Barriers to accessing appropriate health services for children and adolescents

The problem

Refugee children and adolescents are one of the most vulnerable groups in Europe, some of them have fled persecution or war, and others have run away from poverty and destitution. There are also those who are victims of trafficking. For these reasons, mental health conditions such as post-traumatic stress disorder (PTSD), anxiety and depression are frequent (Woodland, Burgner, Paxton, & Zwi, 2010). Among them, unaccompanied refugee children and adolescents are particularly at risk. They live not only in a relatively difficult situation as minor refugees staying in another country, but also face other risks due to the absence of their parents, such as traumatic experiences, exploitation or abuse (Derluyn & Broekaert, 2008).

In EU asylum seeking children have a right to equal access to healthcare under the same conditions as children residing in the Member State where the application for international protection is lodged (Abbing, 2011). However, those who are separated from their families and have no - or only temporary – residence permits are at risk of becoming undocumented children. These children can be minors arriving in Europe to be reunited with their family but not falling under the official family reunification schemes; those who entered with one or more relatives irregularly; or children born in Europe but whose parents are undocumented. They can also include minors who are sent by their families to Europe in search of better conditions or who have run away, and are therefore alone, but who prefer to keep outside the reception circuits for unaccompanied minors and are invisible to social services. As stated in PICUM's report (McDonald, Gifford, Webster, Wiseman, & Casey, 2008) undocumented children encounter enormous difficulties in accessing a high standard of health care, in terms of bureaucratic impediments, lack of adequate information and the fear of being caught.

Evidence on the barrier

The research highlights the need to prioritize support for children and adolescents health needs, in particular those related to mental health following traumatic experiences, such as forced migration. Service-related barriers, low priority on mental health, poor mental-health knowledge, stigma, as well as several social and cultural factors have been observed as barriers (Erminia Colucci, Szwarc, Minas, Paxton, & Guerra, 2014). Furthermore there is little information available on barriers and facilitators to mental service for adolescents. One study identified 8 key themes: "concepts of mental health, illness, and treatment; service accessibility; trust; working with interpreters; engaging family and community; the style and approach of mental health providers; advocacy; and continuity of care."(E. Colucci, Minas, Szwarc, Guerra, & Paxton, 2015).

As regards legal aspects, age has important consequences for young asylum seekers: in particular, it influences access to health care, to education and determines the possibility for family reunification if under 18 years. Many international and national policies for asylum seekers and refugees grant young people under the age of 18 more protection and support (Chiumento, Nelki, Dutton, & Hughes, 2011). Where the age determination of unaccompanied asylum seekers involves medical examinations[1], human rights play an important role. Lack of common practices as regards age determination conflicts with the principle of providing equal access to protection throughout the European Union (Abbing, 2011).
Methods for assessing the age of unaccompanied children and asylum seekers - without official documents proving age – are different across Europe, they include in most countries an interview and visual evaluation,

[1] The medical examinations consist of anthropometric methods, including measurement of the puberty development or radiological examinations, dentition, non dominant hand and wrist (most commonly applied), the medial ends of both collarbones (less usual).

while in other cases medical examinations - radiographs of skeleton and or teeth, anthropometric measurement and sexual development measurement – are performed (Hjern, Brendler-Lindqvist, & Norredam, 2012).
In one study (Human Rights Council, 2010) the Office of the United Nations High Commissioner for Human Rights (OHCHR) highlights that the legal status of migrant parents may affect access to health care by migrant children, particularly if their parents are in an irregular situation and are, therefore, reluctant to seek health care for fear of their immigration status being detected. A particular area of concern is when such children are unable to access to vaccinations in a timely manner.

Lack of information on the rights to health care is a barrier for refugee children as well as adult migrants. Parents often are not aware of their children's right to access free health care or free education. Refugee children can have interrupted education and this reflects on language transitions affecting their development, learning and socialization. Finally, formal and informal barriers affecting access to health care for all migrants also impact on refugee children and adolescents' care. Thus, the inability to navigate the health system, perceived high cost, negative prior experiences with providers, no interpreter support, no means of transport and insurance problems as barriers to care for mothers looking after an ill child have been experienced by refugee children (Wahoush, 2009).

Measures to address the barrier

In literature, several interventions to overcome these barriers are described, including effective health promotion programs and prevention strategies, communities and NGOs engagements, as well as information and education of health-care workers on refugee children and adolescent health-related issues. NGOs often assume an important role in ensuring that the refugee community benefits from services and in filling the gaps, which cannot be covered by government. Furthermore, NGOs collaborate with the health and social services to inform refugees on how to access and navigate services, to organise language courses for women and children, to provide interpretation services and arrange psychological support for women and children (Sandliki, Torun, Karaaslan, & Acar, 2016).

The available literature supports the need for implementation of effective health promotion interventions, including: community participatory and focus groups, participation of refugee nurses, peer educators, health education sessions and reorienting of health and family services. For instance, possible solutions applied in the field of dental care have been identified: intensive health promotion and education campaigns on parents through ethnic media and social networks to encourage utilisation of a new clinical service for refugee children in a targeted group of refugees from Sub-Saharan Africa resulted in significant changes in parental knowledge, attitudes and beliefs on infectious diseases after attending the clinic, including decreased stigma around tuberculosis and more knowledge on immunizations (Sheikh & MacIntyre, 2009).

Also the provision of information for both refugee children and staff plays a central role. In one Swiss hospital a "migrant kit" (Ratnam, Crisinel, & Simeoni, 2016) was proposed for residents and staff in outpatient and inpatient units, it included material regarding asylum seekers' itineraries in the country, social support available, medical guidelines, tools for community interpreters, etc. The tools proposed in this kit contributed on one hand to a more equal access to migrant children's healthcare in Switzerland, and on the other it assured more tailored care for each child (Ratnam et al., 2016).

Although research on interventions facilitating communication between migrant children, youth or families with minority language background and services is scant, a recent review (Wollscheid, Menzies Munthe-Kaas, Hammerstrøm, & Noonan, 2015) on this topic found that the use of interpretation services (in-person interpreter, telephone interpreter, ad hoc-interpreter) or bilingual personnel have a positive effect in facilitating communication (Wollscheid et al., 2015). In conclusion the main implication of these studies is

the demonstration of how enhancing refugee children, adolescents and parents experience and knowledge can reflect with improvement in their quality of care.

Successful example

Child and adolescent psychotherapy
(London, UK)

Service/department in charge of the measure:
Refugee Therapy Centre

Description of the measure:
The Centre provide psychotherapy and associated treatments to people who have been tortured, giving priority to children. The Centre receives referrals for children and young people from schools, colleges, refugee community organisations, social services and health professionals. In order to meet the needs of children, two booklets, "Information for Parents" and "Information for teachers" were provided, on the belief that if children and families are helped early enough, much needless emotional suffering and difficulty in later life may be prevented.
Professionals working at the Centre address the needs of the individual child, working through past experiences, providing support to tackle current difficulties and rebuilding confidence and self-esteem which helps children to make a positive contribution to their new environment. A psychodynamic or psychoanalytic approach in assessment and treatment is used primarily.

Expected outcomes:
To offer children to insight into their problems and to provide them with a space for their own sense-making, helping them to verbalise feelings which they may have feared or suppressed through aggressive or harmful behaviour, working through their experiences in a safe and supportive environment
To support children and their families to tackle this experience and to prepare themselves to psychological consequences

Achieved outcomes:
Enabling children to understand their experiences and feelings helps to relieve their distress and enables them to make positive changes. The Centre focuses on the need to contextualize projects and to give greater attention to ethnographic needs. This assures greater resilience and sustainability and closer and social and cultural adaptation for the community that we set out self to serve.
Working with families and communities in an effort to restore social structures and a sense of normality is a a key factor of this experience.
Need to have access to in-depth information about refugees children's cultural environment, the nature of trauma they have endured and family dynamic is an important issue to carry on.

Available at:
http://www.refugeetherapy.org.uk/

Other resources:
https://refugeportal.wordpress.com/best-practice-guidelines/

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