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Research paper

The mental health and social circumstances of Kosovan Albanian and Albanian unaccompanied refugee adolescents living in London

Kathryn Hollins MSc MBChB MSc MRCPsych
Consultant Psychiatrist in Psychotherapy for Adults, Children and Families, Perinatal Service, Chelsea and Westminster Hospital CNWL Foundation NHS Trust, London, UK

Hamideh Heydari MSc MBChB BSc MPhil MRCPsych
Consultant Psychiatrist in Psychotherapy, Basildon Hospital, UK

Kate Grayson BA MSc FRSS
Statistician, Surrey, UK

Gerard Leavey BSc MSc PhD
Assistant Director R&D, Barnet, Enfield and Haringey Mental Health NHS Trust, and Honorary Senior Lecturer, Department of Mental Health Sciences, UCL, London, UK

ABSTRACT

There is evidence of psychological difficulties amongst asylum-seeking adolescents in Britain. Concern about the mental health and social needs of young unaccompanied refugees in the care of the local authority, Haringey, led to discussions between social workers, and primary care and mental health professionals. In this cross-sectional study using mixed methods we examined the psychological health and social needs of 99 Kosovan-Albanian and Albanian unaccompanied refugee adolescents. Contrary to our expectations, older age at interview and older age on arrival were associated with a significantly higher level of psychological difficulties, rather than younger age. Lack of structured support, such as living in hostel accommodation, and lack of parental contact were also associated. We suggest that the higher level of psychological difficulties among the older adolescents may be in part due to the reduction in the statutory provision of social, practical and emotional support for this vulnerable population, which occurs after the age of 16 years. Service providers need to address the ongoing mental health and social needs of older unaccompanied refugee adolescents.

Keywords: adolescent, asylum seeker, culture, mental health, psychological difficulties, refugee, unaccompanied

Introduction

Conflict across the globe continues to generate upheaval and dislocation for many thousands of children and young people. In a recent review of mental health and refugee children, Fazel and Stein (2002) provided a comprehensive list of pre-migration risk factors for psychological disorders such as experiences of trauma, bereavement and parental mental illness. Post-migration risk factors include problems of language and communication, discrimination and marginalisation. Evidence from European studies suggests that refugee children and adolescents who are unaccompanied, that is, separated from both parents and lacking identified carers (Russell, 1999; Derluyn and Broekaert, 2007), may be particularly vulnerable. A recent prospective

study in the Netherlands found the level of self-reported psychological distress of refugee minors to be severe, chronic and largely undetected (Bean *et al*, 2006, 2007). In the absence of family and other social support and security they are prone to violence, abuse, sexual assault and contact with the criminal justice system. In a recent qualitative study in Wales (Dunkerley *et al*, 2006) school was seen as the key normalising factor for young refugees in that it generated friendships and opened social networks. The researchers reported that for children over 16 years, social integration was more difficult.

It has been argued (Richman, 1998) that, given their ability to escape adversity and find refuge in another country, unaccompanied young people may also be resourceful and resilient (Rousseau and Drapeau, 2003). However, although sometimes contradictory (Kinzie *et al*, 1989; Beise *et al*, 1995), the weight of evidence suggests that the prevalence of emotional and behavioural disorders among refugee children is high (Hodes, 1998; Sourander, 1998; Leavey *et al*, 2004). Evidence points to the longer-term risk of mental health problems in exile (Kinzie *et al*, 1989). The most frequent diagnostic categories are post-traumatic stress disorder (PTSD), anxiety with sleep disorders, and depression. Despite the concerns raised about these individuals, there has been scant research on the level of psychological difficulties experienced by unaccompanied refugee adolescents living in Britain (Hodes, 1998). Nor do we know much about their health and social needs.

Background

The London Borough of Haringey is one of the most ethnically diverse boroughs in Britain. Half of the population are from ethnic minority backgrounds with 193 different languages spoken. A high percentage of the most recently arrived refugees in Britain live in Haringey; Kurdish, Somali and Kosovans are some of the most recent arrivals. Most of the adolescents we interviewed in this study arrived in Britain between 1999 and 2001. In 1999, the Home Office received 3349 applications from unaccompanied children and adolescents, in 2000, 2735 and in 2001, 3469 (Home Office Statistics, www.homeoffice.gov.uk). The highest number of applications received in 2000 was from unaccompanied children and adolescents from the Federal Republic of Yugoslavia (10%).

Study design

In Britain the Children Act 1989 places responsibility for the needs of unaccompanied children and adolescents seeking asylum on social services departments in local authorities in Britain. This is different from the provision for adult refugees who are cared for by the National Asylum Seekers Service. Discussions between social care workers, the housing department and mental health professionals in the London Borough of Haringey raised concerns about the mental health and social needs of young unaccompanied refugees in the care of the local authority. All agencies were interested in improving the provision of care by social, health and education services in addressing the psychological needs of these young people. However, there were no systematically collected data about their health and social circumstances.

We began by examining the database of unaccompanied refugee minors looked after by Haringey social services. The database included information on ethnicity, age, property provider and current address. At the time of this study there were over 350 children and adolescents from many different ethnic and linguistic backgrounds on the database. The main ethnic and linguistic group on the social services register in Haringey Local Authority, North London, were ethnic Albanians from Kosovo and Albania, and consequently we decided to concentrate on this one group. The aims of our study were to:

1 examine the prevalence of psychological problems among unaccompanied refugee adolescents
2 examine the demographic and social factors that may be associated with psychological problems
3 detail their health and social needs and access to local services.

The study was accepted by the local research ethics committee of Barnet, Enfield and Haringey NHS Strategic Health Authority and registered with the R&D Department of Barnet, Enfield and Haringey NHS Mental Health Trust.

Method

Participants were asked to complete two self-assessment questionnaires and a 24-hour diary sheet and to take part in an interview (see Box 1). All the questionnaires were translated into Albanian. The GHQ-28 (General Health Questionnaire) was already translated into Albanian for a study of Kosovan-Albanian refugees in London (Turner *et al*, 2003). A professional translation company prepared the remaining questionnaires. These translations were verified for this population by consultation with a second Albanian translator. This translator also worked with many of these adolescents as a social worker in the unaccompanied refugee minor team, and was able to

give advice on appropriate language usage for these adolescents.

When collecting data, the researcher began by explaining the purpose of the research, that we were doctors (psychiatrists) as well as researchers. We then obtained written consent. The participants were asked to complete the self-assessment questionnaires (see Box 1). Those who had problems with understanding words or concepts could ask for clarification from the researcher via the Albanian-speaking interpreter. The interpreter filled in the questionnaires for those boys with difficulties in reading and writing. At the end of each interview we invited the participant to discuss any problems or concerns they had. If necessary, and with their consent, we wrote to the appropriate social worker or general practitioner (GP) about any problems raised in this discussion.

The participants

We sent a letter to each of the 193 potential participants in order to explain the purpose and structure of the research. Ten pounds was offered to each participant for time and expenses. Those who did not reply were re-invited on two subsequent occasions. Some addresses were incorrect or out of date, while others were without postcode or with incorrect spellings.

A total of 99 Kosovan-Albanian and Albanian adolescents agreed to take part; of these 97 were boys; 78% were aged 16–18 years and were approached directly, while the under-16 year olds were contacted by their individual social workers who explained the aims of the research. All the participants were provided with detailed information sheets written in Albanian. Signed consent was obtained and all participants understood that they could withdraw at any point, free from any

Box 1 Data collection methods

1 Questionnaire about socio-demographic context and access to services
This asked questions about their family, social and migration history, health, education and current living circumstances. For instance, we asked participants about concerns they might have with their accommodation and environment. For example 'Do you have any worries about: (a) the people you live with; (b) being burgled; (c) safety in your neighbourhood; (d) the general condition of the building in which you live?'. Concerns were measured as 'always', 'sometimes' and 'never'. They were also asked about their experiences of, and use of, education, health and social services. As no appropriate measure was available, the questionnaire we used was designed by us through careful consultation with the social workers on the unaccompanied refugee minor team and with other relevant professionals. A copy of this questionnaire may be obtained from the authors.

2 24-hour diary about daily life experience and exclusion
We investigated the adolescents' daily activities by asking them to complete a 24-hour diary sheet with information about the most recent weekday. We encouraged them to record all of the activities in which they were involved. We also used direct and open questioning leading to thematic exploration. Additionally, we explored the adolescents' subjective experience of loneliness and social isolation using the UCLA Loneliness Scale. The 20 items of this well-validated scale (Russell, 1996) are based on statements made by lonely individuals to describe feelings of loneliness. For example, one question asks: 'How often do you feel that there is no one to whom you can turn?'.

3 Psychological difficulties
We used observation and clinical assessment in order to describe the current state of their health. The level of psychological difficulties amongst the adolescents was measured using the GHQ-28. This is a widely used and well-validated screening tool for psychological ill health. It specifically asks questions about the four areas of depression, anxiety, somatic symptoms and social dysfunction, all of which are commonly found in psychological ill health.

4 Clinical interview
Brief clinical interviews were undertaken, with individual adolescents, by KH and HH. We recorded commonly experienced health symptoms and problems and we asked about help seeking in relation to those problems. If clinical assessment led to concern for the current mental or physical health of the adolescent, a referral was made, with consent, to the appropriate service. The majority of the interviews took place in the research department at St Ann's Hospital. We also carried out interviews at the largest place of residence, a hostel. Each interview lasted an average of one and a half hours. The first language of all the adolescents was Albanian. The interviews were conducted in Albanian and English, using an Albanian-speaking interpreter to aid communication.

consequence. The 16–18 year olds were not eligible to have either an allocated social worker or a key worker at the time of the research. Gaining the trust of these adolescents was crucial. Prior to, and throughout the interviews, we stressed that we had no connections with the Home Office or the legal justice system and that the interview content was completely confidential.

Data analysis

We used SPSS Version 11 for Windows to analyse the quantitative data. Statistical analysis included both descriptive and inferential statistics appropriate to the type of data, including χ^2, *t*-tests and one-way ANOVA. Because of the small sample size, exact tests were used where necessary. All the results reported in the 'Socio-demographic context and access to services' section are statistically significant at least at the 0.05 level. In defining the overall level of psychological ill health in this population, we used a cut-off point of 5/6 (GHQ scoring method) as used by Mann *et al* (1983) in their study of psychological ill health in adolescents. There are many studies that use the GHQ to assess psychological ill health but only a few that look specifically at adolescents. The study of Mann *et al* (1983) measures psychological ill health in 15-year-old adolescent girls in south London. Nineteen percent of their sample reported significant psychological difficulties, compared to 23% of our sample. Socio-demographic and gender differences make a direct comparison difficult even though both groups live in inner-city London. For all other results we used the CGHQ scoring method, which enabled more sensitive examination of potential risk factors for ill health.

The qualitative data were analysed through a simple content analysis of all the recorded activities in the adolescents' written diary sheets, allowing us to crudely determine notions of social engagement or exclusion. Our overall understanding of the adolescents' mental health was contextualised by discussion and information gathering with social workers and health professionals.

Findings

Socio-demographic context and access to services

Demographics

Ninety-nine of the 193 eligible participants (51%) attended interview; 97 were boys. The majority (78%) were aged 16–18 years ('older adolescents') and the rest (22%) were 13 to 15 years ('younger adolescents'). The mean age was 16 (standard deviation (SD) 1.19). The majority of the adolescents had a rural upbringing (70%). We used parental occupation as a measure of socio-economic status. Seventy-six percent of fathers and 77% of mothers were in 'routine' or 'manual' occupations by job description. The adolescents reported managerial or professional occupations for 12% of fathers and 8% of mothers. No occupation was given for the remainder of the parents who were either unemployed or dead. Over half of the adolescents (55%) had only four years of formal education or less. This would have been at primary school level.

Reasons for leaving home

Civil disturbance was reported as a problem by the vast majority of adolescents (93%) and was also given as one of the reasons for leaving home by the same percentage (93%). Problems with the law or police were reported by 69%. In Kosovo, this included discrimination by the Serbian police for being ethnic Albanian. However, while civil disturbance predominates as the reason given for migration, economic problems were also reported by 40%, and family and relationship problems were cited by 16%.

Arrival in Britain and family contact

Most (75%) of the adolescents were still under 16 years old when they arrived in Britain and half (47%) reported that an agent had helped them. Most travelled with other asylum seekers who were unknown to them; only six arrived with a relative such as a brother or cousin. The journey was usually overland by lorry. Two-thirds (66%) of the adolescents had no current contact with their parents or anyone else in their family. Half of the adolescents reported that they were uncertain as to the whereabouts of their family members.

Accommodation in the UK

Since their arrival in the UK, over half (61%) of the adolescents reported moving two or more times. One participant reported moving eight times in less than a year. Twenty-three young people (23%) were living in hostel or bed and breakfast accommodation, 8% lived with a foster family or friends, 30% in a children's home and 38% in a shared house. The majority of those living with friends or foster families (88%), staying in children's homes (97%) or in a shared house (71%) liked where they were living. In contrast, the majority (74%) of those living in a hostel or bed and breakfast were unhappy with their accommodation (χ^2 = 32.3, degrees of freedom (df) = 3, $P < 0.001$). Those living in a hostel or bed and breakfast were also significantly more worried about other aspects of their lives. Thus, they were significantly more likely to have worries about the people they lived with ($\chi^2 = 25.7$, df = 6, $P < 0.001$), about safety in their

neighbourhood (χ^2 = 26.7, df = 67, $P < 0.005$) and about being burgled (χ^2 =29.3, df = 6, $P < 0.001$).

Access to primary care

One-fifth (22%) of the adolescents reported not being registered with a GP. Some were waiting for a letter from social services, which was required by GP surgeries before registration. Others had not yet registered because they said they did not need to go to their GP. Two-fifths of the adolescents had been to see their GP recently. The reasons given for visiting the GP were predominantly for physical symptoms, which included skin complaints, toothache and back pain. Several had multiple warts on their hands, an easily treatable yet contagious condition, but few had sought treatment. Some of their reported physical symptoms, such as headaches and sleep disturbance, may be due to psychological difficulties. None directly offered mental health problems as a reason for GP contact.

Social services

The social services team had achieved a good relationship with many of the adolescents, as reported to us at interview. The majority of the adolescents felt that the social workers were available when needed, with over half reporting that the social workers were always available when needed and another third reporting that they were sometimes available when needed. Three-quarters of participants would choose to turn to their social worker for help or support. The majority described being well treated by social services, but one in three reported being discriminated against or unfairly treated by social services sometimes (19%) or always (13%).

Daily life experiences

Diary sheet results

In order to understand the rhythm of daily life for these 99 adolescents, we asked them to fill in a 24-hour diary sheet for the most recent weekday. The basic routine of the day included school or college, eating and sleeping. Those in mainstream schooling reported a more structured and varied routine than the others. Many described spending time with friends, watching television and undertaking self-directed study. This appears to be similar to any adolescent growing up in Britain but there was a lack of variety of daily experience and almost a complete absence of family life and relationships. Long periods of the day, even for those in education, were unstructured or purposeless. Time was often reported as simply 'hanging out with friends'. Owing to lack of money for other 'consumer' activities, the most commonly described activity was informal sport activity, especially playing football.

The UCLA Loneliness Scale was used in order to find out more about the level of social isolation experienced by the adolescents. The results tallied with our knowledge about them, gained from discussion and the diary sheet. Older adolescents, who were less likely to be in education, reported more loneliness and social isolation (UCLA Loneliness Scale) than younger adolescents (t = 2.267, df = 96, P = 0.026).

Education and relationships

Fifty-four (69%) of the older adolescents were in some form of education, compared with 20 (95%) of the younger adolescents who were all in mainstream school. In fact, only the younger boys were given places in mainstream schools, and they were unanimously grateful and positive about the opportunities and hope this gave them for the future. They had relationships with local friends and felt connected into the community. Their command of English was good, and we experienced them as energetic and lively boys, similar to other adolescents in London.

To give an example, Ismail was a 13-year-old Kosovan boy, fresh-faced and smiling throughout the interview. He looked well and already spoke good English. He was accompanied by his female key worker, who was clearly engaged with him and keen to support him. He came from a professional background and had clear aspirations to integrate and become a useful member of society. He lived with a foster family, had friends and enjoyed his mainstream school. He wanted to go to university and become a policeman or a social worker. This is a case example of one young boy who attended mainstream school and lived in foster care. He is unusual compared to the other participants because of his professional background and apparent resilience.

Those adolescents who were attending college, either to learn English or to undertake a vocational course, tended to express a strong belief that education was the ticket to future stability, happiness and an entry into mainstream London life. Being able to travel and buy a car were items high on their wish-lists and represented real success for them. But this group of college attendees often described a wish for more education than the few hours a week they were receiving. They only socialised with their male compatriots and longed to meet British adolescents, especially potential girlfriends, and to be welcomed into local communities. Most of those who were not in education were waiting restlessly to begin. Often it had been delayed for administrative reasons rather than lack of eligibility. This left a small group who wished to work straight away in order to try and earn some money to live on. We were told by the youngsters that many of those who did not attend interviews with us were working, for example on building sites for low pay, hence being unable to come.

Family contact

Finding out about their families of origin was a complex and sensitive issue. It is well known that many people died in Kosovo during the conflict, and our adolescents were directly affected, with some losing their parents. Thus, grief inhibited some in talking to us, while fear of being sent home stopped others from telling us whether they were in contact with any family members. Their method of arrival in London is important in understanding the story of their predicament: almost all arrived on their own, not travelling with anyone familiar, and scared to make friends in case it jeopardised their own chance of success. So while on the one hand these adolescents were lonely and longing to form relationships, on the other it felt risky to trust others from the moment they left home alone.

Exploitation

Risks included exploitation. For example, Anna was 17 years old, a petite and fragile-looking young woman, pushing a rather large old pram, with a baby sleeping in it. She seemed even younger than 17 years and was nervous throughout the interview. She was accompanied by a brash, domineering man, from a similar background, who insisted on trying to answer for her. Her story was that she had been taken in by him on arrival in London. After a short while he insisted that they commence a sexual relationship and soon she found herself pregnant. He was also an asylum seeker, and he believed that her pregnancy would prevent them both being deported. She was isolated and had very little contact with the outside world. She did not speak much English and was clearly frightened of this man. She was preoccupied with her concerns for the baby's welfare.

In this example the girl was particularly vulnerable to exploitation at the time of arrival into the UK. She scored highly on the GHQ-28 with symptoms of depression and anxiety.

Psychological difficulties

GHQ-28 results

Over one-quarter of the adolescents (28%) reported marked psychological difficulties, meeting the criteria for 'caseness' (GHQ scoring method) with symptoms of anxiety (50%) and sleep difficulties (80%). Nearly one in five reported feeling 'life is entirely hopeless' and that they were a 'worthless person'. Table 1 presents socio-demographic and other factors related to higher GHQ-28 scores.

Twenty-seven (35%) of the older adolescents (16 years and over) reported marked psychological difficulties compared with only one (5%) of the younger group (Pearson's χ^2 =7.27, df = 1, P = 0.007). Additionally, arrival in the UK at an older age (16 years and over) was also significantly associated with higher GHQ-28 scores (t = 2.435, df = 97, P = 0.017) as was absence of parental contact (t = 2.469, df = 97, P = 0.015). Assessed simply for caseness on the GHQ, the only associated factors were living in unsupported

Table 1 Socio-demographic factors associated with higher GHQ scores

Socio-demographic factors		*n*	Mean GHQ score (SD)	Significance
Age (years)				
age at interview	<16	21	4.95 (4.0)	$P<0.005$
	16–18	78	9.27 (6.2)	
age on arrival	<16	73	7.49 (5.4)	$P<0.05$
	16–18	26	10.77 (7.1)	
Parental contact	Yes	20	5.45 (3.6)	$P<0.05$
	No	79	9.09 (6.3)	
Accommodation				
Do you like where you live?	Yes	69	6.58 (5.2)	$P<0.001$
	No	30	12.43 (5.8)	
Accommodation type				
hostel or bed and breakfast		23	12.09 (6.6)	$P<0.005$
friend, relative, foster family		8	4.75 (4.7)	
children's home		30	6.80 (4.7)	
shared house or flat		38	8.08 (6.0)	

accommodation (Pearson's χ^2 = 6.87, df =1, P = 0.009) and absence of parental contact (Pearson's χ^2 =7.58, df = 1, P = 0.006).

Clinical interviews

Our observations increased our understanding of the adolescents' fears, anxieties and general health. They needed considerable reassurance that we did not represent the Home Office or the police and that our research would not affect their rights to stay in Britain. The interpreter often described to us the adolescents' reluctance in giving straightforward answers. Using a hospital setting, and being clinicians, helped us to gain their trust as well as address some of their anxieties. Despite this, the high level of anxiety in some interviewees was evident throughout the interview, shown by erratic eye contact, being fidgety and talking nervously. Physical health problems were also easily observable, for example hand warts, severe dental caries, poor hygiene and simply looking pale and unwell. In the last section of the interview some adolescents wished to meet with us individually, knowing we were doctors. They then dared to confide in us, sharing their worries for their lives and the uncertainty they faced regarding their future. Through clinical assessment, we identified depression and severe anxiety states in some of these young people, and in some instances, psychotic symptoms. For example, Mohamet was just 18 years old, a tall, dirty and awkward young man. His disturbed mental state gradually emerged as he began to talk about his living conditions. He described his fear of the men living in the hostel with him, who carried knives and were trying to enlist him in their gangs. He said someone was stabbed the previous day, and he was frightened for his life as he did not belong to a gang. He used to lock himself up in his room most of the time in an attempt to keep safe. A few days following our interview with him, he returned to the hospital for an emergency psychiatric assessment, accompanied by his social worker. By coincidence, one of the researchers was the on-call psychiatrist. He had become psychotic and needed hospital admission and treatment.

Discussion

In this study we combined quantitative and qualitative methods in order to assess the psychological health of unaccompanied refugee adolescents in the context of their social circumstances and needs. Our findings are consistent with the UK literature on refugee children and mental health problems (Hodes, 1998, 2000, 2002; Fazel and Stein, 2002). We also confirm that despite an overall good relationship between the participants and social services, important social and health needs, particularly among the older adolescents, are not being met (Bean *et al*, 2006). A 'commonsense' expectation suggests that younger adolescents would report greater psychological difficulties (Sourander, 1998), however this was not the case. New arrivals under 16 years are looked after within the framework of the Children Act and as with other young people in care, they remain supported by the Leaving Care team when they reach 16 years of age (Mitchell, 2003). In the current study, the younger participants were predominantly living in children's homes or in foster care, and support workers, key workers and named social workers provided other 'substitute parenting' for them. The children in foster care were happy to be in small families receiving parental care. Thus, it appears that structured support within education, social services and accommodation settings benefits the younger adolescents.

In contrast, the older adolescents had significantly more severe psychological difficulties and were significantly more likely to meet the criteria for GHQ-28. Our results suggest that this may be related to the considerable anxieties that are experienced by those adolescents receiving lower levels of support and living in unsupported accommodation. The older participants were also significantly lonelier than the younger boys, and reported greater worries about life in London. Without the same statutory protection afforded to younger adolescents, the majority lived in hostels, bed and breakfast, or a shared house or flat and did not have a named social worker to provide consistent adult guidance or input. The daily lives of these young people, lacking the structure of college and family, seemed lacking in purpose.

The Audit Commission (2000) indicated that 50% of unaccompanied asylum-seeking children over 16 years and 12% of those under 16 years were in bed and breakfast, hostel and hotel annex accommodation. This type of accommodation is generally overcrowded and of low standard. As noted by the Mayor of London's report (Greater London Authority, 2004, p.15) this means that children are obliged to share facilities with adults who are unknown to them. In mixed hostels this constitutes an even greater risk for young girls. The evidence from previous studies raises various child protection issues (Stanley, 2001; Greater London Authority, 2004).

One of the difficulties for the older adolescents is that because they are approaching adulthood, both physically and emotionally, they no longer engender the same feelings of protectiveness in adults as is usual for younger children, even though at times this proactive intervention is both wanted and needed. However, adolescents desire to be independent and are trying to develop their own identity separate from parental figures. Help and advice therefore need to support the growth of adolescents' agency and

individuality, while sensitively recognising when containment and help are required. Structures that provide alternative parenting do seem to be useful in fostering resilience in these younger boys as shown by the lower levels of psychological difficulties. One question to consider is whether the experience of these supportive structures enables them to manage well as adults in their personal lives, employment and links with the community. Unfortunately when mental health services are needed, the older adolescents, being neither children nor adults, can be caught between child and adult services. This issue continues to need careful attention. More prospective research is needed on the health outcomes for this group.

Lastly, in undertaking this investigation we were concerned about the apparent difficulties of social services in maintaining a record of unaccompanied asylum-seeking adolescents and the ease with which these young people seemed to disappear from the records. While the social services refugee team was dedicated and caring, they were nevertheless hampered by poor databases and the lack of affordable, good-quality accommodation. No doubt there are many such adolescents lost to the system. Sometimes this will be through their own volition but in many cases it will be due to their poor environment and lack of focused care. Our concern is that these young people are then vulnerable to a greater risk of psychological ill health, drug misuse and criminality.

Joint working between health, education and social services, which takes seriously the developmental and emotional needs of adolescent refugees, will go a long way in preventing psychological difficulties affecting the lives of these young people.

Limitations

There are a number of limitations to our findings. The response rate was disappointing, but in some respects perhaps not surprising. Our participants were fearful of authority and expressed concern about being deported and it seems likely that for these reasons some were disinclined to make contact. Some were trying to earn money and this prevented them attending our interviews. More alarming was the fact that many of the addresses for the refugee minors were incorrect and that the social services team had lost contact with these individuals. Thus, despite careful attempts at verifying addresses, some letters were returned to us. Additionally, some were unable to read their letters, even though the letters were translated into Albanian. The study was conducted in a deprived area of London where resources are extremely tight. It may not be possible to generalise our findings to more affluent boroughs. The vast majority of the study sample was male. This was a cross-sectional study which allows only a description of associated factors rather than an understanding of causality.

Conclusion

We conclude that lack of structured support for older adolescents adversely affects their mental health. It may increase vulnerability to social exclusion, drug misuse and sexual exploitation as well as involvement in violent crime. Lack of appropriate provision for other vulnerable groups aged 16–18 years is already recognised as a problem. Additional health and social measures could be considered, such as befriending, circles of support, health facilitation and health advocacy. Assistance in regaining contact with parents if possible is an important intervention to consider. We fully support the provision of structured support for adolescent refugees in the UK beyond the age of 16 years.

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CONFLICTS OF INTEREST

None.

ADDRESS FOR CORRESPONDENCE

Dr Gerard Leavey, R&D Department, St Ann's Hospital, St Ann's Road, London N15 3TH, UK. Tel: +44 (0)208 4426503; email: G.Leavey@ucl.ac.uk

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