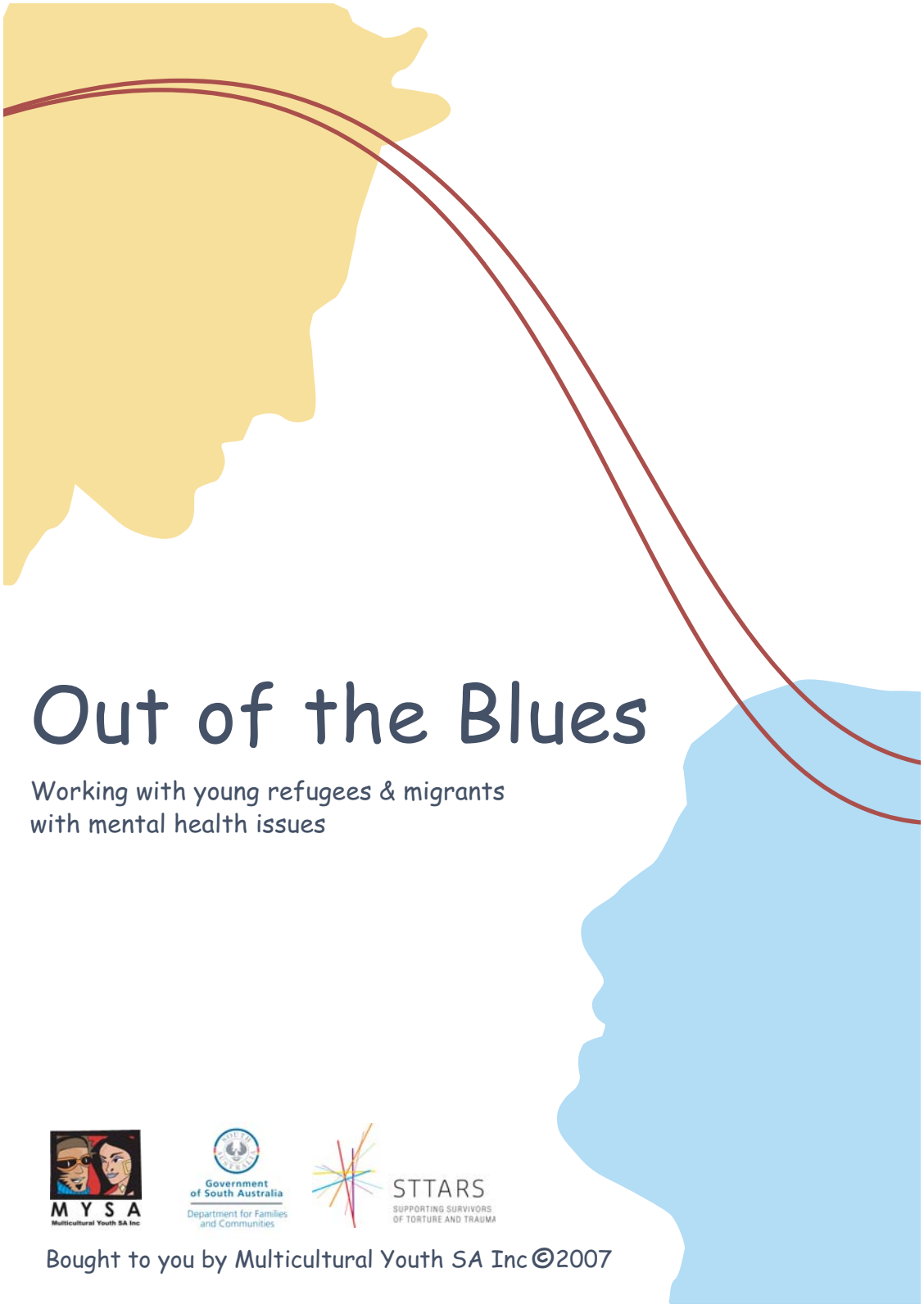

Out of the Blues

Working with young refugees & migrants
with mental health issues

MYSA
Multicultural Youth SA Inc

Government of South Australia
Department for Families and Communities

STTARS
SUPPORTING SURVIVORS OF TORTURE AND TRAUMA

Contents

About this handbook

This handbook draws on the research literature and the service experience of Multicultural Youth South Australia Inc (MYSA) and Survivors of Torture and Trauma Assistance and Rehabilitation Service (STTARS) to provide an overview of mental health issues affecting young refugees aged between 12 and 25 years.

It is widely acknowledged that young refugees are at increased risk of developing a range of social, behavioural and mental health problems due to a complex array of stressful pre and post migration experiences. It is also acknowledged that many young refugees are not accessing mental health services but are instead turning to teachers, school counsellors and service providers with limited experience in the assessment and treatment of mental health problems. The main purpose of the handbook is to help non-mental health professionals identify when a young person may need mental health care and to make competent referrals.

However, the handbook also includes information and practical strategies for making mental health services more culturally responsive and inclusive and therefore may also be of use to mental health professionals with limited experience in working with young refugees. Although South Australia is characterised by considerable cultural and linguistic diversity, there is still much work to be done in making our institutions, including the mental health care system, more responsive to the needs of a culturally and linguistically diverse population. Increasing the access of young refugees to mental health services requires a strong commitment on the part of mental health and allied professionals to making the necessary changes and adjustments to fully accommodate refugee youth access. It is hoped that this handbook will help improve and enhance cross-cultural practice.

About MYSA

Multicultural Youth SA Inc (MYSA) is the state advisory, advocacy and service delivery body for young people from culturally and linguistically diverse (CALD) backgrounds. MYSA's work includes:

- Providing policy and program advice to government and the community services sectors on CALD youth issues;
- Assisting and supporting service providers to work more effectively with CALD young people through information provision, resource development and training;
- Providing direct services and support to CALD young people to enable them to participate more fully in community life;
- Raising awareness of the needs, issues and concerns of CALD young people;
- Strengthening linkages and partnerships with schools, community organisations and government departments to facilitate a whole-of-community approach to meeting the needs of CALD young people;
- Undertaking and supporting research initiatives that aim to increase knowledge about issues affecting CALD young people;
- Representing the needs of CALD young people on state and national policy forums.

About STTARS

The Survivors of Torture and Trauma Assistance and Rehabilitation Service (STTARS) has been providing services to torture and trauma survivors in SA since 1991. STTARS is a non-government, not for profit organisation with no political or religious affiliations. STTARS assists people from a refugee and migrant background who have experienced torture or have been traumatised as a result of persecution, violence, war or unlawful imprisonment prior to arrival in Australia. STTARS provides individual and group counselling, information, support and advocacy.

Definitions

Refugees

The UN sponsored 1951 Convention Relating to the Status of Refugees defines a refugee as a person who is outside his or her country of nationality and is unable or unwilling to return due to a well founded fear of persecution for reasons of race, gender, religion, nationality, membership of a particular social group, or political opinion.

Voluntary migrants

The Refugees Convention makes an implicit distinction between refugees and migrants: a refugee is a person who is forced to leave his or her country whereas a migrant chooses to leave, generally for lifestyle reasons. However, like refugees, many migrants still experience loss, grief and language and cultural barriers in Western resettlement countries, including Australia.

Unaccompanied minors

Unaccompanied minors are a sub-group within the refugee population who have arrived in Australia without their parents. Some arrive with extended family members or siblings but others come alone. These young people may have lost their parents through death, disappearance or separation as a result of social and political upheaval in their country of origin.

Temporary Protection Visa (TPV) holders

Temporary Protection Visa (TPV) holders are another sub-group within the refugee population who face additional problems. The TPV was introduced in 1999 to deter “unauthorised” arrivals from entering Australia (Refugee Council of Australia, 2007). It has effectively created two classes of refugees and treats them accordingly. “Authorised” arrivals receive permanent protection and a comprehensive range of specialist services while “unauthorised” arrivals are left in limbo with no guarantee of gaining permanent residence and with very limited Federal Government support. Unlike other refugees, TPV holders cannot access most Federal Government settlement services and many social security benefits. And unlike other refugees, TPV holders cannot apply to have

immediate family members join them in Australia or visit them without jeopardising their visas (Refugee Council of Australia, 2007). For most refugees, these family reunion and travel restrictions mean many years of family separation, with all the anguish, anxiety and guilt this entails.

Asylum seekers

An asylum seeker is a person who has applied for refugee status in the country to which he or she has fled and is waiting for a decision on that claim. Many asylum seekers have been subject to Australia's mandatory detention policy which has seen them forcibly detained in prison-like conditions for years while waiting for decisions on their refugee claims.

Background

Refugee arrivals to Australia

Australia has welcomed over 600,000 refugees since the end of World War Two. Up to 13,000 more are added to this number each year. Children and young people have consistently represented at least 40% of all refugee arrivals to Australia over the past decade. In the last 12 months this figure has climbed to 58% (Department of Immigration and Citizenship, 2007). In some newly arrived African communities, as many as 64% of refugee arrivals are children and young people.

The refugee experience

Young people from refugee backgrounds are one of the most disadvantaged and marginalised groups in Australia. Some have been child soldiers, some have witnessed or experienced torture and trauma, some have received very little or no formal education, many have lost or become separated from their usual sources of support, including family, friends and familiar networks and some have spent years in refugee camps or immigration detention centres. Young refugees and their families generally arrive in Australia with limited money and few possessions, with poor English language skills and with little understanding of mainstream Australian culture and systems.

It is widely recognised that these pre and post migration experiences place young refugees at increased risk of a range of social, behavioural and mental health problems.

Refugee mental health and wellbeing

While there is a broad consensus in the research literature that young refugees are more vulnerable to mental health problems than the general population, there is less agreement about prevalence rates. Some American studies place the rate for serious psychiatric disorder at 40-50% (Kinzie, Sack, Angell & Manson, 1986; Kinzie, Sack, Angell & Clarke, 1989; Sack & Him, 1999), while Australian studies report a lower rate of 18- 32% (Krupinksi & Burrows, 1986; McKelvey et al., 2002). The rate for psychiatric disorder in the general population is around 14-21%, according to a recent large-scale Australian study (Sawyer et al., 2005).

There is growing concern in the international and national literature that many young refugees in need of mental health care are not accessing mental health services. While very few studies have explored service utilisation among young refugees, research undertaken with non-refugee ethnic populations provides cause for concern. Numerous international studies report under-utilisation of services by ethnic minority populations (U.S. Department of Health and Human Services, 1999, 2001). Studies have also found that when ethnic populations do access services, they are unlikely to receive the same level and quality of care as the general population (U.S. Department of Health and Human Services, 1999, 2001).

If young refugees are not accessing mental health services, where are they turning for help? In the service experience of MYSA and STTARS, many young people are turning to teachers, school counsellors and non-mental health service providers. A recent Australian child and adolescent mental health study found much the same thing with children and young people in the general population (Sawyer et al., 2005). It is widely recognised that non-mental health professionals are finding it very difficult to cope with refugee mental health issues:

> *The schools are being flooded with ----- [name of ethnic group withheld] but they are not getting the preparation they need to cope with the issues. They have worked with Indigenous youth but they have never seen such psychological damage as with the ----- [name of ethnic group withheld]. The anger is off the Richter scale. Chairs are being thrown around the room. They are not*

resourced within the education system to cope with the issues. It has an impact on staff, students and the community. (MYSA focus group with school, 2005)

We've got students who are cutting (themselves) and other self-harming behaviours. (MYSA focus group with school, 2005)

We're seeing patterns of youth depression and other mental illnesses. (MYSA focus group with school, 2005)

It should be noted, however, that most young refugees do not themselves identify a need for mental health care. Mental health issues are often eclipsed by immediate settlement needs such as learning the English language, adjusting to the Australian education system and making new friends.

What is mental illness?

Mental illness is an umbrella term used to group a wide range of psychological conditions that differ in nature and severity. A mental illness can be more or less severe, short or long term, and one-off, intermittent or persistent throughout a person's life. The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR), a widely accepted handbook for mental health researchers and professionals, defines a mental disorder as a:

> clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom. (American Psychological Association 2000, p. xxxi)

What are the causes of mental illness?

Western psychiatry and psychology attribute mental illness to a range of biological and environmental factors:

- **Biological factors** include genetics, disruptions in brain structure, altered neurotransmitter or hormone levels, injury and disease.
- **Environmental factors** include adverse life experiences such as war, poverty, neglect, divorce or a dysfunctional family life.

He spent his childhood in a refugee camp, living with a violent father, his mother, brother and sister. Most of the time he spent his days in a small room - it was too dangerous to play outside unsupervised. On moving to Australia it was not that different. He was confined to his home when not at school for fear that his estranged father would locate the family. School was not working out - he was going to be suspended. (STTARS case study, 2007)

While the exact cause or causes of most mental illness is unknown, it is widely believed that it occurs as a result of the interplay between biological and environmental factors.

Refugee understandings of mental health and illness

What is defined as mental illness in Western culture is often not regarded as such in non-Western cultures (Kleinman, 1987). Some cultures have not yet developed a concept of mental illness (Gongguy, Cravens & Patterson, 1991), much less one that corresponds to Western understandings.

> *We don't have problems like you. In my home country, I never hear from people, "Oh I am depressed" – this depression that you have just does not happen. (African female, MYSA youth consultation, 2007)*

Moreover, many non-Western cultures have different explanations for "mental illness". Where a behaviour or condition is recognised as abnormal, it is often attributed to sin, lack of faith in God, demonic possession, ancestral wrath, hexes, curses or thin blood. There are also cross-cultural differences in the expression of mental illness. As

many non-Western cultures make no distinction between the mind and the body, it is very common for psychological problems to be expressed in physical complaints. As one young woman told MYSA recently, it may be more culturally acceptable to have a physical rather than mental health problem:

> *In my culture, if we had a [mental health] problem, we would just say we have a tummy problem because we just wouldn't tell anyone we had a problem in our head. (African female, MYSA youth consultation, 2007)*

These different cultural understandings about mental illness have been linked to lower use of mental health services by refugee and other CALD populations. It should be noted, however, that as new arrivals become more familiar with western mental health concepts and interventions, they often add them to their own (Leong & Lau, 2001).

Mental illnesses affecting young refugees

The three most commonly reported psychiatric disorders in young refugees are Post Traumatic Stress Disorder (PTSD), Depression and Anxiety (Lustig et al., 2004; Davidson et al., 2004).

PTSD

PTSD can develop in a person following an overwhelmingly frightening or traumatic experience (Australian Centre of Posttraumatic Mental Health, 2003a; American Psychological Association 2000). The disorder is characterised by three classes of symptoms:

- **Intrusive symptoms** include vivid memories, flashbacks and nightmares where those with the disorder relive their traumatic experiences. These memories are often accompanied by grief, guilt, fear and anger.
- **Avoidance symptoms** occur when those with the disorder attempt to avoid situations or people which remind them of the traumatic experience. Those experiencing avoidance symptoms often withdraw from family and friends,

experience numbness and are unable to feel affection or emotion even toward those closest to them.

- **Arousal symptoms** occur when those with the disorder become edgy and on guard, not knowing when they will relive the traumatic experience again. They can become easily startled, very watchful, irritable or angry with themselves and those around them (Australian Centre of Posttraumatic Mental Health, 2003b; American Psychological Association 2000).

PTSD is a very disruptive and distressing disorder for sufferers as well as their family and friends. The disorder often makes it very difficult to function normally at home and work, resulting in strain or breakdown in relationships with family, friends and work colleagues.

Depression

Major Depressive Disorder (MDD) is considered in terms of Major Depressive Episodes, which may last from weeks to months and can be separated by periods of normal functioning or reoccur across the lifespan (American Psychological Association, 2000). A Major Depressive Episode involves the individual suffering either depressed mood or Anhedonia, that is, deriving no joy or satisfaction from activities that would otherwise be fulfilling. To fulfil the criteria for a Major Depressive Episode, an individual must display one of these symptoms in addition to at least five of the following symptoms for a period of two weeks:

- Significant non-diet related weight loss or weight gain or altered appetite;
- Persistent insomnia or hypersomnia;
- Psychomotor agitation or retardation;
- Feelings of worthlessness or guilt;
- Lack or loss of energy;
- Inability to concentrate or make decisions;
- Frequent thoughts of death or suicide (American Psychological Association, 2000).

MDD is attributed to a number of factors:

- Biological factors such as genetic predisposition and neurotransmitter imbalances in the brain (National Institute for Mental Health, 2006).
- Poor self-esteem and defeatist thinking (Mental Health Channel, 2006).
- Stressful or traumatic life experiences such as being physically or sexually abused or experiencing the violent death of a family member or friend (National Institute for Mental Health, 2006).

Anxiety disorder

There are four types of anxiety disorder (American Psychological Association, 2000; Weiten, 2004):

- **Generalized anxiety disorder** characterised by persistent, intense anxiety with no specific source. Those with the disorder persistently worry about issues that would be considered insignificant or trivial to others. The disorder is often accompanied by physical symptoms such as dizziness, diarrhoea, muscle tension and heart palpitations.
- **Phobic disorders** characterised by an intense fear of a specific situation or object that often presents no real or present danger. Great anxiety is produced by imagining or encountering the situation or object. While those with the disorder are often aware that their fears are irrational, they cannot help their reaction.
- **Panic disorder** characterised by seemingly spontaneous and recurrent panic attacks that surface with no warning. Those with the disorder often suffer from chronic stress and anxiety about when the next panic attack will occur. They may also develop agoraphobia for fear that they will have a panic attack in public.
- **Obsessive-compulsive disorder** is characterised by persistent obsessive thoughts that are often irrational or taboo. Those with the disorder attempt to resolve these obsessive thoughts by performing unusual rituals, for

example, compulsive cleaning of self, possessions and home to avoid contamination.

Anxiety disorders have been linked to a range of biological, cognitive and environmental factors (Weiten, 2004):

- **Biological factors** include genetic predisposition, physiological sensitivity to the somatic symptoms of anxiety and neural circuit disruption.
- **Cognitive factors** include maladaptive thinking where those with the disorder persistently focus on perceived threats or view situations as excessively threatening.
- **Environmental factors** include conditioning and observational learning. With respect to conditioning, those with the disorder associate a previous trauma with a stimulus, for example an object, and experience anxiety whenever they encounter that stimulus.

> *Every time my mum hears a bang, even from a car or something, she quickly jumps under the table. It's because of the war. She is so scared she shakes like crazy. (African female, MYSA youth consultation, 2007)*

Those with anxiety disorder, especially children, can also develop fears from observing the behaviours of others (Weiten, 2004).

Risk factors for mental illness in young refugees

A number of pre and post migration factors place young refugees at increased risk of developing social, behavioural and mental health problems.

Pre-migration experiences of loss, trauma and disruption

While young people's refugee experiences vary widely in nature and severity, all have experienced massive disruption to their lives, including multiple personal losses that are outside the experience of

most young Australians. Many if not all young refugees have been affected in some way:

> [Refugees] must deal with significant personal losses, often including the violent death of family and friends. They frequently bear the scars of traumatic experiences; many are the survivors of torture. Refugees are also more likely than other immigrants to arrive without their immediate families, having been forced to separate in flight from persecution. Torn from their social network, uprooted from their cultural familiarity, possibly survivors of torture and trauma, and often fearing for the safety of those left behind, their mental health may be precarious. Because of these situations, refugees often suffer depression, sleeping disorders, nightmares, fatigue, inability to concentrate … (Canadian Council for Refugees, 1998).

Immigration detention

Many young refugees travelled to Australia by boat and were subjected to Australia's mandatory detention policy. Prolonged confinement in immigration detention has been identified in a number of Australian studies as an important risk factor for mental health problems in young asylum seekers. As one study of children in detention found:

> All children were diagnosed with at least one psychiatric disorder and most … were diagnosed with multiple disorders … Two children were diagnosed with all five of the psychiatric disorders assessed. All but one child received a diagnosis of major depressive disorder and half were diagnosed with PTSD. The symptoms of post traumatic stress disorder experienced by children were almost exclusively related to their experiences of trauma in detention … More than half of the children regularly expressed suicidal ideation, many thought they would be better if they were dead … A quarter … had self harmed [slashing their wrists, banging their heads] … (Steel, 2003).

Acculturation stress

Adjusting to life in a new country can be very difficult for any migrant but it can be particularly difficult for refugees who have been subjected to forced migration. Young refugees in the initial stages of resettlement have to contend with many difficult issues including learning a new language, adjusting to a new culture and systems, coping with pre and post migration experiences of loss, trauma and disruption, making new friends and for many, helping parents or guardians cope with the resettlement process.

Previous trauma experiences, difficulties negotiating bi-cultural membership, lack of family, peer and community support and broader social issues such as racism and discrimination can exacerbate acculturation stress and lead to feelings of isolation and alienation (Brough et al., 2003; Nicholson, 1998; Selvamanickam et al., 2001).

> *Aussies don't fully accept me because I am Bosnian and Bosnians don't fully accept me because I am Australianised so I don't really know where I fit. (Bosnian female, MYSA youth consultation, 2004)*
>
> *I had so many friends in Serbia, but none here. (Serbian male, MYSA youth consultation, 2004)*
>
> *The Australian kids wouldn't accept me because I wasn't cool like them and I couldn't speak much English. Even now [12 years later], I'm still trying to fit in. You never fit in. You're always different. (Bosnian female, MYSA youth consultation, 2004)*
>
> *You get homesick, you get lonely. (Serbian female, 18 years, MYSA youth consultation, 2004)*

Poverty and economic hardship

Despite Australia's relative affluence, refugee families often have to endure poverty, unemployment or employment in low-status and low-income occupations, substandard accommodation, overcrowding and poor nutrition. Their former education, training, qualifications and work experience may not be enough to help them re-establish themselves because these are often unrecognised in Australia. Many parents decide not to go through the lengthy process of having their former qualifications recognised, believing that it is "too late" for them and instead transferring their hopes and expectations on to their children.

The family's low socioeconomic status and attendant distress over all that has been lost can adversely affect the emotional wellbeing of young refugees, particularly those who want to participate in Australia's consumer culture to find acceptance and belonging with their peers. Many young refugees, however, lack the basic resources necessary to participate in school and community life.

I met this young 15 year old African male when I was running workshops at a school. A few weeks later he came and saw me. I sat down with him and after a bit of chit-chat he said, "I want to quit school. Don't tell my parents, don't try and stop me, I've had enough, it's too hard, I'm quitting - can you help me?" He told me he felt depressed and physically sick because he did not fit in. As we were talking, I discovered that he liked soccer. So I asked him why he did not play soccer at recess or lunch time with some of the other young guys. He replied, "I don't have any shoes, we can't afford it so no one is going to play with me, no one is going to talk to me. I just wanna' quit." I took him to *Rebel Sport* and bought him a pair of sneakers. Now he plays for a local soccer club and he is still at school. (MYSA case study, 2006)

Other young refugees need money to support family members who have been left behind in another country.

> I had a young client who wanted help finding employment. We tried to help him but we could not find an employer willing to give him a go. He kept coming back to us for help with the same problem when he suddenly started presenting with physical health problems. He said he was not sleeping, frequently felt "sick" and suffered with headaches. When we offered to refer him to a health service, he said, "I don't want to see a doctor. I just need to help my family back home. They have no money and I have this huge phone bill from ringing them all the time. I can't afford it." We worked out a budget for him. He decided to put eight dollars from his Centrelink payments aside each week to send home. He began to feel much better because he was able to give something back to the family he felt he had abandoned. (MYSA case study, 2007)

Racism and discrimination

Many young refugees, particularly those from visible minority groups, routinely experience individual and institutional racism in Australia. Both forms of racism can seriously affect a young person's wellbeing, not only impacting on mental health but also socio-economic status and community participation and involvement (Selvamanickam et al., 2001).

At the individual level, it is common for young refugees to be insulted, harassed or otherwise mistreated by peers, teachers, employers, shop owners, police officers and even the general public:

> *I was walking by myself and two men called me a terrorist because I was wearing a head scarf. (Afghan female, MYSA interview, 2007)*
>
> *They talk behind my back and call me names. (Afghan male, MYSA interview, 2007)*
>
> *The white children insult me and say, ****** you!" (Sierra Leone female, MYSA interview, 2007)*

People calling me names, "nigger". (Sudanese female, MYSA interview, 2007)

*Last week, this Aussie guy in a car yelled out, "you stupid wog *****". (Serbian male, MYSA interview, 2007)*

*They called me: "nigger, black ***** ". (Sudanese male, 15 years, MYSA interview, 2007)*

*Some white guy walk past and call names like: "nigger and black ***** ". (Sudanese male, MYSA interview 2007)*

At the institutional level, many refugees experience racism in the education, employment, housing, legal and welfare systems:

MYSA was recently advised by a young Tanzanian woman that a prospective landlord had refused to rent her a property near her university campus because he believed she would be "trouble" like other "Africans" he had "heard about".

An Iraqi woman recently reported to MYSA that her son had been repeatedly refused interviews with Australian employers despite having a very strong academic record. The family attributed this to his Iraqi name. The mother said that her son had been advised by employment services to change his name to one that sounded "more Australian" to improve his chances of finding work. Understandably, the family was highly offended because in the mother's words, "This is our name, this is who we are. We cannot change who we are." The mother went on to explain how much the family had lost as refugees. "Everything" had been lost – family, friends, home, country, social status, possessions and livelihood. While they were now out of immediate danger and were grateful for it, they still had to contend with a hostile and unsympathetic host country environment.

Given that institutional racism is firmly rooted in every social institution, including the mental health system, it is highly likely that young refugees will encounter it in their interaction with services. They will experience it, for example, if services do not educate themselves about refugee histories, cultures and healing practices, if they do not invest the (additional) time necessary to establish rapport, if they fail to provide interpreters and translated information and if they neglect to address refugee needs in a holistic way. Institutional racism can create a barrier to services or, when services are accessed, it can result in poor service outcomes.

Loss of parents

Some young refugees arrive in South Australia without their parents and are placed under the Guardianship of the Minister for Families and Communities. These young people may have lost their parents through death, disappearance or separation following social and political upheaval and insecurity in their countries of origin.

Some children are placed in the care of older siblings, uncles, aunts, grandparents or other distant relatives while others are fostered by members of their ethnic community. The loss or absence of one or both parents can give rise to or exacerbate existing mental health problems, particularly in younger children and those exposed to abuse or neglect in their new family (Fazel & Stein, 2002).

Limited parental support

Many parents are themselves suffering from mental health problems as a result of their refugee and resettlement experiences. This can lead to substance abuse, gambling and other problems. It can also result in child abuse and neglect or in a general lack of affection and support for children.

Young refugees often have family responsibilities which can affect many aspects of their lives including education, work and developing social networks. These responsibilities may include undertaking significant household duties, caring for siblings and other family members and providing support to parents struggling with pre and/or post migration experiences of loss and trauma. Young people may even be expected to leave school to support the family.

She told me she was Lebanese however both her parents were from Afghanistan. She was born in Lebanon and had moved through many countries on her journey to Australia. Life in Australia has been difficult. Her father is often in the city gambling and her mother busy caring for six children. She was asked to leave school and find a job to support her father's habit and the family home. Her mother was not providing the emotional support she needed in coping with her father's abuse. She made the brave decision to leave home, living in a car, finding a friend's place to stay. When I met her she was going through a particularly difficult time. "Sometimes I just want to walk out on the road when cars are crossing", "life is not good to me", she would say. She needed someone to hear what was happening for her, to be consistent in being there. (STTARS case study, 2007)

As young people generally adapt to mainstream Australian culture and pick up the English language faster than their parents, they may also be expected to help them with the settlement process, including orienting them to mainstream culture and systems, escorting them to medical and other appointments and providing translating and interpreting assistance. This support may be provided for a number of years and can result in role reversal and family problems.

> *Parents get you to do everything – you have to take them to the doctors, fill in forms for them, explain everything to them, everything all the time. (Bosnian male, MYSA youth consultation, 2004)*

> *We were made to grow too fast and suddenly we could not be kids. The first word I learn in Australia was "Housing Trust" – I had to help my parents find house. (Bosnian female, MYSA youth consultation, 2004)*

> *Too much is loaded on to us when we first come here - too much information to adjust to new country. (Serbian female, MYSA youth consultation, 2004)*

Family responsibilities can prevent or limit a young person's ability to access peer and community support networks. They can also result

in family conflict, with young people resenting the impact the added responsibility has on their education, work and social life, and parents feeling disempowered by what they perceive as a reversal in roles.

Many young people cannot expect their parents to provide them with similar support. Parents are often unable to advocate for their children at school or in other areas of their lives because they have limited English language skills and/or are unfamiliar with mainstream Australian culture and systems.

Intergenerational conflict

Intergenerational conflict is a problem for many refugee families, particularly where there is disagreement over a young person's rate and level of acculturation to mainstream Australian culture. This conflict sometimes results in family breakdown and youth homelessness or, where the family remains in tact, abuse or neglect of the child or young person (Refugee Resettlement Advisory Council, 2002; Westermeyer & Wahmanholm, 1996).

Identity issues

According to Western thinking, maintaining a strong sense of self and identity, including cultural identity, is critical to a young person's development. Young people who are able to find a balance between their own culture and that of their new country are better equipped to handle difficulties and challenges and make use of available opportunities. Yet there are very few support services available for young refugees struggling with cultural identity issues.

For many young refugees, however, there can be conflict surrounding cultural identity because they must reconcile two or more very different cultures. Some try to resolve this difficulty by identifying with mainstream Australian culture, which can result in family conflict.

Others respond by identifying with their culture of origin, which can expose them to increased racism and discrimination, especially if they belong to a visible minority group. For those unable to find a

sense of belonging or “fit” to any culture, there may be considerable stress and alienation.

Lack of access to community services, resources and support

Most young refugees do not have equitable access to community services, resources and support for a number of reasons, many of which are discussed in the section on service utilisation.

Making competent referals

Given the important role that schools and non-mental health services play in providing help for young refugees, it is important that they develop the knowledge and skills to identify when a young person may need mental health care. Those with moderate to high contact with young refugees should seek specialised training.

When is it appropriate to refer?

A young person should be referred for a mental health assessment when he or she requests one or when you believe he or she needs one. An assessment may be needed when a young person has a traumatic history and/or has suffered a recent stressful life event and demonstrates one or more of the following:

- Difficulty concentrating
- Anxious, worried or fearful
- Withdrawn, sad or teary
- Loss of interest or pleasure in usual activities
- Irritable, angry or violent
- Persistent disobedience, defiance, obstinacy or delinquency
- Excessive negative self talk
- Regressive behaviour such as refusing to engage in self care
- Loss of appetite
- Suicidal feelings and/or threats
- Excessive tiredness
- Persistent physical complaints
- Dependency
- Addictive behaviour such as substance abuse or gambling
- Mood swings
- Rituals or compulsions

When in doubt, it is always advisable to consult a mental health care agency. A list of support services is included at the back of this resource.

Help-seeking and service utilisation

Barriers to services

Generally, newly arrived young refugees do not access mainstream services beyond immediate support services such as Medicare or Centrelink. This can be attributed to a wide range of barriers.

Lack of knowledge about services

Most young refugees, particularly new arrivals, are not familiar with our monocultural, monolingual service delivery systems. In fact, even the idea of having 'services' is foreign to many because there are often no parallels in their countries of origin. This is especially the case with mental health services given that many young refugees are not familiar with Western mental health concepts and interventions and most do not know mental health services exist or what they can provide.

Language barriers

Limited English language proficiency can present a significant barrier to services, particularly for new arrivals who are in the early stages of resettlement. Many services do not use interpreters or provide translated brochures and pamphlets. Moreover, some are unwilling or unable to spend the extra time required to negotiate language barriers. Working effectively with young refugees and others from CALD backgrounds can require up to double the time taken for other clients. This of course places added pressure on already over-burden services.

Cultural barriers

Cultural stigma associated with mental illness (Papadopolous, Lees, Lay & Gebrehiwot, 2004; Hsu, Davies & Hansen, 2004), particularly in refugee communities where there is little or no understanding of Western mental health concepts and interventions, presents another important barrier to services.

> *People will think I am very sick if I say I have problems in my head like I am possessed or something. (Middle Eastern male, MYSA youth consultation, 2007)*

You know, you need to address the stigma. There is really bad stigma in my community, really bad stigma. Those with mental health [problems] are told that they need spiritual help or something like that. You need to tell them [the young people] that there is nothing wrong with them, that it is alright. You need to educate the ------ community [name of community withheld] about all this. Tell them there is nothing wrong with the young people. (African female, MYSA youth consultation, 2007)

Many young refugees come from a cultural context where personal problems are kept inside the family and, to a lesser extent, the community. Discussing personal problems with "outsiders" can be considered shameful. The fear of bringing shame on oneself or one's family and community can be a powerful deterrent to help-seeking.

If I had a problem in my head I would not tell anyone! They would think I am possessed by the devil. I would be damaged and no one would marry me. (African female, MYSA youth consultation, 2007)

Some young refugees do not accept Western mental health concepts and interventions, particularly those that rely on psychotropic medication to treat mental illness:

What are you giving young people [with mental health problems] medication for? This is not what they need. Young people don't want the medication. It does not help. They will not come [to a service] if you give them medication. (African female, MYSA youth consultation, 2007)

It should also be noted that some young refugees with mental health problems do not recognise them as such because they reserve the term "mental illness" for only the most severe and disabling psychiatric disorders. For many, "mental illness" means "craziness".

For young people from new and emerging communities, parental restriction can be another barrier to services. Newly arrived parents can be very protective of their children until they become more

familiar and comfortable with their new country. Many parents are not aware of Western mental health concepts and interventions while others assume mental health services are only for young people with very serious mental health problems. Parents may also have concerns that service providers will employ mental health interventions that conflict with their cultural values, beliefs and practices.

Distrust

Some young refugees may be suspicious of government affiliated agencies and personnel because either they or their families have experienced corrupt or brutal governments. For former TPV holders, there may be concerns that the information they provide to service providers will be used to withhold Australian citizenship.

Another issue affecting service utilisation by young refugees concerns broken trust. Many young refugees have been very let down by adults. Some have been caught up in adult wars while others have been abused, neglected or otherwise mistreated by parents and other adult relatives. This distrust is often generalised to other adults, particularly authority figures such as service providers.

Confidentiality

Some young refugees do not access services for fear that the information they provide to mental health professionals will be passed on to their families and communities. This fear can be especially pronounced where services employ bilingual professionals because these workers are in a position to disclose confidential information to parents and the young person's broader ethnic community. Given the cultural stigma associated with mental illness and the expectation that personal problems will be kept inside the family, the importance of maintaining confidentiality cannot be overstated.

Contextual barriers

Common contextual barriers affecting service utilisation by young refugees are high residential mobility and difficulties with transport. Another contextual factor concerns the relatively low importance many young refugees place on mental health in the early stages of

resettlement. For new and recent arrivals, practical issues such as housing, education and employment generally take precedence over mental health and wellbeing (Lustig et al., 2004). In many cases, mental health issues do not surface until these practical needs have been met, sometimes several years after migration.

Barriers presented by the mental health care system

Many of the barriers discussed above are exacerbated by a failure on the part of the mental health care system to accommodate the needs of a culturally and linguistically diverse population. Services are predominantly targeted toward the needs of the dominant culture. Most are provided in settings that refugees would find stigmatising and many do not offer an interpreting service or provide culturally and linguistically accessible mental health information.

Many have very limited understanding of refugee histories, cultures and healing practices and most do not incorporate refugee understandings of mental health and illness into their mental health models and interventions. Most do not provide outreach and community education programs and very few consult with refugees in service planning and evaluation (Davies & Webb, 2000; Miller & Rasco, 2004; Watters, 2001).

Additional barriers presented by the mental health care system include long waiting lists for specialist counselling services, high cost of services, service gaps, lack of cooperation and coordination between services and racism and discrimination.

Working more effectively with young refugees

Cultural diversity

Young people from CALD backgrounds currently comprise approximately 25 percent of the youth population of South Australia. Many refugees are among them. Providing culturally responsive services to ensure the full and equitable participation of young refugees in community life should therefore be a priority for all service providers. Some mainstream agencies, however, see it as the responsibility of ethno-specific agencies to meet the mental health needs of young refugees. Important as they are, ethno-specific agencies are just one part of the mental health service network and can only service a small portion of the refugee youth population. Mainstream agencies have a key role to play in providing essential support. The different experience, knowledge, skills and networks that both ethno-specific and mainstream services can offer are needed to reduce barriers and ensure equitable access to services.

What is access and equity in service provision and why is it important?

Access is about ensuring that every young person who is entitled to use your service can do so without difficulty. Equity is about treating them fairly, for example, ensuring that you have policies, procedures and other measures in place that acknowledge and respond to diversity.

The concepts of access and equity are underpinned by the principle that all young people, including those from refugee backgrounds, have the right to access community services, resources and support essential to their development and full participation in community life.

While the concept of access and equity has been around for a long time, it has by no means been achieved as there continues to be a number of barriers to services for young refugees and their communities.

Policy framework for access and equity obligations

A range of international, national and state declarations, charters and policies have been developed with the aim of increasing access and equity in service provision for people from CALD backgrounds. The Australian Government's position on access and equity is articulated in the Charter of Public Service in a Culturally Diverse Society (1998). The Charter has been endorsed by Federal, State and Territory Governments and applies to all government funded services.

The Charter is underpinned by seven major principles:

1. **Access.** Government services should be available to everyone who is entitled to them and should be free of any form of discrimination, irrespective of a person's country of birth, language, culture, race or religion.
2. **Equity.** Government services should be developed and delivered on the basis of fair treatment of clients who are eligible to receive them.
3. **Communication.** Government services should use strategies to inform eligible clients of services and their entitlements and how they can obtain them. Providers should also consult with their clients regularly about the adequacy, design and standard of government services.
4. **Responsiveness.** Government services should be sensitive to the needs and requirements of clients from diverse linguistic and cultural backgrounds, and responsive as far as practicable to the particular circumstances of individuals.
5. **Effectiveness.** Government services should be 'results-oriented', focused on meeting the needs of clients from all backgrounds.
6. **Efficiency.** Government services should optimise the use of available public resources through a user-responsive approach to service delivery which meets the needs of clients.

7. **Accountability.** Government services should have a reporting mechanism in place which ensures they are accountable for implementing the Charter objectives for clients.

Access and equity cannot be achieved through the willingness and dedication of lone workers; it requires a genuine commitment from all levels of management. A Good Practice Guide has been developed by the Department of Immigration and Citizenship (DIAC) to assist service providers to implement the principles outlined in the Charter. This can be obtained online from the DIAC website.

Making your service more youth friendly and culturally accessible

Working effectively with young refugees requires a commitment to implementing access and equity principles in practice. Simply put, this means ensuring that young people not only know about your service and what it can offer them but that they are also able to successfully communicate and interact with it. This involves:

- Engaging in planned, regular outreach to familiarise young people and their communities with your service in recognition that most are not familiar with the community services network or its relevance to their lives.
- Orienting new and recent arrivals to your service to ensure they understand how it operates and what their rights and entitlements are.
- Providing a welcoming, inclusive and youth-friendly environment.
- Addressing language and cultural barriers by recruiting staff and volunteers from refugee backgrounds, using interpreters when needed and providing written information in young people's first languages.
- Regularly reviewing your agency's policies, procedures and practices to ensure they are culturally inclusive and responsive.

- Participating in regular cross-cultural training to improve your knowledge of other cultures and gain a greater understanding of your own culture and how it impacts on your practice.
- Consulting with young people and their communities regularly to improve understanding of migrant and refugee youth issues.
- Facilitating the full and active participation of young people and their communities in needs assessments and service planning and development.
- Sharing decision-making with young people and their communities to increase their participation, empowerment and self-determination.
- Establishing and maintaining effective links and partnerships with multicultural and other agencies involved in service provision to young people.
- Working to reduce racism and other forms of discrimination in your service that limits or prevent access.
- Recognising and responding to the different needs within and between cultural groups based on age, gender, religion, education, social and economic status and other factors including whether they arrived in Australia as refugees or asylum seekers, the extent to which they have acculturated to mainstream Australian culture and where they are situated in the resettlement process.

Counselling & support services

Mental health care services

Survivors of Torture and Trauma Assistance and Rehabilitation Service
12 Hawker Street, Bowden, 5007
T: (08) 8346 5433

Child and Adolescent Mental Health Service
Women's and Children's Hospital
72 King William Road, Adelaide, 5006
T: (08) 8161 6622 (Boylan Ward)
T: (08) 8161 7227 (Dept. of Psychological Medicine)

Northern Region
Sidney Chambers, 50 Elizabeth Way, Elizabeth, 5112
T: (08) 8252 0133

Eastern Region
5 Darley Road, Paradise, 5075
T: (08) 8207 8999

Western Region
78-80 Dale Street, Port Adelaide, 5015
T: (08) 8341 1222

Country Services
T: 1800 819 089

Migrant Health Service
21 Market Street, Adelaide, 5000
T: (08) 8237 3915

Migrant Resource Centre of SA
59 King William Street, Adelaide, 5000
T: (08) 8217 9500

Multicultural services

Multicultural Youth South Australia
Shop 9 Millers Arcade, 28 Hindley Street, Adelaide, 5000
T: (08) 8212 0085
www.mysa.com.au

Australian Refugee Association
304 Henley Beach Road, Underdale, 5032
T: (08) 8354 2951
www.ausref.net

Multicultural Communities Council
113 Gilbert Street, Adelaide, 5000
T: (08) 8410 0300
www.mccsa.org.au

Lutheran Community Care
309 Prospect Road, Blair Athol, 5084
T: (08) 8269 9300
www.lccsa.org.au

Anglicare SA
18 King William Road, North Adelaide, 5006
T: (08) 8305 9200
www.anglicare-sa.org.au

Western Area Multicultural Youth Service
65 Woodville Road, Woodville, 5011
T: (08) 8408 1313
www.charlessturt.sa.gov.au

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For more information about this resource and working with refugee and migrant young people, please contact:

Multicultural Youth South Australia
Shop 9 Millers Arcade, 28 Hindley Street, Adelaide, 5000

Telephone: 08 8212 0085
Fax: (08) 8212 0650
Email: info@mysa.com.au
Web: www.mysa.com.au