PROFIADAU NIWEIDIOL MEWN PLENTYNDOD
ADVERSE CHILDHOOD EXPERIENCES

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Adverse Childhood Experiences in child refugee and asylum seeking populations

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Foreword

This timely report provides an important contribution towards understanding the ways in which Adverse Childhood Experiences affect young Sanctuary Seekers. The stark findings collected in this report demonstrate the need for public services in Wales to be trauma- and adverse childhood experiences-informed. This will enable them to consider the steps they need to take to develop a trauma responsive approach in delivering their services.

Young Sanctuary Seekers contend with adverse experiences in their countries of origin, which often force them to flee. Journeys are arduous and involve further traumatic experiences. Finally, they arrive in the UK and claim asylum but this report shows that they can experience further adverse experiences in the process of claiming asylum and when they seek to integrate into our communities.

The information contained in the report can help public authorities in Wales put in place better, more targeted support for young Sanctuary Seekers and help us to move another step closer to becoming a Nation of Sanctuary.

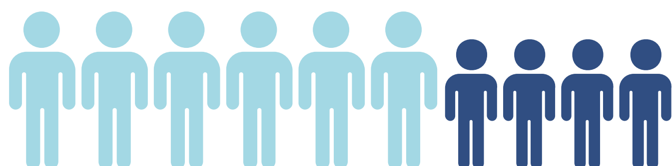
Jane Hutt AM
Deputy Minister and Chief Whip

Adverse Childhood Experiences (ACEs) in child refugee and asylum seeking populations

Applications for asylum* in the UK[1]

29,380 people (excluding dependents) applied for asylum in the UK in 2018.

40% of people granted asylum, humanitarian protection or alternative forms of leave and resettlement in 2018/19 were **children**.

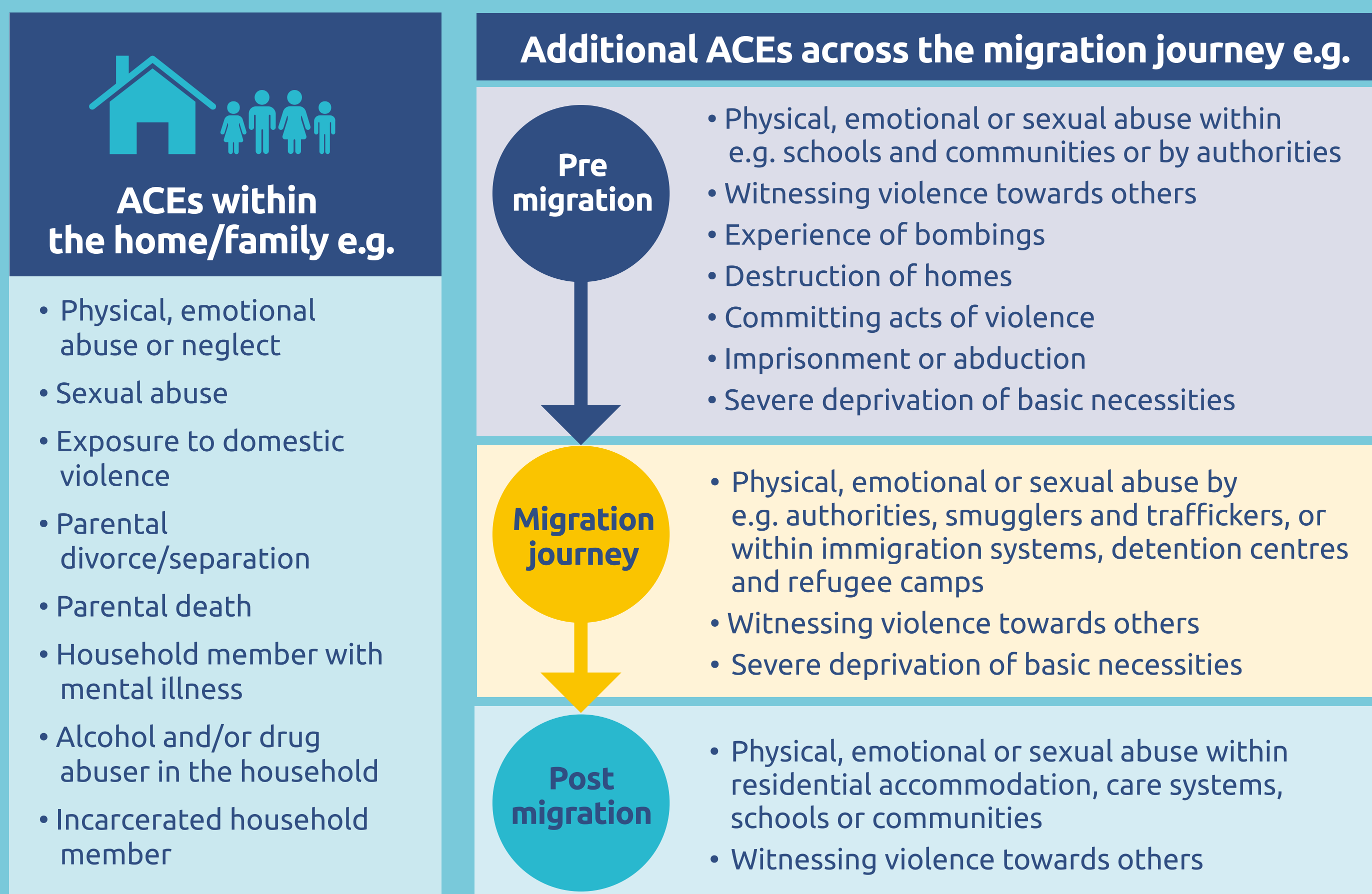


In Wales,

2,842 destitute asylum seekers and their dependents were being supported under section 95[2] of the Immigration and Asylum Act 1999 at the end of March 2019.

394 people were resettled via the Vulnerable Persons'/Children's resettlement schemes in 2018/19.

Children seeking sanctuary may have experienced multiple ACEs across the migration journey



Parental stress and trauma from migration can increase the risk of ACEs occurring within the family during and after migration

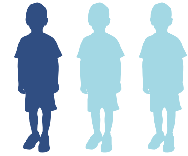
Experience of ACEs among refugee and asylum seeking children can increase the risk of:

Mental health problems such as PTSD, depression and anxiety

Physical health problems including injury and infection

Behavioural problems

And can affect academic achievement


Up to a third of young refugees settling in European countries are thought to be affected by a mental health disorder[3].

Certain factors increase the risk of experiencing harms from ACEs

Experiencing multiple ACEs	Being unaccompanied	Pre-existing vulnerability	Poor parental mental health	Parental financial difficulties
Low host country language skills	Low levels of social support	Perceived discrimination	Longer asylum seeking duration	More relocations in the system

Other factors promote resilience (the ability to overcome challenges)

Individual factors

e.g. pro-social behaviours, belief that life has meaning, the ability to think positively

Family factors

e.g. positive early attachment to caregivers, good family functioning, good parental mental health

Community factors

e.g. peer friendships, school attendance, good community resources

There is much we can do in Wales to prevent ACEs and their negative impacts

- Alongside on-going work on ACEs in general, **develop understanding of ACEs** among refugee and asylum seeking children living in Wales
- **Provide TrACE (trauma and ACE) informed services** for children and families along the pathway of care
- Target **unaccompanied minors** and those experiencing **multiple ACEs** for more comprehensive support
- **Understand and address the challenges of resettlement** in Wales (social, economic, cultural) to help develop and maintain sources of resilience

In Wales, a number of organisations involved in the support and care of refugee and asylum seeking families and children have trained or are training staff in ACE awareness.

* See Box 1 in main report for definitions of an asylum seeker and a refugee 1. Home Office 2019. 2. Section 95 support is for asylum seekers that have on-going claims, who are destitute or almost destitute and their dependents 3. Kien et al, 2018

The information in this infographic is taken from the report: Adverse Childhood Experiences in child refugee and asylum seeking populations. Wood S, Ford K, Hardcastle K, Hopkins J, Hughes K. and Bellis M A (2020). Cardiff: Public Health Wales NHS Trust.

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Introduction

The number of people applying for asylum (Box 1) in the UK has fluctuated over the last couple of decades, largely due to the onset of global events such as conflict. In 2018, the number of people (excluding dependents) applying for asylum in the UK was 29,380 (1; Box 3). The majority were from regions of the Middle East, south Asia and Africa (2). Whilst this figure is high, it is far lower than the peak of applications made between 1999 (71,027) and 2002 (84,132), many of which were made by individuals journeying from countries in conflict, such as Somalia, Afghanistan, Iraq and the former Yugoslavia (2). In the UK, 17,304 people (including dependents) were granted asylum, humanitarian protection or alternative forms of leave and resettlement in 2018/19, a 22% increase from 2017/18 (1). A large proportion of those granted asylum are under 18 years of age (40% in 2018/19 [1]). These children may have travelled alone (known as Unaccompanied Asylum Seeking Children; UASC), with family members, or with smugglers or traffickers (3). Many of these children will have experienced substantial trauma and adversity in their home countries and during their migration journey (4), as well as post migration.

Box 1: Definitions of asylum seekers and refugees

An **asylum seeker** is a person who either: (a) makes a request to be recognised as a refugee under the Refugee Convention on the basis that it would be contrary to the UK's obligations under the Convention for him to be removed from or required to leave the UK, or b) otherwise makes a request for international protection (Home Office [5]).

A **refugee** is a person who "owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of his nationality, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country." (The 1951 Refugee Convention [6]).

Chronic or traumatic stressors experienced early in life are collectively termed Adverse Childhood Experiences (ACEs). A wealth of research has highlighted the impact that ACEs can have on health and behaviour across the life course (7–9) (Box 2). Experiencing ACEs increases the likelihood of children adopting risk behaviours and developing mental health problems and chronic health conditions later in life, and the more ACE types children experience, the greater their risks of poor outcomes. In high-income countries, work on ACEs has largely focused on those affecting children in domestic settings, reflecting a lack of safety and nurturing care within the family. These include physical and psychological abuse, neglect, exposure to domestic violence, and parental substance abuse, mental illness or incarceration. In addition, work on ACEs has explored childhood exposure to sexual abuse, which may occur within family or wider settings. Such ACEs have been measured in national surveys. Elsewhere, however, tools to measure ACEs have been adapted to incorporate other ACE types that can be prevalent among children, such as exposure to violence in the community, persecution or conflict (e.g. the World Health Organization's ACE-IQ; Box 4).

In Wales, 2,842 destitute asylum seekers and their dependents were being supported under Section 95[a] of the Immigration and Asylum Act 1999 at the end of March 2019. In 2018/19, **394** people were resettled in Wales via the vulnerable person's/children's resettlement schemes (1). See Appendix 2.

a Asylum seekers do not have access to welfare benefits and as a general rule are excluded from working in the UK. Section 95 support is for asylum seekers that have on-going claims, who are destitute or almost destitute and their dependents.

Box 2: ACEs and health outcomes in the Welsh population

In Wales, research shows that, compared with adults who suffered no ACEs growing up, those who experienced four or more are (7,10,11):

- 4 times more likely to be a **high-risk drinker**
- 6 times more likely to **smoke** e-cigarettes or tobacco
- 16 times more likely to have **used crack cocaine or heroin**
- 5 times more likely to have **low mental well-being**
- 4 times more likely to have developed **diabetes**
- 3 times more likely to have developed **heart disease**
- 3 times more likely to have developed **respiratory disease**

Whilst our understanding of ACEs within high-income countries is growing, we currently know little about the extent to which refugee and asylum seeking children arriving and settling into these countries are affected by ACEs. Internationally, there are few studies within these populations that make use of ACE-specific tools such as the ACE-IQ. However, a number of studies use alternative measures to examine lifetime stressors among this population (e.g. the Stressful Life Events checklist) and there is a growing body of research examining Potentially Traumatic Experiences (PTEs) relating to conflict in the countries of origin or to the often lengthy and dangerous journeys across borders to host countries. Therefore, although the field of ACEs and the field of trauma/stress among child refugees and asylum seekers have developed separately, the two have much in common.

Box 3: Immigration and the asylum seeking process in Wales

Responsibility for immigration and the asylum seeking process more specifically lies with the UK Government. However, Welsh Government are responsible for the integration of refugee and asylum seekers in Wales, including support within communities, local government, health and education. In Wales, integration of asylum seekers and refugees begins on day one, as set out in the 2019 Welsh Government *Nation of Sanctuary,* outlining work within Wales to address inequalities among refugee and asylum seeking populations and ease their integration within wider society (12). The *Nation of Sanctuary* notes the need to consider the specific circumstances of refugee and asylum seeker children in relation to ACEs and refers throughout to Sanctuary Seekers rather than asylum seekers. This research will directly contribute to the delivery of that plan.

Box 4: The ACE-IQ

The ACE International Questionnaire (ACE-IQ) has been designed by the WHO to include wider forms of adversity for use in all countries. It includes questions on:

- **Witnessing community violence** e.g. seeing or hearing someone being beaten up/ stabbed or shot / threatened with a knife or gun.
- **Exposure to war/collective violence** e.g. forced to go and live in another place due to collective violence, experienced the deliberate destruction of their home, beaten up or had family or friends killed by soldiers, police, militia or gangs.

The better our understanding of ACEs and their longer term impacts within this population, the more we are able to provide children with support, minimising any harmful impacts of adversity and helping to ensure that all children seeking sanctuary can live happy, healthy and productive lives.

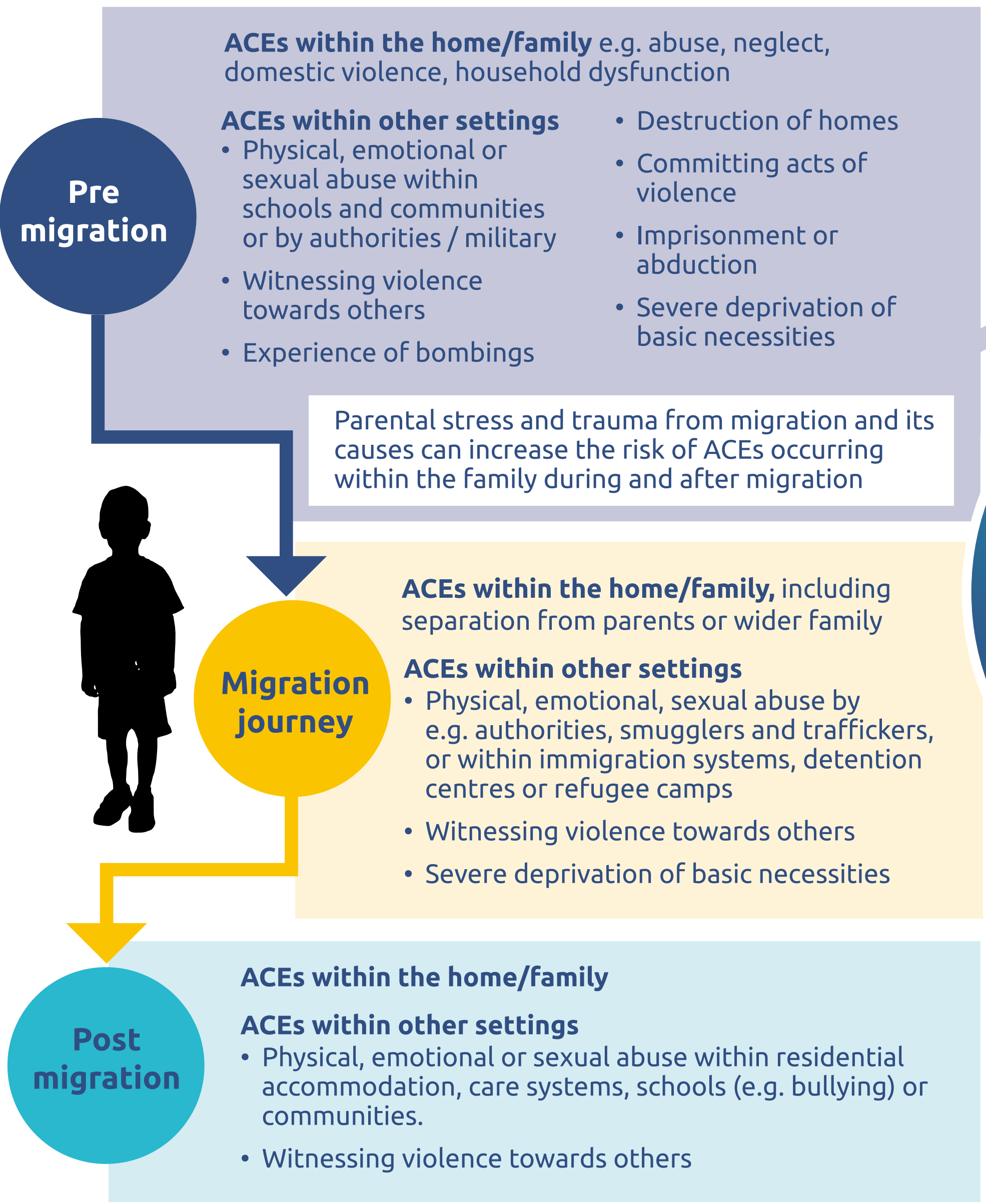
This report aims to bring together what we know about ACEs in refugee and asylum seeking children arriving and settling into host countries, highlighting their nature, extent and impact.

The better our understanding of ACEs and their longer term impacts within this population, the more we are able to provide children with support, minimising any harmful impacts of adversity and helping to ensure that all children seeking sanctuary can live happy, healthy and productive lives.

The report does not focus on children of asylum seekers and refugees born in host countries. However, it recognises that much of the content will also be relevant to this population group and that trauma can impact across generations. It is aimed at professionals working with asylum seeking and refugee populations, as well as those involved in the development of policy, to help improve understanding of child asylum seeking and refugee experiences and ways in which they can be supported as they grow. This report does not provide comment on the political context or legal framework for asylum in the UK, although acknowledges that these broader factors, in addition to ACEs, will impact on the current and future health and well-being of refugee and asylum seeking children.

Refugee and asylum seeking children come from diverse cultures and backgrounds, each bringing their own unique set of experiences, methods of coping, and meaning attributed to those experiences. However, it is possible to draw some commonalities. Using systematic searches of available international literature (see Appendix 1), **Section 1** describes the more common ACEs experienced by refugee and asylum seeking children, and **Section 2** highlights how conflict/migration may impact on ACEs in the family environment through its effects on family functioning and parenting behaviour. **Section 3** discusses the impact of ACEs on child refugee and asylum seekers' health and behaviour. Recognising that many refugee children can adapt to their experiences in positive ways, **Section 4** highlights the risk factors associated with poorer health outcomes following ACEs, and **Section 5** outlines factors associated with resilience and post-traumatic growth, to enhance our understanding of what can protect children from harms in the face of adversity. A brief summary of the report is provided in Figure 1. This review draws on available international literature, some of which is based on small sample sizes. Whilst small samples may affect the reliability of findings, they have been included to help provide a wider reflection of the nature of ACEs faced by child refugees and asylum seekers.

Figure 1: Summary of ACEs, impacts, risk and resilience among child refugee and asylum seeking populations



Section 1: Understanding the nature and types of ACEs

By the time a displaced child arrives in a host country, he or she is likely to have experienced a multitude of ACEs due to their reasons for migrating and on their journeys to host countries, which can often be lengthy and fraught with danger. Other ACEs may have occurred within the household before migration, or as a result of migration (see Section 2) and may be on-going. Subsequent ACEs can occur post-migration, as children wait for asylum decisions, enter the care system, or begin settling into a new community. This section brings together what we know about ACEs within child refugee and asylum seeking populations (Figure 2). As a comparison, the prevalence of ACEs within Welsh and UK population studies are presented in Table 1.

Physical abuse, emotional abuse and neglect

Studies of refugee and asylum seeking children resettled in high-income countries report varying levels of lifetime emotional abuse, physical abuse and neglect within a family setting. For instance, in Germany, 40% of refugee children reported having been ***slapped, punched or beaten up in the family*** (13), whilst in Austria, 15% of unaccompanied refugee adolescents reported neglect (14). Furthermore, among two samples of refugee adolescents newly arriving and settled over time in Sweden, a history of verbal abuse by caregivers was reported by 36% and 17% respectively, whilst physical abuse was reported by 69% and 20% (15). The vast differences in prevalence reported by these two groups could have been related to the different regions that these children resided in before migration, with those newly arriving largely from Afghanistan, Somalia and Syria, and those settled mainly from Iraq, Lebanon and other Middle East countries (15). Risk of exposure to abuse and neglect (and whether parents recognise certain behaviours as being abusive or neglectful) varies by cultural context, relating to home country norms; expectations and laws around parenting and the use of corporal punishment; cultural norms around gender roles and parent-child relationships; and the social and economic conditions in home countries (16). In some instances, experience of or threat of child abuse is a reason for flight e.g. escaping abuse because of their sexual orientation/gender identity (17) or fleeing the threat of genital mutilation (18) (see also ***Sexual abuse and violence*** and Box 5 on gender-based violence).

In Turkey, **26%** of Syrian refugee children had experienced conflict or migration-related cruelty or torture (20).

Physical and emotional abuse is frequently reported in other settings. Some refugee children report physical abuse by school teachers or administrators in home countries (17). Abuse can also be experienced during conflict settings, on migration journeys (19) or post-migration. Among the newly arriving and settled refugee adolescents in Sweden, 38% and 6% had experienced physical violence during migration respectively (15), whilst in Turkey, 26% of Syrian refugee children had experienced conflict or migration-related cruelty or torture (20). Furthermore, in a survey of children following the Central Mediterranean migration route to Europe, three quarters had experienced harassment, aggression or violence by adults on their migration journey, many at border crossings or detention centres (21). Children may be exposed to aggressive or abusive behaviour within refugee camps, often linked to cramped, unsafe conditions and poor mental health (22). Post-migration, children may also be exposed to hate crime. For instance in the UK, qualitative research suggests that young people have experienced hate crime on the streets in their communities (24). They may also be exposed to bullying (physical or verbal harassment by peers) in schools (23, 24), or discrimination within care systems (e.g. Wales; 25).

Many studies of child refugee populations explore lifetime exposure to violence without distinguishing when the violence occurred or by whom. Among studies exploring physical violence, direct experience

of violence ranges from 28% (among Syrian refugee children living in Turkish camps [26]) to 78% (among adolescent UASC in Norway [27]). Whilst prevalence and context varies, it is clear that a substantial proportion of refugee and asylum seeking children have experienced physical or emotional abuse at the hands of adults at some point in their lives.

Table 1: Experience of ACEs in the Welsh and UK population	
Emotional, physical abuse and neglect	In the UK, across studies, median lifetime prevalence of child **emotional abuse is 16%**, **physical abuse 9%** and **neglect 7%** (28)
Sexual abuse	In the UK, across studies, median lifetime prevalence of child **sexual abuse is 11%** (28)
Domestic violence	In the UK, the NSPCC report that **12%** of those aged under 11 and **18%** of 11-17 year olds have been exposed to **domestic violence** in their homes during childhood (29)
Parental separation	In the Welsh ACE survey, **20%** of adults had experienced **parental separation** when they were growing up (7)
Death of a parent	In England and Wales, around **1%** of children are likely to experience the **death of their mother** before the age of 16 (30)
Parental mental illness	In the Welsh ACE survey, **14%** of adults reported that they had lived with a **household member who was mentally ill** while growing up (7)
Parental substance use	The Children's Society estimates that around **12%** of young people in Great Britain (GB) aged 10-17 have a **parent who abuses alcohol** (31)
Parental incarceration	The Children's Society estimates that around **4%** of young people in GB aged 10-17 live in a **household where someone has been in prison** (31)

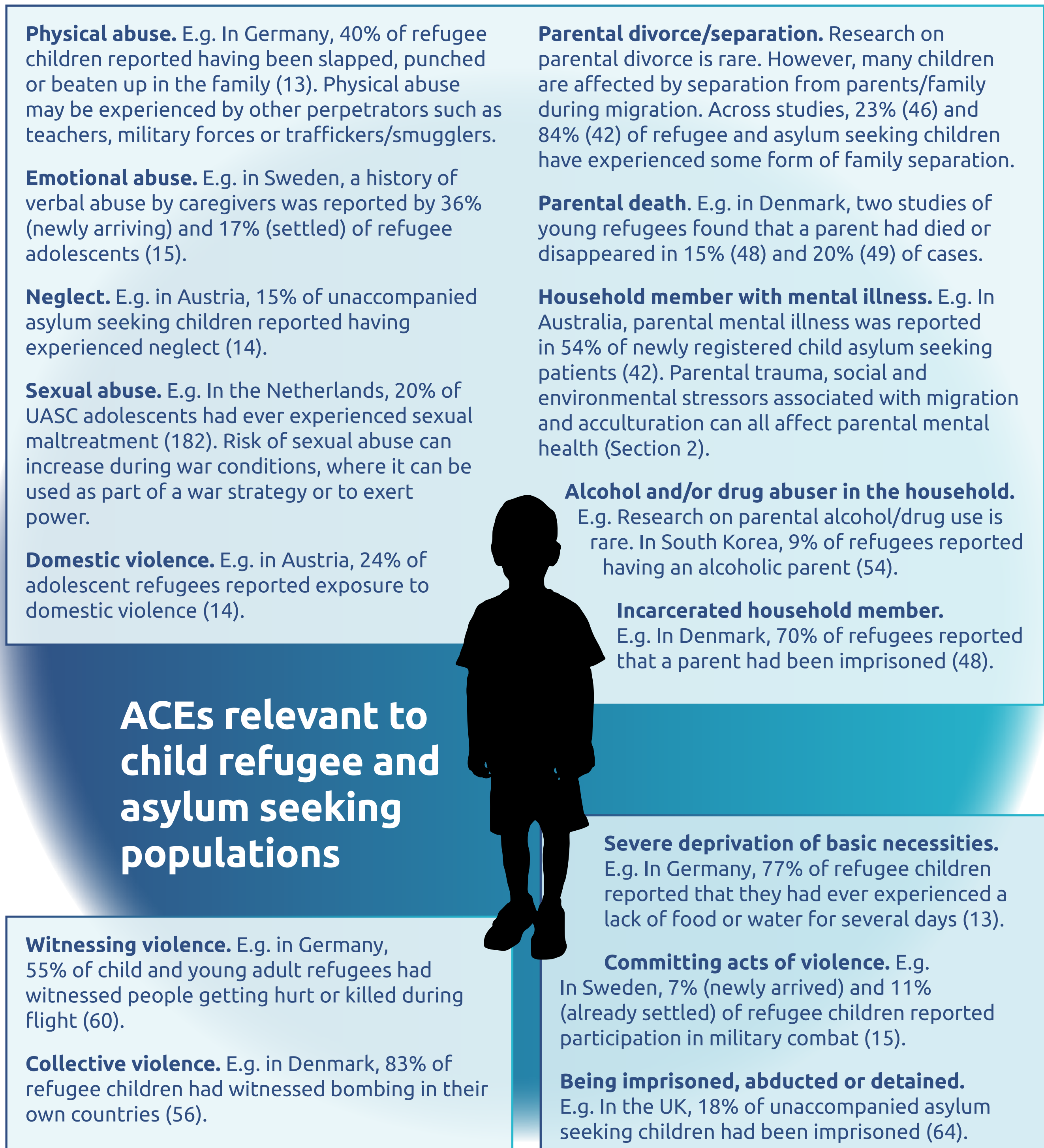
Sexual abuse and violence

A substantial proportion of child refugees and asylum seekers have experienced sexual abuse or violence (a form of gender-based violence; Box 5). The prevalence of lifetime sexual abuse/violence among samples varies, ranging from 3% (***unwanted sexual experience***, refugee adolescents settled in Sweden [15]) to 37% (***sexual abuse,*** unaccompanied refugee minors who had been detained in the UK following an age dispute [32]). However, it is often unknown whether the sexual abuse/violence experienced by child refugees and asylum seekers has been perpetrated within trusted child-adult relationships, intimate relationships, or by strangers (e.g. armed forces, smugglers or traffickers). Refugee and asylum seeking children can be vulnerable to sexual abuse/violence in home countries, during migration and post-migration.

In home countries, sexual violence can occur during conflict, where rape and sexual violence can be used against women (33-36) and men (37) as part of a strategy to achieve military and political goals. Sexual violence can be used as a method of punishment or torture against a population group, or as a way for male fighters to display power and control (33). The risk of child sexual abuse and exploitation can also increase on journeys to host countries, particularly if children are travelling alone or within female headed households (38). Children may be vulnerable to exploitation by traffickers or smugglers, who may demand sexual favours in return for safe onward travel (3) or from armed forces or other authority figures at border crossings or security checkpoints (21). Young females may also be at increased risk of early or forced marriage as a means

of protection in unsafe environments (39) or security for the future (40). In addition, the risk of sexual abuse can increase during residence in temporary settlements, refugee camps or accommodation centres, where destitution, poor conditions, overcrowding, poor security and design of accommodation (e.g. shared toilets), and lack of supervision can increase vulnerability to sexual abuse (33,41).

Figure 2: The nature of ACEs among child refugee and asylum seeking populations and examples from international literature



Exposure to domestic violence

We know relatively little about refugee children's exposure to domestic violence. In Australia, an audit of child asylum seeking patients registering with a health centre found that maternal domestic violence was reported in 10% of cases (42). However, much higher levels were reported among adolescent refugees residing in Austria where 24% reported exposure to domestic violence (14). As with child abuse, prevalence of domestic violence can be culturally specific, relating to gender roles and cultural norms around the use and acceptability of violence within relationships (16; gender-based violence; Box 5). In Wales for instance, research among refugees, asylum seekers and migrants identified that women had often suffered physical or emotional violence from their husbands (as well as in-laws and other family members), often as a result of unequal power relations (43). Living in a conflict-affected area is known to increase the risk of post-conflict intimate partner violence (44). Children originating in areas affected by conflict may therefore have a higher risk of exposure to domestic violence than others (see also Section 2).

Box 5: Gender-based violence

Gender-based violence refers to violence directed at an individual based on gender norms and unequal power relationships ascribed by society. It can include physical, emotional or sexual violence, threats of violence, coercion or deprivation of liberty (based on the United Nations Declaration on the Elimination of All Forms of Violence Against Women, 1993). Whilst the term is most often used to describe men's violence against women and girls, the concept can also include violence against men and boys, such as violence based on sexual orientation / gender identity that does not conform to social norms, or violence used as an attack on masculinity.

Parental divorce or separation (and wider family separation)

Research exploring the prevalence of parental divorce or separation among child refugees is rare. Levels of divorce are likely influenced by the cultural and religious beliefs within refugee and asylum seeking families and social norms. However, they may also be directly affected by the process of migration (e.g. separation of families [45]) or the stress of migration (leading to marital conflict; see Section 2). Importantly, the term 'parental separation' often holds a different meaning for child refugee and asylum seeking populations that is unrelated to conflict within marital relationships. For instance, parents and families more generally may become unintentionally separated in the chaos of flight, intentionally separated (e.g. one family member may be sent ahead of others to find work or accommodation) or forcibly separated (e.g. where one parent may be detained on arrival in the host country). Family separation is fairly common among child refugee and asylum seekers. Studies indicate that between 23% (refugee children living in the UK [46]) and 84% (refugee children registering with health services in Australia [42]) have experienced some form of family separation, although how families have separated and whether it was forced or intended is often difficult to establish. In the UK, around 10% (2,872) of asylum applications in 2018 were for UASC (47).

In Norway and Belgium, **70%** of adolescent UASC reported having lost at least one parent through death (50), whilst in Austria, **54%** and **39%** of adolescent UASC reported having a deceased father or mother respectively (14).

Parental death

Conflict, persecution and dangerous journeys can increase the risk of parental death or disappearance. In Australia, 2% of child refugee patients at a health centre had lost a mother through death and 6% a father (42). Furthermore, in Denmark, two studies of young refugees found that a parent had died or disappeared in 15% (48) and 20% (49) of cases. Levels are often higher in populations of UASC. For instance, in Norway and Belgium, 70% of newly arrived adolescent UASC reported having lost at least one parent through death (50), whilst in Austria, 54% and 39% of adolescent UASC reported having a deceased father or mother respectively (14).

Household member with mental illness

It is likely that a number of refugee and asylum seeking children are growing up in households affected by mental health issues, either before or post-migration. In the Australian health centre study, parental mental illness was reported for 54% of child refugees (42). Among adult refugee and asylum seeking populations more generally, prevalence of ill mental health varies considerably between studies. In one systematic review of war refugees, the prevalence of long-term PTSD (Post Traumatic Stress Disorder), depression and unspecified anxiety disorder were typically in the range of 20% and above, although rates varied widely up to 80% for each condition (51). As well as being related to traumatic experiences across the migration journey, the risk of a mental disorder among adult refugees is also linked to a lack of social integration in the host country (52). Therefore, for refugee children, the risk of living with a parent with a mental illness may increase post settlement.

Alcohol and/or drug abuser in the household

Few studies examine parental substance use problems in refugee and asylum seeking children, particularly those based in high-income countries. In one study of adolescents living in refugee camps in Uganda (from the Democratic Republic of Congo) and Rwanda (from Sudan), 12% and 9% respectively reported that "someone in their household used alcohol and then behaved in a way that frightened them" (53). Additionally, among young North Korean refugees living in South Korea, 9% reported having an alcoholic parent (54). Research within refugee camps in Thailand suggests that alcohol can be used by some parents as a way of coping with difficult experiences (55).

Incarcerated household member

Having a household member imprisoned may be a common experience for refugee children. However, in ACE studies, parental incarceration has typically been used as a measure of parental criminal behaviour. In contrast, within child refugee and asylum seeking populations, the reasons for parental incarceration are likely to be wider, including holding different political, religious or other beliefs. In Denmark, 70% of young refugees reported that a parent had been imprisoned (48), whilst 25% of refugee children had witnessed the arrest of a family member (56). A further, related issue for refugee families is the possibility of parents being detained in transient (i.e. countries during migration) or destination countries during the process of asylum. For instance, 60% and 20% of refugee children arriving in Denmark had a father or mother that had been detained respectively (56).

In Denmark, **70%** of young refugees reported that a parent had been imprisoned (48), whilst **25%** of refugee children had witnessed the arrest of family members (56).

Collective violence

Experience of conflict can involve a range of psychological and physical stressors, many of which are discussed separately within this section. These can include witnessing / being a victim of extreme violence, fear of bombing and shelling, disruption to schooling and education, poverty, shortages of basic necessities such as food and services and the death of family members (57). Many refugee children report direct experience of conflict, ranging from 27% (refugee adolescents living in Belgium [58]) to 94% (refugee adolescents residing in Sweden [15]). Experience of bombings or clashes is common. For instance, 83% of refugee children living in Denmark had witnessed bombing in their home countries (56), whilst in Turkey, 70% had seen explosions or gun battle (20)and 68% had witnessed clashes or blasts (59). Furthermore, a proportion of refugee children are likely to have witnessed or experienced destruction of their home. For example, in Germany, 45% of child and young adult refugees aged up to 24 had experienced their home badly destroyed or damaged (60).

In Germany, **45%** of child and young adult refugees aged up to 24 had experienced their home badly destroyed or damaged (60).

Witnessing violence

Witnessing violence towards others (outside of family settings; see ***Exposure to domestic violence*** for violence in family settings) is a common occurrence among child refugee populations and may include witnessing beatings or shootings, rape or sexual violence, torture or death of family members, friends or strangers. For many children, this is part of pre-migration (e.g. conflict or community violence) or migration experiences, but witnessing violence can also be experienced post-migration (48). Among samples of Syrian refugee children residing in Turkey, 54% had witnessed violence against someone that related to conflict (59), whilst 43% had witnessed conflict-related cruelty or torture of others (20). Furthermore, in Denmark, 22% of refugee children had witnessed the torture, killing or intimidation of family members (56).

Committing acts of violence

A small percentage of refugee and asylum seeking children report their own participation in military combat[b] or violence towards others. For instance, 13% of refugee children living in Germany reported ever committing acts of violence (13), whilst 7% and 11% of refugee children newly arriving and settled in Sweden respectively reported participation in military combat (15). Participation in armed groups may be forced, or may be voluntary as a source of protection, revenge or escape from poverty and poor living conditions. Whilst participation may offer vulnerable children support and belonging, particularly if they have been separated from or have lost their own family, it can also vastly increase the risk of being a victim of violence themselves (61-63).

Being imprisoned, abducted or detained

Within Germany, 36% of refugee children reported having been ever imprisoned or abducted (13), and in the UK, 18% of adolescent UASC had ever been imprisoned (64). Refugee children may also have experience of detention related to the asylum seeking processes within host or transient countries.

Severe deprivation of basic necessities

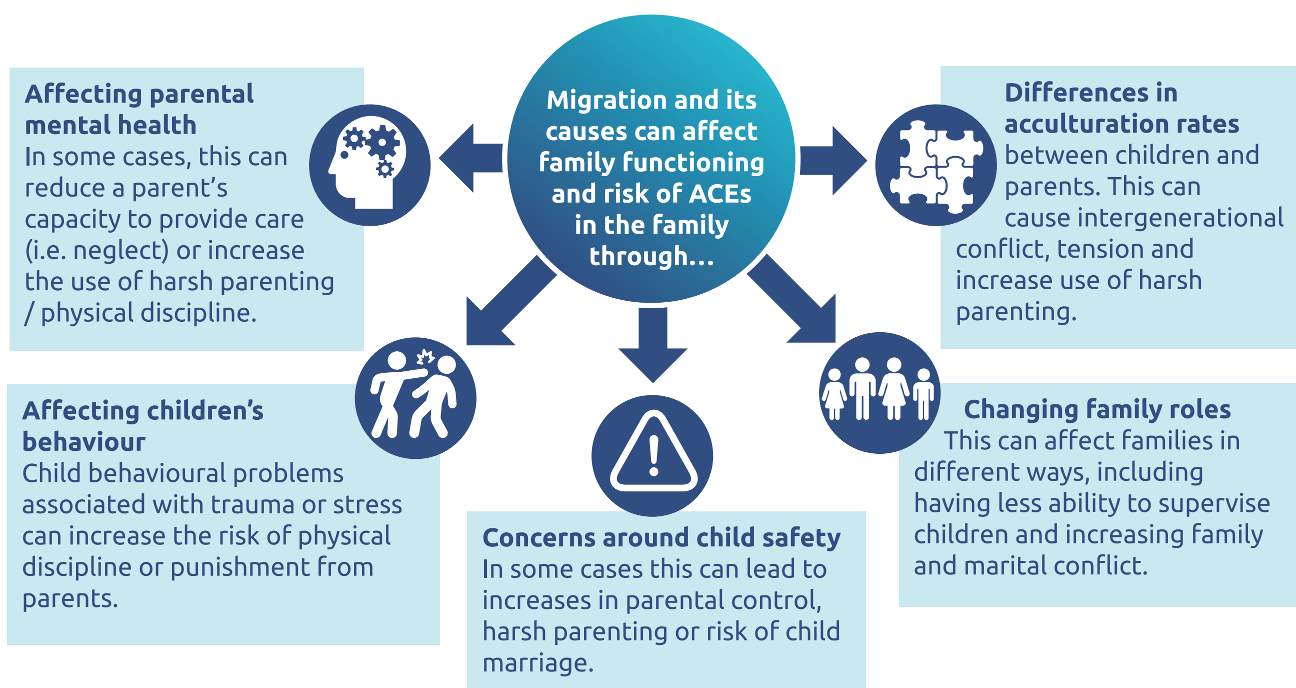
Conflict conditions, as well as migration journeys, can involve severe deprivation of basic necessities such as food, water and shelter for extended periods of time. Even when displaced children arrive at host countries, life in a refugee camp can involve a shortage of food and water, blankets and a dry space to sleep (65). Among refugee children newly arriving and settled over time in Denmark, 69% and 14% respectively reported having been without shelter, food or other necessities as a result of conflict or flight (15). In Germany, 77% of refugee children reported that they had ever experienced a lack of food or water for several days (13). Whilst levels vary considerably across samples, it is clear that a lack of basic necessities can often form part of conflict and migration experiences.

b Children associated with armed forces or armed groups are a particular risk group included within the Welsh Vulnerable Children's Resettlement Scheme (VCRS; see Appendix 2).

Section 2: The impact of migration and its causes on the potential for ACEs in the family environment

The experience of migration and its causes can have direct impacts on the family unit. Adults with caregiving responsibilities are not exempt from the stressors associated with conflict and migration outlined in Section 1, and are likely affected by changes in social, economic and living conditions in settling countries as well as the stress of acculturation (e.g. adapting to life within a different host culture). Furthermore, the challenges associated with migrating to and adapting to life in a host country can lead to parenting in 'transition', whereby individuals need to adapt to the change in challenges and needs of parenting across different countries and cultures (66). These stressors can affect family functioning and, in some cases, increase the risk of children experiencing ACEs such as neglect and child maltreatment within the family environment. This section outlines the effects that migration and its causes can have on the family, including how parental traumatisation, social or environmental stressors, and acculturation can directly and indirectly affect caregiver and parenting quality (Figure 3). Most studies examining the impact of migration and its causes on family functioning focus on parenting and do not often differentiate between parents with children who migrated with them and those with children born in host countries. Therefore, although this section intends to help understand how refugee and asylum seeking children may be affected by migration-related changes in the family, it also draws on studies of parents that migrated before their children were born.

Figure 3: The impact of migration and its causes on family functioning and potential for ACEs



Poor mental health

One of the most important ways in which migration and its causes impacts on parenting is through affecting the mental health of parents. Parental mental health can be affected by parental exposure to conflict or migration adversity (67), particularly through the development of PTSD (where much of the research is focused; see also ***Household member with mental illness*** in Section 1). However, mental health is also determined by social and environmental stressors such as poor living conditions (including overcrowding), economic hardships through un/underemployment and poverty, loss of status, family separation, prolonged asylum procedures, frequent relocations, and acculturation stress including racism or discrimination (67, 69-72). Parental mental illness, including PTSD, can influence the quality of family functioning and parenting behaviour and impair parent–child relationships (73). It can impact on children's development and well-being even when children have not been exposed to trauma themselves (Box 6).

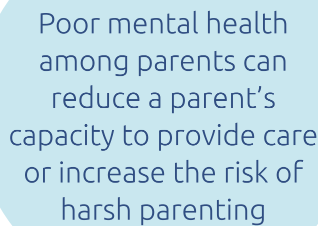
Box 6: The intergenerational transmission of trauma

The intergenerational transmission of trauma is the term used to describe when a child experiences the adverse effects of their parents' trauma exposure, even if a child has not been directly exposed to trauma themselves. Here, trauma in one generation can influence the development and well-being of the next generation (74-76). Although findings vary (77, 76), it has been suggested that parents' poor mental health, such as PTSD and depression is one mechanism through which trauma is transmitted across generations (76).

Experiencing mental health issues as a result of conflict or migration can impact on the capacity of a caregiver to provide care to, and be involved with, a child. Research finds that parents who are facing issues with family separation, loss, or prolonged asylum procedures may, in the face of these struggles, provide lower emotional support to their children (78). In addition, parental PTSD has been associated with withdrawal from children, which may result in a lack of emotional availability or affection, and neglect (67,68,79). Poor mental health can also disrupt parental sensitivity to a child's cues, leaving them unable to interpret their thoughts and feelings, and limit their capacity to consider their child's perspective. A study of refugees and asylum seekers and their young children in the Netherlands found that mothers who were suffering with the stress of trauma (e.g. torture, combat, forced separation of family members) had lower levels of parental sensitivity and were less involved with their children (68). In this sense, poor parental mental health can impact negatively on parent-child attachment - the physical and emotional bond between a child and his/her parent (80,81).

One of the most important ways in which migration and its causes impacts on parenting is through affecting the mental health of parents.

Symptoms of PTSD (e.g. hyperarousal, the experience of irritability and anger, avoidance or emotional numbing), or alternatively, feelings of powerlessness as a result of refugee status or their current situation (e.g. not being able to protect themselves) can damage a parent's internal representation of the self and subsequently prevent them from identifying as a source of protection for their child. Research has identified that parents with PTSD perceive their relationship with their child as poor in comparison to parents without PTSD (68,82). Such perceptions of a negative parent-child relationship can also increase parenting stress (80). Increased child attachment behaviour, such as clinging to the parent can also aggravate any stress experienced by the parent and promote this negative cycle.



Poor mental health among parents can reduce a parent's capacity to provide care or increase the risk of harsh parenting

Poor mental health (particularly among mothers) can also heighten the risk of harsh or punitive parenting (69,83,84). For instance, harsh parenting or physical discipline has been associated with the stressful experience of the asylum seeking process (67), the stress caused by living in refugee camps (67,70) and the effects of trauma, such as PTSD (83,84). PTSD symptoms can also be aggravated by the experience of migration and post-migration stressors. In a study of Australian refugees, caregiver trauma and post-migration difficulties were associated with increased PTSD, which was linked to harsh parenting and in turn, higher levels of child conduct problems (84).

Parental trauma and its associated ill effects on mental health can negatively affect communication between parents and children. In a sample of Syrian mothers, participants acknowledged communication with their children had changed since migration, with a focus on shouts and threats (70). Participants reported a feeling of hopelessness with the change in communication style, and this was connected to an increased focus on harsh parenting (70). Additionally, in a study of Syrian refugees in Lebanon, stress from economic hardship was associated with negative communication styles with children, as well as reduced emotional regulation and increased physical discipline (69).

Studies have also found an association between parental mental illness, such as PTSD and depression, and family-related violence in refugee families (83), meaning that children may be at risk of exposure to domestic violence in the household. Family or marital conflict and family-related violence can be the result of multiple risk factors at the individual, familial, and societal levels, but has been found to be a symptom of, and a reaction to, traumatic experiences and mental illness (83).

Changing child behaviour

An increase in challenging behaviour among children as a result of migration or parental trauma may alter the way in which children are parented. For instance, children who are traumatised through migration and its causes may display behavioural disorders, such as anger, which may provoke physical discipline or punishment (83) (see also Section 3). A study of refugees and asylum seekers and their young children in the Netherlands found that of 29 fathers, over one in four (41%) reported difficulty tolerating their children when they displayed aggressive behaviour (68). In another study, Syrian refugee parents reported that increased misbehaviour among their children, as a result of displacement, led to their use of physical discipline (70).

Living restrictions and safety concerns

Restrictions faced in living environments may limit the ability of parents to adequately care for their children. This may include a reduction in basic resources (e.g. access to health and support services within refugee camps [70]) or limitations in the control that parents have in parenting their children (e.g. restrictions within detention centres that limit parental ability to protect or comfort a child [85]). Parental concerns around the safety of children in the communities in which they live has been linked to increased parental control over children and the use of harsh parenting (69), as well as increased rates of child marriage (87).

Changing family roles

A change in financial circumstances associated with refugee and asylum seeking status has been linked to a shift in gender, household and economic roles (69,83). In particular, studies have shown that financial pressures can lead to mothers needing to engage with employment outside of the home. When combined with limited social support networks, which in some cultures are traditionally used for the provision of childcare (86), this can lead to children being unsupervised. Some studies have indicated that mothers being absent from the home has led to increases in harsh parenting, as increasing child disobedience was linked to the absence of a parent to discipline them (69). Changing household responsibilities post-migration can also lead to increased family and marital conflict, and an increase in the prevalence of domestic violence (74).

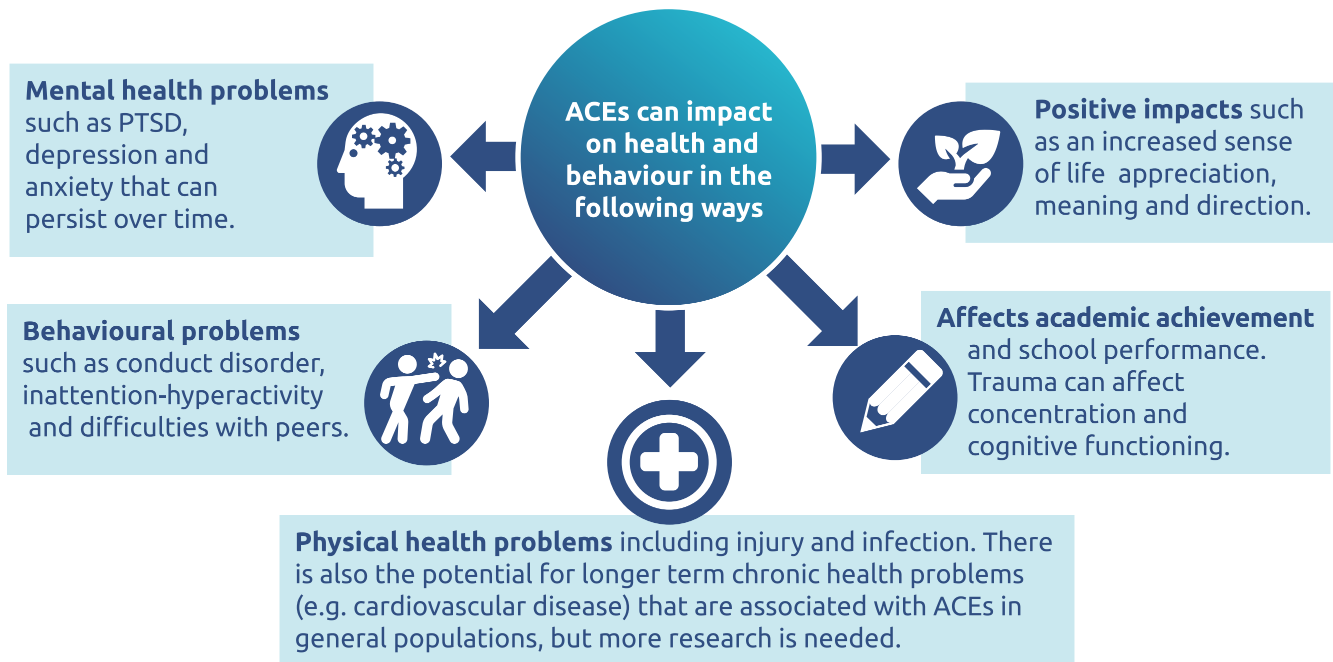
Differences in acculturation

Acculturation (the term used to describe adaptation to a new host culture) can be a source of intergenerational conflict (i.e. conflict between the parent and child) due to the relatively faster rates at which children are able to (e.g. through schooling and peer friendships) and willing to adapt in comparison to older generations (78,86,88). For parents, this can lead to a feeling of a loss of parenting status as children take on responsibilities beyond their years (such as a responsibility for translation or interaction with agencies) and leads to an increased dependence of the parents on the child (89). Concerns for the growing independence of children, their safety, and fear for how child acculturation will impact on parent-child relationships can lead to the use of harsh and punitive parenting (86). In a sample of Cambodian refugee patients at a psychiatric clinic, nearly half (45%) reported becoming angry in the last month towards a child, predominantly due to language barriers which also hindered the resolution of any conflict (88). Forced resettlement can also create strong parental attachment to the ideals or culture of their home countries, which can be in contrast to the pressures that children face to acculturate (90), creating further tension and family conflict.

Section 3: The impact of ACEs on health and behaviour

Whilst many refugee and asylum seeking children function well despite their difficult histories (see Section 5), as a population, they experience more challenges to their health and well-being when compared with general child populations (91) and are likely to have a multitude of complex needs. Few studies have looked at the direct link between exposure to ACEs and child refugee health, mental health or behavioural issues. Those that have are often focused on the shorter-term (i.e. on arrival or in the first few years) rather than longer-term impacts, and many focus on conflict/migration-related ACEs rather than a broader range of adversity. With these limitations considered, this section discusses what is currently known about the potential impacts of ACEs within childhood refugee and asylum seeking populations on mental and physical health, behaviour and academic achievement (Figure 4).

Figure 4: The impact of ACEs on health and behaviour



Mental health

Exposure to ACEs, whether conflict/migration-related or across the life course more generally, has been associated with increased risk of post-traumatic stress / PTSD, depression, anxiety and emotion dysregulation in child refugee and asylum seeking populations (92–96). Although there is less research looking at the impact of ACEs on self-harm and suicide, research within refugee camps in Greece suggests that these behaviours can develop in children as a result of their on-going adversity (as well as a result of imitating others [65]). Other psychological impacts have been reported as a result of conflict-related ACEs, including sleeping problems, somatic complaints and difficulties controlling urination (97,98).

As well as general exposure, some studies explore the impacts of specific ACEs on mental health outcomes. For instance, poor mental health has been reported among:

- *Children experiencing detention*, where mental health difficulties such as depression, anxiety and PTSD, emotional and behavioural problems and developmental regression have been reported (99–101). Longer detention duration increases the severity of symptoms (99).
- *Children who have had a parent detained*, where negative impacts on psychological well-being and risks of post-traumatic stress have been highlighted. Risks increase if the child witnessed the arrest of the parent (102).

Among young refugees settling in European countries, up to a third are thought to be affected by a mental health disorder, with prevalence ranging from **19-53% for PTSD**, **10-33% for depression**, and **9-32% for anxiety disorders**.

These levels are higher than those found in general populations of children and adolescents, where 2.6% experience any kind of depressive disorder and 6.5% any kind of anxiety disorder (91).

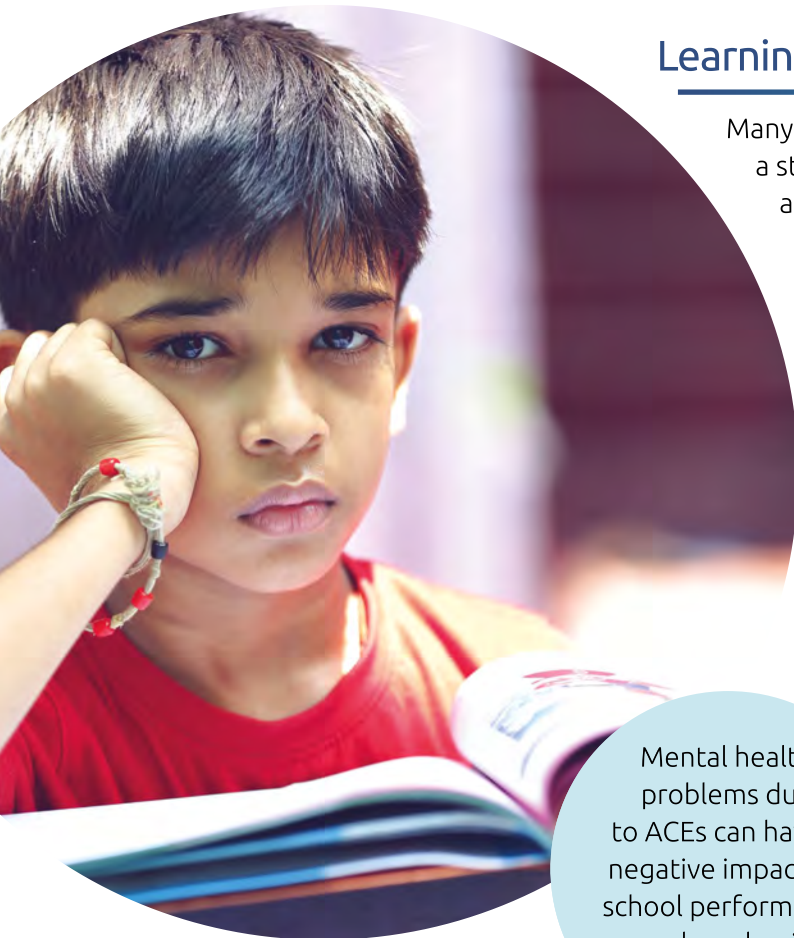
- *Children who have experienced separation from parents*, among whom there is risk of depression, anxiety and post-traumatic stress symptoms, partly a result of the increased number of traumatic experiences that this population experiences (58).
- *Children who have been former child soldiers*, where long-term effects on mental health have been reported including depression, anxiety and suicidal thoughts (62,103).

A number of studies report that mental health issues in child refugees and asylum seekers improve over time in host countries (104) (see also Sections 4 and 5). However, others suggest that negative impacts can persist. For instance, in a twelve-year follow up of war-affected refugee adolescents in the US, researchers reported levels of PTSD similar to those found 6 years earlier (105). Interestingly, this study suggested that those diagnosed with PTSD were often functioning well (e.g. within their family relations, educational achievements, occupation and income generation) regardless of their diagnosis (105). Furthermore, in a study of former displaced and non-displaced children in World War II, displacement was associated with more depressive symptoms, posttraumatic stress symptoms and poorer self-reported health in later life (average age 75 [106]). Studies suggest that whilst pre-migration ACEs are the strongest predictor of mental health on arrival in a host country, the long-term effects depend on further exposure to individual, family or society-related risk factors in the host country (see also Section 4).

Behaviour

Among child refugees, experience of ACEs has generally been linked with behavioural problems such as conduct disorder, inattention-hyperactivity and difficulties with peers (107–109). These findings are not always consistent however, with some studies reporting no association between behavioural problems and exposure to either lifetime violence (110) or violence in the country of origin (111).

There is little research exploring the association between ACEs and risky behaviours such as alcohol and drug use, carrying weapons or aggressive behaviour. However, qualitative research within refugee camps in Greece (65) and refugee communities in Australia (112) suggests that children and youths can engage in alcohol and drug use as a way of coping with past or on-going adversity.



Learning and academic achievement

Many refugee and asylum seeking children display a strong commitment to education and hold high aspirations for entering higher education (183). A number of studies suggest that mental health problems due to ACEs can have a negative impact on school performance and academic achievement (96,113). Refugee adolescents exposed to conflict have been found to experience lower levels of academic achievement than those without conflict exposure (109). Trauma is thought to be related to academic performance in a number of ways, including through difficulties with concentration (e.g. intrusive thoughts), slower cognitive functioning due to depression, loss of motivation and behavioural problems (114). However, not all studies show an association between pre-migration trauma and lower educational outcomes; some suggest that war trauma and mental health problems can have little or even positive impacts on educational outcomes (184). Importantly, adverse experiences that occur post-migration, such as bullying and racial abuse, can also have an influence on learning (184).

Mental health problems due to ACEs can have a negative impact on school performance and academic achievement

Physical health

ACEs can have both acute and long-lasting effects on health. For child refugee and asylum seekers, experience of violence, torture or bombing/shelling due to conflict can result in physical injury, including wounds, burns and head injuries (57,115,116). Deprivation of basic necessities such as food and water can lead to dehydration and malnutrition (116). Furthermore, experience of sexual violence or rape can increase the risk of sexually transmitted infections, abdominal pain, pregnancy, gynaecological problems and infertility (62,115).

There are no studies exploring the relationship between ACEs and longer-term health among child refugees and asylum seekers specifically. However, among general populations, it is well-established that ACEs increase the risks of longer-term health complications such as Type 2 diabetes, cancer, heart disease and respiratory disease (9) (Box 2). It seems likely, therefore, that child refugee and asylum seeking populations experiencing ACEs would also be at greater risk of longer term health complications, particularly given the links between ACEs and mental health reported in both general and child refugee and asylum seeking populations (see earlier section on ***Mental health***). Studies of children in World War II suggest that exposure to bombing, combat or separation from parents in childhood increased the risk of poorer physical health in older age (103). However, not all studies report this link. In Finland, there was no evidence of any long term negative effects on health among Finnish children forced to migrate during World War II, as measured by receipt of sickness benefit, receipt of disability pension and mortality (compared to non-displaced Finnish residents, although this study did not measure specific forms of adversity [117]). Authors suggested these findings could be due to their successful integration into society post war (see Section 5 for a further discussion on resilience/integration).

A sense of loss

One way in which adversity among refugees can affect outcomes such as mental health, behaviour and academic achievement is through a sense of loss. For instance, the loss of parents or loved ones, either through death, disappearance or separation, can involve the loss of role models, stability and a sense of protection. Displacement itself, particularly when separation occurs from extended family, includes the loss of community, social support networks, and cultural identity and belonging (known also as cultural bereavement). Trauma can also involve the sense of a loss of childhood, whilst refugee camps, detention and the asylum seeking process can involve loss of certainty and safety (e.g. the threat of being returned to their country of birth), and loss of control over one's life (118,119).

Appreciation and meaning within life

Although the majority of literature exploring the impacts of adversity focus heavily on negative outcomes, it is important to note that positive outcomes can also be experienced. For instance, qualitative research with refugee youth reports impacts such as a heightened sense of appreciation for what they now have in life, or a stronger sense of meaning and direction (118,120). Traumatic experiences in childhood also have the potential to lead to post-traumatic growth, discussed in more detail in Section 5.

Section 4: Risk factors for experiencing negative outcomes from ACEs

Children are affected by ACEs in different ways. How they make sense of their experiences and cope with adversity can depend on a wide variety of individual, family, community and societal factors. Literature suggests that a good proportion of refugee children function well, despite their negative experiences (i.e. display resilience, see Box 7 and Section 5). This section outlines what is known about factors that increase the risk of poorer outcomes following exposure to ACEs, mainly in terms of mental health, where much of the literature is focused (Box 8). Importantly, these risk factors run across the life course. Whilst certain pre-migration factors increase the risk of a child developing mental health issues following ACEs, other post-migration factors can influence how long a child is affected by these psychological difficulties, or their onset in the longer term.

Box 7: Resilience

Resilience can be defined as the ability to overcome and recover from challenges in life, such as experiencing ACEs. Resilient children are more likely to avoid any negative consequences of adversity on health and well-being. In general populations, sources of resilience include: having a positive and supportive relationship with a caregiver; temperamental characteristics such as self-regulation and self-esteem; participation in social and leisure activities or groups; belief they can influence the course of their life; and having affirming faith or cultural traditions (121–123).

Individual factors

Cumulative adverse experiences

One of the largest and most consistent contributors to poorer outcomes is the total number of ACEs experienced (124). Among refugee children, having a greater number of ACEs has been associated with increased likelihood and symptoms/severity of post-traumatic stress, depression, anxiety and emotional dysregulation (13,50,94,125–129), traumatic stress (e.g. having bad dreams about the events that happened), post-traumatic guilt and shame (130), lower IQ (131) and poorer academic achievement (110,132). Although longer-term research following child refugees and asylum seekers over time is lacking, studies among conflict-affected children (not necessarily refugees) suggest that these risks may still be apparent in older age. For instance, among Germans who had experienced World War II as children, a higher frequency of exposure to traumatic war-events was associated with greater symptoms of post-traumatic stress and depression later in life (average age 75 [106]). These findings reflect ACE literature within general populations, which highlights an increased risk of health and mental health problems across the life course with exposure to multiple forms of adversity (9).

> Having a greater number of ACEs increases the likelihood and severity of mental health problems

Types of adverse experiences

Certain types of experiences appear to increase the risk of mental health issues in child refugee populations. For instance, direct exposure to threatening events, such as experiencing violence (124,133), living under threat (133) and exposure to torture (20) have all been found to increase the likelihood

of experiencing a mental health problem. Equally, witnessing violence, such as the assault or killing of others, or witnessing explosions or gun fights, is predictive of poorer mental health outcomes such as PTSD, anxiety and psychological distress (20). Other important types of ACEs include the loss by death/violent death of an important person (20,46) and separation from parents (58,129) (see also ***Arriving unaccompanied***). A number of studies consider the relative importance of conflict/migration related ACEs and either ACEs within the home/family or community violence post-migration (110,134). These studies highlight the need to consider ACEs across the child's life, rather than a specific point in time (124).

Gender and age

Differences in mental health outcomes between genders and different age groups are generally unclear (124) (Box 8). Some studies suggest that being female is a risk factor for PTSD, anxiety and depression among child refugees (14,64,124,135). However, others report no gender differences (124). Equally, when considering the age of child refugees, some studies suggest that older age is associated with poorer mental health outcomes such as PTSD, whereas others report no association (93). In a systematic review of risk factors (Box 8), Fazel et al (2012) highlights the complexity of age as a risk factor, suggesting that it intersects with the type and duration of adversity (124). For instance, older refugee children may have had the benefit of a stable childhood before the onset of migration-related adversity, or may have experienced cumulative adversity (a risk factor for mental health issues) before migration through, for instance, growing up in a conflict zone (124).

Pre-existing vulnerability

There is some evidence that having pre-existing vulnerability in early childhood, such as severe illness with long-term effects; psychological problems, such as frequent temper tantrums; or delayed development, increase the risk of developing poorer mental health outcomes following adversity. In a Swedish study of young child refugees, such children had an increased risk of experiencing long-lasting post-traumatic stress symptoms (136). Injuries sustained in pre-migration events, particularly head injury, have also been found to increase the risk of PTSD (124).

Box 8: Risk factors for poor mental health

In a systematic review of risk factors associated with poorer mental health among displaced and refugee children, the following factors were important (124):

- Exposure to violence
- Pre-existing physical, psychological or developmental disorders
- Family experiences of adverse events
- Being unaccompanied or separated from relatives
- Poor family support or cohesion
- Perceived discrimination / low peer support
- Low neighbourhood connectedness
- 4+ relocations within the asylum system
- Post-migration detention

The following factors were unclear / unrelated:

- Age (unclear)
- Sex (unclear)
- Education (unrelated)
- Socio-economic status (unclear)
- Parental education (unclear)
- Ethnicity (unclear)

Additional individual factors linked to post-migration

Lower host country language skills have been associated with internalising behaviour, such as anxiety and depression and post-traumatic stress symptoms (13,129,137). A shorter time period in the host country has also been associated with poorer mental health outcomes, suggesting that mental health issues reduce over time (124). However, results are not always consistent, and may depend on the conditions (e.g. quality of accommodation, access to services) and experiences (e.g. bullying, discrimination) refugee children and their families have in host countries (see also ***Community and societal factors***).

Relationship factors

Arriving unaccompanied

Unaccompanied refugee children have a higher risk of developing mental health problems than those who arrive in host countries with family members (91,124). These children are more likely to have experienced a greater number of traumatic events (58,64,124), including death of a parent, and may be more likely to experience child abuse or exploitation along their migration journey (138). Additionally, these children lack the social and emotional support to cope with adversity that could be provided by accompanying parents (58).

Parental education

Parental education has been found to have a variable effect on child refugee mental health outcomes. Some studies suggest that post-traumatic stress levels (139) and emotional problems (140) are higher among children with less educated parents. However, other studies have found no effect (124). It is possible that parents with higher education may have better coping strategies or more ability to maintain a supportive, protective environment for refugee children (140).

Parental mental health, communication and financial difficulties

Family or parental difficulties, particularly those experienced post-migration, appear to be related to a refugee child's mental health. For instance, having a parent (particularly a mother) with poor mental health is a known risk factor for mental health problems among refugee children (124,136). Parental exposure to violence (124) or a history of parental maltreatment / torture (140) is also a risk factor, likely related to parental mental health problems (see Section 2). Research finds that among refugees and asylum seekers, parental trauma, stress and PTSD can affect child cognitive development and child psychosocial outcomes (73,78,141) and is associated with poor child mental health as well as antisocial behaviour and problems at school (142). Family relationships also have an important role to play. For instance, parents who are unable to emotionally invest in their child, due to trauma or PTSD, may be less able to serve as a secure attachment for their children. This may create a sense of worthlessness for their child (76), which can negatively affect the child's mental health. Less family cohesion / less supportive relationships with parents can also increase the likelihood of refugee children experiencing depression and other psychological difficulties (124,143). Additionally, although the link between family socio-economics and child refugee mental health is somewhat unclear (124), family financial struggles within child refugee families post-migration appear to increase the risk of a child experiencing poor mental health (124). This link is also found in general populations, where less financial security has been associated with an increase in the risk of current mental illness (Wales; 122).

Community and societal factors

Post-migration factors arising in the community and wider society are an important consideration in the development of mental health problems in child refugees (124).

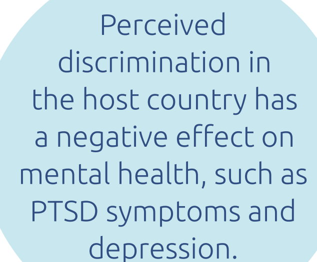
Asylum process

Evidence suggests that a longer seeking asylum duration (e.g. more than one year since arrival in the host country) is associated with increased risk of mental health problems (144). Furthermore, poorer mental health outcomes have been associated with refusal of asylum (145) or uncertainty regarding asylum status (129). Other factors that increase the risk of poorer mental health or behavioural outcomes include more relocations within the asylum system (144), not attending school[c] or frequent school changes in the host country, which can often be linked to host country refugee policies (48). Frequent relocations can prevent children (and parents) from building supportive relationships with others, and in addition to impacting on mental health outcomes, could be detrimental to academic performance (48).

Social support

Having a low level of social support in the host country is a key factor in mental health problems, particularly among unaccompanied refugee children. Living arrangements that offer children low levels of support can increase the risk of psychological difficulties (13,64,145). Among UASC living in the UK for instance, those in low support living arrangements (living independently or semi-independently) had higher post-traumatic stress symptoms than those in high support living arrangements (64). Peer support is also important; among younger child refugees, having fewer peers to play with has been associated with poorer social adjustment in a host country (136), whilst for older children, having fewer friends within host countries is associated with internalising behaviours such as anxiety, withdrawal and depression (48).

Discrimination



Perceived discrimination (e.g. child perceptions that they are treated with less respect, insulted or called names) in the host country has been found to have a negative effect on mental health, such as PTSD symptoms and depression (124,146). In the UK, qualitative research with young refugees has identified experiences of hate crime on the streets in their communities, including verbal and physical abuse (24), as well as discrimination in care systems (Wales; 25). In a study of young refugees living in Sweden, being bullied in school was associated with lower self-worth (136). It is possible that the process of re-developing a sense of self in a different environment and culture is more difficult when a child perceives himself or herself to be discriminated against (146). Furthermore, discrimination may lead to the internalisation of negative thoughts, which may increase the risk of mental health problems (146).

Feelings of safety and connection

Feeling unsafe at school or within accommodation can impact negatively on mental health problems (124). In addition, lacking a sense of belonging in school or a sense of connectedness to their neighbourhood, appears to increase the risk of mental health problems (124).

c Refugee and asylum seeking children may experience delays in or barriers to accessing education.

Section 5: Overcoming adversity - resilience and growth following ACEs

Despite the significant adversity associated with growing up in unstable environments characterised by conflict, disaster and deprivation, and the substantial stressors present during transit and resettlement, many children seeking asylum in the UK do not show considerable levels of psychological harm. Instead, they present with an over-riding willingness to succeed and a desire to overcome the challenges associated with establishing a new life in their host country (147). The process of effectively negotiating, adapting to, or managing significant sources of stress or trauma is known as **resilience** (see Box 7). Even in the face of prolonged or severe adversity, with enough of the right resilience resources, a person can maintain a relatively stable trajectory of healthy psychological, physiological, cognitive and behavioural functioning (see Figure 5). In response to a traumatic experience, a resilient person will access support and coping mechanisms that allow them to 'bounce back'. However, for those with low or poor resilience, normal functioning may give way to a negative psychological change (i.e. mental health problems), from which they must then find ways to recover (148) (Figure 5).

However, for some children and young people, their experiences of trauma may actually have other profound effects. Rather than simply avoiding being negatively affected by adversity, individuals may experience a positive psychological change as they adapt to their new reality. Essentially, when trauma or stress threatens a child's world view, the opportunity arises to introduce new ideas and self-concepts. This **post-traumatic growth** sees the person's healthy functioning reach levels beyond those experienced before the adversity occurred (149) (Figure 5). Experts suggest positive change may act over the following five domains: a greater appreciation for life; more meaningful interpersonal relationships; recognition of personal strength; changed life priorities; and spiritual development (150).

Figure 5: Psychological change following trauma, in people with low or moderate-high resilience

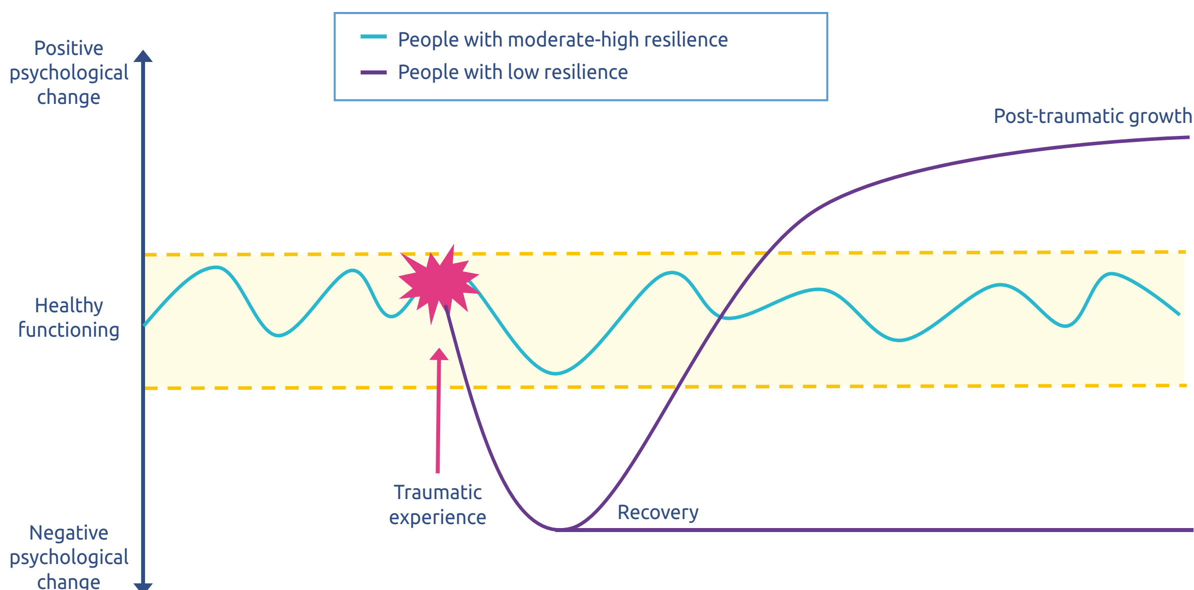


Figure 5 provides a snap shot of resilience over a short time frame, and highlights the difference between resilience and other related factors. However, it is important to note that individuals who show resilience in one aspect of their life (e.g. education), may not show the same level of resilience in other domains (e.g. their personal relationships). Equally, a person may show high levels of resilience at certain times in their

life, but not at other times. Experiences such as discrimination or stigma may erode resilience and what makes people more resilient may differ by factors such as age or developmental maturity, or by important cultural differences (e.g. whether a culture of origin is individual or collectivist). The following sub-sections outline some of the key resilience resources or protective factors that may support the healthy psychological functioning of children and young people seeking asylum.

Personality and dispositional attributes

Certain personality traits or cognitive styles may help children and young people to cope adaptively when seeking asylum and rebuilding their lives in a host country. Those that can continue to **think positively**, maintain a **long-term vision** and focus on particular goals and aspirations may experience a renewed sense of purpose during transit or resettlement (151,152). Positive thinking has been linked to post-traumatic growth among teenage refugees in the Netherlands (152). Further, a qualitative study of unaccompanied refugee minors and dependants aged 9 to 18 years in Wales highlights the importance of both optimism and minimisation (i.e. being able to downplay the effect of racism or discrimination) for psychological well-being (153). Although exposure to conflict can be associated with greater disregard for the future, one study found that young refugees from Sierra Leone that were coping well possessed an enduring belief that their life had **meaning and value**. These individuals expressed personal pride that their lives had not been destroyed by conflict and actively pursued educational, vocational and social goals in an effort to incorporate new experiences into their lives (154). Both education and religion may facilitate young people in making meaning of their suffering, which can also be positively viewed as a sacrifice for the betterment of their families (155). As well as showing appreciation for what they have (156), **pro-social behaviours** and valuing kindness have also been associated with a more positive self-image and increased resilience among young asylum seekers (148,157). In interviews with Iranian refugees living with their parents in Sweden, helping others, distractive behaviour and humour were all cited as key resilience factors (158).

Personality traits such as thinking positively and maintaining a long-term vision are associated with resilience

Education provides a key source of both structure and distraction, supporting young people in gaining control over their fate by facilitating political, economic and social mobilisation. **Educational aptitude and/or a willingness to focus on education** appear to be key resilience resources, identified in studies with unaccompanied Sudanese refugees in the US (159), as well as Palestinian refugees residing in refugee camps (160). Among treatment-seeking refugees aged 13-21 in the Netherlands, feeling proud of educational achievements supported positive well-being (161). In a study of adolescent Cambodian refugees living in Quebec, education was identified as a positive pathway, diverting young people away from delinquent behaviour (162).

Not all factors associated with increased resilience are inherently positive. Evidence describing the experiences of young people with lived experiences of the Holocaust identified the use of **anger and revenge** against injustice as coping mechanisms, including the perpetration of violent behaviour (163). Dispositional attributes such as distrust or self-reliance have also been linked to maintaining normal functioning, as mechanisms for minimising the chances of experiencing breaches of trust or further hurt (164). Although these traits may initially help children to cope with their adverse experiences, they are likely to have important negative implications for engagement with peers, communities and health and other services, making resettlement more challenging in the longer term. Engaging in fun and pleasurable recreational activity, such as organised sport, is linked with effective coping both during transit and resettlement (151,165). However, such activities have also been linked to non-productive coping mechanisms, such as avoiding acknowledging or addressing problems (166).

The context of the family

Resilience is not developed or maintained in a vacuum and individual resilience is often framed in the context of the family. For children who grow up in stable and nurturing home environments, **positive early attachment** and **good family functioning** prior to migration can facilitate the development of socio-emotional skills and coping behaviours that support resilience (151). A study of unaccompanied minors from Sudan resettled in the US found that even when family were no longer physically present, good prior family functioning was linked to a strong moral direction in children (167), which can support positive attitudes and behaviours (see *Personality and dispositional attributes*). In transit and resettlement, cohesive and adaptive families provide a source of **support and guidance**, as well as a lasting connection to the child's culture of origin (148,168). **Kin networks** of extended family members also allow children to extract support from a diverse range of adults. This may be particularly important if parents are also suffering from the effects of exposure to trauma prior to or during transit and resettlement (169). Healthy family **communication** is positively linked with resilience among children with refugee status (156). Families with shared displacement or resettlement experiences are able to talk about these experiences, although parents may need to be selective about the memories they share (155). Studies of refugees in Canada reveal the importance of **good parental mental health** for family functioning and resilience (170). When caregivers are actively engaged in their child's life and able to adapt their parenting style and expectations to the host culture, young people can be supported in adjusting to a new school and community (171). Involvement of parents in education is also linked to the school success of refugee youth (172).

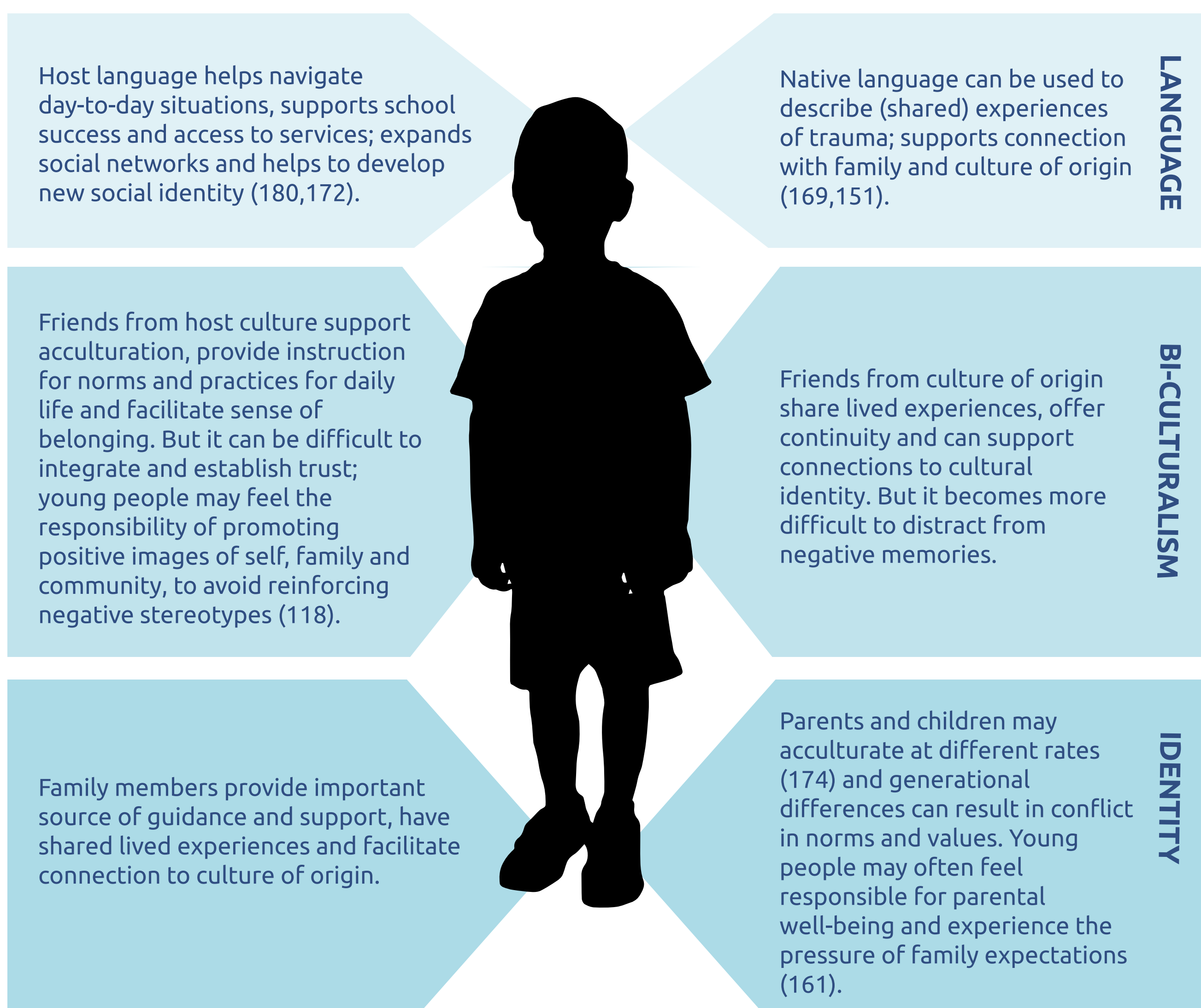
External support factors - the larger social world

Beyond the family, a child will also experience a range of mutual interactions with peer, community and institutional influences. Research highlights the central role of **peers** as protective agents (171); both those from the culture of origin who may have shared experiences of loss (173) (see also Section 3), and those from the host culture who can support adjustment, provide cultural instruction, support integration and foster a sense of belonging (174). **Educational institutions** offer a safe space to develop coping skills (175), with the supportive relationships of teachers and school staff (159). Attending school also provides **structure** for day-to-day life, facilitating a **sense of purpose** and helping to construct a **social network** – both resilience resources (176). Structure and meaning can also be supported by **faith and religious involvement** (177). Interviews with Sudanese teenage refugees shortly after their arrival in the US found that those who were coping well with the loss of living apart from their parents were better able to turn to religion for meaning and guidance on how to live their lives (173). By following faith practices (e.g. attending prayer), children may achieve a sense of **normality or continuity** (169), especially if such practices were a dominant feature of their lives in their country of origin (164,178). **Community resources** can provide recreational activities as well as support and intervention for a range of different health and social care needs. Positive socioeconomic conditions may increase the likelihood or availability of many of the resilience resources described (148). The experiences of asylum seeking children and their families may also be impacted by wider societal views and norms, such as how inclusive communities are or their positive views of integration.

Achieving balance - language, identity and culture

Resilience resources are not only important for overcoming the stress or trauma associated with exposure to violence and deprivation, but also in helping children and young people to deal with the challenges of adapting to life in a new host country. For older children, migration may coincide with the normative developmental challenges of adolescence (179) – a time when young people may typically move away from the influence of the family, and towards establishing a new social identity with peers. For unaccompanied children or those living away from their parents in particular, resettlement may suddenly present the choice of either changing previous behaviours, or continuing with norms and behaviours, such as cultural and religious practices from their country of origin (164). Many of the resilience resources described in the sections above can be thought of as different points on a continuum. For example, associating with peers from one's culture of origin, or developing new friendship networks with peers from the host culture. Figure 6 summarises some of these relationships. Achieving the appropriate balance in each of these areas may be instrumental to maintaining healthy functioning.

Figure 6: Examples of the complex interplay between resilience factors



Section 6: Conclusions

With the number of refugee and asylum seeking children entering and resettling in the UK and other European countries continuing to grow, there is a pressing need to understand the nature and extent of adversity that these children suffer, both in their lives before arrival, and as they navigate their new environments and circumstances.

Current understanding of ACEs reflects experiences common to those who have grown up in high-income countries. However, as this report finds, refugee and asylum seeking children experience a much greater range of adversities in their lives, through the challenges of living in countries affected by conflict or oppression, on the difficult journeys across borders to seek sanctuary, and post-migration (Section 1). These experiences can have a lasting impact on individuals, families and on their ability to integrate into new societies (Sections 2 and 3). This makes them a unique population group, in need of further research and greater understanding to inform services, strategy and policy and to enable them to be supported in the best way possible. While tools such as the ACE-IQ enable the measurement of both household ACEs and additional ACEs relevant to groups of refugee and asylum seeking children, such as exposure to community and collective violence, available literature finds that there are additional adverse experiences that we may wish to consider when thinking about ACEs among this group. These include committing violent acts, experience of imprisonment, abduction or detainment, and periods of severe deprivation of basic necessities such as water, food and shelter.

It is currently difficult to estimate the prevalence of ACEs among refugee and asylum seeking children from existing literature. Studies use different tools and wording, include children from different backgrounds or countries, and examine adverse experiences across differing time frames. ACE exposure varies hugely between samples, and will depend on a wide range of social, economic and cultural factors, as well as migrating experiences and individual meaning attributed to experiences. It is clear, however, that child refugee and asylum seeking populations have a high risk of experiencing multiple ACEs. Along with more consistent measuring tools, there is a need to understand which ACEs are more common and whether certain ACEs are linked to more negative outcomes or are more conducive to building resilience. This type of information can not only help advocate for the prevention of ACEs in countries of origin, but also improve the quality and range of support provided for refugee and asylum seeking children on arrival in host countries (e.g. informing TrACE [Trauma and ACE] informed services). This is particularly important where background information on an individual's prior experience and migration journey is limited.

Importantly, the way in which refugee and asylum seeking children experience ACEs may well be different. Different cultures will have varying norms around what constitutes adversity. Furthermore, concepts such as child maltreatment and neglect may be understood in different ways, or may not be recognised within certain cultures. Physical abuse may occur within contexts outside of home settings, such as within schools, conflict settings or as part of migration journeys. Parental incarceration may not reflect parental criminal behaviour, but may be indicative of differences in political opinion, ethnic or social group, or religious belief. Similarly, parental separation may be experienced differently, with in many cases families separated through force, the chaos of flight or the desire for security, not marital conflict. Thus, the range of ACEs experienced by refugee and asylum seeking children may be broader, but how we understand ACEs amongst this population may also differ.

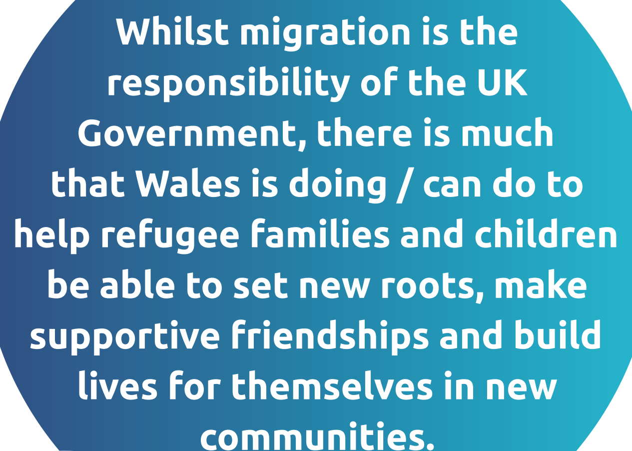
The on-going likelihood of ACEs within child refugee and asylum seeking populations as they journey through the asylum seeking or resettlement process and resettle in host countries is an important consideration. This will include ACEs within the family setting, where we know that the stress and trauma associated with conflict, migration and resettlement can impact on family functioning and the risk of neglect and maltreatment, marital conflict and domestic violence (Section 2). However, it will also include ACEs that may be experienced within the facilities, care settings, communities and schools that children engage with, e.g. discrimination, bullying or experiencing/witnessing violence. Interventions to prevent, identify and address the risk of on-going and new ACEs are therefore important. This could include working within schools and communities to encourage integration and acceptance of different cultures, and working with families to foster positive relationships, manage stressors and increase their capacity to support their children. With economic hardship and different acculturation rates being two important stressors to families, opportunities to help parents learn the host country language and find employment are also likely to have a preventative influence on subsequent ACEs within the family.

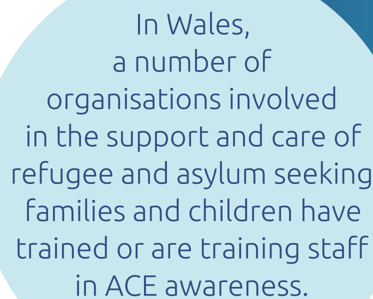
Plans to ensure that refugee and asylum seekers (including children) are supported as they integrate into Wales are set out in the Welsh Action Plan ***Nation of Sanctuary*** (12). Plans to increase access to services and support schools in Wales in increasing educational achievement are a part of the Welsh Action Plan ***Nation of Sanctuary*** (12).

ACEs can impact broadly on the mental health, behaviour, learning and academic achievement, and short term physical health of child refugee and asylum seekers (Section 3). Given the strong links between ACEs and mental health in this population, increased risk of longer term health implications (e.g. chronic health conditions reported in general populations) is also likely. Further research in child refugee and asylum seeking populations is needed to explore this link. Ensuring that children and families have the necessary support available to them, whether that is access to health and mental health services or systems within school to help with academic learning, is essential. Considering and overcoming barriers to accessing services (e.g. within health services in Wales: challenges of communication, transport costs and poor provision of mental health services [181]) is therefore important. However, not all refugee and asylum seeking children will suffer the negative impacts of ACEs, and there are a number of key risk factors for poorer outcomes (Section 4). For instance, unaccompanied minors (compared to accompanied), and children experiencing multiple ACEs, are particularly susceptible to developing poor mental health outcomes, and may be a target group for more comprehensive support. Importantly, the conditions in which refugee families live post-migration influence whether negative outcomes are experienced following ACEs. This includes the asylum process itself. Stability appears to be important, and opportunities should be made to encourage the growth of support networks for both parents and children. Importantly, this research highlights the need for TrACE (Trauma and ACE) informed services along the pathway of support for asylum seeking and refugee families and children.

Evidence suggests that what we already know about resilience (and ACEs) in native populations is also important for refugee and asylum seeking children (Section 5). However, balancing the needs of the individual and the family, and the demands of the native and host culture, can present a real challenge. There are many gaps in our understanding of what resilience entails and how it can be developed. An important gap is how to ensure that the resilience factors that children and their families bring with them into host countries are maintained over time, and not left to deteriorate amidst the social, economic and cultural challenges they face once they resettle. Further gaps can be found in our understanding of the relationship between resilience factors pre-immigration (e.g. early childhood factors) and resilience factors developed as a result of experiences in transit and resettlement, and our knowledge of the importance of different experience types (e.g. type of conflict, reason for displacement, direct exposure to combat) on health and resilience outcomes.

Whilst opportunities to influence adversity experienced by refugee and asylum seeking children before they enter host countries is limited, generating a better understanding of ACEs amongst this group can help advocate for ACE prevention in host countries. Importantly, however, there is much we can do to help prevent further ACEs on arrival in host countries and mitigate the negative impact that ACEs may have on health, well-being, education and broader outcomes in both the short and longer term. This includes developing TrACE (Trauma and ACE) informed services along the pathway of support for refugee and asylum seeking families and children and building the resilience they need to adapt and live new, productive and meaningful lives, whether that is within the host country or their country of origin.





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Appendices

Appendix 1: Methodology

This report used a number of systematic searches across academic and grey literature (including PsychInfo, Medline, Cinahl, ASSIA, PTSDpubs and the WHO Global Index Medicus) from 1999 onwards to identify studies of child refugees and asylum seekers (or their parents), that measured or discussed ACEs/traumatic experiences. Although we did not restrict searches by geography, this report focuses on qualitative and quantitative studies primarily from the UK, Europe and the US, drawing on relevant learning from other parts of the world where research is scarce. Studies explore the experiences of people fleeing a range of different countries and political or social contexts, including both children who arrive as dependents, and those that are unaccompanied.

Appendix 2: UK Resettlement Schemes

The UK offer a number of resettlement schemes for the most vulnerable refugees; those that would benefit most from resettlement in the UK. Under the **Vulnerable Children's Resettlement Scheme (VCRS)**, children would be considered for resettlement if they are: Children without legal documentation; Children with specific medical needs; Children with disabilities; Child carers; Children at risk of harmful traditional practices (including child marriage and female genital mutilation); Children at risk of being forced to work; Children associated with armed forces or armed groups; Children in detention; Children at risk of refoulement (forcible return to a country where they are liable to be subjected to persecution); Child survivors of (or at risk of) violence, abuse or exploitation including sexual and gender-based violence. Under the **Vulnerable Person's Resettlement Scheme (VPRS),** refugees are assessed for resettlement against the following categories: Legal and/or physical protection needs; Survivors of violence and/or torture; Medical needs; Women and girls at risk; Family reunification; Children and adolescents at risk; Lack of foreseeable alternative durable solutions.

Home Office. Resettlement: policy statement. July 2018.

Our Priorities
2018-2030

Building and mobilising knowledge and skills to improve health and well-being across Wales

Influencing the wider determinants of health

Improving mental well-being and resilience

Supporting the development of a sustainable **health and care system focused on prevention** and early intervention

Working to Achieve a Healthier Future for Wales

Promoting healthy behaviours

Protecting the public from infection and environmental threats to health

Securing a **healthy future** for the next generation

Our Values:

Working together with trust and respect to make a difference

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