JÖNKÖPING UNIVERSITY
School of Education and Communication

Interventions with the focus on refugee children´s mental health

A systematic literature review

Franziska Schichtel

One year master thesis 15 credits
Interventions in Childhood

Spring Semester 07/06/2016

Supervisor
Alecia Samuels

Examinator
Eva Björck-Åkesson
Mats Granlund

SCHOOL OF EDUCATION
AND COMMUNICATION (HLK)
Jönköping University

Master Thesis
15 credits
Interventions in
Childhood
Spring Semester
07/06/2016

ABSTRACT

Author: Franziska Schichtel

Interventions with the focus on refugee children´s mental health

A systematic literature review

A systematic review was conducted with the aim to identify interventions in high income countries that address the mental health of refugee children arriving in a new country where they or their parents seek asylum. These children represent a special population in need of special support due to their exposure to various forms of trauma as a result of the refugee experience. A systematic literature review based on a database search of empirical studies concerning interventions for refugee children with a focus on their mental health was conducted. The results shown suggest that there is a lack of empirical interventions concerning support for refugee children with mental health problems and those that do only tend to focus on children in the school going ages. This review recommends the need for additional future research and discusses political and policy amendments to address the mental health situation of refugee children when arriving in high income, western host countries.

Pages: 32

Keywords*: asylum seeking children, child-focused, intervention, mental health, refugee children, western high income countries*

Postal adress
Högskolan för lärande
och kommunikation (HLK)
Box 1026
551 11 JÖNKÖPING

Street address
Gjuterigatan 5

Telephone
036–101000

Interventions with the focus on refugee children´s mental health

"There is no health without mental health" - UN secretary-general Ban Ki Moon mentioned in 2011. Mental health plays a significant role in the health and well-being of individuals and communities. "Successful performance of mental functioning, resulting in productive activities, fulfilling relationships with other people, and the ability to change and to cope with adversity". WHO established the Commission on Social Determinants of Health to facilitate awareness and movement toward policies addressing health inequalities (Keefe & Jurkowski, 2013). The need to promote mental health and well-being is also one of the goals stated by the UN Sustainable Development Summit in September 2015 (WHO, 2015). Concerning the health and well-being of children the UN Convention on the Rights of the Child (1989) states that all children have the right to the enjoyment of the highest attainable standard of health (article 24) which also includes mental health. The UNCRC (1989) also mention in article 22 that refugee children should receive appropriate protection and humanitarian assistance in the enjoyment of the rights set in the UN Convention on the Rights of the Child. And therefore refugee children should be enabled also to enjoy the highest standard of health as well as mental health.

1 Introduction

To date there have been more than 127 wars around the globe since the end of World War II, in addition, this has resulted in masses of refugees and displaced people all over the world and between 21 million and 40 million deaths. Over 80% of victims of today´s warfare are women and children. It is not only that people could be killed or wounded. Also the safety of family members, fear about abductions of young adults and children, both internally displaced and across borders, social breakdown, lack of basic services and meeting of basic needs count towards the frame of problems (Yule, 2002). Defining someone as a refugee in relation to the 1951 United Nations Convention Relating to the Status of Refugees (Geneva Convention) means someone with a "well-founded fear of persecution for reasons of race, religion, nationality, membership of a particular social group or political opinion" (UN, 1951). At the end of 2014, over 59 million people were forcibly displaced worldwide. Over 15 million people are recognized as refugees like the term is used by the 1951 UN Convention, millions of people living in refugee-like situations and millions being internally displaced (UN, 2015). But only a small fraction of refugees really arrives in European countries - around 3 million at June 2015 (UN, 2016) and claim asylum petitioning the right to be recognized as refugees under the Geneva Convention. Most refugees, however, remain internally

displaced or just across the border in neighbouring states (Bronstein & Montgomery, 2011). In the past few years European countries have been confronted with an increasing influx of refugee children (Vervliet et al., 2014). Germany has received the highest number of new asylum applications worldwide with over 159´000 during the first six months of 2015. In comparison, 173'100 asylum applications were registered by the German authorities for the whole year of 2014 (UN, 2015).

The dramatic increase in the absolute number of unaccompanied minors merits consideration: For example, in Germany 6584 unaccompanied minors were taken into care by the youth welfare system in 2013. In 2015, the total number of unaccompanied minors to have entered the country has currently exceeded 60,000 (Hebebrand et al, 2016).

Refugee children are at high risk to develop mental disorders because of their exposure to traumatic events and it is suggest that there is a significant functional impairment in traumatized refugee children (Ruf et al, 2010). These include problems at school and cognitive performance difficulties and can hinder the successful integration of refugee children into the host culture (Ruf et al., 2010). It is known that the mental health of refugee children is severely compromised often by the trauma of war from which they are fleeing and consequent displacement (Yule, 2002). However, little is known about how to support these children in their special life situation.

2 Background

Common experiences for refugees often include the multiple losses of family members and culture, war, persecution, torture, rape, violence and upheaval (Bronstein & Montgomery, 2011). Within the refugee population, over one-quarter are children. The term refugee child can be misleading as not all minors who flee to another country are a coherent group. They have different interests, experiences and expectations. They have in common that they or their parents apply for a legal based residence permit and that they have left their home countries because of war, violence, existential needs, to escape discrimination or a life without prospects (Berthold, 2014). In this study the term refugee child does not include migrant children or children with emigrational background. They have different migration experiences since they have not been forced to leave their country of origin and they also have different reasons to move to another country. Their move to a new country is well planned and organised and different situations and laws are influencing them (Berthold, 2014). This is also in line with the terminology of the UN Convention of the Right of the Child (UN, 1989) and the term used in that. In the German language the terminology “children” is usually used to separate young children from teenagers this would might exclude the situation of young people, but the focus on children's terminology similar to the UN Convention on the Right of the Child is a clear reference which includes the entire group of 0 to 18 year old people (UN, 1989). As

part of their development, children are subjected to various risks or stressors; however, refugee children have the added traumatic stressors inherent in the forced migration process and therefore the effects of traumatic events are even greater for them when that trauma is modern warfare (Bronstein & Montgomery, 2011; Yule, 2002). Nations therefore have a duty under various UN agreements to alleviate the effects of war on children´s mental health and therefore there have been numerous studies reporting the levels of psychological distress in refugee children (Bronstein & Montgomery, 2011; Yule, 2002).

2.1 The three stages of flight

The stressors to which refugees are exposed are described in three stages: firstly pre-flight while in their country of origin which includes war, discrimination, violent conflicts; secondly, the flight stage i.e. during their flight to safety which includes violence, lack on basic needs; and finally the post-flight when having to settle in a country of refuge which includes stressors such as displacement, discrimination, social exclusion (Fazel & Stein, 2002). These experiences are the same for children, too. Refugee children may experience what is termed the cumulative stress of forced migration -events during the pre-flight, flight and post-flight phases together with the compounding stressors of childhood. Consequently, these children are at greater risk for psychological distress than non-refugee children (Bronstein & Montgomery, 2011). There are psycho-social consequences of such complex emergencies which include social and personal effects such as anger, violence, depression, anxiety, early and unprotected sexual activity, teenage pregnancy, alcoholism, promiscuity, prostitution, drug abuse, family breakdown and so on (Yule, 2002; Björn et.al., 2011).

2.2 Psychological consequences

Psychological distress in refugee children is predominantly described as post-traumatic stress disorder (PTSD), depression, and other symptoms such as irritability, restlessness, sleep problems, somatic symptoms and conduct disorders. Refugee children are also thought to suffer from hypervigilance or/and startle reactions as well as conditioned fear, including somatic symptoms, sleeping disturbances, social withdrawal, attention problems, irritability and difficulties in peer relationships (Bronstein & Montgomery, 2011; Björn et al 2011; Fazel & Stein, 2002). In one study (Björn et al 2011) 47% of Bosnian refugee children who resettled in Sweden reported symptoms of depression and anxiety (23%). Co-morbidity with PTSD has also been reported. In the study of 99 school-aged Bosnian refugees in Sweden, 36% were reported as suffering from hypervigilance and startle reactions as well as from conditioned fear (Björn et al 2011). Betancourt and colleagues (2015) mentioned in their study that among resettled refugee children the prevalence of PTSD and depression is estimated to be as high as 54% and 30% respectively, compared with an estimated 5%

PTSD and 11% depression of children with these disorders in the general population (Betancourt, Frounfelker, Mishra, Hussein, & Falzarano, 2015). Also overlapping between attention deficit hyperactivity disorder (ADHD) and PTSD symptoms are represented among refugee children as well as cognitive functions which present associations between low IQ (<84) and having both ADHD and PTSD (Daud & Rydelius, 2009). The refugee experience of pre-flight, flight and post-flight, increases the risk of being exposed to multiple acute and chronic stressors that accumulate and lead to differential mental health outcomes similar to diagnoses of anxiety disorders in children, that include inattention, forgetfulness, social withdrawal, weight loss, and somatic complaints (Betancourt et al, 2015).

It is therefore well established that children living in war zones are at high risk of developing different types of psychopathology, predominantly post-traumatic stress disorders like those described in table 1.

Table 1: Risk factors and Symptoms of mental health of refugee children from Fazel & Stein, 2002:

Risk factors for mental health problems in refugee children	*Summary of common presenting symptoms of psychological disorders in refugee children*
• *Parental factors* • Post-traumatic stress disorder (PTSD) in either parent • Maternal depression • Torture, especially in mother • Death of or separation from parents • Direct observation of the helplessness of parents • Underestimation of stress levels in children by parents • Unemployment of parents • *Child factors* • Number of traumatic events—either experienced or witnessed52 • Expressive language difficulties • PTSD leading to long term vulnerability in stressful situations • Physical health problems from either trauma or malnutrition • Older age • *Environmental factors* • Number of transitions • Poverty • Time taken for immigration status to be determined • Cultural isolation • Period of time in a refugee camp • Time in host country (risk possibly increases with time)	• *Posttraumatic stress disorder* • Persistent avoidance of stimuli: specific fears; fear of being alone; • withdrawal • Re-experiencing aspects of the trauma: nightmares; visual images; • feelings of fear and helplessness • Persistent symptoms of increased arousal: easily aroused; • disorganised and agitated behaviour; lack of concentration • *Other anxiety symptoms* • Marked anxiety and worry: irritability, restlessness • Other sleep disorders • Somatic symptoms including headaches and abdominal pain • *Depression* • Low mood • Loss of interest or pleasure • Declining school performance • Conduct disorders

It has also been established that PTSD is commonly comorbid with other psychiatric disorders, mainly major depression (Thabet, Abed & Vostanis, 2004). Most often it is difficult to separate the effect of war trauma from that of potential confounding factors such as flight stress, separation from family, post-flight stress, socioeconomic adversities and acculturation difficulties. For example stressors of immigration, such as parental unemployment, have been shown to have an independent impact on child psychopathology, thus making findings difficult to interpret (Thabet et al, 2004). Thabet and colleagues mentioned that the two disorders appear to follow different courses over time. PTSD was predicted by earlier war trauma experiences, while depression was associated with recent stressful events related to their current life circumstances. In summary, high prevalence of comorbid PTSD and depression has been established among children who had experienced war conflict, predominantly from studies with resettled refugees or internally displaced children after the conflict, who were thus exposed to a number of confounding variables associated with migration (Thabet et al, 2004).

2.4.3 Mental health of unaccompanied refugee children

Generally there are higher levels of mental health problems and serious psychological problems among unaccompanied children than normative populations and also with respect to the incidence in accompanied refugee children (Abunimah & Blower, 2010). This group of children appear to have a higher incident of clinical or borderline levels of psychiatric and behavioural problems. One-quarter has an acute physical health problem such as untreated physical injury or food poisoning and some are with chronic physical health problems including hepatitis, gastrointestinal difficulties or musculo-skeletal problems (Abunimah & Blower, 2010). One-quarter were also described as experiencing mental health problems, especially symptoms of depression and anxiety, difficulties to sleep and eat, nightmares, homesickness, fears for family members (Abunimah & Blower, 2010; Fazel & Stein, 2002) as well as an inability to concentrate at school, possible psychosomatic symptoms including frequent gastric problems and headaches, and, in a handful of cases, suicide ideation but also missing school regularly. Absences were often associated with reports of symptoms of anxiety (Abunimah & Blower, 2010). Although these can be associated with post-traumatic stress disorder (PTSD), there are few formal psychiatric diagnoses that would allow a general assessment of the prevalence of PTSD. Even so, what is notable is the high overall prevalence of such problems, indicating the high stress associated with being a separated child (Abunimah & Blower, 2010). However, if a refugee child is accompanied by its´ primary care giver or unaccompanied, both groups are vulnerable and require attention equally.

Whilst it is recognized that some of their adverse behaviours were related to the stresses that refugee children had been under, ways of managing it have not always been dealt with. Previously, refugee children with mental health problems would have been referred on to specialists located often many miles away which made it quite often impossible for them to attend the help they needed (Yule, 2002).

2.3 Stressors of forced migration

During the pre-flight and flight phase of forced migration refugee children experience different and/or several stressors which result in increased internalizing, externalizing and PTSD symptoms as well as higher depression levels (Bronstein & Montgomery, 2011). Stressors like separation from parents and direct personal injury appears to be correlated with higher PTSD levels (Bronstein & Montgomery, 2011). Separation from parents was also examined between accompanied and unaccompanied refugee children and it was found that unaccompanied children display greater levels of distress. Also the violent death of a family member appears to contribute to higher post-traumatic stress levels on measures of PTSD symptoms (Bronstein & Montgomery, 2011).

Directly related to higher PTSD and depression levels in refugee children are stressors experienced in the post-flight phase. Specific factors such as uncertainty regarding asylum status or failed claims were related to internalizing problems and depression. Process of immigration and discrimination were both related to higher PTSD levels where as lack of personal and structural support along with restrictions in living arrangements were also related to higher internalizing and depression problems. Lower language skills were related to higher PTSD levels while financial difficulties were related to higher levels of depression (Bronstein & Montgomery, 2011).

The accumulation of stresses does indeed have an adverse effect on the mental health of refugee children and there is a wide array of variables that influence mental health during pre-flight, flight and post flight phases (Bronstein & Montgomery, 2011). These conditions are part of the biography of most refugee children. Escaping to Germany has left its mark on the refugee children. The stressors at the borders of Europe are also often sharply criticized, especially the experience of witnessing thousands of people drowning in the Mediterranean and the obstacles encountered to seek refuge in the host country (Berthold, 2014).

2.4 The situation of unaccompanied and accompanied refugee children in Germany

2.4.1 Accompanied refugee children

It is reported that 90 to 95 percent of refugee children, in absolute terms approximately 36,300 (Berthold, 2014) minors have travelled with their families to Germany in 2013. The separa-

tion between the two groups' i.e. unaccompanied and accompanied children is not always clear since many families are at least temporarily separated as part of their way through Europe (Berthold, 2014). And since it is known that in 2015 up to 60,000 children arrived unaccompanied in Germany it is accomplished that the total number of accompanied refugee children in Germany has also raised since the percentage of these children is higher than the percentage of unaccompanied children.

Even refugee children accompanied by their parents require the same special protection, the same care and the same funding and support. The assumption that all this happens by itself, just because of the presence of a parent, does not match reality (Berthold, 2014). Each refugee child needs the same special support - as any other child. The situation regarding unaccompanied minors has in recent years slowly but steadily improved. In Germany in particular, a comprehensive, practice oriented exchange has developed by the attention of the youth services for this group of children. Also, there are now a large number of publications to this particular group. However, the majority of accompanied refugee children gets too little attention by these services. This is also seen through the low research interest on this issue and the lack of appropriate support measures or their non-application (Berthold, 2014). In December 2013 the German Government presented the grand coalition agreement in which refugee children only played a subordinate role. While the grand coalition agreement notes that the Convention on the Rights of the Child applies for all children living in Germany as well as for unaccompanied refugee minors, the refugee children accompanied by their families - the clear larger group – gets no attention in this context (Berthold, 2014). But the rights of the Convention on the Rights of the Child also apply to them.

2.4.2 Unaccompanied refugee children

Unaccompanied or separated children are a significant subgroup of refugee children. The total number of unaccompanied or separated children arriving in Europe increases each year. Over 24000 unaccompanied children claimed asylum in Europe during 2014 and were referred to the European Commission (Abunimah & Blower, 2010; EMN, 2015) which is nearly double than the year before. They make up 4% of the refugee population in Europe. In Germany, 4400 (18%) unaccompanied refugee children have applied for asylum. Their main countries of origin are Afghanistan, Eritrea, Syria, Somalia, Gambia and Morocco (EMN, 2015). Poverty is a factor that contributes to the decision of whether a child is forced to travel alone since only few families in developing countries have the resources to pay for both the child and the parents to travel. Luckily a growing number of these children can be reunited with family members. Although a small but significant proportion remain in the care of the authorities (Abunimah & Blower, 2010).

There are therefore significant differences between accompanied and unaccompanied children. Unaccompanied children seeking asylum have different needs and characteristics and they are not a homogeneous group (Abunimah & Blower, 2010; Bronstein & Montgomery, 2011). Unaccompanied children have multitude of different risks. They have different and varied types of experience and difficulty, which in turn require different types of needed response or support. In short this group is not necessarily homogeneous (Bronstein & Montgomery, 2011). For more specific events it is mentioned that separation from parents or primary caregivers and direct personal injury correlated with higher PTSD scores. Separation from parents and primary caregivers was also considered in comparison studies between accompanied and unaccompanied refugee children, where unaccompanied children displayed greater levels of distress than their accompanied peers (Bronstein & Montgomery, 2011).

But even if every child is unique all children share some similarities with others. Exploring these similarities makes it possible to identify groups of children who might benefit from similar types of support (Abunimah & Blower, 2010). Unaccompanied or separated children seeking asylum are commonly defined as children under 18 years who are outside their country of origin and separated from parents, guardians or other adult family members (Abunimah & Blower, 2010). Forced to escape their home countries because of armed conflict, violence that has killed parents and other relatives, sexual assault or torture. In some cases they are trafficked for prostitution or domestic servitude or as child brides, and they may be abused sexually and physically along the way. These children are often victims of crime and have faced multiple violations of their human rights (Abunimah & Blower, 2010). Most of the children arrive without any sibling or caregiver and over time only a few were known to maintain contact to family members (Abunimah & Blower, 2010).

The separation of the young person from their primary caregiver may occur in the pre-flight phase, however, the impact may be felt well into the post-flight phase. Young people could very well view the separation from their parents or primary caregiver as a traumatic event and in the post-flight period, the unavailability of the primary caregiver may be a missing protective factor (Bronstein & Montgomery, 2011).

Unaccompanied refugee children in Germany therefore are a highly vulnerable group of children due to their experiences. Their pre-flight experiences place them at risk of developing psychological problems (Abunimah & Blower, 2010). These includes extreme social isolation, anxieties about family members in the home country, fears about future, managing with the day-to-day challenges of school and adjustment to life in a new country. Therefore safety is an essential aspect

of their living situation, yet it appears that overall this group of children had unusually high exposure to dangerous situations. As has been noted, only 43% of the children had been regularly cared for by a parent before arriving in the European host country. One-third were being cared for by non-relatives, institutions or nobody in particular. Almost all of the children in institutions had no knowledge about or contact with their families (Abunimah & Blower, 2010). The majority of the children experienced unstable or violently disrupted social and family relationships. In a large proportion, the children´s parents were missing, ill, imprisoned or dead. Some parents had fled their country, leaving their child cared for by friends or family. Unaccompanied refugee children experience near total social isolation from adults. Indeed the only significant adult present in their lives are complete strangers (immigration officials or professional staff who care for them) (Abunimah & Blower, 2010).

2.5 Refugee status inequalities in accessing support services

In both groups, accompanied and unaccompanied refugee children, an overwhelming majority had been exposed to conditions of war, stayed in refugee camps, witnessed violence and are suffering from anxiety, sleep problems and appeared sad or miserable (Montgomery & Foldspang, 2005). For the needs of women and children UN fund for Children is responsible which runs under the UN High Commission for Refugee and the UN Human Right Commission. In addition the United Nation Convention on the Right of the Child (1989) provides relevant articles in relation to war and refugee children.

In Article 22 it is stated to “ensure that a child who is seeking refugee status or who is considered a refugee, receive appropriate protection and humanitarian assistance in the enjoyment of applicable rights set forth in the present Convention and in other international human rights or humanitarian instruments". And more compared to the issue of health is Article 24: “the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. Ensure that no child is deprived of his or her right of access to such health care services" as well as Article 39: “promote physical and psychological recovery and social reintegration" (UN, 1989).

The legal framework of the current study is the UN Convention on the Rights of the Child (1989) which shall apply to all children and young people living in Germany. Obligation in any action against minors should follow the "best interest of the child" (UN, 1989). This principle is also found in article 24 of the European Charter of fundamental rights. To preserve the rights and interests of children means also that it does not automatically step behind other immigration law

provisions or regulations. In Germany the legal framework of the UNCRC (1989) is supplemented by the standards of the right of help for children and young people (SGB VIII) which states in the general rules specified that each child has "a right of promotion its development and education to become a responsible and socially competent personality". The same applies for refugee children.

No standard or singular policy regarding the granting of asylum or rights and requirements existing across the OECD countries and there are often different laws in different countries restricting individuals with a refugee status or individuals who claim asylum (Bronstein & Montgomery, 2011).

Defining the asylum status or immigration label is often important when it comes to support or opportunities in the host country. Labels are used as a bureaucratic tool to facilitate the management of asylum and immigration in a country and directly impact the rights and requirement of individuals. The denomination of refugee status can influence support and social variables in the host country´s context; for example a person recognized as a refugee is likely to have a different set of rights and requirements in areas such as economic opportunity, living arrangements, or education compared to someone whose asylum claim is still pending or someone whose claim has been refused (Bronstein & Montgomery, 2011). This leads to several problems which asylum seeker have to deal with and often children are most effected through such restrictions. Refugee children are primarily perceived as following their parent status and not as an independent person with their own needs and special child-specific rights. For example, there are specific health risks and inequalities in opportunity of the refugee children, especially if more closely considering specific health determinants of children like the factor of adequate housing (Blättner & Waller, 2011). The German national collecting system for dealing with refugee children tend to focus on adults accompanying children or unaccompanied minor refugees (Berthold, 2014).

With the criteria for adequate housing explained by Blättner and Waller (2011) it becomes clear what for an immense health risk in form of accommodation of the refugees children is there. Many refugee children have to live in mass accommodation without space for privacy, without child-friendly environment and without the possibility to take part in social life. Refugee children experience racism, rejection and unwillingly become objects of political disputes (Berthold, 2014). Good or qualitative environmental factors are important for the positive development of children. Environmental factors defined in the ICF-CY (WHO, 2007) can be physical, social and attitudinal environment in which a child lives. The environmental factor can be a positive factor i.e. a facilitator, or a negative factor i.e. a barrier (WHO, 2007). Children are most affected while they spend the most of their time within the accommodation because of restrictive laws that hinder their ability to

participate in common social activities for children like visiting a playground out of the prescribed area (Berthold, 2014).

Germany refugees are controlled by various legal regulations which affects the abilities of refugee children and their families to develop and grow as a family. From this situation it is hard for children to gain positive experiences and positive development. However these rights are severely curtailed and also partly disregard through the German immigration laws (Berthold, 2014).

2.6 Interventions

An intervention is the interference so as to change a process or situation. In the sector of health it is described as a combination of program elements or strategies designed to yield behaviour changes or enhance health status among individuals or a whole population (Stecker et. al, 1995). Interventions include forming or educational programs, new or stronger policies, improvements in environments, or health promotion campaigns (Sallis J.F., Bauman A. & Pratt M., 1998). Interventions which comprises multiple strategies are typically the most effective in producing sustained change (Smedley et al., 2001) because of the potential to reach a larger number of people in a variety of ways (Burke & Fair, 2003). Evidence has shown that interventions create change by influencing individuals' knowledge, attitudes, beliefs and skills as well as increasing social support and creating supportive environments, policies and resources (Burke & Fair, 2003).Interventions can be implemented in different settings i.e. including societies, communities, workplaces, schools, health care centres, faith-based organizations or in the home of individuals and groups.

To focus on early childhood and interventions in childhood means to have a focus on the foundation and the basis for a positive development of children and consequently a positive influence on the whole life of an individual (Bronfenbrenner & Ceci, 1994).

In September 2015 WHO presented their Agenda for Sustainable Development which builds on the Millennium Development Goals and presents a historic and unprecedented opportunity to bring the countries and citizens of the world together to decide and embark on new paths to improve the lives of people everywhere (WHO, 2015). World leaders gathered at United Nations headquarters in New York to adopt an ambitious new sustainable development agenda (WHO, 2015) which applies to all countries and which addresses the global course of action to end poverty, promote prosperity and well-being for all, protect the environment and address climate change. Agreed by the 193 Member States of the UN the new agenda 2030 Agenda for Sustainable Development consists of a Declaration with 17 Sustainable Development Goals and 169 goal targets (WHO, 2015). One health-related Sustainable Development Goal is Goal 3 which focuses on ensuring healthy

lives and promote well-being for all at all ages. Within goal 3, goal target 3.4 specifically addressing the issue of mental health:

> By 2030: reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being (WHO, 2015).

This declaration thus asks member states of the United Nations to put these goals at the forefront of their national agendas and countries are expected to take ownership and establish a national framework for achieving the 17 Gaols.

An ecological perspective of human development and learning views child functioning as multiply determined, where the processes influencing behaviour and development emanate from different settings and relations between the settings in which children are participating members (Dunst, 2001). Development emerges from the interrelations of biological, psychological and sociocultural forces (Rathunde & Csikszentmihalyi, 2006). Children live and learn in a social context. This could be the family as well as the school, peers or other social settings. Children live in a social context and that providing support to the context may enhance and sustain the effect of child-focused interventions (Ylven & Granlund, 2013). The goal of intervention is that possibilities should be increased for people with special needs to make their voices heard and to control their own environment. It must be possible to apply intervention objectives and strategies in the everyday environment of the individual (Björck-Akesson, Granlund & Olsson, 1996).

In the German context, the protection of children and young people is a priority of the German Federal Government. This protection begins in infancy and should accompany children and young people in all stages of life and life situations (BMFSF, 2015). The Federal Ministry of Family Affairs (BMFSF) is aware of laws and regulations affecting families and children. They are also responsible for the ratified Convention of the Right of the Child (UN, 1989). The Federal Child Protection Act entered into force on 1 January 2012. It creates the basis for comprehensive improvements in child protection in Germany and strengthens all key stakeholders (BMFSF, 2015). The law brings prevention and health promotion ahead equally and represents better assistance to families, parents and children, more collaboration of the relevant stakeholders and strong networks in child protection. It uses knowledge of the action program "Early Assistance" and experiences from the work of the round tables "residential care in the 50s and 60s" and "Child sexual abuse" (BMFSF, 2015). “Early Assistance” is a low-threshold and accessible support. The establishment and expansion of the network “Early Assistance” and psychosocial assistance to families in difficult life situations is a major focus of child and youth policy of the Federal Youth Ministry (BMFSF,

2015). In addition, Germany is one of the signatories of the Agenda for Sustainable Development discussed earlier.

In child mental health services field, the term "evidence- based" is most often used to differentiate therapies—generally psychosocial—that have been studied with varying degrees of rigor from therapies that are used but have not been studied or have not been studied well (Hoagwood et al, 2001). Scientific literature shows a range of evidence-based practice in child mental health services (Hoagwood et al, 2001). The attention to developmental increments in evidence-based practices for children is important and means not only to focus on age-related changes but also complex and dynamic interactions among the child, the family, and the environmental context. In addition, the creation of a treatment for a child is rarely undertaken without consideration of the family context (Hoagwood et al, 2001). Evidence-based practice is connected to the acceptability of engagement and treatment, empirically supported psychosocial outpatient treatments, family-focused treatments, integrational community-based treatment, school-based interventions and psychopharmacology (Hoagwood et al, 2001). Although if the literature with focus on the efficacy of a range of mental health treatments of children is gaining strength for particular clinical syndromes it is still uneven and to improve the evidence more attention to service variables that tend to be neglected in most efficacy-based studies are needed (Hoagwood et al, 2001).

Refugee children living in the German exile are the target group that represents the field of interest in this paper especially their mental health conditions after traumatic experiences. Research on the mental health of refugee children in Germany is relatively rare and special support for these children is not everywhere or easily available or accessible. Refugee children in Germany are at high risk of mental health disorders and few studies suggest that there is significant functional impairment in traumatized children including problems in school and cognitive performance, factors that can exacerbate the adverse effects of mental health problems and these children´s successful integration into the host culture (Ruf et al., 2010). But it is less known how to assist these children during their time in German exile.

It is crucial to give refugee children with mental health problems suitable support as early as possible since it will be more expensive for government and society the longer they wait. Investing in early childhood education and interventions will pay off in the long run much more than programs which focus on catching them up when they are already well entrenched and negatively affecting all aspects of children lives. Society benefits more if it would invest in early support for children (Campbell et al, 2014). Campbell and colleagues say that Germany for example could increase its investment on early intervention and education per child by ten percent which would

bring a more 56,000 Euros in lifetime earnings (Campbell et al, 2014). If society cuts education budgets and stingy in investment in early childhood, society will pay the long-lasting costs if pushing on issues that might be even worse in the future. While programs for older children or after a longer period of time are not useless, they do become much more expensive (Campbell et al, 2014). The data above is based on studies from the USA, but the results could be in a similar in Germany and other countries in Western Europe. Lack of early childhood education affects not only on academic performance but also on the health and the social behaviour of children (Campbell et al, 2014).

2.7 Rational

Mental health disorders are largely preventable, non-communicable diseases which include disorders such as: anxiety, bipolar, eating, depression and suicide – these disorders are identified as the leading causes of illness and death and impact persons or any age, race, religion or income (Keefe & Jurkowski, 2013). As it is mentioned in the UN Convention on the Right of the Child from 1989, every child has the right to the enjoyment of the highest attainable standard of health which also includes the mental health of the refugee child. Many refugee children coming to Europe with traumas and knowledge is required of how to deal with this special population. There is a lot of# knowledge of how important mental health is for a positive development of a child and there are many interventions, programs to increase the mental well-being of children. Refugees experience a wide range of exclusion and discrimination also often through state laws and regulations. In the sector of health and well-fare they often only achieve emergency treatments. Because of their exposure to a multitude of traumatic events, their unique experiences and their different cultural backgrounds, common interventions addressing mental health concerns may need to be adapted for refugee children. More information on specialized interventions for refugee children with mental health difficulties.

2.8 Aim

The aim of this systematic literature review is to identify and discuss existing studies that focus on interventions for refugee children with mental health problems who seek refuge in western, high income countries. Interventions in this systematic review include: strategies, programs, approaches, treatments, therapies and other services whose outcome is to improve the mental well-being of refugee children. The paper also aims to discuss if the identified and presented interventions would work in the German context in light of the legal parameters described.

2.9 Research question

What interventions exist in western, high income countries that address the mental health for refugee children?

What is the focus of these interventions and how and where are they delivered?

3 Method

A systematic review of peer-reviewed literature using seven electronic databases was performed and descriptive statistics was used to analyse the data. Systematic reviews provide a systematic, transparent means for gathering, synthesising and appraising the findings of studies on a particular topic or question. The aim is to minimise the bias associated with single studies and non-systematic reviews (Jesson et al, 2012). Deductive content analysis was carried out. The database search was performed in 2016 from March (14.03.2016) till the end of April (30.04.2016). Inclusion and exclusion criteria were designed according to the aim and the research question. These criteria were used for screening the articles on title and abstract level as well as on full-text level (Lygnegård et al, 2013). In addition, a protocol (table 2 in appendix) was created to assist with data extraction. To fill in the categories in the protocol for all results an excel file was developed which can be obtain by the author. The whole search procedure is documented in a Flow-Chart which can also be found in appendix as table 3.

3.1 Search terms and search procedure

Search terms were identified through the databases during a pre-search and by using the Thesaurus-function in the databases. In all databases the same search words were used. The following search terms has been used with ERIC, CINAHL with full text, PubMed, Scopus, PsycInfo, Medline, and Cochrane. These databases mainly cover the subjects of mental health, children and interventions from a social as well as from a medical view. The advanced search function was used and when the database allowed for it, inclusion and exclusion criteria was added to the search criteria in the different databases.

Used search term:

- (refugees or asylum seekers or displaced) AND (children or adolescents or youth or child or teenager or teens or young people or paediatric) AND (behavioral health or mentally disordered or stress or mental health or mental illness or mental disorder or depression or anxiety or psychiatric illness or psychiatric disorder) AND (strategy or support or approach or intervention or treatment or program or therapy)

3.1.1 Systematic review Boolean search terms

Table 4: search words

MeSH	non MeSH
Population terminology	
	refugee OR asylum seeker
Age Terminology	
	children OR adolescents OR youth OR child OR teenager OR teens OR young people OR paediatric
Exposure terminology	
	mental health OR depression OR anxiety OR stress
Outcome terminology	
	intervention OR treatment OR program OR therapy

3.1.2 Inclusion and exclusion criteria

Table 5: In- and exclusion criteria

Inclusion criteria	**Exclusion criteria**
Population	
Refugee and asylum seeking children	Migrant children
Children of asylum seekers and refugees	Children of migrants
Children between 0 and 18 years	Adults
Children with exposure to mental health problems	Research on refugee children without the focus of mental health support
Outcome	
programs, interventions, treatments, approaches, therapies, support for mental health problems	No focus on/ not related to mental health of refugee children
Design	
empirical studies, also mixed designs	Other systematic reviews, literature reviews or meta-analysis
Research in western, high income countries	Other than western, high income countries

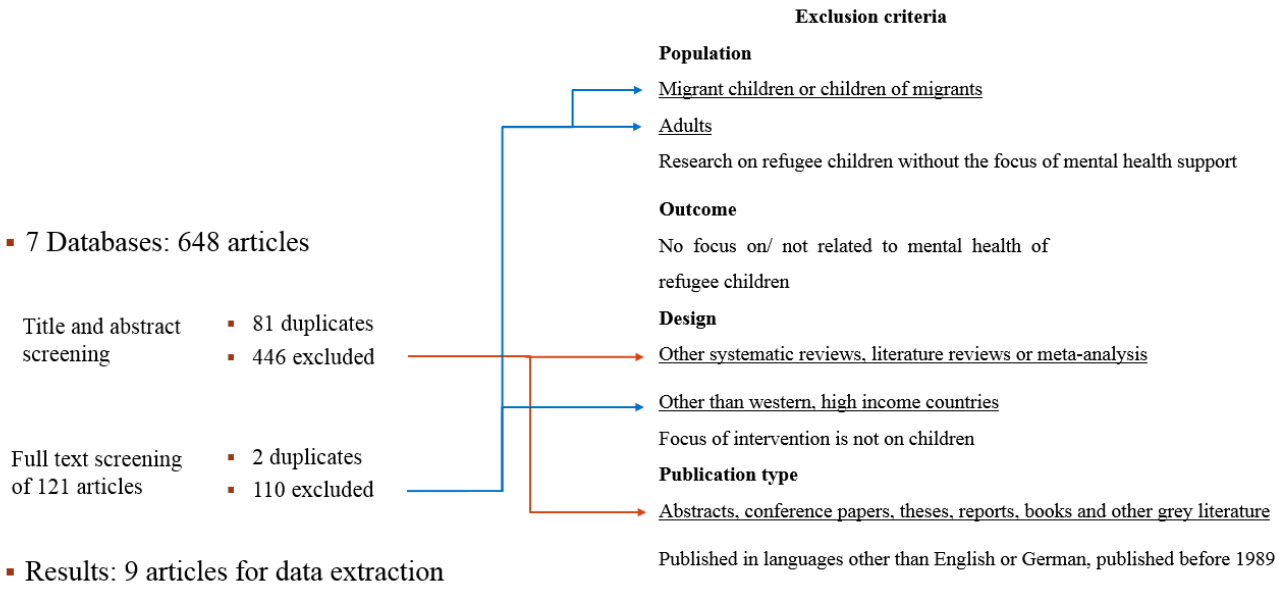
Child-focused interventions	Focus of intervention is not on children
Publication type	
Articles published as full texts in peer review journals	Abstracts, conference papers, theses, reports, books and other grey literature
Time span from 01.01.1989 until today (April, 2016)	Published in languages other than English or German

Inclusion criteria included the study population, outcome, design and publication type (table 5). Because of the lack of literature on the issue, both qualitative as quantitative studies will be included and there are no sample size restrictions. Only studies conducted in western, high income countries will be included so the results can be better generalized to the situation in Germany. The intervention has to be focused on mental health of refugee children. This covers a wide range of outcomes, such as the children's well-being, behaviour, relationships, mental well-being, etc. The screening in the abstract and title level as well as the full text level are based on the same in- and exclusion criteria.

3.1.3 Abstract, title, full-text screening and data extraction

There were 648 search results from the databases with 51 from ERIC, 121 from CINAHL, 102 from MEDLINE, 88 from PsycInfo, 131 from Scopus, 145 from PubMed and 10 from Cochrane. 81 duplicates were identified and excluded. 446 irrelevant articles were excluded on abstract and title screening using the inclusion and exclusion criteria. 121 articles went through full-text screening. 112 articles were excluded on full-text level due to the inclusion and exclusion criteria. Data extraction was therefore undertaken on 9 articles. A flowchart to visualize the search procedure was carried out and is presented in appendix (table 3) as well as the protocol which was used for data extraction and analysis. Articles where mainly excluded because they met the exclusion criteria of population, study design or publication type. The exclusion criteria of title and abstract screening and on full text level are presented in the graphic below (graphic 1).

Graphic 1: Most used exclusion criteria during title and abstract screening and on full text level



3.1.3.1 Quality assessment

The quality of the nine articles used for data extraction was assessed on full-text level with the support of the protocol (table 2 in appendix). The quality was analysed by using the following criteria out of the protocol: specific mental health condition of the participants, participants recruited where and how, role in data collection of the participants, intervention provided through, study design and type (pre- test, post-test), aim of the study (purpose of the study and research question), theory used, conclusion, limitations and implications presented in the study. Each criteria was given a ranking with high, medium or low and the articles than got an overall ranking.

High rankings have been only possible with the use of pre- and post-test or the use of a control group as well as presenting the specific mental health conditions of the participants. A low ranking was given if the study did not present a study design and strategy as well as no specific mental health conditions of their participants. A medium ranking was possible if at least one of the two mentioned criteria was presented.

A table (table 6) was created to present the ranking of the articles with high, medium or low quality results in the quality assessment.

Table 6: Quality assessment of the nine articles used for data extraction

Article	High quality	Medium quality	Low quality
Ehnthold et al, 2005		**x**	
Betancourt et al, 2012			**x**
Oras et al, 2004		**x**	
Ruf et al, 2010	**x**		
O´Shea et al, 2000			**x**
Fazel et al, 2009		**x**	
Fox et al, 2005			**x**
Möhlen et al, 2005	**x**		
Schottelkorb et al, 2012		**x**	

4 Results

Nine intervention studies are identified concerning the mental health of refugee children in western, high income countries. There are three from the UK, three from the US, as well as one from Sweden and two from Germany which are presented below in table 4.

Table 7: Interventions, Strategies, Outcomes, Setting and Participants

Article	Intervention	Strategies	Outcome	Setting	Participants
Ehnthold et al, 2005	School-based, Cognitive-Behavioural Therapy (CBT)	Manual-based intervention of cognitive-behavioural therapy (CBT) techniques. Implemented within secondary schools. Weekly 1-hour group session, 6 weeks. Groups of eight children. Sessions held within school during class time. Each session conducted by clinical psychology trainee	Improvement in children's psychological difficulties. Depression and anxiety scores at follow-up lower than at pre-treatment, decrease was not significant. PTSD symptom scores had risen since post-treatment assessment, particularly for symptoms of arousal.	2 secondary schools in London, UK	26 RC in special classes in secondary school
Betancourt et al, 2012	Multi-Tier Mental Health Program for Refugee Youth, project SHIFA	Adolescents interviewed by trained non-Somali researcher who administered standardized verbal protocol in English; cultural broker was available as needed. All students participated in Tier 2 of the intervention (skill-based groups), 50% participated in Tier 3 (individual), and 13% participated in Tier 4 (home-based).	In Tiers 2, 3, and 4 changes in PTSD symptoms. Time point significantly predicted changes in PTSD symptoms which decreased over time. Participants in all Tiers showed changes in symptoms of depression across time and decreases in resource hardships over time	A middle school in New England, US	30 RC (19boys) between 11-15 years
Oras et al, 2004	eye movement desensitization and reprocessing (EMDR) in a psychodynamic context	The treatment model used is based on psychodynamic theory, including object-relation and family therapy paradigms. Models of treatment combining EMDR with traditional psychotherapeutic methods for children and adolescents: play and art therapy with parental support. An experienced child psychiatrist clinically assessed every child. All children were drug-free. The numbers of psychotherapeutic sessions differed from 5 to 25 sessions (1 to 2 sessions/week), depending on each child. The number of sessions using EMDR varied between 1 and 6 sessions per patient. The length and the contents of the session varied according to several individual factors related to the child or the characteristics of the traumatic event.	Means of PTSD symptom scores significantly decreased in total after treatment, overall symptom scores were significantly improved in all participants, except one who showed higher scores on avoidance and hyperarousal after treatment. Significant improvement achieved in depressive symptom scores, means of GAF scores for all significantly increased after assessment. Only 9 patients exhibited improvement. 4 showed change neither in functioning level nor depressive scores, although they revealed best improvement in PTSD-related and least in PTSD non- related symptom scores. Improvement in functioning level correlated significantly positive with PTSD-non-related and depression symptoms, but not with PTSD-related symptoms.	Sweden, Department of Child and Adolescent Psychiatry at the Uppsala University Hospital during the time 1996 to 1999	13 RC (3boys) 7 from 8 to 11, 6 from 12 to 16
Ruf et al, 2010	Narrative Exposure Therapy	According to treatment protocol, 8 sessions of KIDNET (90–120 minutes per session) were provided on weekly basis per child. Based on clinical impressions and background of child, 2 children received 9, 1 child 10, and 1 child 7 sessions. After 6-month waiting, children of waiting list, still fulfilling PTSD criteria received KIDNET. During KIDNET children construct a chronological narrative of whole life with focus on exposure to traumatic stress. For traumatic experiences therapist asks in detail for emotions, cognitions, sensory information, physiological reactions and records meticulously, linking them to autobiographic context, namely time	The KIDNET-group showed a clinically relevant and statistically significant reduction in symptoms whereas the waiting list did not, overall symptom severity in KIDNET-group decreased by 60%, but no significant change in waiting list group. Significant time effect for the PTSD symptom severity was seen in KIDNET-group	Germany, Research-Outpatient Clinic for Refugees at the University of Konstanz	26 RC from 7 to 16 years.

		and place. At end of treatment children receive written documentation.			
O´Shea et al, 2000	A School-based Mental Health Service for Refugee Children	Child and adolescent mental health professional linked to St Mary's Department of Child and Adolescent Psychiatry visited junior school on a weekly basis for one afternoon in term time. Sessions took place in a small classroom used by the special educational needs department.	Pre-intervention SDQ mean score was 21.3 reducing to a mean level of 15.7 post intervention. This reduction shows a trend but fails to reach significance.	UK, junior school, 7–11 years, inner city area in West London.	14 RC, mainly boys
Fazel et al, 2009	A School-Based Mental Health Intervention for Refugee Children	The core activity of the service was a weekly consultation at each school with the mental health key worker and the link teacher	Over study period (pre- vs post-treatment scores), total SDQ score in all groups decreased significantly with greatest changes evident in peer problems scale and hyperactivity scale. Hyperactivity scores decreased significantly more in refugee group than control groups with suggestion of effect in emotional symptoms score.	UK, schools, Oxford	141 RC, 61 from 5 to 9, 27 from 10 to 13, 53 from 14 to 18
Fox et al, 2005	A School-Based Mental Health Intervention	Intervention placed after school for 1 hour, 8 continuous weeks. Cognitive-behavioural interaction was selected, emphasis on skills building, such as coping, rather than specific treatment of depressive symptoms, Each session, a new set of objectives and strategies were introduced to the children. Strategies included: showing, telling of ethnic traditions, role playing, drawing pictures to express feelings, completing a personal strengths checklist, "homework" designed to foster parent-child interaction. A manual developed for the weekly sessions, with flexibility to change to better meet the needs.	The decrease in CDI scores between time 1 and 2 was weakly significant with a t-value of 1.88 (.073, 2-tail significance). Between time 1 and 3, decrease in CDI scores was highly statistically significant with a t-value of 3.3 (.003, 2-tailed significance). Decrease in CDI scores between time 1 and 4 was again strongly statistically significant with a t-value of 4.89 (.000, 2-tailed significance).	US, urban public school in the Midwest	58 RC (25boys), 6 to 15, mean age of 10
Möhlen et al, 2005	Psychosocial treatment program for war traumatized child and adolescent refugees	Program of 12 weeks. 2 information sessions, 2 diagnostic/evaluation sessions, 6 group sessions, 2 to 4 individual sessions and 1 family session. 1 session with each child's parents. Core aspects: combination of individual, family and group sessions; a trauma- and grief focusing therapy; verbalizing; relaxation techniques; use of creative techniques: painting, playing, acting, fantasy journeys (guided imagery); group discussions, psychoeducation about trauma and trauma reactions (focused on parents).	After the intervention mean PTSD symptom severity score declined significantly (t-test, p = 0.018), as well as the symptom scores of depression (Wilcoxon, p = 0.014) and anxiety (Wilcoxon, p = 0.006). With regard to the CGAS score at baseline and at follow-up, 9 of 10 subjects showed an increase of at least 10 points indicating a substantial gain in psychosocial Functioning.	Germany, refugee accommodation area during 12 weeks in May and July 2000	10 RC (6boys) from 10 to 16, mean age of 13.3
Schottelkorb et al, 2012	child-centred play therapy(CCPT), evidence-based intervention, trauma-focused cognitive-behavioural therapy(TF-CBT)	children in CCPT attended twice weekly 30-min sessions at school for 12 weeks, part of the treatment plan for CCPT were six 15-min parent consultations (one parent consultation after every fourth CCPT session). TF-CBT: children were to participate in nine 30-min weekly sessions. The weekly parent sessions didn´t take place instead, children participated in the twice-weekly 30-min sessions, and the therapists met with the parents a total of 2 to 4 times over the course of the 12 weeks.	Indicated differential attrition across the two intervention groups, with a higher rate of attrition in the TF-CBT group, Results indicate both groups demonstrated a significant decrease in severity rating from baseline assessment to follow-up assessment and there were no differences between the two groups.	US, three elementary schools in the Northwest	31 RC, elementary school 6-13

4.1 Settings

Since it is important to know if the intervention was in an urban or rural area the setting of the interventions were analysed to identify which kind of setting they are placed in and not only the context in which they are.

In the intervention studies which were reviewed, 6 out of 9 interventions took place at schools and in urban areas. The interventions studied by Ehnthold and colleagues (2005) and O´Shea and colleagues (2000) took both place in schools in London UK. Although, Fazel and colleagues (2009) study was placed in the UK, in Oxford. All studies from the US are also placed at school settings. Betancourt and colleagues (2012) and Fox and colleagues (2009) studied interventions in urban school settings whereas it is not clear if the school in the Northwest of the US in the study of Schottelkorb and colleagues (2012) is placed in an urban or rural area.

Two of the studies were conducted in clinical settings in urban regions. The one from Sweden done by Oras and colleagues (2004) took place in a hospital in Uppsala. One of the German studies by Ruf and colleagues (2010) was conducted in a clinic in Konstanz. The other study from Germany done by Möhlen and colleagues (2005) was conducted in a refugee accommodation area but it was not sated where exactly and if it is an urban or rural area.

4.2 Participants

All participants were school aged children between 5 and 18 years since the most interventions took place in a school setting. Participants targeted for intervention in the clinical settings were within between age range of 8 to 16 years (Oras et al, 2004) and 7 to 16 years (Ruf et al, 2010). The participants in the study by Möhlen and colleagues (2005) in a refugee accommodation were between 10 and 16 years of age.

4.3 Intervention concepts and outcomes

It was found that most of the interventions used a group intervention concept. Seven out of nine intervention studies used group interventions (Ehnthold et al, 2005; Betancourt et al, 2012; O´Shera et at, 2000; Fazel et al, 2005; Fox et al, 2005; Möhlen et al, 2005 & Schottelkorb et al, 2012) compared to one individual treatment (Ruf et al, 2010) and one individual treatment compared with family therapy (Oras et al, 2004).

Out of the 6 school-based group interventions 3 used cognitive-behavioural therapy (CBT) (Ehnthold et al, 2005; Fox et al, 2005 & Schottelkorb et al, 2012). Schottelkorb and colleagues (2012) used in addition to the CBT also a child-centred play therapy. 2 of the school- based inter-

vention studies were based on a cooperation between a mental health professional and the schools (O´Shera et al, 2000 & Fazel et al, 2009). One study used a Multi-Tier Mental Health Program with skill-based group sessions, individual sessions at school and home-based sessions (Betancourt et al, 2012).

The clinical intervention studies used individual therapy sessions. One was based on eye movement desensitization and reprocessing (EMDR) using play and art therapy with parental support (Oras et al, 2004). The other one was based on Narrative Exposure Therapy which was adopted to a child context (KIDNET) were children had to construct a chronological narrative of their whole life with focus on exposure to traumatic stress. For traumatic experiences therapist asks in detail for emotions, cognitions, sensory information, physiological reactions and records meticulously, linking them to autobiographic context, namely time and place (Ruf et al, 2010).

One intervention study which was placed in a refugee accommodation had its´ core aspects in a combination of individual, family and group therapy (Möhlen et al, 2005). A trauma- and grief focusing therapy including verbalizing, relaxation techniques, use of creative techniques such as painting, playing, acting, fantasy journeys (guided imagery); group discussions, psychoeducation about trauma and trauma reactions (focused on parents) were used.(Möhlen et al, 2005).

4.3.1 Aim of Interventions

All studies aimed to measure the effectiveness of the interventions they offered to refugee children. Two studies aimed to measure the effectiveness of the intervention for refugee children suffering from symptoms of war related PTSD (Ehnthold et al, 2005; Oras et al, 2004). One study aimed to identify the relationship between several traumatic events and to implement and evaluate the effectiveness of mental health intervention for refugee children related to PTSD symptoms (Möhlen et al, 2005). One other study aimed to identifying the effectiveness of a new designed intervention in relation to an evidenced intervention on PTSD symptoms in refugee children (Schottelkorb et al, 2012). And one study aimed to measure if the intervention is appropriate to provide support matched to symptoms of PTSD and depression and to measure the effectiveness of the intervention on the mental health and resources problems of refugee children (Betancourt et al, 2012).

Two studies aimed to measure the effectiveness of their intervention on PTSD levels in refugee children. In addition, they also focused on providing a mental health service to refugee children (Fazel et al, 2009) and to test effectiveness of school-based intervention to decrease depression among refugee children (Fox et al, 2005).

4.3.2 Data collection

In four of the studies the teachers at school of the refugee children participating in the intervention provided information about the refugee children. three used the SDQ a strength and difficulties questionnaire (Ehnthold et al, 2005; O´Shea et al, 2000; Fazel et al, 2009) and one used the CDI a child depression inventory (Fox et al, 2005). Ehnthold and colleagues (2005) also used the R-IES, a revised impact of event scale, DSRS: depression self-rating scale, RCMAS: revised children´s manifest anxiety scale and the WTQ: war trauma questionnaire.

In three studies the researcher collected the data with the help of an interpreter or translator. All of them used the DSM-IV (diagnostic and statistical manual of mental disorders – 4th edition). Betancourt and colleagues (2012) also used DSRS (depression self-rating scale), WTSS (war trauma screening scale), PWA (post-war adversity scale – adolescent version), EDD (everyday discrimination scale), PTSD-R, PSSM (psychological sense of school membership) and the Acculturative Hassels Inventory. Betancourt (2012) and Ruf (2010) also used the UCLA PTSD scale and Ruf and colleagues also used the Raven´s progressive matrices. Oras and colleagues (2004) used in addition to the DSM-IV a PTSS-C (posttraumatic stress symptom scale for children) and GAF (global assessment of functioning) to collect information about the participation refugee children.

In two of the studies the therapist working with the refugee children collected the data. UCLA PTSD was used by Schottelkorb and colleagues (2012), as well as PROPS questionnaire for parents.

Both used the DSM-IV (Möhlen et al, 2005; Schottelkorb et al, 2012) and Möhlen and colleagues also used K-SADS-PL (schedule for affective disorders and schizophrenia for school-age children-present and lifetime version), HTQ (Harvard trauma questionnaire), DISYPS-KJ (parent version of the diagnostic system for psychological disorders) and CGAS (children´s global assessment scale) (Möhlen et al, 2005).

The identified studies show significant improvement in different psychological difficulties such as PTSD, depression, anxiety as well as in peer problems and hyperactivity.

PTSD symptoms improved in the results of five of the nine studies (Ehnthold et al, 2005; Betancourt et al, 2012; Oras et al, 2004; Ruf et al, 2010; Möhlen et al, 2005 & Schottelkorb et al, 2012) and also depression scores decreased in five of the nine studies (Ehnthold et al, 2005; Betancourt et al, 2012; Oras et al, 2004; Fox et al, 2005 & Möhlen et al, 2005). Anxiety levels improved in two of the nine studies (Ehnthold et al, 2005 & Möhlen et al, 2005). Peer problems and hyperactivity were measured to decrease in one of the intervention study done by Fazel and col-

leagues (2009). In the study of O´Shea and colleagues (2000) SDQ scores showed a reduction but it failed to reach significance.

5 Discussion

Refugee minors, children and adolescents who migrate to another country with or/and without their parents/families, enter European countries for several reasons and under distinct conditions (fleeing persecution, seeking protection, family reunification, economic motives, transit migration, joining diaspora communities, human trafficking and medical concerns). In the past few decades several European countries have been confronted with increasing numbers of refugee children (Vervliet et al., 2014).

Because of the growing difficulties refugee children are suffering with like increasing daily stressors over time related to experiences of discrimination, social stressors like difficulties in relationships with peers and adults, material stressors and in particular insufficient medical care and housing, interventions are needed to support refugee children and support their participation and inclusion into the society in the host country.

The aim of this systematic literature review was to identify and present existing interventions for refugee children with mental health problems in western, high income countries.

Refugee children appear to experience high levels of psychological distress and interventions could have a significant influence on their mental health and well-being. With only 9 empirical studies found that target the mental health of refugee children results indicate that interventions for refugee children with mental health problems in wester, high income countries are not very common. Most of the intervention settings presented by the identified studies were public schools in urban areas. This concludes that mainly school-aged refugee children benefit from these intervention programmes but this excludes children of younger ages who are not in the school age. This can also be seen in the age range of the found studies where the children were between 5 and 18 years old. Therefore it is not known if the found intervention would also work with children below the age of five also when the outcomes of the found interventions show significant improvement in PTSD symptoms, depression, anxieties as well as in peer problems and hyperactivity. However, for many children the school system provides the only available form of mental health treatment (Hoagwood et al, 2001).

5.1 Interventions concerning the three stages of flight

Most of the intervention studies identified in the result part are focusing on mental health problems concerning PTSD symptoms which occur during the first two stages of flight. Traumatic experiences while being in the country of origin which includes war, discrimination, violent conflicts and traumatic experiences during their flight to safety which includes violence and a lack on basic needs are responsible for mental disorders such as PTSD (Fazel & Stein, 2002). Three out of nine studies also focused on symptoms related to the third stage of flight, while have to resettle in a new country, in addition to their focus on PTSD symptoms. The post-flight phase when having to settle in a country of refuge includes stressors such as displacement, discrimination, social exclusion (Fazel & Stein, 2002) which result in higher levels of depression, behavioural difficulties and social problems. The study of Betancourt and colleagues (2012) and the one of Fox and colleagues (2005) also aimed to decrease depression among refugee children. Fazel and colleagues (2009) aimed in their study to provide a mental health service to refugee children at school in addition to decrease PTSD symptoms. It can be mentioned that the intervention studies identified show health more as the absent of symptoms since their focus is mainly on the reduction of PTSD symptoms. It could be asked what mental health means or how it has to be to enable refugee children to have a good and fulfilling live. It is stated by the WHO (2014) that health is described as a state of complete physical, mental as well as social well-being and it is not merely the absence of disease or infirmity. To focus only on the traumatic experiences refugee children face during the first and the second stage of flight should be only one part of interventions concerning the mental health of refugee children. There are several factors in the last stage of flight which have a negative impact on refugee children´s mental health and they should be taken into account as well when designing interventions for refugee children. It is not only about symptoms but also about the current life situation and the social life of refugee children which can have a positive or negative impact on their mental health. With a salutogenic orientation which focus on successful coping and the core concept of the sense of coherence which includes the orientation of the world as comprehensible, manageable and meaningful, are essential for a positive health (Antonovsky, 1985). To foster the sense of coherence and coping strategies while using the concepts of ritualized occasions, social valuation, the gift relationship, and power (Antonovsky, 1985) could meet the need of refugee children with respect to their special life situation in the host countries where they face stressors such as displacement, discrimination, social exclusion.

5.2 Interventions related to the German context

This paper also aimed to discuss if the identified and presented interventions would work in the German context. Within the identified studies two are from Germany. In 2005 Möhlen and col-

leagues presented their results on an intervention for refugee children from 10 to 16 years in a refugee accommodation area in Germany. Ruf and colleagues presented 2010 a clinical intervention approach to treat traumatized refugee children between seven and sixteen years old. Even if the two studies are conducted in Germany it does not seem that these kinds of interventions are totally suitable for refugee children. Especially the one of Ruf and colleagues (2010) since it was conducted in a clinical setting which could be a huge border for refugee children to have access to the intervention. Treatment in clinical settings which is not in line with emergency treatment is often restricted by the German Alien Law and therefore refugee children would not get access to these treatments (Berthold, 2014).

The school-based-intervention studies which present low-threshold support for refugee children especially in mental health concerns since psychological treatment often is quite unknown and includes different ethical and cultural barriers to them (Ehnthold et al, 2005; Betancourt et al, 2012; O´Shea et al, 2000; Fazel et al, 2009; Fox et al, 2005 & Schottelkorb et al, 2012). -But since the school-based interventions in these studies are all set in urban areas it would be difficult to transfer the availability of the support to the German context since refugee accommodations are often set in rural areas and quite often with a lack of infrastructure (Berthold, 2014). A second border to the school-based intervention could be that not in every of the German Bundesländer refugee children do not have the right to attend school and it is up to the school if they accept refugee children or not (Anderson, 2001) as well as the fact that schools in general do not have to accept the application of children of the age of 16 and above. Here refugee children are at high risk to be excluded from school and therefore school-based interventions could maybe not be available to these children.

Unaccompanied children seeking asylum have different needs and characteristics than accompanied refugee children (Abunimah & Blower, 2010; Bronstein & Montgomery, 2011). The identified studies do not present different approaches concerning the different situations in which refugee children find themselves and this does not always make it easy to relate the findings to unaccompanied refugee children since the unavailability of a primary caregiver may be a missing protective factor (Bronstein & Montgomery, 2011). Separated children are at risk for extreme social isolation, anxieties about family members in the home country, fears about future, managing with the day-to-day challenges of school and adjustment to life in a new country. Therefore safety is an essential aspect of their living situation, yet it appears that overall this group of children had unusually high exposure to dangerous situations (Abunimah & Blower, 2010) which emphasis their special need on suitable interventions to target this specific aspect. This concludes that interventions for refugee children should also take aspects of safety of the child in its specific situation into account.

When it comes to refugee children and their treatment in any kind of context several levels are affected and influence the situation of the refugee children. In the case of their mental health and the interventions and treatments needed it is also and still always a political issue and the role of specific changes in daily living conditions, such as residence status, and type of residence together with the traumatic experiences needs to be related to the mental health of refugee children (Vervliet et al., 2014). Therefore both, policy makers and social workers working with refugee children need to acknowledge the large and long-lasting impact of daily stressors on the mental health of refugee children (Vervliet et al., 2014) and their rights to achieve the best medical treatment compared to article 24 in the UN-Convention of the children's rights to provide all children with the right to enjoyment of the highest attainable standard of health (UN, 1989). Therefore European policies need to reduce the impact of daily stressors on the mental health of refugee children by ameliorating the reception and care facilities for this group and moreover, regular mental health screenings are needed in combination with adapted psychosocial and therapeutic care (Vervliet et al., 2014).

In the UNCRC (1989) children are defined from the age of zero up to eighteen years. But in the presented interventions the age range of the participating refugee children is from five to eighteen years. This automatically excludes younger children below five years of age. Therefore it was not possible to identify possible interventions or other programmes concerning the mental health of refugee children under the age of five years. There is therefore an incongruence to the Health-related Sustainable Development Goals by the WHO (2015) state in goal 3 "Ensure healthy lives and promote well-being for all at all ages" which includes to prevent and treat and promote mental health and well-being (WHO, 2015). As well as the German Federal Child Protection Act and the Act "Early Assistance" states protection begins in infancy and should accompany children and young people in all stages of life and life situations (BMFSF, 2015). And also the WHO Sustainable Development Goals from 2015 are not only related to health. Goal 10 contains to reduce inequality within and among countries and to empower and promote the social, economic and political inclusion of all, irrespective of age, sex, disability, race, ethnicity, origin, religion or economic or other status as well as to facilitate orderly, safe, regular and responsible migration and mobility of people, including through the implementation of planned and well-managed migration policies (WHO, 2015).

Inconsistencies are found between the German Alien Laws and the Federal Child Protection Act, the "Early Assistance" as well as the UN Convention on the Right of the Child (1989). Since the two Laws/Acts and the UNCRC are aim to protect and support children in all situations and on all stages of life the German Alien Law acts contra-productive and even restricts refugee children from support and protection. Just for the purpose of the children's welfare many rules and regula-

tions of immigration law are contradictory to the UN Convention on the rights of children. Medical care is provided directly by the social security office. Sickness certificates only available when a refugee suffers from acute or painful illness. It remains open, according to what criteria the agent checks and accepts the needs of concerning health support (FRBerlin, 2013).

The high bureaucratic hurdles in the allocation of health insurance certificates have in practice developed for "assist criterion" for examining the need for treatment. Specialist treatments be approved in part, only after inspection by the public health officer. This leads to delays necessary medical treatments, the number of emergency operations, rescue and emergency trips rises, diseases worsen unnecessary. Sufferers must avoidable pain, exacerbations of existing disease, permanent damage to health and may take death into account (FRBerlin, 2013). But an equality is legally provided and wanted and a disadvantage is accordingly not tenable. The participation and involvement of children plays a key role. The children should have the possibility to become active, to design and to introduce their own wishes and notions (Berthold, 2014). An appropriate support for refugee children is quite possible and even absolutely necessary as it is described in the report on the living situation of refugee children in Germany published by UNICEF in 2014: all minor refugees are still children (Berthold, 2014).

5.3 Methodological reflections and limitations

In all of the used databases the same search terms has been used which could be seen as a strength since it shows that the search was consistent and thus adds to a methodological rigour. Since the inclusion and exclusion criteria was very strict to only account for peer reviewed empirical studies, the use of grey literature such as reports from refugee assistance organisations and people working in practice with refugee children were excluded even if they presented interventions for refugee children. But this was necessary because of the method of systematic literature review which only allows to include empirical evidence based studies. Because of that only nine results were found. This does not mean that there are not many intervention programmes targeting the mental health of refugee children it can be concluded that currently there are not many empirical studies.

Usually systematic reviews are undertaken by more than one person, they work in a team to do scanning, screening and quality assessment to reduce bias and it is time-consuming (Jesson et al, 2012). But the present work was only done by one reviewer which does not really reduce bias since the reviewer decides on his/her own to include or exclude articles and to extract the data. Also the time frame was challenging since the reviewer only had 4 month to perform the present work. On a master level such a review might be called a rapid review. In the professional sphere ´rapid apprais-

als´ are reviews of existing evidence which are not fully developed systematic reviews. They are descriptive and can be completed in 8 to 12 weeks (Jesson et al, 2012). Advised by the Government Social Research Unit rapid evidence appraisals collate descriptive outlines of the available evidence on a topic, critically appraise them, sift out studies of poor quality and provide an overview of what that evidence is telling us and what is missing from it (Jesson et al, 2012). Since the research question does not focus on quality of the interventions and only on presenting existing interventions it was not focused on this topic especially.

It can be mentioned that a lack of long-term follow-up studies in the field leads to an uncertainty regarding whether the interventions are sustainable over time. The lack of knowledge about the long term effectiveness of interventions seriously limits the rigour with which treatment can be offered to an ever-growing number of refugee children (Ruf et al., 2010). The key findings regarding the effectiveness of the interventions therefore need to be investigated in longitudinal studies over longer time spans (Vervliet et al., 2014) to be able to provide the needed interventions and treatments to refugee children and their families.

5.4 Ethical consideration on research with refugee children

Attention to the need for mental health research aimed at describing, understanding, and remedying the disproportionate access to mental health care for racial and ethnic minority groups has increased in the last decades (U.S. Department of Health and Human Services, 2001). Scientific, social, and personal benefits that can be obtained from this initiative also builds the risk of group stigmatization, exploitation, and harm which have occurred throughout history of medical and mental health research involving ethnic minority communities (Fisher et al, 2002). Stakes are especially high for ethnic minority children and youths, who require culturally validated mental health services since they are most vulnerable to harms arise from procedures which do not adequately protect their rights and welfare (Fisher et al, 2002).

Refugee and asylum seeking children are dependent on empathy and specialist psychological skill in evaluating whether traumatic experiences is a significant factor in child behaviour and their health conditions (Anderson P. (2001).

6 Implications

6.1 Future researcher

Since only nine studies in western, high income countries could be identified it is suggested that future research on intervention concerning the mental health of refugee children is needed. Research could usefully be continued on the social and mental issues in refugee children´s life since

these two issues go hand in hand. It could be suggested also to do future research on interventions for refugee children in connection to age groups or different needs of accompanied and unaccompanied refugee children. But also on the focus of the interventions and the outcome since the identified interventions in the present thesis mainly focus on PTSD relevant outcomes and less on peer-relations or other social outcomes for refugee children. It could be suggested that the content of interventions concerning refugee children´s mental health should more focus on their situation related to the third stage of flight when have to settle in a new country and the relevant stressors in this stage i.e. discrimination or social exclusion. Also more longitudinal studies are needed since the evidence for the effectiveness of interventions for children with mental health is still weak (Hoagwood et al, 2001).

6.2 Political perspectives

Refugee and asylum seeking children and youth have almost unnoticed become an integral part of multicultural life´s in most of the large European cities, a fact that governments and large sectors of European society have ignored (Anderson, 2001). It is time to acknowledge plurality of obligation to children´s concerns in European societies and create a future for them build on human dignity and acknowledgement of economic, educational and social rights (Anderson, 2001). The welfare of children should be anchored in the German code of Alien´s Law and the Federal Republic´s reservations regarding ratification of the UNCRC (1989) should be put aside and the convention should be fully applied.

The implication is that all agencies and services have to help children in the aftermath of war and they have to promote good mental health for all children by re-establishing a full range of activities and opportunities for development, recreation, education and, where necessary, specialist therapeutic interventions (Yule, 2002).

7 Conclusion

While the first casualty of war may be “truth”, the mental health of our future generations is also severely compromised. It is now recognised in international agreements that children are badly affected by war and that nations have a duty to alleviate the effects of war on their mental health. This paper has argued that much can be done to ensure that educational and recreational opportunities are re-established as a matter of priority for refugee children with mental health challenges. Good mental health services are not merely confined to clinics. Large scale programmes to educate adults and children play an important part (Yule, 2002).

Interventions for refugee children with mental health problems are needed and it is evident that there are successful concepts to decrease mental health problems in refugee children. The identified studies showed significant decrease in PTSD symptoms and some also mentioned significance in improving social skills. However, there is still much to do in the area of mental health of refugee children and future research will be needed. There should be research more about the social components of refugee children´s mental health. This would also fit with the fact that most interventions for refugee children were set in school settings which is a field of natural socialisation for children in general.

Refugee children are at high risk for mental health challenges due to their unique experiences and are therefore a group of children in need of special support. There is still a huge lack of information about this group of children. In addition coordinated policies in the EU are needed to improve the current situation of refugee children to enable a positive development of these children and to have a positive impact on their future life.

8 References

Abunimah, A. & Blower, S. (2010). *The Circumstance and Needs of Separated Children Seeking Asylum in Ireland.* Child Care in Practice

Anderson P. (2001). *`You Don´t Belong Here in Germany...`: On the Social Situation of Refugee Children in Germany.* Journal of Refugee Studies Vol 14, No 2

Antonovsky A. (1985). *The life cycle, mental health and the sense of coherence.* Israel Journal of Psychiatry and Related Sciences, Vol 22(4), 273-280.

Berthold, T. (2014). *In erster Linie Kinder. Flüchtlingskinder in Deutschland.* Köln: Deutsches Komitee für UNICEF e.V.

Betancourt, T., Frounfelker, R., Mishra, T., Hussein, A. & Falzarano, R. (2015). Addressing Health Disparties in the Mental Health of Refugee Children and Adolecents Through Community-Based Participatory Research: A Study in 2 Communities. American Journal of Public Health 105 (3)

Betancourt T.S, Miller A.B, Adbi S, Barrett C, Blood E.A & Ellis B.H (2012). Multi-Tier Mental Health Program for Refugee Youth. Journal of Consulting and Clinical Psychology

Björck-Åkesson, E., Granlund, M., & Olsson, C. (1996). *Collaborative problem solving in communication intervention.* In S. von Tetzchner & M. Hygum Jensen (Eds.), Augmentative and alternative communication: European perspectives (pp. 324-342). London: Colin Whurr

Björn, G., Boden, C., Sydsjö, G. & Gustafsson, P. (2011). *Psychological evaluation of refugee children: Constraining results from play diagnosis and parental interviews*. Clinical Child Psychology and Psychiatry 16 (4) 517-534.

Blättner, B. & Waller, H. (2011). *Gesundheitswissenschaft. Eine Einführung in die Grundlagen, Theorie und Anwendung*. Stuttgart: W. Kohlhammer

Bronfenbrenner, U., & Ceci, S. (1994). *Nature-nurture reconceptualised in developmental perspective: A bioecological model.* Psychological Review (101(4), 568-86). American Psychological Association, Inc

Bronstein, I & Montgomery, P. (2011). *Psychological Distress in Refugee Children: A Systematic Review.* Clin Child Fam Psychol Rev

Bundesministerium für Familie, Senioren, Frauen und Jugend (BMFSF), (2015). *Kinder- und Jugendschutz (Federal Ministry of Family Affairs-Child and Youth protection).* Webpage publication date: 30.10.2015. 04.05.2016 from: http://www.bmfsfj.de/BMFSFJ/Kinder-und-Jugend/kinder-und-jugendschutz.html

Burke L.E., & Fair J. (2003). Promoting Prevention: Skill Sets and Attributes of Health Care Providers Who Deliver Behavioral Interventions. Journal of Cardiovascular Nursing 18:4 (pp 256–266).

Campbell F., Conti G., Heckman J.J., Moon S.H., Pungello E. & Pan Y. (2014). *Early Childhood Investments Substantially Boost Adult Health.* Science Vol 343, Issue 6178, pp. 1478-1485

Daud, A. & Rydelius, P. (2009). *Comorbidity/Overlapping Between ADHD and PTSD in Relation to IQ Among Children of Traumatized/Non-Traumatized Parents.* Journal of Attention Disorder 13 (2) 188-196.

Dunst, C.J., Bruder, M.B., Trivette, C.M., Hamby, D., Raab, M., & Mclean, M. (2001). Characteristics and consequences of everyday natural learning opportunities. *Topics in Early Childhood Special Education, 21*(2), 68-92.

Ehntholt, K.A, Smith P.A & Yule W (2005). School-based Cognitive-Behavioural Therapy Group Intervention for Refugee Children who have Experienced War-related Trauma. Clinical Child Psychology and Psychiatry

EMN (2015). *Synthesis Report May 2015 – Policies, practices and data on unaccompanied minors in the EU Member States and Norway.* 2016/03/11 from http://ec.europa.eu/anti-trafficking/sites/antitrafficking/files/emn_study_2014_uams_0.pdf

Fazel M., Doll H. & Stein A. (2009). A School-Based Mental Health Intervention for Refugee Children: An Exploratory Study. Clinical Child Psychology and Psychiatry

Fazel, M. & Stein, A. (2002). The mental health of refugee children. Archives of Disease in Childhood 87: 366-370

Fisher C.B, Hoagwood K, Boyce C, Duster T, Frank D.A, Grisso T, J. Levine R.J, Macklin R, Spencer M.B, Takanishi R, Trimble J.E & Zayas L.H (2002). *Research Ethics for Mental Health Science Involving-Ethnic Minority Children and Youths.* American Psychological Association, Inc. Vol. 57, No. 12, 1024–1040

Fox P.G., Rossetti J., Burns K.R. & Popovich J. (2005). Southeast Asian Refugee Children: A School-Based Mental Health Intervention. The International Journal of Psychiatric Nursing Research

FRBerlin (2013). *Stellungnahme zur Novellierung der verfassungswidrigen Regelungen des Asylbewerberleistungsgesetzes.* Flüchtlingsrat Berlin e.V. from http://www.fluechtlingsinfo-berlin.de/fr/asylblg/FRBerlin_AsylbLG_BMAS_060113.pdf

Hebebrand J., Anagnostopoulos D., Eliez S., Linse H., ･Pejovic-Milovancevic5 M. & Klasen H. (2016). *A first assessment of the needs of young refugees arriving in Europe: what mental health professionals need to know*. Eur Child Adolesc Psychiatry 25:1–6

Hoagwood K., Burns B.J., Kiser L., Ringeisen H. & Schoenwald S. (2001). *Evidence-Based Practice in Child and Adolecent Mental Health Services.* PSYCHIATRIC SERVICES Vol. 52 No. 9

Keefe, R. & Jurkowski, E. (2013). *Handbook for Public Health Social Work.* Public Health Social Work Section of the American Public Health Association

Lygnegård, F., Donohue, D., Bornman, J., Granlund, M., & Huus, K. (2013). A Systematic Review of Generic and Special Needs of Children with Disabilities Living in Poverty Settings in Low- and Middle-Income Countries. *Journal of Policy Practice*, *12*(4), 296–315. http://doi.org/10.1080/15588742.2013.827141

Montgomery, E. & Foldspang, A. (2005). *Seeking asylum in Denmark: refugee children´s mental health and exposure to violence.* European Journal of Public Health

Möhlen H., Parzer P., Resch F. & Brunner R. (2005). *Psychosocial support for war-traumatized child and adolescent refugees: evaluation of a short-term treatment program*. Australian and New Zealand Journal of Psychiatry

Oras R., Cancela de Ezpeleta S. & Ahmad A. (2004). *Treatment of traumatized refugee children with eye movement desensitization and reprocessing in a psychodynamic context*. Nordic Journal of Psychiatry

O'Shea B., Hodes M., Down G. & Bramley J. (2000). *A School-based Mental Health Service for Refugee Children.*

Rathunde, K., & Csikszentmihalyi, M. (2006). *The developing person: An experiential perspective.* In R. M. Lerner & W. Damon (Eds.), Handbook of child psychology (6 ed., Vol. One: Theoretical models of human development, pp. 465 - 515). Hoboken, NJ, US: Wiley

Ruf M., Schauer, M., Neuner F., Catani C., Schauer E., & Elbert T. (2010). Narrative Exposure Therapy for 7- to 16-year-olds: A Randomized Controlled Trial With Traumatized Refugee Children

Sallis J.F., Bauman A. & Pratt M. (1998). *Environmental and policy interventions to promote physical activity.* American Journal of Preventive Medicine 15: 4 (pp 379–397).

Schottelkorb A.A., Doumas, D.M. & Garcia R. (2012). Treatment for Childhood Refugee Trauma: A Randomized, Controlled Trial. International Journal of Play Therapy

Smedley B.D., Syme S.L., and Committee on Capitalizing on Social Science and Behavioral Research to Improve the Public's Health, Division of Health Promotion and Disease Prevention, Institute of Medicine (*2001) Promoting Health: Intervention Strategies from Social and Behavioral Research*. American Journal of Health Promotion: January/February 2001, Vol. 15, No. 3, pp. 149-166.

Sozialgesetzbuch (SGB), (2013). Sozialgesetzbuch. Bücher I – XII: All. Teil Grundsicherung; Arbeitsförderung; Gem. Vorschriften; Kranken-, Renten-, UnfallVers.; Kinder-/Jugendhilfe; Rehabilitation; Verwaltungsverfahren; PflegeVers.; Sozialhilfe (42. Auflage). München: Deutscher Taschenbuch Verlag GmbH & Co. KG.

Steckler A., Allegrante J.P., Altman D., Brown R., Burdine J.N., Goodman R.M. & Jorgensen C. (1995). *Health Education Intervention Strategies: Recommendations for Future Research.* Health Educ Behav 22: 307-328

Thabet, A., Abed, Y. & Vostanis, P. (2004). Comorbidity of PTSD and depression among refugee children during war conflict. Journal of Child Psychology and Psychiatry 45:3 (pp 533-542).

UN (1989). *United Nations Convention on the Rights of the Child.* 2015/10/03 from http://www.ohchr.org/EN/ProfessionalInterest/Pages/CRC.aspx

UN (1951). *United Nations Convention Relating to the Status of Refugees (Geneva Convention).* 2016/03/10 from http://www.unhcr.org/3b66c2aa10.html

UNHCR (2016). *Statistics as at June 2015.* 2016/02/29 from http://www.unhcr.org/pages/49e45bb01.html

UN (2015). *UNHCR Mid-Year Trends 2015*. 2016/03/10 From http://www.unhcr.org/56701b969.html

U.S. Department of Health and Human Services. (2001). *Mental health: Culture, race, and ethnicity—A supplement to Mental health: A report of the surgeon general.* Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.

Vervliet M., Lammertyn J., Broekaert E. & Derluyn I., 2014. *Longitudinal follow-up of the mental health of unaccompanied refugee minors*. Eur child Adolesc Psychiatry 2014(23), 337-346

WHO (2015). *UN Sustainable Development Summit 2015.* 2016/05/10 from http://www.who.int/mediacentre/events/meetings/2015/un-sustainable-development-summit/en/

WHO (2014). Mental health: a state of well-being. Updated August 2014. 2016/05/30 from http://www.who.int/features/factfiles/mental_health/en/

WHO (2007). *International classification of functioning, disability and health: Children and youth version: ICF-CY*. Geneva: World Health Organization

Ylvén, R., & Granlund, M. (2013). Collaborative problem solving in the context of early childhood intervention – the link between problems and goals. *Scandinavian Journal of Disability Research, 17*(3), 221–239. From http://doi.org/10.1080/15017419.2013.859175

Yule W. (2002). *Alleviating the Effects of War and Displacement on Children.* Traumatology, Vol. 8, No. 3

9 Appendix

Table 2: Protocol with categories for the extraction table:

Reviewer	
Reviewer 1	Reviewer 2
Identification of paper	
Author	Journal
Title	Publication year
Intervention name/type	
Intervention concept	
Strategy	Data collection
Focus on/Participants	Measurement tools
Setting	
Outcome	
Focus/target group	
Children + age group	Number
Youth + age group	Male

	Female
Quality assessment	
Specific mental health condition of participants	
Participants recruited	Where
	How
	Role in data collection
Intervention provider	
Study design	Type: pre- post test
Aim	Study purpose, research question
Theory	
Conclusion	
Limitations	
Implications	

Table 3: Flow-Chart presenting the search procedure: