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Mental health help-seeking and refugee adolescents: Qualitative findings from a mixed-methods investigation

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Abstract

There is general agreement in Australia and other Western resettlement countries that many refugee adolescents with social, behavioural, and mental health problems are not accessing mental health care. There is, however, a paucity of research on refugee adolescent mental health service utilisation and help-seeking. Most research to date has centred on adolescents in the general population, and even then is still very limited. This paper presents the findings of 13 focus groups held with 85 refugee adolescents aged 13–17 years from Afghanistan, Bosnia, Iran, Iraq, Liberia, Serbia, and Sudan. The study was part of a wider investigation of mental health service utilisation by refugee parents of children aged 4–17 years, and by adolescents aged 13–17 years. With respect to adolescents, the focus group findings indicate that most are very reluctant to venture beyond their close friendship networks for help with their psychosocial problems due to a range of individual, cultural, and service-related barriers. Implications for mental health policymakers, service planners, and service providers are discussed.

Key words: *Adolescence, attitudes, beliefs, cross-cultural psychology, mental health help-seeking, refugee, values.*

Current knowledge suggests that refugee adolescents arriving in Australia may be at greater risk of a range of mental health problems associated with their pre- and post-migration experiences of loss, trauma, and disruption (Lustig et al., 2004). The Australian mental health-care system, however, is often culturally inaccessible to them (Senate Select Committee on Mental Health [SSCMH], 2006). Although various policy and program initiatives have been introduced to improve service uptake by refugee and other ethnic minority populations, there is very little knowledge to guide these efforts.

Mental health service utilisation and help-seeking research is scarce, and what is available generally centres on adolescents in the general population (Sawyer et al., 2001; Zubrick et al., 1995). There appears to be no Australian-based research on refugee adolescent service utilisation and, with the exception of a survey from the Netherlands (Bean, Eurelings-Bontekoe, Mooijaart, & Spinhoven, 2006), and a case–control investigation from Norway (Vaage, Garløv, Hauff, & Thomsen, 2007), very little international research. While both of these studies suggest that refugee adolescents are underrepresented in mental health services, neither sheds any light on why this may be the case.

There is a growing body of professional literature on the potential barriers affecting service uptake by refugee and other ethnic minority populations but this is mostly adult centred, and is based on clinical impressions and expert opinion (Andary, Stolk, & Klimidis, 2003; Gong-Guy, Cravens, & Patterson, 1991; Leong & Lau, 2001; Silove, 2005). Australian survey research with parents of adolescents in the general population has, however, found a number of actual and perceived barriers to services, including high cost of mental health care; lack of knowledge of services; not receiving the help sought; long waiting lists; self-reliance (Sawyer et al., 2000), and, for adolescents themselves, lack of knowledge about available services; negative beliefs and attitudes about the efficacy of professional help; stigma associated with mental health problems and help-seeking; concerns about confidentiality; and a belief that problems are better managed alone or with support from family

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(Rickwood & Braithwaite, 1994; Rickwood, Deane, Wilson, & Ciarrochi, 2005).

While some of these findings may be applicable to refugee adolescents, it cannot be assumed. The unique characteristics of this population group require targeted research. For the sake of brevity, the term ''help-seeking'' is used herein to refer to ''mental health help seeking''.

This paper presents the qualitative findings of a wider investigation of mental health service utilisation and help-seeking by refugee parents of children aged 4–17 years ($n = 462$), and by adolescents aged 13–17 years ($n = 162$) from Afghanistan, Bosnia, Iran, Iraq, Liberia, Serbia, and Sudan. The aim of this study was to fill a number of gaps in knowledge left by previous help-seeking research, including rates and patterns of service utilisation across service sectors, use of informal supports, and actual and perceived barriers to services.

With respect to the adolescent findings, survey results show that between 88% (according to parent reports) and 92% (according to adolescent reports) are not accessing any mental health services, whether they be in the specialist mental health sector, or in any other service sector where mental health care is potentially provided (e.g., primary health and education sectors). The focus group findings add an informative layer to these results.

Method

Participants

Thirteen focus groups were held with 44 male and 41 female refugee adolescents aged 13–17 years from the above countries. Most of the adolescents arrived in Australia between 2000 and 2007 as refugees or as the children of refugees according to the definition provided by the 1951 United Nations Convention Relating to the Status of Refugees. With the exception of a small number of Afghan adolescents who initially arrived in Australia as asylum seekers and/or family sponsored arrivals, all of the participants had access to the full suite of settlement support services at the time of arrival, including specialist mental health services. Despite this, most had no mental health service experience or exposure.

As detailed in Table 1, the focus groups were relatively homogenous with respect to age, gender, and ethnic/cultural background.

Materials

The focus group discussions were informed by a semi-structured interview guide consisting of a series of open-ended questions. Given that the Liberian and Sudanese adolescents were the most recent arrivals to Australia and were known to have less developed English language skills than the other ethnic groups, the interview guide was pre-tested with one male and one female non-participating adolescent from each of these communities first. Different language proficiency levels required some questions to be simplified. The revised guide was then pre-tested and used with the remaining ethnic groups to ensure consistency across groups.

Example questions from the Sudanese male version are as follows: (a) what is the first thing that comes into your mind when you think of the term ''mental health''; (b) what does it mean to young Sudanese guys to feel ''happy'' about life; (c) what does it mean to young Sudanese guys to feel ''unhappy'' about life; (d) do you have any thoughts or stories to tell about what young Sudanese guys do when they are ''unhappy'' (seek help, if so from where; drink; smoke; listen to music); (e) where do you think young Sudanese guys turn for help when they are ''unhappy''; and (f) what do you think stops young Sudanese guys from seeking help when they are ''unhappy''?

The terms ''happy'' and ''unhappy'' were used because they could easily be understood across cultures and they did not carry any obvious stigma that could preclude open communication about mental health issues (Cauce et al., 2002; Selvamanickam, Zgryza, & Gorman, 2001). The term ''help'' was used instead of ''service'' because many refugee arrivals come from countries where there are no equivalent or comparable services (Gong-Guy et al., 1991), and may not be familiar with the term ''service''. The above terms also provided more scope for the adolescents, as opposed to the researcher, to establish the parameters of discussion.

Procedure

A combination of convenience and snowball sampling was used to recruit the participants. A random sample could not be obtained because a refugee population register does not exist. Multicultural Youth South Australia, the State representative

Table 1. Subject characteristics

Afghan	Bosnian/Serbian	Iraqi	Liberian	Persian	Sudanese
8 boy (15–16 years)	5 boys (15–17 years)	9 boys (14–17 years)	7 boys (15–17 years)	8 boys (14–17 years)	7 boys (16–17 years)
8 girls (14–17 years)	5 girls (14–17 years)	8 girls (14–17 years)	8 girls (13–17 years)	6 girls (15–17 years)	6 girls (15–16 years)

advisory, advocacy, and service delivery body for young refugees and migrants, facilitated access to the target groups. The research was also promoted at schools, community services, English-language services, refugee social gatherings, and through ethnic media.

The final size of snowball and convenience samples is often determined by data saturation, which occurs at the point when no new information is obtained and additional recruitment becomes redundant. With respect to informal and formal help-seeking, saturation was reached after 10 groups but additional groups were held to reach saturation on other issues of concern, for example, refugee understandings of their problems and needs.

With the exception of the former Yugoslavian participants, the adolescents were known to each other. This was unavoidable because they came from small and close-knit communities.

Each focus group was conducted in English because most refugee adolescents resettled in Australia 12 months or longer are reasonably proficient in conversational English. With the consent of participants, however, a same-age, same-gender, and same-culture peer support worker was present during the discussions to assist with any communication difficulties that arose.

A record of each focus group discussion was obtained by way of note-taking and audio tape recording. Each discussion was transcribed verbatim, omitting extraneous noises. Abridged transcripts with superfluous dialogue removed were then prepared for analysis (Krueger & Casey, 2000).

The data were prepared, organised, and analysed using a thematic approach following the principles and procedures suggested by Krueger and Casey (2000; pp. 132–141). These authors recommend the traditional ''paper and scissor'' approach, which involves cutting transcripts apart and placing individual participant comments in piles on a long table under the relevant focus group question. In this study a spreadsheet developed with Microsoft Excel was used as another way to undertake this approach.

After individual comments had been copied and pasted across to the relevant focus group question, codes identifying themes (or what was observed in the data) were attached to passages of text. To ensure consistency in coding, passages of text that had been coded in a similar way were compared and, when a given passage did not fit as well with previously coded passages, it was recoded as something else. Codes were based on themes derived from both outside (relevant literature) and inside (new information) the data. As suggested by Kruger and Casey (2000; pp. 136–137), significance was given to themes or comments as follows: (a) frequency: comments made several times were generally accorded more significance than isolated comments; (b) specificity: specific comments and examples were generally accorded more significance than vague or general comments; (c) emotion: comments expressed with emotion, whether passion, enthusiasm, anger, or sadness, were accorded special significance; (d) extensiveness: comments made across groups were generally accorded more significance than those made within groups.

Member checking was used to establish the quality of interpretation during and after data collection. During data collection the participant responses were paraphrased and summarised to ensure congruence between what was reported and what was heard. Following data collection, written summaries of key discussion points, observations, and personal impressions were prepared for each of the peer support workers to review.

Although the workers did not disagree with the summaries, the process of member-checking itself had an impact on their original impressions, leading them to elaborate on the findings or to provide reasons for why participants responded the way they did. As former refugees themselves, they also had their own stories to share. These stories confirmed rather than contradicted the findings.

Results and discussion

The findings from both the male and female focus groups are presented together. Because participants were asked to comment on their own experiences as well as those of their same-age, same-culture friends and peers, some quotations refer to other people. The modifiers ''some'', ''many'', and ''most'' are used to identify the number of groups or participants who raised or supported a particular issue (Krueger & Casey, 2000; p. 141). Where relevant, individual, ethnic, and gender group differences are reported to reflect the range of issues and views expressed.

Informal help-seeking

The adolescents across and within groups consistently reported that they, and other young refugees from their cultural backgrounds, were much more likely to seek help for their psychosocial problems from friends than from any other source. Friends were considered enormously important and completely eclipsed the role played by parents, siblings, extended family, and other adults in their informal networks:

> *First you ask friends and then (if the problem gets worse) closer friends and then closer, closer friends.* [Persian male participant]

(We would tell friends first) because yeah the parents might find you weird (being) depressed. [Afghan female participant]

An important qualifying point needs to be made for both the male and female findings. Although the adolescents clearly preferred their friends, this does not mean that they actually confided in them. Four of the male groups explained that masculine behavioural norms about the expression of emotional and personal problems governed all peer interactions. To talk about an emotional problem is to run the risk of losing face and, as those in one group explained, this may be sufficiently worrying to prevent disclosure:

They just try to like act normal and stuff when they're with their friends and they are unhappy cos they might think like their friends will think differently of them if they actually came out with it or something. So they just try to keep it to themselves. [former Yugoslavian male participant]

For their part, the female participants in four groups expressed reservations about whether and to what extent friends could be trusted with personal information:

That's the problem, (the) real problem . . . you don't trust your friends. You don't trust them, you can't tell them. [Liberian female participant]

Most of the adolescents did not identify their parents and caregivers as a potential source of support, with many expressly stating that they would not turn to them for help with their psychosocial problems. The adolescents in nine groups explained that they came from a cultural context in which parent–adolescent relationships were characterised by less intimacy and more hierarchy than those of the West. Children were not encouraged or accustomed to talking to parents about personal problems because it would require an intimacy that could potentially disturb hierarchical structures and appropriate boundaries of interaction:

The parents don't discuss (issues) with teenagers and if they did I mean they would discuss things (that are) not serious. (They are minor) problems like "How, how was your day at school?" (rather than) how well the (young) person is going and so on. So usually this is not our culture, I mean, that parents discuss problems with their child in order to solve their problems. [Afghan male participant]

In the African groups the adolescents explained that children did not engage in open and direct communication with parents about personal problems, although they did consult parents about serious practical or legal problems and major life decisions:

You can't go and talk to your parent . . . (about) normal (ordinary) issue. If you have big problem like get in trouble with police and that problem (results in) like, going to court, then you can tell your parent . . . or if you (are thinking of getting) married. [Sudanese male participant]

Some adolescents also reported that parents who were recovering from previous war experiences were too psychologically distressed to provide supportive or consistent parenting:

The reason my dad said he gets drunk is because every night when he goes to dream, all he dreams about is the war. He's even been to the doctor's to get like some kind of mental health or mental help. He's even asked for any sleeping pills, anything just to put him to sleep so he doesn't have to dream about that. And he says that alcohol's the only thing that can help him to forget about that. [former Yugoslavian female participant]

It can be strongly inferred from the focus group discussions when taken as a whole, however, that an important underlying issue affecting the apparent low reliance on parents was a desire for a space that was free of adults – whether they be parents or any other adult. The adolescents explained that personal issues were shared with friends because they "understand you better" and "know what you're going through". Parents, in contrast, did not understand young people, and could not be expected to, due to a wide disparity in the experiences, values, and behavioural norms of the older and younger generations:

A lot of younger people would think that they've got different problems than the older people so they won't really understand as well. [former Yugoslavian male participant]

Even if we do tell them our problems, I don't think they'd understand . . . they can't relate to it. [Persian female participant]

Some of the informal help-seeking findings are consistent with what is known about the help-seeking behaviour of adolescents in the general Australian population and some are not. The apparent high reliance on friends finds agreement (Rickwood & Braithwaite, 1994; Rickwood et al., 2005), but the apparent low reliance on parents does not (Rickwood & Braithwaite, 1994; Rickwood et al., 2005).

Formal help-seeking

The adolescents across and within groups consistently reported that they, and other young refugees from their cultural backgrounds, did not and would not venture beyond their informal networks

for professional help with their psychosocial problems:

> *Why would I do that?* [Iraqi female participant]
>
> *Nobody does it . . . they usually tell their friends if they need help*. [Iraqi male participant]
>
> *I won't go to school counsellor*. [Liberian female participant]
>
> *They don't really want anyone else to know*. [former Yugoslavian male participant]

Reasons for not turning to professional sources include low priority placed on mental health; poor mental health and service knowledge; distrust of services; stigma associated with psychosocial problems and help-seeking; and various social and cultural factors affecting how problems are understood, whether help is sought, and from where.

Low priority placed on mental health

The adolescents placed very little importance on psychological issues, identifying instead as their most important concerns family separation, intergenerational conflict, educational difficulties, economic hardship, and various other problems associated with cultural transition and resettlement. Above all else, they wanted tangible opportunities to participate in society:

> *Last year I wanted to play cricket and then it was like $180. I asked my dad and he didn't have the money . . . I felt so low . . . I was thinking of leaving school even . . . I felt so low . . . felt like leaving home . . . Cricket is my favourite sport and I (did not get to) play this for one year . . . I still don't play cricket.* [Afghan male participant]

Moreover, some adolescents attributed mental health problems to social rather than psychological aetiologies. Some of the Afghan and African male participants, for example, attributed mental illness to racism:

> *We are from Afghanistan . . . they (the general public) say, ''You're (from) Afghanistan. Terrorist! Terrorist!'' and (they) keep blaming, keep always . . . harassing him so he will also get a mental illness*. [Afghan male participant]

Other work with refugee adults has found that mental health problems can be attributed to social aetiologies. Qualitative research with Somali refugees, for example, found that insomnia and rumination – symptoms of post-traumatic stress disorder – were attributed to family separation (Guerin, Guerin, Diiriye, & Yates, 2004).

Although that study did not investigate cross-cultural differences in the expression and manifestation of mental health problems, the literature suggests that it is not uncommon for some refugee population groups to display somatic symptoms and complaints when experiencing psychological distress (Hodes, 2000).

Mental health and service knowledge

Many adolescents had little to no knowledge of common mental illnesses and most also lacked knowledge of mental health services. Most of the adolescents in the four African groups had not even heard of the terms ''mental health'' and ''mental illness'', let alone the services established to address psychological problems. Confusion over these terms in one of the female groups prompted the peer support worker to interject in the discussion:

> *(Addressing the girls) Okay, you know back home? Mental health – people are crazy who dance (in the street) and shit? Aha! Those are the people we are talking about. Those ones who run around. Over there, we don't call them mental, just people who are crazy . . . But . . . here it's different. Somebody might not dance in the street. They might be dressed in a suit and still have a mental problem . . . or at school you might notice some people are too excited. Or some people, they always sad and some people they up and down . . . Those are sometimes the symptoms of someone who has a mental health problem. So now you get the picture? (Girls nod)*

While the remaining groups demonstrated a more developed understanding, it was still very limited overall. Poor mental health literacy is of course not unique to refugee populations (Jorm, 2000). The stakes may be higher for refugees, however, given their elevated risk of mental health problems and their greater difficulty in accessing mental health knowledge and services.

Trust and distrust

Distrust of mental health services and helping professionals was a central theme in most groups and this was generally expressed in negative beliefs about their capacity and/or willingness to help. Some of the adolescents based their perceptions on their own or their friends' negative experiences with helping professionals, while others expressed their distrust more generally without referring to actual experiences:

> *Me, myself, if I get in the hardest trouble, like the bad, worst thing ever, I would never go anywhere. I would just keep it to myself cos I think they're not helpful.* [Afghan male participant]

The adolescents in seven groups expected services to have low cross-cultural awareness and competency:

If the counsellor, she wasn't like from your culture or religion, she won't understand you . . . you don't feel like she's (the) same as you. [Iraqi female participant]

(I told) some of my friends (about the services that are available), they say: ''No (I will not go) cos they are not from my background, they are not from my culture. They don't know.'' [Afghan male participant]

While many adolescents initially reported that they were more likely to seek help for their psychosocial problems from a same-culture professional, when questioned further they explained that being able to trust the helping professional was more important than their ethnic, cultural, or religious background:

It depends on the person. You've got to have someone trustworthy. [Iraqi male participant]

An important finding of relevance concerns the use of same-culture professionals and paraprofessionals. Most of the adolescents reported that they, and other young refugees from their cultural backgrounds, would not access a mental health service if it was staffed by a same-culture professional or paraprofessional who was known to, or potentially known to, their families and broader ethnic community. It was suggested that any young person contemplating confiding in a same-culture community member needed to allow for the possibility, even the likelihood, of personal information being disclosed to his or her parents and broader community:

If I knew that person, and they knew my family, I wouldn't go near that place cos they might tell our parents. [Iraqi male participant]

When I'm depressed . . . if I go to the community member, they will take the issue here to the next level then that's how it will be spreading all over. [Liberian male participant]

While distrust of same-culture professionals was evident in most groups, it was more pronounced in the female groups overall. Female participants attributed this to excessive community monitoring and surveillance of girls and women. Some even suggested that an important prerequisite for mental health help-seeking was that the helping professional not be from the same ethnic/cultural background:

I thought to myself, ''Yep, she's not Serbian. She's not going to say (anything). She doesn't know my dad. She doesn't know my uncle. She doesn't know my aunty. She doesn't know my cousins. She's not going to judge me.'' And sometimes people go, ''Why would you want to tell a complete stranger?'' It's because you're surrounded by people that you're so worried (about) how they're going to perceive you to be. And when you talk to a stranger you're like, you know, ''This is good. I'm telling.'' [former Yugoslavian female participant]

Many adolescents also cited a very commonplace reason for not trusting helping professionals: they are strangers. Although it may be acceptable and even preferable to seek help for a personal–emotional problem from an unknown professional in a Western cultural context, this did not make sense to them:

I don't feel comfortable, you know, talking with someone I don't know. [Afghan male participant]

It's just you wouldn't talk to them. I don't feel like they should know about my problems. [former Yugoslavian female participant]

The general findings about trust and distrust are consistent with what is known about the help-seeking behaviour of adolescents in the general population (Rickwood et al., 2005), but the specific distrust expressed towards same-culture professionals conflicts with what is known about the help-seeking behaviour of refugee adults (Silove et al., 1997). How is this to be explained? Perhaps adolescents are more concerned about confidentiality than adults. Another possible explanation is that the need for same-culture professionals is less protracted for adolescents due to their quicker English language acquisition and acculturation to Australian society.

Stigma and misconception

Stigma associated with mental illness and help-seeking was present to a varying extent in all groups, although it was more pronounced among the male groups overall. Many adolescents made no distinction between ''mental health'' and ''mental illness'', equating both with ''craziness'' and describing the mentally ill as ''retarded'', ''weird'', ''sick'', ''crazy'', ''abnormal'', and ''psycho''. Mental illness was perceived as a source of shame and something to be hidden and, according to two groups, those affected and their families were obliged to conceal it to preserve their social status and marriage prospects:

The parents has to find a daughter-in-law for themselves. That's the real point. Like no one, no one, will accept the proposal of crazy guy. [Afghan male participant]

Stigma specifically associated with school counselling was evident in five groups, with visits to the school counsellor reported to attract significant peer disapproval:

I'm a bit worried. If I need to go and see the counsellor and if I walk in, I'll be like, ''Oh god. Did someone saw me? What

are they going to think of me?'' You know?'' [former Yugoslavian female participant]

People might think you're crazy or something. They would. They would think that. [Iraqi male participant]

Many adolescents also held misconceptions about mental illness, for example, that all mental illness was the same; that you could always tell when a person had a mental illness; and that mental illness was a lifelong condition, with little hope of recovery. With the exception of three groups, it was suggested that only the most serious and disabling conditions indicated the presence of mental illness, and in two groups it was also suggested that mental illness did not affect children and adolescents because they had less to ''worry about'' than adults.

Cross-cultural differences in explanatory models

The adolescents had their own explanatory models of mental illness and, in the African groups particularly, these differed markedly from those of the West. In both of the male groups, for example, mental illness was attributed to supernatural causes (the devil and witchdoctors) rather than psychopathology. Witchdoctors were said to be able to cause mental illness, disease, death, and a range of other misfortunes:

Sometimes craziness maybe come from devil cos I've known a lot of people from my cultural background (who have been victims). We have like – I don't know how to say it in English – witches, we have something like that. [Sudanese male participant]

Asked whether witchdoctors were available in Australia, some of the adolescents thought not and some were unsure, but this was immaterial because the witchdoctor's power and reach was believed to extend far beyond Africa. One Liberian participant, for example, explained that his jilted ex-girlfriend could take a photograph of him to a witchdoctor and ''tell him what to do'', either ''kill me'' or ''make me go crazy''.

The African participants also reported cultural differences in the treatment of mental illness. People were said to be treated by a medicine man who prescribed physical and spiritual traditional remedies, or, if they were the victims of witchcraft, they would be treated by a witchdoctor who performed a spell reversal. Those with Christian beliefs were said to be treated by church elders, initially with prayer and then with an exorcism if found to be possessed by an evil spirit.

Some of the female participants explained that African families living in Australia continued to rely on traditional knowledge and healing for a range of physical and mental health problems, if necessary sending away to Africa for indigenous treatments and remedies.

Family privacy

Another issue affecting service uptake identified by seven groups concerns an expectation that personal and emotional problems will be kept inside the family. Afghan, Iraqi, and Persian participants in particular spoke of the shame involved in discussing personal problems with ''outsiders'':

It's all shame, like you might be ashamed of telling your problems to other people. Like, you know, the school counsellor or organisations, you would be ashamed in your soul. [Persian male participant]

They (parents) would make you know that, ''Oh, I'm really disappointed in you. How could you do this to me? Now how can I go outside? People (will) know that my daughter did this to me. You ruined everything.'' [Afghan female participant]

In summary, this study found that refugee adolescents are much more likely to seek help for their psychosocial problems from their friends than from any other source, although the extent to which they actually avail themselves of these resources is in question given the various factors that can and do intervene to prevent friend-to-friend help-seeking. Very few adolescents identified parents as a potential source of help, and even less identified mental health services.

Conclusions

Most of the adolescents lacked the prerequisite service knowledge to access mental health care. This can largely be attributed to a failure on the part of the mental health system to effectively engage refugee and other ethnic minority populations (SSCMH, 2006). Mental health services can improve their service promotion to refugee adolescents by building direct relationships with refugee communities and by establishing intersectoral and interagency partnerships with the wider social service system, including primary health care services, education-based services, and the various settlement agencies that have extensive contact with refugee communities (Hodes, 2000, 2002a,b; Leiper de Monchy, 1991).

Given the distrust expressed towards helping professionals and agencies, trust needs to be established before refugee adolescents will access mental health services and, once they do access services, this trust needs to be consolidated before attempting problem solving. Although this resonates with the general adolescent help-seeking literature (Rickwood et al., 2005), the question remains as to how trust is to be established with refugees who typically do not

discuss their problems with those outside their close informal networks, and who generally have poor mental health and service knowledge.

Of central importance is planned, regular outreach. If refugee adolescents will not go to services, then services must go to them. Rickwood et al. (2005; p. 22) made a similar recommendation when their help-seeking research with youth in the general population yielded similar findings.

Mental health services also need to be offered to adolescents in a form that they can accept. The results of this study suggest that services are more likely to be acceptable if they respond to social and practical concerns in addition to mental health needs (Hodes, 2000, 2002a,b); if they are staffed by culturally astute professionals (Andary et al., 2003); if they are offered in youth-friendly, non-stigmatising community settings (Miller & Rasco, 2004); and if they include youth expertise in service planning, development, and evaluation (Watters, 2001). If same-culture professionals and paraprofessionals are used, special precautions should be taken to ensure that they understand and comply with confidentiality requirements, and adolescents should always be consulted about their preferences.

The findings also suggest a need for school-based education programs to improve mental health literacy, although such efforts should be sensitive to refugee explanatory models of mental health and illness. Given the importance placed on friend-to-friend help-seeking, school-based programs should also aim to support and educate friends and peers who can influence professional help-seeking (Rickwood et al., 2005).

A final consideration concerns whether alternative approaches to refugee mental health may help reduce cultural barriers and improve service uptake by refugee adolescents. Service responses based on refugee cultural meaning systems and healing practices are advocated in the professional literature (Leiper de Monchy, 1991; Minas, 1990), and hold promise (Andary et al., 2003), but they need to be formally researched and evaluated, as do more conventional approaches (O'Shea, Hodes, Down, & Bramley, 2000).

In any case, there is evidence to suggest that cultural barriers are not insurmountable providing that the mental health system is willing to make the necessary changes and adjustments to accommodate the needs of refugee populations (Hodes, 2002a,b; Howard & Hodes, 2000; Nadeau & Measham, 2006; O'Shea et al., 2000).

The continuing presence of major barriers to mental health care for refugee adolescents is an important policy and practice issue that requires attention. The limitations of the study, however, need to be acknowledged. The findings cannot be strictly generalised to the wider refugee adolescent population, although they are likely to have wider applicability. The one-off nature of the focus group method provides a limited account of help-seeking. In-depth knowledge can be acquired only by utilising longer-term, community-based participatory research methods (Guerin & Guerin, 2007).

An important area for further research concerns the impact of culture on mental health help-seeking. Although culture is frequently identified in the professional literature as an important factor in the underutilisation of mental health services by ethnic minority parents and adolescents (Andary et al., 2003; Cauce et al., 2002), research is scant, particularly as it pertains to refugees. Areas requiring further investigation include the impact of culture on how problems are understood, whether help is sought, and from where.

Also neglected are the barriers to, and facilitators of, professional help-seeking, including service system and structural barriers. Previous ethnic minority research has generally centred on professional bias and problems associated with assessment and diagnosis, neglecting the broader structural barriers to mental health care, for example, policy decisions that affect the type and number of services available to refugee families.

Another important area for further research concerns refugee experiences of, and satisfaction with, services, particularly school-based counselling services and child and adolescent mental health services. Very little is known about refugee service satisfaction and even less about service efficacy.

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