researcher remains mindful of child protection issues. Consultation with unaccompanied minors, their carers and service providers is vital in building trust and evaluating the standards of carrying out research (Thomas & Byford, 2003).

Mental health research involving minors has to deal with the phenomenon of the 'unexpressed' that surrounds the extremes of human experience, both at social and at individual level. Ethical and methodological approaches should take this phenomenon into account. Recognition of the importance of what is not spoken may lead to a greater respect and heightened understanding (Cecile, 1993). The Royal College of Paediatrics and Child Health recommends that provision of continuing emotional support for the participants should be built into the research. Young people should be encouraged to discuss the research with carers, and to be given the researcher's contact details in case they wish to ask further questions or require additional help. Debriefing should be undertaken immediately after the interview, allowing the young person to ask questions about the research or discuss the interview (Thomas & Byford, 2003). Some young people may have high levels of anxiety or emotional distress as a result of the trauma of leaving their home country unaccompanied and their initial experiences of the host country. Such distress needs to be treated with sensitivity. In particular, researchers should consider the danger of re-traumatization. Interviewers may be tempted to delve more deeply if they think they are on the verge of an interesting discovery; however, this can sometimes become intrusive and potentially damaging (Raftery, 1997).

Refugee children are also likely to be suspicious of the motives of researcher and may have concerns about participating in the research. They may become weary of signing a consent form, and query why and how this is being used, particularly in relation to how such a document might influence their asylum claim. Therefore, considerable time is needed to be invested to explain the relevant issues (Hopkins, 2008).

Language can serve as a barrier to participation, as differences in proficiency, preference and communication styles can lead to misrepresentation or lack of understanding related to the consent information. Not all words can be translated and terminology can be inexact. It can be argued that, while research ethics committees (RECs) do take issue with interpretation and insist on interpreters being available, there is often the unfortunate practice of selecting the most accessible and available interpreter, alternatively a family or community member, who is just as unfamiliar with scientific or mental health terminology. Researchers should opt for professional interpreters, preferably with experience of the mental health service, and who have the knowledge and language competencies to ensure that consent is indeed informed and voluntary (Fisher, 2002).

The Royal College of Paediatrics guidelines state that, it is the competent minors and not their parents whose consent is required by law. The Declaration of Helsinki, however, recommends that consent should be obtained from the legally authorised representative as well as the young person (Heath & Hill, 2002). When undertaking research with children, parental consent is seen as integral to the ethical process, but this is not possible with unaccompanied minors, and therefore this requirement

falls to the social worker or another acting in 'loco parentis' (Hopkins, 2008). Researchers need to understand unaccompanied minors' capacity to provide informed consent, which depends on several factors, including literacy and mental health. Capacity to give consent sometimes needs to be assessed on an individual basis, for example, if the research involves discussion of difficult issues such as the children's experiences before fleeing their home country. For research into less sensitive topics, however, capacity to give consent can be assumed, based on the expectation for the group as a whole (Thomas & Byford, 2003). Young person's experience of treatment and service provision in this research appears to be one of the comparatively less distressing issues.

Data protection and anonymization to safeguard confidentiality are essential, as these children may be at risk of recrimination and stigmatization. For the same reasons, consideration should be given to the anonymization of communities. The numbers of unaccompanied children seeking asylum in the United Kingdom from particular regions and ethnic backgrounds may be small in any given area, thus children could be easily identified (Thomas & Byford, 2003). Furthermore, concepts such as confidentiality may be alien to the refugee young people, therefore a considerable amount of preparatory work should ensure their understanding. When considering confidentiality, it is common practice for anonymity to be invoked and pseudonyms to be applied to participants as a way of not revealing identifiable personal experiences. This is especially sensitive for unaccompanied minors who may reveal personal traumatic experiences from their country of origin. It may be useful to pilot the dissemination of findings with service providers to test out if they are able to identify any children from the quotes being used before releasing any

reports or papers in the public domain (Hopkins, 2008). Despite the confidentiality guidelines, researchers have a duty to report child protection issues if a young person discloses that they or others are at risk. To anticipate this process, researchers should inform participants of this child protection obligation from the outset (Thomas & Byford, 2003).

Unaccompanied children are a marginalized and vulnerable group, not only because they are separated from their parents or guardians, but their vulnerability is often compounded by their uncertain immigration status (Brownlees & Finch, 2010). The vulnerability of refugee youth during sensitive developmental periods and the current service gaps both challenge and mandate the necessity of high ethical standards. Children may be devoid of both an effective advocate and the awareness of their rights. There is likely to be a major power differential between the provider and the unaccompanied young refugee. These disparities can strain rapport and trust. Neutrality may be interpreted as collusion with the perpetrators of violence, while self-disclosure, when handled appropriately, may help decrease the power differentials (Lustig et al., 2004). Researchers should have an awareness of the importance of scientific, social and political factors governing definitions of race, ethnicity and culture; an understanding of within-group differences; familiarity with and skills in constructing and implementing culturally valid and language-appropriate assessment instruments; and knowledge of the cultural and political circumstances of participants' lives (Fisher et al., 2002). Ultimately, researchers should capture the voices of these young persons themselves, rather than merely those of their service providers or carers (Rutter, 2003).

2.5.2. Addressing ethical issues in the study

Potential ethical concerns were strongly considered prior to commencing data collection and throughout the research process. The study was designed to ensure that it was sanctioned by all research ethics principles. Participants were sent a copy of the Participant Information Sheet, separately for the young persons (Appendix 3) and their carers (Appendix 4). They were allowed adequate time to read the information sheet and enquire about the research if needed. Even though none of the questions were perceived as being potentially uncomfortable to the participants, as these referred to the young person's perceptions of the specialist service rather than their personal life, interviews were carried out in a sensitive manner to avoid any discomfort. It was mentioned in the information sheet (Appendix 3) that the participants could choose not to answer a question or withdraw from the interview at any point if they felt uncomfortable. The information sheet explained that an interpreter, who understood the language of the participant, would be involved in every step of this process if required, to facilitate communication between the young person and the investigator. Participants' understanding of the information about the research was checked again face-to-face prior to commencing the interview.

Children's capacity to participate was assessed by the researcher, who was also a qualified psychiatrist, prior to the interview. The researcher sought their social worker's professional opinion on the participant's capacity to consent. Participants, at this stage, were given an outline of the purpose of the research, and were also made aware that they had the right to change their mind and withdraw at any stage. When needed, information about the study was provided in a language that the young person could understand, alternatively an interpreter was used. They were informed

that their involvement would be kept strictly confidential. Informed consent was obtained from participants prior to the study, and all were fully debriefed at the end. Care was taken to explain the distinction from their asylum application. Informed consent was obtained from each participant on the pre-devised form. Separate consent forms were used for young people (Appendix 1) and their carers (Appendix 2). Consent was also acquired from Social Services, who acted as legal guardians.

The principle of confidentiality was conveyed to the participants before beginning the interviews. This encouraged them to speak more freely about their experiences of services without concerns of undue repercussions. As the potential candidates were identified by reviewing their case notes, any identifiable personal information was screened only by the chief investigator. The participants were informed prior to the interview that, other than the regular treating clinician, only the chief investigator would have access to their personal case notes, and that all the data recorded from the case notes for the purpose of research would be made anonymous from the beginning.

Interviews were conducted in a private room, and were audio recorded. The data was anonymized by the researcher immediately following transcription, with transcripts being identified by a code, rather than by name. The content of each transcript was scrutinized in detail to ensure that no personal identifiable data had been kept that could compromise confidentiality. Names of clinicians or other individuals related to the participants were changed so that the participants could not be identified through them. Audio tapes were stored in a locked cabinet at the Greenwood Institute of Child Health of the University of Leicester, after the

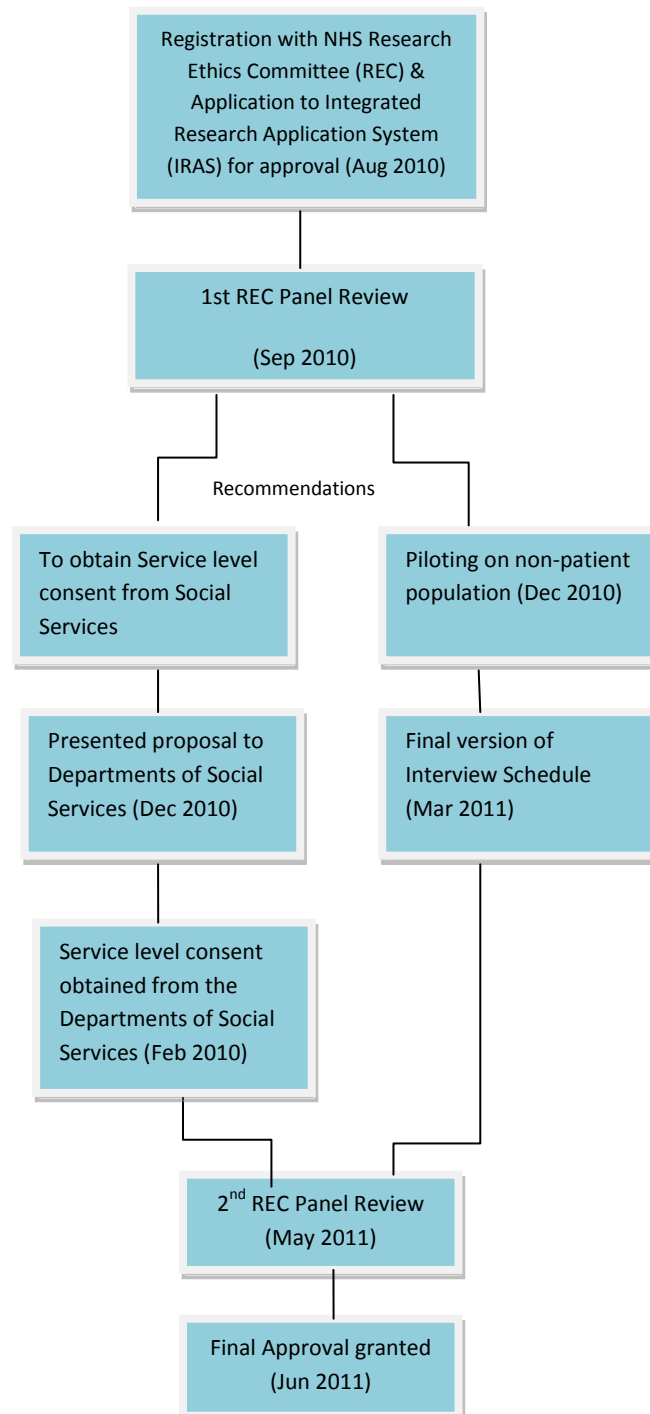
researcher had checked the accuracy of the transcription. The non-anonymized data could only be accessed by the researcher and his two academic supervisors, who were all bound by the same data protection governance (Wilkinson et al., 2004). Participants were notified in the participant information sheet (Appendix 3) that confidentiality would only be compromised if something concerning was disclosed during the interview that needed to be divulged to ensure their safety or the safety of others. In such circumstances, only the necessary information would be passed to the relevant people, which would include the treating lead professional and the Manager of the clinical service. To minimize the potential effect of perceived coercion, the researcher was not involved in the clinical process.

2.5.3. Ethics approval

The project was registered with the NHS Research Ethics and application for ethical approval through the Integrated Research Application System (IRAS) was made in August 2010. The researcher appeared before the first Research Ethics Committee (REC) panel in September 2010. The modifications recommended by the committee were to obtain service level consent from the Social Services Departments in Leicester and Leicestershire, and to pilot the interview with a non-patient population of similar age and cultural background. This piloting was completed accordingly in December 2010. The research proposal was presented to the Leicestershire Local Council's quarterly Liaison meeting in December 2010, and individual meetings were arranged with Managers of both Leicester and Leicestershire Social Services in January 2011. Eventually, service level consent from both Departments was obtained in February 2011 to approach young people under their care. The final revisions of the interview schedule were completed in March 2011, following internal

peer review. The second REC panel review in May 2011, suggested minor corrections. Approval was granted in June 2011 (Appendix 13 & 14) (Figure 2.4). The Research Ethics Committee reference number for this project is 11/EM/0110.

Figure 2.4. The ethics approval process



2.6. ANALYTIC PROCESS

2.6.1. Thematic framework

The analytic method adopted for this study was thematic analysis. As thematic analysis does not require a detailed theoretical and technological knowledge of approaches, it can offer a more accessible form, particularly for those early in their qualitative research career. In contrast to IPA, grounded theory, or other methods like narrative analysis, DA or CA, thematic analysis is not tied to any pre-existing theoretical framework, and therefore can be used within different frameworks (Braun & Clarke, 2006). Through its theoretical freedom, thematic analysis can provide a flexible and useful research tool, which can potentially offer a complex, yet rich and detailed account of data. Thematic analysis can be an essentialist or realist method that reports experiences, meanings and the reality of participants, which is compatible with the aim of this research of gaining knowledge of the unaccompanied refugee minors' experiences of specialist mental health services; or it can be a constructionist method, which examines the ways in which events, realities, meanings, or experiences are the effects of a range of discourses operating within society.

This property of thematic analysis is suitable for the implicit aim of this research of exploring the cultural and national identities of these young persons, and how these impact on their perceptions of western concepts of mental health, illness and services. Thematic analysis can also be a 'contextualist' method, sitting between the two poles of essentialism and constructionism, and characterized by theories such as critical realism (Willig, 1999), which acknowledge the ways individuals make meaning of their experience; in turn, the ways the broader social context impinges on

those meanings, while retaining focus on the material and other limits of 'reality'. Therefore, thematic analysis can be a method that can both reflect reality, and unpick or unravel the surface of such reality. As this was intended by this research project, i.e. to investigate the refugee young people's experience of mental health services; and also their beliefs and perceptions coloured by their individual and collective social, cultural and national identity, a thematic analytic approach was chosen as the preferred method in this research. Thematic analysis is also useful in generating results which are both accessible to the educated general public, and suitable for informing policy development (Braun & Clarke, 2006), which will hopefully facilitate informed changes to current policy.

The analytic framework adopted for this study was thematic analysis, as this descriptive and flexible method allows for important issues to emerge and be explored. Qualitative approaches are incredibly diverse, complex and nuanced (Holloway & Todres, 2003), and a thematic framework should be viewed as a foundational method for qualitative analysis. Thematic analysis is a form of narrative analysis, primarily concerned with what was said (Bryman, 2008c). It aims to analyze the perspectives and meanings made of the subject being investigated in a methodical fashion (Joffe & Yardley, 2004). Throughout this process, the analyst engages at three levels of coding to enable more informative thematic insights to emerge (Boyatzis, 1998).

These codes are the initial indicators of concepts or theories present within the data, although at the stage of first order coding the process remains data driven and descriptive. Initially, descriptive, first order codes are combined into categories for

subthemes to emerge, which are known as second order codes (Boyatzis, 1998). One potential pitfall of the coding process which is to be avoided, is that by fragmenting the text into first order codes, their original context may be lost (Braun & Clark, 2006). Therefore, as second order coding occurs, referral is made back to the audio recording and transcript to ensure that the first order coded fragments of data are kept within their intended context. Thus the process of first order, and then second order coding, involves reading and re-reading of the transcripts. This ensures that the context is not overlooked, and that the researcher is fully immersed in, and highly familiar with, the data. From the second order codes and the first order codes within them, key themes can be identified (Braun & Clarke, 2006). The identification of these themes, the process of third order coding, is when actual thematic analysis takes place. Up to this point, the process is more concerned with describing and organizing the data.

When conducting thematic analysis the researcher needs to avoid being either overly descriptive (simply paraphrasing the data rather than carrying out any actual analysis), or overly interpretative where analytical claims are actually inconsistent with the original data (Braun & Clarke, 2006). It is essential that the analysis remains true to the raw data. This includes taking counter evidence seriously, and not only focusing on those themes or arguments which the researcher believes to be important. Qualitative research has a greater potential to underplay contradictory evidence than quantitative data (Joffe & Yardley, 2004). Quantification of the frequency of occurrence of codes can indicate the prevalence of issues within the participant sample, thus avoiding particular significance being placed on a striking statement by one participant. It also avoids the evidence of a theme being purely

anecdotal, by giving an impression of the prevalence within the body of data to illustrate its pertinence. However, the value of a theme is not necessarily determined by quantifiable means; important themes are those which contribute something important and relevant in relation to the aims of the research (Braun & Clarke, 2006).

2.6.2. Analysis of transcribed interviews

Throughout the process of analysis, the researcher engaged at three levels of coding, as described in the analytic framework section. The issue of bias due to the researcher's subjectivity and their tendency to inadvertently follow their own agenda is tackled through an approach of increased transparency in accepting and embracing the possibility of subjectivity in all research rather than avoiding it. Rigorous attempts were made to minimize this effect as much as possible. Continuous referral was made to original transcripts throughout the analytical process, in order to ensure that any conclusions drawn were not removed from their original context, and that these were not implicated in arguments not intended by the participants (Braun & Clarke, 2006). It was ensured that counter evidence was taken seriously, in order to avoid inadvertently focusing only on those themes consistent with the researcher's beliefs. The frequency of codes in the data corpus reflected the prevalence of important issues and themes. Codes that added value to the research aims were also included. Whether a certain participant's view added value to the research was determined by the novelty and strength of the argument, rather than whether it fitted with the researcher's own opinion or view on the same topic.

Using copy and paste, computerized lists of first and second order codes from within the NVivo software were compiled, while coloured highlighter pens enabled

demarcation of these in the field notes. Coding was periodically checked by the supervisors, to ensure external validation and inter-rater reliability. Although a true and thorough repeat of the coding by another researcher was not possible due to pragmatic constraints such as staff availability and time, this enhanced the quality of the analytic process (Joffe & Yardley, 2004). The key themes identified through this approach will be presented in detail in the next two chapters.

2.6.3. NVivo qualitative data analysis software

The QSR NVivo version 9 software was used to assist the data analysis. NVivo is a qualitative data analysis (QDA) computer software package produced by QSR International. It has been designed for qualitative researchers working with rich text-based and/or multimedia information, where in depth analysis of a relatively large volume of data is required. NVivo is intended to organize and analyze non-numerical or unstructured data. The software allows users to classify and arrange information, and to examine relationships within the dataset. The researcher can test theories, identify trends and cross-examine information in a multitude of ways. NVivo accommodates a wide range of research methods, including thematic analysis, discourse analysis, grounded theory, conversation analysis, ethnography, literature reviews, phenomenology, and mixed methods research. It is compatible with several computer data formats such as Word or PDF documents, audio and video files, spreadsheets, digital photos, and web and social media data. Ideas may be represented as 'nodes', and may, if a coding approach to analysis is being used, be linked to marked up passages in documents. Nodes may be organized into hierarchical trees (NVivo 10, 2012).

The research community is often divided on the use of QDA software. Polarized opinions for or against can be so robustly expressed that the more subtle impacts of specialist software for qualitative research can be obscured. There is sometimes a misconception that the 'node tree' structuring facility equates to a correspondingly hierarchical conceptualization, however inappropriate it might be to the investigation in hand. Others fear that, while it might not necessarily impose a hierarchical approach to substantive conceptualization, the concrete representation of the 'tree' system might lead less independent-minded users to reflect it unquestioningly. In reality, however, the 'tree' structure is simply an organizing system in the software that enables more efficient interrogation of its databases. It can be simply restructured at any time, or it can be ignored and not be used, according to the researcher's discretion. The software provides facilities for data management, coding and retrieving text, and theory testing. Use of such software makes analysis more visible, thereby enhancing transparency, so that the quality of evidence and argument can be more easily judged. It has been stated that the use of this software has significantly enhanced our ability to analyse qualitative data (Crowley et al., 2002).

NVivo can enhance the qualitative research process, speed up the processing of queries, and expand analytical avenues in a more robust way than manual exploration of themes (Auld et al., 2007); especially when the research is dealing with a large amount of data. In this research, there were transcripts of 30 interviews in total, each lasting for between 30 to 60 minutes, which is a large amount of text to efficiently analyse without the help of analyzing software. In the light of all these facts

and dilemmas, it was considered appropriate to use the QSR NVivo version 9 software to analyse the data.

In this chapter, the strengths and limitations of various methodological designs were outlined in the context of available literature and the present research project. This consisted of the theoretical and analytic framework, research setting, sample characteristics, interview schedule, piloting, research procedure, recording and transcription, and ethical issues and approval. This chapter thus sets the background for the analysis of the collected data. The emerging findings will be presented in the next two chapters.

CHAPTER THREE

ANALYSIS 1:
UNACCOMPANIED MINORS' AND THEIR CARERS'
PERCEPTIONS OF MENTAL ILLNESS

The aim of this research was to contribute to the knowledge of these young people's experiences of specialist mental health services, with the objective of generating an evidence-base that will inform improvements in service provision and identify specific service areas for improvement. The research questions were formulated to explore the unaccompanied minors' experiences of mental health services, factors contributing to these experiences, and ways of meeting other young people's future needs. To address these research questions, the analysis has been divided into two chapters, each describing a group of related issues. These are firstly, the participants' perceptions of mental illness and secondly, their perceptions of interventions and service provision.

This first of the two Analysis chapters focuses on the participants' perceptions and understanding of mental illness. In this chapter, three themes considered as integral to either the young persons' or their carers' perceptions of mental illness are outlined and explored. An overview of these themes and their sub-themes are displayed in Table 3.1.

Table 3.1. Key themes and sub-themes on perceptions of mental illness

1. Understanding of mental health and illness	
	1.1. Mental health and well-being
	1.2. Mental health problems and disorders
2. Stigma	
	2.1. Negative perceptions of the concept of mental illness
	2.2. Anticipated social implications of suffering from mental illness
	2.3. Denial of mental illness
3. Perceptions of the cause of their presentation	
	3.1. External factors
	3.2. Internal factors
	3.3. Physical/ somatic factors
	3.4. Cultural factors
	3.5. A combination of factors
	3.6. Maintaining factors

3.1. THEME 1: UNDERSTANDING OF MENTAL HEALTH AND ILLNESS

In this theme, the young persons' concepts of mental health and wellbeing as well as their understanding of the difficulties or disorders of mental health are discussed. This is divided into two subthemes. The first subtheme discusses the refugee minors' own account and the carers' views of the young persons' perceptions of mental health. The second subtheme focuses on their equivalent perceptions of the concept of mental illness.

3.1.1 Mental health and well-being

Some young persons demonstrated an understanding of what mental health meant to them. One of them provided a holistic and balanced description of mental health as a combination of stable emotional state, absence of socio-environmental stressors, being physically healthy, and capacity to cope with problems. Another young person attempted to describe being mentally healthy as having positive relationships, although, there seems to be lack of clarity in their understanding of this concept.

“Not to worry, not to have a problem and your body will be healthy, you don’t think about something. You don’t, you don’t worry about the problem.....”

Young person 3

“Mmm, mental health, means when some people’s not happy or they’ve got a problem I think, I’m not sure..... mental health you’ve got a relationship with another person and.....”

Young person 6

Other participants, however, testified the young persons’ difficulty in describing mental health. These minors’ struggle in conceptualizing of mental health is not entirely different from those of other young people (O’Reilly et al., 2009). One of the participants acknowledged his lack of familiarity with the concept of mental health and attributed this to not having a suitable expression in his first language, whilst the other, speaking via the interpreter, seemed to be equating mental health with well-being or symptoms related to his body. Some of the carers explained that the young

persons either struggled to acknowledge the internal and subjective nature of mental well-being; seemed to attribute it exclusively to their social circumstances and life situations; or were not familiar with the concept of mental health altogether.

“And things like, you know like, what’s called, mental health, yeah? I never heard this word in my language and in English. I don’t know how to explain it.”

Young person 11

Interpreter – “I said what is mental health. He said mental health, my eyes. My eyes and he gets angry, my eyes, my head.”

Young person 7

“He didn’t realise that he carried the pain of the burden of this country in his mind. SB (young person) didn’t realise that, the trouble is in his mind, as well as in Afghanistan.”

Carer 3

“Um, he didn’t really understand it that well, no. I mean he knew it was to do with, you know, the self-harming I explained that to him, but yeah, I don’t think he understood about mental health.”

Carer 11 (J)

Although a few young persons had shown some knowledge of what mental health means, in general there was a lack of understanding of this concept. This can be partially attributed to the lack of familiarity with specific semantics of English language, and their tendency to focus more on physical well-being and environmental factors necessary for survival. Despite this incomplete understanding, the participating young persons had developed some narratives regarding their

personal mental health problems and mental illness in general. Their understanding, however, did not appear to be influenced by their length of contact with CAMHS. While young person 6, who had more contacts, expressed a more holistic view, young persons 7 and 11, despite having significant contacts, struggled with such concepts. In contrast, carers appeared more familiar with notions of mental health.

3.1.2. Mental health problems and disorders

In keeping with their understanding of mental health, a range of responses were elicited from the participants on their understanding of mental illness. Interestingly, some described it as absence of awareness of either their own behaviour or cause of a physical health symptom.

“I think I’m a mental because I don’t know what I’m sometimes doing.”

Young person 1

“Mental is like you know, when you think you’ve got something wrong in your body and you haven’t. You think that, but you haven’t got it. And, you know, if you go to doctor and you say something, oh, I’ve got pain and they say you haven’t got and then, then in the future it might cause you a problem because if you have a real pain, they won’t trust you, they’ll think you’re mental.”

Young person 12

Others used a significant degree of negative language while attempting to describe mental illness. One young person gave examples of when he self-harmed, and emphasised the refusal to comply with others’ suggestions in his definition. This

statement highlighted the negative meaning associated with his understanding of mental illness and the likely link with the stigma attached.

“And I was very crazy actually, because I try twice kill myself, I try hung myself. I cut myself, I really was crazy..... Yeah, it’s not like real crazy, you know, crazy boy. But it’s like crazy, because I didn’t listen to anyone.”

Young person 11

A number of young persons, however, expressed a more balanced understanding of the concept of mental illness. They defined mental illness either as an impaired state of mind and body manifested by difficult feelings like unhappiness or worrying; as problematic or negative thinking triggered by stress; or as worrying about some environmental or life stressors. These descriptions and definitions of mental illness, however, seem to be based more on self-attribution. The young persons contextualise their responses in relation to their own feelings and experiences, but not in a generalised or abstract way.

“Uh, I’m thinking my body. I’m thinking I just, I never feel happy any time, I just, I want to be anyone that been making fun, but my heart feels sad..... I think this is some illness in my mind, both of them, mind and body. You know, my body hurts my mind is no works proper.”

Young person 2

“..... when you worry about something, you’re all the way, not in the same, the same you are before, because you worry about something. If you don’t worry about something, just nothing going to happen..... When you going to

doctor, they will sort out your problems straight away, but my problem is thinking, worrying about that thing.....”

Young person 3

“..... the main problem was like I was stressed and it could come in loads of ways. As I said before, I could get stressed..... and I was just thinking negatively.”

Young person 10

Their reference to such narratives does not necessarily reflect their conceptual understanding of mental illness. This difficulty in formulating a generalised interpretation was illustrated at length by one of the carers. She commented that many of the young persons acknowledged their difficulties with their feelings, cognitions, and symptoms like impaired sleep or flashbacks. Despite this awareness, many might not consider these difficulties as mental health disorder.

“I know a lot of them recognise that they feel sad and they’re not sleeping and they get flashbacks, but whether they recognise that’s just part of life..... Sometimes they say depression or worried. PTSD they don’t, but they do refer to flashbacks.... it’s hard to know whether that’s just their English improving or whether they’ve conceptualised things differently. And language is so bound to your concepts, isn’t it anyway?”

Carer 13

From the above description it seems that, the refugee young persons’ understanding of mental health and mental illness is variable. This ranges from lack of understanding of the concept as a whole to partial acknowledgement of the symptoms of mental health difficulties they have been experiencing, or a holistic view

of this experience as part of an illness or disorder. Again, their perceptions did not seem to depend on their contact with CAMHS, as some young persons with significant contact had incomplete or mainly negative views of mental illness, whereas some of the young persons who shared comparatively more balanced understanding had only attended a small number of appointments prior to their participation. Young person 10, who had longer contact with CAMHS, and also was the only participant to be interviewed along with their carer, expressed a relatively better understanding of mental illness. Carers, in general, seemed to have an appreciation of the young persons' struggle in having a full understanding of the concepts of mental illness. It is possible that their understanding of mental health and mental illness is constrained by the fact that English is their second language, thus making it difficult to articulate their perspectives; but it is also likely that this is influenced by their developmental age, their culture, and the healthcare system in their country of origin. Arguably, the extent of their understanding of mental illness will have an impact on their engagement with interventions and mental health services.

3.2. THEME 2: STIGMA

Mental illness is seen as a stigmatising or taboo topic. Refugee minors have the potential to experience stigma as a consequence of their status. They can experience problems related to their asylum seeking or refugee status, having a mental health problem, and being in care; a 'triple stigma'. These facets of stigma are particularly concerning from a cultural perspective. Mental illness is especially stigmatised in some cultures, which discourages it from being talked about (Delgado et al., 2005). In this theme, the focus of discussion is the negative perceptions of

mental illness, and the possible reasons for such perceptions. This is analyzed in the first two subthemes. In the final subtheme the young persons' resistance in accepting their own mental health difficulties and its possible underlying mechanisms have been looked into.

3.2.1. Negative perceptions of the concept of mental illness

Fourteen out of fifteen young people and many carers expressed their opinions on the young person's negative perceptions of mental illness. Contact with mental health services in the UK did not appear to shift such perceptions. They referred to mental illness by using terms like 'crazy', 'mental' or 'mad' interchangeably. This is again consistent with finding from other young vulnerable groups (O'Reilly et al., 2009). It appeared that, in the majority of cases, the young persons' general understanding of the term mental illness was coloured by their negative view of such a concept.

The narrative of mental illness described by several young persons had a striking similarity, in associating a mentally ill person with someone who has lost all sense of basic upkeep, hygiene, dressing and hair; is locked up in a hospital or prison; sleeps on the streets and drinks alcohol; and is being beaten up or stoned.

“..... then I told this lady I'm not crazy, I'm not like these, these, you know..... I tell her look my hair, look my clothes, I'm not crazy.” *Young person 15*

Interviewer – “I mean, what is your understanding of mental illness, what?”

Young person – “Exactly, I’m not sure, some, some people saying mental, some mental just mental from head, they just don’t know what they’re doing. Some of them been locked in the hospital, or in the prison. I seen lots of mentals in my country.”

Young person 1

Interviewer – “What about mental illness?”

Young person – “I don’t know about mental..... Sleep on street and go crazy, innit.”

Young person 4

“The mental is like people like, you know, crazy or mad and their mind doesn’t work, and some people drink a lot, they go in mental hospital.”

Young person 13

“..... what he thought was, you know, because with being psychiatric doctors and all that, that they’re going to rule him out as being mad. You know, or mental, something like that. But he says there’s nothing wrong with my head, I’m not mad..... Yeah, the idea of mental health is, you know, over there is somebody’s mad. He was telling me that we can stone him and beat him and do, you know, but I said no, here you’ll be treated, you know, for everything.”

Carer 9

“..... with asylum seekers, what I found out from them, what their views was about going for the CAMHS was that mental health issues is for people who consider them as mad.”

Carer 16

The carers, on the other hand, seemed quite insightful into these young persons' views. The sources of negative perceptions of mental illness were also considered by carers. They reflected on the influence of society and culture in shaping the young person's understanding. In particular that, the society and culture possessed a high level of stigma and negative views of mental illness, which discouraged acceptance and admission by those who suffered problems.

“I might be making a bold statement here, but mental health with black and Asian minority ethnic communities is a taboo anyway. People don't say it, people don't say it, people say, oh, he'll get on, he's not right but they manage in their own way.”

Carer 8

“..... if people had them, then it would be, would be almost frowned on or discouraged in his culture from saying I've got these kind of problems.”

Carer 11 (S)

“..... in some cultures, mental health is not perceived the way that we perceive it in the UK, or America or the Western world. You know, some cultures would just say that you're a crazy person perhaps, in terms of summing it up. And therefore the stigma associated with that would consequently lead people not to admit it.”

Carer 12 (S)

This may have influenced the young persons' views on mental illness, and their reluctance to admit their own mental health difficulties. One of the abovementioned carers stated that he "would be almost frowned on or discouraged in his culture from saying I've got these kind of problems". This has clear implications for service engagement. One carer mentioned the steps taken by a clinician to minimise this effect by meeting every young person in a residential home in order to hide the identity of the young person who actually needed mental health service input.

"Thinking about it, all of the asylum seekers, there are now eight of them, they needed this help but to them, all of them, it was the same, same answer from them, so it must be something from back home. The perception about this, anything to do with the term 'mental health' was the same." Carer 16

"..... when M (CAMHS clinician) comes, obviously she will not come for half an hour for F (young person) only, she will come with extra time to speak to other young people so that person who actually has seen M (CAMHS clinician) is not being picked up (on)." Carer 5

There remains perhaps little doubt, after exploring the accounts of the young persons and their carers, that the negative views and stigma attached to any term related to mental illness have a significant impact on a young person's engagement with treatment. Some carers came up with suggestions such as avoiding the terms 'mental illness' or 'mental health' to describe the service, instead replacing them with more neutral words.

“It’s a shame unless you know, instead of saying ‘mental health’ it can be changed into something else, right? Just the word, not mental health issues, where asylum seekers are concerned.”

Carer 16

“..... say it’s (CAMHS) not called mental or medical terms, it’s just called a holiday camp or something nice, a name which has got some nice name like, you know, Butlins has got a nice name.”

Carer 5

“..... he says he’s not mental, why would he want to go and see a mental health service..... If they could just remove that mental health and use it as ‘Westcotes House’ (name of building of mental health service), counselling would be different, but just the fact that it’s mental health..... if they have different headings for services then, I don’t know, you might find you get better results.”

Carer 14

Participants’ statements revealed that the young persons possessed a negative view of mental illness and anybody suffering from it. This is evident in the terms used by the young persons to describe mental illness as well as in their narratives of someone suffering from these difficulties. It is hypothesized that this can at least partially be attributed to the stigma attached in the young persons’ countries of origin, which also influences their behaviour with regard to acknowledging such problems and necessary interventions.

3.2.2. Anticipated social implications of suffering from mental illness

Other than the social stigma, some of the young persons also expressed their worries about the anticipated consequences of being mentally ill. This was corroborated by their carers. Many participants, both young persons and carers, talked about the young person's anxiety that, they might eventually be incarcerated in a secure mental hospital, asylum or prison. Again, there seems to be an important cultural relevance, as the young persons' views are likely to be intrinsically tied to what tends to happen in their own countries of origin.

“Some of them (mentally ill persons) been locked in the hospital, or in the prison. I seen lots of mentals in my country..... So sometime I just think if you grow up or just get more worse, you're going to become one of them.”

Young person 1

“When you disabled, you go in disabled house.”

Young person 15

“He was always thinking that, you know, he might end up in a mental hospital.”

Carer 9

“..... for them it was mad, they are mad. So they should be put in mad asylums.”

Carer 16

Worries appeared to be quite deep-seated across the whole sample, including young person 1, who had the longest contact with specialist mental health services in the UK. This was corroborated by their carers' accounts on their understanding of the

young persons' beliefs. Some young persons' and carers' responses reflected their fears of becoming socially isolated as a result of their mental illness. One participant commented that mental illness would lead to sleeping rough on the streets.

"..... Sleep on street and go crazy, innit?"

Young person 4

As per some other young persons' and carers' account, social isolation can actually be due to abandonment by their friends and family. One young person stated that this abandonment can be because of the behavioural manifestation in the form of "swearing at them back and then shouting at them", and the adverse impact on friendships. The prospect of social isolation was supported by a carer's statement about the young person in her care that he would also lose his friends if they came to know about his mental illness or that he received help from mental health services.

"When someone talking to me nicely and I think they're shouting at me or they're swearing at me, I'm waking up and swearing at them back and then shouting at them..... they say I'm not talking with you. So it's quite affecting me a lot, hurting me as well, so sometime my friends don't wants to be with me because I've got this problem."

Young person 1

"Going there (to CAMHS) for his mental assessment to him it was, no, none of my friends went. If they don't need it. So, I don't then. They won't be my friends once they come to know. I said they don't need to know, he said no, but, they'll know."

Carer 16

On the same subject of anticipated isolation and abandonment by society, carers considered some of the young persons' culture of origin, where mental health can possibly lead to not being taken care of properly and difficulty in getting married in the case of females. Thus carers showed a reasonable level of understanding of the cultural rituals and beliefs of the young persons who were living with them.

“..... in those cultures he would have it as somebody who is mad, is mad, you know, he's mad. Nobody would look up into him properly, you know, and see what's wrong like we do it here.” *Carer 9*

“Because, um, in the Somalian culture they're quite strict, the parents are quite strict and they're very community-based and say from a female's point of view, say if there is a father and mother and their young female daughter wanted help, because then the word gets round it's difficult for them then to get them married off and it affects their future.” *Carer 5*

Young persons' anxiety of the consequences of suffering from mental illness is apparent in their statements. These include being incarcerated and institutionalized; or suffering a downward social drift and social isolation. Their beliefs may have far reaching implications on their views of mental health services and professionals, and ultimately on help-seeking for their own mental health difficulties.

3.2.3. Denial of mental illness

Throughout this research, for the purpose of consistency, young people who were being treated by the specialist mental health service were described as having

presented with 'mental illness'. Western social and cultural notions of mental health and mental illness may be substantially different to those that apply to young persons from other cultures (Honwana, 2006). There is, therefore, a risk of approaching their predicament through a western professional 'goldfish bowl' (Thomas et al., 2004) of 'mental illnesses' by misinterpreting these experiences as diagnostic categories of western systems of psychiatric classification (Majumder et al., 2014). The term 'mental illness', however, was not used in the interviews as a leading question in order not to influence the participants in any way; although 'mental health' or 'mental health service' occasionally came up in the conversation or brought up by the participants themselves. The findings, nevertheless, suggest that young persons perceive the term mental illness as severe, enduring and with significant functional impairment. This may have influenced their engagement with the mental health service, as well as explain at least part of the stigma attached to their construction.

Many young persons denied having any mental illness, despite having attended a mental health service. This seems to be linked to the earlier subthemes of social stigma and fears of untoward social consequences. They thus appeared to be embarrassed about discussing their own mental health difficulties, which was expressed by an increasingly hesitant speech; by evading or altogether avoiding using terms such as 'mental health'; or by giving alternative explanations of coming to see a psychiatrist, such as for physical health problems.

“Um, first of all, I don’t have any, I don’t know, uh, I mean, I’m not, um, mental problem. I got, I saw the bad dream, I didn’t sleep then, sometimes. Uh, maybe that thing, I don’t know, maybe, that’s why……” Young person 6

Interviewer – “So when you asked about mental health, he avoided the term.

Interpreter – “That term…… Other things except that.” Young person 7

Interpreter – “He is saying that he’s going to P (CAMHS doctor) because he’s got a problem with his eyes, he’s got a headache and because of that he wants to get better.” Young person 7

Both young persons 6 and 7, despite having significant contacts with CAMHS, showed a tendency to deny their mental health difficulties. Carers agreed with this notion of the young persons’ propensity to avoid talking about or denying their mental health problems. At the same time, they demonstrated a good understanding of the young persons’ views and the possible origins of their cultural beliefs and experiences. The reasons that the carers attributed to this denial included young persons’ sensitivity to mental illness. This again points towards the social and cultural stigma attached to the concept of mental illness. Carers also re-affirmed the notion that mental illness for refugee minors can mean only having a severe mental disorder.

“It’s sensitive for some young people to admit that they’ve been to CAMHS and that they need that sort of help.” Carer 13

“They don’t see themselves as mentally unwell because when they think of crazy, they think of people who have really, really big problems.” Carer 15

Potentially the nature of the mental condition could exacerbate the denial. For example, one of the participants had a history of psychotic illness, which is characterised by impaired insight into its nature. This can be a reason for not acknowledging his own mental illness while talking to the interviewer. This was later confirmed while talking to his carer. This was, however, a single case, as for the majority of these young persons, denial of mental illness seems to be linked with its social and cultural perceptions, rather than their lack of insight secondary to a psychosis illness.

Young person – “I’m not seeing things, never in my life.”

Interviewer – “Okay, how about, what did you say? Uh, feeling that the people in the TV are talking?”

Young person – “Some, no, uh, like, like, uh, you watch TV and you upset while you, you, you see the newspaper and you see on TV and you upset, innit?”

Young person 8

“No, as far as he believes he didn’t have a mental health issue and even the incident with the fire, you know, at one point he didn’t think he got admitted in hospital because of the fire.”

Carer 8

The young persons’ perceptions of mental illness seem to be coloured by their socio-cultural construction of such concepts. The idea of ‘madness’ as the most prevalent

understanding of mental health difficulties; the feared consequences of social isolation in the forms of abandonment, rejection by friends and family; and the eventual downward drift of social and personal life can all explain young persons' reluctance to accept their mental health difficulties and to engage with mental health services.

3.3. THEME 3: PERCEPTIONS OF THE CAUSE OF THEIR PRESENTATION

While describing their difficulties that lead to contact with the specialist mental health service, young persons reflected on their perceptions of the causes of these difficulties. Their responses varied from attributing the presentations to some internal psychological or biological factors to different other external socio-environmental and physical factors, or to a combination of those.

3.3.1. External factors

Young people and their carers expressed their ideas about different external factors causing, precipitating or maintaining the young person's difficulties. These views were equally shared by both young persons and their carers. Their contact with CAMHS did not appear to make any difference to these views. These factors can be divided into pre- and post-migratory. Participants described the adverse experiences the young persons often endured before arriving in the UK, especially during their journey from their country of origin, and acknowledged them as very traumatizing. The traumatic effect of the migratory journey of young unaccompanied refugees has been well established (Fazel et al., 2012). These experiences, according to some, caused or contributed to their current mental health difficulties.

“..... because I’ve been in a bad problem back home, I see lots of problems in my age when I was in Afghanistan, so from age ten I been seeing people die in front of me. I’ve seen people killing each other in front of me. Dead bodies in front of me, so. I seen this a lot and I keep, then during a nightmare, I’m dreaming all this stuff is just like watching a movie in front of me.”

Young person 1

“I have a feeling, you know with these children because, uh, of the way they have travelled and, you know, all those obstacles that have come their way on the journey up to here, they are really very badly traumatised.”

Carer 9

Stressful environmental factors after arriving in the UK were described as a “culture shock”. These included being separated from their family and going through the process of application for refugee status. One carer emphasized the stressful effect of facing and having to comply with a different set of laws, rules and regulations after arriving in the host country. Young persons acknowledged the harshness and complexity of a new life while living all by themselves.

“W (young person) was referred to CAMHS due to W (young person)’s problem with the westernized culture, so to speak. Because coming to this country was a big, big, big culture shock for him, coming from a routine where there was no structure, there was no routine, there was no education, there was no. I don’t know how to word it but definitely a big, big culture shock in terms of laws and rules and regulations.”

Carer 14

“Well, you know one thing, I missed my family, that’s why; and here my life is a little bit hard.” *Young person 2*

Unaccompanied minors were particularly exposed to this stressful process of re-adjusting to their new environment, because of the lack of family and social support systems. A number of young people reported living alone and missing their family as a crucial factor in causing their distress. This was corroborated by carer’s reports, who also identified missing their family as a major contributing factor.

“Uh, because actually, when I came UK, you know, I was like, I miss my family and when I left my family I was fifteen years old.” *Young person 11*

“I was thinking about my family, so that’s why I was sad.” *Young person 14*

“Well, I suppose what’s happened to him really, the fact that he’s coming here and missing his family and everything like that.” *Carer 11 (J)*

These young persons are, often left to their own device to navigate through the complex and bureaucratic process of seeking asylum and settling in an alien environment and culture. Some young persons emphasised that many times they became preoccupied and distressed by thoughts on their immigration status and the legal process. These cognitions and fears were perceived to be related to their current presenting symptoms including sleep disturbance, nightmares and depression.

“I was worried about immigration, I was worried about like when I sleep I see a lot of bad, bad thing. I didn’t sleep well.”

Young person 3

“It’s really head aching, all the time I’m thinking about my case. So that’s why I feel very upset.”

Young person 13

Young persons faced adversities throughout their journey from their country of origin to the host country. Their ordeal did not end after arriving on these shores, as they struggled to negotiate the demands of settling in a new culture with different rules and regulations, while having no family or social supports at this crucial phase of their development. Their accounts reflected their perceptions of how these socio-environmental adversities impacted on their emotional and mental health.

3.3.2. Internal factors

Some young persons described the causes of their problems to be internal, especially related to their ‘brain’ or ‘head’. This might appear similar to the earlier subtheme of relating their presentation to physical symptoms. However, this subtheme particularly focuses on the view that their mental health problems were caused by an abnormality in their brain. Some stated that a problem in their brain was responsible for altering perceptions or difficulties in learning new information in the class or sitting for exams; while others were not sure why or what was wrong with their brain.

“..... during the day time I find walking outside the street, just I feel someone battering me from the back, I just keep looking back, nothing, no-one is there. So it’s just in my brain.”

Young person 1

“Because my brain not working, teacher explain me everything, my (I am) thinking. It’s never working..... this year exam I didn’t pass, but I don’t know why it’s not working.”

Young person 15

“I’m not, my brain is not very well.”

Young person 8

“No, actually some people miss mother, yeah, father, yeah but I kind of miss these people but I still, I have more like problem in my head, I don’t know what.”

Young person 15

One young person mentioned heritability of mental illness by describing other members of his family who had similar types of mental health difficulties. Like the other participants, he highlighted the importance of brain function in determining mental health outcomes.

“So, my uncle say to me, one of my father’s, uh, sister’s sons, he was similar like you from age young, he start same that as you then when he grew up, he just, his brain is start more gone bad.”

Young person 1

A small number of young persons were able to link their own experiences of mental health difficulties with internal biological factors related to their brain function or

genetic predisposition. This, however, was not the most prevalently perceived cause of mental illness among this group. Such beliefs may have been related to a gradual adoption of western understanding following a period of settlement in the host nation. Young persons with both longer (young person 1) and shorter (young persons 15) contacts with CAMHS occasionally shared this view.

3.3.3. Physical/somatic factors

Young persons and their carers mentioned the usual types of presenting of physical symptoms in emotional disorders. It was particularly common to express their emotional distress through these symptoms. The symptom they mostly attributed to their presentation was headaches, while feeling sick was mentioned by one young person.

“I feel like very sick. If I, if I’m all meeting with any person then I get headache and like two, three days, not going my, my headache, it used, I feel sad.”

Young person 2

“He used to think that he has regular headaches because of the assault but we were told they’re not, that’s not related.”

Carer 7

“They (refugee minors) talk about headaches a lot.”

Carer 13

Although headaches and nausea can be physiological symptoms of anxiety, these possibly also serve the purpose of making sense of their own distressing experience without the need to acknowledge stigmatizing conditions such as mental illness.

Participants also recalled eye problems as causal. They often expressed their need for medication or other physical aids like spectacles from the psychiatrist, to treat what they perceived as physical symptoms.

Interpreter – “He is saying that he’s going to P (CAMHS doctor) because he’s got a problem with his eyes, he’s got a headache and because of that he wants to get better.”

Young person 7

“I want to get better but they are not giving me any medicine. I’m going to treat my eyes and my head.”

Young person 7

“..... he thought if he had a pair of glasses it would all be sorted.”

Carer 2

From this observation, it appears that some of these young persons find it easier to communicate their emotional or mental health difficulties to a medical professional through physical or somatic rather than psychological symptoms. It is difficult to conclude from this finding whether this perception changed with longer contacts with mental health services, as young person 7 still strongly held this view after a long period of contact with CAMHS. This may be a reflection of their understanding of the concept of mental illness and/or their reluctance to share mental health issues secondary to the social stigma attached, as described in the previous section.

3.3.4. Cultural factors

While discussing the possible causes of these young persons’ presentations, one of the carers brought up the issue of the clinicians’ cultural understanding of young

persons' complaints, which were illustrated at length. According to his experience, both mental health and social care professionals often failed to acknowledge the cultural factors contributing to a young person's presentation. Previous literature has reported that the cultural understanding of these presentations can be limited by exclusive reliance on western diagnostic systems, and subsequent medicalization of what elsewhere may be viewed as religious or social issues (Lustig et al., 2004). This carer suggested that there is a need for professionals' training and education in cultural diversity, in order to minimise such possibilities.

"..... it's easy to jump to conclusions, oh, he's from Somalia, you know, he's this, he's this and then you can tick all the boxes and say he meets this criteria, but the thing is you needed to analyse what he was actually saying..... I think the professionals, not just health but social care haven't really understood what was going on with him..... But they're finding his behaviour aggressive because he's talking loudly, or the way he talks, there's a lot of education to be done there with the staff."

Carer 8

Although this particular point was raised by only one carer, it was considered significant, because of the gaps in cultural understanding by professionals showed in previous research, and the conviction with which this view was conveyed by the participant. Disregarding or missing the cultural context of the presentation may lead to a misdiagnosis of a culturally variant manifestation of normal behaviour or emotional reaction, or vice versa to missing an emerging psychiatric disorder.

3.3.5. A combination of factors

A few young persons gave a more balanced view of a combination of factors contributing towards the development of their mental health difficulties. These included external factors such as difficult personal experiences in their country of origin; the traumatic journey they had to endure; leaving the own country, culture and people behind; having to cope with a new society with different rules; and internal factors such as their temperament and ability to cope with stress.

“..... coz I had a difficult journey and you know for me, it was difficult to cope, or to live alone. I mean like you know I left my country, you know, some personal stuff as well..... And might be something about the society, like I grew up with those people and everything changed suddenly. Uh, also it was difficult to cope and I become stressed”

Young person 10

“..... but it was still all stress, you know, about things and people.”

Young person 12

Young person 10 had a significantly higher number of contacts with the specialist mental health service. He was also the only young person who participated in the presence of their carer. This finding, however, is not sufficient to attribute a better understanding of mental illness only to having experienced more service contacts or to being interviewed jointly with their carer. These views, similar to the views on internal factors causing mental illness, were in the minority, as young persons' perceptions of the causes of their problems predominantly focused on either socio-environmental or physical factors.

3.3.6. Maintaining factors

A number of carers commented on the factors that can be responsible for maintaining the initial presentation. This particular issue was mentioned only by the carers, whilst none of the young persons acknowledged it in their interviews. Some carers perceived an external incentive driven maintenance of mental health presentations in the young persons. These can range from ensuring their permanent stay in the country, to acquiring and maintaining the accommodation of their choice such as to remain at the foster home beyond their leaving care age.

“First of all I thought he might be doing this on purpose, as most of the asylum seekers do, unfortunately, as they think these things help them. You know, to stay in this country.”

Carer 10

“..... the thing started when they wanted to take him away from us, because he was already sixteen and they wanted him to live independently. And at that time it's gone bit difficult and S (young person) has started acting very abnormally.”

Carer 10

Carers also perceived that some young persons reported difficulties in order to gain attention from them or from professionals involved, including mental health clinicians. Some, they mentioned, enjoyed being at the centre of attention, while others did it to evoke certain response.

“I say A (another young person) likes attention and the spotlight on him, so that's probably why he's enjoying the CAMHS.”

Carer 12 (J)

“I think he took his initial action to gain a particular response, and I think the following response and the resulting consequences I think he never imagined really. That’s the impression I got, you know.” Carer 12 (S)

To some of the carers, the presentation and maintenance of deliberately produced symptoms in young people does not necessarily have any apparent purpose. One carer, in her attempt to speculate on the potential reasons, hypothesized that it can be just for fun; that there can be some element of truth in it; or it can be a reflection of the young person’s difficulty in comprehending the concept of ‘mental illness’. Another carer emphasized the importance of optimizing the valuable resources of mental health services by ruling out the possibility of a factitiously produced presentation for external incentives.

“Yeah, he used (to) run around saying I’ve got to go and see the doctor ‘coz I’m mental. And I don’t know if that was him joking or him joking around elements of truth, which is probably the more likely, or him not understanding the English concept well enough.” Carer 13

“..... it’s very important you go (to CAMHS) if you need it. But also it’s not something that you should just carry on, you know, for want of a better word, a pretence or something if you don’t need it really, because these people’s time is valuable, and it could be used to help somebody else.” Carer 11 (S)

After exploring the issues covered in this theme on perceptions of the causes of young persons’ presentations, one can speculate that young peoples difficulties to

identify their symptoms as indicative of mental illness may have stemmed from their altered or absent cultural construct of the western notion of mental illness, thus predominantly focusing on either social issues or purely physical medical symptoms that are easier to identify and treat.

This chapter focused on young persons' and carers' understanding and perceptions of the concepts of mental health and illness. After considering the findings, it can be theorized at this stage that young persons' perceptions of mental illness, its causes and consequences can influence their expectations of the help that they believe is required to support them through their difficulties. In the next chapter, unaccompanied refugee minors' and carers' experiences of interventions and mental health care provision will be described.

CHAPTER FOUR

ANALYSIS 2:

UNACCOMPANIED MINORS' AND THEIR CARERS' PERCEPTIONS OF MENTAL HEALTH INTERVENTIONS AND SERVICE PROVISION

In the previous chapter I described the themes and subthemes in relation to unaccompanied minors' and carers' perceptions of mental illness. The three major themes that emerged were understanding of mental health and illness; stigma; and perceptions of the causes. Some pertinent issues in these three areas were important in the context of the research questions, aims and objectives. For example, the young persons' understanding of mental health and mental illness, and the associated social stigma had important implications for their engagement with professionals and services. This influenced their experience of the different components of treatment they were subjected to and other service aspects.

These perceptions of interventions and services will be explored in further detail in this second chapter. This is significantly lengthier than the previous analytic chapter. This structure was deemed necessary to highlight the two main functional aspects of the participants' perceptions, i.e. mental illness and interventions. The five key themes that emerged in relation to participants' perceptions of interventions and care provision are outlined and described here. These were; engagement; perceptions of professionals; perceptions of interventions; perceptions of services; and suggestions on how services could be improved. The themes and their sub-themes are summarised in Table 4.1.

Table 4.1. Key themes and sub-themes on interventions and care provision

1. Engagement	
	1.1. Trust
	1.2. Basic needs
	1.3. Language
	1.4. Experiences of accessing services
	1.5. Perceptions of venue (clinic vs. community)
	1.6. Experience of assessment
	1.7. Experience of interpreter
2. Perceptions of professionals	
	2.1. Expectations of the professional-patient relationship
	2.2. Experience of professionals' attributes
	2.3. Gender of the professional
	2.4. Ethnicity of the professional
3. Perceptions of interventions	
	3.1. Psychological therapies
	3.1.1. Views on 'talking'
	3.1.2. Talking about the past
	3.1.3. Focusing on current problems
	3.2. Activity-based interventions (play, art, drama)
	3.3. Medication
	3.4. Hospitalization
4. Perceptions of services	
	4.1. Experience of mental health care systems in the country of origin
	4.2. Understanding of the mental health care system in the UK

	4.3. Experiences of using mental health services in the UK
5. How to improve services	
	5.1. Engaging with the young persons
	5.1.1. Trust building
	5.1.2. Shared activities
	5.1.3. Flexible approach
	5.2. Connecting with other agencies and communities
	5.2.1. Roles of other agencies in relation to the mental health intervention
	5.2.2. Working on a common agenda with other agencies
	5.2.3. Advocacy to other agencies
	5.2.4. Connecting with the community (friends, relatives and ethnic group members)

4.1. THEME 1: ENGAGEMENT

In this theme, different factors perceived to influence the young persons' engagement with the mental health service are explored. These factors include the young persons' ability to trust the professionals and services, their preference to first address their basic needs, issues of language, experiences of accessing services, setting, assessment, and involving interpreters. These factors are presented as subthemes under the overarching theme of engagement.

4.1.1. Trust

It is not uncommon for young people to disengage with interventions or show some form of resistance to mental health care (O'Reilly & Parker, 2013). This was found to

be more marked among unaccompanied refugees as their lack of trust appeared to be a significant factor that enhanced disengagement. Young persons struggled significantly in trusting any professionals, including mental health clinicians. They also found it difficult to trust people in general, and felt that they might be in trouble or place themselves in an unsafe position if they trusted doctors or other professionals, and shared too much information. Young persons perceived that, even when they did trust somebody, there was no help available; so they preferred to solve problems themselves rather than relying on others.

“..... doctor don’t even know what’s wrong with me, doctor just..... write down this report and they give me tablet the same..... This doctor, I (do) not trust him, I’m not safe.” *Young person 8*

“There’s not many people he can trust. He’s openly told me that he can’t trust people.” *Carer 14*

“Yeah, because I didn’t say to anything about my problem, I didn’t tell it to anybody, you know, because I don’t trust anybody. Because I trust that, you know, like when somebody I trust..... they give me trouble”. *Young person 9*

According to most of the young persons’ views, mental health professionals let them down, did not help them or even hurt them when trusted. Their main focus while discussing the issues around trust, therefore, seemed to be the professionals’ untrustworthiness. Some carers, however, stated that the young persons need to

work through their personal difficulties with trust, before they relax and are ready to establish a meaningful relationship with the clinician, so that an effective intervention can take place. They commented that this process often requires adequate time.

“I’m not sure if the boys ever relaxed into, you know, it’s almost like there were certain vulnerabilities for you to relax enough for somebody to help you get beyond your ailments, and I don’t think they allow themselves to relax to that extent.”

Carer 1

“I just was thinking I was sort of getting a level of trust, but then you realise you still, they’ve got their own systems and their own issues to resolve, and it takes a while.”

Carer 2

It appeared that one of the main reasons for the young people not trusting the clinicians or any other professionals was their fear of this information being fed back to the Home Office, thus leading to them being deported back to their country of origin. This perception discouraged them from disclosing any information that has the potential to compromise their asylum application.

“I was thinking, if I said everything to my solicitor, maybe they’ll put me in jail. Maybe they’ll put me in prison and then after sometime immigration refuse me..... Maybe, you don’t know about government. You don’t know, maybe they can take it.”

Young person 9

“No, because I’m scared, these people there, but I’m scared maybe these people like altogether they (will) put me in Afghanistan, I don’t know.”

Young person 15

“..... (he’s) thinking that information he provides the Westcotes [name of child mental health service] will go to the immigration people, and go back to his country where he’s in danger. And people will know where he is as well.”

Carer 16

“In his mind he thinks, right, are you going to tell them that I’ve said something different to what I said before? See, so ‘coz he knows police, Home Office and solicitor..... they think, hold on, if I say a lot of things here, they may be used against me which is why they may not share stuff.... there’s a lot of issues that are turned round and then they end up believing, thinking, oh so you’re working in cahoots with them..... so that I can be deported back to my country.”

Carer 7

The young persons’ trepidation due to their unfamiliarity with the administrative system, culture and society at large appears to have been adding to their mistrust in the clinicians. This fear of the unknown is reflected in statements like “you don’t know about government. You don’t know, maybe they can take it.” Subsequently, a carer’s obligation to pass on certain information, which can be misinterpreted or distorted, forms the ground for further consolidation of this mistrust. Participants also talked about a certain degree of suspiciousness by young persons towards professionals, which seemed to be a direct consequence of their struggle for survival

over the years. They thus often doubted professionals' intentions to engage them in conversation and to collect information, which ranged from passing on the information to another organization, to having financial gains. Young persons' mistrust of people in authority possibly also originated from their upbringing in the country of origin and their experiences during the journey, where many may have actually been persecuted by authority figures representing the establishment.

“I’m not a celebrity, I’m not a hero, I’m not anyone, I’m just an ordinary person; why are there here so many cameras? When I came here for a check up and I came to a medical place and a medical place with cameras and everything, like you know, what’s going on in here? Make the person really, really, really paranoid, like is there anything going on between these people and other organisations?”

Young person 16

“I did lots of interviews, it’s nothing. They want to work for their job to get the money, that’s it.”

Young person 13

“Mind you, like I said, our children are not brought up the way your children are brought up in this country, your Western children are very confident. A lot of them have very good understanding of what authorities are there for. Our children don’t know that. Our children fear people in position of authority all the time. Our children are suspicious of people of authority all the time.”

Carer 4

As drawn from earlier quotes, young people found it difficult to trust and engage with the clinicians because of their unfamiliarity with systems, but also with individuals. A young person expressed his reluctance to share details of his intimate personal life story with someone he was not familiar with. Carers stated that it was difficult for the young persons to trust clinicians without having adequate time to establish a relationship, get to know them and understand how the systems work, especially in an environment that looked formal, with people taking notes of their account.

“If I knew, then yeah, then I’d be able to tell them, then I can talk to them. But I don’t know them; they didn’t show me anything..... If you never know them, you’ve never been there, it’s very hard, very difficult to go there and talk about yourself and life.”

Young person 13

“And I think, that’s the whole thing about these young people, that they don’t know, and they haven’t got relationship, they don’t want to open up. ‘Coz they need to build that trust.”

Carer 5

“Going to an unfamiliar place with people who they don’t know, and who are writing things down and it seemed quite formal, I can imagine would be, if you didn’t know what their agenda was, would be quite difficult..... why would they trust their word that they’re not going to tell others. And some psychologists to be fair and psychiatrists do go for specific assessments to help their case and things like that.”

Carer 13

“He was frightened. He thought he’s in trouble, you understand, because... something he wrote first of all in his college..... And he did, he wrote that same thing again in at the Centre Project. So he thought they were telling him off, when he first went to CAMHS..... So the first two sessions, M (CAMHS clinician) and the psychologist had with A (young person), was him defending himself: no, I didn’t want to do anything to anybody.” *Carer 4*

The carers here show remarkable insight into the young person’s world, their difficulties in trusting professionals and the possible underlying reasons. The young persons’ struggle in trusting the clinicians seemed to be more prevalent among those who had less contact with CAMHS. Being interviewed and assessed by unfamiliar representatives of unknown government departments without much preparation in familiarizing and rapport building are clear hindering factors in the formation of trust. Conducting such interactions in a formal and official manner can be reminiscent of their earlier experiences of being interrogated for the purpose of ascertaining their continual right to remain in this country. This, in turn, triggers the young persons’ defences against the perceived threat, hence their lack of engagement.

The lack of trust in the clinician can have far reaching implications in the outcome of the intervention. Without establishing a trusting therapeutic relationship, young people would be more likely to drop out. It can also be hypothesized that their basic necessities of survival, including asylum application, take precedence at that stage over other seemingly less important needs such as help for their mental health difficulties.

4.1.2. Basic needs

Many participants, both young persons and their carers, appeared to have been prioritizing basic needs before attempting to engage therapeutically. They discussed at length their key requirements such as food and accommodation, which are at the base of Maslow's pyramid of human motivation (Maslow, 1943). However, for one young person their immigration status seemed to come close to even these basic human needs.

“He (young person) need, uh, to talk, he need to talk with counsellor with help about immigration matter first. When he (is) living (in) the home with somebody, how is that home. (Whether) His food is good.” *Young person 9*

Interpreter – “..... he says he hasn't got any laptop, the lady, the lady from social worker came, he gave her a dinner food, but she didn't give him a laptop or anything, he says.” *Young person 7*

Although having a laptop may not constitute a basic need for survival, it is noticeable that these young persons' accounts of their necessities revolved mostly around material possessions, rather than more abstract ones like nurturing, love, relationships, identity, aspirations, or emotional stability. Few participants talked about finances or employment. One young person reported that he was struggling to buy clothes for himself because of not being given sufficient pocket money, and a carer reiterated why accommodation and finances should be addressed first.

“..... when I came here, I say to my social worker, I need a job, I can’t, I said can you find for me a job please..... I’m not working, clothing is like 50 pounds a month and pocket money is ten pound a week, there’s not really much money. And they said I had to buy myself. Can’t buy.”

Young person 11

“I actually feel that, although you all tried to do the case, it’s a bit like their, their, their immediate needs was about they’ve got somewhere to stay, they’ve got their pocket money and so on.”

Carer 1

Young persons and carers also discussed the interest in pursuing their education, which was more often perceived by them as more important than the mental health intervention. The perception of lack of education as one of the potential “problems” in life may be linked with their idea of the necessity of education for employment and economic survival, as they hailed from countries with political systems without a concept of welfare state.

“..... because now I, I don’t have time ‘coz I have studies.”

Young person 3

“Probably what he sees are the problems in his life, um, well not see them as necessarily problems, just things that he thinks he should be devoting his time to really. And, and to be fair to him and A (another young person), they both, um, devote time to their studies and their school work and they see that as important to their education.”

Carer 12 (S)

The need for education, however, is an example of more advanced necessity on the Maslow's pyramid (Maslow, 1943). These statements were presumably made by the young persons who have been in this country for longer, and had the problems of other more basic necessities already resolved. However, contact with the specialist mental health service did not appear to influence their view on prioritizing their basic needs over their mental health. Some carers illustrated why fulfilling basic needs like food, water, accommodation, security and support were more important than any intervention for their mental health difficulties. Young persons' adverse experiences in their country of origin and throughout their journey may dictate their undue focus on their survival needs, rather than mental health, the concept of which is not as yet well formed in their mind.

“Those basics are not there, so we are just floating here, no foundation. And so, if you, you and I know that. If people have the basics in life, which is food, water and shelter, and then they have security, like they have support, they’re going to stand. If you leave them without all that, the fabric of human nature is just destroyed in the absence of all that.”

Carer 4

“They’ve never been asked about their mental health. It’s something completely new and they’re not looking at it, they look at things in a more practical way, don’t they? Food, sleep, the basics in life, the most important things, that’s what they’re still looking at. If you think where they’ve come from and how they’ve had to behave and what their thought processes have been through that, it’s all about survival, so thinking about something out of the box, it’s beyond their comprehension at first, I would say.”

Carer 15

This experience of being deprived of their basic life necessities seems to influence the young persons' perception of the priorities of engaging with mental health services. Some carers specifically reflected on the priority of resolving the young person's immigration status over any other need, even education. There was a belief that, until this issue was concluded, it would remain unlikely for the young person to relax, feel accepted, engage in any meaningful intervention, and work through their adverse past experiences and traumatic memories.

“So, how are you going to be able to study and things like that when you know that somebody's about to throw you out of your home, or? So, I think the more, the recent trauma is getting in the way of all those things, and it's only when they feel more accepted, belonging and all those sort of things, that they're going to be able to go back (to CAMHS); but I think trying to get them to open up when they've got all these other things running around in their head.....”

Carer 2

“I know, in that pyramid of need, when this immigration thing will be sorted, the pain of this losing his mother and all of his family will kick in.”

Carer 3

“..... his solicitor didn't get his application in on time, so all his rights have gone at the moment. So, that's just really the straw that broke the camel's back really. 'Cos that complete uncertainty, he doesn't know if he can do his college course, housing.”

Carer 12 (J)

This in depth consideration of the young persons' construction of beliefs was mainly delivered by the carers rather than the young persons themselves. It appears that the young persons, after their arrival, can remain occupied with the idea of ensuring the availability of provisions to meet their basic necessities for survival. It is only after these, and most importantly, a sense of permanence are achieved, that the young persons can be ready to participate in treatment.

4.1.3. Language

Language constraints also hindered the young persons' engagement during their initial period of stay in the UK. Young persons and carers shared their experience of difficulties in engaging with mental health services because of language barriers. The young persons stated that, after their arrival, they found it difficult to communicate in general, as English was not their first language and many did not have any formal education in their country of origin. They also revealed how this limited communication with the clinician at their appointment.

“Uh, I can't explain these things because I'm not speak English well. That's the problem.”

Young person 6

“I didn't go to school in Afghanistan, so English is a bit hard for me, so I have to learn English more.”

Young person 7

“I can't speak English, but my aunty said something about fifteen, twenty minutes talking with doctor.”

Young person 9

One carer summarized why language can be a significant barrier in engaging with and completing mental health interventions. The complexity of the constructs of mental health and mental illness makes this task even harder.

“When they first came, they couldn’t speak English……. And so, you’re using here terminologies that are not even common terminologies in English. I mean, I was, I’m in a position to explain something to a child which I don’t understand myself. And then I’m talking through a foreign language.”

Carer 3

Therefore, premature attempts to engage the young persons without ensuring their understanding of these constructs, and their informed consent to participate are unlikely to be successful. Some young persons and carers added that the intervention should be timely in terms of the young person’s proficiency in speaking English. One carer interestingly mentioned that a young person engaged well with treatment because this was incidentally delayed, which gave him time to improve his language skills.

“Before, you know, you know this meeting, this thing, and one thing I wasn’t speaking English, I wasn’t speaking the language.”

Young person 2

“Before I couldn’t do anything because like, before Christmas I couldn’t speak English, not at all.”

Young person 11

“I mean, it’s probably a good thing that he didn’t get to see A (CAMHS clinician) until more recently, because, you know, his language is so much better now. And if he’d have gone earlier, it probably would have been a bit difficult for him.”

Carer 11 (J)

Young persons with both longer and more recent contacts with the mental health service shared this difficulties in engaging because of language barriers, either in retrospect or as a current problem. The importance of sufficient language capacity, however, needs to be balanced against the urgency and seriousness of the presenting mental health problem, such as the potential indication for pharmacological treatment or hospitalization. Clinical decisions are also influenced by how promptly young people and their carers seek access to mental health services, as will be discussed in the next section.

4.1.4. Experiences of accessing services

Although this may not be unique to this group, many of these young persons and carers commented on the prolonged waiting time after the initial referral. One young person stated that he should be seen when he needed help, rather than wait until the immediate need had passed. This was resonated in the carers’ response, who agreed that on several occasions the first appointment was offered a long time after the precipitating event, consequently the young person had lost their motivation or readiness to engage.

“Is good if somebody have a problem they come to CAMHS and they (CAMHS) can help it. Is good but some people, I don’t know about the people, but when I come I was (hoping to) get some fast help.”

Young person 9

“..... if you’ve referred a young person, it takes a long time, by that time that young person has thought, well, I can’t be bothered.”

Carer 5

“..... time needs to be spent on these young people when they are engaged, when they do want to engage, and then they’re told, oh well, you have to wait for a bit, you have to wait this long, you have to wait that long. And it’s just not good enough, when they’re ready, they’re ready, yeah.”

Carer 15

The waiting times were deemed a barrier to service provision and engagement, with carers arguing that “it’s just not good enough”. Young people from such troubled backgrounds may be in need of more immediate sources of mental health support and the waiting times can be at odds with their expectations, as participant 9 notes: “I was (hoping to) get some fast help”. The expectations and long waiting times were argued to contribute to the anxiety of attending services, as participants recalled their anticipatory anxiety before coming to see a mental health clinician. This anxiety could be minimized by reducing waiting times to a few days, and offering ad hoc, unplanned or open appointments.

“You’re waiting for someone, things are going through in your head and you get a bit scared, and the more you’re waiting the worse it gets, so you better get on with it..... So, yeah. It’s like the exam results, you have to wait, wait,

wait, if they give you straight away after two, three days, it's over, you don't need to wait, but if you have to wait one, two months, one, two months you have to wait and worry about it.

Young person 12

"..... they get worked up too much. I remember the night, the first night I told A (young person) that he was going to CAMHS, he was down here with me until 2:00 am. He keep asking me, so what are they going to say?..... I wish they could offer an appointment in a way that I wish they could just say, okay the day you want a doctor, you feel like talking."

Carer 4

"..... you can't plan anything with her, because it could just be out of the window, you could plan it ten times. But you've got to catch her randomly and say, are you okay? Can I talk to you, can we discuss this? Yeah, we can, and then she just gets into that."

Carer 5

A few carers shared their experience of having to go through what was perceived as a cumbersome referral process, where service users might have to go back and forth several times before their referral being accepted. A suggestion was to be able to self-refer without having to go through either their GP or social worker, in order to make the process easier for them.

"I knew about CAMHS but I didn't know how to, uh, refer A (young person). Um, I spoke to the GP and the GP, you know, it was kind of like back and forth, back and forth, we needed a letter from the social worker, the social worker

was saying the GP can write one letter depending on how he assesses A (young person) and I'm there, caught in the middle." Carer 7

"..... isn't there any way the foster carer can make an application? Because I always think going through the social worker, I know they've got files and files of cases, and it takes time." Carer 16

On the other hand, some carers expressed their appreciation of the flexibility and accessibility of the service. They reported that the professionals were always available and contactable, especially when they needed it most.

"I found, not only that intervention, the fact that you can go there in time of need. I know they don't handle crises, I know crisis intervention when you see major crises is different. But the fact that that house runs a flexible shift, kind of situation is very good." Carer 3

"They're easily accessible, there's always somebody that we can refer to."

Carer 14

Some carers appreciated open ended appointments, even when it was felt that ongoing input was not required. One carer pointed out that offering an open appointment can be a useful way of optimizing resources, as the young person could use the service only if he felt motivated or ready to utilize it.

“I might have been a bit iffy, should we just stop it altogether? Because you never know with young people; do we, how they’re going to be from one week to another, you never know what’s going to crop up. So, yeah, definitely I liked the open appointment thing……. And it’s probably, you know, saving money for the NHS, isn’t it really, if people have got that, rather than committing to go back when they’re not sure they need to.”

Carer 12 (J)

“…… that was really good, M (young person) said, right, he doesn’t want to go anymore, he’s okay about it. It was left and he was told that any time he can come and talk to them.”

Carer 16

Overall, participants expressed the wish for shorter waiting times, quick access, and flexible and open appointments as and when required. The views of the young persons and their carers were similar in this regard, although some carers also appreciated the flexible treatment arrangements they experienced. Although in earlier sections participants talked about young persons not being ready to utilize mental health service due to several issues during their early stay in the country, what emerged in this section was their intention to receive help when they perceived the need rather than when it was offered to them. This has implications for planning user- rather than provider-led services.

4.1.5. Perceptions of the venue (clinic vs. community)

Young persons’ experience of the site where they received assessment and intervention may have an impact on their engagement with mental health services and eventual success of treatment. Both physical and psychological aspects of the

venue influenced their overall perceptions. Some participants liked the clinical setting, and found the environment relaxed and appropriate for the therapeutic activities that were carried out.

“..... (Laughs) I liked the building, nice looking, very nice, I like the house.”

Young person 2

“I think the room that was he was in seemed quite relaxed and quite conducive to the environment, conducive to what you were trying to do.”

Carer 1

On the whole, young people and their carers agreed that the venue for the intervention was appropriate and suitable. They liked the general building, its appearance and the relaxing nature of it. In contrast, others described the young person feeling paranoid about a number of features of the venue. They were suspicious about the cameras in the interview room, which they did not expect to find in a normal medical appointment. It was felt that the sessions might have been recorded for information to be passed on to some other agency like the Home Office. Similarly, the one-way screen reminded them of a police interrogation they had experienced.

“..... they’ve been very freaked out at the two-way mirrors, because that’s what they had, ‘coz they’ve been trafficked and that’s what the police were using.”

Carer 13

This perception of refugee young persons may be reflecting their social construction of growing up in countries with often hostile authority and their experience of being a refugee. Some young persons and carers commented that they would prefer therapeutic work for mental health problems to be carried out in an environment that is comfortable for the young person. This should be unlike the usual mental health clinics, which can come across as too formal, impersonal or institutionalized.

“..... when it comes to mental therapy, it always has to be done in a place where the person, the person, the sick person, is feeling comfortable.”

Young person 16

“..... in CAMHS you go in an office, every time I’ve been, small room or an office. You know, but that’s an institution, chairs and tables.”

Carer 14

Carers came up with different ideas of a user friendly, comfortable and non-institutionalized set up for implementing interventions. One suggested a therapeutic holiday camp, where the young person’s identity would be protected, while another carer proposed a familiar place, like a youth project, staffed by trusted people. One carer stated that the venue can be a neutral place other than the home or the mental health clinic, where the young person does not feel restricted either physically or emotionally. It was also suggested that the initial sessions could be carried out in the home environment, until the young person begins to feel secure enough to develop trust in the therapeutic process.

“I suppose ‘coz they met up in the office, um, she found it a bit boring and found it hard to get engaged..... I wonder how it would work if you had like a holiday camp where nobody knows F (young person).”

Carer 5

“And maybe a place that was more familiar to them, with people that they trusted, people with CAMHS coming into a place, safe place for them..... might be an easier way to reach them than take them into a very unfamiliar, an environment they perceive as perhaps a bit threatening.”

Carer 13

“..... whether they could have a room or an area where it’s not Westcotes [name of child mental health service], it’s not mental health, a place other than that, do you understand where I’m coming from, it’s not their home environment and it’s not a mental health environment, somewhere impartial..... somewhere that they can move around, if they’re not feeling comfortable.”

Carer 14

“..... this is where they feel securest, isn’t it, they feel secure here. This is their home..... Once the person is really ready to engage, then coming here, maybe doing a few sessions here, once the trust issues are built up, then going over to the CAMHS.”

Carer 15

Therefore, young persons’ engagement can potentially be enhanced if their comfort level and choice is taken into consideration while selecting suitable sites. The different suggestions of suitable venues, however, were mostly shared by the carers, on behalf of the young persons in their care. Nevertheless, this should be considered

as a valid finding considering the carers perceived good understanding of the minors' beliefs and difficulties. Participants wanted the intervention to take place in a venue that was comfortable, familiar and non-intimidating. The traditional clinic set up did not fulfil much of these criteria. Therefore, alternative locations could include their home, school/college or a youth centre. It can be theorized that these are the places where it is easier for the young person to invest in trusting therapeutic relations, hence engage effectively in treatment.

4.1.6. Experience of assessment

The young persons overwhelmingly agreed that they did not appreciate the process of being asked a long list of questions during their assessment. Many young persons found some of the questions complex and difficult to comprehend. This may be a reflection of their language difficulties and cultural understanding of certain concepts relating to mental health. One young person reported that it was difficult to talk about themselves to an unfamiliar person at their first appointment.

“They ask, they’re asking you very complicated questions, you don’t, you can’t answer proper.” *Young person 2*

“I don’t like question, someone ask me question, when asking question, I don’t like, oh!” *Young person 3*

“But don’t ask them too much question.” *Young person 14*

“Yeah, because you know, when first time going somewhere it’s not really very nice having to speak about myself or yourself or anything. Yeah, that’s why I didn’t like.”

Young person 11

These negative views of assessment were shared both by young persons with fewer (young persons 2 and 3) and relatively greater (young persons 14 and 11) contacts with the specialist mental health service. It is difficult to conclude whether the questions are perceived as “very complicated” due to young people’s limited language capacity, or their lack of cultural comprehension of mental health constructs. Whatever the reason, asking “too much” or too many questions seems to overwhelm the young persons, thus affecting their motivation to engage. Young persons in particular found the process of being repeatedly asked the same questions distressing. They perceived this as unnecessary; instead they expected the clinician to focus only on their presenting problem. Carers shared this view, as young people may have already been interviewed by the Home Office, police, solicitors, their social worker and GP before being referred to the mental health service. This led them to have to repeat their accounts, over and over again, which can be traumatizing in its own right. One carer particularly stated that this can have a negative emotional impact on the young person.

“..... wasting my time, innit. When I got problem, I tell him, yeah I got this problem, but still be asking me question, question. Then I don’t like these things.”

Young person 4

“..... they keep meetings. They ask you one question, they ask you one word like ten times, they keep asking. They know everything but she just keep asking, I said I can’t do this. If you are keep doing this, end of 2012 you’re going to kill me..... I wanted that they stop doing meeting, they stop doing meeting, went to them after this, I said what they doing? Just keep going on this thing, nothing happening.”

Young person 2

“..... he said, why are they asking the same questions, I’ve been asked the same questions all the time.”

Carer 2

“And the fact that, um, when the boy, the lads like him get into this country, they are interviewed, several interviews by the Home Office, by the police by the social workers, by the solicitors. So they are asked one question, say for example one question on five or six different interviews. And imagine being asked how was your father killed, how was your father killed, how was your father killed? I guess it affects.”

Carer 7

One carer asserted that the assessment he experienced with his young person was rushed and inadequate. He commented that it seemed to him as if the clinicians were under pressure to complete the assessment quickly, and suggested that this should be done more comprehensively. He also stated that if there is a resource problem, this should be addressed by offering time-limited interventions rather than making assessments shorter.

“..... when he came to CAMHS, uh, two of your colleagues have assessed him but I think, my opinion he wasn’t assessed properly..... I was bit annoyed and shocked because I thought it was very quick and it was, I was thinking at that time that the person is over-confident that he has diagnosed S (young person) very quickly.”

Carer 10

This particular opinion was, however, out of sync with the remaining views of the assessment process usually being too lengthy and stressful. Participants reported that young persons often felt anxious and suspicious by the atmosphere. This was mostly in contrast with the young person’s expectation of a medical examination. Instead of the expected consultation by a doctor or nurse, the young person was often greeted by a number of professionals without prior intimation of the number expected to be present.

As some of the questions asked during the assessment can sound similar to the ones asked by the Home Office, the clinicians can be misinterpreted by the young persons as covertly serving the interests of that agency; consequently, their intentions as being malicious. This view seemed to be shared mainly by the young persons with fewer contacts with CAMHS, thereby the unfamiliarity of the process possibly attributing to this view. It is, however, difficult to be conclusive about it in the absence of an opposing or different view by the younger persons with longer contacts. One young person suggested that, in order to mitigate this feeling that can jeopardise the whole assessment process, clinicians should explain to them in advance the issues of confidentiality, and the process as a whole.

“I’m scared, I say what’s happened, you know, many people sitting there, I don’t know why, here but I check in like, I think I don’t know what he (would) say. I come in there and I say I’m no crazy like, you know.” Young person 15

“I can’t believe I, like I come in doctor is one person, there is seven people.”

Young person 15

“You’re going through all these questions and they sound like some of the questions the Home Office has given them, you are not seen as helping them, you’re seen as part of the..... Officialdom. Yeah? So you’re trying to help them, but all they’re knowing is that there’s this person asking loads and loads of questions and they’re not helping me.”

Carer 1

“..... have to make things clear in the place, like if we are recording for these purposes, it’s only for that and this is copyrighted, confidential and make the person feel assured that these people are not like you know trying to hit me from the back.”

Young person 16

From these accounts, it seems, however, that for a large part, this phase was missed as the young persons were subjected to thorough assessments without prior preparation or explanation of the process. Consequently, there was a perceived reluctance to engage. The main reason behind this appears to be the large number of similar meetings organised by different agencies but without any tangible benefit to the young person.

“Talking, asking me questions about family, asking me about how I’m feeling, or what did I do last week, why am I taking drugs, what for? And okay, but there’s no other help coming after that.”

Carer 14

The participants offered suggestions on how the assessment process could become easier and less distressing. This was offered predominantly by the carers, on the basis of their experience and understanding of the young persons. If information could be shared between the agencies, this would help reduce the number of questions asked. Hence, the assessment could focus on clarifying previous information or collecting new material. This would also significantly shorten the assessment period. Other suggestions were to avoid using jargon and to keep the sessions brief, so that they can sustain young people’s attention until the end.

“..... you can ask the social worker’s permission to use some of their case history of what they’ve gone through already, so they don’t have to repeat it.”

Carer 1

“..... ask them the things that are not clear on the form, rather than asking them all the things that’s already written.”

Carer 2

“Less jargonistic as well, less using big words, ‘coz that can put young people off definitely. I’ve seen it in meetings, the social workers come and teachers come ‘and this curriculum’. The young person’s (thinking) what’s curriculum. Just the word curriculum, you know. Change that.”

Carer 14

“Brief, their attention is not great when it’s something that they’re just completely disinterested in.” Carer 15

These solutions may, however, be problematic from a service perspective because of complexities around data protection, information sharing, and time pressures on the completion of the assessment and care package. But there is little doubt that a better explanation is necessary to improve young persons’ engagement with assessment and treatment.

4.1.7. Experience of interpreters

Unlike their views on the assessment process, there was disparity in responses between the young persons and their carers, with regards to their experience of interpreters. Young persons were mostly not happy with the quality of the interpreting service they received, whereas most of the responses from the carers contained appreciation of their necessity and usefulness.

“..... he wasn’t happy (with the interpreter) he says. He says three times it happened and third time they cancelled it.” Young person 7

Some young persons reported that they were not able to understand the interpreter because they did not speak the same first language, or for some other communication problem. Whereas others stated that the interpreter did not understand the young person.

“..... before one interpreter (was) there, this guy speak my second language..... And he speak in, I don’t understand proper.” Young person 2

“..... the interpreter she, I can’t remember she or he, anyway they tried to understand me, I couldn’t understand and that was, that was a mess.”

Young person 11

“..... your interpreting is no good, because when I show you this eye, you are showing them this eye.”

Young person 7

One carer elaborated on his understanding of the potential complication of communicating through an interpreter. He asserted that a three-way communication may not be as effective as a direct conversation between the clinician and the young person. Personal and confidential information may thus be withheld by the young person while talking in the presence of an interpreter.

“..... if you’re breaking the conversation up in a three-way, it’s not quite the same as me talking to you one-to-one about my personal issues and discussing it..... if I was talking through an interpreter, I may not want to tell you things that are as completely personal than if I was talking to you face-to-face.”

Carer 11 (S)

Other carers, however, reflected on their experience of the interpreting service, reporting it to be useful. As these perceived the young persons to be still requiring support with their communication, they mostly welcomed the interpreter’s input. As

interpreters are usually ethnically matched, one carer reported, this can be an advantage in building rapport with the young person.

“I think it was useful that they provided, obviously, an interpreting service at the same time, ‘coz when he came his English was not very good, although by the time he started to get therapy from there, it had improved.” Carer 1

“He’d been at the hospital, he was having the interpreter, they’ve built a rapport. The interpreter happens to be from the same kind of clan as him.”

Carer 8

When carers reflected on the young persons’ attitude towards the interpreters, they hypothesized that they might feel embarrassed or ashamed to accept the need for an interpreter to communicate, and therefore, they often resist their presence. They might also try to integrate themselves with the rest by declining an interpreter even when there is a need.

“..... he will always say I don’t need an interpreter, you can just tell me, and it’s very obvious that he doesn’t understand what’s being said, but he’s thinking, well he’s trying to accommodate us by saying, oh, I’ll understand you.”

Carer 8

“Yes, so having an interpreter, I think he does feel embarrassed and ashamed by it.”

Carer 14

Having an interpreter seems to have both strengths and limitations. It can facilitate communication and rapport building towards therapeutic engagement. It can, however, also hinder unobstructed personal and emotional exchanges between the young person and the clinician.

All the factors discussed in this theme influence the engagement of the young person with the service, which is of paramount importance in the future success of the intervention. Young persons' engagement in the process seems to be influenced by their ability to trust, familiarity, level of understanding, language and culture, and other factors impacting on their comfort with the process, especially in the beginning. Unaccompanied minors' reluctance to engage in the process of assessment and eventually intervention could also be possibly related to their high level of arousal associated with such encounters, which can be secondary to underlying post traumatic stress disorder (PTSD). This possibility is supported by the high prevalence of PTSD in this group of vulnerable young people (Geltman et al., 2005). Conducting initial interviews in a formal manner can be reminiscent of these young persons' previous potentially traumatising experience of being interrogated. Assessment or other interviews within the mental health service setting can thus be an aversive experience, as anxiety is heightened as an inevitable symptom, without any effective strategy offered on how to manage it. Equally important for the outcome of treatment is how the service user perceives the practitioner's attributes. This is the focus of the next theme.

4.2. THEME 2: PERCEPTIONS OF PROFESSIONALS

In this section, the participants' experiences of mental health professionals involved in their care and potential factors that might influence these perceptions are discussed. The service user's pre-existing ideas or expectations of such contact and the clinician's personal and group attributes can arguably contribute in forming the participants' opinion of professionals. These factors are, therefore, discussed here separately as subthemes.

4.2.1. Expectations of the professional-patient relationship

Young persons mostly seemed to view their relationship with mental health professionals as asymmetrical, with the professional being positioned as an authority figure and in charge of the direction of the therapeutic relationship. They expected clinicians to be directing and guiding them rather than facilitating the intervention process. Many perceived their own role in the treatment to be following the doctor's instruction without needing to know, clarify or question any aspect of their treatment.

“I say, okay, I deal with this, okay, (but) you know more than me, so I will go ahead with it.” *Young person 1*

Interviewer – “I mean, if it is not helping, why do you still take?”

Young person – “Uh, because she (CAMHS doctor) says.....” *Young person 3*

“When I thought I will tell her something but sometimes I didn't, um, and that's why I will be worried.” *Young person 6*

One young person illustrated the higher position of the doctor or a professional that was perceived to be influencing decision-making regarding the implementation of a particular intervention. The predominant factor was whether this was advised by a professional or a lay person.

“..... it’s in your subconsciousness that, you know this, you might think that someone say you’re not professional..... if I say something to someone, look do that, do this, they don’t listen to me, but if they go to GP and the GP tell them, look do this, do this, so it’s more likely to accept the GPs rather than me. You know what I mean?”

Young person 10

Most of the young persons expected mental health professionals to carry out some actions to solve their problems, while they remained passive recipients. For example, one carer discussed the notion of doctor fixing what is broken, without any mention of the patient’s participation or contribution.

“Yeah, I want help, please fix my brain.”

Young person 15

“P (CAMHS doctor) is a good person, he’s going to make me better, make me feel happy.”

Young person 7

“..... when the, the doctors will tell them something, they just think, oh, it’s almost like if you break something they (young person) expect it to be fixed straight away.”

Carer 1

On occasions, however, young persons also expressed their intentions to have a more mature and emotionally neutral relationship with the clinician, where difficult issues can be discussed and a resolution is reached through collaborative effort. Some shared their positive experience of being able to ask questions on different aspects of the treatment and to receive answers and encouragement rather than prescriptive directions.

“Maybe I don’t want to talk to my friend, only I want to talk to her, the doctor, maybe it’s not emotional like people’s friends.” *Young person 6*

“Talk to me as me, I’m not like baby, man.” *Young person 8*

“You know, like when I have some question, I say to the doctor just like this, he give me reasons about that, and then I think maybe the doctor is right.”

Young person 9

“And the things I like here, you know, it was a good feeling when I was standing here and, uh, a member of your team, she was encouraging me and she was reminding me that it’s not a lonely place and I have lots of guidance from here.”

Young person 10

Although some expected a more collaborative therapeutic relationship, young persons mostly expected to passively receive treatment as directed by the clinician. Both these views were independent of the amount of contact they had with specialist

mental health services. Incompatibility between this pre-existing construction and an experience that is far removed from it may have influenced how actively the young persons participated in the process and the eventual outcome of the intervention offered.

4.2.2. Experience of professionals' attributes

Many young persons and carers shared their positive experiences of professionals' individual qualities. They described some of the clinicians they worked with as nice and likable. Some clinicians were perceived as good listeners, accessible or approachable. Having a good sense of humour was considered a useful engagement tool.

“What I like(d), uh, some people like nice personality, like you, A (CAMHS clinician), anyone, speak to me. Is like lovely personality.” *Young person 11*

“Because he listened to you what I’ve said and then, you know, he thought about it what I’ve said and then he gives advice, so, which is good.”

Young person 12

“..... some people would expect, oh, it’s going to be a bit serious ‘cos he’s a doctor and blah blah, but he’s not, it depends on you and, you know, if they have that sense of humour, it’s perfect, it’s fine, so you have a laugh you know, so it depends on person, people really.” *Young person 12*

“I have had an appointment with C (CAMHS doctor) and P (CAMHS doctor) and these are just real ordinary people. The way they present themselves is just amazing. They are very, very approachable people, they are very likeable people. I mean children, the children I’ve worked with have just, you know, bonded with them straight away.”

Carer 3

It is interesting that, despite positive attributes such as “nice personality”, “sense of humour”, and being “approachable” and “likeable”, young persons in general struggled to trust, understand and engage in the process, as described in the earlier theme. This possibly indicates the importance of other systemic factors in the overall success of mental health intervention. In contrast, few participants had experienced negative attributes in individual clinicians. These young persons reported that their clinicians were mainly concentrating on writing notes and reports about their problems, rather than trying to help with solving them. One young person reported that the doctor could not perform his duty to his expectations as he did not make an effort to understand them, instead he imposed what he thought was right without a proper dialogue. One particular carer commented on his young person’s clinician that he came across as over confident and less professional.

“..... the doctor, only like she write(s), maybe she got my problem, she understands that problem and she is, she (should) do something for helping that problem.”

Young person 6

“..... doctor don’t even know what’s wrong with me, doctor just know, and the doctor write down this report and they give me tablet the same.”

Young person 8

“I’m just (made) a mistake, see, it’s my mum this picture and nobody explain to me, police don’t understand me. I’m not British, I’m from Africa and people don’t even understand, I didn’t speak English that time and nobody bring an interpreter. Nobody bring interpreter and I stayed in hospital 28 days, 28 days doctor didn’t do a job, proper job, doctor he say you have to stay hospital.”

Young person 8

“I was thinking at that time that the person is over-confident that he has diagnosed S (young person) very quickly. And they said ah well I know, I’ve dealt with a lot of people, this, this, this. I think that was not professional.”

Carer 10

Some of the participants, like young persons 6 and 10, who commented on the negative attributes of the individual clinicians, had longer contacts with the mental health service. Therefore, this particular view did not seem to be related to lack of familiarity or trust because of lack of exposure to the service. The majority of young persons and some carers, however, reflected positively on the collective attributes of professionals. For example, young persons held a positive regard of a doctor’s knowledge or of the sincere attempts by a clinician to help them. Doctors in general were described as friendly, informal, less serious, and also empowering; these qualities helped the young person feel comfortable in sharing their personal information. The group of clinicians was positively described by carers as open, accommodating, facilitating and child-centred.

“..... obviously they’re doctors, they’ve been facing this for that many years with others, so they probably helps others, they can help me.”

Young person 1

“She’s a doctor, she know everything. She know everything.”

Young person 6

“But they tried, actually they tried so hard to understand me. That was very, very good.”

Young person 11

“Well, the doctors were friendly they, you know, they don’t talk to you seriously, they’re not formal, they’re informal. They kind of make you feel like friend and you know, they don’t force you, they don’t put pressure on you. They make you feel comfortable, which I think is good, because if you put a little bit of pressure on someone or doctors talk to people in a serious way, um, or formal, they might hide something, they might not tell you.”

Young person 12

“I think the staff there always seemed to be, you know, very open.”

Carer 1

“..... the approach by the professionals, I can’t fault them. I find them very accommodating, facilitating and very child-focused.”

Carer 14

There, however, seem to be some implicit indication in “obviously they’re doctors” or “she’s a doctor, she know everything”, of the young persons’ understanding of doctors being in a higher position in the power hierarchy of the relationship. This might be the reason for a perceived need to please and say positive things about this particular professional group. While most participants’ reported their experiences of the doctors and other clinician groups as positive, one young person in particular expressed a negative view of the medical group.

“English people and doctor people, you don’t understand me anything at all for me.” *Young person 8*

The overwhelming statements on the positive qualities of individuals and professional groups in the mental health service indicates that the scope for further service improvement should probably implicate changes in systems rather than personal attributes of professionals.

4.2.3. Gender of the professional

Carers reflected on their understanding of the young persons’ cultural construction that influenced their view of the intervention in the context of the clinician’s gender. They theorized that a male young person’s predominant world view makes it uncomfortable for them to express their innermost personal and emotional experiences to a female professional. It was hypothesized that the young persons from those particular cultural backgrounds view that, men should be able to carry any burden of stress in order to protect women, who are seen as weak and vulnerable, from harm and suffering. This may have prevented a male young person

from seeking and receiving help from a female clinician or therapist, for fear of troubling her with his burden. Although similar comments were absent from the discussion with the minors, this possibly reflects the carers' insightfulness into the young persons' cultural and personal belief systems.

“I think for somebody whose whole world is totally different, and especially when you’ve got to talk and you’re talking to a woman as well, in there, you know, sitting in a room talking to a woman about your inner feelings or whatever, I think they weren’t comfortable about that.” Carer 1

“To S (young person), women need to be protected, women need to just see the soft side of things and don’t have to suffer, and if there is any burden of suffering, it is good for the man to carry this burden and not for a woman……” Carer 3

“Yes, he looked at A (CAMHS doctor) like a young woman, ‘cos A (CAMHS doctor) is only a small sized woman. He said that’s another young woman who doesn’t need all this trouble…… S (young person) will be thinking, why should I be going to get help from this woman?” Carer 3

Because of the belief that “women need to just see the soft side of things”, some young persons may have struggled to engage with mental health services dominated by female therapists. Perception of their own gender role of “good for the man to carry this burden” further hindered the expression of emotional vulnerabilities and distress in this therapeutic dyad. Amongst all other systemic or cultural factors

having an impact on the young refugee's perceptions of mental health interventions and services, the professional's gender can be a significant factor that should not be disregarded.

4.2.4. Ethnicity of the professional

Young persons had mixed opinions on the ethnicity of clinicians, as one commented that the people of the host nation, including doctors, failed to understand him, while others portrayed the indigenous population in a positive light.

“I trust hundred per cent, ninety, ninety-five per cent English people, but Asian people, other Asian people tell you wrong way in United Kingdom.”

Young person 9

This young person seemed to have a negative experience of ethnic minority immigrants, particularly people who belonged to similar ethnic backgrounds as him. This finding is not consistent, as others described opposite experiences. Although not corroborated by the young persons, carers mainly viewed that ethnic matching with the professional may help young people feel more comfortable, thus engage more easily. It can also be easier for the young person to share their personal and sensitive information with someone from their own community who they can identify with. Even outside their community, as one carer reflected, young people may relate better with professionals of the same skin colour.

“I think if there was a culture, uh, common thing within (between) a young person and the person who's working, I think that generally works.” *Carer 5*

“..... he told the interpreter who is an elderly, well not elderly, middle aged like me, um, forty plus, and he shared with him that when I was growing up every day of my life I would be abused by my family members. And I can’t say that to P (CAMHS doctor) because it’s an embarrassment and I feel I would have betrayed my own people.”

Carer 7

“To him, because of the colour of skin, I’m the same colour of skin, it made him feel at ease, definitely. Straight away I noticed that anyway. He didn’t ask that I was Muslim, whether I was Gujarati, Punjabi whatever, no, he knew. And the fact that and he could relate.”

Carer 14

One particular carer, however, asserted that acculturation or integration into the society is the key to successful engagement and treatment, consequently ethnic mixing with clinicians can be more useful than ethnic matching.

“In this country, people have been living here for the last thirty, fifty years, they can’t even speak English. You know, this is because of the policies we made, you know, help them, you know. There you don’t help them if you keep them aside, if you keep them in their own groups, you’re not helping them, you’re creating classes among classes and among classes. I think this is a wrong policy, and I think your services shouldn’t be, you know, we should be helping mix, for me this is mix, mix is better.”

Carer 10

This participant’s view is compatible with previous research which found social integration and sense of belonging to lead to better engagement and psychological

outcome (Rousseau et al., 2005; Kia-Keating & Ellis, 2007). In general, the participants' perceptions of the issue of ethnicity in a therapeutic environment appeared to be variable and personalized. There was no predominant view, while young persons and carers talked about the pros and cons of both ethnic matching and mixing between the service user and the clinician. It can only be assumed on the basis of the current limited findings, that their perceptions might have been influenced by the individual respondent's personal journey and life experiences, and that there was no evidence of preference of any ethnicity over another.

In this theme, the focus was on participants' perceptions of clinicians in mental health care. This included their expected role, personal and collective attributes, and the potential influence of gender and race in their engagement and ultimately the treatment outcome. In the next section, participants' experiences of the actual interventions is discussed, focusing on the factors that were perceived to be affecting the treatment process and outcome.

4.3. THEME 3: PERCEPTIONS OF INTERVENTIONS

Young people were undergoing a range of different treatments at the time of interview; psychological, activity-based and pharmacological approaches, as well as hospitalisation. For mental health services to be effective, young people's perceptions are equally important to those of professionals. In particular, their views on the factors that influence these perceptions facilitate our understanding of how the needs of these young persons may be better addressed in the future.

4.3.1. Psychological therapies

The participants' perceptions of psychological therapies they received were divided into 'talking' as a treatment modality, and talking about the past as compared to mainly focusing on the 'here and now'.

4.3.1.1. Views on 'talking'

Most young persons did not recognize the benefits of talking with a therapist as treatment per se. Their experiences ranged from passively following instructions to attend sessions without being aware of their purpose, to finding them unnecessary or even unpleasant.

"..... she used to talking about different things and I'd get headache. So I said, sorry I can't do that anymore." *Young person 2*

"..... these things they keep talking to you, that means this person annoying you and you just closing your ears." *Young person 2*

"No, I wouldn't say that, yeah, I honestly wouldn't say that. I'm sorry to say, I wouldn't say it's helping him deal with that, he knows that they are the sessions that he is to attend. But he attends and that's it, he goes..... Now I'm talking to someone who's different, who's professional, okay, I have to talk to them, answer them. They are doctors, all right, or whatever." *Carer 7*

“At first he didn’t know what this therapy was. He kept saying, why are they asking me all this, he didn’t realise talking about a problem even helped him. He didn’t know that.”

Carer 3

Young people experienced a feeling of repetition or stagnation during their talking treatment. It was felt that problems were enquired, discussed and written down regularly in a repetitive manner, but no progress was made in terms of addressing or solving them. Talking was not perceived to be quick enough to be acknowledged as beneficial by most young persons.

“Every time when I come it’s like a rotation or same thing.”

Young person 6

“Yeah, this talking, talking, talking, I think one person, one time, you know, my brain’s not working, what’s happened, I’m scared like.”

Young person 15

“I had a lot of problem coming, so many things, I will tell them but she would write it, speaking to me and discussion, and the rest I didn’t find it nothing. I told her a lot of problems for my life and, I didn’t get it. I didn’t get anything for the problems.”

Young person 6

“So when you’re talking, it’s too slow for them, you know, it’s too slow, so they don’t want to engage in it, ‘cos they’re not seeing any immediate (benefit).”

Carer 1

This focus on acquiring practical and immediate help may indicate their propensity to prioritize their survival needs, which in turn can be related to their traumatic experiences of migration. Sometimes talking was even perceived to make their presentation worse by reminding them of traumatic memories that they thought they have put behind. This intervention brought to the surface adversities experienced in their country of origin and on the way to the new country that they thought had led to the current mental health concerns. This was mostly perceived by the young persons as regressing rather than making progress.

“So, when I went back home, I was thinking about that, especially that time I was talking with the doctors, so I was thinking about him, home, what happened why this happened to me, why I been in this problem and why I’ve been faced with this, uh, depression, that stuff. So it’s quite, wasn’t helping me the way talks.”

Young person 1

“..... talks doesn’t helps me because every time I was talking about it, it just reminded me about home and was hurting me about same, same problem and more worse.”

Young person 1

“..... he was the one that was very adamant that he didn’t see the point in talking, you know, talking about it, because it hurt him.”

Carer 2

Being in contact with the specialist mental health service for longer did not seem to shift this view of talking therapy or make this experience any easier for the young

persons. It appears that, for these young persons, suppressing their traumatic past experiences and concentrating on solving future problems was the best way of coping. This also helped them avoid being overwhelmed by a combination of distressing past events and an uncertain future. Talking therapy was largely perceived as a reverse process. This may explain their general negative views and apparent resistance. Some of those interviewed, however, found the experience of talking helpful. One young person reported that it made him able to talk to someone about his problems, whereas another found the experience of sharing the so far untold stories cathartic, especially as the clinician was impartial and not related to them in their personal life. These young persons probably acknowledged the benefit, if any, but only after starting this process. These fewer younger persons, interestingly, were not necessarily the ones with more contacts with CAMHS, as might be assumed.

“She talked to me about it, and I think it was kind of helpful, because sometimes when you talk to people, you know, everything’s coming out..... and you feel a bit better. ‘Cos if you keep inside for a long time, you’ll be like ahhh, you know.”

Young person 12

“Well people like, you know, from CAMHS and because I don’t know them, so whatever I say, it doesn’t bother me because, you know, I’m not going to see you everyday life.”

Young person 12

“He did not understand that, um, it will help him to share those fears, to express those fears and it’s only when he started talking.”

Carer 3

“I think it’s enabling him to sit down with, um, probably an impartial independent person and discuss his issues and help, obviously, help him to talk through and work through those issues, and perhaps understand them.”

Carer 11 (S)

Carers seemed to have some insight into the underlying cause of the young persons’ predominant reluctance in engaging in therapy, which the minors themselves did not acknowledge or bring up in their discussions. They hypothesized why young persons were mostly not able to derive any benefit from the available talking treatments. This may be because the expected role of children in their cultural context does not encourage them to talk about difficult personal and social issues due to the degree of shame and guilt associated with such topics. Carers reflected that these young persons need a lot of reassurance about the therapist’s neutrality before embarking on such ventures. Moreover, the therapist needs to demonstrate an explicit interest, manifested by active listening and offering practical help.

“..... especially the society where we come from, children don’t talk a lot. Children are not even allowed to reveal things. Children are not even allowed to talk about being abused. Oh, why are you talking. Are you not ashamed to say something like that? There’s a lot of shame and pain and guilt children just have to carry with them, and that will be hurting and disturbing them.”

Carer 4

“There has to be a lot of induction, reassuring kind of thing, uh, session to say you’re not going to say anything bad here that will make us cross with you.”

“Being there for them. Being there to listen helps. Not putting words in their mouths, sitting there taking an interest in what they’re saying. And then within that, they need help within that listening session or whatever. And they might say, oh, I’d like to go to the gym after I’ve been to counselling, and if you do that, you can get the young person to interact.”

Carer 14

Young persons predominantly perceived talking treatment as being ineffective or even as incompatible with moving on. This view might have emerged from the culturally influenced inhibition in talking about one’s private life, especially adverse experiences, and the cultural attitude of secrecy towards mental illness because of the stigma attached. Other factors contributing to this perception may be the unfamiliarity of this modality of treatment and the young persons’ focus on external locus of control (Weiner, 1979), leading to the assumption that every difficulty experienced by them needs to be resolved by external actions.

4.3.1.2. Talking about the past

As discussed in the previous subtheme, most young persons did not find any use in talking about past life events. They reported that this made them even more distressed, especially after the session was over, when memories of adversities resurfaced in their mind. They particularly found it very upsetting to talk about the family they have been separated from at a young age. Carers reiterated this view by adding that the young persons actively resisted remembering past life events, as

they were too painful. When this was attempted by the clinicians, the young persons struggled, and this could even lead to worsening of their distress.

“Uh, that doesn’t helps me, that makes me more hard because, um, the all the time I was talking about the past, so every time I went there reminding me after I went home again, same depression and same problems.” *Young person 1*

“Some of them is talking about your family, ‘coz I don’t want to talk about my family, ‘coz I was, I was young when I left them. When I talk about, I feel really bad, just feel really sad, crying.” *Young person 3*

“It’s like they just don’t want to remember and to get them to go back is too painful, so they don’t want to go there.” *Carer 2*

“..... young people come to Westcotes [child mental health service], have their sessions, come back because they have rehashed the experience, come back and self-harmed.” *Carer 14*

Nevertheless, re-processing traumatic memories has been shown to be necessary in treating mental health problems (Bevin, 1999), even if the young people do not always appreciate the relevance, at least at the outset. In this study, participants wanted to focus on solving the current and future problems instead. Therefore, revisiting their traumatic past was experienced as a waste of time, while they were putting active efforts in forgetting a past that in their opinion could not be turned around.

“I don’t want to waste time on that, so I want to go forwards and look at my future.”

Young person 13

“..... there was a time when I told myself that I have to really think about my future and my present, ‘coz what is gone is gone, you can never bring the past back. So, obviously I was trying to forget my past, obviously so that was really, really hard for me to forget my past.”

Young person 16

This view also, like the previous subtheme, was prevalent regardless of the young persons’ contact with the specialist mental health service. Carers agreed to this notion of disengaging from and forgetting the past as the main coping strategy, in order to enable them to free themselves from the impact of past adversity and to make emotional progress. They believed that the young persons mostly live in the present, without having to think about past traumas and future uncertainties. One carer even suggested suppressing the past as desirable in dealing with traumatic memories.

“They don’t think about future and past, they’re just there in that moment, and it’s really, really difficult to get them to understand that this is something that is going to help you later on in life.”

Carer 15

“..... forgetting for them is their solution to it. Rather than getting underneath what the blockage is.”

Carer 2

“I think his way of dealing with it is to try and cut it all away and not think about it too much, you know.”

Carer 12 (J)

One young person, however, commented that, despite becoming temporarily distressed by discussing their past, it was still useful to explore their past experiences. Although this young person had relatively more contacts with CAMHS, other participants with longer contacts had different view on this issue.

Young person – “Ask him about his life, what he’s been doing and how he came.”

Interviewer – “Okay, trips. But when you’re saying ask them about their life story, I am worried if I ask them about life story they might feel very sad about talking about those stories.”

Young person – “Some of them sad, some of them don’t give a shit.”

Young person 14

Some carers reflected on possible ways of helping young people overcome this obstacle. It was suggested that the involvement of an expert such as a specialist mental health professional, can help them work through difficult past experiences. When young persons struggle with verbally expressing their life stories, indirect ways of communicating their distressing content, for example through creative therapies, should be offered.

“..... they should have some expert to talk to them, you know, ‘coz they open up and talk about the journey. People like CAMHS know how to, you know, sort of talk to them and settle them down, you know. About their experiences and everything.”

Carer 9

“..... he was saying, oh, bad things have happened to me, but I’ll never talk it, I’m not going to CAMHS because I’m never going to talk about it, I’m never going to talk about it. And we were trying to explore with him whether there might other ways like art therapy where he didn’t have to talk about it, but he could just go and express himself.”

Carer 13

Young persons were mostly not keen to revisit their memories of adverse past life events. Their perception was that they should move away from those memories, in order not to be affected by them. This again establishes their construction of locating the problem as well as the solution in the here and now, without linking it with past events.

4.3.1.3. Focusing on current problems

Participants expected and appreciated discussions on current problems rather than the past, as well as practical tips and strategies to address those. They wanted the mental health clinicians to talk about their immigration problems, education, substance misuse, sleep difficulties and other current difficulties, early in the course of their treatment. Carers appeared to agree with this view expressed by the young persons.

“Yeah, talking about the immigration, talking about school or college, talking about smoking..... ”

Young person 9

“..... give them some coping strategies really early on, not sort of four weeks down the line.”

Carer 2

“..... not even talk about what happened but talk about what’s happening to him now, like his sleep problems and some of his symptoms.”

Carer 13

Not all these issues are directly linked to mental health problems. Some rather reflect the young person’s and their carer’s practical concerns relating to their life circumstances that can have a bearing on psychosocial functioning. Carers seemed to take interest in participating in a treatment package that targeted current problems. One carer shared her positive experience of the clinician working on the young person’s current difficulties, whereas another expressed dissatisfaction on not getting enough guidance to deal with the challenges at home.

“And we work quite closely with M (CAMHS clinician) anyway, so she’s regularly updated, especially on F (young person), so she’s got a picture if she does come and see her, just randomly and F (young person) does decide to engage, then at least she’s aware of what to pick up and what to say to her.”

Carer 5

“..... we don’t have a practical, you know, something that I can take away and say right, this is working..... ‘Cos I fear at times I’m just providing you guys with these problems with updates on how A (young person) is doing and not getting very much useful, um, you know, approaches for how to deal with A (young person).”

Carer 7

Young persons and carers seem to be clearly favouring a focus on current problems as part of the psychological intervention. Although the welfare system consists of a number of separate organisations, the participants of this study showed a tendency to blur the boundaries between these agencies and asked for interventions encompassing all aspects of their lives.

Existing therapeutic modalities focus on comprehensive information gathering and assessment, followed by working through significant past issues. This notion was challenged by the unaccompanied refugee minors, for whom suppressing the past trauma was the ideal coping strategy. Instead, they preferred their contact with the clinicians to address their present social and mental health needs.

4.3.2. Activity-based interventions

Some young persons reported that keeping busy by participating in many activities helped improve their mental health. They suggested that any practical task can serve that purpose, and so can extracurricular leisure activities like joining youth groups.

“So, what I mean is you have to apply something or get busy, so those things could result, it could effect, you know, um, mental situation.”

“Yeah, you know, some things like something happened, you know like Army Cadet, gym and done college. Um, something like that, like working with group, doing climbing mountain. Like makes me busy.” Young person 11

Although most of these suggestions fall outside the remit of a mental health service *per se*, these are experienced as directly linked and effective in improving psychological functioning. The social and relational aspects of such activities were particularly valued. People with similar interests may be encouraged to interact by engaging in common activities. This results in spending time together and developing long-term bonds that can sustain positive changes.

“Sometimes you are, (and) your friend is, and (you develop) a relationship, that’s why (when) you are (having) discussion with them, play with them, you, that’s why little by little you change.” Young person 6

“I think just having that, and then they were both interested in football, not in football, boxing, boxing. So they were doing that.” Carer 1

Interestingly, the acknowledgement of activity as therapeutic was mostly made by young persons with relatively more contacts with the specialist mental health service. It is, however, difficult to arrive at a definitive interpretation of this finding. Different kinds of activities were often formally prescribed by mental health professionals as part of the treatment. This was perceived by some as effective, often just because

these were advised by the specialist, rather than the inherent quality of the activity itself.

“I have heard that relaxation, you know, they could help and stuff, but I’ve not had the real experience of it, which I had from here.” Young person 10

“..... do something, or go out for a walk or something. I think on one of them, one of the things, one of the interpreters was actually saying, oh, there’s football on, something was happening at a centre or something like that, and she sort of interceded and that was actually written up as an advice.”

Carer 2

Activities were also suggested as an aid to make the intervention more interesting for the young persons, thereby aiming to improve their engagement in the process. One of the carers reflected that, as the young persons mostly did not prefer prolonged talking sessions, having activities interspersed with ‘talking’ could keep them engaged in the therapy for longer. She also suggested attending social activities with the professionals in order to remain interested and to engage better at a personal level.

“And the sessions are just talking all the time, and she finds that she can’t cope. Just talking constantly, you know, so I suppose from a teenage point of view, if they did something like an activity along with a session, I think they would find that interesting and be engaged a bit more.” Carer 5

“Or, you know, like (if) they do different things, different activities like you know, boot camps and cinema nights, and I don’t know, various activities as well as the sessions, um, you know, as part of treatment, but you’re also having other things with that, make it interesting, not so boring.” Carer 5

Some participants did not find the activity-based interventions useful, either because they were not innovative, or because these were not tailored to individual needs. One carer shared his experience of being advised to do exercises that they had already been practicing at home, while another recalled a young person reporting the play used in therapy as unsuitable for his age.

“I think because the things, the exercises he has done; yeah, he has learned new things, I’m not saying, but those things we were doing already at home. And we were doing those things even a year before, so he hasn’t done anything new.” Carer 10

“..... one day he came back and he came back really quickly and he said, oh, you know, he’s not going back. And, uh, I think that was also the understanding of, you know, sort of, I think he said something about not being a baby, sort of like some of the therapies, like the play therapies or the picture therapies.” Carer 1

Activity-based interventions were clearly more accepted by the young persons as well as the carers, as compared to traditional talking therapies. These were perceived to be acting in different ways. The modes by which they worked, as

understood by the participants were, distraction by keeping them busy, facilitating an environment for social interaction and integration, power of suggestion by the 'expert' professional, evoking interest in therapy, and facilitating clinical engagement.

4.3.3. Medication

As compared to talking therapy, medication in general seemed to generate more positive views as a potential type of treatment. A number of young persons welcomed the notion of medication, predominantly in helping them to feel better and to lift their low mood. It was acknowledged that medicine could improve their functioning, by helping them carry out their expected social activities better.

“..... giving me some medicines to keep my low up, so that was a bit helping me, so when I took the medication and that, that was a bit, I was up sometime while one week I went to Campus with my mum, with my foster mum, I took my tablet and I see that time between if you take tablet and if you didn't take tablet how much is affecting you.”

Young person 1

“That medicine I was taking, it was a anti-depressious, so I was keeping my mood up, so quite was that bit helping me when I was feeling down.”

Young person 1

“..... if you give me tablet I might get better, that's why I want to see P (CAMHS doctor).”

Young person 7

“..... he believes that if he gets pain killers, he feels better.”

Carer 7

These views seem to be linked with the young persons' beliefs of the doctor's primary role in prescribing medication. The basis of these beliefs may be the young persons' experience of doctors pharmacologically treating only physical ailments and the relative absence of a mental health care infrastructure in their country of origin. There was also a perception of medicines helping to stop thinking, or forget difficult past memories and present worries. This, one young person assumed, was achieved through some action on the brain.

“..... the medicines, just probably helps my brains or helps my body to don't think about that.”

Young person 1

“..... just give me tablet too, make me calm down..... give me one kind of tablet that make me forget everything.”

Young person 14

All of the young persons who expressed interest in continuing to be prescribed medication had longer contacts with the mental health service. This could reflect the serious nature of their presentations requiring medication, rather than contacts with CAMHS influencing their views on mental health interventions. Some young persons, however, did not want medication. Their predominantly negative view of medication ranged from adversely affecting the body and making one disabled, to not getting to the root cause of the difficulties, thus being an ineffective remedy. These young persons, interestingly, mostly had relatively less contacts with the mental health service. The young persons who have been recently exposed to the mental health service may be apprehensive about taking medication for what had been described to them as 'mental illness'.

“..... my mum told me if you take medication all the time, all the time, make you sad, make your body, uh, what’s called, like that (disable).”

Young person 8

“They said to me take sleep tablet but, you know, the sleep tablet is not going to help you, is going to kill you, it’s no good for you. I want something to make me better, a tablet, it doesn’t make you better.”

Young person 13

The idea of prescribing medication for emotional difficulties was mostly welcomed by the young persons. However, there seemed to be a sense of using it to block out painful reality and intrusive memories. This is probably compatible with the young person’s afore mentioned preference for quick relief or solution to external problems, rather than engaging in long-term psychological therapies. The young person’s cultural construct of a doctor prescribing medicines for mainly physical conditions is also worth taking into consideration.

4.3.4. Hospitalization

Participants’ views on psychiatric hospitalization in this research was based on the response from the only young person who was admitted to a secure in-patient unit, and his carer. This young person clearly held a negative view of hospitalization from his individual experience. He stated that it is unlikely to improve by staying in a psychiatric hospital for long periods of time. He reported mostly feeling distressed and entrapped, and longed for having a normal life with a family, job and home.

“..... if stay (in) hospital, you coming back, you coming, you coming back and you never get better.”

Young person 8

“I’m a behaving (properly) all the seven month and nobody giving me leave.”

Young person 8

“You feel sad all the time for house and what (else) do you feel? This is prison.”

Young person 8

Others talked about their perceptions of psychiatric hospitalization as a third person, and shared negative views that were predominantly coloured by descriptions of psychiatric asylums in their countries of origin. The carer’s views resonated to a degree the young person’s experience. He also questioned the validity and utility of long-term in-patient treatment, and agreed with the young person’s notion of importance of hope, a prospect of or move towards living a normal life, in the form of increasing leave and independence.

“Social Care was left holding the baby, but he was left institutionalized, and I know he wasn’t going to get discharged from the Section.”

Carer 8

“I’m not disagreeing with the Section, because he’s doesn’t have a lot of insight. What I’m saying is that he needs to have some form of leave, he needs to get out. Psychologically getting out of that hospital just to go to the shop down the road, is beneficial for their mental health.”

Carer 8

It is difficult to draw any conclusions on the general perception of unaccompanied minors on hospitalization from the view of one pair of respondents. These responses, however, indicate that there is tendency of perceiving in-patient treatment, particularly involuntary, as obstructive to progress and persecutory; perhaps in parallel with the young persons' previous experience of being detained, incarcerated and possibly tortured.

In this theme, the participants' perceptions of psychological, activity-based, pharmacological and hospital treatment were presented. The general impression appears to be of young persons seeking a brief, practical, hands-on and prompt resolution of their difficulties, while avoiding revisiting the traumatic experiences of the past. The next theme addresses the participants' experiences of mental health care systems both in their country of origin and in the UK. This highlights their perceived strengths and gaps in these systems, leading to the subsequent theme on suggestions for service improvement.

4.4. THEME 4: PERCEPTIONS OF SERVICES

Young persons' perceptions of mental health services influence how effectively they engage, eventually impacting on their outcome. This theme covers young persons' and carers' perceptions of services in different socio-cultural systems, and their familiarity with those. Participants' experiences of services in both countries (of origin and host), and the contrast between them can formulate the understanding of their views and choices, which in turn can make the existing systems more compatible to the specific needs of this population.

4.4.1. Experience of mental health care systems in the country of origin

As reported by the young persons, doctors in their country of origin focus mainly on prescribing tablets, potions or injections. The process of receiving medical attention was described by some as smooth, as there is no need to arrange an appointment or to navigate through the healthcare tiers. Instead, the service user decides who to approach and when. The disadvantage, however, as reflected by the young persons, is that healthcare is available to only those who can afford to purchase that particular service.

“In my country, just doctor going to put your hand there like this..... and say I feel sick, they give you tablet or something and so go, take these two time a day in morning and evening. Then drink that thing, that’s it. And there is different. Here, have to book appointment first, then go there. There go straight away, just give money, that’s it.”

Young person 4

“..... there is no doctor, they have doctors, one doctor sit here give you medicine when you got there, you say to the doctor I have a headache, and then they can check you and (you) go buy that medicine.”

Young person 9

Financial affordability was reported as an important factor in availing the medical facility. Without money, even basic health needs were perceived to be difficult to meet. Healthcare was described as generally expensive, despite the level of skill of most professionals not being very advanced. The best services were, however, available to who could afford them.

“..... they’re not like European doctors. They just learn only a few things, they keep injecting you..... they injection you and they take from you lots of money.”

Young person 2

“But there’s one thing is good about Afghanistan is the service is good if you’ve got the money, everything will go through, you know, straight away.”

Young person 12

“You give money to doctor is help, you know, you can’t give money, doctor no help man.”

Young person 15

An absence or underdevelopment of mental health care services in the countries of origin was described by most young people. As an alternative to psychiatric services, people visit imams or holy shrines. Sometimes family members look after people suffering from mental illness, but often they can be abandoned on the streets, leading to a downward drift in their social and personal functioning. The life expectancy of these people with mental illness can thus be significantly reduced, as expressed by one young person.

“Probably in Afghanistan they don’t have that much, um, doctors or that much medicine to helps the mental people out, because that’s why they’re in the street..... That’s why they getting more worse and worse until the day they die.”

Young person 1

Interviewer – “And when you say I’m feeling upset and I’m feeling worried, I’m not, you know, I’m feeling down.”

Young person – “No, no, it’s, you have to go to Imam, innit.”

Young person 4

Interviewer – “What happens to people who have mental health problems in Afghanistan?”

Young person – “I don’t know, it’s going like crazy, brothers look after them.”

Young person 15

“..... people who are like mentally ill, they go to the shrines, holy shrines. And shrines do help, because it’s their belief, you know, it’s a psychological thing.”

Young person 16

A total lack of mental health services for young people was also described by the participants. Although absence of infrastructure was apparent on the surface, as mentally ill patients “go to the shrines”, “brothers look after them” and “they get more worse and worse until the day they die”, economic reasons were once again depicted as the main factor responsible for this gap. In the young persons’ countries of origin there are other pressing needs that people have to prioritize to pay for. As parents are not ready to pay for child and adolescent mental health services, and in the absence of a public sector infrastructure, no professionals can be employed to offer this type of intervention. The alternative, therefore, is for parents to look after, to the best of their abilities, children and young people with mental health needs.

“No CAMHS there, there is a hospital if he, there is a, you know, some people trust that, some people not trust that.”

Young person 9

“We don’t have, it’s all the family you can talk to, ‘coz of mum, dad and things. We don’t have CAMHS. Because the CAMHS, if they had a CAMHS, there’s nobody, you know, paying them, so they don’t have it. It’s like hospital, the doctors are there because you have to pay doctors, the government don’t pay. See in England, the government pay.”

Young person 12

“So, people, I don’t think they would like to spend money that much on these kind of things (CAMHS), ‘coz people have got other problems.”

Young person 10

Mental health services as a whole, and particularly those for young people, are not well developed in the countries of origin of the participants. Economic constraints and lack of a robust healthcare infrastructure appears to be the main underpinning reasons. However, there seems to be a difference in the perceptions of mental illness and treatment also at a cultural level. This difference may have reflected in the young person’s expectations and priorities.

4.4.2. Understanding of the UK mental health care system

As a result of this lack of prior exposure to an organized mental health care system, participants did not seem to have a clear understanding of mental health services. This lack of awareness ranged from not having any knowledge of services to possessing some vague ideas that this was to do with helping children, by

prescribing medicine or talking to them. Because they were not clear of their purpose and function, this may have led to feeling suspicious about inter-professional links, and whether their sensitive personal information will remain confidential or be shared with other professionals.

“I don’t know how to come in, the other day who’s working with who I don’t know.”

Young person 8

“I went there and I had no idea, you know, what it was all about.”

Young person 12

“Yeah. Yeah, my mum kind of told me, you know, they’re going to talk about with you about the tablets and stuff but I didn’t know, if it was, I didn’t know at that time, is that to do, like a treatment like a hospital or to talk to you about the problems, why did I take it.”

Young person 12

“Yeah, I think the two things, he didn’t know how it would help him and he didn’t know that that information would be confidential, that it would not be shared with anybody.”

Carer 13

Being introduced to a novel and complex system without much awareness of the purpose, process or function of these contacts may have made the young persons predominantly avoidant and guarded about accessing and engaging with services. Some young persons seemed to lack an accurate understanding of how the system

works, as they conveyed some incorrect information, for example that everyone who comes for help is taken to a hospital; that social workers regularly address the young person's emotional needs; or by mistaking a psychiatrist for a doctor for physical health problems.

“I say, no, I don't want to go hospital to be with the mentals or that kind of people.” *Young person 1*

“In this country, they got to take you to hospital, check your everything. In my country, just doctor going to put your hand there like this.” *Young person 4*

“I don't know when I was upset. Here going to see my social worker, talk to me, that's it. I go talk to him, got this problem, upset thinking about something, he will meet you.” *Young person 4*

Interviewer – “You said P (CAMHS doctor) is helping you a lot, what is he helping you with?”

Interpreter – “He's been helping his eyes, he's been helping his teeth.”

Young person 7

Their understanding of the mental health care system did not seem to improve with longer contact with the service, as young persons with both more (young persons 1 and 7) and less (young persons 12 and 4) contacts with CAMHS almost equally demonstrated their difficulty in grasping the complex nature of how the system

operated. Some participants, however, described the reasons behind their lack of understanding of the system. Here again the young persons and their carers reiterated the idea of not being well informed of the nature and purpose of the service. After their arrival in a new country, it takes time and guidance for the young persons to become familiar with the new system. In the absence of such support and education about the different agencies, disciplines and professionals and their functions, young persons can remain confused or even suspicious of a complex system.

“I didn’t know what’s going to happen, what is this all about, I didn’t know them..... So I was thinking, I don’t know, ‘coz everybody the same thing people asking. So I was scared to tell them.” *Young person 13*

“Yeah, when we come here first time, we don’t know about anything, how to live in United Kingdom..... somebody coming for CAMHS they, maybe they don’t know about the CAMHS, you have to translate to him.” *Young person 9*

“The psychologist and M (CAMHS clinician). And then we had his social worker..... the Connexion worker I think, and the translator. So, it was like a multi-agency meeting to assess him..... he was very suspicious. He thought this was maybe like a police investigation.” *Carer 4*

“It’s quite hard for us to when we want to make a referral to explain to them what CAMHS does, in terms that with their limited English they’d be able to make sense of.”

Carer 13

This lack of preparation and psycho-education, especially against a backdrop of experiences of persecution by authority figures in the country of origin and during migration is likely to enhance suspicion, guardedness, withdrawal and eventual disengagement. Some participants, however, reflected that the understanding of the mental health service improved with time, especially after being briefed about the nature of interventions by carers or other professionals. This better understanding did not depend on the number of contacts either, but rather on the explanation offered to them about the nature of the mental health service. These explanations seemed to be helpful in clearing misconceptions about mental health services, if any, instead introducing more accurate and realistic expectations.

“After some time, as now, you know, like I know about everything. Before I don’t know about everything, now I know about it.”

Young person 9

“I didn’t know actually first time and A (foster mum), I think she explained for me, yeah I think, uh, she told me that’s it’s help for young people and about everything.”

Young person 11

“..... he was getting a picture of, you know, what it is, you know, that he’s not seriously being treated like a mad person or something.”

Carer 9

Young persons who had developed such awareness, elaborated on their understanding of CAMHS (Child and Adolescent Mental Health Service), and what this involved. These young persons did not necessarily have more contacts with the service. They described it as a service for young persons with difficulties with their feelings, thoughts and mental health, and which helps optimize their emotional and mental wellbeing. They elaborated on the available types of interventions such as talking therapy and medication, which were offered to whoever needed them for the above mentioned problems. It was clear that, after acquiring reasonable awareness of the service, young persons were more forthcoming in help-seeking and engagement.

“..... go (to) doctor when you’re feeling no good, sick or flu, or you know. You’re going to doctor, they can give you medicine. But that CAMHS, if you have a thinking about problem or something like that, maybe you have to go to CAMHS.”

Young person 9

“I knew that obviously, and it’s called Westcotes, and they give you a talking therapy and they will help you. I think there’s the prescribing as well.”

Young person 16

“She (foster carer) told me about Westcotes, she goes to me, I will take you to a place where they are going to talk to you..... help you towards your sleeping, towards your relaxation, towards your mental illnesses. And I was really happy to go, because I needed somewhere to go so that I can get my life back.”

Young person 16

Once they became involved in the therapeutic process, their relationship with the clinicians improved. Previous research with other groups of children and adolescents has shown that building a positive relationship may be the key to increasing motivation for therapy, retention in treatment, engagement in tasks, protection against premature attrition, and better outcomes (Kendall et al., 2009). Among this sample, such relationships probably helped to break the negative cycle of lack of understanding, mistrust and disengagement; instead facilitated engagement and perceived benefits. One young person reported that certain treatments like relaxation therapy could only be practiced with professionals' active involvement.

“..... it was like, oh, that was different to what I thought, um, and I was, you know, it was good. I felt that, that, you know, I felt that there are some people that could listen to you, could help you. So, you know, I felt a bit good about it, so, yeah.”

Young person 12

“The relationship between him and A (CAMHS doctor) got better when he understood. At first he didn't know what this therapy was.”

Carer 3

“Like before I heard all the relaxation, the meditation, these things could help you. But I didn't see the real experience. But when I come (to CAMHS) I started to do things, encourage me to do more and I get well and do things, I have improved a lot.”

Young person 10

Participants finally suggested possible ways of increasing young person's service awareness before engaging in treatment. There seems to be a perceived need for

written information about the service, which should be sent prior to the first appointment. A period of detailed induction to all the young persons, or at least those who are not already well aware of the mental health service, can also improve engagement. This can further enhance their understanding of treatment options. However, the young person's cultural context should be taken into consideration while offering this explanation.

“..... it would be good if someone tells you about it, then you think, okay, they might listen to me, help me and give me better advice, which is good, yeah.”

Young person 12

“You should write on a board outside what is this about and write the name, and you have to show that person card and show them, send the letter where you need to write about more information. They will take interest and they will come to you.”

Young person 13

“I think there needs to be a period of induction where young people, let's just not assume they know. So maybe a simple, user-friendly questionnaire asking them what counselling is, how they think it could help them.”

Carer 3

“To do some work on explanation of what it is and how it can help within a cultural context, so communities understand.....”

Carer 13

Limited knowledge of the service was a major factor raised as a reason for non-engagement with treatment. This may result in using pre-existing ideas of mental

illness and treatment, discussed in earlier sections, to frame the information gaps. Not understanding the system can lead to young people feeling suspicious of professionals, thus compromising the therapeutic relationship. A solution suggested by participants is to support the young person through a comprehensive but sensitive process of education, awareness and engagement before initiating the treatment process.

4.4.3. Experiences of using mental health services in the UK

Participants had both positive and negative views of contacts with the mental health care system in the UK. One young person reflected that he benefitted from the real experience of applying interventions in his life, which was more effective than only gaining a theoretical understanding. Another young person appreciated the principles of free healthcare for all, sincere adherence to regulations and guidelines, and the quality of medical professionals, including mental health service staff.

“Uh, you know, I expected that they might give me some different information, but it was the same information, the same sorts. But they have given me different, uh, way, like I couldn’t have the real experience and they gave me the real experience of it.”

Young person 10

“..... in England you don’t pay (for treatment) but you have to..... obey the rules and do the things what they say, you can’t do anything about it. But health, you know, is a lot better here ‘coz, you know, it’s a better environment, better stuff, you know treatment is better as well. So, better doctors.”

Young person 12

Young person 10 had 11 contacts with CAMHS and was also the only participant to be interviewed jointly with their carer. Young person 12, on the other hand, had only attended three appointments. The response of young person 10 might have been influenced by his intention to provide more socially desirable responses in front of their carer. Some carers resonated the young persons' positive experiences. They reported that, once engaged, CAMHS acted as an additional source of support and confidence. This facilitated the further improvement of personal, social and educational functioning. It was argued that any factitious presentation of mental illness for external incentives should be challenged, as CAMHS is a specialized resource to help young persons with genuine mental health difficulties, which is too precious to waste.

“I think, since he’s been going along to CAMHS and since we’ve been sort of trying to reinforce one or two points to support it, he’s gone down a much more positive path.”

Carer 11(S)

“I think it was just after one or two sessions he got the confidence that, yes, there is someone other than me, right, who he can talk to and trust in. And I think, once everything started coming out, it helped him. It really helped him to get all his sleep, he started his education. You know, you see him now and I think that CAMHS helped him, they really helped him to where he is now.”

Carer 16

***“I don’t think there’s nothing wrong with challenging it (false presentation).....
CAMHS is a valuable service, and you know, getting a referral here and getting
an urgent appointment is quite difficult, so it’s a resource.”*** Carer 8

Participants talked candidly about their negative experiences of mental health services. This view, similarly, did not depend on the number of young persons’ contacts with the specialist mental health service. One issue highlighted by more than one interviewee was the lack of information and explanation. This seems to lie at the heart of dissatisfaction of many young persons, who had been offered a treatment without much prior preparation or debriefing afterwards.

“I’ve been facing this problem five years now, haven’t sorted it out, haven’t told me what’s the problems, and they just keep saying me there’s just anti-depression or something I’m not sure.” Young person 1

“Nobody explained to me, nobody come to me, social worker no come visit to me, nobody explain what’s happened to me in my life.” Young person 8

When sought by the young persons, the much required input from specialist professionals seemed to be driven at times by the availability of resources rather than the young persons’ needs. It was suggested that enough resources and clinician time should be available for this service to work optimally.

“When I’m, I don’t have problem then everyone is coming, yeah, you find everything is good..... Now, yeah, then when I got problem they don’t bother.”

Young person 4

“I don’t think it’s working very well at all. I think a lot of times, it’s time, time’s a big issue and a lot of time needs to be spent on these young people when they are engaged, when they do want to engage and then they’re told, oh well, you have to wait for a bit, you have to wait this long, you have to wait that long.”

Carer 15

Participants summarized both their positive and negative experiences of service input. What made a difference appeared to be the young person’s understanding and expectations of the service and the available interventions. This initial phase has significant resource implications, which become even more pertinent in the current economic climate.

The existing health structures, especially mental health care, in young people’s countries of origin were very different from the host country. This difference, in combination with the young persons’ lack of exposure to mental health care in the UK, may explain their initial worries and reluctance to engage with the service. Such interpretations reinforce the importance of clarifying, explaining and educating them about the systems, services and types of treatment. The next theme will focus on participants’ views on ways of improving existing services in order to make them compatible to their needs.

4.5. THEME 5: HOW TO IMPROVE SERVICES

Participants' suggestions on possible ways of facilitating the young persons' engagement have already been discussed. In this theme, their specific views on improving the service provision will be presented. Firstly, the respondents' suggestions on improving the service by applying different strategies to engage the young persons; and, secondly, the different aspects of establishing effective connections with other agencies.

4.5.1. Engaging with the young persons

The participants' views on facilitating engagement are presented as three sub-themes of strategies. These are, building trust with the young person, engaging in shared activities, and being flexible about the contacts between the young person and their clinician. These strategies were, nevertheless, mostly suggested by the carers, rather than the young persons themselves.

4.5.1.1. Trust building

Befriending the young person by the clinician was described as a useful tool to establish trust, and consequently successfully engage them in treatment. The opportunity to befriend, can present itself at any time, either in clinical or non clinical environments. These opportunities, if availed to their full potential, can go a long way towards establishing the foundation for an effective therapeutic alliance.

“Yeah, but after some time when I talked to them, like friends or something, here is.” *Young person 9*

“..... they had a little chat, just a friendly chat over Christmas dinner. Uh, and that got her back into engaging with M (CAMHS clinician) again.” Carer 5

Carers suggested that clinicians should make an effort to get to know the young persons better, which seems like the next obvious step in the process of befriending. Getting to know the young persons and taking interest in their life story was indicated by one carer as an important component or pre-requisite for the young person’s active engagement in the treatment process.

“The doctor knew exactly what he was doing and, you know, what kind of, uh, you know how to talk around with him and get to know him better.” Carer 9

“..... getting to know the young person, knowing more about their background, and you know, so yeah, you can do a lot of stuff like that before the engagement starts, can’t you really?” Carer 15

Another way of building trust, as described by one of the carers, is by meeting the young persons in their own comfort zone, where they feel safer, like their play-area, and joining in their activities. The interactions during those activities can range from talking on neutral topics to more clinically relevant issues, depending on the comfort level of the young person as well as the clinician.

“Yes, so M (CAMHS clinician) is fantastic like that. You know, meeting them where they play, and she just joins in and play, you know, like pool with them.”

And so, A (young person) how you feeling today, or how's it been at College and stuff like that.”

Carer 4

As described in the first section of this chapter, the prevalent lack of trust in the treating clinicians significantly impedes therapeutic engagement, and therefore, the treatment outcome. It seems like a natural inference of that finding, that establishing trust should be considered as an effective remedy of this predicament. The strategies suggested by the participants here appear to be the tools in achieving this remedy.

4.5.1.2. Shared activities

Although clinicians' participation in shared activities has already been discussed in a different context, this is also presented separately as a sub-theme, to enumerate the engagement strategies. One carer suggested dividing the contact between the young person and the clinician mainly into two phases. In the first phase the clinician should focus on non-clinical “fun activities” in order to get to know the young person better and to make them feel more comfortable in their interactions. In the second phase, she suggested, the process of therapeutic engagement should build on this groundwork.

“So, um, I think initially, uh, I think fun activities will sort of get to know them better and then sort of start slowly engaging them, then they might, that's my personal view, they might engage well.”

Carer 5

Non-clinical activities by the practitioners were suggested by the carers as a way of successfully engaging the young people in treatment. This, however, will require significant commitment from clinicians to shift their existing pattern of CAMHS-based working. Moreover, the time and cost implication of such shift would be considerable and would have to be balanced against the anticipated benefits.

4.5.1.3. Flexible approach

Carers overwhelmingly spoke in favour of having a flexible, open and informal way of engaging and helping the young people, in a system that is removed from a formal, bureaucratic and clinic-based service. They presented examples of perceivably good and highly effective practice where the clinician met the young person informally in a youth project, months after being formally discharged from the service, as part of what was described as a ‘therapeutic friendship’; and offered support and, if needed, intervention for their emotional and mental health needs.

“M (CAMHS clinician) still sees him in the project, not formally. They just drop in, M (CAMHS clinician) drops in there, you know, sees him and speaks to him. So, they’re friends in a way that, uh, it’s a therapeutic kind of friendship, so he knows this is somebody I could speak to, if I’m worried, so it’s a very good, I call it therapeutic friendship.”

Carer 4

Carers pointed at the resistance faced by clinicians while attempting to engage the young persons in a formal setting with pre-planned appointments. They also emphasized the importance of consistency from the therapist to mitigate their worries

and defensiveness, preferably in a setting that does not remind them of an institution.

“We could go on Melton Road and say, okay let’s go in a coffee bar or something, and she’ll agree. But if you planned it and say, oh, we’ve got this booked, shall we do this, we have to do this, it might not happen.” Carer 5

“..... have one person dealing with it and, like I say, continuity, consistency; they can take them out, away from the establishment, how are you feeling, you know, take them for a coffee after the session.” Carer 14

Outreach work was considered necessary by carers in engaging the young persons more effectively. One carer viewed that the initial contact with the mental health service should take place at the young person’s residence, if required, with the help of an interpreter. This, according to her, can be a more effective way of relieving the young person’s initial anxiety, than expecting them to arrive at an unknown health setting to face a group of strangers for an intense session of what may feel like an extended interrogation.

“I think they were too quick to close the file because he wasn’t prepared to come. We could have looked at outreach work, you know, another option should have been there.” Carer 8

“..... it will really help that someone comes with an interpreter to where they are based and talk to them, that this is what we’ve got, any help we (you) need, we are here to help you, rather than we received a referral; and the first step is you all are strangers to him, he doesn’t know who you are.” *Carer 16*

Outreach work was described as an effective strategy to engage this marginalized, apprehensive and reluctant to engage group. There seems to be a need of being flexible and innovative at least in the initial phase of treatment, as a rigid adherence to a formal clinic-based approach is more likely to result in disengagement. The strategies put forward by the respondents are valuable findings of this research, but also have financial, systemic and personal implications. Nevertheless, if the formal, inflexible system consistently fails to offer a satisfactory treatment outcome, its continuation will be ineffective in terms of resources, thus defeating the very purpose for which the ideas of change were discarded in the first place. How to resolve this paradox depends on careful consideration of the pros and cons of both trajectories, in order to strike the right balance.

4.5.2. Connecting with other agencies and communities

Another area of improvization suggested by the responders related to improving connections between the agencies and with the community. This includes the role of other agencies, working jointly on common agendas, advocating for the young persons in areas other than mental health, and building relationships with the community they belong to. As compared to the subtheme of enhancing the young persons’ engagement, where mostly the carers contributed their views, both carers

and minors equally shared their opinion of how connecting with other agencies and communities can be effective in improvizing the service.

4.5.2.1. Roles of other agencies in relation to the mental health intervention

Young persons mentioned a range of agencies that they received help from. These were viewed as useful in supporting their mental health. They positively viewed the input from Connexions (a Local Authority organization providing information, advice and guidance on training and employment for young people) and acknowledged the role of continuous, education, employment training and youth groups.

“That’s it, if I’m going (to a professional) I need some help, Connexion there.”

Young person 13

“I start to do a job and I did lots of practical and those things helped me. Yeah.”

Young person 10

“..... when I went to cadet and joined college, they makes me happy and was much better.”

Young person 11

The role of having a stable life status, devoid of much uncertainty in mitigating mental health difficulties, was emphasized. The most important milestone to achieve in this direction seems to be the immigration status. This can be both an important cause and solution to mental health problems according to one carer.

“Yeah. If you have a, if you have a, you know like a successful, you have a visa, you have a home, you have a social worker, then everyone respect you. If you have no visa, no home, no college, no school, no job.....”

Young person 9

“I can put a bet on this, even if it’s five thousand pounds, that I don’t have. I can put a bet and borrow even. If you give S (young person) that indefinite leave today, you may take him out of that medication in a year.”

Carer 3

Moreover, participants also shared their views on the importance of accommodation. They argued that a lack of stable home can be detrimental to someone who is already suffering from significant mental health difficulties, and other disruptions. This also leads to an obvious practical complication of mental health care provision having to be shifted with every move they make. The role of the social worker in this regard was acknowledged, but questioned by one young person.

“Put me away in September, seven months before my eighteenth birthday, is not really. Yeah, that’s not a very good idea. Social worker, I don’t think social worker help young people. I don’t think, never ever.”

Young person 11

“..... when you’ve got mental health problems, then things like, you know, change of stability and continuity can perhaps bring some of those back to the forefront.”

Carer 11 (S)

“If they’re moving about into different places, they sometimes come to light as needing support and then are moved and it takes a while , if at all, for that then to be picked and then to be referred in their new areas.” Carer 13

Some carers drew attention towards the challenges faced by all professionals in contact with unaccompanied minors, including the carers themselves. The need for them to receive adequate training in child mental health and related refugee issues in order to develop the capacity to handle complex situations that can be expected routinely while caring for these young persons, was highlighted. There was also a view that these carers may more often need support and counselling for their own mental well-being, due to being exposed to high levels of stress by caring for a traumatized unaccompanied minor who is also suffering from mental health difficulties.

“I think that’s really, that’s crucial for people within the caring fraternity who are exposed to young people or adults with issues like that, to get training.”

Carer 7

“I know they do need counselling, most of the carers do, you know, apply for counselling and stuff like that from the doctors, you know.....” Carer 9

The participants acknowledged the role of other agencies and professionals impacting on the young person’s mental health. Their immigration status and a stable base are considered most important in this regard. The views of the young persons and their carers seem to be consistent on this. This finding is related to the

previous inference of the young persons' perception of their priority of needs, and the observation that without resolving the socio-environmental issues, any attempt to engage in treatment may prove futile.

4.5.2.2. Working on a common agenda with other agencies

It was mostly the carers who suggested that all agencies involved in the care of the young person should work together and preferably make joint decisions. They shared their understanding that, the identification of a young person's holistic needs should be reflected by a comprehensive care plan. This is possible if discussions on future planning take place in joint forums, rather than through minimal communication and fragmented care.

“..... everybody who is working around that young person can say, right, this is what we need, rather than them going somewhere being therapied and coming back, and nobody really knowing what's going on.” Carer 13

“What Westcotes [name of child mental health service] is doing, what Education is doing, what socially the young person is doing, the trouble is meeting that central goal and W (young person)'s crying out for that need to be met.” Carer 14

The role of other agencies working closely with the mental health service was discussed. These include Social Services, schools, immigration and transitional services. Social Services can help by sharing background information they have collected on the young person, so that they are not unnecessarily subjected to

prolonged periods of questioning by mental health professionals. Schools and colleges were seen as a great source of information about the young person's presentation, as they spend a large proportion of their time with teachers and peers. Remaining in contact and working closely with the school was, therefore, suggested as essential in addressing the young person's needs.

“..... you can ask the social worker's permission to use some of their case history of what they've gone through already, so they don't have to repeat it.”

Carer 1

“..... if schools are involved, you've got your teachers, designated teachers, haven't you for children in care so, and that's why I said it would be good if you could be in either the review meetings, or be around so that you can make these connections with these people that are in this young person's life; and then they should be able to contact you and say, you know, he's opening up a little bit more.”

Carer 15

One carer reflected on the apparent lack of understanding by the mental health service of immigration issues. The clinicians may thus fail to understand the actual problem the young person is facing or the real causes of their mental health presentation. It was considered useful for the mental health service to have a regular link and working relationship with the immigration service, which would facilitate a mutual exchange of knowledge and expertise. The gap in the transitional service when the young person turns 18 years was also pointed out, and the need for flexibility to support a smooth handover of care. Frustration was expressed at the

financial gate-keeping leading to rigidity in the system, which was perceived as unhelpful.

“They don’t have a lawyer working for CAMHS who understands all that. And so this fragmentation here is not helping the young person. Neither is it helping the doctor, because a lot of times the doctor may not even know exactly what’s right that will help..... I wish there was a link between this service and the immigration service.”

Carer 03

“Yeah, so if a young person’s very needy, and is coming up to 18 or is suddenly 18, then there should be a flexibility for that worker to continue working with them and then have a managed transition later to, because the NHS, well with services in general, there’s a lot of gate keeping around finances, it’s the same with everything. Well, he’s no longer our responsibility we’re not going to fund him, he needs to go to them, gate’s closed. And that’s not helping.”

Carer 13

Carers also wanted to work more closely with the mental health service. They proposed that, by establishing a trusting relationship between the carers and the clinicians, and by practicing the principles of joint working consistently, they could maximize and reinforce the impact of therapeutic interventions.

“..... maybe we could work together and try and help, so that’s something to be applauded, and if we could get more of that it would help.”

Carer 7

“..... involve more of the carers, get more information and, uh, trust them. Trust them what they’re telling you.”

Carer 10

“..... working together we can get somewhere. It’s a long process. It’s easily said than done, we can speak it we can preach it, it’s actually how do we do it practically.”

Carer 14

In an ideal service, as put forward by the respondents, mental health professionals should work together with social workers, schools, immigration, adult mental health services, and foster or residential carers. For this model of an integrated care to be realized, what seems to need changing is the financial gate-keeping by different agencies, as suggested by one of the respondents, and the culture of agency-centred responses that constraint the potential of a holistic approach towards the young person’s needs.

4.5.2.3. Advocacy to other agencies

Young persons and carers persistently urged that the mental health service should help with the young person’s immigration application. This usually involves writing letters and reports in relation to their asylum claim. One carer asserted that, if the immigration status is impacting directly on a young person’s mental health, it is only rational and economically efficient to help facilitate the application process, rather than continuing with a uni-dimensional approach of mental health care provision.

“..... they (CAMHS) can’t get it (immigration) for me, but they should, should help me.”

Young person 3

“Just to help me with immigration, just to help. That’s it. I’m worrying all about that thing, I told you from the beginning and the end is that thing. That’s the one question and one answer.”

Young person 3

“Now if the one thing that is cracking them is the immigration decision and they’ve been there three years, accessing your service, taking your time you should have been working with other children. If it means giving them that letter to give them peace, I’m still wondering even as a tax payer, are we, is that good value for money, dragging it like that?”

Carer 3

One young person compared the lack of co-operation of the mental health service with the help he received from Connexions in relation to his immigration application. He expressed frustration in that, although Connexions entertained his pledge for a supporting letter, he received no such assistance from the mental health service. A carer on the other hand, suggested that the mental health service should consider employing a professional with experience in immigration law, who can assist the young persons with their applications.

“Connexions as well, they can help with us in these things. Or anything problem, they can write for you letter and these things, they help a lot. But I didn’t get from where you work, I didn’t get anything.”

Young person 13

“..... maybe making these services more helpful to children can include you having a specialist worker for immigration children. Somebody with immigration law background and experience.”

Carer 4

Another aspect perceived as advocating for the young persons was supporting them when there is a disagreement between them and the social worker. This can include issues of suitable accommodation in the context of their age and mental health needs.

“..... tell my social worker, A (young person) is not happy because you social worker tell me every single meeting live independent on September or after eighteen.”

Young person 11

“I think for A (young person) then to have support from his family, from CAMHS, from his reviewing officer is much better for him when he’s going into, I suppose a difference of opinion with his social worker.”

Carer 11 (S)

Helping with the asylum application was strongly recommended by many participants, as they emphasized the importance of a supporting letter, not only to accelerate the legal process, but also to help with the young person’s mental health. There appears to be a clear consistency in the views of the young persons and their carers on this point. Although the decision-making by the immigration service may be completely independent of the influence of the mental health service, and follows a different set of criteria, the very gesture of writing a supporting letter may have

indirect effect by improving engagement with a perceivably helpful group of professionals.

4.5.2.4. Connecting with the community (friends, relatives and ethnic group members)

Many young persons and carers reported that young persons can be influenced by negative perceptions of mental illness and treatment conveyed to them by their friends or other young people from their community. Young persons described being told by their friends that engaging with the mental health service will essentially lead to them having injected with medication and admitted to mental asylums with other 'crazy' people. Carers re-iterated this and raised the likelihood of getting teased for attending or being persuaded not to comply with medication.

“But if my friend tell me they can give you an injection and they send you in the crazy hospital.....”

Young person 9

“Some of my friends gave me when you see people there you know, some crazy people there, all crazy..... before I listen too much to my friend, tell me everything I believe, everything I believe.”

Young person 15

“Obviously he went and spoke to just the wrong people, just other young people (of) his age in the community, in the Afghani community here. And I bet maybe some of them would have had a laugh at him, say call you crazy, they give you medication. He came back and said, medication, I'm not having this, this will make me go crazy, this will.”

Carer 3

There can be a multitude of misconceptions and rumours in the community that can affect the young person's decision-making with regards to engaging with or accepting treatment. These include attributions of treatment ineffectiveness, that personal information should not be disclosed as it can be used against them, and that nobody outside their own tribe ought to be trusted.

“She might share, obviously you would share things with your best friend, wouldn't you, if I've got a best friend, I'd sort of discuss quite a lot of things with my best friend, wouldn't I? And then what they say, their view might affect you and your decision.”

Carer 5

“And my carer said, I (young person) it's not going to help.... so I didn't tell them. I just answer them, I just say I don't know..... someone told me don't tell them anything about you, 'coz they can't do anything. That's why I didn't tell them.”

Young person 13

“I think that's, there's a lot of rumours out in the communities about not trusting people who are not Afghani, or not trusting people who aren't from your particular tribe. That you can't trust them, you can't trust white women.....”

Carer 13

However, young persons and carers also reflected that if a trusted person from the family or community had good understanding and connections with the mental health service, the process of engaging with treatment would become much easier. It thus seems that the anticipatory anxiety can be addressed more effectively, and that the

phase of preparing and educating the young person is relatively smooth if the information is provided by a person of trust. As suggested by respondents, positive connections with members of the community can set example for others, when the young person can feel comfortable with the clinician watching the carer, and subsequently persuade the others to follow. Such strong connections and trust with fellow members of the same or similar communities can be used to the advantage of the young person to help them engage if used appropriately, as one carer speculated.

“She told me about Westcotes [name of child mental health service], she goes to me, I will take you to a place where they are going to talk to you..... And they’re like going to like help you towards your sleeping, towards your relaxation, towards your mental illnesses and I was really happy to go.”

Young person 16

“..... not to big up (boast of) the foster carers, but if I’m here and I’m showing trust to you, that gives them the example. Oh, well, aunty’s fine with this person, then, you know maybe, maybe I can be like that too.”

Carer 15

“I think after him going there he started persuading his other friends as well who needed that.”

Carer 16

“Sometimes all it takes is somebody you trust within your community to say, I went there, it helped me, it’s fine..... The people they trust most are the people from their tribe. Like the Afghan young person will take the word of

another Afghan person even if it's completely wrong, above anybody else. That can be very helpful, and if it's not used properly, very unhelpful, so, yeah."

Carer 13

The importance of involving the community was emphasized by the respondents. Here again, the opinions of the young persons and the carers were consistent with each other. Both sides of this aspect of service provision were reflected upon. Members of the community can both hinder and facilitate the young person's engagement and treatment, depending on their own understanding and experience of the service. This implies the importance of investing in raising the level of awareness of mental health and illness across the whole community.

It appears that an enhanced multilateral relationship between different agencies and communities to address the overall needs of unaccompanied refugee minors is one way of improving their care, as envisaged by the young persons themselves and their carers. In the process of developing a proposal for optimum mental health care provision, as it emerged, one needs to take a holistic view of the problem, consequently of possible solutions. Intervening on any one circumscribed aspect may prove cumbersome to implement and ineffective, because of the potential inter-connections between different needs. The potential for improving the service, therefore, seems to be lying in the initial step of promoting social connections with the young persons and their communities in an open multi-agency environment. This, however, will have to be considered in the context of the current practical financial, structural and cultural constraints.

This chapter presented the participants' perceptions and experiences of mental health interventions and service provision. The findings indicate the importance of engaging the young persons; being mindful of their priorities; considering associated factors that influence engagement and treatment outcome; and involving young people in decisions based on their preferred intervention, experience of the service, and, possible ways of service improvement. In the next chapter, the findings of chapter 3 and 4 will be critically discussed in relation to the research questions, and in the context of the available evidence. The methodological and service implications will also be critically considered, to draw this research to a conclusion.

CHAPTER FIVE

DISCUSSION

In the previous two chapters, unaccompanied minors' and their carers' perceptions of mental illness, different interventions and service provision were discussed. A number of findings were important in answering the research questions. In this concluding chapter, I shall critically discuss these findings in the context of these research questions and the existing literature. The methodological implications of the study design, procedure and ethics will also be considered. The applications of the findings for policy and service development, in the light of the current evidence base, will then be discussed.

5.1. CRITICAL OVERVIEW OF THE FINDINGS

The aims of this research were to explore unaccompanied refugee minors' experiences of mental health services in the UK, the factors contributing to these experiences, and their perceived ways of improving their future provisions. Three research questions were formulated for this purpose. It is, therefore, logical to discuss the main research findings under these three main domains.

5.1.1. What are unaccompanied refugee minors' experiences of specialist mental health services?

Participants shared their experiences of services in different cultural settings, and their exposure and understanding of these different systems. They reported that mental health services for children are almost non-existent in most of their countries of origin. These young persons also seemed to have very limited exposure and knowledge of services and provisions in the UK. They, however, reported both

positive and negative experiences of their recent exposure to mental health services. Chase et al. (2008) argued that, although unaccompanied refugee minors describe both positive and negative experiences of health services, they do not necessarily engage well, emphasizing the need to explain the benefits of treatment to them. The young persons in the present study generally struggled to trust professionals, partly due to their own personal histories with authorities and partly due to the formal manner in which the process of healthcare is run in the current system. Their main concern was the possibility of information being leaked to the Home Office leading to their deportation. Unfortunately, without establishing a trusting therapeutic relationship, it seems less likely for any treatment to succeed or even complete its full course.

Young persons' perceptions of their priority of needs appeared to be an important factor that influenced their experience. Lustig et al. (2004) proposed that, from an ecological perspective, any effective intervention should invoke protective factors and help mitigate risk factors, often requiring interventions at multiple socio-environmental levels. They also described low priority given to mental health, among other overwhelming needs, as one of the main barriers to utilization of mental health services. In the present study, research participants perceived the basic requirements of survival to be a stronger concern than the treatment of their mental health difficulties. They, therefore, emphasized the necessity of these basic needs being met, before the initiation of treatment for mental health problems.

This belief might have influenced their overall experience. The process of mental health assessment was described by most participants as lengthy, tiresome,

repetitive and often stressful. Lustig et al. (2004) stated that a dearth of clinicians who speak the young persons' language can be a barrier to optimum service utilization. Kennedy et al. (1999) reported that an availability of appropriate interpreting services helped the successful completion of the mental health assessment with a large number of refugees. In contrast, Huemer and Vostanis (2010) argued that the presence of interpreters or carers may affect children's ability or willingness to share difficult feelings. This debate was reflected in the findings of this research. The presence of interpreters in the clinical sessions was perceived to facilitate their communication, hence engagement. It was, however, also perceived to restrict communication of complex or sensitive personal information by creating inconvenient commotions in the therapeutic alliance.

Participants' perceptions of the clinician was another emerging sub-theme. Important aspects of that included their expected role, personal and collective attributes, and their gender and race. Young persons clearly acknowledged and appreciated the positive qualities of individuals and groups of mental health professionals. Nevertheless, they seemed to have found it difficult to share their traumatic experiences and emotions, particularly with female clinicians. Thomas (2007) proposed that practitioners from refugee communities can be desirable. The participants' perceptions of ethnicity in therapeutic relationships in the present research appeared to be variable and personalized, and there was no evidence of preference of ethnic matching, mixing or any ethnicity over other.

The existing evidence-base on the efficacy of specific treatment modalities for unaccompanied minors with mental health difficulties is limited (Huemer & Vostanis,

2010; Entholt & Yule, 2006). Participants talked about their experiences of the main types of interventions; i.e. psychological, activity-based, pharmacological and hospitalization. Perceptions of psychological therapies included young persons' views on 'talking' as a treatment, especially the perceived difference between talking about the past and focusing on current problems. Perceptions of talking treatment in this study ranged from being ineffective to even being harmful. Lynch (2001) argued that some of these young people originate from cultures where perceptions of mental illness are markedly different to western constructs. A suggestion of talking therapy for them can be quite meaningless. This, however, does not mean that their distress should not be acknowledged.

Past research has been divided on the benefits and risks of debriefing. Earlier research showed more convincing evidence that debriefing greatly reduced the distress in traumatized children (Stallard & Law, 1993). However, subsequently some authors claimed that psychological debriefing following exposure to adversities is either not effective (Wessely, Rose & Bisson, 2000) or may even be harmful, and actually increase the rate of symptoms and distress (Kenardy, 2000; Mayou, Ehlers & Hobbs, 2000). The young persons of the present study were particularly avoidant of talking about past events, and of revisiting their memories of past adversities. Respondents clearly favoured focusing the intervention on solving current problems than 'talking' or 'about the past'. Overall, young persons perceived a quick and hands on resolution of their present difficulties to be the ideal intervention. Previous qualitative research showed similar findings, where children and young people talked about their main anxieties as linked to present circumstances, their asylum applications, and their loneliness and isolation (Brownlees & Finch, 2010).

Activity-based interventions were favoured over talking treatments. Although there is limited literature on direct activity-based treatments, a number of case series and single case studies reported positive outcomes for other modalities that can be indirectly linked with activity and creativity, like play, art, music therapy, and storytelling (Fazel & Stein, 2002; Miller & Billings, 1994). Participants reported that activities helped them through distraction and suggestion; and facilitated social interaction, therapeutic engagement and social integration. Prescribing of medication was also viewed positively by some young persons. Nevertheless, they mostly sought medication for immediate relief of intrusive memories and difficult feelings. The only hospitalized young person appeared to have perceived this particular aspect of intervention as not only ineffective, but also against his natural progression to lead a normal life.

5.1.2. Which factors are perceived to influence these experiences?

Limited resources and a different conceptual understanding of mental illness, thus lower prioritization, may explain the apparent gap in the child mental health care infrastructure in the young persons' countries of origin. This difference in the perceptions of mental illness and requirement of intervention is likely to have influenced their experience of, and expectations from the mental health service of the host nation. Lack of exposure and limited knowledge of the system also leads to an information gap and, therefore, potential suspiciousness towards the clinicians and other professionals working in a seemingly complex multi-agency environment. This issue of trust can negatively affect the therapeutic relationship leading to a poor treatment outcome.

It is possible that the young persons' understanding of mental illness may have been influenced by their familiarity with the language, culture and health care system in the UK. Palmer (2006) found Somali individuals to be making considerably lower use of mental health services, mainly because of cultural differences in perceptions and discourses on mental illness. In the present research, the majority of the young persons' understanding of mental illness was coloured by their negative views of the construct. The feared consequences of social isolation, abandonment, and eventual downward drift in their social and personal life appeared to explain their reluctance to accept their mental ill health and to engage with the service. Previous researchers repeatedly identified the reluctance of this group to access mental health services and to engage in treatment. Stigma associated with mental illness and treatment in their countries of origin was depicted as a major underlying reason (Griffith & Chan-Kam, 2002; De Anstiss & Ziaian, 2010; Michelson & Sclare, 2009; Lustig et al., 2004). Lustig et al. (2004) also stated that unaccompanied minors' cultural beliefs of mental illness and treatment are limited by the use of western diagnostic symptoms and instruments, and by the complications inherent in the westernized medicalization of what elsewhere may be viewed as religious or social issues. Therefore, traditional western mental health approaches may not be equally effective with unaccompanied minors, who consequently under-utilize mental health services.

In the present study, some young persons preferred to express their difficult emotions to a health professional through physical or somatic symptoms. This might again be a reflection of their understanding of mental illness or the social stigma attached to the construct. In the absence of a western-like definition of mental illness, the young persons may believe that only social issues or physical symptoms

can be resolved, but not mental illness per se. Honwana (2006) commented that the social and cultural notions of physical health, mental health and healing that apply to these children are often very different from the Eurocentric view, and that addressing such culture-specific perceptions may be fundamental in improving their well-being. Palinkas et al. (2003) stated that negotiation between the health beliefs of refugees and those of their host country could be an important step in mitigating this effect.

Exposure to a complex process of service provision without much groundwork on trust building, familiarization and communication was found to affect the young persons' experience. Their initial understanding of the service, and the preparation they received on what to expect from the intervention, appeared to have influenced their overall perceptions of the service. This preparation, however, has significant repercussions on resources, especially in the current challenging economic climate, which will be discussed in the section on practice implications. In the absence of this process, the young persons' pre-existing cultural constructions seemed to have particularly influenced their expectations of and participation in the treatment process.

The gender of the mental health professional appeared to be a lesser but still significant factor that influenced some young persons' engagement in the treatment process. The strong cultural expectation that the female gender should be protected from any exposure to trauma, adversities and harsh realities of life appears to have acted against young persons trusting female therapists with their own painful memories and emotions. The cultural constructs of shame and privacy may have contributed to their difficulties in talking about personal aspects of their lives and in

sharing emotions. These young persons are more likely to attribute both cause of problems and their solutions to factors in the outside world. Therefore a modality of treatment aiming to enhance the internal locus of control can be novel to them (Weiner, 1979).

Melzak (1999) reported that refugee children often need time and help in sharing their stories, which initially emerge as a series of fragments that may be unspeakable and shared non-verbally. The therapist must build a relationship of trust with each young person and hold their experiences for an extended period, before gradually reprocessing them. The young person thus slowly becomes able to take responsibility and ownership of these experiences. Summerfield (2000), however, questioned the extent to which the pain, suffering and difficult experiences of these young persons can be reduced to a matter of mental health and whether painful memories could be worked through therapy.

Rousseau et al. (1998) raised the issue of culturally-based coping strategies used by unaccompanied refugee minors. For young persons in the present study, suppressing the past trauma appeared to operate as a coping mechanism, as they preferred their contact with the clinicians to be more about addressing the current needs. Their reluctance to talk about the 'past' reflects a belief that locates the problem and the solution not only externally, but also in the here and now, and does not link the current problem with past events. This seems contradictory with the principles proposed by psychodynamic psychotherapy frameworks (Fonagy & Target, 2008). Young persons stated that the ideal help should be prompt, and should offer immediate relief and solutions. This possibly helps explain their

reluctance to engage in long-term psychological therapies. Young persons' cultural belief of doctors only prescribing medicines for physical conditions may be another potentially influencing factor. The negative perception of being hospitalized shared by the sole respondent is highly likely to have been influenced by his previous experience of being detained, imprisoned or tortured.

More contacts with the specialist mental health service did not appear to influence the refugee minor's understanding of mental health or mental illness. The only participant to be interviewed along with the carer expressed a relatively more comprehensive understanding of mental illness. It is, however, difficult to draw conclusions on any effect of the carer's presence on the basis of this finding from one participant. Regardless of the degree of contact with CAMHS, young persons feared the consequence of suffering from mental illness leading to denial. The young persons' contacts with CAMHS also did not seem to make any difference in their views of different factors causing, precipitating or maintaining their presentations. The findings of the present study, therefore, are not enough to attribute a comprehensive understanding of mental illness only to a higher number of CAMHS contacts or to being interviewed with their carer.

Although young persons' views of assessment were not influenced by the number of their contacts with the service, those who had less contacts seemed to struggle in trusting professionals. This finding, however, is not conclusive, given the small sample size. Nevertheless, trust formation is likely to be hindered by interviews carried out by unknown professionals from departments that are unfamiliar with minors, without a detailed process of familiarizing. Previous research with other

groups of children and adolescents has shown that building a positive relationship may be the key to increasing motivation for therapy, retention in treatment, engagement in tasks, protection against premature attrition, and better outcomes (Kendall et al., 2009). Young persons with fewer contacts also reported suspicion of the mental health service passing on information to the Home Office. Unfamiliarity of the process, again, may have contributed to this perception, although no opposing view was expressed by the ones with longer contacts. Views on individual attributes of the clinicians, however, did not depend on contacts and lack of familiarity or trust. The negative view of therapy, especially talking about the past, was prevalent regardless of the young persons' contacts with the mental health service. Young persons who wished to remain on medication had more contacts, although this might be a reflection of the serious nature of their presentations rather than service contacts shifting their views. Their understanding of the mental health care system did not seem to improve with more service contacts, as young persons with both more and less contacts shared these difficulties. Explanation and familiarization may be a more important factor in this regard. Young persons' experience of services, similarly, did not depend on the number of their attended appointments.

Carers, in contrast, were more familiar with notions of mental health and mental illness. Moreover, they seemed to have a good understanding of the young persons' beliefs and their possible sources, including their negative views of mental illness and intervention, propensity to avoid talking about, or denying their mental health problems. Carers demonstrated insight into the beliefs, rituals and cultural construction of the young persons they cared for. Young people and their carers' views of the factors causing, precipitating or maintaining the young persons'

difficulties were largely consistent with each other. A number of carers, however, perceived the factors described as secondary gains or external incentives, apparently contributing to maintaining the mental health presentations. This was reported only by the carers, while none of the young persons acknowledged this phenomenon.

The views of the young persons and their carers were similar in suggesting better access to care, pointing out the distress of lengthy assessments, suppressing the past as the young persons' main coping strategy, preference of getting help for their current problems, connecting with other agencies and communities, and receiving help with the asylum application. The suggestions on making the assessment process easier, strategies to facilitate engagement, and need of multi-agency working, nevertheless, came mainly from the carers. They demonstrated sensitivity to the young persons' difficulties with trust, prioritizing their basic needs, disapproval of interpreting service, perceptions of the therapist's gender, reluctance in engaging in therapy, and the possible underlying mechanisms. Many of these issues were not acknowledged by the young persons. Here again, the carers' views overall reflected their insightfulness into the young persons' cultural and personal belief systems.

However, there are other variables and individual life experiences in play, which have the potential to influence these young persons' beliefs and perceptions of mental health care. These young persons' perceptions of mental health and illness, and experiences of the service are, therefore, likely to be influenced by a multitude of factors, human experiences and their social construction, which is difficult to sum up through visible demographic characteristics such as the number of CAMHS

appointments or the presence of their carer. The small sample size in each of these categories in the present study also makes any such finding, even if elicited, difficult to generalize or be reliably conclusive about. A future mixed-methods study with a larger sample size should aim at establishing such associations in more depth.

5.1.3. How could mental health and related services address the needs of this vulnerable group in the future?

It is important to ensure that this vulnerable group of young people are not deprived of treatment. There is, however, a risk of misinterpreting the experiences of these young persons as diagnostic categories of western systems of psychiatric classifications and therapies without paying heed to their narratives of their experiences and wishes within their cultural norms (Majumder et al., 2014). Thomas et al. (2004) argued that we should not be looking at these children through a western, professional, 'goldfish bowl', as it is easy to stereotype them as being 'unwell'. Diagnostic systems that are culturally biased can, however, generate misdiagnoses, thus fail to identify presentations of mental health problems in young people from other cultures, consequently deprive them of much needed treatment (Lustig et al., 2004; Hodes, 2002). A UNICEF report in 2010 identified a lack of appropriately skilled mental health professionals, as a result of which young people's mental health problems may remain unrecognized (Brownlees & Finch, 2010).

Participants echoed this by reporting that mental health and social care professionals may have missed the cultural context contributing to their presentation, thus leading to misdiagnosis of a normal experience as mental illness or vice versa. Training and education for professionals in cultural diversity and culture-specific needs, was

suggested in order to minimize such risk. A previous study reported that it is important for professionals to have an awareness of the relevant risk and protective factors specific to this group (Ehnholt & Yule, 2006). Lynch (2001) suggested that mental health professionals require understanding of different terms such as 'asylum seekers' and 'refugees', have some knowledge of entitlements, be interested in learning about different cultures, and be prepared when necessary to advocate on their patient's behalf.

Participants also proposed that more effort should be made to explain and educate young persons about the mental health care system; and to address any potential biases in the initial phase, even before the actual therapy begins, in order to enhance their awareness and engagement with the service. This is consistent with Thomas et al. (2004), who suggested that health education can play a vital role in improving refugee young peoples' help-seeking and engagement. Inter-agency partnerships can facilitate this process further. Participants also emphasized the need to acquire proficiency in communicating in English before initiating any therapeutic intervention. Huemer and Vostanis (2010) commented that sometimes psychological intervention that requires verbal skills may need to be deferred until their language has improved. This however, needs to be balanced against the urgency of the mental health presentation.

Findings of this research suggest that the young persons preferred to receive help when they perceived the need rather than when this was available. Bean et al. (2006) found that most referrals of refugee young persons to mental health services were not driven by their reported need, but rather by the need and emotional distress

perceived by their guardians. This resulted in almost half of these young persons reporting their needs for mental health care to be unmet. In the present study, service users wanted shorter waiting time; and responsive, flexible and open-ended appointments as and when required. What is being proposed is a user-led service instead of the providers, which would then be guided by population needs to evolve further. There is existing evidence supporting this notion. The University of Colorado Health Sciences Centre and Colorado Refugee Services Program developed a framework to ensure quick access through a single point. Its evaluation demonstrated significantly better engagement in the initial 2.5 years of its establishment (Kennedy et al., 1999).

Surprisingly, however, many young persons also expected to receive a prescriptive treatment from professionals, with them being only passive recipients. These apparently paradoxical findings can possibly be explained by a gradual shift in the young persons' perceptions of being a passive subject, whose fate is decided by others, to a more active member to be able to make decisions and assert their rights. This may happen through a process of education by the supporting professionals, but also by the young persons' self-learning while settling in the new country and familiarizing themselves with its values and systems.

Participants wished the interventions to take place in venues that were comfortable, familiar and non-intimidating. The existing clinic-based system did not conform with this expectation. Locations other than clinics were proposed such as at their home, youth centres or school. Although there has been limited research on the efficacy of such treatment sites for unaccompanied minors, policy has recently focused on

schools as potential venues for mental health interventions. It has been argued that school can be used as a vehicle of universal service provision and prevention, improved access to specialist mental health services, and integration to society (Fazel & Stein, 2002; Kia-Keeting & Ellis, 2007; Lustig et al., 2004; Davies & Webb, 2000; Chiumento et al., 2011). Fazel and Stein (2002) stated that school-based interventions have advantages, especially for those who might have a lingering distrust of authority. There should, however, be more inter-disciplinary clinical practice and research, to develop and evaluate school-based joint education and mental health initiatives for refugee young people (Rousseau & Guzder, 2008).

The findings suggest that the attempts for further service improvement need to be focusing on systems rather than individual clinicians, who were perceived positively by most participants. In relation to system improvisation, emerging sub-themes were engagement strategies, and establishing effective connections with other agencies and communities.

This study found that young persons' engagement can be facilitated by building a trusting relationship, sharing apparently neutral activities and being flexible in therapeutic contacts. Strategies to develop trust, as recognized by the participants, include befriending, making genuine attempts to know the young person, and meeting and interacting with them within their own comfort zones. Initially becoming involved in non-clinical, neutral activities was suggested as an effective mode of engagement. Open, flexible and informal contacts such as outreach work were considered as potentially effective. Harris (2008) showed that refugee young persons who received outreach input prior to enrolment at the clinic were less likely to drop

out of treatment. O'Shea et al. (2000) described a school mental health service, where refugee young persons were referred to an outreach mental health worker, who established contact with them in the school. Therapeutic intervention with young persons in the school environment led to a significant reduction in mental health problems and severity. Implementing strategies of enhancing engagement will, however, require a significant shift in clinicians' culture and will have major financial implications, particularly in the current shrinking phase of the NHS and the public sector as a whole.

Strategies on connecting with other agencies and the community also emerged from the participants' responses. A number of researchers emphasized the importance of multi-agency input in helping this particular group of young people (Huemer et al., 2009; Thomas et al., 2004; Asgary & Segar, 2011). Fazel and Stein (2002) stated that addressing the treatment needs of refugee children does not easily fit with prescribed care packages, and often requires working with different professionals and agencies, thus demanding more time and resources. They argued that a successful service should emphasize the role of cross-cultural teams, who can work in an extended outreach model. Respondents of the present study recommended enhanced participation of other agencies in helping with mental health issues secondary to socio-environmental problems, working jointly with other agencies on presentations that involve multiple domains of the young person's life, acting as advocates to these agencies, and building a positive relationship with their communities.

Previous studies suggested that, even after their arrival at the host country, unaccompanied refugee minors remain vulnerable to subsequent or ongoing traumatic experiences (Sack et al., 1993; Boehnlein et al., 1985; Kinzie et al., 1989). It appears that socio-environmental issues which fall within the remit of other agencies contribute significantly to young person's mental health problems. Any contribution by these agencies towards solving these problems can, therefore, have a positive impact on their mental health. A number of examples reiterating this point emerged from the participants' responses. Sharing information with Social Services and their School or College was considered as useful in avoiding prolonged and repetitive questioning during assessments. The respondents perceived that socio-environmental issues like immigration status and a stable base were their highest priorities, which needed to be tackled first. This is consistent with previous findings, as more moves between locations during the asylum process were associated with poorer mental health outcome (Nielsen et al., 2008) and feelings of safety were associated with low occurrence of PTSD (Geltman et al., 2005).

The uncertain status of the asylum application has been associated with poor psychological functioning, whereas a quicker resolution of asylum claims has been found to reduce the period of uncertainty and insecurity associated with the process of asylum application, consequently distress (Bodegard, 2005). Huemer and Vostanis (2010) stated that a lengthy asylum process, combined with social isolation, can place these youths at a considerable risk of psychiatric morbidity. Wallin et al. (2005) found that most of their participants expressed satisfaction with their lives after gaining residency status, with only one participant out of eleven still suffering from PTSD. In the present study, participants recommended that the mental health

service should have closer links with, and experience of, immigration services. The importance of supporting the young persons, through letters and reports, was emphasized. Apart from direct assistance, this may also have the indirect potential of improving rapport between the young person and the clinician. This is compatible with Rothe's (2008) suggestion that the role of therapist should involve becoming an advocate for the refugee young person, thus helping them attain control over the forces that threaten their coping capacity.

Lustig et al. (2004) argued that social relations and networks are important factors in mediating the impact of adversities. Communities and families are fundamental partners in the development of mental health programmes for these children, therefore their engagement can help diminish the power differentials and facilitate clients' trust. Collaboration with key stakeholders can enhance cultural appropriateness and break down some of these barriers (Ellis et al., 2011). In the present study, participants reflected on their experience that friends, family and other members of the community can be a strong influence in either facilitating or obstructing their engagement and treatment. This depended on those members' own beliefs, understanding and previous experiences of the service. Therefore, it is important to also raise awareness of mental health and illness in these communities.

5.2. METHODOLOGICAL IMPLICATIONS

In this section, the limitations, strengths and different aspects of methodology, including the study design, procedures and ethical implications, will be critically discussed in the context of the present study and the available literature. Although the main identified limitations will be discussed in the beginning, they will also be

elaborated and reflected upon while considering the individual methodological components in respective sub-sections. The section will be concluded with recommendations on future research directions to utilize and further propagate the findings of this study.

5.2.1. Limitations and challenges

The main methodological limitations and challenges of this research will be enumerated in this part. Some aspects of these limitations will also be discussed in more detail in subsequent sub-sections, thus leading to some inevitable overlap. The researcher's subjectivity may have influenced the interpretation of data, as in any other qualitative analysis. A repeat analysis by a second neutral person was not carried out, which was a limitation of this study. The sample was predominantly consisted of male young unaccompanied refugees from Afghanistan, with a few young persons of other nationalities and one female. The sample was selected from a designated service for looked after children. This setting and its referral pathways may have influenced the selection of participants. This sample was representative of the young refugee population of Leicestershire, but may not represent the demographics of other regions or countries (Jones, 2010; Geltman et al., 2008). The occasional fragmented nature of narratives, together with the need for interpreters, reflects the practical difficulties of obtaining qualitative data, however, overall the participants were able to express themselves in a coherent and meaningful way.

Young persons who suffer from traumatic experiences, may have inconsistencies in recollecting their memories of past traumatic events. 'Avoidance' and 'numbing' symptoms of an underlying post traumatic stress disorder (PTSD), according to

DSM-IV diagnostic criteria, include psychogenic amnesia (Grey et al., 2010). This indicates difficulty in providing detailed accounts of events surrounding the traumatic experiences. It can be challenging to assess the reliability of the young people's account of such events in this context. While reliability was not systematically assessed in this research, it is important to acknowledge the possibility of potential contamination of the findings due to this effect. In the context of the present research, and considering the area on which the research questions primarily focused, one might, however, imply that the interviews mostly concentrated in the area of the young persons' perceptions of their experiences of specialist mental health services. This pertinent issue in the present research may be relatively free from the effect of the refugee young persons' possible inconsistent memory around their past traumatic experiences. Research involving the perceptions of other stakeholders such as teachers, social workers and youth workers can add to the understanding of these issues, and so can other methodologies, including longitudinal, quantitative and mixed method studies on this topic.

Conducting research with unaccompanied refugee minors had some significant ethical implications due to their age, language, cognitive capacity, religion, social and cultural background, absence of parents, traumatic experiences, and mental ill health. All these factors can be important in acquiring a truly informed consent. Young persons' compromised understanding of participation may have persisted even after a thorough process of informing and debriefing. Their perceptions of implicit pressure due to an apparent power differential are difficult to detect and rule out completely. Moreover, participants may have been inhibited, due to being tape recorded or wanting to sound more socially desirable, in sharing their negative

experiences. In turn, this may have resulted in a degree of avoidance in discussing their true perspectives. Despite a robust ethics protocol and careful planning, it was difficult to predict all potential ethical issues that could be encountered.

5.2.2. Study design

In this part, the discussion will mainly focus on the design of the present research. This will include the implications of the framework used to analyze the data, the characteristics of the study sample and the measures used for data collection. All these aspects will be critically examined in the light of the existing literature.

5.2.2.1. Analytical framework

The qualitative method of thematic analysis was the framework of the research. Qualitative methods are mainly concerned with words, descriptions and meanings; dealing mainly with the depth of subjective experiences (Braun & Clarke, 2006). Despite being data-driven, the process of data collection is not structured, which is helpful in exploring what the participants feel and believe, rather than proving or disproving a pre-formed hypothesis (Bryman, 2008b). In keeping with this, the aim of this study was to explore unaccompanied minors' beliefs and experiences in a particular area. However, the issue of subjectivity of the researcher in drawing conclusions from unstructured descriptions is difficult to ignore. The possibility of such bias can be tackled through increased transparency in accepting and embracing subjectivity rather than avoiding it. Transparency in the present research was achieved by clear recording, systematizing and discussing the methods of analysis in detail. The theoretical framework, therefore, matched what the research questions aimed to explore. A quantitative methodology would be more appropriate

in testing the effectiveness of specific interventions or service models, or in establishing predictors of outcomes. A mixed methods approach could help further integrate the data with socio-demographic variables and psychosocial outcomes across different groups. It would, however, be difficult to draw generalizable conclusions from such research if the number of respondents in each of these groups is small.

Thematic analysis is compatible with both essentialist and constructionist epistemological positions. In this research, the essentialist mode of thematic analysis that reports experiences and reality of participants helped in achieving the aim of gaining knowledge of the unaccompanied refugee minors' experiences. The social constructionist mode facilitated the implicit aim of exploring the cultural meanings of these experiences, and how these influenced their perceptions of mental illness, its treatment and services in the host society. Thematic analysis differs from other analytic methods, as most of them are theoretically bound and, therefore, have less freedom of application. Discourse analysis (DA), interpretative phenomenological analysis (IPA) and grounded theory seek to describe patterns across qualitative data (Smith & Osborn, 2003). IPA focuses on a deeper understanding of people's everyday experiences of reality in great detail, whereas grounded theory attempts to generate theory that is based within the data (McLeod, 2001). Because of its inherent theoretical flexibility, thematic analysis can be a useful model of providing a detailed and rich account of data to explore a range of phenomena. Moreover, as thematic analysis does not demand a detailed technical knowledge of the theory, unlike the other models, it can be useful, particularly for those who are at an initial

stage of their qualitative research career. For all these reasons, thematic analysis appears to be the best suited model for this study.

Throughout the process of data analysis, the researcher carried out three levels of coding. At the stage of first order coding, the process was predominantly descriptive, which was combined into categories for subthemes or second order codes. From the first and second order codes, the key themes were identified. When conducting thematic analysis, the researcher needs to avoid being either overly descriptive or interpretative (Braun & Clarke, 2006). In qualitative research, although the principle is to explore the participants' own subjective experience and follow their agenda, the researcher's subjectivity can bias the interpretation of the data (Fine, 2002). It is, therefore, important to ensure that participants' experiences are truly represented in the findings. Steps were taken in the present research to ensure that this did not adhere to the researcher's own agenda. A semi-structured schedule was followed, in order to retain the open and flexible nature of the interviews that were guided by the participants' responses. The interview transcripts were repeatedly referred to, throughout the three levels of coding, in order to ensure loyalty of the themes to the original context (Braun & Clarke, 2006).

Joffe and Yardley (2004) suggested that counter evidence should be taken seriously by not only focusing on those themes or arguments which the researcher believes to be important. This was pursued in the present research. Although more prevalent responses were valued, any response that added something meaningful to the research aims was also acknowledged. The complete analysis was not repeated by an independent second researcher; however, coding was periodically performed and

checked by the two supervisors to achieve a high degree of validity and inter-rater reliability. Despite all these measures, it is also acknowledged by the researcher, in the reflective section, that it is perhaps not possible to completely eliminate any chance of their own subjectivity influencing the interpretation of the data. This possibility is rather embraced and reflected on in the present research, in order to offer enough transparency to allow an open discussion of this notion. The data generated a large amount of transcribed material, which was difficult to analyze through manual exploration of themes. The NVivo qualitative data analyzing software was, therefore, used. NVivo has been described as being capable of speeding up the process, thereby expanding the potential of analyzing qualitative data (Auld et al., 2007). This enabled the researcher to carry out a more robust, systematic and in-depth analysis.

5.2.2.2. Study sample

Although refugee populations are difficult to access, participants should be recruited according to scientific questions of interest, and should not be selected or excluded solely due to convenience (Ellis et al, 2007). In the present study, all unaccompanied refugee minors who received treatment from the designated service during the years 2010 and 2011 were invited to participate. There were 21 in total, out of which 15 young persons finally participated. Although the age range for inclusion was 13 – 18 years, the final age range of the sample was 15 – 18. The final number of carers interviewed was also 15. Establishment of saturation in qualitative research is an increasing point of debate among methodologists, without consensus on its criteria. In contrast with quantitative research, no power calculation is carried out at the planning stage to determine a precise and predetermined sample size required for

the findings to be generalizable. Rather, the number depends on the nature and complexity of the subject being explored. Qualitative methodology thus mainly focuses on the depth and richness of data, and the adequacy of the sample to achieve such richness, rather than the actual size. To ensure that thematic saturation has been reached, data collection should continue until any new themes, patterns or ideas stop emerging (O'Reilly & Parker, 2013; Guest et al., 2006). Recruitment of participants in the present study, therefore, continued until thematic saturation was perceived to have reached. Fifteen young persons and their carers were interviewed in total. This was consistent with the guidelines of Francis et al. (2010), which propose that 12 interviews would cover 97% of all important themes, and three additional interviews can act as 'stopping criterion' to ensure complete saturation. Data was thus collected through semi-structured interviews with 15 young persons and their carers, resulting in a total of 30 interviews by the end of the study. Although new themes stopped emerging in both groups after approximately 12 interviews, data collection continued for three more, to utilize the available sample in order to ascertain a complete- or 'near complete'- saturation.

The sample appears to be skewed as it consisted predominantly of older adolescent boys from Afghanistan. This, however, is representative of the local and regional unaccompanied young refugee population (Jones, 2010). Future research should thus be extended to younger children, female adolescents, and different ethnic groups. Refugees, by their very nature, are a heterogeneous population. Different studies have been carried out with refugee groups of a multitude of different socio-political and cultural circumstances. These include studies with unaccompanied refugee minors from the Balkans living in London (Hodes et al., 2008), Bosnian

refugee children resettled in Massachusetts (Geltman et al., 2000), Bosnian refugee children in Sweden (Goldin et al., 2001), Sudanese refugee minors resettled in the US (Geltman et al., 2005; Geltman et al., 2008; Grant-Knight et al., 2009), Central American and Southeast Asian refugee children resettled in Canada (Rousseau et al., 1996), Cambodian children living in the US (Sack et al., 1993), Somali children re-settled in Uganda (Onyut et al., 2005) and the US (Kia-Keeting & Ellis, 2007), and Cambodian children living in the US (Boehnlein et al., 1985; Kinzie et al., 1989; Sack et al., 1993; Daley, 2005) amongst others. Despite this heterogeneity, a number of underlying common themes and similarities also emerge from these studies such as their situation, vulnerabilities (Reed et al., 2011; Fazel et al., 2012), mental health problems (Fazel & Stein, 2002; Leavey et al., 2004; Derluyn & Broekaert, 2007; Henderson et al., 2010), interventions (Davies & Webb, 2000; Hodes, 2002; Lustig et al., 2004; Entholt & Yule, 2006; Huemer et al., 2009; Huemer & Vostanis, 2010), and perceptions of mental illness and its treatment (Daley, 2005; Chase et al., 2008; Brownlees & Finch, 2010). Therefore, the results of the present study conducted with an apparently skewed sample may be generalizable to other unaccompanied minors' groups to some extent. Nevertheless, there is a clear need for more research in this area with other refugee groups.

5.2.2.3. Interview schedule

A semi-structured interview schedule was developed to explore young persons' experiences, perceptions and beliefs about their contact with mental health services. This particular aspect was difficult, as the researcher did not have previous information on these young persons' lives, therefore, which questions to ask. To address this problem, the interview schedule was less structured in order to create

opportunities for the participants to use their discretion and to direct the interview. Follow-on probes were useful for this purpose to complement the more structured interview guide. The introductory part of the schedule covered neutral topics that helped the researcher put the young persons at ease by building rapport. This helped to set the ground work for a later in-depth discussion of the core issues. The open-ended nature of most questions in the main body of the interview schedule gave participants opportunities to introduce their own narratives. Detailed responses were encouraged by explicit use of pauses, nodding, affirmative sounds, facial expression and body language. The final open enquiry about what else was not discussed so far allowed the participants to raise anything they felt had not been covered, offering another opportunity to explore any unknown dimensions.

Research consultation with participants is vital in pre-empting similar issues (Thomas & Byford, 2003). Pilot interviews included discussing the interview schedule with the young persons and incorporating their ideas. Their suggestions on its content, language and approach were presented at an academic peer group, following which these were integrated in the revised version. These measures helped refine the questions, pitching them at an appropriate level for age, cognitive ability, cultural background and language proficiency. As a result of the pilot interviews, techniques such as summarizing, clarifying, paraphrasing and rephrasing were introduced to enhance young persons' understanding, and some technical words like 'professionals' and 'services' were replaced, as most struggled to fully comprehend them.

5.2.3. Research procedure

Emmel et al. (2007) suggested that it is important to utilize certain strategies to improve the quality of research with vulnerable young people. Being patient, staying calm and recognising that research of this nature would be time consuming, are useful attributes for the researcher. One should not be undertaking a project with this group if there is not sufficient time at the early stages to achieve engagement. Being polite and professional, keeping communication channels open and sending e-mail or postal reminders without being coercive were successfully used throughout the present research. The researcher kept in touch with participants and other stakeholders with regular phone calls, tried to remain friendly with them, and identified a contact person amongst the gatekeepers. Participants were identified by the clinicians, following which the researcher requested individual social workers to contact the young persons and their carers.

Co-operation from all stakeholders is crucial in accessing and conducting research with refugee young persons, and steps should be taken in advance to facilitate this (Munford & Sanders, 2004). Collaboration with Social Services is especially required to help identify the young persons who meet the inclusion criteria and to liaise with foster carers. However, reliance on individual social workers can have its drawbacks, as a particular professional may be un-cooperative due to time constraints or personal beliefs (Heptinstall, 2000). Therefore, care was taken to establish and maintain an effective relationship simultaneously with individual social workers, Social Services departments, refugee organisations, and other service providers and stakeholders.

To make the process easy to understand for the young persons, the information leaflet was written in a simple and clear style. It was possibly still difficult for certain young persons to fully comprehend what it meant to participate in the research. This was addressed by encouraging carers to reassure and explain further before giving consent, with additional help from an interpreter if necessary. It was essential to go through this process with every young person to ensure that there was no perception of coercion or pressure to participate. As the subjects of our study were unaccompanied by definition, and therefore had no one with parental responsibility, block consent was obtained from two Social Services Departments, who acted as their legal guardians. This also facilitated the process, as acquiring consent from individual social workers would have entailed significant delay in accessing participants and potential apprehension from some social workers.

Each of the interviews lasted for up to one hour. The choice of venue was guided by the participant's preference, which could be at a clinic, home or youth project. Although interpreters were provided, whenever needed, only two young persons used an interpreter, whereas the rest opted to talk to the interviewer in English. As there was a possibility that the young persons might have had reservations in sharing their negative experiences with the service, the interviewer explained his neutral position outside the team responsible for treatment. The possibility of tape-recording making the participants self-conscious or causing them to give more socially desirable responses was minimized by reassuring them of the confidentiality of the recorded data and by building an effective rapport prior to the interview.

5.2.4. Ethical implications

Rutter (2003) asserted that researchers investigating matters involving young persons should primarily attempt to capture their voices, rather than those of their service providers or carers. This was carried out in this research, and was complemented by the carers' perspectives. The group of young people, however, raised several ethical implications due to their age, unaccompanied status, cultural differences and mental health difficulties. Issues that are commonly encountered in qualitative research using interviews include perceptions of implicit coercion, participants' anxiety, confusion between research and therapy, and identification of further needs (Richards & Schwartz, 2002). Fisher et al. (2002) suggested that applying a cultural perspective to the evaluation of research risks and benefits, developing and implementing respectful informed consent procedures, constructing confidentiality and disclosure policies sensitive to cultural values, and engaging in community and participant consultation are all essential tasks for researchers.

Young persons need to be assessed for their ability to understand the implications of participating (Balen et al., 2006), and their informed consent should be sought along with the guardian's consent (Taylor, 1998; Heath & Hill, 2002). In the refugee population, however, the issues of culture, language, religion, social norms, educational background and experiences of oppression can make it difficult to truly acquire informed consent (Leaning, 2001). While carrying out research with this population, there also needs to be an understanding of the trust and interpersonal relational context in which data is gathered. Without this, it is not possible to sufficiently ascertain the validity of the data and the conclusions reached (Miller, 2004). In the present study, the researcher attempted to establish a trusting

relationship with the young persons before seeking consent, as suggested by Christensen (2004). For this to be achieved, the researcher had to immerse himself in their milieu, spending considerable time amongst the community. The purpose was to ensure that by the end of the process of obtaining informed consent, young persons had sufficient knowledge of the meaning of participation, confidentiality and purpose of the research, and felt empowered to make a decision on their participation. Even though a robust process of ensuring informed consent should be considered at the planning stage, it remains challenging to predict all potential outcomes in advance (Heath et al., 2007). Unforeseen circumstances were still encountered in the process of conducting the research that required incorporating new solutions.

A particularly difficult area in conducting ethically justified research with this group can be working within legal and cognitive boundaries, whilst maximizing inclusion. Ethical thinking should guide decision-making as a continuous process of tackling principles rather than rules applied to a number of evolving phenomena. It is only through this dialectical process that applied ethics can be constructed (Hoagwood et al., 1996). The refugee minors' capacity to participate was assessed by the researcher, who was also a qualified psychiatrist, in conjunction with the opinion of the named social workers. Although mental state should be considered an important component of their capacity to participate (Claveirole, 2004), young persons with the maturity and ability to consent were not excluded only on the basis of their mental illness. On a few instances the researcher had to identify appropriate clinicians or agencies if their input was required.

Thomas and Byford (2003) stated that confidentiality should be ensured by data protection and anonymization, as these children may be at risk of recrimination and stigmatization. This, however, is overruled by any potential child protection concern or risk to others. In this study anonymity was ensured by using code numbers in place of names or pseudonyms for participants. Names of professionals and other related people were altered to rule out the possibility of participants being indirectly identified. These arrangements were conveyed to the participants before the interviews, which encouraged them to share their experiences without undue anxieties. In this type of research, a power differential in the relationship between the researcher and the participants is likely to exist (Hugman et al., 2011). One way of mitigating this can be through the researcher disclosing his own professional position (Lustig et al., 2004). This technique was used in this study with significant success in establishing trust.

When recruiting refugees, the researchers need to reflect on their own role, and to avoid coercion or come across as patronizing (Hugman et al., 2011). In this study, the researcher assured the participants that declining to participate or withdrawing at any stage would not have negative consequences for their treatment. Despite also working as a clinician for the service, he refrained from any clinical involvement with the participants. Interviewees could opt not to answer any particular question or to withdraw altogether at any point if they felt uncomfortable. This situation, however, was not encountered during the study, possibly as the interviews were carried out in a sensitive manner to avoid any discomfort. Despite this assumption, the invisible effect of young person's perceptions of pressure and powerless position are difficult

to eradicate. An interpreter was made available in every step of this process, if required, to facilitate communication.

5.2.5. Future research

Future research in this area should employ qualitative, quantitative and mixed methods, and should be conducted in an ethical way. There is no single approach to ensure that research with this group is effective, scientifically sound and ethically valid, as each model has strengths and weaknesses. Following a carefully developed and well thought out protocol is an important safeguard. Future qualitative studies can involve multiple centres with larger and more diverse samples. As already stated, knowledge can be propagated further through quantitative research methods to investigate the effectiveness of specific interventions and service models, and to establish a range of predictors of outcome. Mixed method studies can help contrast the perceptions of refugee minors from different socio-demographic and cultural groups.

5.3. CLINICAL PRACTICE AND SERVICE IMPLICATIONS

The implications of the findings for clinical practice and service development are discussed in this section. These include ways of improving the effectiveness of assessment and treatment, service models and policy implications in the context of these findings and the existing literature.

5.3.1. Assessment and treatment

The findings of the present research suggest that a thorough groundwork of educating, familiarizing and trust building is required prior to a mental health

assessment. This could be initiated through outreach work at the young person's residence, school or youth project. The assessment should not be lengthy, and previous questions, if possible, should be avoided. If the corroboration of information and the subsequent process of assessment can be made less intimidating and more transparent to the young person, this could be the inception of a trusting therapeutic relationship leading to a positive treatment outcome. Problems faced by the young person need to be acknowledged in their entirety, with an overall conceptualization rather than as isolated fragments of the problem. Subsequently, the intervention should have to be holistic too, and should be integral to a multi-agency care plan. Entholt and Yule (2006) proposed such a holistic model of psychological intervention for refugee young persons, albeit without a strong socio-environmental contribution. Interventions for unaccompanied refugee young persons should, however, facilitate their integration to a social system.

The intervention offered should be evidence-based, either in individual or group format provided in school, at centres run by social enterprises like the "Freedom Project" for Leicester City and "Baca Project" for Leicestershire, or mental health outpatient clinics for the more complex presentations. In addition, regular consultation should be offered to agencies involved, i.e. by building a strong interface between universal and specialist services. Regular training on refugee mental health and management can also be arranged for frontline practitioners. Each referral to the specialist service should be assessed using the Payment by Results (PbR) framework accounting for additional complexities because of their unaccompanied refugee status (Department of Health, 2010 and 2012; Wolpert et al., 2013).

Moreover, the potential resource implications of initial groundwork, extra efforts to facilitate engagement, and consultation need to be catered within a payment systems framework, as current commissioning mechanisms, because of their focus on direct contacts, might fail to acknowledge the need for such additional activities for this population. Standard outcome measures like the Strengths and Difficulties Questionnaire (SDQ) (Goodman, 1997), Mood and Feelings Questionnaire (MFQ) (Angold et al., 1995) and Trauma Symptom Checklist for Children (TSCC) (Briere, 1996) should be routinely collected from service users before and after the intervention in order to assimilate evidence of effectiveness in terms of symptom reduction and well-being. Information on costs and user satisfaction should also be collected by child mental health services (NHS Commissioning Board, 2012). Data should be regularly analyzed and fed back to service commissioners and providers.

5.3.2. Service models

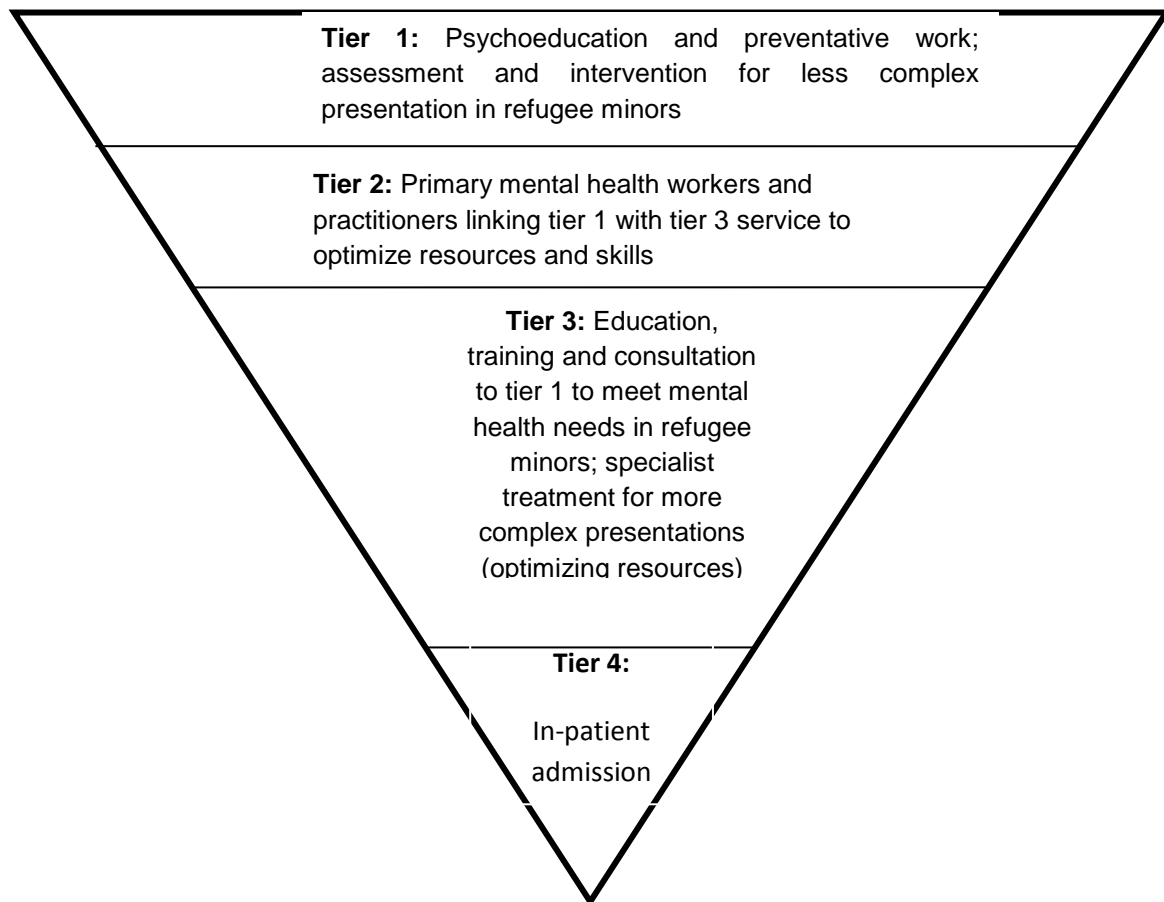
Nadeau and Measham (2005) found that the most salient features that have been found to be linked with the effectiveness of service models for unaccompanied minors were, improving service access, good communication, addressing cultural differences, and collaboration with other professionals. The latter is important between hospital and community staff, at both multi-disciplinary and multi-agency level. All these points were raised by the participants of this study.

In the present research, many participants asserted that intervention or 'help' should cover all aspects of their lives, especially focusing on their current situation. This necessitates breaking artificial barriers created between agencies for administrative convenience, rather than for the users' benefit. Services, therefore, need to adapt

radically to address the needs of this vulnerable group. Participants' reflections point towards a service model fit to view and treat these young persons' predicaments as complex human problems with multiple facets. Professionals from mental health, social care, education, legal systems and charities with the right skill mix and competencies should operate in an enhanced multi-agency environment to provide the 'help' that the young persons and their carers expect to receive. This can be achieved either by creating a multi-agency team specialized in helping refugee young people, or by making strategic changes to multi-agency collaboration, including information sharing, joint working, and appointing link or liaison workers.

There are, however, several obstacles in developing such services. A significant amount of preparation would have to be invested into developing the skill base among existing staff. These include training in therapeutic modalities like Eye Movement Desensitisation Reprocessing (EMDR), trauma-focused CBT, narrative, testimonial, multimodal, group, school-based, attachment-focused, drama, art, storytelling, or play therapy. The service capacity will have to be carefully mapped against a needs analysis so that additional funding can be sought to meet the extra requirements for staff and other resources. Successful implementation will require active staff involvement in implementing changes. Moreover, in the context of the current fiscal climate and commissioning, developing a service requiring a longer duration to meaningfully engage service users would need substantive supporting evidence.

Figure 5.1. Application of four-tier structure of CAMHS in service delivery for refugee minors



Refugee children and young people's access to psychiatric services can be improved by developing a multi-agency and community-based model of service delivery (Majumder, 2014). The four-tier CAMHS framework described in the Methods chapter can be a useful guide in the implementation of the findings of this research in clinical practice. Joint working between universal (tier 1) and specialist (Tier 2/ 3) services to optimize skills and resources through training, consultation and direct clinical work should be planned. A significant component of service provision by specialist services should be offering psychoeducation and training in

transcultural and child mental health to universal services like schools, primary care and social enterprises involved in the care of these young people. The primary objective of this proposed model should be prevention and mental health promotion by means of psychoeducation to young people, carers and other related practitioners.

Specialist professionals based in the tier 2 or 3 service in this proposed service model will thus provide psychoeducation and training sessions for groups or consultation sessions for individuals at tier 1. Regular consultation services can also be offered to schools, social enterprises and primary care for less serious presentations to ensure an effective filtering mechanism at the interface between universal and specialist services. Regular training sessions on refugee mental health and management can be arranged for all universal and primary care services. For more severe mental health presentations, specialist services should be encouraged to develop a skill-base in a multitude of complex therapeutic modalities as described above, which are consistent with the treatment of the prevalent difficulties these young people present with.

5.3.3. Policy implications

Sourander (1998) asserted that the existing dichotomy of social security and mental health care does not guarantee an appropriate level of support for unaccompanied refugee young persons. Asgary and Segar (2011) commented that barriers to the care of unaccompanied refugee minors are inter-related and should be addressed by individual professionals, service providers, policymakers, and regulators through

continuous collaboration between governmental, non-statutory, health, welfare and legal agencies.

Because of the constant changes in immigration and asylum-seeking trends, commissioners and policy makers of welfare, public and mental health services should remain informed of patterns of numbers and characteristics of young refugee people, their impact on existing services, and the extent to which their needs are being met. Service provision should be sustainable and mainstreamed into public funding rather than relying on short-term charity initiatives. At strategic level, planning should include joint commissioning and care pathways with welfare agencies, establishment of multi-agency networks, and development of specific interventions which integrate existing knowledge and emerging evidence with this group. Issues that also need to be taken into consideration include the integration of treatment for mental health problems with other aspects of the care plan; flexibility, cultural appropriateness, and sensitivity of interventions; children's engagement; and assurance of ethical practice. Besides multimodal and culturally sensitive approaches, interventions for unaccompanied minors should take into account that the vulnerability of their age combined with the adverse events they are likely to face, need to outweigh their legal status. Internationally established guidelines and standards should thus comply with the children's right framework (United Nations Convention on the Rights of the Child, 1989).

A UNICEF report recommended that child mental health services and central government should work closely to meet the specific needs of unaccompanied refugee minors with mental health problems (Brownlees & Finch, 2010). It also

proposed that services should be developed in collaboration with professionals who have knowledge and experience of the culture and available interventions in the young person's country of origin, as well as cross-cultural communication skills. Suitable training courses should be developed for General Practitioners and CAMHS professionals to ensure that they are equipped to respond to the needs of unaccompanied minors. Specialist GP services should be developed in each local authority area where unaccompanied minors have been placed, and social or support workers should accompany young people to mental health appointments to maximize engagement and collaboration.

A similar framework of integrated care emerged from respondents' reflections in the present study, where child mental health, welfare, education, immigration, transitional, adult mental health, and fostering agencies should work closely and in an integrated model without bureaucratic boundaries. Policy and thinking need to move away from the current financial gatekeeping, and agency-centred work culture. The practical barriers to achieve such an idealized paradigm however, are difficult to disregard.

Despite the compelling proposals by previous researchers and the findings of the present study, translating these theoretical notions into practice and policy changes in real terms faces significant financial challenges. The decision to implement efficiency savings of between £15-20 billion in the NHS over the period of this parliament term is predictably impacting upon the level of care and services it is able to provide. With increased demand, services are being pressurized to have to deliver far more with less resources. The cost improvement programme achieving savings

of 5% year-after-year will be a really challenging task. Current issues in England such as financial cuts in other services, replacement of Primary Care Trusts' (PCT) commissioning by Clinical Commissioning Groups (CCG), Payment by Results (PbR), and patient-reported outcomes make the implementation of more strategic changes challenging (Majumder, 2012).

One such key challenge is to successfully convey this vision to all stakeholders, agencies, staff and commissioners. In the current NHS climate of efficiency saving, external competition and a constant drive to optimize available resources, any service re-configuration proposing to attract new funding should balance between financial robustness and clinical quality, and this should be informed by research evidence (DH/NHS Finance, Performance and Operations, 2011). Unfortunately, the existing evidence on mental health service provision for unaccompanied refugee young persons is not extensive. The findings of the present study can, nevertheless, be used as a baseline to evaluate new interventions and service indicators.

The changes proposed by these findings will hopefully lead to a significant change in the existing work culture requiring the clinical staff to depart from the practice of clinic-based, formal, one-to-one interventions. This would naturally cause a degree of anxiety that will have to be expected, monitored and contained throughout the period of transition. Although it can be challenging to convince all stakeholders of potential benefits, effective communication, transparency and consistency within and between services can help to achieve this. Involving the public and service users in decision-making can also facilitate the process of change, as well as frontline voices (Heifetz & Linsky, 2002). While implementing these changes, however, we should

remain reflective and aware of the prejudice and preferences within self, others, society and cultures.

5.4. REFLECTIVE SECTION

It is also important to reflect on the researcher's journey through this project. Because of the interactive nature of data collection, researcher's own influence on the research process and findings can be significant. One purpose of the researcher's reflection is to acknowledge and explore this potential impact of his presence. This allows the researcher, by critically looking back at the whole experience, enrich the knowledge of the research process and develop an understanding of what can be done differently in future research.

My knowledge and experience of both qualitative research and mental health issues of refugee young persons were limited at the beginning of this project. At that point, I did not possess any formal knowledge or training on these subjects. However, I was already a qualified psychiatrist, and had developed expertise in clinical interviewing, and competencies on the assessment and treatment of mental health disorders. This gave me the required confidence to feel comfortable in understanding this apparently challenging project. I was, at the same time, aware of the need to develop new skills in qualitative methods and in relation to mental health presentations among the unaccompanied refugee minors.

For several months prior to the data collection, and in parallel with the ethics application process, I initially worked on developing such knowledge through literature searches and background reading around these two subjects. In addition,

completing an online qualitative interviewing course, and carrying out four pilot interviews, helped me practice my interviewing skills. I met with many relevant people (such as Social Services managers, social workers, youth project workers and clinicians), within the mental health service and beyond, prior to commencing interviews, which gave me further understanding of related organizations. These liaisons, outside the narrow scope of this study, also helped me develop my networking and other skills required from a clinical academic. The knowledge base and skills thus acquired, helped me to construct the interview schedule, begin the interviewing process with a certain degree of confidence in my awareness of the subject, and perform a detailed and well informed data analysis. The ongoing experiential development and learning on several other aspects of qualitative interviewing and unaccompanied refugee minors continued throughout the data collection phase, and was reinforced by more detailed study of the literature and discussion with the supervisor.

Because of the very nature of this group and their reluctance to engage with anybody perceived as authority, I anticipated a degree of resistance in the young persons. This led to some apprehension before the interviews, which I attempted to sublimate into positive action through preparation in collecting available background information, and in facilitating relation-building before each interview. This technique of self-management worked well for me as I gained sufficient understanding of the potential obstacles, which enabled me to approach and relate to the young persons, and to modify my interactions, depending on the need of the particular participant and their circumstances. I became increasingly aware of the effectiveness of strategies such as using natural icebreakers, meeting once before the interview

appointment for better familiarization, moderate self-disclosure, and clarify my position outside the clinical team. Not being involved in the direct care of unaccompanied minors, therefore holding no authority over the participants, afforded me the distance required to encourage free expression of their views.

Lustig et al. (2004) suggested that research with refugee minors on their concepts of mental illness must account for differences in their cultural understanding of what North Americans and Europeans deem as mental illness. My own South Asian cultural background and subsequent education in western psychiatric medicine probably offered a vantage point at the confluence of two different cultural perspectives. I, however, may have had my own inadvertent presumptions of what the responses of these participants might be. These may have been influenced by my personal and social constructions. I could reflect and observe myself identifying with the young persons giving priority to their socio-economic needs over the requirements of support for their emotional needs. This might be linked with my upbringing in a middle income developing country, but also a family environment where social and economic theories, and local, national and international problems related to those had been at the forefront of most discourses. Because of my awareness of this potential bias, I remained careful throughout the data analysis by taking every piece of evidence that opposes this particular notion seriously, and by not discounting them in the coding process.

Over the course of this research, I learned and refined many new skills, including critical appraisal and literature searches, qualitative research methods and analysis, problem solving throughout different stages of research, interpersonal skills and

networking, and effectively communicating with participants and other stakeholders. I also acquired insight into the aspects of the process that could be carried out differently. These included information sharing and effective communication with staff before recruiting participants, and becoming familiar with the participant's asylum application status. I, however, remained reflective throughout this process with help from my supervisors, making this an effective learning experience.

5.5. CONCLUSIONS

This study investigated unaccompanied refugee minors' experiences of mental health services, factors influencing these experiences, and their suggestions for improvement. Overall, they demonstrated limited knowledge of mental health service provision in the UK. This influenced their overall views and led to suspiciousness towards professionals. Such lack of trust can affect service engagement, thus leading to a poor outcome. Stigma and fear of negative social consequences may explain young people's reluctance to accept mental illness or treatment. Participants appreciated the qualities of professionals, and there was no evidence of preference of ethnic matching. Young people clearly prioritized meeting their basic socio-environmental over their mental health needs. The process of mental health assessment was often described as quite stressful and psychotherapy was mostly seen as ineffective. Interviewees preferred to suppress the past and expected clinicians to help them address their present needs. Pharmacological treatment was commonly viewed positively, while activity-based were favoured over talking interventions for the relief of distressing emotions and memories.

Cultural training to professionals and education to young persons about our mental health care system should enhance their awareness and engagement. Participants proposed an accessible and flexible service. Young persons preferred to be seen, at least to start with, at their home, youth centre or school, rather than at a mental health clinic. Strategies to engage them in this process, and connection between agencies and their communities were major recommendations. Establishing relationships, sharing activities, and flexibility emerged as useful ways of facilitating engagement. Input from other agencies to address socio-environmental problems and joint-working, were also perceived as valuable.

The findings of this study support an integrated holistic model of care, with different agencies working in unison. Expertise from a multitude of professionals from mental health, social care, education, legal systems and charities underpins such service philosophy. Collaboration between universal and specialist services can be extended by establishing routine consultation and training on refugee mental health for frontline professionals. The changes proposed call for a significant shift in service and practice cultures. One can, however, predict various potential obstacles to such changes, notwithstanding the financial constraints. A balance should, therefore, be stricken, and reliably conveyed to policy makers, between economic and clinical quality, while applying the findings of this study.

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APPENDICES

Appendix 1

Date: 15.10.2010

Version: 02

Research Participant Consent Form

Title of Project: Experience of unaccompanied refugee minors of their contact with specialist mental health service

Name of Researchers: Dr Pallab Majumder (Chief Investigator)
Prof Panos Vostanis (Research Supervisor)

Please tick the yes box if you agree with what the words say:

1. I confirm that I have read and understand the information sheet dated 15.10.2010 (version 03) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. Yes No

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected. Yes No

3. I understand that relevant sections of my medical notes and data collected during the study may be looked at by researchers, regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records. Yes No

4. I agree to my GP being informed of my participation in the study. Yes No

5. I agree to take part in the above study. Yes No

If you are happy to talk to the doctor who is doing this research, please sign below. If any of your answers are 'no' or if you do not want to talk, then please do not sign.

My name is..... Date.....

Signature of Person taking consent..... Date.....

Appendix 2

Date: 15.10.2010

Version: 01

Patient's Carer's Participation Consent Form

Title of Project: Experience of unaccompanied refugee minors of their contact with specialist mental health service

Name of Researchers: Dr Pallab Majumder (Chief Investigator)
Prof Panos Vostanis (Research Supervisor)

Please tick the yes box if you agree with the following statements:

1. I confirm that I have read and understand the carers' information sheet dated 15.10.2010 (version 01) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

Yes

No

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason,

Yes

No

3. I understand that the data collected during the interview may be looked at by researchers, regulatory authorities from the NHS Trust, where it is relevant. I give permission for these individuals to have access to these records.

Yes

No

5. I agree to take part in the above study.

Yes

No

If you are happy to participate in the research interview, please sign below. If any of your answers are 'no' or if you do not want to participate, then please do not sign.

Signature..... Date.....

Signature of Person taking consent..... Date.....

Appendix 3

Participant Information Sheet (For Patients)

Date: 20.05.2011

Version: 04

Data set number:

Research title: Experience of unaccompanied refugee minors of their contact with specialist mental health service.

Protocol reference number:



Dear Participant

My name is Dr Pallab Majumder. I'm a doctor and I help children and young people who struggle with their feelings, behaviour and thinking. Such doctor is called a psychiatrist. I work for CAMHS (Child & Adolescent Mental Health Services), of which Young People's Team is a part.

Regarding taking part in this research conducted by us, I would like you to read the following information. This has been designed to offer you information about the research.

What is research? Why is this project being done?

Research is how we find out the answers to questions. We want to know what needs to be done differently to make young people's experience and treatment by the mental health services more effective.

Why have I been asked to take part?

We have asked you to help us with our research so that we can find out what you need to be changed in the mental health service

Did anybody else check that the study is Ok to do?

This research has been checked by a group of people called the Research Ethics Committee. They have made sure that the research is safe for you to take part in.

Do I have to take part?

The doctor who is doing this research will meet you only once for about 60 minutes. You can decide whether you would like to talk to the researcher. If you do not want to talk to the researcher, you do not have to.

What will happen to me if I take part in the research?

If you decide to help us with our research, the researcher will talk to you about yourself and why you are receiving treatment. He will also ask you about your experience of your treatment so far. **At the end of the interview, you will be asked whether you want to tell us anything else about your experience of the treatment that has not been discussed so far.**

When you talk to the researcher, we will use a tape recorder to record our conversation just to make sure that we remember everything that you tell us.

You do not have to worry about saying the wrong thing because there are no right or wrong answers to any of the questions. We just want to know about what you think, and this includes positive things and negative experiences.

Will taking part upset me?

The researcher will try not to ask you any upsetting questions. If he asks you any questions that you do not want to answer, you can just tell him that you do not want to answer that question.

Will joining in help me?

The aim of this study is not to help individual young people, but we hope that the finding will help us to improve the service, for young people, who attend in the future.

What if I don't want to do the research anymore?

If you change your mind and decide that you do not want to do the research anymore that is OK. Just tell the researcher that you want to stop doing the research and you will not have to talk to him anymore.

What if something goes wrong with the project?

If you feel unhappy about talking to the doctor then please tell either him or tell your carer.

Will anyone else know I'm doing this?

Nobody will know that you are participating in the research apart from your regular doctor and your carer, who will accompany you when you take part in the research. The only way that other people will find out about your participation is if you tell them. If you tell the names of any of your friends or family we will not use those names in any of our work. **When writing up the research we may use some of the words you used during the interview, but nobody will know who said those words.** Only if you tell us something concerning, that needs to be divulged to ensure your safety or safety of others, we shall pass that information to the relevant people, which would include your treating doctor and the team leader of the Young People's Team.

What if I have difficulties in communicating with the researcher during the interview?

If you have any problem in communicating with the researcher, your carer will let us know in advance and we shall arrange an interpreter, who speaks your language.

What would happen if I did not want my carer to be in the interview with me?

You will be asked before the interview starts, whether you would like your carer to be with you or not. If you don't want to have your carer with you during the interview, then you wouldn't have to.

Yours Faithfully

Dr Pallab Majumder (Chief Investigator)

Professor Panos Vostanis (Research Supervisor)

Name, address and telephone number of the chief investigator:

Dr Pallab Majumder

Lecturer and Clinical Research Fellow

Greenwood Institute of Child Health

Department of Health Sciences

University of Leicester

Westcotes Drive

Leicester; LE3 0QU

Tel: 01162252885

Appendix 4

Information Sheet for Carers as Participants

Date: 15.10.2010

Version: 01

Data set number:

Research Title: Experience of unaccompanied refugee minors of their contact with specialist mental health service.

Protocol reference number:



Dear Carer/Social Worker

My name is Dr Pallab Majumder. I'm a Child and Adolescent Psychiatrist. I work for the Leicestershire Partnership NHS Trust in the department of CAMHS (Child & Adolescent Mental Health Services), of which Young People's Team is a part. I am also a Lecturer of Child and Adolescent Psychiatry at the University of Leicester.

Regarding taking part in this research interview, we would like you to read the following information sheet. This has been designed to offer you information about the interview process; to enable you to understand what it means for **yourself to participate** in this research interview.

Please take your time to read the following information carefully and please speak to us if anything is not clear, or if you would like any further information before you make your decision.

Do I have to take part?

It is up to you to choose whether you want to take part or not. If you agree to take part, you will be asked to sign a consent form. You will be free to withdraw from this research at any time, without giving us any reason for this. If you decide to withdraw from the research, we will destroy any information that may identify you (i.e. address, telephone number) but we will need to use the anonymised data that we have collected from you up until the point of your withdrawal.

What will I have to do?

Although services routinely collect information on their activities, we particularly want to know from you, what is the experience of this service for people who support our service users. Your opinions and suggestions are therefore of paramount importance in services evaluation. If both you and the young person under your care agree to help us, the researcher will contact you to arrange a suitable time for the interview to take place. The interview will be informal and the researcher will ask the young person and also you separately about what experiences you and they have had with services in your area. You do not have to worry about saying the right or

wrong thing because there are no right or wrong answers! We just want to know what you think. The interview will not include any personal questions and you can choose not to answer any questions you feel uncomfortable with. During the time that you are with the researcher, you can also ask to stop for a break or terminate the discussion at any time that you wish.

How long will it take?

The total interview process including talking to you and the young person will take about 60 minutes.

Will it be anonymous?

Nobody except the research team will have access to what was said during the interview, and your interview tape will not be available to anyone except members of the research team. We will make sure that confidentiality is strictly protected. When this research is presented as a report, interview sections may be quoted anonymously (without name). The research team will ensure that it is not possible for anyone who reads the research report to identify the young person or the carer who took part. If any names of places or people are mentioned, these will either be changed or deleted.

Your interview will be audio recorded with your agreement, and will then be typed up onto paper. This is nothing to worry about; it is just to make sure that we do not miss anything that you tell us. If you prefer to participate in the interview without this being recorded, please let the researcher know, and he will take hand written notes instead.

What are the possible disadvantages and risks of taking part?

This study has been designed to ensure that the possible disadvantages and risks to the participants from taking part in this study are minimal. If you feel any associated distress, the researcher, who is a qualified Psychiatrist, will listen to your worries and advise on the most appropriate kind of help.

What are the possible benefits of taking part?

There will not be any payment for participation in this research study and we cannot promise that taking part in this research will help you or the young person directly. However, the information that you share with us will help us to better understand the changes that are needed to enable mental health services to deliver more effective intervention for the young persons under your care and other similar young people.

Will taking part in the study be kept confidential?

Yes, all information that is shared with us will be handled in confidence and stored securely. Information that is disclosed to us that could be used to identify you (i.e. name, address, telephone number) will be stored separately from the research data and will be destroyed at the end of the research programme. Access to research data will only be available to members of the study team. Only if you or the young person tells us something concerning, that needs to be divulged to ensure his/her safety or safety of others, we shall pass that information to the relevant people, which would include the young person's treating doctor and the team leader of the Young People's Team.

What will happen to the results of the study?

The results will be presented and circulated through project reports, seminars, academic publications (i.e. journal articles) and conferences. As explained above, no personal details that might identify you will be included. Please ask if you wish to receive a copy of the findings of the study.

Who is organising and funding the research?

The sponsor of the study is the University of Leicester. The research team consists of Dr Pallab Majumder (Lecturer in Child Psychiatry), Professor Panos Vostanis (Professor of Child Psychiatry), and Dr Michelle O'Reilly (Lecturer in Psychology).

Who has reviewed the study?

This research has been reviewed by an independent group of people called a Research Ethics Committee. This study has been given a favourable opinion by the Research Ethics Committee on 27.05.2011.

What if there is a problem in the future?

If you have any concerns about any aspect of this study, or it is felt that you or the young person has experienced any harm from taking part, then please contact a member of the research team who will do their best to solve any concerns or deal with your worries.

If you remain unhappy and feel that either you or the young person was harmed during the research and that this is due to somebody's negligence, then you may have grounds of a legal action for compensation against the University of Leicester.

What if I have any more questions now?

If you would like to request any further information or talk to a member of the research team at the University of Leicester, then please contact in the first instance:

Dr Pallab Majumder
Lecturer in Child Psychiatry
Greenwood Institute of Child Health,
Westcotes House,
Westcotes Drive,
Leicester, LE3 0QU.
Tel: 0116 2252885

Or, you can also contact the research supervisor of this study, Professor Panos Vostanis, who is contactable at the same address above, or on 0116 2252885, pv11@le.ac.uk

What should I do next?

If you agree to contribute to the study by taking part in the research interview, then you will sign a consent form before participating.

We shall appreciate if we can be informed about your and the young person's decision to take part within the next one week by returning the attached reply slip to the investigator. We'll look forward to hearing from you

We thank you for taking the time to read this information sheet and hope that you will be willing to help us with our data collection.

Yours Faithfully

Dr Pallab Majumder (Chief Investigator)

Professor Panos Vostanis (Research Supervisor)

Name, address and telephone number of the chief investigator:

Dr Pallab Majumder

Lecturer and Clinical Research Fellow

Greenwood Institute of Child Health

Department of Health Sciences

University of Leicester

Westcotes Drive

Leicester; LE3 0QU

Tel: 01162252885

Appendix 5

Information to the GP/ Clinician about the research

Research Title: Experience of unaccompanied refugee minors of their contact with specialist mental health service.

Date: 15.10.2010

Version: 02

Re:; DOB:

Address:

Dear Sir,

My name is Dr Pallab Majumder. I'm a Child and Adolescent Psychiatrist. I work for the Leicestershire Partnership NHS Trust in the department of CAMHS (Child & Adolescent Mental Health Services), of which Young People's Team is a part. I am also a Lecturer of Child and Adolescent Psychiatry at the University of Leicester.

This letter is intended to inform you that the above named patient of yours has agreed to participate/ being contacted to participate in a qualitative research conducted by us. The title of this study is "Experience of unaccompanied refugee minors of their contact with a specialist mental health service."

This study will mainly involve interviewing the participants and their carers with an objective of finding out their beliefs, perceptions and experiences of specialist mental health services.

The participants will be interviewed only once, which will last for about 60 minutes. Information regarding the procedure and their right to withdraw has been/will be sent to the participant in the form of an information leaflet and will be further explained prior to the

interview, following which written consent will be taken. During the interview, the participant will be given the choice to be accompanied by a carer.

You do not need to do anything following receiving this letter as it is for information only, however if you would like to request any further information or talk to a member of the research team at the University of Leicester then please contact the address or the number below. Please also let us know if you have any concern regarding the participation of the above named patient in this study.

I shall keep you informed of any clinically relevant issues, might it arise from the interview process within the remits of confidentiality.

Thanking you

Yours Sincerely

Dr Pallab Majumder (Chief Investigator)

Lecturer and Clinical Research Fellow
Greenwood Institute of Child Health
Department of Health Sciences
University of Leicester
Westcotes Drive
Leicester; LE3 0QU
Tel: 01162252885

Professor Panos Vostanis (Research Supervisor)

Professor of Child and Adolescent Psychiatry
Greenwood Institute of Child Health
Department of Health Sciences
University of Leicester
Westcotes Drive
Leicester; LE3 0QU
Tel: 01162252885

Appendix 6
Interview Schedule - 1

Research Title: Experience of unaccompanied refugee minors of their contact with specialist mental health service.

Date: 09.07.2010

Version: 01

A. Socio-demographic and Clinical Data:

1. Age:
2. Gender:
3. Nationality:
4. Reasons for referral:

5. Diagnosis:

B. Beliefs, perceptions and experiences (For Participants):

1. How long have you been attending this mental health service?

2. How frequently have you been seeing a professional of this team?

3. How many times have you seen a professional so far?

4. Do you see any professional other than this team?

5. How would you describe the reasons for coming to this service?

6. How would you describe your experience of the help that you have received from this mental health service?

7. What difference, if any, do you believe did this service make in solving your difficulties?

8. What aspect of the contact with this service in your experience was most helpful, and why?

9. What aspect of the contact with this service in your experience was least helpful, and why?

10. What aspect of the service you received you think should be changed to make it more useful for other young people with similar difficulties?

11. Do you think that you should continue receiving this help (for those still in attendance)?

12. Why are you no longer attending this service (for those young people who have been discharged by the time of the research interview)?

13. Do you want to tell us anything else about your contact with this mental health service that could be useful for other young people?

C. Beliefs, perceptions and experiences (For Carers):

1. How long has the young person been attending this mental health service?

2. How frequently has he/she been seeing a professional of this team?

3. How many times has the young person seen a professional so far?

4. Does he/she see any professional other than this team?

5. How would you describe the young person's reasons for coming to this service?

6. How would you describe your experience of the help that this young person has received from this mental health service?

7. What difference, if any, do you believe did this service make in solving his/her difficulties?

8. What aspect of the contact with this service in your experience was most helpful, and why?

9. What aspect of his/her contact with this service in your experience was least helpful, and why?

10. What aspect of the service he/she received you think should be changed to make it more useful for other young people with similar difficulties?

11. Do you think that the young person should continue receiving this help (for those still in attendance)?

12. Why is the young person no longer attending this service (for those young people who have been discharged by the time of the research interview)?

13. Do you want to tell us anything else about this young person's contact with this mental health service that could be useful for other young people?

Appendix 7

Interview Schedule - 2

Research Title: Experience of unaccompanied refugee minors of their contact with specialist mental health service.

Date: 01.02.2011

Version: 02

A. Socio-demographic and Clinical Data:

1. Age:
2. Gender:
3. Nationality:
4. Reasons for referral
5. Diagnosis:

B. Beliefs, perceptions and experiences (For Participants):

1. How long have you been coming here to see the person/ doctor/ nurse?

2. How frequently have you been seeing the person/ doctor/ nurse?

3. How many times have you seen the person/ doctor/ nurse so far?

4. Do you see any worker other than coming here?

5. Why did you start coming here to see the person/ doctor/ nurse?

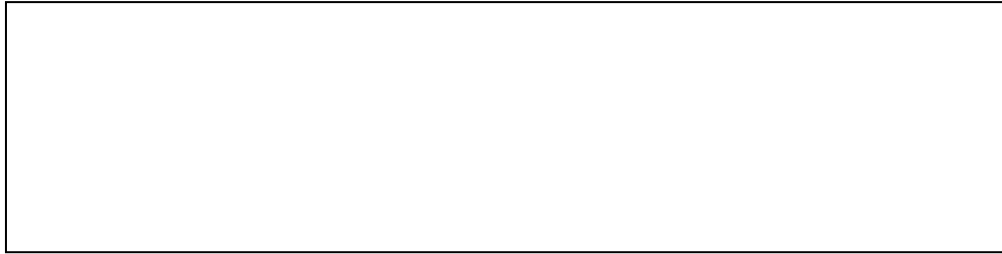
6. Can you tell me about your experience of the help that you have received here?

7. What was most helpful about coming here to see the person/ doctor/ nurse? Why was it so helpful?


8. What was not helpful about coming here to see the person/doctor/ nurse? Why was it not helpful?

9. What should be changed here to make it more useful for other young people like you?

10. Do you want to keep getting help from the person/ doctors/ nurses here (for those still in attendance)? Why?



11. What reasons have stopped you from coming here to see the person/ doctor/ nurse (for those young people who have been discharged by the time of the research interview)?



12. What else you want to tell us that will be helpful for other young people?



C. Beliefs, perceptions and experiences (For Carers):

1. How long has the young person been attending this mental health service?

2. How frequently has he/she been seeing a professional of this team?

3. How many times has the young person seen a professional so far?

4. Does he/she see any professional other than this team?

5. How would you describe the young person's reasons for coming to this service?

6. How would you describe your experience of the help that this young person has received from this mental health service?

7. What difference, if any, do you believe this service made?

8. What aspect of the contact with this service in your experience was most helpful, and why?

9. What aspect of his/her contact with this service in your experience was least helpful, and why?

10. What aspect of the service he/she received you think should be changed to make it more useful for other young people with similar difficulties?

11. Do you think that the young person should continue receiving this help (for those still in attendance)?

12. Why is the young person no longer attending this service (for those young people who have been discharged by the time of the research interview)?

13. What else about this young person's contact with this service you want to tell us?

Appendix 8

Invitation letter to participate in the research

Research Title: Experience of unaccompanied refugee minors of their contact with specialist mental health service.

Date: 15.10.2010

Version: 02

Re:; DOB:

Address:

Dear,

I would like to invite you and your carer to participate in the above mentioned research. The details of what it means to participate in this research are described in the attached information leaflet. The participation is purely voluntary and will mainly involve both of you answering questions about your experience of the help you have been receiving from the mental health services. Please get in touch with us if you want to ask any question or clarify anything regarding your participation in the research.

We shall appreciate if you can let us know about you and your carer's decision about participating in this study within the next one week by returning the attached reply slip to the investigator. We'll look forward to hearing from you.

Thanking you

Yours Sincerely

Professor Panos Vostanis (Research Supervisor)

Professor of Child and Adolescent Psychiatry
Greenwood Institute of Child Health
Department of Health Sciences
University of Leicester
Westcotes Drive
Leicester; LE3 0QU
Tel: 01162252885

Dr Pallab Majumder (Chief Investigator)

Lecturer and Clinical Research Fellow
School of Medicine
Greenwood Institute of Child Health
Department of Health Sciences
University of Leicester
Westcotes Drive
Leicester; LE3 0QU
Tel: 01162252885

Appendix 9

Reply Slip

To

Dr Pallab Majumder (Chief Investigator)

Lecturer and Clinical Research Fellow
School of Medicine
Greenwood Institute of Child Health
Department of Health Sciences
University of Leicester
Westcotes Drive
Leicester; LE3 0QU

Research Title: Experience of unaccompanied refugee minors of their contact with specialist mental health service.

Date: 15.10.2010

Version: 01

Re:; DOB:

Address:

We shall appreciate if you can let us know about you and your carer's decision about participating in this study within the next one week by returning this reply slip to the investigator:

I and my carer are interested in taking part in the above study

Yes

No

Appendix 10

Trent Research Ethics Committee

Research Ethics Office
Derwent Shared Services
Laurie House
Colyear Street
Derby
DE1 1LJ

Telephone: 01332 868905

Facsimile: 01332 868930

04 August 2010

Dr Pallab Majumder
Lecturer and Clinical Research Fellow
University of Leicester
Greenwood Institute of Child Health
Westcotes House, Westcotes Drive
Leicester
LE3 0QU

Dear Dr Majumder

Full title of study: Experience of unaccompanied refugee minors of their contact with a specialist mental health service

REC reference number: 10/H0405/72

Thank you for your application for ethical review, which was received on 04 August 2010. I can confirm that the application is valid and will be reviewed by the Committee at the meeting on 02 September 2010.

Meeting arrangements

The meeting will be held in the Riverside Centre (Derwent Room), Pride Park, Derby, Riverside Court, Pride Park, DERBY, DE24 8HY on 02 September 2010. The Committee would find it helpful if you could attend the meeting to respond to any questions from members. Other key investigators and a representative of the sponsor are also welcome to attend. This may avoid the need to request further information after the meeting and enable the Committee to make a decision on the application more quickly.

If you have a disability and need any practical support when attending the REC meeting you may wish to contact the REC office so appropriate arrangements can be made if necessary.

If you are unable to attend the meeting the Committee will review the application in your absence.

The review of the application has been scheduled for 10:45. Would you please let me know whether or not you would be available to attend at this time. Please note that it is difficult to be precise about the timing as it will depend on the progress of the meeting. We would kindly ask you to be prepared to wait beyond the allocated time if necessary.

Committee meetings are occasionally attended by observers, who will have no vested interest in the applications under review or take any part in discussion. All observers are required to sign a confidentiality agreement.

Documents received

The documents to be reviewed are as follows:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Investigator CV		
Protocol	01	16 July 2010
CV for Panos Vostanis		
REC application		28 July 2010
Covering Letter		30 July 2010
Interview Schedules/Topic Guides	01	09 July 2010

Letter of invitation to participant	01	09 July 2010
GP/Consultant Information Sheets	01	09 July 2010
Participant Information Sheet: For participants	02	16 July 2010
Participant Information Sheet: For Carers	01	09 July 2010
Participant Consent Form	01	16 July 2010
Evidence of insurance or indemnity		06 August 2009

No changes may be made to the application before the meeting. If you envisage that changes might be required, we would advise you to withdraw the application and re-submit it.

Notification of the Committee's decision

You will receive written notification of the outcome of the review within 10 working days of the meeting. The Committee will issue a final ethical opinion on the application within a maximum of 60 days from the date of receipt, excluding any time taken by you to respond fully to one request for further information or clarification after the meeting.

R&D approval

All researchers and local research collaborators who intend to participate in this study at sites in the National Health Service (NHS) or Health and Social Care (HSC) in Northern Ireland should apply to the R&D office for the relevant care organisation. A copy of the Site-Specific Information (SSI) Form should be included with the application for R&D approval. You should advise researchers and local collaborators accordingly.

The R&D approval process may take place at the same time as the ethical review. Final R&D approval will not be confirmed until after a favourable ethical opinion has been given by this Committee.

Guidance on applying for R&D approval is available at <http://www.rdforum.nhs.uk/rdform>.

There is no requirement for separate Site-Specific Assessment as part of the ethical review of this research. The SSI Form should not be submitted to local RECs.

Communication with other bodies

All correspondence from the REC about the application will be copied to the research sponsor and to the R&D office for Leicester Partnership NHS Trust. It will be your responsibility to ensure that other investigators, research collaborators and NHS care organisation(s) involved in the study are kept informed of the progress of the review, as necessary.

10/H0405/72

Please quote this number on all correspondence

Yours sincerely

Mrs Carol Marten

Committee Co-ordinator

Email: carol.marten@derwentsharedservices.nhs.uk

Enclosure: Location Map

Copy to: Professor Panos Vostanis
Greenwood Institute of Child Health
School of Medicine
Westcotes House
Westcotes Drive
LE3 0QU

Dr David Clark
Leicestershire Partnership NHS Trust
R&D office, Daisy Peake Building
Towers Hospital, Gipsy Lane
Leicester LE5 0TD

APPENDIX 11



National Research Ethics Service

Trent Research Ethics Committee

Research Ethics Office
Derwent Shared Services
Laurie House
Colyear Street
Derby
DE1 1LJ

Telephone: 01332 868905
Facsimile: 01332 868930

09 September 2010

Dr Pallab Majumder
Greenwood Institute of Child Health
Westcotes House, Westcotes Drive
Leicester
LE3 0QU

Dear Dr Majumder

Study Title: Experience of unaccompanied refugee minors of their contact with a specialist mental health service
REC reference number: 10/H0405/72

The Research Ethics Committee reviewed the above application at the meeting held on 02 September 2010. Thank you for attending to discuss the study.

Ethical opinion

The members of the Committee present decided that it was unable to give a favourable ethical opinion of the research, for the following reasons:

- The committee noted these were a very vulnerable group of participants.
- It was unclear to the members who was going to look at the interview schedule prior to it being used in the study, question A14-1 suggests it would be members of the public but does not state exactly who, they also had concerns that if this group had no understanding of the issues impacting this group of young people, could they fully inform the schedule. When asked to clarify who would be doing the assessment of the interview schedule, you informed the member this was going to be piloted with a group of similar aged people, the committee informed you that you should use non NHS patients for this, and to ensure it was an appropriate population, you agreed.
- The members thought the interview schedule should be finalised before resubmitting
- It was felt by the committee that 30-40 minutes for the interview could be a little short
- It was unclear to the committee at what stage consent would be sought,
- The recruitment and identification of the participants was discussed, it was unclear from the application who would be doing this, as the members were not sure if the you are a member of the clinical team and as such would not have access to their notes. You informed the members that you are not involved with the children, the clinical team leader will go through the notes, these will not be medical notes. They will identify potential participants, at that stage their capacity will be assessed before they are approached. The members informed you the first approach must come from someone known to the child and their carer, you stated you were happy with this

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National Patient Safety Agency and Research Ethics Committees in England

and took on the suggestion that a reply slip could be used to facilitate further contact with yourself.

- The committee queried who held parental consent for the children, they were informed that social services did, you were advised that you would need to seek consent from them in the first instance and advised this may take a while as it was unlikely that an individual social worker would be able to sign this off
- It was noted there was no information sheet and consent form for the carers, as they were going to be interviewed separately the members felt this was needed
- It was unclear from the application if 13-18 years was inclusive, and what would happen if the child did not want the carer to be in the interview with them, the members felt they should be offered the option at the beginning of the interview and this should be mentioned in the PIS. You assured the committee that the child could refuse to have the carer in the interview.
- The members felt that all literature for this study should be offered to the participant in their own language to ensure informed consent
- The committee had a number of comments on the participant information sheet:
 - A telephone number for the researcher should be provided at the bottom
 - An introduction of the researcher should be at the front
 - Replacement of the phrase 'kept secret', and inclusion of information regarding disclosure if something of concern is to be divulged
 - 'What if I don't speak English' should be removed, and all PIS's should be provided in the language of the participant
- When asked if the PIS would be available in different languages, you informed the members that it would also be sent to the carers and they would offer to help understand the forms, you stated that you felt that as the children would have been in the country for between 6-12 months they would have a good understanding of English, and as such had not considered to translate the PIS and consent form.
- You assured the members that interpreters would be used and the carers would not be asked to do this
- When asked to clarify what procedures were in place to deal with disclosure of either bad practice or potential harm, the members were informed that you would inform the clinician and the team leader, the committee reminded you this would need to be in the PIS
- The members informed you that they felt this was a very worthwhile study
- The committee were unsure if you would be able to reach your numbers, and would want reassurance of this.

I regret to inform you therefore that the application is not approved.

Options for further ethical review

You may submit a new application for ethical review, taking into account the Committee's concerns. You should enter details of this application on the application form and include a copy of this letter, together with a covering letter explaining what changes have been made from the previous application. We recommend that the application is submitted again to this Committee, but you may opt to submit to any another Research Ethics Committee within this domain.

Alternatively, you may appeal against the decision of the Committee by seeking a second opinion on this application from another Research Ethics Committee. The appeal would be based on the application form and supporting documentation reviewed by this Committee, without amendment. If you wish to appeal, you should notify the relevant Research Ethics Service manager (see below) in writing within 90 days of the date of this letter. If the appeal is allowed, another REC will be appointed to give a second opinion within 60 days and the second REC will be provided with a copy of the application, together with this letter and

other relevant correspondence on the application. You will be notified of the arrangements for the meeting of the second REC and will be able to attend and/or make written representations if you wish to do so.

The contact point for appeals is:

Joan Kirkbride
 Head of Operations
 National Research Ethics Service
 C/o Janet Kelly
 Darlington Primary Care Trust
 Dr. Piper House
 King Street
 Darlington
 Co. Durham
 DL3 6JL

Tel: 01325 746167
 Mobile: 07979 806425
 Email: joan.kirkbride@nres.npsa.nhs.uk

Documents reviewed

The documents reviewed at the meeting were:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Investigator CV		
Protocol	01	16 July 2010
CV for Panos Vostanis		
REC application		28 July 2010
Covering Letter		30 July 2010
Interview Schedules/Topic Guides	01	09 July 2010
Letter of invitation to participant	01	09 July 2010
GP/Consultant Information Sheets	01	09 July 2010
Participant Information Sheet: For participants	02	16 July 2010
Participant Information Sheet: For Carers	01	09 July 2010
Participant Consent Form	01	16 July 2010
Evidence of insurance or indemnity		06 August 2009

Membership of the Committee

The members of the Ethics Committee who were present at the meeting are listed on the attached sheet.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Now that you have completed the application process please visit the National Research Ethics Service website > After Review

Here you will find links to the following:

- a) Providing feedback. You are invited to give your view of the service you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website
- b) Re-submission/Appeal.

10/H0405/72

Please quote this number on all correspondence
--

Yours sincerely

PP G. Braithwaite

**Mr Peter Korczak
Chair**

Email: carol.marten@derwentshredservices.nhs.uk

Enclosures: List of names and professions of members who were present at the meeting and those who submitted written comments.

Copy to: Professor Panos Vostanis
Greenwood Institute of Child Health
School of Medicine
Westcotes House
Westcotes Drive
LE3 0QU

Dr David Clark
Leicestershire Partnership NHS Trust
R&D office, Daisy Peake Building
Towers Hospital, Gipsy Lane
Leicester LE5 0TD

Trent Research Ethics Committee

Attendance at Committee meeting on 02 September 2010

Committee Members:

<i>Name</i>	<i>Profession</i>	<i>Present</i>	<i>Notes</i>
Dr Peter Allmark	Principal Lecturer	No	
Mr John Beswick	Lay member	No	
Dr Helen Busby	Researcher	No	
Dr Tim Coleman	GP	No	
Mr Peter Fox	Principal Pharmacist	Yes	
Ms Karon Glynn	Head of Mental Health	Yes	
Dr Brian Hands	General Practitioner	Yes	
Dr David Henson	Principal Clinical Biochemist	Yes	
Mr Peter Korczak	Consultant Maxillo-facial Surgeon	Yes	
Dr Simona Lampariello	Paediatric Intensivist	No	
Mrs Judith Neal	Lay member	Yes	
Dr Helen Sammons	Senior Lecturer	Yes	
Dr Nick Taub	Statistician	Yes	
Ms Hannah Wall	Lay member	No	
Ms Kay Wheat	Academic Lecturer	Yes	
Mr Terence Wiseman	Lay Member	Yes	

Also in attendance:

<i>Name</i>	<i>Position (or reason for attending)</i>
Mrs Carol Marten	Co-ordinator

Written comments received from:

<i>Name</i>	<i>Position</i>
Ms Hannah Wall	Lay member

APPENDIX 12



National Research Ethics Service

NRES Committee East Midlands - Derby 1

Research Ethics Office
The Old Chapel
Royal Standard Place
Nottingham
NG1 6FS

Telephone: 0115 8839436
Facsimile: 0115 8839294

13 May 2011

Dr Pallab Majumder
Lecturer and Clinical Research Fellow
Greenwood Institute of Child Health
Westcotes House, Westcotes Drive
Leicester
LE3 0QU

Dear Dr Majumder

Study Title: Experience of unaccompanied refugee minors of their contact with a specialist mental health service
REC reference number: 11/EM/0110

The Research Ethics Committee reviewed the above application at the meeting held on 05 May 2011. Thank you for attending to discuss the study.

Documents reviewed

The documents reviewed at the meeting were:

Document	Version	Date
Covering Letter		17 March 2011
Evidence of insurance or indemnity		13 August 2010
GP/Consultant Information Sheets	02	15 October 2010
Interview Schedules/Topic Guides	01	09 July 2010
Interview Schedules/Topic Guides	02	01 February 2011
Investigator CV		
Letter of invitation to participant	02	15 October 2010
Other: Academic Supervisor CV		
Other: Reply Slip	01	15 October 2010
Other: Leicestershire County Council Consent Letter		04 March 2011
Other: Leicester City Council Consent Letter		15 February 2011
Other: Letter of Unfavourable Opinion		09 September 2010
Participant Consent Form: Research Participant Consent Form	02	15 October 2010
Participant Consent Form: Patient's Carer's Participation Consent Form	01	15 October 2010
Participant Information Sheet: For Patients	03	15 October 2010
Participant Information Sheet: For Carers	02	15 October 2010
Participant Information Sheet: Information Sheet for Carers as	01	15 October 2010

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WPH 1370

Participants		
Protocol	02	17 March 2011
REC application	55944/19820 0/1/632	17 March 2011

Provisional opinion

- When asked to clarify who would be obtaining consent and making initial contact with the patient, you explained to the members your supervisor, who is the team leader and has access to records would identify potential candidates, their lead clinician will approach and take consent. You informed the committee you would be starting work in YPD and therefore have access to medical records
- When asked to clarify why consent was being obtained by the treating clinician you informed the members that in most cases the researcher would also be the treating clinician
- When asked why travel expenses are not being paid, you informed the members this was usual practice, if the participants required transport this would be made available to them, the members were satisfied with this
- You were informed the use of audio tapes and direct quotes would need to be mentioned in the PIS
- When asked to clarify some wording in the PIS, you informed the committee the participant would lead the interview as there was not an interview schedule and you wanted to inform them that any other issues could be raised at this point, the members were satisfied with the explanation however advised you that you would need to amend the wording in the PIS

The Committee is unable to give an ethical opinion on the basis of the information and documentation received so far. Before confirming its opinion, the Committee requests that you provide the further information set out below.

The Committee delegated authority to confirm its final opinion on the application to the Chair.

Further information or clarification required

1. Please make the following changes to the PIS:
 - a. (PIS for Patients) page 3, 1st paragraph please reword 'In the end....so far.'
 - b. Please include information regarding the use of audio tapes and direct quotes

If you would find it helpful to discuss any of the matters raised above or seek further clarification from a member of the Committee, you are welcome to contact the committee coordinator.

When submitting your response to the Committee, please send revised documentation where appropriate underlining or otherwise highlighting the changes you have made and giving revised version numbers and dates.

If the committee has asked for clarification or changes to any answers given in the application form, please do not submit a revised copy of the application form; these can be addressed in a covering letter to the REC.

The Committee will confirm the final ethical opinion within a maximum of 60 days from the date of initial receipt of the application, excluding the time taken by you to respond fully to the above points. A response should be submitted by no later than 10 September 2011.

Membership of the Committee

The members of the Committee who were present at the meeting are listed on the attached sheet.

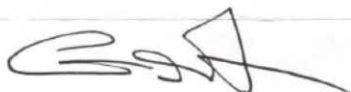
Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

11/EM/0110

Please quote this number on all correspondence

Yours sincerely



**Mr Peter Korczak
Chair**

Email: carol.marten@nottspct.nhs.uk

Enclosures: List of names and professions of members who were present at the meeting and those who submitted written comments.

Copy to: Professor Panos Vostanis
Greenwood Institute of Child Health
School of Medicine
Westcotes House, Westcotes Drive
Leicester LE3 0QU

Dr David Clarke, Leicestershire Partnership NHS Trust

NRES Committee East Midlands - Derby 1

Attendance at Committee meeting on 05 May 2011

Committee Members:

<i>Name</i>	<i>Profession</i>	<i>Present</i>	<i>Notes</i>
Dr Peter Allmark	Principal Lecturer	Yes	
Mr John Beswick	Lay member	Yes	
Dr Helen Busby	Researcher	No	
Mr Peter Fox	Principal Pharmacist	Yes	
Ms Karon Glynn	Head of Mental Health	Yes	
Dr Brian Hands	General Practitioner	Yes	
Dr David Henson	Principal Clinical Biochemist	Yes	
Mr Peter Korczak	Consultant Maxillo-facial Surgeon	Yes	
Dr Simona Lampariello	Paediatric Intensivist	No	
Mrs Judith Neal	Lay member	No	
Dr Helen Sammons	Senior Lecturer	No	
Dr Nick Taub	Statistician	Yes	
Ms Kay Wheat	Academic Lecturer	Yes	
Mr Terence Wiseman	Lay Member	Yes	

Also in attendance:

<i>Name</i>	<i>Position (or reason for attending)</i>
Mrs Carol Marten	Co-ordinator

APPENDIX 13



National Research Ethics Service

NRES Committee East Midlands - Derby 1

Research Ethics Office
The Old Chapel
Royal Standard Place
Nottingham
NG1 6FS

Telephone: 0115 8839436
Facsimile: 0115 8839294

27 May 2011

Dr Pallab Majumder
Lecturer and Clinical Research Fellow
University of Leicester
Greenwood Institute of Child Health
Westcotes House, Westcotes Drive
Leicester
LE3 0QU

Dear Dr Majumder

Study title: Experience of unaccompanied refugee minors of their contact with a specialist mental health service
REC reference: 11/EM/0110

Thank you for your letter of 26 May 2011, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

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WPH 1370

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	Version	Date
Covering Letter		17 March 2011
Evidence of insurance or indemnity		13 August 2010
GP/Consultant Information Sheets	02	15 October 2010
Interview Schedules/Topic Guides	01	09 July 2010
Interview Schedules/Topic Guides	02	01 February 2011
Investigator CV		
Letter of invitation to participant	02	15 October 2010
Other: Academic Supervisor CV		
Other: Reply Slip	01	15 October 2010
Other: Leicestershire County Council Consent Letter		04 March 2011
Other: Leicester City Council Consent Letter		15 February 2011
Other: Letter of Unfavourable Opinion		09 September 2010
Participant Consent Form: Research Participant Consent Form	02	15 October 2010
Participant Consent Form: Patient's Carer's Participation Consent Form	01	15 October 2010
Participant Information Sheet: For Carers	02	15 October 2010
Participant Information Sheet: Information Sheet for Carers as Participants	01	15 October 2010
Participant Information Sheet: For Patients	04	20 May 2011
Protocol	02	17 March 2011
REC application	55944/19820 0/1/632	17 March 2011

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Now that you have completed the application process please visit the National Research Ethics Service website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document "*After ethical review – guidance for researchers*" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nres.npsa.nhs.uk.

11/EM/0110

Please quote this number on all correspondence

With the Committee's best wishes for the success of this project

Yours sincerely



Mr Peter Korczak
Chair

Email: carol.marten@nottspct.nhs.uk

Enclosures: "After ethical review – guidance for researchers"

Copy to: Professor Panos Vostanis
Greenwood Institute of Child Health
School of Medicine
Westcotes House, Westcotes Drive
Leicester LE3 0QU

Dr David Clarke, Leicestershire Partnership NHS Trust

APPENDIX 14

FINAL APPROVAL (NHS & University
INDEMNITY)

Leicestershire Partnership 

NHS Trust

A University Teaching Trust

Research & Development Office

Daisy Peake Building
Gipsy Lane
Leicester

Direct dial: 0116 225 3743
Email: david.clarke@leicspart.nhs.uk

Tel: 0116 225 6000
Fax: 0116 225 3684
Web: www.leicspt.nhs.uk

DC/PM/PV/Minors

Dr Pallab Majumder
MBBS; MRCPsych; MIPS; MD
Lecturer and Clinical Research Fellow
Department of Health Sciences
University of Leicester
University Road
Leicester; LE1 7RH;

24th June 2011

Dear Dr. Majumder

RE: Experience of unaccompanied refugee minors of their contact with a specialist mental health service

Thank you for applying for Research Governance Approval for the above study. I am pleased to inform you that the formal review of the project is now complete, and has been formally approved to be undertaken at Leicestershire Partnership NHS Trust. Your activity in relation to this project is covered by NHS and University Indemnity as set out in HSG(96)48 and your study has been entered onto the Trust database. This study has now been validated and reviewed according to the Standard Operating Procedure for research appraisal. The study therefore has been granted the following level of approval:

Full Approval	<input checked="" type="checkbox"/>	Approval in Principle	<input type="checkbox"/>	Approval refused	<input type="checkbox"/>
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This approval applies to all documents as listed in your favourable opinion letter from the ethics committee, and any amendments must also be submitted to this office as well as the approving ethics committee if a substantial amendment is appropriate.

Your responsibilities are set out in the attached agreement, which must be signed and returned to the Research Office. You should keep a copy for your records. All research must be managed in accordance with the requirements of the Dept. of Health Research Governance Framework (RGF), and to ICH-GCP standards. In order to ensure compliance with these standards, the trust may randomly select your study for audit against these standards at any time, and may employ an external agency for this purpose

The duration of this approval extends only to the date specified in your NRES submission, and you should inform the Trust if this is to be extended. Action may be taken to suspend Trust approval if not conducted to these standards, and the study must commence within two years of the REC approval date, and within six months of R&D Approval.

I hope the project goes well, and if you need any help or assistance during its course, please do not hesitate to contact me.

Regards,



Dr. Dave Clarke
[Associate Director of Research & Development]

Trust Headquarters: George Hine House, Gipsy Lane, Leicester, LE5 0TD
Chairman: Professor David Chiddick CBE Chief Executive: John Short



RESEARCH GOVERNANCE

Principal Investigator Agreement & Responsibilities

Project Reference:	CHAF0571
Project Title:	Experience of unaccompanied refugee minors of their contact with a specialist mental health service

As Principal Investigator for this study I agree to the following:

- I understand the responsibilities of a Principal Investigator defined in the Research Governance Framework and agree to abide by these.
- I will ensure that the study does not proceed until there is written approval from the Research Office.
- Summary information about the study can be submitted to the National Research Register and other publicly accessible systems, except where this would compromise the protection of intellectual property.
- I will assist with any audits or monitoring of research whether conducted by the Trust, sponsor, University (when acting as Sponsor), or regulatory authority.
- I will co-ordinate completion and submission of annual and final reports according to funders, ethics committee and Trust requirements.
- I will ensure that the protocol and any subsequent changes to the study design are conveyed to and approved by the relevant authority, and where necessary are independently peer-reviewed and notified to the host Research Office.
- I will ensure that any serious adverse events (SAEs) are reported following the procedures set out in the Trust's policy on reporting research-related adverse events.
- I will notify the Research Office if there is any need or intention to change the principal investigator for the study (perhaps requiring a new honorary contract etc.)
- I will make every reasonable effort to disseminate the findings of the study, including through peer-reviewed publication, and will lodge a copy of any such publication with the Research Office.

Name: PALLAB MAJUMDER
(Local) Principal Investigator

Signature:  Date: 25.06.2011

Note: The Principal Investigator may delegate some or all of the responsibilities listed above but they will remain accountable to the Chief Executive for the overall conduct of the study. Any delegation of responsibility must be explicit and documented.

Please return the signed agreement to the Research Office.



APPENDIX 15



Date: 4th March 2011
My ref:
Your ref:
Contact:
Phone:
Email:

To Whom It May Concern

Re: Experience of unaccompanied refugee minors of their contact with specialist mental health service

Dr Pallab Majumder is conducting the above research project. He has discussed this project in detail with me and I am writing that I support this initiative.

Dr Majumder has successfully piloted this programme with an unaccompanied refugee young person who is under the care of social services.

I am writing to confirm that I give consent for Dr Majumder to interview the young people in our care, subject to their consent and that of relevant staff.

Thanks in advance for your support with this project

Yours sincerely

Joanna Parfitt
Team Manager
Children in Care Team
Loughborough

Children and Young People's Service, Leicestershire County Council
Pennine House, 2 Lemington Street, Loughborough, Leicestershire LE11 1UH
Telephone: 01509 266641 Fax: 01509 210167 Email: childrenservices@leics.gov.uk

Gareth Williams, Director of Children and Young People's Service

www.leics.gov.uk



APPENDIX 16

Please ask for: Mike Evans
Direct Line: 0116 299 5875
Fax: 0116 299 5887
E Mail: mike.evans@leicester.gov.uk



Date: 15th February 2011

To Whom It May Concern

Re: Experience of unaccompanied refugee minors of their contact with specialist mental health service.

Dr Pallab Majumder is conducting the above research project, as part of his role within CAMHS. He has discussed this project in detail with me and I am writing to confirm that I support this initiative.

Dr Majumder has successfully piloted this programme with a Looked After Young Person, who is currently in our care.

I am writing to confirm that I give consent for Dr Majumder to interview the young people in our care, subject to their consent and that of relevant staff e.g. Social Workers.

Thanks in advance for your support with this project.

Yours sincerely

Mike Evans

**Mike Evans
Service Manager
Looked After Children's Service
(Young People's Residential Homes)**

APPENDIX 17



Professional Risks
Dawson House
5 Jewry Street
London EC3N 2PJ
Tel: +44 (0)20 7488 2345
Fax: +44 (0)20 7481 0511
www.miller-insurance.com

VERIFICATION OF INSURANCE

To Whom It May Concern

We, the undersigned Insurance Brokers hereby confirm that the following described Insurance is in force at this date.

CLINICAL TRIALS NO FAULT COMPENSATION & LEGAL LIABILITY INSURANCE

Insured: University of Leicester and/or subsidiary companies and/or any officer or members of the Council or the Senate or a committee whilst acting on behalf of the Assured

Period of Insurance: From: 1st August 2010
To: 31st July 2011

Interest: To indemnify the Assured in respect of claims for compensation first made in writing against the Assured during the period of the Policy in respect of all trials undertaken.

Limit of Indemnity: GBP 10,000,000 any one event and in all in the Period of Insurance plus costs and expenses

Conditions: As per Policy, plus:
Excess: GBP5,000 any one event including costs and expenses increasing to GBP12,000 any one event including costs and expenses in respect of Children's Cancer and Leukaemia Group trials sponsored by the University of Leicester

Insurers: Novae Insurance Company Limited (50%) and Brit Insurance (50%)

Policy No.: B0621PUNI03610

This document is furnished to you as a matter of information only.

The issuance of this document does not make the person or organisation to whom it has been issued an additional Assured, nor does it modify in any manner the contract of insurance between the Assured and Underwriters. Any amendment, change or extension of such contract can only be effected by specific endorsement.

Should the above mentioned contract of insurance be cancelled, assigned or changed during the above policy period in such manner as to affect this document, no obligation to inform the Holder of this document is accepted by the undersigned Insurance Brokers.

Signed

Dated

13th August 2010