Barriers to and facilitators of utilisation of mental health services by young people of refugee background

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Contents

Abstract

The aim of this project was to explore the perspectives of experienced practitioners – working in mental health services or in contact with mental health services- about "what works" and "what does not work" in successfully engaging young people from refugee backgrounds with mental health services. Effective utilisation of services included first contact access as well as access to appropriate follow-up care, if needed. The resulting report on the findings identified what are considered to be effective and ineffective approaches to engage this population with such services.

Background

Australia responds to the mental health needs of the general population through a system comprised of specialist clinical and non-clinical mental health services, primary health care services, general social (including school-based) services and voluntary support services. While mainstream services form the cornerstone of the specialist mental health care sector, several specialist (such as refugee-specific) and ethno-specific services have also been established. Despite these well-developed general and specialist arrangements, many refugee children and young people with mental health problems are not accessing mental health services (de Anstiss, Ziaian, Procter, Warland, & Baghurst, 2009; Michelson & Sclare, 2009). National and international studies reveal that service underutilisation is an issue for all children and young people. The National Survey of Mental Health and Wellbeing (Australian Bureau of Statistics, 2010) showed that, while the prevalence of mental illness is relatively high in young people, they have a relatively low use of mental health services compared with older age groups. However, as also observed by de Anstiss and collaborators (2009) the stakes may be higher for refugees, who have multiple risk factors for mental health problems and suicide and for whom accessing services is more difficult. Newly arrived refugees can often experience difficulties in accessing health and community services in a timely and effective way(Victorian Department of Human Services, 2008). Children are identified as being particularly at risk of suboptimal health care due to the impact of pre- and post-migration factors combined with the effect of resettlement stresses on a parent's ability to care for their children (Davidson et al., 2004).

In view of high risk of mental health problems among children and young people of refugee background, concerns about underutilisation of mental health services and unmet needs, it is important to improve knowledge of factors that may constitute impediments to service use and factors that may facilitate appropriate access to services. It is important to highlight that there is very little refugee-specific and child and youth-specific research in the area of mental health help-seeking and service utilisation. Barriers to seeking services are poorly understood as are factors that influence effectiveness of services for refugees once accessed (Ellis et al., 2010). A recently completed systematic literature review identified only 11 studies on mental health service utilisation by children and young people of refugee background(Colucci, Szwarc, Minas, Paxton, & Guerra, Submitted). Of these, only one article (de Anstiss, et al., 2009), which focused on 13-17 year old refugees who have settled in Australia, explicitly examined service-

related barriers. These included low priority placed on mental health by refugees, poor mental health and service knowledge, distrust of services, stigma associated with psychosocial problems and help-seeking, and social and cultural factors affecting how problems are understood, whether help is sought and from where. The current study complements the study by de Anstiss and collaborators (2009) by exploring the perspectives of experienced practitioners who are working in mental health services or in contact with mental health services about "what works" and "what does not work" (i.e. barriers and facilitators) in engaging young people from refugee backgrounds with mental health services. It also extends the aforementioned study by examining professionals' experiences working with a clinical population of young refugees.

Investigation of barriers to and facilitators of formal help-seeking among children and young people from refugee backgrounds as distinct from factors important for refugee adults and non-refugees children/youth is important because, 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).

This research arose from a roundtable discussion convened at the end of 2009 at The University of Melbourne with experts involved with refugee youth, during which the view was expressed that service providers have a lot of knowledge from their experience about what works and does not work in engaging young people of refugee background but their experience had not been documented. It was decided to examine what is known about successful engagement strategies and to identify what is not known and should be further researched. A second roundtable discussion was held at the end of the data collection for this research project involving young people of refugee background and service providers, representatives of relevant Victorian government departments and academics at which preliminary findings of the project were presented and discussed.

Method

Participants

A total of 15 tape-recorded focus group discussions and 5 individual interviews were held with 115 mental health and non mental health service providers. Providers who were involved in the initial roundtable described before were invited to participate in this study. Further participants were suggested by the recruited practitioners (snowball sampling) as well as by contacting other services identified through a search of literature and in the websites of relevant agencies. To be eligible for the study, participants had to be service providers[1] in the Greater Melbourne area who worked in a mental health serviceor were in contact with such services (e.g. referred their clients). Only professionals who reported experience with young people (i.e. between 13 and 25 years of age)of refugee background were recruited in the project. Practitioners identified as potential participants were invited by email or telephone to take part in a 60 to 90 minute-long focus group discussion. Five participants were interviewed individually either because the person was the only professional in the organization who met the inclusion criteria or he/she had particularly extensive experience with the group under study which could not have been fully communicated in a group discussion or could have dominated the group discussion. A "saturation" sampling strategy was employed and practitioners were interviewed until saturation was achieved, i.e. further interviews /focus group discussions did not elicit substantially new information from participants (Wynaden et al., 2005).

The average age of participants was 38.6 years[2] and 74% were female. Participants included psychiatrists, psychologists and counsellor advocates/counsellors in specialist and non-specialist mental health services; paediatricians, refugee health nurses, school teachers and coordinators, youth and social workers, community liaison workers, general medical practitioners in community health services, naturopaths, and workers in the Department of Human Services and in settlement services.

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[1] Throughout the project, the following definition of "mental health service provider" was used: an individual or organization "providing as its core activity assessment, treatment or support to consumers with mental illness and/or alcohol and drug problems" (Ministry of Health, 2006)

[2] Note that 19 participants preferred to not give their age.

The organisations in which participants were employed were:

- Victorian Foundation for Survivors of Torture (Foundation House)
- Centre for Multicultural Youth (CMY)
- DouttaGalla Community Health Centre
- Adult Multicultural Education Services (AMES)
- Department of Human Services (DHS)
- Melton Catholic Regional College
- English School Language (ESL), (i.e. Mullauna College and Western)
- Croydon Secondary College
- Ruthven College Whittlesea Community Connection
- Child and Adolescent Mental Health Service Dandenong
- Salvation Army Sunshine
- Royal Children Hospital
- Headspace Western Melbourne

It is important to note that participants were invited to express their own views and did not represent the views of the organisations in which they worked.

Procedure

All interviews were tape-recorded (after receiving written consent) and, in all but one instance, were carried out within the facilities where the service was located. Keynotes were taken by the moderator and an assistant.

Interviews were semi-structured and a mixture of questioning strategies was implemented. The two main areas covered in each individual/group interview were about what works and does not work in:

    a) Accessing MH services/initial referrals, i.e. successes and failures in the initial engagement of young people from a refugee background;

    b) Maintaining the engagement, when this was considered to be necessary, in addition to what was already indicated for the initial engagement.

Before attending the session, participants were invited to write a short "story" about a young person of refugee background who successfully accessed mental health services and a young person who did not access the service or accessed it initially but later discontinued contact with the service. Although they were invited to think about real stories of young people they had worked with in the past, participants were asked to write stories that did not contain any personal identifying information to protect confidentiality.These vignettes/case scenarios were used during the interview to stimulate discussions about what works and what does not work.

During the interviewsparticipants were invited to focus particularly on aspects that were considered as important influences on successful engagement that were thought to be specific to refugees. At the beginning of the group discussions, participants were also reminded that the scope of the project was young people between 13 and 25 years of age. However, those who had experience also with children (12 and under) were invited to indicate what must be taken into consideration when working with children.

As done in previous studies (Shuval et al., 2008), the interviewer reviewed the keynotes to reflect on each session before conducting the next, thereby enabling newly identified concepts to be examined in subsequent sessions while allowing more time to be spent on concepts that had not emerged in the previous interviews.

A combination of verbatim transcripts and key notes were analysed using content analysis following the standards of qualitative data analysis procedure - coding, identifying categories, clustering, and identifying themes (Wynaden, et al., 2005). The analysis was carried out by EC and validated through comparison with the findings of an independent rater.The keynotes written by the assistant and discussion with the research team, as well as themes identified in the relevant literature(de Anstiss & Ziaian, 2010; Ellis, et al., 2010; Gulliver, Griffiths, & Christensen, 2010; Watters, 2010), also contributed to the process of themes generation so to increase the trustworthiness, credibility and transferability of the research findings.

Results

The findings from the 15 focus group discussions and five individual interviews are presented in the following section. Because there was a great deal of commonality in the barriers and facilitators identified for initial and continuing engagementthey have been presented together, although some specific comments will be made concerning issues specific to referral and initial engagement.

Quotations from focus group discussions will be labelled with "FG" and from individual interview "Ind". The number indicates the number of the interview (from FG1 to FG15 and from Ind1 to Ind5).

Cultural competence and sensitivity

A substantial number of the barriers to and facilitators of mental health service utilisation identified in the interviews fell under the category of "cultural competence and sensitivity". Participants observed that to be able to engage the young person, respect and understanding of the culture must be shown, by the worker and by the service organisation. Absence of such respect and understanding was thought to negatively affect engagement with that service as well as 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"* (FG13).

It was suggested that a culturally appropriate, competent and sensitive service does not use "*a one size fits all approach*" (FG10) and matches the young person and professional by ethnic background and/or gender ("*chose the 'right' worker*", FG8). In some cases, religious match should also be considered. When matching on relevant characteristics is not possible, the mental health professional should be aware of the impact of their own gender, ethnicity, religion and ageon their relationship with the young person.Also the way the professional should "not" be dressed should be considered.

An aspect that was particularly emphasized is that the professionals should show interest in knowing more about the young person's culture while, at the same time, being able to demonstrate a certain degree of existing awareness and knowledge about the young person's and their family's experiences as refugees. Showing awareness of what they have experienced before moving to the host country and of what they are experiencing in the present was seen as important in making the young person feel understood, building trust and facilitating engagement with services.

In order to be culturally competent, some participants suggested that mental health workers "should do their research" and should receive relevant education/training.

Several other issues raised throughout the data collection are strictly connected to cultural competence and sensitivity including understanding refugees' conceptions of "mental health" and treatment; fear of services and importance of developing trust; awareness of language barriers and being prepared and able to work with interpreters; and the need to understand the role of families and communities. These themes will be discussed in the sections below.

Conceptions of mental health, illness and treatment

Across groups, participants discussed the different understandings of mental health in different cultures and the frequent lack of congruence with the dominant "Western" conceptual frameworks that underpin mental health practice. The view was expressed that professionals and services must attempt to understand how the person presenting to the service conceptualises the issues, rather than presume that the person shares "Western" constructions 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* (FG1).

In particular, some participants indicated that because of different cultural conceptions, the young person or his/her family might not recognise the presence of a mental health problem or

not identify the issue as a mental health problem, thus do not identify the need for support from mental health services. Even if a need for support was identified, the person and their family might not understand the concept of a "mental health service" and the idea of receiving such support from a stranger out of their social network. This issue will be further discussed in the section on Access.

Mental health literacy and "normalization"

While the understanding of mental health conceptions held by the young person, family and the community was seen as paramount in enabling engagement with mental health services, low mental health literacy was identified in the discussions as a barrier to effective engagement with young people froma refugee background. Participants suggested increasing the young person's, family's and community's mental health literacy while at the same time avoiding imposition of Western conceptions of mental health and trying to understand their perspectives. Suggestions for improvingmental health education included school-based education programs, using Youth, Family and Community Services to engage young people in activities (especially activities they are already involved in), peer groups, advertising campaigns (TV campaigns in particular), and using brochures and other print materials (although a few participants observed that such means are not effective). Participants also suggested implementing peer mentor and group activities, especially in schools, and positive role-models to 'normalize' mental health problems and symptoms:

> *Groups can help normalize mental health symptoms over the long term. Share in group session, not isolated, 'it's not happening just to me'* (FG10).

Participants also recommended the introduction of mental health issues in a non-threatening way (such as not using "labels" including the word "mental health") and targeting education programs to community members (e.g. elders) who could influence the larger community's attitudes. Some of the participants identified as one of the main barriers to accessing services the cultural stigma towards mental illness and mental health services, because of the negative connotations of this concept (it was asserted that *mental health* was closely associated to *crazy, lunacy, abnormality*- therefore rejected- among a number of ethnic groups).

Access

The concept of service accessibility was described as operating at different levels: easiness of accessing service as described before (e.g. waiting list, criteria to access service such as diagnostic labels and location of service), be "user friendly", and knowledge about what services are available and how to access them:

> *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* (FG8).
> *It's about teaching them how to access services as they need to, rather than developing that dependant relationship*" (FG9).

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",* FG13) and be easy to find. It was suggested that they 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 CAMHS 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"* (FG13).

A few participants suggested that services should be affordable or totally free although some participants believed that a free service might generate suspicion among refugees ("*nothing is for free*", FG14) or devalue the service.

Fear of services and building trust

Fear and distrust of services was seen to be an important barrier to effective engagement. Participants discussed issues of pre-resettlement negative experiences with people in authority, including experience of abuses of power. It was suggested that there is a lack of trust in institutions such as hospitals, and any closed environments, and there may be fear of anyone in uniform, which would be seen as representing authority.

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' (FG8).

Negative experiences of services may also occur after resettlement in Australia.

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 (FG9).

Fear of services and authorities was related also by a few participants to fear of providing personal information, undergoing formal assessments and filling out forms. This was seen as being connected to past negative experiences of authorities abusing informationand situations where sharing personal information with a stranger had placed young people and/or their families in danger. According to the participants such fears could be overcome by good practice: carefully explaining what was happening, what the service offered and did not offer (see Expectations), being a reliable and consistent presence, not wearing uniforms or, where this is not possible, clarifying the role of the people in uniform to dispel assumptions, explaining the referral process and what the forms and assessments are used for, and who could access services.

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. (FG8).

Some participants highlighted the need to foster trust in the agency as well as in individual workers so that the young person could be referred to others in the service if needed. Trust needs to be developed not only with the young person but also their family and the community and having *"a good reputation as an organization can short cut the trust"* (Ind20).

Across interviews it was emphasised that "*the integral factor in engaging young refugees is developing trust*" (FG12) and mental health professionals and other people in the service need to allow time for trust to be established from the beginning of the contact.

Confidentiality

Confidentiality was also described as leading to the building of trust. The fear that other members of the community may get to know that the young person is accessing mental health services was seen as an important barrier to engagement. Thus, confidentiality must be assured at several levels: first, the practitioner must give 'permission' to the young person to share their thoughts and experiences (including their 'secrets', see Family-related issues) while being clear about the use of the information they record, and about any circumstances in which they may have to break confidentiality (e.g. immediate risk) and how they would proceed in such circumstance (e.g. if they will inform the young people that they need to disclose the information). Confidentiality should also be assured at a service level, for instance by making mental health services more "discreet", e.g. different entrance from other services in the same facility (see Access). Confidentiality was described as an important point of concern particularly when working with interpreters, which is the topic of next section.

Working with interpreters

There was a general agreement that working with interpreters, and health professionals being competent in working with interpreters, is important for effective engagement and for young people to feel understood. However, it was also recognised that working with interpreters can be problematic in small communities or for specific dialects, as young people may feel that their confidentiality could be compromised and their problems become known to their families and their ethnic community (see below). A few participants indicated experiences of what was seen as unprofessional conduct by interpreters, such as interpreters who make their own judgments on what they should translate or interpreters who, instead of translating, provide their own view on the matter.

> (…) *and the reason why the child was crying was that the interpreter was saying him that the father was a really bad man*"(FG12).

It was suggested that telephone interpreters are a good option if there are concerns about confidentiality and that employing bi-lingual workers avoids problems that may be associated with working with interpreters.

The mental health professional must be aware of inter-cultural complexities including the specific dialect spoken by the interpreter as well as hostility that may exist between some ethnic groups who speak the same language. Because of this, it was recommended that young people should be asked, at the time of referral, if they have a preferred interpreter, if they wish to have someone with or without a similar cultural or ethnic background (*"they preferred somebody else, without a similar background, which was interesting"*, FG18) and to check with them at the end of the session their experience with the interpreting service used.

> *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 (prefer) to use the same interpreter next time? I'll really keep a good eye on that* (FG2).

Working with the same interpreter, when the young person has provided positive feedback, was indicated as contributing to establishing trust.

Involvement of the family and family-related issues

There was general agreement among participants concerning the need to address family issues, and that not addressing them could serve as a barrier to engagement.

> *Sometime 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*(FG13).

There was, however, some complexity in the discussion. While it was thought that in some cultures families needed to be directly involved to understand the service and support the young person engaging with the service, it was also recognised that for some young people this would be problematic. This could be for a number of reasons. In some circumstances the family "is the problem" or there might be "family secrets" that are best left undisturbed. A substantial number of young refugees have come as unaccompanied minors so they lack family support, or the family might hide or not recognize the presence of a problem. In some families, if the family

gets to know that the young person is experiencing a mental health issue and that he/she is receiving professional help for it, this could also lead to problems.

> *You deal with it in the family's wall (…), it's a sign against the family don't be cared for within the family*(FG18).

Understanding the roles of different family members ("*who is in charge of this family*", FG9), as well as building trust with the family, were identified as important.

Overall, it was agreed that giving consideration to the role of family was vital but also that it was not possible to generalise about what role the family should play, every community is different, every family is different and every individual young person is different.Therefore, asking the young person what role they would like his/her family to play and, after receiving consent, engaging with and involving the family, was seen as optimal.

Community involvement and partnership

Many young refugees come from collectivistic cultures. To be able to engage them with services, it was seen as crucial that mental health professionals engage also with their community and build a good reputation in the community.

> *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* (FG1).

Community members (such as community liaison workers employed by certain organizations, or volunteers) were seen as important resources to facilitate trust between the agency and the young person, give information on services available, work in partnership with the professional to provide monitoring and support, and to provide an alternative to interpreters.

Mental health professionals' style and approach

One of the main themes of discussion across interviews and participants was the approach and style of the mental health professionals, their communication and questioning style, and their involvement of the young person in making decisions.

Professionals working with young people of refugee background must, in the participants' opinion, show warmth and empathy, be youth-friendly, approachable, patient, understanding, non-judgemental, respectful, compassionate, have an "informal" approach ("*it's more valued who you are than what you are*", FG9), be able to connect, and be experienced and knowledgeable about working with young people. Participants highlighted the importance for the professionals to build a relationship and trust with the young person, and to show him/her that they care, for instance by persisting with offering opportunities for the young person to engage ("*chase them up*", FG17) and by doing something extra, such as calling after-hours because: *(…) if the client sees that you don't care, things are not going to go anywhere* (Ind3). Being reliable and consistent was indicated as an important facilitating factor in engagement. However, it was also observed that because some services have high turnover of staff, building consistency might be difficult in such services.

In one group it was observed that it is important that the professional *"gives permission to feel their feelings in a safe environment"* (FG4), because young refugees may have learned to repress their feelings or might not be able to verbalize what they are feeling.

One issue that received particular attention was the professionals' way of communicating and asking questions (e.g. for assessment). Participants noted that, although this can be time consuming, practitioners working with young people of refugee background must be eclectic and ask questions in different ways. Although using a conversational and narrative style of questioning (e.g. eliciting stories) and an indirect style were seen as preferable, in some instances a structured (such as "yes/no" and very specific questions) style might be more effective. However, "*firing questions*" was seen as something to be avoided in all circumstances, since this may evoke previous traumatic 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* (FG8).

It was also suggested that 'direct probing' should be avoided and more indirect methods used, such asfocusing initially on the young person's areas of interest (*"I started playing chess with him (…) and as soon as we did that, during the game, he started to talk to us"*, FG1). Using pictorial language and other arts-based means (music or watching a film on the topic) to encourage conversation were also seen as facilitators, particularly with younger refugees.

Participants pointed out that, because of fear and mistrust towards services and to avoid generating further fears and misinterpretation, the professional should explain why they are posing such questions and what will be done with the information they are receiving (see Trust). Non-verbal issues, such as physical proximity, body language, and tone and speed of talking, should be considered with particular attention when working with refugees.

The kind of "language" used was also seen as a potential barrier or facilitator. 'Medical jargon', formality and the use of 'mental health' terminology were seen as alienating and threatening.

Apart from 'how' to ask questions and converse with young refugees, participants indicated barriers and facilitators also in terms of the content of communication. It was suggested by participants that sensitive questions (including disclosure of possible 'secrets') should not be asked too early, before trust is established, and that it may be preferable to keep the focus on the 'here and now', especially at the beginning. Attention should be given to the young refugee's current concerns such as resettlement issues and the future ("*I just want to move forward*", FG14) rather than "*digging into the past*" (FG14), which, it was suggested, can be a distressing and re-traumatizing experience. While professionals dealing with refugees should be aware of and acknowledge the negative experiences of refugees, assessment and treatment should not be focused on recounting such experiences.

> *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* (Ind20).

Participants raised issues of deference and empowerment. Practitioners must explain their rights to young refugees, including the right to opt out of the relationship and treatment, and *"involve them in their own care"* (FG9). Involving the youth as much as possible in the treatment and decisions (including asking their views about any proposed care plan, the interpreter, who they want to be accompany them to appointments, and where to meet) was seen as particularly important with young refugees to help them to regain the control that they might have lost. However, practitioners must also consider that the young person might come from a system where the person in need is expected to be in a passive role: *"some people have never been asked what do you think?"* (FG10).

Finally, although participants indicated several barriers and facilitators to engagement that professionals must consider in their approach with the young person, the concern was also

raised that professionals must be aware of their work-load and time limits and manage their case load, for instance by transferring the client to another worker.

> D*o 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* (FG5).

Referrals and intake process

As indicated before, most of the issues raised by participants applied both at the time of first arrival/intake (i.e. referral) and to maintenance of engagement with services. However, a number of suggestions were made specifically to facilitate the referral process. These included consideration of the timing of referral (i.e. conflict with other more urgent priorities, see later) and making it a straightforward intake process (i.e. easy and fast). In particular, the presence of waiting lists was seen as problematic ("*people fall into the cracks*", FG18; "*don't just make appointment two months later, you are going to lose the young people*", FG13).

Assisted referral was seen to work, both in the initial engagement and in maintaining engagement. The issue emerged, firstly, in regard to how clients understood referrals and secondly, regarding how the person would engage with a new service. The point was made that referrals could be misinterpreted by people as being sent away. The person making the referral should check the young person's understanding of the referral process.

> *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* (FG9).

Accompanying the young person to a referral, attending the first appointment and explaining the process to the person were seen as an important task that a case coordinator/manager, worker in another service, or a trusted member of the community or school (e.g. teachers, school nurses, welfare coordinators) could carry out.

> *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(FG9).

However, a few participants who were not working in the mental health sector indicated concerns and fears with referring a young refugee to a mental health services and expressed the need to improve non mental health workers' ability to assess the need for referral and refer to a service when needed.

An issue that was raised specifically inregard to referrals was about criteria for service intake. In participants' experience, referral to mainstream mental health services can be made only if the young person has a clear diagnosis andgenerally is restricted to major psychiatric disorders ("*the system is overloaded, they have found their own way of gate-keeping*", Ind16). Thus, the issue was not always about the young refugee not accessing the service but about the service being unable to respond because the young person does not meet intake criteria.

> *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* (FG17).

Having been previously rejected by another service, or having received unclear explanations resulting in a misinterpretation of the situation, was seen as a barrier to engaging with other mental health services.

Finally, it was suggested that services should be engaging with people pre-referral, i.e. young people should be made aware of services available and start building a relationship with workers from the service before the need for referral arises (as preventative measure). However, it was recognised that mental health services have limited capacity for preventative work, so the importance of working with other parts of the health service, schools and community was emphasised.

Appointment systems and system flexibility/responsiveness

Beside the issues with waiting lists mentioned above, rigid appointment systems were seen as a major barrier to engagement by participants, including strict length of the appointment ("*work*

by the clock", FG9), having a maximum number of sessions or length of the program (e.g. first 12 months after arrival), and intensity and frequency of appointments.

Participants identified the clashing of the mental health service appointments with other activities, such as scheduling appointments during school times, as problematic ("*And we are open 9 to 5, when they are supposed to be in school, not in the doctors' waiting rooms!*", FG9). The importance of health services having a relationship with schools to avoid any misunderstanding of absence from school was proffered as a solution and it was also recommended that appointments be organized around or in conjunction with other activities. The suggestion was made in several occasions that drop-in services might work better for young people.

A lack of awareness of different 'concepts of time and age' was also seen as problematic.

> *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* (FG9).

The issue of age was related to different cultural expectations about the age at which a young person becomes independent ("*in Australia 18 years is adult but in our country [an African nation] he is still a child*", FG1), thus a young person may not be offered a service they need because of the age limits.

> *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* (FG9).

Service system rigidity was also seen as a contributor to inability to access services if the young person "*does not fit a category*" (FG8), as described before (see Referral).

Participants suggested that services and practitioners need to be flexible in regard to contacting the young person or their family to remind them of the appointments ("*chase them up*", FG17)

the way they are contacted (e.g. SMS might be better than phone calls, which are better than letters), and the consequences of missing appointments.

> "*If they don't turn up they get back on the waiting list*" (FG18); "*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!*" (Ind20).

It was suggested that service flexibility and responsiveness is shown by combining Western and traditional/alternative approach, by using a client-centred approach and offering them different services and style of engagement, which was one of the main themes discussed by participants and will be further discussed in next section: "*So I ask myself, sometimes, are we responding in the right way? Are we flexible enough?*" (FG18).

Mode/method of service delivery

There was considerable discussion about what was described as a lack of an enabling environment inmental health services (whichwere seen as too clinical and sterile,and set in closed room that can revoke negative experiences among refugees) and the effectiveness of outreach services, i.e. engaging young people from refugee background in their natural community settings where mental health professionals could be seen in a less formal way: "*we sit and wait!*" (FG14); "*go where the young people are*" (FG8). Schools were seen as having natural access to young people, so working with schools for early identification of mental health issues and to offer a "safe place to talk" was seen as important.
Engaging the young person in informal ways, such as through recreational activities and out of the office, was suggested as helping to build a relationship and to improve the accessibility of the service.

> *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?*" (Ind20);
> *Outreach was somuch more successful than ask people to come to the office all the time particularly with people from different cultural background*(FG13).

Setting up activities for groups of young people, engaging them through art, movies, sport and dance, and organizing peer support groups and group sessions were seen as effective strategies for engagement as well as to address social isolation ("*More contact activity instead of therapy*", FG18).

Participants were critical of the 'sectoral' way in which services operate (see also Coordinated approach) and the emphasis that mental health services place on symptoms and diagnoses. Participants suggested "*looking at everything holistically not just symptoms and prescribing medication*" (FG13). A holistic approach, as a few participants described it, means looking at different realms, at every aspect of the person, seeing the person as a "whole". A holistic model integrates treatment with activities (as described above) and works with the person's goals, focusing on what the person thinks he/she needs (including practical needs, see later Advocacy role). A holistic model of mental health would also be a way to combine Western with traditional approach (as also indicated before), and this combination of approaches was seen by some participants as a way to improve outcomes ("*maybe taking a combination of this Western ways and this traditional ways, mixing them maybe you can have a good outcome*", Ind3).

There was a clear sense among participants that the current model of service for young refugee was limited and a variety of options should be made available to be able to engage this population.

> *I can maybe think that is important to have individual support for young people, and that's the model of Headspace, but this is quite Western as well and I think to be refugee friendly you need other kinds of model* (FG18).

Attending to the priorities of the person: Advocacy role

There was general agreement across interviews that the issues presented by young people with a refugee background cannot be seen just as mental health problems but ought to be seen through the lens of resettlement. Young refugees often have to face a number of resettlement issues (such as family separation and visa-related issues, housing stability, isolation, economic and food security), which might represent a priority for them over their "self" wellbeing and mental health.

> *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 wellbeing, not recognize it as important* (FG2).

In participants' opinions, mental health professionals who deal with young refugees cannot be "*stuck into their own professional roles*" (FG4) and should deal also with the immediate needs

of the person, i.e. being also an advocate around their basic needs. Some participants emphasized in particular 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 no income, or very little income, so very quickly we got him linked into Centrelink and got him onto the right, the appropriate amount of money he was meant to be on and that made a significant positive impact on him and straight away he identified that we are a service who can support him into getting some positive change in his life* (FG8).

Meeting the practical needs of young people contributes to building of trust (with young people, their family and community), builds rapport more quickly and effectively, and makes them feel understood. This was seen as even more important with refugees, who usually belong to cultures where the notion of "counselling" and "talking therapy" are foreign to them.

> *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* (Ind16).

Some participants indicated that once young people experience that the mental health worker meets their expectations and helps also on a practical level they start opening up, are more willing to share their stories and engage with the service.

> *(Refugee) people don't just come in our door and say: "I know what you are offering me, I'm ready for that" there is more a sense of sussing you out and I think if he can get some practical things sorted (…) there is a willingness to consider going to the next step* (FG18).

Expectations

Clarifying expectations and meeting expectations were often raised as keys issue by participants while discussing barriers and facilitators. As indicated by one of the participants, since the initial contact the young person needs to feel that the mental health professional is going to help him/her and not "*just talk about the past*"(Ind3) because it is that initial contact that determine if he/she will return ("*They can decide to reject you from the first instance*", Ind3). It was suggested that it is vital that, from the beginning, the worker is clear about what he/she can and

cannot do, including the number of times or length of time he/she is able to see the young person, and what are his/her role and boundaries.

> *"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"* (FG7).

If "*getting some wins*" (FG18), such as housing, 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)",* (FG8). 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*?" (FG10).

Continuity of care

Participants acknowledged that refugees are usually "complex cases". Different players in different sectors are involved and the young person is often referred from one specialized service to another, or seen by multiple services and workers at the same time ("*each has a niche*", FG15). Because of this, lack of continuity of care and fragmentation of service provision were seen as an important barrier, even more so among refugees than other young people. Participants, however, thought that this situation could be improved by acting at several levels:

a. services can facilitate referrals to other services (see Referral);
b. ensuring greater cooperation and coordination between agencies (e.g. mental health services communicate and collaborates with GPs, community services and other community groups, government agencies such as child protection, and with alternative/spiritual healers) and within agencies (collaboration and communication between workers), and
c. establishment of a common agenda for the person in need, embracing an integrated approach.

> *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*(FG8).

Participants indicated that partnership between organizations can be a good way to deal with lengthy waiting lists because the young person could remain engaged to a servicewhile waiting to be seen by the other (e.g. specialist service).

A few participants, however, indicated that young refugees have high degree of mobility, which makes it difficult sometimes to find them. This could represent a possible obstacle for follow-up and to maintenance of continuity of care.

Other barriers and facilitators

A number of additional barriers and facilitators were identified by participants.

The establishment of a key worker in health services accessed by people of refugee background to build trust with the young person and assisting them to overcome their fears was emphasized in the focus group discussions. Having a key worker also promoted continuity of care. The key worker role was seen as active in explaining treatments, assisting in referrals, accompanying the person to appointments at new services, regularly enquiring whether the person was satisfied with the service and understood what services could and could not deliver, and advocating on the person's behalf to ensure access to services they required.

Young people of refugee background were seen by a few participants as reluctant to seek professional help for a number of additional reasons to those indicated so far, including the lack of acknowledgment that they need help or that they need "mental" health help, shame and self-reliance, and lack of belief that anyone can help them. The point was also raised that among some young refugees there is the belief that problems should not be shared with outsiders and "*for some of them it's the culture of not complaining*" (FG9), thus they might not disclose that they have a problem or not express that a treatment is not working ("*the quiet one are the most dangerous to themselves, because they can keep quiet, see things are not working and do something bad to themselves*", Ind3). Workers in mental health and other sectors must be aware of these barriers and find ways (such as education) to tackle them.Furthermore, the worker must be aware (e.g. when assessing the need for help) that in some instances "*their great resilience masks what's going on inside them*" (Ind16) or they might express or interpret a mental health issue as a physical problem and seek other sources of help, such as GPs or traditional/alternative healing.

The point was raised in one group that some young people of refugee background might not access a service because of "*what the service represents*" (FG15). Examples were provided of what it might mean for a young Muslim to use a Christian service ("*he would be cheating their family*", FG15).

Before moving to the discussion, the table below summarises some of the key issues presented.

Table 1 Key issues

Themes	*Major issues*
Cultural competence and sensitivity	Show respect and understanding of the person's cultural background
Conceptions of mental health, illness and treatment	Understand how the person (and their family) conceptualises the problem
	Increase mental health literacy in the young person, family and community
Access	Improve service accessibility (including location and transport)
Trust and confidentiality	Develop trust in the person, their family and community
	Assure and maintain confidentiality
Interpreters	Be aware of issues surrounding working with interpreters
	Work with professional and trusted interpreters
Family	Consider family issues and discuss the role of the family
Community	Involve and engage community
Mental health professionals' style and approach	Show qualities that improve engagement (e.g. warmth, empathy, care, reliability, empowerment)
	Ask appropriate questions in the appropriate time using an appropriate style
Referrals and intake process	Make the process easy and clear (no clashes nor waiting lists, assisted referral, etc.)
System flexibility and responsiveness	Non-rigid appointment system
	Drop-in and outreach services
	Holistic approach
Advocacy	Attending to the priorities of the person, including practical needs
	Clarify and meet expectations
Continuity of care	Greater coordination and cooperation between services

Discussion and conclusions

Australia has a well-developed policy framework for continuing reform and improvement of mental health services. The Fourth National Mental Health Plan (Commonwealth of Australia, 2009), provides the overall direction and identifies areas for particular attention, among which is a focus on "Service access, coordination and continuity of care". This includes the requirement that front line mental health workers need to be able to recognize and respond appropriately to those who present with more complex problems as well as having an appreciation of issues facing particular groups, such as refugees. The Victorian Government has been a leader in mental health development and is now engaged in a 10-year process of mental health system reform. The mental health reform strategy(Mental Health and Drugs Division, 2009)identifies refugees as being at particular risk of developing mental health problems andthe need to develop more culturally responsive services for culturally and linguistically diverse (CALD) communities, including refugees. The government of Victoria has also developed an action plan that specifically addresses the health and wellbeing needs of refugees(Victorian Department of Human Services, 2008). The document identified three strategic priorities:

1. Provide timely and accessible services for refugee new arrivals;
2. Build the capacity and expertise of mainstream and specialist services and health care practitioners in the area of refugee health care;
3. Support and strengthen the ability of individuals, families and refugee communities to improve their health and wellbeing outcomes.

Given the significant number of refugee children and young people settling in Victoria and the prevalence of mental health problems in this group, it has been acknowledged that attention needs to be given to the development of models of care that appropriately respond to the needs of children and young people (Victorian Refugee Health Network, 2009).

Although there is an enabling policy environment at both national and state levels, there are substantial challenges in policy implementation. Among these challenges is the paucity of evidence of "what works" in engaging young refugees and in providing effective mental health services. The study by de Anstiss and colleagues (2009) is an exception.

In this project, the aim was to examine the experiences and views of experienced practitioners concerning barriers to and facilitators of access and engagement of young refugees in mental health services.Multiple barriers and facilitators were identified by the participants, among young people, their families and their communities, and in relation to the practices of health professionals and the structure and operations of mental health service agencies. These were broadly consistent with the results of previous work (CMY, 2008, 2011; de Anstiss & Ziaian, 2010; de Anstiss, et al., 2009; Victorian Refugee Health Network, 2009).

The following section will provide the key findings comparing them, whenever possible, with current literature and findings from the roundtable (CMY, 2011)[3].

Participants observed that a key factor in promoting access and engagement is respect and understanding of the young person's ethno-cultural background by health workers and in the way the service is structured and delivered. The essential features of a culturally competent and sensitive mental health service have been previously described and are generally agreed(Minas, 2001, 2007). Although the participants highlighted ethnic matching of worker and client as a feature of such cultural competence, the evidence for ethnic matching (Jerrell, 1998; Nadeau & Measham, 2006) is equivocal. De Anstiss and Ziaian (2010) wrote about "culturally astute professionals" to deal with adolescents from refugee backgrounds. Certainly knowledge and awareness about pre and post-settlement circumstances that the young refugee might have experienced is important for effective engagement, while at the same time showing curiosity and interest in learning more directly from the person. In this regard, Watters(2010) highlighted the importance of having political awareness when working with this population, meaning awareness of the situations from which refugees have escaped as well as "awareness of the changing laws and policies of the host societies and the pressures that arise from public perception of refugees" (p. 34). This is important also because, as highlighted by Tribe (2002), refugees may assume, often incorrectly, that the service provider is familiar with the politics and human rights record of their country, and may therefore not volunteer important information.

As with many immigrant groups, people of refugee background are likely to have varying conceptions of mental health and illness, and of mental health treatment and services (Hsiao, Klimidis, Minas, & Tan, 2006; Kiropoulos, Klimidis, & Minas, 2004; Klimidis, Hsiao, & Minas, 2007; Minas, Klimidis, & Tuncer, 2007). This was highlighted in this study and in the

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[3]Readers are also referred to Colucci and colleagues (submitted) and de Anstiss and colleagues (2009) for a review of previous studies, and to the article by Guerin, Guerin, Diiriye and Yates (2004) which, although not specific for young refugees, highlighted several of the barriers and facilitators indicated in this study.

roundtable discussion with young refugees (CMY, 2011), in which the young people pointed out several issues with the translation of 'mental health', both literally and conceptually, (*"The community will think you are crazy"*) and they discussed the use of "wellbeing" as alternative. De Anstiss and Ziaian (2010) found that most of the young people from Africa interviewed in their study had not heard of the terms 'mental health' and 'mental illness'. African conceptions of mental illness were found to be notably different to Western conceptions, and some of the African female participants reported that their families continued to rely on traditional knowledge and healing, "*still, if necessary, sending away to Africa for indigenous treatments and remedies*" (p35). Palmer and Ward (2007) observed that in some societies a binary understanding of mental health is prevalent - people are either mad or sane. It is clear that understanding how refugee communities' cultural interpretation of health and illness may impact on potential access to and use of mental health services is essential if service providers are to meet the needs of refugees.

Participants in the roundtable observed that there is insufficient education and awareness about mental health and, therefore, of understanding among young refugees, their families and their community. A previous study in Australia also showed that most young refugees have little knowledge of available services and how to get access to them (de Anstiss & Ziaian, 2010). Young refugees at the roundtable also noted that Western mental health practices may seem alien to people of refugee background and not be valued, as has been indicated in previous studies (Behnia, 2003; Ellis, et al., 2010; Guerin, et al., 2004; Palmer, 2006; Palmer & Ward, 2007; Tribe, 2002; Ward & Palmer, 2005). Participants in this study also suggested increasing the young person's, family's and community's mental health literacy while at the same time avoiding the imposition of a Western model of mental health and trying to understand their perspectives[4]. A peer education approach was seen as a valuable approach to provision of training and support, as has been highlighted in the report *Enhancing refugee young people's access to health services*(Victorian Foundation for Survivors of Torture, 2000). English classes attended by newly-arrived refugees and migrants were particularly seen as a good opportunity to raise awareness and provide information in the roundtable discussions (CMY, 2011). In this roundtable participants noted that one-off meetings/sessions are not sufficient for 'real learning' to take place and also that it should not be taken for granted that all refugees want to connect to

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[4] In this regard, Blackwell (1989, cited in (Tribe, 2002), wrote: "It's all too easy to repeat the colonizing process by imposing a therapeutic ideology rooted in the culture of the host community, giving meaning to the survivors' experience in the language and symbols of that host community and its professionals, and failing to recognize the rich sources of meaning and symbolism available to the survivor from his or her own culture". Nadeau and Measham(2006) suggested that that the clinician should search for an understanding of the present difficulty, including the meaning of symptoms, with the person, his or her family and cultural brokers to learn more about the problem: "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).

their own community, so training sessions to the broader community (including refugees and non-refugees) were suggested as a preferable modality. Both participants in the study and in the roundtable (CMY, 2011) pointed out that education and training must go in both directions: education of the refugee communities about mental health and services as well education of service providers in engaging young people from refugee background. In particular, a previous study in Victoria (Collinetti & Murgia, 2008) has shown that clinicians working with CALD clients had rated "understanding values and beliefs across cultures" as the training they would find most useful (84.9%), followed by training on how to engage with these clients (78%) and on the "impact of trauma on refugee client and their families" (73.1%).

Service availability and accessibility - in terms of awareness, costs and transport - was indicated as an important issue in a previous consultation (Victorian Refugee Health Network, 2009) and by young refugees taking part in the roundtable, (CMY, 2011) who specified that this is particularly important in the early period after arrival and for people released from immigration detention centres. Young refugees participating in the roundtable discussions made the important observation that "access" is a two-way issue, access by young person and their families to services, and access by services to refugee communities. Services should seek to create "user friendly" environments (Watters, 2010). "Brokers", "advocates" or "mediators" also have an important role to play in ensuring good access and appropriate referral (Warfa et al., 2006). As argued by Cauce(2002), "culturally relevant mental health services quickly become irrelevant if ethnic minority adolescents do not find their way into them" (p. 53). Understanding the process by which refugee adolescents and their families identify problems, seek help and engage in treatment should be a top priority for those concerned with service provision.

Many refugees have experienced multiple losses, including often the basic assumption that people are trustworthy and that the world is an essentially safe and benevolent place.Some refugees may have a generalised fear of 'doctors' and other people in authority (Victorian Foundation for Survivors of Torture, 2000). As argued by Nadeau and Measham(2006) for some of the families of refugee children, mistrust and social isolation have been an important survival strategy during times of organized violence. Families may also be suspicious because they have not felt well received or have been discriminated against by host country institutions. Thus, developing trust was seen as an integral factor in engaging young refugees, even more so than for other young people or other migrants, because of their past experiences. Time must be allowed for trust to be established. Also in the roundtable young refugees indicated that for

them "*trusting a stranger with personal details of one's life is difficult*" (CMY, 2011). These young people suggested that community leaders are "the only way" to establish trust in the community. Procter (2006) has suggested practical strategies for the generation of trust among refugees and asylum seekers.

Particular attention must be given to explaining and ensuring confidentiality, as suggested by participants in this study and in the roundtable (CMY, 2011). Extra precautions must be taken around confidentiality in those instances where the professional (or the interpreter) is of the same ethnic/cultural background. A similar finding was reported by de Anstiss and Ziaian (2010), who found a greater mistrust of professionals of the same culture if the young person believed the professional was known, or potentially known, by their family or the broader community. This was especially so for female participants, and was attributed to the greater level of community surveillance of girls and women. Some female participants even suggested as a prerequisite that the professional *not* be from the same ethnic/cultural background. Based on this finding and the opinion of participants in our study, service providers should ask the young person what is their preference in this regard and not take for granted that they would prefer a worker and/or interpreter from their ethnic background or community.

Issues around language are central in the utilisation of health services (Cooke et al., 2004; Stuart, Minas, Klimidis, & O'Connell, 1996). Although working withinterpreters was indicated as important for effective engagement, several concerns have been raised around interpreters by participants in this project, the roundtable, and in previous studies (Minas, Stuart, & Klimidis, 1994; Misra, Connolly, & Majeed, 2006; Renzaho, 2008; Ward & Palmer, 2005). Recommendations and guidelines have been developed for engaging interpreters(Miletic et al., 2006), which could assist professionals working with young refugees.

It was clear from the discussions that when working with a young person from refugee background, the engagement must go beyond the young person and involve also the family and the larger community. The study by Leavey, Guvenir, Haase-Casanovas and Dein(2007) supports the view that family plays a pivotal role in the nature and timing of help-seeking. The service providers interviewed generally thought that families must be directly involved in the process to understand the service and support the young person engagment with the service. However, the engagement of the family can be a source of difficulty for some young refugees. Thus, the worker should not generalise about what role the family should play, and should involve the young people in making decisions about what role their family should play. The

study by de Anstiss and Ziaian (2010) highlighted that the young people did not feel comfortable discussing personal issues with their parents. On the other hand, the involvement of the broader community was strongly supported both in our study and the roundtable discussion (CMY, 2011) and by other scholars (Behnia, 2003; Ellis, Miller, Baldwin, & Abdi, 2011; Leavey, et al., 2007; Palmer, 2006; Palmer & Ward, 2007). The young refugees involved in roundtable discussions noted that the community can help to create a link between the young person and the service and suggested that community leaders should receive training to assist them to be advocates in their communities. In particular, older members of the community and spiritual/religious leaders were identified as having significant influence over community perceptions and beliefs (Cauce, et al., 2002; Department of Human Services, 2010; Ellis, et al., 2010). However, as indicated also by Ellis and collaborators (2010), if the community can play an important role in identifying young people in need, it may also happen that "community talk" may discourage them from telling their parents or others about their problem. The same study also showed 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. Workers should be aware when working with young refugees of these and other issues related to the involvement of the family and the community.

Mental health professionals' style and approach were seen as being of great importance to facilitate engagement.Professionals' ways of communicating and asking questions received particular attention, especially the need to avoid doing anything that might resemble an interrogation (such as "firing questions") and "digging into the past". In this regard, also Pottie(2011) argued about possibly greater negative than positive effects of pushing for disclosure of traumatic events, and Guerin and collaborators (2004) reported clients' concerns that mental health professionals focus too much on past experiences (trauma) rather that problems in the current situation. Simplifying the language used to talk about mental health and avoiding jargon can facilitate communication and understanding between the worker and the young person. The Centre for Multicultural Youth (CMY, 2008) and Procter (2006) also suggested the use of indirect questioning, as did some of the participants in this study.

The professional also should, whenever possible, involve the young person in making decisions and include the youth's expertise in planning, development and evaluation, as suggested also by de Anstiss and Ziaian (2010)and by participants in a previous forum (CMY, 2008). In this regard, Watters and Ingleby(2004) suggested that the health services response to refugees can be characterized as being 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 (p. 1710).

As observed in previous studies (Guerin, et al., 2004; Misra, et al., 2006; Palmer & Ward, 2007), referrals to mental health services are often problematic. For instance, refugee clients may not understand what the specialist referral is about or why they need to go or may not follow Western time schedules (Guerin, et al., 2004), or may feel they have been waiting for too long (Palmer & Ward, 2007). Thus, it is not surprising that in this study, a number of suggestions were made specifically to improve referral and intake processes, such as simplifying the process, eliminating or reducing waiting lists, accompanying the person to the first appointment and having specialized services that can be accessed without a specific diagnoses and that are not restricted to people with major psychiatric disorders (McCrone et al., 2005). The appointment (and appointment reminder) system currently in place showedseveral pitfalls, which also a previous consultation(Victorian Refugee Health Network, 2009)saw as contributing to high failure to attend ratesin some services. It was suggested that to improve the engagement of young refugees the services must not overlap appointments with other important tasks or priorities and have a less rigid appointment system. Drop-in services were seen as a possible solution and the study by Palmer (2006) supports this suggestion, showing that adopting a flexible approach to appointments was successful in working with clients who have difficulty in understanding the boundaries and systems in more formal settings. Clear pathways to services must also be established (Victorian Refugee Health Network, 2009). Apart from appointments, services should show a greater degree of flexibility and responsiveness to the need of the young refugee. A greater flexibility was highlighted also in a government consultation paper, which indicated the benefits and limitations of a list of strategies for involving young refugees (Department of Human Services, 2010). Offering a variety of modes and methods of service delivery was seen as fundamental also in this study. In particular, seeing the young person out of a closed room, increasing outreach services and having a more holistic approach were all described as important facilitators. In other words, the counsellor who 'sits and waits' in the office and is 'stuck in his/her role' was seen as not likely to be successful with this population. Organizing sport, recreational and artistic programs, as well as running programs based in schools, language centre and other educational settings, were some of the suggested strategies to "reach" young refugees. Planned and regular outreach has

previously been recommended also by other scholars (Palmer & Ward, 2007)and was suggested also in the roundtable (CMY, 2011).

Because young people of refugee backgrounds have to juggle with a variety of issues related to the resettlement process, mental health professionals who deal with young refugees must also take on an advocacy role and assist as far as they are able with the immediate needs of the person. This is particularly important in light of the fact that, as highlighted in this and previous studies (Behnia, 2003; de Anstiss & Ziaian, 2010; Palmer, 2006), mental health is often considered a low priority among this population. A similar suggestion about services assisting with the practical concerns of the young people and having a holistic approach has been made in previous reports (Behnia, 2003; de Anstiss & Ziaian, 2010; Hodes, 2002; McColl & Johnson, 2006; Misra, et al., 2006; Palmer, 2006; Ward & Palmer, 2005; Watters & Ingleby, 2004). Woodland and collaborators (Woodland, Burgner, Paxton, & Zwi, 2010) listed a number of key issues for advocating for refugee children. Mental health professionals should also be clear and open with the young person about what they can do and what they cannot do, giving realistic expectations and, then, meeting those expectations.

Involving experienced workers from different agencies and sectors as research participants in this study reinforced the point that, to achieve the aim of improving access and engagement with mental health services among young people of refugee background, different players must be involved. These include general practitioners and other health service providers, resettlement agencies and schools. In particular English Language Schools were seen as playing a key role in improving access to services at several levels, such as for improving mental health literacy (as indicated also by de Anstiss &Ziaian, 2010), to start establishing a rapport with the young person before the need for a mental health service arises, for outreach and group-based service delivery (see also Ellis et al., 2011) and to identify young people in need and link them with services. Insufficient continuity of care and the fragmentation of service provision were seen as impediments to successful engagement and care of young people of refugee background by participants in this study, by participants in the roundtable (CMY, 2011) and in a previous consultation (Victorian Refugee Health Network, 2009). Also de Anstiss and Ziaian (2010) recommended that mental health services should build direct relationships with refugee communities and develop intersectoral and interagency partnerships with the wider social service system, including resettlement programs. An integrated approach was also one of the four components of good practice identified by Watters (2010). Ellis and collaborators (2010) suggested that through partnerships between mental health service providers, communities, and

religious organisations, pathways to care may be opened. A previous study (Savin, Seymour, Littleford, Bettridge, & Giese, 2005) showed that among the factors that were important in ensuring that refugees with probable mental disorder accessed mental health treatments there were: the co-location of the physical and mental health services and good communication and working relationship between the agencies involved (e.g. clinical staff, case managers, Department of Public Health).

In regard to continuity of care, follow-up and ongoing engagement are important facilitators of engagement but these require resources in terms of time, costs and workforce (CMY, 2011)and can be difficult to achieve (Cauce, et al., 2002), also because of the mobility of people of refugee background (Warfa, et al., 2006; Watters & Ingleby, 2004).

In addition to the main issues described so far, other barriers and facilitators mentioned by participants includedlack of acknowledgement of the need for mental health treatment and care (Palmer, 2006; Silove, Steel, Bauman, Chey, & McFarlane, 2007; Weine et al., 2000), which might result in seeking help from other professionals such as GPs(Behnia, 2003; Ellis, et al., 2010; Leavey, et al., 2007; Misra, et al., 2006; Palmer & Ward, 2007; Sheikh-Mohammed, Macintyre, Wood, Leask, & Isaacs, 2006; Steel, Silove, Chey, Bauman, & Phan, 2005)or traditional/alternative healers (Behnia, 2003; Guerin, et al., 2004; Leavey, et al., 2007; Palmer, 2006). Also, many people from refugee background "consider the care of a sick member a collective responsibility of the family, as long as his/her behaviour can be managed at home (Behnia, 2003) and seek professional help only when the problem can no longer be kept hidden or is unmanageable. Both of these barriers (i.e. general reluctance to seek help for mental health problems and seeking help from different sources, including traditional, religious and cultural healing practices) were also pointed out by young refugees in the roundtable (CMY, 2011).

Lastly, an overarching theme that was mentioned by workers, both in mental health sector and not, was about the emphasis of the mental health system on diagnosis and symptoms, and the problems that a system based on labels and "ticking boxes" creates in regard to service access.

In conclusion, this study identified multiple barriers to and facilitators of access and engagement with mental health services. Many of the issues raised in regard to access and engagement among young people of refugee background were similar, as would be expected, to what previous literature hasidentified for young people in general and for the general immigrants (e.g. Dow, 2011; Gulliver, et al., 2010; Victorian Foundation for Survivors of Torture, 2000). However, there are added factorsfor young people of refugee background.

There is a need for further investigation of this issue, in order to inform service responses. It is particularly necessary to explore the views of young refugees concerning barriers and facilitators. People of refugee background, particularly users of services, their families and other community members, must be involved in this process. The young refugees who took part in our roundtable discussion (CMY, 2011) were disappointed and frustrated by the general failure to integrate the refugee's experiences and voices in the design of service delivery, and this in their opinion represents a barrier to accessing services. Thus, we recommend that this research project be repeated with a larger population of young refugees who have been in touch with services. The study by de Anstiss and collaborators (2009) was based on a general population of adolescents from refugee background. Similar work needs to be done with a population of young refugees who are service users, and young refugees with mental health problems who avoid engagement with mental health services. Such workwould enrich our understanding of how to improve the services available and what else needs to be created.

In addition, better ways to translate the findings of such studies into policies and practice, and service delivery, must also be explored.As one of the 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).

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References

Australian Bureau of Statistics. (2010, 26 June 2011). Mental health of young people, 2007. *Mental Health Service Use*, from http://www.abs.gov.au/AUSSTATS/abs@.nsf/Latestproducts/4840.0.55.001Main Features82007?opendocument&tabname=Summary&prodno=4840.0.55.001&issue=2007&num=&view=

Behnia, B. (2003). Refugees' Convoy of Social Support: Community Peer Groups and Mental Health Services. *International Journal of Mental Health Special Issue: Disasters: The Mental Health Component (I), 32*(4), 6-19.

Cauce, A. M., Domenech-Rodriguez, M., Paradise, M., Cochran, B. N., Shea, J. M., Srebnik, D., et al. (2002). Cultural and contextual influences in mental health help seeking: a focus on ethnic minority youth. *Journal of Consulting and Clinical Psychology, 70*(1), 44-55.

CMY. (2008). Engaging refugee and migrant young people around mental health: Exploring strategies that work Retrieved 25 March 2011, from http://www.cmy.net.au/Assets/475/1/ForumReport_SMYIN_MentalHealth_161008.pdf

CMY. (2011). Young people of refugee backgrounds share their thoughts on mental health issues and services Retrieved 24 June 2011, from http://www.cmy.net.au/Assets/1747/1/MentalHealthRoundTableDiscussionDec2010final.pdf

Collinetti, S., & Murgia, S. (2008). Child & Adolescent Mental Health Services statewide culturally and linguistically diverse (CALD) survey 2008: A Victorian Transcultural Psychiatric Unit Initaitive. Melbourne: Victoria Transcultural Psychiatric Unit (VTPU).

Colucci, E., Szwarc, J., Minas, H., Paxton, G., & Guerra, C. (Submitted). The utilisation of mental health services among children and young people from a refugee background: A systematic literature review. *Journal of Culture and Mental Health*.

Commonwealth of Australia. (2009). Fourth National Mental Health Plan: A agenda for collaborative government action in mental health 2009-2014. Canberra: Department of Health and Ageing.

Cooke, R., Murray, S., Carapetis, J., Rice, J., Mulholland, N., & Skull, S. (2004). Demographics and utilisation of health services by paediatric refugees from East Africa: implications for service planning and provision. *Australian Health Review, 27*(2), 40-45.

Davidson, N., Skull, S., Burgner, D., Kelly, P., Raman, S., Silove, D., et al. (2004). An issue of access: Delivering equitable health care for newly arrived refugee children in Australia. *Journal of Paediatrics and Child Health, 40*(9-10), 569-575.

de Anstiss, H., & Ziaian, T. (2010). Mental health help-seeking and refugee adolescents: Qualitative findings from a mixed-methods investigation. *Australian Psychologist, 45*(1), 29-37.

de Anstiss, H., Ziaian, T., Procter, N., Warland, J., & Baghurst, P. (2009). Help-seeking for mental health problems in young refugees: a review of the literature with implications for policy, practice, and research. *Transcultural Psychiatry, 46*(4), 584-607.

Department of Human Services. (2010). *Connections for "At Risk" young refugee people: Making Crisis Supports Work.* Armadale: LDC Group.

Dow, H. D. (2011). Migrants' mental health perceptions and barriers to receiving mental health services. *Home Health Care Management & Practice, 23*(3), 176-185.

Ellis, B. H., Lincoln, A. K., Charney, M. E., Ford-Paz, R., Benson, M., & Strunin, L. (2010). Mental health service utilization of Somali adolescents: religion, community, and school as gateways to healing. *Transcultural Psychiatry, 47*(5), 789-811.

Ellis, B. H., Miller, A. B., Baldwin, H., & Abdi, S. (2011). New directions in refugee youth mental health services: Overcoming barriers to engagement. *Journal of Child and Adolescent Trauma, 4*, 69-85.

Guerin, B., Guerin, P., Diiriye, R. O., & Yates, S. (2004). Somali conceptions and expectations concerning mental health: Some guidelines for mental health professionals. *New Zealand Journal of Psychology, 33*(2), 59-67.

Gulliver, A., Griffiths, K. M., & Christensen, H. (2010). Perceived barriers and facilitators to mental health help-seeking in young people: a systematic review. *BMC Psychiatry, 10*, 113.

Hodes, M. (2002). Implications for psychiatric services of chronic civilian strife: young refugees in the UK. *Advances in Psychiatric Treatment, 8*, 366-376.

Hsiao, F. H., Klimidis, S., Minas, H., & Tan, E. S. (2006). Cultural attribution of mental health suffering in Chinese societies: the views of Chinese patients with mental illness and their caregivers. *Journal of Clinical Nursing, 15*, 998-1006.

Jerrell, J. M. (1998). Effect of ethnic matching of young clients and mental health staff. *Cultural Diversity and Mental Health, 4*(4), 297-302.

Kiropoulos, L. A., Klimidis, S., & Minas, H. (2004). Depression and anxiety: a comparison of older-aged Greek-born immigrants and Anglo-Australians. *The Australian and New Zealand Journal of Psychiatry, 38*(9), 714-724.

Klimidis, S., Hsiao, F. H., & Minas, H. I. (2007). Chinese-Australians' knowledge of depression and schizophrenia in the context of their under-utilization of mental health care: an analysis of labelling. *The International Journal of Social Psychiatry, 53*(5), 464-479.

Leavey, G., Guvenir, T., Haase-Casanovas, S., & Dein, S. (2007). Finding help: Turkish-speaking refugees and migrants with a history of psychosis. *Transcultural Psychiatry, 44*(2), 258-274.

McColl, H., & Johnson, S. (2006). Characteristics and needs of asylum seekers and refugees in contact with London community mental health teams: a descriptive investigation. *Social Psychiatry and Psychiatric Epidemiology, 41*(10), 789-795.

McCrone, P., Bhui, K., Craig, T., Mohamud, S., Warfa, N., Stansfeld, S. A., et al. (2005). Mental health needs, service use and costs among Somali refugees in the UK. *Acta Psychiatrica Scandinavica, 111*(5), 351-357.

Mental Health and Drugs Division. (2009). Because Mental Health Matters: Victorian Mental Health Reform Strategy 2009-2019. In D. o. H. Services (Ed.). Melbourne.

Michelson, D., & Sclare, I. (2009). Psychological needs, service utilization and provision of care in a specialist mental health clinic for young refugees: a comparative study. *Clinical Child Psychology and Psychiatry, 14*(2), 273-296.

Miletic, T., Piu, M., Minas, H., Stankovska, M., Stolk, Y., & Klimidis, S. (2006). Guidelines for working with interpreters in mental health settings. Melbourne: Victorian Transculutral Psychiatry Unit.

Minas, H. (2001). Service responses to cultural diversity. In G. Thornicroft & G. Szmukler (Eds.), *Community Psychiatry*. Oxford: Oxford University Press.

Minas, H. (2007). Developing mental-health services for multicultural societies. In D. Bhugra (Ed.), *Cultural Psychiatry* (pp. 389-401). Cambridge: Cambridge University Press.

Minas, H., Klimidis, S., & Tuncer, C. (2007). Illness causal beliefs in Turkish immigrants. *BMC Psychiatry, 7*, 34.

Minas, H., Stuart, G. W., & Klimidis, S. (1994). Language, culture and psychiatric services: a survey of Victorian clinical staff. *The Australian and New Zealand Journal of Psychiatry, 28*(2), 250-258.

Ministry of Health. (2006). Te Kokiri: The Mental Health and Addiction Action Plan 2006-2015. Wellington, New Zealand: Ministry of Health.

Misra, T., Connolly, A., & Majeed, A. (2006). Addressing mental health needs of asylum seekers and refugees in a London Borough: epidemiological and user perspectives. *Primary Health Care Research and Development, 7*(3), 241-248.

Nadeau, L., & Measham, T. (2006). Caring for migrant and refugee children: challenges associated with mental health care in pediatrics. *Journal of Developmental and Behavioural Pediatrics, 27*(2), 145-154.

Palmer, D. (2006). Imperfect prescription: mental health perceptions, experiences and challenges faced by the Somali community in the London Borough of Camden and service responses to them. *Primary Care Mental Health, 4*(1), 45-56.

Palmer, D., & Ward, K. (2007). 'Lost': listening to the voices and mental health needs of forced migrants in London. *Medicine, Conflict, and Survival, 23*(3), 198-212.

Pottie, K., Greenaway, C., Feightner, J., Welch, V., Swinkels, H., Rashid, M., et al. (2011). Evidence-based clinical guidelines for immigrants and refugees. *CMAJ : Canadian Medical Association journal, 183*(12), 824-925.

Procter, N. G. (2006). 'They first killed his heart (then) he took his own life'. Part 2: Practice implications. *International Journal of Nursing Practice, 12*(1), 42-48.

Renzaho, A. (2008). Re-visioning cultural competence in community health services in Victoria. *Australian Health Review 32*(2), 223-235.

Savin, D., Seymour, D. J., Littleford, L. N., Bettridge, J., & Giese, A. (2005). Findings from mental health screening of newly arrived refugees in Colorado. *Public Health Reports, 120*(3), 224-229.

Sheikh-Mohammed, M., Macintyre, C. R., Wood, N. J., Leask, J., & Isaacs, D. (2006). Barriers to access to health care for newly resettled sub-Saharan refugees in Australia. *The Medical Journal of Australia, 185*(11-12), 594-597.

Shuval, K., Weissblueth, E., Araida, A., Brezis, M., Faridi, Z., Ali, A., et al. (2008). The role of culture, environment, and religion in the promotion of physical activity among Arab Israelis. *Preventing Chronic Disease, 5*(3), A88.

Silove, D., Steel, Z., Bauman, A., Chey, T., & McFarlane, A. (2007). Trauma, PTSD and the longer-term mental health burden amongst Vietnamese refugees : a comparison with the Australian-born population. *Social Psychiatry and Psychiatric Epidemiology, 42*(6), 467-476.

Steel, Z., Silove, D., Chey, T., Bauman, A., & Phan, T. (2005). Mental disorders, disability and health service use amongst Vietnamese refugees and the host Australian population. *Acta Psychiatrica Scandinavica, 111*(4), 300-309.

Stuart, G. W., Minas, I. H., Klimidis, S., & O'Connell, S. (1996). English language ability and mental health service utilisation: a census. [Research Support, Non-U.S. Gov't]. *The Australian and New Zealand journal of psychiatry, 30*(2), 270-277.

Tribe, R. (2002). Mental health of refugees and asylum-seekers. *Advances in Psychiatric Treatment, 8*, 240-248.

Victorian Department of Human Services. (2008). Refugee health and wellbeing action plan 2008-2010: Current and future initiatives. Melbourne.

Victorian Foundation for Survivors of Torture. (2000). Enhancing refugee young people's access to health services. Melbourne, Australia: Victorian Foundation for Survivors of Torture.

Victorian Refugee Health Network. (2009). Access to specialist services by refugees in Victoria Retrieved 15 January 2010, from http://www.refugeehealthnetwork.org.au/LiteratureRetrieve.aspx?ID=58185&A =SearchResult&SearchID=2179612&ObjectID=58185&ObjectType=6

Ward, K., & Palmer, D. (2005). *Mapping the provision of mental health services for asylum seekers and refugees in London: a report*. London: Commission for Public Patient Involvement in Health.

Warfa, N., Bhui, K., Craig, T., Curtis, S., Mohamud, S., Stansfeld, S., et al. (2006). Post-migration geographical mobility, mental health and health service utilisation among Somali refugees in the UK: a qualitative study. *Health Place, 12*(4), 503-515.

Watters, C. (2010). Migrants, refugees and mental health care in Europe. *Hellenic Journal of Psychology, 7*, 21-37.

Watters C. (2010). Migrants, refugees and mental health care in Europe. *Hellenic Journal of Psychology, 7*, 21-37.

Watters, C., & Ingleby, D. (2004). Locations of care: meeting the mental health and social care needs of refugees in Europe. *International Journal of Law and Psychiatry, 27*(6), 549-570.

Weine, S. M., Razzano, L., Brkic, N., Ramic, A., Miller, K., Smajkic, A., et al. (2000). Profiling the trauma related symptoms of Bosnian refugees who have not sought mental health services. *The Journal of Nervous and Mental Disease, 188*(7), 416-421.

Woodland, L., Burgner, D., Paxton, G., & Zwi, K. (2010). Health service delivery for newly arrived refugee children: a framework for good practice. *Journal of Paediatrics and Child Health, 46*(10), 560-567.

Wynaden, D., Chapman, R., Orb, A., McGowan, S., Zeeman, Z., & Yeak, S. (2005). Factors that influence Asian communities' access to mental health care. *International Journal of Mental Health Nursing, 14*(2), 88-95.