

## School-Based Prevention Programs for Refugee Children

Cécile Rousseau, MD, MSc\*, Jaswant Guzder, MD

*Department of Psychiatry, McGill University, 7085 Hutchison,  
Room 204.2, Montreal, Quebec, Canada H3N 1Y9*

Global migratory phenomena are shaping the experiences of families fleeing war, dictatorships, or poverty and insecurity linked to social turmoil. Although survival and the absence of meaningful prospects for the future, for oneself or one's family, still are very powerful incentives for migration, the chances of obtaining asylum have declined progressively as international migration control policies have become a burning issue in Western countries. In this context, the number of accepted refugees and asylum seekers has been falling, and that of undocumented immigrants and those who have an uncertain, precarious status has been rising. Simultaneously, immigration to North America has shifted from a majority of European immigrants to a majority of immigrants from developing countries, including large numbers of families fleeing direct persecution or social insecurity in their country of origin, thus blurring the classical distinction between immigrant and refugee [1]. As a result, many immigrant and refugee children share a common direct or family experience of organized violence in their homeland and a context of poverty combined with a precarious social environment in the host country [2–4]. Despite this high exposure to adversity, immigrant and refugee families persistently underutilize mental health services [5,6]. Therefore schools play a key role, both as mediators in helping children and youths adapt to their host country and as the main access point to prevention and treatment services for mental health problems.

Even if the theoretic importance of schools is well recognized, educational institutions, like other host-country institutions, often unwittingly replicate minority–majority tensions and become places where exclusion and discrimination are experienced at different levels by immigrant and refugee children [7,8]. For children who have identified difficulties, cultural

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\* Corresponding author.

*E-mail address:* [cecile.rousseau@mcgill.ca](mailto:cecile.rousseau@mcgill.ca) (C. Rousseau).

misunderstandings about mental health or educational issues may produce problems regarding diagnosis and the appropriateness of the treatment and remedial measures proposed [9]. For example, mental health intervention may accelerate marginalization by labeling adjustment problems stemming from migratory difficulties or resistance strategies adopted by adolescents to respond to social inequalities as behavioral disorders [10,11].

In countries hosting a large number of immigrant and refugee children, schools are the institutions best positioned to implement prevention and treatment programs [12,13]. Tolfree [14] suggests a number of ways in which schools can meet the psychosocial needs of children affected by war or displacement, especially through programs that provide them with avenues for emotional expression, personal support, and opportunities to enhance their understanding of their past experiences. Setting up a classroom program to prevent psychological distress in newly arrived immigrant and refugee children presents several challenges, however. First, the population is heterogeneous, both culturally and in terms of experiences in their homeland and during migration. Furthermore, the gap between school and family is wide, and a program devised by host-country therapists or educators easily could become just one more disparate element in the children's two separate worlds [15]. Last, despite many small-scale innovative projects, little is known, either in theory or in practice, about the types of activity that may work best for children from different cultural backgrounds [16]. In spite of these difficulties, numerous school programs, often based on ecologic principles, have been developed to prevent emotional and behavioral problems and to foster the ability of adolescent refugees to adapt to their new lives [14].

This article reviews the school programs developed to improve the mental health of refugee children, available through initiatives or activities integrated into the curriculum or for specific groups identified as being at risk or through mental health services located within the school. These programs address a wide range of issues but focus on overall adaptation and well-being and place special emphasis on the psychologic consequences of trauma or loss.

First, the authors briefly review the role of school-based prevention programs in the area of youth mental health and define prevention for refugee children. Second, they present programs that seek to facilitate the overall adjustment of refugee children to the host country through a transformation of the school environment and curriculum and then look at programs that use a specific treatment modality (creative expression or spirituality) or that focus on a specific issue (intercommunity tensions). Third, they describe some of the secondary prevention programs that have been proposed to overcome the underutilization of services through the implementation of school-based mental health services. For each type of program, they review the existing literature produced by nongovernmental organizations or schools working in the field, briefly discuss the existing evaluations and

any related evidence, and illustrate the different categories of intervention by describing some representative programs.

### **Prevention programs for refugee children: between standard practice and cultural specificity**

In the field of refugee studies, posttraumatic stress disorder (PTSD) seems to be the most popular descriptor of refugee illness and distress [17]. As a result, programs addressing PTSD are the most common and are given top priority. Recently, however, longitudinal studies of outcomes and meta-analyses of risk and protection factors for refugees have emphasized the importance of postmigration social factors [18], suggesting that greater consideration of the social environment may be required within prevention and treatment programs and policies. In an analysis of European Union good practices in refugee health, Watters and Ingleby [19] stress the risk inherent in a victimizing perspective that portrays refugees as passive, helpless, and afflicted by psychopathology and insist on the need to co-construct services and programs with the refugees themselves to develop culturally appropriate interventions and to foster a sense of ownership and empowerment in refugee communities. These authors put the emphasis on school-based preventive activities for refugee youth, arguing that school-based prevention programs and activities should represent an alternative to current mental health practices. In a paper on prevention for refugee children, Williams [20] notes that prevention is difficult to define when speaking about refugee mental health because the notions of prevention and promotion have been borrowed from the public health field and cannot be transferred to directly mental health. In mental health, prevention may be used both in the context of diagnosable illnesses and to address the psychologic distress or interpersonal turmoil that may stem from adverse life experiences. Williams distinguishes among three types of prevention: primary, which is directed toward a group before significant maladjustment is experienced; secondary, which enables a person to regain his or her normal level of function and prevents further development of illness after its occurrence; and tertiary, which focuses on rehabilitation and on limiting the impairment associated with an illness.

At present, school-based prevention programs for refugee children are being developed at a time when evidence-based studies are guiding mainstream professional practices. In a review of the evidence supporting 322 evaluative studies of school programs, Green and colleagues [21] underscore the frequent lack of grounding in theory of the diverse interventions proposed and the absence of careful evaluation of many potentially interesting initiatives. In that review, culture and the migratory or refugee context are not mentioned. Increasingly, program designs must refer in some way to the practice parameters defining the reference standard in a particular field. The

American Association of Child and Adolescent Psychiatry (AACAP) PTSD practice parameters for children and adolescents [22] state that in trauma-related situations, the most commonly recommended interventions are focused on trauma and include some degree of direct discussion of it. Cognitive behavior therapy is at the forefront of evaluated techniques, as are some relaxation techniques. Some school-based grief- and trauma-focused psychotherapy methods are mentioned also, including the intervention performed and evaluated by Goenjian and colleagues [23] in Armenian schools after an earthquake. Similarly, in the AACAP practice parameters for psychiatric consultation in schools [24], although the main emphasis is on clinical consultation, school-based prevention programs that have been found to be effective for children presenting some symptoms without reaching full diagnostic criteria are recommended in the aftermath of traumatic exposure [25–27]. These recommendations include a very broad statement about the need to consider the local cultural and social characteristics in the school consultation process.

Within the practice parameters the understandable concern for rigor, replicability, and evidence may favor the development of preventive intervention programs for minority, refugee, and immigrant children that tend to replicate programs developed for mainstream North American children without giving sufficient consideration to refugee-specific characteristics. This practice, in turn, may compromise the validity of the intervention and the measurement instrument used to assess its efficacy [28]. In this context, one of the risks of standardization is that it leaves no room for the integration of community voices and knowledge or the development of alternatives to mainstream approaches [19,20]. On the other hand, because of the precariousness of refugee family situations and the wide heterogeneity of refugee children, many innovative initiatives rooted in school and refugee community experiences have not been evaluated in a way that facilitates transferability.

### **Programs that address the overall adaptation of refugee children to host-society schools**

A number of school programs try to avoid medicalizing the problems of refugee children and raising the potential stigma of being considered “at risk.” These programs are directed at broader aspects of the social experience of these children and their families rather than at discrete psychopathologic manifestations. These programs target three main areas: the adjustment of the school to the needs of refugee children through professional development, the improvement of the relationship between the school and the home, and the development of classroom or after-school programs intended for the children themselves.

Many programs have a teacher-training and teacher-support component, especially at the elementary level where children have a more direct, ongoing

relationship with a specific teacher. Although some teachers become passionate advocates of refugee children and may work outside their academic role to support refugee families, others are quite reluctant to take refugee-specific characteristics into consideration. This reluctance needs to be understood. On the one hand, teachers may fear being overwhelmed by the complexity of the situation and by their own limitations in trying to deal with it. On the other hand, contact with the refugee experience may force teachers to face the reality of human rights abuses in their immediate environment, a confrontation that may elicit anxiety and feelings of insecurity. Different methods have been proposed to support and train teachers. For example, in a London borough, refugee support teachers have a mandate to provide peer support, including supervision of classroom management and case discussion and also counseling for feelings of helplessness and anger aroused by empathy with the situation of refugee families in the host country [13]. Other schools emphasize cultural competency training for teachers or professional development courses that examine refugee mental health issues [29]. Although teacher training is a component of most initiatives, some qualitative evaluations of classroom programs note that the intervention per se often also constitutes an eye-opener for the teachers, who suddenly see their students and their families in another light [30].

The home-school relationship is another challenging area. The literature on family-school interactions focuses on the quality of the relationship over time and on the importance of reaching a shared understanding of situations [31,32]. From this perspective, the involvement of parents is conceptualized as an empowerment process through concrete practices [33]. This emphasis on empowerment is particularly appropriate because of the striking power imbalance between refugee families and host-country institutions. Beyond common obstacles of interpretation and translation caused by the language barrier, creating family-school links is a difficult task because of diverging perceptions about the role of the school and the participation of parents and about the definition of “normal” child development [34,35]. Quite often, North American schools promote autonomy as a key value, whereas immigrant and refugee families stress the importance of conforming to family or community norms [36]. Frequently, community organizations play a key role as mediators among students, their families, and the school, especially when feelings of distrust are present on all sides [37].

In the last few decades some very promising classroom programs have been developed specifically for refugee children in the Netherlands. The Pharos school-based prevention program is based on the premise that school has healing capacities because it provides children with personal attention and structure while encouraging their socialization with peers and with meaningful adults in the host society. In this capacity, school serves as a bridge to the new society and allows refugee children to project themselves into the future. One of the basic principles of the Pharos program is

that catering to children's problems and strengthening the support systems around them should occur simultaneously and can be implemented by teachers while performing their normal teaching duties [38].

The Pharos program provides activities in both elementary and high schools. For each developmental level, there is a training course for teachers supported by multimedia material, along with two series of classroom lessons focusing on the shared refugee experience and on recreating links at school and in the new social environment. Both elementary and high school programs rely on combined verbal and nonverbal techniques (eg, the creation of a personal book that brings together representations of family and home and representations of school through pictures, drawings, and stories). These activities cover a wide range of issues pertaining to the past and present (with a focus on daily life, school, and social relations). They also address identity issues, feelings of trust and safety, and developing a sense of agency.

The programs have been manualized and evaluated by youth and teachers in the Netherlands, although the results of the evaluation have not been published. Subsequently, the programs have been transferred to the United Kingdom and implemented in Kent and Manchester [19]. The transfer process highlighted the importance of contextual differences: in the United Kingdom, refugee children attend regular schools, whereas in the Netherlands they are segregated in special schools. In the United Kingdom, the prevailing multicultural model was no doubt a major factor in favor of involving refugee parents and the communities themselves in the running of the programs; in the Netherlands, the likelihood that most asylum-seeking families would to be deported at some point considerably limited their interest in learning Dutch and consequently their link to the schools. This small-scale transfer experiment shows that the sociopolitical context of the refugee-receiving country is a crucial consideration in shaping the prevention program and that more attention should be given to the localization and empowerment of programs than to content standardization.

### **Programs that use a specific treatment modality: artistic expression as a means of promoting child mental health**

Play and artistic expression are used commonly in therapeutic and educational settings. Improved self-esteem, expression of emotions, problem solving, and conflict resolution are the most frequently mentioned benefits of therapy methods based on creative expression [39,40]. Although creative expression frequently is used clinically and in groups of children at risk, few programs have undergone impact assessment. In the last 20 or 30 years, creative expression activities have come to be regarded as a good way of working with migrant children, helping them construct meaning and identity [41,42], and with refugee children or others who have experienced armed

conflict [43], allowing them to work through their losses, come to terms with trauma, and re-establish social ties broken by repression [15,39–43].

With a view to building on prior work documenting the usefulness of creative expression programs for immigrant and refugee children in clinical and community settings [15,43–46], a Montreal team made up of schools, community organizations, and health professionals developed a set of prevention programs for preschools, elementary schools, and high schools. The aim of the programs was to help recently arrived children and adolescents bridge the gaps between home and school and between past and present and to work through experiences of loss and trauma [44–48].

Designed for preschoolers, the sandplay program consists of 10 workshops, given every second week over a period of 4 months, which are integrated into the regular kindergarten school day. As the opening ritual for each session, the children sit in a circle to sing an action song. They then create their own worlds in sand trays. The class is divided into groups of four. In the sand trays, the children have the opportunity to play by themselves or with the other children in their group, using verbal and nonverbal expression. They can choose from a variety of traditional sandplay figurines: people, animals, vehicles, housing, food, religious figures, and so on. The results of an earlier pilot project had shown, however, that a relative lack of multicultural figurines limited the children's ability to create other-than-host-society scenes, so the authors added a number of culturally diverse spiritual symbols and everyday figurines: different types of housing, people in national costumes, flags of different countries, and houses of worship and deities of several religions. Sometimes a theme is suggested, which the children may explore if they wish. The themes suggested are related to the children's everyday lives: for example, family, siblings, transportation to school, language, seasons. After creating a world, the children are invited to share with their group the story of the scenes they have created, supported by an adult from the intervention team. The closing ritual is another action song led by the teacher [47].

The elementary creative workshop program is made up of three types of activities and always combines verbal and nonverbal means of expression (drawing or painting a picture and telling or writing a story); during the activities the children alternate between working on their own and going back to their groups to listen or to present their work. In the first activity, children illustrate and comment on myths, tales, or legends from nondominant cultures. These stories are used to represent the stress and tension but also the richness of a minority position, although the traditions to which they refer are not necessarily those of the participating children. The stories are chosen to evoke specific themes to do with migration or the transformation induced by traumatic experiences. Qualitative analysis of the children's productions showed that myths of the homeland provide a basic framework on which to build a representation of experience and emotions [48]. Myths facilitate the attribution of meaning to a personal or family experience of

trauma or migration [49]. They propose a narrative structure, a set of shared symbols and coping strategies, and a specific vision of time [50]. Having been handed down from generation to generation, they provide a reassuring structure, but they are malleable and flexible enough to be appropriated and adapted. Thus the workshop stories become adaptable metaphors that children can use to structure their own experiences. In the second activity, called "The Trip," the children are asked to draw and tell the story of a character of their choice who has been through a migration process. They are encouraged to tell or draw about the past (life in the homeland before migration), the trip itself, the arrival in the host country, and the future. In the last activity, the "Memory Patchwork," the children are asked to bring in myths and tales from their families and communities; these provide a more direct representation of the children's identities [51]. Children usually bring in one of three types of stories: traditional tales, historical accounts, or stories about family experiences. This activity reinforces the dialogue between children and their parents about positive aspects of their past and helps bridge the gap between home and school by symbolically introducing the family into the classroom.

Finally, the high school program is based on Boal's forum and Fox's playback theater. Playback theater is a type of improvisational theater that aims to achieve personal and social transformation through sharing a theater experience within a ritual space [52]. It places the marginalized and excluded in the position of subject, which can empower them to change themselves and their environment [53,54]. The drama program was developed in a multiethnic district in Montreal with a high proportion of recently arrived immigrants and refugees. The goal of the drama therapy program was to give young immigrants and refugees a chance to reappropriate and share group stories, to help them construct meaning and identity in their personal stories and establish a bridge between the past and the present. The workshop is part of the regular school day. The teachers are present and participate whenever they wish to, for example by commenting or contributing a personal story. The students take part in 12 weekly sessions. Within a safe and respectful atmosphere, a play director supports the storyteller by eliciting the story as it unfolds, while actors and musicians gather the information to play the story back to the teller and the group. The stories told can be transformed and replayed through alternative scenarios developed by the group of adolescents. The idea is to alter the situation to empower the storyteller and the others, by changing the meaning, building a relationship, or creating an opening or dialogue with others that was missing from the original story. This part of the workshop becomes a collective effort, focusing on co-creating a story or situation in which the adolescents look for alternatives to their first reactions and strategies. Supported by the intervention team, the young people use sound, movement, and a few words while relying mostly on images and working with metaphor to reflect the point of view and feelings of the teller.



Repeated qualitative evaluations identified four key elements indicative of the effects of the workshops: constructing a safe space, acknowledging and valuing multiplicity, establishing continuity, and transforming adversity [55]. A quantitative evaluation (experimental versus control) of the three programs (preschool, elementary, and high school) showed that all had a significant effect on child and youth mental health. At the elementary level they increased children's self-esteem and reduced their level of emotional and behavioral symptoms [30]. In high school they diminished impairment and improved school performance [56]. Finally, in preschool, the evaluation took place just after the tsunami, and results provided evidence that the creative workshops can have a beneficial effect on preschoolers who have experienced adversity either directly or through intergenerational transmission and also may provide some protection against a retriggering of trauma in such children when exposed to distressing events through the media, as occurred with the tsunami [48].

Despite follow-up requests from the schools, replication of these successful and innovative programs has been limited by the lack of resources needed to implement them in their current format. At present, teachers and specialized resources in schools, who always have been an essential part of the team, are being trained to reproduce the workshops without the on-site support of the external research team, thus reducing the cost of the programs and making it possible to implement them on a broader scale.

### **Programs inspired by tradition and spirituality**

Traumatic experiences often challenge the belief systems of individuals, families, and communities. Religious and spiritual belief can be either shattered or strengthened as people struggle to make sense of their experiences. Spirituality often occupies an important place in healing and may even intervene in the clinical realm, either through a quest for meaning or as an integral part of the reconstruction process [57]. For refugee children, religion and spirituality may provide tools to mourn the diverse losses they or their families have undergone and also may help them make sense of a world in which evil may be too present and in which parental figures may seem helpless to provide needed protection. Although no school-based prevention programs have focused directly on spirituality as a means of fostering resiliency, some community organizations provide interesting examples of how traditional rituals may play a preventive role [20].

Duncan and Kang (unpublished manuscript, 1985) describe a program targeting unaccompanied Cambodian minors resettled by Catholic community services in Tacoma, Washington. Theravada Buddhist ceremonies and rituals to honor the dead and consultation with Buddhist spiritual leaders were among the main components of the program designed to help these young people overcome the staggering losses they had suffered. Three

ceremonies were performed for each of the unaccompanied minors and their foster families during the first year of the resettlement. The qualitative evaluation suggested that the program promoted grief resolution, reduced sleep disturbance and spirit visits, and increased foster family bonding. Although it clearly is not the mandate of the school to enter into the religious realm, it may be worthwhile for schools to establish links with religious and spiritual leaders who support refugee communities. Such leaders may provide bridging and networking for more isolated families, who may express spiritual longing or the need to reconnect to a religious group.

### **Moral development programs: the challenge of the awareness of the other in a polarized global world**

The current international situation is characterized by mounting intercommunity tensions, a widespread culture of fear, and a striking reduction in opportunities for dialogue and willingness to debate [58,59]. The oversimplification of the representation of the “other” directly influences the way in which majority and minority children perceive themselves and their peers. Conflict-situation research suggests that children’s moral development and mental health are linked and underscores the temporary protective effect of a strong ideology portraying the collective self as good and the enemy as evil, although this position actually may fuel the conflict and hamper reconciliation [60]. Greater long-term resiliency may be associated with the capacity to perceive complexity, face moral dilemmas, and develop empathy and awareness of the other [61]. In multiethnic societies the latter position ultimately may be more protective because it can help children resolve the loyalty conflict between school and home.

Schools are at the forefront in the transmission of representations (stereotypical or not) of the “other.” In this capacity, they have been used less to promote conflict resolution than to increase partisanship and further aggravate conflicts by radicalizing children and recruiting them [62]. Although diverse conflict-resolution models have been proposed—antiracist pedagogy, peace education, conflict resolution approaches [63]—very few programs have addressed the ways in which these programs should be adapted in multiethnic societies that must integrate refugee and immigrant children.

During the Iraq war, a school-based preventive pilot project was developed to reduce anxiety and intergroup tensions in recent immigrant refugee children [64]. The project was structured to take advantage of the school’s key position as the meeting point between the world of the homeland and home and the world of the host country. Its principal aim was to create a space—a political forum—that would allow peaceful and respectful coexistence of these different worlds, without pushing for consensus or convergence.

Different activities were organized. Children were asked to bring in newspaper clippings or short summaries of television or radio programs that

interested them. Because not all children had access to newspapers, some newspapers were also provided by the school. To ensure representation of a range of viewpoints and identities, children were encouraged to bring in papers in different languages (mainly French, English, Urdu, and Hindi). Children worked in groups to decide which news stories or issues would be discussed. Decisions about a general topic or specific activity (drawing, writing a letter together) were taken collectively. The children usually wanted to vote and abided by the results of the votes.

In the forum, the children were able to go back and forth naturally between discussing highly charged issues and joking or chatting about lighter topics. In that sense, the forums provided the opportunity to identify with the traumatic experiences of other communities while simultaneously maintaining a distance from painful emotions when they became too much to bear. The forum also made room for the respectful coexistence of a multiplicity of voices: the children's voices and the collective voices of a number of communities represented in the newspapers or stories discussed. The children were able to express empathy both for the families of the American soldiers who have died in Iraq and for the Iraqi families suffering from the bombing. The children felt a sense of agency when they decided to write a collective letter of solidarity calling for an end to the war, which they published in the school newspaper.

The analysis of the forum process and of the content brought in it by the children suggests that school may be a pivotal place where thinking about moral complexity can be taught in a way that counteracts the oversimplification and graphic images often channeled by the media. Transforming representations of the other and recognizing otherness in oneself may pave the way to a more peaceful future among minority and majority groups in our societies.

### **School-based mental health services**

To address the underutilization of mental health services by immigrant children and certain minority groups, some initiatives aimed at providing clinical services through the school have been put forward. In this area, as in more adaptation-focused programs, the immigration context of the host country has a significant influence on what services are offered. A large number of Central American families fleeing war have taken refuge in the United States but have not been identified as refugees simply because they do not have this legal status. Some programs designed to respond generally to the needs of Latino children and families by improving the cultural sensitivity of the services they provide make a special effort to take into consideration the difficult migratory journey and premigratory trauma that many Central American families have experienced [65]. The AMIGO program, for instance, provides mental health services to 15 elementary schools in Montgomery County, Maryland. Its goals are to enhance students' personal,

social, and academic development; to improve family communication and reduce stress; and to facilitate the cultural adjustments of recent arrivals to the host country [65]. The program offers a wide array of mental health services: individual, group, and family therapy; in-home and crisis intervention; school consultation; interagency collaboration; and parent education/support. The emphasis is on building trust by catering to families' basic subsistence needs and facilitating access to services for those who cannot be reached by written material or telephone or who are unable to come to school.

AMIGO groups for children help them adjust to life in the United States, to cope with the grief and loss associated with premigratory adversity, to resolve language differences between home and school, and to promote multicultural appreciation. Although probably based on the subjective appraisal of parents, teachers, and the youths themselves, the program evaluation report states that AMIGO activities are perceived as bringing a significant improvement to the lives of the children and their families. A more in-depth qualitative and quantitative evaluation of the program would provide more objective support for these perceptions.

In California, a high level of exposure to violence was found in immigrant school children, with 49% of students reporting victimization in the previous year and 32% presenting with clinical levels of PTSD symptoms [4]. In response to these findings, the Los Angeles Unified School District developed a trauma-focused program called the Mental Health for Immigrant Program (MHIP). Although the MHIP was offered to a multiethnic group, most participants were Latino [25]. The intervention consisted of eight group sessions of cognitive behavioral therapy, and four 2-hour optional multifamily group sessions for parents, which included support for common experiences of loss and separation that many had suffered during migration.

The results of a quasi-experimental study conducted to evaluate the intervention showed a moderate decline in children's relative PTSD symptoms. According to the authors, these results suggest that cognitive behavioral therapy can be delivered effectively by school clinicians to treat children exposed to a wide range of community violence. The bias in participation may be related to the cultural appropriateness of group-based psychologic interventions, which may be more significant for some groups than for others [66].

The United Kingdom has been receiving a steady flow of refugee families, and clinical studies have suggested a high incidence of psychiatric disorders in these families [12]. To provide appropriate services for these children, a primary school in an inner London borough set up an on-site mental health unit to treat refugee children referred by their teachers [67]. Treatment chiefly addressed disorders related to past violence, losses, and present socioeconomic precariousness but also addressed specific learning and scholastic difficulties. Evaluation results showed a decline in overall symptom scores and highlighted the model's acceptability to children, families, and

school. This small pilot project is the only published study about a school-based mental health service designed specifically for refugees. In all likelihood, the service was set up only because of the school's very high number of refugee children and strong advocacy position. Despite its limitations, the project underscores the difficulties inherent in providing mental health care to refugee children because of the persistent precariousness of their family and social environment, which forces the families into a survival mode that leaves them little time and energy for coming to terms with past adversity and adapting to the new society.

## Summary

In light of the tendency of refugee families to underutilize mental health services and the high exposure of refugee children to adversity, there is a broad consensus that primary and secondary school-based prevention programs can play a key role in promoting the mental health of these children. Unfortunately, the development of school-based prevention programs is hindered by a number of major obstacles. First, refugee families and communities are afraid of the stigmatization that may be associated with any initiatives focusing on the adversity of their experiences, especially if these programs portray them as victims or use a psychopathologic model. Second, refugee children in schools represent a very heterogeneous group, both culturally and in terms of migratory experience, and it is not easy to address their diverse needs through culturally appropriate programs. Third, schools in refugee-receiving countries face widely different social and institutional realities; therefore the extensive local adaptations that are needed make program transferability challenging.

A review of existing school-based prevention program initiatives identifies a number of promising avenues:

- Ecologic models of intervention that address the whole-school environment are useful because they provide a systemic understanding of the interactions among the different players. They propose supporting and training teachers so that they can help their refugee students without becoming too distressed. These models also insist on parent–school interactions, which should be understood in terms of cultural differences and also as reflecting power imbalances between refugee families and host-country institutions.
- Classroom activities addressing the overall adjustment of refugee children to the host society and their well-being have an important role. They support the children in assimilating past and present experiences by presenting these as learning opportunities, facilitating emotional expression with respect to the experiences, and promoting the development of relationships among refugee children and with children and adults of the host society.

- Some prevention programs that use specific treatment modalities such as artistic expression also seem to be protective at different moments of children's development. They can be implemented in kindergarten, elementary school, or high school. They support the transformation of past and present adversity through creativity and metaphorical representations and foster the development of solidarity among children.
- Secondary prevention, which includes group intervention for children presenting with PTSD symptoms and school-based clinical services for individual children presenting with emotional and behavioral problems, seems to have some efficacy and to be well accepted by refugee parents. There is, however, a need to document more thoroughly the group or personal reluctances to participate in these services to understand better their cultural appropriateness.

In general, the development of school-based prevention programs seems to be hindered by three main factors. Health professionals' preoccupation with evidence-based treatment may hamper the already slow development of alternatives to mainstream practices, although these alternatives could provide a wider array of programs addressing the different cultural and contextual needs of refugee families. The existing services and programs developed by schools and nongovernmental community organizations often are not evaluated rigorously, either qualitatively or quantitatively. Finally, the precariousness of refugees' family and social environment hinders their capacity to become involved fully in the development of such programs.

Multidisciplinary school-based prevention programs that combine a mental health with an educational perspective and that promote a continuous partnership with community organizations may be one way of overcoming these obstacles.

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