

Child development, social-emotional wellbeing and settlement: a longitudinal study of refugee children

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UNSW
AUSTRALIA



Health
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Local Health District

What we know about refugee children

- **Highly vulnerable** yet **resilient** group
- **Routine screening is highly effective** in identifying physical health conditions
 - high rates of infectious diseases, incomplete immunisation, growth and nutrition problems, poor dental health
- **Psychological wellbeing is less well documented**
 - variable rates of post traumatic stress disorder (PTSD); depression, anxiety and behavioural problems
- **Development: very limited evidence**
- **Predictors of wellbeing requires research over long term - presents multiple challenges**



Known risk and protective factors

▣ **Mental health** population studies (refugee children)

▣ RISKS

- ▣ parental mental illness
- ▣ restricted economic opportunity
- ▣ time in detention
- ▣ exposure to violence/discrimination
- ▣ unaccompanied children/single parents

PROTECTIONS

- young age
- family cohesion
- employment
- socio-economic support

▣ **Few Longitudinal** follow-up studies

- ▣ time in Australia
- ▣ family and peer support; social inclusion
- ▣ fall in social status of family



Child development and wellbeing: a longitudinal cohort study of refugee children

Investigators

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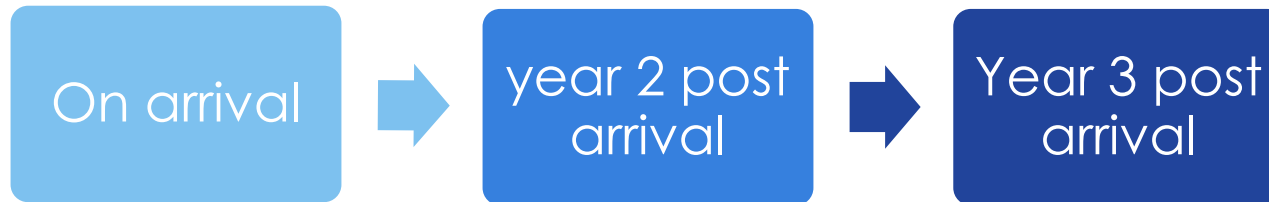


Aims



1. To assess over time

- **Physical health**
- **Development** (6 mths-5yrs)
- **Social-emotional wellbeing** (4-15 yrs)



2. Identify risk and protective factors that contribute to health outcomes **in order to provide early intervention for optimal outcomes**

Measurements: Outcomes



Physical Health

- Ht, Wt, BMI
- GP examination
- Blood tests



Development (6mths – 5yrs)

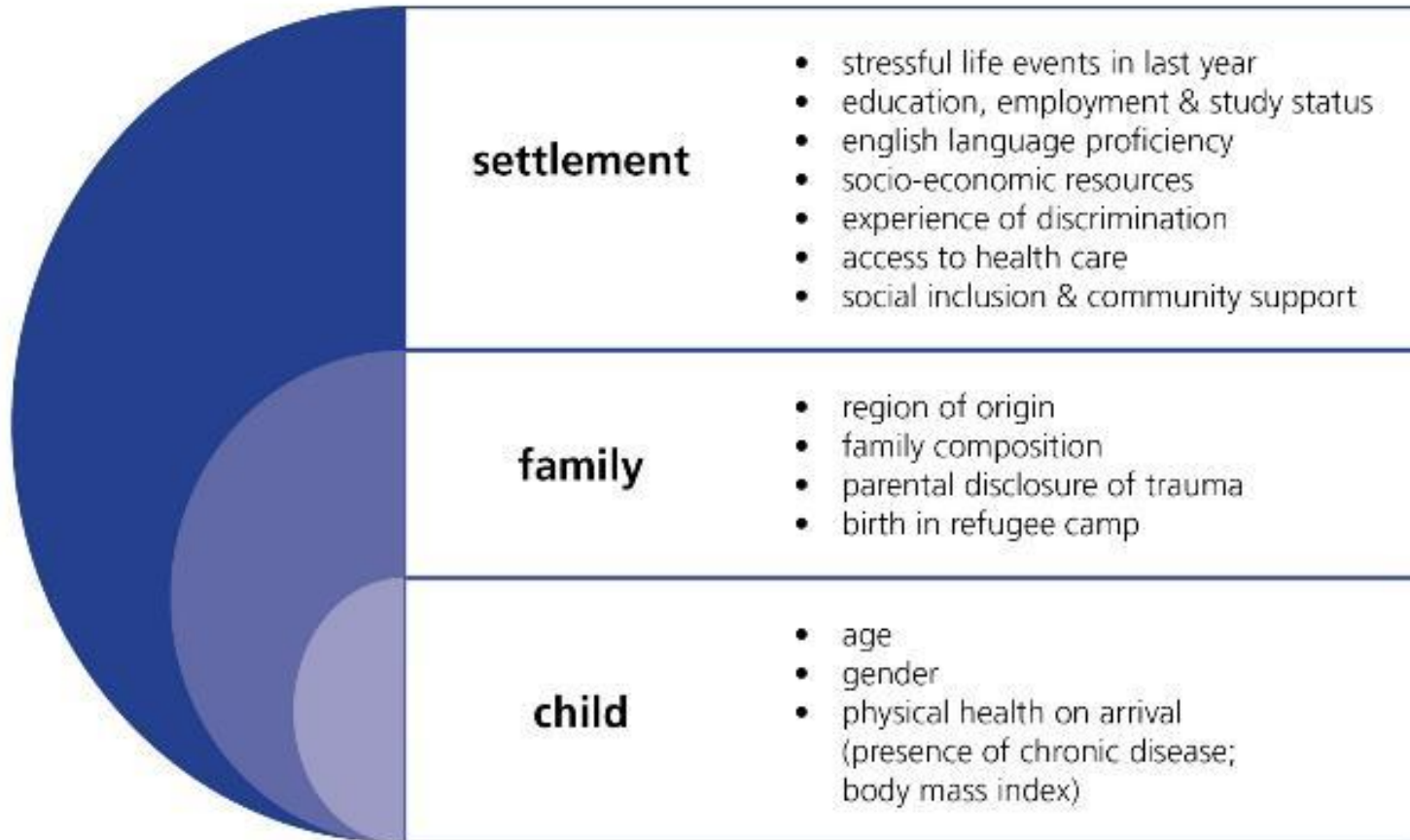
Australian Developmental Screening Tool (ADST)



Social-emotional wellbeing (4-15yrs)

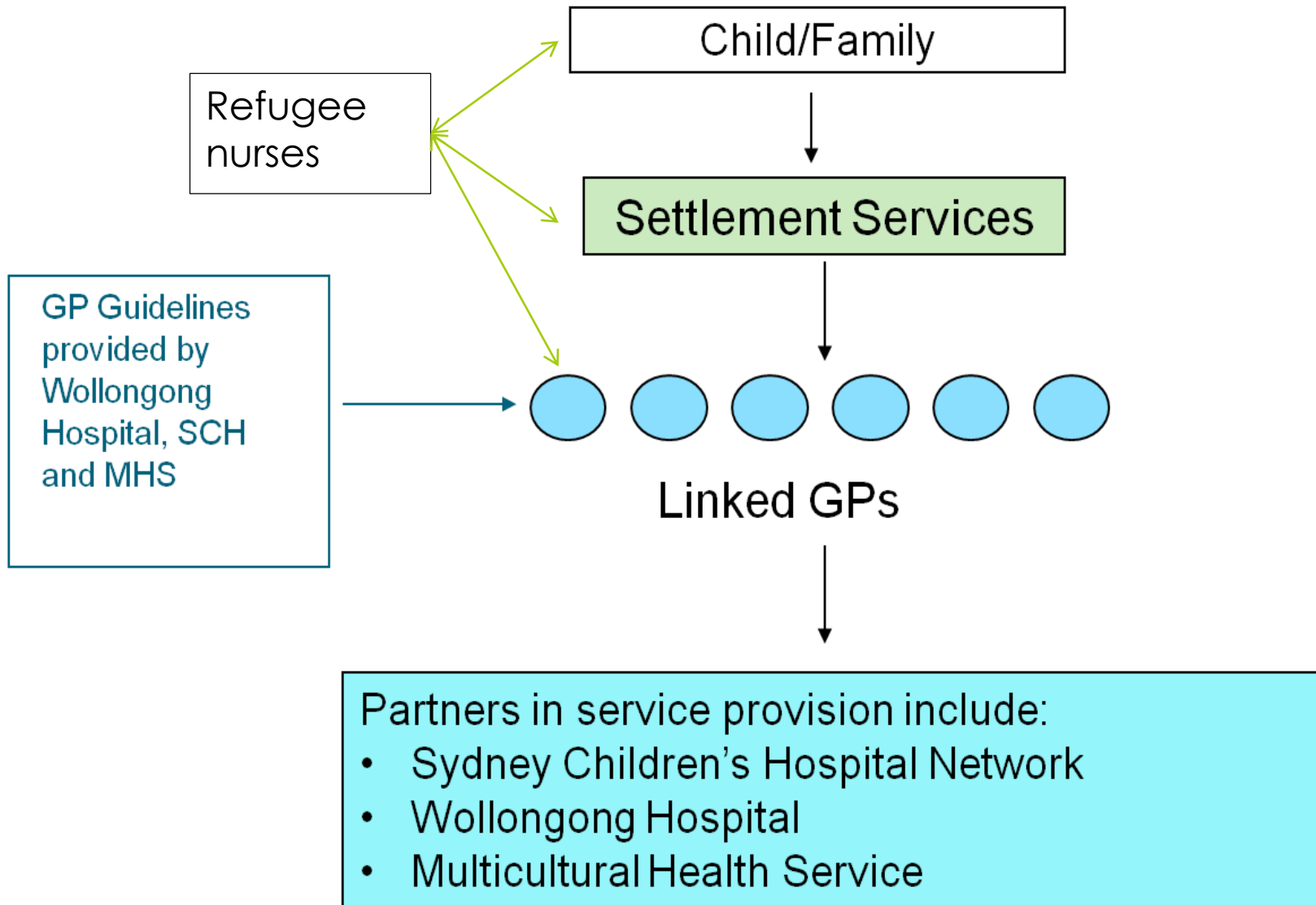
The Strengths and Difficulties Questionnaire

Measurements: Risk and Protective factors



Bio-ecological model: Bronfenbrenner

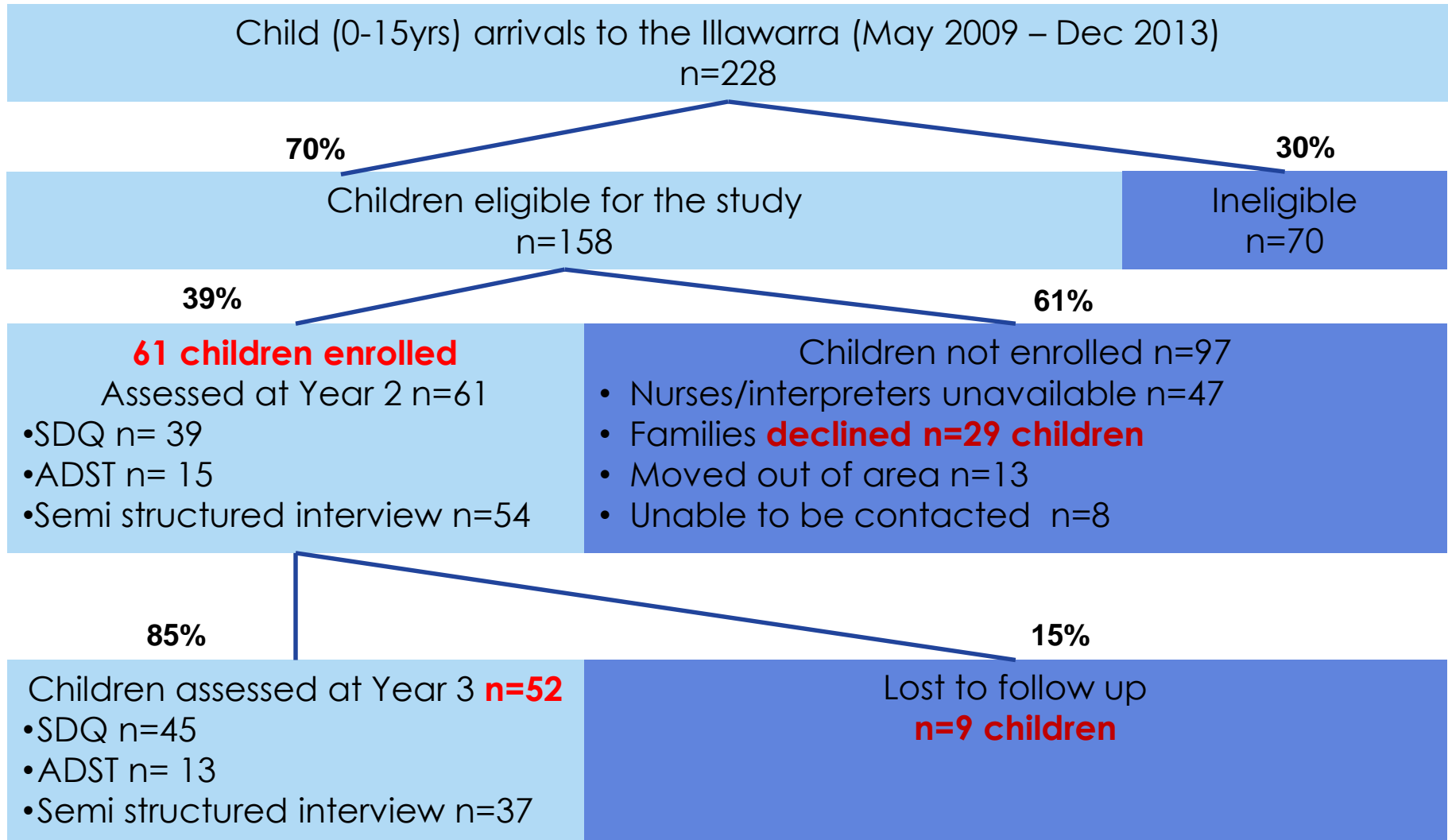
Study Setting: regional NSW



Study methods and power

- ▣ SPSS version 22.0
- ▣ Univariate associations between SDQ score and predictors - exact chi-square
- ▣ Highest P values on univariate analysis selected for inclusion in computing protective factor scores for SDQ score at year 3
- ▣ Power calculation: power set at 0.8, significance 0.05 and the prevalence of risk factors 11-97%, required a sample size of 40-60 children given a 25-30% difference in SDQ between exposure groups
- ▣ Hypothesis: 80% of children would have normal SDQ by year 3; 20% would have ongoing social-emotional difficulties associated with predictive factors

Study sample and follow up to 3 years



Demographics of study sample

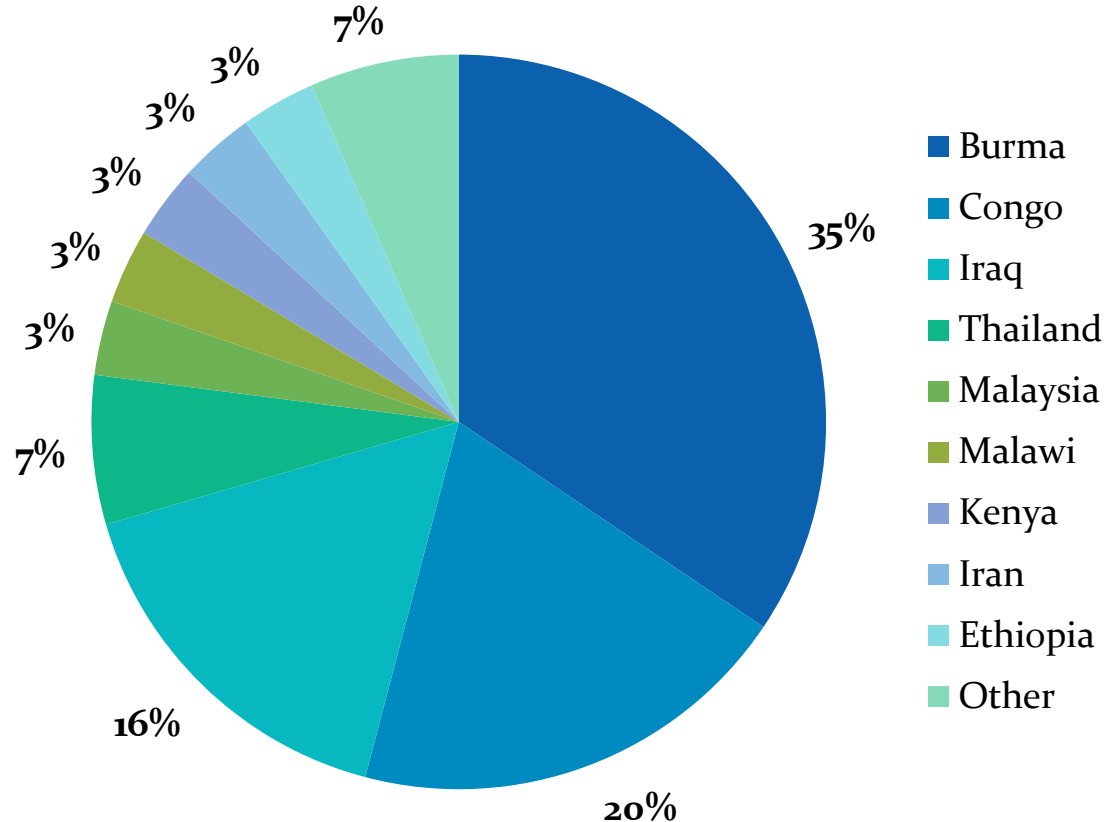
♀ n = 32 (52%)

♂ n = 29 (48%)

Mean age: 6 years;
Range : 6 months -15
years

- ▣ 40% of parents had low levels of education
- ▣ 30% of fathers were absent on arrival
- ▣ 13% of children were born in refugee camps, and
- ▣ 11% of parents self-disclosed previous trauma

Countries of Origin



Physical health

Health condition	% positive
Nutritional deficiencies	35%
Parasitic infections	7%
Latent TB positive screen	11%
Chronic Hep B	2%
Chronic disease (LTBI, Hep B, schisto)	15%
Weight status	5-6% underweight 8-14% overweight 5-8% obese No change over time



Results: Development in 6mth - 5yo

Year 2 post arrival
n=15 (71%)

Year 3 post arrival
n=13 (81%)

In preschool children, 27% had mild developmental problems in year 2; all were normal by year 3. Abnormal SDQ total difficulties scores reduced over time from 13% to 6%



Social-emotional wellbeing improved over time

SDQ	No. children requiring further assessment	
	Year 2	Year 3
Overall score	5/39 (13%)	2/36 (6%)
Emotional symptoms (headaches, worries, feeling unhappy or fearful)	9/39 (23%)	3/36 (8%)
Conduct problems	5/39 (13%)	1/36 (3%)
Hyperactivity & inattention	3/39 (8%)	3/36 (8%)
Peer relations (preferring to play alone, not having friends, being bullied)	8/39 (21%)	2/36 (6%)
Pro-social behaviour	0/39 (0%)	1/36 (3%)



Access to health care

Access to health care (Parent report)	Year 2 post arrival	Year 3 post arrival
Visited GP (every 1-3 months)	38/51 (75%)	22/54 (41%)
Good access to GP	50/51 (98%)	45/52 (87%)
Presented to ED (last 12 months)	6/51 (12%)	4/51 (7%)
Visited Early childhood services (last 12 months)	5/22 (23%)	1/26 (4%)
Visited Dentist (last 12 months)	26/51 (51%)	33/52 (63%)
Fully Immunised	42/51 (82%)	48/51 (94%)

Changes over time

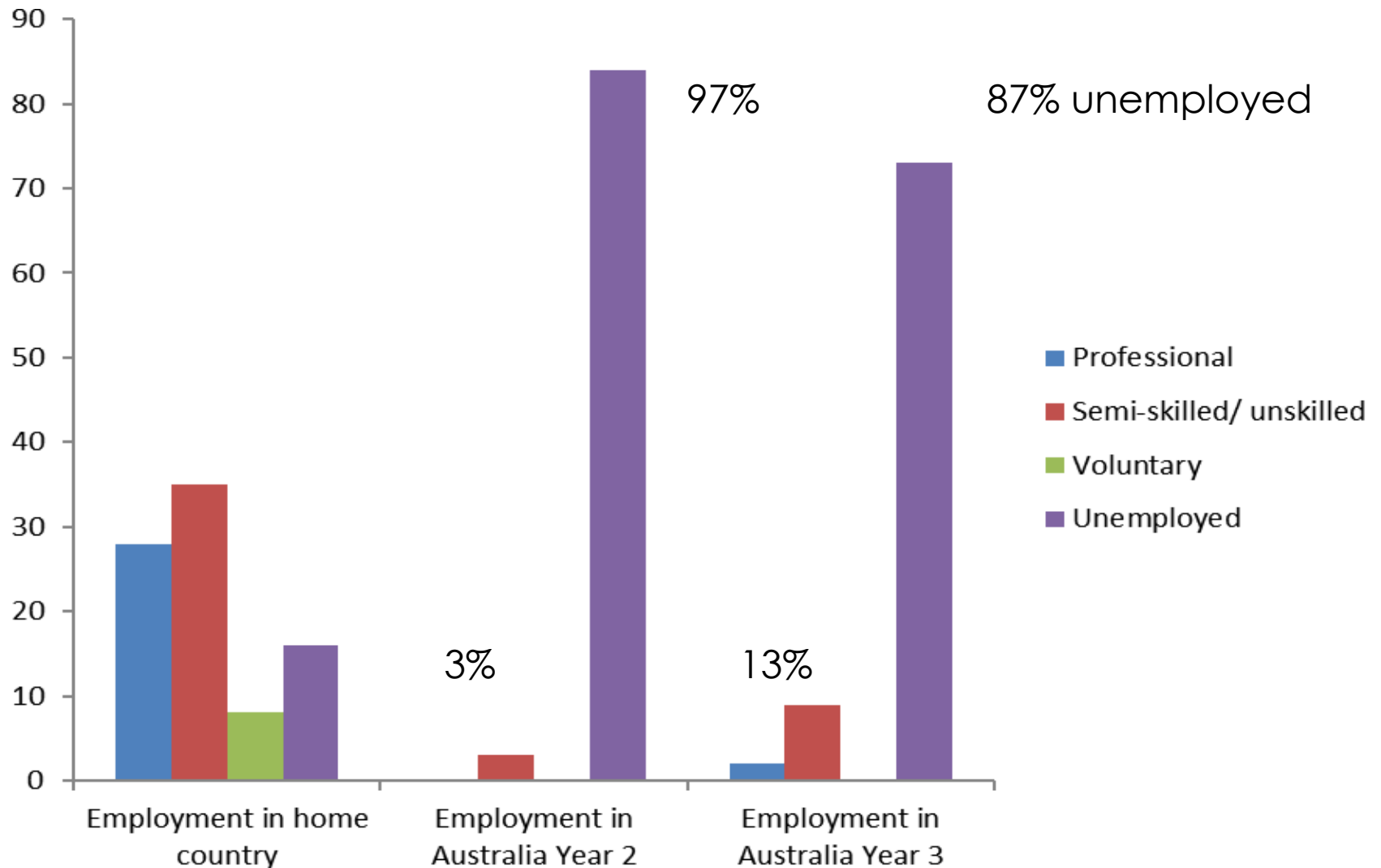


- ▣ increased parental employment ($p=0.001$)
- ▣ improved English proficiency for partners ($p=0.02$)
- ▣ reduced stressful life events in the last 12 months ($p=0.003$)

Parents were:

- ▣ studying English (96% at year 2 - 76% at year 3)
- ▣ accessing government financial support (96%;100%)
- ▣ feeling supported by their own community (78%;73%)
- ▣ feeling supported by the general community (69%;63%)

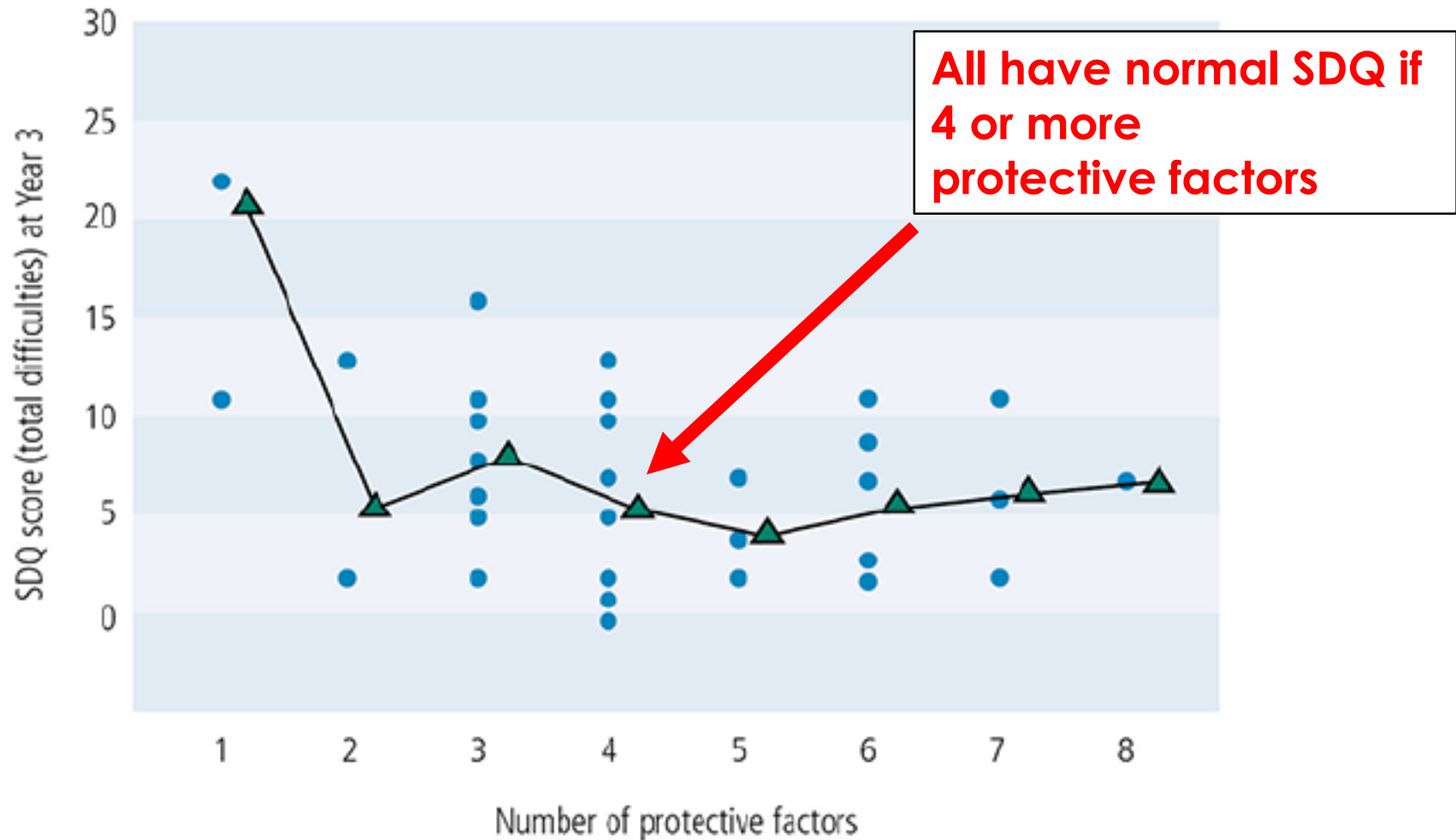
Parental employment over time n= 87



Protective Factors for social-emotional wellbeing at Year 3

Child factors	Younger age Chronic disease Gender BMI
Family factors	Region of origin - Africa Family composition – father present No parental disclosure of torture or trauma Birth in a refugee camp
Settlement factors	Fewer stressful life events in the past year Social inclusion and community support proximity to ones own community and external community support Stability in child's school and residence Parental employment Financial stability Marital stability Education, and study status English language proficiency Access to health care

Cumulative protective factors predict social-emotional wellbeing



Participant experience

All parents found the research respectful

The majority found the questionnaires:

easy to answer (83%)

did not raise uncomfortable feelings (92%-100%)

Study retention was high (85%)



Summary of findings

- ▣ Most refugee children do well over the first 3 years:

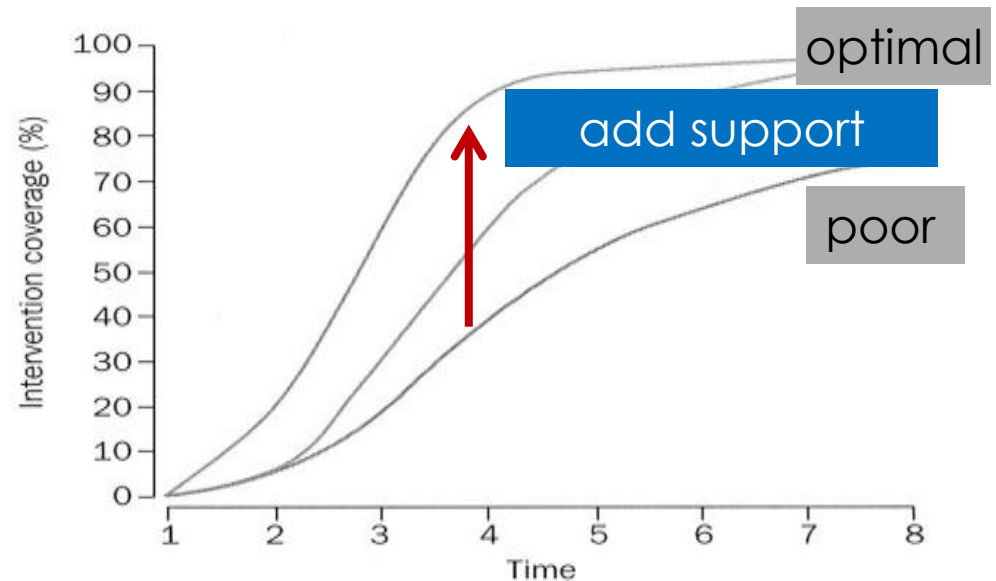
Physical, developmental, social-emotional



- ▣ We can predict social-emotional wellbeing by measuring protective factors

What this study adds

- Measurement of health over time
- Developmental and psychological wellbeing
- Identification of early protective factors
- Predicting children requiring proactive follow-up if <4 protective factors



Implications for policy and practice

- ▣ recommendations likely to promote resilience and optimise outcomes in accompanied refugee children settling in high-income settings include:
 - ▣ child and family level:
 - ▣ reduce postmigration exposure to violence & discrimination
 - ▣ promote stability and belonging in school and residence
 - ▣ promote access to health services
 - ▣ facilitate integration of children and families into host communities
 - ▣ prioritise reunion of children with families and provide support for families to remain intact
 - ▣ community and societal level:
 - ▣ promote welcoming environment in the host country
 - ▣ facilitate employment opportunities
 - ▣ provide supported educational placements
 - ▣ provide access to social and economic resources

Next steps in research

How do we do that?

Which interventions are effective in producing better outcomes?

How do we promote
employment?
social inclusion?
education...?



Thank you and questions

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