"There is no mother to take care of you"

Zijlstra, A. Elianne ; Menninga, Marijke C.; Rip, Jet A.; Van Os, E. C. Carla; Knorth, Erik J.; Kalverboer, Margrite E.

Published in:
Residential Treatment for Children and Youth

DOI:
10.1080/0886571X.2018.1559118

Publication date:
2019

Residential Treatment for Children & Youth

ISSN: 0886-571X (Print) 1541-0358 (Online) Journal homepage: https://www.tandfonline.com/loi/wrtc20

'There is No Mother to Take Care of You'. Views of Unaccompanied Children on Healthcare, Their Mental Health and Rearing Environment

A. E. Zijlstra, M. C. Menninga, E. C. C. Van Os, J. A. Rip, E. J. Knorth & M. E. Kalverboer

To cite this article: A. E. Zijlstra, M. C. Menninga, E. C. C. Van Os, J. A. Rip, E. J. Knorth & M. E. Kalverboer (2019) 'There is No Mother to Take Care of You'. Views of Unaccompanied Children on Healthcare, Their Mental Health and Rearing Environment, Residential Treatment for Children & Youth, 36:2, 118-136, DOI: 10.1080/0886571X.2018.1559118

To link to this article: https://doi.org/10.1080/0886571X.2018.1559118

Published online: 25 Dec 2018.

RESIDENTIAL TREATMENT FOR CHILDREN & YOUTH
2019, VOL. 36, NO. 2, 118–136
https://doi.org/10.1080/0886571X.2018.1559118

Routledge
Taylor & Francis Group

'There is No Mother to Take Care of You'. Views of Unaccompanied Children on Healthcare, Their Mental Health and Rearing Environment

A. E. Zijlstra[a], M. C. Menninga[a], E. C. C. Van Os[a], J. A. Rip[a], E. J. Knorth[b], and M. E. Kalverboer[a]

[a]Study Centre for Children, Migration and Law, Faculty of Behavioural and Social Sciences, University of Groningen, The Netherlands; [b]Department of Special Needs Education and Youth Care, Faculty of Behavioural and Social Sciences, University of Groningen, The Netherlands

ABSTRACT

This study aimed to shed light on the opinions of unaccompanied refugee children (N = 98) in various care facilities in the Netherlands (small living groups, small living units, foster families, large reception centres) about their mental health, their healthcare needs and their rearing environment. A mixed methods design was applied. The quality of the child-rearing environment and the age on arrival in the host country proved to be predictive of mental health outcomes. Unaccompanied children living in large reception centres experienced the lowest quality of rearing environment, the highest mental health problems and poor access to mental healthcare. Implications for practice and research are reflected upon.

KEYWORDS

Unaccompanied children; mental health; healthcare; rearing environment; care facility

Introduction

In the Netherlands, residential care facilities fulfil an important role in the reception of unaccompanied refugee children. In the Dutch context, unaccompanied children are defined as children who are under the age of 18 years on arrival in the Netherlands, whose country of origin is outside the European Union and who travelled to the Netherlands without a parent or another person exercising authority over them. The Nidos Foundation, the Dutch guardianship organization, is responsible for the children's safety and well-being. The guardian arranges the reception of unaccompanied children. By the end of 2016, Nidos had guardianship over 1,869 unaccompanied children, 65% of whom were 16 or 17 years old (Nidos, 2017).

On arrival in the Netherlands, unaccompanied children are housed in large reception centres, foster families or small care facilities (i.e. small living groups and small living units). Most children younger than 15 and the most vulnerable children are placed in foster families, while 15 to 18-year-olds are

CONTACT A. E. Zijlstra a.e.zijlstra@rug.nl Study Centre for Children, Migration and Law, Department of Special Needs Education and Youth Care, Faculty of Behavioural and Social Sciences, University of Groningen, The Netherlands

placed in other types of reception facilities (Kalverboer et al., 2016). The small care facilities are comparable to the living groups and independent living programmes in residential child and youth care respectively. Small living groups accommodate 12–20 children and provide 24-hour supervision. Children in the small living units live together in groups of three or four children and supervision is available for a few hours a day (28 hours a week). Unaccompanied children are housed separately from other children in residential care. Campuses accommodate an average of 100 unaccompanied children and there is little supervision available (Zijlstra et al., 2018).

As in many countries in Europe or close to conflict zones, the Netherlands faced a rise in the number of unaccompanied children seeking asylum from 2014 (962) to 2015 (3,859), which increased the pressure on care facilities. In 2016, the number of children arriving fell by over 50% (1,706), but it was still almost twice the number of arrivals in 2014. In 2016, most unaccompanied children came from Eritrea (45%), Afghanistan (11%), and Syria (11%), together making up two-thirds of the total influx (IND, 2016). On arrival in the Netherlands, almost all these children applied for asylum.

A good deal of research has been conducted on the vulnerability of refugee children (Fazel, Reed, Panter-Brick, & Stein, 2012; Lustig, Kia-Keating, Knight, Geltman, & Ellis, 2004). Unaccompanied children are shown to be the most vulnerable within this group. They often suffer from post-traumatic stress, depression and psychosomatic complaints (Oppedal & Idsoe, 2012). Often, they have experienced traumatic events such as the death of a parent, war or exposure to violence. They lack parental support and care when fleeing and during their stay in the host country (Bean, Derluyn, Eurelings-Bontekoe, & Spinhoven, 2007; Fazel et al., 2012; Hodes, Jagdev, Chandra, & Cunniff, 2008; Vervliet, Lammertyn, Broekaert, & Derluyn, 2014). The period spent in the host country is also stressful and their mental health problems may increase because of the long period of uncertainty about a residence permit, among other things (Bronstein & Montgomery, 2011).

The psychological and psychiatric needs of unaccompanied children are often not met by mental health services (Heidi, Miller, Baldwin, & Abdi, 2011; Hopkins & Hill, 2010; Majumder, O'Reilly, Karim, & Vostanis, 2015). There is a discrepancy between the mental health problems among the population of refugees and asylum seekers and their use of the healthcare system (Gerritsen, Bramsen, Deville, Van Willigen, Hovens, & Van der Ploeg, 2006). Furthermore, the need for mental healthcare as perceived by the unaccompanied children themselves is very high compared to the need as assessed by their guardians and teachers (Bean, 2006). In the Netherlands, unaccompanied children have legal access to mental healthcare services irrespective of their residence status. Nevertheless, practice shows that guardians face difficulties arranging mental healthcare for unaccompanied children (Zijlstra et al., 2018).

Aside from mental healthcare needs, there is evidence that unaccompanied children do better in highly supportive reception facilities than in large-scale centres (Ni Raghallaigh, 2013; Wade, 2011). A study by Kalverboer et al. (2016) of unaccompanied children's perceptions of their daily lives shows that children living on campuses are most negative about their life circumstances compared with children residing in foster families. A study by Reijneveld, De Boer, Bean, and Korfker (2005) shows that unaccompanied children in more restrictive care facilities report emotional problems more often. Also, unaccompanied minors living in semi-independent accommodation in the United Kingdom have more traumatic symptoms than unaccompanied children in foster families (Bronstein, Montgomery, & Dobrowolski, 2012). There is limited research into the quality of the rearing environment of unaccompanied children in relation to their mental health status. It is known that a high-quality child-rearing environment creates opportunities for development (Zijlstra, Kalverboer, Post, Knorth, & Ten Brummelaar, 2012) and is linked to fewer social-emotional problems (Zijlstra, Kalverboer, Post, Ten Brummelaar, & Knorth, 2013). Creating a supportive and stimulating rearing environment for unaccompanied children could be a protective factor for mental health problems (Kalverboer et al., 2016; Zijlstra et al., 2012, 2013).

With this study, we sought to shed light on the perceptions and opinions of unaccompanied children in different care facilities regarding their (mental) health, their healthcare use and needs, and their feelings of being cared for. We also explored the relationship between the mental health of unaccompanied children and the quality of their rearing environment. The results of this study have implications for practice and policy on the care for unaccompanied children.

Method

On a yearly basis since 2010, the Study Centre for Children, Migration and Law at the University of Groningen has monitored the perception of unaccompanied children in the Netherlands regarding different aspects of their daily life, including their mental health situation. The monitoring study is an initiative of Nidos, the guardianship agency for unaccompanied children, and aims to improve the quality of the agency's policy and practice. About 25 children under Nidos' guardianship are interviewed each year. The data collected during the period 2012–2016 are included in this study.

A mixed methods design was applied in this cross-sectional study. First, we used a *qualitative* approach to find out about the (mental) health of unaccompanied children, their healthcare use and needs, and their perceptions of feeling cared for. Second, we used a *quantitative* approach to explore the relationship between their mental health situation and their rearing environment.

Participants

The research group consisted of 98 unaccompanied children (see Table 1). Some of the participants were also included in the study by Kalverboer et al. (2016). Most of the participants were male (70%) and their average age was 16.3 years (*SD* = 1.13). The children came from 27 different countries of origin, with most from Afghanistan, Somalia and Eritrea. Almost half of the children lived with a foster family (*n* = 42), 14 children resided in a small living group, 25 in a small living unit, and 17 on a campus. Forty-five percent of the unaccompanied children had a permanent or temporary residence permit. The remainder were still involved in an application procedure or their application had been unsuccessful. Most of the children in foster families had a residence permit. The mean age of children on arrival in the Netherlands was 14.5 years (*M* = 14.5, *SD* = 4.5). At the time of the interview, they had on average spent 43 months in the Netherlands (*M* = 43, *Md* = 24, *Min* = 6, *Max* = 204).

Procedure

An annual sample is taken of unaccompanied children who are under Nidos' guardianship and living in foster families or different types of care facilities. If the guardian of the unaccompanied children agreed, the children were invited to participate in the monitoring study. They received written and verbal information about the research. Children who were willing to participate were invited for an interview. Before the start of the interview, informed consent was obtained from each child. The research procedure and the

Table 1. Characteristics of participants (*N* = 98).

	N
Gender	
Male	69
Female	29
Age	
<15	8
15	12
16	25
17	49
>17	5
Type of care facility	
Foster family	42
Small living group	14
Small living unit	25
Campus	17
Top 3 of countries of origin	
Afghanistan	24
Somalia	12
Eritrea	9

confidentiality of the information shared with the interviewer were explained. The children were told that they could end the interview at any time if they no longer wished to take part in the study. If necessary, the guardian or caregiver provided aftercare for children who had negative feelings about the interview. The Ethics Committee of the University of Groningen had approved the research design.

A protocol was used for the semi-structured interview. The interviewers were trained Master's students in Pedagogical Sciences. The interview took between 45 minutes and two hours, depending on the children's desire to talk and open up. To provide agency, the children could decide on the location of the interview. The interviewer was also flexible about the timing of the topics during the interview. If the children did not have an adequate command of spoken Dutch or English, a translator was arranged. With the children's permission, the interviews were voice-recorded. Some children did not give their permission, in which case notes were taken and written up afterwards in the form of a report.

After the interview, the children completed the Strengths and Difficulties Questionnaire (SDQ) to identify social and emotional problems. If the child could not read, the translator read out the questions. Five children were unable to complete the SDQ, mainly because they were tired after the interview.

Based on the information gathered in the interview, the Master's students completed the Best Interests of the Child-Questionnaire (BIC-Q) to describe the rearing environment that the unaccompanied child was currently living in.

Instruments

Semi-Structured Interview

The interview protocol is based on a joint FRA (European Union Agency for Fundamental Rights) study, which was conducted in 12 European countries in 2009 (FRA, 2011). The interview contains several topics relating to the perceived quality of life. Only the topics '(mental) health' and '(mental) healthcare' were included in the qualitative part of this study

Strengths and Difficulties Questionnaire (SDQ)

The SDQ is a short questionnaire to assess a child's psychosocial adjustment. In this study, we use the self-report version for children up to 17 years old. The SDQ has been translated into more than 40 languages. The 25 items in the questionnaire are divided into the following scales: total problems, emotional problems, conduct problems, hyperactivity and peer problems. The response categories for the questions are: not true, somewhat true and certainly true. The outcomes of the SDQ on the scales are presented in four categories: 'on average,' 'slightly raised,' 'high,' and

'very high'. For the total problems, a score of 15–17 is 'slightly raised,' a score 18–19 is 'high,' and a score > 19 is 'very high'. For emotional problems, a score of 5 is 'slightly raised,' a score > 5 is 'high,' and a score > 6 is 'very high'. For conduct problems, a score of 4 is 'slightly raised,' a score of 5 is 'high,' and a score > 5 is 'very high'. For hyperactivity, a score of 6 is 'slightly raised,' a score of 7 is 'high,' and a score > 7 is 'very high'. For peer problems, a score of 3 is 'slightly raised,' a score of 4 is 'high,' and a score > 5 is 'very high' (www.sdq.info.com).

The reliability and validity of the SDQ are satisfactory. The SDQ is seen as a very useful screening tool for children's mental health problems (Achenbach et al., 2008; Goodman, 2001; Goodman, Renfrew, & Mullick, 2000; Mullick & Goodman, 2001).

Best Interests of the Child-Questionnaire (BIC-Q)

The BIC-Q measures the quality of the child's rearing environment as identified by a professional (Kalverboer & Zijlstra, 2006). The questionnaire contains 24 questions about the following 14 conditions for development, which together represent the quality of the rearing environment: Adequate physical care (1), Safe direct physical environment (2), Affective atmosphere (3), Supportive, flexible child-rearing structure (4), Adequate examples by parents or caregivers (5), Interest (6), Continuity in upbringing conditions (7), Safe wider physical environment (8), Respect (9), Social network (10), Education (11), Contact with peers (12), Adequate examples in society (13) and Stability in life circumstances (14). The first seven conditions relate to the family context, the last seven to the societal context. To qualify these conditions, the following answer categories were used: unsatisfactory (0), moderate (1), satisfactory (2) and good (3). The quality of the rearing environment was determined by adding up the qualifications for the 14 conditions. The total score ranged from 0 to 42. A score of 42 means that all conditions are qualified as 'good' (Zijlstra, 2012).

The inter- and intra-rater reliability of the BIC-Q were good (kappa = .65 and .74, respectively). The scalability and reliability of the general scale 'quality of the rearing environment' was also satisfactory (H = .55; Rho = .94) (Zijlstra et al., 2012).

Data Analysis

The interviews are transcribed. The answers of the 98 children on the interview topics '(mental) health' and 'healthcare' were first qualitatively analysed using a mixed deductive and inductive strategy. Based on the interview protocol, the deductive themes were health, access to healthcare, wishes concerning healthcare, use of healthcare, quality of care and care received by (foster) family, friends and social workers. During the coding process, inductive codes were added and recorded under the existing deductive themes in the codebook. The data corpus was read twice and ten interview transcripts were coded: meaningful text

fragments were assigned a code, similar codes were merged and partial recoding took place. The researcher then coded all the interview transcripts and added new inductive codes where necessary. The final recoding of transcripts and the finalizing of the codebook resulted in six deductive themes with 43 inductive codes. After the qualitative analysis, the codes were converted into quantitative variables. For example, for the theme 'use of healthcare', an assessment was made of how many children made use of the different types of healthcare (DeCuir-Gunby, Marshall, & McCulloch, 2011).

To identify the children's mental health, the mean scores and standard deviation on the scales of the SDQ were determined, as well as the numbers and percentages of children with 'high' and 'very high' scores on the SDQ. The SDQ scores and the interview outcomes were presented for the whole sample and for the subsamples of children living in the different care facilities.

To explore the relationship between mental health problems (measured with the SDQ) and the quality of the rearing environment (measured with the BIC-Q), an independent sample t-test was used. Here we compared the mean score on the quality of the rearing environment for the group with a '(very) high' SDQ score for total problems, emotional problems and peer problems with the group with an 'average' or 'slightly raised' score.

The association between the unaccompanied children's age on arrival in the Netherlands and additional predictors (type of care facility, residence status and duration of stay in the Netherlands) was estimated in order to prevent multicollinearity in the regression model (using ANOVA and Pearson correlation). We had expected this relationship because the Dutch reception and migration policy means that younger children (<15 years) have an additional opportunity to be granted a residence permit and are placed in highly supportive care facilities, which contribute to a healthy development on arrival in the Netherlands (Bronstein & Montgomery, 2011; Kalverboer et al., 2016).

A multiple linear regression analysis was performed to explore the relationship between the mental health problems of unaccompanied children (measured with the SDQ) and the quality of their rearing environment. The additional predictors (type of care facility, residence status, duration of stay in the Netherlands or age on arrival in the Netherlands) were added separately to the model later. In case of a high association between the predictors, a selection was made based on conceptual and statistical criteria. The assumptions of normality, linearity and homoscedasticity of the regression models were checked.

Results

Children's Views on Their (Mental) Health

When children were asked about their (mental) health, 42% of the unaccompanied children responded that they felt healthy. However, 11% of this

subgroup had had problems in the past. The other 57% indicated that they had problems with their (mental) health. About one-third (36%) of the subgroup that felt unhealthy said that they struggled with emotional problems, a further third (34%) reported sleeping problems, and 22% had (psycho) somatic symptoms. For example, children complained about headaches, stomach aches, problems with urinating, difficulties falling asleep, stress, feelings of depression or traumatic memories. Some children had physical problems such as an allergy or a knee injury. It is striking that some unaccompanied children associated health with physical health alone: although they reported feeling healthy, they also reported complaints associated with their mental health.

Almost all the children in the small living groups (13 children, 93% of subgroup) indicated that they had (mental) health problems, whereas 18 children in the small living units (72%), 9 children on campuses (53%) and 15 children in foster families (36%) reported (mental) health problems.

> I feel healthy, I have one problem: always when I eat and when I don't eat I have stomach ache. I try to drink my medicine but I don't know if it helps or what. Because every day I feel this and it make me feel bad. (small living group)

Feeling Cared For

Most unaccompanied children felt cared for when they were ill. Foster parents took care of children living in foster families, and children living in the other care facilities reported that their mentor looked after them when they were ill. Other peers in the living group or friends were also mentioned as people who took care of them when they were ill.

> When I am ill and lie on bed, my mentor takes care of me. (small living group)

Six children who lived in a small living group or campus mentioned that no one took care of them when they were ill. They had to look after themselves.

> There is no one who takes care when you get ill. If you are ill you have to go to the doctor and then you get tablets or something. There is no mother to take care of you. (campus)

Healthcare

About two-thirds (61%) of the unaccompanied children reported that they had recently made or were currently making use of healthcare provisions. Most of them had visited a general practitioner (34 children, 35%), often with (psycho) somatic complaints. These children spent most of the time living on campus, in small living units and in small living groups. Several children

reported that they had received care at a hospital or other public healthcare service. Some children took medicines for their sleeping problems.

Seventeen children (17%) had contact with mental health services at the time of the interview or had visited these services in the past. None of these 17 resided on a campus. Only 7 of the 27 children with a (very) high score on the emotional problems scale of the SDQ made use of mental healthcare or had done so in the recent past (outcomes SDQ, see below).

Most children were satisfied with the healthcare options in the Netherlands because they felt healthy and made only incidental use of healthcare. Most children who had attended mental healthcare services were satisfied about the care they received. Despite the difficulty of talking about their past and their problems, the children felt it was important to do so. One reason why some children were not satisfied with the mental healthcare that they received was that they did not feel understood by their therapist.

> The mental healthcare is good but I don't want to talk always about my problems with someone … I don't want to talk, but I try. I try, because I don't want to take medicines only and don't talk. I have to talk and take medicines together. That's why I speak. I'm talking because this helps me and also the medicines help. Therefore, it is important for me. But in my heart, I don't want it. (small living unit)

> My psychologist is listening to me but does not understand me. It is easier to talk with someone who really understands you. The boys who have experienced the same things understand me better. (small living unit)

Children who went to see a general practitioner with complaints such as a headache or stomach ache did not feel helped. The main wishes of unaccompanied children concerning healthcare were related to being taken seriously by a doctor who took the time to respond to their needs.

> If I'm sick, there is not taken well care of me. We need to make an appointment with the doctor, but they often give paracetamol, paracetamol only. We take care of ourselves, but if we ask the mentor to help, they will. (small living unit)

The Mental Health of Unaccompanied Children

The results of the SDQ demonstrate that about 30% of the unaccompanied children had emotional problems and a similar percentage had peer problems. They reported fewer conduct and hyperactivity problems (see Table 2). Children living on campuses and in small living groups experienced significantly more emotional problems than children living in foster families (M = 5.43 (campuses), M = 5.43 (small living groups), M = 3.10 (foster families); $p < .05$).

Table 2. Results SDQ Self Report (N = 93).

SDQ Scale	*M (SD)*	Number of children with (very) high score (% sample)
Total problems	11.47 (6.13)	13 (14%)
Emotional problems	4.09 (2.80)	27 (29%)
Conduct problems	1.59 (1.49)	4 (4%)
Hyperactivity problems	3.16 (2.01)	4 (4%)
Peer problems	2.65 (1.88)	29 (31%)

The Mental Health of Unaccompanied Children and Their Rearing Environment

Table 3 presents the results for the quality of the rearing environment of unaccompanied children. The mean score for the quality of the rearing environment was 29.48 (SD = 8.55).

Concerning unaccompanied children with a (very) high score on the SDQ-scales 'emotional problems' and 'total problems', the living environment is judged significantly lower compared with children with an average of slightly raised score (emotional problems: M = 32.18 and M = 24.93 respectively, $p < .001$; total problems: M = 21.69 and M = 31.44 respectively, $p < .001$). A difference in the quality of the rearing environment was also found between unaccompanied children with a (very) high SDQ score for peer problems and children with an average or slightly raised score. However, this difference was not significant (M = 27.28 and M = 31.34 respectively, p = .06).

Table 3. Mean score of the quality of the rearing environment (BIC-Q), related to the social-emotional well-being of the child (SDQ) and the type of care facility the child is living in (N = 98).

	Quality of rearing environment (BIC-Q)[a] *M (SD)*
Total sample (n = 98)	29.48 (8.55)
SDQ Emotional problems	
High/very high score (n = 27)	24.93 (8.90)*
On average/slightly raised score (n = 66)	32.18 (6.98)
SDQ Peer problems	
High/very high score (n = 29)	27.28 (10.01)
On average/slightly raised score (n = 64)	31.34 (7.00)
SDQ Total problems	
High/very high score (n = 13)	21.69 (9.06)*
On average/slightly raised score (n = 80)	31.44 (7.28)
Type of care facility	
Foster families (n = 42)	35.14 (5.89)**
Small living groups (n = 14)	25.14 (5.87)
Small living unit (n = 25)	28.76 (5.48)***
Campus (n = 17)	20.12 (9.31)

[a]Range from 0 (lowest quality) to 42 (highest quality).
*Significant difference with the subgroup with an on average/slightly raised score ($p < .001$)
**Significant difference with the other three care facilities ($p < .001$)
***Significant difference with the campus ($p < .001$)

The quality of the rearing environment was significantly higher for children in foster care than those living in a small living group, small living unit and on a campus (M = 35.14, M = 25.14, M = 28.76 and M = 20.12, respectively, $p < .001$). The quality was lowest for the campus (M = 20.12; SD = 9.31).

The children's age on arrival in the Netherlands was related to the type of care facility (foster families: M = 9.67, SD = 5.40; small living group: M = 15.18, SD = 1.02; small living unit: M = 15.14, SD = .90; campus: M = 15.34, SD = 1.04; $p < .001$). 'Age on arrival' was also related to the child's residence status (children with a permanent or temporary residence permit: M = 11.95, SD = 5.44; children without a permanent or temporary residence permit: M = 15.07, SD = .93; p = .004) and the duration of stay in the Netherlands (r = .98, $p < .001$).

Regression analysis, using 'quality of the rearing environment' as the main predictor, showed that 23% of the variance in the 'emotional problems' of unaccompanied children could be explained (adjusted R^2 = .23, F(1,91) = 28.72, $p < .001$; see Table 4, model 1). The addition of 'age on arrival' improved the prediction: the model explained 33% of the variance in 'emotional problems' (adjusted R^2 = .33, F(2,85) = 22.33, $p < .001$; see Table 4, model 2). This means that the lower the quality of the rearing environment and the higher the age on arrival, the higher the incidence of emotional problems among the children. The assumption of normality, linearity and homoscedasticity of the regression model were not violated. The addition of 'type of care facility', 'residence status' or 'duration of stay in the Netherlands' did not make a significant contribution to the prediction model.

Although significant, the prediction of the SDQ scores for 'total problems' and 'peer problems' showed a weaker prediction model. The regression analysis showed that the quality of the rearing environment explained 20% and 10% of the variance respectively (total problems: adjusted R^2 = .21, F(1,91) = 23,64, $p < .001$; peer problems: adjusted R^2 = .11, F(1,91) = 11,18, $p < .001$).

Discussion

Unaccompanied children benefit from a good-quality child-rearing environment: those who feel loved and cared for, respected and stimulated in their

Table 4. Regression analysis for the prediction of emotional problems of unaccompanied children (SDQ) (N = 93).

Model	*Predictor*	*B*	*SE*	*Beta*	*t*	*Sign.*
1	Constant	9.12	.97		9.37	.00
	Quality of the rearing environment	−.17	.03	−.49	−5.36	.00
2	Constant	5.80	1.49		3.53	.00
	Quality of the rearing environment	−.13	.03	−.37	−3.84	.00
	Age on arrival	.21	.06	−.34	3.57	.00

development seem to have fewer emotional problems. We regard this as the main result of our study. We used the BIC-Q to measure the perceived quality of the living environment in reception facilities, foster families and in the wider society. This quality was strongly associated with the outcomes on the children's 'emotional problems' scale of the SDQ: the better the caregivers were able to support the children's development, the fewer emotional problems the children seemed to have. This is not a surprising result since the BIC-Q is based on a broad international overview of the literature on conditions that need to be fulfilled to protect the safe and continuous development and social-emotional well-being of children (Kalverboer & Zijlstra, 2006; Zijlstra et al., 2012). The BIC-Q differentiates between family conditions, such as the extent to which parents provide an affective and structured climate at home, and conditions in society, such as education and peer contacts (Kalverboer & Zijlstra, 2006; Zijlstra et al., 2012). Previous research has indicated that the best conditions for the development of unaccompanied children are provided in foster families and small-scale residential care facilities rather than in large reception centres such as campuses (Kalverboer et al., 2016). More than a decade ago, other researchers found similar results when comparing the mental health of unaccompanied children in restrictive large-scale reception centres in the Netherlands with that of unaccompanied children in 'regular' reception centres offering more autonomy (Bean et al., 2007; Reijneveld et al., 2005). British research among unaccompanied children confirmed that those living with foster families had significantly fewer trauma-related symptoms than their peers in semi-independent care arrangements (Bronstein et al., 2012).

The child's age upon arrival appears to correlate significantly with mental health outcomes. This could be explained by the fact that the chance of being granted a residence permit and being placed in a highly supportive environment – two factors that promote the well-being of refugee children (Bronstein & Montgomery, 2011; Kalverboer et al., 2016) – is higher when children are younger on arrival in the Netherlands. The same effect of age upon arrival, mediated by the type of residence where the children live, has been found in other research in the Netherlands (Bean et al., 2007).

More than half (57%) of the unaccompanied children in this study reported health problems in the interviews, whereas 43% felt healthy. Almost one-third of the children showed emotional problems and another third reported having problems with peers (SDQ). These percentages of self-reported health problems are considerably higher than for other adolescents in the Netherlands. Within the Dutch population of 16 to 20-year-olds, 89% consider their health as 'good' or 'excellent' (Ministry for Public Health, Well-being and Sports, 2014). This percentage is comparable to the situation

in Norway, for example, where 88% of 13 to 19-year-olds assess their health as being '(very) good' (Breidablik, Meland, & Lydersen, 2008).

Our study found that the quality of the rearing environment was lowest for children living in large reception centres (see also Kalverboer et al., 2016). This same subgroup was also more likely to experience emotional and peer problems. Against this background, it is surprising that none of the children residing at a campus had been in contact with mental health services. Some children in our study reported that they did not feel that they were taken seriously by the 'doctor' (usually a nurse) at the reception centre because they were only given painkillers. This limited access to healthcare for unaccompanied children in reception centres has also been reported in other Dutch research (Buil & Siegel, 2014; Van Os, Zijlstra, & Grietens, 2017).

At the same time, many of the children seem to have interpreted health in physical terms and often hesitated to talk about their (mental) health problems with professionals. Similar results have been reported in other studies. For example, studies of unaccompanied children in the United Kingdom and Australia found that the children had negative attitudes towards mental health in general and mental health services in particular (Colucci, Minas, Szwarc, Guerra, & Paxton, 2015; Majumder et al., 2015), and that, considering the high level of emotional symptoms they presented, they were underutilizing mental health services (Colucci et al., 2015; Sanchez-Cao, Kramer, & Hodes, 2013). Bean et al. (2007) reported: '… guardians and teachers are not always accurate in the individual assessment of the well-being of refugee children'.

Strengths and Limitations

An important strength of this study is its mixed methods design. We used interviews to gain insight into the opinions and perceptions of unaccompanied children about their (mental) health and their experiences with (mental) healthcare. A special feature was the quantitative part of the study, in which the quality of the children's rearing environment was related to their mental health outcomes.

This study also has some limitations and the results must therefore be interpreted with some caution. The study's relatively small sample ($N = 98$) is not representative of all unaccompanied children in the Netherlands and the study only included unaccompanied children who wanted to participate. There is little information on the children who did not want to take part or who were not invited to do so by their guardians. As a result, children living in foster families were better represented than children living in small care facilities and large reception centres.

The needs of unaccompanied children are also very complex (Thomas, Thomas, Nafees, & Bhugra, 2004). We were not able to include all the

variables associated with mental health outcomes, such as the extraordinarily stressful life events that these children had experienced (Vervliet et al., 2014) or the current stress relating to acculturation in the host country (Keles, Friborg, Idsøe, Sirin, & Oppedal, 2016). In addition, resilience factors are relevant in the context of mental healthcare for unaccompanied children (Sleijpen, Boeije, Kleber, & Mooren, 2016). Our study involved resilience factors relating to the rearing environment (e.g. education and contact with peers). However, how the children actually coped with stress remained outside the scope of this study (see Woodland, Porter, & LeBuffe, 2011).

The unaccompanied children's lack of familiarity with the (Western) healthcare system may have influenced their opinions about mental health and mental healthcare services. This explorative study has shed some initial light on children's experiences with healthcare and has shown that their mental healthcare needs are high and that access could be better. Heidi et al. (2011) have reported several barriers to accessing or using mental healthcare services for refugee youth: mistrust of authorities and systems, the stigma of mental illness, and language and cultural barriers. Further in-depth research on the perceptions of unaccompanied children regarding healthcare should include the barriers that they experience.

Implications for Practice and Research

This study underlines the need for a longitudinal study of the mental health and rearing environment of unaccompanied children. Repeated measurements provide insight into the patterns relating to healthy/unhealthy developmental outcomes of unaccompanied children. It is important to monitor the (mental) health of unaccompanied children in practice – at least from their arrival in the host country to the time a durable solution regarding their future place of residence has been found (cf. Vervliet et al., 2014). On arrival, many unaccompanied children experience anxiety, depression and trauma-related stress disorders (Van Os, Kalverboer, Zijlstra, Post, & Knorth, 2016). Another study shows that unaccompanied children with severe stress-related symptoms on arrival were still experiencing emotional distress one or two year's later (Bean et al., 2007).

The needs of unaccompanied children evolve due to changes in flight streams, policy and characteristics of the population. To identify the actual needs of this vulnerable group, annual research is recommended. This should include the quality of the rearing environment, mental health, traumatic events and acculturation stress.

In addition, it can be difficult for professionals to assess these emotional symptoms with the children (Bean et al., 2007; Vervliet et al., 2014). Professionals – such as guardians, caregivers and social workers – need to take time to build trust and establish a bond (Van Os, Zijlstra, Post, Knorth, & Kalverboer, 2018). Without that, they cannot be expected to see or hear, let

alone understand, all the mental health problems that unaccompanied refugee children may experience (Adams, 2009; Chase, 2010; Katsounari, 2014; Kohli, 2006). It is important that the causes of mistrust, and how to address mistrust, be included in the curriculum of professionals working with unaccompanied minors.

As in non-refugee households, the parents are most influential in the help-seeking process of adolescents (Wahlin & Deane, 2012). For unaccompanied children, the daily caregivers are the ones who have to support them in accessing healthcare whenever necessary. Frequent relocations of unaccompanied children present an additional barrier to building trust with social workers in the host country (Ní Raghallaigh, 2014). At the same time, discontinuity of care is a barrier to the use of mental health services by unaccompanied children (Colucci et al., 2015). Relocations should therefore be avoided as much as possible.

This study provides a relevant contribution to research and practice concerning unaccompanied children. It is in line with the guidelines of the Committee on the Rights of the Child (2013) to gather the opinions of unaccompanied children when trying to act in their best interests in decision-making about healthcare and shelter. It is also important to involve the voices of children in research on out-of-home care services (Holland, 2009). The children in this study have clearly shown the importance of investing in the quality of care facilities and of taking their (mental) healthcare needs seriously.

A high-quality rearing environment can be very important for the mental health outcomes of unaccompanied children. As shown by previous research in the Netherlands, unaccompanied children in foster families and small-scale reception facilities perform best (cf. Bean et al., 2007; Kalverboer et al., 2016). To ensure better mental health for older unaccompanied children, the special safeguards in the Dutch reception and migration policy for younger unaccompanied children should also be available to older children to protect their developmental interests. As with research on out-of-home care provisions, family-based settings – such as foster homes or family-like group care – are preferred for these children (Leloux-Opmeer, Kuiper, Swaab, & Scholte, 2016). The positive impact of living in a family-like, small-scale setting or community cannot be underestimated for young people who are alone, on the move and in search of protection.

References

Achenbach, T. M., Becker, A., Dopfner, M., Heiervang, E., Roessner, V., Steinhausen, H. C., & Rothenberger, A. (2008). Multicultural assessment of child and adolescent psychopathology with ASEBA and SDQ instruments: Research findings, applications, and future

directions. *Journal of Child Psychology and Psychiatry*, *49*, 251–275. doi:10.1111/j.1469-7610.2007.01867.x

Adams, M. (2009). Stories of fracture and claim for belonging: Young migrants' narratives of arrival in Britain. *Children's Geographies*, *7*(2), 159–171. doi:10.1080/14733280902798878

Bean, T., Eurelings-Bontekoe, E., & Spinhoven, P. (2007). Course and predictors of mental health of unaccompanied refugee minors in the Netherlands: One year follow-up. *Social Science and Medicine*, *64*(6), 1204–1215. doi:10.1016/j.socscimed.2006.11.010

Bean, T. M. (2006). *Assessing the psychological distress and mental health care needs of unaccompanied refugee minors in the Netherlands*. PhD Thesis, University of Leiden.

Breidablik, H., Meland, E., & Lydersen, S. (2008). Self-rated health in adolescence: A multifactorial composite. *Scandinavian Journal of Public Health*, *36*(1), 12–20. doi:10.1177/1403494807085306

Bronstein, I., & Montgomery, P. (2011). Psychological distress in refugee children: A systematic review. *Clinical Child and Family Psychology Review*, *14*(1), 44–56. doi:10.1007/s10567-010-0081-0

Bronstein, I., Montgomery, P., & Dobrowolski, S. (2012). PTSD in asylum-seeking male adolescents from Afghanistan. *Journal of Traumatic Stress*, *25*(5), 551–557. doi:10.1002/jts.21740

Buil, C., & Siegel, M. (2014). *Afghan unaccompanied minors in the Netherlands: Far away from home and protected?* (UNU-MERIT Working Papers, 2014-037). Retrieved from: http://pub.maastrichtuniversity.nl/6b861e3f-bd86-4d33-8faa-cc19a71b66cf

Chase, E. (2010). Agency and silence: Young people seeking asylum alone in the UK. *British Journal of Social Work*, *40*(7), 2050–2068. doi:10.1093/bjsw/bcp103

Colucci, E., Minas, H., Szwarc, J., Guerra, C., & Paxton, G. (2015). In or out? Barriers and facilitators to refugee-background young people accessing mental health services. *Transcultural Psychiatry*, *52*(6), 766–790. doi:10.1177/1363461515571624

Committee on the Rights of the Child (2013). *General Comment No. 14 (2013) The right of the child to have his or her best interests taken as a primary consideration* (art.3, para 1). UN docs: CRC/C/GC/14.

DeCuir-Gunby, J. T., Marshall, P. L., & McCulloch, A. W. (2011). Developing and using a codebook for the analysis of interview data: An example from a professional development research project. *Field Methods*, *23*(2), 136–155. doi:10.1177/1525822X10388468

Fazel, M., Reed, R. V., Panter-Brick, C., & Stein, A. (2012). Mental health of displaced and refugee children resettled in high-income countries: Risk and protective factors. *Lancet*, *379*(9812), 266–282. doi:10.1016/s0140-6736(11)60051-2

FRA. (2011). *Separated, asylum-seeking children in European Union Member States, Comparative report*. Luxembourg, Luxembourg: Publications Office of the European Union.

Gerritsen, A. A. M., Bramsen, I., Devillé, W., Van Willigen, L. H. M., Hovens, J. E., & Van der Ploeg, H. M. (2006). Use of health care services by Afghan, Iranian, and Somali refugees and asylum seekers living in the Netherlands. *European Journal of Public Health*, *16*(4), 394–399. doi:10.1093/eurpub/ckl046

Goodman, R. (2001). Psychometric properties of the strengths and difficulties questionnaire. *Journal of the American Academy of Child and Adolescent Psychiatry*, *40*(11), 1337–1345. doi:10.1097/00004583-200111000-00015

Goodman, R., Renfrew, D., & Mullick, M. (2000). Predicting type of psychiatric disorder from strengths and difficulties questionnaire (SDQ) scores in child mental health clinics in London and Dhaka. *European Child and Adolescent Psychiatry*, *9*, 129–134.

Heidi, B., Miller, A., Baldwin, H., & Abdi, S. (2011). New directions in refugee youth mental health services: Overcoming barriers to engagement. *Journal of Child and Adolescent Trauma*, *4*(1), 69–85. doi:10.1080/19361521.2011.545047

Hodes, M., Jagdev, D., Chandra, N., & Cunniff, A. (2008). Risk and resilience for psychological distress amongst unaccompanied asylum seeking adolescents. *Journal of Child Psychology and Psychiatry*, *49*(7), 723–732. doi:10.1111/j.1469-7610.2008.01912.x

Holland, S. (2009). Listening to children in care: A review of methodological and theoretical approaches to understanding looked after children's perspectives. *Children and Society*, *23* (3), 226–235. doi:10.1111/j.1099-0860.2008.00213.x

Hopkins, P., & Hill, M. (2010). The needs and strengths of unaccompanied asylum-seeking children and young people in Scotland. *Child and Family Social Work*, *15*(4), 399–408. doi:10.1111/j.1365-2206.2010.00687.x

IND (2016). *Asylum trends. Monthly report on asylum applications in the Netherlands*. December. Rijswijk, The Netherlands: Author. Retrieved from: https://ind.nl/en/Documents/AT_December_2016.pdf

Kalverboer, M., Zijlstra, E., Van Os, C., Zevulun, D., Ten Brummelaar, M., & Beltman, D. (2016). Unaccompanied minors in the Netherlands and the care facility in which they flourish best. *Child and Family Social Work*. doi:10.1111/cfs.12272

Kalverboer, M. E., & Zijlstra, A. E. (2006). *Het belang van het kind in het Nederlands recht: Voorwaarden voor ontwikkeling vanuit een pedagogisch perspectief [The interests of the child in Dutch law: Conditions of child development from a pedagogigal perspective]*. Amsterdam, The Netherlands: SWP Publishers.

Katsounari, I. (2014). Integrating psychodynamic treatment and trauma focused intervention in the case of an unaccompanied minor with PTSD. *Clinical Case Studies*, *13*(4), 352–367. doi:10.1177/1534650113512021

Keles, S., Friborg, O., Idsøe, T., Sirin, S., & Oppedal, B. (2016). Depression among unaccompanied minor refugees: The relative contribution of general and acculturation-specific daily hassles. *Ethnicity and Health*, *21*(3), 300–317. doi:10.1080/13557858.2015.1065310

Kohli, R. K. S. (2006). The sound of silence: Listening to what unaccompanied asylum-seeking children say and do not say. *British Journal of Social Work*, *36*(5), 707–721. doi:10.1093/bjsw/bch305

Leloux-Opmeer, H., Kuiper, C., Swaab, H., & Scholte, E. (2016). Characteristics of children in foster care, family-style group care, and residential care: A scoping review. *Journal of Child and Family Studies*, *25*(8), 2357–2371. doi:10.1007/s10826-016-0418-5

Lustig, S. L., Kia-Keating, M., Knight, W. G., Geltman, P., Ellis, H., Kinzie, J. D., … Saxe, G. N. (2004). Review of child and adolescent refugee mental health. *Journal of the American Academy of Child and Adolescent Psychiatry*, *43*(1), 24–36. doi:10.1097/00004583-200401000-00012

Majumder, P., O'Reilly, M., Karim, K., & Vostanis, P. (2015). 'This doctor, I not trust him, I'm not safe': The perceptions of mental health and services by unaccompanied refugee adolescents. *International Journal of Social Psychiatry*, *61*(2), 129–136. doi:10.1177/0020764014537236

Ministry for Public Health, Well-being and Sports. (2014). *Prevalentie ervaren gezondheid jeugd 2014 [Prevalence self-reported healthyouth 2014]*. The Hague, The Netherlands: National Institute for Public Health and Environment (RIVM). Retrieved from https://www.volksgezondheidenzorg.info/onderwerp/ervaren-gezondheid/cijfers-context/huidige-situatie#node-prevalentie-ervaren-gezondheid-jeugd;http://statline.cbs.nl/Statweb/publication/?DM=SLNL&PA=83005ned&D1=0&D2=0-13&D3=0&D4=l&VW=T

Mullick, M. S., & Goodman, R. (2001). Questionnaire screening for mental health problems in Bangladeshi children: A preliminary study. *Social Psychiatry and Psychiatric Epidemiology*, *36*(2), 94–99.

Ní Raghallaigh, M. (2013). *Foster care and supported lodgings for separated asylum seeking young people in Ireland: The views of young people, carers and stakeholders*. Dublin, Ireland: Barnados and the Health Service Executive.

Ní Raghallaigh, M. (2014). The causes of mistrust amongst asylum seekers and refugees: Insights from research with unaccompanied asylum-seeking minors living in the Republic of Ireland. *Journal of Refugee Studies*, *27*(1), 82–100. doi:10.1093/jrs/fet006

Nidos (2017). *Jaarverslag 2016* [Annual report 2016]. Utrecht, The Netherlands: Author. Retrieved from: https://www.nidos.nl/wp-content/uploads/2017/05/Nidos-jaarverslag-2016.pdf

Oppedal, B., & Idsøe, T. (2012). Conduct problems and depression among unaccompanied refugees: The association with premigration trauma and acculturation. *Anales De Psicologia*, *28*, 683–694.

Reijneveld, S. A., De Boer, J. B., Bean, T., & Korfker, D. G. (2005). Unaccompanied adolescents seeking asylum: Poorer mental health under a restrictive reception. *Journal of Nervous and Mental Disease*, *193*(11), 759–761. doi:10.1097/01.nmd.0000185870.55678.82

Sanchez-Cao, E., Kramer, T., & Hodes, M. (2013). Psychological distress and mental health service contact of unaccompanied asylum-seeking children. *Child: Care, Health and Development*, *39*(5), 651–659. doi:10.1111/j.1365-2214.2012.01406.x

Sleijpen, M., Boeije, H. R., Kleber, R. J., & Mooren, T. (2016). Between power and powerlessness: A meta-ethnography of sources of resilience in young refugees. *Ethnicity and Health*, *21*(2), 158–180. doi:10.1080/13557858.2015.1044946

Thomas, S., Thomas, S., Nafees, B., & Bhugra, D. (2004). 'I was running away from death' - the pre- flight experiences of unaccompanied asylum seeking children in the UK. *Child: Care, Health and Development*, *30*(2), 113–122. doi:10.1111/j.1365-2214.2003.00404.x

Van Os, C., Zijlstra, E., & Grietens, H. (2017). Haalbaarheidsonderzoek Geweld in de Jeugdzorg – Alleenstaande minderjarige vreemdelingen. [Feasibilty study into experiences of violence in care with unaccompanied minors] In Commissie Geweld in de Jeugdzorg Ed. *Aanvullend vooronderzoek*, 79–141. The Hague, The Netherlands: Commissie Geweld in de Jeugdzorg. Retrieved from https://www.commissiegeweldjeugdzorg.nl/binaries/Aanvullend%20vooronderzoek%20Commissie%20Geweld%20Jeugdzorg_tcm18-269213.pdf

Van Os, E. C. C., Zijlstra, A. E., Post, W. J., Knorth, E. J., & Kalverboer, M. E. (2018). Finding keys: A systematic review of barriers and facilitators for refugee children's disclosure of their life stories. *Trauma, Violence, & Abuse*, 1–19. doi:10.1177/1524838018757748

Van Os, E.C.C., Kalverboer, M. E., Zijlstra, A. E., Post, W. J., & Knorth, E. J. (2016). Knowledge of the unknown child: A systematic review of the elements of the Best Interests of the Child Assessment for recently arrived refugee children. *Clinical Child and Family Psychology Review*, *19*(3), 185–203. doi:10.1007/s10567-016-0209-y

Vervliet, M., Lammertyn, J., Broekaert, E., & Derluyn, I. (2014). Longitudinal follow-up of the mental health of unaccompanied refugee minors. *European Child and Adolescent Psychiatry*, *23*(5), 337–346. doi:10.1007/s00787-013-0463-1

Wade, J. (2011). Preparation and transition planning for unaccompanied asylum-seeking and refugee young people: A review of evidence in England. *Children and Youth Services Review*, *33*, 2424–2430. doi:10.1016/j.childyouth.2011.08.027

Wahlin, T., & Deane, F. (2012). Discrepancies between parent- and adolescent-perceived problem severity and influences on help seeking from mental health services. *Australian and New Zealand Journal of Psychiatry*, *46*(6), 553–560. doi:10.1177/0004867412441929

Woodland, S., Porter, R. E., & LeBuffe, P. A. (2011). Assessing strengths in residential treatment: Looking at the whole child. *Residential Treatment for Children and Youth*, *28*(4), 283–302. doi:10.1080/0886571X.2011.615233

Zijlstra, A. E. (2012). *the best interest of the child? A study into a decision-support tool validating asylum-seeking children's rights from a behavioural scientific perspective*. PhD Thesis, University of Groningen.

Zijlstra, A. E., Kalverboer, M. E., Post, W. J., Knorth, E. J., & Ten Brummelaar, M. D. C. (2012). The quality of the childrearing environment of refugee or asylum-seeking children and the best interests of the child: Reliability and validity of the BIC-Q. *Behavioral Sciences and the Law*, *30*(6), 841–855. doi:10.1002/bsl.1998

Zijlstra, A. E., Kalverboer, M. E., Post, W. J., Ten Brummelaar, M. D. C., & Knorth, E. J. (2013). Could the BIC-Q be a decision-support tool to predict the development of asylum-seeking children? *International Journal of Law and Psychiatry*, *36*(2), 129–135. doi:10.1016/j.ijlp.2013.01.005

Zijlstra, E., Rip, J., Beltman, D., Van Os, C., Knorth, E. J., & Kalverboer, M. (2018). Unaccompanied children in the Netherlands: Legislation, policy, and care. *Social Work and Society*, *15*(2), 1–20.