

**Brave in their new world: Service provision for refugee youth
with comorbidity in northern metropolitan Adelaide**

Miriam Posselt

DISCIPLINE OF PSYCHIATRY

SCHOOL OF MEDICINE

FACULTY OF HEALTH SCIENCES

UNIVERSITY OF ADELAIDE

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So how do you sit with a shattered soul?

Gently, with gracious and deep respect.

Patiently, for time stands still for the shattered, and the momentum of healing will be slow at first.

With the tender strength that comes from an openness to your own deepest wounding, and to your own deepest healing.

Firmly, never wavering in the utmost conviction that evil is powerful, but there is a good that is more powerful still.

Stay connected to that goodness with all your being, however it manifests itself to you.

Acquaint yourself with the shadows that lie deep within you.

And then, open yourself, all that is you, to the light.

Give freely. Take in abundantly.

Find your safety, your refuge, and go there as you need.

Hear what you can, and be honest about the rest: be honest at all cost.

Words won't always come;

sometimes there are no words in the face of such tragic evil.

But in your willingness to be with them, they will hear you;

from soul to soul they will hear that for which there are no words.

Steele, K. (1989). Sitting with the shattered soul. *Pilgrimage: Journal of Psychotherapy and Personal Exploration*, 15(6), 19-25.

SUMMARY

Northern metropolitan Adelaide, South Australia is an area which experiences considerable social disadvantage. It is also an area in which a significant number of (predominantly young) refugee background individuals have resettled. Research indicates that refugee youth may be at elevated risk of mental health (MH) and alcohol and other drug (AOD) problems. These factors, combined with the low socio-economic status of northern Adelaide, the number of refugee youth residing there, and the added complexity of treating comorbid MH and AOD problems (comorbidity) prompted this research.

This thesis explored the experiences and needs of young people from refugee backgrounds with comorbid MH and AOD disorders living in northern metropolitan Adelaide. The first aim was to identify risk factors which lead to the development of comorbid MH and AOD disorders among refugee youth living in this region. The second aim was to explore the challenges refugee youth experience once they develop comorbid MH and AOD disorders and how these may impact on the provision of MH and AOD services. The third and final aim was to identify the barriers and facilitators to effective, culturally responsive service provision for refugee youth with comorbid MH and AOD disorders.

This research employed a sequential exploratory mixed-methods design drawing on principles of Participatory Action Research (PAR) and with theoretical underpinnings in critical theory and constructionism. Qualitative interviews were conducted with refugee youth aged 12-25 years from African, Bhutanese, and Afghan backgrounds ($n = 15$) and with service providers from MH, AOD and refugee support services ($n = 15$). Interview data were analysed using a thematic approach. The findings from the interviews then informed development and analysis of the quantitative online survey which was conducted with managers of MH, AOD and other services ($n = 56$).

Overall, this research highlighted significant difficulties which impact on the ability of a young person from a refugee background with comorbidity to access and receive adequate service provision. This thesis discussed ways of overcoming these challenges in order to improve the service response to this client group in this region. It is hoped that the findings presented in this thesis are of value to both policy makers and clinicians.

DECLARATION

I, Miriam Posselt, certify that this work contains no material which has been accepted for the award of any other degree or diploma in any university or other tertiary institution and, to the best of my knowledge and belief, contains no material previously published or written by another person, except where due reference has been made in the text.

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Miriam Posselt _____

Date _____

Published works

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- Posselt, M., Procter, N., Galletly, C. & de Crespigny, C. (2015), Aetiology of Coexisting Mental Health and Alcohol and Other Drug Disorders: Perspectives of Refugee Youth and Service Providers. *Australian Psychologist*, 50(2), 130–140.
- Posselt, M., Procter, N., de Crespigny, C., & Galletly, C. (2015). Merging perspectives: Obstacles to recovery for youth from refugee backgrounds with comorbidity. *Australasian Psychiatry*, 23(3), 293-9.
- Posselt, M., Mc Donald, K., Procter, N., de Crespigny, C., & Galletly, C. (2016) Improving the provision of services to young people from refugee backgrounds with comorbid mental health and substance use problems: Addressing the barriers. Manuscript submitted for publication.
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Table of Contents

1. Chapter One: Introduction.....	11
Overview	11
Project affiliations and funding partners	14
Region of focus: Salisbury and Playford Local Government Areas	15
Definitions and key concepts.....	16
1.1.1 Mental health and mental illness	16
1.1.2 Alcohol and other drug, substance use disorder and addiction	18
1.1.3 Comorbidity	19
1.1.4 Youth	19
1.1.5 Cultural responsiveness	19
1.1.6 Refugees and asylum seekers	20
Refugees and the refugee experience	20
1.1.7 Migration trends in Australia and humanitarian arrivals.....	20
1.1.8 Recent changes in asylum seeker and immigration policies.....	22
1.1.9 South Australia.....	24
1.1.10 The refugee experience	25
1.1.11 Refugee background clients: A priority area?.....	36
The present study	38
1.1.12 Aims and research questions	38
1.1.13 Organisation of the thesis.....	38
1.1.14 Conclusion.....	39
2. Chapter Two: Paper One.....	40
Mental health and drug and alcohol comorbidity in young people of refugee background: A review of the literature.....	40
3. Chapter Three: Methods.....	54
Introduction	54
Scaffolding the research	54
Personal influences	55
Constructionism	56
Critical Theory	57
Methodology: Participatory action research	59
Methods: Research Design: Mixed methods.....	62
Ethical considerations	66

3.3.1	Human Research Ethics Committee.....	68
	Conclusion.....	69
4.	Chapter Four: Paper Two	70
	Aetiology of coexisting mental health and alcohol and other drug disorders: Perspectives of refugee youth and service providers	70
5.	Chapter Five: Paper Three	83
	Merging perspectives: Obstacles to recovery for youth from refugee backgrounds with comorbidity.....	83
6.	Chapter Six: Paper Four	92
	Improving the provision of services to young people from refugee backgrounds with comorbid mental health and substance use problems: Addressing the barriers	92
7.	Chapter Seven: Conclusion	143
	Introduction	143
	Summary of findings	144
	7.1.1 Research question one: What are the aetiological and risk factors which lead to young people from refugee backgrounds developing MH and AOD problems?.....	145
	7.1.2 Research question two: What are the biggest challenges for young people from refugee backgrounds with comorbidity and how might these impact service provision?.....	146
	7.1.3 Research question three: What are the barriers and facilitators to effective, culturally responsive service provision for young people of refugee background with comorbid mental health and alcohol and other drug conditions?.....	147
	Significance of the findings	148
	Implications of the findings – policy and clinical practice	149
	7.1.4 Policy.....	150
	7.1.5 Practice.....	151
	Strengths.....	151
	Limitations	154
	Future research.....	156
	Personal reflection	159
	Final comments.....	160
8.	References	161
9.	Appendices.....	166
	Appendix A: Paper Five	167
	Appendix B: STTARS report.....	179
	Appendix C: Paper Six	202

Appendix D: Conference Abstract 1..... 212
Appendix E: Conference Abstract 2 214

1. Chapter One: Introduction

This chapter introduces the research problem, defines key concepts, identifies the study aims and research questions, and outlines the structure of this thesis.

Overview

In Australia approximately 13,000-14,000 humanitarian visas are granted to refugees annually (Department of Immigration and Border Protection [DIBP], 2014). A large proportion of these visas are granted to refugees under the age of 25 years. For example, in the five year period from the 1st of July 2009 to the 30th of June 2014 71,171 humanitarian (refugee) visas were granted in Australia, 50% of which were granted to refugees under the age of 25 years on arrival. For this reason there is a need for Australian health services to adapt and respond appropriately to the needs of not only a multicultural population, but also an increasing number of young people from refugee backgrounds. To date, the focus of much research has been to consider the types of psychopathology experienced by refugee groups. The majority of the available literature suggests that resettled refugees are at an elevated risk of developing significant psychiatric and substance related disorders resulting from a variety of stressors pre, during and post migration (Haasen, Sinaa, & Reimer, 2008; Porter & Haslam, 2005; Schweitzer, Melville, Steel, & Lacherez, 2006; Sowe, 2005). More recent research has begun to acknowledge that despite having an elevated risk of developing psychopathology, including substance related disorders, significant barriers to accessing mental health services exist for resettled refugees (Minas et al., 2013; Van de Gaag, 2007). Whilst research has increasingly begun to look at help-seeking behaviours and service engagement for mental health problems among resettled refugees, there is still very little research that considers the unique experiences and needs of young people from refugee

backgrounds living in South Australia. Research in Australia indicates that young people in the general population access mental health services less often than older people (Australian Bureau of Statistics, 2007). Of the one in five young people who experience mental illness, only 30% are reported to receive professional support (Australian Bureau of Statistics, 2007; Burns, Ellis, Mackenzie, & Stephens-Reicher, 2009). Recent studies highlight that adolescents and young adults from refugee backgrounds may experience unique and additional barriers to accessing support and are even more underrepresented in the services (Colucci, Minas, Szwarc, Paxton, & Guerra, 2012; De Anstiss & Ziaian, 2010; De Anstiss, Ziaian, Procter, Warland, & Baghurst, 2009). Furthermore, research to date has tended to focus on either mental health (MH) problems or alcohol and other drug (AOD) problems within refugee and migrant groups without considering the two types of problems together.

It is well established that AOD problems are commonly experienced by individuals with MH problems (Australian Institute of Health and Welfare, 2005). In Australia, it has been acknowledged that effective service provision is of particular concern for individuals with co-existing MH and AOD conditions, also termed 'comorbidity' (Allsop, 2008; Merkes, Lewis, & Canaway, 2010; Teesson & Burns, 2001), and young people experiencing comorbidity are reported to face even more significant barriers to service provision (Szirom, King, & Desmond, 2004). Health workers report feeling ill-equipped in dealing with clients with comorbidity due to a lack of confidence and training (Adams, 2008; Allsop, 2008). Research has shown that comorbidity is often associated with greater difficulty in implementing effective treatment with poorer outcomes (Australian Institute of Health and Welfare, 2005; Szirom et al., 2004; Teesson & Burns, 2001).

Although much of the literature discusses why refugees in particular are at high risk of developing psychiatric disorders or at risk of AOD problems, very little research considers

refugees experiencing co-existing MH and AOD disorders and how best to address these issues. While it has been established that significant barriers to service engagement and service provision exist for young refugees with a mental health disorder, the risk may be higher for those experiencing comorbidity as they not only face cultural and linguistic barriers but are also often required to effectively navigate two different service sectors.

Overall, this study sought to investigate comorbidity amongst young people of refugee backgrounds. This was achieved by investigating the aetiology of such disorders, the challenges they encounter once these problems do coexist and finally, by identifying barriers and facilitators to effective service engagement and comorbidity service provision for this client group. It was intended that the findings of this research would go some way towards establishing a knowledge base to assist MH and AOD clinicians and researchers, provide a greater understanding of how the reported barriers might be ameliorated or overcome in the future, and finally, to inform policy and practice.

Using both qualitative and quantitative research techniques, this research was exploratory in nature and aims to generate knowledge concerning the experiences and needs of young people from refugee backgrounds with co-existing MH and AOD problems, who are living in the northern metropolitan region of Adelaide. The cultural responsiveness of organisations providing services to refugee background youth experiencing comorbidity was considered. This study ultimately sought to identify barriers and facilitators to accessing and receiving culturally appropriate comorbidity care for refugee youth. This research discusses these issues from two important perspectives; service providers or professionals (managers and clinicians), and young refugees themselves who identified as either community advocates or consumer representatives.

Project affiliations and funding partners

This project was part of a broader Australian Research Council funded project called ‘Comorbidity Action in the North (CAN); Stopping the run around’. This project was a collaboration between The University of Adelaide (lead partner) and Northern Adelaide Local Health Network (NALHN) (industry partner). Other official partners included Northern Area Medicare Local (NAML), Aboriginal Health Council of South Australia (AHCSA), The University of South Australia, The Salisbury Council, and SA Network of Drug and Alcohol Services (SANDAS). The CAN project aimed to improve service delivery and support to individuals aged 12 years and over with comorbid mental health and alcohol and other drug conditions in the disadvantaged northern region of Adelaide, South Australia. The CAN project involved a participatory action research approach and collected quantitative and qualitative data in order to identify problems with comorbidity service provision and identify ways of improving service provision for this client group. CAN involved extensive consultation with consumers, community advocates, policy makers, and government and non-government service providers. Data collection involved large scale surveys with staff and managers of mental health, alcohol and other drug and ‘peripheral’ comorbidity services such as Ambulance, Police, and Emergency Departments. Semi-structured interviews with service providers were also conducted. The CAN project conducted a series of workshops following the data collection phase, sharing the knowledge with the community and providing training to various health professionals. While the greater CAN project considered the needs of all individuals with comorbidity in this region, the present study or components presented in this dissertation focussed on youth aged 12-25 years from refugee backgrounds as a group with specific needs. The aims of the present study were similar to those of the broader project as this research also sought to provide an evidence base from which solutions could be identified and improvements made to comorbidity service provision. However, our specific

focus was on achieving this in relation to clients who are young people from refugee backgrounds experiencing both MH and AOD problems in the northern region of Adelaide.

Region of focus: Salisbury and Playford Local Government Areas

The northern region of Adelaide, South Australia consists of the local government areas (LGAs) of Playford, Salisbury, Gawler, Tea Tree Gully and Port Adelaide Enfield. The northern region of Adelaide is acknowledged as a significantly disadvantaged region in Australia (Australian Bureau of Statistics, 2006; DEEWR, 2011). This area is disadvantaged on many measures of social wellbeing, with a high proportion of people in receipt of government benefits, high unemployment rates, low levels of education and high rates of mental health and substance use problems (Australian Bureau of Statistics, 2011; The University of Adelaide, 2014). Of the northern region, the Playford and Salisbury LGAs are considered to be particularly disadvantaged. The Australian Census of Population and Housing (2011) which was conducted in the year prior to this research commencing, revealed higher unemployment rates in Salisbury (6.97%) and Playford (8.01%) compared to the rest of South Australia (5.31%), and Australia (5.65%). Education levels were also reported to be lower than state and national averages as fewer people indicated having a Bachelor Degree as their highest level of education in Salisbury (5.56%) and Playford (3.04%) than the rest of SA (9.53%), and Australia (10.88%) (Australian Bureau of Statistics, 2011). Salisbury and Playford are also reported to have high proportions of people in receipt of government benefits. For example, in June 2013 greater proportions of families residing in both Salisbury (14.8%) and Playford (23.6%) were assessed as low income and welfare dependent compared with the South Australian (10.1%) or Australian (9.8%) average (The University of Adelaide, 2014). Overall, the Socio-Economic Indexes for Areas (Index of Relative Socio-Economic Advantage and Disadvantage) showed that Salisbury and Playford ranked highly on levels of

disadvantage. Salisbury ranked in the third decile (out of 100) and Playford in the first decile (areas are ranked lowest to highest and the lowest 10% of areas, that is, the most disadvantaged, are given a decile number of one) (Australian Bureau of Statistics, 2011).

This region also contains high proportions of people born overseas, people not fluent in English and people from refugee backgrounds (Australian Bureau of Statistics, 2011; The University of Adelaide, 2014). In the last 10 years 33% of humanitarian entrants to South Australia have been resettled in the Salisbury and Playford areas (Department of Immigration and Border Protection, 2014). Of these, 62.2% were under the age of 25 years on arrival. Therefore we have a large and predominantly young, refugee background population living in areas of substantial socioeconomic disadvantage. Both mental health conditions and illicit drug use are known to be more prevalent in areas which experience high levels of poverty, unemployment and educational disadvantage (Beyer & Reid, 2000). Given the low socioeconomic status of these areas and the large number of refugee youth who reside there, the two LGAs of Salisbury and Playford were the focus of this study.

Definitions and key concepts

Throughout this dissertation (including the papers within) a number of terms are used interchangeably to encompass the diversity of terms used throughout the literature and to suit the preferred terminology of the target journal. The following key concepts are defined and the use of certain terms is explained.

1.1.1 Mental health and mental illness

Definitions of mental health and mental illness vary significantly. As a starting point, the World Health Organisation (WHO) defines mental health as not just the absence of mental disorder but “a state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and

fruitfully, and is able to make a contribution to her or his community” (WHO, 2013, p. 1). It fits within the mental well-being component of WHO’s broad definition of health which is: “A state of complete physical, mental and social well-being, and not merely the absence of disease”(WHO, 2013, p. 1). The South Australian Mental Health Act (2009) defined mental illness simply and broadly as “any illness or disorder of the mind” (Government of South Australia., 2009, p. 11). There are two main standard classification systems used for identifying and diagnosing mental health problems. These are the Diagnostic and Statistical Manual of Mental Disorders (DSM) for which the 5th edition (DSM-5), released in 2013 is current (American Psychiatric Association, 2013), and The International Classification of Diseases (ICD) for which the 10th edition (ICD-10) which came into use in 1994, is the current edition (WHO, 1994). Throughout this dissertation the terms mental health problem, mental disorder, mental illness, psychiatric disorder and psychological problem or disorder are used interchangeably. However, due to the ease of using a consistent acronym, mental health (MH) problem, was predominantly used. It is assumed that we are essentially referring to the same concept. That is, a broad notion of a mental health problem- ranging from the experience of distress, dysfunctionality or symptoms of mental disorder (though not necessarily meeting criteria for a specific diagnosis) through to more severe or diagnosable mental disorders. I believe that an individual does not have to present with a diagnosable mental disorder to require treatment or support. Therefore the focus remains broad so as to not exclude consideration of those who are experiencing mental health problems or symptoms and who may benefit from receiving support.

1.1.2 Alcohol and other drug, substance use disorder and addiction

Alcohol and other drug problems (AOD) and substance use disorder (SUD) are terms again used interchangeably throughout. Substance use disorder is a diagnostic category within Substance-Related and Addictive Disorders in the DSM-5. According to the DSM-5, SUD is conceptualised as a single disorder measured on a continuum from mild to severe with each substance being referred to as a separate use disorder (e.g. alcohol use disorder) (American Psychiatric Association, 2013). Consideration of the different terms used to refer to AOD problems is necessary. Firstly, there are differences in the way this disorder was categorised in DSM-IV and DSM-V. In DSM-IV, SUD was referred to as a maladaptive pattern of alcohol or substance use and distinguishes between abuse and dependence- abuse being defined as a mild or early phase of the disorder and dependence as more severe (American Psychiatric Association, 2013). Contrary to DSM-IV definitions, the WHO does not use the term abuse due to its ambiguity and the idea that abuse of a substance can also be considered severe in its manifestation. Instead, the WHO use the terms 'harmful use' and 'hazardous use'. Harmful use refers to a pattern of substance use that is causing damage to either physical or mental health, or with potential adverse social consequences (WHO, 2014). Hazardous use refers to a pattern of substance use that increases the risk of such harmful consequences. The ICD-10 categorises the equivalent of SUD as 'dependence syndrome', defined as occurring when the use of a substance takes on a much higher priority than other behaviours which once held high value and is combined with a desire to take the substance (alcohol or other drug) (WHO, 2014). This thesis predominantly uses the term 'AOD problems' to broadly encapsulate all of these differing concepts: SUD, harmful use, misuse, abuse, and dependence. Ten separate classes of substances are outlined in DSM-5: alcohol; caffeine; cannabis; hallucinogens; inhalants; opioids; sedatives, hypnotics, and anxiolytics; stimulants;

tobacco; and other (unknown) substances. The term ‘AOD problem’ includes the harmful use of or dependence on these ten separate classes of drugs unless the substance is specifically stated.

1.1.3 Comorbidity

‘Comorbidity’ is a term used to describe the co-occurrence of one or more diseases or disorders in an individual (Allsop, 2008). This thesis uses the term ‘comorbidity’ exclusively to refer to the co-occurrence of a MH problem and an AOD problem. ‘Dual diagnosis’ is another term frequently used to describe this phenomenon. However, this term was avoided by the researcher as it implies the existence of only two problems and negates the likelihood of multiple morbidities.

1.1.4 Youth

There is a general consensus across literature and policy that the age bracket 12 to 25 years defines youth in Australia and this is therefore the definition used in the present study (McGorry, Parker, & Purcell, 2006). ‘Young people’ and ‘youth’ are terms used interchangeably throughout this thesis and refer to the age bracket defined above unless otherwise stated.

1.1.5 Cultural responsiveness

The terms cultural competency, cultural sensitivity, cultural awareness, and cultural intelligence are often used interchangeably in the literature. Cultural competency is defined as “a set of congruent behaviours, attitudes, and policies that come together in a system, agency, or among professionals and enable that system, agency or those professionals to work effectively in cross-cultural situations” (Cross, Bazron, Dennis, & Isaacs, 1989, p. 28). There has been debate concerning the use of the term cultural competency as it is argued that it suggests a categorical or absolute view, that one is

either competent or not, which has led to the use of the term ‘cultural intelligence’ which is defined as “a person's capability to function effectively in situations characterized by cultural diversity” (Van Dyne, Ang, & Koh, 2008, p. 3). In this dissertation, these constructs are conceptualised as part of a broader notion termed ‘cultural responsiveness’. Cultural responsiveness is defined in the Victorian Cultural Responsiveness Framework (2009) as “the capacity to respond to the healthcare issues of diverse communities” (State Government of Victoria, 2009, p. 4). Cultural responsiveness encapsulates the various terms effectively and places an emphasis on the capacity and need for both organisations and professionals to *respond* to diverse individuals. This response includes being equipped with cultural knowledge and sensitivity to how an individual’s explanatory models, family dynamics, belief systems, language, histories, and other aspects of their culture might influence service access, engagement and treatment (State Government of Victoria, 2009).

1.1.6 Refugees and asylum seekers

The following section will discuss what constitutes a refugee, will describe common experiences of refugees, and will consider resettled refugees in the context of Australia at this moment in history.

Refugees and the refugee experience

1.1.7 Migration trends in Australia and humanitarian arrivals

Australia is a country characterised by its migration history. Currently it is estimated that 38% of the Australian population were born in a country other than Australia (DIBP, 2014a). Since the end of World War II approximately 7.5 million people have migrated to Australia. Of these, approximately 800,000 arrived as refugees and asylum seekers (DIBP, 2014a). At the end of 2010 there were approximately 43.7 million forcibly

displaced people or 'refugees' worldwide (DIBP, 2014a). The term refugee is defined according to the United Nations High Commissioner for Refugees 1951 Convention as a person who has fled their country due to a:

well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it (UNHCR, 2001, p. 14).

Australia is one of the nineteen signatories to the United Nations 1951 Convention relating to the Status of Refugees and therefore has a responsibility to assist in the protection and resettlement of refugees (UNHCR, 1951). A major component of this responsibility is reflected in Australia's Humanitarian Program. In Australia, since 2000, approximately 13,000- 14,000 humanitarian visas are typically granted each year. Humanitarian visas are granted under either onshore protection or offshore resettlement. The onshore component of the humanitarian program is for people who apply for asylum after arrival in Australia and who are found to be refugees through the refugee status determination process under the definition of the UNHCR 1951 Convention. The offshore resettlement component accounts for the majority of humanitarian visas granted. The offshore component consists of two categories of permanent visas. Firstly, Refugee Visas are granted to individuals who are typically outside their own country and cannot return as they are subject to persecution in their home country. The majority of these individuals are identified and referred by UNHCR to Australia for resettlement. Secondly, the Special Humanitarian Program is for those who

meet the UNHCR definition of refugee and these applications must be supported by a proposer who is an Australian or eligible New Zealand citizen or permanent Australian resident.

1.1.8 Recent changes in asylum seeker and immigration policies

Recently in Australia there has been an increase in the number of people seeking protection after arrival in Australia and a subsequent increase in the number of onshore humanitarian visas granted. For example, in the 2006-2007 year period 1,793 visas were granted under the onshore category, this had been steadily increasing until the 2010-2011 year period where 4,828 visas were granted under this category. In 2011 UNHCR reported a 31% increase in claims for refugee status in Australia and New Zealand compared to the previous year (Procter, Williamson, Gordon, & McDonough, 2011). Many of these people arrived by boat and were formerly referred to as Irregular Maritime Arrivals (now referred to as Illegal Maritime Arrivals) or 'asylum seekers'. The term 'asylum seeker' refers to an individual who is seeking protection and has applied (or intends to apply) for refugee status but is waiting for this status to be granted or denied (DIBP, 2014a). Until a decision is made as to whether these individuals are classified as refugees and while their applications are being assessed, they are detained or held in detention facilities in Australia or since August 2012, in offshore detention facilities in Nauru and on Manus Island in Papua New Guinea. Previous research has investigated the impact of detention on refugee and asylum seeker mental health and this will be discussed later in this chapter.

The determination of refugee status and the humanitarian visa application process for asylum seekers may take many months, sometimes years, and during this time asylum seekers do not know whether their claims will be approved or if they will be returned to their country of origin. The Liberal Party of Australia (the Coalition) was elected to Federal

Government in September 2013 and immediately implemented policies in an effort to stop asylum seeker arrivals to Australia by boat. These policies have been the topic of much debate and public attention in Australia and internationally. They have been widely criticised by advocacy groups and human rights lawyers, and have been debated in various high court challenges due to claims that these policies are in breach of the UNHCR 1951 Refugee Convention, The Universal Declaration of Human Rights, and The Convention on the Rights of the Child. These policies include mandatory offshore detention (initially adopted by the Australian Labour Party (ALP) in 2012) for undefined periods of time. In 2013, Scott Morrison, the Minister for Immigration and Border Protection at the time, announced that anyone arriving by boat to Australia would not be resettled in Australia (DIBP, 2014b). These policy changes are also reported to impact those already living in Australia with permanent residency status. This is either indirectly, by the perceived negative portrayal of refugees and asylum seekers in political debates and the media, as well as fear of terrorism and radicalisation of migrants (Esses, Medianu, & Lawson, 2013; O'Doherty & Lecouteur, 2007) or directly, by changes which impact anyone who arrived to Australia by boat (DIBP, 2014a). These changes are relevant to this research as it was predicted to result in a change in the types of issues services were being presented with, in regard to this population.

In recent years there have also been changes to the number of humanitarian visas granted in Australia. In September 2012 the government at the time (the ALP) increased the humanitarian intake to 20,000 places. In 2014 the Prime Minister Tony Abbott along with Immigration Minister Scott Morrison announced that the humanitarian program would comprise 13,750 visas granted annually (DIBP, 2014b). Needless to say, this is an area in which there have been constant changes, heated debates and as a result has necessitated keeping up to date with current affairs in order to understand changes in mood among the

communities and follow the topics of conversation when speaking with community members and participants. Similarly, it has also been necessary to follow current migration trends, specifically the number of humanitarian arrivals and the countries from which they are arriving. The migration trends and statistics presented in this dissertation are relevant to the period of time in which this research took place.

1.1.9 South Australia

Over the last 10 years, from the 1st of July 2004 to the 30th of June 2014, South Australia has resettled 151,134 refugees under the humanitarian program (Department of Immigration and Border Protection, 2014). Of those, 59% were under the age of 25 years on arrival and 31.5% were aged between 12 and 25 years. The top ten countries of birth of humanitarian arrivals aged between 12-25 years to South Australia over the last decade are presented in Table 1.1.

Table 1.1: Top ten countries of birth: Humanitarian arrivals to South Australia from 2004-2014 (aged 12-25 years)

Country of Birth	Number of arrivals
1. Afghanistan	1202
2. Sudan	518
3. Iran	355
4. Democratic Republic of the Congo	292
5. Liberia	287
6. Burma	286
7. Bhutan	271
8. Nepal	268
9. Burundi	203
10. Iraq	161

1.1.10 The refugee experience

It is important to acknowledge the diversity of the refugee experience. Refugees have originated from many different countries, cultures, historical and political environments and are forced to flee due to a vast variety of circumstances. Refugees are certainly not a homogenous group. Rather, as Malkki (1995) states, the label of refugee, in addition to the true UNHCR definition, can encompass diverse socioeconomic statuses, histories, journeys

and religious backgrounds rather than a generalisable type of person or situation. However, refugees have many similar experiences in that they are forced to flee their homeland and often share common reasons for this flight such as war or political, religious or ethnic persecution (Williams, 2009). Stein (1981) argues it is possible and even beneficial to consider the consistencies across the refugee experience and refugee behaviour in order to look at the accumulated research and knowledge and learn from the past. By not simply focussing on one arrival group, we are able to view refugee experiences as recurring phenomena with similar patterns. Stein also argues that specific refugee situations should not be perceived as unique, atypical, individual historical events but rather as part of a wide-ranging subject, that is, refugee behaviour, problems and situations that recur in many contexts, times and regions. This position is important to acknowledge as it informs the present research. This research did not focus specifically on a particular cultural group but sought to consider and identify common elements and similarities and patterns across individuals and communities from various refugee backgrounds. This is not to ignore the unique experiences and nature of each individual refugee or subgroup of refugees. However, for the purpose of the present research it is useful to consider and reflect on common characteristics.

Further, this broad focus may allow the findings to have greater applicability to services in the target region that are working with people from multiple refugee and cultural backgrounds. Therefore, one specific ethnic or cultural group was not the focus, but rather the issues relating to diverse refugee backgrounds were investigated.

However, in saying this, this research acknowledged that young refugees certainly have unique experiences and needs compared to other age groups. This view is consistent with that of the Refugee Council of Australia (RCOA, 2014) who state that refugee young

people, by virtue of their age, have needs differing from those of their parents or older refugees, as they are in a difficult transitional stage of their life, negotiating developmental challenges alongside resettlement and a multitude of other challenges. This is explored in greater depth in Chapter Two: Paper One.

The majority of the literature conceptualises the refugee experience as a three stage process: pre-migration/ pre-flight, transition/flight and resettlement (Lewig, Arney, & Salveron, 2009; Lustig et al., 2004; Stein, 1981). Lustig et al. (2004) states that “a culturally relevant developmental theoretical foundation is essential to understanding the experience of refugee youth in the context of flight and resettlement”. As young refugees are the focus of this research, Bronfenbrenner’s bioecological theory of human development (Bronfenbrenner, 1986; Bronfenbrenner & Morris, 1998) alongside Stein’s three-stage conceptualisation of the refugee experience (described above) provides a useful meta-framework from which to consider the refugee experience, and its potential impacts, on young refugees. These frameworks and theories have been integral in informing the present research and understanding of the factors which impact development and mental health outcomes.

1.1.10.1 Bronfenbrenner’s bioecological theory

Bronfenbrenner’s theory accounts for the impacts of culture, among multiple other influences, on development, and highlights the complex interrelatedness of different factors which impact on a young person’s developmental trajectory. This in turn has obvious implications for mental health or psychological development. Bronfenbrenner originally emphasised the aspects of context (microsystem, mesosystem, exosystem and macrosystem) and the interconnections between those and the individual in human development (Bronfenbrenner, 1986). He revised his theory in 1998 to incorporate the Process- Person-

Context- Time model (PPCT) (Bronfenbrenner & Morris, 1998; Tudge, Mokrova, Hatfield, & Karnik, 2009). Consideration of these four concepts and the interaction between them is useful in capturing the diverse influences on the development of a refugee young person.

1.1.10.2 Process- Person- Context- Time Model

Process, or proximal processes, refers to the influence of reciprocal interactions between the ‘biopsychological human’ and the stimuli (people, objects) in their immediate environment.

The concept of ‘person’ acknowledges the biological and genetic influences on development and emphasises personal characteristics (of which there are three types; demand, resource and force) that influence development. Personal characteristics include temperament or motivation (force characteristics), intelligence, and emotional resources, which can also be influenced by an individual’s experiences. A person’s material resources such as access to food, housing, care and education obviously also influence development and are particularly relevant to refugee children living in camps or other transient accommodation where there is often a lack of food and water (demand characteristics). Characteristics such as age and gender can influence the types of experiences a refugee may be exposed to. For example, adolescent girls are more likely to experience sexual abuse and violence (Miller & Rasco, 2004). This model emphasises how personal characteristics can influence environment as they may determine whether a person has the motivation to either flee or stay when faced with adversity. It may also apply to variations in resilience, emotional resources, and access to supports among refugees, potentially mediating the impact of exposure to trauma on subsequent psychological development. It also highlights how environments, exposure to trauma and violence, and malnutrition can influence personal characteristics and impact on development.

Context refers to the influence of environment on development and involves four interrelated systems. The microsystem is the environment where the individual spends the majority of their time such as home, church, school or in the context of the transition stage of the refugee experience- a refugee camp or a detention centre. The mesosystem refers to the interrelations between the various microsystems including the interactions between the people from each microsystem, for example, the interactions between the detention centre guards or doctors with family members, or religious leaders and peers. The exosystem refers to the environment in which the individual is not directly exposed but which indirectly impacts on their development- such as a political situation in a country. Finally, the macrosystem describes the culture or subculture the individual is situated in, where a group shares beliefs and values which influence the lifestyle and life-course of the individual. The macrosystem also includes the socioeconomic status or ethnicity and the influence this has on their development. This concept posits the differential influence of two macrosystems on young people's development. For example, two adolescents from different cultural backgrounds may be living in the same city – one is from a persecuted ethnic group and the other is not. The impact this has on their interactions with each other and the environment and the activities they engage in has implications for their development. One may be able to attend school and the other is forced to stay home.

The final aspect of the PPCT model is time, which acknowledges the interaction of time with all the other influences or elements of the model on the way people and environments change. This is also of particular importance as it emphasises the differential impact on people from refugee backgrounds resettling in different stages of life such as during childhood or adolescence. It acknowledges potential variation in developmental trajectories at different points in time as “developmental processes are likely to vary

according to the specific historical events that are occurring as the developing individuals are at one age or another” (Tudge et al., 2009, p. 201). This allows us to consider what may be developmentally disruptive to the development of a refugee young person. It also highlights the diversity of refugee experiences and the differing impact on development and other outcomes. A chronological framework in addition to Bronfenbrenner’s theory allows discussion of the distinct stressors and experiences that each stage can elicit and the differing impact of these based on process, person, context and time. Drozdek explains the importance of merging these concepts when considering refugee and asylum seeker mental health:

To fully understand the complexity of traumatic life events, it is essential to frame them in what Bronfenbrenner called “the ecological environment” ... In building on Bronfenbrenner’s work and others, it is important to understand that “the ecological environment” is a dynamic system that can change over time. In the case of asylum seekers and refugees or other non- Western people, the time line can include the premigratory and the postmigratory periods, as well as the period of forced migration and resettlement. Included in these intervals are many secondary stressors and intersecting variables that effect patterns of posttraumatic adaptations and disposition to the development of PTSD (Droždek, 2013, p. 59).

1.1.10.3 The three stage framework of the refugee experience

Keller (1975) describes the stages of the refugee experience as involving the following: perception of a threat, decision to flee, the period of extreme danger and flight, reaching safety, camp behaviour, repatriation, settlement or resettlement, the early and late stages of resettlement, adjustment and acculturation, and finally, residual states and changes

in behaviour caused by the entire experience. These stages sit within with the three broader stages described; pre-migration, transition and resettlement.

1.1.10.4 Pre- migration

The literature highlights common pre-flight experiences across a variety of refugee backgrounds and situations. High rates of pre-migration exposure to traumatic experiences are often reported by refugees and asylum seekers in the literature (Procter et al., 2011). Exposure to traumatic situations often characterise “pre-migration” or “pre-flight” experiences. Traumatic events often witnessed or experienced by refugees include forced labour, mass killings, sexual abuse, extreme violence, starvation, torture, death/murder of loved ones, drownings at sea, and suicide attempts (Lewig, Arney & Salveron, 2009; Lustig et al, 2004).

One study found that 90% of Sierra Leon refugees reported experiencing at least one of the following traumas: separation from family, being close to death, murder of family or friend, and lack of food, water and shelter. Over 60% of participants reported experiencing either ill health and no medical care, being lost or kidnapped, or being exposed to a combat situation (Fox & Tang, 2000).

Refugees from a range of backgrounds living in Australia have been found to report common pre-flight experiences of witnessing or experiencing human rights violation, extreme deprivation, separation from or loss of family and friends, and periods of starvation (Lewig et al., 2009). Schweitzer, Brough, Vromans, and Asic-Kobe (2011) interviewed resettled Burmese refugees in Australia. The most frequent experiences they reported included lack of food or water (73.5%), combat situations (57.6%), ill health without medical care (55.9%) and forced separation from family members (45.6%). Schweitzer et al. (2006) found high levels of exposure to traumatic events pre-migration in a group of 63 Sudanese

refugees living in Queensland, Australia. All participants reported exposure to at least one traumatic event, assessed using the Harvard Trauma Questionnaire. Eighty five percent of participants reported separation from family, 68% had experienced murder of a family member or friend, 59% had experienced lack of food and water, 28% of participants had experienced torture and 11% had experienced rape or sexual abuse. Similarly, Iraqi refugees living in Australia reported pre-flight experiences of being close to death (49.5%), lack of food and water (42.5%), unnatural death of family or friend (41.3%), murder of family or friend (39%) and ill health without medical care (27.9%) (Nickerson, Bryant, Steel, Silove, & Brooks, 2010).

It is important to understand, in relation to the pre-flight stage of the refugee experience, that the refugee is usually forced to migrate, whereas the migrant may choose to leave. This has also been described as reactive as opposed to proactive migration or involuntary versus voluntary migration (Richmond, 1993). Kunz (1973) proposed a kinetic model which describes the immigrant as 'pulled' to the new land, often attracted by greater opportunity and new success, whereas the refugee is 'pushed' out for fear of persecution. For the refugee it is often the case that any destination will suffice, whereas the immigrant has a preferred destination (Stein, 1981).

1.1.10.5 Flight

Once refugees have fled their home due to violence, war or persecution and begun the migration process, they are in the transition or flight stage. They may enter a lengthy period of danger and uncertainty, involving high risk journeys, refugee camps, detention centres and ongoing experiences of trauma (Lewig, Arney & Salveron, 2009). The experience of a refugee camp may be characterised by separation from the host population, sharing of facilities, no privacy, overcrowding, a restricted area in which daily life is lived, and limited food and water (Stein, 1981). Living in a refugee camp is reported to have a negative impact

on the psychological wellbeing of children, particularly those with a history of trauma exposure and those who have parents who are not coping well (Lewig, Arney & Salveron, 2009). Stein (1981) denotes the transition stage as being the stage in which the focus is on what has been lost, and uncertainty about the future:

Besides the suffering, trauma and persecution already endured, and the loss of loved ones, the refugee must now face up to the loss of homeland, identity and former life. A new life in a strange land awaits. Anxiety, fear, frustration and emotional disturbance appear... (p. 324).

Keller (1975) argues that the trauma of flight produces psychological states that will continue to affect the individuals' behaviour into the future. As stated earlier, many people who are already in Australia including those who previously arrived by sea or air, make applications for protection (DIAC, 2012). The vast majority of asylum seekers are held in detention facilities throughout Australia and offshore in Nauru and Papua New Guinea (PNG), while their claims are being processed.

Research conducted by Green and Eagar (2010) on the impact of detention centres in Australia on asylum seeker health found that those who had been detained for longer than a year suffered higher rates of MH problems and that these problems became more severe the longer they lived in detention. Their research suggested that those in detention suffer greater levels of trauma than those not detained (Lewig, Arney & Salveron, 2009).

The importance of this research is of ongoing relevance as the issue of asylum seeker mental health and the impact of immigration detention continues to receive great public attention. In February 2014 the Human Rights Commission (HRC) launched the National Inquiry into Children in Immigration Detention. At the time there were 983 children in

detention facilities across Australia and Nauru, 54 of whom were unaccompanied and 128 of whom were babies born in detention (HRC, 2014). From January 2013 to March 2014 there were 128 reported incidents of self-harming by children in detention. Dr Peter Young, the former director (2011-2014) of the mental health program for International Health and Mental Services (IHMS), the health service provider for the detention centres, gave evidence for the inquiry which suggested that the rate of mental health problems among child detainees is 30% greater than children in the Australian population (HRC, 2014). This, considered alongside the factors impacting developmental outcomes according to Bronfenbrenner's theory help us understand possible mental health outcomes and increased vulnerability when children and young people are exposed to such experiences in the flight and transition stage.

1.1.10.6 Post Migration

A considerable amount of research has focused on the post-migration or resettlement phase of the refugee experience. It is generally acknowledged that adjustment to a new country, culture and language poses many difficulties. Migrants in general experience major challenges in this area, however, refugees have to deal with the additional challenges of *forced* migration. For refugees, resettlement often results in loss of identity, social status, education and employment status, and loss of family, culture, and community which in turn has the potential to lead to poverty, social exclusion, and further marginalisation (Beyer & Reid, 2000; Brough, Gorman, Ramirez, & Westoby, 2003; K. Milner & Khawaja, 2010; Sowe, 2005).

Stein (1981) categorises the resettlement process into four stages. During the initial arrival period of the first few months many refugees will be confronted by the reality of what has been lost. For example, those who have come from a high occupational or social status may now face being a part of a minority and possibly impoverished. They may struggle with

loss of culture, identity and habits, and experience difficulties within the family as traditional roles may be challenged. For example, women may commence work and children may not adhere to traditional behaviours. Nostalgia, depression, anxiety, guilt, anger and frustration may appear or increase throughout this period (Stein, 1981). Secondly, Stein suggests that throughout the first two years of resettlement many refugees demonstrate an attempt to succeed in their new life, to 'rebuild'. Acculturation, language improvement, retraining programs, hard work, and determination often characterise this period. After four to five years a major part of adjusting to a new culture has been completed and less change occurs after this point. Finally, a decade or more later, Stein suggests that many refugees reach a more stable stage of resettlement. Of course, this is dependent on multiple other influences including those which impact developmental processes such as those highlighted by Bronfenbrenner's model, as well as the influence of earlier stages of the refugee experience and access to opportunities, support and resources during resettlement.

Research has consistently shown that specific factors encountered in each stage of the refugee experience place refugees at significant risk of developing MH and AOD problems (Beyer & Reid, 2000; Brune, Haasen, Yagdiran, & Bustos, 2003; O'shea, Hodes, Down, & Bramley, 2000; Sowe, 2005; Teesson & Burns, 2001). The literature also suggests that psychological distress as a result of a turbulent migration experience, in turn places refugees at increased risk of substance misuse (Sowe, 2005). The idea that refugees may be at risk of developing comorbidity as a result of their refugee background and resettlement experience, and the implications this has for formal support seeking and access to adequate service provision, is in need of further investigation. This will be the focus of the following chapter- Chapter Two: Paper One.

1.1.11 Refugee background clients: A priority area?

Whether or not providing services to individuals from refugee backgrounds is considered a priority area varies across policies and frameworks in Australia. At a national level, The Fourth National Mental Health Plan (2009-2014) mentioned refugees only once, stating that they are a group with complex needs which should be acknowledged and addressed. It further states that front line workers need “an appreciation of the issues facing particular groups such as refugees” (p.35-36). The National Drug Strategy (2010-2015) made no specific mention of refugees, however did acknowledge that Culturally and Linguistically Diverse (CALD) groups “may have higher rates of, or [be] at higher risk of drug use” (p.7). The National Standards for Mental Health Services (2010) states that services must take into account the cultural diversity of consumers (Standard Four: Diversity Responsiveness) (Department of Health and Ageing, 2010).

At a state level, the current South Australian Mental Health and Wellbeing Policy (2010-2015) states that CALD communities are a “priority area” and that there is a need to understand the possible effects of resettlement and the refugee experience on mental health (p.11). It further emphasises the need to increase the involvement of CALD consumers and representative organisations in service design, delivery and evaluation in order to inform culturally appropriate mental health care and improve health outcomes. Conversely, the Social Inclusion Action Plan for mental health reform in SA (2007-2012) did not mention CALD, migrant, non-English speaking background (NESB), or refugee clients in the plan. The South Australian Mental Health Act (2009) states that as a guiding principle, a person should receive ‘culturally appropriate care’. Although refugees are not receiving a great deal

of attention at a policy level in South Australia or Australia, the extent to which their needs are being addressed by services in our study region requires evaluation:

While there are many positive statements of policy intent in relation to immigrant and refugee communities in national mental health policies and strategies there is virtually no reporting by Commonwealth or State and Territory governments of whether policies that are relevant to immigrant and refugee communities are effectively implemented. It is not possible, on the basis of the data collected, to determine whether immigrant and refugee communities are benefiting from the mental health system reforms that are being actively carried out. The majority of Australian mental health research does not adequately include immigrant and refugee samples. (Minas et al., 2013, p. 2).

Colucci, Minas, Szwarc, Paxton, and Guerra (2011) conducted a two-stage national survey to develop an Australian mental health research agenda concerning people from refugee backgrounds. During stage one they surveyed 51 researchers, health policy makers and refugee health and mental health service providers. The second stage involved another survey and condensed the research domains that were originally suggested by participants in stage one. Thirty nine of the original 51 participants completed the second survey. These findings determined the key research priorities. These included studying the prevalence of mental health problems in refugee clients and research into factors which promote resilience and successful re-settlement. Additionally, and of particular relevance to the present study, research concerning mental health service delivery and design for refugee clients was determined to be a research priority in Australia. Further, research investigating how existing services can be adapted and extended to suit the needs of refugee clients was considered a priority.

The present study

1.1.12 Aims and research questions

Based on the gaps in knowledge described in the review paper presented in Chapter Two, the following aims were generated. Broadly, this research aims to explore comorbidity in resettled refugee background youth living in northern metropolitan Adelaide, South Australia. More specifically it aims to investigate factors which place refugee young people at risk of developing MH and AOD problems, the challenges faced by refugee young people with comorbidity, and the response of the services to this client population. This project also aims to identify barriers and facilitators to effective service provision for young refugee background individuals with comorbidity. This is done with the intention of identifying ways in which we can improve the provision of services to and outcomes for this particular population.

This study seeks to answer three main research questions:

1. What are the aetiological and risk factors which lead to young people from refugee backgrounds developing mental health and alcohol and other drug problems?
2. What are the biggest challenges for young people from refugee backgrounds with comorbidity and how do these impact service provision?
3. What are the barriers and facilitators to effective, culturally responsive service provision for young people of refugee background with comorbid mental health and alcohol and other drug problems?

1.1.13 Organisation of the thesis

This thesis is a combination of a conventional thesis and a ‘thesis by publication’.

This results in some chapters being written in a traditional format (Chapters One, Three and

Seven), some being presented as published papers in peer reviewed academic journals (Chapters Two, Four and Five) and manuscripts submitted for publication (Chapter Six).

The thesis contains seven chapters; Chapter One is an introductory chapter which introduces the focus and defines key terms. Chapter Two is a published paper summarising the relevant literature. Chapter Three briefly describes the methods used in this research. Chapters Four, Five and Six present the findings from the research and are in the form of manuscripts either published or submitted for publication. Finally, Chapter Seven is the conclusion which provides an overall summary of the main findings of the project and considers the strengths, limitations and possible future directions. The appendices contain an additional publication generated from this research which focused on ethical issues encountered in the larger CAN study, a report concerning effective therapeutic interventions for refugee and asylum seeker clients produced by the researcher for an organisation which provides treatment for refugee and asylum seeker survivors of torture and trauma, and one other published paper related to the CAN research project as a whole.

1.1.14 Conclusion

This chapter has outlined the context of the research problem. Key concepts have been defined and the significance of comorbidity, study region, and refugee experience with the focus on young people, has been presented. This chapter has begun to highlight the gaps in knowledge and provide a context and rationale for the present research. The following chapter (Paper One) continues to review the existing literature. Finally, the study aims and research questions were presented and the organisation of the thesis was explained.

2. Chapter Two: Paper One

Mental health and drug and alcohol comorbidity in young people of refugee

background: A review of the literature

Miriam Posselt¹, Cherrie Galletly¹, Charlotte de Crespigny² and Nicholas Procter³

¹ Discipline of Psychiatry, University of Adelaide, Adelaide, Australia;

² School of Nursing, University of Adelaide, Adelaide, Australia;

³ School of Nursing and Midwifery, University of South Australia, Adelaide, Australia

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Statement of contributors

Miriam Posselt (Candidate)

I was responsible for review of the literature, manuscript drafting and preparation, manuscript submission, response to reviewers and revisions to the manuscript.

Signed:

Date: 14/01/2016

Cherrie Galletly, Charlotte de Crespigny and Nicholas Procter (Co-authors)

We provided ongoing supervision throughout the literature review process and manuscript development. There was ongoing collaboration between Ms Posselt and us in refining the direction of the paper. Ms Posselt was responsible for writing this manuscript and our role was to comment on drafts, make suggestions on the presentation of material in the paper, and provide editorial input. We hereby give our permission for this paper to be incorporated in Ms Posselt's submission for the degree of Doctor of Philosophy from the University of Adelaide.

Signed:

Date: 14/01/2016

Signed:

Date: 15/01/2016

Signed:

Date: 14/01/2016

Posselt, M., Galletly, C., de Crespigny, C., & Procter, N. (2014). Mental health and drug and alcohol comorbidity in young people of refugee background: A review of the literature.
Mental Health and Substance Use, 7(1), 19-30.

NOTE:

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It is also available online to authorised users at:

<http://dx.doi.org/10.1080/17523281.2013.772914>

3. Chapter Three: Methods

Introduction

This chapter briefly describes the philosophical underpinnings of this research and the methodological approach used, that is, elements of a participatory action research (PAR) framework. This is followed by the rationale for using a mixed-methods approach. Finally, ethical considerations are presented. This chapter does not discuss the study methods as information about procedures (sampling, participants, and data collection and analysis, as well as research rigour and validation checking techniques) is presented in the papers which comprise Chapters Four, Five and Six.

Scaffolding the research

In order to meet the objectives of this research, as outlined in Chapter One, and explore service provision for young resettled refugees with comorbidity, the perspectives of both young people from refugee backgrounds and service providers were sought. This required a framework which emphasised community members' knowledge and involvement in the research. Although it was beyond the scope of this research to implement a full cycle of a PAR study and conduct and evaluate an intervention or action component, the methodological framework chosen incorporated elements of a PAR approach in order to maximise the involvement of the community. Further, this research enabled the use of both qualitative and quantitative methods of data generation and had theoretical underpinnings in critical theory and constructionism. Table 3.1 is based on Crotty's (1998) basic elements of research and depicts the perspectives and approaches which form the structure of this research.

Table 3.1: Underpinnings of the research

Epistemology	Theoretical perspective	Methodology	Methods
Constructionism	Critical Theory	Participatory Action Research (PAR)	Mixed-methods: Survey and semi-structured interviews. Statistical and Thematic analysis

Personal influences

As this research largely emphasised qualitative methodology, it is important to acknowledge the theoretical ideas which influenced me during the development of this research project and in the analysis and interpretation of data. Qualitative research requires the researcher to acknowledge any potential bias and constantly reflect on and consider how such biases might be impacting on the research. It is therefore important to draw the reader's attention to these considerations. First, the following discussion of the theories which influenced my perspective go some way in allowing the reader to understand the context in which this research was conducted. Secondly, during the second year of my candidature, I gained employment as a Counsellor/ Advocate for refugee and asylum seeker survivors of torture and trauma. Therefore, in the writing of this dissertation I had both clinical and research experience in the area of service provision for refugee clients. It is important to understand these influences - not only in relation to potential bias but also regarding the possibility that these experiences may have enriched and strengthened my understanding of the area. I believe my clinical experience made me better informed regarding some of the issues that refugee communities living in northern Adelaide faced. I heard many stories of

people trying to get help and wanting to be better understood and accepted. Additionally, being a part of the main specialist mental health service for refugees in Adelaide made me more aware of the way mainstream services were struggling to engage refugee background clients. As a result we were inundated with referrals that were often not necessarily appropriate for our service, for example, where the individual did not have a history of torture or trauma. Consequently, we sometimes had waiting lists which lasted over 12 months. It became clear to me that many of the referring services could have handled such clients had they had the necessary resources and knowledge. Overall, my role as a counsellor intersected well with my research and I believe the study was enriched as a result. In the papers that make up Chapters Four, Five and Six, it is discussed how biases were addressed and research integrity was ensured.

Constructionism

The epistemological position of a researcher forms the philosophical basis of a research project and is therefore important to acknowledge as it impacts aspects of the research such as the methodology and methods used, as well as how the data is analysed and interpreted (Crotty, 1998). Constructionism underpins this research as it is believed that knowledge is socially constructed from people's interaction with each other and their world, and therefore developed within a social and cultural context. A constructionism approach emphasises our dependence on culture and context to direct our behaviour and give meaning to our experience (Crotty, 1998). As was explored in Chapter One through discussion of Bronfenbrenner's and Morris' (1998) theory, this notion is highly relevant to understanding the refugee experience and the impact of culture and context. Constructionism was selected as a guiding philosophy over constructivism. Constructionism differs from constructivism as the focus of meaning making includes consideration of the collective generation of meaning

rather than focusing on meaning making of the individual mind, as is the case in constructivism (Crotty, 1998). Constructionists recognise the influence our culture has on us and on our perspectives and experiences of the world. However, constructivists emphasise each individual's unique experiences. Whilst not denying the importance of an individual's experience in understanding a phenomenon, privileging commonalities and a collective generation of meaning was of great relevance to this research (as was explained in section 1.1.9 'The refugee experience'). Constructionism also suggests that moving from one culture to another, "provides evidence enough that strikingly diverse understandings can be formed of the same phenomenon" (Crotty, 1998, p.47). This is particularly pertinent to this research as differing conceptualisations of health, mental health, and substance use, as well as differing definitions and understandings of treatment, care, and recovery, were of significant interest.

Critical Theory

The philosophical and theoretical perspective guiding this project is influenced by critical theory. Similar to constructionism, critical theory views the social world as constantly being constructed through human interactions and therefore understood through the perspectives of people involved in meaning-making actions (Bohman, 2013). However, it further suggests that for change to eventuate, a society must reflect on its problems, so as to identify solutions and do so in a practical as well as theoretical way (Crotty, 1998; Reeves, Albert, Kuper, & Hodges, 2008). This is consistent with the aims of the present research. The critical theory paradigm posits that knowledge is not universal but rather, is created and that the creation and interpretation of knowledge is dependent on language (Campbell & Bunting, 1991). Therefore research guided by critical theory explores the knowledge which is created by those individuals' being studied, and the language used to communicate that knowledge

(Campbell & Bunting, 1991). Thus, interviews are conducted and meaning emerges from the interaction of both the participant and the researcher. This is different from phenomenology where the researcher focuses on simply describing the participant's meanings. An additional level of analysis and interpretation is required in critical theory and is not simply descriptive (Campbell & Bunting, 1991). Critical theory evolved from the Frankfurt School in Germany and was based on the ideas of Marxism (Carr & Kemmis, 2003; Kincheloe & McLaren, 2005; Reeves et al., 2008). Critical theorists were originally concerned with issues of domination and oppression in society and it is for this reason that elements of this theory are applied to this research (Reeves et al., 2008). The idea that dominated or marginalised groups exist in our society whose interests are not best served by current societal systems and structures is an assumption of critical theory and a notion that this research sought to consider.

Consistent with the ideas of the principal researcher in this study, critical theorists aim to confront injustices in society and are interested in understanding the complexities and interconnections between different types of oppression (eg. class, race, gender) (Crotty, 1998). As Kincheloe and McLaren (2005) state "critical theory is never static; it is always evolving, changing in light of both new theoretical insights and new problems and social circumstances" (p.306). The present research was concerned with a relatively new problem. That is, how best to provide support to a group of young individuals who have experienced forced migration- an injustice confirmed by meeting the UNHCR definition for refugee, who are now residing in a particularly disadvantaged region in Australia. Therefore it was appropriate to apply critical theory to the present research. Consistent with the aims of the study, critical theory seeks to identify factors that impede empowerment or success within a society, and emphasises engagement and consultation with those individuals who potentially

possess less power. In other words, research guided by critical theory “must explain what is wrong with current social reality, identify the actors to change it, and provide both clear norms for criticism and achievable practical goals for social transformation” (Bohman, 2013, p.1). This enables solutions to be grounded in the community’s or consumer’s experience and knowledge. In the context of this research, the purpose is not simply to determine the problem but also aims to identify the favourable aspects, or facilitators which are more conducive to successful outcomes. This is in order to inform and transform the community and specifically, comorbidity services for refugee youth, for the better (Reason & Bradbury, 2006).

Methodology: Participatory action research

Participatory action research (PAR) was developed by Orlando Fals Borda with the aim of producing research anywhere in the world which solved unique local problems with local knowledge and resources (Kamberelis & Dimitriadis, 2005). Freire, a well-known critical theorist who emphasised researchers must fully immerse themselves in the community in order to understand the problem (Freire, 1972), influenced the PAR movement (Kamberelis & Dimitriadis, 2005). Like critical theory and constructionism, PAR is interested in the social processes and interactions in collaborative learning and encourages people to join together to remake the practices in which they interact. Habermas, another well-known critical theorist, called this “opening communicative space” (Kemmis & McTaggart, 2005, p. 563).

By incorporating the guiding philosophies of critical theory and constructionism, the methodological framework of this research additionally drew on principles of PAR. To put it simply, PAR is a methodology of social, collaborative, and phase-based investigation of a problem (Kemmis & McTaggart, 2005; Reason & Bradbury, 2006). As its name suggests,

participation and action are the two key concepts involved. The participation component stipulates that the research is a participatory process involving collaboration with the community of research interest (Kemmis & McTaggart, 2005; Reason & Bradbury, 2006). The action component proposes that research should involve an action which seeks to stimulate change in that community (Kemmis & McTaggart, 2005). The aims of PAR can be summarised as follows:

One aim is to produce knowledge and action directly useful to a group of people through research, adult education or socio-political action. The second aim is to empower people at a second and deeper level through the process of constructing and using their own knowledge... (Denzin & Lincoln, 2008, p. 271).

The present research sought to address the first of these aims and emphasised the collaboration and participation of community and participants. A traditional PAR study would involve the implementation of an intervention or 'action' based on the knowledge generated in an earlier phase. It was beyond the scope of this study to implement an intervention based on the findings or to subsequently reflect on or observe the impact of such an action. Despite not being able to implement action, aspects of PAR corresponded well to the research aims and underlying guiding philosophies, and were therefore selected and applied to this research. Community involvement and community meetings were a large component of this research and are a particularly important aspect of PAR as they served to identify issues, reclaim a sense of community, make sense of the information collected, and reflect on the progress of the project (Reason, 1994). PAR differs from other forms of action research in that the involvement of 'ordinary' people is central, whereas in other forms of action research it is generally the 'experts' and outside parties who determine what problems to address. In PAR, members of the community or those directly involved in the problem,

assist in deciding the core objectives of the research (Park, 2001). In addition, in PAR, participants, or those involved in the problem, collaborate at any stage of the research- during design, data collection, analysis and interpretation of findings, or in forming conclusions. Giving a voice to concerned individuals, allows their perspectives to become known and leads to the generation of knowledge through reflection (Park, 2001; Reason & Bradbury, 2006).

This research initially involved a number of consultations with community members who collectively formed an advisory group. Early in the study, this advisory group assisted with establishing, guiding and advising the research questions and study design, and then facilitating recruitment opportunities (Park, 2001; Reason, 1994). Later in the study, this advisory group merged with an already established network of service providers and community members. I was a co-facilitator of this network and involved in the coordination of network meetings. Drawing on PAR methodology, I used this group as an avenue to share the knowledge produced throughout the project back to the community. This way, the information produced and shared was immediately useful to those involved in the community. Further, being a co-facilitator of the network, combined with my own clinical work, immersed me in the topic and provided a new way of understanding the situations faced by all who work and seek help for problems in this space. Figure 3.1 depicts the phased PAR process of the study. Community involvement also enabled the continuation of community development regarding this topic once the research project was finished.

Additionally, as I engaged with the refugee youth participants, I was able to provide them with knowledge of mental health and substance use issues, available services, and other information not readily available. This was in an attempt to empower individuals and encourage social advocacy through the sharing of knowledge.

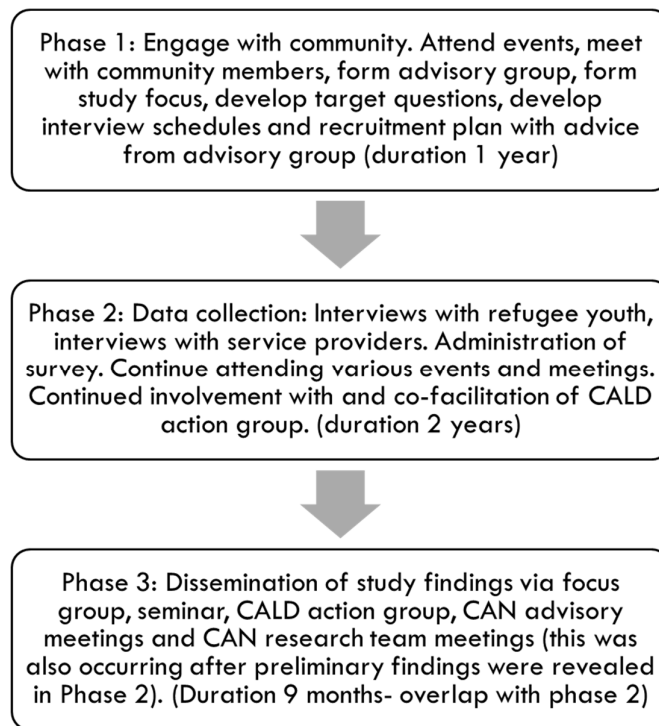


Figure 3.1: PAR phases of this research

Finally, PAR can incorporate diverse methods of gathering data, both qualitative and quantitative. The following section describes how both types of methods were used in order to produce knowledge by including a variety of sources and methods of data generation (triangulation).

Methods: Research Design: Mixed methods

This project used a mixed-methods design, that is, the use of both quantitative and qualitative research methods to collect data. As there has been debate in the literature concerning the appropriateness and validity of mixed-methods studies, at the outset of this project, the advantages and disadvantages of mixing paradigms were considered. Researchers have argued that as qualitative and quantitative paradigms rest on different assumptions, combining methods is inappropriate (Cameron, 2009; Creswell & Plano Clark, 2011; Tashakkori & Teddlie, 2010). However, others maintain that combining quantitative and

qualitative approaches can be more powerful than using either on their own as drawing on the strengths of both approaches provides richer, more elaborate data (Tashakkori & Teddlie, 2010).

Clark (2000) states that quantitative methods assume the researcher to be value-free and separate to the topic that is being researched whereas qualitative methods assume that the researcher interacts with the research topic and subjects and brings certain values and assumptions to the research. However, it can be argued that even the quantitative researcher brings values and assumptions to the research by the act of choosing a field of study and which analyses to conduct, which may indicate a certain level of bias (Crotty, 1998). Creswell and Plano Clark (2011) suggest that researchers should consider using different assumptions within each phase of a mixed-methods study. For example, when the researcher is conducting the quantitative component of the study, they may begin with a positivist perspective to measure variables and conduct statistical analyses. Then during the “qualitative phase of the research which values multiple perspectives and in-depth description, there is a shift to using the assumptions of constructivism” (Creswell & Clark, 2011, pg 83). This approach would be most relevant to a study in which the quantitative component was driven by a theory.

This research was exploratory rather than experimental and did not seek to confirm a theory, did not require variables to be controlled, and did not intend to produce generalisable findings. Instead we sought to develop a more complete understanding of the research topic. Therefore, the paradigm and philosophical underpinnings chosen and described, and the use of both survey and interview data were appropriate for this type of mixed-methods research. As Tashakkori and Teddlie (2010) state, “a variety of paradigms may serve as the underlying

philosophy for the use of mixed methods” and it is unnecessary to endorse only one paradigm and exclude those whose conceptual orientations are different (p. 9).

Creswell (2003) states that a mixed-methods design is useful and advantageous when seeking to best understand a novel research problem. Creswell and Plano Clark (2011) argue that researchers should design their mixed methods studies with at least one clear reason as to why they plan to combine methods. There were multiple reasons I chose to employ a mixed-methods design. Firstly, triangulation allows for convergence and corroboration of results from different methods and different perspectives, as well as highlighting divergent findings. Triangulation enables the researcher to be confident in the validity of the results if similar findings are emerging from different sources (interviews and survey), and groups of people (service providers and refugee youth) (Cameron, 2009). Secondly, completeness, which refers to the idea that combining methods will generate a more comprehensive account of the research topic, was also a reason to utilise mixed methods. Finally, similar to triangulation, it was argued that employing mixed methods will enhance the credibility of the findings. In summary, these methods of data generation (interviews and survey) allowed a large amount of information concerning the views and knowledge of participants to be gathered from various sources and through various means (Cameron, 2009).

Mixed methods can be sequential, concurrent, or transformative in their design and can either involve equal weighting of both methods or emphasise one method over the other (Creswell & Plano Clark, 2011; Tashakkori & Teddlie, 2010). This research utilised a sequential exploratory design and prioritised or emphasised the qualitative component (Cameron, 2009; Terrell, 2012). In sequential designs, the research is conducted in two distinct phases and the collection and analysis of one type of data occurs before the collection and analysis of the other type of data (Cameron, 2009; Creswell & Plano Clark, 2011). Figure

3.2 depicts the phases of an exploratory sequential mixed methods design and which methods were used to generate the three research papers. Paper Two reported on purely qualitative aspects of the research, Paper Three reported on qualitative data which had also been quantified for the purposes of comparison and discussion and finally, Paper Four reported on and integrated both qualitative data and quantitative data.

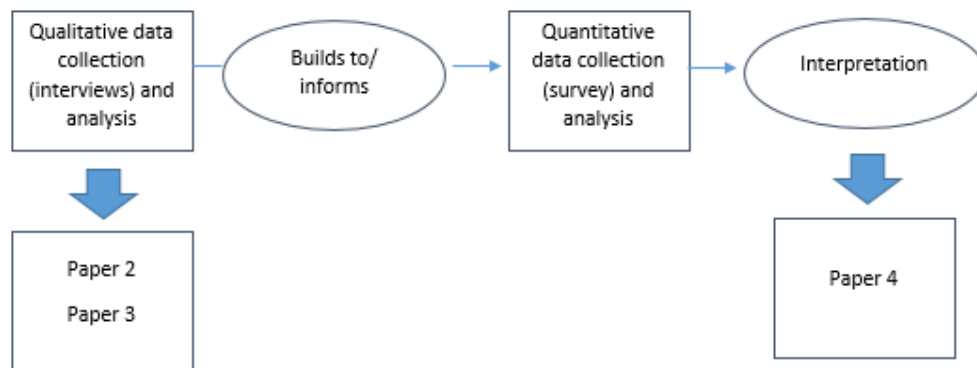


Figure 3.2: The use of exploratory sequential mixed methods design. Figure adapted from Creswell and Clark (2011)

As will be described in the papers comprising Chapters Four, Five and Six, the qualitative data were analysed using thematic analysis. Briefly, thematic analysis is a way of identifying patterns in the data and interpreting these patterns in relation to the research topic (Braun & Clarke, 2006). Using the process of thematic analysis described by Braun and Clarke (2006), data analysis followed six phases: 1) familiarising yourself with your data, 2) generating initial codes, 3) searching for themes, 4) reviewing themes, 5) defining and naming themes, and 6) producing the report. The papers presented in the subsequent chapters will provide detail regarding how the validity and credibility of my analysis was ensured.

Ethical considerations

A number of ethical considerations were raised at the initial stage of the research and plans were established in order to minimise any potential problems.

There has been discussion in the literature about methodological and ethical considerations of conducting research with vulnerable groups such as refugees and displaced populations (Dyregrov, Dyregrov, & Raundalen, 2000; Pittaway, Bartolomei, & Hugman, 2010; Schweitzer & Steel, 2008). These considerations range from common difficulties in conducting research with refugee population such as recruitment difficulties due to fear and distrust of researchers, to ethical concerns such as participants feeling that they are excessively researched yet the promised changes never occur (Pittaway et al., 2010).

In a paper titled “‘Stop stealing our stories’: The ethics of research with vulnerable groups”, the authors document many ethical challenges involved in researching refugee populations and discuss a framework which can be consulted in order to minimise such ethical dilemmas (Pittaway et al., 2010). Although the paper was primarily concerned with research taking place in international refugee camps, some of their recommendations apply to research in Australia. They emphasise that researchers need to consider and negotiate the reciprocal benefit of the study and justify the research by its benefit to the community. The PAR approach adopted in my research facilitated discussion of this issue and it was concluded that the potential benefits to the community justified the need for this research. In fact, it was discovered through discussions with the community that refugee youth were a somewhat neglected group in the region of interest. Pittaway et al (2010) recommend that researchers choose a methodology that collects information “from vulnerable populations in a way that is empowering, not harmful or exploitative, and which has the potential for bringing about social change” (p.247). This statement also supports the use of PAR principles of

collaboration, knowledge sharing, and empowerment. One study has shown that conducting research with traumatised or bereaved refugee populations can be beneficial to the participants who rated the overall experience as positive (Dyregrov et al., 2000). This is consistent with research which has suggested that sharing distressing stories with a researcher can have a healing effect (Cook & Bosley, 1995).

Other ethical concerns which were considered in this research related to practical aspects of the research and consent process. Firstly, for participants in the youth sample and for whom English was a second language, a two-stage consent process enabled participants to decide whether they were comfortable with the content of the interview and the level of English required to participate. Participants were asked if they would like to stop the interview or continue after having participated for 15 minutes. No participants withdrew from the interview. All research participants were informed that they were free to withdraw at any stage of the research. Participants were also encouraged to let the researcher know if they wanted to take a break, skip a question or section or reschedule the rest of the interview for another occasion.

Secondly, although it was not anticipated that participants would become distressed as a result of taking part in this research, initial ethical considerations required procedures to be put in place in the event of this occurring. Adequate time was allocated to each interview in order to allow sufficient time to build rapport, conduct the interview in a sensitive manner and allow time for debriefing and a more casual conversation on completion. I conducted all of the interviews and have previously been trained in and had over two years of experience conducting interviews with populations who have experienced torture and trauma. Additionally, as mentioned, I was concurrently working as a counsellor for refugees who have experienced torture and trauma and therefore, all interviews were conducted in a

sensitive and cautious manner. As part of the PAR approach, by interviewing and involving the young people in the research it was possible to provide information about mental health symptoms and substance use and provide information on where they are able to go for help and support if required. If it was required, referral procedures were put in place. This was only necessary on one occasion and was unrelated to the interview itself. Rather, the participant indicated he wished to seek mental health support and asked me to facilitate this process. I was trained in suicide risk assessment and intervention if any participants began to display signs of or speak of any intention to harm themselves. However, this did not occur.

Thirdly, as this study included young people aged 12-18 years we needed to obtain parental consent for those under the age of 18 years. The purpose, significance and risks of the study were outlined on participant information sheets and consent forms which the parents or guardians were required to read and sign. Although this consent process was approved by the Human Research Ethics Committee, I had concerns regarding the utility of English information sheets given that these documents were not translated into other languages due to financial constraints. Fortunately, my involvement in the community enabled me to meet many of the parents, guardians or family members of the participants who were under the age of 18 years. Therefore I was confident that this ethical concern was minimised and through my own verbal and follow-up consent process during the interview, I believe that there was no coercion of participants. All participants were informed of the reasons for the research and were assured that the information provided was to be kept confidential.

3.3.1 Human Research Ethics Committee

Ethics approvals were obtained from The Women's and Children's Health Network Human Research Ethics Committee and the University of Adelaide Human Research Ethics

Committee. The process of obtaining ethics approval for this study and the CAN parent project led the researchers to observe some interesting discrepancies between what was required for studies involving refugee participants and studies involving Aboriginal participants. These observations, along with a reflection and critique of the ethical review process was documented in a paper published in 'Mental Health and Substance Use' titled 'Ethics overload: Impact of excessive ethical review on comorbidity research' (Posselt et al., 2014). This paper is presented in Appendix A.

Conclusion

This chapter has discussed the theoretical and philosophical underpinnings of this research (constructionism and critical theory), explained the use of PAR methodology, and provided a rationale for the use of a mixed methods approach. This chapter concluded with a discussion of ethical considerations. The following papers will describe the materials and methods used within each phase of the research.

4. Chapter Four: Paper Two

Aetiology of coexisting mental health and alcohol and other drug disorders:

Perspectives of refugee youth and service providers

Miriam Posselt¹, Nicholas Procter³, Charlotte de Crespigny² and Cherrie Galletly¹

¹ Discipline of Psychiatry, University of Adelaide, Adelaide, Australia;

² School of Nursing, University of Adelaide, Adelaide, Australia;

³ School of Nursing and Midwifery, University of South Australia, Adelaide, Australia

Published manuscript:
Australian Psychologist

Statement of contributors

Miriam Posselt (Candidate)

I was responsible for study conception, literature review, data collection and analysis, manuscript drafting and preparation, manuscript submission, response to reviewers and revisions to the manuscript.

Signed:

Date: 14/01/2016

Cherrie Galletly, Charlotte de Crespigny and Nicholas Procter (Co-authors)

We provided ongoing supervision throughout the research program that led to the development of this manuscript. There was ongoing collaboration between Ms Posselt and us in refining the direction of the research. Ms Posselt was responsible for writing this manuscript. Our role was to comment on drafts, make suggestions on the presentation of material in the paper, and to provide editorial input. We hereby give our permission for this paper to be incorporated in Ms Posselt's submission for the degree of Doctor of Philosophy from the University of Adelaide.

Signed:

Date: 14/01/2016

Signed:

Date: 14/01/2016

Signed:

Date: 15/01/2016

Posselt, M., Procter, N., Galletly, C. & de Crespigny, C. (2015), Aetiology of Coexisting Mental Health and Alcohol and Other Drug Disorders: Perspectives of Refugee Youth and Service Providers. *Australian Psychologist*, 50(2), 130–140.

NOTE:

This publication is included on pages 72 - 82 in the print copy of the thesis held in the University of Adelaide Library.

It is also available online to authorised users at:

<http://dx.doi.org/10.1111/ap.12096>

5. Chapter Five: Paper Three

Merging perspectives: Obstacles to recovery for youth from refugee backgrounds with comorbidity

Miriam Posselt¹, Nicholas Procter³, Charlotte de Crespigny² and Cherrie Galletly¹

¹ Discipline of Psychiatry, University of Adelaide, Adelaide, Australia;

² School of Nursing, University of Adelaide, Adelaide, Australia;

³ School of Nursing and Midwifery, University of South Australia, Adelaide, Australia

Published manuscript:
Australasian Psychiatry

Statement of contributors

Miriam Posselt (Candidate)

I was responsible for study conception, literature review, data collection and analysis, manuscript drafting and preparation, manuscript submission, response to reviewers and revisions to the manuscript.

Signed:

Date: 14/01/2016

Cherrie Galletly, Charlotte de Crespigny and Nicholas Procter (Co-authors)

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Posselt, M., Procter, N., de Crespigny, C., & Galletly, C. (2015). Merging perspectives: Obstacles to recovery for youth from refugee backgrounds with comorbidity. *Australasian Psychiatry*, 23(3), 293-299.

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6. Chapter Six: Paper Four

Improving the provision of services to young people from refugee backgrounds with comorbid mental health and substance use problems: Addressing the barriers

Miriam Posselt¹, Karalyn McDonald⁴, Nicholas Procter³, Charlotte de Crespigny² and Cherrie Galletly¹

¹ Discipline of Psychiatry, University of Adelaide, Adelaide, Australia;

² School of Nursing, University of Adelaide, Adelaide, Australia;

³ School of Nursing and Midwifery, University of South Australia, Adelaide, Australia

⁴ School of Public Health and Preventive Medicine, Monash University, Melbourne, Australia

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Submitted to BMC Public Health

Statement of contributors

Miriam Posselt (Candidate)

I was responsible for study conception, literature review, data collection and analysis, manuscript drafting and preparation, manuscript submission, response to reviewers and revisions to the manuscript.

Signed:

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Karalyn McDonald, Cherrie Galletly, Charlotte de Crespigny and Nicholas
Procter (Co-authors)

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Improving the provision of services to young people from refugee backgrounds with comorbid mental health and substance use problems: Addressing the barriers

Abstract

South Australia (SA) has resettled 151,134 refugees in the last ten years (Department of Immigration and Border Protection, 2014). Northern metropolitan Adelaide, an area which experiences significant social disadvantage, has received a significant number of (predominantly young) refugees. Research indicates that refugee youth are at elevated risk of mental health (MH) and alcohol and other drug (AOD) problems. These factors, along with the low socio-economic status of northern Adelaide, the number of refugee youth residing there, and the added complexity of treating comorbid MH and AOD problems (comorbidity) prompted this research. We investigated the barriers and facilitators to culturally responsive comorbidity care for these youth and whether the MH and AOD services were equipped to provide such support. This mixed-methods study employed semi-structured interviews with refugee youth and service providers and an online survey with managers of services. Thirty participants (15 refugee youth, 15 service providers) took part in the semi-structured interviews and 56 (40 complete, 16 partially-complete) in the survey. Thematic analysis of the interview data revealed the most commonly reported barriers related to four broad areas: (1) organisational and structural, (2) access and engagement, (3) treatment and service delivery, and (4) training and resources. Survey data supported the barriers identified in the qualitative findings. This research highlights significant gaps in the response of MH and AOD services to refugee youth with comorbidity. Based on the findings, ways of overcoming the barriers are discussed, and are of particular relevance to policy makers, organisations and clinicians.

Key words: Refugee, youth, comorbidity, service provision, mental health, substance use

Background

Comorbidity is defined as the existence of one or more clinical conditions (Allsop, 2008). However, the use of the term comorbidity in this research refers exclusively to the co-existence of mental health (MH) and alcohol and other drug (AOD) problems (also commonly referred to as dual diagnosis or co-occurring disorders). Comorbidity is prevalent among the general population of Australia and treatment for individuals with comorbidity is often complicated by a number of challenges relating to detection, diagnosis and treatment, including the separation of MH and AOD service sectors (Allsop, 2008; Australian Institute of Health and Welfare, 2005). While we have a growing understanding of the implications of these challenges for treatment of individuals in the general population, there is little knowledge concerning how these issues may impact on individuals from refugee backgrounds.

The Significance of Comorbidity

The aetiology of comorbidity is complex. Researchers suggest there are three main explanations as to how comorbidity occurs; that causal relationships are either direct or indirect or that common reasons lead to both conditions developing (Allsop, 2008; Jacobs, Cahill, & Gold, 2005). Establishing the cause of comorbidity and determining which disorder came first may be useful in understanding the development of the problem, which can therefore be addressed during treatment (Allsop, 2008). However, regardless of causal relationship, it is understood that each condition assists in maintaining or exacerbating the other and that addressing both conditions is critical (Mills et al., 2008). Research has consistently reported that individuals with comorbidity experience poorer prognoses, premature mortality, higher rates of suicide, a more severe illness course, greater burden of disability, difficulty obtaining correct diagnoses, greater difficulty accessing effective treatments and greater use of health services than those with only one disorder (Holt et al.,

2007; Merkes, Lewis, & Canaway, 2010; Mills et al., 2008; Teesson & Burns, 2001). Many reports and guidelines have been produced in an attempt to improve the outcomes for individuals with comorbidity. The majority of the literature states that integrated and coordinated treatment models addressing both conditions (usually concurrently) are necessary, see, for example, Allsop (2008), Donald, Dower, and Kavanagh (2005), de Crespigny and Talmat (2012), and Gordon (2008).

The Prevalence of Comorbidity

Large-scale prevalence studies have reported high rates of comorbidity. For example, the National Comorbidity Survey in the United States found that in a sample of 8,100 people, 41-65% of people with an addictive disorder also had at least one mental disorder and 51% of those with a mental disorder also had at least one addictive disorder (Kessler, Nelson, & McGonagle, 1996). In Australia, MH problems are prevalent among clients of AOD services and AOD use is more common among those with MH diagnoses than in the general community (Allsop, 2008; Australian Institute of Health and Welfare, 2005). For example, the 2013 National Drug Strategy Survey found that the prevalence of mental illness was greater among adults who had used illicit drugs within the past 12 months (21%) or past month (24%) than those who had not used (12.6%) (National Drug Strategy, 2013). Comorbidity is also an important issue among young people in Australia. According to the most recent Mental Health and Wellbeing Survey (2007), 26% of young people (aged 16 -24 years) had a recent (within the past 12 months) mental disorder and 13% reported a recent substance use disorder (Australian Bureau of Statistics, 2007). Young people with a recent mental disorder (36%) were five times more likely than those without mental disorders (7%) to have misused drugs in the previous year. Further, large proportions of those with mood (37%) and anxiety (32%) disorders reported misusing drugs within the last 12 months. The most common substance use disorder found among young people was harmful use of alcohol (9%) and 57% of those with a recent mental disorder reported consuming alcohol at least

weekly compared to 35% of those without a mental disorder. Like most prevalence surveys, refugee background was not measured and it is therefore difficult to determine the extent to which these findings are likely to be generalisable to young refugees in Australia.

Instead, we draw on studies considering rates of MH conditions among this population and other research investigating the risk factors of developing AOD problems. Research indicates that refugee young people are faced with multiple risk factors pre-, during and post-migration, placing them at risk of MH and AOD disorders (Henley & Robinson, 2011; Horyniak et al., 2014; Olliff & O'Sullivan, 2006; Refugee Council of Australia, 2009; Schweitzer, Melville, Steel, & Lacherez, 2006; Sowe, 2005). Research has reported high rates of PTSD, depression and other psychiatric problems among refugee groups. For example, prevalence studies concerning refugee young people have reported that rates of PTSD vary from 19-54% and rates of depression vary from 3-30% (Bronstein & Montgomery, 2011). Further, there are well-established links between PTSD and AOD disorders (Australian Centre for Posttraumatic Mental Health, 2013), as well as between socio-economic disadvantage and AOD use among migrant populations (Beyer & Reid, 2000; Reid, Crofts, & Beyer, 2001).

Service Utilisation

Many individuals with comorbidity do not access treatment or support for their problems (Stohler & Rössler, 2005). This is reported to be the case for young people in Australia (Australian Bureau of Statistics, 2007; Szirom, King, & Desmond, 2004) and for culturally and linguistically diverse (CALD) individuals across the lifespan (Malak, 2001). In Australia, only 23% of young people in the general community who reported having a MH problem in the previous 12 months had accessed a service within that time period and young people with AODs were even less likely to have accessed formal support (11%) (Australian Bureau of Statistics, 2007). Young refugees in particular are underrepresented in support

services and face substantial barriers accessing support and treatment for both MH (Colucci, Minas, Szwarc, Paxton, & Guerra, 2012; De Anstiss & Ziaian, 2010; Ellis, Miller, Baldwin, & Abdi, 2011) and AOD problems (Greater London Authority, 2004; Mario-Ring et al., 2005; Van de Gaag, 2007). Given these findings, it is likely that those young people from refugee backgrounds with comorbidity are facing additional obstacles to service engagement and to receiving appropriate assessment, support and treatment. Research conducted in Sydney, Australia investigated the barriers that culturally and linguistically diverse clients with comorbidity experience in receiving support (Flaherty & Donato-Hunt, 2012; Flaherty, Donato-Hunt, Arcuri, & Howard, 2010). Flaherty and colleagues (2012) interviewed service providers and clients and found that services not only struggle to effectively help those with comorbid MH and AOD conditions but also fail to adequately accommodate cultural and linguistic diversity (Flaherty & Donato-Hunt, 2012). There has been no such research looking specifically at young people from refugee backgrounds. However, it is likely that the additional complications concerning ethnicity and cultural diversity would apply to refugee youth. Further, these difficulties may be compounded by the backgrounds of these young people as many will have had traumatic experiences, by the very definition of refugee (UNHCR, 1951). As this is a topic characterised by little research and discussion, this paper goes some way towards addressing the paucity of research concerning comorbidity among refugee youth.

The Study Region

The local government areas (LGAs) of Salisbury and Playford in the northern suburbs of Adelaide experience significant social disadvantage. At the time the research was conducted, the Australian Census of Population and Housing (2011) revealed high unemployment rates in Salisbury (6.97%) and Playford (8.01%) compared to the rest of South Australia (5.31%), and Australia (5.65%) (Australian Bureau of Statistics, 2011). Lower levels of education were also reported in these regions as fewer people indicated having a

Bachelor Degree as their highest level of education in Salisbury (5.56%) and Playford (3.04%) than the rest of SA (9.53%), and Australia (10.88%) (Australian Bureau of Statistics, 2011). High proportions of people in these LGAs are in receipt of Government welfare benefits. For example, in June 2013 greater proportions of families residing in both Salisbury (14.8%) and Playford (23.6%) were assessed as low income and welfare dependent compared with the SA (10.1%) or Australian (9.8%) average (The University of Adelaide, 2014).

Over the last decade SA has resettled 151,134 refugees under the humanitarian program (Department of Immigration and Border Protection, 2014). One third of these arrivals were resettled in the LGAs of Salisbury and Playford. The majority (63%) of these refugees were under the age of 25 years on arrival. As a result, SA has a large young refugee population particularly in the northern suburbs. Furthermore, to our knowledge, there has been no investigation into whether the MH and AOD services are equipped to respond appropriately and effectively to clients from refugee backgrounds or consideration of what factors might impede such service delivery in this region.

The Present Study

This research aimed to determine the barriers and facilitators to effective, culturally responsive service provision for young people of refugee background living in the study region with comorbid MH and AOD problems. It is hoped that the findings from this research will lead to the barriers being addressed in policy and practice.

Method

This mixed methods study involved three components of data collection:

1. Interviews with consumers (refugee youth)
2. Interviews with service providers ('on the ground')
3. Online survey of MH, AOD and related services (management staff)

Mixed methods

This research employed a sequential exploratory mixed methods design where the qualitative component informed the development, analysis and interpretation of the quantitative survey. The survey aimed to provide additional data to the interview findings, as well as help verify the qualitative findings. The use of more than one approach to investigate a research question, known as data triangulation, was important because it enabled comparison of findings from the different data sources and methods and therefore can ensure greater confidence in the findings. Similarly, a mixed methods approach to address a complex area also provides valuable data because it draws on the strengths of both methods and allows us to compare findings from different perspectives (Tashakkori & Teddlie, 2010).

Participatory Action Research

This research drew on principles of participatory action research (PAR) by involving community members and participants in all stages of the research process (Reason & Bradbury, 2006). Numerous meetings were held with community members, stakeholders and refugee advocates to optimise the research objectives, the interview guides, provide valuable assistance with recruitment, and provide insight into the findings. This approach facilitated the recruitment and data collection process and provided the community with an opportunity to contribute to the research and have their perspectives heard and considered at every stage of the research. This process also assisted with the interpretation and validation of the results through the sharing and discussion of findings with the members of the community via a group discussion ($n = 3$), individual consultation ($n = 2$) and a meeting of local health professionals ($n = 10$, 2 of whom were participants). Although a PAR study would typically involve an intervention or ‘action’ phase of the research after having engaged with the community, collected data, and shared with findings back to the community, an intervention was beyond the scope of this study. However, as this research was situated within a larger

project, our specific findings then informed the delivery of workshops for health professionals regarding the service provision for individuals with comorbidity in this region (de Crespigny et al., 2015).

Ethics approvals were obtained from the Women's and Children's Health Network Human Research Ethics Committee and The University of Adelaide Human Research Ethics Committee. All interview participants or their guardians gave written informed consent and survey participants indicated their consent online before continuing to the questions.

Qualitative Component

Sampling and recruitment. The relationships established using the PAR approach with community leaders, members and advocates facilitated recruitment of both refugee background young people and service providers. The principal researcher (MP) was invited to attend various community events to hand out flyers and promote the study to both health professionals and people from refugee communities. Interview participants were recruited using purposive sampling techniques by identifying individuals who possessed knowledge related to the research question and who would be able to provide rich, in depth information. Using snowball-sampling techniques, participants were also asked to identify other relevant individuals who could potentially participate. Some refugee youth participants ($n = 4$) were recruited by their MH or AOD workers encouraging them to participate in the study as they were identified as being able to advocate for refugee background youth with comorbidity. Careful attention was given to avoid practices of coercion of potential participants by the principal researcher. This was done by ensuring oversight of information being distributed, reinforcing the voluntary nature of participation and how the information would be used in a de-identified manner. In addition to using the established networks to recruit service providers, MH, AOD and refugee support services were contacted and professionals were invited to participate.

Data collection. Interviews with service providers and refugee youth were conducted during 2013 and 2014. Interviews were conducted in locations where the participant felt most comfortable including libraries, cafes, various health services or at the local Migrant Resource Centre. Interviews were semi-structured and an interview schedule was used. The interviewer used prompts, probes, clarification, and follow-up questions to enable deeper exploration of the participants' knowledge and lived experiences. Questions were broadly focused on the difficulties for refugee youth resettling in Australia, what specific risk factors are related to the development of MH and AOD problems and comorbidity, what challenges youth face once they are experiencing MH and AOD problems and comorbidity, and what barriers and facilitators are perceived to impact on access to and receipt of treatment for youth with comorbidity. Interviews ranged from 45–90 minutes in length, were audio-recorded and transcribed verbatim. All interviews were conducted and the majority were transcribed by the principal researcher to allow total immersion in the data. Refugee youth who participated in the interview received a AUD\$20 shopping voucher to compensate for the time spent participating and any travel costs.

Analysis. Data were analysed using a thematic approach guided by a commonly applied protocol for thematic analysis (Braun & Clarke, 2006) and with the assistance of NVivo 9 software (QSR, 2010). Data were initially coded and then re-coded as additional themes emerged. A coding structure was determined where coded categories were collapsed and organised with notes identifying their relationships to other codes and overarching themes. All emergent themes (derived from the corresponding codes) were then categorised under the broad over-arching themes presented in this article.

Validity checking of the qualitative data. In addition to utilising triangulation techniques, employing a mixed methods design, and consulting the community to verify the findings, potential biases of the principal researcher were addressed by regular meetings with the authors to discuss and interpret the qualitative findings. Individual transcripts and

emerging themes were discussed to develop and enrich the interpretations and subsequent conclusions drawn.

Quantitative Component

Recruitment. An initial scoping study was conducted within the larger parent project and is published elsewhere (Cairney et al., 2015). This scoping study identified 70 services which provided treatment and support for individuals with MH or AOD problems living in northern Adelaide. Of these, 26 services were deemed relevant for young people from refugee backgrounds. Using this directory, the relevant services were contacted and email addresses were obtained. An email was then sent with the study information and a link to the survey. Workers employed in a management or leadership role at a MH, AOD or related service, which provided support or treatment for youth aged 12-25 years in northern Adelaide, were eligible to participate in the 10-20 minute online survey. By way of snowball sampling, participants were encouraged to forward the link and email to other eligible colleagues. Given that participation in the survey was anonymous and that there may be a number of management positions within each service, we are unable to estimate how many services took part in the survey or estimate a response rate. However, this survey did not aim to generate a representative sample but rather, aimed to collect information from a number of managers from various services. Therefore this recruitment technique was adequate for the purposes of our exploratory research.

Data collection. The survey consisted of 35 questions regarding service provision for refugee background clients aged 12-25 years. The questions concerned staff training, data collection and access to resources, funding and interpreters as well as asking participants to identify barriers and facilitators within their organisation to culturally responsive care for this population. The survey was conducted from May to July 2014.

Data analysis. Data were analysed using SPSS (IBM, 2012). The analyses were guided by findings from the qualitative data. For example, interview participants reported

marked differences in the way refugee youth were treated, as well as the cultural competence of the staff depending on the type of MH or AOD organisation. Therefore in addition to the descriptive statistics obtained from the data as a whole, further analyses examined differences in responses between Government Organisations (GOs) and Non-Government Organisations (NGOs). In order for differences to be examined, a series of Chi-square tests were conducted. In cases where the assumptions of the Chi-square test were violated such as if the cell count was less than five, Fisher's exact test of significance was also calculated to determine if there were any significant differences between groups. A p value less than .05 was considered significant. Cohen's (1988) definition of effect size is used, suggesting that 0.2 is a small effect, 0.5 is a moderate effect and 0.8 is a large effect.

Results

Participant Description

Qualitative component.

Refugee youth. Fifteen young people aged between 12 and 25 years (average 17.7 years) participated in the study. There were more female ($n = 9$) than male ($n = 6$) participants. Participants were from Afghan (60%), African (27% [Congolese, Liberian, Burundian]) and Bhutanese (13%) backgrounds, and had been living in Australia for an average of 4.9 years. Two participants had arrived as unaccompanied minors.

Service providers. Service providers interviewed were from Government ($n = 7$) and Non-Government ($n = 8$) MH, AOD and refugee support services. They were qualified social workers ($n = 10$, 5 of whom were program managers), psychologists ($n = 2$) and mental health nurses / nurse practitioners ($n = 3$).

Quantitative component.

Fifty-six participants took part in the survey (40 complete and 16 partially complete). Demographics for survey participants are presented in Table 1. All respondents were

employed in management or leadership positions: team leaders (58.5%, $n = 24$), service managers (26.8%, $n = 11$), section managers (9.8%, $n = 4$) and program managers (4.9%, $n = 2$).

Table 1. Service/ participant characteristics

	Government	Non-Government	Total
MH	26	10	36
AOD	1	3	4
Combined MH/AOD	4	5	9
Other (correctional, homelessness, gambling)	3	4	7
Total	34	22	56

MH: Mental health service

AOD: Alcohol and other drug service

Results from thematic analysis.

Four broad themes relating to the barriers and facilitators to effective service provision for refugee youth with comorbid MH and AOD problems were identified:

1. Organisational and structural barriers
2. Access and engagement
3. Treatment and service delivery
4. Training and resources

Within each of these broad themes, there are a number of subthemes that are described. Many of the themes and subthemes are interrelated and have been organised in a way which best reflects the reported importance of each of the barriers. There was overall consistency in the perspectives of both groups of interview participants and they are therefore organised and presented together. Any differences or contrasting perspectives are highlighted. Some subthemes were predominantly reported by service provider participants. Where this occurred, the quotes presented are exclusively those of service providers. More commonly, participant quotes are presented from both groups of participants and are identified by either 'RY' indicating a quote by a refugee youth participant or 'SP' for a service provider participant.

Results from quantitative analysis

Overall, there was convergence between the results of the qualitative and quantitative data. The findings from the total dataset are presented in Table 2 and show the general trends reported by survey participants. However, survey data which relate specifically to the qualitative themes are presented within each corresponding or relevant theme to complement and strengthen the research findings.

Table 2: Cultural responsiveness of MH and AOD services: Summary of all respondents

	Yes n (%)	No n (%)	Other (response specified) n (%)	Total n (%)
Does your service allow home visits?	40 (71.43%)	16 (28.6%)		56 (100%)
Do your clients have access to accredited interpreters?	52 (92.9%)	3 (5.4%)	1 (1.7%) (Unsure)	56 (100%)
Is your service adequately funded to provide treatment to refugee background clients?	17 (30.4%)	39 (69.6%)		56 (100%)
Is your service adequately resourced to provide treatment to refugee background clients?	19 (33.9%)	37 (66.1%)		56 (100%)
Does your organisation collect data regarding if client is of refugee background?	13 (23.2%)	27 (46.8%)		40 (100%)
Do your staff receive any training for working with CALD clients?	26 (65%)	14 (35%)		40 (100%)
Do your staff receive any training for working with refugee background clients?	10 (25%)	30 (75%)		40 (100%)
Does your service employ 1 or more CALD/ cultural liaison/ consultation or bi-cultural workers designated to work with CALD clients?	19 (47.5%)	21 (52.5%)		40 (100%)
In your opinion are the staff in your service adequately trained to provide treatment for refugee background clients?	6 (15%)	18 (45%)	16 (40%) (There is room for improvement.)	40 (100%)

Do refugee clients and potential clients experience any barriers to accessing your treatment service?	27 (67.5%)	13 (32.5%)	40 (100%)
Do you think young people from a refugee background have the same access to services as other young clients?	9 (22.5%)	31 (77.5%)	40 (100%)
Do you think young people from a refugee background with drug dependency issues and mental illness get the same level of treatment as people who only experience one or the other?	13 (32.5%)	27 (67.5%)	40 (100%)
Do you think young people from a refugee background with drug dependency issues and mental illness get the same level of treatment as young people in the general population with drug dependency issues and mental illness?	12 (30%)	28 (70%)	40 (100%)

Theme 1: Organisational and structural barriers

One of the most commonly reported barriers for clients accessing and receiving appropriate comorbidity care was the fragmented structure of services. This fragmentation related to the divide of MH and AOD services, as well as that between mainstream services and CALD/ refugee specific services. This fragmentation increased the experience of ‘run around’ for refugee youth clients, where young people were required to attend multiple services, potentially risking further disengagement. This was highlighted by service providers:

“Probably one of the biggest problems is the way in which services are funded to work in silos, there is that disconnection.” SP201

The interviews with refugee youth revealed that they often were unaware of services that were available to them. Many refugee youth participants indicated they were willing to seek assistance from agencies if they deemed their services to be of benefit:

“If the services are well known or better known in the migration agencies this could increase access. So if services worked with settlement support agencies they would know where people can get help and give advice.” RY110

Related to the fragmentation of services, interview participants reported there was an unaddressed need for stronger partnerships and collaborative interagency projects. It was generally agreed that the need for partnerships or collaboration was greater when dealing with refugee communities because some agencies had the skills, resources and connections with communities. They did not however have the ability to take on more clients. In contrast,

others had the capacity and desire to take on the clients but faced significant barriers to engaging refugee clients. Therefore, the lack of collaboration between MH and AOD sectors resulted in further isolation of one sector and reduced access opportunities for the youth:

"I think services need to work in partnership with one another; it needs to be a joint initiative." SP201

Service providers often spoke about the need for partnerships and collaboration between organisations with various specialities or expertise as a way of addressing the lack of funding for community engagement efforts:

"They need to create partnerships with services that do [have funding for CALD community engagement] and can because they are out there. They need to reach out and they also need to be receptive..." SP201

A further barrier identified by service providers was the lack of available funding for improving the cultural responsiveness of their service, such as community engagement efforts. The need for these efforts was also recognised by refugee youth. Young people reported that more presentations and attempts by organisations to promote mental health awareness and knowledge of services within community groups would reduce some of the stigma and create a feasible way of accessing services. Service providers acknowledged that although they knew these efforts were necessary, limited funding and resources prevented this from occurring:

"I think one of the things in our current health environment that we are struggling to hang on to, is community engagement." SP 202

This finding was corroborated by survey participants who said they believed their service was inadequately funded to provide treatment to young refugee background clients (69.6%, $n = 39$) and inadequately resourced (bi-lingual materials, assessment tools and so on) to provide treatment to these clients (66.1%, $n = 37$).

The final barrier identified by service providers for access and appropriate comorbidity care for refugee youth was the lack of data collection concerning refugee background clients. Most service providers reported that their organisations did not collect any data regarding the background of their clients. Most service providers understood this to be because few young refugee clients accessed their services (unless they were specifically funded for refugee clients) and therefore it was hard to justify the allocation of scarce resources, as well as there being no perceived need by the organisations to collect such data. Service providers also reported that this in turn provided justification for the lack of funding allocated to efforts to engage this population in the services. However, most felt that the collection of this kind of data was important:

"It [refugee background] is often recorded in consultation but not on the data system and I think that's a problem across the state." SP202

Consistent with reports from interview participants, only a small number of survey participants (32.5%, $n = 13$) reported that their organisation collected data concerning refugee background. The majority of participants (67.5%, $n = 27$) indicated their service did not collect data about whether clients are from refugee backgrounds. However, just over half (57.5%, $n = 23$) of participants reported their service collected country of birth.

Theme 2: Access and engagement

The second theme identified from the interview data was access and engagement with services. Of particular importance was the perception that stigma and shame was a significant barrier to refugee young people's willingness to access or remain engaged with services. Given that MH stigma is a problem in the general population and reported to be greater in CALD communities, it was not surprising that shame and stigma associated with experiencing MH and AOD problems was a frequently reported barrier to accessing services. Service providers discussed the stigma associated with mental health issues within the wider community as well as concerns by young people themselves accessing services that have Mental Health within the name of the organisation:

"I don't think that this client group readily access mental health services anyway and when you've got mental health in your name it's a real issue." SP 202

Young people also spoke about their concerns of being seen by their community members in a service that provides mental health services and the subsequent conclusions that would be drawn by others:

"If I go alone to hospital and someone saw me and they would say- you have been there, I saw you. You have been attending appointment." RY106

Participants reported they had very little knowledge of mental illness, addiction and the potentially harmful consequences of drug and alcohol use, as well as very little awareness of MH and AOD support services among refugee youth. Lack of information, compounded with the fear and mistrust of services was reported to result in the lack of help-seeking:

"No I couldn't find anyone, I couldn't trust anyone...I was embarrassed too but it's just that there was no one to trust." RY 114

There was also agreement among refugee youth that when this information was presented in schools or at community events, it was rarely delivered in a way that was meaningful to CALD or refugee background individuals which has important implications for engagement of refugee youth:

“... even if you do [receive drug and alcohol education] you might see that as just a western thing”. RY 115

Participants suggested an information exchange between service providers and resettled refugee communities as a way of meaningfully engaging refugee background youth in health and support service promotion:

“If they [MH workers] give lots of information to the refugees, [they] get lots of information from them [refugees] - what kind of situation the refugee people got”. RY106

Increasing the profile of services, including their work in MH and AOD issues, was also considered as important by refugee youth as not only increasing information and education but also fostering trust and familiarity:

“So when they [workers from local MH service] came to the school they introduced themselves, they talk about themselves and that’s when you find them more interesting and can go and see them once you know about them” RY 110

There was agreement among all participants that fear and distrust was a major barrier to accessing and engaging in services. This included a fear of disclosing personal information, fear of retribution, such as being deported or put back in immigration detention, a fear of any

people in authority related to their previous experiences with corrupt or violent government officials, a fear of gossip by interpreters (and reported experiences of this occurring), and fear of clinicians informing parents of their difficulties:

“Lack of trust also is a big problem and the larger CALD communities, they think if I tell them this will they tell the police? Will they tell the child protection agencies?” SP 206

Similarly, one participant indicated that she differentiated whom she could confide in:

“... but worried [it is] not confidential. I can trust doctors- they know better. But counselling- not really.” RY 105

Some refugee youth also indicated that they did not think many of the services were culturally appropriate or likely to offer them the same services that were offered to Australian born youth:

“... even with counselling or any of those kind of health services, they are using western point of view and that is different to what other cultures believe so, it's totally different” RY115

“If you are born in Australia you get more respect- they care more about you because you are part of them, one of them. Rather than coming from overseas you get treated... [trails off]...I think they care more about you if you are citizen and you are born in Australia.” RY110

Not surprisingly, most participants (SP and RY) reported that language barriers were a significant obstacle to accessing services. Service providers said that some services did not have funding to use interpreters and those that did were sometimes encouraged to avoid using

them wherever possible due to the high associated costs. Service providers reported that in recent years it was less common for family members to be used as interpreters. However, the youth interviewed reported that they often have to act as interpreters for their relatives in such services. It was also reported that sometimes there was a preference by clients to not use interpreters for fear that the interpreter would not keep their information confidential and young people reported being concerned their parents would find out if they used an interpreter with a health professional. Although this was a reported barrier to effectively engaging in support and treatment, young people were reported by service providers to be less likely to need interpreting services as many refugee youth acquired English skills faster than their older relatives. However, this was not always the case and one refugee youth participant reported his frustrations with not being able to communicate his experiences adequately:

“They haven’t seen that stuff, so it’s hard to explain to them also. Some people who can’t speak English so they don’t know how to tell them, they don’t know how to say some words in English.” RY105

There was some disparity between what interview and survey participants reported in relation to access to accredited interpreting services as the majority of survey participants reported that their clients do have access to interpreters (92.9%, $n = 52$).

Service providers also stated that it was common for refugee youth experiencing comorbidity to only access support services once they had reached a point of crisis and had been referred through emergency departments, crisis intervention services, homelessness agencies or through the criminal justice system. Service providers generally agreed that the ability to intervene early was challenging because refugee youth did not usually access services during periods of stability:

“Most people from these communities don’t seek help until they are dying. If it’s not serious, they don’t seek help until it is a crisis” SP 206

Again, related to the fragmentation of MH and AOD services, as well as refugee and mainstream services, it was reported that when a refugee young person did access a service, being referred back and forth between services was a common occurrence. Service provider participants stated that they witnessed an ongoing referral process where each service would determine that they were not equipped or suitable to deal with this client group or their presenting problem and therefore refer them to other services. This was referred to as “handballing” and was reported to result in further disengagement of refugee background complex clients:

“The biggest difficulty was trying to get mental health services on board. Often a response was, we won’t take that client on until you have dealt with their drug and alcohol issue... There are a lot of services out there that are happy to handball to the other service sector. They put it in the too hard basket.” SP 208

“that problem [back and forth referral] is even worse for the CALD communities, because apart from the fact that the services don’t necessarily have that cultural understanding, which makes it worse -but even within mainstream services, you’ve got mental health and drug and alcohol services trying to work together...” SP 205

Some service providers recognised that the constant “handballing” of clients is not in the best interests of the young refugees with comorbidity:

“...the idea that you would send somebody away to deal with a substance use issue and then deal with the mental health issue doesn't work. You actually have to deal with them concurrently.” SP 202

Consistent with the qualitative findings, the majority (67.5%, $n = 27$) of survey participants reported that young refugee background clients and potential clients face barriers to accessing their service. Similarly, most (77.5%, $n = 31$) perceived that young people from refugee backgrounds do not have the same access to services as other young clients. Survey participants ($n = 40$) reported the top five barriers to accessing their service to be (1 = most significant barrier): 1. language, 2. shame and stigma, 3. unaware of service, 4. fear of deportation, and 5. fear of authority.

Theme 3: Treatment and service delivery

Additional barriers identified concerned the provision of treatment and support by health professionals. Although type of therapeutic approach was not specifically explored, some service provider participants reported that Western therapeutic approaches may not always be appropriate for refugee background clients. However, others stated that it was possible to work therapeutically within Western modalities if the treatment was delivered in a flexible and culturally appropriate way.

The following subthemes relate to some of the organisational processes or systems in place which were reported to impede service access and effective service delivery. ‘Flexible service delivery’ which was described by participants to mean being flexible with inclusion criteria, rules around missed appointments or late arrivals, as well as where the service was delivered, was reported to be a facilitator to more effective engagement with this population.

A common concern reported by both service providers and refugee youth was that often the policies and procedures of services prevent refugee youth clients engaging in services.

This related to both the experience of comorbidity and therefore not meeting inclusion criteria, appointment based services versus drop-in services, and time limitations such as a limited number of sessions and therefore not being able to accommodate CALD clients who may require more time to engage:

“The organisation says ok this particular client seems like they are not interested in engaging with us, they look like they don’t need help but of course deep down they do need help, they just don’t know how to express it in a timely manner- in our time frame” SP207

Other barriers concerning service delivery related to where the treatment was delivered and both service providers and refugee youth reported that offering the option of appointments outside of the office environment could facilitate access and engagement:

“Sometimes the actual policies and procedures make it a barrier to these people accessing the services. Like the rigid “you’ve got this number of appointments, you can’t do this, your contract says you’re not allowed to work past 6pm or no home visits, no you can’t go to their house, they have to come here- well maybe they don’t feel safe coming here, maybe they would like me going out to meet in their environment” SP 205

It was also reported that although some services were able to offer home visits, many were not which sometimes resulted in workers not adhering to policies and procedures in order to engage the client. This was not surprising given that other service providers spoke about the need for such flexibility:

“I rarely see people in the office. Home visits, schools wherever they want to meet. I know that not all services are that flexible.” SP 202

There was general agreement among refugee youth participants that offering flexibility in appointment location encouraged engagement and could even facilitate deeper communication. It was also suggested that changing the format from sitting down, face-to-face to walking side-by-side could enhance communication:

“Maybe they meet somewhere else like in a park one day and not in the hospital every time. When you walk the environment it feels good and then you feel you can talk about whatever you want.” RY 106

Although home visits were not common practice among the 15 service providers interviewed, the majority of survey participants reported their service allows home visits (71.4%, $n = 40$). In light of the qualitative data, it was encouraging that service managers reported they were able to offer a flexible service to their clients to facilitate greater access and engagement.

A common theme from the interviews with service providers and refugee youth concerned holistic care and consideration of clients’ non-clinical needs in addition to their MH and AOD issues. When services were able to offer this, it was reported to encourage engagement, continuity of care, and foster trust and the therapeutic relationship. However, funding barriers and limited resources were reported to impede this option and therefore result in discontinuity and reduced ability to engage in treatment. This also related to the fragmentation of services and holistic care was seen as an alternative and a solution to the problems associated with disjointed care:

“I think that sometimes when services are funded so specifically “well no, we are not funded, it is not in our service agreement to work with a client experiencing mental health issues, it

clearly states that all we work with is the drug and alcohol” and then you have the mental health services that say “no, no, we are not going to address the drug and alcohol issue, we are not going to address homelessness, we are only funded to help with mental health” ... It’s really hard for the young person to understand why their issues have to be broken down the way they are, why they have to see so many services... we have to look at problems holistically. Even though we are funded to work with ... (omitted for confidentiality) we would still address their homelessness situation” SP 201

It was commonly identified by service providers in the interviews that without the option of offering holistic comorbidity services which have the capacity to address other needs, one way of reducing the disengagement resulting from siloed and fragmented services was to employ liaison, bi-cultural or CALD consultation workers to act as a buffer between all the relevant services:

“Having some kind of overarching case manager or liaison officer who can work with that client side by side in referring them to different services, explaining the purpose, escorting them to their first appointments... We have a number of CALD liaison officers whose primary role is to just do that, start people off on their journey and guide them through” SP 201

It is worth noting that the survey data revealed that approximately half (47.5%, $n = 19$) of the services reported that their service employed individuals in roles dedicated to working with CALD clients such as a CALD worker, cultural liaison, or CALD consultation worker. Although their role descriptions varied slightly, the primary goals for these positions were to act as a support and advocate for CALD clients and a cultural resource to other staff.

Discussions about treatment and service delivery during the interviews also raised the topic of the possible involvement of the family in the treatment of the young people. There

were divergent perspectives between the refugee youth and service providers concerning this topic. Refugee youth participants described the idea of involving family members as highly undesirable and spoke of the fear young people experience when they think clinicians are going to involve the family. This was also reported to be a reason why young people did not seek help. Service provider participants, on the other hand, believed that where it was appropriate, possible and able to be negotiated, treatment involving the family was often more beneficial:

“The more you involve the family the more it becomes successful.” SP 206

Consistent with the interview findings, the majority of survey participants (67.5%, $n = 27$) believed that young people from refugee backgrounds with comorbidity do not get the same level of treatment as those who experience only a MH problem or an AOD problem. Further, only 30% ($n = 12$) of participants believed that refugee youth with comorbidity receive the same level of treatment as young people in the general population with comorbidity.

Survey participants ($n = 40$) also reported that the main difficulties of working with refugee youth clients are (top 5 in order, 1 = most significant difficulty): 1. managing languages differences, 2. having access to sufficient bi-lingual resources, 3. negotiating family attitudes and perception of treatment, 4. managing cultural differences, and 5. negotiating clients attitudes and perception of treatment. These barriers are consistent with those reported by service providers during the interviews.

Theme 4: Training and resources

Service providers reported a widespread unmet need for training in working with refugee background clients. Overwhelmingly, they described the lack of training offered by training

institutions such as universities and vocational training establishments, as well as by the organisations for which they worked:

“One of the biggest challenges I see is workers with limited cultural awareness, cultural competence in mainstream services and not necessarily through any fault of their own, just not understanding the challenges, the differences and even presentations of whether it is psychosis or other mental health issues. Even having experienced clinicians and doctors not understanding that that presentation may not be schizoaffective disorder, it might just be a reaction to torture and trauma, or to someone in their homeland who has just passed away...”
SP205

Refugee youth agreed with service providers saying that they thought it was necessary for workers to be trained in how to work effectively with refugee background individuals:

“I would say to people, like a counsellor or a psychologist, to try to understand different cultures because you never know who you could be working with, so while they are doing their training and education... I'm sure they might do it but it's still from a Western point of view and you really inhibit people from just accessing those kind of services and even if they do, they don't feel satisfied” RY115

“You should learn about our country. You should use an interpreter. You should ask if they have any problems like coming to Australia, if they feel free or is something missing?” RY105

It is important to note that service providers reported that even when CALD or refugee training was offered, it was usually optional to participate rather than compulsory. Therefore only those clinicians who were seeking it out would receive it and service providers emphasised the need for widespread training:

“Generally training the use of interpreters is compulsory but generally the other stuff is not. So really we have to make it look as interesting as possible to sell it to everyone.” SP202

Overall, the survey findings corroborated the interview findings regarding staff training for working with refugee background clients. Only 25% ($n = 10$) of managers reported that their staff received this type of training. More participants reported that their staff received training for working with CALD clients generally (65%, $n = 26$), however, service provider interview participants often commented that this was primarily focussed on working with Indigenous Australian clients. According to the survey data, the perceived competence of staff was reported as low, with only 15% ($n = 6$) of survey participants reporting that staff within their service were adequately trained to provide treatment for refugee background clients and 40% ($n = 16$) reporting that they believe there is room for improvement.

The discussions during the interviews with service providers about the need for training and upskilling the workforce were primarily centred on the need for training for working with refugee background clients rather than training for working with individuals with comorbidity. However, the survey findings suggested that clinicians may not be adhering to best practice guidelines regarding detection of comorbidity and may not be adequately assessing refugee youth clients for comorbidity. Less than half of survey participants (48.7%, $n = 19$) reported that they screen all refugee youth clients to detect the co-occurrence of MH and AOD disorders, 20.5% ($n = 8$) reported they screen most clients, 10.3% ($n = 4$) reported screening some and 20.5% ($n = 8$) reported they do not screen any clients.

Service providers highlighted in the interviews that often assumptions are made about a client's cultural background, religion or traditional values, which leads the provider to believe there is no need to inquire about substance use:

"That is part of the mindset as well, 'they are Muslim so they don't drink'. They are Islamic so they don't have drug and alcohol problems, and that is part of Western mainstream thinking." SP205

Government versus non-Government.

Interview participants suggested there were marked differences between the response of GO and NGO organisations to refugee youth with comorbidity. Therefore it was of interest to determine whether there was any evidence of this in the survey data. Table 3 displays the results of Chi-square tests which were used to compare GO and NGO organisations on a variety of variables. There were statistically significant differences between type of service; GO or NGO and four out of ten variables. The available sample size per cell was more than five in the majority of cases and therefore the assumptions for using Chi-square were met in seven cases. The assumption of Chi-square that the cell count is greater than five was violated in three cases and therefore a Fisher's exact test of significance was calculated and reported where necessary to account for this.

Table 3: Comparison of Government and non-Government services

	Government		Non-Government		Total n (%)	X(df), p value Chi-Square (df), significance	Effect size (Cramer's I)
	Yes n (%)	No or otherwise specified n (%)	Yes n (%)	No or otherwise specified n (%)			
Does your service allow home visits?	21 (37.5%)	13 (23.2%)	19 (33.9%)	3 (5.4%)	56 (100%)	3.960 (1), $p = .047^*$.266
Do your clients have access to accredited interpreters?	33 (58.9%)	1 (1.78%) (no/ unsure)	19 (33.9%)	3 (5.4%) (no/ unsure)	56 (100%)	2.304* (1), $p = .129$ Fisher's exact test (2- tailed): $p = .289$.203
Is your service adequately funded to provide treatment to refugee background clients?	8 (14.3%)	26 (46.4%)	9 (16.1%)	13 (23.2%)	56 (100%)	1.908 (1), $p = .167$.185
Is your service adequately resourced to provide treatment to refugee background clients?	10 (17.9%)	24 (42.9%)	9 (16.1%)	13 (23.2%)	56 (100%)	.788 (1), $p = .375$.119
Does your organisation collect data regarding if client is of refugee background?	5 (12.5%)	19 (47.5%)(no/ only country of birth)	8 (20%)	8 (20%)(no/ only country of birth)	40 (100%)	3.723 (1), $p = .054$.305
Do your staff receive any training for working with CALD clients?	11 (27.5%)	13 (32.5%)	15 (37.5%)	1 (2.5%)	40 (100%)	9.689 (1), $p = .002^{***}$.492

Do your staff receive any training for working with refugee background clients?	3 (7.5%)	21 (52.5%)	7 (17.5%)	9 (22.5%)	40 (100%)	5* (1), $p = .025^*$ Fisher's exact (2-tailed) = .059	.354
Does your service employ 1 or more CALD/ cultural liaison/ consultation or bi-cultural workers designated to work with CALD clients?	5 (12.5%)	19 (47.5%)	14 (35%)	2 (5%)	40 (100%)	17.109 (1), $p = .000^{**}$.654
In your opinion are the staff in your service adequately trained to provide treatment for refugee background clients?	0 (0%)	24 (60%) (No/ There is room for improvement)	6 (15%)	10 (25%) (No/ There is room for improvement)	40 (100%)	10.5888 ^a (1), $p = .001^{**}$ Fisher's exact test (2-tailed): $p = .002^{**}$.514
Do refugee clients and potential clients experience any barriers to accessing your treatment service?	17 (42.5%)	7 (17.5%)	10 (25%)	6 (15%)	40 (100%)	.304 (1), $p = .581$.087

* $p < .05$ ** $p < .01$

^a 1 or more cells contain a value less than 5 breaching the assumption of Chi-square test of Independence

Fisher's exact test is only calculated where 1 or more cells have a count less than 5.

From these results, a relationship between type of service and allowing home visits was shown, as GOs (23.2%, $n = 13$) were more likely to not allow home visits than NGOs (5.4%, $n = 3$), $\chi^2 (1, N = 56) = 3.96, p < .05$. Cramer's V indicated that this finding had a small effect size, .27. There was also a significant association between the type of service (GO or NGO) and staff training for working with CALD clients. GOs (32.5%, $n = 13$) were more likely to report that their staff had not received training for working with CALD clients than NGOs (2.5%, $n = 1$), $\chi^2 (1, N = 40) = 9.689, p < .01$, (moderate effect size, .49). There was a significant association between type of service and employment of a CALD specialist worker, with NGOs (35%, $n = 14$) more likely to employ CALD specialist workers than GOs (12.5%, $n = 5$), $\chi^2 (1, N = 40) = 17.109, p < .01$, (moderate effect size, .65). A relationship was also observed between type of service and whether participants perceived their staff to be adequately trained to provide treatment to refugee background clients. GOs (60%, $n = 24$) were more likely to report that their staff were not adequately trained than NGOs (25%, $n = 10$). $\chi^2 (1, N = 40) = 10.588, p < .01$, Fisher's exact test, $p = .002$. (Moderate effect size, .514).

Discussion

Little is known about the provision of services to young refugees with comorbidity in Australia. This study sought to determine whether services in a particular region of South Australia were able to respond to refugee background youth with comorbidity, and identified some of the potential barriers and facilitators to culturally responsive comorbidity care. It was apparent that a number of services were attempting to meet the needs of refugee clients and endeavouring to be culturally responsive. For example, a large proportion of services had access to accredited interpreting services, almost half the services had hired bi-cultural or CALD workers, and a large number of services allowed home visits. However, the findings

highlighted significant gaps in the service response to young refugee background clients with comorbid MH and AOD problems as well as those with only one condition.

The barriers reported in this research were consistent with literature outlining barriers to service provision for resettled refugee youth in Australia. A recent study using focus groups with key informants found that barriers and facilitators to engaging refugee youth in mental health services identified themes of: cultural concepts of mental health, illness, and treatment; service accessibility; trust; working with interpreters; engaging family and community; the style and approach of mental health providers; advocacy; and continuity of care (Colucci, Minas, Szwarc, Guerra, & Paxton, 2015). The fact that two simultaneous and independently conducted studies in different Australian states yielded consistent findings in the area of access and engagement by refugee youth reflects that this is a widespread concern. Our findings add to this by suggesting that not only do refugee clients not get the same access to treatment as Australian born clients, but that refugee clients with comorbidity do not get the same access to treatment as those who experience only either a MH or AOD problem in isolation. Therefore our findings indicate that refugee youth with comorbidity are at greater risk of ‘falling through the gaps’ and not receiving appropriate care.

The gaps in service provision highlighted by the present findings warrant immediate attention in order to reduce some of the reported barriers and improve the delivery of support to this population. As our key focus was on the provision of services to those experiencing comorbidity, the following discussion and identified solutions are central to that objective. From the qualitative component, the four broad themes concerning service provision for refugee youth with comorbidity were related to organisational and structural barriers, access and engagement barriers, treatment and service delivery, and training and resources. When these themes and subthemes were considered alongside and integrated with the survey findings, three key areas were emphasised; organisational changes, policies and procedures;

accessibility, engagement and treatment delivery; and workforce development. We discuss the integrated findings under these key domains.

Organisational Changes, Policies and Procedures

The National Practice Standards for the Mental Health Workforce (2013) (the practice standards) outline requirements for Australian nurses, psychologists, psychiatrists, social workers, and occupational therapists (Department of Health, 2013). These standards emphasise cultural responsiveness. One particular standard, Standard 3: Meeting Diverse Needs, states that MH workers should acknowledge diversity and facilitate care, treatment and support in a manner that “demonstrates respect for the diversity of people, family and carers, and the cultural and social context in which they live”(p.13). Further, workers should use culturally appropriate assessment tools and demonstrate an awareness of the cultural issues which may impact upon assessment, care and treatment. Our findings suggest that this standard is not sufficiently met by health professionals and there is a lack of awareness in the workforce about how to approach working with this population.

Fragmented services. The emphasis on the fragmentation of services by participants in the present study was not surprising given the existing literature highlighting that this is a widespread problem resulting from separate funding and organisation of MH and AOD services (Canaway & Merkes, 2010). Our findings have drawn attention to an additional fragmentation of specialist (migrant/refugee) and mainstream services which creates the additional ‘run-around’ for comorbidity clients who are also from refugee backgrounds. Colucci et al (2015) also identified fragmented service delivery as a barrier to engagement for refugee youth with MH problems. Based on these findings and consistent with those of Flaherty et al. (2010), it is reasonable to hypothesise that this is a population at greater risk of ‘falling through the gaps’. The reported ‘handballing of complex clients’ given their refugee background and comorbidity status emphasises the need for policies and procedures to be

produced for organisations and clinicians to be aware of this vulnerable group, develop sufficient competency in managing their difficulties and provide coordinated care.

The lack of data collection by services concerning refugee background clients further serves to exacerbate these problems. Without data it is difficult to determine needs, plan services, and justify the need for additional funding, staff training and resources. Therefore, a paradoxical situation is evident where without organisations experiencing an increase in the number of young refugees accessing services, there is no argument to increase staff training, funding or access to necessary resources or to work on establishing connections with communities and promoting their service. However, without such funding and resources, there will continue to be significant access barriers in place, clinicians will continue to lack effective engagement strategies with this population, and the necessary community education, capacity building and service promotion will not occur.

Community engagement and interagency collaboration. Based on these findings, some of the solutions may lie in relevant MH and AOD services taking responsibility for community engagement and service promotion, and developing the necessary partnerships to facilitate this process, as was suggested by participants in this research. Participants across all data sources identified the need for mainstream services to collaborate with specialist agencies that have existing knowledge and links with communities from refugee producing countries. A recent study in Sweden found that lack of collaboration between services was a major barrier to working effectively with refugee clients (Bäärnhielm, Edlund, Ioannou, & Dahlin, 2014). Creating formal or informal partnerships has previously been identified as a means for improving the provision of services to young people with comorbidity (Szirom et al., 2004). This need may be even greater in addressing service provision for refugee background young people with comorbidity. Participants who were successfully collaborating and communicating with other services or professionals reported smoother transitions

between services for clients, increased accessibility, and greater continuity of care. The majority of service providers expressed the need for communication between services and workers to be strengthened. Although the nature of competitive tendering for funding and grants was seen to hinder this process and encourage the siloing of services, participants reported that partnerships and collaborative work could help overcome funding barriers and enable greater scope in community engagement initiatives. Young people interviewed also expressed the need for community development work and capacity building in order to increase awareness of problems and support services, reduce the fear and stigma around accessing them and provide them with a feasible way to make contact. A recent study of drug use among African youth in Victoria recommended targeted programs to improve health literacy to prevent drug use (specifically injecting drugs), increase awareness of MH problems, and reduce stigma among African youth (Horyniak et al., 2014). Other researchers recommend creating strong partnerships between MH services, refugee communities, and social and settlement services (De Anstiss & Ziaian, 2010; Kirmayer et al., 2011) and suggest using these partnerships to better coordinate interagency service planning and delivery for CALD clients with comorbidity (Malak, 2001).

Bi-cultural workers and culture brokers. Our findings highlight that where possible, services would benefit from hiring CALD or bi-cultural workers to act as advisors, culture brokers and a resource for other staff and to improve interagency liaison and collaboration. Survey data suggested this had already been initiated in some services and interview participants spoke of the resulting benefits. Our survey analyses suggest that this occurs more in NGOs than GOs. Increasing the number of bilingual health professionals in services has previously been recommended to improve comorbidity care for CALD clients (Malak, 2001). CALD workers can document, interpret and provide valuable insights into hidden, nuanced and sensitive material, elements of distress and deterioration that are

unlikely to be detected by mainstream workers. Kirmayer et al. (2011) describes a stepped process of working effectively with interpreters and culture brokers and outlines how this can improve communication and reduce some of the commonly reported language barriers. The National Practice Standards specifically state that MH workers should liaise or work collaboratively with CALD ‘care partners’ such as religious and spiritual leaders, traditional healers and community-based organisations, and bilingual counsellors (Department of Health, 2013). Participants commonly suggested hiring liaison officers as a solution to the difficulties clients experience navigating multiple services. Further, many participants suggested integrating the roles of CALD workers and liaison workers to prevent disengagement by refugee clients when they are engaged with multiple services. Some services reported already trialling this, the outcome of which should be evaluated by future research.

As has been highlighted, the apparent disconnect between organisational policies and what is actually occurring “on the ground” was repeatedly reported and observed throughout this research. Almost all organisations have objectives and mission statements stating they are committed to responding to the needs of the community. The Mental Health Service Guidelines states that the MH services must deliver services that take into account the cultural and social diversity of its consumers and meet their needs (The Department of Health, 2010). The lack of cultural responsiveness by services and lack of community engagement and workforce development efforts in a multicultural region is not congruent with such statements and standards. Findings from the larger project highlighted the general “run-around” and inadequate care for comorbidity clients in this region, as well as the need for greater acknowledgement of the high prevalence of comorbidity by organisational staff and policies (Cairney et al., 2015; de Crespigny et al., 2015). Evaluations in organisations of cultural responsiveness and comorbidity responsiveness, and increased data collection were

recommended from all data sources and are clearly needed. This would assist in establishing a more effective way of approaching refugee background clients who are presenting with MH and AOD comorbidity.

Accessibility, Engagement and Treatment Delivery Solutions

The study findings also highlighted the underrepresentation of refugee youth with comorbidity in receipt of services. Given that this did not reflect the representation of refugee youth in the northern suburbs, it is a significant concern. Across our survey and interview findings, a number of barriers to access were reported with emphasis placed on resources, funding, screening for comorbidity, cultural responsiveness, fear, shame and stigma, and awareness of services.

The trend that emerged from the interviews was that young people were either not aware of support services or if they were, many reported a lack of faith in them for a variety of reasons. Some refugee young people interviewed stated that they would rather speak with friends about MH difficulties or AOD use, and that they would not trust services because they feared family involvement.

Young people also reported that MH was not a priority. If the clinicians were not able to simultaneously assist with migration issues, housing issues, social, educational and occupational issues, then they very quickly disengaged. A recent qualitative study interviewing experienced therapists working with refugee clients found that meeting the practical resettlement needs of clients was vital in acknowledging the wider socio-political context relevant to the individual and in which this work takes place (Schweitzer, Wyk, & Murray, 2015). The National Comorbidity Clinical Guidelines also argue that clients with complex needs such as comorbidity require a holistic approach to treatment and that clinicians should assist with other needs where possible (Mills et al., 2008). We have previously emphasised the importance of a holistic approach to this particular client group

(Posselt, Procter, de Crespigny, & Galletly, 2015). Flexibility with regards to appointment location was identified by participants as a critical aspect to engagement and also has the potential to reduce the perception of stigma for the young person requiring the service. This finding is consistent with recent research that concluded services should have the “flexibility and accessibility to engage the child, and mental health input should always be integrated with welfare, education and physical health services” (Majumder, O’Reilly, Karim, & Vostanis, 2015, p. 7). Concurrent advocacy and the meeting of ‘non-clinical’ needs was considered essential by the participants in this study in facilitating and maintaining engagement with refugee clients and this is consistent with other recent studies (Colucci et al., 2015; Schweitzer et al., 2015).

Professionals’ knowledge and explanatory models. There was agreement among all participants that counsellors and psychologists needed to understand where their clients have come from or show an interest in their culture and refugee past. They suggested that health professionals learn about the refugee experience in order to better understand their problems. We conceptualise this knowledge as a combination of trauma-informed and culture-informed care. It requires professionals to explore the meanings that clients attach to their experiences and problems, have an understanding and an interest in their clients’ past and cultural background, and an appreciation of the refugee experience, which includes the ongoing impact of the journey, and the ongoing difficulty of adjusting to a new culture. The aforementioned practice standards also considers access barriers and states that MH workers should gather information relevant to service access and take into account possible migration and refugee history, exposure to torture and trauma, and the impact of cultural adaptation, integration and marginalisation (Department of Health, 2013).

Although repeatedly documented in the literature concerning service provision for refugee clients, the findings from our study indicate that there is still an apparent need for MH

and AOD professionals to understand the explanatory models of individuals. Kleinman (1978) defines explanatory models as understandings or explanations of illness or treatment within the context of social and cultural beliefs and history. This requires an understanding of the way in which symptoms are presented, when, how and why help is sought, and what is considered a good outcome. The Diagnostic Manual for Mental Disorders Fifth Edition (DSM 5) includes a section on cultural formulation and offers a series of questions (the cultural formulation interview) which enables clinicians to obtain information about the impact of culture and emphasises explanatory models in various domains (American Psychiatric Association, 2013). Research has found that consideration of the cultural formulation in assessment is useful in improving diagnostic accuracy and reducing misdiagnosis of CALD individuals (Adeponle, Thombs, Groleau, Jarvis, & Kirmayer, 2012). These approaches to assessment and formulation could be easily incorporated into future training efforts of AOD and MH service providers.

Workforce Development

The lack of training in this area was evident from the survey responses and the interviews. Cultural competence for working with refugee clients was reported to be low and training opportunities were minimal and limited. The need for workforce development was apparent in two particular areas; training on working with individuals from refugee backgrounds, and training on the assessment, diagnosis and best treatment for individuals experiencing comorbidity. We suggest that the integration of these two areas of training may serve to improve the provision of services to this population.

Training regarding working with refugee clients. There is a clear need for health professionals to be more aware of the factors that are impeding access to services, effective engagement, and continuity of care for clients both with comorbidity and from refugee backgrounds. Many organisations have compulsory training for working with indigenous

clients and service providers commented that given the demographics of the region, their skill base does not accurately reflect the diversity of the population in which the services are located. Considering that the majority of managers reported that their staff did not receive professional development opportunities to gain knowledge and skills in relation to this population and further, did not perceive their staff to be adequately trained to work with refugee background clients, up-skilling the workers to reflect the large CALD and refugee background population should be considered a priority. This may be more pertinent to GOs given that our survey found that none of the managers in GOs perceived their staff to be adequately trained to work with refugee youth. It was reported that initiatives to prioritise this training were being provided by certain organisations but again this was minimal and not widespread. Certainly very few offered training specific to working with clients from refugee backgrounds. Bäärnhielm et al. (2014) argued that access to care by refugees is influenced by professionals' knowledge about cultural aspects of patients' expressions and understanding of mental distress. We would argue this relates to the need for health professionals to understand differing explanatory models. Bäärnhielm et al. (2014) evaluated the impact of cross cultural training on working with refugees and found an increased ability to understand the vulnerability and contextualised health of newly arrived refugees, as well as increased empathy with ways of expressing distress which were unfamiliar to them. However, they acknowledged that this training was insufficient because it had no impact on the lack of collaboration between services and workers, the latter of which was seen as a more significant barrier. The authors also reported that participants perceived the lack of collaboration to be an organisational responsibility. Similarly, Colucci et al (2015) stated that "enhancing the cultural competence of services is important but not sufficient to ensure children and young people in need are able and willing to access assistance" (p.17). Although there is insufficient evidence of the benefits of improving the cultural competency of services in improving outcomes (Kirmayer, 2012), our findings suggest that the self-perceived lack of competency

by staff is leading to the “handballing” of clients, resulting in further disengagement and loss of hope by youth, signifying that training is certainly necessary.

Training regarding Comorbidity. Almost half of the survey participants reported screening their refugee youth clients for comorbidity. This finding was promising, however, given the prevalence of comorbidity in Australia and mental health services, it would be ideal and considered best practice if clinicians screened all of their clients. Findings indicated that there was an assumption by many workers that if a client was Muslim or from a country with conservative views of AODs that they would assume there was no AOD use. There is a need for clinicians to be aware of the high prevalence of comorbidity in order to identify if AOD use is contributing to or maintaining the problems, and if there is a need to involve other workers and services. Given the high prevalence of comorbidity in service settings, many guidelines have recommended compulsory training for clinicians in order to be equipped with skills in screening for and treating comorbidity (de Crespigny & Talmet, 2012; Mills et al., 2008).

Divergent findings

Overall, there was great convergence between the three methods of generating data. However, through the comparison of findings from different data sources, there were some inconsistencies between what was reported by survey participants and what was reported by service providers and youth in the qualitative interviews. For example, although the majority of service managers reported they had access to interpreters, service providers in the interviews stated they are often encouraged to avoid using them due to the associated high costs. Refugee youth participants reported that they often act as the interpreter for relatives and friends accessing health services, suggesting they may be filling the interpreter role. Such divergent findings support the need for further research.

Limitations

Although yielding important findings and adding to the paucity of literature on this topic, this study was not without limitations. The survey response was overwhelmingly from the MH sector, or from services that identified as being ‘combined’. Therefore the findings might be limited to only MH or combined services. However, it should be noted that there certainly are fewer AOD services and programs and therefore the low response rate from AOD services may reflect the fact there are less AOD services and service providers. Additionally, we also acknowledge the potential for selection bias because it is possible that only those with a particular interest in the research topic participated in the survey (much like the trend for seeking professional development in this area). Although we made concerted efforts to contact all eligible services in the region, we cannot be confident this was a broad sample of the services. Further, we were unable to determine if multiple people from the same organisation were responding to the anonymous survey as many services had various management positions.

The relatively small number of individuals who participated in the interviews and online survey, and the fact that the study was limited to a particular region of SA, does not allow us to make broader generalisations, although this was certainly not the aim of this research. It is not uncommon for refugees to be resettled in areas of social disadvantage, often on the outskirts of cities where there is affordable housing. Therefore the findings from this research may well apply to other areas across Australia with similar demographics, particularly if services are structured similarly and there are similar funding limitations and limited training opportunities.

Conclusion

Considering the large number of refugee background youth who reside in northern Adelaide, it is essential that MH and AOD services have the capacity to respond appropriately to the needs of this diverse community. Our research has found there are significant gaps in the service response to this population and findings highlight a general and widespread lack of cultural responsiveness by services in dealing with refugee youth clients experiencing comorbidity. The implications of these findings have been discussed and we have reported various solutions which warrant consideration by Governments, organisations, and MH and AOD staff.

References

- Adeponle, A. B., Thombs, B. D., Groleau, D., Jarvis, E., & Kirmayer, L. J. (2012). Using the cultural formulation to resolve uncertainty in diagnoses of psychosis among ethnoculturally diverse patients. *Psychiatric Services, 63*(2), 147-153.
- Allsop, S. (2008). *Drug use and mental health: Effective responses to co-occurring drug and mental health problems*. East Hawthorn, Victoria: IP Communications.
- American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders (DSM-5®)*. Arlington, VA: American Psychiatric Publishing.
- Australian Bureau of Statistics. (2007). *National Survey of Mental Health and Wellbeing*. Canberra: ABS.
- Australian Bureau of Statistics. (2011). *Australian Census of Population and Housing* Canberra: Australian Government.
- Australian Centre for Posttraumatic Mental Health. (2013). Australian guidelines for the treatment of acute stress disorder and posttraumatic stress disorder. Melbourne: ACPMH.
- Australian Institute of Health and Welfare. (2005). *National comorbidity initiative: A review of data collections relating to people with coexisting substance use and mental health disorders*. Canberra: AIHW Retrieved from <http://www.aihw.gov.au/publication-detail/?id=6442467722>.
- Bäärnhielm, S., Edlund, A.-S., Ioannou, M., & Dahlin, M. (2014). Approaching the vulnerability of refugees: Evaluation of cross-cultural psychiatric training of staff in mental health care and refugee reception in Sweden. *BMC Medical Education, 14*(1), 207.
- Beyer, L., & Reid, G. (2000). *Drugs in a multicultural community: An assessment of involvement*. Victoria: McFarlane Burnet Centre for Medical Research for the Department of Human Services.
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77-101.
- Bronstein, I., & Montgomery, P. (2011). Psychological distress in refugee children: A systematic review. *Clinical Child and Family Psychology Review, 14*(1), 44-56. doi: 10.1007/s10567-010-0081-0
- Cairney, I., Galletly, C., de Crespigny, C., Liu, D., Moss, J., & Procter, N. (2015). Stopping the run-around? A study of services for people with comorbid mental health and substance use disorders in northern Adelaide. *Australasian Psychiatry, 23*(3).
- Canaway, R., & Merkes, M. (2010). Barriers to comorbidity service delivery: The complexities of dual diagnosis and the need to agree on terminology and conceptual frameworks. *Australian Health Review, 34*(3), 262-268. doi: 10.1071/AH08723
- Cohen, J. (1988). *Statistical power for the social sciences*. Hillsdale, NJ: Lawrence Erlbaum and Associates.
- Colucci, E., Minas, H., Szwarc, J., Guerra, C., & Paxton, G. (2015). In or out? Barriers and facilitators to refugee-background young people accessing mental health services. *Transcultural Psychiatry*.
- Colucci, E., Minas, H., Szwarc, J., Paxton, G., & Guerra, C. (2012). Barriers to and facilitators of utilisation of mental health services by young people of refugee background: Foundation House, University of Melbourne, Centre for Multicultural Youth, Royal Children's Hospital.
- 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. doi: 10.1080/0050060903262387
- de Crespigny, C., Grønknær, M., Liu, D., Moss, J., Cairney, I., Procter, N., . . . Banders, A. (2015). Service provider barriers to treatment and care for people with mental health and alcohol and other drug comorbidity in a metropolitan region of South Australia. *Advances in Dual Diagnosis, 8*(3), 120-128.
- de Crespigny, C., & Talmat, J. (2012). *Alcohol, Tobacco and Other Drugs: Clinical Guidelines for Nurses and Midwives*. Adelaide.

- Department of Health. (2013). *National practice standards for the mental health workforce*. Melbourne: Victorian Government Department of Health Retrieved from www.health.gov.au.
- Department of Immigration and Border Protection. (2014). Settlement reporting facility Retrieved 10/07/2014, from DIBP, Australian Government <http://www.immi.gov.au/settlement/>
- Donald, M., Dower, J., & Kavanagh, D. (2005). Integrated versus non-integrated management and care for clients with co-occurring mental health and substance use disorders: A qualitative systematic review of randomised controlled trials. *Social Science & Medicine*, 60(6), 1371-1383.
- 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 & Adolescent Trauma*, 4(1), 69-85.
- Flaherty, I., & Donato-Hunt, C. (2012). Cultural and family contexts for help seeking among clients with cannabis, other drug and mental health issues. *Mental Health and Substance Use*, 5(4), 328-341.
- Flaherty, I., Donato-Hunt, C., Arcuri, A., & Howard, J. (2010). *Finding the right help: Pathways for culturally diverse clients with cannabis use and mental health issues*. Sydney: DAMEC & NCPIC.
- Gordon, A. (2008). *Comorbidity of mental disorders and substance use: A brief guide for the primary care clinician*. Hume Drug and Alcohol Services South Australia (DASSA).
- Greater London Authority. (2004). Young refugees and asylum seekers in Greater London: Vulnerability to problematic drug use: Final report. In J. Fountain (Ed.): Greater London Alcohol and Drug Alliance.
- Henley, J., & Robinson, J. (2011). Mental health issues among refugee children and adolescents. *Clinical Psychologist*, 15(2), 51-62.
- Holt, M., Treloar, C., McMillan, K., Schultz, L., Schutlz, M., & Bath, N. (2007). *Barriers and incentives to treatment for illicit drug users with mental health comorbidities and complex vulnerabilities*. National Drug Strategy
- Horyniak, D., Higgs, P., Cogger, S., Dietze, P., Bofu, T., & Seid, G. (2014). Experiences of and Attitudes Toward Injecting Drug Use Among Marginalized African Migrant and Refugee Youth in Melbourne, Australia. *Journal of Ethnicity in Substance Abuse*, 13(4), 405-429.
- IBM. (2012). IBM SPSS Statistics (Version Version 21). Boston: International Business Machines Corp.
- Jacobs, W. S., Cahill, K. S., & Gold, M. S. (2005). Historical and Conceptual Issues In R. Stohler & W. Rossler (Eds.), *Dual Diagnosis: The Evolving Conceptual Framework*. Basel: Karger.
- Kessler, R., Nelson, C., & McGonagle, K. (1996). The epidemiology of co-occurring addictive and mental disorders: Implications for prevention and service utilisation. *American Journal of Orthopsychiatry*, 66, 17-31.
- Kirmayer, L. (2012). Rethinking cultural competence. *Transcultural Psychiatry*, 49(2), 149.
- Kirmayer, L., Narasiah, L., Munoz, M., Rashid, M., Ryder, A. G., Guzder, J., . . . Pottie, K. (2011). Common mental health problems in immigrants and refugees: General approach in primary care. *Canadian Medical Association Journal*, 183(12), E959-E967.
- Kleinman, A. (1978). Concepts and a model for the comparison of medical systems as cultural systems. *Social Science & Medicine. Part B: Medical Anthropology*, 12, 85-93.
- Majumder, P., O'Reilly, M., Karim, K., & Vostanis, P. (2015). 'This doctor, I not trust him, I'm not safe': The perceptions of mental health and services by unaccompanied refugee adolescents. *International Journal of Social Psychiatry*, 61(2), 129-136.
- Malak, A. (2001). Comorbidity and cultural diversity In M. Teeson & L. Byrnes (Eds.), *National Comorbidity Project* (pp. 73-77). Sydney: National Drug and Alcohol Research Centre.
- Mario-Ring, A., Belay, D., Nyiransabimana, I., Otto, J., Bangura, J., & Robe, Z. (2005). Fun and forgetting: Alcohol and other drug use by African young people in Hobart: The Link Youth Health Service, Hobart.
- Merkes, M., Lewis, V., & Canaway, R. (2010). Supporting good practice in the provision of services to people with comorbid mental health and alcohol and other drug problems in Australia:

- Describing key elements of good service models. *BMC Health Services Research*, 10(1), 325. doi: 10.1186/1472-6963-10-325
- Mills, K., Deady, M., Proudfoot, H., Sannibale, C., Teesson, M., Mattick, R., & Burns, L. (2008). *Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings (National Comorbidity Clinical Guidelines)*. Sydney: National Drug and Alcohol Research Centre (NDARC).
- National Drug Strategy. (2013). *2010-2013 Series of national drug strategy household surveys*. Canberra: AIHW.
- Olliff, L., & O'Sullivan, K. (2006). Refugee young people and drug prevention: Addressing risks and tapping into strengths *Drug Info*, 4(4), 4.
- Posselt, M., Procter, N., de Crespigny, C., & Galletly, C. (2015). Merging perspectives: obstacles to recovery for youth from refugee backgrounds with comorbidity. *Australasian Psychiatry*, 23(3), 293-299. doi: 10.1177/1039856215584512
- QSR. (2010). NVivo 9. Doncaster, Victoria, Australia: QSR International.
- Reason, P., & Bradbury, H. (2006). *Handbook of action research*. California: Sage Publications.
- Refugee Council of Australia. (2009). Amplifying the voices of young refugees, from www.refugeecouncil.org.au/docs/current/
- Reid, G., Crofts, N., & Beyer, L. (2001). Drug Treatment Services for Ethnic Communities in Victoria, Australia: An examination of cultural and institutional barriers. *Ethnicity and Health*, 6(1), 13-26.
- Schweitzer, R., Melville, F., Steel, Z., & Lacherez, P. (2006). Trauma, post-migration living difficulties, and social support as predictors of psychological adjustment in resettled Sudanese refugees. *Australian and New Zealand Journal of Psychiatry*, 40(2), 179-188. doi: 10.1111/j.1440-1614.2006.01766.x
- Schweitzer, R., Wyk, S., & Murray, K. (2015). Therapeutic practice with refugee clients: A qualitative study of therapist experience. *Counselling and Psychotherapy Research*, 15(2), 109-118.
- Sowey, H. (2005). Are refugees at increased risk of substance misuse. Sydney: Drug and Alcohol Multicultural Education Centre (DAMEC).
- Stohler, R., & Rössler, W. (2005). *Dual diagnosis: The evolving conceptual framework* (Vol. 172): Karger Medical and Scientific Publishers.
- Szirom, T., King, D., & Desmond, K. (2004). Barriers to service provision for young people with presenting substance misuse and mental health problems. *Canberra: National Youth Affairs Research Scheme*.
- Tashakkori, A., & Teddlie, C. (Eds.). (2010). *Handbook of Mixed Methods in Social & Behavioral Research* (2 ed.). Thousand Oaks, California: Sage Publications.
- Teesson, M., & Burns, L. (2001). *National comorbidity project*. Canberra: Commonwealth Department of Health and Aged Care.
- The Department of Health. (2010). *National standards for mental health services 2010*. Barton: Commonwealth of Australia.
- The University of Adelaide. (2014). Social Health Atlases of Australia. from Public Health Information Development Unit <http://www.adelaide.edu.au/phidu/maps-data/maps/>
- UNHCR. (1951). Convention relating to the Status of Refugees. Geneva: United Nations.
- Van de Gaag, K. (2007). Identifying ethnicity: Representation in drug and alcohol treatment services data *Sydney: The Drug and Alcohol Multicultural Education Centre (DAMEC)*.

7. Chapter Seven: Conclusion

Introduction

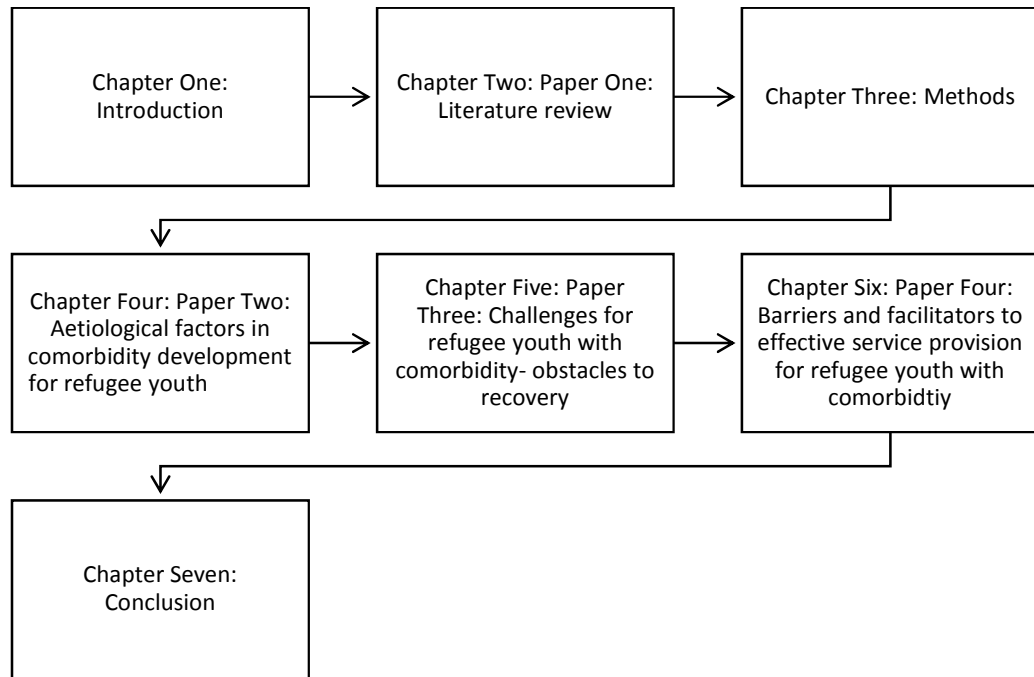


Figure 7.1: Diagram depicting thesis structure.

The thesis has considered an important and previously unaddressed topic by exploring multiple areas related to the provision of services for young people from refugee backgrounds with comorbid mental health and alcohol and other drug problems (comorbidity). Previous literature regarding service provision for resettled refugee youth in Australia was reviewed to explore what barriers and facilitators exist for accessing support for mental health problems, substance use problems, and comorbidity. Previous research concerning service provision for clients with comorbidity identified the numerous obstacles comorbidity clients from the general community face in accessing and receiving appropriate support. To date, the unique experiences of young refugee clients have remained unexplored. No literature has specifically

examined service provision for refugee youth with comorbidity. In addition, there is no previous research concerning comorbidity among refugee groups utilising the dual perspective of refugee youth and service providers.

As portrayed by Figure 7.1, using a mixed methods design, this thesis examined; the aetiological and risk factors which lead to young people from refugee backgrounds developing MH and AOD problems; the challenges which exist for young people from refugee backgrounds experiencing comorbidity and how these may impact service provision; and finally, the barriers and facilitators to effective, culturally responsive service provision for young people of refugee background with comorbidity.

Summary of findings

This thesis explored three main aspects of comorbidity among refugee background youth and has looked at how these relate to the provision of services to this population. These areas correspond to the three research questions addressed in three chapters of this thesis (Chapters Four, Five and Six). This section summarises and integrates the findings, linking them back to the original research questions.

Paper One, presented in Chapter Two, reviewed the available literature and identified gaps in knowledge. The relevance of this literature in relation to service provision was discussed in this paper, along with directions for future research. Papers Two, Three and Four reported on the study findings. Taken together, this thesis answered the following research questions.

7.1.1 Research question one: What are the aetiological and risk factors which lead to young people from refugee backgrounds developing MH and AOD problems?

Using a qualitative approach, Paper Two investigated the aetiology of MH and AOD disorders in young refugees and discussed the themes which emerged from interviews with refugee youth and service providers. The analysis provided in-depth perspectives of the plight of the refugee young person and hardships faced and demonstrated how interrelated risk factors may lead to the development of comorbidity. These findings showed that shared or common risk factors are important in the development of both MH and AOD problems, as well as factors which were found to be specific to the development of either MH or AOD problems.

Similarities and differences between the perspectives of refugee youth and service providers were considered. Overall, there was considerable convergence, which enhanced confidence that the themes identified were a true summary of causal factors. As far as I am aware, a study using a dual perspective approach to investigate the aetiological factors surrounding MH and AOD problems among refugee youth in Australia has not been previously conducted and therefore this was the first study to utilise this method. The themes identified provide an original contribution to existing knowledge by exploring and documenting the complexities of these situations and how these might impact on service access and treatment, as well as by documenting the voices of young resettled refugees themselves and the workers who seek to support them. The contribution of this paper is significant as it also provides insight into the issues refugee youth face where targeted early intervention may be valuable. This is particularly crucial in a time when refugees and migrants are potentially facing increasing challenges being accepted into the wider community of resettlement (Esses et al., 2013). The findings of my study drew attention to

refugee youth in this region being at risk of unemployment, homelessness, involvement in crime, and becoming further disenfranchised. Indeed, young people with poor English language skills are at risk of living a restricted life on Government welfare payments and with all the problems which arise from unemployment and socioeconomic disadvantage (A. Milner et al., 2014). Importantly, in 2013, General Motors announced that they would close the Holden's motor vehicle factory in Elizabeth (Burns, 2014). This is predicted to have a devastating impact on the community where youth unemployment is already so high (Burns, 2014; A. Milner, 2014). Burns (2014) states that although ensuring access to MH services is certainly important in this region at this time (due to Holden's closure), prevention of mental disorders as a result of unemployment and socioeconomic disadvantage is equally important. My paper points to initiatives which could ultimately change the trajectories for refugee youth in this region. For example, the findings support the need for an integrated program between MH services and settlement services, perhaps at the transition phase of refugee resettlement. There is scope for the development of a transition program for refugee youth in this region where new arrivals and MH services interact as early as possible. As a society we need to assist those at risk of MH, AOD and other problems to become healthy contributing members of our communities. This paper goes some way in highlighting how we can accomplish this in relation to refugee youth.

7.1.2 Research question two: What are the biggest challenges for young people from refugee backgrounds with comorbidity and how might these impact service provision?

Paper Three considered the difficulties and challenges faced by refugee young people experiencing comorbidity. Although we found consistency in what was reported by study participants, some differences in perspectives between refugee youth and service providers

were identified. Importantly, I found that refugee background youth reported that social disconnectedness was the biggest challenge they face once they were experiencing comorbidity. Young people highlighted how community and family rejection, often due to shame, stigma and intergenerational conflict resulted in social isolation which only served to maintain the problem. Service providers, on the other hand, were more concerned with the difficulties these young people face in accessing and receiving culturally competent comorbidity treatment. These findings were discussed with a focus on how clinicians can prioritise areas of care and assist with other, non-clinical needs despite organisations often not supporting such essential holistic care frameworks. Although the importance of holistic, integrated approaches for complex clients is well documented in the literature, my findings point towards the particular necessity of this approach when working with this client group given their vulnerability (described in Paper One and Two), ongoing challenges (outlined in Paper Three), and tendency to not engage, or remain engaged, with services (discussed in Paper Four). Based on the study findings and in light of other literature, this paper also proposed clinical implications and offered practical suggestions for clinicians and organisations.

7.1.3 Research question three: What are the barriers and facilitators to effective, culturally responsive service provision for young people of refugee background with comorbid mental health and alcohol and other drug conditions?

Paper Four focused on the barriers and facilitators to service provision for this population. This paper utilised a mixed methods approach and reported on and compared the findings from both the qualitative and quantitative components of the research. Consistencies between methods of generating data were revealed, increasing my confidence in the validity of the findings. This paper added to the knowledge base regarding the unique barriers to

access and treatment that exist for comorbidity clients from refugee backgrounds. The quantitative analysis emphasised access and treatment barriers related to the cultural responsiveness of services. My findings also suggested differences in how government and non-government organisations are responding to this client population. Qualitative analysis highlighted the common themes related to structural and organisational barriers; access and engagement barriers; treatment and service delivery; and workforce development.

Taken together, the integrated findings collapsed into three areas of discussion. These discussion points are potentially valuable in the development of policies and guidelines, in identifying areas in need of workforce development and training, and in providing both clinicians and organisations with an awareness of what obstacles are preventing this at-risk population from accessing and receiving support or treatment. With the final research question and influence of critical theory in mind, this paper went beyond simply identifying the problem and provided discussion on ways of overcoming the identified barriers. This was done by drawing on the qualitative and quantitative data, considering what I have found from the existing literature, and synthesising the accumulated knowledge gained throughout this research. These findings are of considerable value as they combine the richness of the qualitative data with the clear situation suggested by the quantitative data which ‘paints a picture’ of how services are delivered for this population and what could be done to improve the situation.

Significance of the findings

The three research papers that make up this thesis present the most important findings that arose from the data and addressed the overall research aim. Collectively, the findings from these three papers have generated an increased understanding of the experience of refugee youth with comorbid MH and AOD problems, ranging from the factors which may

place them at risk of developing such conditions, to the significant psychosocial and social challenges they face, and to the numerous difficulties they may experience in accessing or receiving treatment and support for their problems.

This work has generated a greater awareness of what it may be like for a young person from a refugee background with MH/AOD comorbidity living in Australia and attempting to engage with, or possibly more likely, currently disengaged from support. For clinicians to be able to work effectively with such clients, a sound understanding of the factors which led to their problems is essential. Likewise, it is vital to understand that their mental health needs are not necessarily prioritised in the context of socio-political-cultural factors, as well as other more pressing social challenges. An increased understanding of these factors is important in order to effectively engage and work with this population.

Finally, interviews and community consultations revealed that there was a desire among clinicians to acquire more knowledge concerning working with refugee youth and complex clients. My findings and the resulting publications go some way to providing a resource which clinicians can draw on. The findings also provide a rationale for increasing the training opportunities available to these staff, as well as for ensuring there is greater collaboration, networking and sharing of resources between organisations.

Implications of the findings – policy and clinical practice

The implications of each study have been discussed in the individual papers. This conclusion integrates the key implications across two domains- policy and practice. Overall, the findings of this research are valuable for policy makers, service managers and clinicians. My findings have contributed to the knowledge base regarding the challenges refugee youth face in general as well as when they are experiencing comorbidity. The findings also reveal the difficulties services and clinicians are faced with as they attempt to engage with and treat

refugee background young people with comorbidity. This research has shown that refugee youth with comorbidity do not get the same access to or level of treatment as either young people with comorbidity in the general population, or refugee youth with isolated MH *or* AOD problems. Both service providers and refugee youth emphasised that more initiatives are needed to improve the situation for this client group. Although this may start with basic training around working with refugee youth and working with comorbidity clients, this is not the only solution. Changes need to be incorporated into policy and practice.

7.1.4 Policy

Health and social service policies need to reflect the reality that this is a population which may require an alternative approach to engagement and treatment, and need to outline evidence based approaches for working effectively with such clients. Although, as this thesis has demonstrated, there is a clear gap in the evidence base for working with refugee background clients with comorbidity and while we wait for more research to emerge in this area, we are forced to draw on the available literature highlighting best practice with refugee clients (see Appendix B), as well as best practice with comorbidity clients. Although this thesis goes some way in outlining ways we can tailor approaches to encourage service access and treatment, the need for more research is clear.

The National Mental Health Plan and other relevant policies should acknowledge the critical need for community engagement, education regarding MH and AOD problems, and service promotion among new arrival and existing refugee communities. Training for working with refugee clients should also be considered a priority issue in updated versions of these policies. These policies should also specifically stress the need to establish partnerships and collaborative projects across MH and AOD service sectors, and specialist (CALD/ refugee services) and mainstream services.

7.1.5 Practice

The findings of this thesis have highlighted the particular vulnerability of this client group and the importance of initiatives to improve the way in which services and MH and AOD clinicians respond to this population. The extent of fragmentation between services and sectors was very apparent. My findings suggest solutions that lie in strengthened partnerships, collaboration and enhanced communication between sectors, services and clinicians. The findings presented in this thesis also support the need for increased education in the two particular areas; comorbidity awareness and working with refugee clients. Training opportunities in these areas in South Australia were reported to be minimal. Access to this training needs to be increased at both undergraduate and postgraduate levels particularly for those professions who work closely with these clients (psychiatrists, psychologists, social workers, MH nurses, and occupational therapists). Organisations should also offer and support professional development for their workforce in these crucial areas. My findings also support the need for increased access to resources such as bi-lingual materials, interpreters, and culturally appropriate assessment tools including comorbidity screening tools. A final key practice implication of my findings is the obvious necessity for holistic approaches to assessment and treatment. This has been discussed at length in the papers as well as the need for a more flexible model of care with less rigid rules concerning appointment times, length of treatment time in a service, and location of session.

Strengths

Whilst strengths and limitations of the research have been discussed within each paper, this conclusion acknowledges them overall. The main advantage of this research was the diversity of methods used to gather information and gain a deeper understanding of comorbidity among refugee youth. The research design employed triangulation of data

methods, sources and researchers to reduce potential researcher bias, ensure the validity of interpretations, and increase my confidence in the findings. The use of a mixed-methods approach was valuable as it drew on different assumptions, forms of data collection, and analytical methods. This research was based on the premise that for the purpose of an exploratory research objective, neither qualitative nor quantitative methods were alone sufficient in capturing the depth of information required. The use of surveys provided evidence of patterns among a larger service population and the use of interviews allowed me to gather more in-depth insights, opinions and ideas (Kendall, 2008). These two methods ultimately served to complement one another and each aided interpretation of the other. Rather than a mixed methods approach used the entire way through, in this research, each research aim emphasised a different method. Paper One reported on purely qualitative aspects of the research, Paper Two reported on the quantitative aspects embedded within the qualitative method (interviews) and used the qualitative aspects to aid the interpretation and discussion, and finally, Paper Three integrated both qualitative and quantitative data in the discussion and compared both data results.

Further, triangulation of multiple data sources allowed me to capture data from a variety of perspectives (managers, service providers, and refugee youth) and compare their perspectives and opinions to identify consistencies or inconsistencies in what was reported and cross-validate the findings. The use of investigator triangulation was also a strength of this study as involvement of multiple colleagues and supervisors, all with different expertise (qualitative, quantitative, health services research, refugee health research and comorbidity) in the discussion of research progress, emergent themes, and interpretation of overall findings served to enhance my understanding of the research topic, check the validity of the results and again reduce any potential bias.

Similarly, the PAR approach proved valuable in terms of my immersion in the research problem and community, as well as providing an avenue to share my findings with the community. Presentation of the qualitative findings and interpretations to individuals from the community through a seminar and CALD network meeting, a focus group, and individual consultation, also enhanced the validity of the interpretations and results. The PAR approach also aided the recruitment process which is a significant strength of this research considering that this is generally a difficult population from which to recruit. The involvement of the community was also a valuable motivator as the various events attended, constant discussions with community members and professionals, and field observations (for example, witnessing a young African boy crying in the gutter with a bottle of alcoholic spirits) resulted in me becoming increasingly convinced of the need for this research and a desire to provide the larger community with some practical solutions.

A final strength of this research was interviewing the potential consumers of these services, that is, young people from refugee backgrounds. This was important as it gave those who had accessed services a voice, as well as enabling those who had not, to speak on behalf of all young people within their communities, particularly those who they had seen “lose their way”. The PAR approach also allowed for this more broadly from the community by engaging with community members and consumer advocates and enabling their perspectives to be heard. This was especially important in confirming that there was a need for this research in the initial pre-data collection stages. In an article describing the importance of qualitative methods in cross-cultural mental health research, Bolton and Tang (2004) state that successful interventions “require the collaboration and support of those for whom they are intended” (p.97). They further state that for interventions to be effective, the target community must confirm there is a problem and that addressing it is a priority. By including

refugees from diverse cultural backgrounds and focussing on commonalities, it was intended that the findings would be more applicable and useful to services and clinicians. However, I do acknowledge that this could also be considered a limitation as this may be at the cost of not addressing unique aspects of one culture or allowing for deeper exploration of youth from a particular culture.

Limitations

Despite these strengths and as with all research, there were limitations. As highlighted in the papers, the limitations to this research related to the design, sampling and data collection. First, snowball and purposive sampling methods were used to recruit interview participants in the qualitative component and although there were reasons for doing so, such as targeting those with knowledge on the topic, this creates a potential for selection bias. Therefore these perspectives might not be representative of all service providers or refugee youth in this region. However, obtaining a representative sample is not the aim of qualitative research and for our research purposes of exploring a topic in depth, this was entirely appropriate.

Another limitation included the extensive time needed to collect and analyse data. Despite the advantages of using a PAR approach, it is time consuming and requires a great deal of commitment and out of hours work by the researcher. As described, there were many advantages of using a mixed methods approach, however, this may have compromised gaining a deeper understanding had the research used only quantitative or qualitative methods. Expanding the quantitative component may have provided more extensive data or a focus on solely qualitative data may have revealed richer findings. The concept of data saturation may be considered a limitation in this research. It has been suggested that after 12 interviews data saturation will occur (Guest, Bunce, & Johnson, 2006). This was found to be

the case in the present research as after the 12th interview, it became apparent that no new themes were emerging and therefore I stopped interviewing at 15 interviews. However, we cannot know that had I continued interviewing, other issues may have been discovered and more themes identified. It was noted that towards the end of interviewing process with service providers, there was increasingly more media attention and political debate concerning refugees and asylum seekers in Australia. As was mentioned in Chapter One, this resulted in conversations emerging on the impact of this negative portrayal and negative treatment of refugees and asylum seekers. Paper Two documented this theme as it was spoken about by refugee participants and by service providers. Had I continued interviewing, this may have become a more prominent theme and given more attention.

Due to ethical concerns such as participant safety and recruitment difficulties in sampling service users from refugee backgrounds, I decided to interview young people from refugee backgrounds who identified as advocates for refugee youth and who may or may not have attended MH or AOD services. This proved useful in getting a broader perspective of issues that impact them and their community and peers. However, this is a limitation of this study. Had we interviewed only those who had accessed services, we may have revealed different findings, different barriers and different facilitators. Additionally, due to resource and financial restraints, I was not able to use interpreters. This resulted in not interviewing anyone who did not possess reasonable conversational English and therefore may have excluded the voices of some of the most marginalised individuals in the community. Using community advocates and peers as the informants somewhat reduced this limitation as they were encouraged to speak on behalf of those who were not able to have their voices heard directly.

The survey component had several limitations relating to recruitment of participants. Although recruitment involved contacting all eligible MH, AOD and related services who provide support to young people in the northern suburbs of Adelaide and inviting managers to participate, due to the anonymity of the survey, I was not able to identify how many services were involved or how many survey participants were from the same service. Additionally, as the survey was self-report and respondents were in management roles, there is the possibility that participants responded in ways that made their service look more favourable. However, the anonymity of the survey should have reduced the likelihood of this occurring and based on the criticisms of the services which emerged, it would seem that this was not a real concern. A significant number of respondents did not complete the survey to the final question ($n = 16/ 56$). As participants were all in management positions it is likely that they did not have sufficient time to complete the survey. However, as there was no opportunity for participants to explain why they did not complete the survey, I cannot know if they discontinued for a particular reason.

Finally, as this research was limited to a particular region of metropolitan Adelaide, the findings of this research may not be generalisable. However, as highlighted in Paper Four, it is possible that the findings are transferable to areas with similar demographics. This, of course could be one focus for future research.

Future research

This research has only begun to explore the concept of comorbidity among refugee youth and future research should continue to address this gap in the literature and add to this growing knowledge base. While this research goes some way in identifying the risk factors in the development of comorbidity, quantitative research is needed in order to identify the extent

to which these and other factors contribute to the development of such disorders, as well as identifying protective factors which could have implications for early intervention pursuits.

Further, as a limitation of this research was not being able to confirm the prevalence of comorbidity among resettled refugee youth, either in the community or in the service population, there is a need for future prevalence studies to investigate this. For example, the next Australian Mental Health and Wellbeing Survey should include measures which specifically identify individuals from refugee backgrounds in order to estimate prevalence and ascertain the degree of the problem within this sub-group. Although there are some limitations to this approach regarding language barriers and cross-culturally valid assessment tools, this does not excuse not making any attempts to include this population.

It was beyond the scope of the present study to consult specifically with refugee youth with comorbidity and who had been engaged with MH or AOD services. Subsequent research should specifically recruit service users to elucidate their personal experiences of services and identify their perceived needs. This knowledge would further aid clinicians in tailoring treatment for this population. Additionally, asylum seekers and unaccompanied minors were identified in this research as potentially at greater risk or more vulnerable due to reasons such as often being away from their families and therefore very isolated, as well as experiencing a great deal of uncertainty regarding their future and their families' future. As this was an incidental finding, this issue requires further investigation. We suggest future research consider co-occurring MH and AOD problems specifically among these populations.

This research has identified the difficulties young people face accessing and receiving support and treatment, as well as the problems service providers experience in striving to assist such young people. Although it goes some way in providing a knowledge base which services and clinicians can consult in order to improve their response to this client group,

more research is needed to trial and evaluate some of the suggested strategies outlined in this thesis to improve service provision to this population. For example, research should examine the outcome of using CALD liaison officers in improving integrated interagency service delivery for complex comorbidity clients. Likewise, evaluation of training efforts and other strategies aimed at improving the cultural and comorbidity responsiveness of services is needed. As a key finding of this research was the identified pressing need for MH and AOD education and service promotion to be woven into 'refugee youth friendly' community engagement efforts with new arrival groups, future research should examine the impact of this on the uptake of services, levels of stigma, prevalence of disorders, MH and AOD literacy levels, and the new arrivals' knowledge of available supports. As lack of partnerships and collaboration was identified as a significant barrier to effective service provision, an in-depth exploration of what prevents this from occurring may aid efforts to enhance such necessary collaboration.

Additionally, future studies should attempt to increase involvement of the AOD sector in this type of research considering that the MH sector was overrepresented in the present study despite attempts to ensure a more balanced representation. This partly reflects the fact that MH services are much larger and employ more staff than the AOD sector. It should be noted that the majority of AOD workers from the main Government AOD service who were approached and invited to participate in an interview declined, stating that they did not have any refugee background clients in their service and did not possess any knowledge on the topic. Although I thought it possible that they did have some refugee background clients engaged with these services, as given the extent of the problem it seemed unlikely there would be no refugees in contact with AOD services, attempts to verify this claim were unsuccessful due to the lack of data collection by this Government AOD service.

Finally, due to the limited literature regarding the treatment of refugee young people with comorbidity, and considering the suggestions made by the present study, future research should also investigate integrated treatment programs which simultaneously address MH and AOD problems for young refugees. Considering that we were aware of some services already providing such an approach, we suggest that researchers and services collaborate and comprehensively evaluate these efforts.

Personal reflection

Throughout this research I encountered clinicians and academics who debated the need for this research given that refugee populations tend not to prioritise mental health nor appear to want any assistance. As has been highlighted in the literature and the papers which comprise this thesis, marginalised, disadvantaged refugee background youth (particularly those who have fallen out with their communities or families) are at an increased risk of involvement in criminal activity, subsequent engagement with the criminal justice system, homelessness, unemployment, and suicide. I started this research at a time where there had been a spate of suicides in refugee communities in the northern suburbs. My first community engagement activity was attending a Burundian youth group where two other MH workers and I spoke with the young people about mental health and suicide. What was striking to me at that first encounter was the number of young people wanting to know how to assist their peers when they had “lost their way” or were indicating an intent to end their own life. From the outset of this research I observed a desire among the communities and refugee individuals to better understand mental health problems, even when they did not have a language for them. As I conclude this research I am more convinced than ever that a significant social problem exists for young people from refugee backgrounds, not only living in this area of South Australia but all over Australia. As mental health organisations and professionals are,

as defined by the codes and guidelines that govern their practice, committed to responding to the needs of the community and delivering 'client centred care', it perplexes me why the service response appears so dire. I have come to understand systemic and financial barriers which prevent much needed developments. However, given that certain professionals and services have found ways around these barriers, one is left wondering why this is a population who are left to 'fall through the cracks' without adequate acknowledgment or assistance.

Final comments

This thesis has explored a novel topic in Australian refugee health research by acknowledging a seemingly ignored or forgotten population of young people in Australia. For many of these young people, their past is marked by suffering, whether it be by the tragedies from which they fled or the ongoing battle to recreate a new life and identity in Australia. We, as health professionals are in a position to significantly alter the future of these young peoples' lives and all those who arrive to our country in the future. At the very least, support services and professionals should be directing resources and energy into better understanding and addressing the needs of these vulnerable individuals. This thesis has highlighted that despite the difficulties in doing so, there are ways to improve the delivery of support and treatment to young people from refugee backgrounds in Australia who are experiencing mental health and substance use problems.

- They don't believe that this much trouble can exist in a life, they don't believe me-

(18 year old Afghan Hazara male participant, fled Afghanistan alone at age 16 years after his mother disappeared)

8. References

- Adams, M. (2008). Comorbidity of mental health and substance misuse problems: A review of workers' reported attitudes and perceptions. *Journal of Psychiatric and Mental Health Nursing*, 15(2), 101-108.
- Allsop, S. (2008). *Drug use and mental health: Effective responses to co-occurring drug and mental health problems*. East Hawthorn, Victoria: IP Communications.
- American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders (DSM-5®)*. Arlington, VA: American Psychiatric Publishing.
- Australian Bureau of Statistics. (2006). *A Social Atlas: 2006 Census of Population and Housing*. Canberra: ABS.
- Australian Bureau of Statistics. (2007). *National Survey of Mental Health and Wellbeing*. Canberra: ABS.
- Australian Bureau of Statistics. (2011). *Australian Census of Population and Housing* Canberra: Australian Government.
- Australian Institute of Health and Welfare. (2005). *National comorbidity initiative: A review of data collections relating to people with coexisting substance use and mental health disorders*. Canberra: AIHW Retrieved from <http://www.aihw.gov.au/publication-detail/?id=6442467722>.
- Beyer, L., & Reid, G. (2000). *Drugs in a multicultural community: An assessment of involvement*. Victoria: McFarlane Burnet Centre for Medical Research for the Department of Human Services.
- Bohman, J. (2013). Critical Theory. In E. N. Zalta (Ed.), *The Stanford Encyclopedia of Philosophy (Spring 2013 Edition)*.
- Bolton, P., & Tang, A. M. (2004). Using ethnographic methods in the selection of post-disaster, mental health interventions. *Prehospital and Disaster Medicine*, 19(01), 97-101.
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77-101.
- Bronfenbrenner, U. (1986). Ecology of the family as a context for human development: Research perspectives. *Developmental Psychology*, 22(6), 723.
- Bronfenbrenner, U., & Morris, P. A. (1998). The ecology of developmental processes. *Handbook of Child Psychology*, 1, 993-1028.
- Brough, M., Gorman, D., Ramirez, E., & Westoby, P. (2003). Young refugees talk about well-being: A qualitative analysis of refugee youth mental health from three states. *Australian Journal of Social Issues*, 38(2), 193-208. doi: N/A
- Brune, M., Haasen, C., Yagdiran, O., & Bustos, E. (2003). Treatment of drug addiction in traumatised refugees. *European Addiction Research*, 9(3), 144-146. doi: 10.1159/000070985
- Burns, J. (2014). The human cost of the shifting economy: Holden's closure and Elizabeth's future. *Australian and New Zealand Journal of Psychiatry*, 48(4), 375-376. doi: 10.1177/0004867414526790
- Burns, J., Ellis, L., Mackenzie, A., & Stephens-Reicher, J. (2009). Reach Out: Online mental health promotion for young people. *Counselling, Psychotherapy, and Health*, 5(1), 171-186. doi: N/A
- Cameron, R. (2009). A sequential mixed model research design: Design, analytical and display issues. *International Journal of Multiple Research Approaches*, 3(2), 140-152.
- Campbell, J. C., & Bunting, S. (1991). Voices and paradigms: Perspectives on critical and feminist theory in nursing. *Advances in Nursing Science*, 13(3), 1-15.
- Carr, W., & Kemmis, S. (2003). *Becoming critical: Education knowledge and action research*: Routledge.

- Clark, J. (2000). Balancing qualitative and quantitative methodology in health services research: How can qualitative research methods best complement administrative data analysis. Ontario, Canada: Central East Health Information Partnership.
- Colucci, E., Minas, H., Szwarc, J., Paxton, G., & Guerra, C. (2011). A mental health research agenda for people of refugee background in Australia: A consensus study.
- Colucci, E., Minas, H., Szwarc, J., Paxton, G., & Guerra, C. (2012). Barriers to and facilitators of utilisation of mental health services by young people of refugee background: Foundation House, University of Melbourne, Centre for Multicultural Youth, Royal Children's Hospital.
- Cook, A. S., & Bosley, G. (1995). The experience of participating in bereavement research: Stressful or therapeutic? *Death Studies*, 19(2), 157-170.
- Creswell, J. (2003). *Research design: Qualitative, quantitative, and mixed methods approaches* (2 ed.). Thousand Oaks, California: Sage Publications.
- Creswell, J., & Plano Clark, V. (2011). *Designing and conducting mixed methods research* (2nd ed.). Thousand Oaks, California: Sage Publications.
- Cross, T. L., Bazron, B., Dennis, K., & Isaacs, M. (1989). *Towards a culturally competent system of care: A monograph on effective services for minority children who are severely emotionally disturbed*. Rockville: National Institute of Justice.
- Crotty, M. (1998). *The foundations of social research: Meaning and perspective in the research process*. Sydney: Allen & Unwin.
- 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. doi: 10.1080/0050060903262387
- 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.
- DEEWR. (2011). Labour Market Conditions in Northern Adelaide. *Labour Market Research and Analysis* Retrieved 02/11/2011, from <http://www.deewr.gov.au/Employment/LMI/Pages/default.aspx>
- Denzin, N. K., & Lincoln, Y. S. (2008). *Strategies of qualitative inquiry* (Vol. 2): Sage.
- Department of Immigration and Border Protection. (2014). Settlement reporting facility Retrieved 10/07/2014, from DIBP, Australian Government <http://www.immi.gov.au/settlement/>
- DIBP. (2014a). *Fact Sheets*. Canberra: Australian Government Retrieved from <http://www.immi.gov.au/media/fact-sheets/02key.htm>.
- DIBP. (2014b). Media Centre. <http://www.minister.immi.gov.au/media/sm/2014/sm214431.htm>
- Droždek, B. (2013). *If you want to go fast go alone, if you want to go far go together: On context-sensitive group treatment of asylum seekers and refugees traumatized by war and terror*. Enschede, The Netherlands: Ipskamp Drukkers
- Dyregrov, K., Dyregrov, A., & Raundalen, M. (2000). Refugee families' experience of research participation. *Journal of Traumatic Stress*, 13(3), 413-426.
- Esses, V. M., Medianu, S., & Lawson, A. S. (2013). Uncertainty, threat, and the role of the media in promoting the dehumanization of immigrants and refugees. *Journal of Social Issues*, 69(3), 518-536.
- Fox, S. H., & Tang, S. S. (2000). The Sierra Leonean refugee experience: Traumatic events and psychiatric sequelae. *The Journal of Nervous and Mental Disease*, 188(8), 490-495.
- Freire, P. (1972). *Pedagogy of the oppressed*. Middlesex, England: Penguin Books.
- Government of South Australia. (2009). *SA Mental Health Act*. Adelaide: Government of South Australia Retrieved from <http://www.sahealth.sa.gov.au/wps/wcm/connect/e76b440043346e90a64cfe15eab6e6ef/clinicians-guide-and-code-of-practice-mha-mhsb-02130320.pdf?MOD=AJPERES&CACHEID=e76b440043346e90a64cfe15eab6e6ef>.

- Green, J. P., & Eagar, K. (2010). The health of people in Australian immigration detention centres. *Medical Journal of Australia*, 192(2), 65-70.
- Guest, G., Bunce, A., & Johnson, L. (2006). How many interviews are enough? An experiment with data saturation and variability. *Field methods*, 18(1), 59-82.
- Haasen, C., Sinaa, M., & Reimer, J. (2008). Alcohol use disorders among afghan migrants in Germany. *Substance Abuse*, 29(3), 65-70.
- HRC. (2014). National Inquiry into Children in Immigration Detention, from <http://www.humanrights.gov.au/our-work/asylum-seekers-and-refugees/national-inquiry-children-immigration-detention-2014>
- Kamberelis, G., & Dimitriadis, G. (2005). Focus groups: Strategic Articulations of Pedagogy, Politics, and Inquiry. In N. Denzin & Y. Lincoln (Eds.), *The Sage handbook of qualitative research* (3 ed.). California: Sage Publications.
- Keller, S. L. (1975). *Uprooting and social change*. New Delhi, India: Manohar Book Service.
- Kemmis, S., & McTaggart, R. (2005). *Participatory action research: Communicative action and the public sphere* (Vol. 3). California: Sage Publications.
- Kendall, L. (2008). The conduct of qualitative interviews: Research questions, methodological issues, and researching online. In J. Coiro, M. Knobel, C. Lankshear & D. Leu (Eds.), *Handbook of research on new literacies* (pp. 133-149). New York: Lawrence Erlbaum Associates.
- Kincheloe, J., & McLaren, P. (2005). Rethinking critical theory and qualitative research. In N. Denzin & Y. Lincoln (Eds.), *The Sage handbook of qualitative research* (3 ed., pp. 303-342). California Sage Publications.
- Kunz, E. F. (1973). The Refugee in Flight: Kinetic Models and Forms of Displacement. *International Migration Review*, 7(2), 125-146.
- Lewig, K., Arney, F., & Salveron, M. (2009). *The working with refugee families project*: Australian Centre for Child Protection.
- Lustig, S. L., Kia-Keating, M., Knight, W. G., Geltman, P., Ellis, H., Kinzie, J. D., . . . Saxe, G. N. (2004). Review of child and adolescent refugee mental health. *Journal of the American Academy of Child & Adolescent Psychiatry*, 43(1), 24-36. doi: 10.1097/00004583-200401000-00012
- Malkki, L. H. (1995). Refugees and exile: From "refugee studies" to the national order of things. *Annual Review of Anthropology*, 495-523.
- McGorry, P., Parker, A., & Purcell, R. (2006). Youth mental health services. *InPsych* (August).
- Merkes, M., Lewis, V., & Canaway, R. (2010). Supporting good practice in the provision of services to people with comorbid mental health and alcohol and other drug problems in Australia: Describing key elements of good service models. *BMC Health Services Research*, 10(1), 325. doi: 10.1186/1472-6963-10-325
- Miller, K. E., & Rasco, L. M. (2004). An ecological framework for addressing the mental health needs of refugee communities. In K. E. Miller & L. M. Rasco (Eds.), *The mental health of refugees: Ecological approaches to healing and adaptation* (pp. 1-64). Mahwah, New Jersey: Lawrence Erlbaum Associates Publishers.
- Milner, A. (2014). Response: The human cost of the shifting economy: Holden's closure and Elizabeth's future. *Australian and New Zealand Journal of Psychiatry*, 48(4), 378-383.
- Milner, A., Page, A., Morrell, S., Hobbs, C., Carter, G., Dudley, M., . . . Taylor, R. (2014). The effects of involuntary job loss on suicide and suicide attempts among young adults: Evidence from a matched case-control study. *Australian and New Zealand Journal of Psychiatry*, 48(4), 333-340. doi: 10.1177/0004867414521502
- Milner, K., & Khawaja, N. G. (2010). Sudanese refugees in Australia: The impact of acculturation stress. *Journal of Pacific Rim Psychology*, 4(01), 19-29.

- Minas, H., Kakuma, R., Too, L. S., Vayani, H., Orapeleng, S., Prasad-Ildes, R., . . . Oehm, D. (2013). Mental health research and evaluation in multicultural Australia: Developing a culture of inclusion. *International Journal of Mental Health Systems*, 7(23), 1-25.
- Nickerson, A., Bryant, R. A., Steel, Z., Silove, D., & Brooks, R. (2010). The impact of fear for family on mental health in a resettled Iraqi refugee community. *Journal of Psychiatric Research*, 44(4), 229-235.
- O'Doherty, K., & Lecouteur, A. (2007). "Asylum seekers", "boat people" and "illegal immigrants": Social categorisation in the media. *Australian Journal of Psychology*, 59(1), 1-12.
- O'shea, B., Hodes, M., Down, G., & Bramley, J. (2000). A school-based mental health service for refugee children. *Clinical Child Psychology and Psychiatry*, 5(2), 189-201.
- Park, P. (2001). Knowledge and participatory research. In P. Reason & H. Bradbury (Eds.), *Handbook of Action Research* (pp. 83-93). London: SAGE.
- Pittaway, E., Bartolomei, L., & Hugman, R. (2010). "Stop stealing our stories": The ethics of research with vulnerable groups. *Journal of Human Rights Practice*, 2(2), 229-251.
- Porter, M., & Haslam, N. (2005). Predisplacement and postdisplacement factors associated with mental health of refugees and internally displaced persons. *The Journal of the American Medical Association*, 294(5), 602-612. doi: 10.1001/jama.294.5.602
- Posselt, M., Galletly, C., de Crespigny, C., Cairney, I., Moss, J., Liu, D., . . . Banders, A. (2014). Ethics overload: Impact of excessive ethical review on comorbidity research. *Mental Health and Substance Use*, 7(3), 184-194.
- Procter, N. G., Williamson, P., Gordon, A., & McDonough, D. (2011). Refugee and asylum seeker self-harm with implications for transition to employment participation: A review. *Suicidologi* 16(3).
- RCOA (Producer). (2014). Youth and Family Issues. Retrieved from <http://www.refugeecouncil.org.au/f/smt-y&f.php>
- Reason, P. (1994). Three approaches to participative inquiry. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of Qualitative Research* (pp. 324-339). Thousand Oaks: Sage.
- Reason, P., & Bradbury, H. (2006). *Handbook of action research*. California SAGE
- Reeves, S., Albert, M., Kuper, A., & Hodges, B. D. (2008). Why use theories in qualitative research? *British Medical Journal*, 337, 631-634.
- Richmond, A. H. (1993). Reactive migration: Sociological perspectives on refugee movements. *Journal of Refugee Studies*, 6(1), 7-24.
- Schweitzer, R., Brough, M., Vromans, L., & Asic-Kobe, M. (2011). Mental health of newly arrived Burmese refugees in Australia: Contributions of pre-migration and post-migration experience. *Australian and New Zealand Journal of Psychiatry*, 45(4), 299-307.
- Schweitzer, R., Melville, F., Steel, Z., & Lacherez, P. (2006). Trauma, post-migration living difficulties, and social support as predictors of psychological adjustment in resettled Sudanese refugees. *Australian and New Zealand Journal of Psychiatry*, 40(2), 179-188. doi: 10.1111/j.1440-1614.2006.01766.x
- Schweitzer, R., & Steel, Z. (2008). Researching refugees: Methodological and ethical considerations. In P. Liamputtong (Ed.), *Doing cross-cultural research: Ethical and methodological perspectives* (Vol. 34, pp. 87-101). Netherlands: Springer.
- Sowey, H. (2005). Are refugees at increased risk of substance misuse. Sydney: Drug and Alcohol Multicultural Education Centre (DAMEC).
- State Government of Victoria. (2009). *The Cultural Responsiveness Framework*. Melbourne: Rural and Regional Health and Aged Care Services Retrieved from <http://www.health.vic.gov.au/calcd>.
- Stein, B. N. (1981). The refugee experience: Defining the parameters of a field of study. *International Migration Review*, 320-330.

- Szirom, T., King, D., & Desmond, K. (2004). Barriers to service provision for young people with presenting substance misuse and mental health problems. *Canberra: National Youth Affairs Research Scheme.*
- Tashakkori, A., & Teddlie, C. (Eds.). (2010). *Handbook of Mixed Methods in Social & Behavioral Research* (2 ed.). Thousand Oaks, California: Sage Publications.
- Teesson, M., & Burns, L. (2001). *National comorbidity project.* Canberra: Commonwealth Department of Health and Aged Care.
- Terrell, S. R. (2012). Mixed-methods research methodologies. *The Qualitative Report, 17*(1), 254-280.
- The University of Adelaide. (2014). Social Health Atlases of Australia. from Public Health Information Development Unit <http://www.adelaide.edu.au/phidu/maps-data/maps/>
- Tudge, J. R., Mokrova, I., Hatfield, B. E., & Karnik, R. B. (2009). Uses and misuses of Bronfenbrenner's bioecological theory of human development. *Journal of Family Theory & Review, 1*(4), 198-210.
- UNHCR. (1951). Convention relating to the Status of Refugees. Geneva: United Nations.
- UNHCR. (2001). Convention and protocol: Relating to the status of refugees. Retrieved 05/03/2012, from <http://www.unhcr.org/pages/49da0e466.html>
- Van de Gaag, K. (2007). Identifying ethnicity: Representation in drug and alcohol treatment services data Sydney: *The Drug and Alcohol Multicultural Education Centre (DAMEC).*
- Van Dyne, L., Ang, S., & Koh, C. (2008). *Handbook of cultural intelligence: Theory, measurement and applications.* Armonk, New York: M. E. Sharpe.
- WHO. (1994). *The ICD-10 classification of mental and behavioural disorders: Clinical descriptions and diagnostic guidelines.* Geneva: World Health Organization.
- WHO. (2013). Mental Health: A state of well-being Retrieved 8.8.14, 2014, from http://www.who.int/features/factfiles/mental_health/en/
- WHO (Producer). (2014). Management of substance abuse. *Diagnostic categories and terms.* Retrieved from http://www.who.int/substance_abuse/terminology/diagnostic_categories/en/
- Williams, N. (2009). Establishing the boundaries and building bridges. A literature review on ecological theory: Implications for research into the refugee parenting experience. *Journal of Child Health Care, 14*(1), 35-51. doi: 10.1177/1367493509347116

9. Appendices

Ethics overload: Impact of excessive ethical review on comorbidity research

Miriam Posselt¹, Cherrie Galletly¹, Charlotte de Crespigny², Imelda Cairney², John Moss³, Dennis Liu⁴, Hepsibah Francis², Janet Kelly⁵, Nicholas Procter⁶ and Andris Banders⁷

¹ Discipline of Psychiatry, University of Adelaide, Adelaide, Australia;

² School of Nursing, University of Adelaide, Adelaide, Australia;

³ School of Population Health, University of Adelaide, Adelaide, Australia

⁴ Northern Mental Health Service, Lyell McEwin Hospital and Discipline of Psychiatry, University of Adelaide, Adelaide, Australia

⁵ School of Nursing, Flinders University, Adelaide, Australia

⁶ School of Nursing and Midwifery, University of South Australia, Adelaide, Australia

⁷ South Australian Network of Drug and Alcohol Services (nongovernment), Adelaide, Australia

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Appendix B: Survivors of Torture and Trauma Assistance and Rehabilitation Service
(STTARS) report

Survivors of Torture and Trauma Assistance and Rehabilitation

Service (STTARS): Clinical Services Review 2015

The assessment and treatment of refugee and asylum seeker survivors of torture and trauma: A review of the literature

Miriam Posselt, The University of Adelaide.

Contents

Background	2
Intake and assessment.....	2
Cultural Formulation Interview.....	3
The Cultural Awareness Tool	3
The Refugee Health Screener-15	3
Self-report measures	4
Treatment	4
Phase Based Treatment Models	4
Individual interventions	5
Interventions with asylum seekers	6
Cognitive Behavioural Therapy.....	6
Narrative Exposure Therapy	8
Cognitive Processing Therapy	9
Acceptance and Commitment Therapy	10
Interpersonal Therapy.....	11
Narrative therapy- Tree of Life	11
Eye Movement Desensitisation and Reprocessing (EMDR).....	12
Psychodynamic	13
Group work	14
Casework and advocacy.....	16
Complementary and alternative therapies.....	16
Conclusion.....	17
References	19

1

Survivors of Torture and Trauma Assistance and Rehabilitation Service (STTARS): Clinical Services Review 2015

Background

There is a wealth of literature documenting effective interventions for survivors of trauma in the general population who are experiencing posttraumatic stress disorder (PTSD) and other mental disorders. Much of this research has been conducted with individuals who have been exposed to single traumatic events (Cloitre et al., 2011). There is less evidence regarding effective treatments for those who are experiencing a more complex type of PTSD, often the result of prolonged or repeated exposure to torture or trauma. Further, there is even less research documenting best practice in relation to the treatment of refugee and asylum seeker populations experiencing such problems. Research has consistently reported elevated prevalence rates of PTSD, depression and anxiety among refugees and asylum seeker groups living in developed countries (Steel et al., 2009). Additionally, refugees and asylum seekers face a multitude of ongoing resettlement and social difficulties which highlights the need for interventions to be delivered within a broader contextual focus (Droždek, 2014; McFarlane & Kaplan, 2012). Not surprisingly, given the emphasis on PTSD in the refugee literature, the available evidence is predominantly concerned with the treatment of PTSD and therefore this inevitably was the focus of the current review.

This review of the literature aimed to investigate what psychosocial interventions have been found to be effective for refugee and asylum seeker survivors of torture and trauma. Many asylum seekers will face unique and additional difficulties due to the uncertainty of their asylum claims and future. For this reason, treatments for asylum seekers were considered separately where possible. Similarly, differences in age and gender regarding treatment outcome will be discussed where possible. The majority of literature highlights that as refugees and asylum seekers often present with unique challenges and multiple complex problems, contextual factors as well as cultural differences need to be considered in the initial intake and assessment procedures. There has been much discussion regarding the use of assessment tools and procedures which may not be culturally relevant or appropriate for use with this population. For this reason, this review will start by briefly addressing what we know regarding the appropriate assessment process for this client group.

Intake and assessment

The guidelines for the treatment of acute stress disorder and PTSD state that a holistic approach to assessment and treatment is necessary when working with asylum seekers and

2

Survivors of Torture and Trauma Assistance and Rehabilitation Service (STTARS): Clinical Services Review 2015

refugees (Australian Centre for Posttraumatic Mental Health, 2007). Likewise, Droždek (2014) provided a detailed description of the importance of holistic assessment with refugee and asylum seeker survivors of torture and trauma. ‘Holistic assessment’ involves consideration of psychosocial processes and cultural, social and political factors (see chapter three for his detailed contextual model of assessment).

Cultural Formulation Interview

The most recent edition of The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) places a greater emphasis on understanding cultural influences in mental illness than previous editions and includes the Cultural Formulation Interview (CFI) (American Psychiatric Association, 2013). The CFI enables clinicians to use a series of questions in order to collect information about the impact of culture in relation to mental health and emphasises the importance of understanding clients’ explanatory models. ‘Explanatory models’ being the way people communicate about their illness, present their symptoms, when, how and why help is sought, and what is considered a good outcome (Kleinman, Eisenberg, & Good, 1978). The use of the CFI has been found to reduce misdiagnosis in culturally diverse clients and improve diagnostic accuracy (Adeponle, Thombs, Groleau, Jarvis, & Kirmayer, 2012; Rohlof, Knipscheer, & Kleber, 2009).

The Cultural Awareness Tool

Mental Health in Multicultural Australia, through funding from the National Mental Health Strategy, developed ‘The Cultural Awareness Tool’ which also offers a detailed way of conducting a culturally appropriate mental health assessment. It outlines a series of questions again aimed at obtaining information about a client’s explanatory models and negotiating an appropriate treatment plan based on this comprehensive understanding (Seah, Tilbury, Wright, Rooney, & Jayasuriya, 2002).

The Refugee Health Screener-15

The Refugee Health Screener-15 was developed to be a cross-culturally valid screening tool for mental disorders such as anxiety, depression and PTSD in refugee clients (Hollifield et al., 2013). It has been validated for use with refugees aged 14 years and older

3

Survivors of Torture and Trauma Assistance and Rehabilitation Service (STTARS): Clinical Services Review 2015

from Burmese, Iraqi and Nepali Bhutanese backgrounds (Hollifield et al., 2013). The items were developed using qualitative research methods with Vietnamese and Kurdish refugees. Although this screening instrument is in the preliminary evaluation period, so far it has shown effectiveness in screening newly arrived refugees to increase early access to support for those most distressed.

Self-report measures

Harvard Trauma Questionnaire

The Harvard Trauma Questionnaire (HTQ) was designed in an attempt to create a cross-culturally valid assessment instrument for use with refugee populations. It is a self-report measure which consists of two sections. The first section lists 16 common traumatic events including torture in order to ascertain the client's past exposure to torture and trauma. The second section consists of 16 items assessing symptoms of PTSD (Mollica et al., 1992). The HTQ is a widely used tool in both research with refugees and clinical practice (Kleijn, Hovens, & Rodenburg, 2001). For example, ter Heide and Smid (2015) report using the HTQ as a routine intake assessment instrument with refugee clients in their Psychotrauma Mental Health Institute.

Hopkins Symptoms Checklist-25

The Hopkins Symptoms Checklist-25 (HSCL-25) is a valid measure of anxiety and depression and has been used with a wide range of refugee groups demonstrating transcultural validity (Derogatis, Lipman, Rickels, Uhlenhuth, & Covi, 1974; Hollifield et al., 2002). The HSCL also includes questions assessing somatisation symptoms in order to capture culturally-relevant symptoms.

Treatment

Phase Based Treatment Models

The literature consistently documents the appropriateness of phase based models in the treatment of individuals presenting with complex PTSD (Grey & Young, 2008; National Institute for Clinical Excellence, 2005). Findings from a recent expert consensus study suggests multi-modal, phase based treatment approaches are necessary regardless of the

4

Survivors of Torture and Trauma Assistance and Rehabilitation Service (STTARS): Clinical Services Review 2015

psychological intervention chosen to be integrated into this approach (Cloitre et al., 2011). They state:

Contemporary formulations of this approach to complex PTSD have recommended that the initial stage of treatment focus on patient safety, symptom stabilization, and improvement in basic life competencies. A second and later stage includes the exploration of traumatic memories for the purposes of first reducing acute emotional distress resulting from the memories and then reappraising their meaning and integrating them into a coherent and positive identity. (p. 616).

This process will often involve moving back and forth between the phases as issues arise (Grey & Young, 2008). Droždek (2015) acknowledged that integrating multimodal and trauma-focused treatments can be effective and proposes that his Integrative Contextual Model may facilitate this approach. In their review of the literature, Nickerson, Bryant, Silove, and Steel (2011) stated that multimodal approaches did not have sufficient evidence for their effectiveness. However, they acknowledged that multimodal approaches such as interventions which include a stabilisation phase may allow clinicians working with refugee clients to address other psychosocial issues not addressed by a stand-alone trauma-focussed intervention.

Individual interventions

As previously mentioned, research concerning the psychopathology of refugees and asylum seekers has tended to focus on PTSD and other psychological sequelae as a result of exposure to trauma. Therefore the focus of many intervention studies has been to examine the impact of various treatments on PTSD symptoms. As a result, the majority of literature reviewed in this section is inevitably focussed on the treatment of refugees and asylum seekers experiencing PTSD. However, we acknowledge the potential for multiple other physical, social and psychological outcomes of torture and trauma and where there is available literature, have documented interventions addressing other mental health needs.

For individuals in the general population, the evidence supports the use of trauma-focussed cognitive behavioural therapy (CBT) and eye movement desensitisation and reprocessing (EMDR) for the treatment of PTSD as well as comorbid anxiety and depression (Australian Centre for Posttraumatic Mental Health, 2007; Kar, 2011; National Institute for

5

Survivors of Torture and Trauma Assistance and Rehabilitation Service (STTARS): Clinical Services Review 2015

Clinical Excellence, 2005; Shapiro, 2014). While there is significantly less evidence supporting the effectiveness of any particular intervention for refugee and asylum seeker groups, we attempt to compile the available knowledge with respect to a number of therapeutic modalities.

Interventions with asylum seekers

Contrary to a previous belief that asylum seekers who face an uncertain future regarding protection and visa status are unlikely to benefit from mental health treatment, more research is highlighting that this perspective is not supported and rather, asylum seekers have been found to improve as a result of psychotherapy (Grey & Young, 2008; Hensel-Dittmann et al., 2011; Stenmark, Catani, Neuner, Elbert, & Holen, 2013). Although the results of these studies outline therapeutic improvements for asylum seekers, the findings must be taken with caution given that they included participants who had received permanent visas during the research. However, Droždek (2014) has also documented findings where asylum seekers (who did not receive visas) made significant clinical improvements as the result of psychotherapy. Therefore we can be more confident that this is a population with whom we can work clinically.

Cognitive Behavioural Therapy

As cognitive behavioural therapy (CBT) is one of the most supported treatments for PTSD, much of the literature concerning interventions for refugee and asylum seeker survivors of torture and trauma has focussed on whether CBT is also effective with this population. Paunovic and Öst (2001) found that both CBT and exposure therapy (ET) significantly reduced symptoms of PTSD and other anxiety disorders in refugee patients and that this outcome remained at six month follow-up. This research was conducted with a relatively small number of participants (n = 16) and excluded those refugees who were not able to engage in therapy without an interpreter. Further, the majority of participants (75%) were already receiving pharmacological treatment. Therefore these findings may only apply to those combining medication with therapy, those with permanent visas, and those who are proficient in the host country's language.

More recent research examining the effectiveness of CBT with refugees has reported on CBT approaches which are trauma-focussed and culturally adapted in order to more effectively tailor CBT to this population. As a result, culturally adapted CBT approaches often integrate aspects of other therapeutic approaches. Vindbjerg, Klimpke, and Carlsson (2014) have designed a randomised controlled trial investigating a culturally adapted CBT model which integrates elements of acceptance and commitment therapy and mindfulness for use with refugees. The results for this study are not yet available, however, the components of their manual are described (Vindbjerg et al., 2014). Hinton and Jalal (2014) present guidelines which can be used to increase the cultural sensitivity of CBT approaches and recommend CBT interventions integrate techniques which acknowledge common cultural complaints such as somatic symptoms and utilise spiritual or culturally specific coping strategies such as meditation. Hinton, Rivera, Hofmann, Barlow, and Otto (2012) describe the components of their culturally adapted CBT (CA-CBT) manualised program. They describe integrating relaxation, meditation, mindfulness, and body work into their program. They also address somatic symptoms and cultural syndromes. See Hinton et al. (2012) for a description of the components within each session. Hinton, Pich, Hofmann, and Otto (2013) present case examples of applying the CA-CBT approach to traumatised Latino and Cambodian refugee populations. Research evaluating this program has shown promising results, particularly with Southeast Asian refugees (Hinton et al., 2005; Hinton, Hofmann, Pollack, & Otto, 2009; Hinton et al., 2004). A recent meta-analysis reviewed trauma-focussed intervention studies for refugees and concluded that trauma-focussed CBT and narrative exposure therapy (NET) produced overall large effect sizes compared to control conditions, therefore suggesting that traumatised refugees can be most effectively treated with these approaches (Lambert & Alhassoon, 2015). CA-CBT is clearly effective with Latinos and Southeast Asians. However, this approach needs to be studied further with refugees from other cultural backgrounds. Drozdek's (2014) group therapy program integrates CBT with other approaches and has found promising outcomes with Iranian and Afghan refugees (this research is discussed further in the group work section of this review).

Buhmann et al. (2015) integrated CBT with mindfulness and acceptance and commitment therapy (ACT) with promising results. They evaluated a six month treatment program which consisted of an average of 13.5 sessions with 85 clients aged 18 years and older who were all diagnosed with PTSD and/or depression. Outcomes were measured by the HTQ, HSCL-25, the World Health Organisation quality of life scale and the Sheehan

7

Survivors of Torture and Trauma Assistance and Rehabilitation Service (STTARS): Clinical Services Review 2015

Disability Scale. Interestingly they found that the more CBT, ACT and mindfulness methods used and the more times each method was used, the better the outcome. They also found participant engagement in homework exercises was associated with better outcomes. This study was limited by the lack of a control group and by the fact that participants were also on psychopharmacological medication. However, it again demonstrates that structured CBT can be successfully applied to refugee clients.

CBT with refugee children

CBT has also been researched with refugee children. Ehntholt, Smith, and Yule (2005) found that six sessions of a weekly, school-based group CBT program with 26 refugee children resulted in reductions in PTSD symptoms, behavioural problems and emotional symptoms. However, these outcomes were not maintained at three month follow-up. A review also conducted by Ehntholt and Yule (2006) reported that although our knowledge base with respect to treatment for traumatised refugee children is limited, CBT, EMDR, testimonial psychotherapy and NET are showing the most promise.

Narrative Exposure Therapy

Narrative exposure therapy (NET) was originally created in an attempt to meet the mental health needs of survivors of organised violence living in refugee camps. Since then, it has been conducted and researched with refugee and asylum seeker populations living in developed countries. NET incorporates aspects of CBT and testimony therapy (Robjant & Fazel, 2010). Testimony therapy was originally developed in Chile as a treatment for survivors of organised violence (Van Dijk, Schoutrop, & Spinhoven, 2003). There is increasing evidence that NET is particularly effective for both refugee and asylum seeking children and adults (Robjant & Fazel, 2010).

Neuner et al. (2010) compared NET with treatment as usual with asylum seekers living in Germany. They measured PTSD symptomatology, pain, and depression. Unlike most studies they did not exclude individuals who needed an interpreter or individuals with additional disorders, suicidal ideation or substance abuse, potentially making their findings more applicable to our client population. At post-treatment, they found significant reductions in symptoms of PTSD for those in the NET group compared to those in the treatment as usual (TAU) group. No improvements were observed with regard to depressive symptoms.

Although this research was conducted with a relatively small sample size (14 participants in NET group, 16 participants in TAU group), the findings are promising.

Stenmark et al. (2013) also compared NET to TAU with a larger sample of 81 participants and included both refugees and asylum seekers living in Norway. TAU was described as assistance with sleeping difficulties, depressive symptoms and problems related to asylum status. Treatment was ten 90 minute sessions of either NET or TAU. Their study yielded similar findings to those of Neuner et al. Participants were assessed using the Clinician Administered PTSD Scale, the Hamilton Rating Scale for Depression and the MINI Neuropsychiatric Interview. Participant symptoms in both treatment groups improved. However, they found significantly greater improvement as a result of NET for both refugees and asylum seekers in terms of reduction of PTSD and depressive symptoms and reduction in participants who met diagnostic criteria for PTSD. Interestingly, in 2014 the same researchers investigated the factors associated with treatment response in the aforementioned study (Stenmark, Guzey, Elbert, & Holen, 2014). They found that females were more likely to respond to NET than males and that those males who were violent offenders were the least likely to respond. Torture status, asylum status, age, or number of reported exposures to traumatic events did not account for differences in response.

Additionally, a meta-analysis of the literature documenting the effectiveness of NET for refugees concluded that based on the results from seven studies, NET produced treatment outcomes which had medium effect sizes and sufficient statistical power (Gwozdziewicz & Mehl-Madrona, 2013).

As mentioned, the effect of NET has also been explored in refugee and asylum seeker children (Robjant & Fazel, 2010). Ruf et al. (2010) found that eight sessions of Kidnet (NET adapted for children) resulted in reductions of PTSD symptoms compared to a waitlist control group in children aged 7-16 years living in Germany. The effect of this intervention appeared enduring as these reductions in symptoms were maintained at 12 month follow-up.

Cognitive Processing Therapy

Cognitive Processing Therapy (CPT), a manualised treatment designed as a 12 session protocol combines cognitive therapy with written exposure and is found to be effective for people with PTSD in the general population. One study has investigated the effectiveness of

Survivors of Torture and Trauma Assistance and Rehabilitation Service (STTARS): Clinical Services Review 2015

CPT with 53 refugees at a community health clinic in the US (Schulz, Resick, Huber, & Griffin, 2006). The sample included refugees from Afghanistan and the former Yugoslavia and approximately 66% of participants were survivors of torture. Interpreters were used with almost half of the participants. Using the PTSD Symptom Scale, they measured the outcome of 17 sessions lasting 1.5-2 hours in duration. Results showed significant improvement (reduction in PTSD symptoms) from baseline to post-treatment. They also found that there were no significant differences in treatment outcomes for those who required an interpreter and those who did not. Limitations include the lack of a control or comparison group and that the treating therapists assessed the post-treatment outcome.

Bolton et al. (2014) conducted a randomised controlled trial investigating two treatments: behavioural activation treatment for depression (BATD) and CPT for survivors of systematic violence in northern Iraq. They found that both interventions were effective for reducing depression and dysfunction (measured by HSCL and a locally developed dysfunction scale). Although CPT produced improvements in these studies, more research is needed.

Acceptance and Commitment Therapy

Aside from the research describing integrated principles of acceptance and mindfulness with CBT in treatment programs with refugees (Buhmann et al., 2015; Hinton et al., 2013), there is a lack of research in which ‘pure’ acceptance and commitment therapy (ACT) has been investigated with respect to refugee or asylum seeker clients. Follette, Palm, and Pearson (2006) suggest that mindfulness principles can be integrated into any traditional intervention for trauma and discuss the literature that has found ACT to be effective in the treatment of trauma in the general population. Orsillo and Batten (2005) describe how ACT can be implemented in the treatment of PTSD and along with Twohig (2009) provide a case example demonstrating the application of ACT in trauma treatment.

The evidence is scarce for the effectiveness of ACT as a stand-alone treatment with refugees, asylum seekers or even cross-culturally. However, the previously mentioned CA-CBT model clearly integrates acceptance and mindfulness techniques and has demonstrated how these components improve the cultural sensitivity of treatment. Therefore ACT and mindfulness should not be discounted as useful treatment components.

Interpersonal Therapy

Research looking at the use of interpersonal therapy with refugees is limited but worthy of attention as it has been found to result in significant improvements in low income countries and with traumatised groups. Comparison of NET with interpersonal therapy found NET to be more effective than interpersonal therapy for reducing PTSD in refugees in Rwanda. However, interpersonal therapy was still found to be effective as 29% of participants no longer met criteria for PTSD at six month follow-up (Schaal, Elbert, & Neuner, 2009). Group interpersonal therapy has been found to be effective cross-culturally. Bass et al. (2006) conducted a randomised control study examining group interpersonal therapy (n = 103) compared to TAU (113) with individuals in Uganda. At post-treatment and six-month follow-up they found significant reductions in depression symptoms as measured by the HSCL-25.

Betancourt et al. (2012) looked at outcomes of group interpersonal therapy with war-affected youth in Uganda. Compared to a creative play/ recreation group and a waitlist control condition, differences in outcome between gender and abduction history were observed. Improvements in depressive symptoms were observed in both males and females. However, interpersonal therapy was most effective among females without a history of abduction. Non- abducted males were the least likely to benefit from interpersonal therapy whereas abducted males did improve as a result of interpersonal group therapy. Interestingly, depressive symptoms increased from time one to time two for abducted males in the creative play group. Overall, more research is warranted regarding interpersonal approaches for refugee and asylum seeker survivors particularly as it may have specific usefulness in treating comorbid depression.

Narrative therapy- Tree of Life

The 'tree of life' is a narrative based therapeutic intervention and although there has been little research conducted examining its effectiveness, the available literature reports positive outcomes. Reeler, Chitsike, Maizva, and Reeler (2008) found that after delivering 'tree of life' to survivors of torture in Zimbabwe, participants reported better coping abilities at three month follow-up. More recently, Schweitzer, Vromans, Ranke, and Griffin (2014)

11

Survivors of Torture and Trauma Assistance and Rehabilitation Service (STTARS): Clinical Services Review 2015

documented their experiences of implementing a manualised version of ‘tree of life’ with a young woman from a Liberian refugee background living in Australia. They reported that using a narrative therapy approach assists refugee clients in integrating their past experiences with their preferred self-narrative and appears to help promote a sense of hope for the future. Other research reports integrating narrative approaches into other treatment models (Stepakoff et al., 2006).

Eye Movement Desensitisation and Reprocessing (EMDR)

As previously mentioned, there is a significant amount of literature documenting the effectiveness of EMDR for individuals presenting with PTSD in the general population (Australian Centre for Posttraumatic Mental Health, 2007; Shapiro, 2014). Although there has been some consideration of the effectiveness of EMDR with refugee populations, more research in this area is warranted. ter Heide, Mooren, Kleijn, de Jongh, and Kleber (2011) compared eight sessions of EMDR with stabilisation (establishment of safety in physical, cognitive-behavioural, interpersonal, and social areas of functioning, as advocated by Herman (1992)). Interpreters were used in therapy and the study included both asylum seekers (n = 3) and refugees. This study was limited by a high attrition rate (50%) leaving only five participants in each condition. Although difficult to draw conclusions with such a small sample, they concluded that it was feasible to treat refugee clients with EMDR and reported a small improvement in the EMDR group compared to individuals in the stabilisation condition which saw symptoms worsen from pre to post treatment.

EMDR was found to be effective when used in a psychodynamic context for children from refugee backgrounds (Oras, Ezpeleta, & Ahmad, 2004). In a study of 13 children in Sweden, researchers found a reduction in symptoms of PTSD and depression. Although these were promising results, there were again significant limitations to this study such as the low sample size and that the number of sessions of psychotherapy (5-25 sessions) and EMDR (1-6 sessions) varied dramatically across participants. Further, the lack of a comparison group means that we cannot know if it was the psychodynamic aspect of therapy, the EMDR or the combination of both that was causing the improvement. Finally, seven out of nine participants received residency while they were participating in the study and this would have likely had a significant impact on their scores at post-treatment.

Psychodynamic

In addition to the aforementioned research on EMDR in a psychodynamic context, research conducted in Germany following clients of a torture treatment centre examined the outcome of a predominantly psychodynamic approach (83% were treated with psychodynamic, as well as 7% with Gestalt therapy and 7% with systemic therapy) (Birk, 2001). They measured clients pre-intervention and at two-year follow-up. Treatment ranged from seven to 40 months, was conducted weekly and also included medical and social support. They found that two years post-treatment there were no observed changes in symptoms of PTSD, anxiety or depression. However, there were reductions in intrusion symptoms of PTSD and through qualitative interviews, clients reported clinically significant improvement in symptoms. Although this study has major limitations such as huge variation of length of time in treatment, no control group, and a mixture of interventions, it is considered useful in that it is conducted in a naturalistic setting (van Wyk & Schweitzer, 2014).

Dickerman and Alfonso (2015) discuss the difficulty in conducting psychodynamic psychotherapy involving interpreters. They consider the potential usefulness of 'split transferences' and the use of the interpreter as a cultural broker. However, they conclude there is insufficient evidence regarding how to work in a psychodynamic way with clients who require interpreters. Likewise, Baker, Izzo, and Trenton (2015) discuss conducting psychodynamic therapy with three examples of refugee background clients. Although not documenting the outcomes of therapy, they provide a consideration of involving interpreters in psychodynamic therapy. Katsounari (2013), on the other hand, documents a case example in which an interpreter was used in the majority of sessions of a psychodynamic therapeutic intervention with a 16 year old trauma survivor from a refugee background. Katsounari describes the progress of 16 weekly sessions with the client using relational psychodynamic therapy integrated with trauma focused psychoeducation as well as explaining the link between thoughts, feelings and behaviours. Using client self-report and clinician observation, it was noted that the client experienced a reduction in PTSD symptoms, changes in emotional expression and interpersonal contact, and an increased sense of agency. Although this paper has major limitations as it is a case study and as it did not use any objective outcome measures, it is a useful illustration of an integrated therapeutic approach which could be researched further. Overall, there is currently very little evidence for the effectiveness of 'pure' psychodynamic interventions with this population.

13

Group work

There is increasingly more research emerging which highlights the effectiveness of group interventions for refugee and asylum seeker populations. The most comprehensive research concerning group work for refugee and asylum seeker survivors of torture and trauma has been conducted by Drozdek and colleagues (2014). The 'Den Bosch' phase-orientated trauma group treatment model combines CBT, psychodynamic, imaginal exposure, empowerment, exploration of coping styles and supportive approaches and does so in the context of addressing multiple ecological factors (factors based on Bronfenbrenner's model but expanded on by Drozdek). The program combines verbal and non-verbal (psychomotor, art and music) therapies. The non-verbal component is included in acknowledgement of the difficulties survivors have in verbally expressing traumatic memories. The group program is 85 sessions (bi-weekly) for one year. This program has been found to be more effective than a control group for Iranian and Afghan males (Droždek, Kamperman, Bolwerk, Tol, & Kleber, 2012). Further, a seven year follow-up of this group treatment program collated data from seven treatment groups over a 12 year period (including the sample from the 2012 outcome study) (Droždek et al., 2014). This research found that the treatment resulted in reduction of PTSD, depression and anxiety symptoms at post-treatment and that this reduction was maintained up to five years post-treatment. Although symptoms started to worsen again after five years, at seven years the symptoms were still at lower levels than baseline.

Salem and Renner (2015) report findings from a randomised, controlled study comparing four interventions with asylum seekers and refugees from Chechnya. Participants (n = 94) were allocated to either 15 weekly 90 minute sessions of a guided self-help group, 15 weekly 90 minute sessions of group CBT, three sessions of EMDR or a wait-list control condition (no treatment, 15 weeks). Using the HTQ, the HSCL-25 and the post-traumatic growth inventory they found that the self-help group and the CBT group produced significant reductions in PTSD, depression, anxiety and somatoform symptoms compared to the wait-list control. These outcomes were maintained at three and six month follow-up. No changes were observed across time on the post-traumatic growth inventory and EMDR did not produce any effect after the three sessions.

Stepakoff et al. (2006) describe a phase-based group counselling program in West Africa. Their therapy model integrates elements of psychodynamic, relational/interpersonal, CBT, narrative, and expressive/humanistic approaches. They also state the importance of allowing expression of affect using drawings, drama and music and therefore integrated elements of West African culture into the program. This included healing rituals, traditional stories, drumming, clapping, and songs. There were 10 weekly sessions lasting approximately two hours each. Measures were administered at intake and one month, three months, six months and 12 months after intake. They report significant reductions in trauma symptoms and increases in social support and daily functioning as a result of group therapy. Although this research is limited by a lack of detail concerning measures, statistical analyses, and study rigour, it does describe powerful events qualitatively demonstrating the value of such a group program and its acceptance by refugee survivors of trauma.

Reading and Rubin (2011) have developed a group therapy program for lesbian, gay bisexual, and transgender (LGBT) asylum seekers and argue that the group context is particularly important to counteract social isolation, create a sense of safety, draw on the strengths of collectivist cultures, and promote a sense of solidarity and empowerment among group members. Likewise, Tucker and Price (2007) demonstrate how groups provide a safe structure and symbolic home for refugees and asylum seekers offering an environment in which clients can begin to process traumatic memories. Robertson, Blumberg, Gratton, Walsh, and Kayal (2013) describe their phase-based integrative group CBT orientated treatment program at The Traumatic Stress Clinic in the United Kingdom. They describe how they have adapted this model for refugee and asylum seekers survivors and present two case examples illustrating the beneficial and empowering aspects of being involved in group therapy. Given the rationale and wide use of group therapy with this population, there is a clear need for more evaluative research to be conducted on such group treatment programs. As previously mentioned, Drozdek's extensive and ongoing group evaluation research provides significant evidence of the benefits of group work for this population and therefore there is enough support that these approaches should continue to be developed, utilised and evaluated.

Casework and advocacy

A recent qualitative study conducted by Schweitzer, Wyk, and Murray (2015) found that therapists working with refugee clients emphasised the importance of assisting with practical resettlement needs in order to promote acculturation and improve client well-being. This was seen as particularly important as post-migration difficulties often exacerbate trauma symptoms. This perspective is supported by the guidelines for the treatment of acute stress disorder and PTSD which recommend holistic treatment when working with asylum seekers and refugees (Australian Centre for Posttraumatic Mental Health, 2007). In Drozdek's group treatment program, advocacy work is acknowledged as necessary in order for treatment to be suitable for this population. However, in this model they address advocacy and case work issues in a separate way (Drozdek, 2014). At the beginning of treatment it is negotiated with clients what they will focus on outside of the therapy group and allocate the afternoon session purely for settlement issues which are agreed upon by the group. These topics will include general settlement issues, life-stress, child-rearing, job/professional problems, medication issues, migration/ visa issues, and legal problems. Overall, it is widely acknowledged that the complex nature of these clients requires therapists to address practical issues in some way.

Complementary and alternative therapies

The efficacy of the use of complementary and alternative medicine (CAM) with torture and trauma survivors in the general population has been investigated through a systematic review conducted by the Department of Veteran Affairs in the United States (Strauss & Durham, 2011). They found there was surprisingly minimal research conducted on the topic despite the widespread use of CAM by trauma survivors. Of the research which was available, the findings indicated positive outcomes on PTSD symptoms and health-related quality of life. However, the studies rarely included a follow-up and were generally of poor-quality, therefore concluding that further research was needed.

Of greater relevance to torture and trauma survivors from refugee backgrounds, a review of the literature conducted by Longacre, Silver-Highfield, Lama, and Grodin (2011) examined the effectiveness of a variety of complementary and alternative therapies in the treatment of the mental and physical sequelae of torture and trauma. These therapies included meditation, dance and movement, spirituality, music, acupuncture, T'ai Chi, Reiki, or an integration of various CAMs. Although again finding that there was a lack of research

16

Survivors of Torture and Trauma Assistance and Rehabilitation Service (STTARS): Clinical Services Review 2015

conducted in this area, they conclude that the preliminary findings suggest these therapeutic approaches are an important component of the integrated treatment of torture and trauma survivors. They state “holistic treatments, including many CAM modalities, fundamentally recognise the interrelationship of the mind–body system, and view health as an ongoing process encompassing interdependent physical, psychological, and social factors” (p40). Due to the somatisation, chronic pain and physical injuries often seen in torture and trauma survivors, treatment should consider ways to simultaneously address these aspects. Although there is limited evidence and literature documenting the outcome of complimentary or alternative approaches such as massage and body work, preliminary and qualitative findings suggest clients certainly value these therapies (Longacre et al., 2011), with other studies reporting positive outcomes when certain CAMs are integrated with psychotherapy (Droždek, 2014; Hinton et al., 2012).

Conclusion

This review began by outlining some important considerations in the assessment of refugee and asylum seeker survivors of torture and trauma. Different therapeutic modalities were then listed and the available literature documenting their effectiveness has been discussed. While there is some evidence for the effectiveness of individual psychotherapeutic interventions in the treatment of PTSD, depression and other mental disorders among refugee and asylum seeker survivors of torture and trauma, the literature highlights the need for more research. CA-CBT, NET, and group interventions appear to be the most comprehensively studied and supported therapeutic approaches with adult refugees and asylum seekers (Lambert & Alhassoon, 2015) and this is also the case for refugee and asylum seeker children (Ehnholt & Yule, 2006). However, based on the treatment descriptions, it is apparent that these modalities often integrate aspects of other approaches such as ACT, mindfulness, narrative, and art and music based therapies in an attempt to make interventions more culturally appropriate and holistic. Although brief, this review has also acknowledged that the complex presentation of these clients often necessitates the therapist to address practical “non-clinical” needs as the broader socio-political and resettlement context of such therapeutic work is emphasised in the literature (McFarlane & Kaplan, 2012; Schweitzer et al., 2015). Additionally, the literature highlights that psychoeducation about trauma plays a fundamental role in therapy and therefore needs to be integrated into any treatment approach

(Cloitre et al., 2011). Overall, the interventions which are documented to possess the most evidence of efficacy and effectiveness for the treatment of PTSD are those which share two important therapeutic elements- exposure to the traumatic memory and cognitive processing of the meaning of their experiences (Droždek, 2014; Forbes et al., 2007). Therefore clinicians should ensure that they are including these two key aspects in any therapeutic approach. This of course requires a strong therapeutic alliance between client and therapist and a safe therapeutic environment. The establishment of such safety is reported to be facilitated by phase-based treatment models and the evidence supports the use of these (Cloitre et al., 2011; Droždek, 2014; National Institute for Clinical Excellence, 2005).

References

- Adeponle, A. B., Thombs, B. D., Groleau, D., Jarvis, E., & Kirmayer, L. J. (2012). Using the cultural formulation to resolve uncertainty in diagnoses of psychosis among ethnoculturally diverse patients. *Psychiatric Services, 63*(2), 147-153.
- American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders (DSM-5®)*: American Psychiatric Pub.
- Australian Centre for Posttraumatic Mental Health. (2007). *Australian guidelines for the treatment of adults with acute stress disorder and posttraumatic stress disorder*: National Health and Medical Research Council.
- Baker, S. W., Izzo, P., & Trenton, A. (2015). Psychodynamic considerations in psychotherapy using interpreters: Perspectives from psychiatry residents. *Psychodynamic psychiatry, 43*(1), 117-128.
- Bass, J., Neugebauer, R., Clougherty, K. F., Verdelli, H., Wickramaratne, P., Ndogoni, L., . . . Bolton, P. (2006). Group interpersonal psychotherapy for depression in rural Uganda: 6-month outcomes. *The British Journal of Psychiatry, 188*(6), 567-573.
- Betancourt, T. S., Newnham, E. A., Brennan, R. T., Verdelli, H., Borisova, I., Neugebauer, R., . . . Bolton, P. (2012). Moderators of treatment effectiveness for war-affected youth with depression in northern Uganda. *Journal of Adolescent Health, 51*(6), 544-550.
- Birck, A. (2001). Torture victims after psychotherapy: A two-year follow up. *Torture, 11*(2), 55-58.
- Bolton, P., Bass, J. K., Zangana, G. A., Kamal, T., Murray, S. M., Kaysen, D., . . . Murray, L. K. (2014). A randomized controlled trial of mental health interventions for survivors of systematic violence in Kurdistan, Northern Iraq. *BMC psychiatry, 14*(1), 360.
- Buhmann, C., Andersen, I., Mortensen, E. L., Ryberg, J., Nordentoft, M., & Ekstrøm, M. (2015). Cognitive Behavioral Psychotherapeutic treatment at a psychiatric trauma clinic for Refugees: description and evaluation. *Torture, 25*(1), 17-32.
- Cloitre, M., Courtois, C. A., Charuvastra, A., Carapezza, R., Stolbach, B. C., & Green, B. L. (2011). Treatment of complex PTSD: Results of the ISTSS expert clinician survey on best practices. *Journal of traumatic stress, 24*(6), 615-627.
- Derogatis, L. R., Lipman, R. S., Rickels, K., Uhlenhuth, E. H., & Covi, L. (1974). The Hopkins Symptom Checklist (HSCL): A self-report symptom inventory. *Behavioral science, 19*(1), 1-15.
- Dickerman, A. L., & Alfonso, C. A. (2015). Words Apart: The Challenge of Using Interpreters in Psychodynamic Psychotherapy. *Psychodynamic psychiatry, 43*(1), 129-134.
- Droždek, B. (2014). If You Want to Go Fast Go Alone, If You Want to Go Far Go Together: On Context-Sensitive Group Treatment of Asylum Seekers and Refugees Traumatized by War and Terror.
- Droždek, B. (2015). Challenges in treatment of posttraumatic stress disorder in refugees: towards integration of evidence-based treatments with contextual and culture-sensitive perspectives. *European Journal of Psychotraumatology, 6*.
- Droždek, B., Kamperman, A., Bolwerk, N., Tol, W. A., & Kleber, R. J. (2012). Group therapy with male asylum seekers and refugees with posttraumatic stress disorder: A controlled comparison cohort study of three day-treatment programs. *J Nerv Ment Dis*(200), 758-765.
- Droždek, B., Kamperman, A. M., Tol, W. A., Knipscheer, J. W., & Kleber, R. J. (2014). Seven-Year Follow-Up Study of Symptoms in Asylum Seekers and Refugees With PTSD Treated With Trauma-Focused Groups. *Journal of clinical psychology, 70*(4), 376-387.
- Ehnholt, K. A., Smith, P. A., & Yule, W. (2005). School-based cognitive-behavioural therapy group intervention for refugee children who have experienced war-related trauma. *Clinical Child Psychology and Psychiatry, 10*(2), 235-250.
- Ehnholt, K. A., & Yule, W. (2006). Practitioner Review: Assessment and treatment of refugee children and adolescents who have experienced war-related trauma. *Journal of Child Psychology and Psychiatry, 47*(12), 1197-1210.

19

Survivors of Torture and Trauma Assistance and Rehabilitation Service (STTARS): Clinical Services Review 2015

- Follette, V., Palm, K. M., & Pearson, A. N. (2006). Mindfulness and trauma: Implications for treatment. *Journal of rational-emotive and cognitive-behavior therapy*, 24(1), 45-61.
- Forbes, D., Creamer, M., Phelps, A., Bryant, R., McFarlane, A., Devilly, G. J., . . . Merlin, T. (2007). Australian guidelines for the treatment of adults with acute stress disorder and post-traumatic stress disorder. *Australian and New Zealand Journal of Psychiatry*, 41(8), 637-648.
- Grey, N., & Young, K. (2008). Cognitive behaviour therapy with refugees and asylum seekers experiencing traumatic stress symptoms. *Behavioural and Cognitive Psychotherapy*, 36(01), 3-19.
- Gwozdziwycz, N., & Mehl-Madrona, L. (2013). Meta-analysis of the use of narrative exposure therapy for the effects of trauma among refugee populations. *The Permanente Journal*, 17(1), 70.
- Hensel-Dittmann, D., Schauer, M., Ruf, M., Catani, C., Odenwald, M., Elbert, T., & Neuner, F. (2011). Treatment of traumatized victims of war and torture: A randomized controlled comparison of narrative exposure therapy and stress inoculation training. *Psychotherapy and psychosomatics*, 80(6), 345-352.
- Herman, J. (1992). *Trauma and recovery*: New York: Basic Books.
- Hinton, D. E., Chhean, D., Pich, V., Safren, S. A., Hofmann, S. G., & Pollack, M. H. (2005). A randomized controlled trial of cognitive-behavior therapy for Cambodian refugees with treatment-resistant PTSD and panic attacks: A cross-over design. *Journal of traumatic stress*, 18(6), 617-629.
- Hinton, D. E., Hofmann, S. G., Pollack, M. H., & Otto, M. W. (2009). Mechanisms of efficacy of CBT for Cambodian refugees with PTSD: improvement in emotion regulation and orthostatic blood pressure response. *CNS neuroscience & therapeutics*, 15(3), 255-263.
- Hinton, D. E., & Jalal, B. (2014). Guidelines for the implementation of culturally sensitive cognitive behavioural therapy among refugees and in global contexts. *Intervention*, 12, 78-93.
- Hinton, D. E., Pham, T., Tran, M., Safren, S. A., Otto, M. W., & Pollack, M. H. (2004). CBT for Vietnamese refugees with treatment-resistant PTSD and panic attacks: A pilot study. *Journal of traumatic stress*, 17(5), 429-433.
- Hinton, D. E., Pich, V., Hofmann, S. G., & Otto, M. W. (2013). Acceptance and Mindfulness Techniques as Applied to Refugee and Ethnic Minority Populations With PTSD: Examples From "Culturally Adapted CBT". *Cognitive and Behavioral Practice*, 20(1), 33-46.
- Hinton, D. E., Rivera, E. I., Hofmann, S. G., Barlow, D. H., & Otto, M. W. (2012). Adapting CBT for traumatized refugees and ethnic minority patients: Examples from culturally adapted CBT (CA-CBT). *Transcultural psychiatry*, 49(2), 340-365.
- Hollifield, M., Verbillis-Kolp, S., Farmer, B., Toolson, E. C., Woldehaimanot, T., Yamazaki, J., . . . SooHoo, J. (2013). The Refugee Health Screener-15 (RHS-15): development and validation of an instrument for anxiety, depression, and PTSD in refugees. *General hospital psychiatry*, 35(2), 202-209.
- Hollifield, M., Warner, T. D., Lian, N., Krakow, B., Jenkins, J. H., Kesler, J., . . . Westermeyer, J. (2002). Measuring trauma and health status in refugees: a critical review. *Jama*, 288(5), 611-621.
- Kar, N. (2011). Cognitive behavioral therapy for the treatment of post-traumatic stress disorder: a review. *Neuropsychiatric Disease and Treatment*, 7, 167.
- Katsounari, I. (2013). Integrating Psychodynamic Treatment and Trauma Focused Intervention in the Case of an Unaccompanied Minor With PTSD. *Clinical Case Studies*, 1534650113512021.
- Kleijn, W., Hovens, J., & Rodenburg, J. (2001). Posttraumatic stress symptoms in refugees: assessments with the Harvard Trauma Questionnaire and the Hopkins symptom Checklist-25 in different languages. *Psychological reports*, 88(2), 527-532.
- Kleinman, A., Eisenberg, L., & Good, B. (1978). Culture, illness, and care: clinical lessons from anthropologic and cross-cultural research. *Annals of internal medicine*, 88(2), 251-258.
- Lambert, J. E., & Alhassoon, O. M. (2015). Trauma-focused therapy for refugees: Meta-analytic findings. *Journal of counseling psychology*, 62(1), 28.

20

Survivors of Torture and Trauma Assistance and Rehabilitation Service (STTARS): Clinical Services Review 2015

- Longacre, M., Silver-Highfield, E., Lama, P., & Grodin, M. (2011). Complementary and alternative medicine in the treatment of refugees and survivors of torture: a review and proposal for action. *Torture: quarterly journal on rehabilitation of torture victims and prevention of torture*, 22(1), 38-57.
- McFarlane, C. A., & Kaplan, I. (2012). Evidence-based psychological interventions for adult survivors of torture and trauma: A 30-year review. *Transcultural psychiatry*, 49(3-4), 539-567.
- Mollica, R. F., Caspi-Yavin, Y., Bollini, P., Truong, T., Tor, S., & Lavelle, J. (1992). The Harvard Trauma Questionnaire: validating a cross-cultural instrument for measuring torture, trauma, and posttraumatic stress disorder in Indochinese refugees. *The Journal of nervous and mental disease*, 180(2), 111-116.
- National Institute for Clinical Excellence. (2005). The management of posttraumatic stress disorder in primary and secondary care. *London: NICE*.
- Neuner, F., Kurreck, S., Ruf, M., Odenwald, M., Elbert, T., & Schauer, M. (2010). Can asylum-seekers with posttraumatic stress disorder be successfully treated? A randomized controlled pilot study. *Cognitive behaviour therapy*, 39(2), 81-91.
- Nickerson, A., Bryant, R. A., Silove, D., & Steel, Z. (2011). A critical review of psychological treatments of posttraumatic stress disorder in refugees. *Clinical psychology review*, 31(3), 399-417.
- Oras, R., Ezpeleta, S. C. d., & Ahmad, A. (2004). Treatment of traumatized refugee children with eye movement desensitization and reprocessing in a psychodynamic context. *Nordic Journal of Psychiatry*, 58(3), 199-203.
- Orsillo, S. M., & Batten, S. V. (2005). Acceptance and commitment therapy in the treatment of posttraumatic stress disorder. *Behavior modification*, 29(1), 95-129.
- Paunovic, N., & Öst, L.-G. (2001). Cognitive-behavior therapy vs exposure therapy in the treatment of PTSD in refugees. *Behaviour research and therapy*, 39(10), 1183-1197.
- Reading, R., & Rubin, L. R. (2011). Advocacy and empowerment: Group therapy for LGBT asylum seekers. *Traumatology*, 17(2), 86.
- Reeler, T., Chitsike, K., Maizva, F., & Reeler, B. (2008). The Tree of Life: a community approach to empowering and healing the survivors of torture in Zimbabwe. *Torture: quarterly journal on rehabilitation of torture victims and prevention of torture*, 19(3), 180-193.
- Robertson, M. E., Blumberg, J. M., Gratton, J. L., Walsh, E. G., & Kayal, H. (2013). A group-based approach to stabilisation and symptom management in a phased treatment model for refugees and asylum seekers. *European Journal of Psychotraumatology*, 4.
- Robjant, K., & Fazel, M. (2010). The emerging evidence for narrative exposure therapy: A review. *Clinical psychology review*, 30(8), 1030-1039.
- Rohlof, H., Knipscheer, J. W., & Kleber, R. J. (2009). Use of the cultural formulation with refugees. *Transcultural psychiatry*, 46(3), 487-505.
- Ruf, M., Schauer, M., Neuner, F., Catani, C., Schauer, E., & Elbert, T. (2010). Narrative exposure therapy for 7-to 16-year-olds: A randomized controlled trial with traumatized refugee children. *Journal of traumatic stress*, 23(4), 437-445.
- Salem, I., & Renner, W. (2015). EDUCATING ASYLUM SEEKERS AND REFUGEES TO COPE WITH POST-TRAUMATIC STRESS: AN ETHNIC APPROACH TO PROFESSIONAL AND LAY INTERVENTIONS. *European Scientific Journal*, 11(10).
- Schaal, S., Elbert, T., & Neuner, F. (2009). Narrative exposure therapy versus interpersonal psychotherapy. *Psychotherapy and psychosomatics*, 78(5), 298-306.
- Schulz, P. M., Resick, P. A., Huber, L. C., & Griffin, M. G. (2006). The effectiveness of cognitive processing therapy for PTSD with refugees in a community setting. *Cognitive and Behavioral Practice*, 13(4), 322-331.
- Schweitzer, R., Vromans, L., Ranke, G., & Griffin, J. (2014). Narratives of healing: A case study of a young Liberian refugee settled in Australia. *The Arts in Psychotherapy*, 41(1), 98-106.
- Schweitzer, R., Wyk, S., & Murray, K. (2015). Therapeutic practice with refugee clients: A qualitative study of therapist experience. *Counselling and Psychotherapy Research*, 15(2), 109-118.

- Seah, E., Tilbury, F., Wright, B., Rooney, R., & Jayasuriya, P. (2002). *Cultural awareness tool: Understanding cultural diversity in mental health*: Multicultural Mental Health Australia.
- Shapiro, F. (2014). The role of eye movement desensitization and reprocessing (EMDR) Therapy in medicine: addressing the psychological and physical symptoms stemming from adverse life experiences. *The Permanente Journal*, 18(1), 71.
- Steel, Z., Chey, T., Silove, D., Marnane, C., Bryant, R. A., & Van Ommeren, M. (2009). Association of torture and other potentially traumatic events with mental health outcomes among populations exposed to mass conflict and displacement: a systematic review and meta-analysis. *Jama*, 302(5), 537-549.
- Stenmark, H., Catani, C., Neuner, F., Elbert, T., & Holen, A. (2013). Treating PTSD in refugees and asylum seekers within the general health care system. A randomized controlled multicenter study. *Behaviour research and therapy*, 51(10), 641-647.
- Stenmark, H., Guzey, I. C., Elbert, T., & Holen, A. (2014). Gender and offender status predicting treatment success in refugees and asylum seekers with PTSD. *European Journal of Psychotraumatology*, 5.
- Stepakoff, S., Hubbard, J., Katoh, M., Falk, E., Mikulu, J.-B., Nkhoma, P., & Omagwa, Y. (2006). Trauma healing in refugee camps in guinea: A psychosocial program for Liberian and Sierra Leonean survivors of torture and war. *American Psychologist*, 61(8), 921.
- Strauss, J. L., & Durham, V. (2011). *Efficacy of complementary and alternative medicine therapies for posttraumatic stress disorder*: Department of Veterans Affairs Health Services Research & Development Service.
- ter Heide, F. J. J., Mooren, T. M., Kleijn, W., de Jongh, A., & Kleber, R. J. (2011). EMDR versus stabilisation in traumatised asylum seekers and refugees: results of a pilot study. *European Journal of Psychotraumatology*, 2.
- ter Heide, F. J. J., & Smid, G. E. (2015). Difficult to treat? A comparison of the effectiveness of treatment as usual in refugees and non-refugees. *The Psychiatrist*, pb. bp. 114.047928.
- Tucker, S., & Price, D. (2007). Finding a home: Group psychotherapy for traumatized refugees and asylum seekers. *European Journal of Psychotherapy and Counselling*, 9(3), 277-287.
- Twohig, M. P. (2009). Acceptance and commitment therapy for treatment-resistant posttraumatic stress disorder: A case study. *Cognitive and Behavioral Practice*, 16(3), 243-252.
- Van Dijk, J. A., Schoutrop, M. J., & Spinhoven, P. (2003). Testimony therapy: Treatment method for traumatized victims of organized violence. *American journal of psychotherapy*, 57(3), 361.
- van Wyk, S., & Schweitzer, R. D. (2014). A systematic review of naturalistic interventions in refugee populations. *Journal of Immigrant and Minority Health*, 16(5), 968-977.
- Vindbjerg, E., Klimpke, C., & Carlsson, J. (2014). Psychotherapy with traumatised refugees-the design of a randomised clinical trial. *Torture: quarterly journal on rehabilitation of torture victims and prevention of torture*, 24(1), 40-48.

Appendix C: Paper Six

de Crespigny, C., Grønkjær, M., Liu, D., Moss, J., Cairney, I., Procter, N., Posselt, M., Francis-Jebaraj, H., Schultz, T., Banders, A., King, R., Lee, D., & Galletly, C. (2015). Service provider barriers to treatment and care for people with mental health and alcohol and other drug comorbidity in a metropolitan region of South Australia. *Advances in Dual Diagnosis*, 8(3), 120-128.

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Appendix D: Conference Abstract 1

The “too hard basket”: service delivery and support for young people of refugee background with mental health and substance use conditions.

Miriam Posselt^{1*}, Professor Cherrie Galletly¹, Professor Charlotte de Crespigny¹, Professor Nicholas Procter²

¹University of Adelaide, South Australia

²University of South Australia, South Australia

This paper presents findings from a qualitative study conducted in the disadvantaged northern region of Adelaide, South Australia. We investigated the cultural competency and responsiveness of mental health and drug and alcohol support services when dealing with young people from refugee backgrounds. The local government areas of Salisbury and Playford experience the highest proportion of people in receipt of government benefits, high unemployment rates, low levels of education and significantly high rates of mental health and substance use problems. This area also contains high proportions of people born overseas, people not fluent in English and people from refugee backgrounds. In the last 10 years 33% of humanitarian entrants to South Australia were resettled in the Salisbury and Playford areas. Of these, 62.2% were under the age of 25 years on arrival. Given the low socio-economic status of these areas and the large number of refugee youth who reside here, this region, and young people, were the focus of this study.

In-depth semi-structured interviews were conducted with both young people aged 12 -25 years from a variety of refugee backgrounds living in the northern suburbs, as well as health professionals working in various government and non-government mental health and drug and alcohol support services. Based on the findings from the youth and professionals, this paper discusses the main challenges that services are faced with when trying to engage and provide treatment to young people from refugee background with comorbid mental health and alcohol and other drug conditions. Thematic analyses indicated that barriers and facilitators to culturally competent service delivery related to the broad themes of access, knowledge and awareness, staff training, referral pathways, and resources. By considering the perspective of both the worker and the consumer, we discuss ways in which service provision can be improved for resettled refugee youth with comorbid mental health and alcohol or other drug conditions in this particular demographic.

Appendix E: Conference Abstract 2

The cultural responsiveness of mental health and drug and alcohol support services for resettled refugee youth in northern Adelaide

Miriam Posselt¹, Professor Cherrie Galletly¹, Professor Nicholas Procter² Dr Dennis Liu³, Professor Charlotte de Crespigny¹

¹*University of Adelaide, Adelaide, Australia*

²*University of South Australia, Adelaide, Australia*

³*Northern Mental Health Service, Lyell McEwin Hospital, Adelaide, Australia*

This presentation is part of the TRU NORTH Mental Health Research Group within The Northern Adelaide Local Health Network (NALHN)

Background: Over the last ten years South Australia (SA) has resettled 151,134 refugees under the humanitarian program. One third (33%) of these arrivals were resettled in the Salisbury and Playford areas of northern metropolitan Adelaide. The majority (63%) of refugees in this region were under the age of 25 years on arrival. Research indicates refugee youth are faced with multiple risk factors pre, during and post migration, placing them at risk of developing psychiatric and substance use disorders. Northern Adelaide is an area which experiences significant disadvantage with the highest proportion of people in receipt of government benefits in SA, high unemployment rates and low levels of education. The low socio-economic status of these areas and the large number of refugee youth residing there prompted investigation into whether the mental health (MH) and alcohol and other drug (AOD) services are adequately equipped and resourced to respond appropriately to this population.

Methods: Workers employed in a management or leadership role at a MH, AOD or related service which provides support to youth aged 12-25 years in northern Adelaide were invited to participate in an online survey. Information was collected concerning culturally appropriate service provision such as staff training, data collection and access to resources, funding and interpreters.

Results: Fifty-six participants took part in the survey (40 complete, 16 partially-complete). Participants indicated that their organisation engaged with individuals from a variety of cultural and refugee backgrounds. Despite this, findings highlighted inadequate data collection by services regarding this population, a lack of staff training and inadequate access to resources and funding. Only 15% of managers believed their staff were adequately trained to provide treatment to refugee clients.

Conclusion: Results yielded significant gaps in the service response for resettled refugee youth. Priority areas were identified and recommendations for organisations to improve their cultural competency and responsiveness are presented.