Analysis and critique of 'Transforming Children and Young People's Mental Health Provision: a Green Paper': Some implications for refugee children and young people

Introduction

The long-awaited consultative Green Paper, **(**Department of Health and Department of Education, 2017) co-authored by both government departments, sets out preliminary proposals for addressing the mental health and wellbeing needs of children and young people in England and Wales; it encouraged submission of a range of views during the consultation period (December 2017- early March 2018). In this paper we analyse and critique the strengths, limitations and challenges of the Green Paper, assessing the extent to which they could meet the mental health and wellbeing needs of refugee children, young people and their families.

Our writing is informed by our professional practice backgrounds in Social Work and in Health; by a children's rights perspective (United Nations Convention on the Rights of the Child 1989; Ruck et al, 2017), and by the understanding that refugee children and young people (aged eighteen years or under), are children and young people first (Crawley, 2006), with rights to express their views and experiences (UNCRC, 1989) and to contribute meaningfully to developing policies and services which impact upon their lives and relationships. While acknowledging that refugee children and young people share with other groups of similar ages challenges in securing mental health and wellbeing, for example: asylum-seeking children and young people; those who are looked after; lesbian, gay, bisexual and transgender children and young people and Black and minority ethnic children and young people, as well as with children and young people in the general population, in our analysis and critique we consider only those proposals in the document which are relevant to our

focus, although we envisage that some findings may be generalizable to other young populations.

We use the term 'refugee children and young people' to include all who have fled from their home country with their families and are unable to return: '…owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion', and who are awarded some form of recognized legal status within the UK according to the Convention Relating to the Status of Refugees (1951). There are no official figures for the number of refugees settled within the UK, nor aggregated figures for the number of dependents (https://fullfact.org/immigration/uk-refugees/). The rationale for our focus on refugee children and young people is in response to their perceived - both by receiving societies and by themselves - vulnerability (Spiers, 2000). Factors commonly associated with migratory experiences and exile (Fiddiam-Qasmiyeh et al, 2014); exposure to hostile and oppressive environments in the country of settlement (Lentin, 2008; Mulvey, 2010); their low service uptake (Majumder et al, 2018) and being poorly served by current provision (Cox, 2013: Polzer, 2008) are among the external risks which increase their potential exposure to vulnerability, including increased risk of mental ill-health. Everyday challenges that may be perceived or experienced by the individual as threatening or disempowering, suggest the need to seek to strengthen refugee children's and young people's sense of agency, self-efficacy, potential for personal growth and ability to navigate such challenges successfully. (Spiers, 2000). There is an imperative to develop and strengthen refugee children and young people's sense of agency, self-efficacy, resilience, potential for personal growth and ability to navigate everyday challenges.

Investing in mental health provision for refugee children and young people recognizes the benefits of intervening in trajectories of unresolved adverse mental health conditions, anticipating and acknowledging the contributions of many young refugees as future adult

citizens (Greater London Authority, 2004: Williams and Graham, 2014). We do not address the mental health and wellbeing needs of asylum-seeking children and young people; nor do we define mental health or wellbeing; we work with the terms in the document (see Methodology and Methods). Thus far we have written 'children and young people' (the term used throughout the Green Paper), recognizing the emerging capacities, experiences and developmental competencies across the 0-18 life trajectories; for the remainder of this paper we use 'children' (to refer to children and young people in the general population) and 'young refugees' to indicate those who are the focus of our concern. From this point forwards, unless otherwise stated, all in-text citations refer to pages in the Green Paper.

Methodology and Methods

Documentary research methodology underpins our critique and analysis, being recognized for its role in assisting critical interrogation of: language, values, writing style and content; in discerning author bias, and in aiding identification and understanding of arguments, the use of selected concepts to support them, as well as omissions (Peräkylä and Ruusuvuori, 2017). We identified and read preceding policy documents that have influenced or directly contributed to this Green Paper, considering these as contextualization (Prior, 2003). As in all qualitative research, transparency about researchers' epistemological positions matters (Denzin and Lincoln, 2017): see above at second paragraph, which together with statements here, provides clarity and underscores the credibility of the research approach we undertake.

Context and Policy

Interest in issues related to Mental Health recently have gained prominence within the UK, with a greater openness to sharing personal experiences of mental illness in media and public

fora, increased appreciation of the debilitating and undermining impact of mental illness on quality of life for an individual and their family, and calls for improvements in preventive and supportive provision (Davies, 2017). Particular attention is paid to the growing numbers of children developing mental health problems; an estimated 850,000 in the UK are believed to experience a clinically significant problem, with 1 in 4 showing some evidence of mental ill-health (Young Minds, 2018).There now is greater understanding of the emotional and mental health needs of children, including: awareness of the links between parental mental health (particularly maternal perinatal depression) and children's mental health; the influences of adverse childhood events (ACEs) and the role that inequality plays in increasing risks for developing mental health problems. In addition, mental health needs such as eating disorders, self-harm, and suicide among young men, currently are emerging alongside the most common diagnostic categories: conduct disorder, anxiety, depression and hyperkinetic disorder (DOH & NHS England, 2015)

Alarm at these increasing trends in mental ill-health, together with respected research evidence demonstrating the importance of good mental health in early childhood for long-term health and wellbeing, (Schoon and Parsons, 2002) has led to a proliferation of policy, research and professional practice interest in taking forward, what traditionally has been a neglected field (Frith, 2016; Young Minds, 2017). This interest occurs at a time of austerity, government funding cuts and reduced service provision, reinforcing imperatives to secure a mental health strategy for children; cost-effective, quality provision which 'works'. Therefore the aim of our critique is to assess the extent to which the Green Paper addresses the mental health and wellbeing needs of young refugees in England and Wales (Fazel, 2015), identifying strengths, limitations and challenges for future policy and practice.

Analysis and Critique: Overview

The authors of this Green Paper describe it as 'ambitious'. And so it is, endeavouring to transform mental health provision for children. There is a positive paradigm shift from an illness model of mental health (with symptomology, diagnosis and treatment), to a wellness model with concepts of happiness, fulfilment, and emotional wellbeing as core goals of a mental health strategy for children. The prevalence of mental health conditions among children is acknowledged, with a commitment to parity of esteem between mental and physical health, underpinned by governmental financial investment. A strategic re-orientation centralizes the significance of mental health vulnerability and risk factors in children, and the need for preventative approaches and early intervention into experiences of low emotional wellbeing and mental health conditions, to prevent trajectories of unresolved adverse mental health outcomes into adulthood (Children and Young People's Mental Health Taskforce, 2015). The relationship between experiencing childhood mental health conditions and low wellbeing and unequal chances in adolescence and adulthood, is affirmed.

Acknowledgment that historic social injustices suffered by individuals with mental health conditions must be redressed, including tackling past and present impacts of stigma on self-worth (Fazel, 2015), could benefit the lives of young refugees. However, the document's authors either ignored or failed to follow through with structural issues raised here (and earlier: Children and Young People's Mental Health Taskforce, 2015), not acknowledging societal and social diversity in the England and Wales (Maegusuku-Hewett, Dunkerley et al, 2007; Williams and Graham, 2014; Williams and Guémar, 2008). From our perspective of centralizing social justice for children and young people, including young refugees, opportunities to include their voices and experiences have been missed.

Despite the recognised vulnerability to mental health issues that their experiences may indicate (Hands et al, 2016; Ryan el al, 2008; Stedman, 2003), young refugees are not mentioned in this document. In addition, although the need to confront attitudes to mental

health conditions and stigmatizing practices is recognised, racism, xenophobia, religious prejudice and oppression receive no mention. Newly-arriving and more established migrant (including refugee) children, their families and communities are invisible in this paper (Castles, de Haas et al, 2014), implying that mental health issues generally are similar for children in both settled and migrant communities. As noted above (Introduction), some young refugees are future adult citizens and should receive support, so that any unresolved childhood or adolescent mental health issues do not persist into adulthood.

Most significant is failure to strategize for mental health and wellbeing within a framework that includes the diverse cultures, values, traditional practices and religious beliefs, of many children. There is one mention of 'culture' (2017:139). Culture, which usually refers to shared practices which permeate family and social life and which provides meaning to life experiences (Calhoun and Sennett, 2007), also shapes understandings, including those of mental health and wellbeing. Cultural practices have significance for many young refugees and their families who, having lost their homes and in processes of settling, draw upon them to navigate everyday life challenges in their new communities (Eastmond, 2007). Thus, there is failure to address the wider contexts of young refugees lives within their local communities; to examine their health determinants and secure mental health and wellbeing for *all* children.

This omission is perhaps unsurprising. Adopting an inclusive cultural framework in developing a mental health strategy for all children is complex and challenging. It requires suspending our Western cultural beliefs and frameworks about the nature of mental health conditions, wellbeing, dis-ease and recovery (Anderman, 2002; Ungar; 2004; Zack-Williams, 2006); creating time and spaces to listen to different beliefs and accounts; navigating diverse and sometimes conflicting opinions to develop comprehensive responses.

For the remainder of our analysis and critique, we adopt a cultural 'lens' to make visible those proposals which have potential to promote and secure mental health and wellbeing for young refugees, examining strengths, limitations and challenges. We also apply the concept of intersectionality (Crenshaw, 2015) - broadly, the interconnectedness of two or more overlapping identities, each of which renders someone susceptible to experiencing prejudice, oppression and discrimination – to highlight some of the issues for young refugees. We begin with the focus on prevention and early intervention.

Prevention and early intervention

Knowledge that the foundations of good mental health are best prepared in childhood, leads to prevention and early intervention in promoting mental wellbeing being central to the proposed strategy (2017:3). In educational settings children's awareness and knowledge of 'mental wellbeing', healthy relationships and safety will be developed. Whole school and whole college approaches to promoting physical health already exist. Such approaches seek to promote health and educational outcomes using a variety of complementary strategies with the aim of developing and facilitating knowledge and actions enabling individuals and communities to increase control over their health and secure the necessary resources with which to do so (Weare, 2015, online). As stated in the Green Paper, whole school and college approaches to promoting mental health and wellbeing in combination with supporting staff in building confidence, and with expertise from designated colleagues undertaking additional mental health awareness training, will enable early identification of children struggling with mental health issues. Proposals include that treatment for 'mild to moderate' mental health 'disorders', can be delivered by 'non-clinical staff with adequate supervision, leading to outcomes comparable to those of trained therapists' (2017:10).

There are strengths here. Education is a valued resource for many young refugees who are ambitious to improve themselves and their families' situations (Adams, 2009). It provides valuable opportunities in acquiring language skills; building friendships and learning new cultural practices. Greater involvement of schools and colleges in monitoring and responding to mental health issues may result in young refugees accessing support more easily. And recruitment of 'non-clinical staff' may release mental health professionals with expertise to attend to those with complex needs. Provided that young refugees feel safe and confident in their educational environments, they may feel able to express any mental health or wellbeing concerns and seek support.

However, there are limitations and challenges. As noted by Weare, in whole school approaches: '…academic learning……liaison with parents, outside agencies and communities' are linked (Weare, 2013, p129). According to the Green Paper, school and college leads with 'designated responsibilities' must ensure the proposed 'whole school/college approaches'; support 'staff in contact with children with mental health needs to help raise awareness, and give all staff the confidence to work with young people.' (2017:19) Unless more than one or two people assume this role, it will be an enormous undertaking requiring support and workload relief and given, it is questionable whether staff will have the capacity to identify and support the particular needs of young refugees.

Refugee populations are heterogeneous (Vostanis, 2014); young refugees are not easily identifiable, as individuals or as groups, and may share family, cultural or religious norms (Eastmond, 2007) about expressing mental health concerns. They may experience PTSD or other trauma; but these are western concepts and not universally recognised or shared (Anderman, 2002; Hughes, 2014; Zack-Williams, 2006). Thus, any deterioration in the wellbeing of young refugees may be overlooked by staff unfamiliar with differences in understanding and expressing mental health concerns and conditions.

Education and training for *all* school and college staff - not only those with designated responsibilities; all students on initial teacher education courses; for non-clinical recruits and for other professional health, social work and social care staff, must include cultural competence, cross-cultural communication skills (Ben Ari and Strier, 2010) and the effects of all forms of prejudice and discrimination on refugee children and young people (Suárez-Orozco, 2000). Such education and training must include intersectionality also - see above, Crenshaw (2015) - not only as a concept, but as lived experiences for many young refugees, their families and carers. Not all young refugees require therapeutic or medical intervention, but those who struggle with mental health issues are more likely to be identified by staff who are 'tuned in' to the emotional and mental wellbeing of *all* their pupils.

Person-centred approaches

We now explore the undertaking to include children, parents and carers, at all decision-making stages and in the design, commissioning, delivering and evaluation of services. This determination to put children, their families and carers at the centre of all levels of developments, involving both adult and young service users, is an obvious strength of the document.

Within the document, children are regarded as agents, to be equipped with knowledge and understanding of the importance of their own mental health and wellbeing and building healthy relationships, in addition to supporting others through mentoring interventions (2017: 41). Positioning children and young people as active agents in maintaining their own mental health through their involvement in developing services could be particularly beneficial for young refugees, as predominant societal discourses frequently position refugees, including young refugees, as devoid of agency, voice and subjectivity (Majumder et al, 2018; Marvakis, 2011).

Among the significant challenges in achieving this aim, is that young refugees often act as carers for their parents and carers. Unless sufficient detail about service design is provided to all family members and interpreting services provided (Williams, 2005), there is the possibility of agreements and decisions not being fully informed by knowledge of health and social care systems. Increased participation and engagement would, if achieved, present opportunities for refugee families - and members of new refugee communities, which exist within and alongside settled communities, many of whom want to participate in community life with neighbours in their new home (Cox and Geisen, 2014) - to contribute to designing services that are culturally meaningful, effective, and delivered by well-informed, culturally competent professionals. Managers and providers of such services must ensure also that mental health services for young refugees are integrated with systems and agencies already delivering forms of welfare and health provision (Vostanis, 2014).

While some pupils may develop trusting relationships with supportive staff in educational settings, some refugee parents and carers may be mistrustful of organisations and services, based on encountering state agencies during and after migration (Mulvey, 2010) and fearing possible negative consequences for their future status. Some parents and carers view services and organisations as discriminatory. These challenges of engaging refugees of all ages in formal organizational processes already are reflected in low take-up of services and low participation in service evaluations (Doná, 2007; Liamputtong, 2010; Limbu, 2009). Their mobility is another barrier to building trust to enable meaningful engagement with service development (Cox, 2013; German, 2008). While increased participation from children, young people, their families is fundamental to designing informed and effective services, explicit consideration must be given to identifying and overcoming the barriers which reduce refugee engagement, if services are to meet the needs of *all* children.

Mental health stigma

Next, we examine proposals concerning the stigma of mental health. As noted recently in this journal (Wilkinson and Carter, 2016), language is powerful; words (and behaviour) can wound. Damage to self-worth engendered by stigma is recognised widely; within health services: '…the shift to person-centredness has required a more sensitive consideration of how language is used.' (Wilkinson and Carter, 2016:417). Strengths include raising the profile of the national (government-supported) mental health anti-stigma campaign 'Time for Change'. It is proposed that from 2018 this campaign will be extended further, training members of the public in basic awareness.

Acknowledgement of the contribution of neuroscientific research to current understandings of the impact of stress and trauma on brains and on emotional development is welcome (Center on the Developing Child, 2017). Stigma can undermine self-esteem and the development of a positive self-identity (Fazel, 2015); this government-sponsored endorsement of established knowledge of the links between emotions, brains and bodies (Frank, 1995; Levitin, 2015), should benefit anti-stigma activities. Young refugees are very likely to have experienced trauma and stress before leaving their homes, during their migratory journeys (Hart, 2008), and during processes of settling, which may include derogatory attitudes, words and behaviours. However, acknowledgement of the impact of stress and trauma on emotional development and brains is not extended within the document (as logically it might be) in being applied to the experiences of young refugees (Vostanis, 2014). Another opportunity to consider their situations has been missed.

Applying a cultural lens in centralizing the needs of young refugees, the limitations of these proposals are apparent. Intersectionality (Crenshaw, 2015, above) applies to young refugees who are exposed to stigmatizing attitudes and behaviours in response both to their mental health condition and their culture, religion, or refugee status. This stigmatizing 'double whammy' can undermine young refugees' adaptation and flourishing in their new countries

(Adams, 2009; Schoon and Parsons, 2002). An approach foregrounding both cultural and intersectional awareness is essential in all anti-stigma initiatives.

Research

This document is grounded in research evidence which is cited throughout. There are undertakings to 'improving data and tackling variation' (2017:16-17). Research to inform service developments is ongoing, foregrounding improvements in the quality and consistency of data collected. Evaluation will strengthen the research evidence base which informs service design and delivery. Endeavours to understand what works for those most vulnerable are commendable and this stated openness to emergence of new data augurs well for the future of the strategy.

Limitations are apparent in that currently no particular model of intervention is favoured; it appears that data about different models will be evaluated on a 'what works' basis. We question whether any of the models being evaluated includes the particular cultural and intersectional issues for young refugees, as discussed above. It is unclear to what extent children were involved in the research for this Green Paper. However children and young people can be partners in research about issues which concern them, including their mental health concerns (Res Publica and Sim, 2017). As future citizens, it is essential that they are partners in all future research.

Children needing additional support.

Emphasizing the importance of children's feelings and emotions is an example of how children are positioned at the centre of changes proposed. The transition from children and young people's services to adult services is acknowledged as traditionally problematic

(2017:13). Changes are underway to 'improve journeys' and 'signpost pathways' through multi-agency working and individual person-centred approaches (see also Partnership, below) and specialist services. This is of particular benefit for those children identified as vulnerable requiring improved targeted care.

However, placing importance on children's emotions and feelings is predominantly a Western-centric concept, which may not be familiar or comfortable for young refugees (Kohli, 2006; Hughes; 2004; Zack-Williams, 2006). And determination to 'improve journeys' does not (apparently) include attention to issues of inaccuracy in age-related assessments of young refugees (Fazel and Stein, 2004; Fekete, 2007; Refugee Council, 2018)

The document's authors acknowledge that currently the system struggles to respond to vulnerable children with deep-seated and complex needs. Such needs 'require targeted, person-centred interventions, and appropriate assessment is essential to ensure the right support is offered' (2017:14). This acknowledgement resonates with our concerns about the inclusion of young refugees in consultation about and forward planning for services they may need (Majumder et al, 2018). We argue that young refugees should be listed as a group 'with complex needs', possibly requiring additional targeted support.

Partnership

Working together to promote and achieve mental health and wellbeing for children is a central tenet of the document, consisting of joined-up working, partnerships and engagement; strengthening existing partnerships and building new ones (2017:3). Cross-agency working between the NHS, Local Authority, schools, colleges and the voluntary sector will facilitate joint commissioning and service innovation. Sharing expertise; promoting person-centred approaches in identifying need; increasing effectiveness in meeting the often-complex mental health needs of vulnerable children and young people, are core

tasks. Joint agency Local Transformation Plans will continue to guide local planning; development of integrated services, and conjoint new models of service delivery.

Building and strengthening collaborative working practices across agencies could be beneficial for young refugees, given the frequently multi-faceted nature of their vulnerabilities (Ryan et al, 2008). For example, lack of knowledge about availability and nature of services - which can contribute to poor service uptake (Durá-Vilà et al, 2012; Papadopoulos et al, 2004) - may be resolved by the introduction of a single point entry integrated service model, with allocation and sign-posting to other agencies based on presenting needs, as noted by Vostanis (2014), op. cit. Direct access for educational staff to mental health expertise increases possibilities for appropriate responses, including securing specialized assessments and therapeutic interventions for young refugees who may require specialist support following experiences of trauma resulting from war, sexual exploitation and multiple losses (Hart, 2008: Stedman, 2003).

Interagency partnerships and collaboration may facilitate co-ordinated approaches to achieving shared goals, but they present well-known challenges: (Moran et al, 2007; Salmon and Rapport 2005; Stuart, 2012). If not anticipated, such challenges may result in young refugees' mental health needs being ignored, or referrals passing between agencies with no professional taking responsibility.

The commitment to partnership working includes partnerships with children, young people, parents and carers (as above). Engaging and working with service users is a strength; there are, too, significant challenges. Recognition of children's possible caring responsibilities is to be welcomed, given that research indicates increased incidences of mental and physical concerns with persistent long-term symptoms, among refugee and forced migrant adults (Burnett and Peel, 2001; Fazel and Stein, 2003; Hodes, 2000). Partnerships

with parents and carers are recognized as significant in working effectively with children, although it is acknowledged that parents may suffer with their own mental health issues, with children undertaking caring responsibilities. However, opportunities to explore issues for young refugees, their parents and carers and members of new communities, have not been taken.

Wider structural influences

Following on from examination of partnerships and agency responsibilities, we assess proposals concerning the wider structural influences upon mental health. The undertaking to increase focus on 'prevention and the wider determinants of health' (2017:31) is a significant driver in the document for transforming children and young people's mental health. Local Authorities will lead partnerships to: 'address the social determinants of mental health'(2017:31). Inequalities in accessing and obtaining quality mental health services which some children encounter; the increased risks to mental health, and poorer mental health trajectories for vulnerable or marginalised individuals and groups, are identified. The ambition to implement preventative approaches and early interventions, suggests that the Green Paper is aligned with a Health Inequalities agenda (Marmot 2010). Consideration is given to predisposing risk factors that undermine mental health and wellbeing, with ways to increase protective factors proposed, supported by increasing the evidence base of 'what works'.

Engagement with mental health inequalities is to be welcomed, yet in the document, plans to address the wider structural factors which undermine wellbeing and contribute to unequal mental health outcomes, focus on promoting such activities as: maintaining good intra-parental relationships; developing secure parent-child attachment; building parenting skills and encouraging employment: responses which are at the level of individual responsibility,

rather than that of structural changes. While these plans derive from established protective factors, there are no recommendations for collaborative action to resolve structural risk factors of personal and institutional discrimination; poverty; social isolation and social exclusion. Young refugees are at increased risk of vulnerability to poor mental health and wellbeing. Without action to resolve structural issues, they are likely to remain disadvantaged in achieving good mental and wellbeing outcomes.

Conclusion

To achieve some of the changes in understanding, attitudes, practice and service delivery which are anticipated in this paper, a paradigm shift will be necessary if good emotional wellbeing and positive mental health for all children is to be realised. Specialist education and training for staff - and for students - in the health, social work and education professions is essential (Mlcek, 2014), to equip them with cultural understanding, knowledge and skills to empower them to engage confidently in promoting the mental health and wellbeing of all young refugees. Such a paradigm shift is implicit throughout this document, but neither the implications, nor the scale and timeframe of necessary change, are addressed.

From our perspective the overarching challenge here is that much of the emphasis upon personal understanding and recognition of mental health and emotional wellbeing, together with encouragement to speak about and share mental health issues is premised upon Western-centric models of experiencing and managing trauma, low wellbeing and mental health conditions (Burnett and Peel, 2001; Papdopoulos et al; 2004; Zack-Williams, 2006). Such models may be unfamiliar and alienating to members of cultures and communities where emotional containment and self-reliance may be, or may have been, among their traditional practices.

As noted above, recognition must be given to diversity and difference and attention paid to the involvement of all communities in engagement, involvement and support for young refugees' mental health issues. The Green Paper was made available for public consultation until 2nd March 2018, with a commitment to publish findings. In advocating a social justice agenda for young refugees, we raised our concerns with the consultation; research in action influencing policy and practice.

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