How we can help refugee kids to thrive in Australia
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When we think about refugee children’s health, we tend to assume bad news. But refugee children are highly resilient. This means they can thrive, mature and develop despite poor circumstances, and can adapt despite severe and long-term hardship.

Our newly published research is the first of its kind to track the long-term health of newly arrived refugee children in Australia.

We showed which children tend to do well in the community, and the factors that predict this. We also give evidence for what Australia can do to help all refugee children thrive in the longer term.

Who are these refugee children and their families?

Between May 2009 and April 2013, a total of 228 refugee children under 15 years, who were granted refugee status under Australia’s humanitarian program, arrived in our study area. We followed 61 of these children for three years. None of them had
been detained for any length of time, as they had been granted refugee status overseas and flown to Australia.

The children were on average six years old, with equal numbers of boys and girls. They came from south-east Asia (46%), Africa (33%) and the eastern Mediterranean (21%) regions (as defined by the World Health Organisation).

When they arrived, 30% of children were living in a family with one parent absent (almost always the father).

Many parents had high levels of education (20% had university or trade qualifications) and had been employed before coming to Australia; only 6% had no education and 20% reported unemployment in their home countries.

**What physical and mental health issues did we see?**

We checked the children’s physical health when they arrived and their development and social-emotional well-being over the next two and three years after settling in Australia.

Refugee children have well known physical, mental and developmental health issues, and our research supported this.

Iron and vitamin D deficiency were the most common conditions we saw. Only a few children had infectious conditions needing treatment.

After two and three years in Australia, most parents said their child had good access to primary health care and visited their GP every one to four months. About half the children had visited a dentist.

About a quarter of young children had developmental delay (mostly delayed speech and language) at the start, but all had caught up by their third year in Australia.

However, children’s social and emotional wellbeing was most strikingly affected by their refugee experiences. After two years of being in Australia, over 20% of children
were experiencing emotional symptoms (such as sadness or fear) and/or peer problems (like difficulties making friends).

But by year three, these problems had decreased to below 10%, no different to the general Australian population, illustrating their resilience.

**Which children do well and not so well?**

Many studies have highlighted factors that make it more likely for refugee children to have poor health and well-being. These include economic and social conditions related to where people come from and where they settle.

We cannot change certain factors before children arrive, like pre-migration violence. But we can change factors once they’re here. In fact, research suggests post-arrival factors have a bigger impact than pre-arrival factors on refugee well-being.

Post-arrival factors that lead to poor outcomes include: time in immigration detention, exposure to violence post-migration, family separation, poor mental health of carers, negative school and peer experiences, perceived discrimination, parental unemployment, fall in socio-economic status and financial stress.

The most common stressful life events children and families experienced in our study were changes in the child’s school and home, parental unemployment, marital separation and financial stress.

For instance, single parent families became more common (38%) three years after settlement, largely due to marital breakdown; almost all families were receiving government financial benefits and living in rented accommodation two and three years after settling; half of the families had a weekly income under A$800, about 30% below the average weekly income in Australia; and unemployment was high (by year three, only 12% of parents were employed, mainly in semi-skilled and unskilled jobs).

Refugee children with stable accommodation tend to do better than those forced to move home multiple times. from shutterstock.com
Researchers have also identified factors linked with better outcomes and resilience, and that increase the chance of good health and well-being.

These include living close to the family’s own ethnic community and having external support from the general community.

In our study, most families (more than 80%) knew someone in Australia before immigrating and felt supported by either their own ethnic (more than 73%) or the general community (more than 63%). Most parents said Australians displayed tolerance towards people of other religions, cultures and nationalities (more than 78%), although several volunteered anecdotes of their perception of discrimination related to property rental.

What can we do to make a lasting difference?

By addressing the factors that predict poor health and enhancing those that predict a good outcome, we can make a significant difference to refugee children’s lives.

Our research and others’ shows what policymakers and governments can do to help refugee children thrive in Australia. We need to:

- integrate children and families into host communities
- support families to stay intact
- provide stable settlement with minimal relocations
- support children’s education
- support parents’ employment
- ensure access to health, social and economic resources
- reduce post-migration exposure to violence and threat, including detention, racism and bullying.

If these recommendations are implemented, it is very likely refugee children can realise the resilience they bring with them to Australia.