Young People From Refugee Backgrounds
Help-Seeking for Mental Health Problems

Background

- Funded by the Australian Research Council
- Partnership between the University of South Australia, the University of Adelaide, the Women’s and Children’s Hospital, and industry partners, Multicultural Youth South Australia (MYSA) and the Migrant Resource Centre of South Australia (MRCSA)
- Survey (n=152) and focus groups (n=85) with male and female refugee adolescents aged 13-17 from the Former Yugoslavia (Bosnia, Serbia), the Middle East (Afghanistan, Iran and Iraq) and Africa (Liberia and Sudan)
- Aims: (1) determine the nature and scope of help-seeking and service utilisation by adolescents; (2) identify the service access barriers they face; (3) explore the meanings and understandings they give to their problems and needs; (4) identify their most important priorities for wellbeing

Survey Findings (n=152)
Pre-Migration Experiences

- 27.8% separated from parents and/or siblings
- 29.3% lived in refugee camps
- 36% exposed to one or more traumatic events, for example:
  - Threatening events happening to someone close to them (50.9%)
  - Witnessing someone being badly injured or killed (47.2%)
  - Unnatural death of family member or friend (45.3%)
  - Combat situation (41.5%)
  - Being close to death (37.7%)
  - Murder of family or friends (32.1%)
  - Witnessing the murder of stranger or strangers (22.6%)
- 29.9% (n=101) disrupted education

Survey Findings (n=152)
Post-Migration Experiences

- Top 5 most commonly reported resettlement difficulties:
  - Missing family and friends left behind (62%)
  - Finding suitable accommodation (56%)
  - Understanding Australian culture and systems (55%)
  - Adjusting to the Australian education system (48%)
  - Homesickness (46%)
- 41% - increase in family responsibility with migration
- 11% - increase in child-parent conflict
- 33% - decrease in ability to practice culture
- 23% - decrease in social participation
- 48% - never or rarely participate in own ethnic community events
- 21% - would like to return home if circumstances were different

Survey Findings (n=152)
Mental Health Issues

- The prevalence rate for depression was 8% (assessed using the CDI) and 10.8% for emotional and behavioural problems (assessed using the SDQ) based on parent reports (teachers put it higher)
- Service utilisation very low – 75.9% with an identified mental health care need do not access services

Qualitative Findings (n=85)
Mental Health Issues

- Young people make no distinction between “mental health” and “mental illness”, equating both with “craziness” and describing the mentally ill as “crazy”, “retarded”, “weird”, “sick”, “abnormal”, and “psychotic”
- Mental illness was perceived as a source of shame and something to be hidden
- In some communities, stigma carries special implications for girls and women due to a cultural expectation that they preserve the family’s honour and reputation
Qualitative Findings (n=85)
Mental Health Issues

- Most do not realise that mental illness covers a wide spectrum of conditions - only the most serious and disabling conditions indicate the presence of mental illness.
- Mental illness is attributed to God, the devil and witch doctors.
- Males say they don’t talk to anybody about their problems.
- Not talking about problems reflects their need to emulate a certain masculine ideal (resilient, self-reliant, independent, protective of women, and invulnerable).
- Professional help-seeking generally not seen as a potential coping strategy for psychological distress, even if the distress is adversely affecting daily life.
- Very poor mental health service knowledge overall.

Qualitative Findings (n=85)
Issues Impacting on Mental Health

Family
- Young people frequently report child-parent conflict, which often centres on their level of acculturation to Australian culture and society.
- Some young people can be the parent substitutes for younger siblings after the loss or death of parents.

Poverty
- Economic hardship and poverty affects most young refugees and impacts on their education, their capacity to engage in leisure and social activities, their opportunities to participate in community life and their self-esteem.
- Reasons include family welfare dependency, under-employment, employment in low-skilled, poorly paid jobs, and financial commitments to family members dispersed in other parts of the world.

Education
- Not adequately prepared for the transition into mainstream schools.
- Placed in year levels appropriate for their age regardless of prior education, English language skills, and current learning capacity.
- Perceived differential teacher treatment based on low expectation.
- Teachers described as having little faith in their abilities and as expecting them to under-achieve.

Racism
- Young people receive persistent reminders of the importance of race (expressed in overt or subtle ways).
- Many young people believe that social inclusion depends on them fully assimilating into Australian society and divesting themselves of the cultural, linguistic, and religious manifestations of their identities.

Police
- Poor police-youth relations.
Qualitative Findings (n=85) Service Delivery Issues

- Most young people do not access mainstream services beyond GPs and Centrelink
- Key barriers to services:
  - Distrust of everyone outside informal networks
  - Lack of familiarity with the welfare state generally and services particularly
  - Cultural barriers e.g., reluctance to seek outside help
  - Concerns about confidentiality (particularly if same-culture workers are used)
  - Reservations about the usefulness of services
  - Lack of cultural awareness and competence among mainstream services
  - Re: mental health services: (a) cross-cultural differences in the definition and expression of mental health problems; (b) individual and network stigma; (c) poor mental health literacy; (d) lack of service knowledge

Policy and Practice Implications

- A well established goal of federal and state public policy is to facilitate the access of migrant and refugee populations into mainstream public services, with the same access to quality care as the general population
- The continuing presence of major barriers to services for young refugees presents an important public policy and practice issue that requires attention
- Access and equity in service provision can be improved if the mental health system is willing to make the necessary changes and adjustments to accommodate a culturally diverse population
- Strategies are required at both the policy and service delivery levels

Policy and Practice Implications

At the policy level:
- Need refugee youth-specific policy and planning
- Need more integrated, multi-sectoral, multi-agency early intervention and prevention programs
- Ethno-specific services need to consider the special needs of children, adolescents and young people
- Need a greater commitment to improving system-wide cultural competence and capacity
- Re: multicultural policy, children, adolescents and young people need to be seen as a special needs group within the broader multicultural population (there is an absence of Federal and State multicultural policy for child and youth resettlement in general and mental health in particular)

Policy and Practice Implications

At the service delivery level:
- Engage in planned regular outreach
- Agencies need to collect accurate data re: cultural and linguistic identity of service users (poor data collection systems continue to impede service planning and development across the country)
- Need a more concerted effort to build organisational and worker cultural competency and reduce the barriers refugees face to services
- Include young people in the planning of services (meaningful participation is not just about opportunity; it is about seeing refugee youth as equal partners and equipping them to effectively participate)
- Ensure special precautions are in place to preserve confidentiality

Policy and Practice Implications

At the service delivery level:
- Re: mental health services:
  (a) Address individual and network induced psychiatric stigma via school-based stigma reduction programs
  (b) Offer services in a form young people can accept (e.g., basing them in schools and community settings)
  (c) Respond to practical and social needs in addition to psychological issues
  (d) Education to improve mental health literacy (but this should be based on intercultural exchange and negotiation rather than cultural imposition)
  (e) Establishing interagency and intersectoral partnerships with the wider social service system including primary health care services, education-based services, and the various government and non-government services that have extensive contact with refugee families

Thank you