

**In or out? Barriers and facilitators to refugee background young people
accessing mental health services.**

Erminia Colucci

Harry Minas

*Global and Cultural Mental Health Unit, Centre for Mental Health, School of
Population and Global Health, The University of Melbourne*

Josef Szwarc

Victorian Foundation for Survivors of Torture (Melbourne)

Carmel Guerra

Centre for Multicultural Youth (Melbourne)

Georgia Paxton

Immigrant Health Service at the Royal Children's Hospital (Melbourne)

Abstract

Refugee young people have been identified as a group with high risk for mental health problems, due to their experience of trauma, forced migration, and stressors associated with settlement. A high prevalence of mental health problems is reported in this group, however some research suggests refugee young people have low rates of mental health service access after settlement. There is little information available on barriers and facilitators to mental service delivery for this group. Using data from 15 focus groups and five key informant interviews with a total of 115 service providers from 12 agencies in Melbourne, Australia, this paper explores barriers and facilitators to engaging young people from refugee backgrounds with mental health services.

Eight key themes emerged: cultural concepts of mental health, illness, and treatment; service access; trust; working with interpreters; engaging family and community; the style and approach of mental health providers; advocacy; and continuity of care.

Keywords: youth, mental health, service utilization, barriers, facilitators, refugee

Young people of refugee backgrounds may have multiple risk factors for mental health problems, including exposure to trauma, forced migration and stressors associated with settlement (Hodes, 2002). Surveys of refugee children and adolescents have reported varying prevalences of mental health symptoms and problems, with estimates for post-traumatic stress disorder (PTSD) ranging from 3-94%, for depression/depressive symptoms from 3 – 47%, and for anxiety symptoms from 3 – 95% (reviewed in Paxton, Smith, Win, Mulholland, & Hood, 2011).

In Australia, mental health services are provided in a variety of different settings, including specialist clinical services (e.g. refugee and youth specific), primary and hospital-based care, and school-based services. Despite multiple access points for mental health services, children and young people show relatively low use of such services, even though they have a relatively high prevalence of mental health issues (Australian Bureau of Statistics, 2010). As in many other countries of resettlement (see Colucci, Szwarc, Minas, Paxton, & Guerra, 2014; Nadeau, Rousseau, & Measham, 2014), in Australia refugee children and young people have even lower rates of service utilisation (Paxton, et al., 2011) and face significant barriers to accessing mental health services (de Anstiss, Ziaian, Procter, Warland, & Baghurst, 2009; Michelson & Sclare, 2009), which may include: the low priority that children and young people of refugee backgrounds place on mental health; lack of knowledge of “mental health” and services; distrust of services; and the stigma associated with psychosocial problems and help-seeking. It is important to examine barriers and facilitators to mental health service access and delivery for refugee young people specifically; in the absence of such research, “policy makers, service planners, and mental health professionals have little option but to draw unreliable inferences from research based on children in the general population or ethnic minority adults”

(de Anstiss, et al., 2009, p. 598).

Barriers to seeking services and factors influencing the effectiveness of services are not well understood (Ellis et al., 2010). A recent literature review identified only 11 studies specifically addressing mental health service utilisation by children and young people of refugee background (Colucci et al, 2014). Of these, only one (de Anstiss, et al., 2009) explicitly examined service-related barriers.

The purpose of this study was to explore the perspectives of service providers on barriers and facilitators to engaging refugee-background young people with mental health services. The study arose from a 2009 roundtable on the subject convened by the Centre for International Mental Health (CIMH) at the University of Melbourne, the Royal Children's Hospital (RCH), the Centre for Multicultural Youth (CMY) and the Victorian Foundation for Survivors of Torture (VFST, also known as Foundation House). Participants included clinicians, academics, policy makers, representatives from community organisations, and refugee young people. The roundtable identified that practitioners working with refugee young people could offer valuable insights into what worked or did not work in engaging refugee young people but that their experiences had not been well documented.

Method

The study was conducted between April 2010 and November 2011 in Melbourne, Australia. Ethical approval was obtained from the ethics bodies of the University of Melbourne (HREC 0933025) and Foundation House. Representatives from the four lead organisations (CIMH, CMY, RCH, VFST) identified services and stakeholders in the provision of mental health care for refugee "young people" (defined as 13 – 25 years old). Purposive sampling was used, and based on their experience in either

adolescent mental health or refugee health, service providers were invited to participate in the study. Participants were asked to provide a de-identified vignette based on their experience as a basis for discussion.

Focus group discussions (FGD) were conducted by a moderator, with an assistant present. Interviews were semi-structured and a mixture of questioning strategies was employed around two main issues. Providers were asked to express their views and experiences related to barriers and facilitators for refugee young people (13 – 25 years) in: (i) Referrals and initial access to mental health services; and (ii) Maintaining engagement with mental health services. Data collection continued until saturation was achieved, i.e. interviews/focus groups no longer elicited substantially new themes (Wynaden et al., 2005).

FGD were recorded and transcripts and field notes taken during the discussion were used for data analysis. Field notes were reviewed before subsequent FGD to allow exploration of emerging concepts (Shuval et al., 2008). Qualitative data analysis was completed using a process of coding, identifying categories, and clustering and extracting themes (Pope, Ziebland, & Mays, 2000; Wynaden, et al., 2005) by the first author, and reviewed for validity by an independent rater.

After data collection and analysis were completed, the findings were discussed with young people of refugee background and service providers, academics and representatives of State government departments (CMY, 2011). In addition to offering an opportunity to share the key findings that emerged with the data collection, this meeting allowed the researchers to solicit the views of the young people to assist in interpreting the implications of the findings for services and practitioners. Some of the comments made by young people during the roundtable will also be presented in the discussion.

Results

Fifteen FGD were completed with 115 service providers from 12 agencies, including three mental health services, three community support organisations, two health services, two schools, the state government health department and the lead agency assisting refugee settlement. A further five key informant interviews were conducted. Participants included: psychiatrists, psychologists and counsellors in specialist and non-specialist mental health services; paediatricians, general practitioners, and nurses; teachers; social and youth workers; naturopaths; and settlement workers. The average age of participants was 38.6 years (n=91, 19 participants did not disclose their age). 74% of participants were female.

Eight key themes emerged from FGD and key informant interviews (Table 1), which could be divided further into associated facilitators and barriers.

INSERT TABLE 1 HERE

Cultural concepts of mental health, illness and treatment

Across groups, participants noted that most people of refugee background came from cultures where conceptualisations of mental health, illness and treatment differ from the dominant “Western” frameworks underpinning mental health practice in Australia. Providers recognised that professionals and services must attempt to understand how clients conceptualise their own issues, and not presume a shared construct of mental health, illness and treatment.

When we talk with different cultures, like the new arrivals, or the refugee people, what is their understanding about mental health? Is it exactly like

what we say here, or is it something different? So I think, first of all, we have to try to understand the other. How much is their understanding about mental health, the mother to tell you ‘my son or my daughter, she has a mental problem’, what does that mean? (...) So when we say all this, really, sometimes people say jargon, or we will say ‘they have [a] mental problem’. But the mental problem itself is not known as like what we see it here, as it is seen in the African community. (FGD1)

Providers felt that the concepts of mental health common in some cultures could be a significant barrier to recognising the presence of mental health problems and need for support (“for some of them it’s the culture of not complaining”, FGD9). Further, even if a need for support was identified, the young person and their family might not be familiar with mental health services or consider it appropriate to receive assistance from a stranger:

They might be told to go to a mental health service and, not knowing what’s ahead of them, it’s easier just not to go (FGD8).

It’s about teaching them how to access services as they need to, rather than developing that dependent relationship (FGD9).

Providers suggested that measures to increase the mental health literacy of young people and adults (without imposing Western conceptions of mental health) were likely to facilitate access to and engagement with mental health services. Suggestions for improving mental health literacy included school-based education programs, advertising on television and other media, peer mentor and group activities

and using positive role-models to ‘normalize’ mental health problems: “Groups can help normalize mental health symptoms over the long term. Share [experience] in a group session, not isolated, ‘it’s not happening just to me’” (FGD10).

Further suggestions included targeted education programs for leaders who might be in a position to influence community attitudes toward mental illness and mental health services, although potential challenges were also noted. For example, practitioners pointed out that even the term “mental health” may have negative connotations and be associated with terms such as “crazy,” “lunacy,” and “abnormality”.

An understanding and consideration of the impact of culture was identified as the cornerstone of effective engagement of refugee background young people who did access services. Participants observed that in order to be able to engage the young person, the worker and the service organisation must show respect and understanding of his or her culture. Absence of such respect and understanding was felt to negatively affect engagement with mental health and other services.

They don't really have faith in the system to begin with (...) and I think that if they have the information and they want to come (...) and then the system is not culturally appropriate for them, you can really damage them in [the] long term whether or not they would access the system again. (FGD13)

Providers suggested that culturally competent and sensitive services do not use “a one size fits all approach” (FGD10) and instead match the young person and professional by ethnic background and/or gender (“chose the ‘right’ worker”, FGD8),

and sometimes also by religious affiliation. Where matching was not possible, providers felt mental health professionals should be aware of the impact of their own gender, ethnicity, religion, mode of dress and age on their relationship with the young person.

Providers indicated that the refugee experience itself was an aspect of culture, and that this was an important consideration in working with clients. While having an understanding of the refugee context was felt to be important, providers also acknowledged the complexity of understanding their clients' refugee background, and that asking too much about the refugee experience could be a barrier to engagement.

A trauma-centered approach acknowledges that the trauma is in the room, [the need to] work differently with youth with a trauma history, it's not about having to talk about the trauma. (Ind5)

Access

A range of factors was seen as enhancing or impeding service accessibility, including the location and appearance of services, the criteria for acceptance, and appointment systems. Participants stated that services must be accessible by public transport ("Especially for new refugee, they put them in areas where there is very really bad access to the public transport and they can't get to places", FGD13) and be easy to find. It was suggested that services should preferably be discreet and "out of sight:"

Going to a building that [says on it] 'Mental Health Services'. When I was in case work a client had to go to (a service) and when she walked out of the building, other people were actually waiting at a bus stop which was right in front and they said to her: "Why do you go in that place? That's for crazy people" (FGD13).

There was considerable discussion about what was described as a lack of an enabling environment in mental health services, which were seen as too clinical and sterile, and set in closed rooms liable to evoke negative experiences among refugees. Participants suggested greater use of outreach services, and engaging young people from refugee backgrounds in community settings where mental health professionals could be seen in a less formal way: “we sit and wait!” (FGD14); “go where the young people are” (FGD8). Schools were considered to be good environments for early identification of mental health issues and to offer a “safe place to talk” (FGD6). Engaging young people in informal ways, such as through recreational activities out of the office (“More contact activity instead of therapy”, FGD18) was suggested as beneficial to build relationships and improve service accessibility:

Young people won't go out of their way for a mental health service. They can check you out on their own territory: who are you and how well do you understand me? (Ind5)

Outreach was so much more successful than ask people to come to the office all the time particularly with people from different cultural backgrounds (*FGD13*).

Waiting lists were considered to be particularly problematic (“people fall into the cracks”, FGD15; “don't just make appointment two months later, you are going to lose the young people”, FGD13), but understandably difficult to avoid for agencies with resource constraints. Providers also identified other aspects of service processes as barriers, including rigid appointment systems, strict length of sessions (“work by

the clock”, FGD9), lengthy periods between appointments, and having a maximum number of sessions. They identified the difficulty of scheduling appointments for young people with other commitments, particularly school (“we are open 9 to 5, when they are supposed to be in school, not in the doctors’ waiting rooms!” FGD9), and suggested improving relationships between mental health services and schools to improve student engagement with mental health care. Strategies suggested to improve attendance included contacting the young person or their family to remind them of appointments, being flexible in the means of contact (e.g. SMS might be better than phone calls, which were felt to be better than letters), and addressing the systemic consequences of missing appointments.

If they don't turn up they get back on the waiting list. (FGD15)

If you set the rules about people turning up too strict then you'll end up with all the adolescents who don't really need your help!

(Ind5)

The impact of age criteria for services—which are sometimes imposed by funding sources—was explicitly identified as a barrier to access and engagement with reference to cultural norms. For instance, a person considered young and not yet independent in their country of origin might be excluded because of different cultural perspectives in this country (“in Australia 18 years is adult but in our country [an African nation] he is still a child”, FGD1).

I have found people over 25 who would fit into our youth program, and fit in very well, but because of the age limit, I can't

offer them that, even though I think it would probably benefit them hugely (FGD9).

Cultural beliefs and practices were also felt to be important influences on concepts of time and age, presenting challenges for service delivery.

If I worked by the clock or my watch with this community, I would probably be requiring mental health services as well! If I set the appointment for 3:00 in the afternoon, unless I say 2:30 in the afternoon, then they leave the house at 2:30 and be here for 3:00. So if I say 3:00 in the afternoon, that's when I know when they are leaving the house (...). They are not all like that; we can't put them all in one basket. But you learn about the individuals, and who can or cannot keep time. And you organize your appointments accordingly (...). But you know, I've also got clients who can't read the clock, and my first job is to teach them how to read the clock (FGD9).

Providers felt that referral to mainstream mental health services was often only successful in young people with a clear diagnosis, and thus was generally restricted to those with major psychiatric disorders ("the system is overloaded, they have found their own way of gate-keeping", Ind4).

Mental health services are so strict with their boundaries, they don't take people... You can't get mental health services for kids unless you have an

acute diagnosed, often psychotic, illness. (FGD14)

Key findings were that services need to be more flexible and adopt “different services and style of engagement” utilising a client-centred and reflective approach: “So I ask myself, sometimes, are we responding in the right way? Are we flexible enough?” (FGD15).

Trust

Fear and distrust of services were felt to be significant barriers to effective engagement with mental health services. Conversely, across interviews providers emphasised that “the integral factor in engaging young refugees is developing trust” (FGD12) and that developing trust takes time and must start from the initial contact. Participants noted that people of refugee backgrounds may have had negative experiences with authority during their migration path, resulting in lack of trust in institutions and professionals, including hospitals and people in uniform:

One client who I worked with, he relayed that any uniform evokes a lot of fear for him, whether it be ambulance, police, a helper (...). I guess if we see an ambulance officer our first thought is, ‘there’s help arrived’, but this young boy was, ‘uniform, I’m out of here’ (FGD8).

Having been rejected by another service, or having previously received unclear explanations resulting in a misinterpretation of a situation such as a referral, were identified as barriers to accessing and engaging with mental health care:

A few hoops you have to jump through to access the appropriate treatment. You may have tried to present to hospitals on a few occasions and been sent away, so that may have been a negative experience. (FGD9)

Providers felt addressing young people's anxieties about disclosing personal information was essential to facilitate engagement. Some participants suggested that certain experiences in countries of origin may evoke fear of providing personal information, undergoing formal assessments and filling out forms. Young people may have experienced or been aware of instances where authorities abused information or where sharing personal information with a stranger endangered them or their families. Providers reported that young people were often concerned that their use of mental health services would become known to their families or others in their community.

For people who have been through certain traumas and come from countries with very difficult political situations, providing that amount of information on paper, in black and white on the referral form can be really confronting and a lot of people might be reluctant to do that with that information and not know where it's going or what it's going to be used for. So I think the actual referral process and referral forms are a barrier to people getting service, the service that they need. I suppose I'm just thinking recently in a conversation with some Somalian women that they were concerned about where certain information was going to go and who would see it and what it would be used for. They needed

clear explanation about what that information was going to be used for, to feel okay about disclosing that (*FGD 8*).

Providing assurance of confidentiality was felt to be critical to establishing and maintaining trust. Good practice requires professionals to explain why they are gathering information, how this information will be used, circumstances where they may have to break confidentiality (e.g. immediate risk) and how they would proceed in such an event. These issues of defining confidentiality are even more complex when interpreters are engaged.

Trust and confidentiality were also felt to be important at a service level. Providers reported that clients were often more comfortable when mental health services were discrete (e.g. had a different entrance from other services in the same facility) and they identified benefits in young people and their families coming to trust an organisation (rather than just an individual worker); this type of trust was implicated in facilitating engagement, enabling referral to other clinicians within a service when needed, and developing acceptance within communities. As one participant stated, “[having] a good reputation as an organization can short cut the trust” (*Ind5*).

Working with interpreters

There was a general agreement that health professional competency in working with interpreters is important for effective engagement. However, providers also recognised that young people from small communities may be concerned about their confidentiality being compromised because interpreters may know them or their families. Some providers reported they experienced instances of unprofessional

interpreter conduct, such as interpreters not interpreting comprehensively or inappropriately commenting on the content of clinical sessions (e.g. "... and the reason why the child was crying was that the interpreter was saying [to] him that the father was a really bad man" (FGD12).

In selecting interpreters, mental health professionals should consider gender, age, dialect, and cultural factors such as dynamics between different ethnic groups. Providers suggested that young people should be asked, at the time of referral, if they have a preferred interpreter and whether they wish to have someone with or without a particular background ("they preferred somebody else, without a similar background, which was interesting", FGD15). Other suggested options to maintain confidentiality were engaging telephone interpreters and employing bilingual mental health workers. Clarifying the client's preference, seeking feedback on the interpreting experience, and working with the same interpreter over multiple sessions (where possible) were also felt to improve client confidence and trust:

I'll ask the client every time, if I use an interpreter was that good? Did you understand everything? Is that OK if I use the same interpreter next time? I'll really keep a good eye on that (FGD2).

Engaging family and community

Participants generally agreed it was important to identify and address family issues, while acknowledging that this could be complex. They identified that in some cultures families need to be directly involved in order to understand the service and support the young person in engaging with the service. Understanding the roles of different family members ("who is in charge of this family", FGD9), and building trust with the family, were viewed as facilitators:

Sometimes in the mental health system they don't put enough effort into their “how to” work with the family, in spending time just sitting with the family in their home; talking takes lots of time. Mental health services don't have time to do it, and it means that young people disengage and they get lost in the system. (FGD13)

Conversely, families could also play a negative role in service engagement, and for some young people family involvement could be problematic, or even impossible in the case of unaccompanied minors. For some young people, problems or secrets within the family, or family attitudes toward mental health problems or care acted as direct barriers to service engagement:

You deal with it in the family's wall (...), it's a sign against the family don't be cared for within the family (FGD15).

Overall, participants agreed that it was not possible to generalise about the role played by family, noting that every community, family and individual young person is different. Providers felt best practice was asking the young person what role they would like their family to play, and, after obtaining his/her consent, engaging with and involving the family.

Community engagement was viewed as a further facilitator to mental health service delivery, particularly for young people from collectivistic cultures (“Most of the Asian cultures are community cultures instead of the Western individual culture, so if you're working with someone you need to work with the community too” FGD1).

Community members (such as community liaison workers, or volunteers employed within mental health services) were viewed as important resources to facilitate trust between the young person and the agency, as they are able to provide information and work in partnership with professionals to provide monitoring and support as well as an ‘informal’ alternative to interpreters.

Mental health professionals’ style and approach

The style and approach of mental health professionals emerged as a major theme, covering communication, reliability, boundary-setting, involvement of young people in decision-making and the non-verbal aspects of consultations. Key stylistic strengths named by participants included: empathy; being youth-friendly, approachable, patient, understanding, non-judgemental, respectful, and compassionate; and taking an “informal” approach (“it’s more valued who you are than what you are”, FGD9). Having knowledge and experience working with young people was also felt to be important.

Participants highlighted the importance of building a relationship and trust through being reliable and consistent, persisting with opportunities for the young person to engage (“chase them up”, FGD14), and when possible, doing “something extra” because “(...) if the client sees that you don’t care, things are not going to go anywhere” (Ind3). Conversely, complex interactions with staff (multi-stage intake procedures) and inconsistency in staff (e.g. through high staff turnover) were felt to affect engagement negatively.

Participants spoke at length about the practical aspects of clinicians’ communication and questioning style(s). A conversational, narrative style of questioning through eliciting stories was seen as preferable, but in some instances

providers reported that a structured style (“yes/no” or specific questions) might be needed. “Firing questions” was felt to be a negative style, with the potential to evoke experiences of interrogation:

I recently sat in with a client on a psychiatrist’s appointment and that was basically a 30 minutes interrogation. I mean, for a refugee, for someone that has experienced persecution in their past, I can’t even imagine how terrifying that would be. (FGD8)

Providers also suggested “direct probing” should be avoided, and indirect approaches using the young person’s interests were often advantageous (“I started playing chess with him (...) and as soon as we did that, during the game, he started to talk to us”, FGD1). The use of pictorial language, visual cues or other arts-based media (e.g. listening to music or watching a film on the topic) to encourage conversation were also felt to facilitate engagement, particularly in younger people.

The sequence of questions was also felt to be important; providers reported benefit in addressing the “here and now” and the young person’s direct concerns early, leaving sensitive questions until trust had been established rather than immediately “digging into the past” (FGD10). This was felt to facilitate initial engagement: the young person needs to feel that the mental health professional is going to help him/her from the outset, and not “just talk about the past” (Ind3). This, in turn, was described as important in ongoing engagement (“They can decide to reject you from the first instance”, Ind3).

It was also suggested that the mental health professional should “keep checking in with the young person, ask them if they are happy with the service, are

they getting what they need?” (FGD10).

Boundary setting was identified as an essential component of establishing a therapeutic relationship. Participants felt it was critical for mental health professionals to be clear about what they and the service could (and could not) do, how they worked, and to ensure that client expectations were realistic: (“They’ve got in touch already with many others who have ‘tried to help’ so better to explain who you are and what you do,” FGD7).

Practitioners described explaining to clients about their rights, including the right to opt out of treatment, and how they would “involve them in their own care” (FGD9). Involvement in care was viewed as particularly important to help young people regain the control that they might have lost through their refugee experience. However, practitioners also noted that young people might come from cultures where the person in need is expected to take a passive role: “some people have never been asked what do you think?” (FGD10).

Finally, providers felt the non-verbal aspects of consultations, including physical proximity, body language, and, on occasion, (providers) wearing modest clothing, played an important role in working with young people of refugee background. Provider manner, especially appearing too busy or distracted, was felt to affect engagement in a negative manner: “Do not take on too much and transferring a message that you are overloaded to the client (...); they feel you are overloaded and don’t want to burden you” (FGD5).

Advocacy: attending to the priorities of the young person

Participants were critical of mental health services operating in a disease-focussed model, placing emphasis on symptoms and diagnoses, and working “in silos.” They

suggested “looking at everything holistically, not just symptoms and prescribing medication” (FGD13). A holistic approach was described as one that sees the young person as a “whole”, integrates treatment with (recreational, arts, group) activities, and works with the person’s goals, focusing on what the person thinks he or she needs.

Participants generally agreed that issues faced by refugee young people are rarely limited to the domain of mental health alone. Providers reported that young people often have other concerns, such as family separation, housing stability, isolation and economic security, which might be higher priority (than mental health) for the young people themselves:

They've got an agenda of issues and this is all related to settlement, part of this could be thinking about immediate family members left behind or housing if they are not settled, or it could be other physical health, so they put it all in one basket if you like just to simplify, and they tend to not prioritize the self, not recognize it as important. (FGD2)

Participants suggested that best practice mental health care for refugee young people requires professionals who are not “stuck into their own professional roles” (FGD4), and should work to address immediate needs, which might involve advocacy on the young person’s behalf. Providers emphasized the importance of making tangible early gains with the young person so that the benefit of engaging with the service becomes evident:

When you can make something happen for them and they do get something

out of the relationship early, if you can get some momentum going early, it's important; if they're not getting anything out of it early it's hard to keep them engaged. We had a young guy who had very little income, so very quickly we got him linked into (the social security agency) and got him onto the right amount of money he was meant to be on and that made a significant positive impact on him and straightaway he identified that we are a service that can support him into getting some positive change in his life. (FGD8)

Meeting the practical needs of young people contributed to building trust and rapport with clients, their families and communities, especially for those from cultures where "counselling" and "talking therapy" are unfamiliar. "Support them with something that is practical because having an adult to just be talking to a youth is a concept which is foreign to many of them; it proves that you are useful" (Ind4).

Some participants indicated that once young people experience that the mental health worker meets their expectations and helps also on a practical level they are more willing to share their stories and engage with the service. However, participants were also mindful that if "getting some wins" (FGD18), such as housing assistance, helps to build trust, giving young people false and unrealistic expectations can break the trust: "make sure you follow up on things that you tell them (you'll do)" (FGD8).

Continuity of care

Participants acknowledged that young refugees are commonly "complex cases" who are often referred from one specialized service to another, or seen by multiple services and workers at the same time ("each has a niche", FGD11). This may cause fragmentation of care and service provision. Care coordination (across health, mental

health, and other welfare agencies) was felt to be a potential solution to facilitate engagement:

They need sort of to have a care coordination plan. Say, for example, once a patient is discharged from mental health service to the GPs, they still need to keep in touch with each other so that if the patient relapses, then the GP can refer back to mental health service immediately (*FGD8*).

Assisted referral was felt to be positive, both in the initial engagement and in maintaining engagement. This might involve, for example, finding a suitable person to accompany the young person to a referral and to the first and (if required) subsequent appointments:

A couple of kids that I worked with (...), I had to literally explain every step of the process, like, it will take us 15 minutes to drive there, we'll park the car, we will walk for maybe 10 minutes to get to the hospital, we'll do this, and each step of that day had to be really explained to them so there weren't going to be any surprises for them (*FGD9*).

Participants suggested that referring health professionals need to ensure that young people understand the purpose of the referral so they do not think they are simply being sent elsewhere. Similarly, people accepting referred clients should ensure that clients understand why they have been referred:

And if you don't tell them that Dr A [name withheld] has referred you and

these are the reasons why, but it doesn't mean Dr A is tired of seeing you and doesn't want to see you any more [otherwise] they won't come back (...). So it's actually telling them that the doctor is not shoving you off because you're too hard, the doctor is just referring you because you look healthier. I think we forget to tell them those things. And they don't come back. It's the interpretation of the referral (*FGD9*).

Discussion and Conclusion

Australia's policy framework for mental health services recognises the need to respond to issues facing particular groups including those of refugee backgrounds, (e.g. Commonwealth of Australia, 2009; Victorian Department of Human Services, 2008). Despite an enabling policy environment, there are substantial challenges in program and service implementation, in part due to limited evidence on "what works" to engage and maintain engagement of refugee young people with mental health services in Australia. This project aimed to identify some of the barriers and facilitators. The key themes identified by providers in this study were: cultural concepts of mental health, illness and treatment; service access; trust; working with interpreters; engaging family and community; the style and approach of mental health providers; advocacy; and continuity of care.

Congruent with previous literature on culturally competent mental health services (Minas, 2001; 2007), this study found that key aspects of engaging refugee young people included understanding of the young person's ethno-cultural background, migration pathway and possible trauma, and consideration of cultural interpretations of health and illness. The same aspects emerged in our literature review (Colucci et al., 2014).

Like other groups, people of refugee background have varying conceptions of mental health, illness, and treatment and services (Hsiao, Klimidis, Minas, & Tan, 2006; Kiropoulos, Klimidis, & Minas, 2004; Klimidis, Hsiao, & Minas, 2007; Minas, Klimidis, & Tuncer, 2007). De Anstiss and Ziaian (2010) have previously described the role of “culturally astute professionals” in dealing with adolescents from refugee backgrounds, and negotiating a shared understanding of concepts of mental health, illness and treatment was felt to be essential. Nadeau and Measham (2006) have also suggested clinicians should work with the client, his/her family, and culture brokers to develop a shared understanding of the present difficulty and the meaning of symptoms: “By exploring meaning from the family’s worldview, an understanding of the patient’s difficulties and further paths for healing can often be elicited” (p. 150). Improving client mental health literacy was felt to be a component of negotiating a shared understanding and pathway to care, as has been suggested by other researchers working in a variety of settings (de Anstiss & Ziaian, 2010; Victorian Foundation for Survivors of Torture, 2000). For instance, a study of 13-17 year old African refugees settling in Australia found most young people surveyed had not heard of the terms “mental health” and “mental illness” (de Anstiss & Ziaian, 2010). Concepts of mental illness employed by participants were notably different from Western constructs, and some participants reported that their families continued to rely on traditional knowledge and healing, including “sending the person away to Africa” for indigenous treatments and remedies. Most young refugees had little knowledge of mental health services and how to access them. The authors suggested that while it is important to address mental health literacy in young people, it is equally important for health professionals to understand the young people’s perspectives and avoid imposing Western models of mental health.

Watters (2010) has highlighted the importance of clinicians being aware of the situations refugees have fled, and also being aware “of the changing laws and policies of the host societies and the pressures that arise from public perception of refugees” (p. 34). While clinicians may obtain this background information during the clinical consultation, it is important to note that people of refugee background may assume service providers are familiar with the political and human rights situation in their countries of origin (Tribe, 2002). Local data suggest mental health clinicians value training on trauma related to the refugee experience (Collinetti & Murgia, 2008).

Enhancing the cultural competence of services is important but not sufficient to ensure children and young people in need are able and willing to access assistance: “culturally relevant mental health services quickly become irrelevant if ethnic minority adolescents do not find their way into them” (Cauce, 2002, p.53). Participants identified user-friendly environments, including drop-in and outreach services, as facilitating engagement, similar to the findings of Watters (2010) and Palmer and Ward (2007). Arts-based and creative activities can also facilitate access and engagement, while contributing to social cohesion and self-esteem (Hodes, 2000; Rousseau, Measham, & Moro, 2011; Rousseau, Armand, Laurin-Lamothe, Gauthier, & Saboundjian, 2012). Palmer (2006) also observed that a flexible approach to appointments and outreach was successful with clients who had difficulty understanding boundaries and systems in formal settings. Other authors have suggested brokers, advocates or mediators to ensure appropriate referrals and access (Warfa et al., 2006). School-based prevention and intervention programs may also have a key role to play (see also Hodes, 2000; Rousseau & Guzder, 2008; Rousseau et al., 2011; 2012).

Refugee young people may be reluctant to seek help for mental health problems (Behnia, 2003; Ellis, et al., 2010; Guerin, Guerin, Diiriye, & Yates, 2004; Palmer, 2006; Palmer & Ward, 2007; Tribe, 2002; Ward & Palmer, 2005). Behnia (2003) indicated that refugee clients may consider the care of a sick family member a family responsibility as long as his/her behaviour can be managed at home and that families will seek external help only when the problem can no longer be kept hidden, or becomes unmanageable. External help commonly includes traditional, religious, and cultural healing practices (CMY, 2011). Ellis (2010) observed that partnerships between mental health service providers, communities, and religious organisations can open pathways to mental health care, and colocation of physical and mental health services (with improved service relationships) has also been found to be important (Savin, Seymour, Littleford, Bettridge, & Giese, 2005).

Providers in this study identified the establishment and maintenance of trust as a key factor in engaging young refugees, and suggested it might be more important for this group than for other young people or other immigrants. Many refugees have had traumatic experiences that may shatter “core assumptions about human existence” and destroy “trust in the world or oneself as a safe place” (Victorian Foundation for Survivors of Torture, 1988, p.50). They may have a generalised fear of ‘doctors’ or other authority figures (Victorian Foundation for Survivors of Torture, 2000). Mistrust and social isolation may have been survival strategies during times of organized violence (Nadeau & Measham, 2006), and hostility or discrimination in the country of resettlement may also influence client interaction with services. At the roundtable where the findings from this study were discussed, some young people of refugee background pointed out that “trusting a stranger with personal details of one’s life is difficult” (CMY, 2011). Procter (2006) has suggested practical strategies for the

generation of trust among refugees and asylum seekers.

Confidentiality is a critical aspect of trust. Clients may be particularly concerned about confidentiality where the professional or the interpreter is of the same ethnic/cultural background. De Anstiss and Ziaian (2010) found a greater mistrust of professionals of the same culture when young clients believed the professional was known, or potentially known, by their family or the broader community. This was more apparent for female participants, which was attributed to greater community surveillance of girls and women. In their study, some female participants felt professionals should not be from the same ethnic/cultural background as their clients. While some participants in the current study suggested ethnic matching (of worker and client), the evidence for this is mixed (Jerrell, 1998; Nadeau & Measham, 2006) and ethnic matching can be a barrier to service engagement if it raises concerns (whether or not these concerns are substantiated) about client confidentiality. Existing literature has pointed out that working with interpreters raises specific issues related to confidentiality (Minas, Stuart, & Klimidis, 1994; Misra, Connolly, & Majeed, 2006; Renzaho, 2008; Ward & Palmer, 2005), despite best-practice recommendations addressing ethical concerns and confidentiality (Miletic et al., 2006; Rousseau, et al., 2011). The overriding suggestion therefore is that service providers should explicitly clarify young people's preferences for workers and interpreters.

Involvement of the broader community was strongly supported by providers in our study, and has been recommended by several other scholars as well (Behnia, 2003; Ellis, Miller, Baldwin, & Abdi, 2011; Leavey, et al., 2007; Palmer, 2006; Palmer & Ward, 2007). The young people's roundtable suggested that community leaders are "the only way" to establish trust in their communities. They noted that the

community can help link young people with services and suggested training community leaders as advocates (for mental health education) in their communities.

Elder community members and spiritual and religious leaders have been previously identified as having significant influence over community perceptions and beliefs (Cauce, et al., 2002; Department of Human Services, 2010; Ellis, et al., 2010).

Nevertheless, as also noted by Ellis and collaborators (2010), community involvement can also raise concerns about confidentiality (e.g. when members provide an “informal” alternative to interpreters) and discourage young people from disclosing to parents or others about their problems.

Providers expressed different views on involving families in mental health care, depending in part on the clinical situations being discussed. Leavey, Guvenir, Haase-Casnovas and Dein (2007) suggested families should be engaged because they play a pivotal role in the nature and timing of help-seeking. In contrast, de Anstiss and Ziaian (2010) highlighted that young people may not feel comfortable discussing personal issues with their parents and Ellis and collaborators (2010) found that youth were concerned that telling their parents—who had already many other significant worries associated with war and resettlement—about their problems would unduly burden them. As suggested by the service providers in this study, best practice may be asking the young person what role they would like their family to play.

Participants felt strongly that the style and approach of mental health professionals was important to facilitate engagement. They suggested that pushing for early disclosure of trauma and focusing more on past experiences than on current concerns were barriers to engagement, which has also been found in other studies (Guerin, et al., 2004; Palmer, 2006).

Advocacy was related to provider’s style and viewed as facilitating

engagement. Participants noted that refugee young people (and their families) frequently balance competing settlement priorities, and that dealing with clients' immediate needs can provide an entry into a therapeutic relationship. This was suggested as particularly important in the context of mental health, which is often considered a low priority (Behnia, 2003; de Anstiss & Ziaian, 2010; Palmer, 2006). Previous literature has supported the importance of taking an advocacy role, addressing practical concerns, and adopting a holistic approach (Behnia, 2003; Cleveland, Rousseau, & Guzder, 2014; de Anstiss & Ziaian, 2010; Hodes, 2002; Kirmayer, Guzder, & Rousseau, 2014; McColl & Johnson, 2006; Misra, et al., 2006; Palmer, 2006; Ward & Palmer, 2005; Watters & Ingleby, 2004; Woodland, Burgner, Paxton, & Zwi, 2010).

Unsurprisingly, poor continuity of care and fragmented service delivery were identified as barriers to engagement. As noted by other authors (Guerin, et al., 2004; Misra, et al., 2006; Palmer & Ward, 2007), referrals to mental health services were seen as problematic; providers indicated that refugee clients may not understand why they have been referred to a specialist service. An integrated approach to mental health service delivery has been suggested by multiple authors (de Anstiss & Ziaian, 2010; Watters & Ingleby, 2004; Woodland, et al., 2010) and De Anstiss and Ziaian (2010) proposed that mental health services should build direct relationships with refugee communities and the wider social service system, including settlement programs. Facilitating continuity and integrated care presents time and workforce costs (Cauce, et al., 2002; CMY, 2011) and is a challenge in mobile populations (Warfa, et al., 2006; Watters & Ingleby, 2004). Nevertheless, collaborative models of care have shown positive outcomes in terms of improved access to and efficiency of mental health care (see, for instance, Rousseau, Measham & Nadeau, 2012; Nadeau,

Rousseau, & Measham, 2014).

De Anstiss and Ziaian (2010) and a previous young people's forum (CMY, 2008) suggested that professionals should involve young people in making decisions about their own care, whereas health services' response to refugees is often distinctly "service-led" rather than "user-led":

Without an opportunity to articulate their own experiences in their own terms and to identify their own priorities in terms of service provision, refugees may be the subject of institutional responses that are influenced by stereotypes and the homogenising of refugees into a single pathological identity" (Watters & Ingleby, 2004, p. 1710).

This perspective was strongly endorsed by young people consulted about the findings of this study, who voiced disappointment and frustration with the general failure to consider the experiences and voices of people of refugee backgrounds in the design and delivery of services (CMY, 2011). As one of the study participants, who was himself from a refugee background, observed:

There is need (...) for people to do the research, get this information, then there is need for the sharing of this knowledge within the services, within the professionals so that people know this is what would work with these people (Ind3).

Conclusion: Future Priorities

This study presents the views of providers; in future research, it is essential that the perspectives of young people of refugee background are sought, including

those who use mental health services and those who avoid engagement with services. Acknowledging the importance of hearing the views of young people, Foundation House has initiated a follow-up study to interview young people of refugee background about their experiences of using mental health services. It is also imperative that the findings of research are translated into policy and practice to improve the quality and accessibility of services for people of refugee background.

Acknowledgements

The authors would like to acknowledge the service providers who participated in this study. We are thankful to Tommaso Partesana, Rita Manassis and Gerard Reed for their contribution to the data collection and/or analysis. Thanks also to Selene Martin, Alice Baroni and Thuy Nguyen for their support.

The financial support for the project was provided by the William Buckland Foundation and Sidney Myer Fund and is gratefully acknowledged.

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Biographical Notes

Erminia Colucci is Research Fellow at the Global and Cultural Mental Health Unit, Centre for Mental Health, School of Population and Global Health, The University of Melbourne and Coordinator of the Melbourne Refugee Studies Program. She is currently the Principal Investigator on the MHiMA Suicide First Aid guidelines for people from migrant and refugee backgrounds, MHiMA Mental health and suicide research agenda for people from immigrant and refugee backgrounds, and an ethnographic documentary project on domestic violence against women in the Philippines.

Josef Szwarc is the Manager of Research and Policy at the Victorian Foundation for

Survivors of Torture (Melbourne). He has worked on range of social policy and human rights issues for government and non-government agencies in Australia and UK.

Harry Minas is Head of the Global and Cultural Mental Health Unit, Centre for Mental Health, School of Population and Global Health, The University of Melbourne, Director of the Victorian Transcultural Psychiatry Unit, Convenor of the Melbourne Refugee Studies Program, Chair of the Executive of Mental Health in Multicultural Australia (MHiMA) and Editor-in-Chief of International Journal of Mental Health Systems.

Carmel Guerra is the founder and Chief Executive Officer of the Centre for Multicultural Youth (CMY) based in Melbourne, Australia. CMY is a community-based organisation that provides services to and advocates for the needs of young people from refugee and migrant backgrounds.

Dr Georgie Paxton is Head of the Immigrant Health Service at the Royal Children's Hospital (Melbourne), an Honorary Fellow at Murdoch Childrens Research Institute, (Melbourne), and Chair of the Victorian Refugee Health Network. Her work includes clinical care, research, education and policy development in paediatric refugee health.

Table 1

Key Facilitators and Barriers to Refugee Youth Engaging and Continuing Mental Health Services

Themes	Facilitators	Barriers
Cultural concepts of mental health, illness and treatment	<p>Recognising that how the person and his/her family conceptualise the problem may differ from Western constructs of mental health symptoms and diagnoses</p> <p>Increasing mental health literacy in the young person, family and community</p> <p>Acknowledging and respecting the person’s cultural background</p> <p>Considering cultural concepts of mental health and illness</p> <p>Considering the impact of collectivist cultures on the mental health consultation</p> <p>Using a ‘trauma informed’ approach, where relevant</p>	<p>Young people not identifying need for help or that mental health service is appropriate to need</p> <p>Bringing up trauma too early, going into the past</p> <p>Focusing on ‘refugee’ past rather than ‘here and now’</p> <p>Cultural mismatch</p> <p>Providers failing to acknowledge or understand the impact of resettlement</p>
Access	<p>Improving service accessibility (including location and transport)</p>	<p>Lack of after hours services</p> <p>Service age restrictions (rather</p>

	<p>Clear and straightforward referral process</p> <p>Flexible appointment systems</p> <p>Drop-in and outreach services</p> <p>Key workers</p>	<p>than developmental approach)</p> <p>Service intake restrictions and ‘gatekeeping’</p> <p>Lack of activity-based programs</p> <p>Ineffective reminder systems</p> <p>Differences in time concepts</p>
Trust and confidentiality	<p>Targeted work on establishing trust around mental health care by the person, their family and community</p> <p>Defining (and assuring) confidentiality, including confidentiality of interpreting staff</p>	<p>Fear of authority among people of refugee background</p>
Working with interpreters	<p>Asking young people’s preferences for interpreter use at the outset</p> <p>Considering issues in working with interpreters, including the need for professionally qualified interpreters, and defining interpreter confidentiality</p>	<p>Mismatch of client and interpreter based on gender, age, dialect, and ethno-cultural factors</p>
Engaging family and community	<p>Considering family issues and discussing the role of the family in the context of the presenting concerns</p>	<p>Ignoring or underestimating the role of family and community</p>

	Involving and engaging community	Services directed solely at young people
Mental health providers' style and approach	<p>Personal qualities - e.g. warmth, empathy, care, reliability, clothing style (may need to be culturally acceptable)</p> <p>Matching providers to young people (e.g. gender, background, religion)</p> <p>Interview style and technique, with preference for narrative style</p> <p>Holistic approach</p> <p>Clarifying expectations early</p>	<p>Providers being overloaded</p> <p>High staff turnover within organisations</p>
Advocacy - assisting young people with their priority areas	<p>Recognising the priorities of the young person may be different from those of the provider.</p> <p>Addressing practical needs (where possible) can be a form of advocacy, and can facilitate engagement</p>	
Continuity of care	Ensuring coordination and cooperation between services	Lack of communication by mental health services to referring clinicians and other agencies, with possible impact on subsequent referrals to

		mental health services
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Title:

In or out? Barriers and facilitators to refugee-background young people accessing mental health services

Date:

2015-12-01

Citation:

Colucci, E., Minas, H., Szwarc, J., Guerra, C. & Paxton, G. (2015). In or out? Barriers and facilitators to refugee-background young people accessing mental health services. *TRANSCULTURAL PSYCHIATRY*, 52 (6), pp.766-790.
<https://doi.org/10.1177/1363461515571624>.

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