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SCOPING REVIEW ON MENTAL HEALTH AND CHILD PROTECTIVE SERVICES OF MIGRATED AND REFUGEE CHILDREN AND YOUTH

ABSTRACT

One of the long-term consequences related to migration due to wars, violence, and ecological and climate crises is the additional challenges to the health and child welfare systems in the host country. Previous research has shown that the need for the help of migrant children and children of migrants differs from the help needs of the main population of the host country.
In the current scoping review, our objective is to describe how the mental health and child protection services needs and use of child and youth refugees and migrants differ from those of the natives in the host country, and also to identify the main obstacles in receiving suitable mental health or child protective services. Implications for healthcare and child protective services are discussed.

KEYWORDS: REFUGEE, MIGRANT, MENTAL HEALTH, CHILD PROTECTION, OUT-OF-HOME CARE

INTRODUCTION

With the growing number of refugees and migrants worldwide, there is a growing need to understand the different challenges to the mental health of children and adolescents with a migrant background. It is essential to understand their specific needs relating to mental health and child protective services in order to create appropriate social and healthcare systems to address these needs. In Finland, there is very little research on mental health and child protection of migrant children. The few existing studies implicate the need for more research and the need to focus on developing more appropriate services for the diversifying population (1–3).

In this article, we use the concepts refugee and migrant to distinguish their different meanings (4). According to the 1951 Refugee Convention, a refugee is a person who is unable or unwilling to return to their country of origin owing to a significant fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion (5). It is possible to get refugee status either as a quota refugee or by seeking and getting asylum from the host country. An asylum seeker is a person who has fled their country of origin and is seeking international protection as a refugee but whose claim for refugee status has not yet been determined (6). Once the asylum claim has been accepted, they are called refugees (7). For refugees, the refusal of their request for asylum and return to their country of origin is likely to have dire consequences. Voluntary migrants, on the other hand, leave their home countries for different reasons, such as the wish to improve their lives by finding work, or in some cases for education, family reunion or other reasons. Their access to human rights is not necessarily threatened. In addition to adult refugees and families with children, an increasing number of refugee minors who are unaccompanied by their parents or carers seek asylum (8). By the terms first- and second-generation immigrant, we refer to people who are foreign-born or whose parents are born abroad, respectively. However, we emphasize that these concepts do not necessarily correspond to the identities of the people concerned (9).

Child and adolescent migrants are a heterogeneous group. Different studies may focus on children who arrive in the host country without their parents – as foreign-born adoptees whose parents are residents in the host country or unaccompanied refugee minors (URM, or asylum-seeking children) who have fled the adversities of their country of origin and arrived in the host country without their parents or caregivers. Other studies focus on children and young people who arrive in the country with their parents and are not separated from their parents, that is, foreign-born immigrant children (i.e., 1.5 generation immigrant children (10)), and 2nd generation immigrants – born in the host country to immigrant parents. There are different threats to mental health and specific mental health and child protection service needs that are connected to each of these groups. However, the available research on most of these groups is still scarce.

Child and adolescent refugees, who account for more than half of the world's refugees, have a higher prevalence of mental disorders (PTSD, depression and anxiety being among the most reported) than children and adolescents of local populations in both high- and low-income countries (11). Migrant children who experience pre-migratory trauma due to events such as war, displacement or violence, face unique challenges that can significantly impact their mental health and wellbeing. Additionally, they may have experienced the loss of social support networks, including family, friends and community ties, due to displacement (7). In addition to pre-migratory trauma, migrant children often also face peri- and post-migratory adversities that may increase their mental health concerns (12–14). Racism and discrimination that many refugees and migrants experience in the new country cause stress (12) and these experiences of discrimination correlate significantly with worse health outcomes and lower quality of life (15,16).

Migrant children may be in heightened need for child protective services compared to their non-migrant peers. Studies from Finland, Sweden and Norway have indicated that immigrant children and youth are more likely to enter out-of-home care than children of the host country's population (3,9,17–20). On average, immigrant families have more welfare risks than the host population. For example, in Finland child family poverty is significantly more common in families with a migrant background than the host population (21) . Children with a refugee background also experience more stressful events in their new home country, for example, bullying and anxiety at school, than average during their lives (22,23). Acculturation stress that families face in adjusting to their new home country has been recognized as a risk factor for family-related violence in refugee families, especially in relatively new immigrants (24,25). It has been suggested that getting settled into a new environment and learning about Western child-rearing practices and laws may in time decrease physical discipline practices (24). In a cohort study, parental trauma history and PTSD were associated with

harsh parenting styles (26). In order for refugee children to recover from their pre-migration negative experiences and avoid the negative effects of transgenerational trauma as well as additional post-migration traumatization, it is important to make treatment of traumatized children and their families early and easily available upon arrival in the host country (27). The host country needs to use a trauma-informed and culturally sensitive approach to provide social and health services to immigrant children and young people (7).

The current article was born in cooperation between two projects: "Co-research and co-creation of child welfare social work and adolescent psychiatry" (LANUPS) and "Child protection expertise in social work with immigrant children and families (LAMPE). In the LANUPS project, the focus was on young people who needed both mental health services and child protective services, whereas in the LAMPE project, the focus was on social work with immigrant children and families. Therefore, we were interested in previous research on migrant children and youth and their mental health challenges and child protective service needs.

In this scoping review, we aim to present research results concerning the mental health and child protection services need and use of children and youth who have migrated to another country or were born to a migrated family. Due to the limited availability of prevalence studies on the topic, we included review articles and editorials in which the topic was covered. Since the included studies mainly focus on mental health perspectives and the child protection service aspects are very limited, the main emphasis in this review is on the mental health services of children, and child protection issues are more as a context to the analysis (21,22).

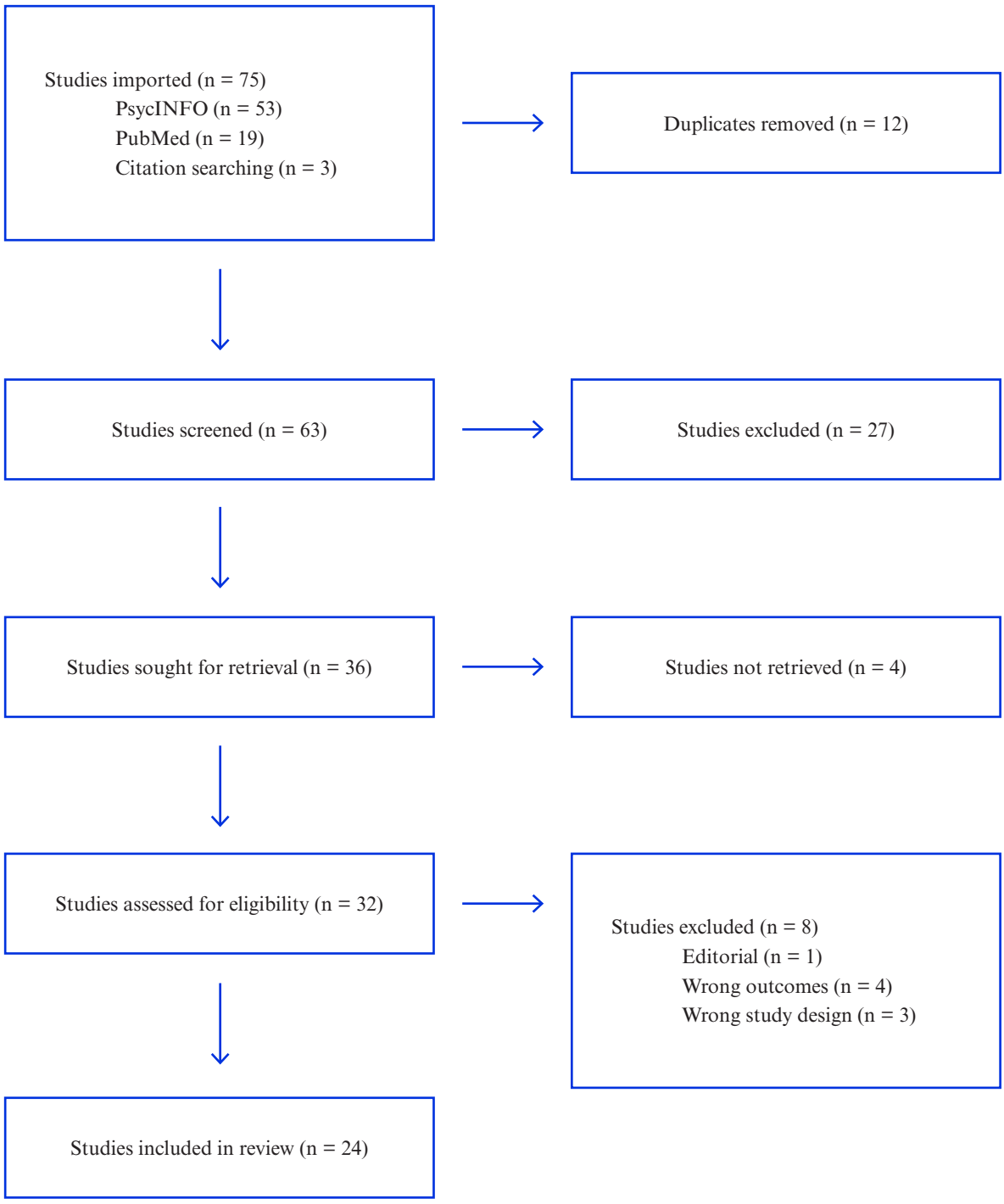
Focusing on migrant and refugee children and comparing this diverse group to the host population causes methodological, and also ethical, issues for the study. The review concerns both first- and second-generation immigrants, refugees, and asylum-seeking children and youth. Migrants/immigrants as a group is very heterogeneous, and the services and service systems that support them vary according to the host country and society. Comparative research settings and results may strengthen stereotypes and prejudices if the interpretations do not consider ethical aspects. We are aware of these concerns and aim to apply ethically sensitive ways of interpreting and writing the results (3,9,28). Reviewing research internationally can produce knowledge for developing services in the Finnish context.

METHODS

The aim of the current review is to present research results concerning the mental health and child protection services use of children and youth who have migrated to another country or were born to a migrated family. In March 2023, we searched the electronic databases PsychINFO and PubMed for peer-reviewed journal articles written in English using the following search terms: (refugee* OR "asylum seeker*" OR displace* OR migrant* OR immigrant* OR "asylum-seek*" OR "displaced child*" OR "resettlement country") AND ("mental health" OR "mental illness" OR "mental disorder" OR psychiatric) AND ("foster care" OR "out of home care" OR "foster group care" OR "adopted child*" OR "child protective services"). The search was conducted within the titles and abstracts in each database. Additional filters were used to limit the results by age: in PsycINFO 0-29 years (childhood, adolescence, young adulthood), and in PubMed 0-24 years (childbirth to 18 years, and young adult 19-24 years).

Seventy-two studies were found in the databases and imported to the Covidence program. 12 duplicates were removed. Additionally, references to the articles were searched, and in this way three additional articles were added to the screening. All entries were screened by two researchers and conflicts were discussed before making a final decision. After screening 63 abstracts, 27 studies were found irrelevant, and 36 full-text studies were assessed for eligibility. Finally, 24 studies were included in the review (*Figure 1*).

Figure 1. PRISMA flow chart of the review process



RESULTS

Twenty-four full-text articles were included in this review. These included sixteen original research articles, seven reviews and one column. The oldest of the articles were two original research articles from 2004 and the newest two reviews from 2022. Most of the studies were conducted in the USA and UK and the target groups varied in the different studies. The studies in this review focus mainly on migrants/immigrants or refugees, but research concerning asylum-seeking children is also included. The full list of articles included, with their main contribution to our research question are listed in *Table 1*.

Table 1. The articles included, with their main contribution to the research questions

1st author	Year	Type of article	Country	Context, participants' age.	Results of the research questions.
Bronstein	2012	Original research. Cross-sectional	UK	PTSD in asylum-seeking Afghan children (N=222, male, age 13–18 years, separated from parents).	1/3 had PTSD. Cumulative trauma predicted PTSD. Semi-independent or independent accommodation is associated with higher level of symptoms than foster care.
Dettlaff	2010	Original research. Cross-sectional (with a retrospective component)	USA	Latino children of immigrant parents (N=430, age 2–14 years) vs native parents in U.S. based on NSCAW survey. Analyses were based solely on children living with biological parents at the time of the baseline interview.	Latino preschool-aged children of immigrant parents have more mental health service needs (based on Child Behavior Checklist) than children of U.S.-born Latinos. Latino children of immigrants have more mental health services (based on data gathered from caregivers) and less unmet mental health needs (estimated by the percentage of youth who demonstrated a clinical need for mental health services but had not received any during last year) than children of U.S.-born Latinos.
Finno-Velasquez	2016	Original research. Prospective	USA	Mental health and service use of Latino children who remained in home after child maltreatment investigation (N=390, age birth–17.5 years, mean 8.48 years). NSCAW II survey.	Compared to children whose parents were U.S. citizens, children of undocumented immigrant parents received less mental health services. There were no significant differences between the groups in mental health service needs.

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1st author	Year	Type of article	Country	Context, participants' age.	Results of the research questions.
Geltman	2008	Original research. Descriptive survey	USA	Effectiveness of mental health counselling and health services on functional health outcomes among Sudanese refugee minors in USA foster care (N=304, 84% of the sample were male, mean age 17.6 years).	45% of minors received counselling. Counselling was not associated with health outcomes. The majority of participants, especially those with PTSD, sought medical care for symptoms associated with emotional or behavioural problems.
Grumi	2017	Original research	Italy	Comparison of social records of Italian (N=153) and immigrant families (N=175) referred to CPS for child maltreatment. The study concerned 328 minors (48.8% male, mean age 8.41 years, range 0-17).	In prevalence of child maltreatment there were no differences in Italian and migrant families. Immigrants approved violence and punishments and suffered from low SES. In Italian families were more distal and proximal risk factors.
Horn	2017	Original research, register-based	USA	Experiences of Somali and Oromo youth who attended public school between 2008–2011 (early childhood education to grade 12) and were involved in Minnesota's child protection system (CPS) between 2000 and 2013. (N=691, 53.4% male).	Somali and Oromo youth were involved in CPS at low rates (3.7%). Caregivers whose children were in CPS need social support and mental health/coping support and parenting skills. According to CPS workers Somali and Oromo youth and their caregivers had significant mental health needs. For out-of-home placements relative foster care was used infrequently, whereas they were often placed into restrictive forms of out-of-home placement.
Huemer	2016	Observational	Austria	A retrospective analysis (2001-2007) of clientele in a clinic offering short-term trauma therapy. (N=2510, age range 1-17 years, 50% male).	In the first years only about 10% of the clientele were immigrants, whereas in 2007 20% of the patients were immigrants and children of immigrants.

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1st author	Year	Type of article	Country	Context, participants' age.	Results of the research questions.
Leavey	2004	Original research. Cross-sectional	UK	Strengths and Difficulties Questionnaire scores' association with sociodemographic variables including language preference in a London school. (N=329, age mean 13.2 years, 59.9% male).	Migrant and refugee children had higher level of psychological distress on the Strengths and Difficulties Questionnaire than their non-migrant peers. Young migrant boys had more emotional difficulties than their UK-born peers, but fewer conduct and hyperactivity problems.
Luster	2010	Original research. Qualitative	USA	Factors supporting or hindering positive adaptation over the long term (seven years) after resettlement in USA. Interviews with Sudanese URM (N=19, mean age 22 years, 17 of 19 male) and their foster parents (N=15 foster families).	Foster parents and youth agreed on education and work as key indicators of success. For youth it was important to help those left behind, whereas foster parents saw this obligation sometimes problematic. Foster parents talked more than youth about mental health problems as risk factors for successful adaptation.
Pedrini	2015	Original research. Observational study	Italy	Analysis of access patterns and care pathways at first-time contact at child and adolescent mental health services (N=399, mean age 10.5, 56.9% male).	Compared to Italian children, children of immigrant families were more often referred to children and adolescent mental health services by teachers rather than parents. Causes may be related to language or social inclusion issues.
Rajendran	2010	Original research. Observational study	USA	Analysis of family service use by immigrant families in the U.S. child welfare system. (N=312, families, age of children 2–15 years, 44% male). NASCAW survey.	Child-related factors for greater use of family support services were higher levels of internalizing and externalizing problems, as well as experiences of neglect. Caregiver-related factors included mental health problems, history of arrests and prior reports of maltreatment. Caseworker-related factors were training on cultural issues, and perception of organization's problems.

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1st author	Year	Type of article	Country	Context, participants' age.	Results of the research questions.
Rousseau	2013	Original research. Case study	Canada	Through three cases (a young boy, a 6-year-old boy, a 7-year-old girl), the collaborative care model in mental health is described and analysed. Emphases on trauma awareness.	Helping refugee children whose families have experienced trauma requires a combination of cultural knowledge and trauma therapy. Primary care institutions that are very close to the family living environment may be appropriate to help establish a support network.
Sirriyeh	2018	Original research	UK and Ireland	The role of foster care in helping unaccompanied asylum-seeking young people's transitions to adulthood (N=23 foster carers and N=21 URM from England, age range 13-18 years, all male; N=16 foster carers and N=21 URM from Ireland, average age 15.8 years, 13 of them male).	After leaving foster care the impact of the care and the relationships with foster parents will endure. Providing foster carers training in emotional, legal and social recognition (Honneth's theory of recognition) will help build self-confidence, self-respect and self-esteem in URM as they transition into adulthood.
Tan	2016	Original research	USA	Incidence of emotional and behavioural disorders in immigrant children. The study included 1.5 generation immigrants (N=1378, mean age 11.2 years), 2nd generation immigrants (N=4194, mean age 8.4), foreign adoptees (N=270, mean age 10.7) and non-immigrants (N=54877, mean age 9.5).	Odds for having ADD/ADHD, conduct disorder, anxiety or depression were the lowest for 1.5 generation immigrant children, followed by 2nd generation and the highest in non-immigrant children. Connection to heritage culture may explain the lower rates of mental disorders in recent immigrants.
Thomas	2004	Original research. Qualitative	UK	Pre-flight experiences of unaccompanied asylum-seeking children (UASC) (N=100, 59% male, mean age 15).	UASC have different traumatic experiences and there is a need for culturally appropriate research methods to identify their health and social needs after arrival and to develop and improve the services.
Tordön	2019	Original research. Cross-sectional questionnaire	Sweden	Highschool students in out-of-home care (OOHC) were compared to students not in OOHC (N=5839 students, mean age 17.97, 44.6% male).	Being an immigrant and having parents born abroad was more common in OOCH group than in non-OOHC group.

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1st author	Year	Type of article	Country	Context, participants' age.	Results of the research questions.
Abraham	2019	Review	USA	Review of epidemiology, risk and protective factors associated with youth suicide, and global strategies to address it.	Refugee, immigrant, and indigenous youth as well as those in foster care or homeless are more vulnerable and at increased risk for youth suicide.
Fledderjohann	2021	Review	UK	Review included original research articles, based on UK data that focused on mental health in children and young people.	Compared to UK-born peers, migrant children and young people, especially younger boys scored lower for conduct problems and higher for emotional and peer problems. In 14-16-year-olds conduct problems were more prevalent than in UK-born peers. In immigrant detention centres extremely high levels of depression and anxiety. Inconsistent findings regarding ADHD.
Gao	2022	Systematic review and meta-analysis	China	The relationship between migration status and risk of autism spectrum disorder (ASD) and attention-deficit-hyperactivity disorder (ADHD).	Migration was associated with increased risk for ASD. No association was found between migration and ADHD or hyperactivity.
Hornfeck	2022	Scoping review	Germany	Effects of asylum process on mental health.	Refusal of asylum had a negative effect on the wellbeing due to instability and fear of return. Rather than asylum process or status per se, the instability and uncertainty affect the wellbeing of young refugees. Maternal migration was a risk factor of ASD, and it was likely for migrant children to have ASD comorbid with intellectual disability.
Mitra	2019	Systematic review	UK	Prevention of psychological distress and promotion of resilience amongst Unaccompanied Refugee Minors in resettlement countries.	URMs are less likely than accompanied immigrant children to receive mental health services. CBT was found beneficial to PTSD. Those living in foster care had lower depression and PTSD symptoms than those in independent care arrangements. Living reception settings that restricted freedom was connected to more anxiety.

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1st author	Year	Type of article	Country	Context, participants' age.	Results of the research questions.
O'Higgins	2018	Systematic review and meta-analysis	UK	Impact of placement type on educational and health outcomes in unaccompanied refugee minors.	Eight studies focused on accommodation type and mental health outcomes. Results suggested that foster care and placements that are culturally sensitive are associated with better mental health outcomes.
Seeman	2020	Review	Canada	Comparison of psychosis risk in immigrants and adoptees.	The risks of mental health in immigrants and adoptees are similar. Being exposed to one's ethnic and age peers who share a similar background may protect against the incidence of psychosis in immigrants and adoptees.
Murray	2018	Column	USA	Description of the effects of toxic stress in child refugees.	Prevention of toxic stress in child refugees should be the main goal of healthcare services in the receiving country. Efforts should be made to address caregiver stress and improve their ability to provide safe, reliable and nurturing care.

Abbreviations: ADD – attention deficit disorder; ADHD – attention-deficit hyperactivity disorder; ASD – autism spectrum disorder; CPS – child protective services; NSCAW – National Survey of Child and Adolescent Well-being; OOCH – out of home care; PTSD – post-traumatic stress disorder; URM – Unaccompanied refugee minors

MENTAL HEALTH PROBLEMS OF MIGRANT AND REFUGEE CHILDREN AND ADOLESCENTS COMPARED TO THEIR HOST COUNTRY-BORN PEERS

There are contrasting results regarding the mental health needs of migrants compared to their non-migrant peers. In the articles included in this scoping review, there were several studies and reviews emphasizing the increased mental health issues in refugee and migrant children and adolescents. In a UK sample of asylum-seeking minors from Afghanistan, over a third of study participants had post-traumatic stress disorder (PTSD), and cumulative trauma was associated with higher PTSD scores (29). In the first school-based study to compare the emotional and behavioural problems of migrant and refugee children with those of their UK-born peers, Leavey et al. (2004) found that migrant boys and younger migrant children exhibited significantly higher levels of emotional symptoms than their UK-born counterparts (30). In an American study, preschool-aged Latino children of immigrant parents were found twice as likely to score in the clinical range of the child behaviour checklist than Latino children of U.S.-born parents (31). A review article focusing on the relationship between migration status and the risk of autism spectrum disorder (ASD) and attention-deficit hyperactivity disorder (ADHD) found that maternal migration is a risk factor for ASD, and migrant ASD children are more likely to have a comorbid intellectual disability. The role of migration on ADHD remains controversial, more studies are needed to assess the association between migration status and ADHD (32). Seeman (2020) analysed the reasons why immigrant status can be associated with an increased risk of psychosis: experiencing trauma, difficulties in assimilating into the new family or country and identity questions. Abraham and Sher (2019) recognized, in their review article concerning the epidemiology of risk and protective factors of youth suicide, immigrants and refugees as a vulnerable group who are at a higher risk of suicide. Furthermore, living

in foster care or homelessness increased the risk of youth suicide, indicating an even higher risk for immigrant or refugee youths who are separated from their parents (34). Survivor guilt was apparent in the record of several suicide attempts of one Sudanese unaccompanied refugee minor, who was traumatized by experiences on his way from Sudan to the U.S. (35).

On the other hand, in some respects, immigrant children seemed to cope better than non-immigrants or equally well. Tan (2016) compared four different groups of children: non-immigrant children, foreign adoptees (whose adoptive parents were U.S.-born Americans), 1.5 generation immigrant children (children who have migrated with their parents) and 2nd generation immigrant children. They found that the prevalence of ADD/ADHD, conduct disorder, anxiety and depression was the highest in foreign adoptees, followed by non-immigrant children. Both 1.5 and 2nd generation children had a low prevalence of the four mental disorders. Additionally, Leavey and colleagues found that migrant and refugee children had higher pro-social behaviour scores and fewer conduct and hyperactivity problems, and they were less likely to use alcohol than their UK-born peers (30). Finally, among U.S. child welfare clients there were no differences in mental health between children of Latino immigrants and children of U.S.-born parents (31,36).

CONSIDERING EFFECTS OF TRAUMA ON MIGRANT OR REFUGEE CHILDREN'S WELLBEING

Refugees often experience significant traumatic events, that may happen not only before leaving the country of origin but also during the migration process and after that. Among the reasons why unaccompanied asylum-seeking children have fled their country of origin are: the death of parents, the disappearance or imprisonment of family members; persecution on the grounds of ethnicity, religion or sexuality; forced recruitment into rebel factions, and armed conflict (37). In his column, Murray (2018) warns against the toxic stress caused by accumulating adverse childhood experiences that child refugees face. Toxic stress is defined as exposure to extreme, frequent and persistent adverse events without the presence of a supportive caretaker (39). Toxic stress results in biological alterations, which affects the nervous, endocrine and immune systems, and can extend well into adulthood (38).

Sometimes, refugee minors are not willing or able to verbalize their traumatic experiences and seek help for mental reasons. In these circumstances, the symptoms may present in different ways. Geltman and colleagues (2008) found that among Sudanese minors, who arrived in the U.S. unaccompanied, there were high levels of help-seeking for health problems and symptoms that may be consistent with somatization, especially among those with PTSD (40). Foster parents of the so-called 'lost boys of Sudan', unaccompanied minors who resettled in the USA, on average prior to their 18th birthday, described in interviews the effects of trauma and adversity being the reason for excessive alcohol consumption among those 'lost boys' who did not to succeed in adapting to American culture (35). Seeking help because of somatization problems from general healthcare providers was associated with worse functional and behavioural health (40).

Huemer and colleagues (2016) analysed the clientele and service utilization of the low-threshold, short-term trauma therapy clinic "The Buoy" in Austria during the first six years (2001-2007) of the clinic's existence. They noticed that compared to locals, it took longer for the immigrant children and young people to find their way to the clinic. During the first years only around 10% of all patients were immigrants, the utilization rates of immigrants rose throughout the observation period to 20% in 2007. There is a paucity of information about specific barriers that prevent service utilization by immigrants. According to Rousseau (2013), it is important to understand cultural factors and incorporate trauma therapy methods when working with refugee children and families – a comprehensive approach that considers individual, familial and social aspects is required for effective treatment and support. Notably, Bronstein and colleagues (2012) noticed that those unaccompanied asylum-seeking children placed in foster care rather than in independent or semi-independent accommodation had lower levels of PTSD.

DIFFERENCES IN CHILD PROTECTION SERVICE UTILIZATION BETWEEN REFUGEES OR MIGRANTS AND THEIR NON-MIGRANT PEERS

In addition to differences in mental health and healthcare needs between migrant and non-migrant children and youth, migrant families also have different patterns of utilizing child protection services due to cultural and socioeconomic differences. Dettlaff and Cardoso (2010) and Dettlaff et al. (2009) pointed out that there are significant differences in the risk factors and type of maltreatment experienced by Latino children of immigrants when compared to children of U.S.-born parents. Grumi et al. (2017) compared the Italian and immigrant families' records

of child protective services (CPS) from 2004–2016. They found that two different patterns of factors characterize Italian and foreign cases: immigrant families seem to suffer more from low socioeconomic status and have more positive attitudes concerning corporal punishment, whereas Italian families have more distal (experience of neglect or violence in parent childhood) and proximal (parent psychopathology, problematic relationship with family of origin) risk factors. There were no differences in typologies of maltreatment between Italian and immigrant families. The most relevant factor that affected the CPS workers' placement decisions for both Italian and immigrant parents was "lack of knowledge or interest relating to child development". This factor increased the odds of child removal from immigrant parents by 205% and from Italian parents by 2931%.

OBSTACLES IN PROVIDING ADEQUATE SERVICES TO MIGRANTS AND REFUGEES

In the National Survey of Child and Adolescent Well-Being (NSCAW) study, a surprising difference was found relating to the mental health service utilization by children of Latino immigrants compared to children of U.S.-born Latinos. The children of immigrants had higher mental health needs (indicated by the scores of the Child Behavior Checklist) and they were also more likely to receive mental health services and, therefore, less likely to have unmet mental health needs compared to children of U.S.-born Latinos (31). This difference could be attributed to immigrants' children being exposed to the social service system, or a result of U.S.-born Latinos having previous negative experiences with the mental health system due to a lack of culturally competent service providers (31). In another U.S. study, immigrant families of Black non-Hispanic children and families with Hispanic children used fewer services compared to immigrant families of White non-Hispanic children (42). These findings underline the lower rates of service access by minorities. In Italy, immigrant children are most often referred by teachers for first-time consultations at child and adolescent mental health services, which may be partly caused by language-related difficulties, social inclusion issues, or that parents belonging to minority ethnic groups have limited information about the function of mental health services (43).

Importantly for the case of the 'lost boys' of Sudan, the reported receipt of mental health counselling had neither a positive nor negative association with health outcomes (40). However, refugees and asylum seekers may be particularly anxious about personal information affecting their legal status, leading to a lack of trust in mental health providers (34). Even if children of immigrants are citizens themselves, parental immigration status can serve as a barrier to accessing services (31). Finno-Velasquez and colleagues (2016) used the data of the NSCAW II study to compare the mental health service needs and utilization in child protection clients based on their parent's immigration status. In their study, a gap between overall clinical need and service receipt was identified only for children with undocumented parents.

One consideration when creating or improving systems to help immigrants adjust to their new country is sensitivity to cultural differences regarding beliefs about mental disorders and respective mental health services. Whilst unaccompanied minors from Sudan appreciated the advice and support they received from their foster parents or caseworkers, they were unwilling to engage in counselling. They believed people who get counselling to be "crazy, mental" (35). Rajendran and Chemtob (2010) found that cultural issues and concerns with bureaucracy may influence the utilization of social services by immigrant families. Caseworkers who receive training in cultural issues are more likely to support and address the unique needs of immigrants, leading to increased service use. However, concerns with bureaucracy and rigid adherence to rules and regulations may pose barriers for immigrants in accessing and navigating social services effectively. Furthermore, healthcare practitioners should consider screening and providing extra resources for migrant children (32).

DISCUSSION

The chief result of our scoping review is that migrant children and young people are a heterogeneous group and that there are conflicting results regarding their mental health status and needs. Articles included in this review identified several barriers that hinder optimal mental health and child protection services provision for refugees, asylum-seekers and other immigrants. The need for culturally competent service providers and trauma-aware services has been emphasized.

The initial research question for this review rose from our work with children and adolescents who need both child protective services and mental health services at the same

time. Therefore, we searched for articles that mentioned both mental health and child protective services in migrant children and youth. There were only a few articles that focused on both of our topics of interest simultaneously. In the majority of articles the focus was on mental health and in only a few also on child protection. Therefore, in the current review we have the child protection aspect mainly as a context to mental health issues.

COMPARISON WITH PREVIOUS LITERATURE

The "immigrant paradox" has mostly been described in the physical health of first-generation immigrants who initially have health advantages over their local counterparts, but the more immigrants get assimilated into the social and cultural norms, the more their health status resembles the locals' (44,45). Even though the same effect has been less prevalent in the studies of migrants' mental health, it has been suggested that it may partially explain the conflicting results concerning the mental health issues in immigrants and non-immigrants and why foreign-born immigrant children often outperform their non-immigrant counterparts on a variety of outcome measures (10). According to the "immigrant paradox" phenomenon, recently arrived immigrants do better in mental health outcomes than their non-immigrant peers in the host country (46). These advantages typically dissipate after living in the host country for several years (47) and in future generations (10). The explanation for the "immigrant paradox" remains unclear. A possible reason why immigrant children, according to some studies, do seemingly better than their non-immigrant peers may be cultural or caused by the family's pre-, peri- and post-migration experiences. According to Leavey and colleagues (2004), psychological distress in migrant and refugee children might be experienced by the child internally as emotional difficulties that they are unable to process or resolve through outward displays of anger and aggression. Tan (2016) suggests that the likely cause of foreign-born and U.S.-born immigrant children's better adjustment compared with the foreign adoptees lies in the congruency between a child's genetic predisposition and the US culture. Having a family who provides a connection to their heritage culture serves as a protective mechanism against emotional and behavioural problems (10).

Another thing that stood out from our selection of articles, compared to previous literature regarding migrant mental health, is that only one study in our search results mentioned increased risk of psychosis (48). Risk of non-affective psychosis in refugees and migrants has been studied extensively, and noted consistently throughout different studies (49–51). A meta-analysis combining data of nine studies from Scandinavia and Canada concluded that the risk of the manifestation of schizophrenia and associated non-affective psychoses is statistically significantly increased in refugees compared with the native population as well as compared with non-refugee migrants (52). A Dutch study comparing prevalence of psychotic experiences in majority and minority general population adolescents found that prevalence of psychotic experiences was associated with perceived personal discrimination, and a weak ethnic identity (marginalization and assimilation) (53).

THE BARRIERS FOR UTILIZING MENTAL HEALTH AND CHILD PROTECTIVE SERVICES

The barriers to mental health and child protective services utilization could be described from three different perspectives. Firstly, barriers related to migrant children and their families. An important consideration is the cultural differences in the attitudes toward having psychiatric symptoms that may pertain to migrants. For many, it may be considered too humiliating to admit or not acknowledged as a problem at all. A qualitative study brought out that a concern of stigma related to the child's "madness" inhibited British Asian parents from seeking help from mental health professionals (54). Bradby and colleagues (2007) described three ways in which Asian parents were resisting the "stigma of madness": 1) whenever possible parents prefer to frame their child's problems as a behaviour (naughty, immature), not an illness; 2) if the mental illness was serious, persistent or was obvious, parents tried to minimize gossip by insisting that it is a particular and limited deficit or that their child had problems previously, but had been cured now; 3) the most extreme strategy adopted by migrant parents in order to avoid gossip was to remain beyond the reach of service provision. On the other hand, Luster et al. (2010) conducted in-depth interviews with Sudanese unaccompanied asylum-seeking minors and their foster parents. They noticed that foster parents often saw mental health problems (psychosomatic symptoms, fits of rage, substance abuse or psychosis) as a significant problem in adaptation, whereas migrant youth

had a different view, seldom mentioning mental health problems, and not readily accepting counselling. It is also possible that migrant parents and youth experience ´othering´ in many encounters in the new host society, and as a consequence they want to emphasize their ordinariness and respectability instead of revealing possible difficulties and the need for health and social services (55,56).

Secondly, barriers to mental health services utilization may be related to service providers. The host country may lack culturally sensitive and knowledgeable specialists to treat and support migrant children and youth. For example, culturally sensitive trauma therapy and trauma-informed social work is of utmost importance in creating social and health services for immigrants (7). Thus, if caseworkers and foster parents were provided with an opportunity for higher education in counselling and mental health help, it could be easier to provide some support to those immigrants who are hesitant in accepting help for fear of stigmatization. There may also be a lack of culturally or linguistically appropriate resources to help migrant communities (57). As noted by Dettlaff and Cardoso, (2010),2nd generation immigrants may have lower levels of help-seeking because they have prior negative experiences with the mental health system where culturally competent service providers are lacking. The inability to communicate in the local language is a major barrier to accessing and remaining in healthcare, including mental healthcare (45,58,59). Also, the Finnish research on the health and welfare of adult immigrants (60) emphasizes the importance of improving the mental healthcare services for immigrants, because the use of services is significantly low in comparison to the need of those services. Severe depression and anxiety symptoms of studied immigrants were as common as in the host population, but the use of mental health services was a lot lower. Finnish studies also indicate that the early intervention services do not meet the needs of immigrant families and children, since out-of-home care placements more often concern children with an immigrant background than children with Finnish origin (3,9).

Finally, there may be structural barriers to mental health services utilization. Structural inequalities, such as poverty, unemployment, discrimination and experiences of temporality and everyday insecurity, which may lead to societal marginalization, concern immigrant families more than the host population (61). Service systems and practices which do not take into account multilingual and culturally diverse populations can also build structural barriers hindering access to services (1). Lack of a supportive network is more common in immigrant families than in majority population (41). Resettling organizations and community-based resources have been found to be an effective way of buffering toxic stress in child refugees (38). As was proposed in the review article by Abraham and Sher (2019), providing more social support for refugee youth, as well as promoting the socioeconomic wellbeing of immigrants and refugees may be effective in improving mental health in these groups.

CONCLUSIONS

Our article presents a rather small number of studies on a variety of topics, and therefore the conclusions are suggestive, and the recommendations remain very general. However, our scoping review is in agreement with other authors – differences in mental health issues and mental health and child protection services needs and use comparing migrant and non-migrant children and adolescents in a particular country is a topic that needs more research. Additionally, research is needed to determine if parents of different immigration status (recent immigrants vs non-immigrants) might have different concepts of mental health problems in children (10), or to what extent do the attitudes change when a family lives in their new country for a longer period of time. Longitudinal studies are required in addressing unaccompanied refugee minors and examining how they develop and change from the beginning of placements, through the leaving care stage and into adulthood (62). Furthermore, research is needed to investigate how parents of children with different backgrounds (foreign adoptees, non-immigrant, immigrant, refugees and asylum seekers) perceive mental health and other welfare issues and their help-seeking behaviours on behalf of their children (10). Research on child welfare and especially child protection services concerning migrants is very limited according to our literature search, and needs more focus in the future.

The current research emphasizes the importance of building culturally appropriate support for those immigrants experiencing mental health problems. To avoid or mitigate toxic stress in child refugees, early intervention is essential to improve the child's environment and help children build resilience and provide care based on the most recent evidence.

Further research is needed particularly in the context of the Finnish society and service system to explore and understand the specific cultural obstacles faced by immigrants and to develop strategies that mitigate bureaucratic challenges,

thereby promoting better service provision and utilization among diverse immigrant populations.

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